EXPLORING SELF-ORIENTATION IN PERSONAL NARRATIVES
OF MENTAL HEALTH AMONG A LATINO CLINICAL SAMPLE

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Exploring Self-orientation in Personal Narratives of Mental Health among a Latino Clinical Sample

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ABSTRACT

Using a postmodern approach and multicultural perspectives, I sought to explore the context and narratives of 49 Latino adults who described their psychological distress. A critical perspective of the dominant theories and literature surrounding multicultural psychologies and cultural formulations of mental health was presented and explored. This mixed-methods study used data from quantitative measures of demographic characteristics and standardized levels of relationality, as well as narratives of present illness experience. The individuals had been interviewed about their personal experiences with mental health and distress, including beliefs about the nature of their current distress, perceived causation, and perceptions of what might be helpful in treatment. The current study utilizes a secondary thematic analysis (Braun & Clarke, 2006) of these narratives. Results demonstrate diverse experiences and complex descriptions of mental health, influenced by a number of individual and contextual factors. Major factors that impact the illness experience include social connection and isolation, illustrating relational themes that are present in the individual experience of mental health. Using a feminist ecological framework (Ballou, Matsumoto, & Wagner, 2002), the sociopolitical, structural, historical, and systemic forces which intersect with individual narratives are also examined. The study critically examines these results in relation to existing literature and theory.

Keywords: Latino, mental health, illness narratives, ecological, cultural formulation, multicultural psychology
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Chapter 1

Introduction

This chapter will serve as an introduction to the background and theoretical framework of the study. It will examine areas for further exploration within the current literature, and discuss the purpose and potential benefits of the research. Finally, it will present the present study and relevant research questions.

Background of the Topic

Evolution of cultural psychologies. Traditionally, psychology has evolved based upon Western and European interpretations of the mind. Biological assumptions evolved into a major component of psychology, encouraging a more scientific rather than philosophical study of the mind. Through this paradigm, the study of the human mind was moved to an objective practice, and the study of intrapsychic phenomenon was viewed as effective only when isolated from the environment (Shweder, 1991). This perspective has not respected the impact of ecological realities on the individual person, and the study of cultural and systemic influences was left mostly to the fields of sociology and anthropology.

More recently, the study of psychology has shifted to include a more complex view of the individual which incorporates intrapsychic and contextual experiences, as well as the interaction between these realms. Culture can be conceptualized as an integral part of this interaction. Cultural psychologies have developed with and been informed by feminist and liberation theorists and have generally recognized that psychological processes are affected by contextual influences. Cultural psychology describes the study of the way in which cultural traditions and social practices regulate, express, and change human psychologies (Shweder, 1991). Cultural psychology differs from general and more traditional psychologies because from this
perspective, a study of the human mind becomes possible only within its environment; mind without content is inconceivable (Shweder, 1991). All individuals exist within multiple contexts beyond the individual level, and feminist ecological models stress the ways in which individuals interact dynamically with these other systems (e.g. social, historical, political, economic, and cultural structures) (Ballou, Matsumoto, & Wagner, 2002). This interaction is an integral part of individual’s health and development, and it also can create suffering and distress.

**Defining and expanding multicultural psychologies.** The definition of multicultural has been debated by researchers and remains a complex term requiring exploration and dialogue (Constantine, Melincoff, Barakett, Torino, & Warren, 2004). Some approaches have focused on characterizing individuals and diverse social groups with simple and homogeneous characteristics (e.g. Greenfield, Keller, Fuligni, & Maynard, 2003). However, these theories and therapies may be shortsighted in capturing this dynamic when they stress descriptions of ethnicity and race as culture while neglecting other more complex systems and cultural variables. This is because ethnic and racial categories are not universally descriptive, and cultural variables are not characteristic of entire groups of people. In other words, there is a high level of cultural variability within those ethnic and racial groups. Multicultural competence has sometimes stressed racial and ethnic heritage over other aspects of cultural identity that have been less studied because they are harder to understand and measure.

An understanding of culture goes beyond ethnic and racial backgrounds to describe the more complex belief systems and value orientations that are learned through groups and forces on groups, and that influence socialization (Fiske, Kitayama, Markus, & Nisbett, 1998). Cultural psychologies must acknowledge the wide range of cultural variables that influence psychological processes beyond specific racial and ethnic categories, including roles of culture and
socialization; and intragroup variables such as language, history, traditions, belief, and values should also be respected by culturally sensitive therapies (Triandis, 1995). The current research will adopt this broad and inclusive understanding of culture, as any important or meaningful way in which a person identifies with an affiliation or group (e.g. Sue, Ivey & Pedersen, 1996).

The key to these theories becomes how culture influences socialization, meaning making, and individual psychologies. As Shweder (1991) describes, “…the study of genuine psychological differences between ethnic groups should be conceived as the study of how different sociocultural environments become different by virtue of the ways they are differently constituted psychologically by different peoples so as to possess different response evocation potentials” (p. 79). Cultural psychology acknowledges the interdependence of culture and person which create each other’s existence and development through dynamic interaction (Shweder, 1991). Along with this interpretation of interdependence and the construction of culture and psychology, people become capable of shaping their own culture as well, adopting some influences and rejecting others (Ratner, 2006).

**Other cultural influences: Cultural values and self-orientation.** While a number of aspects of culture can potentially influence a person’s psychology, cultural values may have an especially significant impact as the standards by which behaviors, thoughts, and feelings are understood by a person as normal or not (Constantine, Myers, Kindaichi, & Moore, 2004). Accordingly, cultural values are highly relevant for psychologists. Cultural values are those aspects of one’s culture that impact how people understand themselves and others.

There are numerous examples of cultural values, such as cultural-orientation. Cultural-orientation includes the terms individualism and collectivism. Individualism is a cultural orientation with a focus on the individual, and collectivism is a worldview whereby groups unite
individuals, and the individual is primarily a part of the social (Oyserman, Coon, & Kemmelmeier, 2002). The philosophical worldviews of collectivism and individualism, which were initially voiced by anthropological and sociological studies, have since been extensively applied to other disciplines. Collectivism has been studied frequently for its utility in aspects of business including consumer habits (Kongsompong, Green, & Patterson, 2009), task completion (Taggar & Haines, 2006), management traits (Pan, Song, Goldschmidt, & French, 2010), business ethics (Husted & Allen, 2008), encouraging corporate social responsibility (Hu & Wang, 2009), and in predicting organizational commitment (Walumbwa & Lawler, 2003; Wang, Bishop, Chen, & Scott, 2002). Cultural orientations have also been studied for their usefulness in understanding academic self-efficacy (Kononovas & Dallas, 2009), conflict management (Komaraju, Dollinger, & Lovell, 2008), membership in trade unions (Thomas, 1999), values in the U.S. military (Ottati, Triandis, & Hui, 1999), and in the construction of professional ethics (Rossiter, Walsh-Bowers, & Prilleltensky, 2002). Even so, much of this existing literature on these variables remains based on studies of cross-national samples examining differences among ethnic groups and countries. Furthermore, this literature is mostly confined to organizational dynamics. To more fully understand these differences and values, researchers have started to recognize these orientations not only across cultures, but as individual and self dimensions (e.g. Singelis, 1994; Triandis, 1994).

Self-orientation, therefore, is related to cultural-orientation but speaks to the individual’s orientation despite the group’s. Self-orientation describes how a person defines and understands themselves and their social relationships as well as their context. Idiocentrism is a self-orientation that stresses personal goals and the individual. Allocentrism is a self-orientation that
emphasizes group goals and social harmony. These self-orientations may or may not parallel the general culture’s orientation.

**Relevance of cultural values for psychology.** Mental health and illness has traditionally been focused on the individual level, and research has been encouraged to expand our understanding of environmental influences of mental health and intervention. An understanding of differences amongst individuals and groups has important implications for psychology as psychologists are called upon to build nurturing relationships with many others. Furthermore, when the counselor uses goals consistent with the experiences and values of the client, and when the selection of helping responses respects the person and their culture, multicultural counseling and therapies become more effective (Sue et al., 1996).

Cultural values are highly relevant for psychologists to consider, and they are important to assess to ensure that mental health services are responsive to individual identity and experience. For example, there are many documented differences in perceptions of mental health and effective treatments that originate in cultural values. Understanding the person’s worldview may allow practitioners to create goals for clients that are in line with their cultural backgrounds and treatments that are most likely to address the person’s distress.

Self-orientation specifically is important to acknowledge because it is a cultural factor which is a reflection of how a person perceives their relationship to the environment and other entities (Sue, 1977). Self-orientation speaks to a person’s individuality and relationality which then impacts the person’s psychology in how they think, act, experience, and feel. Self-orientation also impacts the individual’s relationship to the environment around him or her. Psychology has made some strides in understanding how this awareness facilitates certain
aspects of the therapeutic relationship, and a continued awareness of self-orientation can potentially enhance the process of counseling psychology. Allocentrism and idiocentrism reflect values and beliefs that the person has about the self and the world that may have powerful implications for how that person experiences distress, describes symptoms, and what they understand as their primary problem. During the counseling process, a person’s worldview reflected in their self-orientation may affect that person’s subjective feeling, expression of that feeling, and behavioral outcomes. Culture has a profound effect on the way people make sense of their world, create meaning, and find value in experience. This is why the continued development of the study and practice of multicultural competence is approved as policy of the American Psychological Association, and mental health providers have been called upon to be culturally competent in their profession and practice (APA, 2002).

Statement of the Problem

Approximately seventy percent of the world’s cultures could be described as collective (Triandis, 1989), including many cultures of Africa, Asia, the Middle East and Latin America. Although the now extensive literature in cultural psychology has acknowledged the important role of culture and context, psychological research and theory continue to target distress at an individual level, particularly for adults. Despite an often referred to biopsychosocial model in psychology (e.g. Engel, 1977), the social aspects of distress and intervention are less frequently acknowledged. The structural aspects of human distress are even more seldom acknowledged in mainstream psychological literature. Additional research is needed to expand our understanding of mental health and illness to involve ecological considerations and pay attention to the contexts in which we work.
Multicultural research has suggested that orientation may be an important influence in understanding numerous cultures, racial, and ethnic groups (Sue & Sue, 2003). Although multicultural research has been adept at exploring these intergroup differences, such as differences in orientation between racial and ethnic groups, intragroup differences have been less explored as aspects of individual’s experiences. Ballou et al. (2002) reminds us that working toward human welfare means identifying differences both between and within groups as aspects of a person’s identity and experience. Within the literature on orientation, its role as a socio-cultural value for individuals is missing, and there is virtually no literature examining its role in the counseling process specifically.

Additional research could be useful to explore whether this cultural variable of self-orientation is represented within the range of individual perspectives, even within diverse ethnic and cultural groups. Many scholars have begun to suggest that orientation is not only as a tendency across groups, but also informs a way of perceiving the self that coexists with individuals. The construct could be a useful component of multicultural psychological theory. In addition, there is very little research looking at the possible role of self-orientation in counseling psychology. Scholarly work has suggested a possible role of self-orientation in help-seeking behaviors and counselors’ perspectives (McCarthy, 2005). More investigative research has begun to document its role in promoting treatment effectiveness (LaRoche, D’Angelo, Gualdron & Leavell, 2006) and treatment compliance (LaRoche & Turner, 2002). Scholars have urged additional research on the association between cultural orientation and the entire counseling process, as relatively few studies have examined this relationship (McCarthy, 2005).

Although psychology has made important strides in recognizing cultural considerations as an integral part of psychological theory, when culture is explored in research, it is sometimes
used synonymously with race, ethnicity, or other demographic factors and variables. Of course, some scholars have pointed out that variables of race and ethnicity are so critical that a more inclusive dialogue of culture would risk attention to these areas (e.g. Helms, 1994). This is a crucial point and the field has benefited from developing an awareness of the impact of race and ethnicity on individual psychologies. However, multicultural psychologies are sometimes limited in their acknowledgment of other cultural influences on psychology, and they do not necessarily acknowledge those structural and systemic forces which shape aspects of culture.

**Purpose of the Study**

The purpose of this study is three-fold. First, the purpose of the present study is to explore the experiences and narratives of a group of Latino individuals seeking mental health services for psychological distress. This exploration will use information gathered in narrative form and also from standardized measures. The analysis will be grounded in the feminist ecological model, to acknowledge individual perspectives and the sociopolitical context of which they are a part (Ballou et al., 2002).

Second, this study will explore the role of orientation as an individual level cultural variable. The study of intergroup differences has dominated multicultural psychology, which has sometimes led to a focus on groups as homogenous. As a result, respect for intragroup differences and individual voices and experience has been neglected in research. The study will explore the diversity of self-orientations that are represented in one clinical setting. This exploration will further contribute to an awareness of the diversity of perspectives even within a sample that is considered to be ethnically homogenous, Latinos. Without this awareness and
understanding of the diversity of cultures and worldviews within cultures, psychologists are at risk for sustaining biases and assumptions about persons.

Thirdly, this study will offer a critical discussion of psychological theory and counseling process. The possible role of orientation in informing counseling will be examined, given the use of orientation as a variable in other aspects of the counseling process, such as selecting treatment interventions for mental illness. An exploration of how individuals understand their mental health symptoms, distress, and treatment could support or challenge the usefulness of considering self-orientation in the counseling process. Exploring personal narratives of mental health and illness may reveal themes that illustrate the social aspects of mental distress. It will explore infrequently discussed self and cultural conceptualizations of psychological phenomenon. By using a feminist ecological model for contextualizing these narratives, the study will explore not only the individual, but also those structural forces which impact the individual, and comment on what this means for theory and intervention (Ballou et al., 2002).

The goal of this study is to gain insight into individuals’ self-orientation, and the social and individual themes present in the personal narratives of mental health, within a Latino clinical sample. This will add to the multicultural literature on self-orientation and most notably create an opportunity for individual voices to be heard. The intent of this research is further to provide information that can facilitate improved mental health services for a specific clinical community.

**Theoretical and Philosophical Frameworks of the Current Study**

Psychology in the modern era evolved based upon Western, European, and biological assumptions. Psychology focused on the individual level, neglecting interactions with others and the value of the community (Ballou et al., 2002). However, perspectives from multicultural,
liberation, feminist, and ecological psychologies have challenged the field toward a postmodern awareness of the contextual forces and lived experiences which shape individual psychologies. These perspectives have also been informed by the disciplines of sociology and anthropology which lay a framework for understanding the organization of human social activity.

Multicultural theories provide a major base and influence for the current work. Multicultural psychologies were in part developed as a response to more traditional assumptions that the most significant forces on individuals were tied to the Eurocentric values of personal autonomy, individuality, achievement, and responsibility (Ballou et al., 2002). These assumptions are biases that have not respected the significant influence of culture and socialization on psychology. At best, these biases are not helpful to some individuals, and at worst, they may be directly harmful. The multicultural perspective emphasizes the relationship between the individual with social and cultural influences and traditions, and it reminds us that other non-Western values and worldviews have been lacking in psychological theories and practice (Sue et al., 1996). For example, collectivistic cultures are considered to be non-Western cultures and have been less considered in psychological theories about human development, identity, and illness. The current study will explore some of these non-dominant yet equally valid perspectives. Transformative multiculturalism is often described as the deconstruction of mainstream perspectives towards a critical self-understanding and acknowledgment of diverse and equally valid ways of knowing (Ballou et al., 2002). It is also a practice which de-emphasizes the individual and focuses on social goals with a call for action to address marginalized groups.

The ecological model as first introduced by Bronfenbrenner (1979) stresses the systems of relationships that interact to shape the individual’s environment and thus development.
According to ecological theories, the individual is not isolated but highly embedded as a part of multiple systems and forces. The model uses a framework of various levels of the person including the macrosystem (global influences and ideologies), exosystem (social and governmental institutions and cultures), and microsystem (family, community, and peers), which interact as an open and dynamic system (Bronfenbrenner, 1979).

Feminist theories provide important theoretical underpinnings for this project, through the feminist ecological theory which expands upon ecological principles to acknowledge the multiple influences in people’s lives including sociopolitical dimensions, time, history, and the dialectical nature of these (Ballou et al., 2002). Feminist theories emphasize social power and the complex ways in which institutions and societies maintain power. Social power has an inextricable role in how people understand themselves, their worlds, and their sense of agency. Particularly relevant to this project is the emphasis feminist theories put on relationships and connection, and the ways in which structural forces impact our realities and psychologies. Feminist theories in many ways counter other theories of psychotherapy which adopt an individualized approach (Miller, 1986). The feminist ecological model also embraces critical theories to move past a description of recontextualizing individuals, toward implications for challenging assumptions and reconstructing theory and practice (Ballou et al., 2002).

**Research Questions**

The research study addresses the following questions. Research questions are also accompanied by additional categories for consideration, for guiding analyses and discussion.

1) How does a Latino clinical group of adults compare in idiocentrism and allocentrism, as measured by the Individualism-Collectivism Scale (Singelis, Triandis, Bhawuk, &
Gelfand, 1996) and the Sociocentrism/Egocentrism Questionnaire (Shweder & Bourne, 1982)?

2) What do these individuals describe as their primary mental health problem?
   a. How are people expressing distress?
   b. What is the range of symptom manifestation?
   c. Is the problem individual, socio-cultural, or both?

3) How do these clients understand what has caused their mental health problem?
   a. What are the perceived influences on mental health?
   b. Are beliefs of causation individual, socio-cultural, or both?

4) What do these individuals tell us about what has helped to fix the problem and what would be helpful in their treatment?
   a. How has health been sustained?
   b. What does coping look like?
   c. What resources are needed for healing?

5) What is the relationship between the themes accessed through the INDCOL, SEQ, and personal narratives? What is the relationship between these themes and the context in which they are assessed? What does this say about the group, the individuals, and a possible role for exploring self-orientation, relational values, and contextual forces in counseling psychology?

