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VARIABLES RELATED TO UTILIZATION OF MENTAL HEALTH CARE SERVICES BY HISPANIC ADOLESCENTS

by

Mary Ann H. Garcia

A Thesis Submitted to the Faculty of the Graduate School

of Loyola University of Chicago in Partial Fulfillment

of the Requirements for the Degree of

Masters of Arts

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VITA

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In the fall of 1984, Ms. Garcia was granted the American Psychological Association Minority Fellowship enabling her to complete the Master of Arts in psychology at Loyola University of Chicago in 1987. In

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TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS	ii
VITA	iii
LIST OF TABLES	vi
CONTENTS OF APPENDICES	ix
INTRODUCTION	1
REVIEW OF THE RELATED LITERATURE	3
Demographics	3
High Risk Status	4
Underutilization	6
Theories of Underutilization	8
Alternative Sources of Help	12
Attitudes	16
Adolescent Attitudes	17
Readiness for Self-Referral	19
Acculturation	21
Present Study	29
METHODS	31
Subjects	31
Materials	34
Procedures	44
RESULTS	46
Hypothesis One	46
Hypothesis Two	47
Hypothesis Three	49
Hypothesis Four	51
Related Analyses	55
Evaluation of Sources of Help	58
Hypothesis Five	62
Hypothesis Six	69
Hypothesis Seven	71
Hypothesis Eight	71
Additional Analysis	75
Ethnicity and Use of MHCS	75
Sources of Information	75
Sex Differences	77

Page

DISCUSSION.................................... 79

REFERENCES.................................... 89

NOTES.................................... 98

APPENDIX A.................................... 99

APPENDIX B.................................... 111

LIST OF TABLES

Table Page

1. Demographics.................................. 32

2. Demographics: Hispanics.................... 33

3. Mean Scores on the Attitudes, Knowledge and Information Scales by Hispanics and Blacks...................... 48

4. Self-Reported Use of Alternative Sources of Help............................ 53

5. Preference of Sources of Help as a Function of Ethnic Status.............. 56

6. Preference of Sources of Help as a Function of RR......................... 59

7. Preference for Source of Help as a Function of Use of MHCS................ 60

8. Evaluation of Sources of Help for Teen Problems as a Function of Ethnic Status........................... 63

9. Evaluation of Sources of Help as a Function of Use of MHCS............... 65

10. Readiness for Self-Referral: Current Study.............................. 68

11. Readiness for Self-Referral................. 70

12. Use of MHCS as a Function of Level of Acculturation......................... 72

13. Self-Reported Use of Alternatives as a Function of Level of Acculturation............................... 73

14. Use of MHCS as a Function of Readiness for Self-Referral................. 74

Table | Page

15. Use of MHCS as a Function of Ethnic Status........ 76

16. Most Helpful Sources of Information........ 78

CONTENTS OF APPENDICES

Page

APPENDIX A Questionnaire 100

APPENDIX B Final Scale Items

I. Attitudes Scale: Final Items............. 112
II. Knowledge Scale: Final Items............. 113
III. Information Scale: Final Items........... 114
IV. Acculturation Scale: Final Items......... 115

INTRODUCTION

The Hispanic population in the United States is rapidly growing in numbers and is quickly becoming a force to be reckoned with. It has only been in the last few decades, with the establishment of such research centers as the Spanish Speaking Mental Health Research Center at UCLA, and the Hispanic Research Center at Fordham University, that the Hispanic population has been more systematically studied. Over the past decade, research involving Hispanics has focused on such topics as acculturation, bilingualism, family structure, migration, and mental health services (Padilla & Lindholm, 1984). While the list of accomplishments in Hispanic research is growing, there still remain many areas of research that require systematic examination. One such area is the investigation of Hispanic adolescents. Considering the psychological and emotional changes that accompany the critical period of adolescence, it is surprising that so little research has been conducted with Hispanic adolescents. Research on Hispanic adolescents to date has concentrated on delinquent behaviors such as substance abuse, dropping out of school, or gang related activities (Adler, Ovando

& Hocevar, 1984; Morales, 1978; Scopetta, King & Szapocznik, note 1).

Of equal importance should be the study of sources of help or support utilized by Hispanic youth during the stressful period of adolescence. Do Hispanic youth take sufficient advantage of professional sources of help such as mental health care services? Or do Hispanic youth prefer to utilize alternative/ nonprofessional sources of help such as family and friends? The purpose of this study is to investigate several variables potentially related to the utilization of mental health services by Hispanic adolescents.

REVIEW OF RELATED LITERATURE

Demographics

Hispanic Americans constitute the second largest and fastest growing group in the United States (Russell & Sutterwhite, 1978). Four distinct groups can be identified on the basis of ethnic origin: Mexican Americans, Puerto Ricans, Cubans, and Central and South Americans. The U.S. Bureau of the Census (1980) figures show the overall Hispanic population to number 14.6 million, consisting of 8.7 million Mexican Americans; 2.0 million Puerto Ricans; .8 million Cubans; and 3.1 million Spanish, which included natives of other Latin American countries and of Spain itself (e.g., Dominicans, Equadorians, Columbians, etc.). It has been documented that almost fifty percent (6 million) of the Hispanic population is made up of children and adolescents (U.S. Bureau of the Census, 1985). The estimates reported by the census are probably conservative given the difficulties in collecting accurate data from this group, as well as inadequate census procedures (i.e., an insufficient number of bilingual interviewers). Macias (1977) arrived at a liberal figure of 23.4 million for the Hispanic population when attempting to correct for

increases attributable to births, legal immigration and for the presence of undocumented workers.

High Risk Status

It is suggested in the literature that numerous sociological and economic factors place Hispanics at high risk for psychopathology. These factors include the poverty cycle and associated stressors, the immigrant experience in low-income communities, and cross-regional migration (Brody, 1970; Durkheim, 1967; Favazza, 1980; Srole & Fisher, 1980; Vega, Hough & Miranda, 1985).

Karno and Edgerton (1969) found the Mexican American population in California to be subjected to numerous "high stress indicators" which were correlated with mental breakdown (or some type of self-destructive behavior) and subsequent need for treatment.
The indicators included:
(1) the poverty cycle - limited education, lower income, depressed social status, deteriorated housing, and minimal political influence, (2) poor communication skills in English, (3) the continuance of coping styles from a rural agrarian culture which are relatively ineffectual in an urban technological society, (4) the very stressful process of acculturation into a society

which is often prejudicial, hostile, and rejecting of immigrant groups, (5) the necessity of seasonal migration (for some).

Karno and Edgerton concluded that the consequence of such pressures should be an increased incidence of psychopathology in Hispanics. Furthermore, high risk status coupled with possible underutilization of mental health care services by Hispanic Americans suggests a grave problem (Karno & Edgarton, 1969).

While it is probable that Hispanics are under a great deal of stress, and that this may in term lead to greater psychopathology, the available information does not allow for a thorough examination of these theories. Regrettably, there is little valid and reliable information that is national in scope which would allow researchers to assess adequately the mental health status of the Hispanic population. "This lack of an adequate data base has resulted from the failure to identify Hispanics as a group in the compilation of epidemiological data and other statistics" (President's Commission on Mental Health, 1978; p. 2). Nevertheless, the potential for higher risk of psychopathology has received much attention in the Hispanic mental health literature since Hispanics are believed to underutilize mental health services.

Underutilization

Hispanics constitute at least 6% of the general population yet only represent 3% of all admissions to State and county facilities (Bachrach, 1975). It has been noted in the literature that Hispanics, in general, receive the least amount of mental health care as compared to other minorities (Padilla, 1971; President's Commission on Mental Health, 1978). Underutilization, as defined in the literature, generally is assessed by comparing the admission rates of the target population (Hispanics) with that of the mainstream population (Anglos).

Given this definition, it is not clear whether Hispanics of all age groups underutilize services, since adolescents (14-18 years) appear to be represented at least as much as Anglos in admissions to State and county facilities. However, this statistic is probably best taken with caution for five reasons.

One, there are no available statistics on adolescent populations' use of private mental health facilities. Without this data Hispanic adolescents may appear to utilize mental health care services (MHCS) as often as Anglo adolescent, despite the proposition that Anglos tend to utilize private facilities more often because they are financially disposed to afford more

costly mental health care services.

Two, previous investigators of underutilization patterns have failed to obtain data in relation to need for services by Hispanics (Lopez, 1981). In effect, although, it is conceivable that adolescent Hispanics may appear to utilize public services in parity with Anglos when compared to relative need Hispanics could very likely be underutilizing services. Three, researchers who have depended on United States census population figures in assessing utilization rates, have failed to compensate for the fact that such figures are probably conservative underestimates of the current Hispanic population. Since underutilization is assessed by comparing percentage of admission rates to population percentage, a failure to correct current Hispanic population statistics will result in overestimates of utilization rates for this group. Four, it is well documented that many Hispanic clients who do seek out treatment terminate services prematurely. Studies investigating premature termination patterns have reported a range of 2-6 sessions as the average number of sessions attended by Hispanic clients before terminating services, as compared to a range of 8 to 12 sessions by Anglo clients (Miranda, Andujo, Caballero, Guerrero & Ramos, 1976; Chavez, 1979). Five, in using

admission rates as a measure of utilization, one must consider that for Hispanics most admissions to state and county facilities are involuntary civil commitments (55%) (Bachrach, 1975). A strict assessment of admission rates does not differentially weigh nor provide any information on whether Hispanics initiated services freely or whether they were committed against their own volition.

Given these methodological problems it appears that 1) one needs to review the utilization statistics cautiously; 2) it is not presumptuous to assume that Hispanics of all ages are currently underutilizing MHCS both in relation to other populations and in relation to their need for services.

Theories of Underutilization

The following is a summary of the most commonly held explanations for underutilization of mental health services by Hispanics, as modified from those reviewed and presented by Karno and Edgerton (1969). Although they refer to Mexican Americans only, most of their explanations are pertinent to other Hispanic sub-groups.

1) Symptom substitution: Mexican Americans suffer as much or more from psychiatric disorder than do Anglos, but this disorder is less visible because it is

masked or confounded by criminal behavior, narcotics addiction or alcoholism. Hence, Hispanics are less likely to label these behaviors as pathological and seek out services.

2) Divergent views/knowledge of mental illness: Mexican Americans perceive and define psychiatric disorder differently than do Anglos. Specifically, they are more tolerant of idiosyncratic and deviant behavior and hence are less likely to seek professional help. A common variation of this viewpoint is expressed in the belief that Mexican Americans are simply ignorant of the signs and symptoms of mental illness. They are also presumed to be ignorant about why or how to seek professional help. Karno and Edgerton report that such beliefs may result from the very limited development of mental health resources and education in Mexico itself.

3) Negative attitudes: As a result of the Mexican Americans value system they are too proud and too sensitive to self-disclose personal problems; they feel too much shame or stigma attached to an admission of need for professional help. Thus the mental health system is not congruent with their values of self-reliance, privacy, and self-respect. The discrepancies that exist between the Hispanic's value system, and the

values and demands placed upon them by the mental health system may potentially result in negative attitudes toward mental health care services.

4) Cultural insensitivity: Facilities which offer psychiatric services do not operate in ways which fit the needs of Mexican Americans. It is believed that MHCS are infrequently used due to insufficient numbers of Spanish speaking personnel, high cost, inconvenient locations and hours, and staffs that do not demonstrate sufficient sensitivity to Hispanic concerns related to respect and self-dignity. As a result, Hispanics are discouraged from taking sufficient advantage of available professional services.

5) Use of alternative sources of help: Instead of utilizing formal mental health services, Mexican Americans seek out the assistance of priests, family physicians, family members, and others for help. It is also believed that some return to Mexico to 1) reestablish kinship or other supportive ties, or 2) to seek out folk or professional help in more familiar contexts.

6) Fear of repatriation: Mexican Americans who are citizens of Mexico, or who are U.S. citizens but have family members in the U.S. illegally, avoid any

contact with the "establishment" that may threaten the security of their (or their relatives') presence in the U.S.

