University of New Mexico
UNM Digital Repository

Sociology ETDs

Electronic Theses and Dissertations

8-27-2012

Conceptualizing Mental Health: A Qualitative Study on Mexican Immigrant Mothers' Definition of Their Children's Mental Health in New Mexico

Cirila Estela Vasquez Guzman

Follow this and additional works at: https://digitalrepository.unm.edu/soc_etds

Cirila Estela Vasquez Guzman
Candidate

Sociology
Department

This thesis is approved, and it is acceptable in quality
and form for publication:

Approved by the Thesis Committee:

 Nancy López, Co-Chairperson

 Kimberly Huyser, Co-Chairperson

 Tamar Ginossar

 Howard Waitzkin

CONCEPTUALIZING MENTAL HEALTH:

A QUALITATIVE STUDY ON MEXICAN IMMIGRANT MOTHERS'

DEFINITIONS OF THEIR CHILDREN'S MENTAL HEALTH IN NEW

MEXICO

By

Cirila Estela Vasquez Guzman

B.A., Sociology, Whitman College, 2010

THESIS

Submitted in Partial Fulfillment of the
Requirements for the Degree of

Master of Arts
Sociology

The University of New Mexico
Albuquerque, New Mexico

July 2012

iii

Dedication

I dedicate this thesis to my mother, Elena Aurora Vasquez Guzman. Her love and words of encouragement regardless of the distance between us have been instrumental to my ability to overcome challenges. Although my mother obtained only a fifth grade education, her story as a Mexican immigrant mother reflected the same passion and dedication I saw among the participants of the focus groups with regards to their children's well-being. My discussions with my mother kept my curiosity and investigation alive. Working on this thesis has been overwhelming at times, but I have persisted, poring over the data as well as theory. It has been an important journey, one that has taught me the uniqueness of the sociological perspective and has exposed me to brilliant scholars, allowing me to learn more about the research process. It has been a wonderful experience that would not have been possible without my mother's agency and advocacy on my behalf in all my years of education. Aurora, *"mucha gracias."*

Acknowledgements

CONCEPTUALIZING MENTAL HEALTH:

A QUALITATIVE STUDY ON MEXICAN IMMIGRANT MOTHERS'

DEFINITIONS OF THEIR CHILDREN'S MENTAL HEALTH IN NEW

MEXICO

By

Cirila Estela Vasquez Guzman

B.A., Sociology, Whitman College, 2010
M.A., Sociology, University of New Mexico, 2012

Abstract

Parents play a significant role in many areas of their children's mental health, including understanding the concept, detection, utilization, and treatment options. Despite the importance of parents' role, there is relatively little research in the United States on Latino parents' conceptualization of the term mental health. This study focuses on understanding conceptualization patterns of children's mental health among low-income Mexican immigrant mothers. I utilize the social construction framework to investigate the social nature of the construct mental health. I also engage with the medicalization literature to shed light on the biomedical model's perspective on mental health. Nine focus groups were conducted with 75 low-income Mexican immigrant mothers in New Mexico. Through inductive qualitative analysis of how participants define the term mental health of their children, five coexisting conceptualizations of mental health emerged: cognitive, emotional, behavioral, positive outlook, and social environment. I found that Mexican immigrant

mothers have a complex, multifaceted conceptualization of children's mental health. The mothers in this study defined mental health first in the arena of larger social dynamics and contexts in which children are embedded and then included definitions that aligned with the traditional Western biomedical framework. Mexican immigrant mothers' concept of mental health is not a fixed, purely biological or psychological concept, but instead it is an evolving, social, and multidimensional category that includes a variety of overlapping conceptualizations. The analysis suggests a need for additional research to continue to investigate the concept of mental health within this and other communities. Furthermore, this community's conceptualization of mental health was tied to the participants' identity and everyday experiences. Contextualizing the definition of mental health should add to the understanding about mental health disparities among Latino children and suggest strategies to increase better communication between Latino parents and mental health providers. This study emphasizes the social determinant framework highlighting the importance of context in regards to the construction of children's mental health.

Table of Contents

List of Figures

List of Tables

Introduction

Mental health disparities in treatment, services, and diagnosis among Latino[1] children are a growing area of concern for scholars. Latino children are underdiagnosed, underutilize services, and are undertreated or mistreated with regards to their mental health (Eiraidi & Diaz, 2010; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Kataoka, Zhang, & Wells, 2002; Leslie, Lambros, Aarons, Haine, & Hough, 2008; Pham, Carlson, & Kosciulek, 2010; Teagle, 2002; Zimmerman, 2005). Scholars concerned with understanding the persistence of mental health disparities among Latino children often point to this population's disadvantages in the socio-demographic, linguistic, stress, and access areas (Aneshensel, Rutter, & Lachenbruch, 1991; McKinlay, 1972; Pescosolido, 1992; Zimmerman, 2005). However, these explanations do not fully explain the rates of mental health underutilization and undertreatment among Latino children.

Studies have found that Latino parents' conceptualization of mental health is related to the mental health utilization and treatment patterns (Arica & Fernandez, 1998; Yeh, Hough, McCabe, Lau, & Garland, 2004; Yeh et al., 2005). Conceptualization refers to an idea or an explanation of a concept. A growing body of literature provides information concerning how conceptualization of the concept of mental health among Latino parent's plays a significant role in understanding mental health disparities among their children (Arnold et al., 2003; Eiraidi & Diaz, 2010; Fuller, Edward, Procter, & Moss, 2000). Therefore, to promote mental health among Latino children, investigating parents' definition of children's mental health is imperative.

---

[1] Latino: This term refers to both Latino and Latina. For clarity, I primarily use Latino. However, for

The manner in which Latino parents' define mental health matters for children's mental health outcomes is understudied. Evidence suggests that Latino parents do not always endorse the Western biomedical perspective of mental health (Arica & Fernandez, 2003; Bava, 2009; Schmitz & Velez, 2003). While the applicability of the medical model to mental health and mental illness has been a focus among sociologist for the past 30 years, what is meant by the term remains vague (Busfield, 2000). The biomedical perspective of mental health emphasizes the dichotomous mind/body relationship as well as emphasizes individual biological process or the genetic, hormonal causes of mental illness without an exploration of the social forces. This approach is detrimental to the analysis of individuals immersed in and interacting with the environment. While it is documented that Latino parents often do not endorse the biomedical model, there is a lack of knowledge regarding Latino parent's alternative conceptualization of mental health (Bava, 2009). This gap in the literature calls attention to the need to investigate how Latino parents define children's mental health to better meet their needs. This study explores the manner in which Mexican immigrant mothers conceptualize mental health and adds to the scant existing body of literature on this topic.

The intent of this study is to explore the definition of mental health among a community of immigrant mothers in Albuquerque, NM. I ask the following questions: first, how do low-income Mexican immigrant mothers talk about, describe, and define children's mental health? And second, what are the major conceptualizations of mental health among low-income Mexican immigrant mothers? To answer these key research questions, this study utilizes data from a larger research study, "Promoting Knowledge of Childhood Development and Screening: A Community Based Participatory Research," which was

conducted with focus groups of Spanish-speaking, low-income, immigrant Latino parents to capture their understanding and experiences of children's development and behavioral health. Dr. Ginossar the PI of the larger study collaborated with La Communidad Habla "The Community Speaks" to investigate Latino parents information needs, information seeking, and concerns regarding children's developmental and behavioral health. Building upon this earlier study, I conducted inductive qualitative analysis that focused on capturing the Mexican immigrant mother's conceptualization of children's mental health.

Latino children born to Mexican immigrant parents are an important population to investigate conceptualization patterns of children's mental health because they face multiple disadvantages in achieving better mental health outcomes (Padilla, Radey, Hummer, & Kim, 2006; Vega, 1990). Mental health disparities with regards to access to services among Latinos in general have increased over the last decade (Alegria, Mulvaney-Day, Whoo, Torres, Gao, & Oddo, 2007). Alegria and colleagues found nativity, language, age at migration, years of residence in the US, and generational status were associated with lack of access. Furthermore, the demographic profile of the general Latino population often is associated with increased risk of children's mental disorders (Escobar, Nervi, & Gara, 2000; Gudino, Lau, & Hough, 2008; National Coalition of Hispanic Health & Human Services Organization, 1995). However, children born to Mexican immigrant parents are even more likely to be part of this high-risk profile.

This profile includes lower socioeconomic status, and higher rates of single-parent households, lower rates of insurance, and ethnic minority status (Rogler, Malgady, & Rodriquez, 1989); 88% of Mexican immigrant parents have less than a ninth grade education, and about half do not have a high school diploma (Fortuny, Hernandez, and Chaudry, 2010).

Approximately 70% of Latino children born to Mexican immigrant parents in the United States are members of lower income families compared to 38% of Latino children born to non-immigrant families. In addition, nearly half of the children born to Mexican immigrant parents in the United States live in isolated households without anyone who is English proficient (Fortuny et al., 2010). Children of Mexican immigrant parents also are more likely to not be covered by health insurance compared to all children with U.S.-born parents (Solis, Marks, Garcia, & Shelton, 1990). Latino children of immigrants are more vulnerable to mental health problems as the result of immigration and acculturation stress and pressure experienced by their families (Finno, Vidal de Haymes, & Mindell, 2006; Segal & Mayadas, 2005). To summarize, Latino children of immigrant parents face educational, socioeconomic, and linguistic disadvantages. Additionally, they experience limited access to mental health services and treatment due to a lack of health insurance.

For these reasons, mental health disparities among young Latino children with Mexican immigrant parents not only are important but are complex and multifaceted. Furthermore evidence suggests that Latina immigrants' perceptions might conflict with Western mental health conceptualizations (Bava, 2009; Moses, 2011; Pam, Calson, & Kosciuklek, 2010; Schmitz & Velez, 2003). Flores-Ortiz (2003) argued that traditional Western concepts of mental health fall far from promoting a holistic understanding of the experiences of Latinos. In light of this background, this study investigates conceptualization patterns of children's mental health among Mexican immigrant mothers. Understanding their perspective about mental health is underexplored. I found that this community of mothers has complex and multifaceted definitions of mental health that urge scholars to reconceptualize mental health and mental illness.

4

Chapter One: Sociological Theory and Literature Review

The social construction framework illustrates the need to scrutinize accepted social reality such as the concept of mental health (Goldstein, 1979; Schwartz, 2002; Walker, 2006; Warner, 2009). The social constructionist perspective emphasizes that there is no single, true, and objective reality, but rather, reality is socially constructed (Brown, 1995; Conrad, 2007; Pilgram & Rogers, 1999). This perspective sheds light on the role that rules, norms, values, and ideology play for constructing reality that vary among communities. I apply this perspective to my investigation, arguing that the concept of mental health is socially constructed. Walker (2006) has eloquently applied the social constructivism framework to demonstrate the fluid nonstatic definition of mental health. There is no objective definition of mental health; rather, mental health is a social construct grounded in contextual experiences and shaped by social structures such as the medical institution. The utilization of the social construction framework allows me to investigate the conceptualization of children's mental health among low-income Mexican immigrant mothers.

In this chapter, I first examine the literature and focus on defining mental health. I evaluate mental health as distinct from mental illness while arguing for more sociological research in defining mental health. Next, I engage in the medicalization literature that elaborates on the critical role that power dynamics plays for constructing reality. The Western biomedical conceptualization on mental health is a dominant ideology I cannot ignore. Then, I offer an overview of studies focused on Latino conceptualization of mental health to show the divergent and unique perspective in this community. Finally, I end with a section on the importance of research contextualizing the concept of mental health. I argue that there are multiple definitions and perspectives on the construct of mental health. The

conceptualization of mental health among racial/ethnic minorities such as Mexican immigrant mothers, however, remains poorly understood.

The Conceptualization of Mental Health in Sociology

Sociology scholars have engaged in more investigation of the definition of mental illness rather than of mental health. Parsons (1951), Foucault (1967), and Szasz (1970) are three prominent sociologists who define mental illness as a social process. Parsons (1951) asserted that mental illness is a construct defined by deviance based on societal standards. He characterizes mental illness as a social process rather than a biological phenomenon. Those labeled as having a mental illness not only were "ill" but more importantly they were deviant, based on what society considered acceptable human behavior. Talcott Parsons described the general treatment of individuals. His work heavily focused on the sick role which is a temporary medically sanction role that should not be prolonged. This sick role is what accepts the diagnosis of the medical institution. Individuals therefore have a function within the larger system upholding the medical model. Diagnosis, however, are not biological. Parsons' definition of mental illness is rooted in behaviors deviating from acceptable societal norms.

Foucault's (1967) conceptualization of mental illness also demonstrated the reliance on the societal subjective standards. He defined mental illness primarily in terms of the mind, viewing mental illness as a construct of reason and rational behaviors. Mental illness, for Foucault, is not solely a biological conceptualization, but instead, mental illness is better conceptualized as interdependent with social processes. Society dictates what is "rational" behavior and holds everyone accordingly to such subjective standards. Szasz (1970), extended understanding of mental illness as the furthest breaking point of any societal,

political, or ethical norm. His work was formulated independently from Foucault own work but similarly demonstrated the importance of social norms. Mental illness is therefore not grounded nor defined in biological vocabulary, but instead is the product of deviant or abnormal behaviors labeled as problematic by society.

These three scholars and many others who followed have been instrumental in conceptualizing mental illness as a social process rather than as a purely biological phenomenon. This rich body of theoretical work has been a major component for many scholars inside and outside sociology who are moving toward a reconceptualizing of mental illness as a social process. The definitions for mental illness are grounded in societal expectations. The construct, mental health, is similar to mental illness with regards to its diverse conceptualization, but it remains underexplored among current sociologists.

One general agreement among scholars is that mental health captures a multitude of human experiences and behaviors and is not defined as merely the absence of mental illness. Psychiatrist Marie Jahoda (1958) points out that there is a tendency to equate mental health and mental illness, but they are very distinct constructs. She argues there is a need to investigate mental health rather than mental illness because mental health is a broader concept that encompasses mental illness among other things: "…would seem to be more fruitful to concentrate on the concept of mental health in its more positive connotation, noting, however, that the absence of disease may constitute a necessary, but not a sufficient criterion for mental health" (p. 15). As Jahoda said, the construct of mental health must be scrutinized because it captures more than the absence of mental illness. Other scholars also have argued the need to clearly differentiate between mental health and mental illness (Busfield, 2000; Goldstein, 1979; Macklin, 1971; Scott, 1958). Mental illness is part of

8

mental health, but mental health is not merely defined as the absence of mental illness. Instead, mental health, as depicted in Figure 1, is a larger concept that encompasses mental illness as well as other concepts.
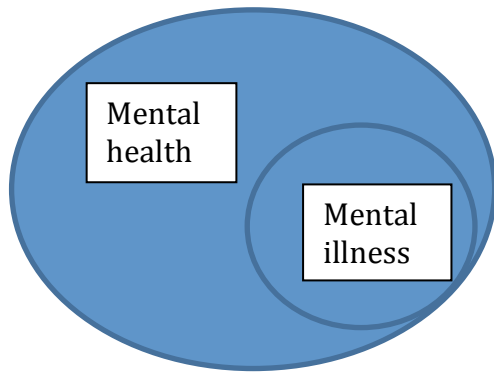
Figure 1: **The Construction of Mental Health**

Unlike mental illness, which focuses on abnormality, the concept of mental health reflects on a person's overall well-being, with or without disease. This concept of mental health, according to the World Health Organization, captures social and physical environments because individuals do not exist in isolation (WHO, 2005). Mental health is influenced by multiple factors and experiences, such as family relationships and the wider community. Mental health, however, is a concept underexplored, and little agreement exists on its definition (Aneshensel, 2002; Busfield, 2000; Macklin, 1971; Scott, 1958). The ideas and thoughts contributing to the construct of mental health vary depending on who is asked.

Mid-20th century psychologists and psychiatrists have performed major work exploring the concept of mental health. Jahoda (1958) defines mental health as "a relatively constant and enduring function of personality, leading to predictable differences in behavior and feelings depending on the stresses and strains of the situation in which a person finds himself; or as a momentary function of personality and situation" (p. 8). For others, mental

health captures the philosophical meaning of a good life, where an individual has a sense of purpose and possesses self-respect and mastery (Ryff & Singer, 1998). May's (1954) definition of mental health captures more of the social dimension of human well-being. May, a psychologist, says mental health is about an individual's successful engagement in social relations with himself/herself and others in his/her environment. Other psychologists tend to move away from a purely biological definition of mental health, but their conceptualization of mental health remains at the individual level. Such a conceptualization of mental health emphasizes the individual's emotions and coping abilities to function in society. This body of work has strengthened the evidence that mental health is clearly much broader than a lack of mental illness, but has not considered the social dimension in depth. My study will add to this body of literature and continue the discussion of the conceptualization of mental health.

I define mental health as a process that captures a wide range of human life experiences and behaviors interdependent with social life and social structures. It is a concept that is not merely defined as the absence of mental illness, but does captures ideas and concepts part of mental illness. The concept of mental health for me aligns with the WHO definition that sheds light on family dynamics and social environments as well as discusses emotional wellbeing. Ignacio Martín-Baró (1994), a psychologist in Latin America, is a highly influential scholar who conceptualized mental health as interdependent with the social context. He rejected the idea of universal or impartial psychology and instead argued the importance of addressing the historical and social context individuals are embedded within. I like his approach and also emphasize social conditions. For me, mental health is a concept interconnected with social structures and social environments.