**Purpose and Potential Benefits of this Research**

This research will explore the role of a significant variable in the multicultural literature, orientation, within a clinical sample. It will contribute to the work on cultural-orientation to also
examine self-orientation. The study will explore whether orientation is reflected in individual narratives. It will examine individual narratives to better understand the ways individuals experience psychological distress. With this awareness and respect we are closer to conceptualization by describing and seeing the ways in which people understand and make meaning of their world, rather than through pathologizing those worldviews (Ballou et al., 2002). By understanding how someone perceives their world and what they value, we can get a better understanding of what well-being means for that person.

In addition, measurement of cultural dimensions at the individual level allows researchers to avoid the tendency to stereotype whole cultures (e.g. Ballou et al., 2002) while accounting for the very real existence of idiocentric persons from collectivistic cultures and allocentric persons from individualistic cultures. In assessing and understanding the worldview of the client, psychologists can begin to match the vision of a culturally competent provider as one who hears and respects the values and beliefs the person has about themselves and their world. It is only by asking and truly listening that we can understand our clients’ orientations thus overcoming our own biases and stereotypes to truly understand the culture of the client.

The research presents the issues that play a major role in the lives of the people actually seeking mental health care. Results may inform the contextual aspects of clinical conceptualizations, and understanding subjective perceptions of distress. This will further add to the literature how mental health care can be better tailored to the personal needs, voices, and contexts of not only those considered diverse clients, but all of us as cultural beings. In this way, mental health assessment and treatment can be more closely oriented to personal and social goals, and intervention can target all those systems which hold the individual. The person’s
context and orientation to self is understood and respected before defining major clinical issues or pathology.

Finally, the current research will also create some space for individual stories and narratives of psychological suffering to be heard. This research may widen an understanding of the variety of experiences of distress that exist for persons, challenging traditional assumptions of intrapersonal forces, and acknowledging the role of interpersonal, sociocultural, and political processes as they influence mental health. This is in line with recommendations that psychologists’ definitions of illness and wellness should be viewed from a cultural perspective rather than universal norms (Chin, De la Cancela, & Jenkins, 1993).
Chapter 2

Literature Review

This chapter will review the literature that is relevant to the proposed study. It will examine the impact of socio-cultural factors on psychological perspectives of mental health and illness, and it will provide a basic introduction to suggested cultural considerations for counseling with Latinos. Existing research on the self-orientations of idiocentrism and allocentrism will be examined. This chapter will highlight how personal narratives of mental health may be shaped by personal and socio-cultural values to influence the assessment process, helping to establish a culturally sensitive formulation and treatment approach.

Intersection of Culture and Mental Health: Cultural Psychology

Although traditionally psychology has ignored contextual and cultural factors in favor of individual perspectives, psychologists are increasingly called upon to serve diverse social groups, and counseling requires connecting with clients from a wide variety of backgrounds. Therefore, culture and cultural values have become more reflected in the literature acknowledging its profound effect on the way people make sense of their world, create meaning, and find value in experience. Culture, although a broad term, can be understood using an anthropological lens as people who have common and shared values; customs, habits and rituals; systems of labeling, explaining, and evaluating; social rules of behavior; perceptions about human nature, natural phenomena, interpersonal relationships, time, and activity; symbols, art, and artifacts; and history (Sodowsky, Lai, & Plake, 1991). Given the ecological and cultural theories that guide the current research proposal, an exploration of the intersection of culture with individual health and wellness becomes important.
A number of perspectives and theories have contributed to the scholarly work on the essence of human health and suffering. The current research will focus on mental health and distress, specifically, which may be particularly difficult to define. For example, Shweder et al. (1997) understands human suffering as “to experience a disvalued and unwanted state of mind, body, or spirit.” The terms ‘disvalued’ and ‘unwanted’ imply that human suffering is subjective and not easy to conceptualize or assess. From this perspective a wide range of experiences of health and suffering become apparent, as values change across cultures and persons.

Cultural psychologies specifically adapt a viewpoint that psychology is developed in how people socially organize their lives (Ratner, 2006), and therefore emphasize a social component of health and illness apart from other intrapsychic forces. In other words, “in the language of cultural psychology there are no psychological laws…cultural psychology signals an end to the purely psychological in psychology” (Shweder, 1990, p. 1, 24). A contextual and ecological perspective on health, as summarized by Grzywacz and Fuqua (2000) acknowledges the different dimensions of well-being and an interactional view of individual health as an outcome of a person-environment interaction. A feminist ecological model describes the dynamic systems which the individual is part of and influenced by, the ways social institutions perpetuate power differentials, and it uses critical thought to challenge the status quo (Ballou et al., 2002).

Even within a shared environment, individuals may differ in their values and realities and this difference can be a powerful force in defining mental health. This can result in part from the individual factors which traditional psychological perspectives have been very good at recognizing such as biology, temperament, personality, and cognitive style. This range in vantage points can also be shaped by the wide range of forces on an individual including gender, history, economic resources, political pressures, social and personal experiences which impact
individuals differently. Realities of suffering also include products of human representation and narratives across multiple contexts and meanings (Stigler, Shweder, & Herdt, 1990). Arthur Kleinman is an American psychiatrist who has focused his work on medical anthropology, cross-cultural psychiatry, and the expression of mental distress. He expressively describes one perspective on mental illness as (1988):

For the anthropologist, the forms and functions of mental illness are not ‘givens’ in the natural world. They emerge from a dialectic connecting- and changing- social structure and personal experience. That dialectic is a golden thread running through ethnographies of life in different cultural systems…Mental illnesses are real; but like other forms of the real world, they are the outcome of the creation of experience by physical stuff interacting with symbolic meanings. (p. 3)

These symbolic meanings are shaped by cultural forces but they may also be shaped at the individual level. On this individual level, a person may explain his or her suffering from a number of different realities and vantage points within his or her culture.

It is obvious that a number of factors interact to create the existence of multiple individual realities of mental health and suffering. Illness can be understood as a construct which exists at the intersection of personal, interpersonal, and cultural reactions to discomfort (Kleinman, Eisenberg and Good, 1978). It is shaped by these aspects that impact the person’s perception and understanding of their problem or distress (Kleinman et al., 1978). Therefore, Kleinman asserts that our explanations of distress may be related as much to our values and our social experiences as they are to clinical indicators and symptoms. In other words, there is a cultural and social function of specific psychological phenomenon. Studying the intersection
between contextual and individual perspectives allows the clinician a more comprehensive understanding of the person’s experience, and many scholars argue that awareness of these perspectives is essential to understand and diagnose illness (e.g. Mezzich & Caracci, 2008).

Assessing Cultural Values, Socialization, and Context in Psychology and Implications for Counseling

With this variation across the perspectives and influences of mental distress, a number of problems arise with the assessment of psychiatric illness. Psychological assessment is often extremely difficult because symptoms incorporate feelings, beliefs, and behaviors that are interpretable only within context. It is therefore difficult to specify clear boundaries for any diagnosis of mental illness (Mezzich & Caracci, 2008). Furthermore, the idea of categories that are universally applicable becomes even more problematic due to cultural differences in ideas about the self, reality, social rules, and emotional expression (Mezzich & Caracci, 2008). In this way, ideas about what is normative versus not become difficult to delineate, and psychological assessment, evaluation, and diagnosis becomes prone to misinterpretation. In addition, categorization of these symptoms interacts not only with the context of the culture in which the problems emerged but also the context in which it is currently being evaluated (Mezzich & Caracci, 2008). This is because the practitioner has also been socialized toward a certain collective experience of illness, and the practitioner has been trained to see through certain theoretical lenses of their practice (Kleinman, 1988).

Despite this dilemma, assessment and clinical formulations remain an important piece of mental health care. When an individual seeks psychological evaluation and treatment within a mental health system of care, that individual recognizes psychology as a potentially healing
force. The ultimate goal for the clinician becomes to join the person in identifying the nature of their distress and subsequently how to relieve it (Fabrega, 1987). Clinicians rely on having a way to elicit and make sense of clinically relevant information. Clinical case formulations are an important part of the counseling process because they encourage this understanding of the individual client and their reported clinical problems.

Assessment must also have a way to avoid the misinterpretation of psychological phenomenon; because clinicians’ encounters with their clients are in effect relationships across subcultures, the assessment process is vulnerable to overvaluing or undervaluing certain influences (Good & Good, 1986). It becomes imperative that an understanding of any mental health problem must consider the impact of cultural variables and values, the person’s experience of distress, and the provider’s framework for distress. For this reason, the APA has asserted that ethical conduct and cultural competence is enhanced when psychologists understand the differences in beliefs emerging from socialization in our clients and ourselves (APA Code of Ethics, 2002).

Research has clearly urged for this consideration of culture before case conceptualization and possible assessment of pathology (e.g. Lewis-Fernandez and Kleinman, 1994), although specific ways of doing this have been infrequently proposed. Some suggestions include minimizing biases during a mental status exam, phrasing questions in a culturally sensitive way (e.g. not asking collectivistic persons to compare themselves to others), comparing behavior to what is expected in a cultural reference group, and assessing for cultural identity (Paniagua, 2001). Cultural formulations may be one additional way to encourage culturally sensitive assessment and care. These formulations are an important part of clinical work because through
this assessment of the client’s unique experience culturally valid treatments can be implemented (LaRoche, 2002).

Evaluating clients from various backgrounds requires a thorough assessment of not only the individual and his or her symptoms, but also the cultural factors which are impacting the person’s presentation and behavior (Lewis-Fernandez & Diaz, 2002). Some have advocated supplementing a behavioral observation of symptoms with an idiographic formulation of psychopathology that encourages understanding the patient as a whole rather than assuming generality between human subjects (Caracci, 2000). From this perspective, conceptualization of any mental health problem must consider the impact of cultural variables and values, and also the person’s unique experience of distress. This belief is the backbone of the cultural formulation, which offers one way to assess and diagnose across cultures and create treatment plans that are in line with the client’s values (Lewis-Fernandez & Diaz, 2002).

To encourage culturally valid assessment and formulation, clinicians should have a method that encourages the examination of culture during a clinical evaluation (Lewis-Fernandez & Diaz, 2002). There have been a number of proposed ways to obtain a cultural formulation (e.g. Lewis-Fernandez & Diaz, 2002; Alarcon, 1995). Some common elements of a cultural formulation include establishing the cultural identity of the individual, the cultural explanation of the individual’s illness, and awareness of the psychosocial environment (Caracci, 2000). In a cultural formulation, a more thorough understanding of the sufferer should emphasizes the patient’s subjective experience, the patient’s unique form of suffering, and the expression of psychopathology in their interpersonal world (Caracci, 2000). In this approach the patient is seen as unique and encouraged to verbalize his or her own perspective and self-conceptualization of mental anguish and primary problems (Caracci, 2000). The Cultural Formulation model expands
upon a biopsychosocial approach by recognizing the effect of culture on symptomatology, explanatory models of disease, help-seeking, and expectations. It is recommended for use during assessment of every clinical encounter according to the DSM-IV (APA, 2000).

The person’s conceptualization of their problem guides the clinical presentation and impacts the symptoms that are experienced as problems and discussed with the provider. This is because our experiences of distress are related as much to our values and our social experiences as they are to any clinical indicators and symptoms (Kleinman, 1988). The person’s self-conceptualization ultimately impacts any cultural formulation and the practitioner’s response to that problem. The person’s perception also clarifies his or her hopes for treatment and should inform the eventual treatments that are utilized. This is because when counselors encourage clients to share their beliefs about the etiology of the distress, explanations for illness, and beliefs about what may help this serves to maximize treatment effectiveness (Constantine et al., 2004; Paniagua, 2001). This all suggests that the person’s own conceptualization of their problem is as integral a part of assessment as other clinical symptom indicators.

This chapter has reviewed research that describes ways culture influences individual perspectives on mental health, and ways that the person him or herself constructs the illness experience. As referred to in Chapter 1, the current study adopts a broad and inclusive understanding of culture, as any important or meaningful way which an individual identifies with an affiliation, ideology, or group (e.g. Sue et al., 1996). The context of the individual’s experience overlaps yet is different than this understanding. Context includes those proximal and distal systems which structure the realities and environment we have access to, and an individual does not necessarily identify with or see the context. The feminist ecological model is one approach which brings a contextual lens to individual assessment (Ballou et al., 2002). This
model is commended for extending the cultural and individual frameworks of health and illness which are being reviewed here yet are not sufficient in conceptualizing a problem.

**Self-Orientation: Idiocentrism and Allocentrism**

Although research has demonstrated the importance of acknowledging racial, ethnic, and cultural backgrounds in understanding illness and distress, this study will use a more specific cultural factor of self-orientation. Self-orientation describes the existential dilemma faced by societies and persons of the relationship of the individual to the group, to society, and to collectivity (Shweder, 1991). Self-orientation is the pattern of thoughts, feelings, and actions that describe the self as distinct from others and in relation to others (Singelis, 1994). Self-orientation is one such cultural value that may impact individual conceptualizations of distress. Self-orientation contributes to how people understand themselves and others. It shapes concepts of identity, meaning, value, and belief that affect the person’s mental health. Self-orientation is an interactive variable as it speaks to the intersection of personal values and cultural values and also one’s perception of self and relationships.

Self-orientation describes the way people understand themselves and the relational dimensions of the world (Triandis, 1995). The literature of self-orientation mostly focuses on two variables: the idiocentric and the allocentric self (Triandis, 1994). These are the terms which will be used in the current research study. Across the literature the idiocentric self is also described as the egocentric self (Shweder & Bourne, 1982) and the independent self (Markus & Kitayama, 1991). The allocentric self (Triandis, 1989) is also described as the interdependent self (Markus & Kitayama, 1991) and the sociocentric self (Shweder & Bourne, 1982) in other studies.
Allocentrism reflects a self-orientation that is contingent on one’s relation to the social environment. From this perspective, individuals are seen as contextualized and primarily a part of the group. Allocentric traits tend to prioritize group goals and emphasize social support and the creation and maintenance of social harmony (Triandis, 1989). Allocentrism also encourages responsibility, honesty, politeness, respect and loyalty (Harwood, 1992). In describing the self, allocentric persons may offer descriptions that are specific to situation, such as “I am kind to children” (Shweder & Bourne, 1982). Idiocentrism reflects a self-orientation that is in isolation from others. Idiocentric traits tend to emphasize personal goals and de-contextualize the individual. This often translates to maximizing the self and developing independence, creativity, curiosity, assertiveness, and self-esteem (Greenfield et al., 2003). The idiocentric self is seen as unique and is typically engaged in the individual process of discovery and expression (Markus & Kitayama, 1991). The idiocentric self also desires to master the environment (Triandis, 1994). In describing the self, idiocentric persons may offer more de-contextualized self-descriptions and traits, such as “I am honest” and “intelligent” (Shweder & Bourne, 1982). According to Triandis (1994) allocentrism and idiocentrism do not exist in opposition to each other; they are orthogonal self-orientations meaning a person’s level in one does not affect their level in another orientation.

For example, it is possible for a person to score as high in idiocentrism and allocentrism at the same time. These orientations also tend to be consistent traits (Oyserman, Coon, & Kemmelmeier, 2002).

Whereas individuals are acknowledged to have two dimensions of the self in idiocentrism and allocentrism (Triandis, 1994), cultures are described in the literature as either individualist or collectivist. These corresponding terms of collectivism and individualism describe societies and cultures, rather than the person at the individual level. Individualism is a cultural orientation with
a focus on the individual. European Americans (Harwood et al. 1996) and Western industrialized cultures such as Germans (Keller, Voelker, & Yovsi, 2002) and Dutch (Harkness et al. 2000) often emphasize the independence of idiocentrism. Higher SES and formal education is also associated with a more idiocentric orientation (Keller et al., 2002). Research has also suggested that men within the United States and Western countries are more likely to display idiocentric orientations than women in these countries (Oyserman & Markus, 1989).

Collectivism is a cultural orientation with a focus on the social environment. Non-Western cultures such as Chinese (Chao, 1994), Japanese (Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000), Indians (Keller et al. 2002; Saraswathi, 1999), Nigerians (Ogunnnaike & Houser, 2002) and Puerto Ricans (Harwood et al. 1996) typically represent the interdependence of allocentrism. Allocentrism is also characteristic of ethnic and racial minorities in the United States (Oyserman et al., 2002). For example, Asian Americans and Latinos living in the United States often report higher levels of collectivism than Whites who more frequently report higher levels of individualism (Oyserman et al., 2002; Triandis, 1994).

Despite general tendencies for groups to be of particular orientation, it is important to remember that there are, for example, many Latinos who are predominantly idiocentric even though as a group they tend to be collectivistic. In addition, a culture can be described as primarily individualistic (e.g. White Americans), but individuals within that culture may differ in their levels of allocentrism and idiocentrism. In other words, one’s individual orientation does not necessarily coincide with their culture’s orientation, as cultural match theory sometimes assumes. This is another reason why measuring specific cultural variables may give a more inclusive description of the person’s culture than ethnic and racial categories alone. For the
current proposal, the terms of idiocentrism and allocentrism will refer to individuals rather than groups.

Researchers in multicultural literature have begun to document the existence of these constructs and comment on their usefulness in psychology. In their research, Greenfield, Keller, Fuligni, & Maynard (2003) demonstrated that these orientations, which guide social relations, also guide concepts of parenting in many cultures. Therefore, they suggest that these orientations can be understood as socialized developmental dimensions (Greenfield et al., 2003). From this perspective, idiocentrism encourages individuation as a developmental goal while allocentrism prioritizes conforming to social norms as a developmental goal (Kitayama, 2002; Nsamenang & Lamb 1994, Weisner, 2000). In addition, positive psychologists have emphasized that both individualistic and collectivistic perspectives have advantages for people, and aspects of each can be embraced by individuals within different environments and for different purposes (Snyder & Lopez, 2007).

