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Walden University
2023

Abstract

Family Perceptions of Mental Health Service Use Among Mexican Americans

by

Vickie Nethercott

MSN, California University Dominguez Hill, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

February 2023

Abstract

Mexican immigrants are less likely to use psychiatric services compared to people from other race or ethnic groups in the United States, yet little is known about the reasons why the Mexican American population are less likely to seek mental health services. A qualitative descriptive study, guided by Leininger's culture care diversity and universality care theory, was used to explore the perceptions of mental health service use and barriers to psychiatric services for Mexican American immigrants living in the United States. After institutional review board approval was obtained, flyers were placed in five churches in a northwestern U.S state where Mexican Americans attended. Six volunteers for the study were family members of Mexican immigrants who experienced mental health issues, and consented to participate in face-to-face interviews using semi-structured and open-ended questions. Interviews were recorded then manually transcribed for analysis using Miles, Huberman and Saldana's method of qualitative thematic analysis. Three themes resulted from the analysis: Mental health is a private and individual issue, culture plays a role in accessing mental health care, and religion contributes to decisions to seek mental health services. Results of this study may contribute to positive social change as providers become aware of the unique cultural and religious beliefs that influence Mexican Americans' access to psychiatric health services. Future studies are needed to identify educational strategies that promote access to mental health services for Mexican American patients and families.

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Dedication

This is dedicated to my family: my sons, Brandon, Bucky, Trevor, Trenton, and Tristan; my daughter, Autumn; and my parents, Edward Fleming and Paula and Frank Toth.

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I would like to thank those people who have provided guidance and support during this experience: Janice M. Long, PhD; Rachel Pittman, PhD; Maria Ojeda, PhD; and Marilyn Losty, PhD.

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Chapter 1: Introduction to the Study

The U.S. population comprises 57.5 million people of Hispanic origin, with people of Mexican origin constituting 36.3 million (63.2%) of the total U.S. Hispanic population. The U.S. Census Bureau (2012) projected an increase to 26.5% of people of Hispanic origin by 2060, making Hispanics the third fastest growing ethnic population in the United States. With people of Mexican origin making up over 60% of the Hispanic population, the Mexican population growth may exceed that of other racial/ethnic populations (U.S. Census Bureau, 2012). The U.S. Census Bureau (2020) Hispanics were 18.9% with the overall population of 62.1 million Hispanics living in the U.S. In 2020 (2022) Mexicans ranked the largest population in the U.S. at 61.6 percent. Although the growth of the Mexican immigrant population has slowed since 2008, people of Mexican origin are still the largest driver of population growth in the United States (Flores, 2017) with the United States being home to the largest Mexican community in the world outside of Mexico.

The Mexican population in the United States is a vulnerable group due to challenges and barriers to acculturation, limited health literacy, shortage of Hispanic health care providers (HCPs), and uninsured or underinsured status of the population that often results in limited access to health care (Velasco-Mondragon et al., 2016). Barriers that further contribute to the population’s vulnerability are those related to mental health access to care. Only about 20% of Mexican Americans who live with mental illness have shared their symptoms or concerns about their mental health with their provider (Villatoro et al., 2014). Reasons for Mexican Americans not speaking of their mental health symptoms to their provider may be related to not realizing that their symptoms are not something that everyone faces. They may not recognize anxiety, depression, posttraumatic stress, alcoholism, or suicide as symptoms of mental illness (Lopez et al., 2012). Mexican Americans may see mental illness conditions as a sensitive subject and as a result may not be willing to share their experiences. Therefore, working with the family of the Mexican population with mental health problems is essential. Researchers who addressed other ethnic groups have utilized the family as a source of information about people who suffer from psychiatric conditions. Researchers have focused on how a family member feels about their family member's psychiatric condition, which has contributed insights into the experiences of the person who has a mental illness and to their family's feelings (Price-Robertson et al., 2012). The population addressed in the current study is referred to as Mexican Americans or Mexican immigrants living in the United States.

Mexican Americans not only contribute to the U.S. population but make up a significant portion of the population that faces health disparities and often lack access to health care services or to quality health care services compared to those received by their White non-Hispanic counterparts (Institute of Medicine, 2003). The Institute of Medicine (2003) addressed health disparities and inequalities for ethnic minority populations such as Mexican Americans by recommending actions by all HCPs, administrators, professionals, policymakers, and consumers of all racial groups to establish trusting relationships with ethnic minority populations. One such area that is disproportionally lacking among Mexican Americans is mental health. Although research has demonstrated that the rates of mental illness among Mexican Americans are similar to rates of mental illness among their White non-Hispanic counterparts, historical and sociocultural factors suggest that the need for mental health services is greater among Mexican Americans (Keys et al., 2012; Office of the Surgeon General, 2001).

Healthy People 2020 promoted the goal of improving mental health by encouraging prevention and ensuring access to quality psychiatric health services (PHS) to all, regardless of their cultural differences (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2010). Disparities in PHS due to cultural and societal barriers often contribute to underutilization of PHS by many ethnic minority patients (Rastogi et al., 2012). Cook et al. (2017) demonstrated that cultural and societal barriers impede access to PHS. Little progress has been made toward meeting the goals of Healthy People 2020 (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2010).

Despite mental health becoming more widely acknowledged and accepted, many cultures within the U.S. population . deny the existence of mental illness and as a result do not seek appropriate care (Henderson, 2013). For many, the term *mental illness* has a negative connotation because it separates what is whole and normal with what is considered abnormal and different (Dichoso, 2010). Among the Mexican immigrant population, mental illness is a condition that is hidden (Naso, 2016) and often ignored because having a mental health condition may be considered shameful to the family. Mental illness may place stress and strain on personal relationships within the Mexican immigrant family, which often results in ambivalence among the family members (Naso,

2016) in addressing appropriate treatment for the illness. As a result, families are prone to experience the dilemma of caring for an ill family member while experiencing shame with the family as well as the stigma mental illness places on them within their community (Naso, 2016).

As a result, Mexican immigrants may not seek treatment because of the shame and stigma associated with mental illness in the Mexican culture (Naso, 2016; National Alliance on Mental Illness, 2017). For this study, I used qualitative methodology to explore the perceptions of family members of Mexican immigrants living in the northwestern United States to identify the factors that impact psychiatric health and health care access that Mexican immigrants experience in the United States. The study may lead to an understanding of the perceptions related to psychiatric health services in the United States and how access to the services affect patients and families, which may promote the development of strategies that could assist in improving psychiatric care among the Mexican immigrant population.

Chapter 1 provides an introduction to the study. The background includes a brief review of the literature on Mexican immigrant mental illness and their families. The problem statement, purpose of the study, research question, and theoretical framework used to frame the study are also presented. Last, I present the nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study.

Background

Over 4.6 million people in the United States, or 1 in 5 adults, experience a mental illness in their lifetime (National Institute of Mental Health, 2018). However, people from racial and ethnic minority groups are less likely to have access to mental health services and are more likely to delay or seek treatment as compared to their White counterparts (McGuire & Miranda, 2008). Healthy People 2020 reported the need to eliminate these psychiatric care disparities due to cultural differences (Institute of Medicine, 2003; U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2010). A study of Mexican American immigrants found that only a small percentage of Mexican American immigrants seek out mental services, and a larger percentage does not access PHS because of cultural differences such as using alternative medicine and failure to acknowledge psychiatric conditions (Derr, 2016). Derr (2016) posited that improved psychiatric treatment rates can be achieved if access to PHS is promoted and encouraged among ethnic minority populations; however, few researchers have addressed the experiences and health-seeking behaviors of Mexican immigrants’ families in relation to accessing effective PHS for their family members (Derr, 2016; Villatoro et al., 2014).

Immigrant status of Mexican Americans is a social determinant of health that contributes to the disparities of health care access for the Mexican immigrant (Immigration as a Social Determinant of Health, 2018). Observed disparities have been seen in treatment of vulnerable populations with severe mental illness, such as using psychiatric emergency services versus services in community settings, being less apt to seek initial treatment, receiving poorer quality of care, and having poorer treatment outcomes (Maurai & Weisman de Mamani, 2017). The major factor that contributes to these disparities is the associated stigma of mental illness (Maurai & Weisman de Mamani, 2017). The general mistrust that decreases confidence in PHS is the lack of engagement in the Mexican American with mental health problem's (Maurai & Weisman de Mamani, 2017). Little research has been done to address this gap in the literature in which inconsistent and limited information on the connection between Mexican immigrant family members and the impact mental illness has upon their family dynamics is available (Alegria et al., 2007; National Institutes of Health, 2001).

Little is known about Mexican immigrants with psychiatric disorders who seek help for their psychiatric illness. Potential issues that prevent access to PHS include a lack of information and misinformation about mental illness, lack of privacy, language barriers and cultural competency, lack of insurance, legal status, cultural beliefs such as reliance on faith and alternative medicine, and the stigma associated with mental illness (Guarnaccia et al., 2005; Interian et al., 2007; Lewis-Fernandez et al., 2005; National Institutes of Health, 2001). The influence of these factors has not been clarified, so it is not known whether one factor is dominant in preventing Mexican immigrant families from accessing PHS or to what extent the family perceives their family member's care is affected by these factors.

The reasons behind the lack of PHS utilization by ethnic minorities are dependent on several factors. No studies were identified that addressed the immigrant family or the depth and extent of the family's influence on their family member's access to mental illness care. Alegria et al. (2007) studied Mexican Americans as a whole but did not address Mexican immigrants as a group. Undocumented Mexican immigrants are less likely to come forward for any type of medical treatment, including PHS. Furthermore, undocumented Mexican immigrants do not qualify for help due to local and federal restrictions (Cleveland, 2011). Sound conclusions regarding mental health and undocumented Mexican immigrants have not been validated, and more studies are needed to understand the experiences of Mexican immigrants who live with mental health-related problems (Alegria et al., 2007; Sullivan & Rehm, 2005).

With the high number of Mexican immigrants in the United States, the need for changes in health care delivery is pressing (Alarcon et al., 2016). The steady growth of Mexican immigrants in the U.S. population makes providing adequate mental and physical health care imperative and raises awareness among care providers of the need to understand the mental health care experiences of this population (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2010). Researchers have examined the factors that prevent Mexican immigrants from accessing PHS (Bario et al., 2008; Dubard & Gizlice, 2008; Pérez-Escamilla, et al., 2010), yet little is known about how Mexican immigrants perceive access to PHS.

The Hispanic American community includes groups from many different countries and ethnicities (e.g., people from Latin and Central America, Puerto Rico, and Mexico). Many are new to the United States, while others have lived in this country for many years. They face a multitude of inequities related to education, social status, and access to health care (American Psychiatric Association [APA], Office of Minority and

National Affairs, 2010). The U.S. population consists of 36 million people who identify as Hispanic American (Zong & Batalova, 2017). Over one third of this population are younger than 18. Disparities in PHS use are noted in the Mexican American population across all age groups (Office of Minority and National Affairs, 2010). The most at-risk groups of Mexican Americans are older adults and youths. The youths and older adults are vulnerable due to psychological stressors such as acculturation and immigration (APA, Office of Minority and National Affairs, 2010). One in 10 Mexican Americans are likely to see a general practitioner for their mental illness, while only 1 in 20 see a psychiatrist. In comparison to 27.3% of Mexican Americans who use PHS, 46.3% of non-Hispanics use PHS, 29.8% of Black or African Americans use PHS, 41.6% of American Indian or Alaska Natives use PHS, 18.1% of Asians use PHS, and 44.8% of people of two or more races use PHS (APA, 2017; APA, Office of Minority and National Affairs, 2010).

Understanding factors that prevent ethnic minorities from taking advantage of psychiatric services is important to improving PHS utilization (Fripp & Carlson, 2017; Soto, 2016; Sun et al., 2016). Exploring Mexican immigrants' feelings toward PHS for their family members is an important step toward understanding treatment strategies (Hernandez & Bario, 2015). Having the understanding of the experiences of mentally ill patients and their families regarding PHS may improve utilization of PHS because providers and care givers may be better able to provide services and outreach that targets the unique cultural beliefs, barriers, and experiences related to access to PHS.

Mental illness in the Mexican immigrant family presents a unique challenge in view of the stigma associated with mental illness (Derr, 2016). The stigma associated with mental illness is debilitating (National Alliance on Mental Illness, 2017). The family faces the dilemma of caring for their loved one and being shunned by their community (National Alliance on Mental Illness, 2017; Rastogi et al., 2012). The problem arises by the family shielding the mentally ill person from the community by hiding their mental illness. The stigma of being considered “loco” or “crazy” by the community and therefore becoming an outcast makes the family hide mental illness (National Alliance on Mental Illness, 2017). The dilemma can prevent the Mexican immigrant family from seeking PHS by pretending the mental illness does not exist. The family of the Mexican immigrant may be either supportive or not supportive regarding PHS, a phenomenon present in many cultures; however, it is an important characteristic of the Mexican immigrant family. Feelings of obligation and connection are stressors for Mexican immigrant family (Alegria et al., 2017), and the cohesiveness of the Mexican immigrant family may interfere with acculturation into the new environment (Alegria et al., 2017).

The social change implications of the current study include the ability of providers to provide effective PHS to mentally ill Mexican immigrants who may not seek care due to factors such as trouble understanding the language, fear of legal recourse, and lack of financial resources (Alegria et al., 2017). Engaging in PHS may exclude the families from social activities and community support. The families may experience critical and insensitive comments (Henderson et al., 2013). The families may be labeled as crazy by association. Many will not seek help and therefore will go without PHS

(Henderson et al., 2013). The Mexican immigrantfamily members may feel they have to choose between their family member's mental health and social inclusion. When the Mexican immigrant family decides to ignore their family member's mental illness, they may prevent access to PHS.

Differences in risks for psychiatric illness between native born Mexicans and Mexican immigrants may alter social, economic, and health experiences and may be a social determinant in receiving PHS (Castaneda et al., 2015; Osypuk, 2013). Mexican immigrants who experience discrimination and stressors related to acculturation in the United States may have an increased risk of suicidal behaviors and psychiatric disorders (Alegria et al., 2017). Social alliance and living in neighborhoods largely composed of Mexican immigrants provide societal insulation (Alegria et al., 2017). One reason is the strong connection the Mexican immigrant family has with other Mexican immigrant families. Understanding this connection or *familismo* is important in arriving at solutions to improving PHS for Mexican immigrants (Villatoro et al., 2014). Family value versus individual well-being is thought to be a protective factor for Mexican immigrants, but it may create internal stressors. Familismo is not uniformly a protection against psychiatric disorders (Alegria et al., 2017). Understanding the dynamics between family, social, and individual influences on the willingness of Mexican immigrant to access PHS was important in the current study.

Examining the reasons behind lack of PHS used by Mexican immigrants is important to developing improved treatment adherence. Attitudes of mentally ill Mexican immigrants can deter PHS utilization (Naso, 2016). The indication is that negative feeling toward PHS prevents many from seeking care. Contextual factors such as family, neighborhood, language competency, acculturation, and exposure to discrimination affect Mexican immigrant psychiatric treatment use (Alegria et al., 2017; Villatoro et al., 2014). Investigation of these factors may improve PHS for Mexican immigrants.

PHS are available for Mexican immigrants; however, many choose not to utilize these services. Only 1 out of 3 Mexican Americans seek out PHS because they feel out of place or feel that they will be labeled crazy. In addition, there may be problems due to lack of insurance and lack of transportation to reach services. Few Mexican immigrants in the United States seek help for their psychiatric illness (Naso, 2016). Improving access to psychiatric care for Mexican immigrants is integral to improving the mental health of this vulnerable population. To provide better psychiatric nursing care, improved strategies for care delivery are needed to promote this social change (Fitzgerald et al., 2017). To improve access to PHS, health organizations need to have an understanding of why PHS are not being utilized.