Within sociology, Engels, Virchow and Allende during the early 1900's as discussed by Waitzkin (2004) have done early theoretical work on understanding the social origins of mental health. Their work demonstrated the impact of social conditions and social structures have on individual's mental health. However as Waitzkin (2004) points out, "conditions of society that generate illness and mortality have been largely forgotten and rediscovered with each succeeding generation" (p. 41). In today's discourse the social determinants of health and mental health elucidates the critical role of social context. Regardless, the emphasis on the social environment as a whole has been meager within the field of psychology and sociology with regards to mental health. What is clear is that mental health is a much broader concept than mental illness, thereby necessary to explore and better understand. Sociologists have a unique standpoint to engage with this literature to continue emphasizing the social origins of mental health.

Despite the conceptual distinction between mental health and mental illness, sociologists have yet to explore the sociology of mental health conceptualization. Bernice Pescosolido, Jane McLeod, and William Avison (2007) looked at the kind of mental health and mental illness research conducted by sociologists published in either the American Journal of Sociology (AJS) or American Sociological Review (ASR) from the early 1990s to the early 2000s. These scholars concluded that sociological research primarily dealt with understanding the social conditions that increase the likelihood different groups experience mental illnesses (Pescosolido, McLeod, & Avison, 2007), which aligned with Horwitz's critique of the sociology of mental health and illness. Horwitz (2002) points out the void in sociological literature on the concept of mental health. Sociologists are concern primarily with the unequal distribution of mental illness and understanding the social causations of

11

mental illness. Currently, we know more about mental illness than about mental health. Due to this gap in the literature, there is a need to study the construct mental health rather than just mental illness.

Medicalization of Mental Health and Mental Illness

The literature on medicalization is important to examine because it recognizes the power relations embedded in the definition and treatment of mental illness and of mental health. This body of literature discusses the dominant Western biomedical ideology and sheds light on socially sanctioned agents and institutions that dictate diagnostic categories, symptoms, signs, and state of mind, known as mental illness. Medicalization demonstrates the fluid nature of medical categories such as mental health.

The Western biomedical framework is the dominant perspective applied to both physical and mental health in the United States, which emphasizes intra-organism and physiopathology causes. According to Peter Conrad (1975, 2007), medicalization is the process by which human conditions of everyday life come to be redefined as treatable disorders. This concept of medicalization originated among sociologists so that researchers could explore how medical knowledge is applied to explain a series of behaviors that once were not self-evidently medical or biological (Conrad, 2007). The process of medicalization operates under the biomedical framework, which redefines a range of human life experiences as problematic with biological origins needing medical treatment. Menopause, childbirth, baldness, and others are among the conditions that have been medicalized in the United States (Conrad, 2007). Medicalization, therefore, is the process by which the medical institution defines and redefines mental illness and mental health categories.

Children's mental health has been a particularly significant area of study, because attention deficit hyperactivity disorder (ADHD) has been widely cited as the prime example of medicalization (Conrad, 1975; Leslie et al., 2008; Livingston, 1999; Pham et al., 2010). Peter Conrad (1975) demonstrates that hyperkinesias, also known as minimal brain dysfunction, hyperactive syndrome or hyper disorder of childhood, and today referred to as ADHD, is a dialogistic category that evolved socially. Multiple social forces, such as the pharmaceuticals, the government, and others, were at play for ADHD to become an accepted medical diagnosis. Children mental health is a growing area of study for studying medicalization.

Medicalization, therefore, sheds light on the elasticity of medical categories but the process of medicalization also sheds light on the power upheld by the medical institution. Power dynamics are important with regards to the social constructivist nature of the definition of children's mental health. Who decides what is a mental health concern is an important question because the process of medicalization relies heavily on the opinion of health providers who have the authority to dictate. Medicalization, as a result, has the opportunity to marginalize the perceptions of nondominant communities about children's mental illness and mental health.

The process of medicalization enhances medicine's jurisdiction by shifting responsibility from the individual or society to the medical institution. When children's mental health is medicalized, such as with ADHD, the child's behavior is viewed as the result of biological processes. Medicalization thereby enhances medicine's jurisdiction over children's bodies by legitimizing a medical diagnosis as well as medical oriented treatments (Brown, 1995; Conrad, 2007; Conrad & Barker, 2010). The medical diagnosis label re-

frames the origins of ADHD from social to biology thereby marginalizing alternative

perspectives and authority concerning the diagnosis, causes, and treatment. For example,

ADHD in children is defined as the result of chemical imbalances within the child's brain.

As a result, this medicalization process has categorized children's hyperactivity as a medical

diagnosis that requires medical intervention and treatment. The discourse surrounding

ADHD reframes children's behavior as a problem rooted in biological processes rather than

blaming the parents or introducing societal level causes (Brown, 1995; Conrad, 2007). This

medicalization process has determined that the appropriate interventions are medically

oriented treatments (Conrad, 2007; Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007).

The resulting medical interventions for ADHD are pharmaceutical drugs to address the

defined abnormality. Pescosolido, Fettes, and colleagues (2007) document the significant

increase among the general public in support and encouraging use of coercion on

families/parents to increase the use of medication for ADHD. As a result, the process of

medicalization enhances use of medication while failing to recognize alternative

conceptualizations and disregards alternative treatment options outside of the medical

institution. Notably, racial/ethnic minorities often are part of this alternative perspective.

Multiple studies find racial/ethnic minority parents are less likely to medicalize their

children's behavior and emotions. Studies report that racial/ethnic minorities have a higher

threshold for concerns about children's mental health (Leslie et al., 2008; McKay & Bannon,

2004; Weisz & Weiss, 1991). In general, these studies find racial/ethnic minorities are less

likely than members of the White population to perceive a problem and seek help. Roberts

and colleagues (2005) found that Latino American and African American caregivers are less

likely than European caregivers to detect mental health problems among adolescents.

European American caregivers were twice as likely to report their adolescent had fair or poor mental health compared to African American or Latino American caregivers. In light of their findings, these authors argue that there is a need to address the conceptual differences about mental health among different racial/ethnic groups (Roberts R., Algeria, Roberts, C., & Chen, 2005).

This literature primarily relies on survey data to convey whether racial/ethnic minorities are in agreement or disagreement with the biomedical perspective of mental health. Yeh and colleagues (2004) found Latino American and African American parents are less likely to endorse a bio-psychosocial belief about mental illness, but the researchers do not elaborate on the perceptions of mental illness held by Latino Americans and African Americans. There is a lack of knowledge of how parents conceptualize mental health. Pescosolido, Jensen, Martin, Perry, Olafsdottir, and Fettes (2008) investigated parents' knowledge and beliefs about mental illness to understand child and adolescent psychiatric help, seeking delays and low treatment use patterns. Using the National Stigma Study of Children (N: 1,393 adults), they found there is a lack of general knowledge and misinformed beliefs about children's mental health problems. Only 58.5% correctly identified depression, 41.9% correctly identified ADHD, and a large proportion of people who correctly identified each disorder rejected the mental illness label (ADHD, 19.1%; depression, 12.8%). The authors found that racial/ethnic minority parents have different perceptions and attitudes toward mental illness that do not align with the biomedical model of mental health. It is unclear, however, whether parents' refusal to medicalize their children's mental health problems is due to conceptual differences or to the lack of knowledge. In summary, racial/ethnic minority parents' do not seem to adopt the Western biomedical perspective.

Many of these studies focus on mental illness. In this study I am interested in exploring Latino parents' conceptualization of mental health, a broader concept.

The medicalization of children's mental health also places an emphasis on pharmaceutical treatments as solutions—without acknowledging alternative options. However, racial/ethnic minorities are less likely to give medication to their children as treatment for mental health problems (Eiraidi & Diaz, 2010; Gudino, Lau, & Hough, 2008; Kataoka, Zhang, & Wells, 2002). One study on medication found ethnic minority parents such as African Americans and Latino Americans were less likely to prefer medication over counseling, and they were less satisfied overall with medication as the treatment for their children's mental health problem (Dosreis, Zito, Safer, Soeken, Mitchell, & Ellwood, 2003). Another study compared caregiver's treatment interventions about mental health between a group of youths in San Diego and one in Puerto Rico (Leslie et al., 2008). The investigators found caregivers in San Diego were more likely to give stimulant medication for mental illness. These authors suggest this finding might be due to different perceptions about the etiology of mental illness between caregivers in San Diego and caregivers in Puerto Rico. Although medication has been combined successfully with psychosocial interventions for some children's mental health problems (Majewicz-Hefley & Carson, 2007), the use of psychosocial interventions among Latino children remains low (Leslie et al., 2008; Pham et al., 2010; Roberts et al., 2005). An ongoing debate among these scholars is whether non-dominant groups such as Latino parents are less likely to accept a medical model perspective for their children's mental health and, therefore, are less likely to give medication to their children. What is fairly consistent is that these studies do not address the core beliefs or knowledge parents have about mental health.

Qualitative studies have explored parents' conceptualization of mental illness and mental health in an inductive manner. One study conducted semistructured interviews with participants from northern and western regions of South Australia residing in rural communities. They were asked to define mental health problems. Researchers found most participants associated mental health problems with severe psychiatric disorders, equated to "insanity," that required detention (Fuller et al., 2000). Only a small number of informants saw their own stress or everyday struggles as part of a mental health problem. These authors argued that participants viewed mental illness under a biopsychological framework. Another qualitative study asked about participants' definition of mental health rather than of mental illness (Armstrong, Hill, & Secker, 2000). They used focus group discussions and individual interviews with 145 young people from high schools in Scotland. They found that youth tended to talk about physical activities such as diet and exercise. The participants in this study defined mental health as capturing a wide range of activities that promoted well-being, such as diet. The youth also associated the term mental health with the idea of normality, but there was a lack of consensus among participants as to what normality meant. Interestingly, this study found that minority youth had less difficulty in defining the term mental health by referring to either the absence of illness or the presence of positive features, such as happiness and confidence.

In summary, three gaps exist in the literature concerning the sociology of mental health conceptualization. First, few scholars theorize about mental health, and few studies investigate the manner in which group(s) define mental health in the United States. Second, the few studies that do undertake to investigate parent's perceptions, attitudes, or definitions of mental health seldom engage in exploratory qualitative investigations. Many scholars

17

utilize survey research with quantitative methods that allow little flexibility for understanding communities' definition beyond agreement/disagreement with the Western biomedical conceptualization of mental illness. Third, children's mental health in particular remains a relatively unexplored area of study compared to the larger body of literature on adolescent and adult mental health (Armstrong et al., 2000). This research attempts to address the existing gaps and need for more exploratory studies focused on the concept of children's mental health in light of the mental health disparities Latino children face, particularly for those born to immigrant parents. Latino children are more likely to underutilize mental health services, be undertreated, as well as be under or miss-diagnosed (Kataoka, Zhang, & Wells, 2002; Leslie et al., 2008; Teagle, 2002; Zimmerman, 2005).

Existing Literature on Latino/a Parent's Conceptualizations of Mental Health

Few studies have specifically engaged the Latino population concerning their conceptualization of mental illness and/or mental health. The process of medicalization emphasizes an ideology in medicine that validates the values and beliefs of the Western dominant group(s). Scholars have argued that as a result, the voices and experiences of nondominant communities such as racial/ethnic background groups are minimized (Arcia, Reyes-Blanes, and Vasquez-Montilla, 2000; Bava, 2009; Flores-Ortiz, 2003). Latino parents' valuable perspective has been relatively overlooked in the existing literature concerning children's mental health.

One qualitative study targeted Latina mothers and inquired about their perception of mental health problems (Arica & Fernandez, 2003). A total of 62 Latina mothers of children aged 4-10 participated. Some 62% were Cuban, 18% Dominican, and 19% Puerto Rican. They found that Latina mothers frequently cited hyperactivity, aggression/temper tantrums,

18

sibling rivalry, and school complaints as primary reasons to be concerned about their child's mental health. They saw these as reasons to inquire about their children's mental health. Latina mothers from Puerto Rico, Cuba, and the Dominican Republic viewed children's hyperactivity and oppositional/ noncompliant behaviors as the result of a lack of self-control, not that children were disobedient toward their disciplinary techniques. According to these three Latino subgroups, children with strong behavioral problems can be managed if parents are stronger than the children. This study found Latina mothers did not describe their children's behaviors in ways consistent with the psychiatric language. For this community of Latina mothers, the concept of mental illness seems to be related to behavior: the physical expression of hyperactivity, anger, or jealously rather than the psychiatric illness. In light of their findings, the authors argue that Latina mothers' concerns do not fit neatly into the current psychiatric model of "disruptive behavior."

Another qualitative study by Bava (2009) similarly targeted Latina mothers, and they inquired about their mental health definition and needs. Fifteen participants were recruited. All were immigrants from Mexico, Argentina, El Salvador, Colombia, Chile, and Guatemala. And, all of the participants were residents of Southern California. A mix of language ability, education, and socioeconomic status was captured. They found Latina immigrants' definition of mental health concerns was based on the degree to which there was impact on a person's emotional state and functioning. They also defined mental health concerns based on causation or etiology on the following four criteria: severity, childhood trauma, organic causes, and/or deviant behaviors. Both Arica and Fernandez (2003) as well as Bava (2009) have demonstrated through open-ended studies the diverse and multifaceted understanding of mental health Latino parents endorse that does not always align with the medical model.

Arica and Fernandez (2003) discuss how the mismatch between parents and clinicians' conceptualization is a contributor to mental health disparities among Latino children. Their study calls attention to the unique and different experiences Latina mothers' experience, whose perspectives were not congruent with the Western biomedical discourse on mental health. Bava (2009) also engages in a rich discussion about Latina mothers' unique perspective. Discrepancies between Latina immigrants' worldviews and the traditional Western mental health perspective as a biological-psychological process call attention to the importance of examining low-income Mexican immigrant mothers' understanding of mental health from their own narratives (Arica & Fernandez, 2003; Bava, 2009). Further exploration would help expand understanding of alternative conceptualization among nondominant groups on mental health. This study is interested in the same population but instead investigates Mexican immigrant mothers' definition with regards to children's mental health rather than to mental health problems or concerns.

It is imperative to discuss three well-researched mental health phenomena to underscore the importance on qualitative methods that allow participants to self-define. Three intriguing alternative conceptualizations of health and mental health among Latinos are *Ataque de nervios,* "Attack of the nerves/nervous breakdown*"; Nervios,* "Nerves" or "Anxiety"; and *Sustos,* "Scares" or "Frights."

Ataque de nervios and *Nervios* are culturally sanctioned expressions of distress that occur in response to acute stressors, especially when related to the family as described primarily among Puerto Ricans (Guarnaccia, Lewis-Fernandez, & Marano, 2003; Guarnaccia, Rivera, Franco, & Neighbors, 1996; Guarnaccia, Rubro-Stipec, & Canino, 1989). They are behavioral manifestation such as shouting and/or falling to the ground, but

20

there also are a number of somatic symptoms such as trembling, heart palpations, and chest-tightness, among others. These cultural concepts frame emotional distress of the body and perception of illness as mediating between the personal and social spheres. Guarnaccia and colleagues (2003) discuss the interplay between popular categories and psychiatric diagnosis, arguing for a need to expand Puerto Rican experiences of *nervios* into future clinical work with Latino groups in the United States.

The second is Susto. With *Susto,* "a scare," Rubel and colleagues (1984) explain is "based on people's understanding that an individual is comprised of a body and an immaterial substance, an essence, that may become detached from the body and either wander freely or become captive of supernatural forces" (p. 8). Consequently, when one experiences *Susto*, also referred to as *asustado* (in a state of fright), this essence is believed to leave the body during very unsettling or frightening experiences. In this community, mental health is more of an interplay between their physical body and spiritual being (Rubel, O'Nell, & Collado-Ardo, 1984). Both *Ataque de nervios* and *Sustos* are intriguing phenomena found in non-Western cultures. Latino understanding of mental health is not always defined according to common biomedical language.

These findings suggest the importance of letting go of pre-established medical model approaches to disease or illness to truly understand health and illness. More qualitative research that would allow the nondominant community to self-express and self-define the experience of mental illness would certainly be fruitful to the developing sociology of mental health and mental illness conceptualization.

Conceptualizing Mental Health

Sociologists have had a profound impact on the study of mental health disparities by examining the social constructivist nature of the concept of mental illness and mental health. The sociological body of literature on mental health and mental illness has strengthened our understanding of the social factors and the role social structures play with regards to conceptualization patterns, treatment, and outcomes in mental health and mental illness (Conrad & Barker, 2010; Macklin, 1971). It is well documented that Latino children born to immigrant parents face additional barriers and challenges in accessing mental health services and are more likely to suffer from mental health problems (Finno, Vidal de Haymes, & Mindell, 2006; Fourtuny, Hernandez, & Chaudry, 2008). However, we are still limited in our understanding of Latino parents' conceptualization of mental health among their children that may demonstrate how to better meet this community's needs.

To study the conceptualization of children's mental health, contextualizing is imperative. The term Latinos is often used as a monolithic term that captures the experiences of diverse subgroups. We need more studies that distinguish Puerto Rican from Dominican Latinos from Mexican Latinos (Arica & Fernandez, 2003; Bava, 2009; Vega, 1990). It is critical to contextualize the definitions of mental health because the definitions are dependent on social processes that vary by group and shape the manner in which communities define mental health. Contextualization is defined as the approach that analyzes society as a whole to capture the social processes that underpin inequalities (Chapman & Berggren, 2005). Specifying the population of interest therefore lends insight into specific dynamics, processes, or mechanisms.