Karno and Edgerton (1969) offered their opinions of the relative merits of the above mentioned theories. For example, they maintained that most important factor was the discouraging nature of mental health institutions, e.g., language barriers, the self-esteem reducing nature of agency-client contacts, lack of facilities. Of lesser importance are the notions that Mexican Americans underutilize MHCS because they define and perceive mental illness in significantly different ways than do Anglos; demonstrate lower incidence rates of psychopathology; prefer alternative sources of help or due to fear of repatriation.

Unfortunately Karno and Edgerton's conclusions cannot be properly evaluated since many of the theories reviewed have not been empirically investigated. It would appear that this is the case since some theories are more easily studied than others. For example, as mentioned previously, incidence rates of psychopathology are difficult to assess as a result of limited documentation of epidemiological data on a national scale. The following section is a review of Karno and

Edgerton's theories that have been more thoroughly investigated and two that have not been previously considered but bare examination.

Alternative Sources of Help

The utilization of alternative resources has received a great deal of attention in recent years. Padilla, Carlos and Keefe (1976) state that the most significant reason for lack of use of mental health clinics by Hispanics is the preference for alternative resources when dealing with emotional problems. In response to a general question asking for the first place a Mexican American who has an emotional problem should go for help; the most common replies included: a relative or compadre, a physician, or a priest/minister. Subjects' recommendations for help varied considerably, when asked about specific emotional problems (including depression, anxiety, bewitchment, suicidal tendencies, alcoholism and drug addiction). For example, a suicide attempt was most commonly felt to be an emotional problem best dealt with by a psychiatrist. Respondents felt specialized professional assistance was required for alcoholism and drug addiction (i.e., alcoholics anonymous, drug abuse clinic), but preferred nonprofessional sources of support in all other cases.

Padilla et al. (1976) maintained that underutilization does not occur because of negative attitudes about mental health services. As many as 60% of the respondents indicated willingness to use available mental health facilities. Very few (4%) were unwilling to do so because they believed the "services are not worthwhile". However, only 10% had ever used local MHCS services and of these, only 2% had done so during the past two years.

The use of folk medicine has also been stated as a reason for underutilization of mental health care services. Within the Hispanic culture folk systems have evolved to expel illness. Some Hispanic sub-groups appear to prefer folk systems; Mexican Americans believe in curanderismo, while Puerto Ricans adhere to espiritismo, and Cubans to santeria.

The extent to which folk medicine is practiced today by Hispanics is not clearly established. The popularity of folk medicine and belief in folk illnesses varies in different regions of the country. In one southwestern city 15 out of 75 Mexican American females reported having sought assistance from a curandero. In addition, 97% of the sample reported having one of the five main folk illness (i.e., mal ojo, nerveos); and

95% stated having known someone who had suffered from each of the folk illness (Martinez & Martin, 1966). Holland (1963) interviewed 250 families of which 55% expressed a strong belief in folk diseases while only 22% claimed that they held no belief in curanderismo.

In contrast to these findings, one survey revealed that treatment by a physician was preferred over treatment by a curandero (Karno & Edgerton, 1969). Additionally, Mexican Americans in Los Angeles indicated a preference for a priest or a friend over a curandero (Derbyshire, 1968).

More recent studies indicate that modern oriented, urban, and middle-class Hispanics seldom subscribe to folk medicine. Practice of curanderismo was mentioned infrequently by Mexican Americans interviewed over nine census tracts (three towns) in southern California (Padilla et al., 1976); and four Nebraska communities (Welsh, Comer, & Steinmann, 1973).

Furthermore, the preference to consult with family, friends and clergy does not seem to be limited to Hispanic Americans. In a major national survey, Whites and Blacks alike demonstrated a preference to seek the assistance of family, friends and clergy (Veroff, Kulka & Douvan, 1981). Compared to Keefe,

Padilla, and Carlos (1978) who suggest that although there are no differences between Anglo Americans and Mexican Americans' tendency to consult with relatives about emotional problems, ethnic differences are apparent in reliance on friends. While Anglos and Mexican Americans both preferentially rely on relatives, Anglos are more likely to turn to friends as well. This apparent reluctance by Hispanics to reveal personal problems to non-family members has been observed in other studies (Madsen, 1964; Rubel, 1966). However, age differences have not been studied and one might suspect that this difference would disappear for the adolescent age group given their strong reliance on friends during this developmental stage.

In light of the above mixed findings, it would seem unlikely that underutilization of mental health facilities by Hispanics could be solely explained by their reliance on folk beliefs and folk healings. This especially seems the case since the use of folk medicine is largely confined to a limited number of rural and/or migrant people. There does seem to be some support, however, for a preference of alternative sources of treatment such as family, friends and clergy by Hispanics.

Attitudes

Studies investigating attitudes toward mental health services, likewise, do not provide any clear answers regarding underutilization of services. On a scale devised to measure subjects' perception of the usefulness of psychotherapy, Mexican American college students perceived psychotherapy as more helpful for the emotionally disturbed than did Anglo students (Acosta, 1975). Keefe, Padilla and Carlos (1978) in general found no strong evidence of negative attitudes toward mental health care services in either Anglos or Mexican Americans. However, while both Anglos and Mexican Americans claim to be willing to use a mental health clinic neither group has a very high rate of utilization of facilities in their geographic region. Similarly, Karno and Edgerton (1969) cite that Mexican Americans, when compared to Anglos, tended to believe more that "psychiatrists really help the people who go to him". Eighty percent of both groups said that "a psychiatric clinic could help a person with psychiatric disorder; however, 80% of both Mexican Americans and Anglos were unable to identify, name or locate a single psychiatric clinic.

The presence of negative attitudes toward MHCS by Hispanics has not been supported by investigations of

adult populations. On the contrary, adult Hispanics appear to possess positive attitudes toward MHCS; however, such positive attitudes do not appear to be related to utilization of services.

Adolescent Attitudes

While there has been a paucity of research investigating the minority group adolescent, some researchers have made some initial attempts to examine their attitudes toward helping services. One investigation suggests that unlike the adult Hispanic, school-age Hispanics possess some negative attitudes toward counseling. In a study of junior high school Hispanics and Anglos responded to a set of hypothetical client/counselor interactions. Ethnicity of the hypothetical counselor was not specified in the first protocol, was specified as Hispanic in the second protocol and Anglo in the third. In each case, Anglos expressed more positive attitudes about counseling (Rippee, 1967).

Contrary to Rippee (1967) findings, Khaton and Carriera (1972) in a brief exploratory survey of adolescent attitudes toward mental health found that, overall, they demonstrated a high level of knowledge about psychiatry and viewed it as helpful. Although Khaton and Carriera (1972) concluded that Anglo,

Hispanic and Black students were generally well informed about mental illness and existing mental health facilities, and as having positive attitudes, they do not describe how they empirically assessed their data or how the thirty item scale they used was devised and what psychometric properties it possessed.

While the information collected in this investigation is difficult to interpret, it does speak to the need to assess empirically adolescents attitudes toward MHCS, knowledge of MHCS, and information about mental illness. Adolescents in general, and Hispanic adolescents especially, have gone largely unresearched in these three areas. Further exploration of attitudes toward MHCS, knowledge of MHCS, and information about mental illness may contribute greatly to the understanding of utilization of MHCS by Hispanic adolescents.

While use of alternative sources of help and attitudes toward mental health services have received much attention in the literature, two potentially useful variables in understanding utilization of MHCS have gone relatively unexamined. These two variables are readiness for self-referral and acculturation.

Readiness For Self-Referral

Veroff, Kulka and Douvan (1981) attempted to examine the changing patterns of formal help-seeking in America between the years of 1957 to 1976. A national sample of adults (over age 21) were interviewed - 87% of the sampled population was white, 11% black and 1% other. Veroff and associates did not directly assess attitudes as a contributing factor in seeking out services, but they did examine a related construct labeled readiness for self-referral. Veroff and associates believe that there are two psychological processes contributing to readiness for self-referral (RR): 1) realizing that one can have the kind of personal problem appropriate for seeking help outside of one self; 2) acknowledging that professional helpers, and not friend or family or oneself, are at times the best or most effective resources. Veroff et al. divided the construct RR along a five point continuum ranging from extremely accepting of professional services (I) to extremely resistant to professional help (V). A person is placed into one of these five categories on the following basis:

Group I: Person has previously used professional help for personal problems

Group II: Person acknowledges that they could have used professional help for a personal problem

Group III: Person can imagine himself/herself as potentially having a problem for which professional help would be useful

Group IV: Person cannot imagine himself/herself as potentially having a problem for which professional help would be useful

Group V: Person strongly endorses self-help

Veroff et al. (1981) found that there was a substantial increase in readiness for self-referral over the twenty-year period from 1957 to 1976. The proportion of adults reporting actual use of professional help nearly doubled (from 14% to 26%) and the proportion reporting that they could always handle problems on their own declined almost ten percent from 44% to 35%. A multivariate analysis ruled out the possibility that these effects were overtime due to increases in education or to age differences. While one can be optimistic about the increased rates of readiness for self-referral, one can not also help but also be impressed that there is still a substantial group of Americans (35%) who resist the idea that they may at times need to seek professional assistance.

The construct readiness for self-referral may provide a better understanding of the discrepancy that exists between reported acceptance or positive attitudes toward MHCS and underutilization by Hispanics. Veroff and associates propose that RR depends upon two psychological processes (i.e, definition of a problem and recognition of the need for professional assistance) which provides a more complex approach to understanding Hispanics willingness/readiness to initiate MHCS.

Acculturation

Acculturation, as a variable that might be related to utilization of MHCS, also has not been given much attention. From a historical perspective, most research on acculturation has been anthropological in nature and has focused on the acculturation of third world nations to industrialized western societies (Olmedo, 1979). Acculturation has been defined as "those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original pattern of either or both groups" (Redfield, Linton, & Herskovits, 1936, p.149). Early anthropological investigations within the United States were concerned with the acculturation of American Indians to European culture. Sociologists who

later began investigations with other American ethnic groups were primarily concerned with issues of minority group and race relations as opposed to cultural dimensions. It has only been in the last decade that psychologists have begun to investigate the acculturation process, and this has occurred primarily within the context of the more established area of cross-cultural psychology (Olmedo,1979).

Recently the scope of the behavioral science acculturation literature has begun to expand. Olmedo (1979) outlined three recent trends in the field. The first trend is a movement in the direction of studying ethnicity, or ethnic identity. More specifically, there has been an attempt to understand ethnic groups on their own terms rather than comparing them to other cultural or reference groups. An important effect has been the development of a greater interest in understanding individual acculturation as it relates to group acculturation.

A second trend, has been a change in the target group of interest to include European ethnic groups and most recently, Asian-Americans and Hispanics. The third trend, is an increased emphasis on such methodological issues as precision in defining and measuring

acculturation and ethnic identity. This trend has had the heuristic effect of encouraging the development and application of a variety of quantitative models of acculturation.

The initial acculturation studies in the psychosocial literature focused on the measurement of acculturation and how this related to demographic and socioeconomic variables. Generation level is a robust predictor variable on determining extent of acculturation. Investigators have found that generation level is positively related to level of acculturation (Cuellar, Harris, & Jasso, 1980 Padilla, 1980; Szapocznik & Kurtines, 1980; Szapocznik, Scopetta, & Kurtines, 1978). Additionally, income, and level of education were also found to be positively related to level of acculturation, while ethnic density of neighborhood was negatively related to level of acculturation (Padilla, 1980).

The rate of acculturation has also been studied as it relates to sex and age. The rate of acculturation was found to be inversely related to age with younger Hispanics acculturating more quickly than the older Hispanics (Szapocznik & Kurtines, 1980; Szapocznik, Scopetta, & Kurtines, 1978). Only sex differences

seem to be less inconsistently observed. Under two separate investigations, males were found to acculturate more quickly than females (Szapocznik & Kurtines, 1980; Szapocznik, Scopetta, & Kurtines, 1978). However, Padilla (1980) did not observe any significant sex differences.