Other research has more directly explored implications of self-orientation in the counseling process. This research and cultural match theories assert that treatments are most effective when they match the culture and values of that person and treatments may also be more effective when they match self-orientation, as one cultural variable (e.g. LaRoche et al., 2006). For example, allocentric values can be used to develop treatment groups as a modality for therapy (Constantine et al., 2004). Allocentric values have also been used to create a Culturally Competent Relaxation Intervention (CCRI) for anxiety symptoms. Using imagery to promote relaxation for persons with anxiety is an established intervention, but when the actual content of the imagery was allocentric rather than idiocentric, allocentric Latinos demonstrated more treatment compliance and frequency in use, and this led to a reduction in anxiety symptoms
(LaRoche et al., 2006). Although cultural values such as idiocentrism and allocentrism are established constructs within the multicultural literature, additional research is needed in this area to target the role that these values play in other aspects of counseling and mental health.

There has been some criticism of these terms and their use in cultural psychologies which should be acknowledged. A weakness of cross-cultural psychology is its construal of cultural and psychological variables to be separate, simple, and homogeneous traits (Greenfield et al., 2003). The cultural variables of collectivism and individualism have been similarly targeted as abstract and irrelevant features which overlook differences in practice between cultures and do not substantially influence psychological phenomena within individuals (Ratner, 2006). These terms have also been criticized for neglecting within-culture variability amongst collectivistic and individualistic cultures (Harkness et al., 2000). Scholars have warned that the use of these variables can lead psychologists toward overgeneralizations about members of certain groups as homogeneous, for example, concluding that East Asians are a homogeneous group because East Asia is regarded as a cultural variable (Ratner, 2006). In this light of universality, variation can become irrelevant (Ratner, 2006). Another common criticism is that the dichotomous assumption of these variables is too simplistic and reductionistic (Killen & Wainryb, 2000).

The current study acknowledges these points. Collectivism and individualism as cultural variables do not necessarily reflect the individual’s level of allocentrism or idiocentrism. Individual values or experiences can override an environment or culture that is heavily influenced by a different value, and individuals are influenced by multiple other factors beyond their nation of origin. Within-culture variability must be acknowledged and accounted for to avoid viewing groups as homogeneous or stereotyping individuals. The current research argues that these variables are not treated as dichotomous in this study. Although two variables of
interest are being examined, idiocentrism and allocentrism, they will be approached as neither jointly exhaustive nor mutually exclusive. An individual can have low levels of both traits, for example, and these traits can and do overlap in persons. Conceptually, these variables are respected to exist in different degrees in different individuals from different and similar cultures. This study also acknowledges that these traits interact with multiple other individual level variables such as SES, gender, and education (e.g. Hofstede, 2001), and multiple variables external to the individual.

**Cultural Factors and Orientation in the Assessment and Counseling of Latinos**

Assessment of mental health problems and approaches to counseling must consider the impact of cultural variables and values on the experience of distress. Evaluating clients from various backgrounds requires a thorough assessment of not only the individual and his or her worldview and symptoms, but also the cultural factors which interact with the person’s presentation and behavior (Lewis-Fernandez & Diaz, 2002).

The Latino population in the United States is growing rapidly, most recently consisting of 16.3% of the entire U.S. population with expectations to increase (U.S. Bureau of the Census, 2010). This population of over 50 million persons does not even account for undocumented Latinos who have migrated to the United States, and this rapid growing rate is significantly shifting the demographics of the United States (Alegria et al., 2007).

In the assessment, diagnosis, and formulation of Latino clients, cultural variables are useful to consider because they interact directly with the counseling process. *Familismo* is a central aspect of collectivism and it describes a strong family loyalty, included extended family, and the tendency to turn to family members in times of difficulty (Sue & Sue, 2003). A
customary pattern of behavior for many collectivistic Latinos is often to handle one’s difficulties from within the family and discreetly (Casas & Vasquez, 1996), although in instances where formal care is sought the family is considered and included (Paniagua, 1994). Values of familismo and family loyalty intersect gender roles in many Latino groups. Many Latina women are socialized as self-giving, encouraged to bear children, and to take strong pride in their role of mother (Guarnaccia, 1996). The role of mother may also serve as a cornerstone to the woman’s social order, and her self-image may be tied to her ability to support her family, perform key social duties, and prevent conflicts (Guarnaccia, 1996).

Personalismo includes an emphasis on developing a personal connection and relationship with a person, including for example a relationship with one’s clinician. Not meeting expectations of personalismo can may impact the therapeutic relationship and prevent the clinician from accessing enough information for diagnosis (e.g. Paniagua, 1998). Relatedly, simpatia is the tendency to aim for harmony in personal relationships (Arredondo & Perez, 2003). In the counseling setting, this value may impact how distress is expressed, to simultaneously maintain harmonious social order. In addition, cultural values contribute to the underreporting of distress as a way of showing respect and not bringing shame to the family while maintaining the social order. These cultural values interact and have the potential to influence symptom presentation in Latino clients.

Indeed, Latinos are largest group of color in the United States, and they are exposed to many stressful experiences included elevated rates of poverty, maltreatment, trauma, acculturation difficulties, and possibly interpersonal stress as a result of discrimination or clashing cultural values. Despite possibly high levels of stress, many Latinos are socialized to restrain emotional response for the benefit of the collective and family pride. For example,
research has suggested that in collectivist cultures where interpersonal harmony, group cohesion, and emotional restraint are of high value, internalizing problems may be more prevalent, while in individualistic cultures where individual expression is valued, externalizing symptoms may be more visible (Ollendick et al., 1996). In addition, the symptom of somatization, or a tendency to express psychiatric distress in physical terms, is also common in collectivistic cultures. Latin American culture favors a mind-body connection and may use of somatic complaints as a way to communicate stress. This tendency toward somatic symptoms and internalizing problems may partially explain the relationship between Latinos and anxiety disorders (e.g. Breslau et al., 2006). The same values that promote interpersonal and social harmony within the Latino culture may also reinforce a perspective that psychological and emotional difficulties are shameful to the person and family and should therefore not be endorsed (Salman, Diamond, Jusino, Sanchez-LaCay, & Liebowitz, 1997).

One specific example of a culturally sanctioned problem, ataque de nervios, is a culturally acceptable way to communicate distress among Latinos from the Caribbean, but it is also recognized among many other Latino groups (Guarnaccia, Rivera, Franco & Neighbors, 1996). Symptoms of ataque or nervios include feeling a loss of control, a tightening or pressure of the chest, feeling heat in one’s body, shaking, crying, screaming, and perceptions of fainting (Guarnaccia et al., 1996). Often, these ataques follow a threat to the order of the social world, which then leads the person to perceive a loss of control; triggers often reflect a disruption in crucial Latino values and social relationships (Guarnaccia et al., 1996). An ataque is often a response to something perceived as a collective threat, a high priority concern for many Latino cultures. It is a culturally accepted and expected way to react to unnerving disruptions in the
social order in a way that respects *dignidad*, or self-respect. A fear of associated negative social consequences may also intensify the *ataque de nervios*.

Finally, in consideration of Latinos and mental health, one must recognize the profound impact of racial and ethnic discrimination on people’s lives and wellbeing. Latinos in the U.S. face many ecological challenges related to living as ethnic minorities and sometimes as immigrants or children of immigrants. Many Latinos have a history as a subjugated and colonized people; this mentality impacts the psychology of persons by effecting the perception of oneself, others, and the world as a just place (Comas-Diaz, 2007). Often, this mentality and experiences with racism and discrimination lead to changes in the sense of trust, power, and safety, and can create shame, rage, fear, and depression which are visible in the symptom presentation and counseling process (Comas-Diaz, 2007).

This is a brief review of how cultural factors and a collectivistic orientation impact the assessment and counseling of Latino individuals. Nonetheless, Latinos vary significantly in their values and beliefs, and so this understanding of cultural background serves only as a starting point before exploring individual factors. Conceptualization of any mental health problem must consider the impact of cultural variables and values, but also the person’s unique experience of distress. Further exploring these individual narratives from an ecological approach is the focus of the proposed research. It is important to simultaneously understand the client’s worldview regarding mental health and distress, likely within the context of community and cultural norms.

**Using Kleinman’s Questions to Guide Cultural Formulation**

Arthur Kleinman is an American psychiatrist who has focused his work on medical anthropology, cross-cultural psychiatry, and the expression of mental distress. Although his
focus is mostly on the theoretical nature of illness narratives, he offers usable suggestions to increase the practitioner’s understanding of the illness experience for the patient. Kleinman developed a series of eight questions to conceptualize illness and its meaning from the patient’s point of view (Kleinman, Eisenberg and Good, 1978). They are important to review because they were used to gather and structure the information which is later analyzed in this project.

Through these questions the patient can communicate his or her understanding of the problem’s name, cause, trigger, effects, severity, and treatment. An analysis of the client’s response to Kleinman’s questions can answer the question, “What is the person’s conceptualization of their clinical problem?” These questions are one current method created to guide health care professionals in appreciating how the person understands his or her problems.

In this way, Kleinman’s questions may offer a particularly effective way to examine a person’s narrative to facilitate a culturally sensitive approach.

In this proposed study, participants’ responses to Kleinman’s questions (Kleinman et al., 1978) will be analyzed to understand how a primary mental health problem is experienced by that person. The participants have shared their responses to a condensed version of the questions which involved only four questions, but nonetheless addressed each of Kleinman’s initial concerns. The answers to these questions reflect an important aspect of clinical work because they assist an assessment that is respectful not only of clinical symptoms but the person’s lived experience.

The first of these four questions asks, “What is the problem?” Clinically, this reflects the person’s description of their primary problem. A client’s description of the problem also parallels their symptom presentation. Symptoms are typically a subjective yet distressing experience of
the person and they are often the reason for seeking help. Distress can be explained across multiple ecological levels. It can be individual, such as subjective feelings of tension. Distress can also be familial, communal, social, and relational.

Researchers have suggested a wide range of symptom manifestations in different ethnic groups. People from various backgrounds hold different cultural beliefs and concepts about mental health and illness. There are conceptual differences of mental illness between groups, such as Western dualism versus the mind and body connection, that may impact symptom differences. For example, for Caucasian Americans depressive symptoms tend to manifest as psychological and internal mood states such as sadness, whereas Asians tend to experience these symptoms in somatic terms such as fatigue and sleep problems (e.g. Castillo, 1997). Latino cultures also tend to value a mind body connection and may use somatic complaints to communicate distress (e.g. Bates, Rankin-Hill, & Sanchez-Avendez, 1997).

Research has suggested that in collectivist cultures where interpersonal harmony, group cohesion, and emotional restraint are of high value, internalizing problems may be more prevalent, as externalizing could disrupt the social community (Ollendick et al., 1996). For example, within many Latino groups, a fear of negative social consequences associated with expressing distress may actually drive anxiety symptoms and the high prevalence of syndromes such as ataque de nervios (Guarnaccia et al., 1996). Latinos tend to understand this anxiety as related to a fear of hurting someone or themselves, which could further disrupt the valued social order (Guarnaccia et al., 1996). Interpersonal difficulties also have much more significance in depression amongst Japanese persons who generally placed a high value on interpersonal harmony (Iwata & Roberts, 1996). In individualistic cultures where individual expression is valued, externalizing symptoms may be more visible (Ollendick et al., 1996). Cultural scripts
may embrace certain symptoms as a more appropriate way to express distress while maintaining values of expressing the self or harmonious social order.

The complexity of one’s perception of “what is wrong” cannot be overstated. Although racial and ethnic background may influence understanding by way of cultural values, a number of other cultural factors such as gender, generation, and class significantly impact these conceptualizations. This intersection is an important concept in understanding mental health. For example, many Latina women are socialized as self-giving, encouraged to bear children, and to take strong pride in their role of mother as a cornerstone to the social order (Guarnaccia, 1996). Within this culture, a woman’s perception of health may be based on her ability to support her family and prevent conflicts as key social duties (Guarnaccia et al., 1996). La Roche (2002) describes a specific case of his work with a Dominican woman who came to therapy with a problem that she was no longer useful to her family. When asking a client to define their problem, the person’s report will reflect individual factors and experience as well as contextual factors which influence the interpretation of these experiences. In this case, the woman’s primary problem reflected familistic and allocentric characteristics that are typical of her ethnic background and cultural values.

The intersection of these cultural factors and the unique presentation of every individual is an important concept in understanding symptom presentation and response to treatment. Sometimes, the individual narrative will reflect similar values that parallel culture, ethnicity, spirituality, and gender scripts. Nonetheless, obtaining the individual’s narrative is helpful to avoid stereotypes and essential to truly understand the person’s lived experience. For example, although interpersonal difficulties are a larger experience of depression for Japanese, these
results were limited, as the youngest generation of Japanese persons exhibited depressive symptoms more similar to Caucasian Americans (Iwata & Roberts, 1996).

Secondly, Kleinman suggests asking, “What has caused the problem?” to assess the person’s perceived causation. There are many experiences that have potential influence on mental health, but the significance and visibility of these factors may vary across persons. People and cultures have different ideas about what impacts the well-being of a person’s mind. For example, supernatural powers are perceived causes for many Dominicans (Sanchez, 2002). Western studies have suggested poverty, stress, and physical illness as major perceived influences on mental health (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). A universal sociopolitical causal ontology is suggested by Kleinman as an explanation for depressive and neurasthenic suffering (1986). The most common causal attribution for suffering noted by South Asians and Indians in one research study was compromised morality (Shweder, 1991). Shweder (1991) has suggested a number of other possible causal ontologies for suffering inspired by his work in Orissa, India, and these include attributions of current distress that are moral in nature (e.g. sin, sacrifice, karma), interpersonal (e.g. sorcery, envy, evil will), biomedical (e.g. foods, fluids, hormones), and psychological (e.g. desires, frustrations).

Individual attributions of causation may reflect larger cultural values. As suggested above, various ethnic and cultural groups may tend to attribute mental suffering to certain culturally acceptable types of stressors or imbalances. Individual attributions of causation may also reflect more individualized cultural values such as the person’s perceived relationship with their social environment, or their self-orientation. For example, a person who tends to be more allocentric and relational may be more likely to report distress that is caused by disruptions in the
interpersonal environment, even if that person identifies with a culture that tends to be more individualistic.

Clinically, hearing the client’s perception of etiology is important because it directly assesses the client’s view on how the problem works. Clients do not often continue with treatments that counter their causal understandings (e.g. Lewis-Fernandez & Diaz, 2002). For example, if a person describes anxiety that has been caused by familial stressors, then treatment should involve a focus on improving familial relationships. Understanding both the individual’s and the socialized cultural explanations may foster the development of a more ecologically valid conceptualization and interventions.

Thirdly, Kleinman’s questions assess the person’s understanding of coping by asking, “What has helped to fix the problem and what would fix it?” Coping involves a person’s response to stress with a goal of fixing, mastering, tolerating, or lessening the conflict to reestablish health. Research has suggested that the coping process is complex and affected by dynamics between relational and cultural factors (Wang & Heppner, 2011). It can also be affected by a number of other forces including the person’s gender and also spirituality. As one example, for some persons who are religious they may handle stress by avoiding it or rationalizing the stress as self-punitive (e.g. “It was my punishment for not recognizing God in my life.”) The current research examines coping as an individual process and as facilitated by others, which may be a reflection of the person’s self-orientation and cultural values. This may also inform preferred healing practices. Self-orientation and personal values may also play a role in coping mechanisms and what resources the person perceives needing for healing. For example, a person who is more idiocentric than allocentric may prefer to cope in isolation from others, or may perceive needing more individualized resources such as strength, intellect, or
mental clarity. For a person who is more allocentric, the person’s typical response to stress may be more affiliative in nature. This person may perceive needing more social resources to manage the problem and maintain health, such as connections to the community or family support.

Clinically, understanding coping experiences is important to the counseling process because what the person has found soothing in the past may reflect what is likely to be soothing in the future. An understanding of coping experiences can also clarify how what interventions are likely to be helpful for the person and what resources may be needed to facilitate healing. This information may also bring awareness to what interventions may actually counter the person’s values, orientation, and culture.

Finally, Kleinman’s questions explore the person’s perception of helpful treatments by asking, “What kind of treatment should you receive and what is helping you or not about your treatment?” This is clinically relevant because it affects the person’s decision whether and when to use formal care (as opposed to being self-reliant or seeking local social help), and it also affects the type of treatment that is likely to be seen as effective and adequate (e.g. Lewis-Fernandez & Diaz, 2002). The responses may suggest what types of mental health treatment are likely to be accepted or rejected by the client, and what treatment outcomes may be. This could include any possible combination of social supports, family therapy, individual therapy, group therapy, home remedies, spiritual intervention, indigenous healing practices, and psychiatry referrals. Responses to this question may also inform the clinician about how his or her role is perceived by the client in the therapy process (as teacher, expert, guide, advocate, etc.).

A patient’s cultural identity may explain help-seeking and treatment. Cultural match theories have asserted that treatments are most effective when they match the culture of that
person. Cultures may prefer some modes of help-seeking and healing over others, and reject other types of treatment and healing. For example, many persons from non-European and collectivist backgrounds have lower usage of formal mental health services in response to stress in their lives (Tata & Leong, 1994). A more idiocentric person may connect to values of self-sufficiency and this may translate into seeking a helping relation that is briefer as well (McCarthy, 2005).

A patient’s own values and self-orientation may also help to explain perception of helpful treatment. For example, an allocentric worldview may lend itself to more ecological and community oriented interventions. The path to symptom relief for more allocentric persons may then be more relational. For someone who embodies a more idiocentric orientation, individual skill building and interventions may be perceived as most helpful. This information is clinically relevant because treatments are more effective when they match self-orientation (e.g. LaRoche, D’Angelo, Gualdron & Leavell, 2006). Treatment compliance can also be enhanced when treatments match self-orientation (LaRoche and Turner, 2002).

**Critiques of Kleinman’s Theories**

This analysis has described in some detail the thinking of Kleinman because his theory of illness and questions are an integral part of the proposed research. Kleinman’s research has eloquently offered a theory of human illness narratives that is inclusive of constructivist thought and cultural themes. Although he has expanded on these theories in depth and they have been useful in conceptualizing the current study, there is nonetheless existing criticism of his thinking.