Americans of full or partial Mexican descent, as of July 2018, made up of 11.3% (37.0 million) of the U.S. population (U.S. Census Bureau, 2018). According to the U.S. Census Bureau (2018), Mexican Americans are projected to be the third fastest-growing U.S. population. Currently, the Mexican American population accounts for 17% of the U.S. population; by 2060 their number is expected to increase by 19 million or 25% of the U.S. population (U.S. Census Bureau, 2012).

Problem Statement

Few researchers have addressed the experiences, coping strategies, and problems Mexican immigrant families experience while their family members seek psychiatric care. The Institute of Medicine (2003) exposed the disparities in health care due to racial and ethnic differences. The goals of Healthy People 2020 expressed the need to eliminate psychiatric care disparities that are due to cultural differences (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2010). However, Cook et al. (2017) demonstrated that little progress had been made between 2004 and 2012, and the same disparities existed and remained a high priority. The disparities seen in psychiatric care can occur as a result of several factors including cost of the service, location of a qualified HCP, linguistic needs, cultural factors, and societal factors. Barriers exist that impact utilization of PHS. Noted barriers are stigma associated with PHS, fear about legal implications, concerns regarding racism, and cultural miscommunication (Rastogi et al., 2012).

Closeness to family was also found as a reason for not seeking psychiatric care. Family members can provide care and emotional and spiritual support. The cohesiveness of family is felt to be better than outside services and care. Many Mexican Americans feel that their family and spiritual support is all that they need to get well (Soto, 2016). Acknowledging a shared culture is important, and the feeling that PHS do not validate Mexican American culture prevents Mexican Americans from accessing care. Also, the lack of Spanish-speaking providers is a big deterrent (Soto, 2016). Ethnic, language, and cultural factors can determine whether PHS is utilized. Strategies employed to encourage treatment access should be used to improve PHS utilization (Keyes et al., 2012). Given these barriers and disparities, there is a need to explore how cultural and social factors play a role in treatment-seeking behaviors of mentally ill Mexican immigrants. Factors that need to be explored are ways to address the PHS needs and develop effective modalities to deliver culturally and socially relevant care to mentally ill Mexican immigrants.

Psychiatric nursing care for Mexican immigrants has been problematic for many years. Mexican immigrants face challenges in accepting PHS, and nurses need to be aware of this factor. In addition, family dynamics, religious beliefs, alternative medicine utilization, and bias are challenges in delivering psychiatric nursing care to Mexican immigrants (Fitzgerald et al., 2017). An example of the challenges nurses face is watching a caregiver give a treatment or medication when the patient does not understand what the nurse is saying (Fitzgerald et al., 2017). Because of the unwillingness to acknowledge that the patient may have limited understanding due to their language barrier and to provide nurses who speak Spanish, patient care is compromised (Fitzgerald et al., 2017). Patients must understand before they can legally give consent. There also may be cultural differences that must be acknowledged to provide appropriate psychiatric nursing care. For instance, mistrust of HCP, religious and family beliefs, and stigma need to be understood so nursing care can be effective (Fripp & Carlson, 2017). Nurses' inability to follow the American Nursing Association's code of ethics places patients at risk of receiving substandard nursing care. Nurses need to be aware that delivering substandard care puts more patients at risk (Fitzgerald et al., 2017). Examination of

Mexican immigrants' perceptions of psychiatric nursing care is vital in determining appropriate care. The current study was conducted to fill a gap in the research by focusing on the development of psychiatric nursing care that is appropriate for Mexican immigrants.

Purpose of Study

The purpose of this qualitative exploratory descriptive study was to explore the experiences of Mexican immigrants in a northwestern U.S. state who had family members who have or had a mental illness, and to explore the family members' perceptions of PHS. Little is known about the Mexican immigrants or their family's experiences in seeking help for their psychiatric illness (Naso, 2016). To understand the experiences of the Mexican immigrants who seek psychiatric health services, I conducted a qualitative study interviewing Mexican immigrants who have a family member who has used or has not used psychiatric health services in the United States. Improving access to psychiatric care for Mexican immigrants is integral to improving the mental health of this vulnerable population (Fitzgerald et al., 2017). By understanding the experiences and beliefs of Mexican immigrants who have a family member who sought psychiatric care, I hoped to present information to providers of PHS may that help in developing strategies for care delivery that may promote positive social change by improving the PHS care delivered. This study was unique because it addressed an under researched area of mental health care for Mexican immigrants.

Research Question

What are the Mexican immigrant's family's perceptions of PHS regarding their family member who has received PHS?

Theoretical Foundation

The theoretical base for this study was Leininger's (1970) culture care diversity and universality theory. The theory focuses on studying and understanding other cultures and understanding how care and culture constructs relate to health (Leininger, 1970). The theory directs researchers to discover and use culturally based knowledge to provide better care (McFarland & Wehbe-Almah, 2015). The theory addresses how culture plays an important role in determining how people react in society.

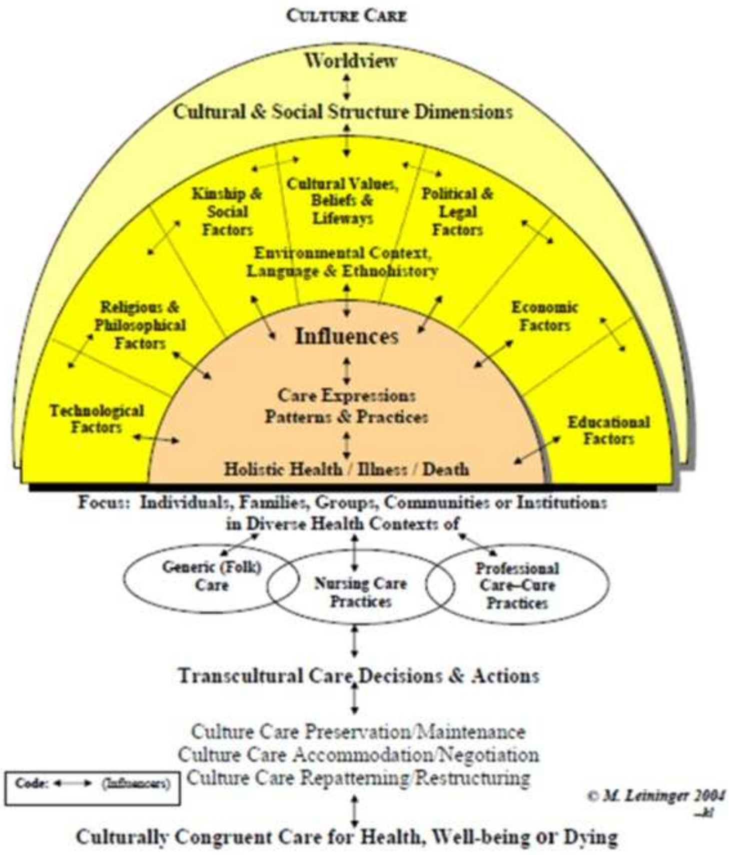
Leininger's (1970, as cited in McFarland & Wehbe-Almah, 2015) theory has shown the way toward providing nurses' response to culturally diverse patients. The culture care and diversity and universality theory provides a framework for examining the care and health needs of diverse cultures that influence individuals' decisions to utilize health services (Leininger, 2002). The theory provides a model to ensure that culturally competent and safe nursing care is provided for culturally diverse patients (Leininger, 2002). Leininger (2002) noted that to provide transcultural nursing, nurses needed to understand culturally based phenomena.

The culture care and diversity and universality theory guided the current study by emphasizing the importance of culture and how it influences Mexican immigrants' use of PHS (see Leininger, 2002). It is essential to understand the impact of culture and lifestyle on maintaining health. The increase in encounters by HCPs and ethnic minority patients emphasizes the need to improve health outcomes and to avoid culturally discordant encounters (Kagawa-Singer & Kassim Lakha, 2003). Defining the strengths and nuances in the Mexican immigrant culture will help improve health outcomes and provide guidelines for providing culturally competent care (Kagawa-Singer & Kassim Lakha, 2003). Leininger’s (2002) theory helped me bridge the research gap and improve PHS care for culturally diverse patients (see Figure 1). Leininger’s theory helped guide the current study to understand what is necessary to improve health outcomes for Mexican immigrants who seek PHS (see Kagawa-Singer & Kassim Lakha, 2003; Leininger, 2002). Chapter 2 provides further details of the theoretical framework used to ground this qualitative study.

Figure 1

Leininger's Sunrise Enabler to Discover Cultural Care

Fig. 1 - Leininger's Sunrise Enabler to Discover Cultural Care



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Nature of the Study

I used a qualitative approach with an exploratory descriptive design to provide depth of understanding of the experiences of Mexican Americans who live with a family member with a mental health condition. I have worked with Mexican American families who have mentally ill family members. The qualitative descriptive (QD) method is a widely used research tradition and has been recommended for research questions focused on discovering the who, what, and where of events or experiences. In addition to learning information regarding a poorly understood phenomenon, the purpose is to observe, describe, and document natural occurrences (Polit & Beck, 2014). QD is useful when information that is being studied is descriptive in nature. QD is a term that is widely used to describe qualitative studies that pertain to nursing and health care phenomena (Kim et al., 2017; Polit & Beck, 2014).

QD was the research design chosen for my study. QD was used to gain an understanding of the phenomenon. QD involves interviewing techniques that were appropriate for my study (see Kim et al., 2017). Attaining data saturation is a recommended practice in QD. It is commonly understood that on the basis of the data that will be collected or analyzed, further data collection is unnecessary (Saunders et al., 2018). QD involves investigating information in a natural state; QD is less theoretical and is more flexible than other forms of qualitative approaches (Kim et al., 2017). By using QD, I hoped to produce an accurate and comprehensive description of the perceptions of the families of individual Mexican Americans who have sought mental health services using the least interference (see Kim et al., 2017).

The study's purpose aligned with QD, which addresses the perceptions of a person. Leininger's (1970) theory also aligned with QD and the exploration of the experiences of the participants in this study. Leininger's theory is used to find answers to how culture affects outcomes, and QD is used to investigate the unnoticed issues. The two of them are used to see how factors such as ethnic and racial differences impact the way people respond to care (McFarland & Wehbe-Almah, 2015; Polit & Beck, 2014).

The QD goal of my research was to describe and understand the experiences of Mexican immigrant families (see Polit & Beck, 2014).

Definitions

Acculturation: The process in which individuals adapt to a new environment by adopting the norms, values, and practices of the new culture or society (Abraido-Lanza et al., 2016).

Ethnocentricity/ethnocentrism: A universal adapting of attitudes and behaviors typical of a group (Fischer & Zeugner-Roth, 2017).

Familismo: A word in Spanish that means being helpful to one another and emphasizes the strong family bond among Mexican American families (Menselson et al., 2008).

Immigrant paradox: The phenomenon that recently arrived immigrants have fewer psychiatric problems due to protection from their cultural beliefs (Moore, 2018).

Mental illness: Any psychiatric or mental condition that can be identified with a unique set of symptoms as defined by the DSM5, also referred to as psychiatric illness (APA, 2017).

Primary care services: Care provided by a clinician or caregiver (Donaldson & Lohr, 1996).

Psychiatric health services: Services pertaining to psychiatry, psychologists, and social workers and the care and prevention diagnosis of a psychiatric disorder or mental illness (Shiel, 2019).

Stigma: A complex social process of labeling and identification that involves devaluation and discrimination (Knaak et al., 2017).

Assumptions

This qualitative study included several assumptions related to the participants. An assumption is a fact or belief that is taken or felt to be true (Avant & Avant, 2011). The first assumption was that Mexican immigrant families would be reluctant to share their experiences regarding the psychiatric conditions of their family members. The stigma attached to mental illness makes it difficult to be open about the condition, especially in the Mexican immigrant family (Hernandez & Barrio, 2015). However, I adopted a nonintrusive and respectful and patient descriptive approach so that the participants would become more open and honest when sharing their experiences regarding mental health services. I assumed that this information would be provided willingly and voluntarily.

Scope and Delimitations

The scope of this study was Mexican immigrant families in the United States who have or had family members with a mental illness and had experiences with PHS. A delimitation is the circumstances that determine the choice of the participant (Leedy & Ormrod, 2010). In the current study, family members of the mentally ill person were interviewed to gain insights into how their family member gained access to or was limited in gaining access to PHS.

The geographic area that was the state of Washington. The participants were able to speak and understand English and had a mentally ill family member who was 18 years of age or above. The participants also had a family member who had been accessing PHS for at least 6 months.

Limitations

Challenges and limitations were due to the nature of the issue, which was that the vulnerable mentally ill person must be protected. Using the descriptive approach in qualitative studies is not without limitations. If the researcher does not place themself out of the study, an interference can occur with data interpretation (Creswell, 2013). Another limitation was that those participating in the study may not be able to articulate their experiences due to issues such as embarrassment or not feeling comfortable discussing their feelings (see Creswell, 2013).

I limited the participant pool to English-speaking participants. Doing this limited the participant number; however, interpretation through translation was not desirable. I am not fluent in Spanish and therefore limited my participants to those who speak and read English.

Due to the sensitive nature of this issue, the following barriers may have occurred: fear of exclusion (e.g., the family may have feared they may be ostracized because they have a family member who has a mental illness), fear of being judged because they have a mentally ill family member, and fear of being shamed and stigmatized for having a mentally ill family member (see Hernandez & Barrio, 2015). I provided complete privacy and confidentiality with all information obtained. I also allowed the participant to choose where they would be interviewed so could maintain privacy.

My personal biases, feelings, and worldview may have influenced the ways I interpreted the data (see Creswell, 2016). My intent was to recognize my personal biases and put them aside so that I could collect data objectively to yield trustworthy findings. By investigating the data objectively, a researcher can address their feelings and remain unbiased during the study (Laureate Education, 2009).

Significance

The results of this study may provide insights into the processes that are implemented when treating mental health issues by focusing on the factors that prevent access to psychiatric nursing care for Mexican immigrants. For the psychiatric nurse, the goal is recovery for the mentally ill patient. Recovery means that the mentally ill patient is returned to their level of mental health wellness (Chisholm & Petrakis, 2019). Insights from this study may aid psychiatric nurses in providing culturally congruent nursing care for Mexican immigrants. Appropriate psychiatric care needs to be a force for positive social change by addressing inequities and by making PHS more accessible (Kallakorpi et al., 2018).

The Mexican immigrant population decreased between 2014 and 2017. However, Mexican immigrants are still the largest foreign-born immigrant group in the United States, accounting for 25% of all the immigrants in the United States (Zong & Batalova, 2018). The current study may help psychiatric treatment facilities develop quality treatment programs and better access to care for Mexican immigrants with psychiatric disorders.

Summary

This chapter provided a brief overview of my qualitative exploratory descriptive study. This study was conducted to explore the perceptions of the families of mentally ill Mexican immigrants regarding accessing psychiatric services. The key to obtaining a clear understanding of the mental health disparities that are faced by Mexican immigrants was to explore the experiences their family members have while seeking PHS. The experiences of Mexican immigrant families who have a mentally ill family members had not been studied. Chapter 2 provides an exhaustive review of literature that was used to support the need for this study.