The psychosocial adjustment of immigrant families undergoing the acculturation process has also been of interest in the psychological literature. One general finding has been that intrapsychic status depends on family stability and upon cultural values capable of supporting the family (Opler, 1967). For example, a commonly held tenet is that cultural values and orientation having to do with kinship and sex-role behavior are very resistant to change (Bruner,1956; Doobs, 1960). Some evidence exists that when traditional family-related beliefs and values cease to be reinforced by a host culture the result is personality maladjustment. For example, the traditional sex-role conception held in Puerto Rican society of male superiority and submission of women is not reinforced in American society; consequently, with increased urbanization and an increased status of Puerto Rican women in the mainland U.S., sex-role conflicts arise

within the family (Brameld, 1959; Murillo-Rohde, 1976; Torres-Matrullo, 1980). In addition, Opler (1956) postulated that the process of rapid urbanization and the increased presence of Puerto Rican women in the work force has lead to such increased symptomatology as, psychosomatic problems, digestive disorders, anxiety, conflictual marriages and male fears of impotency.

Torres-Matrullo (1980) found that along with increased acculturation, traditional family and sex-role attitudes/values are changing among Puerto Rican men and women in Mainland United States. In addition, she replicated her finding that women who were less acculturated were significantly more symptomatic, exhibiting such symptoms as depression, aggression, hostility, isolation, loss of self-esteem, and a sense of personal inadequacy. The men in this sample demonstrated little, if any, psychopathology.

Scopetta, King and Szapocznik (note 1) studied 55 Cuban families who sought treatment for a problem adolescent. The families were divided into three categories: 1) families in which the adolescent abused drugs, 2) families in which the adolescent did not abuse drugs, but the mother abused nonprescription sedatives or tranquilizers, 3) the remaining families in which

there was no drug abuse. The families with the greatest intergenerational behavior-acculturation differences presented the most disturbed youths, usually a drug abusing adolescent with high levels of acting out and poor school adjustment. Scopetta et al. demonstrated that drug-abusing youths appeared overlyacculturated when compared to other non-drug abusing adolescent. Moreover, in those families in which mothers were least acculturated, mothers abused sedatives and tranquilizers more frequently.

Few studies have examined the effects of acculturation on treatment or utilization of treatment. Miranda, Andujo, Caballero, and Ramos (1976) studied Mexican American dropouts in psychotherapy as related to level of acculturation. In a sample of Hispanic females (21-55 years of age) seeking services, they found that the more acculturated subjects attended more therapy sessions than the less acculturated subjects.

Castro (1977) conducted a field study, with Mexican American adults who had previously been in outpatient care, in an attempt to examine the effects of the degree of acculturation and of other variables related to desire to continue/ discontinue psychotherapy. Castro's prediction that subjects low in

acculturation would drop out of treatment prematurely was not substantiated, apparently due to the skewed sample toward high in acculturation. Further, Castro maintained theoretically that the concepts of locus of control and future time perspective were positively related with degree of acculturation and tested there association with satisfaction/ dissatisfaction with treatment. Castro reported that dissatisfied clients demonstrated a significantly greater sense of external locus of control than did satisfied clients. In addition, dissatisfied clients demonstrated a trend toward a shorter future time perspective than did satisfied clients. Implying that clients degree of acculturation is positively related to satisfaction with psychotherapy. With good reason, Castro holds that these findings are only impressionistic since client sampling was greatly affected by the client's willingness to participate. Additionally, the relationship between locus of control and future time perspective must be explored on an empirical basis before it can be concluded that these two variables are directly related to level of acculturation.

Beyond these few studies the literature has little to say of the relationship between acculturation and the

phenomenon of underutilization of mental health care services. It would seem that one of the changes Hispanics would undergo, as a result of continuous contact with a society that advocates the use of professional help during times of duress, is a greater use of mental health services. Yet, few investigators have attempted to explore this potentially important factor in understanding utilization of mental health care services and how utilization patterns change as a function of acculturation.

Summary of the Literature

Although Hispanic American may possess a strong need for mental health services, they appear to underutilize mental health services. Though there are many theories attempting to explain why underutilization occurs, support of these theories has been inconsistent and the research supporting or disconfirming differing theories currently investigating these issues has not been carefully done. In particular, the contribution of such potentially important variables as acculturation and readiness for self-referral have been neglected. Furthermore, many investigations have studied Mexican-Americans exclusively and very few have focused on adolescents. As a result, it is difficult to draw any

definite conclusions regarding the factors affecting the utilization of helping services by Hispanic populations.

Present Study

The main purpose of this study is to investigate six variables potentially related to utilization of mental health care services by Hispanic youth. These variables are: attitudes toward helping services, knowledge about mental health services, information about mental illness, use of alternative (nonprofessional) sources of support, readiness for self-referral, and level of acculturation. Generally, the literature indicates that while Hispanics may have positive attitudes toward MHCS they still do not take advantage of the services available to them.

It is expected that this study will reveal that Hispanic subjects will 1) have generally positive attitudes toward MHCS; 2) have "limited knowledge" of services available to them; 3) have "little accurate information" of mental illness; 4) have used or are open to the use of alternative sources of help; 5) have limited readiness for self-referral; 6) demonstrate an inverse relationship between use of MHCS and level of acculturation. In comparison to the general school population, subjects currently receiving professional

services, are expected to 7) have higher readiness for self-referral 8) have "more positive attitudes", "more accurate knowledge" of MHCS and information about mental illness.

The present study will attempt to test these eight hypotheses by means of the survey method. This study will investigate a sample of adolescents of various ethnic backgrounds and school years. Comparisons will be made between subjects of different ethnic backgrounds and between subjects who have and have not received mental health services.

The simplicity with which demographics and behaviors could be examined or reported advanced the development of behavioral acculturation scales. Though scales of psychological acculturation have been developed and are currently being investigated, only the behavioral scales seem to consistently have good reliability (Szapocznik, Scopetta, & Kurtines (1978).

METHOD

Subjects

The participants for this study were 292 students recruited from three inner-city Chicago public high schools with representative Hispanic and Black populations. The number of subjects recruited from each school were as follows: School 1 (N=148), School 2 (N=63), School 3 (N=81). Within these schools, samples were taken from two populations: 1) the general school population (N=201); and 2) students currently receiving services through their school counseling center (N=89). Two students failed to complete more than 50% of the survey questionnaire; therefore only 290 students were used in the final analysis. In the final sample there were 166 Hispanics, 87 Blacks, 12 Anglos and 24 other students. Of these students, 135 were female and 152 were male. Three students chose not to identify their sex. There were 98 freshmen, 74 sophomores, 53 juniors and 59 seniors. The majority of students fell within the lower socioeconomic classes (IV and V according to Hollingshead & Redlich, 1958 categorization's). For more detailed demographic information refer to Tables 1 and 2.

Table 1
Demographics

Group	Hispanics (N = 166)	Blacks (N = 87)	Anglos (N = 12)
Age			
≤ 16	45%	48%	50%
17 to 18	42%	40%	42%
19 to 21	13%	12%	8%
Sex			
Male	57%	47%	58%
Female	43%	53%	42%
Religion			
Catholic	85%	25%	50%
Baptist	4%	49%	0%
Protestant	9%	13%	17%
Other	2%	13%	33%
Year			
Freshman	33%	33%	55%
Sophmore	23%	31%	27%
Junior	21%	16%	9%
Senior	23%	20%	9%
SES			
I	0%	3%	0%
II	4%	11%	0%
III	14%	36%	56%
IV	29%	36%	44%
V	53%	14%	0%
Years of Education			
Father	43%	2%	11%
0 - 8	46%	74%	56%
9 - 12	11%	24%	33%
13 +			
Mother	45%	0%	11%
0 - 8	51%	67%	56%
9 - 12	4%	33%	33%
13 +			
No. persons at Home	53%	68%	75%
0 - 5	47%	32%	25%
5 +			
Counseling			
Never	70%	72%	58%
Curr/Past	30%	28%	42%

Table 2
Demographics: Hispanics

Group	Mexican Mexican/ American (N = 84)	Puerto Rican (N = 69)	Cuban (N = 5)	Central/ South American (N = 8)
Age				
≤ 16	48%	31%	25%	75%
17 to 18	40%	52%	50%	25%
19 to 21	12%	17%	25%	0%
Sex				
Male	42%	55%	40%	63%
Female	58%	45%	60%	37%
Religion				
Catholic	100%	65%	25%	100%
Baptist	0%	4%	75%	0%
Protestant	0%	25%	0%	0%
Other	0%	6%	0%	0%
Year				
Freshman	38%	24%	30%	50%
Sophmore	22%	27%	0%	25%
Junior	18%	25%	70%	25%
Senior	22%	24%	0%	0%
SES				
I	0%	0%	0%	0%
II	2%	6%	0%	0%
III	10%	14%	20%	75%
IV	26%	29%	80%	25%
V	62%	51%	0%	0%
Years of Education				
Father				
0 - 8	53%	34%	0%	50%
9 - 12	42%	55%	100%	0%
13 +	5%	11%	0%	50%
Mother				
0 - 8	53%	41%	0%	0%
9 - 12	47%	55%	50%	50%
13 +	0%	4%	50%	50%
No. persons at Home				
0 - 5	43%	59%	80%	88%
5 +	57%	41%	20%	13%
Counseling				
Never	77%	57%	100%	88%
Curr/Past	23%	43%	0%	12%
Subject's Generation				
1st	41%	18%	20%	80%
2nd	54%	79%	80%	20%
3rd - 5th	5%	3%	0%	0%

Materials

The questionnaire used in this investigation is presented in Appendix A. Following are the seven measures discussed in the order of their appearance in the questionnaire.

Demographic information. On the face sheet, information was secured regarding subjects' age, sex, year in school, parents occupation, and whether they have ever received services at their school counseling center. See page one of questionnaire.

Readiness for self-referral. This measure was adapted from Veroff, Kulka, and Douvan (1981). Veroff et al. (1981) postulate that people are ordered on a continuum from readiness to seek out professional help for a personal problem to being extremely resistant. A person can be placed in any one of five categories along this continuum based on their response to four questions. Initially, the subjects were asked to consider whether they had ever experienced troubles or complaints like other people have, such as felt depressed, or nervous, used drugs, or drank too much. This first question provides the frame of reference for answering four subsequent questions used to categorize subjects in terms of readiness for self-referral (RR).

First, subjects are asked to indicate whether they had ever talked to any of the formal and informal sources of help provided in a list below. If subjects indicate that they had used professional sources of help in the past, they were placed in group I. Second, subjects are asked if they had ever had a problem for which going to a professional might have been helpful. If subjects indicate yes, to question two, they were placed in group II. Third, subjects are asked if they could ever have a personal problem where they thought they might seek help. If the subjects indicate yes, then they are placed in group III; however, if they indicate no, then they are placed in group IV. Fourth, subjects are asked if they thought they could always handle any problems themselves. If the subjects indicate yes, they are placed in group V. In the case were a subject indicated a response from more than one category the more conservative score was used. For example, if a subject answered yes to both questions two (II) and four (IV) then the subject would be placed in group V. (See page two of questionnaire.)

To summarize, the five groups are:

Group I: Person has used professional help for personal problems

Group II: Person sees that they could have used professional help for a personal problem

Group III: Person can imagine himself/herself as potentially having a problem for which professional help would be useful

Group IV: Person cannot imagine himself/herself as potentially having a problem for which professional help would be useful

Group V: Person strongly endorses self-help

For the purposes of this study, the original questionnaire was slightly modified in its language to be age appropriate for adolescents. Additionally, while Veroff and associates initially intended this measure to be given to adults in an interview fashion, its original form was not incompatible to the questionnaire format used in this study.

Attitudes, Knowledge and Information. This measure, composed of 30 five-point Likert type items, was developed to assess attitudes toward MHCS, knowledge of mental illness, and information about MHCS. For example, in assessing attitudes toward MHCS, the subject was asked to indicate whether she agreed that "People with personal problems can be helped by a therapist/counselor." Knowledge of MHCS was assessed by items such as, " my school has a place to help people who have personal problems." An example of an item

assessing information about mental illness would be, "personal problems only happen between the ages of 12 and 60."The items for these three scales were derived from several sources including theoretical conceptualizations in the literature (Chen, 1977; Khaton & Carriera, 1972; Padilla, 1971).