From a theoretical perspective, Kleinman’s thinking contends that categories of knowledge and reality (illness and disease) are created by social relationships. His theories
describe “truth” as constructed and therefore relativistic. In some ways, this represents progressive thought which allows non-dominant groups to reconstruct the reality of illness with respect to their unique values. From a pragmatic point of view, with a constructivist theory of illness it may be impossible to compare clinical indicators and symptoms if they are based upon worldview. Concepts of severity and chronicity of disease may therefore become void using Kleinman’s descriptions of illness. Even the general truth or falsity of a given symptom presentation cannot readily be established from a constructivist viewpoint, and so diagnosis and classification becomes impossible. Again, this may be construed as a practically difficult realization, but the theory simultaneously encourages providers to respect multiple realities of distress and illness, because it is grounded in the idea that there is no way to disprove or invalidate these claims.

Although recognizing the value in this work, limitations of this work have also been noted. For example, with the idea that culture resides within individuals and their beliefs, the social world is again neglected for the psychological world (Lopez & Guarnaccia, 2000). Furthermore, culture must be seen as a dynamic process, and freezing culture into a set of values may be overly simplistic and a misrepresentation (Lopez & Guarnaccia, 2000).

One of the leading direct criticisms of Kleinman’s work has been by the cultural anthropologist Richard Shweder. He has criticized the discrepancy between Kleinman’s constructivist approach to illness narratives with his simultaneous hypothesis of a universal sociopolitical causal ontology of depression. As part of his argument, Shweder cites research by Murdock (1980) that suggests causal ontologies of suffering are not equally distributed across the geographic world. Shweder’s own research has also documented some of the different ways in which cultures and persons conceptualize the etiology of mental distress. Shweder therefore
argues that Klienman abandons his constructivist views at this point to try to establish these ontological causations that are independent of meaning, but rather assume a universal and natural world (Shweder, 1991).

**Limitations of the Current Literature**

The literature review has acknowledged the dynamic role of culture intersecting with personal values and psychologies. Assessing culture, socialization, and cultural values in psychology has considerable implications for counseling, including but not limited to the assessment, conceptualization, and intervention stages. However, psychological theory has continued to target distress at an individual level; its social aspects and nature are less frequently visible, possibly due to the predominately and traditionally individualized approach to psychology. The current study presents individual narratives, and also brings attention to the social and contextual aspects of health that are less frequently acknowledged.

According to the research presented in this chapter, orientation has been suggested as a useful variable in the multicultural literature. Research on the implications of orientation has been integral to expanding our awareness of cultural factors in psychology. Nonetheless, these variables have been narrowly described and mostly referred to as differences across ethnic and racial groups. They have been less studied in psychology to examine potential usefulness at the individual level, such as implications for counseling and intervention. Furthermore, frequently used quantitative methods of understanding and using these variables have stressed a precise identification of the constructs based on endorsement of certain traits, tendencies, and beliefs. Research has firmly established existing characteristics and measurements of allocentrism and
idiocentrism, but it is less clear how these orientations are represented in people’s lived experience, and whether they are a useful construct in counseling.

The variable of orientation offers an effective way to summarize an awareness of often overlooked relational values and collective goals. An enhanced awareness of orientation as a cultural factor could help clinicians to better understand their clients’ values to better match counseling and intervention services. As a first step, exploratory research is helpful to examine whether these constructs are actually relevant to people’s lives and lived experience. Specific to the counseling experience, research can explore whether these variables do in fact capture individual experience, and whether they seem to organize naturally occurring perspectives on mental health and illness.

Employing qualitative methods to complement the study of dimensions of allocentrism and idiocentrism would offer context to these orientations and provide a richer description of the variables under consideration, and their application to lived experience. An exploratory and thematic analysis of personal narratives of mental health would provide information about the usefulness of these constructs to counseling psychology. This would additionally contextualize results to the relevant social and cultural dynamics of the particular group. This would provide an open analysis that is less constrained by notions about what types of values or beliefs are expected of persons, to access the uncontained subjective experiences of clients, and to assess whether orientation emerges as a theme within personal narratives. A thematic and ecological analysis of personal narratives would also make visible the systems and forces which intersect with individual wellness yet are harder to measure and so largely ignored in psychological research.
Chapter 3
Research Methods

This chapter presents a description of the existing data set, information about participants and the surrounding community, and the format and content of the information gathered along with the instruments used. It also reviews the coding process which was used to understand qualitative data. This chapter restates the research interests and describes the analyses that were used to answer these questions.

Research Design

The purpose of this study is to gain an understanding of the individual’s experience of distress by assessing relationality, examining personal narratives, and contextualizing this data. This research study is descriptive and phenomenological in nature. In order to test the proposed research questions, a mixed-methodology approach was used. Data analysis strategies were both quantitative and qualitative. Quantitative analyses were used to describe the orientation of participants using reliable and valid measures. A standardized way of assessing self-orientation became important to assess levels of the existing research based constructs of allocentrism and idiocentrism. In addition, this allowed for a comparison of the participants not only with each other but also as compared to the original research sample, in order to describe participants as high or low on these variables.

Because this research was also concerned with the clients’ personal and subjective understanding of their mental health and distress, qualitative analyses were used to capture the person’s voice in the data. In recognizing the client as an expert voice in the experience of mental health conceptualization, feminist theories are drawn upon which suggest experiential
methods of listening to the voices and realities of persons (Ballou et al., 2002). This research explored personal accounts of mental health with a thematic analysis. This is one method of qualitative research which attempts to understand the individual’s experience related to their social context. Individual narrative experiences of mental health using open-ended questions were selected over other ways to measure symptoms and experience with health and distress because they are believed to be the closest measure of the person’s experience and voice. Open-ended questions also help to eliminate possible researcher bias in conceptualization that may bend more toward dominant views of health and distress.

During the analyses, an exploration of narratives remained open to thematic patterns which emerged from the ways individuals describe their problem. For example, analyses were used to examine subjective experience including relational conceptualizations of distress and coping, the presence or absence of social and community disruptions in individual narratives. Thematic and subsequent ecological analyses sought an individual and contextual awareness of these experiences.

Contextual Understanding of the Community and Participants

The Martha Eliot Health Center (MEHC) is a community health center affiliated with Children’s Hospital Boston, and the site where this data was initially gathered. The agency offers primary care, mental health, and crisis related services to children, adolescents, adults, and families. It is located in Jamaica Plain, an urban neighborhood situated in Boston, with a rich history and diverse population, including a significant Spanish-speaking population.

A snapshot of Jamaica Plain. Boston has recently been described as a “majority-minority” city with 53% of its residents of a non-white race or ethnicity. Within Boston, Jamaica
Plain has a population of 37,468 (Boston Redevelopment Authority U.S. Census, 2010), and its racial makeup includes approximately 62% of the population describing themselves as White, 16% as Black or African American, 8% as Asian, and 14% as biracial or some other race. In addition, 22% of Jamaica Plain residents identify as Latino, although this is a great decline since the 2000 census (Boston Redevelopment Authority U.S. Census, 2010). When compared to the greater Boston community however, Jamaica Plain remains home to a significantly larger Latino community. Many of Jamaica Plain’s residents are immigrants, with many from the Dominican Republic, Colombia and Cuba specifically. Approximately 35% of the adult population in J.P. does not speak English as a first language, and the majority of these persons are native Spanish speakers (Boston Redevelopment Authority U.S. Census, 2010).

Reflecting its residents, Jamaica Plain boasts a number of subdistricts with significant Spanish-speaking populations. The Jackson Square area of Jamaica Plain is one such community which borders Roxbury. The area has deep cultural and historical roots, which will be explored more in a discussion of the Martha Eliot Health Center’s history. Today, it boasts a number of culturally-relevant and minority-led businesses such as restaurants, salons, bakeries, botanicas, and markets which thrive and reflect the rich cultural communities.

Jamaica Plain’s population is young, compared to Boston as a whole. A recent analysis by the Jamaica Plain Neighborhood Development Corporation looked at the demographic makeup of the Hyde/Jackson Square section of Jamaica Plain, where Martha Eliot is located. About 27% of the community is 19 years old and younger, and about half of those youth are between 15-19. The community has the third highest concentration of Latino youth in all Boston neighborhoods, and 78% of its youth are racial and ethnic minorities (Boston Redevelopment Authority U.S. Census, 2010)).
The median household income within Jamaica Plain is $62,629 (Massachusetts state average is $68,398), although there is incredible diversity in household income. This economic diversity is a newer phenomenon, as the inner city has again become a fashionable place to live, and gentrification has further stratified the community. A reflection of this is visible in transforming historical buildings and social institutions around Jamaica Plain (e.g. the old high school, police station, and an old asylum) into costly condominiums.

Despite the increasing median household income, Jamaica Plain continues to struggle with extensive poverty, which is closer to the experiences of many in this participant group. Approximately 16% of its residents live below poverty level, compared to 9% across Massachusetts. One quarter of the adult population does not have a high school diploma. Housing vacancies include about 5.3% of the total housing market, however this rate is very stable compared to elsewhere in Boston. The area is home to mostly renters (65%) and includes 16,797 housing units (Boston Redevelopment Authority U.S. Census, 2010). Reported crime rates in Jamaica Plain are very high; they are two times the national average, and more than two times the Massachusetts average. This includes a high prevalence of homicide, rape, and assault, and motor vehicle theft that is two times the national average, and robbery which is five times the national average.

**Historical roots of the Martha Eliot Health Center.** The data which will be used for this study was collected within the Human Services department of the Martha Eliot Health Center, in Jamaica Plain. The Martha Eliot is Children’s Hospital Boston’s community health center. The health center’s origins go back to the Bromley-Heath community, which was created in 1941 as the first federally funded low-income housing development to be managed by its own
tenants (Heath, 1999). Today, Bromley Heath is a 23 acre public housing development in Jamaica Plain’s northern end. Familiarity with its history is important to situate the origins and context of the Health Center.

With the onset of the Great Depression in the U.S., the housing needs of the nation and Boston could no longer be ignored. A controversial and unpopular decision was made around that same time to make housing a federally recognized and funded issue. Before that time, the private and philanthropic sector managed housing services. The planning and construction of housing developments was taken on as the government’s responsibility, and Boston was part of this new trend, developing the Boston Housing Authority (Heath, 1999).

The Heath Street area was chosen as a suitable location for a government run housing development because its factories were already deteriorating, land was cheap, and the area was accessible to street cars, trains, and buses (Heath, 1999). At the time, the Boston Housing Authority tended to name developments after a major street where they were located, for tenants to feel part of the community and not separate from it. The Heath Street housing development opened in 1942. The development followed trends as a self-contained community, and with an “international style” architecture which was created to be economic and culturally “neutral” (e.g. not in the tradition of any country’s architectural style). The development first housed Italian-Americans who worked in the surrounding factories and bottling plants, and families were offered housing given low income, substandard housing conditions, or for males returning from war (Heath, 1999).

Housing needs remained high and twelve years later architects were asked to create a space the same size, but with room for twice as many units. The result was the addition of
Bromley, leaving a very dense housing complex of 732 apartments, and what we currently know as Bromley-Heath (Heath, 1999). With this development, cramped space eliminated most green areas, open space was turned into parking lots, and the housing development was stretched out to border the main road. The Bromley-Heath buildings continue to be visibly mismatched to Center Street in Jamaica Plain; the buildings have close brick walls that nearly touch and look impenetrable, and they are much taller and more crowded than the rest of the community.

One year after the establishment of Bromley-Heath, residents were in need of pediatric health care, and a small infant and pre-school child clinic was started in 1957 by Dr. Martha May Eliot, a social pediatrician at Harvard. She later collaborated with the Boston Health Commisioner to found the Bromley-Heath Clinic in 1966. The clinic expanded its services to serve as a primary health care center providing family primary care and community based prevention initiatives, and was renamed as The Martha Eliot Health Center.

The affordable housing in the area continued to attract new groups, including blacks moving to northern cities, and in the 1960s and 1970s many new Cuban, Puerto Rican, and other Latin American immigrants (Heath, 1999). These new groups brought diversity to the white working class residents of Jamaica Plain. The area became one of the most varied neighborhoods in Boston, which inspired both conflict and energy. More Spanish-speaking newcomers arrived and the neighborhood became immersed in the Spanish language and culture. Reflecting its Latin residents, the neighborhood offered foods, products, and arts from all over the Caribbean and Latin and South America. One of the treasures of the community remains a beautiful mural painted in 1984 by a visitor to Jamaica Plain, Rafael Rivera Garcia, a Puerto Rican university professor and artist, to celebrate the indigenous people of Puerto Rico and their Taino gods.
These groups often had little access to political voice or money, and Jamaica Plain struggled to secure government resources or social services. Brookside was created in 1970 by its residents out of a church, to provide medical and social services to residents. At this same time, Jamaica Plain began its long history of community activism and empowerment which continues to be a part of the city today.

J.P. is an active community that has a number of initiatives geared toward community wellness. The Jamaica Plain Neighborhood Development Corporation is just one example of the community’s commitment to building toward a healthier neighborhood. It has been active for decades creating jobs, creating housing, offering child care, empowering residents, and supporting the children of the community. In the 1980’s, the Hyde Square Task Force was formed by a diverse group of neighbors in response to escalating youth violence in the Hyde-Jackson Square area. This neighborhood which borders Jamaica Plain and Roxbury was known in the 1980’s as the ‘cocaine capital of Boston;’ drug dealing was visible on the streets and gang related violence pervasive. In response, neighbors coordinated peace marches, street cleanups, and public meetings. Since that time, the Hyde Square Task Force has led youth and their families in multiple community initiatives. As one example, the murals on the façade of the Jackson Square and Roxbury Crossing stations were created by its youth in responding to shootings at the Jackson T Station in 2004. These murals were the youth’s declaration of peace and their right to live safely in their communities.

The Martha Eliot Health Center has a long history of serving the Jamaica Plain area, and this health center currently employs over 120 persons and serves thousands of patients. It continues to be adjacent to the Bromley-Heath Housing Development, although the MEHC mission is no longer focused on offering care to its residents, and as a result Martha Eliot’s
connection to the Bromley-Heath community has been tenuous. Martha Eliot has a long history of research on prevention and clinical initiatives, and the current study used existing data which was generated as part of an intervention study on a Culturally Competent Relaxation Intervention (LaRoche et al., 2006), delivered at Martha Eliot. Participants had been identified as in need of human services by themselves or a referring provider. Therefore, they represented a clinical sample, and presented with at least one primary mental health problem. The existing data was made available here for analysis.

**Description of Participants and Format**

This research employed a secondary data analysis, and the data used for this study was initially collected as part of an intervention study on a Culturally Competent Relaxation Intervention (LaRoche et al., 2006). Participants were identified as in need of human and mental health services by themselves or a referring provider. Therefore, they represented a clinical sample, and presented with at least one primary mental health problem. Participants completed quantitative as well as qualitative measures. The measures used for the current study included demographic information along with: 1) two measures examining self-orientation variables including the Individualism and Collectivism scale (IndCol) and the Sociocentrism/Egocentrism Questionnaire (SEQ), and 2) qualitative descriptions of the person’s current problem. Qualitative data was collected through the use of open ended questions, based on Kleinman’s questions. Questions were asked of participants in the language they initiated use of (Spanish or English), and most participants responded in the Spanish language. These open ended questions were an attempt to access experiences that participants had with mental health problems, health maintenance, and treatment. A total of 52 adults completed both the open-ended interview for qualitative descriptions of the current problems and the self-orientation scales (IndCol and SEQ).
This group was ethnically similar, and only three of the adults were non-Latinos. The three non-Latinos were excluded for the purposes of the current research, because limiting analyses to this sub-group allowed for an examination of diverse perspectives within persons who share a similar ethnic identity. By exploring the perspectives of Latino persons in particular, the results may contribute to an understanding of the diversity of experiences even within one cultural group, and the intersection of individual and cultural perspectives may be more visible in thematic analyses.

Therefore, 49 Latino adult participants were identified for the study. A sub-group of 20 was then drawn at random from this larger group for the initial stages of thematic analyses. Quantitative methods were also used to describe this sample in a way that could be compared to other populations. In this sub-group, participant ages ranged from 18-65 years old, with an average age of 42 ($SD=10.69$). The group included 7 males and 13 females. Participants ethnically identified as Cuban, Puerto Rican, and Dominican, or nonspecifically as “Hispanic.” This perhaps reflects one social-political construct of ethnicity used in the U.S. census, which asks individuals to categorize their membership in one of two ethnicities, which are “Hispanic or Latino” and “Not Hispanic or Latino.” With the exception of one person, all others were born in a country other than the United States. The majority of participants were born in the Dominican Republic ($n=15$), which is also reflective of the larger health center and surrounding community. Participants immigrated to the U.S. at different points in their lives; some during childhood (18 years of age represents the 25th percentile), and most as adults ($M=26.32$, $SD=12.82$). Individuals spent an average of 16 years living in the U.S., although this ranged from one year through 32 years ($M=16$, $SD=9.12$). Likewise, 90% of the sample learned Spanish as a first language.
Participants endorsed mixed marital status: most were married (35%), and some were also separated (10%), divorced (4%), single (16%), partnered (30%), and widowed (5%). Of the participants who have children (90%), all but one person live with their children. Religion and spirituality was also assessed as a measure of social support. Although 90% of the sample identified with an organized religion, half did not endorse a sense of spirituality or connectedness to their faith. Notably, 75% of the sample endorsed significant health problems or concerns. Specific health problems that were reported include high blood pressure, diagnosed depression, pain, vision problems, asthma, and diabetes.

The participants also represent a wide range of education and economic position. Participants range from elementary level education (25%), high school level education or graduation (60%), and college level education or graduation (15%). The group averages a low yearly income; only 30% of the sample is currently employed, and 70% of participants report earning at or less than $20,000 per year. The remaining 30% of participants earn between $20,000-$50,000 per year. All of the participants are renting an apartment for housing, except for one person currently living in a shelter.