Furthermore, contextualization not only encourages specification of the population of interest, but it also allows scholars to arrive at new insights. Chapman and Berggren (2005) elaborate that contextualization allows scholars to re-frame the debate regarding the topic of health inequalities[2] from micro to macro processes. These authors said, this strategy "problematizes structural inequality which is often regarded as natural or unavoidable from the point of view of the dominant culture. Such work also reveals the otherwise invisible daily structural constraints on health-related behaviors frequently attributed to poor lifestyle choices, in appropriate values or lack of information" (Chapman & Berggren, 2005, p. 15). In other words, when scholars contextualize the area of inquiry they are likely to shed light on larger structural inequities that matter for persisting disparities otherwise attributed to poor lifestyle choices, values, or lack of information. Individual-level interventions are no longer sufficient to eliminate disparities, such as mental health disparities among Latino children. Contextualization for this study would translate into research that describes the population of interest and inductively lets communities describe their definitions and experiences to understand larger social dynamics part of health inequities. New theoretical frameworks that aid in understanding the dynamics or mechanisms of sustaining disparities are possible when data are contextualized.

Research that embraces geographically based, contextual-level variables and multi-level analysis has been largely absent. Pescosolido, McLeod, & Avison, (2007) encourage sociologists to look at providers, organizations, and "the system" because these factors play a role in how the concept of mental health is socially constructed. Other scholars also have

---

[2] A disparity is a concept used to mean injustice while inequality is used to describe differences in outcomes (Braveman, 2006). These terms are used interchangeable but it is important to note they have conceptual distinctions.

argued that sociologists of mental health and mental illnesses must look at the macro, meso, and micro levels manifestation or discourse of the conceptualization of mental health. Contextualization is important to capture the intricacies and social dynamic processes relevant to mental health disparities. Although this study is primarily concerned with the definitions of Latina immigrant mothers, findings suggest a need for future scholars to more systematically address the role of larger social structures such as the medical institution and the biomedical discourse as they relate to the conceptualization of mental health. Each community is grounded in unique social experiences with beliefs that may or may not align with the dominant discourse of mental health.

Given the disparity of concepts of mental health between racial/ethnic groups and the biomedical model and the context-dependent nature of the definition of mental health, I seek to understand how Mexican immigrant mothers conceptualize their children's mental health. This study addresses some of the existing gaps in the literature by actively looking at the conceptualization of mental health rather than of mental illness. The study also captures the definition beyond mental illness and allows participants to conceptualize mental health without imposing the biomedical model. A large body of literature has been concerned with whether groups agree with the dominant perspective of mental illness. Among those who engage in exploring beliefs of groups on the concept of mental illness, few explore inductively and still fewer focuses on immigrant Latino populations. This study inductively explores the conceptualization of mental health among Mexican immigrant mothers in the state of New Mexico qualitatively. I ask the following research questions: first, how do low-income Mexican immigrant mothers talk about, describe, and define children's mental health? And second, what are the major conceptualizations of mental health among low-

income Mexican immigrant mothers? The intent of this study is to explore the definition of

mental health among a community of immigrant mothers in Albuquerque, NM.

Chapter Two: Methodology and Research Design

This study investigates Mexican immigrant mother's conceptualization of children's mental health. The original research project, "Promoting Knowledge of Childhood Development and Screening: A Community Based Participatory Research," investigated low-income Latino parents' health information needs, experiences, and perceptions regarding young children's development and behavioral health (ages birth to 7). Dr. Ginossar, the PI, and La Communidad Habla, "The Community Speaks," are the primary researchers involved from the research design to the dissemination stage. Funding for the larger project was provided by the National Center for Research Resources and the National Center for Advancing Translational Sciences of the National Institute of Health through Grant No. 8UL1TR000041. Funding was also provided by *La Tierra Sagrada,* "The Sacred Earth," a society established in 1996 at the University of New Mexico's School of Medicine (PI: Tamar Ginossar). Access to the original data was gained through my involvement as a research assistant on the larger project. I was a research assistant who helped the team with data collection as a note taker and transcriber. This study utilizes the existing data from the larger study to perform a subanalysis that examines the conceptualization of children's mental health among low-income Mexican immigrant mothers. Institutional review board (IRB) was requested and approved for both studies (IRB No.10-405). The IRB approved all Spanish and English consent forms, all questionnaires administered, and the focus group guides.

In this chapter, I first discuss the Community Based Participatory Research (CBPR) approach this study utilized for the larger study. I then discuss the data collection method followed by a discussion of the recruitment procedures. Next, I discuss the analytical

approach this sub-study utilized for analysis of the secondary data. Lastly, I describe the

participants' demographic that took part in this sub-study.

Research Design

The model used throughout the research reflected a community based participatory

research (CBPR) design. CBPR is a growing research framework used across disciplines

with the goal of producing reliable and high-quality research with community collaboration

(Wallerstein & Duran, 2006; Wallerstein & Duran, 2010). The larger research study

partnered with a local grass-roots community organization, *La Communidad Habla*[3] (LCH),

"The Community Speaks." LCH is based in the southern Albuquerque neighborhoods of La

Mesa and Trumbull Village and is supported by a variety of local foundations and state

agencies. LCH are engaged in empowering Latina/Hispanic women through technology and

health communication workshops to create economic opportunities and advance health equity

in the community (Ginossar & Nelson, 2010a). LCH has achieved notable success as

documented in Ginossar (2011) as well as Ginossar and Nelson (2010b) publications. Please

see these articles if further interested in this local grass-root organization. LCH remains an

integral part of the Albuquerque community.

The CBPR research approach requires both the researcher and the community partner

to acknowledge each other's participation throughout the entire research process, from study

design to reporting of the results. LCH therefore participated in the formulation of the

questions, facilitation of the focus groups, analysis of the data, and in the presentation of the

findings. Furthermore, the research project originated because the community themselves

identified a need to explore and understand Latino parents information seeking and needs as

---

[3] IRB gave approval to use the actual name of the organization with whom this study collaborated.

well as concerns regarding children's development and behavioral health. The goal of the

larger project was to obtain data in order to design effective interventions within La Mesa

community. Dr. Ginossar and LCH were the primary investigators addressing this

community's needs rather than imposing their own research agenda. Multiple scholars have

used CBPR (Israel, Eng, Schultz, & Parker, 2005; Wallerstein & Duran, 2006). This is a

well-utilized research design approach, especially when dealing with vulnerable or

marginalized communities. The community partner enabled us to gain access to the Latino

parents residing in Albuquerque's La Mesa Community. LCH participation was instrumental

to the success of the larger study.

Data Collection Procedure

Researchers from the larger research conducted focus groups for the data-collection

method. Focus groups originated among those interested in market research (Edmunds,

2000). Over time, social scientists became interested in the basic elements of focus-group

interviewing (Hamel, 2001). This approach strives to learn about research topics through

discussions where researchers can gain insight into conscious, semiconscious, and

unconscious psychological and sociocultural characteristics as well as of dynamic processes

occurring among groups. Focus groups are one of the most common methods used in

qualitative research (Babbie, 2007; Berg, 2007; Maxwell, 2005). As defined by Babbie

(2007), focus groups are formed when 12-15 individuals come together in an environment

conducive to guided discussion on the topic of the investigation. Focus groups are a strategic

form of soliciting information from participants organically.

There are multiple advantages and disadvantages to using focus groups (Babbie,

2007; Berg, 2007; Krueger, 1988). First, this technique is a socially oriented research

method that captures real-life data in a social environment. Secondly, focus groups allow for flexibility as well as high face validity. Face validity is whether the study measures what it is intended to measure. And lastly, focus groups produce speedy results. Rather than interviewing one person at a time, with a focus group, multiple participants can be interviewed simultaneously.

However, focus groups have limitations. Although focus groups provide flexibility, the researcher sometimes has less control. Building a focus group also can be a laborious task that requires careful consideration of the participants and the environment in which the group is conducted. Furthermore, moderators should have special skills and training to successfully navigate the discussion to collect fruitful data. "Group think" is a phenomenon that describes the tendency for members of the focus group to agree with opinions of the most outspoken member of the group (Babbie, 2007). Facilitators must be cautious and actively try to collect thoughts from every member of the focus group. Despite their challenges, focus groups remain a useful methodological tool used by many social scientists on a diverse range of topics. Interestingly, focus groups have not been utilized much among scholars interested in the conceptualization of mental health.

Previous studies that investigate the conceptualization of mental health or mental illness have relied primarily on surveys. The few that do engage in qualitative methods have mainly used one-on-one interviewing approaches. Moses (2011) conducted semistructured interviews with their participants and used thematic analysis to break down parents' conceptualization of mental health into "Alternative" "Uncertain" and "Psychiatric." Lauber, Nordt, Falcato, & Rossler (2003) used vignettes. They constructed various vignettes and presented them to parents to determine whether parents defined mental illness in biological-

psychological terms or in some other manner. To the best of our knowledge, this is the first study that employed focus groups rather than one-on-one interviews or on vignettes. Although Arica and Fernandez (2003) conducted one-on-one semistructured interviews, they analyzed their data inductively. These scholars used the words and ideas directly from the participants to create a theory on how they conceptualized mental health problems. Therefore, I take the same analytical approach with focus-group data as discussed in the next section.

We employed multiple focus groups on the topic of children's development and behavioral health with the goal of providing a space for groups to engage in critical discussions via self-reflection and critique of other comments. Considering the sensitive nature and diverse experiences on the research topic of children's development and behavioral health, the research team believed focus groups would provide fruitful discussions on this stigmatizing and complex phenomenon. In alignment with the research interest of the larger research study, these semistructured focus groups asked parents to speak about their experiences, when they needed mental health information, their understanding of the term mental health, as well as how they prefer to receive information about mental health (see Appendix A for the list of questions). Enrollment of the participants stopped when saturation was reached (Babbie, 2007; Maxwell 2005) about parents' seeking health information, understanding of mental health, and suggestions on how to better receive health information. Saturation is when the same themes are emerging from the data with regards to the topic of interest. In this study at about the 7th focus group similar themes for the larger project purposes were emerging and therefore a few more were conducted. This substudy was interested primarily in the definition of mental health that was discussed among participants.

Recruitment Procedures

Participants were recruited by La Communidad Habla (LCH) *promotoras*. The team of three Spanish-speaking LCH *promotoras,* "women community leaders," recruited participants for the focus groups. LCH *promotoras* recruited with a purposeful sampling technique, posters, and snowball sampling technique.

A purposeful sampling technique seeks to enroll participants who meet certain criteria (Babbie, 2007). LCH *promotoras* targeted Spanish-speaking, low-income, immigrant Latino parents from Albuquerque who had children 7 and younger. This study did not require participants to have children with developmental or behavioral disorder(s). To minimize recruitment bias, the *promotoras* from LCH posted flyers in the community and in schools seeking participants from Spanish-speaking, low-income, immigrant Latino parents with children 7 and younger. Furthermore, to increase the response rates, LCH *promotoras* employed a snowball sampling technique (Babbie, 2007). Parents who attended the focus groups were asked to inform potential participants about the study and to have them contact LCH *promotoras*. The recruitment of participants occurred through direct formal outreach, as well as informally by word of mouth among community members.

The focus groups took place from December 2010 to March 2011 in different locations, all within the La Mesa Community, such as La Mesa Elementary School and La Mesa Community Center. Two LCH *promotoras* facilitated these focus groups, and one research assistant from Dr. Ginossar's research team took notes. Two sets of focus groups were conducted. Part A was with Spanish-speaking Latino parents, and Part B was with English-speaking Latino parents. My study used this data from Part A—those with Spanish-speaking Latinos. Dr. Ginossar, the PI, at this time was still involved in the data collection

phase for Part B of the study. My study therefore utilized already collected and transcribed

data from Part A, focus groups with Spanish-speaking Latino parents. All participants

received a $30 grocery gift certificate for their time and participation.

The two LCH *promotoras* were given guides for facilitating the focus groups. This

guide consisted of the nine questions as well as probing cues they could use. They received

training before conducting the focus groups. LCH *promotoras* were instructed to ensure that

all major topics were covered; they also were told they could be flexible during their

dialogue. One of the LCH *promotoras* led all the focus groups alongside any of the other

five LCH *promotoras* for Part A to maintain consistency in approach. Once the focus group

commenced, the discussion was closed. Late participants had to reschedule. Furthermore,

the focus groups were audio-recorded for transcription purposes. Native Spanish-speaking

team members transcribed the dialogue verbatim from Spanish to English. I was one of the

three transcribers and translators of the focus groups. Although previous research states that

direct translation into the native language is imperative, due to the linguistic diversity of our

research team, we had the audio from the focus groups directly transcribed into English to

facilitate analysis.

Analytical Approach

For this study, the objective was to explore low-income Mexican immigrant mothers'

conceptualization of children's mental health. I employ generic inductive qualitative

methods (GIQM) analysis on the transcriptions. This GIQM approach uses the categories

developed inductively to inform the theorizing stage about the conceptualization of mental

health (Strauss & Corbin, 1990).

The GIQM approach could be considered similar to grounded theory, but it is a process that focuses less heavily on verifying or refining a theoretical model. Jane Hood (2006) in her article discusses the method of grounded theory as being overly cited or incorrectly used. In the general discourse grounded theory is described as obtaining theory from data, but this method is more complex with specific procedures. Hood (2006) emphasizes work utilizing grounded theory must employ theoretical sampling. The data this thesis utilizes did not do so. Theoretical sampling is when saturation is reached based on the topic of investigation (Babbie, 2001). Conceptualization of mental health was among the topics of interest but the primary concern for the larger study was on Latino parents' information needs and seeking. During the collection of the data themes on the conceptualization were not utilized to determine when data collection would stop. As a result this study uses Strauss and Corbin's GIQM analysis, a general inductive qualitative method.

In the first stage of analysis, I highlighted any relevant material to the research questions. According to Strauss and Corbin (1990), the first stage of open coding is to categorize the data. I highlighted all material relevant to the research questions in the transcripts. I started open coding with this focus group question: "When someone uses the term "children's mental health" – what do you think they mean? How does it make you feel about young children's mental health?" I then read the entire transcriptions from all the focus groups, making notes of the themes/categories that emerged related to their conceptualization of mental health. All focus group transcriptions from Part A with Spanish-speaking Latino parents were analyzed. During the first stage of analysis, the point is not to

interpret, question, or answer anything. See Figure 2 for a depiction of the themes that emerged for focus group No. 3 as an example of the first stage of coding.

Figure 2: **Focus Group 3, Stage One of GQIM Analysis: Open Coding**

The second stage consisted of narrowing down the categories identified by going back and forth between the data and the research questions. I did three readings of the transcriptions–line by line. The focus groups were used as the primary unit of analysis, and my review was conducted over several months. A theme was constituted when it was represented in at least a third of the focus groups. After multiple reviews of the emerging categories, I was able to identify the core themes. In addition, I found additional information within the broader theme that highlighted how those conceptualizations intersected with this community's identity and unique social experiences. Results are, therefore, presented in terms of discussing the conceptualization, and then, secondly, discussing the manner these conceptualizations played out in participants' experiences.

The third and last stage for Strauss and Corbin (1990) is the interpretation of the coding. Although the interview protocol was not designed to focus on understanding

conceptualizations of mental health, one question did specifically tap onto this topic. Analysis revealed intriguing beliefs and experiences among low-income Mexican immigrant mothers related to their definition of children's mental health.

Researchers' Positionality and Transparency

Maxwell (2005) elaborates that the key for validity and reliability is to obtain grounds for distinguishing accounts that are credible from those that are not. Validity is whether the research is actually measuring the phenomenon he/she sets out to investigate, and reliability is whether the same findings are found when the study is replicated. Addressing the researcher's positionality is part of addressing validity and reliability in order to be more confident in the findings.

I am a Spanish-speaking Latina born in Mexico and identify myself as Mexican. In addition, my Mexican parents, who are native-Spanish fluent, immigrated to the United States. Research on immigrants is an area that often directly speaks to my experiences as well as challenges my experiences. Furthermore, my interest in mental health stems from my extensive volunteer work and from my mother's experience as a social worker. I have seen, heard, and had dialogues with multiple families about their ideas, experiences, and challenges with mental health. My family has had its share of mental health issues, and often I have engaged in deep discussions with my mother about why she does not take her medication or why she dislikes the counselors she has seen. My experiences could be seen as an asset by drawing attention to what could be overlooked by someone who does not have an insider perspective.

My background, values, and beliefs bring a unique perspective to the investigation. Collins (2000) has done extensive work on social location and standpoint theory. She

35

discusses the manner in which knowledge is produced moving away from a positivist

approach that views knowledge as being true or correct only when the observer separates

him/herself from that which is being studied. *Her alternative epistemology argues primarily*

that knowledge is grounded in experiences. A person's unique social location such as

gender, race, and socio-economic status each shape that person's experiences. Standpoint

theory demonstrates individuals own perspectives are fostered by his or her experiences in

unique social locations. From Collins' (1990) perspective, there exists a wide diversity of

"knowledge," not one objective but multiple grounded and shaped by multiple experiences

and social interactions. Depending on your social location your standpoint will vary from

someone else. Who I am and my experiences overlap with those of the participants;

therefore, my perspective is useful in the investigation of this community's conceptualization

of mental health.