Chapter 2: Literature Review

The purpose of this qualitative exploratory descriptive study was to explore the experiences of Mexican immigrants in a northwestern U.S. state who have family members who have had a mental illness, and to explore the family members' perceptions of PHS. Few Mexican Americans suffering with a psychiatric disorder have spoken to their doctor about their mental health conditions (Villatoro et al., 2014). In the United States, only 20% of Mexican Americans seek PHS, and even fewer (only 10%) have contacted a mental health specialist (Villatoro et al., 2014). However, most people with mental health disorders do not receive treatment (National Institute of Mental Health, 2018; U. S. Department of Health and Human Services, 2001). Many people fail to receive psychiatric treatment, and the reasons for this are personal and private. Stigma and feelings of shame often prevent access to quality treatment (Young, 2015). In the United States, an estimated 18 million adults who have a mental illness do not receive treatment (USDHHS, 2001). The Substance Abuse and Mental Services Administration (2018) found that little change was noted between the years 2002 and 2017 regarding mental service use and barriers, and low incidence of mental health service use was recorded (Substance Abuse and Mental Services Administration, 2018).

People may fail to receive psychiatric treatment for a number of personal and private reasons. Stigma and feelings of shame surrounding mental health disorders often constitute a barrier to access to quality treatment (National Alliance of Mental Illness, 2017; USDHHS, 2001; Young, 2015). Stigma is defined as a mark of shame or discredit often associated with a disease (Merriam Webster, 2012). Stigma can be *self-stigma,* defined as a self-perceived sense of shame, or it can be *social stigma*, which manifests through society’s negative connotations about a condition (Dichoso, 2010). People with mental illness may feel shame and fear discrimination due to a condition that is as disabling as any other serious condition (Interian et al., 2007). Self-stigma and social stigma are significant barriers to receiving mental health care, especially for ethnic groups including Mexican Americans (Dichoso, 2010).

In the Mexican American population, self-stigma is evidenced by perceptions or feelings of weakness and an inability to cope (Interian et al., 2007). Besides perceptions and experiences of stigma, many mentally ill Mexican Americans do not know how to access existing services, and when they do they may find it hard to understand the treatments that are recommended because of language and cultural differences (Interian et al., 2007). Mexican American ethnocentricity may exacerbate the stigma of seeking treatment for a psychiatric condition. Ethnic identity, language use, and preferences for associating with their own ethnic group may impact Mexican Americans’ utilization of care. These factors suggest that Mexican Americans view mental health conditions to be more stigmatizing than how the general population views these conditions (Keyes et al., 2013).

Literature Search Strategy

Multiple sources addressing the topic were reviewed for this paper, including books, internet sites, documents produced by government agencies and universities, and psychiatric and medical professional journals. Specific sources included the Cumulative Index to Nursing and Allied Science, EBSCO megafile, Google Scholar, and the National

Institute of Health Index. Disciplines represented in the search included psychiatry, psychology, sociology, nursing, community health, anthropology, social welfare, medicine, behavioral medicine, and human ecology. Keywords for the search for documents and articles included *stigma Latinos* and *mental health*, *stigma* and *depression treatment utilization among Latinos*, *stigma* and *Hispanics*, *stigma* and *mentally ill Hispanics*, *stigma* and *Latino families*, *stigma* and *Mexican families*, *stigma* and *Mexican Americans*, *stigma* and *Hispanic Americans*, *stigma* and *Spanish speaking Mexican Americans*, *Mexican American immigrants*, *stigma* and *English speaking Mexican Americans*, *stigma* and *English speaking Latinos*, *stigma* and *English speaking Hispanics*, *stigma* and *Spanish speaking Latinos in America*, *stigma* and *Spanish speaking Hispanics in America*, *culture* and *bias* and the *mentally ill Mexican American*, *culture* and *bias* and *the mentally ill Mexican*, *bias* and *culture* and the *mentally ill Hispanic*, *culture* and *bias* in the *Mentally ill Latino*, *exploring the effects of stigma in the sub groups of Latinos in America*, *stigma* and *bias* in the *mentally ill*, *caring for the mentally ill Latino*, *caring for the mentally ill Mexican*, *caring for the mentally ill Mexican American*, *caring for the mentally ill Latino*, *barriers to care for the Latino mentally ill*, *stigma and the mentally ill migrant Mexican American farmworker*, and *research articles on mental illness on stigma in different ethnic groups.* Availability of articles was expanded when words and phrases were varied, and *stigma* and *Latino* were included in the keyword search. The initial range of publication dates for articles or documents considered for review was 2000 to 2019. However, because several important articles were found in the years prior to 2000, the search interval was extended to cover 1990 to 2019. To meet inclusion criteria, sources had to be written in English and pertinent to the topic of stigma and Latinos with mentally illness. Excluded from consideration were articles that were not originally written in English or did not address the topic of stigma and Latinos with mental illness. Approximately 100 articles were reviewed for content, and 39 were chosen for inclusion in the literature review for this study.

Theoretical Framework

Leininger (1970) saw the change in nursing by the introduction of people of various cultures and realized nursing needed to change. Leininger became interested in finding a way to properly care for people of different cultures and ethnicities or transcultural nursing. Leininger (1970, as cited in Parker & Smith, 2010) believed that transcultural care was necessary to promote healing, meaningful, and culturally competent nursing care. Leininger (1991, 1995) introduced the theory in the 1960s to provide culturally congruent and competent nursing care. Leininger’s (1970, as cited in Parker & Smith, 2010) culture care diversity and universality theory established new dimensions of caring for people of diverse cultures.

Leininger’s (2002) theory is the only theory that focuses on the close relationships between culture and care of health, death, illness, and well-being. The theory focuses on comparative culture care. Leininger’s theory is a holistic and multidimensional theory that seeks to understand and discover culturally based meanings and practices. It is also the first nursing theory to address global cultural care differences and commonalities, to be designed for a research method, and to have both abstract and practical features and three action models for delivery of culturally congruent care. It is the first theory based on generic care and professional or culture care.

Leininger's (1991, 1995) theory was developed to establish a knowledge base to guide nurses with the use of transcultural nursing practices. The major goal of this theory is to discover and explain diverse and culturally based care and how it influences health, illness, and death of groups and individuals (Leininger, 2002). The purpose of this theory is to use it in studies to provide culturally congruent, safe, and meaningful care to patients of similar or different cultures (Leininger, 2002). The major tenet of this theory is that commonalities will be found within cultures. The second major tenet is that worldview and social structure factors are important influences on health care. The third major tenet is that differences and similarities exist between professional and traditional care. The differences in care influence the health and well-being of the patients (Leininger, 1991, 1995). Leininger's (1970, 1977, 1981, 1984, 1991, 1997) theory is based on the following assumptions: Care is essential to human growth, development, and survival; care is essential to curing and healing; forms of care vary; every culture has traditional care; culture care values vary with worldview; therapeutic nursing can only occur when cultural values are known; differences between caregiver and patient are known; culturally congruent care is seen to be essential; and nursing is a transcultural care profession and discipline.

Three researchers utilized Leininger's theory to construct their research studies. Plowden (2003) used Leininger's theory to understand health-seeking behaviors. Plowden stressed that health-seeking behaviors are influenced by society. Individuals' development is explained by a combination of factors based on their cultural development (Plowden, 2003). Steefel (2008) explored cultural humility and how it affected correctional nursing practice and relied on Leininger to guide the study. Culture is necessary to provide holistic care, and care is the essence of nursing (Steefel, 2008). Leininger's theory emphasizes that culture must be included in care; if it is not, there is no care (Leininger, 2002; Steefel, 2008). Finally, Broch et al. (2017) used Leininger's theory to analyze violence against women as a culture and that women deserve appropriate care. Leininger's theory was adopted for understanding the elements of care, cultural context, and cultural characteristics of these vulnerable women (Broch et al., 2017). The similar traits of vulnerability, cultural humility, and help seeking found in these articles were intended to enhance my understanding of the Mexican immigrant population. The three researchers applied Leininger's theory to discover cultural congruent care, and did the same in my study.

The culture care diversity and universality theory emphasizes the need to base health care on cultural congruence of each different culture (Leininger, 2002). PHS for Mexican immigrants with unique culture and care needs should be devised based on their unique culture. The current study addressed the perceptions of family members of mentally ill Mexican immigrants using Leiningers theory.

The theoretical base for this study was Leininger's culture care diversity and universality, which focuses on studying and understanding other cultures and knowledge about care and culture constructs related to health. The theory directs researchers to discover and use culturally based knowledge to provide better care (McFarland &

Wehbe-Almah, 2015). The theory addresses how culture plays an essential role in determining how people react in society. Leininger's (1970, as cited in (McFarland & Wehbe-Almah, 2015) theory has shown the way toward nursing's response to culturally diverse patients.

Literature Review Related to Key Variables and/or Concepts

The results of the literature review are presented by each of the variables. The key variables were organized by mental health issues in the Mexican American population, mental health disparities in ethnic minorities, and mental illness and stigma.

Mental Health Issues in the Mexican American Population

Mexican American culture is not made up of a single ethnic group. It comprises many subgroups, each with unique cultural perspectives and traditions. Consequently, the use of a general label is inappropriate. Each Latino group differs in national origin and history (Guarnaccia et al., 2005). Major subgroups include those born in America of Latino parents, Mexican-born Latinos, Cuban-born Latinos, Latinos of Cuban descent, Dominicans, Puerto Ricans, English-speaking Latinos, Spanish- or other-language-speaking Latinos, and Caribbean-born Latinos, not to mention the many Latinos who come from Central or South America (Guarnaccia et al., 2005). The wide variation among the different Latino subgroups is significant to appreciate because each group can have a different perspective about health, illness, and treatment of conditions including mental health disorders. Variations based on country of origin, dialect spoken, and health beliefs are vital to providing health care services, particularly PHS, to Mexican American populations.

The United States has been the destination for immigration for many Mexicans. Mexican immigrants constitute over 25% of the 44.5 million immigrants in the United States (Zong & Batalova, 2018). The impact of immigration is an integral part of the emotional well-being of Mexican Americans. The social networks Mexican Americans have improved the adaptation process and coping strategies with immigration stressors (Alegria et al., 2017). Latinos of Mexican origin compose 55% of the U.S. Latino population (Vega et al., 2003).

The prevalence of mental illness in Mexican American populations is indicated by criteria that show this as being a high-risk group for depression, anxiety, and substance abuse. Mexican American women are a higher risk for depression than White and African American women (De Oliveira et al., 2017). The prevalence of psychiatric disorders in Mexican Americans varies in severity and incidence depending on many variables. In a cross-sectional analysis of 15,864 men and women, deemed the largest study done of this community, by the Center of Epidemiology between 2008 and 2011 (Wassertheil-Smoller et al., 2014), Latino-based communities in the United States from Bronx, New York; San Diego, California; Miami, Florida; and Chicago, Illinois were chosen to participate. The study incorporated Hispanics/Latinos from different origins: Mexico, Puerto Rico, Dominican Republic, Cuba, Central America, and South America. The goal was "examine depressive and anxiety symptomatology and use of antidepressant and antianxiety medications in Hispanic/Latino groups of different national backgrounds, by age, sex, and related to cardiovascular disease and risk factors for cardiovascular disease" (Wassertheil-Smoller et al., 2014, p. 823).

A cross-sectional analysis with depressive and anxiety symptoms being assessed was completed using a shortened Center for Epidemiological Studies Depression Scale and Spielberger Trait Anxiety Scale. The study showed high depressive symptoms such as loss of interest in activities, feelings of hopelessness, and trouble sleeping and anxiety exacerbation. The analysis showed ranges from 22.3% (95% confidence interval) to 38% (95% confidence interval). Antidepressant use was only 5% with higher use by those with cardiovascular disease (15.4%) and higher with those with insurance (8.2%) and only (1.8%) by those uninsured. High depression and anxiety symptoms had a great variance based on the Latino background, sex, and history of cardiovascular disease. These disease components act as a common determinant for depression in Mexican American women.

Depression in women varied by age, and Mexican American women had a higher incidence of depression (32.8%) than ethnic minorities (20.7%; Wassertheil-Smoller et al., 2014). The following age groups showed differences in depression prevalence: 18–44 years had 24%, 45–64 years had 32.1%, and 65–74 years had 29.4%. Age at immigration and being U.S. born were also contributing factors. Results also indicated that acculturation plays a part in the prevalence of depression. The analysis indicated that depression varies among Latino groups, continued acculturation and exposure to American culture appears to correlate to slightly lower rates of depression and anxiety, and undertreatment of depression exists. Certain factors between men and women affect how Mexican Americans react or display psychiatric illness.

Understanding the reasons for inadequate PHS is imperative to developing better utilization of services by Mexican immigrants. Ruiz and Prim (2010) sought to address issues that impeded access to PHS in the Mexican American population. Ruiz and Prim used an integrated literature review that included 10 articles that were published between 1998 and 2008. The integrated review included the numbers, demographics, educational and socioeconomic status, and cultural attributes that affect the mental health of Mexican Americans. As a result, the authors identified three key issues that impede access to mental health care: (a) the development of a comprehensive health and mental health care system that integrates different disciplines, (b) the promotion of appropriate professional representation from ethnic minority groups, and (c) allocating appropriate research funds for investigations that focus on the unique health and mental health needs of the U.S. Mexican American population and other minorities in this country (Ruiz & Prim, 2010). The results of this review found that among Mexican American U.S. citizens with a mental illness, fewer than one in 11 contacted a mental health specialist; and fewer than one in five contacted general health care providers. The study identified differences within various subgroups in the Mexican American population in terms of accessing PHS. For example, fewer Mexican American immigrants seek PHS than Mexican Americans who were born in the U.S. (Ruiz & Prim, 2010).

Mental Health Disparities in Ethnic Minorities

Ethnic minorities have less access to and availability of PHS and are less likely to receive the PHS that they need. It has been documented that when they do access services, the care that they receive is of poorer quality (Keyes et al., 2013; Leong & Kalibatseva, 2011; USDHH, 2001). Disparities in care can occur as a result of several factors, including the cost of the service, location of a qualified health care provider

(HCP), and cultural and societal factors. Among these barriers, there remains a need to examine further how cultural and social factors play a role in treatment-seeking behaviors of mentally ill ethnic minorities.

Ethnic homophily may contribute to the diminished use of services by ethnic minorities. Ethnic homophily can be a result of culturally specific perceptions about and experiences of stigma as well as attitudes that are held by the cultural group about psychiatric disorders and PHS (Keyes et al., 2013). Ethnic homophily, the "love of the same," is the tendency of individuals to associate and bond with others who are like themselves. There are more than 100 studies that have documented homophily in some form or another, and how this leads to a strong connection to others in a culture or society (Dehghani et al., 2016; McPherson et al., 2001).

Mental Illness and Stigma

The lack of societal understanding about and acceptance of mental illness as a chronic disease similar to other chronic medical diseases is a major problem. Many people with mental illness, especially those from certain cultures, are ostracized or ignored by their families as a result of the stigma associated with the diagnosis of mental illness (Keyes et al., 2013). Stigma can contribute to a delay in or lack of seeking psychiatric services by the mentally ill person. There remains a need to further examine what role cultural and social factors play in influencing treatment-seeking behaviors, especially among ethnic minorities. By doing this, there can be an increase in the knowledge about how to decrease the documented ethnic disparities in accessing PHS that exist.

Types of Stigma

No Soy Loco! / I'm Not Crazy! is the cry of many Mexican Americans who have a mental illness. The loss of status and disrupted identity revolve around this complex phenomenon. Stigma is a major barrier to receiving mental health care for Mexican Americans (Dichoso, 2010; Keyes et al., 2013 Kramer et al., 2009).