**Instruments**

The measures that were administered to participants included: 1) qualitative descriptions of the person’s current problem (based on Kleinman’s questions), 2) two measures examining self-orientation variables including the Individualism and Collectivism scale (IndCol) and the Sociocentrism/Egocentrism Questionnaire (SEQ), 3) one measure of acculturation stress, and 4) measures of anxiety and depressive symptoms. For the purposes of the current research, the only
data used for analyses was demographic information, qualitative descriptions of the person’s current problem (based on Kleinman’s questions) and two measures examining self-orientation.

**Individualism and Collectivism scale.** The Individualism and Collectivism scale (IndCol) was originally developed by Hui (1988) and then revised by Singelis, Triandis, Bhawuk, & Gelfand (1996). The IndCol has a strong research basis for describing orientations of individualism and collectivism. The instrument began with 96 items and eight scales targeting Family, Acquaintance, Spouse, Parent, Kin, Neighbor, Friend, and Co-worker. The instrument was reduced to 63 items and the Family and Acquaintance subscales were removed due to low Cronbach alphas, to help raise instrument reliability. At this point the scale was established as a 6-point Likert scale instrument with ratings from 0 (strongly disagree) to 5 (strongly agree). The INDCOL’s reliability was established as the subscales were found to have reliability coefficients at about .60 for such a complex construct. Construct validity was also established for the measure.

Currently, the INDCOL uses two sub-scales of 16 questions, one for allocentrism and one targeting idiocentrism. The person is asked to rate statements from 1 (strongly disagree) to 9 (strongly agree). These statements include, for example, ‘I prefer to be direct and forthright when discussing with people.’ Responses assess the levels of idiocentrism and allocentrism in an individual within a culture. Scores across the 32 items allow for quantitative measure and can be used to describe and compare individuals. In one research sample which investigated the usefulness of the INDCOL within the United States, participants showed M=6.2(SD=2) on allocentric traits and M=6.3(SD=2) on idiocentrism (Singelis et al., 1995)
The INDCOL remains reliable and valid across samples of different ethnic groups (e.g., Oyserman et al., 2002). Results are orthogonal meaning idiocentric traits and allocentric traits are not exclusive of one another nor inversely related. This allows the person to assess both their idiocentric and allocentric tendencies whether they are high on both traits, low on both traits, or high on one while low on another. The IndCol has demonstrated modest internal consistency reliability. An alpha of .78 (p<.01) was found for the collectivism scale and an alpha of .66 (p<.01) for the individualism scale (Singelis et al., 1994), and its scales converge well with another standardized measure of self-orientation, the Self-Construal Scale (Singelis et al., 1995).

**Sociocentrism/Egocentrism Questionnaire.** The Sociocentrism/Egocentrism Questionnaire (SEQ) was originally developed by Shweder and Bourne (1982) and adapted by La Roche, Poplock, Batista, Lustig and Brahms (under review). The SEQ measures two worldviews, egocentrism and sociocentrism. These were originally constructed as cultural orientations rather than individual orientations. Egocentrism and sociocentrism are described by Shweder and Bourne (1982) as discrete possibilities of one construct, unlike Triandis’s (1995) orthogonal orientations. Egocentrism describes a society as serving the individual, where individuals are seen as decontextualized and autonomous from the collective. Sociocentrism describes individuals are inseparable from and secondary to their social environments. Despite its initial intention as a measure of cultural orientation, the SEQ has a strong potential for clinical usefulness due to its open ended, time-efficient, and non-directive format. Research has demonstrated that the SEQ can be adapted to a revised version which asks the participant to describe three characteristics of three different individuals. Verbal responses are analyzed and the researchers chose to report results as composites, or one number to summarize all available information about the individual’s response according to that variable. This revised version is
more sensitive to measuring individual differences, clinically useful, and it has been validated using the IndCol (LaRoche, Poplock, Batista, Lustig, and Rowe, under review), on the sample.

**Open-ended individual interview: Kleinman’s Questions.** The open-ended interview is the core of the thematic analysis. The aim of the interview was to access the illness experience and descriptions of a mental health problem from the patient’s perspective. Kleinman developed a series of eight questions to conceptualize illness and its meaning from the patient’s point of view (Kleinman et al., 1978). These questions answer, “What is the person’s conceptualization of their clinical problem?” and they formed the basis of the open-ended individual interview.

The participants were asked four questions which targeted each of Kleinman’s suggested points. These questions included: 1) What is the problem?; 2) What has caused the problem?; 3) What has helped to fix the problem and what would fix it?; and 4) What kind of treatment should you receive and what is helping you or not about your treatment? Answers to these questions were transcribed by the initial researcher.

**Procedures and Data Analyses**

This study used the INDCOL and SEQ measures to target the proposed research questions, and Kleinman’s questions were previously asked of participants but that narrative data examined until this proposed study. Upon initial collection, patients were asked the open-ended question and verbal responses were recorded in that person’s preferred language (English or Spanish). In this study, content and thematic analyses were used to analyze the data collected from the interviews.

There was a larger eligible group of 49 participants, from which 20 participants were randomly selected for further analyses, since qualitative samples should be large enough to revel
most or all relevant perspectives, yet not too large to lead to repetitive data. Samples for qualitative studies are in general smaller than those used in quantitative studies because with qualitative research more data does not necessarily lead to more information, a code need only appear once to become part of the analysis, data quickly becomes saturated to interfere with drawing conclusions, qualitative research is focused on meaning, and qualitative research is labor intensive (Ritchie, Lewis, & Elam, 2003). The current study adopted this framework in its methods. Twenty participants were randomly selected for the initial establishment of codes and themes.

The thematic analysis outlined by Braun and Clarke (2006) was used to analyze the participants’ data. A six-step instruction is described and outlined by Braun and Clarke (2006) to help identify, analyze, and report themes that are present in qualitative data. The six steps include: Phase 1, familiarizing yourself with the data; Phase 2, generating initial codes; Phase 3, searching for themes; Phase 4, reviewing themes, Phase 5, defining and naming themes, and Phase 6, producing the report.

During the first phase, familiarizing yourself with the data, written transcripts of the data were read several times by the raters to gather an overall impression. Initial impressions of transcribed data were written down. Secondly, in generating initial codes, interesting aspects of the data are collated according to codes. In other words, data was organized into meaningful groups that attempted to answer the research questions, and they were given brief verbal descriptions. As part of this process a description of each code was formulated, and examples of the code’s boundaries grouped together (MacQueen, McLellan, Kay, & Milstein, 1998). A highlighter and notes were used to guide the exploration of potential patterns. As a guideline, as many codes and patterns were recorded as possible.
Thirdly, searching for themes, required that the researchers review the coded and collated data to brainstorm how the different codes can be combined into potential themes. The themes are expected to integrate sets of codes. For example, if codes appeared similar, they were merged with each other under one theme. Similarly, when codes appeared dis-similar, they were categorized under different themes. A visual map was also used to identify the research questions and sort the codes into relevant themes. It was important to researchers to note data that departed from major themes, and codes that uniquely stood apart. A “miscellaneous theme” was created to group these codes temporarily. Once saturation had been reached, new themes were not emerging from new codes or cases. In this third step, the researchers thought about relationships between the data, its codes, and themes.

The fourth phase, reviewing themes, involves comparing themes to the narratives, to help validate the findings. Themes may be further refined, specified, or merged to best capture the narratives. This step analyzes the fit of the themes with the narratives, to understand an overall story of the data, and is critical about themes which do not seem to reflect the spirit of the narratives. The fifth phase, defining and naming themes, aimed to specify each theme. The researcher tried to understand the story that each theme tells and how it relates to a broader story of the data and research questions. Clear definitions and names of themes were created so that it was clear to others exactly what the theme is. A final set of themes was thus created. The remaining participant data was then examined to ensure that the themes adequately organized these responses as well. Finally, the sixth phase was producing the report, in which the researchers reflected on the process, found vivid narrative examples to illustrate themes, and related this back to an analysis of the proposed research questions and literature.
Because this researcher is not a fluent Spanish speaker, translation services were considered. Instead, coding was done directly from the person’s transcribed responses. The purpose for this was to ensure that the qualitative data was a valid representation of the person’s experience as originally described in their language. Coding Spanish responses directly facilitated capturing the original and even subtle meanings communicated by participants and it buffered the messages from being distorted in translation. Two bilingual (Spanish and English) masters level clinicians who are also familiar with the population served by this community health center were trained to do this coding. Clinicians received approval from the institutional review board at Children’s Hospital. They were trained in qualitative methods and to use thematic analysis to code sample responses. After training, the bilingual coders independently coded the 20 cases and corresponding transcribed responses. They reviewed their codes with each other and this researcher to process agreement and acknowledge difference in perspective. While the researchers were generally in agreement with codes, discrepancies were processed until a mutual perspective was constructed, although notes were taken to describe this process as part of the results. Codes were then organized into themes collaboratively by the bilingual clinicians. This researcher also acted as a critical voice to observe and question themes that were created, and encourage comparison between the themes and original narratives for validity sake. This process became a critical part of understanding the results as well. Finally, themes were translated to English and subtle differences in meaning between Spanish and English translations were explored and debated. Throughout this process, themes were guided by theory and high levels of frequency in certain thematic responses in the data, and reviewed by myself, my dissertation committee, and the original researcher and data collector.
Exploring validity of research studies is an important part of methodology, and in qualitative research the literature can be used to support the credibility of themes found in the data (Aronson, 1994). The current study fulfilled this standard through literature review, a detailed description of the topic within the literature review, careful choice of methodology, keeping notes, using an adequate sample, and analyzing data until saturation was achieved (Aronson, 1994; Frankel, 1999; Meadows & Morse, 2001). The process of analysis was organized using data analysis strategies and coding and continuous dialogue and adjustment. The experience was also shared, evidenced by continuation of themes within data. For the current study, consultation with the original researcher who collected this data and thus familiar with the setting and participants is crucial to credibility, to ensure themes were faithful to the transcripts. Peer review consultation with a graduate student in psychology who is also familiar with the population and themes offered useful feedback. Results should be useful, and this was sought through a contextualization of participants and narratives. Credibility was also sought by looking for pieces of the narrative which contradicted analyses, and acknowledging them as such.

In addition, each participant in the current sample had data on levels of idiocentrism, allocentrism, egocentrism, and sociocentrism. Two instruments were used to assess self-orientation in participants across four separate variables: idiocentrism and allocentrism (IndCol), and egocentrism and sociocentrism (SEQ). The IndCol has previously been used for these participants and those self-orientation descriptions remained useful for this current research. Means and standard deviations for IndCol scales were determined for this sample. The sample’s means were compared to normative data using single-sample t-tests. The SEQ descriptors have been analyzed in a qualitative manner and are coded to detect cultural variables in participants’ language. In the original coding and scoring for the SEQ, there was a wide range of number of
descriptors given by each participant. For example, some participants gave up to six descriptors, while others gave only one or two. Each of the SEQ categories were scored from 0-2, according to the number of times they appear in each of the nine descriptors (not at all, one description, and more than one description as 2). Because of this variation in numbers of coded responses, results from the Shweder-Bourne scales are best reported as variables of a composite score. Scores were summed and then divided by the total number of descriptions; higher scores representing a higher frequency of responses grouped into that theme. Participant characteristics were described and also examined for their relationship to orientation. A summary of results was facilitated by incorporating this information with themes noted in personal narratives of mental health for case study and discussion.
Chapter 4

Results

This chapter will present the results of the quantitative and qualitative analyses. Quantitative analyses were used to describe the relationality and individuality of this clinical group according to standardized measures. Qualitative analyses examined narratives of mental health and problems from this same clinical group, and these analyses were guided by multicultural and ecological perspectives. Several major themes emerged which will be reported in this chapter, along with quotes and case studies, to bring forth people’s voices and perspective on mental health and problems.

Quantitative Research

Research Question 1: How does a Latino clinical sample of adults compare in idiocentrism and allocentrism, as measured by the Individualism-Collectivism Scale (Singelis et al., 1996) and the Sociocentrism/Egocentrism Questionnaire (Shweder & Bourne, 1982)?

Quantitative methods, and the measures detailed in Chapter Three, were used to explore the first research question. One-sample t-tests were used to compare the mean of the current sample and participants with the population mean, for both the INDCOL and SEQ.

Results for Individualism-Collectivism Scale. The INDCOL assesses levels of allocentrism and idiocentrism, and these levels can be used to describe and compare individuals and samples. In one research sample in the United States using the INDCOL, which attempted to demonstrate the viability of these constructs in the U.S., participants showed $M=6.2$ ($SD=2$) on allocentric traits and $M=6.3$ ($SD=2$) on idiocentrism (Singelis et al., 1995). In the current
research sample, participants averaged $M=6.73$ ($SD=1.61$) on allocentric traits, which is not significantly different than the population average; $t(18)=1.43$, $p=.169$. Sample participants averaged $M=5.2$ ($SD=1.43$) on idiocentric traits using the INDCOL, which is significantly lower than the population average; $t(18)=-3.40$, $p=.003$. Another way to view these average INDCOL scores is that there was not a significant difference in levels of allocentrism between this sample and a U.S. population, but individualistic traits were significantly less represented in this sample than in a general U.S. population. Our group’s levels of idiocentrism were inconsistent with and lower than the comparison sample, but levels of allocentrism were consistent with the comparison sample. These results further support an orthogonal, or uncorrelated, perspective on orientation (Singeles et al., 1996).

**Results for Sociocentrism/Egocentrism Questionnaire.** The revised version of the SEQ guides a systematic interview for clients, to measure the cultural variables and themes (e.g. social, contextual) embedded in a person’s language (LaRoche et al., under review). As described in the methodology, results from the SEQ are best reported as composite scores. There is also research to support the existence of two distinct factors using the SEQ categories; these factors are highly social (social, self-reference, together, action, and contextual) and individualistic (individual, alone, trait, and non-contextual) (LaRoche et al., under review). Average composites were calculated to organize the sample’s SEQ data according to these two factors; results indicate that the group mean for social categories is $M=.60$ and for individualistic categories is $M=.37$. For the current sample, the highest mean score for any SEQ category is for the theme of social, $M=.82$ ($SD=.15$), which contributes to the highly social factor. Scores for the social category are higher when descriptions of a person include activities or traits for which a social component is required, even if another person is not specified (e.g., he likes to teach), as
opposed to responses in the *alone* category that do not involve others (e.g., he works hard). The *social* category also reflected the least amount of range or variance in responses. The next highest mean score was for the SEQ category of *self-referential*, $M=0.72$ ($SD=0.06$), which also contributes to the highly social factor. *Self-reference* is scored when the ratee is included in the response description (e.g., she helps me), while *non-reference* does not include the participant.

**Qualitative Research**

The qualitative component of this research is the backbone of the study, and is primarily interested in presenting and describing the experiences of these participants with aspects of their mental health. Participants’ responses to Kleinman’s questions (Kleinman et al., 1978) were analyzed to understand how a primary mental health problem is experienced by that person. The qualitative data set started with 49 collected and transcribed interviews. The process for selecting a group within that, and then analyzing this data using thematic analysis, was described in Chapter Three.

Arranging the meanings and codes into clusters resulted in multiple themes for each research question. A phenomenological approach was taken to examine these questions from the perspective of the individuals. Interviews were used to gather information, and analyses were used to construct themes and experiences from the participants themselves, to allow room for other than dominant categorical assumptions. The themes which were generated are grouped below. To support themes, direct quotes from participants are included within the text. Participants’ voices are identified with quotation marks and italicization.

**Process.** Feminist qualitative researchers suggest that researchers are not neutral or objective and therefore research is always an interactional process (Speer, 2002). Researchers’
experiences and perceptions shape the questions they ask and the direction and interpretation of their research. For this reason, it is important to be curious about how interpretations and meanings have been attributed, and to make the researcher a visible part of understanding results (e.g. Plummer 1983). This perspective was adopted for this research. The content analysis was an active process conducted and observed by co-researchers. The process by which raters coded information, and understood what language belonged together and why, is important to acknowledge for discussion. Throughout the entire process, I took notes on the interesting conversations, impressions, and conflicts which arose, and these notes facilitate the reflection here.

First, it is important to describe the vantage points of the co-researchers involved in coding data, by understanding some of our experiences and lives. This respects the role of researchers in shaping the interpretation and presentation of data. This writer and researcher identifies as a 31 year old woman who is of mixed European descent, and is a third generation Italian-American. I am familiar with this ethnic culture, and share values including a strong family commitment, shared family identity, value for self-sacrifice within the family, and the practice of traditions associated with Roman Catholicism. I was born in a suburb of Connecticut, in a town with a predominately Italian population, and identify my own family and community as of a lower-middle working class, struggling with lack of higher education, unemployment, unstable employment, and reliance on social and familial supports. I consider myself to be a highly relational person, likely corresponding to gender, familial, and socio-cultural socialization, and define myself and my own wellness according to my relationships. I also consider myself to have strong individualistic values, likely based in my Western education and socialization. I am a doctoral level student in Counseling Psychology, within a program and
mentors who have emphasized an ecological, developmental, and critical model of psychology. I have had personal and familial struggles with health and illness, and the current research resonates with some of my own experience.

Another co-researcher is a doctoral level student in Clinical Psychology. She identifies as a multicultural young woman who was born in a large urban city of California, and whose family is from Mexico and Guatemala. She embraces her multicultural identity, and sees her own worldview as expanded and rich due to this. She has interests in strengthening family relationships through her clinical work, and has chosen to focus on Latino mental health and community based care in her career. She shares an intention to return to California after graduate school to practice as a psychologist in her home community. This young woman describes holding many of the values common to her culture including a focus on family and building harmonious relationships.