I now will describe the participants' demographic characteristics from Part A of the

larger study. This study relied solely on the data targeted at Spanish-speaking Latino parents.

Sample Demographic Profile

Nine focus groups were conducted in the La Mesa Community[4] in Albuquerque, NM

from December 2010 to March 2011. Seventy-five Latino parents participated in the

research project headed by Dr. Ginossar. The number of participants in the nine focus

groups varied from three to thirteen. On average, the focus group had about eight to ten

participants, and each group's discussions lasted about 90 minutes.

We did not collect demographic information on the parents during the focus groups

due to IRB reasons. Instead, the researchers and LCH held a community event and invited

---

[4] IRB approved using the names of the actual community in which this study was conducted, La Mesa Community.

all 75 participants. The event served three purposes. First was to validate and/or clarify

findings on the research questions from the larger study, and second was to provide an

opportunity for Latino parents and friends to ask a child psychologist any questions or to

share concerns related to child behavior and development. Third, the event allowed the

larger study to administer a demographic survey. However, only 21 of the original 75

participants attended the community event. The follow-up survey provided information

about their socio-economic status (SES), education level, and other social demographic data

(N: 21).

From this survey, the following can be extrapolated about one-third of the

participants. Among the 21 who completed the survey, only two self-identified as male; the

rest, 19, self-identified as female. We decided it was better to interpret and report findings

from a Latina mother's perspective because we cannot adequately speak to the experiences of

fathers due to their small sample size. Male responses were excluded from any analysis.

Sixteen of the 21 immigrant mothers held a high school degree or equivalent; 14 are living

near or below the poverty level; and 19 have no health insurance coverage. On average, the

21 participants were 33.3 years old and had resided in the United States an average of 10.9

years. It may be those who completed the survey were most likely to have the human capital

or educational attainment to do so while others were unable. Although the demographic data

are neither exact nor reflective of the entire sample size (N=75), they do provide valuable

information.

With regards to the entire sample, all 75 Latino parents were Spanish-speaking

mothers. The focus groups were conducted in Spanish in order to facilitate a rich discussion

among this population's dominant language, Spanish. Although many could understand

some English, a significant number had limited English proficiency. Also, all 75 participants were immigrants. During the focus group discussion, many said they were from Mexico. Although we are not certain, this study assumes the majority of Latina mothers are immigrants from Mexico. At the time of the focus groups, it became apparent that many of these women have created a life in the United States–they work, play, and have lived in the United States for a significant portion of their life. In addition, all 75 participants were of low socioeconomic status, and all had at least one child 7 or younger. This study, therefore, speaks to the conceptualization patterns of Spanish-speaking, low-income, Mexican immigrant mothers with children ages zero to seven.

La Communidad Habla (LCH) *promotoras*, during the last five of the nine focus groups, asked participants to report the number of children they have and their ages (N=33). This provided additional information. Seventeen reported having at least two children, and 16 reported having three or more children. Only two mothers said they have five or six children. There were 84 children among the 33 mothers. The ages of these children ranged from 6 months to early 20s. Despite the diversity in the ages, all of the mothers had at least one child 7 or younger. Furthermore, nonbiological children were not explicitly excluded, but none of the mothers said she had foster children or adopted children. All of the children in this study were biological children of the participants. Lastly, we did not require for participants' children to have mental health problems in order to be included in the study. There was a mixture of children with mental health problems and without mental health problems. The demographic profile of the children is diverse.

This study in sum captured young pre-school age children born to Spanish-speaking, low-income, Mexican immigrant mothers residing in La Mesa Community Albuquerque.

This population is an important sector of society with regards to children's mental health. Mental health disparities among Latino children in New Mexico are among one of the state's chief concerns.

The immigrant population is about 10% in New Mexico (New Mexico Fiscal Policy Project Report, 2008), but 45% of the population identifies itself as Hispanic, according to the US census. Latino children born to immigrants, however, are a rapidly growing population in New Mexico. New Mexico experienced a 93% growth in the number of Latino children born to immigrants–as compared to 11% in 1990 to more than 20% in 2008 (Fortuny et al., 2010). With regards to health access, employer-based health insurance is a major barrier for noncitizens compared to citizens in the state of New Mexico–63% of noncitizens lack health insurance vs. 38% of citizens (New Mexico Fiscal Policy Project, 2008). We did not inquire about immigration status. Furthermore, access to psychological health care in the state is also a challenge because New Mexico only has one bilingual child psychologist who resides in Albuquerque, even though this city's population is about 545, 852 as of 2010 (U.S. Census State & Country Quick Facts, 2010). Rural areas and other parts of New Mexico have limited mental health services. In light of these statistics, the importance of investigating mental health conceptualization among Mexican immigrants in New Mexico becomes evident.

In summary, this study explores inductively Mexican immigrant mothers' conceptualization of children's mental health. The larger study took a CBPR approach and collaborated with LCH. Focus groups were conducted for data collection, and this substudy utilized GIQM to employ the analysis on the definitions of children's mental health among Mexican immigrant mothers. I also discussed the importance of transparency and my role as

the researcher. This study discusses the conceptualization of children's mental health of Spanish-speaking, low-income, Mexican immigrant mothers.

Chapter Three: Findings on Mothers' Overlapping Conceptualization of Mental Health

Mexican immigrant mothers discussed a diverse range of definitions that coexist and overlap when asked about their conceptualization of the term children's mental health. Five themes emerged: behavior, cognitive, emotional, positive outlook, and social environment. See Table 1 for an overview of themes and their definitions as they emerged from the data. The study found that mothers defined mental health in the arena of larger social dynamics and contexts in which children are embedded and also included definitions that aligned with the traditional Western biomedical framework. Mental health was not defined solely as a fixed or purely biological concept. Participants understood children's mental health as a multidimensional construct that emphasizes the social context and social processes in which children are embedded. I found Mexican immigrant mothers have a complex, multifaceted conceptualization of children's mental health. The five conceptualizations capture biological processes as well as nonbiological social processes. Furthermore, this community's conceptualization of mental health was tied to the participants' identity and everyday experiences.

Table 1: *Mexican Mother's Overlapping Conceptualizations of Children's Mental Health*

Theme	Mental Health Overlapping Definitions
Cognitive	The child has an alert, responsive, and working mind. The child displays appropriate mental abilities according to his/her age.
Emotional	The child is in a state of happiness. The child does not display feeling of depression, anxiety, shyness, or jealousy.
Behavior	The child displays appropriate physical conduct. The child does not display excess energy or physical displays of aggression.
Positive Outlook	The child has a positive attitude about themselves, their home, and their larger surroundings.
Social Environment	The child is embedded in supportive social, culture, and political environments such as their home and school.

In this chapter, each theme begins with a quote from the participants in the focus groups to provide the reader with an understanding of low-income Mexican immigrant mothers' perspective. I then elaborate on the definition of the theme using supporting quotes followed by a discussion of the theme from this communities' unique social perspective.

Cognitive

> Irelene[5]: "Well, my girl, right, it is not that she is crazy but simply maybe she is not producing something to make her do things like any other kid."
> Researcher: "And when you say she is not producing something, are you talking about inside the mind?"
> Irelene: "Yeah, like ADHD." (Focus Group (FG) 3)

Mexican immigrant mothers often conceptualized mental health as the appropriate cognitive development process children experience. Participants defined children's mental health as when the child has an alert, responsive, and working mind. The child displays appropriate mental abilities according to his/her age. This cognitive theme was found in

---

[5] All names used in this chapter and theses are pseudonyms to protect the participants' identity.

nearly all of the focus groups. One mother, when asked to define mental health, said, *"It also has to do with the mind. Mental health is when everything is remembered [and] recorded"* (Focus Group1). For a majority of the participants, children's mental health is when children are able to remember things and have the ability to process information. For example, Virginia, when asked to define mental health, said, *"They can keep information on their disk. I tell my kid they have a disk in their head"* (FG2). When she says, "Keep information on their disk," Virginia is referring to the child's mind, as the mind for her is equivalent to a disk. For Virginia, a properly functioning disk (mind) would be one that takes in information, stores it, and is able to play it back. Another mother, Alejandra, when asked to define mental health, said, *"When they start asking questions and observing (that is when) I know that their mind is working"* (FG4). Alejandra is explicitly saying children's mental health is when her child's mind is alert and responsive. For her, the questions and observations that children make are an indication of good mental health status. The definition of mental health for Alejandra, Virginia, and others was tied to the mind, which speaks to the cognitive development process. This theme is reflected once again in Cruz's response, *"Well, that they do not have adequate mental capabilities according to their age"* (FG5). Children's mental health for participants was when the children's minds worked properly; meaning children are able to engage in information storing, information sharing, asking questions, and being responsive.

As this community of mothers discussed the definition of mental health as a cognitive process, they covered the topic of medication. The theme of cognitive is related to biological conceptualization of mental health. Biology is not a separate theme but found under this theme because these mother elicited ideas of genetics and chemical balance. Having a

working mind seemed to be related to having the right chemical processes. There were as a result mixed feelings among participants' perception regarding the use of medication. First, I discuss those who support medication, followed by a discussion of those who do not. The bottom line is that this community understood the value of medication but felt other interventions were needed because mental health is not just a biological process.

Participants discussed the mind as producing the right chemicals, which enable it to work properly. Such perception led some to more likely accept the use of medication. For example, Irelene said, "*Well, my girl, right, it is not that she is crazy but simply maybe she is not producing something to make her do things like any other kid.*" (FG3). Irelene understood ADHD to be about a chemical imbalance or an absence of chemicals that is causing her daughter to experience mental health problems. Medications could help address this chemical imbalance. In another focus group during a discussion about medication, Josephine said, "*There are individuals who need medication because there are chemicals in the brain that are not being produced" (FG1).* Josephine was in full support of medication to address the chemical imbalances. In general, participants saw the need for medicine to correct the chemical imbalances occurring in their children's minds. In fact, another participant Lillia, during the focus group, said, "*The medication does help or else it would not exist, but it also depends on other things*" (FG3). The perception that mental health was associated with cognition fostered an acceptance of the medication, but not always. For Lillia, although she supports the use of medication, medication should not be the only solution. Other mothers agreed.

Not all participants supported using medicine even when they conceptualized mental health as a cognitive theme—partly because they perceived a tendency in the United States to

overmedicate. This community was aware of the culture in medicine to give a pill for any condition. Participants discussed the ease with which medication is administered. For this community, the doctor's proof for the use of medication was necessary. Ana elaborates on this and said, "*I say a doctor needs to do analysis; they need to have actual proof in order to give treatment. Imagine if they go to (the) park, they are going to want to give medication to all the children (implying just because kids are running around and jumping does not equate to a mental health problem). No, the doctor needs to know which kids have needs*" (FG1). This respondent, Ana, believed medications must have a specific protocol to be systematically administered. In a different focus group, Mariana said, "*And why have I heard for anything hyperactive the solution is always medication. Is there no other treatment?*" (FG6). The push and the tendency from providers to medicate children was a consensus feeling expressed by participants. Many mothers felt pressured to medicate, which was startling because of their own experiences in Mexico. For example, Gloria said, "*And I have always told them that they always want to give them medication. I have asked and they do not want to give them medication. However it is, in Mexico the way we were brought up, well, I am not sure if everyone here is from Mexico but how we grew up there, troublemakers everywhere but never did they give us medication*" (FG6). Mothers such as Gloria discussed the lack of administering medication to children in Mexico. In sum, regardless if mothers conceptualized mental health as cognitive, many mothers conveyed mixed feelings about the use of medication for their children. Mixed feelings about medication may be partly attributed to Mexican immigrant mother's experience of not overmedicating children in Mexico.

Emotional

> Anna: "When I think 'they have good mental health.'
> I think that he is a happy child. I relate it to that" (FG9).

Participants also discussed children's mental health as a concept related to the emotional development process occurring in children. The definition of the emotional theme was when the child is in a state of happiness and has the ability to express emotions in an appropriate manner. The child does not display feelings of depression, anxiety, shyness, or jealousy. When asked to define mental health Anna, a participant, said, *"When I think 'they have good mental health.' I think that he is a happy child. I relate it to that" (FG9).* Other mothers also offered similar responses by speaking about the importance of having children who were not sad or constantly showed anger. Multiple mothers framed mental health as relating to emotions. Elisa responded, *"I think it (mental health) is an emotional issue"* (FG5). For Elisa, mental health dealt with emotions. During the discussion in a different focus group, another mother, Ana, said, *"(Mental health is) an emotional development"* (FG1). Many participants defined mental health as an emotional theme. When a child was either depressed or too quiet, this was viewed as problematic. For Mexican immigrant mothers, having happy children meant having good mental health status.

In addition, children's mental health was also about the appropriate expressions of emotions. One mother, Maria, said, *"[The manner] they express their emotions. That they know how to [do so appropriately]"* (FG1). Maria spoke about how it was important for her child to express his anger in appropriate ways. She made sure to teach her younger child when he felt anger to hit the pillow rather than throw a tantrum. Maria also discussed how she actively taught her son to express his emotions. She said, *"I tell my kid when he is mad he needs to deal with it on his own. Go to the bedroom and yell; do whatever you need to but*

do not harm your brother" (FG1). Maria conceptualized mental health as the appropriate expression of emotions. Although emotions translate into behavioral expressions, this theme of emotion speaks about the expression of emotions not necessarily about the behavior itself. As an emotional theme in regards to children, mental health captured both the state of happiness as well as the ability to express emotions appropriately.

It was interesting to note that when participants discussed mental health as an emotional theme, a majority of their discussion centered on jealousy. Limiting sibling jealousy emerged from the focus groups as extremely important to this community of mothers. Mexican immigrant mothers' value brotherhood and sisterhood, which seemed to be the motivating force as to why jealousy was an emotional state that should be addressed. Maria once told her children, "*If I had my brother here, even though they are much older, I would say hi but I can't and I am trying to give you (children) examples*" (FG1). Many other participants, like Maria, are immigrants who have moved far from their own communities and social support networks. This experience seems to have enhanced the importance for them to foster positive sibling interactions. Another mother expressed similar perceptions about brotherhood and sisterhood. She talked about how her children needed to learn to be there for one another and to always support each other because the family was a unique relationship that must be cultivated. Children must care, protect, and respect each other as brothers and sisters. In fact, Ana and Gloria engaged in a rich dialogue about emotional difficulties they had with their children. Ana, from FG1, discussed how she had severe concerns for the emotional well-being of her oldest son because of potential sibling jealousy once her newborn comes home; however, she found her worries were unnecessary after seeing that her oldest was endearing with the baby. Gloria's story, on the other hand, was not

47

the same. For Gloria, her concern about jealousy among siblings did occur. She discussed

how her son would tell her things such as, "*Let's put Jose in the trash can, maybe they will*

take him away" (FG2). Hearing her own child say he wanted to throw away his little brother

horrified Gloria, but when she shared her concerns with her provider, she was told sibling

jealousy was normal. Sibling jealousy was an emotion discussed frequently in this

community.

For these mothers, emotional issues such as jealousy were critical to address, but they

felt providers disregarded their concerns. Mental health for Mexican immigrant mothers

captures the absence of sibling jealousy. Gloria, like other mothers, became fed up when she

was told by her provider that jealousy issues were normal, stating, "*When it comes to be*

extreme, God forbid, then it will no longer be normal" (FG2). Many participants vocalized a

general attitude that in the United States, everything was normal, but for this community,

sibling jealousy was a real issue. The idea that jealousy was an important emotion seems to

be grounded and tied to Mexican immigrant mothers' everyday experiences. The concern

regarding jealousy could be attributed partly to the significant values this community placed

on family or as a result of being immigrants removed from their own families.

Behavior

> Researcher: "*What comes to mind when I say mental health?*"
> Victoria: "*What activities they have and how they behave*" (FG 6).

Low-income Mexican immigrant mothers also defined children's mental health as

related to behavior. This behavior theme was defined as when the child displays appropriate

physical conduct. The child has no excess energy or physical displays of aggression. This

behavior theme, more than any other theme, drew on discussions about the mental illness

diagnosis of attention deficit hyperactivity disorder (ADHD). Alejandra talked about her

granddaughter's hyperactive behavior, saying, "*I have a granddaughter, she is 5 years old. She is very hyperactive. My daughter does not know what to do with her. I have told my daughter to look for help for her because she is very hyperactive and she does not stay still for even a second*" (FG4). For Alejandra, the hyperactivity was problematic and required treatment or attention. Another participant also brought up similar behavioral issues of hyperactivity. Cecilia says, "*I have a cousin who is 5 years old and I see he does not behave like my girl. My girl does the good and bad; all the kid knows he is just walking or running and gets hurt. I tell the mother, 'like he behaves differently' but 'oh, he is just interactive.' And she does not pay attention but I think his behavior is a bit strange*" (FG2). This quote demonstrated how the behavioral theme for this community was more than tantrums or rebellious acts. Behavior captured the extreme degree of hyperactivity that children display. Cecilia was worried about her cousin, who can't stay still, and even labeled this behavior as "strange." In another focus group, Lucia also brought up another example of behavior problems when she was asked to define mental health. She discussed her neighbor, who she believes needs to seek out treatment. Lucia says, "*Like my neighbor. She has a 3-year-old boy. That boy is very hyperactive. He gets into everything. Picks up. Climbs. And he almost doesn't talk. He eats his nails and even pieces of flesh. If you see his fingers he has them like this—red from blood. They told him that his boy needed therapy. She said no*" (FG8). Lucia disagreed with her neighbor's opinion of the 3-year-old boy. For Lucia, the child was too hyperactive and unable to be still. Hyperactivity seems to be defined as constantly jumping or running around with no down time. These mothers discussed the prevalent discourse concerning ADHD and defined mental health as the absence of such hyperactive behaviors. For them, children's mental health was when children are able to sit

still and pay attention. The behavior theme primarily defined mental health as the absence of hyperactivity and inattentiveness.