There are two types of stigma that have been described in the literature, *self-stigma* and *social stigma* (Interian et al., 2007). Self-stigma is defined as perceived stigma. For Mexican Americans, this self-stigma is evidenced by a perception of weakness and an inability to cope (Interian et al., 2007). Social stigma is evidenced by the negative connotation of mental illness as viewed by society. The idea that a person who has a mental illness is crazy and even dangerous is a common public perception. The label of being "loco" or "loca" shapes the stigma of mental illness in Mexican American communities (Kramer et al., 2009).

Stigma is derived from culturally induced stereotypes about a person (Horsfall et al., 2010). Victimization is prevalent in those who are stigmatized, as evidenced by exploitation and bullying. Stigma can cause many reactions in the victim, including feelings such as hurt, disgrace, shame, guilt, secrecy, and anger.

Stigma can become an insidious, overriding blanket that covers the mentally ill. Horsfall et al. (2010) noted that character-driven stigma refers to those who suffer from addictions as well as homosexuals, attempted suicide events, ex-prisoners, mentally ill, and people involved with radical political groups. Everyone in the categories as mentioned earlier can be labeled by society. These people are stigmatized or blamed simply because of a character trait or illness (Horsfall et al., 2010).

The issue of stigma towards people with mental illness has long been a problem and has prompted many research studies. The main findings reported in research investigating the critical issues to address in mental illness are stigma, underutilization of services, cultural issues, and family-centered care (Vega et al., 2001). Stigma affects the likelihood that persons with mental illness will be diagnosed, and it can affect their treatment outcomes (Sickel et al., 2019; USDHHS, 2001). Stigma is a significant obstacle preventing mentally ill people from getting help. According to the USDHHS (2001), the myths surrounding mental illness need to be dismantled. The initiation of and adherence to treatment cannot occur if access to PHS is not improved. Once they do engage in care, patients who feel embarrassed to seek help are apt to find it very hard to follow treatment plans to improve their illness (Knaak et al., 2017; Vega et al., 2001).

Synthesis of Literature Review

Mental illness has negative connotations for many groups in the United States. The stigma felt by mentally ill persons becomes a powerful barrier that can keep them from seeking treatment. People with mental illness feel shame and have a fear of discrimination that can be so disabling that it prevents them from seeking care for their illness (Thornicroft, 2008). Cultural issues add to the isolation that is felt by individuals living with mental illness. Mexican Americans feel this stigma in many ways due to their cultural heritage. Cultural bias towards mental illness prevented many of the patients from seeking care. The negative feelings leveled at mental illness and the cultural repercussions they would suffer when they were labeled mentally ill, kept them from accessing care. Patients mentioned that they were shunned and even hidden away when they revealed they were mentally ill. As a result, providers have viewed the cultural and social stigma attached to mental illness as a substantial barrier to accessing PHS (O'Mahony & Donnely, 2007). Patients of many cultures expressed significant negative feelings towards mental illness. Sealing with a diagnosis of mental illness prompted a period of denial (O'Mahony & Donnely, 2007).

Perceptions of stigma and shunning of mentally ill patients by their families and communities, exert an influence over patients' perceptions of mental health care (O'Mahony & Donnely, 2007). O' Mahony and Donnely (2007) conducted a qualitative study investigating PHS for Mexican American women. They interviewed seven HCPs about their perceptions about PHS available to this group of women. A counselor spoke of the unassailable cultural taboos. They don't want counseling...it's considered a taboo...something is wrong with you...they don't want people [health care provider] to tell them what to do. They like to deal with their problems themselves...when you try to tell them that there may be different ways of doing things, it is not considered good in the culture. (O'Mahony & Donnely, 2007, p. 461-462). The lack of community support and high stigma regarding mental health might be other barriers to seeking mental health care services for some immigrant Mexican American women.

Access to care for individuals with mental illness began to change in the 1960s and 1970s when patients were discharged from inpatient units of psychiatric hospitals and mainstreamed into outpatient settings for care. Deinstitutionalization produced a costbenefit by discharging chronically mentally ill patients back into the community (Bachrach, 1976). Little thought was given about how to finance this change from inpatient to outpatient care or how to care for patients who were suddenly ousted from inpatient units. As a result, this crisis within the mental health system has affected communities, the mental health care system, people with mental health issues, and their families. Lack of housing has resulted in having to move back with their families, others live on the streets or have been incarcerated. Research has been conducted regarding the financial and emotional impact on individuals with mental illness and their families. Snowden and Yamada (2004) examined whether the shift from fee for services to capitation could lead to minorities receiving less mental healthcare. Managed care had relatively no impact on the use of inpatient or outpatient PHS of foreign immigrants (Snowden &Yamada, 2004).

Variations exist among ethnic groups' perceptions of the role of the family in the care of ill family members. Where one culture may view the care for a mentally ill family member as the duty of other family members, another cultural group may view it as something done by outside providers (Guarnaccia & Pilar, 1996). Due to the stigma attached to mental illness, duty can sometimes lead families to avoid seeking care for a family member who is mentally ill (Rios-Ellis, 2005). Mental health problems are more distressing in immigrant populations that have left their families and social support in their countries of origin (Rios-Ellis, 2005). For this reason, understanding conflicting feelings towards mental illness among different cultures are necessary in order to address the specific needs of patients and their families.

In Mexican American cultures, the care of mentally ill individuals is viewed as family duty, with the primary caregivers usually the parents and, most often, the mother (Guarnaccia & Pilar, 1996; Rios-Ellis, 2005). The stigma felt by Mexican Americans with mental illness can be described as *quediran estigma* which implies that the family must take care of their own. Their problems are not to be discussed or revealed outside of the family (Rios-Ellis, 2005).

The first provider to see most mentally ill patients is the primary care physician. Often these doctors manage the care of people with mental illness, and frequently, a patient is never referred to a psychiatrist. Consequently, the mentally ill person is usually diagnosed and treated solely by their primary care doctor (Vega et al., 2009). Primary care physicians must be able to accurately diagnose, appropriately treat, and when indicated, refer patients for psychiatric care. They should be familiar with the cultural perspectives about mental illness in order to be able to understand these and be able to support the patient and the family to facilitate continued access to care (e.g., follow-up visits) and adherence to treatment for the patient.

Certain requirements for improving Mexican Americans' mental health care remain unmet due to several factors, including limited psychiatric services, and the need for community education about mental illness (Wells et al., 2001). It is essential to be aware of a cultural group's perceptions about mental illness in order to provide appropriate care, as well as to educate the patient, the family, and the community about mental illness. In the case of Mexican American families, there is a strong expectation that individuals will be cured of their mental illness (Wells et al., 2001) Because Mexican

American families tend to be highly involved with a mentally ill family member's care, psycho-education of these families can be very useful. Mexican American families have strong religious beliefs and believe in the healing power of God, which may delay a mentally ill family member from seeking care (Guarnaccia & Pilar, 1996).

Guarnaccia and Pilar (1996) conducted a qualitative study to investigate how having a mentally ill family member affects the entire family. The study included a sample of 90 family caregivers from diverse backgrounds living in family groups in urban New Jersey. The study was restricted to the public and community mental health clinics. The utilization of these clinics was based on financial need. The study examined families' experiences with PHS and support systems, perceived family burdens, and their concepts of mental illness. The results of this study suggest that members of cohesive ethnic groups feel the impact of mental illness in especially profound ways because they shoulder the burden as if the mental illness were their own. Very few families sought the help of professionals except in times of crisis. The results of the study also found that language barriers and minimal understanding of mental illness were issues facing Mexican American families in the U. S., when dealing with a mentally ill family member (Guarnaccia & Pilar, 1996). Additional studies have also found the underutilization of PHS by Mexican Americans was associated with their emotional support systems (Interian et al., 2007; Vega et al., 1999; Vega & Alegria, 2001).

The label of madness or "locura" carries negative connotations to the Mexican American family member. The family often disguises mental illness by merely stating that the condition is just "nerves" or "nervios," terms that serve to destigmatize that person’s experience within both the family and the community (Guarnaccia, 2002). Another culture-bound syndrome among Mexican Americans is “ataque de nervios” a name for distress particularly prominent among Latinos from the Caribbean but recognized among many Latino groups. “Ataque de nervios” typically occurs as a direct result of a stressful life event, specifically relating to the family (Carillo & Guarnaccia, 2008). Mexican Americans tend to have large family networks that are extremely important for social support and problem-solving in times of crisis. However, these extended family support systems may also serve as barriers to seeking treatment when problems like mental illness are predominantly dealt with in the privacy of the family (Guarnaccia, 2002).

Because Mexican American families care for persons with mental illness at home, a major fear is what will happen to that person when the caregivers are gone. In Guarnaccia and Pilar’s (1996) study, few families sought the help of professionals except in times of crisis. The results of the study also found that language barriers and minimal understanding of mental illness were issues facing Mexican American families when dealing with a mentally ill family member. Underutilization of PHS by Mexican Americans was associated with their emotional support systems (Vega et al., 1999; Vega & Alegria, 2001; Interian et al., 2007; Barrera & Longoria, 2018). “Familismo”, being helpful to one another, is a word unique to the Spanish language that emphasizes strong family relationships, that may serve as a protective factor, fostering positive support and protecting individuals against depression even in the face of substantial social and environmental risk (Menselsone et al., 2008). Whereas the support of the family for a mentally ill member is a decisive factor, in some cases, it may deter the patient from seeking care outside of the family.

Several underlying issues have been found to influence Mexican Americans' underutilization of mental health services. A probability sample (*N*=3,012) was used to represent the Mexican American population residing in Fresno County, CA. The researchers conducted face-to-face interviews using the World Health Organization World Mental Health Composite International Diagnostic (WHO WMH-CIDI) Interview or CIDI (Vega et al., 1999). The CIDI is an interview tool used to determine psychiatric disorders. It is designed for epidemiological studies and can be administered by anyone (WHO, 2016). The interview consists of 109 questions overall, however, the first 20 questions are demographics and identifiers. The CIDI has Sections 1-42, section one is the first 20 questions. The remaining sections are focused on different areas that pertain to mental disorders. The interview is given over a 15-minute period and is used as a diagnostic tool (WHO, 2016). Bivariate and multivariate analyses were used to analyze data focusing on mental health diagnosis and service utilization. Participants with disorders such as schizophrenia and manic-depressive psychosis approximately one-fourth had used a service in the past 12 months, and Mexican immigrants' rate was only two-fifths of that of Mexican Americans born in the U. S. The overall use of mental health providers by participants with diagnosed mental disorders was 8.8%, use of providers in the general medical was 18.4%, use of other professionals 12.7%, and informal providers use only 3.1% (Vega et al., 1999). Immigrants are unlikely to utilize PHS, despite having a diagnosed psychiatric disorder. However, they may use general practitioners, which indicates that the appropriateness, accessibility, and cost-effectiveness of mental health care for this population is still a problem (Vega et al., 1999).

One important finding from a study conducted by Vega et al. (1999) was that Mexican Americans born in the U.S. were more likely to seek care for mental illness than were immigrants, especially immigrants born in Mexico. Besides, traditional healers or family members were preferred by foreign-born Mexican Americans for all health care services. Both U.S. and foreign-born Mexican Americans with mental illness were more likely to use services if they are publicly financed (Kohn et al., 2004; Vega et al., 1999). These factors contribute to the gap that exists between those Mexican Americans who have a mental illness and receive treatment and those who do not receive treatment. Determining ways to eliminate the factors associated with this treatment gap is essential and will improve the utilization of PHS by Mexican Americans (Kohn et al., 2004).

The cultural dimension of mental health care is of great importance. Some Mexican Americans internalize their feelings more than non-Mexican Americans. The internalization of their feelings is often exhibited through somatization (e.g., pain). Among Mexican Americans who are less acculturated to the U.S., a mental illness may be perceived as the result of fate (Rojas-Vilches et al., 2011). A patient’s cultural background colors every facet of mental illness (Alegria et al., 2004) in particular, the way people think about a cure. Among Asians, Mexican Americans, and African Americans there is a prevalent belief that mental illness can be treated or overcome by willpower and stoicism or by avoiding bad thoughts, rather than by seeking professional help (Leong & Kalibatseva, 2011). Exploring the role of social position, environmental context, and psychosocial factors may help identify the mechanisms that link acculturation to a diagnosis of psychiatric illness and PHS in Mexican American populations.

Language is a factor that has a tremendous effect on how Mexican Americans can access adequate health care. Individuals with limited English proficiency (LEP) are a rapidly growing segment of the U.S. population. Limited English proficiency remains a barrier to care and decreases access and treatment adherence, as well as decreases the overall quality of care for Mexican Americans (Bauer et al., 2010). Federal laws protect individuals from other countries and include LEP provision. The executive order signed by President George W. Bush ordered that LEP services be available to all LEP individuals (Limited English Proficiency, n. d.).

It has been reported that English-speaking Mexican immigrants had higher rates of mental illness than Mexican immigrants who do not speak English (Breslau et al., 2007). Breslau et al. (2007) conducted two separate surveys of Mexican populations, one in the U.S. and one in Mexico, to determine the prevalence of mental illness. The researchers compared depressive (major depressive episode, dysthymia) and anxiety (generalized anxiety disorder, social phobia, panic disorder, and posttraumatic stress disorder) disorders among immigrants after their arrival in the U.S. to nonimmigrant Mexicans who have an immigrant in their immediate family. The English-speaking immigrants were found to have a higher prevalence of anxiety or mood disorder, and their illness often became a persistent problem. It is possible that English speaking immigrants were better able to express themselves. The researchers concluded that the psychiatric disorders were due to the stress of being an immigrant, the acculturation and assimilation into American life, along with the disconnection from their native country (Breslau et al., 2007).

Immigrants in the U.S. face challenges with every aspect of American life. Mexican Americans leave behind a culture rich in heritage and must integrate into the melting pot that is America. The immigration experience evokes many factors that influence psychiatric illnesses and PHS. Information that needs to be considered when evaluating immigrant populations for psychiatric disorders includes their place of birth, English language proficiency, and years of residence in the U.S. (Takeuchi et al., 2007).

Mexican Americans consider mental illness a problem they need to take care of themselves within their own family. The reluctance to speak to providers about mental illness can be due to this factor. The family often denies that their loved one has a mental illness because of the stigma they feel (Rios-Ellis, 2005). Often help is not sought until symptoms are very severe, and the family is unable to care for the individual at home. Besides, the Mexican immigrant suffers a psychological loss due to immigration. The Mexican immigrant endures the stress of leaving the country they have known all their lives and traveling to the unknown. Family in both countries, Mexico and the U. S., experience loss. They suffer the loss of family connection and support, loss of family by absence, and loss of psychological and physical support (Solheim, Zaid, & Ballard, 2016).

Summary

The main concepts that emerged from this literature review were: (a) stigma associated with mental illness in Mexican American populations occurs at the individual, family, and community levels; and (b) the underutilization of existing PHS by mentally ill Mexican Americans is multifactorial and can include cultural beliefs, low socioeconomic status, and perceptions or experiences of stigma.

Stigma

The first significant concept is Mexican Americans' perceptions or experiences of stigma related to mental illness. Mental illness itself has many negative connotations, even without including culturally specific issues. People with mental health disorders suffer stigmatization and require caregiver support and long-term professional treatment for stabilization and improved personal functioning. The lack of culturally sensitive care for Mexican Americans is a reason that research is needed to determine approaches that will successfully increase culturally appropriate and effective treatment for this vulnerable group. In 2007, 15 researchers participated in a workshop to identify research issues for improving the quality and effectiveness of treatment for Mexican Americans experiencing persistent mental disorders. The researchers concluded the following issues needed to be addressed: (a) the role of stigma as it affects the willingness to seek care, access to care, and perceived barriers to care; and (b) the development of psycho-educational efforts to increase awareness and knowledge of the symptoms of severe and persistent mental illness, to help combat stigma, and decrease the reluctance to seek professional care in Mexican American communities (Vega et al., 2007).