Subjects were instructed to indicate their level of agreement with each statement on a five-point Likert-like scale. The possibilities were: strongly agree, moderately agree, agree slightly, moderately disagree, and strongly disagree. Scoring of items was such that higher values would indicate more positive attitudes, knowledge or information. Subjects received a score on each of the three scales consisting of the subjects mean score per item. Final scale items can be found on page three of the questionnaire.

An initial Cronbach alpha, equaling .65, was computed on the original 11 items of the attitudes scale. Cronbach alpha was .70 when 4 of the original 11 items on the attitudes scale were dropped due to low item-whole correlations. The final attitudes scale thus consisted of seven items. A reliability analysis of the original 10 items of the knowledge scale revealed a Cronbach alpha of (.35). Cronbach alpha rose to .55

when one of the original 10 items on the knowledge scale were dropped due to low item-whole correlations. The final knowledge scale thus consisted of nine items. The initial Cronbach alpha on the information scale was .32 for the original 10 items. Cronbach alpha rose to .48 when four of the original ten items on the information scale were dropped due to low item-whole correlations. The final information scale thus consisted of six items. (Final attitude, knowledge and information scale items can be found in Appendix B.)

Knowledge of Mental Illness. A series of four vignettes were created to assess knowledge of the signs of common mental illnesses. (Vignettes and inquires can be found on pages 4 to 7 in the questionnaire.) These vignettes were adapted from two survey studies (Latino Institute, Note 2; Starr, 1955). The four brief scenarios presented a person who had symptoms suggesting either simple schizophrenia, conduct disorder non-aggressive, compulsive-phobic, or schizoid personality. The original vignettes were modified to make the characters similar to the subjects in terms of age and ethnicity.

Following the presentation of the vignettes, subjects were asked to indicate "what kind of problem do

you think X has?" "very serious", "moderately serious", "not very serious", or "not at all a problem". Each response was given a value ranging from four to one. Scoring was such that a higher value (4) indicated a higher level of severity. The ratings of two expert judges were used to group the vignettes according to serious (Story 1 and story 4) and not as serious (Story 2 and Story 3) problems. This method was modified from previous surveys in which subjects were simply asked to indicate in a yes or no manner whether anything was wrong with the person presented in the scenario.

Sources of Information. Subjects were requested to indicate where they have gotten most of their information about personal and emotional problems. A list containing various media, kin, and informal resources was provided. In addition, they were asked to list which source of information had been most helpful. Depending upon whether subjects indicated a preference for a particular category of information, they were given either a score of one (yes) or two (no) for each of three categories: 1) media, 2) kin, or 3) other informal sources of information.

Evaluation of Sources of Help. This section consisted of a series of inquiries developed to answer

pertinent questions for the school settings that provided the student sample. Listed were fifteen age relevant problems (i.e., wanting to quit school, gang violence, etc.) for which the subject was asked to indicate "who might be of help with the problem". The problems presented could be grouped into three categories: 1) school/ vocation related problems, 2) sex related questions/ problems, 3) personal/ familial problems. The resources listed were: therapist/counselor, family member, friend, pastor/minister, teacher, doctor, and school counselor. Responses to this measure were scored according to subjects' preferences for particular sources of help in relation to different types of problems. While subjects were allowed to indicate more than one resource, they were placed into one of three categories depending upon which category was endorsed with the greatest proportion. Subjects who indicated a preference for mental health professionals, such as therapist/counselor were grouped under Source I. Subjects who viewed family members and friends as the most likely source of help were grouped under Source II. Subjects who indicated a preference for non-mental health professionals, such as school counselor

(academic), teacher, priest or doctor, were grouped under Source III.

The sources of information and teen problems sections can be found on page eight of the questionnaire.

Acculturation Index. A modified version of the Acculturation Rating Scale for Mexican-Americans (ARSMA) developed by Cuellar, Harris, and Jaso (1980) was chosen because of its potential adaptability to various Hispanic populations. Cuellar et al. (1980) devised this scale to be suitable for use with Mexican Americans of varying socioeconomic, educational, and linguistic levels, as well as with either a normal or clinical sample. The ARSMA has demonstrated high levels of reliability and validity with both clinical and normal adult Mexican American populations (Cuellar et al., 1980; Montgomery & Orozco, 1984). The original ARSMA consists of twenty items, however; due to time constraints in the current study the ARSMA was shortened by dropping several items (#'s 11, 14, 15, 16, & 19) and combining others (#'s 6 & 7). The shortened acculturation scale thus consisted of 14 items. In addition, the wording of certain items were modified to enhance applicability across Hispanic subgroups. For

example, in the modified version, one item read "How do you identify yourself?" 1) Mexican, Puerto Rican, South American (Peruvian, etc.), 2) Mexican-American, Puerto Rican-American, 3) Latin American (Latino), Hispanic American (Hispano), 4) American, 5) Anglo-American, 6) Other (please specify). Whereas, in the original ARSMA, questions only referred to Mexicans and Mexican Americans.

The acculturation scale was only applicable to the Hispanic sample. A few subjects (*n*=9) failed to complete at least two-thirds of the acculturation scale and were therefore not used in the final analysis. The initial Cronbach alpha was .81 for the original fourteen items. Cronbach alpha was .82 when 2 of the original 14 items on the acculturation scale were dropped due to low item-whole correlations. The final acculturation scale thus consisted of 12 items. (The final scale items can be found in Appendix B.)

Acculturation scores were computed by using the scoring procedures developed by Cuellar et al. which involves calculating mean item scores. Examination of the acculturation scale scores demonstrated a tripartite sample distribution (range=1.23 - 4.54; *M*=2.83, *SD*=.55). Accordingly, respondents were

categorized as either 1) high in acculturation (*n*=14; scores 3.62 to 4.54), 2) bicultural (*n*=124; scores 2.23 to 3.46), or 3) low in acculturation (*n*=12; scores 1.23 to 2.15).

Alternative Sources of Help. This particular measure was composed of two parts appearing in two separate sections in the questionnaire. The first measured self-reported actual use of professional or alternative services; while the second indicated the preference for professional or alternative services in response to a hypothetical situation.

The first portion was found in the readiness for self-referral section. (See top of page two of questionnaire.) Here the subject was given the opportunity to 1) indicate whether they had ever had a problem (i.e, felt depressed, drank too much, etc.); and 2) indicate if they had ever talked to any of the formal or informal sources listed. Subjects were given a score of one or two according to the sources of help they had endorsed on the list provided. A score of two indicated that respondent reported having actually used professional sources of help. A score of one indicated that the subject has used an alternative source of help.

The second part of this measure assessed the subject's preference for informal or formal sources of help in response to hypothetical situations presented in the form of vignettes. Following the presentation of the vignettes subjects were asked to check off the sources who could help "X" if they believed "X" had a problem. A list of formal (i.e., social worker) and informal (i.e., friend) resources was provided for subjects to indicate their preference. For example, subjects were placed into one of three categories depending upon their endorsement of sources of help. Subjects who preferred to enlist the help of family members and friends were placed in group I. Subjects who indicated a preference for non-mental health professionals, such as teacher, priest or doctor, were placed in group II. Subjects who indicated a preference for mental health professionals, such as social worker, or psychologist, were placed in group III. (See vignettes above.)

Procedures

The subject sample was secured in the following manner. School principals identified teachers who would cooperate in the data collection. Subjects were taken from either general English or science classes or a

required study hall. During these class times students were asked to volunteer for the project. Subjects representing the counseling population were asked to volunteer for the research project by their individual or group therapists. Only a handful of subjects who were solicited chose not to participate in the study.

Subjects were asked to respond anonymously to a questionnaire "which aims to get a better idea about what your age group knows and thinks about person/emotional problems, helping services and what their sources of information are regarding these matters". The examiner read the consent form out loud to the students noting that participation was both voluntary and confidential. The examiner remained in the room throughout the administration and answered students questions. Students took between 30 to 45 minutes to complete the questionnaire. After the administration of the questionnaire the examiner answered questions regarding the study and questions that had arisen as a result of taking the questionnaire.

RESULTS

At the outset, it is important to note that while the initial intention was to obtain three separate ethnic samples, the study sample contained only a few Anglo students (*N*=12). Subsequently this sample was dropped from the major analyses. Furthermore, while the major hypotheses were directed at Hispanics, whenever appropriate, the same analyses were executed on the Blacks and/or direct comparisons were made between Hispanics and Blacks to see if findings were unique to Hispanics. In addition, whenever appropriate, comparative analyses were conducted on users and non-users of MHCS.

Hypothesis One

The first hypothesis predicted that Hispanic subjects would have generally positive attitudes toward MHCS. Subjects' attitude scores were based upon their mean score per item, with higher values indicating more positive attitudes. A one sample *t*-test was computed to examine whether the mean score across the seven attitude items differed from the theoretically neutral mean value of 3. The mean score (*M*=3.77, *SD*=.61) was significant in the positive direction

($t(148)=15.4$, $p<.001$) indicating that Hispanic subjects possessed positive attitudes toward MHCS as predicted. Similarly, Black subjects also held positive attitudes ($t(76)=8.63$, $p<.001$).Hispanics ($M=3.77$, $SD=.61$) and Blacks ($M=3.69$, $SD=.72$) demonstrated no significant differences in their attitudes toward MHCS ($t(224)=.81$, n.s). (Table 3 presents means and standard deviations for the attitudes, knowledge and information scales.)

Hypothesis Two

The second hypothesis predicted that Hispanic adolescents would have "little accurate knowledge" about MHCS available to them. Subjects' knowledge scores were based upon their mean score per item. Scoring of items, based on a five-point Likert-like scale, were such that higher values would indicate more accurate knowledge. A one sample t-test was computed for the nine item knowledge scale to examine whether the mean score across items varied significantly from the theoretically neutral mean value of 3. The results, $t(140)=12$, $p<.001$, were significant in the <u>opposite direction</u> indicating that Hispanics generally have accurate knowledge about MHCS available to them. Thus, hypothesis two was not confirmed. Similarly, Black subjects generally showed accurate knowledge regarding

Table 3

Mean Scores on the Attitudes, Knowledge and Information Scales by Hispanics and Blacks

	Group	
Scales	Hispanics	Blacks
Attitudes		
M	3.77	3.69
SD	.61	.72
Knowledge		
M	3.60	3.64
SD	.58	.60
Information		
M	3.58	3.51
SD	.58	.51

MHCS, $t(69)=8.50$, $p<.001$. Hispanics ($M=3.60$, $SD=.58$) and Blacks ($M=3.64$, $SD=.60$) and did not differ significantly from each other, $t(209)=-1.09$, ns.

Hypothesis Three

The third hypothesis predicted that Hispanic adolescents would have "little accurate information" of mental illness. This was evaluated by looking at two sources of data: 1) information scale, and 2) subjects' ratings of problems' level of severity on the vignettes.

In the former case, (using the same procedures as for hypotheses one and two) results, $t(153)=11.8$, $p<.001$, indicated that Hispanics generally have accurate information ($M=3.77$, $SD=.61$). Similarly, Black subjects generally showed accurate information regarding mental illness, $t(69)=8.50$, $p<.001$. Additionally, a t-test, $t(233)=.78$, ns, comparing Hispanics ($M=3.58$, $SD=.58$) and Blacks ($M=3.51$, $SD=.51$) demonstrated that the groups did not significantly from each another on information about mental illness.

The second method for assessing subject's information about mental illness consisted of having subjects rate the seriousness of problems described in vignettes. The procedure was as follows. First, two

expert judges rated the four stories for level of severity, and based on these ratings the problems described in the stories were divided into serious (Story 1 and Story 4) and less serious categories (Story 2 and Story 3). Second, a difference score were computed by subtracting the respondents' total ratings on the two less serious problems (Story 2 and Story 3) from their ratings on the two more serious problems (Story 1 and Story 4). These calculations would yield positive scores if subjects accurately distinguished the seriousness of the presented problems. The results of a Correlated t-test, $t(251)=18.68$, $p<.001$, indicated that subjects viewed the more pathological stories as more serious (Story 1 & 4: $M=1.63$; Story 2 & 3: $M=.93$) demonstrating that students were able to discriminate level of severity.