Interestingly, the behavior theme did not describe tantrums or physical displays of rebellion/aggression. This theme instead shed light on more psychological processes. The behaviors the participants discussed were not equated to physical activity. For example, a participant, Sara, who has a child with ADHD, elaborated on her conceptualization of mental health as a behavior concept, not a physical concept. *"There are parents who have kids (that) are sick and cannot get up (who) would love to have a child like that. I tell my husband because he does get sad, 'well, what do you want, that your child be playing and yelling, or just have her sit there sick?' I prefer that she is active as opposed to being sick, in reality"* (FG3). For this mother, Sara, a sick child was unable to move or engage in activities. Although her own child has a mental health problem, ADHD, the child is not suffering physically because the child can still jump and run. Physical limitations were not equated with behavioral limitations.

However, behavioral problems can be the result of a physical limitation. One mother discussed how her child had behavior problems because she did not follow instructions or participate in class activities. With more investigation, it was discovered that the child suffered from vision impairment, which prevented her from being able to imitate or follow in class. Another story illustrated a mother who became frustrated and often yelled at her child for not following instructions. The child was disobedient, the mother said. Later, the family, however, discovered the child suffered from hearing loss. This story demonstrates the interplay between behavior and physical health. The relationship between mental health and physical health is delicate, but this community makes a distinction. Although a physical

disability could cause a mental health problem, it is not equated with mental health. "Good" behavior for this community was therefore a mix of both social and physical. Mexican immigrant mothers discussed their role in fostering appropriate conduct while recognizing it is also interconnected with physical abilities linked to biology.

Positive Outlook

> Researcher: *"Oh, okay, okay. So you think mental health is like a disease?"*
> Elisa: *"No, no. Mental health is being fine with what you have and not wanting to change yourself. Like that is a mental disease or something…where you are not content and want to change" (FG5).*

Participants conceptualized children's mental health as a mind state of contentment. This theme, positive outlook, is defined as when the child has a positive attitude about themselves, their home, and their larger surroundings as well as about their future. This theme first captured children as being content with their own body image. As one mother, Johana, said, *"Mental health is being fine with what you have and not wanting to change yourself. Like that is a mental disease or something, everything is for you, where you are not content and want to change"* (FG5). In this quote, the mother discussed her 4-year-old niece, who was unhappy with her weight. The girl does not want to be obese in the future, and this seemed to be a major concern, which for Johana was related to her niece's mental health. Isabella, another participant, said, *"Mental health means to look at everything in a positive light… If you teach them to look at everything negatively, they will have a negative perception, and if you teach them in a positive then they will develop differently"* (FG3). This mother discussed how mental health as a positive outlook meant having a perception of a bright future. In another instance, a mother spoke about her child, who always thinks or says, *"I can't."* This simple expression is problematic to this mother. She believes her child needs to get rid of the negative energy and think positively. The theme positive outlook does

51

not talk about emotions such as happiness directly, but instead refers to a more enduring contentment. In this community, having a positive outlook refers to children being content with who they are, their home, and their larger surroundings.

The positive outlook theme in life is also related to the parents' backgrounds and their experiences as immigrants. Maria, from FG1 discussed how she viewed her role as talking to and supporting her children so they have a brighter outlook on life in general. She discussed how children with parents who do not pay attention to them often lose the opportunity to receive encouragement. Maria would tell her son to give his friends advice about the future and to have a positive attitude. For Maria, the lack of giving advice or guidance is what may bring the child to experiment with drugs or engage in other illegal behaviors. The advice that mothers gave to their children was rooted in the perception that in the United States, opportunities are endless. The same occurred in another scenario. Rosa said, *"I do become frustrated, and he gets mad. I don't want to hit him or yell at him so I leave him alone. Later, I tell him, 'son, you need to go to school, you need to learn, you need to enhance yourself.' Don't be like me, who did not have the opportunity they have now, but he doesn't seem to want to do anything"* (FG2). Rosa is primarily concerned with the performance of her son in school. Although any parent would want the best academic performance from his or her child, many of the mothers in this community seemed to tie their children's education to their own experience. Mexican immigrant mothers often talked to their children about the importance of education and the importance of believing in themselves because they themselves did not have the same opportunity. The experience of not being able to go to school has fostered a unique perspective and is an area of concern for these mothers. The

positive outlook theme is tied to the future and the need for their children to endorse a positive attitude about who they are and where they are going.

Social Environment

 Bianca: "(Mental health) is when they (children) are not abused/been harassed"(FG5).

 Low-income Mexican immigrant mothers conceptualized mental health as a concept that was interconnected with the environment. The social environment theme highlights the importance of having a supportive social, cultural, and political environment in which a child is embedded, such as his/her school. One mother, Letty, when asked to define mental health, said, *"A problem that they have... It could be, um, a problem between adults that they see. The problems that we have as adults fall on them"* (FG8). For Letty, when she used the word "problem," she gave the example of relationship difficulties. Mental health, she conceptualized, is when any kind of problem adults have translates into the children's problems. In another focus group, Esperanza, when directly asked the definition of mental health, said, *"It is something mental (health) because they have a trauma and are not developing well"* (FG2). Similarly, Letty understood the concept of mental health as being related to problems and/or trauma. She, however, linked mental health to the absence of trauma or any sort of violence. Blanca, when asked to defined mental health, said, "[*(Mental health) is that they (children) are not abused/been harassed"* (FG5). The mothers, such as Blanca, frequently expressed concern for how living in problematic or traumatic environments was related to their definition of children's mental health. The social environment theme emerged among Mexican immigrant mothers to capture their understanding of mental health. This community believed the existence of violence or trauma was relevant to their children's mental health well-being.

The social environment theme emerged as participants described their children's school and home experiences. The unique exposure to domestic violence or trauma among this community seemed to foster their conceptualization that children's mental health is interconnected with social context and social processes. Mental health among Mexican immigrant mothers was seen as a phenomenon interconnected by what occurs around the children, especially in the school and home settings. I first will provide a synopsis of their discourse centered on the school and then on the home.

First, the social environment theme is related to the school. For example, Virginia told a story about the significant role teacher(s) play in fostering positive school environments.

> Virginia: "I was worried because my son in the first year, well, my son is in school since Head Start since age 3 and I never had a problem with his teachers. In his first year, I did have a lot of problems. My kid cried a lot, he did not want to go to school; he did not want anything because he didn't like his teacher. My son isn't like this, so I had fears. Right now he has a different teacher, and he hasn't complained. In fact, no one has complained my son or the teachers. But when he was in first grade, he cried, "Mom, I don't want to go to school," and I noticed (with) other years he was happy and motivated with his homework. Now he is entering into fourth grade, and I don't know if he will be assigned to that teacher because she works at that school. What can I do? I don't want him to have that teacher because then the whole year, he will not want to go to school and he will be crying and sad…I talked to the director about this problem. I am not the only one. There are many mothers who complain about this teacher. There are many (who) complain and there are also many who don't complain, but the director didn't pay attention. I think he spoke to the teacher, maybe."

> Berenice: "Many times the teachers are ugh. There are so many kids."

> Virginia: "My son says, 'Mama, all of the kids, a large majority, do not want to go with Ms. Sophia.' He says, 'Mama it isn't just me.' I think out of despair my son said, 'Mama, it isn't just me. Another classmate told me the same thing.' So among classmates, they tell each other the same thing."

> Aurora: "It's the teachers."

54

Virginia: "So I talked to the director and I said I have never had a problem with my child's behavior. So what do I do? I don't want that teacher."

Berenice: "Are you trying to find a teacher he likes?"

Virginia: "No. Not that he likes, but that he feels comfortable."

Berenice: "Well, how would you know. I mean, let's say that next year the teacher that he has he says I am not comfortable and then again the next teacher he has – again he won't feel comfortable. Then the next one either."

Virginia: "No, I know, I know. But we can't leave our children all day, the whole year, if they do not feel comfortable."

(FG2)

For Virginia, the absence of a supportive school environment impacted her son's mental health and wellbeing. Her son was experiencing severe trauma in the classroom setting, which partly contributed to his unhappiness and tears. It was important for Virginia to place her child in an environment where he felt comfortable. The concept of mental health is connected to the idea of ensuring her child is comfortable at school because he spends a significant amount of time each day at school. Virginia, furthermore, described the struggles she encountered when trying to deal with the unsupportive environment her child was part of at the school. It was difficult for her to be heard and to create change. Another mother, Cruz, also discussed the traumatic experiences a negative school environment had on her daughter's mental health. This story is a powerful narrative that illustrated how participants understood the concept of children's mental health to be interrelated with the school environment.

Cruz: "Because for Carla, my oldest child. This is what happened. When she was in first grade, she did not want to go to school anymore. She cried and yelled. And she would get under the table. It came to the point where, I think, I had a journal like a diary, and there she wrote that she wanted to die. She wrote, 'I want to die.'"

Researcher: "Oh, wow, what age?"

55

Cruz: "She was 5 years old, and she started writing as a little kid. So I told her, why? And she would not tell me. She would just look at the teacher and tremble with fear. I would tell her, why? And she would not tell me. So one time after school, one person talked to me and said, 'I want you to come, please do not give my name, but Carla has been in the sun for three hours and is bleeding from her nose. The teacher took her outside. She said, 'But she is too good of friends with the director that I do not know what you will do.' I said I will do it and I have to do it. I went to the director, and she told me it was a rumor and she did not accept this. If said, 'If you do nothing then I will go to the next level (higher authority). I do not care that she is your friend. I do not care that she is your right hand. I do not care.' So then I went to the teacher and told her that I knew about the kind of treatment she was giving my daughter. And she said, 'A stupid, undocumented person like me does not have any right to do anything or say anything.' I said, 'Undocumented or citizen or whatever you want, I will kick you out and the director.' I did almost the impossible. I went to APS and I submitted a (complaint) over there, and the director is now changed, and she (the teacher) is no longer her teacher."

Researcher: "Ah, wow."

Cruz: "My daughter has been in counseling for five years because she acquired a lot of fear. She did not want to go to school and was afraid of everyone. The mistreatment of the teacher and what she did was to get the other kids to mistreat my daughter as well. Each day she would come home messy and dirty…"

Researcher: "So when all this occurred, was she in a depression?"

Cruz: "Oh, yes, she would just cry all the time. My confidant can testify how she would not stand being at practices. She would cry and cry and cry, and she did not accept things. That is why I do not know if there was more with the teacher or something, but one does need to pay attention."

(FG5)

In this narrative, Cruz discussed a time when young Carla was part of a negative school environment. Cruz believed she had to address the mistreatment because her daughter's emotional well-being had become a significant concern. Carla would yell, cry, and feared going to school. Although Cruz seems to have tried to resolve the harassment her child was receiving at school, she was told by the teacher that she could not change the situation because she was an undocumented person. Similar to Virginia, Cruz faced challenges in

being heard to create change. Fortunately for Cruz, in this situation she was able to change

her daughter's teacher by taking her plea to higher authorities. Cruz's story clearly

demonstrated the relationship between her child's mental health and the school environment.

For both Virginia and Cruz, fostering a supportive environment for their child was important.

Mexican immigrant mothers on numerous occasions' conceptualized mental health as a

concept interrelated to the social environments their children are part of, which must be

supportive. These stories also illuminate the challenges these Spanish-speaking, low-income,

Mexican immigrant mothers faced with their children's public schools.

Although the school environment was important, the home environment was also

important for the social environment theme. Participants perceived parental relationship

problems or trauma as interconnected with the concept of mental health. For example,

Elizabeth said, *"I have a problem with my husband and I don't want it to affect my children.*

I may separate. I am going because he just takes away the car when he wants to or the

phone. I have had to walk with just my kids. I want to be independent and have a job and

buy my own car and phone. (If) my kids are with us, I prefer to be alone than to live (with)

such problem" (FG2). A few participants in the study were involved in or have been

involved in a domestic violence situation. Another mother, Rosa, elaborated and said, *"My*

son right now, um, I hurt them because in reality, um, I don't know if I can talk about this

here. I don't know, but when I had the baby girl, I was in a domestic violence situation. I

was hit a lot by the father of the kids, and they were raised in fear. Right now, I am with the

father of the baby girl, but they have fear if they are going to reach for something, they think

he will say something to them. Right now, we have a social worker that give us advice on

how to treat (and interact with) the children" (FG2). Rosa is traumatized as a result of her

past home experience. She was involved in a long-term domestic violence situation. Her

children were affected, she said. She and her children had to learn to cope with such

experiences. In this community, these stories show that a relationship exists between the

external environment, such as their home, and the children's mental health.

The social environment theme also covered traumatic events that members of this

community encountered as immigrant parents. In another story, by Irelene, the concept of

mental health is discussed as interconnected with the social environment. She described and

traced her children's mental health problems, which originated from the moment the

deportation officers took their father away:

> Irelene: "My husband was deported about a month ago. And well in front of my kids
> they took him and all [participant cries]. My daughter got very aggressive with the
> authorities, and my son just kept watching TV, and one hour after which (this)
> occurred, well, that occurred in December. My daughter was prescribed pills to sleep
> because she could not sleep, and my son, well, at night he cried and many (people)
> told me to go to school to get help with counseling. My daughter is about to start a
> counseling program, and my daughter is still not yet normal. I see her even more
> affected. The(y) prescribed her pills to sleep…"
>
> Sara: "Well, the kid is, well, how do I say this? All the attention was with her and the
> father. But like she said, the kids has (kept) it all inside, kept there. They want to see
> the father, but we can't yet because they still have him and all. Well, they cry and,
> well, we don't know what to do with him. He gets aggressive and, well, I am not
> often with her, but she does tell me my cousin that he does get aggressive with her
> (the mother). Well, I tell him, 'Take care of your mommy and both of you support
> her.' They are kids, and I do understand them at times too. But I don't know, with
> him, the girl does understand more but him…she needs to know places for the kid
> because the girl is not connected with therapy, but the boy has not yet."
>
> (FG3)

Irelene described how the moment her children's father was taken into the custody triggered

emotional and psychological difficulties for both herself and the children. Her experiences

led her to define children's mental health as interrelated with the social environment. The

trauma they all experienced changed their everyday life substantially. Her youngest child no longer could be alone or sleep in the dark. Her oldest child became absent-minded. This story illustrated the complexity of these women's lives and observations of the impact that larger social context/environment had on the children's mental health.

This community's experiences with marital troubles, trauma, domestic abuse, family deportation, discrimination, etc. foster a unique perspective about their understanding of the concept of mental health. A participant, Kimberly, captured the social environment theme nicely in her response to the question of what mental health is, *"(Mental health) was something like a taboo or something that was embarrassing because parents felt culpable. They would blame the family, the mom, or the dad. But now in actuality, it is something that you should not worry about because it is not the parent's fault but also in the time that we are in….it (mental health) is also affected by the contamination"* (FG8). Kimberly's point was that the presence of mental illness or even the lack of positive mental health is not the parents' fault, but instead it is the responsibility and result of other processes outside of the parents' control. This participant uses the term "society" to refer to the larger social, cultural, and political environments within which children are embedded.

In sum, the social environment captures a wide range of contexts and experiences, all of which are important in how this community understands and defines children's mental health. The school atmosphere, home environment, parents' relationships, parks, and even day-care experiences are related to Mexican immigrant mother's conceptualization of children's mental health. It's imperative to note the concept of children's mental health is not purely a biological process but instead also captures social processes. Overall, Mexican

immigrant mothers conceptualized children's mental health was related to having supportive environments, free from violence and trauma.

Summary

Participants discussed five overlapping, coexisting definitions of children's mental health: cognitive, emotional, behavioral, positive outlook, and social environment. Mental health for these participants was not only about having the right chemical balances or displaying the appropriate behaviors in public, but also having healthy, functioning, and supportive environments. Participants understood children's mental health as a multidimensional construct that emphasizes the social context and social processes in which children are embedded. Their conceptualization of mental health was not defined solely in biological terms. The five conceptualizations capture biological-psychological processes as well as non-biological social processes. Furthermore, the unique social experiences of this community added depth to their understanding of children's mental health. This study found that low-income Mexican immigrant mothers' employed complex and multifaceted conceptualizations concerning children's mental health.

Chapter Four: Discussion

This study explored the concept of children's mental health among low-income Mexican immigrant mothers. The conceptualization of mental health is a relatively underexplored research area (Busfield, 2000; Macklin, 1971; Pescosolido, McLeod, & Avison, 2007; Scott, 1958). We know, however, that Latino parents often play a significant role in the diagnosis, utilization, and treatment of their children's mental health problems. Mental health disparities among Latino children warrant the importance of investigating how Latino parents define children's mental health. Through inductive exploratory methods, this study found that Mexican immigrant mothers have a wealth of knowledge and ideas about the construct of children's mental health.