Underutilization

Current research about the underutilization of PHS by Mexican Americans revealed three main issues contributing to this problem: (a) inadequate sources of treatment, (b) insufficient numbers of Mexican American health professionals, and (c) socioeconomic barriers (Cardemil et al., 2007). The problem of limited mental health care services for all patients is compounded by issues specific to Mexican American patients. For example, Mexican American patients may lack knowledge about where to seek treatment, while those who do seek services may find themselves geographically far from treatment centers and grappling with transportation barriers.

Another contributing factor to underutilization of PHS by Mexican Americans is the inadequate number of HCPs who are Mexican American or are Spanish speaking providers who are culturally trained to meet the needs of Mexican Americans. During 2001-2004 a research study was conducted in San Diego County, California, U. S., examined the effects of language on mental health service use for Mexican Americans. The sample included 539 Spanish-speaking Mexican Americans, 1,144 English-speaking Mexican Americans, and 4,638 Caucasians who were initiating treatment for schizophrenia, bipolar disorder, or major depression. The use of multivariate regressions, differences were examined among the groups in the type of mental health service that was first used; the probability of use of four types of PHS. PHS were divided into

> Four categories: 1) Inpatient psychiatric hospitalization and crisis residential treatment programs, 2)Emergency, which included the emergency psychiatric unit (the single county-operated psychiatric emergency room) and the psychiatric

> emergency response team (a law enforcement officer paired with a licensed clinician who responds to 911 calls involving mentally ill persons), 3) Jail (only clients who received PHS while in a San Diego County jail) and 4) Outpatient services, which included medication management, psychotherapy, and case management and the intensity of outpatient treatment. (Folsom et al., 2007, p. 1174)

Folsom et al. (2007) found that a Spanish speaking caregiver positively impacts the Mexican American patient even more than shared ethnicity. Folsom et al. suggested that “Latinos, preferred language may be more important to them than ethnicity in mental health service use. Future studies comparing mental health use may need to differentiate between Spanish- and English-speaking Latinos” (p. 1173). This information suggests that until Mexican Americans are able to receive care by professionals who represent their population, understand their cultures, and speak their language, mental health issues will continue to disproportionately affect the fastest-growing sector of the U. S. population, and the stigma surrounding mental health care will further deter Mexican Americans from accessing services (Rios-Ellis, 2005).

Socioeconomic barriers also exist that prevent Mexican Americans from seeking PHS. Help-seeking behavior is especially inhibited when a Mexican American is uninsured. It has been documented that Mexican Americans were more likely to seek care and continue treatment if they were insured, and the reverse was found to be true of those who had no insurance. Barriers to receiving care also included lack of transportation, time, and limited availability of appointments (Cardemil et al., 2007).

Conclusion

There is a pattern of problems in the delivery of PHS to Mexican American individuals in the U.S. A problem that needs further exploration is the underutilization of care by Mexican Americans with a mental illness. Existing studies indicated many factors that may account for this underutilization, including culturally specific effects of stigma. The stigma experienced by Mexican Americans with a mental illness often serves to deter the patient from accepting the diagnosis of their condition. One of the first steps toward improving mental health care for Mexican Americans must be public education aimed at increasing knowledge about mental health issues in this population. Another critical issue is to make culturally sensitive care accessible and affordable to this group of patients. In order to do this, a deeper understanding of what contributes to the problem and what solutions might be possible needs to be pursued through ongoing research.

Future Implications

Psychiatric illnesses are conditions that affect all people, regardless of ethnicity or race. Minorities have less access to and receive a lower quality of mental health care. Furthermore, minorities are underrepresented in research studies (USDHHS, 2001). Future research needs to target specific areas to decrease the disparity seen in mental health care for Mexican Americans. Such studies might include the following: (a) the evaluation of cultural differences regarding perceptions or experiences of stress and stigma, (b) coping abilities that affect Mexican Americans’ mental health, (c) ways to improve access to and availability of mental health care by training professionals and providing care in areas where ethnic and racial minorities live, and (d) the evaluation of strategies for improving mental illness screening and services for ethnic minorities, specifically Mexican Americans

Chapter 3: Research Method

The purpose of this qualitative exploratory descriptive study was to explore the experiences of Mexican immigrants in a northwestern U.S. state who had family members who had a mental illness, and to explore the family members' perceptions of PHS. A qualitative exploratory descriptive method has been frequently used in the health sciences and has been supported by previous researchers (Colorafi & Evans, 2016). The qualitative exploratory descriptive research approach I used was an appropriate method because my study was health related and the methodology provided a rich illustration of the collected data (see Colorafi & Evans, 2016).

The current study contributed to the understanding of the effect of cultural factors related to mental illness among Mexican immigrants and their PHS. The ways individuals perceive their health, respond to treatment, and accept programs are related to their cultural perspectives, beliefs, and ideology (Jia et al., 2017). Culture influences how people process information, and their behavior may affect their health due to the relationship between health behaviors and health-related outcomes (Jia et al., 2017). Mexican Americans utilize PHS at a rate that is about half that of non-Hispanic Whites. Stigma, cultural values, and religious values are prevalent factors that influence PHS utilization by Mexican immigrants and are a significant factor in this disparity (Caplan, 2016). Cultural attitudes affect the way Mexican immigrants understand and relate to PHS. When health care providers can align programs to the perspectives of Mexican immigrants, improved treatment outcomes are possible. The current study filled a gap in the literature and addressed recommendations previous researchers had made to develop culturally oriented PHS. In this chapter, I discuss the research design and rationale, the role of the researcher, methodology, and trustworthiness.

Research Design and Rationale

Research Question

What are the Mexican immigrant's family's perceptions of PHS regarding their family member who has received PHS?

Central Concepts and Phenomenon

Researchers have shown that there is a correlation between the perceptions of mentally ill Mexican immigrants and their accessing PHS. Cabassa et al. (2007) explored Mexican immigrants' attitudes toward PHS treatment for depression. Patients reported apprehension toward medication use. Demographic factors, acculturation, symptoms, and previous PHS use influenced their attitude toward receiving PHS. Cabassa et al. emphasized the need to include Mexican immigrants' perceptions and feelings regarding treatment and PHS.

It is essential to incorporate research on ethnic minority groups with a focus on cultural traditions (Roosa et al., 2008). However, little was known about how the families of Mexican immigrants who have used PHS perceive the experiences and whether their feelings influence their family member's access to PHS. My study may fill the gap in the literature by highlighting the perspectives of Mexican immigrant families when accessing PHS. The most suitable approach for exploring this social problem was a qualitative exploratory descriptive design.

Rationale for Exploratory Descriptive Approach

An exploratory descriptive method is consistent with the rigor needed to analyze the essential elements of experiences that are common to the same culture or society (Vaismoradi et al., 2013). An exploratory descriptive method is used for research due to the comprehensive summary of events experienced by individuals or groups of individuals. The exploratory descriptive method is a viable and acceptable qualitative design and is the method of choice for straight descriptions of phenomena (Sandelowski, 2000). Exploratory descriptive studies tend to draw from naturalistic inquiry, which aligns with studying the phenomenon in its natural state to the extent it is possible in the research arena (Sandelowski, 2000). The goal of my exploratory descriptive study was to provide a comprehensive summary of the perceptions and experiences of Mexican Americans who have a family member who has used PHS.

Researchers conducting exploratory descriptive studies stay close to the meaning of their data. Exploratory descriptive researchers use an eclectic combination of data collection, sampling, representation techniques, and analysis. When straight descriptions of phenomena are desired, the exploratory descriptive design is the appropriate choice (Sandelowski, 2000). Any of the purposeful sampling techniques may be used in exploratory descriptive studies; especially useful is maximum variation sampling. Maximum variation sampling allows the exploration of specific manifestations of the targeted phenomenon. I used purposeful sampling to find participants who had useful information for the study (see Sandelowski, 2000).

Data collection techniques in exploratory descriptive studies are directed toward finding the who, what, and where of events or experiences. The data collection approach includes individual or focus group interviews (Sandelowski, 2000). I selected the interview approach because it focuses on interviewees who can contribute to the information necessary to understand the phenomenon being studied (Rudestam & Newton, 2015). Although quantitative methods are used to examine relationships and patterns using numbers and probabilities where researchers have control over the process, qualitative research is concerned with exploring the phenomenon in the participants' natural settings (Rudestam & Newton, 2015). The qualitative approach fit with the purpose of the current study.

There are several forms of qualitative research designs that I considered for this study: case studies, phenomenology, ethnography, grounded theory, and the exploratory descriptive design. Case studies address an event, organization, process, or person (Patton, 2015) and therefore were not the best option for my study. I chose not to use phenomenology because it is used to explore how people of a specific population perceive their world (see Patton, 2015). Ethnography is used to explore the cultural experiences of a group over a prolonged period (Rudestam & Newton, 2015) and therefore was not chosen for my study. Grounded theory is used to develop a theory and was not appropriate for my study (see Patton, 2015). Qualitative methodologies including content and thematic analysis approaches are commonly used in nursing research (Vaismoradi et al., 2013). The qualitative exploratory descriptive design focuses on straight descriptions of phenomena (Sandelowski, 2000) and therefore was consistent with the intent to advance knowledge of the families of mentally ill Mexican immigrants when accessing PHS.

Role of the Researcher

Qualitative studies rely on the integrity of the researcher because the researcher is the main instrument used in the data collection process (Rudestam & Newton, 2015). Quality depends on the researcher, and quality needs to be assured in the process of qualitative analysis in all phases and especially in collecting and analyzing data (Creswell, 2014). Researchers need to be objective to reduce subjectivity and to aim for neutrality (Patton, 2015).

As the researcher and the data collection instrument, I conducted, recorded, and transcribed the interviews. I was aware and noted any nonverbal communication such as body language and facial expressions of each participant. Bias can occur in data collection, planning, publication, and analysis. It is important to understand research bias when developing studies (Pannucci & Wilkins, 2010). I realized research bias was a possibility and make every effort to avoid it. I did my best to put aside preconceived thoughts regarding the participants and their beliefs and practices to make objective observations. As the researcher, I secured signatures of participants on all participant forms required by Walden University, including informed consent, the method of communication, and the interview protocol.

Methodology

Study Participants

Mexican Americans in a northwestern U.S. state who have family members who had a mental illness and who had sought access to PHS were the participants in this study. I used purposive sampling with an estimated sample size between 10 and 20 or continuing until saturation was reached (see Coyne, 1997). The final number of six participants was decided after the study interviews were conducted, and I began to see saturation so when no new participants brought new information to the interviews.

Sampling Design

Sampling is a process that defines which candidates to include and exclude from the research process (Martínez-Mesa, et. al, 2016). Sampling procedures in qualitative studies may be less rigid; however, sample selection has a profound effect on the quality of the research (Coyne, 1997). Although quantitative researchers use random and representative sampling for generalizable findings, qualitative research involves purposive sampling, and the researcher's focus is on selecting participants who can provide the information being sought (Ravitch & Carl, 2016; Rudestam & Newton, 2015). In purposive sampling, the sample is directed by the needs of the study (Coyne, 1997). Purposive sampling was used in the current study. The logic behind purposive sampling was the need for in-depth and information-rich data to explore the perspectives and experience of the families of mentally ill Mexican immigrants in the state of Washington. This sampling method is consistent with exploratory descriptive studies (Patton, 2015; Rudestam & Newton, 2015).

Inclusion and Exclusion Criteria

In exploring the perceptions of Mexican immigrants who had family members who suffer from a mental illness, the following inclusion selection criteria were used:

- Mexican immigrant who has a family member who is a Mexican immigrant
- 18 years or older in age
- nondisabled
- has a family member who has or has had a mental illness
- speaks or reads English
- agrees to be interviewed and audio tape-recorded
- able to use language to tell their stories
- able to travel to an interview site or select a site of their own or agree to a phone or online interview

Exclusion criteria included the following:

- participants with English proficiency challenges
- children
- participants who are unable to travel independently to the interview site
- prisoners
- those who are cognitively impaired
- those who are unable to read and understand the consent document
- mentally/emotionally disabled individuals

Sample Size

I planned for 10 participants; however, I interviewed participants until the content became repetitive and saturation was reached. To obtain the purposive sample, I sent flyers (see Appendix D) to five large churches where Hispanic congregants attend. The churched bulletins, emails, and online services that were sent to congregants so congregants could gain access to local events and services. The churches were all located in the northwest region of the United States. The flyer provided an email address for potential participants to contact me. I then emailed each participant who responded and set up a time for a call with the participant. The participant's return email was their consent to participate in an interview online, by phone, or face-to-face. Interviews were all conducted face-to-face. No contacts or interviews began until Walden University's Institutional Review Board (IRB, approval number 09-09-20-0912254) provided approval for the study.

Sampling continued until saturation was reached (see Lincoln & Guba, 1985). The number of interviewees depended on the point at which the interviews captured critical information and established theoretical relevance so that themes could be formed that explained the phenomenon being studied (see Rudestam & Newton, 2015). When considering sample size in qualitative research, both the number of participants and the extensiveness of information gathered from each participant are considered (Creswell & Poth, 2018). There is a wide range for sample sizes that can be appropriate, and there are no set rules that govern sample size selection for qualitative research (Patton, 2015). Using this sampling strategy, the researcher focuses on sampling adequacy (Bowen, 2008; Lincoln & Guba, 1985; Strauss & Corbin, 1990). Attaining saturation is an accepted practice in QD (Saunders et al., 2018).

Interviews

Prospective participants underwent an interview conducted face-to-face. Interviews were used as the primary tool to gather data. These interviews would help to explain the perceptions of the families of mentally ill Mexican immigrants when accessing PHS. Flyers were posted at churches, and invitations to participate were sent to those who responded to the posted flyers. Interviews were held at the participant's choice of location. All interview protocols followed IRB requirements including maintaining participants' privacy and confidentiality. Confidentiality was maintained by strict adherence to IRB requirements and maintaining safe and secure containment of all documents pertaining to the study.

As recommended by Creswell and Poth (2018), the interview guide had 10 central questions. I conducted one-on-one, semi structured interviews with participants. All of the questions in the interview guide were open-ended and written simply and clearly (see Appendix C). Qualitative interview questions should be open-ended and clear to help participants provide answers that are meaningful to the study (Patton, 2015).

Clarity in the interview questions was crucial for the selected population of my study. It is important for the researcher to reduce bias in the research process and enhance comparability by presenting the interview questions in a standardized and open-ended format (Patton, 2015). Standardization of the main interview questions allows participants to answer the same initial questions while creating variability with probes and follow-up questions (Patton, 2015). The main interview questions were blended with prompts and follow-up questions to generate depth and detail (Rubin & Rubin 2012). Researchers should prepare questions in advance when conducting qualitative studies and modify them as needed as the interview process proceeds (Rudestam & Newton, 2015). I provided an opening statement that included a greeting to the participants before each interview, and ended with closing statements, debriefing, and thanking the respondents for their participation. I also reiterated assurance of confidentiality and asked for follow-up information and potential future interviews as suggested by Creswell and Poth (2018). All interviews were audio recorded. A maximum of two interview sessions were scheduled per day over the data-gathering period. The interviews lasted between 22 and 67 minutes. I labeled all data collected, including field notes, to make it easy to retrieve them during analysis. I conducted the interviews with genuineness, empathy, neutrality, attentiveness, and trustworthiness, as recommended by Patton (2015).

Confrontations were curtailed, because resolving contradictions is less of a priority than information seeking. I sought nonthreatening clarification from participants and remembered to back away from information that seems sensitive to them (Rubin & Rubin, 2012). All interviews were held face to face in a quiet, private location of participant's choosing. The collected data, namely the recordings, notes, and signed consent materials will be stored in a locked area.