The final co-researcher is a 29 year old man who identifies himself as bilingual and bicultural. He was born in Lima, Peru, and migrated to the United States at age eight. His experience with immigration, and also living in a politically unstable area in Peru, has led to a worldview which can readily identify with the ruptures in families, relationships, and one’s sense of safety and connection which can accompany political strife and immigration. He describes his unique experience of holding a minority status in both countries, of indigenous origin in Peru, and as Latino in the United States, and the aspects sociopolitical oppression he experienced in both countries. He grew up in a poor and underprivileged area of New Jersey, which impacted his values and commitment toward social justice and questioning health and economic disparities. He describes himself as more individualistic than his cultural and familial
background, likely due to his development in the United States and his Westernized higher education.

In the first phase of analyses, initial impressions of transcribed data were discussed by raters. Raters immediately commented on the sense of distress in the responses, and feelings of frustration that came up for us in reading the narratives. One co-researcher stated at this point, “There is so much, just being stuck. Not knowing where to turn.” They also noticed quickly the role environment played in the personal narratives. One researcher shared a personal reaction to a participant’s experience with amplified suffering and distress after getting out of prison: “Sometimes we think that most people want to be out of prison, so they are probably better off and maybe content with their release. With this story I noticed my reaction to how strong the environmental effects actually were on his functioning and disability after prison. I don’t think I realized how hard that transition could be.” Researchers also commented on a seemingly shared experience of “…having to just put up with things,” noting that many stressors described were out of the person’s control, evoking a sense of helplessness even within the readers. Finally, researchers expressed surprise with participants’ treatment experiences, “As a clinician in training, it felt good to see how helpful just talking to someone was for people, even when they felt totally overwhelmed. But I was also shocked by how many people wanted medication as part of their treatment. I just don’t think of that with Latinos.” Interestingly, one co-researcher joked that, “I feel like these are all my patients.” Beyond the humor, there was a shared truth to this statement, since we had all worked in community health settings previously and had come across similar individual and contextual problems in our work. The three of us could relate to feeling like we knew the participant group, not because we had met, but because we had heard many of these stories before in the words and experiences of others.
To assist in generating initial codes, the smallest units of meaning were pulled from the transcript, at first independently. Upon review, raters expressed some confusion, as one rater tended to find multiple codes in one sentence, whereas the other rater tended to look at and report data more holistically, capturing an entire sentence with one code. This researcher made the decision to keep to the guideline of documenting as many codes as possible, as to not miss multiple layers of meaning (MacQueen, McLellan, Kay, & Milstein, 1998).

In clustering codes into themes, several items of data were noted to refer to the same topic. For example, some codes appeared strikingly similar, such as the descriptions of “I think a lot” (“Pienso mucho”) and “I have a lot of preoccupation” (“Tengo mucha preocupación”). In this way, themes emerged that were common to participants’ transcripts. This process was mostly a co-construction between the researchers. Examples such as the one above were easily agreed upon and merged under one theme. Other codes appeared immediately dis-similar, and a decision to group them separately was obvious to all researchers.

Still other codes initially appeared to refer to the same topic, and so were grouped into one theme, but upon later reflection and comparison to the narratives, differences in meaning were more apparent. As a notable example, raters initially grouped these three examples as an interpersonal theme emerging from participants: “problems with people in the shelter” (“problemas con personas en el shelter”), “the death of my father” (“la muerte de mi padre”), and “domestic violence from my husband” (“la violencia doméstica de mi marido”). Though these examples do involve relationships, when comparing this theme back to the narratives, it was obvious that participants were going further to describe an essence of that relationship. In looking back from theme to the original words, raters agreed that participants were describing
very different relational dynamics that manifest in conflict, death, and violence, and that themes should be allowed to emerge to reflect this specificity as well.

Sometimes, researchers did not share a consensus about whether items of data referred to the same theme, as different coders varied in their interpretation of a text’s meaning. As an example, one male respondent described the support he needed as, “...perhaps coming here and talking with others” (“...quizas viniendo aquí y hablando con otros”). When differences in perspective became apparent, they were discussed. In this example, one researcher believed that this fit with a theme of ‘social support and socializing.’ Another researcher was struck by the meaning the health clinic held for this man, and thought this best fit with a theme of ‘supportive therapy and health providers.’ The process itself of establishing codes and themes enabled researchers to discuss what each theme represented, to co-construct a meaningful category. Sometimes this resulted in the adjustment of a theme. In this example, the data seemed to belong with multiple themes, and when this happened it was often listed under all of those themes with which it could apply. In this way, the researchers were respecting the multiple and overlapping contexts within which individuals live and experience their lives. For this man, he could access socialization through the health clinic, and both of these held value for his healing. As thematic analyses continued, repeated discussion and clarification of these themes resulted in converging standpoints for researchers. In general, these aspects of the process allowed coders to have their perspectives represented, while also reaching some level of agreement, that would allow for meaningful interpretations.

This critical approach to the thematic analyses was imperative to describing participant meaning, and evolved as the researcher encouraged raters to be aware of their own perspectives that are very much a part of the process. As one example, raters shared their results with this
researcher for the analysis of Question 1, “What is the problem?” Initial themes had been organized into something resembling the DSM-IV, with identified groups as “depressive symptoms,” and “anxiety and fear.” While the themes appeared to organize the codes, they did so from the perspective of the raters, who are two clinical psychology doctoral students. Together, we reflected on these themes and compared them back to the original narratives. We discussed and agreed that these themes were imposed from a clinical perspective, and actually disguised the meaning and spirit behind the narratives. For example, in “I am scared that my wife will be deported,” (“Tengo miedo que mi esposa sea deportada”) raters had captured the symptom of fear, but not the content behind it which involves a complex socio-political structure and layers of meaning. The researchers were challenged to use a critical lens and abandon these clinical descriptors in favor of an attempt to describe stories from people and allow themes to emerge which were not imposed by psychological jargon. This was a remarkable lesson in how each of us as clinicians carries a psychological perspective, and adopting an empirical standpoint where researcher is expert and unbiased may actually distort the voices of real people. Through a critical and feminist perspective we were able to identify our unique perspectives and incorporate this into the analysis process.

Naming themes that had emerged was another interesting aspect of process. For example, codes describing positive thinking and distraction clearly grouped together as ways participants attempted to manage distress. Raters debated the appropriateness of a “coping” theme, however wanted to avoid overly clinical language. Raters had a very difficult time staying with Spanish for naming this theme. They shared an interesting experience that in English there are multiple and less clinical ways to describe the concept of coping (e.g. to get through, survive, deal with, manage, tolerate), but that in Spanish they could not identify a clearly used way to capture this
idea. As a monolingual researcher and clinician, I observed the dialogue between the bilingual raters as they struggled with capturing this sentiment (eventually settling on “manejando los pensamientos,” or “managing the thoughts”).

A final piece of the process involved a reflection on the results of thematic analysis, to discuss our perspectives of the overall story behind the data. We had many vivid narrative examples to refer to, and were truly impressed with how rich this data was with meaning, experience, and perspective. These major themes will be presented here along with quotes that embody the spirit of each theme.

**Research question 2:** What do these clients report as their primary mental health problem? How are people expressing distress? What is the range of symptom manifestation? Is the problem individual, socio-cultural, or both?

Participants identified a range of mental health problems that they were experiencing, and several themes emerged from these discussions that captured perceived difficulties and symptom descriptions: (1) trouble with “state of being” (estado de ser); (2) my body (mi cuerpo); (3) thoughts (pensamientos); (4) relational problems (problemas relacionales); (5) societal problems (problemas de la sociedad); and (6) problems of spirituality and morality (problemas de espiritualidad y moralidad).

**Theme 1: The state of being / Estado de ser.** “Estado de ser” refers to internal energy and overall sense of one’s state of being or inner self. There are, of course, contextual influences that shape the experience of the inner self. Although raters attempted to contextualize all participant responses, nonetheless, participants described aspects of individual psychologies and self states that did not clearly state a context. It is possible that the context of these descriptions
is not easily seen or described, for we all experience even our environment through the perspective of the self. These disruptions and distress within the state of the being were identified by many participants as a major problem, and so the sentiment of an internal struggle will be acknowledged here.

Participants often described individual problematic energy states such as anxiety, “My problems with my anxiety are affecting me,” (“Mis problemas con mi ansiedad me está afectando”). Another woman shares “sometimes I just get really nervous” (“a veces me pongo muy nerviosa”). Many of these clients also verbalized feeling depressed and sad, and simultaneously communicate a sense that the meaning of their lives has been challenged, through descriptions of feeling trapped, out of control, without direction, and remorseful. Participants also endorsed general disinterest as a major problem. One man describes, “I feel sad and empty. Nothing interests me” (“Me siento triste y vacía. Nada me interesa”). Another participant states, “I feel depressed...there is nothing to do. I do not want to go anywhere. I do not want to go out. I just want to stay at home” (“Me siento deprimida...no hay nada que hacer. No quiero ir a ningún lado. No quiero salir. Solo quiero quedarme en la casa.”) For many of these individuals, there is a sense of internal struggle and lack of being (“una falta de ser”).

**Theme 2: My body / Mi cuerpo.** Illness through symptoms of the body was a shared experience discussed by many participants. Many individuals expressed these bodily sensations as symptoms relating to feelings of depression and anxiety. One of the women who described a problem with anxiety elaborated further that, “It causes my legs to feel asleep, like nothing is there, dead, and consequently it suffocates me and I cannot breath and then I collapse” (“Hace que mis piernas se sientan dormidas, como si no estubieran, muertas, y entonces me sofoca y no puedo respirar y entonces me desmayo”). Other narrative data describes an experience similar to
a panic attack, or anxiety manifesting through the body, “I believe that I have a panic attack… I feel tired. And I also feel that my heart will explode; and I get very nervous, I panic and I can’t sleep.” (“Creo que tengo un ataque de pánico…Me siento cansado. Después siento que el corazón se me va a explotar y me pongo muy nervioso, me da pánico y no puedo dormir”). Problems with exhaustion and sleeping were endorsed by many participants.

**Theme 3: Thoughts / Pensamientos.** The experience of “thinking too much” was discussed by many participants as a major problem. For some individuals, this was described a general tendency: “I think a lot” (“Pienso mucho”), “I think too much” (“Pienso demasiado”), and “I have preoccupation with problems getting worse” (“Tengo preocupación con los problemas se empeorando”). For other individuals, thoughts were highly distressing, although specifically within the context of other factors, reflecting in the next theme. As one example, a participant describes, “I worry more than usual about things. Now I am worried about health; and that something small eventually becomes something larger” (“Las cosas me preocupan más de lo normal. Ahora estoy preocupado de la salud; y que algo pequeño con el tiempo se convierta en algo más grande”).

**Theme 4: Relational problems/ Problemas de relacion.** For some participants, internal worry was directly tied to conflict in relationships, for example, “I think too much about problems in my family” (“Pienso mucho en los problemas de mi familia”). For many participants, relational problems are described as the primary reason for seeking help, and a primary problem with mental health. Conflict with spouses, overwhelming family responsibilities, and the loss of family members are some of the primary difficulties verbalized. One participant describes that, “I am the backbone of my entire family, the one who could help everyone, I have also lost a lot of people in my family…there are so many responsibilities with my family” (“Yo soy el pilar de toda la familia, la que puedo ayudar a todos el mundo, y también...”)
he perdido mucha gente en mi familia...hay tantas responsabilidades en mi familia”). Other participants were mostly affected by the absence of relationships as a primary symptom, such as feeling alone and urges to isolate from interactions.

**Theme 5: Societal problems/Problemas de sociedad.** Aspects of society were occasionally identified as part of an individual’s primary difficulty. One 26 year old female from the Dominican Republic described her primary symptom as a strong feeling of remorse about moving to the United States, and a perception that life for her in the United States was difficult, and led to an increase in suffering. Another participant described worrying too much, but the nature of his worry was limited to fears about his wife being deported. Yet another male participant discussed the harm that the institution of prison caused to his mental health. He expressed, “I am hyperactive but my mind is changing even more. I’m not sure if prison has made it worse; it did me a lot of harm...being in prison has worsened the problem” (“Soy hiperactiva pero mi mente está cambiando aún más. No estoy seguro si la carcel lo ha hecho peor; eso me ha hecho mucho dano...estar en la carcel ha empeorado el problema”).

**Theme 6: Spirituality and morality / Esperitualismo.** Spirituality emerged as a theme to capture the perception of feeling cursed or punished, when this experience was the primary complaint. For example, one woman describes her distress as “It’s just shit, like someone has it in for me. It is as if someone has given me a curse. But likely it might be just a case of bad luck” (“Es una mierda, como si alguien la hubiera agarrado conmigo. Es como si alguien me hubiera dado una maldición, pero solamente es un caso de mala suerte”). This experience of feeling cursed or with bad luck is her primary symptom; it is the nature of her distress, which she later makes sense of as a punishment.
**Research question 3:** How do these clients understand what has caused their mental health problem? What are the perceived influences on mental health? Are beliefs of causation individual, socio-cultural, or both?

Participants shared a number of different perceived causes for their mental health problems, and several themes emerged to organize these narratives: (1) interpersonal dynamics (dinámicas interpersonales), (2) violence (violencia), (3) loss and death (perdidas y fallecimientos), (4) spiritual forces (fuerzas espirituales), (5) health problems (problemas con la salud), (6) work (trabajo), (7) society (sociedad). Interestingly, although mood and internal experience was the most frequently endorsed symptom of mental illness, there was a shared and obvious perspective in this group that social disruptions and dynamics, rather than internal dynamics, were the most frequent cause of individual distress.

**Theme 1: Interpersonal dynamics / Interpersonal.** Some individuals described a lack of social support as a cause for their illness or symptoms. The same woman who endorsed regret and distress surrounding her immigration to the United States stated that the reason it was so problematic was that, “I was alone. I did not receive any help from anyone” (“Estaba solo. No recibí apoyo de nadie”). This parallels other responses in the group describing being alone causing illness. General relationship problems are also endorsed as the cause of distress, such as familial strain, having many family responsibilities, and family illness. Finally, changes in the social network are described as major causes for distress for some people, such as having a new baby, or transitioning to a housing shelter.

**Theme 2: Loss and death / Perdidas.** In this group, loss and death was often viewed as a major influence on mental health. Very often, individuals described the death of a loved one, family member, or child was a major trigger of distress for individuals. Loss often preceded the
symptoms of feeling lonely, sad, and overwhelmed that individuals were seeking help and support for. Other participants experienced some social disruption or loss which precipitated their symptoms, such as a separation from a partner. A case study will be reviewed later in the results that illustrates one woman’s struggle with feelings of loss related to her immigration.

**Theme 3: Violence/Violencia.** Separate from general interpersonal relationships, this theme emerged from those individuals who attributed their current difficulties to violent and abusive relationships. One woman clearly asserts that her problems began when she experienced domestic violence in her relationship with her husband, twelve years ago ("Los problemas comenzaron por el abuso de violencia de mi esposo hace ya 12 anos"). Yet another woman described general pain and sadness as her primary symptom, and explained the cause as,

“I think it was that my partner treated me as I was useless. An “idiot”. He treated me like that after our kids were born.” One male participant described his primary problem as feeling out of control. Even though he did not speak to one specific violent relationship, he expresses a general sentiment of discontent with relationships, “I am worried...because there is just so much hate in the world, and natural disasters. I believe that the world will end soon” (“Estoy preocupada... porque hay tanto odio en el mundo, y desastres naturales. Creo que el mundo va a terminar pronto”). This example also ties into the next theme of spirituality.

**Theme 4: Spiritual forces/Esperitualismo.** Spiritual causes were sometimes endorsed by participants to explain pain and illness. In the example given earlier about one woman who experienced “bad luck,” she suggests a cause as, “It is a bad karma. It feels like I am being punished” (“Quizas sea un mal karma. Se siente como que estoy siendo castigado”).

**Theme 5: Health / Salud.** According to participants in the current research study, poor health is a significant cause of distress. Interestingly, this took the form of both personal health
problems and pain, as well as the distress caused by concern with the health of others. A number of participants spoke about the experience of pain and poor health causing other symptoms such as worry and depression. One woman described feeling depressed, tired, and isolating herself at home. She explained how her own pain and the health of loved ones has impacted her symptoms:

“I feel depressed. I get tired very easily. I don’t know what to do. I don’t want to go anywhere. I just want to stay home. I feel alone. And I fear that my back pain will leave me paralyzed. My father’s illness also worries me a lot. And the illness of my sons.”

(“Me siento deprimida, me canso muy fácilmente. No sé qué hacer. No quiero ir a ningún lado. Solo quiero quedarme en la casa. Me siento muy sola. Y temo que mi dolor de espalda me deje paralítica. La enfermedad de mi padre también me preocupa mucho. Y la enfermedad de mis hijos.”)

**Theme 6: Work / Trabajo.** Many participants in the group have lost jobs and have had difficulty finding work. The loss of a job was attributed to distress for some individuals. Some individuals attributed an increase in symptoms to new or existing jobs, such as one woman who started feeling very anxious after beginning a job at a local hospital. Although she does not elaborate on this further, she clearly asserts a connection between her symptoms and her work experience. Yet another person describes a sense of loneliness that began after losing a job, suggesting a social benefit to employment as well. This individual and dynamic will be explored further in a case study.

**Theme 7: Society / Sociedad.** Participants also introduced the role of larger social institutions as an influence on health. Prison is one social institution that was discussed for its influence on mental health. One middle aged man had been feeling overwhelmed with thoughts and distress in his body; he clearly states, “I’m not sure if prison has made it worse. It did me a
lot of harm. Being in prison has worsened the problem” (“No estoy seguro si la carcel lo ha empeorado. Eso me hizo mucho dano...Estando en la prision ha empeorado el problema”). Immigration was a notable force recognized by many as impacting social relationships, work opportunities, and participation in the larger community. This complex socio-political dynamic affects individuals on many levels. For those who “I don’t have papers” (“no tengo papeles”), that alone was communicated as an explanation for feeling lonely, trapped, and isolated. Many of these individuals discussed feeling out of control of their own lives. There was also a strong sentiment of worry and fear that one’s self or a loved one would be deported, resulting in separation and social disruption.