I found that low-income Spanish speaking Mexican immigrant Latina mothers had diverse overlapping, coexisting conceptualizations of children's mental health. This community discussed the concept of mental health as not merely equated to mental illness, captured ideas beyond the biomedical perspective, and described mental health as a social process. Five major conceptualizations of mental health among Mexican immigrant mothers were found: cognitive, emotional, behavior, positive outlook, and social environment. Furthermore, this community's concept of mental health emerged from their experiences and identity. Participants from La Mesa Community in Albuquerque revealed that the concept of mental health is multifaceted and complex, thereby leading to the need for scholars to reconceptualize the concept of mental health. This thesis provided grounds for conceptualizing the concept of mental health as a biological, psychological, as well as social process. The social determinants of mental health is a conceptual framework that needs further investigation and exploration.

Reconceptualizing Mental Health and Mental Illness

First, Mexican immigrant mothers did not define mental health as merely the absence of mental illness—although they did capture ideas directly related to mental illness, such as ADHD, depression, and anxiety, among others. For example, the theme behavior emerged as the result of mothers defining mental health as the absence of hyperactivity or of inattentiveness. The construct of mental health was articulated when referencing the absence of certain behaviors already accepted as mental illness. However, other themes that emerged, such as social environment, did not reference ideas linked to mental illness. Mental health, therefore, is a construct that is not equated to merely the absence of mental illness among Mexican immigrant mothers.

The concept of mental health for this community moves beyond the construct of mental illness, which is consistent with scholars' conceptualizations of mental health. Previous scholars have argued that mental health is a broader concept capturing a range of ideas such as happiness, self-esteem, environment mastery, and other ideas (Busfield, 2000; Macklin, 1971). I found that Mexican immigrant mothers have multiple ideas about a variety of themes they believed were related to their definition of mental health. See Figure 3 for a depiction of mental health as a concept that encompasses mental illness as well as other qualities, such as a positive outlook.
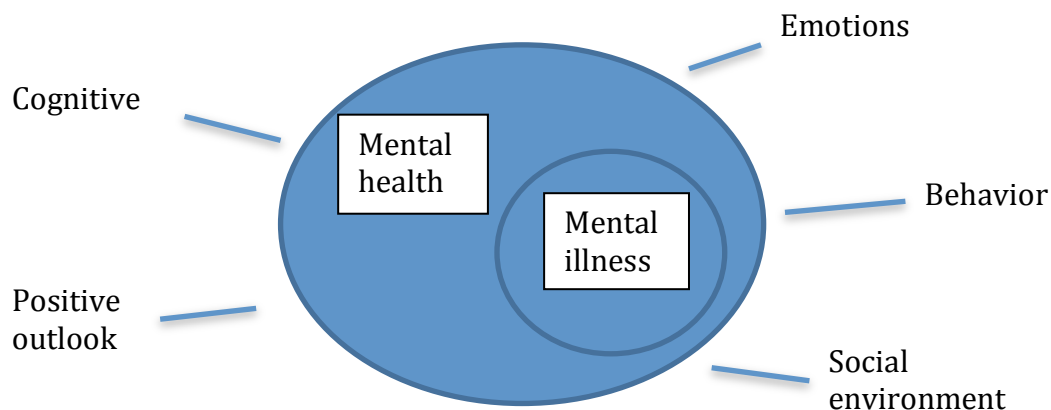
Figure 3: **The Construct of Mental Health among Mexican Immigrant Mothers**

The disciplines of sociology, psychology, and others have a tendency to study mental illness rather than mental health, but this study found that Mexican immigrant mothers did not merely equate mental health to mental illness. It is not easy to separate mental health and mental illness. They are interconnected and in some ways interdependent on each other for their definitions (Busfield, 2000; Goldstein, 1971). Concepts related to mental illness were present in the discussions demonstrating the fluid boundary between mental health and mental illness. Therefore, it is important for scholars to revisit the relationship between mental health and mental illness. The overemphasis on theories of mental illness has created a gap in theories on mental health (Warner, 2009). Future researchers should emphasize on building mental health theories and inquiring how these theories related to mental illness theories.

Secondly, this study found that Mexican immigrant mothers discussed the concept of mental health in relation to the biomedical model. The biomedical model is defined as the framework that emphasizes intraorganism and physiopathology phenomena. Previous studies have argued that Latino parents do not endorse the biomedical model of mental

illness (Arcia & Fernandez, 2003; Armstrong et al., 2000; Bava, 2009; Pham et al., 2010), which in their opinion is problematic. However, contrary to these studies, I found that among this community of Latina mothers, they do in fact endorse the Western biomedical conceptualization of mental health. Three of the five conceptualizations of mental health themes that Mexican immigrant mothers discussed aligned with the biomedical framework: cognitive, emotions, and behavior. This group of Latina mothers conceptualized mental health as a concept related to the biological/psychological process occurring with their children. This community clearly voiced a perspective that discussed children's mental health as a construct related to their children's cognitive, emotional, and behavior development.

Mexican immigrant mothers may not necessarily be able to define ADHD or autism, but they are aware of these mental health conditions. Other studies have argued that Latino parents do not detect ADHD, depression, or other mental health problems, which the studies think is the result of a lack of knowledge or understanding (Leslie et al., 2008; McKay & Bannon, 2004; Pescosolido et al., 2008; Roberts et al., 2005; Weisz & Weiss, 1991). This study was not concerned with investigating whether there was a lack of knowledge. Whether this community is able to articulate certain terms translates into meaning that these studies accept the established mental health construct. This study found that mental health for this community captures ideas in the biomedical model but also expands beyond the biomedical model. The participant's conceptualization touched on other topics less traditionally thought of as related to mental health.

Unlike previous studies that have investigated the conceptualization of mental illness and/or mental health, this study did not impose the biomedical perspective nor were I

interested in whether participants agreed with the Western biomedical perspective (Moses, 2011; Roberts et al., 2005; Schmitz & Velez, 2003). Instead, this study openly coded for any theme related to this community's conceptualization of mental health. Interestingly, however, I found that even when using an open-ended approach, this community's definition of children's mental health (three of the five conceptualizations: cognitive, emotional, and behavior) reflected traditional Western biomedical perspectives about mental health. Conceptualizations of mental health therefore cannot be described neatly as being in agreement or disagreement with the dominant biomedical perspective. This study adds complexity to this dichotomy. Mexican immigrant mothers have a spectrum of ideas that captures both biological and non-biological processes. The concept of mental health is fluid and multidimensional rather than fixed or stable. Future scholars must reconsider the value of assessing Latino parent's beliefs or knowledge in dichotomous ways.

The diverse conceptualization of mental health found among Mexican immigrant mothers furthermore adds interesting insight into the assumption that parents who endorse the biomedical model exhibit compliance with the use of medication. The cognitive theme/definition of mental health among Mexican immigrant mothers most directly spoke to this topic. Previous studies have reported that a lack of treatment adoption among Latino children with ADHD, for example, is due to the lack of knowledge among parents (Eiraldi & Diaz, 2010; Kataoka, Zhang, & Wells, 2002). Scholars have described the prevalence within dominant U.S. culture to medicalize and medicate children with ADHD (Conrad, 2007; Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007). This study found that even though Latino parents discussed mental health as being related to chemical or biological processes, there were mixed feelings about medication use. This contradicts previous literature because

scholars have argued that it is the lack of knowledge and/or belief with the biomedical model among Latino parents that contributes to the low rate of mental health treatment among children (Eiraidi & Diaz, 2010). Many describe Latino parents' reluctance to give medication to their children, and it appears as though with more education, Latino parents would be more likely to give medication to their children. However, this community of Spanish-speaking, low-income Mexican immigrant mothers believed medication is only a step toward either addressing mental health problems or promoting children's mental health. This community had diverse conceptualizations of mental health.

The construct of mental health among Mexican immigrant mothers captured biomedical ideas and expanded beyond the biomedical perspective, which consequently sheds light on their request for alternative treatment options that are not individual based, as are pharmaceutical drugs. For example, the social environment theme/definition of mental health alluded to the importance of addressing the social context in which children are embedded. This conceptualization of children's mental health highlighted the importance of creating supportive environments, which in this community's opinion requires family therapy, safe parks and neighborhoods, and other societal level interventions. These conceptualizations of mental health demonstrate that medication does not address the core issue that promotes or prevents healthy mental growth among Latino children. Link and Phelan (1995) as well as other scholars such as Engels (1945) and William and Sternthal (2010) have expanded the literature on the social conditions that play a fundamental role in health and disease. They argue that overlooking these social causes, such as housing, will enable disease and illness to persist. Although this study did not focus on medication usage or treatment options of mental health, the desire for alternative treatment options emerged

66

among Spanish-speaking, low-income Mexican immigrant mothers because of their diverse conceptualization of mental health. Participants' conceptualizations that moved beyond the biomedical framework endorsed a belief that medication was one solution.

To recap thus far, and see Figure 4 for a visual, this study found that Mexican immigrant Latina mothers had diverse, overlapping, and coexisting conceptualizations of children's mental health. First, mental health is not defined as merely the absence of mental illness. The outer circle, mental health, is larger than the inner circle labeled mental illness. Mental health captures a wide spectrum of ideas some related to mental illness but not all Secondly, this communities definition of mental health expanded beyond the biomedical perspective of mental health. Research that dichotomizes Latino parent's belief with the biomedical model may be undermining fruitful data. Their conceptualization of mental health moved beyond the Western biomedical model. The conceptualization of mental health among Mexican immigrant mothers shed light on the biology and the psychology, as well as the social dimensions. We can also think of these are micro, meso, and macro level processes. The biology captures the micro level ideas relevant to mental health such as cognitive and emotions. The psychological captures the meso level ideas relevant to mental health. For example, emotions are not only the state of being happy but also the ability to express them appropriately according to societal norms. And lastly the macro is the social. Children's mental health is related to the social processes, which is overlooked by the biomedical framework. The triangle with the word context alludes to these social processes grounded in this community's conceptualization of mental health. These discussions on the social environment furthermore provided grounds for this community to advocate for treatment outside of pharmaceutical drugs. I will now discuss more in depth the social.
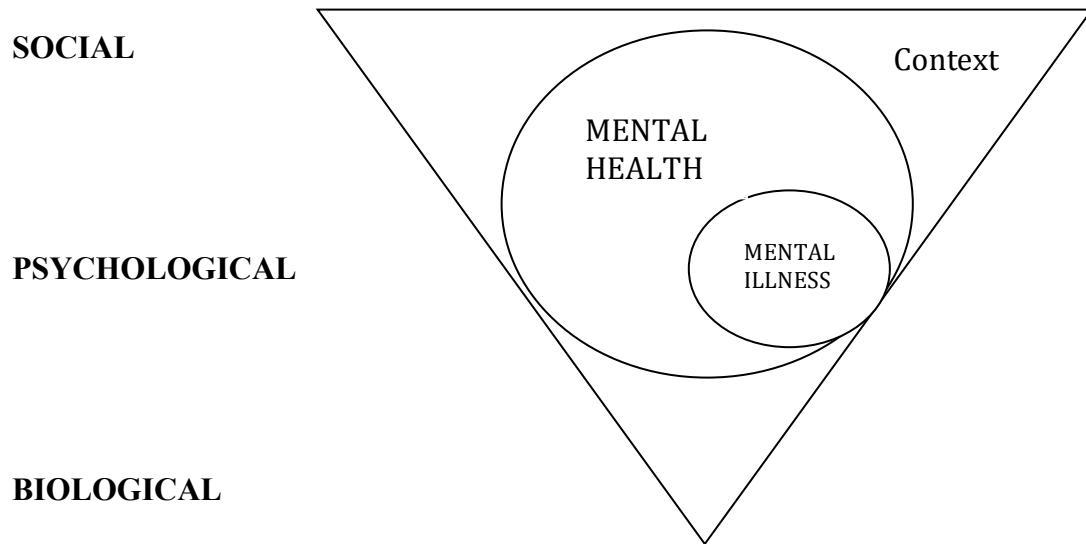
67

SOCIAL

PSYCHOLOGICAL

BIOLOGICAL

Context

MENTAL
HEALTH

MENTAL
ILLNESS

Figure 4: **Re-conceptualizing Mental Health**

Thirdly, a reconceptualization of mental health is urged because Mexican immigrant

mothers discussed the concept of mental health as a social process. The conceptualizations

that emerged among low-income Mexican immigrant mothers reflected ideas tied to social

context. A growing body of literature emphasizes the social conditions that matter for

physical health as well as mental health (Link & Phelan, 1995; Phelan, Link, & Tehranifar,

2010). Having more sociological work and applying a sociological perspective on the

conceptualization of mental health could be useful to highlighting social determinants of

mental health.

I will discuss three of the themes to demonstrate how this community's definition of

mental health captured ideas found in psychology but shed light on more social processes.

Many of the conceptualizations that emerged among low-income Mexican immigrant

mothers reflect ideas found in the discipline of psychology; however, the perspective of this

community moved beyond individualistic-centered personalities and characteristics. I then

will discuss their emphasis on social processes as they related to the growing body of literature on the social determinant of health and illness.

To start, this community defined children's mental health as centered on emotions. Mental health for low-income Mexican immigrant mothers was defined by their children's state of happiness. Jahoda (1954) discusses the definition of mental health in terms of being in a state of happiness, which frames a discussion on mental health as a process centered on the individuals' personality. She notes that this definition does not take into account the environment. For Jahoda, a definition that frames happiness as a state depending on circumstances is less useful than when mental health is defined only as a state of happiness. It would be interesting for scholars to research this community's definition of happiness and to further explore this theme. Mexican immigrant mothers certainly pointed out that mental health is interconnected with the environment, but there was little elaboration on whether their emotional theme with regards to happiness was related to the environment. Mexican immigrant mothers merely believed it was necessary for the child to not feel depressed, anxious, shy, or jealous. Those feelings were perceived as negative for their child's mental health. These feelings, however, are not independent of children's social context.

Another theme, the positive outlook, demonstrated that the concept of mental health isn't purely an individual-level process. Positive outlook paralleled psychological terms such as self-confidence, self-esteem, and self-respect. These terms are expressed when the children or individual have a strong sense of self. Scholars have utilized these concepts frequently to define mental health (Jahoda, 1954). Mexican immigrant mothers discussed the importance for children to have high self-esteem and confidence in their abilities. This idea of self-determination also is reflected in this community's definition of mental health with a

positive outlook theme. Self-determination is expressed when an individual does all that can be done to fulfill his or her human potential, without disowning any feelings, impulses, capacities, or goals (Mayman, 1955). These ideas of self-esteem and self-determination are part of the positive outlook theme. Mothers talked about the importance for their children to accept their body image and to feel empower or an attitude of I can do anything. Positive outlook does parallel with psychological conceptualization of mental health, but this theme captures more.

Ideas under the self-concept (self-efficacy, self-determination, or self-esteem) neglect to recognize that children are part of a larger social, cultural, and political structure/context. Mexican immigrant mothers' concept of positive outlook alludes to ideas of self-confidence, self-esteem, self-identity, and self-actualization. Positive outlook, however, goes beyond personal characteristics. The positive-outlook theme alludes to ideas of the self within an environment. This concept of positive outlook captured more than just qualities of a person's self. Instead, the positive-outlook theme described children who are content with themselves, their abilities, and their surroundings as well as with their future. It was the mother's role to foster this ability, and it was parent's role to spend time with their children, to cultivate contentment among their children. Although the positive-outlook theme describes children as having high self-esteem, believing in themselves, and self-determination, this theme operated beyond the individual level. Mental health for low-income Mexican immigrant mothers captured the child's self as independent but also as interdependent within their social context.

The social environment theme is the last theme that captures concepts in the literature of psychology but emphasizes the social more than the individual. The literature on mental

70

health does discuss environments but uses language that focuses on the individual rather than on external forces that construct the environment. For example, environmental mastery has been used as a criterion for mental health (Jahoda, 1958). This usage of environmental mastery implies mastery in various areas of human functioning, such as efficacy in meeting situational requirements and capacity for adaptation and adjustment. This perspective, however, assumes the environment is "right" and that the individual must change to match the environment. The community of Spanish-speaking, low-income Mexican immigrant mothers demonstrate environment matters and emphasizes on the external forces that construct a supportive or nonsupportive environment. Mothers discuss the social environment theme where problems or trauma occur that impact children regardless of the children's behaviors or emotions. In other words, children are passive and have no ability to control these environments but are affected by them.

This community discussed the various environments that have an impact on the concept of children's mental health. This finding may be the result of mental health as a concept with regards to children who often are perceived as powerless, compared to a discussion on adult mental health when the adults are perceived as being more in control. Regardless, the social environment theme does not discuss environmental mastery but instead discusses the importance of children developing in supportive environments. Social environment did not speak to the child's ability to cope with the social context. Within this community of low-income Mexican immigrant mothers, the construct of mental health as intrinsic to the social environment turn the focus away from the individual's personality and/or characteristics. Parents, schools, and even family members play a large role in

71

fostering supportive environments. All three of these entities demonstrate the need to emphasize the social perspective on the construct of mental health.