Interview Questions

The principal question guiding this research was: What are the Mexican immigrant's family's perceptions of PHS regarding their family member who has received PHS? The interview questions I developed to generate the data for this research were the following:

1. Please tell me about your experience with your family member's mental illness.
2. How does your family member's mental illness affect your daily life?
3. Tell me about experiences you have had with accessing psychiatric services for your family member.
4. How does your culture influence the way you care for your family member's mental health?
5. Tell me more about how your friends and family affect your family member's mental illness or mental health?
6. To what extent does your community affect how you care for your family member's mental illness?
7. Does your family member's mental illness affect how you participate in your community? (Probe from # 7 In what way does your family member's mental illness affect your participation in your community activities [work, school, church]).

Instrumentation

This study involved collecting participants' reported experiences and separating them into codes, patterns, and categories to understand the perceptions of the families of mentally ill Mexican immigrants when accessing psychiatric services. Qualitative analysis involves converting interview data into findings that are plausible from the information gathered from participants, with no set rules for the process (Patton, 2015).

Researchers use a variety of means to reach the same qualitative analysis conclusions. Creswell and Poth (2018) provide qualitative data analysis strategies that involved organizing the data by preparing the files of the data and making sure they are securely stored. I followed this strategy by reading the transcripts and taking notes by hand. The most frequently adopted form of analysis in qualitative studies is to denominate the data with codes so they can be assigned to manageable groups for analysis (Ravitch & Carl, 2016). I transcribed and coded the data as soon as they were collected while the interview events were fresh in my mind and did not wait until later when recall may be difficult, and the data had become voluminous.

Themes were aggregated into events to generate ideas that provide answers to my research question (see Creswell & Poth, 2018; Ravitch & Carl, 2016). Answers to the research question might help healthcare professionals and other relevant officials understand the perspectives and experiences of the selected group so that they can make critical decisions that improve programs. To ensure data consistency, triangulation was done by comparing interview data with my field notes. Copies of interview transcripts were provided to participants to ensure their words and ideas were accurately represented.

Basis for Instrument Development

The instrument used throughout qualitative research and data collection is the researcher (Patton, 2002). As recommended by Creswell (2013) and Maxwell (2012), I conducted interviews using self-created, semi structured questions. Open-ended along with a few closed questions were used to obtain participant's perspectives and experiences. A self-created 10-minute demographic questionnaire was also used (Appendix B). An interview guide was developed for the purpose of narrowing interview questions that allowed the participants to reflect on how their experiences with PHS for their family members impacted PHS (Appendix C).

Establishment for Content Validity and Sufficiency

To ensure the credibility and validity of the study, several actions were performed. Credibility was achieved by gathering data devoid of gaps and represented depth of the phenomenon under exploration (Rubin & Rubin, 2012). I established saturation of data through interviewing participants until no new information was presented. All data obtained were reviewed by an experienced doctoral-prepared individual, myself and my research reviewer. There was a review by the participants of their interview transcripts which provided trustworthiness of the study (Shipman et al., 2016). Triangulation of current data was related to the phenomenon that is present in the literature review. The results of the study were compared to previous studies to show transferability. All planned and completed processes of the study was disclosed in the next chapter to allow for similar future studies and to achieve dependability. Audit trails were completed throughout the research study process, which allowed for disclosure of how and why actions were completed during the data collection and analysis (Shipman et al., 2016). The actions noted above assisted in demonstrating the credibility and validity of the proposed study.

Procedures for Recruitment and Participation

Participants were recruited by displaying notices at churches in Washington state after receiving approval from IRB. Permission was obtained prior to putting notices on bulletin boards in churches. Participation was voluntary and prospective participants underwent an interview conducted by the student. I complied with state and federal guidelines by informing participants of the level of confidentiality that I assured with my study. I informed the participants of their right to ask any questions about the study, which was done by face-to-face interaction. I did not include anyone in the study with whom I have a personal relationship to include professional colleagues, academic colleagues, friends, family members, or coworkers.

Upon the receipt of their consent to participate the participants were given a copy of the consent for their records. The interview was scheduled in a place convenient for the participant. The study did not cause any acute emotional or psychological discomfort. However, to protect participants from psychological distress they were informed of local resources in their areas if they experience any negative side effects or discomfort from their participation.

Details of Data Collection

Data were collected by interviewing participants, writing down observations, and tape recording the interviews after obtaining their permission. The interviews were then transcribed, and data were analyzed manually.

Data Analysis Plan

This study involved collecting participants' reported experiences and separating them into codes, patterns, and categories using thematic analysis which can be accomplished with software such as NVivo, or by manual coding using a systematic method of coding. I chose to use manual coding for thematic analysis for this study.

Coding is a process that is necessary in qualitative methods and involves assigning a label that has significant meaning to data that are collected when conducting a qualitative study (Creswell, 2013). Thematic analysis, precoding, first cycle coding, and second cycle coding was used to analyze data. Thematic analysis is an adaptable method that enables themes and patterns to be identified, described, analyzed, and reported (Miles et al., 2014). Consistent with Miles et al.'s (2014) recommendation for thematic analysis, I familiarized myself with the data by reading the contents of the transcribed interviews to become familiar with the contents. I generated labels through coding so that I can uncover important features found within the data that would be helpful in answering the research questions. Uncovered themes were reviewed against the data set to determine if they answered the research questions. During this phase, themes were defined, refined, and named after a detailed analysis.

Coding included several processes such as analysis, condensing data into meaningful matter, and was a pathway for discovery. Coding was categorized into two stages which were first cycle coding and second cycle coding. First cycle coding can be inclusive of 25 different approaches, each complete with their own unique purpose (Miles et al., 2014). For this study, descriptive coding was used. According to Miles et al.

(2014), when researchers utilize first cycle coding processes, the data that are obtained are congregated into codes that are often recurrent to see if different themes will emerge as well as summarize different segments of data.

For descriptive coding, I looked at basic passages of the interviews and assigned labels, short phrases, or a word to summarize the data. Descriptive coding yielded a list of topics that will be indexed and categorized as codes. The words or phrases from the participant's interviews were placed in quotation marks which set them apart from the codes I generated. Repetitive words or phrases from the participants led to patterns. Second cycle coding involved taking the summaries of data segments obtained from first cycle coding and breaking them down into smaller segments or themes; this will also be considered pattern coding (Miles et al., 2014). I used pattern coding to take large amounts of data and then condense it into smaller units. I was able to analyze collected data which will help me understand interactions, incidents, and laid the foundation for cross-case analysis (Miles et al., 2014).

Issue of Trustworthiness

Researchers performing qualitative studies seek to understand what has happened in the lives of people not to predict future events (Rubin & Rubin, 2012). In qualitative studies, trustworthiness or validity of qualitative research and transparency of the study are crucial to the integrity of the study findings (Cope, 1969). The rigor of a study or trustworthiness refers to the degree of confidence in the methods, data, and interpretation, which ensures the quality of the study (Polit & Beck, 2014). Trustworthiness in qualitative research incorporates credibility, transferability, dependability, and confirmability (Connelly, 2016).

Credibility

Research findings need to be credible if they are to have information relevant for professionals use in enhancing practice and developing programs (Rubin & Rubin, 2012). According to Polit and Beck (2014), confidence in the truth and findings or the credibility of the study is the most important criterion. Specific techniques can be used to establish credibility, prolonged engagement with participants, continuous observation, reflective journaling, and repeated iterative questioning (Connely, 2016). In my study to assure credibility, I performed participant checks by emailing participants a copy of the interview transcripts, so they were able to check for accuracy. I l also established credibility by using iterative questioning in order to obtain detailed information from participants (Connely, 2016).

Transferability

The ability in which research findings are found useful by other readers in their own situations is transferability (Polit & Beck, 2014). Qualitative researchers focus on participants telling their own story and support the transferability by providing a detailed description of this story and by being transparent in their analysis (Connely, 2016). Transferability is possible when findings are separated into variables, where the researcher can define which of the study variables relate directly to parts of variables of another population (Patton, 2015). Ultimately, the focus of the qualitative researcher is to provide depth and information that is rich in detail (Connely, 2016). To assure transferability, I established by providing accounts of the social, personal, environmental, and social experiences the participants will experience and how it might be transferred to other people, settings, or situations (Elo et al., 2014).

Dependability

Dependability refers to data stability over time and within the circumstances of the study (Polit & Beck, 2014). Dependability is similar to reliability in quantitative research, with the understanding that the stability of conditions depends on the nature of the study. Dependability in qualitative research relies heavily on the accuracy and record-keeping of the study (Connely, 2016). For this study, dependability included collaborating with the writing center, my committee chair, and other committee members who will act as auditors and reviewers of my work. I continually sought guidance to ensure procedures were followed throughout the study process. Dependability included the effective management of all records and documents of the study. Saving and backing up my reports throughout my dissertation was essential components of ensuring dependability.

Confirmability

Confirmability is the degree to which findings are consistent and could be repeated (Polit &Beck, 2014). Qualitative researchers use methods to ensure confirmability, which include maintenance of an audit trail of analysis and detailed notes of all their decisions and their analysis as it progresses (Connely, 2016). To assure confirmability, I checked with the participants during the duration of the study. To establish confirmability an audit trail was provided which will highlight each step of data analysis process and will provide a rationale for the decisions that was made. Providing an audit trail helped to establish the study findings accurately detail the participants answers (Connely, 2016).

Ethical Procedures

Working with human subjects requires an application to the Walden University's IRB before proceeding with data collection. Walden University's IRB must approve the application before any human subject interviews may commence. Approval was granted by Walden University's IRB and informed consent was obtained from participants. A consent form was given to the participants for signature. Project identification, purpose of study, procedures, risks, benefits, confidentiality, and an explanation of participant's rights were included in the consent form. Participants were advised of all rights to include withdrawal from study participation and the right to ask questions. If participants showed signs of agitation or distress, the interview ceased. All participants received a list of available resources in the area if they needed further assistance. The informed consent included the following information:

1. A brief description of the study
2. Inclusion criteria
3. Voluntary nature of the study
4. Informed consent process
5. Brief description of the procedures
6. Sample questions from the interview
7. Benefits of the study

8. Confidentiality of the study
9. My contact information if questions should arise

Confidentiality and anonymity were maintained by informing the participants that the researcher will used codes to identify data.

Summary

In this chapter, I discussed the research design and rationale, the role of the researcher, the methodology, and trustworthiness. In Chapter 4, I discuss the setting of the interview, demographics of participants, data collections process, data analysis, and produce evidence of trustworthiness.

Chapter 4: Results

The purpose of this qualitative exploratory descriptive study was to explore the experiences of Mexican immigrants in a northwestern U.S. state who have family members who had a mental illness, and to explore the family members' perceptions of PHS. I sought to investigate the challenges of Mexican immigrants' PHS use in the United States. The research question guiding this study was the following: What are the Mexican immigrant's family's perceptions of PHS regarding their family member who has received PHS? Chapter 4 includes the setting, demographics, data collection, data analysis, evidence of trustworthiness, and results of the analyses related to the research question.

Setting

Following IRB approval, participants for this study were recruited after they responded to a flyer posted in churches in northwestern U.S. state. Flyers were also hand distributed to potential participants who expressed an interest in participating in the study. Participants were then screened to determine whether they met the inclusion criteria. Twenty-five individuals met the inclusion criteria and were contacted to verify interest and potentially schedule a time and location for their interview. Of the 25 who met the inclusion criteria, six agreed to participate in the study. Once participants agreed to be in the study, they gave their preferred date, time, and location for the interview. Two participants requested a date change after their interviews were scheduled, and those date changes were made to accommodate the participants' schedules.

Demographics

Two men and four women participated in the interviews. The mean age of participants was 37.3 (*SD* = 14.58) with a range of 21 to 62. Five of the participants were Mexican and one was White, although the White participant's family member was a Mexican immigrant. Five of the participants were of Hispanic origin and one was non-Hispanic. Two of the participants were born in Mexico and four were born in the United States. All participants spoke English. Five of the participants had some college education and two had minimum education in grammar school. All participants had family members who were Mexican immigrants who had a mental illness.

Data Collection

The interviews for the six participants occurred in a location selected by the participant (e.g., a library, a common room of their choosing, their personal home, or their place of work). I explained the purpose of the study, privacy, risks, and benefits to each participant, and provided the informed consent. A preformatted interview guide was used to guide the interview. The questions were presented to each participant and repeated if the participant requested. I recorded the interviews with the permission of all participants using an audio recorder. I took field notes to describe my observations during the interview and journaled personal thoughts and feelings after the interviews. Following the interview, the participants were thanked for their contribution to the study.

Once the interviews were completed, I transcribed the recorded audio files for each interview verbatim. To validate the transcripts, I listened to the audio recording of each interview with the transcript and checked that each interview transcript was true to the recording. Additionally, the transcripts and audio files with no identifiers were uploaded for my committee chair to review and to check for consistency in the interview technique and content. The files were then uploaded to a password-protected hard drive that will be maintained for a minimum of 5 years, after which time the files will be destroyed.

Data Analysis

I familiarized myself with the data by reading the contents of the transcribed interviews to become familiar with the contents. I generated labels through coding so that I could uncover important features found within the data that would be helpful in answering the research question. Transcripts were reviewed three times, and terms were color-coded to determine patterns in each interview transcript. I reviewed the transcripts three times and had the chair of my committee review transcripts and terms to validate my initial coding. I continued to use this pattern of coding and an inductive approach to take large amounts of data and condense it into smaller units.

Analysis of the transcripts involved collecting participants’ reported experiences and separating them into codes, patterns, and themes using thematic analysis to understand the perceptions of the families of mentally ill Mexican immigrants when accessing PHS. Qualitative analysis involves converting interview data into findings that are plausible from the information gathered from participants, with no set rules for the process (Castleberry & Nolen, 2018; Patton, 2015). The terms in each interview were color-coded, and then the terms were listed in columns to establish patterns. Straight descriptions of phenomena are desired, and exploratory descriptive design is the appropriate choice (Sandelowski, 2000). The basic descriptive design was used to analyze data in the current study.

Coding included several processes for analysis including condensing the data into meaningful pathways for discovery. Coding was categorized into two stages that included first cycle coding and second cycle coding. According to Miles et al. (2014), when researchers use first cycle coding processes, the data that are obtained are congregated into codes that are often recurrent to determine whether different themes will emerge as well as summarize different segments of data. For the current study, descriptive coding was used. I examined basic passages of the interviews and assigned labels, short phrases, or a word to summarize the data. Descriptive coding yielded a list of topics that were indexed and categorized. The words or phrases from the participant's interviews were placed in quotation marks, which set them apart from the codes I generated. Repetitive words or phrases from the participants led to the identification of patterns.

Second cycle coding involved taking the summaries of data segments obtained from first cycle coding and breaking them down into smaller segments or themes. This is also considered pattern coding (Miles et al., 2014). I used pattern coding and an inductive approach to take large amounts of data and condense it into smaller units. I was able to analyze collected data that would help me understand interactions and incidents and would lay the foundation for cross-case analysis (see Miles et al., 2014). The use of an inductive approach allowed me to determine the themes.

I separated the data into codes, patterns, and themes to analyze the data thematically. Thematic analysis is an adaptable method that enables themes and patterns to be identified, described, analyzed, and reported (Miles et al., 2014). Thematic analysis was used as the primary exploratory descriptive data analysis (see Miles et al., 2014). The themes were reviewed against the codes and patterns to determine whether they answered the research question. During this phase, three individual themes were defined, refined, and named.