An additional analysis attempted to examine whether users ($N=74$) or non-users ($N=178$) of MHCS differed in their accuracy in discriminating pathology. Results of the t-test, $t(250)=1.90$, $p=.06$, indicated that respondents ratings of pathology did not differ as a function of utilization of MHCS. However, the direction of the means between users ($M=1.81$) and non-users ($M=1.43$) suggest a trend in which users were able

to detect signs of mental illness and their level of severity more accurately.

Finally, an analysis, *t*(250)=.11, *ns*, comparing Hispanic and Black adolescents demonstrated that there were no significant differences in their ability to discriminate level of severity.

In summary, Hispanics demonstrated accurate information about mental illness on the information scale and in their ability to discriminate between more and less serious problems. These results are in direct contrast to hypothesis three, which predicted that Hispanic youth would demonstrate "little" accurate information of mental illness.

Hypothesis Four

The fourth hypothesis predicted that Hispanic subjects have used or are open to the use of alternative sources of help. This was assessed by analyzing two sources of data: 1) self-reported *actual use* of professional versus alternative services 2) preference for professional versus alternative services over professional services in response to a *hypothetical situation*. To conduct these analyses, two groups were created according to whether respondents were users (*N*=210) or non-users (*N*=42) of alternative sources of

help. These groups were then compared on ethnicity and preference for sources of help in response to hypothetical situations. First, subjects were grouped according to users (82.6%) and non-users (17.4%) of alternatives. Second, a simple binomial test was computed on the survey responses reporting actual use or non-use of alternatives which demonstrated significant differences, ($\text{binomial}_{z=4.93}$ $p<.001$) supporting the prediction regarding Hispanic's prior use of alternative sources of help (87.9%). Similarly, Blacks also indicated actual use of alternative sources of help (74.7%) at levels greater than chance ($\text{binomial}_{z=2.30}$, $p<.05$). Additionally, a two-by-two Chi-Square analysis (X^2 =6.19, $p\leq.01$) indicated that Hispanics report utilizing alternative sources significantly more than Blacks. These results confirm hypothesis four. The data for the for Chi-Square is presented in Table 4.

Another analysis was computed to determine whether those students who reported actual use of alternative sources (N=210), and those who reported use of formal sources of help (N=42), would vary in their evaluations of sources of help in response to common teen problems. Initially, both Hispanic and Black subjects were grouped according to users and non-users of alternative sources

Table 4

Self-Reported Use of Alternative Sources of Help

	Use of Alternatives	
Group	Yes	No
Hispanices (N = 165)	Freq. (145)	Freq. (20)
	Exp. Val. (137.5)	Exp. Val. (27.5)
Blacks (N = 87)	Freq. (65)	Freq. (22)
	Exp. Val. (72.5)	Exp. Val. (14.5)

X^2 = 6.19, $p \leq .01$

of help based on their self-report and then compared on their evaluations of alternative sources of help in response to common teen problems. An evaluation score for alternative sources was based upon subjects' endorsement of six alternative sources. A single sum was calculated for all six alternatives across 15 common teen problems. Subjects received one point for each alternative they endorsed and could receive up to a maximum of 90 points. The results of the t-test, $t(48.78)=2.85$, $p<.01$, indicated that those subjects who self-reported actual use of alternative sources of help recommended significantly more alternative sources of help in response to teen related problems.

Data on alternative sources of help was also assessed according to preferences in response to hypothetical situations presented in the form of vignettes. Since survey items regarding preference for alternatives, were grouped into three main categories (I: family/friends, II: non-mental health professionals, III: mental health professions), each was considered to have an expected response probability of 33% if all were equally preferred. The expected probabilities were compared to actual response probabilities by means of a binomial test for each of the Hispanic and Black groups

individually and then combined.

A simple binomial test ($binomial_z$=50, $p<.001$) computed on the theoretical probability (.33) of preferring Group III (professional mental health workers) indicated that Hispanics preferred Groups II more (57.7%), and Group I (21.5%) and III (16.3%) less than would be normally expected. Demonstrating an identical pattern, Blacks ($binomial_z$=43.7, $p<.001$) indicated a preference for Group II more (69.1%), and Groups I (16.2%) and III (14.7%) less than would be normally expected. Both of these results appear to indicate that while subjects prefer non-mental health professionals (Category II) more, they prefer family/friends (Category I) equally to mental health professionals (Category III). Additionally, a two-by-three Chi-Square (X^2=2.47, *ns*) indicated that Blacks and Hispanics did not differ in their preference for sources of help in response to hypothetical situations. (Chi-Square data are presented in Table 5.) In summary, both means of assessing use of alternative sources of help appear to support hypothesis four.

Related Analysis. Analysis were conducted to determine whether Hispanics' and Blacks' collective preferences for help would vary according to problem's

Table 5

Preference of Sources of Help as a Function of Ethnic Status

Source	Group	
	Hispanics	Blacks
I. (Family/Friends)		
Freq.	28	11
Exp. Val.	(25.6)	(13.4)
II. (Non-Mental Health Professionals)		
Freq.	75	47
Exp. Val.	(80.1)	(41.9)
III. (Mental Health Professionals)		
Freq.	27	10
Exp. Val.	(24.3)	(12.7)

X^2 = 2.47, *ns*

level of severity. A one-way ANOVA was computed on each of the two problem categories by preferred source of help. Problems were grouped, as described earlier, into 1) serious (Story 1 & 4) and 2) less serious (Story 2 & 3). No significant differences, $F(197)=.92$, *ns*, emerged for the serious problems indicating that preference for help did not vary according to level of severity for serious problems. However, the one-way conducted on the less serious category resulted in significant differences, $F(196)=6.27$, $p<.05$. A post-hoc Duncan analysis indicated that Group III ($M=4.27$, $SD=1.17$) significantly differed from both Groups I ($M=5.15$, $SD=1.13$) and II ($M=4.99$, $SD=1.23$). The direction of the means indicate that when subjects perceived the less serious problems as being more severe, they were more likely to endorse use of alternative sources of help.

Additionally, Chi-Square analyses were computed to determine whether preference for sources of help varied as a function of use of MHCS. Similarly, analysis were conducted to examine differences in preference according to RR. Neither analyses, ($X^2=2.14$, *ns*; $X^2=6.56$, *ns*) respectively resulted in significant differences. Taken together, the above analysis suggested that preference

for sources of help varied more as a function of the presenting problem as opposed to previous use of MHCS or RR. (Chi-Square data are presented in Tables 6 and 7.)

Evaluation of Sources of Help. A series of tests of the normal curve approximation of the binomial were computed on evaluations of sources of help according to type of common teen problems. Teen problems were grouped into three categories: 1) school/vocational, 2) sex related questions/problems, and 3) personal/familial problems. Since survey items regarding evaluation of sources of help, were grouped into three main categories (I: counselor/ therapist, II: family/friends, III: non-mental health professionals), each was considered to have an expected response probability of 33% if all were equally evaluated. The expected probabilities were compared to actual response probabilities by means of a binomial test for both Hispanic and Black subjects.

A simple binomial test ($\text{binomial}_{z=26.83}$, $p<.001$) computed on the theoretical probability (.33) of preferring Source III (non-mental health workers), in reference to school/vocational related problems, indicated that subjects preferred Source III (77.8%) more and Source I (.5%) and II (21.7%) less, than would be normally expected. A similar analysis

Table 6

Preference of Sources of Help as a Function of RR

	RR				
Sources	I	II	III	IV	V
I. (Family/Friends)					
Freq.	10	2	11	2	14
Exp. Val.	(6.1)	(3.3)	(11.6)	(3.5)	(14.4)
II. (Non-Mental Health Professional)					
Freq.	15	13	35	12	47
Exp. Val.	(19.1)	(10.5)	(36.4)	(11.1)	(45.0)
III. (Mental Health Professional)					
Freq.	6	2	13	4	12
Exp. Val.	(5.8)	(3.2)	(11.0)	(3.4)	(13.6)

Note. RR = Readiness for self-referral.

$X^2 = 6.56$, *ns*

Table 7

Preference for Source of Help as a Function of Use of MHCS

Source	Use of MHCS Users	Non-Users
I. (Family/Friends)		
Freq.	15	24
Exp. Val.	(11.4)	(27.6)
II. (Non-Mental Health Professionals)		
Freq.	34	88
Exp. Val.	(35.7)	(86.3)
III. (Mental Health Professionals)		
Freq.	9	28
Exp. Val.	(10.8)	(26.2)

Note. MHCS = Mental health care services.

X^2 = 2.14, *ns*

($binomial_z$=25.17, $p<.001$) was conducted on sex related questions/problems indicated that subjects viewed Source II (53.2%) (Family/Friends) as the most likely source of help as compared to Source I (4.4%) and III (42.4%). A third binomial test ($binomial_z$= 36.64, $p<.001$) was computed for personal/familial problems and demonstrated that Source II (51.6%) was selected as the most likely source of help when compared to Source I (17.4%) and III (31.1%).

Thus, family/friends and non-professional mental health workers were viewed as the most likely sources of help in relation to common teen problems. Counselor/therapists (Source I) was not considered a preferred source of help with respect to any of the common teen problems presented.

Additionally, analysis were performed to examine whether any relationship existed between ethnic groups or users and non-users of MHCS in relation to choice of source of help across teen problems. Separate Chi-squares were computed for each of the three categories of teen problems. There were no significant results for ethnicity. One significant result appeared regarding use of MHCS. A two-by-three Chi-Square (X^2 =12.11, $p<.01$) computed on users and non-users of MHCS on source

of choice across sex related questions/problems detected the existence of some significant differences. (Refer to Tables 8 and 9 for Chi-Square data.) Examination of expected frequencies indicated that whereas MHCS users preferred Sources I and III more, non-users preferred Source II. These results seem to indicate that, at least where problems/questions regarding sex are concerned, users prefer formal sources of help, (i.e., doctor/nurse, therapist/counselor) and non-users prefer informal sources,(i.e, family and friend).

Hypothesis Five

The fifth hypothesis predicted that Hispanics would demonstrate limited readiness for self-referral. The five categories developed by Veroff et al. (1981) are:

Group	I	Has used help
Group	II	Could have used help
Group	III	Might need help
Group	IV	Self-help
Group	V	Strong self-help

A one sample t-test was performed on the five RR groups to demonstrate whether Hispanics differed from the theoretically neutral midpoint of 3. The *t*-test, $t(165)=3.55$, $p<.001$, illustrated that Hispanic's group mean ($M=3.40$, $SD=1.36$) differed significantly from the theoretical mean in a direction which indicated less

Table 8

Evaluation of Sources of Help for Teen Problems as a Function of Ethnic Status

	Group	
	Hispanics	Blacks
Problem 1: School Vocational		
I.		
Freq.	1	0
Exp. Val.	(.7)	(.3)
II.		
Freq.	35	13
Exp. Val.	(32.1)	(15.9)
III.		
Freq.	112	60
Exp. Val.	(115.2)	(56.8)

X^2 = .63, ns

	Hispanics	Blacks
Problem 2: Sex		
I.		
Freq.	7	2
Exp. Val.	(5.9)	(3.1)
II.		
Freq.	70	38
Exp. Val.	(70.8)	(37.2)
III.		
Freq.	56	30
Exp. Val.	(56.3)	(29.7)

X^2 = .63, ns

(continued)

Table 8 (continued)

Evaluation fo Sources of Help for Teen Problems as a Function of Ethnic Status

	Group	
	Hispanics	Blacks
Problem 3: Personal/Familial		
I.		
Freq.	22	16
Exp. Val.	(24.1)	(13.9)
II.		
Freq.	77	36
Exp. Val.	(71.7)	(41.3)
III.		
Freq.	40	28
Exp. Val.	(43.2)	(24.8)

Note. Survey items regarding evaluation of sources of help were grouped into three main categories: counselor/therapist (I), family/friends (II), and non-mental health professionals (III).