**Research question 4:** What do these clients tell us about what has helped to fix the problem and what would be helpful in treatment? How has health been sustained? What does coping look like? What resources are needed for healing?

Themes emerged across multiple levels including: (1) social support and socializing (apoyo social y socializando), (2) family relationships (relaciones familiares), (3) spirituality and hope (espiritualidad y esperanza), (4) economic stability (estabilidad economica), (5) calming my body (relajando mi cuerpo), (6) managing one’s thoughts (manejando mis pensamientos), (7) therapy and mental health providers (terapia y provedores de salud mental), and (8) medication (medicamentos).

**Theme 1: Social support and socializing / Apoyo social y socializando.** It is not surprising that given the role disruption in relationships played in the group’s experience of symptoms and illness, having relationships is also recognized as a powerful way to maintain health. A very common group experience is a shared value for being with and talking to other people, which has helped to manage stress and difficulties in the past. For some people, benefit
even comes from “being on the streets” (“cuando estoy en las calles con otras personas”) or “watching other people” as a social outlet. Social opportunities are viewed as important in themselves, and also for their potential to offer help and support when needed. Many participants also felt that relationships and socializing would be needed to manage their current distress.

Some identified a desire to have new relationships (“tener relaciones”). For others, a sense of belongingness and relationality with a more general ‘others’ and community was sought; one person hypothesized that “Maybe becoming more involved with others” (“Quizas integrarme mas con otras personas”) could be helpful. Talking and conversation is viewed as helpful for many, “I believe that talking will do me good” (“Creo que el hablar me va a hacer bien”), “I need to talk about this” (“Necesito hablar de esto”). Isolation was discussed earlier as a major symptom for many, and there is a simultaneous recognition that socializing is a natural anecdote for many:

“Going out and being with others helps me to feel less alone. When I am indoors trapped alone, it’s not good for me. When I am content, I do not feel any physical pain” (“Salir y estar con los otros me ayuda a no sentirme tan solo. Cuando estoy en casa trancada sola, eso no es bueno para mi. Cuando estoy contenta, no siento ningún dolor físico”).

In addition, family relationships emerge as so significant for this group, that they will be discussed as a distinct theme.

**Theme 2: Family relationships / Familia.** Individual narratives reflected a general sense of wellbeing achieved by being with family members. Similar to general human interactions, participants emphasized the value of these relationships by describing enjoyment in simply being with family members (e.g. children, grandchildren, mothers). The group felt comforted by being with family, and this sentiment was expressed even for those individuals whose family relationships were also a source of tension. For example, given this mostly immigrant participant
group, the pain of family disruptions have been a reality for many individuals. At the same time, hopes of reunification and appreciating current connections are voiced as a powerful motivation toward health. One client will be reviewed in a case study for his especially powerful description of this dynamic. Notably, it also appears evident that above and beyond general human interactions, family relationships held a special function and utility to support the individual. Many participants identified family members as helping to manage problems in the past, and also currently. Family members are described as active participants in client’s goals for health, for example, “My mother helps me with these issues” (“Mi mama me ayuda con mis asuntos”) and “My son also gives me a lot of hope and strength to help me” (“Mi hijo me da mucha esperanza y fuerza que me ayuda, tambien”).

Theme 3: Therapy and mental health providers / Terapia y proveedores de salud mental.

In the present study, many participants identified their therapists as helpful in the past. For one victim of previous domestic abuse, the most helpful support to her has been, “…when I talk about the pain with my therapist” (“…cuando hablo de el dolor con mi terapista”). Another woman with a history of intimate partner physical and emotional abuse came into the clinic; the violence had occurred fifteen years prior, and this client had moved far away to help ensure her safety, nonetheless she was actively looking for help with severe stress and anxiety. She describes that, “In therapy, I get to talk about a situation that I have been in, that I have kept to myself for many years.” The space to talk about difficulties and pain without shame is a part of therapy that is highly regarded by participants. Feeling heard and understood is another invaluable element of a therapeutic relationship. The man discussed earlier who was struggling with life after prison stated, “It helps me being able to talk, and feeling like someone is understanding me, which is very important to me” (“Me ayuda poder que pueda hablar, y que me
sienta comprendido por alguien me está entendiendo, que es muy importante para mi”). As another woman stated, “Talking to the doctor has helped me. She gives me a lot of confidence” (“Me ha ayudado que puedo hablar con el doctor. Ella me da mucha confianza”). Finally, for some individuals, the clinic in itself has offered a sense of connection, belonging, and warmth. One person with high levels of anxiety, depression, and feeling lonely, stated, “Perhaps coming here and talking with others” (“Quizas viniendo aqui y hablando con otros”). In this way, the clinic represented a community home, even beyond individual relationships with providers.

**Theme 4: Medication / Medicamentos.** Some group members endorsed using medication in the past for stabilization, complementing therapy, “I need to talk about this and I need the doctor’s prescriptions” (“Necesito hablar de esto y necesito medicamentos del Dr. Green”).

Several group members were thinking about medication as a potentially useful part of their treatment and healing, suggesting that medication might be necessary for them. Researchers were somewhat surprised to see just how many clients believed that medication should be part of their treatment, with research that Latino persons tend to seek psychiatric treatment less, are more likely to seek therapy than medication, and have more psychotropic nonadherence. Nonetheless, this may also speak to the clinical makeup of the group, and the normalization of or education about psychiatric treatments in this setting.

**Theme 5: Relaxing my body / Relajando mi cuerpo.** Interestingly, managing distress using relaxation of the body was very frequently endorsed by participants. It was described as a way the group had coped in the past with mental distress. The group discussed the benefit of activities such as going to the gym, muscle relaxation, and deep breathing, “I have made a lot of efforts, and the breathing is helping me a lot” (“He hecho muchos esfuerzos y el respirar me
Managing physical pain is also acknowledged as a part of prevention and wellbeing. The shared significance of this piece of health maintenance for individuals likely speaks to the context within which the data was collected (a relaxation group on managing anxiety with imagery), or the effects of therapy. It may also speak to the mind, body, spirit continuum imbedded within many Latin cultures.

**Theme 6: Changing thoughts / Manejando mis pensamientos.** Most participants acknowledged some aspect of their thoughts or beliefs playing a role in maintaining or achieving mental health and wellness. For example, one woman struggling with feeling lonely, isolated, and disappointed in living in the United States agrees that what has been helpful has been, “To stay and to think positive, that sooner or later there will be a solution” (“En pensar y ser positive de que tarde o temprano habra una solucion”). Many participants also express a desire to evade thinking about stressful things, such as past traumas, tense relationships, or worries. There is an expressed desire to refocus the thoughts and attention onto meaningful current events, or onto hope. It is difficult to assess how much of this thinking might be influenced by the prevalence of CBT approaches in therapeutic intervention.

**Theme 7: Spirituality and hope / Espiritualidad y esperanza.** This theme emerged as a perceived resource that many participants had drawn upon in the past, and sought for the future. The role of faith, religion, spirituality, and hope intersected with many of the individual narratives. Some participants keep a tradition of going to church which offers them support through stress and illness. Many receive strength from a sense of spiritual and religious connection, “God has given me strength and my spirit gives me strength” (“Dios me da fuerza y

*ayudaria mucho*”). There is a common sentiment that, “Learning how to relax would help a lot” (“Aprender a relajar me ayudaria mucho”).
mi espíritu me da fuerza”). When discussing hopes for future treatment, narratives echo a general sentiment that faith motivates and inspires, and also “A little bit of peace and tranquility would help me” (“Lo que me ayudaría en un poco de paz y tranquilidad”).

**Theme 8: Economic stability / Economica estabilidad.** Just as unemployment is a major stress for individuals, a desire for economic stability was explicitly voiced by some participants in response to hopes for treatment. For some, economic stability was identified as a resource needed for healing. Many participants described financial, economic, or housing supports and the ability to move as basic to relief. For some, despite the symptoms experienced, this was literally the only expressed need, “I want a good house, a good job, and financial assistance” (“Quiero una buena casa, un buen trabajo y ayuda financiera”) and “Money; having money would fix all of it” (“Dinero; tener dinero arreglaría todo”). For others, not all individuals who expressed financial instability necessarily viewed financial stability as a solution to their distress.

**Case Studies**

A presentation of two individual cases may illustrate the intersection of these themes more cohesively. Only two individuals were selected for case study rather than every participant, due to the high number of participants in this study. These two were selected for discussion to illustrate idiocentric and allocentric perspectives within an individual and mental health narrative. Quantitatively, their perspectives were stronger in either direction than other group members. These individuals will be presented as case studies using a pseudonym, a presentation of demographic characteristics, and an analysis of the person’s quantitative and narrative data.

**Andre.** Andre is a 54 year old male who has been living in the United States for 22 years. He identifies as Hispanic, and was born in the Dominican Republic, coming to the United States as an adult at age 32. Although it is not clear when he arrived in the Boston area, it is worth
noting that Massachusetts ranks fourth in states which have the highest number of
Dominican born residents (Boston Redevelopment Authority, 2009), and the vast majority of
these individuals reside in the Boston area and specifically Jamaica Plain. In addition, when
Andre came to the United States in the late 1980’s, immigration to the United States from the
Dominican Republic rose drastically for persons seeking economic opportunity.

Andre came to the United States with very little education; he did not finish elementary
school, although this is not uncommon for adults his age in the Dominican Republic. His primary
language is Spanish. Although he has been employed in the past, he is currently struggling with
unemployment, and his income is primarily based on Social Security earnings. For an individual
who likely migrated to the United States for economic growth, he struggles with an income of
$10-20,000 per year, and he needs state support to rent an apartment in the greater Boston area.

Andre is concerned with his health and identifies several health problems including an
eye injury which has affected his vision, stomach obstructions, and high blood pressure. He has
used the hospital twice in the past year, once for stomach pain, and once when he was concerned
about his level of depression. Andre identifies himself as Catholic, although he does not view
religion to hold much importance in his life, and never attends religious services. He is separated
from his partner and has four biological children, although he does not live here with them.

Andre completed the open-ended interview using Kleinman’s questions to better understand
his conceptualization of his mental health difficulties. When asked to describe his current problem,
Andre described, “I am so depressed. I feel tired, and then I feel that my heart will explode and I get
very nervous. I panic and I can’t sleep.” (“Estoy muy deprimido. Me siento cansado, despues siento
que mi corazón va a explotar y me pongo muy nervioso, me del panico”)
y no puedo dormir”). This speaks to the theme of internal and bodily distress noted by many of the participants.

He then summarized his own perspective on what caused this distress. Andre expressed a belief that his depression and panic began after he lost his job; “I believe that all of these problems started after I lost my job. I started feeling alone, and it was then that I started to feel depressed” (“Yo pienso que todos estos problemas comenzaron después de que perdi mi trabajo y me comencé a sentir solo y entonces me comencé a sentirme deprimido”). Here, Andre very clearly connects the loss of a job to feeling lonely and the loss of social connection, exemplifying the theme of interpersonal dynamics influencing mental health. Andre’s reality is that feeling lonely led to his symptoms and perceived depression. Andre perceived work as a place of support, suggesting a social benefit to employment for some individuals, perhaps especially for immigrants who are away from their families to pursue economic opportunity. We can also question whether the loss of income affected Andre’s perceived depression, although it is not explicitly stated. With the loss of a secure and steady income, he likely had to continue to face all of the hardships of immigration without the economic benefit, perhaps leaving him more prone to feeling disconnected.

When Andre shared ways he has attempted to manage and comfort himself in the past, and what might be helpful for his treatment in the future, he readily describes the support he needs as, “...when I am alone in the streets or with other people. And perhaps coming here and talking with others. Just talking, and being with others.” (“Cuando estoy solo en las calles o estoy con otras personas. Quizas viniendo aquí y hablando con otros. Si, hablando y estando con otros.”) Social support and socializing emerged as a major theme for many participants in this study. Similarly, Andre’s narrative suggests that talking and being with others, in a personal or
casual way, has helped him to sustain wellbeing. He suggests that this will be an important resource for his healing, and connects his need for relationships to considering therapeutic relationships also in the future, another common theme reported by participants for healing.

In summary, Andre’s narrative speaks to themes of internal and bodily distress, separation from family, the social aspect of employment and the social loss of unemployment. His narrative also describes the lack of human interaction as a personal explanatory model for depression, and human interaction itself as a healing force. Additional clinical data suggests that Andre does have a severe and clinical level of anxiety, using the Beck Anxiety Inventory, and a moderate level of depression, using the Beck Depression Inventory.

Andre’s IndCol score for collectivism was 8.13, which is in the highest quartile of the sample ($M=6.73$, $SD=1.614$), and also high when compared to persons living in the U.S. ($M=6.2$, $SD=2$). This was assessed through items that Andre strongly identified with including My happiness depends very much on the happiness of those around me; I would do what would please my family, even if I detested that activity; if a co-worker or neighbor gets a prize I would feel proud; and I usually sacrifice my self-interest for the benefit of my group and family.

Although the reasons for Andre’s migration are not clear based on the information I had access to, we can imagine based on the last descriptor specifically, that his migration was perhaps in the collective interest. In addition, it is of little surprise that Andre endorsed, To me, pleasure is spending time with others; and it makes sense that feeling detached from others would cause him distress. Results of his SEQ also indicate that Andre described others from a highly social lens, moreso than typical within the sample, and using descriptors that were frequently self-referent (asserting the person’s relationship to him), together and social (social component stated or suggested in the description) (composite score $M=.71$).
His final score for individualism was 4.50, which is lower than both the U.S. average ($M=6.3$, $SD=2$) and the sample average ($M=5.2$, $SD=1.43$). This includes endorsements of *I usually sacrifice my self-interest for the benefit of my group/family*, and strong disagreements with statements like *It annoys me when other people perform better than I do, I enjoy working in situations involving competition with others, I enjoy being unique and different from others, I am a unique individual*, and *I like my privacy*. In an analysis of his descriptions of others using the SEQ, Andre quite infrequently (and less than the sample average) described others from an individualistic perspective by defining their traits, or describing them alone and as individuals (composite score $M=.16$).

**Eva.** Eva is a 51 year old woman who has been living in the United States for 10 years. She was also born in the Dominican Republic, and identifies with this ethnic background. Her primary language is Spanish. Eva is divorced from her husband and she has two biological children, who remain behind living in the Dominican Republic. Eva came to the United States with a high school diploma, so she is fairly well-educated compared to other adults born in the Dominican Republic. She is currently working as a housecleaner, although her hours are less than predictable. As a result, her annual income is less than $10,000, and it makes sense that she struggles with paying bills and supporting herself financially. Eva does receive housing support and she rents an apartment alone. Eva identifies as Roman Catholic. She goes to church regularly for services, and her religion is very important to her, which she uses as a source of support and strength.

Eva completed the open-ended interview using Kleinman’s questions to better understand how she conceptualizes her current difficulties. When asked to describe her current problem, she described it this way: “*I feel trapped. I believe that it (life) is difficult, but I hope that by being*
with God it is all okay” (“Me siento atrapado. Yo creo que es difícil pero yo espero que estando con Dios estare bien.”). This illustrates the theme of experiencing distress through “estado de ser,” or the state of being. This theme captured those individuals who described a sense of struggle, without a clear context. They often described some problem with internal energy, inner self, and overall sense of being. Similarly, Eva endorses a sense of feeling “trapped,” also describing an internal struggle between her reality of life experiences, and her desire for hope. As her narrative evolves, one can witness the descriptor of “trapped” also reflecting very literally her undocumented status; with this, we can see how societal problems manifest as personal difficulty.

For Eva, she simply yet clearly states her personal beliefs of causation as: “I don’t have papers, and so I can’t see my family” (“No tengo papeles y no puedo ver a mi familia”). Eva clearly connects her inability to see her family to her feeling overwhelmed and “trapped.” In this example, her perception of causation is familial and socio-cultural. Her narrative is best captured by themes of interpersonal dynamics, loss and death, and societal barriers. For participants, a common theme in the group is being alone causing illness. Eva clearly describes a lack of contact with her family as a primary cause for her symptoms. Loss and death is another theme which organizes those participants who experienced some social disruption which precipitated their symptoms. This case study illustrate’s the connection between Eva’s struggle and her undocumented status, which prohibits her from returning home to see her children and family. There is a societal barrier present in Eva’s narrative; “I don’t have papers” alone is communicated as a notable socio-political force, and an explanation for feeling lonely, trapped, and isolated.
Eva was asked to discuss what in the past has been helpful in her attempts to cope; “I go to church to pray. Only God gives me strength” (Voy a la iglesia a rezar. Solamente Dios me da fuerza). When discussing what resources would be needed to support her health in the future, she states “I’ll be fine when I am with my entire family. What I need, is to be with my family.” (“Voy a estar bien cuando estoy con toda mi familia. Lo que yo necesito es estar con mi familia”). In other words, Eva tells us that her health has been sustained through her religious beliefs, captured by the theme of spirituality and hope. In many narratives captured by this theme, hope is accessed through spirituality, and is a powerful motivator toward health. It is also clear that family relationships have a special ability to support Eva, and she values physical closeness to them. Nonetheless, an important part of her contextual reality is her undocumented status which when situated in this place and time, results in an inability to leave and come back into the country without legal consequence. Eva knows what she needs for healing, yet is unable to pursue it.

In summary, Eva’s narrative is one that speaks to internal distress resulting from her current social realities. Her narrative also illustrates her faith in God and her religious traditions as powerfully supportive, and helping her to cope with suffering in the face of these realities. Data from the BAI and BDI do not support a pathological or clinical level of depression or anxiety, but nonetheless, Eva’s reality is one of profound distress and seeking support for this.