Evidence of Trustworthiness

Researchers performing qualitative studies seek to understand what has happened in the lives of people, not to predict future events (Rubin & Rubin, 2012). Trustworthiness or validity of qualitative research and transparency of the study are crucial to the integrity of the study findings (Cope, 1969). The rigor of a study or trustworthiness refers to the degree of confidence in the methods, data, and interpretation, which ensures the quality of the study (Polit & Beck, 2014). The characteristics of trustworthiness of my study include credibility, transferability, dependability, and confirmability (see Connelly, 2016).

Credibility

Research findings must be credible if they are to have information relevant for professionals to use in enhancing practice and developing programs (Rubin & Rubin, 2012). According to Polit and Beck (2014), confidence in the truth and findings or the credibility of the study is the most important criterion. Specific techniques can be used to establish credibility, including prolonged engagement with participants, continuous observation, reflective journaling, and repeated iterative questioning (Connely, 2016). To ensure credibility, I used reflective journaling and repeated questioning as needed during the interviews. Additionally, I performed participant checks by emailing participants who agreed to review their interview transcripts, giving them the opportunity to check for accuracy. Of the six interviewees interviewed, three agreed to review their transcripts and were emailed a copy. The three participants returned the transcripts with indications that interview transcripts reflected their conversations and were accurate regarding what they stated.

Additionally, by using iterative questioning to obtain rich, detailed information from participants, I was able to ensure credibility of the responses. When any one response was not clear, I repeated the question to ensure the participant understood the question. By iterative questioning and finding similar responses, I could ensure the participant understood and the responses were clear. Last, I used reflective journaling to establish credibility. During the interviews with the six participants, I wrote down my observations after meeting with each person.

Transferability

The degree to which research findings are found useful by other readers in their own situations is transferability (Polit & Beck, 2014). The focus of the qualitative researcher is to provide depth and information that is rich in detail so that findings of the study may be applied to other settings (Connely, 2016). To ensure transferability, I presented the demographics of the participants so that results could be transferred to similar populations.

Dependability

Dependability refers to data stability over time and within the circumstances of the study (Polit & Beck, 2014). Dependability is similar to reliability in quantitative research with the understanding that the stability of conditions depends on the nature of the study and relies on the accuracy and record keeping of the study (Connely, 2016). For the current study, dependability was ensured by collaborating with the writing center, my committee chair, and other committee members who acted as auditors and reviewers of my work. I continually sought guidance to ensure procedures were followed throughout the study. Dependability also included the effective management of all records and documents in the study. Additionally, dependability included participants evaluation and validation of the findings, and interpretation and recommendations for the study. Finally, saving and backing up my reports throughout my study were essential in ensuring dependability.

Confirmability

Confirmability is the degree to which findings are consistent and can be repeated (Polit & Beck, 2014). Qualitative researchers use methods to ensure confirmability, which include maintenance of an audit trail of analysis and detailed notes of their decisions and analysis as it progresses (Connely, 2016). To ensure confirmability, I gave participants the opportunity to review a copy of their interview transcript. Three participants agreed to review their transcripts, and a copy of the transcript was emailed to each of the three. Each of the three participants responded that the interview transcripts were accurate as to what they had said during their interview. Additionally, an audit trail was created to highlight each step of the data analysis process and to provide a rationale for the decisions that were made. This enhanced the confirmability of the study by establishing the study findings.

Research Question

What are the Mexican immigrant's family's perceptions of PHS regarding their family member who has received PHS?

Results

The data were simultaneously collected and analyzed. Once the interview responses became repetitive and no new information was revealed, I determined that saturation had been reached. However, I continued with three additional interviews to confirm saturation. I had no discrepant cases that needed to be factored into the analysis. Each of the six participants' responses showed consistency in codes and categories. Themes were visible and consistent between the findings in each interview, and themes were evident by seeing codes present in 25% of the interviews (see Hyde, 2003).

Theme 1: Mental Health Is a Private and Individual Issue

The highly sensitive nature of mental illness of the Mexican immigrant was expressed by five of the six participants. The participants described the private nature of mental illness among their families and how mental illness was often hidden from family members. Five of the six participants shared the private nature of mental illness in their families:

- "He wouldn't go for help because he couldn't let his family know he had a problem even though they knew he had a problem" (Participant 01).

- “It’s not necessarily shared … because of it being hidden … it’s not like we talked about it’s not talked about at all … it is ignored until it’s a bigger problem than it was originally was” (Participant 03).
- “My family is … embarrassed and does not talk about her mental illness. They just ignore that anyone has a mental illness” (Participant 03).
- “We need to understand that mental health is an actual issue … it needs to be addressed it needs to be stopped being dismissed” (Participant 04).
- “Some take care of themselves” (Participant 05).
- “My family is still embarrassed and does not talk about … mental illness. They just ignore that anyone has a mental illness” (Participant 06).

Theme 2: Culture Plays a Role in Accessing Care

Culture plays an integral part of the family and the mentally ill person’s life. Each of the six participants expressed the importance of culture as an influence on perceptions of mental illness and PHS for their family member:

- “In his culture … it was really frowned upon and not really even talked about so with that being said just that person wouldn’t go for help because of the stigma in his culture … it’s the culture … mental illness doesn’t exist in their minds” (Participant 01).
- “No one sought help for any kind of mental health care” (Participant 02).
- “It’s not talked about in our culture … if I feel like I’m having a mental health issue, I’ll never bring it up to my family … it is just not talked about at all. If someone does have a mental health issue, they’re just labeled as crazy instead

of finding adequate help. In our culture … they can't really have mental health issues because our culture doesn't really accept it as a problem … because of stigma" (Participant 03).

- "I think they really tend to just put it underneath the rug and just really not like oh that's just all in your mind it's all in your head you can overcome" (Participant 04).
- "People who have a mental illness are kept away from everyone else … they are afraid they might get crazy too" (Participant 06).

The secretive nature regarding mental illness of the individuals remained very personal. It evolved to the extent that the family members often made the decision to disclose based on the situation and to whom they were disclosing. The impact of these decisions were detrimental to how each person felt. As demonstrated by this theme, culture plays an important role in openly discussing and accessing care as evidenced by the responses of the participants.

Theme 3: Role of Religion in Mental Health Care

Five of the participants in my study shared that for their family member, it was the church that would provide treatment instead of seeking formal PHS:

- "She was so religious-so I think all her activity outside of the home was dealt with religion…going to church …. As the illness got worse, she resorted to the church versus anything else when things were bad so that was her way of coping versus getting help for herself. Most (try to) take care at home … because they don't want to worry the other relatives … they will take care by themselves at home … will go to church and pray mental health issues" (Participant 02).

- "(They go to) church every Sunday to try to get better … I keep going back to the religion but I know that a lot of people have long rituals for like praying … they'll do like a ritual for that person to drive the evil spirit out" (Participant 03).
- "I know that as far as ask my mom or usually discovered praying or using like religion as a way to cope with it and not actually seeking medical attention depression Praying or using like religion as a way to cope with it and not actually seeking medical attention … one of my aunts had depression and that wasn't really talked about she went to church every Sunday to try to get better" (Participant 04).
- "Most (try to) take care at home … because they don't want to worry the other relatives … they will take care by themselves at home … will go to church and pray mental health issues. This is the depends depend on how you feel … Sometimes they go to church and pray it just depends on how you feel if you feel really bad depending on how you feel or pray they have different ways … religion part where so there's praying … they pray" (Participant 05).

As demonstrated by the findings of this study, religion plays a major role in the families of those with mental illness and in some cases, may prevent the individual from seeking out professional mental health. Thus, understanding the importance of religion among this population is key in creating strategies to address the needs of this population.

Discrepant Cases

The data analysis in qualitative design requires the investigation of discrepant evidence that runs counter to themes (Creswell, 2013). The responses from the participants did not illuminate any nonconforming or discrepant data. The answers to the interview questions remained within a narrow range of barriers and did not receive any responses that required further clarification. The use of PHS was a discrepant case because the family members stated that their mentally ill family members refused or did not use or pursue PHS.

Summary

The purpose of this qualitative descriptive study was to examine and explore the perceptions of family members who have Mexican immigrant family members with a mental illness. In Chapter Four, I provided an overview of the processes used to collect, manage, and analyze the data obtained from six in-person interviews which was explored by examining the thoughts, beliefs, and perception of these family members. All identified codes were color coded and categorized then themes were identified. The themes that emerged from this study included mental health is private and individual issue; culture plays a role in accessing care, and role of religion in mental health care. The next chapter will provide an overview of the interpretation of research findings, limitations of the study, recommendations, implications on positive social change, and conclusion of the research study.

Chapter 5: Discussion, Conclusions, and Recommendations

Mental illness services in Mexican American society continue to be underserved and underutilized (Interian et al., 2007; Vega et al., 1999; Vega & Alegria, 2001). It had been a dream of mine to research and discover ways to help provide PHS to underserved populations. One way to do this is to identify factors that prevent PHS from being utilized. Previous studies also found the underutilization of PHS by Mexican Americans is prevalent and needs to be considered when addressing PHS (Interian et al., 2007; Vega et al., 1999; Vega & Alegria, 2001). According to findings in the current study, possible reasons for not using PHS may be that mental health is a very individual and personal issue, that culture plays a role, and that religion plays a role in mental health. Determining reasons behind this lack of utilization may enable health care professional to provide improved PHS. The purpose of this qualitative exploratory descriptive study was to explore the experiences of Mexican immigrants in a northwestern U.S. state who had family members who had a mental illness, and to explore the family members' perceptions of PHS. Chapter 5 provides the interpretation of the findings, limitations, recommendations, implications, and conclusions.

Interpretation of Findings

The research question for this study was the following: What are the Mexican immigrant's family's perceptions of PHS regarding their family member who has received PHS? To discuss the interpretation of the results of the study, I present the interpretation in the context of the three themes that emerged from the thematic analysis.

I also discuss how the findings confirm, disconfirm, and extend the knowledge of the discipline.

Theme 1: Mental Health Is a Private and Individual Issue

People with mental illness tend to feel shame and have a fear of discrimination to the point that they may not actively seek care for their illness (Thornicroft, 2008). Mexican immigrants may not willingly seek treatment because of the shame and stigma associated with mental illness within the Mexican culture (Naso, 2016; National Alliance on Mental Illness, 2017). The participants in the current study shared that their family members tended to deal with their mental illness by themselves and made the conscious decision not to share the information with others. O’Mahony and Donnely’s (2007) findings are similar to my finding because in many societies, the family members do not share their mental health issues to maintain privacy. De Freitas et al. (2018) posited that individuals with mental health issues and families of individuals with mental health issues often fear being labeled; therefore, the illness may go undiagnosed and left untreated. Mulfinger et al. (2019) supported this finding that many individuals with a mental illness do not discuss their illness to avoid stigma. Further, individuals with mental health illnesses may not engage with appropriate resources given the fear and personal anguish that may follow them if identified as someone seeking appropriate services (Perry, 2011). However, as demonstrated by the findings of my study, the reason for maintaining privacy was related to shame and isolation among individuals with mental illness. This aligns with the current literature that indicates mentally ill people often do not share the fact that they are mentally ill, and it is a conscious decision to keep their illness hidden to outsiders (O'Mahony and Donnely, 2007).

One possible reason for barriers to PHS for this population may be that mental health is a private and individual issue. Each of the current participants described their private and individual issues in connection with the mental illness of their family member, and noted that it may be the private nature of the illness that creates the barrier to assessing treatment for the illness. Mental illness and the role of mental illness in society has been linked to negative thinking and negative feeling (Scheff, 1999). Societal norms of who is normal and who is not normal impact how the mentally ill are accepted by society (Lo et al., 2020). The literature indicates that Hispanic Americans tend to have better mental health as compared to non-Hispanic Whites (Lo et al., 2020). However, given the challenges of American life, Cobb et al. (2021) found that mental illness is growing among this population. Given the findings of the current study, assisting this population in understanding the importance of mental health as well as the need for transparency in discussing mental health is paramount for this population. As demonstrated by the results of this study, individuals with a mental illness may not acknowledge that mental illness due to the stigma associated with mental illness, and may prevent themselves from accessing PHS. Recognizing these personal and individual perceptions are important considerations when creating strategies to improve PHS use among this population.

Theme 2: Culture Plays a Role in Accessing Care

As demonstrated by the current study, the culture of the individuals may have prevented many of the family members not only from discussing their mental health concerns but also from seeking care for their mental health concerns. The fear of being labeled and ostracized from their society influenced their family member's behavior. The literature supports the results of my study. The secretive and predominant characteristic of culture playing a role in accessing care for mental illness in the family is evident in the Mexican immigrant families (Mulfinger et al., 2019). Disclosure of mental illness compared to keeping it to oneself is a common trait in those suffering from mental illness (Mulfinger et al., 2019). The choice to disclose carries with it the added fear of being ostracized and segregated from society (Mulfinger et al., 2019). Other ethnic disparities related to treatment and trust of treatment, self-felt stigma, coping styles, and distinctive cultural beliefs deter Hispanics from accessing PHS (Snowden & Yamada, 2004). Participants in my study voiced that being labeled loco was common when a mentally ill person revealed they had a mental illness. The literature indicates the negative feelings leveled at mental illness and the cultural repercussions that one would suffer when labeled mentally ill may keep individuals from assessing care (O'Mahony & Donnely, 2007). This was the case in the current study. The results indicated that fear of labeling and the stigma associated with mental illness acted as a deterrent to accessing and utilizing PHS. My results confirm the literature by indicating that culture influences how mental illness is viewed. The association between cultural barriers and PHS utilization indicate that culture needs to be considered when providing PHS to Mexican immigrants.

As demonstrated in the literature as well as in my study, culture is an important factor and a plausible barrier in mental health treatment and access to PHS. As a result, strategies are needed to encourage individuals to overcome the stigma of mental illness and cultural factors that may otherwise prevent them from seeking appropriate treatment and care. For example, Leong and Kalibatseva (2011) examined the importance of acculturation and the process by which individuals change their behaviors and attitudes toward mental health illness. Individuals with low levels of acculturation perceive more cultural barriers to seeking help. By addressing acculturation, more individuals are receptive to mental health treatment (Leong & Kalibatseva, 2011). As a result, providers may have an important role in supporting populations that may be at risk for mental illness as well as the cultural barriers that may prevent individuals from accessing care.

Theme 3: Role of Religion in Mental Health Care

Faith and spirituality are often relied on when coping with mental health issues. Religion may be used as a coping mechanism or treatment for those suffering with mental illness or stress (Ozcan et al., 2021). However, despite being a coping mechanism, religion may also serve as a deterrent and prevent the seeking of PHS (Ayvaci, 2017). Mexican American families have strong religious beliefs and believe in the healing power of God, which may delay or prevent mentally ill family member from seeking care (Guarnaccia & Pilar, 1996). Stolley and Koenig (1997) posited that most Mexican Americans are “self-reported Roman Catholics” (p. 33). The literature is replete with examples of the role that religion and religious values play in the lives of Mexican Americans (Hill & Pargament, 2003; Lujan & Campbell, 2006). The findings from my study align with the literature because the current participants shared that family members relied heavily on religion to help them with their mental illness. The participants expressed that their family members utilized prayer and religion to cope with their mental illness; in cases in which the mental illness was exacerbated, the individual spent more time in church and praying.

The literature supports the role of religion in mental health. For example, Weber and Pargament (2014) posited that religion and spirituality can promote mental health and well-being and offer a sense of meaning and purpose in times of difficulty. Participants in my study indicated that when the mental illness was exacerbated, the individual would “pray harder” or “go to church more.” As a result, there is a need for providers to understand this important relationship between the role of religion and mental illness among this population.