$X^2 = 2.21$, ns

Table 9

Evaluation of Sources of Help as a Function of Use of MHCS

	Use of MHCS	
	Users	Non-Users
Problem 1: School Vocation		
I.		
Freq.	1	0
Exp. Val.	(.3)	(.7)
II.		
Freq.	12	36
Exp. Val.	(14.3)	(33.7)
III.		
Freq.	53	119
Exp. Val.	(51.4)	(120.6)
X^2 = 2.96, *ns*		
Problem 2: Sex		
I.		
Freq.	5	4
Exp. Val.	(2.4)	(6.6)
II.		
Freq.	19	89
Exp. Val.	(29.3)	(78.7)
III.		
Freq.	31	55
Exp. Val.	(23.3)	(62.7)
$X^2 = 12.12$, $p \leq .05$		

(continued)

Table 9 (continued)

Evaluation of Sources of Help as a Function of Use of MHCS

	Use of MHCS	
	Users	Non-Users
Problem 3: Personal/Familial		
I.		
Freq.	14	24
Exp. Val.	(10.8)	(27.2)
II.		
Freq.	25	88
Exp. Val.	(32.0)	(81.0)
III.		
Freq.	23	45
Exp. Val.	(19.3)	(48.7)

Note. MHCS = Mental health care services.

X^2 = 4.51, ns

readiness for self-referral. The results thus confirmed hypothesis five. Likewise, Blacks, $t(86)=3.93$, $p<.001$; $M=3.63$, $SD=1.46$, demonstrated low readiness for self-referral.

Additionally, a two-by-five Chi-Square was computed to examine whether Hispanics and Blacks differed significantly on their readiness for self-referral. A significant differences detected by the Chi-Square analysis ($X^2=9.64$, $p<.05$) appeared to result from the bi-modal distributions exhibited by both ethnic groups with high concentrations of their respective populations falling within Groups III and V. Furthermore, the results seem to suggest that while Hispanics possess limited readiness for self-referral, they demonstrate higher readiness for self-referral than their Black counterparts. (Chi-Square data are presented in Table 10.)

Additionally, since Veroff et al. (1981) were reluctant to place subjects into Group V, Groups IV and V were collapsed for purposes of comparison. Examination of sample distributions indicate that Hispanic and Black adolescents possess RR which is most similar to Anglo adults sampled in 1957, while demonstrating lower RR when compared to Anglo adults

Table 10

Readiness for Self-Referral: Current Study

RR Categories	Group: Hispanics	Blacks
I. Has used help		
Freq.	20	14
Exp. Val.	22.3	11.7
Percentage	12.1%	16%
II. Could have used help		
Freq.	19	2
Exp. Val.	13.8	7.2
Percentage	11.4%	2.3%
III. Might need help		
Freq.	57	2.3
Exp. Val.	52.5	27.5
Percentage	34.3%	26.4%
IV. Self help (cannot imagine having problem for which help is needed)		
Freq.	16	11
Exp. Val.	17.7	9.3
Percentage	9.6%	12.6%
V. Strong self help (can always handle own problems)		
Freq.	54	37
Exp. Val.	59.7	31.3
Percentage	32.5%	42.5%

Note. RR = Readiness for self-referral.

$X^2 = 9.64$, $p \leq .05$.

sampled in 1976. The Veroff et al. samples were most heavily concentrated in Groups IV/V, while being equally distributed among groups I and III. The present samples, however, are most heavily concentrated in Groups IV/V and secondly in Group III. While portions of all samples across studies indicated strong endorsement of self-help (35%), a greater proportion of Anglos also endorsed use of professional services (26%). (These distributions are presented in Table 11.)

Hypothesis Six

The sixth hypothesis predicted that Hispanics would demonstrate an inverse relationship between use of MHCS and level of acculturation. Hispanic subjects were grouped into three categories based upon their scores on the revised ARSMA: 1) high in acculturation (*N*=14), 2) bi-cultural (*N*=124), and 3) low in acculturation (*N*=12) and compared on their use of MHCS. Use of MHCS was examined in two ways: 1) use of school counseling center; and 2) self-reported use of formal sources of help. A two-by-three Chi-Square (X^2 =3.98, *ns*) analysis indicated no significant differences among users of school counseling services (*N*=44) and non-users (*N*=100) according to level of acculturation. The majority of Hispanic users (91%) and non-users (77%) fell within the

Table 11

Readiness for Self-Referral

	Current Study		Veroff et al. (1981)	
	Hispanics	Blacks	1957	1976
RR Categories				
I.	12%	16.1%	14%	26%
II.	11.4%	2.3%	9%	11%
III.	34.3%	26.4%	27%	22%
IV/V.	42.2%	55.2%	44%	35%
Not Ascertained	.1%	0%	6%	6%
	100%	100%	100%	100%

Note. RR = Readiness for self-referral.

bi-cultural range of acculturation. (Data are in Table 12.)

A two-by-three Chi-Square (X^2 =2.46, ns) analysis indicated that Hispanics who self-reported use and non-use of formal MHCS source did not vary according to their level of acculturation. (Refer to data presented in Table 13.)

Hypothesis Seven

The seventh hypothesis predicted that users of professional services would demonstrate a higher level of readiness for self-referral than non-users. A two-by-five Chi-Square was computed on both Hispanics and Blacks users and non-user of MHCS to test this hypothesis. The Chi-Square (X^2=38.66, p<.001) analysis demonstrated that significantly more users of MHCS fell within Group I than expected, while more of the non-users of MHCS fell within Group V indicating that users of MHCS show higher readiness for self-referral. Thus the results support hypothesis seven. (Refer to Table 14 for Chi-Square distributions.)

Hypothesis Eight

The eighth hypothesis predicted that users of MHCS would demonstrate more positive attitudes, more accurate

Table 12

Use of MHCS as a Function of Level of Acculturation

	Use of MHCS	
	Users	Non-Users
Level of Acculturation		
High		
Freq.	2	14
Exp. Val.	(4.9)	(11.1)
Percentage	4.5%	14.0%
Bi-cultural		
Freq.	40	77
Exp. Val.	(35.8)	(81.3)
Percentage	90.9%	77.0%
Low		
Freq.	2	9
Exp. Val.	(3.4)	(7.6)
Percentage	4.5%	9.0%

Note. MHCS = Mental health care services.

X^2 = 3.98, *ns*

Table 13

Self-Reported Use of Alternatives as a Function of Level of Acculturation

	Use of MHCS	
	Yes	No
Level of Acculturation		
High		
Freq.	14	1
Exp. Val.	(13.1)	(1.9)
Bi-cultural		
Freq.	100	17
Exp. Val.	(102.3)	(14.7)
Low		
Freq.	11	0
Exp. Val.	(9.6)	(1.4)

Note. MHCS = Mental health care services.

X^2 = 2.46, *ns*

Table 14

Use of MHCS as a Function of Readiness for Self-Referral

	Use of MHCS	
	Users	Non-Users
RR Categories		
I.		
Freq.	25	9
Exp. Val.	(9.9)	(24.1)
II.		
Freq.	3	18
Exp. Val.	(6.1)	(14.9)
III.		
Freq.	21	59
Exp. Val.	(23.4)	(56.6)
IV.		
Freq.	5	22
Exp. Val.	(7.9)	(19.1)
V.		
Freq.	20	71
Exp. Val.	(26.6)	(64.4)

Note. RR = Readiness for self-referral.
MHCS = Mental health care service.

$X^2 = 38.66$, $p < .001$.

knowledge of MHCS and more information about mental illness than non-users. Three individual t-tests were computed on users and non-users of MHCS across the three scales measuring attitudes, $t(224)=-.68$, ns, knowledge, $t(209)=-.94$, ns, and information, $t(233)=-.15$, ns, none of which indicated significant differences. Thus hypothesis eight was not supported.

Additional Analysis

Ethnicity and Use of MHCS. A two-by-two Chi-Square was computed on Hispanic and Black adolescents to examine whether either group was more highly represented among users of MHCS. Results indicated that Hispanics and Blacks did not vary significantly ($X^2=.075$, ns) in their representation among users and non-users of MHCS. (Data are presented in Table 15.)

Sources of Information. Hispanic and Black subjects were divided into one of three categories based on their response to the question, "where have you gotten most of your information ...". The three categories were: 1) "media" 2) "kin" and 3) "other informal sources". A simple binomial test ($binomial_z= 4.03$, $p<.001$), computed on the expected proportions of the three categories of information, indicated that subjects cited "other informal sources of information"

Table 15

Use of MHCS as a Function of Ethnic Status

	Group	
	Hispanics	Blacks
Use of MHCS		
Users		
Freq.	50	24
Exp. Val.	(48.6)	(25.4)
Non-Users		
Freq.	116	63
Exp. Val.	(117.4)	(61.6)

Note. MHCS = Mental health care services.

X^2 = .076, ns

(i.e., doctor/nurse, speaker/talk, teacher) significantly more of the time. In response to "what source of information has been most helpful", the most frequently cited sources were: 1) family, 2) friends, 3) television, 4) other, and 5) speaker/talk. There were two common "other" responses: 1) professional mental health worker (i.e., counselor, social worker), 2) self/experience. See Table 16 for a rank order of all twelve sources of information.

Sex Differences. Possible sex differences among all ethnic groups, including Anglos, were examined by using relevant Chi-Square or t-test analysis on the following variables: use of MHCS, RR, preference for alternative sources of help, and level of acculturation, and knowledge of MHCS for which no significant differences emerged. Only two differences emerged: attitudes toward mental health care services, $t(221)=-4.59$, $p<.05$, and information about mental illness, $t(230)=-4.61$, $p<.001$. In each of these cases, females demonstrated more positive attitudes toward MHCS and more accurate information about mental illness.

Table 16

Most Helpful Sources of Information

Rank Order		Percentage
1.	Family	19.6%
2.	Friends	17.6%
3.	Television	16.1%
4.	Other	11.9%
5.	Speaker/talk	10.1%
6.	Doctor/Nurse	6.5%
7.	Newspaper	4.2%
8.	Magazine	4.2%
9.	Book	3.6%
10.	Movie	3.0%
11.	Radio	1.8%
12.	Teacher	1.2%

DISCUSSION

There is empirical evidence that Hispanics, in general, receive the least amount of mental health care as compared to other minorities (Padilla, 1971). As a result, several theories have arisen to explain this phenomenon (Karno et al., 1969). Negative attitudes toward, and lack of knowledge of mental health services, ignorance of the signs of mental illness and personal problems, and preference for alternative sources of help have all been offered as theoretical explanations for Hispanics' apparent underutilization of MHCS (Karno et al., 1969).

In general, results of this study have failed to provide support for any of these theories. This is so in two respects. One, it was found that Hispanic adolescents possessed accurate information and positive attitudes toward MHCS, and seemed able to discriminate more from less serious psychological problems. Second, none of these variables were significantly related to actual or preferred use of MHCS. Hispanics did express a strong preference for alternatives but this preference was not associated with use of MHCS. The implications of such findings are that current theories regarding

Hispanics' apparent underutilization of MHCS must be re-examined and re-formulated, at least with respect to adolescents.

To elaborate on the above findings, data illustrating that Hispanic adolescents generally possess positive attitudes toward MHCS, are consistent with results reported from studies conducted with Hispanic adults (Acosta, 1975; Karno et al., 1969; Keefe et al., 1978).

The commonly held explanation that Hispanics maintain negative attitudes toward the mental health system has gone unsupported in investigations conducted with adult Hispanics (Acosta, 1975; Keefe et al., 1978). Current data suggest that Hispanic adolescents may be no different from their parents with respect to possessing positive attitudes toward MHCS. Most importantly, the data indicate that non-users and users of MHCS do not differ significantly in their attitudes toward MHCS. Similarly, females, who demonstrated more positive attitudes than their male counterparts do not utilize services more than males. Once again, these findings are consistent with previous investigations suggesting that although Hispanic and Anglo adults have positive attitudes toward MHCS, attitudes do not appear

to translate directly into utilization of services (Keefe et al., 1978).