This community's articulation of the social processes and social context shifts conceptualization of children's mental health from a pure biological process to one that is interconnected with social structures. There is a larger body of literature in sociology on the social origins of illness. Waitzkin (2004) stressed that the importance of understanding access to medical care may do little to improve population health because social structures are not being addressed. The social determinants of health describe social structures of oppression such as social class, racism, gender, the organization of work, and the distribution of toxic substances. These are the fundamental causes of disease. Although the social determinants of health is a growing perspective among social scientists, the discovery of health linked to social structure occurred long ago.

Three early contributors to understanding the effects of social structures on health and illness were Friedrish Engels, Rudolfo Virchow, and Salvador Allende. Waitzkin (2004) provides an excellent overview of these three scholars. Engels and Virchow wrote during the 1840s and described the impact of early capitalism. Allende wrote in 1930 on the effects of capitalist imperialism on health, which had profound impact on health planning and strategy in Latin America. Engle (1945) wrote a well-acknowledged book, *The Conditions of the Working Class in England,* in which he describes the working-class life in England or as he calls them, "the England proletariats." He characterized the kind of inhuman conditions industrialization produces, such as the centralization of great populations in cities, the lack of oxygen in the atmosphere, the absence of proper ventilation systems, and high levels of carbonic gas. These ill-provided conditions, he links to the deterioration of the workers'

physical, mental, and moral status. Engels as well as Virchow and Allende provided

analyses of the direct impact that social conditions have on health. These scholars early on

demonstrated the significant impact social structures and social conditions have on physical

as well as mental health.

Findings from the study continue this dialogue and emphasize the importance of

social environment on children's mental health. Mexican immigrant mothers understood

children's mental health as interconnected with their children's social context. This

community associated the domestic violence or the abuse from the education system as social

processes and dynamics integral to describing their children's mental health wellbeing.

When their children had supportive teachers, the mothers believed their children's mental

health was better when compared to the children being in a negative or unsupportive

environment. A recent study published in the *Journal of Health and Social Behavior*

investigated classroom learning environment and the mental health of first-grade children.

Milkie and Warner (2011), using a social structural approach among a nationally represented

sample of first graders, found the classroom environment affects children's emotional and

behavioral problems. More studies on the role that social structures play for children's

wellbeing are important. In another study, a scholar explored the general effects of violence

on children's wellbeing in Ciudad Juarez, Mexico. Hernandez (2011) found that proper

development becomes a challenge when children are not receiving adequate health care,

educational enrichment, and housing, which are amplified when children are embedded in

violent environments. Her 16 in-depth interviews and 151 surveys looked at effects the drug

war on children's wellbeing in Ciudad Juarez. She found that children's social, economic,

and cultural capital were affected negatively by the war. A body of literature continues to

grow that demonstrate the role social structures and social conditions have with health. This study contributes to this body of literature by demonstrating children's mental health is conceptualized among Mexican immigrant mothers as a social process. Mothers observed and experienced the impact of domestic violence, unsafe parks, or disrespectful schools had on their children's mental health. This community discussed the role social environment and social context has on their children's mental health wellbeing. The social was an important idea for this community's conceptualization of children's mental health.

More research is needed on the social determinants of mental health. It seems as though using Waitzkin's (2011) words that conditions of society that generates illness and mortality are largely forgotten with each generation. Health and mental health have social origins. Where we work, play, and live are environments that can either threaten or enhance the survival of humanity and other life forms. It is important for policy to not only be concerned with whether Latino children are accessing mental health services or treatment, but also with whether they are growing up in high quality neighborhoods, in safe parks, or in respectful schools. Williams and colleagues (2008) emphasizes the importance of studying and understanding the social determinants of health in order to improve health and reduce disparities. The sociological literature is integral to re-conceptualizing mental health as not purely a biological process but also one linked to social processes. In the discipline of psychology, Ignacio Martín-Baró (1994) has been instrumental in Latin America for shifting the discourse and level of policy intervention with regards to mental health. His work emphasized the importance of addressing the social conditions to promote mental health. Sociologists have important theoretical work to contribute in demonstrating the social origins

of mental health. The social determinants of health is a growing discourse and this thesis sheds light on the relevancy of this conceptual model for children's mental health.

Empirically, this thesis adds to the body of literature on the conceptualization of mental health. We found among Mexican immigrant mothers there were five: cognitive, emotion, behavior, positive outlook, and social environment. However, theoretically this thesis adds to the discipline of sociology of mental health by demonstrating the important role that social context and social environment play for mental health wellbeing. Theories of mental health have been largely absent because the study of mental illness seems to have taken priority. It is clear, however, that mental health is equally grounded in social processes. This thesis shows the relevancy of social structures and social environment for the concept of mental health. Moving away from solely understanding mental health solely as an access issue can foster dialogue and promote theoretical models that shed light on social conditions.

Thus far, I have discussed Mexican immigrant mothers' discussions about mental health, which captures mental illness, expands beyond the medical model, and highlights the social processes. Lastly, I wish to briefly discuss how Mexican immigrant mothers' background and experiences impact the way they define mental health. This community's unique social position led its members to experience domestic violence, language barriers, and/or discriminatory practices from schools or medical institutions. Members of this community's experiences as immigrants add a dimension to their experiences and knowledge.

The five themes emerged from their everyday lives and experiences. A significant number of the participants were not in stable marriages, and many have been or still are part

of a domestic violence situation. This community also experienced a significant amount of domestic violence, which generated specific concerns among its members about their children's physical and mental health. They also experienced discrimination due to their immigrant status and their powerlessness to select on alternative treatments for their children's mental health problems. Future research will need to explore extensively these hierarchical power dynamics to understand the social construction of children's mental health and the power dynamics that exist. Although this study attempted to conceptualize the concept of mental health, and due to the use of secondary data, my ability to engage in a more in-depth exploration of the concept of mental health is limited. It does seem, however, that who this community identifies as and where this community comes from played a significant role in their conceptualization and experiences regarding children's mental health.

This community also experienced power struggles because of having nondominant ideologies. Divergent conceptualizations were met with opposition from the medical system for this community of mothers. Medication was often "forced" upon many mothers by both the medical and education system. This community believed their options were limited. With regards to the emotion theme, Mexican immigrant mothers struggled with health providers addressing their children's sibling jealousy. This perception that sibling jealousy was bad is not consistent with the developmental stages of children in the United States (Geronimus & Thompson, 2004). Geronimus and Thompson elaborate on the unspoken normative norms and rules by which the health care system operates. For example, teenage rebellion is a normal part of the Western developmental process, but in other communities this may not be the case. Although this study's analysis is applied to African Americans, their findings are generalizable. Anyone who grew up in a different culture or with different

76

norms, such as Latinos, may have deviating understandings of developmental stages than the dominant group. It appears that sibling jealousy is another trait that the medical institution does not regard as a normal process of childhood development. However, other scholars investigating mental health and mental illness among Latina mothers have documented their concern of sibling rivalry (Arcia & Fernandez, 1998). Spanish-speaking, low-income Mexican immigrant mothers conceptualized sibling jealousy as not part of normal mental health development but instead perceive sibling rivalry as a trait needing intervention. The emergence of emotions adds complexity and sheds light on this themes relationship to norms, values, and beliefs. Making the assumption that there are shared conceptualizations of even accepted biomedical terms cannot be made.

This study found the concept of mental health and mental illness is grounded in contextual experiences. The classifications of emotions or behaviors as "healthy" or "sick" are dependent on the norms and values of the community of interest (Pilgrim & Rogers, 1999; Walker, 2006; Warner, 2009). Whether such classifications are different racial/ethnic minorities are rarely considered or explored. I encourage other researchers to engage in this discussion on the conceptualization of mental health with other communities such as those of African Americans and Asian Americans. More contextualized research is needed; the conceptualization of mental health is embedded in the unique socio-historical-economic position as well as rooted in power dynamics that display hierarchical structures (Chapman & Berggren, 2005; Singh & Clarke, 2006; Walker, 2006). Latinos, African American, and other groups have different socio-historical economic positions that theoretically would foster unique definitions and perceptions of children's mental health. It is imperative that researchers continue this investigation. More research from a sociological perspective is

instrumental considering the social nature of mental health. The construct that mental health is similar to mental illness is social, but this remains an underexplored area of research.

In summary, more research is needed to investigate the construct of mental health as opposed to mental illness and as independent of the biomedical model. Also, more empirical and theoretical research is needed to strengthen the social perspective on the construct of mental health. Mexican immigrants' definition of mental health is not merely the absence of mental illness; it captures and moves beyond biomedical perspectives and alludes to external processes outside of individual biological processes. It would be valuable for the conceptualization and contextualization of mental illness and mental health would be great to expand on the mechanism by which meaning making occurs. Meaning making refers to not only the conceptualization, but to the process by which such conceptualization are formed. These must be a priority for current and future sociologists. I advocate that additional research be conducted to take a deeper look at the conceptualization of mental health is to better understand persisting mental health disparities among Latino children.

With regards to policy implications, these complex, coexisting conceptualizations prompted Mexican immigrant mothers during their discussion on alternative conceptualizations to indicate a need for safe parks, good teachers, and counseling of parenting skills to help construct positive outlooks and supportive environments for their children. The health care system does have a role and a responsibility to engage with the families and to understand their perspective or to at least validate their concerns.

Scholars have suggested the need for more cultural, competent mental health systems (Arcia, Reyes-Blanes, & Vasquez-Montilla, 2000). There seems to be a miscommunication and misunderstanding between Latino parents and professional health care providers that

must be strengthened to address mental health utilization disparities among Latino children. Atdjian & Vega (2005) found a need for clinicians to better communicate and better engage with Latino families about mental health. A focus on this could potentially increase the use of mental health services among Latino families. Policy efforts need to address communication difficulties stemming from conceptual differences between providers and Latino populations.

There is a growing movement in the field of mental health wherein providers are encouraged to not disregard parents' knowledge or perspective but instead to listen to and engage with parents about their concerns and ideas on potential mental health treatments (Singh & Clarke, 2006). This trend has grown because parents are with their children most of the day, unlike health care providers, who evaluate children for only about 15minutes maximum. The increasing minimization of contact and expansion of gatekeepers to mental health services has fostered more reliance of providers on parents' descriptions and concerns. Historically, providers have had played dominant roles in diagnosing, treating, and addressing mental health issues (Singh & Clarke, 2006). Although this study did not investigate patient provider dynamics, future studies should engage this topic. From the little that was found from the focus groups, Mexican immigrant mothers did express their desire for more recognition and partnership as well as for treatment options outside of drugs. Latino parents, just as providers do, have knowledge, and although it may be not be considered traditional medical knowledge, it still is information that adds to the providers' information about the children's mental health. This study would fully support the trend that emphasizes listening to parents and encourages professionals to recognize the body of knowledge that Latino parents can bring to the table.

Limitations

There are some limitations to this study necessary to discuss. The first is with regards to the facilitation of the focus groups. When the facilitator of the focus groups first asked the Mexican immigrant mothers to define mental health, they seemed confused or often said, "I don't know." Similar to a previous study by Bava (2009) that also engaged in interviews with Latina immigrants about the construct of mental health, problems about getting their perspective rose. The researcher therefore had to emphasize they were not looking for an "expert" definition which did alleviate any apprehension (Bava, 2009). The same dynamics occurred in this study. The concept of mental health encompasses diverse ideas and topics. Previous scholars have argued that mental health is not merely the absence of mental illness and that when mental health is equated to mental illness, it limits the kind of social phenomenon captured (Carol, 2002; Schwartz, 2002). Facilitators tried to ensure participants any answer was appropriate but the prompting for this question varied from focus group to focus groups. Future studies need to pay attention to the facilitation method in order to prevent bias answers. Mental health includes a wide range of social phenomenon. However, the hesitancy or the likelihood to answer "I don't know" prompted intriguing discussion among the researchers with regards to terminology. Future facilitators also need to think critically and assess the term mental health and the usefulness of the direct translation, *salud mental*. Other terms might be better translations, such as "children's well-being."

Furthermore, this study was interested in Spanish-speaking, low-income, Mexican immigrant mothers in New Mexico. Although this study cannot speak to the experiences of all Latinos in the United States, it does capture the conceptualization patterns of a particular subgroup of Latinos in a particular region of the United States. This data provided a wealth

of knowledge on the definition of mental health among a population that is relatively underexplored despite its growing numbers in the United States. Despite the uniqueness of the population, due to institutional review board (IRB), issues the collection of the demographic information on this population was incomplete. Future research needs to become cognizant of this population and be careful when conducting research with this population.

More in-depth investigation of a broader and inclusive sample of Latinos would be ideal. Few studies research Spanish-speaking low-income, Latino immigrants because of mobility or language barriers. This community is relatively difficult to access. Our community partner, *La Communidad Habla,* was instrumental to the study's ability to gain access to this population. Mexicans do make up a significant portion of the Latino population, and despite beliefs to the contrary, a significant number of Latinos in the United States have minimal English-speaking abilities (Padilla et al., 2006; Vega, 1990). Future studies should, however, investigate conceptualization patterns with English-speaking Latinos as well as with higher socio-economic status Latinos. Studies have found there are major variations among different ethnic groups, but too often Latino is viewed as a monolithic group (Pham et al., 2010; Roberts et al., 2005; Schmitz & Velez, 2003).

In addition, another limitation that should be considered is the scant number of questions that asked the participants to define mental health. Of the nine questions, only one asked participants about their definition of mental health. Additional questions might have fully discovered this community's conceptualization of children's mental health. As a result, some themes were less explored than others. For example, although this community did discuss spirituality as part of their conceptualization of mental health, I was not able to

81

elaborate on this theme because existing data did not lend more insight into the concept. Previous scholars have, however, discussed the idea of spirituality (Martin, 2009). It would have been ideal to have multiple questions on the definition of mental health during the focus groups to foster more in-depth discussions. Additional questions would also have increased the opportunities for further probing. Future research will need to engage this topic more to understand the meaning and the definition of spirituality as well as others that might have gone unnoticed in this study as spirituality and others relates to the conceptualization of children's mental health. Despite these limitations, the findings still provided insightful descriptions of the conceptualization of mental health among low-income Mexican immigrant mothers.

Conclusion

Conceptualization of mental health has been vastly understudied. This study is among the first to inductively investigate the definition of children's mental health among Mexican immigrant mothers. Parents play a significant role in many areas of their children's mental health, including understanding the concept, detection, utilization, and treatment options. The intent of this study was to inquire, first, how do low-income Mexican immigrant mothers talk about, describe, and define children's mental health? And second, what are the major conceptualizations of mental health among low-income Mexican immigrant mothers? I found Mexican immigrant mothers' definitions of children's mental health captured a wide range of social processes that expand and challenge existing literature on the concept of mental health. The subject of mental health among Mexican immigrant mothers does not solely capture the biomedical framework: children's biological or psychological process, such as cognitive, or the psychological processes, such as emotions. Instead, the concept of mental health also captures the social dynamics and experiences that occur around the children, such as positive outlook and social environment. This study adds to the social determinants of mental health literature emphasizing the important of safe and supportive environments for Latino children's wellbeing. The concept of mental health is diverse and captures a broad range of ideas.

Participants understood children's mental health as a multidimensionality construct, and furthermore, their unique social experiences added depth to their conceptualization of children's mental health. These findings urge scholars to reconceptualize the construct of mental health. Mental health is more than merely the absence of mental illness and different groups with unique social experiences, values, and norms. All of which potentially could

83

foster divergent conceptualization of children's mental health. Research is necessary to

stress the socially constructed reality of mental health thereby expanding the social

determinants of health literature. The lack of awareness of Latino parents' definitions may

contribute to the mental health disparities Latino children face.

Bibliography

Alegria, M., Mulvaney-Day, N., Woo,M., Torres, M., Gao, S., & Oddo, V. (2007). Correlates of past-year mental health services use among Latinos: Results from the national Latino and Asian American study. *American Journal of Public Health, 97*(1), 76-83.

Aneshensel, C. S. (2002). Answers and questions in the sociology of mental health. *Journal of Health and Social Behav*ior, *43*(2), 236-246.

Aneshensel, C. S., Rutter, C. M., & Lachenbruch, P. A. (1991). Social structures, stress, and mental health: Competing conceptual and analytic models." *American Sociological Review,* 56(2):166-176.

Arcia, E., & Fernandez, M. C. (1998). Cuban mothers' schemas of ADHD: Development, characteristics, and help seeking behaviors. *Journal of Child and Family Studies, 7*(3), 333-352.

Arcia, E., &. Fernandez, M. C. (2003). Presenting problems and assigned diagnoses among young Latino children with disruptive behavior. *Journal of Attention Disorders, 6*(4), 177-185.

Arcia, E., Reyes-Blanes, M. E., & Vasquez-Montilla, E. (2000). Constructions and reconstructions: Latino parents' values for children. *Journal of Child and Family Studies, 9*(3), 333-350.

Armstrong, C., Hill, M., & Secker, J. (2000). Young people's perceptions of mental health. *Children and Society, 14*(1), 60-72.

Arnold, E., Elliott, M., Sachs, L., Bird, H., Kraemer, H., Wells, K., Abikoff, H. B., Comarda, A., Conners, C. K., Elliott, G. R., Greenhill, L. L., Hechtman, L., Hindshaw, S. P., Hoza, B., Jensen, P. S., March, J. S., Newcome, J. H., Pelham, W. E., Severe, J. NN., Swanson, J. M., Vitello, B., & Wigal, T. (2003). Effects of ethnicity on treatment attendance, stimulant response/ dose, and 14-month out-come in ADHD. *Journal of Consulting and Clinical Psychology, 71*(4), 713-727.