Leininger’s Culture Care Diversity and Universality Theory and Barriers to PHS

The theoretical base for this study was Leininger’s (1970) culture care diversity and universality theory, which focuses on studying and understanding other cultures and knowledge about care and culture constructs related to health. Leininger’s (1970, as cited in McFarland & Wehbe-Almah, 2015) theory directs researchers to discover and use culturally based knowledge to provide better care. The theory addresses how culture plays an essential role in determining how people react in society. Leininger’s (1970, as cited in McFarland & Wehbe-Almah, 2015) theory has shown the way toward nursing’s response to culturally diverse patients.

Theme 1: Mental Health Is a Private and Individual Issue

Leininger (1970) supported examining the whole person when considering care. As demonstrated in the current study, it is important to understand that a person's perceptions of an illness are part of that individual. Therefore, it is important to recognize that the individual's view of their illness is a personal issue when examining the individual. One of the concepts of Leininger's theory is human beings. This concept relates to the findings of the current study (see McFarland & Wehbe-Almah, 2015).

Theme 2: Culture Plays a Role in Accessing Mental Health Care

The data directly reflect cultural constructs and their effects on PHS. Understanding how culture impacts when a mentally ill Mexican immigrant seeks and uses PHS was evident within the findings. One of Leininger's (1970) Theory concepts is culture. Care needs to be culturally congruent to the individual's needs (McFarland & Wehbe-Almah, 2015). Current participants emphasized how their culture influenced how a person treated their mental illness, which was the reason they utilized their primary care physician instead of going to a psychiatrist. Participants stated that their family members were only comfortable seeing a general physician.

An individual's culture plays a role in accessing mental health care. When analyzing and interpreting the data findings using Leininger's theory, I noted other factors within the data. Leininger (1970, as cited in McFarland & Wehbe-Almah, 2015) included society and culture and thought it was important to a patient's care to remember they do not stand alone and that they are a part of a society and culture. Culture plays a role in accessing care in mental health and intimates that caregivers should include culture in how they care for a patient. The implied stigma people experienced due to having a mental illness was derived from their cultural beliefs of how mental illness is viewed in their culture. Leininger's theory can be used to help nurses understand the cultural implications that are present when a Mexican immigrant seeks PHS.

Theme 3: Role of Religion in Mental Health Care

When analyzing and interpreting the data findings using Leininger's (1970) theory, I noted other factors within the data. Leininger also placed importance on looking at the spiritual part of a person when giving them care. Cultural and social structure is specific to each culture, and it includes religious values and kinship (McFarland & Wehbe-Almah, 2015). The current participants emphasized the importance of religion in their culture.

Leininger (1970) encouraged seeing a person in a three-dimensional way whereas in the past they were looked at as an illness. Leininger emphasized that everyone is composed of other entities, and caregivers need to look at them that way when giving them care (McFarland & Wehbe-Almah, 2015). In the current study, the role religion played was engrained in the Mexican immigrant's way of life. Religion was a part of their culture that was learned and shared and transmitted into their beliefs (Guarnaccia & Pilar, 1996). My study findings supported this concept.

Limitations of the Study

Despite best practices, there are limitations to every study (Creswell, 2013). First, using the descriptive approach in qualitative studies is not without limitations (Cresswell, 2013). If the researcher does not place themself outside of the study, an interference can occur with data interpretation (Creswell, 2013).

Another limitation is that those participating in the study may not be able to articulate their experiences due to issues such as embarrassment or not feeling comfortable discussing their feelings (Cresswell, 2013). Due to the sensitive nature of the current study, some participants may have declined to participate for fear of being ostracized or judged for participating in the study. To mitigate this concern, I provided complete privacy and confidentiality with all information obtained. Further, participants were allowed to select the location of their interview so they could maintain their privacy.

Third, findings were limited by the inclusion criterion of being English speaking. Interpretation through translation is not desirable in research (Berman & Tyyska, 2011). Issues with ambiguity and misinformation have been found problematic when using translators (Berman & Tyyska, 2011). Researchers have found cultural differences and mistakes in the translation by translators (Berman & Tyyska, 2011). Therefore, it is preferable for the researcher to fully understand the language used in study (Berman & Tyyska, 2011).

One limitation in qualitative research is social desirability bias in which the participant's responses reflect what the participant thinks the researcher wants to hear (Risvi, 2019).. Respondents feel that they want to help the researcher, so they may respond accordingly but not truthfully (Risvi, 2019). My interview questions were selected to prevent this from happening. The questions were designed to allow participants to respond freely. In addition, the participants were aware that they could end the interview at any time if they felt uncomfortable.

Recommendations

One of the first steps toward improving mental health care for Mexican Americans must be education to the general public aimed at increasing knowledge about mental health issues in this population. Another critical issue is to make culturally sensitive care accessible and affordable to this group of patients by obtaining grants and public assistance aimed at improving PHS, with the goal to improve all PHS to all Americans. To do this, a deeper understanding of what contributes to the problem and what solutions might be possible needs to be pursued through ongoing research.

Improving Mental Health Care for Mexican Americans

One of the first steps toward improving mental health care for Mexican Americans education must be directed to the general population aimed at increasing knowledge about mental health issues (Maura & Weisman de Mamani, 2017). Observed disparities have been seen in treatment of vulnerable populations with severe mental illness (SMI), such as use of psychiatric emergency services versus services in community settings, less apt to seek initial treatment, receive a poorer quality of care, and have poorer treatment outcomes (Maura & Weisman de Mamani, 2017).

Currently, there are many advertisements showing psychiatric drugs and mentally ill people. However, there are few advertisements about people from different cultures and advertisements do not show people refusing to seek care. General public education and awareness are needed for the public to see that mental health issues are a true problem that needs to be addressed. In addition, future needs of Mexican population need to be addressed. By learning the barriers that prevent PHS, health disparities may be addressed for the Mexican immigrants.

Culturally Sensitive Care Mexican Americans

Another critical issue is to make culturally sensitive care accessible. With the high number of Mexican immigrants in the U.S. the need for changes in health care delivery becomes more apparent (Alarcon et al., 2016). The steady growth of Mexican immigrants in the U.S. population makes providing adequate mental and physical health care imperative and raises awareness among care providers of the need to understand the mental healthcare experiences of the population (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2010). For PHS to be successful there needs to be routine follow up care. The literature review indicated that PHS is not routinely sought by Mexican immigrants nor is treatment adherence routine (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2010). One issue that was found is that there is a lack of Spanish speaking providers (U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, 2010). To serve a population that is not always fluent in English, Spanish speaking providers are also needed.

Accessible and Affordable Care for Mexican Americans

Mexican immigrants do not always know where to go for help and are often afraid to seek help due to their immigration status. One possible way to establish PHS in settings that offer anonymity and privacy. Potential issues that prevent access to PHS include a lack of information and misinformation about mental illness, lack of privacy, language barriers and cultural competency, lack of insurance, legal status, cultural beliefs such as reliance on faith and alternative medicine, and the stigma associated with mental illness (Guarnaccia, et al., 2005; Interian et al., 2010; Lewis-Fernandez et al., 2005; National Institute of Mental Health, 2018).

Understanding of What Contributes to the Problem

Psychiatric illnesses are conditions that affect all people, regardless of ethnicity or race. Minorities have less access to and receive a lower quality of mental health care (USDHHS, 2001). Future research needs to target specific areas to decrease the disparity seen in mental health care for Mexican Americans. Such studies might include the following: (a) the evaluation of cultural differences regarding perceptions or experiences of stress and stigma, (b) coping abilities that affect Mexican Americans' mental health, (c) ways to improve access to and availability of mental health care by training professionals and providing care in areas where ethnic and racial minorities live, and (d) the evaluation of strategies for improving mental illness screening and services for ethnic minorities, specifically Mexican. This study shows that PHS is a personal and individual concern. My findings confirm that culture plays a large role in PHS. I recommend further research be conducted to delve deeper into how health care providers can provide culturally sensitive and personal and individualized PHS for Mexican immigrants.

Implications

There are possibilities for positive social change from this study. Social change is the ability to bring awareness, change in cultural standards, or values about a topic and is a learned condition (Glenn, 2004). The aim of the current study was to examine and explore the perceptions of family members who have Mexican immigrant family members with a mental illness. The impact for positive social change would be to the individual and their family. Ethnic minorities have less access to and availability of PHS and are less likely to receive the PHS that they need (Keyes et al., 2013 Leong & Kalibatseva, 2011; USDHH, 2001). My findings showed that Mexican immigrants feel their mental illness in a very personal and individual manner. By learning the barriers that prevent PHS, Mexican immigrants may have better access to care.

Theoretical Implications

The study was guided by Leininger's culture care diversity and universality theory. According to Leininger, a person's behavior is controlled by culture (Leininger, 1970). The theory focuses on studying and understanding other cultures and knowledge about care and culture constructs related to health. The theory directs researchers to discover and use culturally based knowledge to provide better care (McFarland & Wehbe-Almah, 2015). The theory examines how culture plays an essential role in determining how people react in society. (McFarland & Wehbe-Almah, 2015). Leininger's theory is the most appropriate theory for describing the perceptions of barriers in PHS by Mexican immigrant in the United States. I found these three themes: theme #1: Mental Health is Private and Individual Issue, theme 2: Culture Plays a Role in Accessing Care, and theme #3 Role of Religion in Mental Health Care these barriers may contribute to the reason that these individuals do not engage in the PHS.

Methodological Implications

I used a qualitative descriptive design as it focused on perceptions of a specific culture sharing group, Mexican immigrants in the United States. The objective of this study was to explore the perceptions of barriers to PHS and the descriptive design answered the research question. The results from this study imply that a qualitative descriptive design was an appropriate research method to understand the perceptions of PHS of Mexican immigrants in the United States.

Recommendations for Practice

The findings of this study indicated these three themes: Theme 1: Mental Health is Private and Individual Issue Theme 2: Culture Plays a Role in Accessing Care and Theme 3: Role of Religion in Mental Health Care can present barriers. Theme 1 indicates the importance of how mental illness is very individual and private, therefore the mental health provider needs to provide a safe place for care. Theme 2 emphasizes how important it is to recognize a person’s culture and to provide culturally sensitive PHS. I recommend that health professionals should use this study to develop culturally sensitive interventions that increase the PHS behavior in this vulnerable population. For example, more Spanish speaking providers and educating health care providers on culturally sensitive practices. The use of these strategies will enhance PHS by addressing many of the concerns these patients can have, such as trouble understanding. In addition, with health care providers understanding the patients’ cultures they can introduce care that will be acceptable and treatment adherence may become possible. Theme 3 shows the importance religion plays in PHS and that health professionals need to respect and honor our patient's beliefs. In addition, mental health care providers need to recognize the impact religion has on PHS. Health care providers should use the findings of this study to identify unique strategies to improve PHS utilization. Such as family and community education on PHS to improve the mental health of Mexican immigrants in the United States.

Conclusion

This study identified three important themes that may be used to enhance the use of PHS among Mexican immigrants living in the US. specific to PHS in the United States, which may help the health care providers to develop mental health care programs that increases the level of PHS and improves the mental health of this population. This study reveals the culturally specific barriers encountered by Mexican immigrants in the United States.

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Appendix A: Invitation for Participation

Dear [Name will be inserted here],

My name is Vickie Nethercott and I am currently a doctoral student at Walden University. I am investigating the personal, social, and environmental experiences of Mexican Immigrants who suffer from mental illness as it relates to accessing mental health services.

Your participation will be greatly appreciated. Participation will involve completing a brief demographic questionnaire which will take approximately 10 minutes as well as participating in an interview which will take approximately 60 minutes. For local participants, interviews will be conducted in a place that is convenient to you. The interviews will be conducted during a time that is most convenient for you.

All information obtained from the demographic questionnaire and interviews will be kept strictly confidential. Those who choose to participate will not be identified in any findings from the study or prepared reports. Should you have any questions about the study, please feel free to contact me at [vickie.nethercott@waldenu.edu] or [7078125223].

If you are interested in participating in the study or would like to recommend another Mexican immigrant who has a family member who suffers from a mental illness please complete the following questions and email responses to the email address listed above.

Thank you in advance for your consideration and assistance with my research.

Sincerely,

Vickie Nethercott

Appendix B: Demographic and Screening Questionnaire

1. Are you willing to participate in this study?

a) Yes

b) No

2. What is your full name? (

3. Do you have a family member who is a Mexican immigrant and has a mental illness?

4. What is your highest level of education?

a)Grammar school

b)Some high school

c)High school graduate

d)Some college

e) Trade/Technical/Vocational Training

f) College Graduate

g) Some Post Graduate Work

h) Post Graduate Degree

5.Have you ever been diagnosed with a mental illness?

a) Yes

b) No

6. Is English your primary language?

a) Yes

b) No

Please provide your contact information below:

Name_________________________________

Email address__________________________

Appendix C: Interview Guide

Study: Exploring experiences among Mexican immigrant family members who have a mental illness

Date: ____________________

Time: ____________________

Location: _________________

Interviewer: _______________

Interviewee: _______________

Consent form signed? _______

Introduction

☐ Provide introduction and welcome participant to the interview

☐ Provide a general overview of the study and why participant was chosen to participate

☐ Discuss the interview process and purpose

☐ Provide an explanation of why recording equipment is present and will be used

☐ Discuss general guidelines and expectations for interview

☐ Reassure the participant of confidentiality

“Hello. My name is [insert researcher’s name] and I am a doctoral student currently attending Walden University. I would first like to thank you for taking the time out of your schedule to participate in this study Mexican immigrants and mental health services. You were chosen for participation in this study because you met the requirements. “Your perception and experiences are very important and will add to our understanding of mental illness and Mexican immigrants. Your experiences may help us to make improvements to mental health and support resources and programs. The results of this study may improve mental health and support service utilization, inform policies, and increase awareness. Ultimately, I hope the results of this study will improve the experiences of Mexican immigrants in order to help them successfully navigate any barriers to mental health care. “I would like to remind you that you can withdraw from this study and interview session at any time; any information that you share with me during this interview will be kept strictly confidential. The interview will last for approximately 60 minutes and will be digitally recorded. I would also like to remind you that I will also be taking notes during the interview. When the interviews are transcribed, your name will not be included or disclosed. Do you have any questions? Are you ready to proceed? Let’s begin”.

Demographic questions

☐ “Please tell me your name, age, and marital status.”

☐ “Please tell me your highest level of education.”

Interview Questions

Please tell me about your experience with your family member’s mental illness.

How does your family member’s mental illness affect your daily life?

Tell me about experiences you have had with accessing psychiatric services for your family member?

How does your culture influence the way you care for your family member's mental health?

Tell me more about how your friends and family affect your family member's mental illness or mental health?

To what extent does your community affect how you deal with your family member's mental illness?

Does your family member's mental illness affect how you participate in your community?

In what way does your family member's mental illness affect your participation in your community? Probe from # 14 In what way does your family member's mental illness affect your participation in your community activities (work, school, church).

Conclusion

"Is there anything else you would like to share on this before we conclude this interview? Do you have any questions for me at this time? Again, I would like to thank you for participating in this interview. I appreciate your time and most importantly your thoughts and views."

Appendix D: Flyer

ARE 18 YEARS OF AGE OR OLDER?

ARE YOU A FAMILY MEMBER OF A MEXICAN IMMIGRANT WHO HAS A MENTAL ILLNESS?

We are trying to understand the reasons why mental health services are not being used by Mexican immigrants.

Q? What will I have to do?

One 1-hour interview to be done at a place of your choosing.

CALL NOW at (707)812-5223