Hispanic adolescents were also found to possess generally accurate knowledge of mental health care services, and have accurate information about mental illness. In addition, users of MHCS did not exhibit more accurate knowledge about MHCS nor did they demonstrate more accurate information about mental illness. Likewise, while females emerged as demonstrating more accurate information about mental illness, females were not more highly represented among users of MHCS than were males. These findings are rather interesting given that lack of knowledge of mental health services and ignorance of the signs of mental illness have been long standing explanations given for underutilization. Although the poor reliabilities of the knowledge (r=.55) and information scales (r=.48) temper any conclusions, current results suggest that the roles of knowledge of MHCS and information about mental illness can not account for Hispanics' current patterns of utilization.

Perhaps the most notable finding in this study has been the overwhelming preference for alternative sources of help by Hispanic youth. The results, indicated that

Hispanic subjects self-reported having used alternative sources of help significantly more than would be expected by chance. While Black subjects also preferred alternative sources, Hispanics reported utilizing such sources significantly more than Blacks. The preference for alternatives was consistently obtained regardless of whether respondents were asked about actual past use, or suggested use in response to hypothetical situations.

It is clear that alternative sources of help are preferred and that this is consistent with previous findings conducted with Hispanic, Black and White adults (Padilla et al., 1976; Veroff et al., 1981). In addition, while all Hispanic adolescents appear to prefer alternative sources, those who self-report having used these sources themselves are more likely to recommend their use to others. Most importantly, the use of alternatives extends across users and non-user of MHCS. These findings suggest that while Hispanic youths use or prefer alternatives use/preference is not related to use of formal MHCS.

This study also investigated two additional variables potentially related to MHCS use: level of acculturation and RR.

Contrary to prediction, Hispanic users and non-users of MHCS did not vary significantly in level of acculturation; nor did they vary in their preference for alternative sources of help. While these findings suggest that acculturation may have little influence on utilization of MHCS, nevertheless, the question remains unresolved, due to two possible methodological limitations.

One, the majority of Hispanic users (N=91%) and non-users (N=77%) sampled in this study fell within the bi-cultural range of acculturation putting into question the comparability of this sample to the general Hispanic adolescent population. Descriptive data of Hispanics' distribution along the acculturation continuum are not available for purposes of comparison with the present sample. However, previous studies have shown that younger Hispanics acculturate more quickly than older Hispanics (Szapocznik et al., 1980; Szapocznik et al., 1978) suggesting that these current data may be an accurate description of today's Hispanic youth.

Two, since the revised ARSMA scale used in the present study was initially developed for use with Mexican and Mexican American populations the instrument may not make fine discriminations in the ranges of high

and low acculturation resulting in a preponderance of bi-cultural subjects. In addition, the acculturation scale utilized in this study was only a measure of behavioral acculturation. It is possible that use of MHCS is related to psychological acculturation. Previous acculturation studies have indicated the need to obtain psychological measures of acculturation in addition to the usual measures of behavioral acculturation (Miranda & Castro, 1976). It is argued that changes resulting from the acculturation process are not only experienced on the behavioral level but on a psychological level as well (i.e., locus of control, future time perspective, etc.). Perhaps a holistic approach to acculturation would assist in making finer discriminations on the high and low ends of the acculturation continuum. Unfortunately, at the present time measures of psychological acculturation are still being investigated. In addition, currently available measures of psychological acculturation are targeted at single Hispanic sub-groups and have not been adapted for use with heterogeneous Hispanic samples. Until valid and reliable measures of both behavioral and psychological acculturation are developed for heterogeneous Hispanic samples, the question of

acculturation's role with respect to utilization of MHCS will remain unresolved.

The last variable to be discussed is readiness for self-referral. The data indicate that as predicted Hispanic youth demonstrate limited RR with 75.5% endorsing neutral (III) to strong self-help (V) positions. These data are similar to findings from Black and Anglo adults sampled in 1957 and less similar than those sampled in 1976 (Veroff et al., 1981). The movement from less to more RR exhibited by Veroff's adult sample might be some indication of the movement in which Hispanics may be expected to proceed with increasing exposure to MHCS.

Findings demonstrating that users possessed greater RR than non-users as predicted indicates that the variable RR may play an important role in influencing use of MHCS. This statement must be taken with some caution since, scores on RR were in part based upon use of services. Nevertheless, it remains that a disproportionate number of non-users fell within group V on RR. Unfortunately we don't know if use of services increases RR or whether RR leads to use of services. Although results indicate that Hispanic adolescents have positive attitudes toward mental health services,

accurate knowledge of services available to then, and accurate information about mental illness, they still demonstrate limited readiness for self-referral. These data indicate that RR is an important mediating factor influencing utilization of MHCS.

In general, current results support the notion that while Hispanic adolescents have positive attitudes toward mental health services, accurate knowledge of services available to them, and accurate information about mental illness, they still demonstrate limited readiness for self-referral, and prefe alternative sources of help. Thus, these variables have less effect on readiness to seek out professional mental health care than some theorists\researchers have previously suggested (Karon et al., 1969). Similarly, level of accurturation was demonstrated to have less effect than was originally predicted. The variable readiness for self-referral seems to be the most potent factor of those studied here affecting utilization of professional mental health care services.

The apparent need for increased readiness for self-referral and the overwhelming preference of alternative sources of support point to the need to: 1) undertake an aggressive approach in reaching the youth

in our schools; and 2) develop referral networks between formal and informal sources of help. Such networks would ensure that frequently consulted informal sources are adequately informed of the need, availability and nature of MHCS available to members in their community.

While this study has served its intended purpose to investigate factors potentially related to utilization of MHCS, in addition, it has also broadened the current limited data base available on adolescents, especially Hispanic adolescents. Unfortunately, data were not collected on enough Anglos for comparisons to be made between White and minority youth. In the future, it would be fruitful to make direct comparisons between Anglo, Hispanic and Black adolescents to examine whether the findings described in this study are unique to minority youth.

Additionally, future research is needed to develop psychometrically sound measures of knowledge about MHCS and information regarding mental illness. Although, the measures used in the present study demonstrated low reliabilities, these measures may serve as a model for developing more reliable direct measures of knowledge and information.

Finally, an investigation of Hispanic youths' perceptions of alternative sources may illustrate what characteristics make MHCS less appealing than alternatives. Karno et al. (1969) remarked that certain characteristics of mental health institutions (i.e., staff that do not demonstrate sufficient sensitivity to Hispanic concerns, inconvenient locations and hours, insufficient numbers of Spanish speaking personnel, etc.) discouraged Hispanics from utilizing MHCS. While this theory was not examined by this study, the overwhelming way in which Hispanics preferred alternative sources speaks to the need to further explore characteristics which may discourage Hispanic youth from preferring and\or utilizing MHCS.

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APPENDIX A

March 1987

Hello,

Thank you for volunteering to participate in our project. Your contribution is greatly appreciated. The purpose of this study is to get a better idea about what your age group knows and thinks about 1) personal/emotional problems and 2) about helping services such as counseling, otherwise known as therapy. Another purpose is to learn where you have gotten your information regarding these matters.

Please know that all of the information that we collect today is confidential. This means that it will be seen only by myself and other qualified researchers and will be used for research purposes only. Further, the information is anonymous. Your name will not appear anywhere. Instead, we are coding all of the information by number, not by name. Finally, should you decide to discontinue your participation in our project, for any reason, please feel free to do so. Though we do not expect that this will happen, we want you to know that you are free to leave the study at any point.

Please feel free to ask any questions. Once again, thank you for participating in our project.

Sincerely,

Mary Ann Garcia

I have read the above and understand it

____________________________ ____________________

Initials Date

Date of Birth: ______ / ______ / ______ (month / day / year)   Sex: /_/ Male   /_/ Female

School: ______________________   Religion: ______________________

Year in School: /_/ Freshman   /_/ Sophomore   /_/ Junior   /_/ Senior

Parent(s) Occupation: Mother: ______________________

Father: ______________________

Highest Grade of School Completed: Mother: __________   Father: __________

Number of People Living at Home: __________   Income: ______________

Ethnic Background:

Caucasian:

/_/ Irish

/_/ German

/_/ Polish

/_/ Other (Please Specify) ______________

/_/ Mexican

/_/ Mexican-American

/_/ Puerto Rican

/_/ Cuban

/_/ Central American (Please Specify) ______________

/_/ South American (Please Specify) ______________

/_/ Black/Afro-American

/_/ Caribbean (Which Island) ______________

/_/ Asian (Please Specify) ______________

/_/ Other (Please Specify) ______________

____ Have never received services at Youth Guidance.

____ Have received services at Youth Guidance in the past but am no longer receiving services.

____ I am currently receiving services at Youth Guidance.

Sometimes people have troubles and complaints. For example, sometimes people troubled can't sleep; used drugs or drank too much; stayed away from other people, got angry at them; can't get along with each other; or feel so depressed or nervous that they can't do anything. Have things like this ever happened to you?

/_/ Yes   /_/ No

When people have problems and feel bad sometimes they talk it over with other people. Have you ever talked to any of these people below about any problems you have had?

/_/ mother/father
/_/ brother/sister
/_/ friend
/_/ co-worker
/_/ neighbor
/_/ other family member
/_/ another person not on this list (please specify)

____

/_/ teacher
/_/ priest/pastor
/_/ counselor
/_/ doctor/nurse
/_/ social worker

/_/ psychologist/psychiatrist
/_/ other people like: faith healer, espiratistas, curandero, yerbero
/_/ talked to no one

Can you think of anything that's happened to you, any problems you've had in the past where going to a professional like those listed <u>might have</u> helped you in any way?

/_/ Yes   /_/ No

Do you think you <u>could ever</u> have a personal problem that got so bad that you might want to go someplace for help?

/_/ Yes   /_/ No

Or do you think you could always handle things like that yourself?

/_/ Yes   /_/ No

Please mark the response that shows how much you agree or disagree with each statement.	Strongly Agree	Moderately Agree	Agree Slightly	Moderately Disagree	Strongly Disagree
People with personal problems can be helped by a therapist/counselor.					
My school has a place to help people who have personal problems.					
Personal problems only happen between the ages of 12 and 60.					
Therapists/counselors are really interested in the people they help.					
My community/neighborhood has a place to help people who have personal problems.					
A person who has an emotional/personal problem is likely to recover faster if staying with family.					
All emotionally ill people are born that way.					
If I went to see a therapist/counselor I would never tell my friends.					
Therapists/counselors are there to give advice.					
A therapist/counselor would keep what you tell them a secret.					
If you go see a therapist/counselor it means you can't handle your own problems.					
Someone who is slow-to-learn can be helped by a therapist/counselor.					
Personal problems usually come from tensions and trouble in the family.					
Therapists/counselors really mess up people's minds.					
Therapy/counseling is helpful only for people who hurt others.					
Most deaf or blind people do not have personal problems.					
Therapy/counseling is only for weak people.					
People who take drugs have problems that could be helped by a therapist/counselor.					
Emotional problems usually arise from lack of willpower.					
Even if I had a serious problem I would not go to a therapist/counselor.					
Therapists/counselors sometimes help courts put people in jails and in the Audi-Home.					
If the home environment is really bad, that is, there's not enough money or nobody is working, too much arguing, anyone can develop an emotional problem.					
People who are violent and who have very bad tempers have an emotional problem.					
People have no one to blame but themselves for their own problem.					
Therapists/counselors only help people in mental hospitals.					
Emotional problems are usually brought on as a punishment for sins.					
People feel better after they have seen a therapist/counselor.					
Mental health/counseling centers are always located away from the city.					
I'd feel ashamed if I had to see a therapist/counselor.					
There are no medicines to treat personal problems.					

People are faced with many different situations in life. We all have opinions about them and we deal with them in our own way. Now I would like you to read a few stories about some different people and would like you to answer the questions following each story.

STORY #1:

Juana Mendez is 17 and is in her last year of high school. She has always been a moody girl and has never gotten along well with people. A few months ago she began to cry all the time and became very afraid of everyday things. She has stopped going to school and stays at home. She screams at her parents and a lot of times doesn't make any sense at all. She has talked about hearing voices talking to her and thinks that she is somebody other than herself.