Atdjian, S., & Vega, W. A. (2005). Disparities in mental health treatment in U.S. racial and ethnic minority groups: Implications for psychiatrists. *Psychiatric Services, 56*(12), 1603-1605.

Babbie, E. (2007). *The practice of social research.* Belmont, CA: Thomas Wadsworth.

Bava, L. (2009). *Latina Immigrants: Defining and Achieving Mental Health Needs.* Ph.D. dissertation, Department of Sociology, University of La Verne: UMI Dissertation Publishing /Pro-Quest.

Berg, B. L. (2007). *Qualitative research methods for social sciences.* New York: Pearson.

Braveman, P. (2006). Health disparities and health inequities: Concepts and measurements. *Annual Review of Public Health, 27*,167-194.

Brown, P. (1995). Naming and framing: the social construction of diagnosis and illness. *Journal of Health and Social Behavior, 35* (extra issue), 34-52.

Busfield, J. (2000). Introduction: Rethinking the sociology of mental health. *Sociology of Health and Illness, 22*(5), 543-558.

Carole, S. A. (2002). Answers and questions in the sociology of mental health. *Journal of Health and Social Behaviors, 34*, 236-246.

Chapman, R. R., & Berggren, J. R. (2005). Radical contextualization: Contribution to an anthropology of race/ethnic health disparities. *Health (London), 9*(2), 145-163.

Collins, P.H. (2000). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York, NY: Routledge Classics publishing.

Conrad, P. (1975). The discovery of hyperkinesis: Notes on the medicalization of deviant behavior. *Social Problems, 23*(1), 12-21.

Conrad, P. (2007). *The medicalization of society: On the transformations of human conditions into treatable disorders*. Baltimore: The John Hopkins University Press.

Conrad, P., & Barker, K. K. (2010). The social construction of illness: key insight and policy implications. *Journal of Health and Social Behavior, 51*(S), S67-S79.

Dosreis, S., Zito, J., Safer, D., Soeken, K., Mitchell, J., & Ellwood, L. (2003). Parental perceptions and satisfaction with stimulant medication for attention-deficit hyperactivity disorder. *Journal of Developmental and Behavioral Pediatrics, 24*(3), 155–62.

Edmunds, H. (2000). *Focus Group Research Handbook.* New York: McGraw-Hill.

Eiraidi, R., & Diaz, Y. (2010). Use of treatment services for attention-deficit/hyperactivity disorder in Latino children. *Current Psychiatry Reports, 12*, 403-408.

Engels, F. (1845). *The conditions of the working class in England in 1844.* Moscow, Leipzig; Progress Publishers.

Escobar, J. I., Constanza, H. N., & Michael, A. G. (2000). Immigration and Mental Health: Mexican Americans in the United States. *Harvard Review Psychiatry, 6*(3), 64-72.

Finno, M., Vidal de Haymes, M., & Mindell, R. (2006). Risk of affective disorders in the migration and acculturation experience of Mexican migrants. *Protecting Children, 21*(2), 22-35.

Flores-Ortiz, Y. (2003). *Re/membering the body.* In A.J. Aldama (Ed.), Violence and the body: race, gender, and the state (pp.347-359). Indiana: Indiana University Press [e-book].

Foucault, M. (1967). *Madness & civilization: A history of insanity in the age of reason.* London: Routledge.

Fortuny, K., Hernandez, D.J. & Chaudry, A. (2010). Young children of immigrants: the leading edge of America's future. Children of immigrants, Brief 3. *The Urban Institute:* Washington, DC.

Fuller, J., Edward, J. Procter, N., & Moss, J. (2000). How definitions of mental health problems can influence help seeking in rural and remote communities. *American Journal of Rural Health, 8*(3), 148-153.

Geronimus, A.T., & Thompson, J. P. (2004). To denigrate, ignore, or disrupt : the health impact of policy-induced breakdown of urban African American communities of support. *Du Bois Review*, *1*(2), 247-279.

Ginossar, T. (2011). Bridging the health and digital divide in a low-income Hispanic community: Using community-based participatory research to advance communities' well-being. In: M.Brann (Ed.). *Contemporary case studies in health communication: Theoretical and applied approaches.* Kendal Hunt.

Ginossar, T., & Nelson, S. (2010a). Reducing the health and digital divides: a model for using community-based participatory research approach to E-health inventions in low-income Hispanic communities. *Journal of Computer-Mediated Communications*, *15*(4), 530-551.

Ginossar, T., & Nelson, S. (2010b). *La Comunidad Habla*: Using Internet community-based information interventions to increase empowerment and access to health care of low-income Latino/a immigrants. *Communication Education, 59*(3), 328-343.

Goldstein, M. S. (1979). The sociology of mental health and illness. *Annual Review of Sociology, 5*:381-409.

Guarnaccia, P.J., Lewis-Fernandez, R., & Rivera Marano, M. (2003). Towards a Puerto Rican popular nosology: *Nervios and Ataques de Nervios. Culture, Medicine, and Psychiatry,* 27:249-257.

Guarnaccia, P. J., Rivera, M., Franco, F., & Neighbors, C. (1996). The experiences of *Ataque de Nervios*. Towards an anthropology of emotions in Puerto Rico. *Culture, Medicine, and Psychiatry, 20*, 343-367.

Guarnaccia P. J., Rubro-Stipec, M., & Canino, G. (1989). *Ataque de Nervios* in the Puerto Rican diagnostic interview schedule: The impact of cultural categories of psychiatric epidemiology. *Culture, Medicine, and Psychiatry, 13*, 275-295.

Gudino, O. G., Lau, A. S., & Hough, R. L. (2008). Immigrant status, mental health need, and mental health service utilization among high-risk Hispanic and Asian Pacific Islander youth. *Child Youth Care Forum, 37*, 139-152.

Hamel, J. (2001). The focus group method and contemporary French sociology. *Journal of Sociology, 37(*4), 341-353.

Hernandez, A. (2011). Child development and child rearing in Ciudad Juarez, Mexico colonias: Economic, social, and cultural capital. *ETD Collection for University of Texas, El Paso.* Paper AAI1494353. http://digitalcommons.utep.edu/dissertations/AAI1494353

Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence based practice in children and adolescent mental health services. *Psychiatric Services, 52*(9), 1179-1189.

Hood, J. C. (2006). Teaching against the text: The case of qualitative methods. *Teaching Sociology, 34*, 207-223.

Horwitz, A. V. (2002). Outcomes in the sociology of mental health & illness: where have we been and where are we going? *Journal of Health & Social Behavior, 43*(2), 143-151.

Israel, B., Eng, E., Schultz, A. J., & Parker, E. A. (Eds). (2005) *Methods in community-based participatory research for health*. Jossey-Bass: San Francisco, CA.

Jahoda, M. (1958). *Current concepts of positive mental health.* New York: Basic Books, Inc., Publishers.

Kataoka, S. H., Zhang, L., & Wells, K. B., (2002). Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *The American Journal of Psychiatry, 159*, 1548-1555.

Krueger, R. A. (1988). *Focus groups: a practical guide for applied research.* Newbury Park, CA: Sage Publications, Inc.

Lauber, C., Nordt, C., Falcato, L., & Rossler, W. (2003). Do people recognize mental illness? Factors influencing mental health literacy. *Eur Arch Psychiatry Neuroscience, 253*(5), 248-251.

Leslie, L. K., Lambros, K. M., Aarons, G. A., Haine, R. A., & Hough, R. L. (2008). School based service use by youth with ADHD in public-sector settings. *Journal of Emotional and Behavioral Disorder, 16*(3), 163-177.

Livingston, R. (1999). Cultural issues in diagnosis and treatment of ADHD. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 1591-1594.

Macklin, R. (1971). Mental health and mental illness: Some problems of definition and concept formation. *Philosophy of Science, 39*(3), 341-365.

Majewicz-Hefley, A., & Carson, J. S. (2007). A meta-analysis of combined treatment for children diagnosed with ADHD. *Journal of Attention Disorders, 10*(3), 239-250.

Martin, S. S. (2009). Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants: Health. *Health and Social Work, 34*(2), 117-126.

Martín-Baró, I. (1994). *Writing for a liberation psychology.* A. Aron., & S. Corne, (Eds.). Cambridge, MA and London, England: Harvard University Press.

Maxwell, J. A. (2005). *Qualitative research design: an interactive approach, second edition.* Thousand Oaks, CA: Sage publishers.

May, R. (1954). A psychologist look at mental health in today's world. *Mental Hygiene*, *38*: I.

Mayman, M. (1955). The diagnosis of mental health. *Menninger Foundation.*

McKay, M. M., & Bannon, W. M. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America, 13*(4), 905-921.

McKinlay, J. B. (1972). Some approaches and problems in the study of the use of services – An overview. *Journal of Health and Social Behavior, 13*(2):115-152.

Moses, T. (2011). Parents' conceptualization of adolescents' mental health problems: who adopts a psychiatric perspective and does it make a difference? *Community Mental Health Journal, 47*(1), 67-81.

Milkie, M.A. & Warner, C.H. (2011). Classroom learning environments and the mental health of first grad children. *Journal of Health and Social Behavior, 52*(1), 4-22.

National Coalition of Hispanic Health and Human Services Organization (COSSMHO). (1995). Mental health of the immigrant child: A report to Annie E. Casey Foundation. Washington, DC: Author.

New Mexico Fiscal Policy Report. (2008). Immigrants and the New Mexico Economy: Working Hard for Low Wages, *New Mexico Voices for Children, June,* 1-6.

Padilla, Y. C., Radey, M. D., Hummer, R. A., & Kim, E. (2006). The living conditions of U.S. born children of Mexican immigrants in unmarried families. *Hispanic Journal of Behavioral Sciences, 28*, 331-349.

Parsons, T. (1951). *The Social System.* Glencoe, IL: The Free Press.

Pham, A. V., Carlson, J. S., & Kosciulek, J. F. (2010). Ethnic differences in parental beliefs of attention-deficit/hyperactivity disorder and treatment. *Journal of Attention Disorders, 13*, 584-591.

Pescosolido, B.A. (1992). Beyond rational choice: The social dynamics of how people seek help. *American Journal of Sociology, 97*(4): 1092-1138.

Pescosolido B. A., Fettes, D. L., Martin, J. K., Monahan, J., & McLeod, J. D. (2007). Perceived dangerousness of children with mental health problems and support for coerced treatment. *Psychiatric Services, 58*(5), 619-624.

Pescosolido, B. A., Jensen, P. S., Martin, J. K., Perry, B. L., Olafsdottir, S., & Fettes, D. (2008). Public knowledge and assessment of child mental health problems: Findings from the National Stigma Study-Children. *Journal of American Academy of Child and Adolescent Psychiatry, 47*(3), 339-349.

Pescosolido, B. A., McLeod, J. D., & Avison, W. R. (2007). Through the looking glass: The fortunes of the sociology of mental health. *Mental Health, Social Mirror,* Part i, 3-32.

Pilgrim, D., & Rogers, A. (1999). *A sociology of mental health and illness.* Buckingham, PA: Open University Press.

Roberts, R. E., Alegria, M., Roberts, C. R., & Chen, I. G. (2005). Mental health problems of adolescents as reported by their caregivers: A comparison of European Africana and Latino American. *Journal of Behavioral Health Services and Research, 32*(1), 1-13.

Rogler, L. H., Malgady, R. G., & Rodriguez, O. (1989). *Hispanics and mental health: a framework for research*, Malabar, FL: Robert E. Krieger Pub. Co.

Rubel, A. J., O'Nell, C. W., & Collado-Ardon, R. (1984). *Susto: a fold illness.* Los Angeles, CA: University of California Press.

Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry*, *9*(1), 1-28.

Schmitz, M. F., & Velez, M. (2003). Latino cultural differences in maternal assessment of attention deficit/hyperactivity symptoms in children. *Hispanic Journal of Behavioral Sciences, 25*, 110-122.

Schwartz, S. (2002). Outcomes for the sociology of mental health: Are we meeting the goals? *Journal of Health and Social Behavior, 43*(2), 223-235.

Scott, W. A. (1958). Research definitions of mental health and mental illness. *Psychological Bulletin, 55*(1), 29-45.

Segal, U., & Mayadas, N. (2005). Assessment of issues facing immigrant and refugee families. *Child Welfare, 84*, 563-583.

Singh, R., & Clarke, G. (2006). Power and parenting assessments: the intersecting levels of culture, race, class, and gender. *Clinical Child Psychology and Psychiatry, 11*, 9-25.

Solis, J. M., Marks, G., Garcia, M., & Shelton, D. (1990). Acculturation, access to care, and use of preventative services by Hispanics: Findings from HHANES 1982-84. *American Journal of Public Health, 80*(5), 11-19.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications, Inc.

Szasz, T.S. (1970) *The manufacture of madness*. Harper and Row, New York.

Teagle, S. E. (2002). Parental problem recognition and child mental health service use. *Mental Health Service Research*, *4*(4), 257-266.

Vega, W. A. (1990). Hispanic families in the 1980s: a decade of research. *Journal of Marriage and Family,* 52(4):1015-1024.

U.S. Census State and County Facts. (2010). *US Census Bureau.* doi: http://quickfacts.census.gov/qfd/states/35000.html

Waitzkin, H. (2004). *At the front line of medicine: How the health care system alienates doctors and mistreats patients…and what we can do about it.* Oxford, England.

Walker, M. T. (2006). The social construction of mental illness and its implications for the recovery model. *International Journal of Psychosocial Rehabilitation, 10*(1), 71-87.

Wallerstein, N., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice, 7*(3), 312-323.

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *American Journal of Public Health, 100*(S1), S40-S46.

Warner, J. (2009). The sociology of mental health: a brief review of major approaches. *Sociology Compass* 3(4):630-643.

Weisz, J. R., & Weiss, B. (1991). Studying the referability of child clinical problems. *Journal of Consulting and Clinical Psychology*, *59*(2), 266-273.

WHO resource book on mental health, human rights and legislation. (2005). Geneva. Geneva, World Health Organization, 2005.

William, D.R., Costa, M.A., Odunlami, A. O., & Mohammed, S.A. (2008). Moving upstream: How interventions that address the social determinants of health can improve health and reduce disparities. *J Public Health Management Practice, Nov (suppl)*, S8-S17.

Yeh, M., Hough, R. L., McCabe, K., Lau, A., & Garland, A. (2004). Parental beliefs about the causes of child problems: Exploring racial/ethnic patterns. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(5), 605-612.

Yeh, M., McCabe, K., Hough, R. L., Lau, A., Fakhry, F., & Garland, A. (2005). Why bother with beliefs? Examining relationships between race/ethnicity, parental beliefs about causes of child problems, and mental health service use. *Journal of Consulting and Clinical Psychology, 73*(5), 800-807.

Zimmerman, F. J. (2005). Social and economic determinants of help-seeking for child mental health problems; evidence from a national sample. *Health Research and Educational Trust, 40*(5), 1514-1533.

Appendix A: Focus Group Guide

Promoting Knowledge of Childhood Development and Screening:
A Community-Based Participatory Research
Focus Groups Interview Guide

To moderators: please note that this is a semi-structure guide. You do not have to ask the questions in the exact wording and order. You want to make sure that the conversations flow, and that you follow up on each topic the participants want to talk about as it relates to the topic. Do make sure that at the end of the interview, you covered all of the topics.

<u>Introduction:</u>

Thank you for coming today. We are going to talk about your experiences in looking for information about children's behavior and development. (moderators introduce themselves) You are all here because you have young children, or take care of young children. When we raise children, we have many questions. We have questions especially when we feel that there might be a problem, or when a child has some difficulty. We will talk about these times, what information you wanted, what information you found, and how you and people that you know would like to get information about children's developmental and behavioral health.

Because we are talking about your experiences, there are no "right" or "wrong" answers. I also want to ask everyone to keep the content of conversation here confidential. That means that we do not talk about what other people said, and we do not mention their names or personal details about them to other people that did not participate today. We want everyone to feel comfortable to talk and share their experiences.

Also, if anything here makes you feel uncomfortable or if you are concerned about something, please let us know. We are going to record our conversation today and later we will listen to the recording and write the content of the conversation, but without names.

After we do this, we will erase the recording so no one can know who participated and what they said.

Before we begin, do you have any questions or concerns?

<u>Questions</u>

1. When you think about your experiences of being parents, or taking care of children, were there moments when you wanted to know more than you already knew about young children's development and behavior?

    (probe- what made you want to know more? What did you feel that you needed to know? Why?)

2. What type of information do you think parents and caregivers like you need to know about children's development and behavior?

3. What kind of development and behavioral problems do young children in your community have?

4. What can parents and caregivers do when they think a child might have such a problem?

5. Where would be a good place to look for information?

6. Is the Internet a good information source about this topic? If you needed information about children's development and behavioral health, would you try the Internet (why or why not).

7. What can be done when a child has a behavioral or developmental problem?

8. How difficult is it to receive information about children's development and behavior? What are the difficulties you had in looking for information?

9. When someone use the term "children's mental health"-- what do you think they
    mean? How does it make you feel to talk about young children's mental health?

10. Is there anything else you would like to share today about children's development and
    behavior?