What kind of problem do you think Juana has?

very serious	moderately serious	not very serious	not at all a problem
/_/	/_/	/_/	/_/

If Juana has a problem who do you think could help Juana with her problem?

/_/ mother/father

/_/ brother/sister

/_/ friend

/_/ co-worker

/_/ neighbor

/_/ other relative

/_/ another person not on this list (please specify)

____

/_/ teacher

/_/ priest/pastor

/_/ counselor/therapist

/_/ doctor/nurse

/_/ social worker

/_/ psychologist/psychiatrist

/_/ other people like: faith healer, esperatistas, curandero, yerbero

STORY #2:

Bobby Grey is a twelve year old boy. He is bright and in good health, and he comes from a comfortable home. But his father and mother have found out that he's been telling lies for a long time now. He's been stealing things from stores, and taking money from his mother's purse, and he has been playing truant, staying away from school whenever he can. His parents are very upset about the way he acts, but he pays no attention to them.

What kind of problem do you think Bobby has?

very serious	moderately serious	not very serious	not at all a problem
/_/	/_/	/_/	/_/

If Bobby has a problem who do you think could help Bobby with his problem?

/_/ mother/father

/_/ brother/sister

/_/ friend

/_/ co-worker

/_/ neighbor

/_/ other relative

/_/ another person not on this list (please specify)

____

/_/ teacher

/_/ priest/pastor

/_/ counselor/therapist

/_/ doctor/nurse

/_/ social worker

/_/ psychologist/psychiatrist

/_/ other people like: faith healer, esperatistas, curandero, yerbero

STORY #3:

Trina Jones seems happy and cheerful; she's pretty, has a good job, and is engaged to marry a nice young man. She has lots of friends; everybody likes her, and she's always busy and active. However, she just can't leave the house without going back again just to make sure she locked the door. And one other thing about her: she's afraid to ride up and down in elevators; she just won't go any place where she'd have to ride in an elevator to get there.

What kind of problem do you think Trina has?

very serious	moderately serious	not very serious	not at all a problem
/_/	/_/	/_/	/_/

If Trina has a problem who do you think could help Trina with her problem?

- /_/ mother/father
- /_/ brother/sister
- /_/ friend
- /_/ co-worker
- /_/ neighbor
- /_/ other relative
- /_/ another person not on this list (please specify)

  ____

- /_/ teacher
- /_/ priest/pastor
- /_/ counselor/therapist
- /_/ doctor/nurse
- /_/ social worker
- /_/ psychologist/psychiatrist
- /_/ other people like: faith healer, esperatistas, curandero, yerbero

STORY #4:

Justin Smith is a young man in his twenties. He has never had a job, and he doesn't seem to want to go out and look for one. He is very quiet, he doesn't talk much to anyone -- even his own family, and he acts like he's afraid of people, especially young women his own age. He won't go out with anyone, and whenever someone comes to visit his family, he stays in his own room until they leave. He just stays by himself and daydreams all the time, and shows no interest in anything or anybody.

What kind of problem do you think Justin has?

very serious	moderately serious	not very serious	not at all a problem
/_/	/_/	/_/	/_/

If Justin has a problem who do you think could help Justin with his problem?

/_/ mother/father

/_/ brother/sister

/_/ friend

/_/ co-worker

/_/ neighbor

/_/ other relative

/_/ another person not on this list (please specify)

____

/_/ teacher

/_/ priest/pastor

/_/ counselor/therapist

/_/ doctor/nurse

/_/ social worker

/_/ psychologist/psychiatrist

/_/ other people like: faith healer, esperatistas, curandero, yerbero

Well, we've been talking about all these personal problems. Now I'd like to ask you where you've gotten most of your information about personal and emotional problems. Please check those you've used.

/̅/ newspaper	/̅/ movie	/̅/ doctor/nurse
/̅/ magazine	/̅/ radio	/̅/ family
/̅/ book	/̅/ teacher	/̅/ friends
/̅/ television	/̅/ speaker/talk	/̅/ other ______________

Which source of information did you find most helpful? ______________________________

Below are a list of problems that people your age might have and some of these who might be of help with the problem. For each problem, place a check in the column if you think that person can help with that problem. You can check as many different people for each problem as you like.

	Therapist/ Counselor	Family Members	Friend	Pastor/ Minister	Teacher	Doctor	School Counselor
Scheduling classes							
Need help finding a job							
Wanting to quit school							
Trouble with parents							
Failing in school							
Telling my parents I'm pregnant							
Can't make friends							
Thinking about suicide							
Gang violence (trouble)							
Questions about sex							
Possible suspension							
Questions about birth control							
Feeling sad or bored all the time							
One or both of my parents drinks too much							
Can't get high enough grades							

Circle the number next to the answer that best fits the question.

What language do you speak?
1. Spanish only
2. Mostly Spanish, some English
3. Spanish and English about equally (bilingual)
4. Mostly English, some Spanish
5. English only
6. Other (please specify) ____________________________

What language do you prefer?
1. Spanish only
2. Mostly Spanish, some English
3. Spanish and English about equally (bilingual)
4. Mostly English, some Spanish
5. English only
6. Other (please specify) ____________________________

How do you identify yourself?
1. Mexican, Puerto Rican, South American (Peruvian, etc.)
2. Mexican-American, Puerto Rican-American
3. Latin American (Latino), Hispanic American (Hispano)
4. American
5. Anglo-American
6. Other (please specify) ____________________________

What ethnic identification does (did) your mother use?
1. Mexican, Puerto Rican, South American (Peruvian, etc.)
2. Mexican-American, Puerto Rican-American
3. Latin American (Latino), Hispanic American (Hispano)
4. American
5. Anglo-American
6. Other (please specify) ____________________________

Which ethnic identification does (did) your father use?
1. Mexican, Puerto Rican, South American (Peruvian, etc.)
2. Mexican-American, Puerto Rican-American
3. Latin American (Latino), Hispanic American (Hispano)
4. American
5. Anglo-American
6. Other (please specify) ____________________________

What is the ethnic origin of your friends?
1. Almost exclusively Mexicans, Puerto Ricans, South Americans
2. Mostly Mexican-Americans, Puerto Rican-Americans
3. About equally Latino-Hispano and Anglo or other ethnic groups
4. Mostly Anglos, Blacks or other ethnic groups
5. Almost exclusively Anglos, Blacks or other ethnic groups
6. Other (please specify) ____________________________

Whom do you now associate with outside your neighborhood/community?
1. Almost exclusively Mexicans, Puerto Ricans, South Americans
2. Mostly Mexican-Americans, Puerto Ricans, South Americans
3. About equally Latino-Hispano and Anglo or other ethnic groups
4. Mostly Anglos, Blacks, or other ethnic groups
5. Almost exclusively Anglos, Blacks or other ethnic groups
6. Other (please specify) ____________________________

What is your music preference?
1. Only Spanish
2. Mostly Spanish
3. Equally Spanish and English
4. Mostly English
5. English only

What is your TV viewing preference?
1. Only programs in Spanish
2. Mostly programs in Spanish
3. Equally Spanish and English programs
4. Mostly programs in English
5. Only programs in English

Where were you born?
- /_/ Mexico
- /_/ Cuba or other Caribbean
- /_/ Puerto Rico
- /_/ U.S.
- /_/ Central or South America
- /_/ Other (specify) ______________

Where was your father born?
- /_/ Mexico
- /_/ Cuba or other Caribbean
- /_/ Puerto Rico
- /_/ U.S.
- /_/ Central or South America
- /_/ Other (specify) ______________

Where was your mother born?
- /_/ Mexico
- /_/ Cuba or other Caribbean
- /_/ Puerto Rico
- /_/ U.S.
- /_/ Central or South America
- /_/ Other (specify) ______________

Where was your father's father born?
- /_/ Mexico
- /_/ Cuba or other Caribbean
- /_/ Puerto Rico
- /_/ U.S.
- /_/ Central or South America
- /_/ Other (specify) ______________

Where was your mother's father born?
- /_/ Mexico
- /_/ Cuba or other Caribbean
- /_/ Puerto Rico
- /_/ U.S.
- /_/ Central or South America
- /_/ Other (specify) ______________

Where was your father's mother born?
- /_/ Mexico
- /_/ Cuba or other Caribbean
- /_/ Puerto Rico
- /_/ U.S.
- /_/ Central or South America
- /_/ Other (specify) ______________

Where was your mother's mother born?
- /_/ Mexico
- /_/ Cuba or other Caribbean
- /_/ Puerto Rico
- /_/ U.S.
- /_/ Central or South America
- /_/ Other (specify) ______________

Where were you raised?
1. In Mexico, Puerto Rico, etc. only
2. Mostly in Mexico, Puerto Rico, etc., some in U.S.
3. Equally in U.S. and Mexico, Puerto Rico, etc.
4. Mostly in U.S., some in Mexico, Puerto Rico, etc.
5. In U.S. only

Can you read Spanish?
1. Read Spanish better than English
2. Read both Spanish and English equally well
3. Read English better than Spanish
4. Read only English
5. Read other language than English and Spanish (specify) ______________

Can you write in Spanish?
1. Write Spanish better than English
2. Write both Spanish and English equally well
3. Write English better than Spanish
4. Write only in English
5. Write other language than English and Spanish (specify) ______________

How would you rate yourself?
1. Very Latino/Hispanic
2. Mostly Latino/Hispanic
3. Bicultural
4. Mostly Anglicized (American)
5. Very Anglicized (American)

APPENDIX B

ATTITUDES SCALE: FINAL ITEMS

1. People with personal problems can be helped by a therapist/counselor.
2. Therapist/counselors are really interested in the people they help.
3. Therapist/counselors really mess-up people's minds.
4. Therapy/counseling is only for weak people.
5. Even if I had a serious problem I would not go to a therapist/counselor.
6. People feel better after they have seen a therapist/counselor.
7. I would feel ashamed if I had to see a therapist/counselor.

Chronbach Alpha ($\underline{r}$) = .70

KNOWLEDGE SCALE: FINAL ITEMS

1. My school has a place to help people who have personal problems.
2. My community/neighborhood has a place to help people who have personal problems.
3. Someone who is slow-to-learn can be helped by a therapist/counselor.
4. Therapist/counselor is helpful only for people-who hurt others.
5. People who take drugs have problems that could be helped by a therapist/counselor.
6. Therapist/counselors sometimes help courts put people in jails and in the Audi-home.
7. Therapists/counselors only help people in mental hospitals.
8. Mental health/counseling centers are always located away from the city.
9. A therapist/counselor would keep what you tell them a secret.

Chronbach Alpha ($\underline{r}$) = .55

INFORMATION SCALE: FINAL ITEMS

1. Personal problems only happen between the ages of 12 and 60.

2. Emotional problems usually arise from lack of willpower.

3. If the home environment is bad, that is if there's not enough money or nobody is working; too much arguing, anyone can develop an emotional problem.

4. People who are violent and who have very bad tempers have an emotional problem.

5. Emotional problems are usually brought on as a punishment for sins.

6. There are no medicines to treat personal problems.

Chronbach Alpha (*r*) = .48

ACCULTURATION SCALE: FINAL ITEMS

1. What language do you speak?
2. What language do you prefer?
3. How do you identify yourself?
4. What ethnic identification does (did) your mother use?
5. What ethnic identification does (did) your father use?
6. What is your music preference?
7. What is your TV viewing preference?
8. Where were you born?
9. Where was your father born?
10. Where was your father's father born?
11. Where was your father's mother born?
12. Where was your mother born?
13. Where was your mother's father born?
14. Where was your mother's mother born?
15. Where were you raised?
16. Can you write in Spanish?
17. Can you read Spanish?
18. How would you rate yourself?

Note. Items 8-14 are combined into one item to determine subject level of generation.

Chronbach Alpha (r) = .82

APPROVAL SHEET

The thesis submitted by Mary Ann H. Garcia has been read and approved by the following committee:

Dr. Joseph A. Durlak, Director
Professor, Psychology, Loyola

Dr. Alan DeWolfe
Professor, Psychology, Loyola

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Masters of Arts.

August 25, 1987
Date

Director's Signature