Eva’s IndCol score for collectivism was 8.25, which is the highest within this sample ($M=6.73$, $SD=1.614$), and also as compared to persons living in the U.S. ($M=6.2$, $SD=2$). This was assessed through items that Eva strongly identified with including My happiness depends very much on the happiness of those around me; I would do what would please my family, even if I detested that activity; I usually sacrifice my self-interest for the benefit of my group and family;
It is important for me to maintain harmony within my group/family; I would sacrifice an activity that I enjoy very much if my family did not approve of it; Children should be taught to place duty before pleasure; and Before taking a major trip, I consult with most members of my family and many friends. Eva’s scores on the IndCol suggest a strong value for duty and self-sacrifice to one’s family and group. Results of her SEQ illustrate that Eva was able to describe others from a social lens (composite score \( M = .468 \)), but this is balanced with an individualistic lens also.

Her final score for individualism was 5.75, which is lower than the U.S. average (\( M = 6.3, \ SD = 2 \)) but higher than the sample’s average (\( M = 5.2, \ SD = 1.43 \)). This includes strong endorsements of: What happens to me is my own doing; I often “do my own thing”; I like my privacy, and strong disagreement from statements like I hate to disagree with my group. In the analysis of her descriptions of others using the SEQ, Eva described others from both a social (\( M = .47 \)) and an individualistic (\( M = .49 \)) lens.
Chapter 5
Discussion

A major finding of this thematic analysis was that while distress often manifested as an internal and private experience, the cause for individual distress was most often explained as interpersonal, contextual, and socio-cultural. This chapter will extend the analysis of individual perspectives as reviewed in Chapter 4, using critical and feminist ecological frameworks in psychology. The feminist ecological model will guide a discussion of the participant information across multiple layers of complex and dynamic human existence (Ballou et al., 2002). This section will explore those distressed human contexts that individuals are coming from, and the systemic influences on human beings and this participant group. Specifically, a description of findings will be presented in an ecological and contextual analysis which incorporates the levels of the individual, microsystem, exosystem, and macrosystem. This analysis attempts to reconcile individual and personal narratives of mental health offered by informants with the contextual realities that are present yet often not visible for individuals. Limitations and contributions to theory will be offered, along with implications for practice and application.

Ecological Analysis

The results as reviewed in Chapter 4 acknowledge individual voices and offer a phenomenological description of narratives of mental health. Results can be discussed even further at an interpretive level, to understand the data using a framework of the feminist ecological model, along with psychological theory. Mainstream psychological theory offers analysis at the individual level, while the feminist ecological model structures an analysis which includes the individual along with micro, exo, and macrosystems, as they intersect with planetary
Orientation in Narratives of Mental Health and historical conditions (Ballou et al., 2002). This analysis will use the feminist ecological model to examine the meaning within personal narratives of mental health, and offer a conceptual discussion of the information. The discussion is presented by myself, an outside observer who is attempting to understand a particular group’s narratives on mental health, from their words and standpoints.

**Individual.** Quantitative results of this study align with research that has suggested ethnic minorities in the United States report higher levels of allocentrism than Whites (Oyserman et al., 2002; Triandis, 1994). A wide range of individualistic and allocentric traits were endorsed by respondents. As a group, participants endorsed allocentric traits similar to the general population average, but individualistic traits were significantly less represented. Idiocentric and allocentric traits varied in different directions amongst individuals, although the group can be described with low levels of idiocentrism, and a tendency toward sociocentrism. In addition, most individuals used sociocentric categories to communicate about and describe individuals; suggesting an experiential framework that is often social, self-referent, interrelated, and contextual.

The group’s results are also in line with an orthogonal model of orientation where levels of idiocentrism and allocentrism are not jointly exclusive or mutually exhaustive (Singeles et al., 1996). Furthermore, individuals endorsed different levels of allocentric traits despite all persons identifying with a sociocentric ethnic and cultural group (Latina/o), reinforcing an appreciation for within-group diversity and variability.

Exploration of personal narratives of mental health allowed for common themes and experiences to emerge, to better understand individual experiences of mental health problems.
and distress. Responses from interviews and standardized instruments converged in displaying a range of individual perspectives that were both individually and collectively focused. Employing qualitative methods to complement the study of dimensions of allocentrism and idiocentrism offered context to these orientations to provide a richer description of the variables, and their application to lived experience. Individuals expressed distress using a range of identified problems and symptoms, although a dominant theme for most symptoms was a problematic internal energy state, involving feelings of struggle, displaced life and meaning, lack of control, and emptiness. Bodily sensations were frequently used to describe distress. A common experience for the group was that symptoms were often expressed as individual and internal problems.

As suggested by these participants’ stories and experiences, there are diverse ways of experiencing illness and healing, illness narratives are complex, and the experience of illness is related to a number of individual and contextual factors. Results also suggest that we do not all experience distress similarly, and a person may explain suffering from a number of different vantage points. This finding challenges assumptions of psychiatric normalcy and supports that individuals use many aspects of their lives, including individual and social experience, to experience health and illness. From an individual perspective, the results suggest multiple and diverse standpoints on mental health and distress.

Individuals shared different beliefs of causality about the creation of the problem. Perceived causes of psychological distress were diverse and varied. Although mood and internal experience was the most frequent manifestation of distress, there was a clear shared perspective in this group that social disruptions and dynamics, rather than internal dynamics, were the defining cause of individual distress. Health problems were also perceived as a cause of distress.
because poor health could result in dependence on a family unit or an inability to care for others. Interestingly, individuals did not tend to endorse biomedical causes of illness such as food reactions, hormonal imbalances, or brain and neurological deficits. Health problems were commonly described as a cause of mental distress, but not through problems of the self as a biomedical model would propose, but through the implications poor health has on one’s feeling able to care for others. This tendency is a different dynamic than Western studies have suggested, where biomedical causes remain a major perceived influence on mental health (Link, 1999). Still others described the role of societal systems in individual distress.

Individuals also discussed their understanding of what might help to reestablish individual health. Coping and distress tolerance were viewed as both an individual process and one facilitated by others. Individual strengths such as spirituality, faith, physical activity, relaxation, and positive thinking were endorsed. Many also described religious traditions and faith as a way to foster hope, motivation, and inspiration, while also being a source of social support. Relationships were commonly recognized as a powerful way to maintain and renew health, because they facilitate the experience of belongingness, and provide help and support to the individual. A common group experience was the belief that having relationships maintained health and supported healing, whereas not having relationships or having strain or distance in one’s relationships could cause distress and disrupt wellness. Family relationships were described as a special type of relationship, through which individuals feel connected and have access to support.

Another interesting theme that emerged was the perceived benefit of psychological and psychiatric services. Respondents describe the benefits of the therapeutic relationship as a place to share painful experiences in a non-judgmental environment, feel understood, and acquire of
confidence and hope. Many participants identified their therapists as an important part of healing. Many participants had been in therapy in the past, some wanted to begin for the first time, and psychiatric medications were an acceptable aspect of treatment for many. These findings contradict past research suggesting that persons from non-European and collectivist backgrounds have low usage of formal mental health care (Tata & Leong, 1994). In the present study, however, participants diverged from that notion. These results can be understood in the context that this group was a clinical one whose presence in the clinic suggests an acceptance of a medical model of healing. Furthermore, participants in the study were actively seeking relief from high levels of distress, and some had been referred by therapists and primary care physicians. Nonetheless, this observation challenges the literature’s description of a static underutilization of mental health services for Latino persons. Although research has described this ethnic group to be at risk for underutilization of mental health care, individual narratives speak to how familiarity and positive experiences with mental health services have reinforced these services as an acceptable and helpful option that also provides social support. The physical space of the clinic was also described as a place of warmth and with opportunities for connections.

**Microsystem.** The microsystem level includes relational and interpersonal influences including one’s family, work, peers, and immediate community. From the microsystem, we consider aspects of the person’s immediate and personal environment which affect him or her day-to-day. Interpersonal factors impact individuals across many levels, including psychologically, emotionally, socially, spiritually, and economically.

The desire for belonging and connection was often described by participants. They clearly perceived interpersonal relationships as a valued and healing force. Strong cultural values
for interpersonal connections are discussed often in the literature for Latinos, including *familismo* which is a central aspect of collectivistic societies, describing strong family loyalty, included extended family, and the tendency to turn to family members in times of difficulty (Sue & Sue, 2003). A customary problem-solving approach for many collectivistic Latinos is often to handle difficulties within the family system and discrete from the larger community (Casas & Vasquez, 1996). Many participants in this study described the notion of family as providing relationships with a strong sense of connection, and serving as primary support in times of need or despair.

Apart from biological or familial relationships, the impact of meaningful social connections including neighborhood and community is also seen as valuable. For many participants, separation from family or one’s homeland is a reality of their current situation. Some are able to reestablish social connections at work, through the health clinic, or in the neighborhood. For others, church and religious tradition offer opportunities for social connections.

Many participants attributed the origination of distress to social disruptions and interpersonal problems. Often, these problems were in the realm of separation, loss, and isolation. This includes not having relationships (e.g. isolation, lack of support), disruptions to the family relationship (e.g. immigration, strain, illness), and structural changes (e.g. giving birth, separation from a partner, losing a parent). It is a common experience that when participants cannot access familial support specifically, wellness can be compromised. This may reflect the common and significant experience of familial separation for immigrants, alongside barriers and difficulties to finding social attachments in the local community.
Participants have been resourceful in finding ways to connect with others for health and wellbeing, and we heard from individuals who have met this need through sitting in the health center, finding a small job, or walking the streets. Nonetheless, this is a constant struggle for many. Individuals continue to feel isolated in communities where social supports are either not available, the individual is excluded from the community, or where safety becomes a barrier to genuine connection to others. This exclusion and separation can be seen across diverse experiences, including the imprisoned man, the undocumented person, and the woman who has been abused and violated.

Survivors of violence and abuse report, not surprisingly, high levels of distress. Experiencing violence and abuse negatively impacts an individual’s psychological and physical development and wellbeing. For some, this experience has occurred within intimate partner violence, while others have experienced this in institutions such as prison, shelters, or within the community. Regardless of by who or how the violence is perpetrated, or under what conditions, this experience tends to affect the person’s worldview, often shifting the vision of the self as isolated and of the world as unsafe and unwelcoming.

Separation can also come in many forms. A geographically isolated person may want to attend a church or participate in psychotherapy groups at the health clinic, but may lack the transportation to get there readily. It is not uncommon to hear from the patients at the Martha Eliot Health Center that they take three different busses to get to the clinic, even among some who live a close distance away. Many participants are immigrants who are geographically isolated from their homelands. These individuals often described being socially or emotionally isolated. Isolation in this sense can be cultural and linguistic. Politically, people can be alienated.
when their local needs do not match or are not represented by the dominant political voices. In these cases, their voices and experiences are often ignored or excluded.

As previously described, interpersonal relationships and social supports are valued by these participants. When these social needs are met, individuals gain a sense of community, attachment, connection, cohesiveness, stabilization, resilience, and wellbeing. However, when individuals are unable to meet these needs, they describe isolation, loneliness, apathy, a lack of support, exclusion, and a life lacking meaning. At an individual level and from a psychiatric perspective these symptoms become easy to pathologize as depression, dissociation, disability and dependence. At a systemic level, there is an understanding that the individual’s ability to connect socially is affected by internal and external factors and systems. Society purposely isolates some groups (e.g., prisoners, individuals with certain medical and psychiatric conditions or disabilities) which affects the microsystem. In other ways, social structures contribute to social isolation through the exclusion and segregation of individuals based on gender, social class, economic status, education, religion, race, skin color, and sexuality. This raises the question as to why so many individuals in this study are not able to engage in social aspects of their communities including the workforce, which would provide both social and economic benefits (or, why their work is not visible). Socially, I recognize that this group is profoundly isolated and craving interpersonal connections, which they lack access to. The barriers preventing individuals from access to interpersonal connections and relationships will be explored further in the realm of exo and macrosystems, however one can see that disruptions at the micro level cause the most observable impact on individual’s lives. Regardless of the mechanism of exclusion, for many of these individuals, the result of social isolation is hopelessness, feeling out of control, and having limited access to resources for healing.
Exosystem. The exosystem consists of the local and national institutions (e.g. legal, political, economic, academic, social, cultural). This is an especially important system to explore for this group, because of the concerns with marginalization and exclusion already introduced. The exosystem often maintains and perpetuates the inequalities and disparities that trickle down to the microsystem and individuals (Ballou et al., 2002). Although all individuals are deeply embedded within these institutions, they are sometimes most visible to those without privilege. It is likely because many in this group do not have economic or political privilege, that they readily offer experiences of societal barriers impacting their health and wellness.

Within the exosystem, individuals are connected to certain relationships and systems even when they are not present, not aware, or not active participants of it. Individual health is deeply influenced by interactions in the exosystem, including the health care systems. As one example, health care systems profoundly impact this group’s ability to access services and afford services. Poor individuals cannot often pay for health services, and so rely on external judgments of the significance of their health problems in order to be treated. This also leaves many vulnerable to a lack of primary or prevention oriented care, in favor of health centers which are already strapped for resources to triage only the most “significant” problems to be treated.

The issue of access to healthcare services is an especially salient problem for this group. During my training at the Martha Eliot Health Center, the agency ended a contract with the CeltiCare Health Plan of Massachusetts. CeltiCare Health Plan of Massachusetts was contracted to cover the immigrant documented residents, who had lost healthcare coverage as a result of a 2009 funding cut by the Massachusetts Legislature. This decision sparked concern given the large immigrant population living in Hyde Park and served at Martha Eliot, but was quickly established. In another recent decision in January of 2013, the Boston Children’s Hospital
publically stated an intention to transfer the care of adult patients to other providers in the community, and limit services to only children and adolescents in the community. Decision makers confidently stated that, “We remain firmly committed to improving the health of children and adolescents in Boston and we will continue to operate and support community health and outreach efforts that address the needs of Boston’s children and teens” (Kowalczyk, 2013). Those closer to the clinic’s community understand the shortsightedness of such a decision, which seems to be detached from the reality that healthy children need healthy communities and healthy adults to care for them. The consequence is that adults (including some of these participants) who have been treated for many years at the Martha Eliot, will be excluded from yet another community risking further marginalization.

The majority of this group is classifiable as below poverty level in the United States. An ecological consideration would suggest that access to education is intricately linked with economic status. Education is also a major determinant of economic mobility, which poses a problem when we question whether the educational system is always just or equitable. Relevant issues for this group include access not only to public education, but also to college education which is not fully funded in the United States. For many young adults who are not documented, ineligibility for federal student aid impacts the accessibility of even community and public colleges. Discrimination on the basis of nationality can be evident in access to education, scholarships, and employment. Devaluation of educational qualifications also functions to discriminate against many from South or Central America, who may come to the United States with a professional degree yet are unable to practice their trade without significant and costly retraining.
More frequently within this group, lack of employment opportunities and a livable wage were more likely to be described as difficulties. Many individuals are simply excluded from economic structures and workforce. This can lead once again to social and community isolation, as individuals feel disconnected from systems, and feel judged as unable to economically contribute to society and family. Lack of economic resources can play out in individual lives as harsh self criticism, feeling out of control, and isolated.

Cultural and religious values are also considered part of the exosystem. These values can certainly impact an individual’s values and health. For women in particular who are often socialized as self-giving and to take strong pride in a role of mother, self-image may be tied to her ability to perform these key social duties (Guarnaccia, 1996). As a result, caretaking of family becomes an expectation which when compromised, affects the woman’s psychological experience and view of herself and how she is viewed by others. Some participants also describe culturally sanctioned expectations for work or providing economically, which impact perceptions of the value of the self.

The local police force which is charged with protection of the public is also part of the exosystem. As a government funded institution, political motivations are always part of who the police serve, and what they respond to. Although no participants explicitly mentioned ways their lives intersect with local law enforcement, we heard from several women who experienced violence in their homes and communities, but no mention of legal protection. We must question whether these individuals have access to law enforcement, and whether the system as it exists is helpful for them. In addition, the criminal justice system as a whole has been criticized for apparent racially discriminatory sentencing, and our prison systems serve to institutionalize a disproportionate number of Black and Latino males. Furthermore, for many undocumented
immigrants, calling the police is more readily seen as punitive rather than helpful, as individuals may risk deportation, harassment, or simply being ignored. Across the globe, law enforcement and policing is associated with political motivations, unjust enforcement, and violence. For individuals living in poor and underserved areas, the police are often not visible, and the pursuit of law and order is often met by the communities themselves.

Federal and state policies on immigration also fall within this realm, and are a major influence on individuals’ access to resources and wellness. The immigration debate in this country has been fueled even more intensely by the construction and proposition of the Immigration Reform Bill, focused on stringent border control, a long path to citizenship, and expanded prospects for the DREAM Act and reunification efforts. Scholars have brought attention to the long legacy of discrimination and maintaining global inequities in the U.S., and the historical structures that privileged white people in the U.S. which continue to shape immigration policy (Chomsky, 2007).

This participant group has been profoundly affected by this stringent immigration policy, and it has impacted their microsystems and individual wellness. A common group experience is feeling trapped and isolated by a system that targets immigrants and where fears of deportation block individual’s perception of safety, belongingness, and self-control. Immigration policy cuts off people’s ties to their homelands and their families. Clearly, individuals know that they need family and ties to community, yet often fear or can’t get there or back. For many undocumented immigrants, the system is set up to promote social and political exculsion, and individuals are left feeling isolated and feel alone. Ironically, these symptoms are then attributed to pathology by mental health workers, when they are more accurately understood as a manifestation of an individual’s attempt to function in a system that was not set up for their protection or health.
When individuals do attempt to move in a direction of health within this system, they risk being perceived as criminal, oppositional, or anti-social. Unjust immigration policies play out for struggling immigrants as psychological symptoms of isolation, depression, fear, sadness, disconnection, lack of control, feeling trapped, immobilization, and loneliness.

**Macrosystem.** The macrosystem level focuses on global forces including politics, economies, and distribution of resources (Ballou et al., 2002). Ideologies and constructed beliefs about race, ethnicity, sex, and class can also impact how individuals understand themselves and others. These forces often produce inequalities and discrepancies which shape the exosystem, microsystem, and the individual. Once again, the macrosystem is less obvious at the individual level, but an in depth analysis can begin to address these influences.

If the U.S. immigration policy is a salient force of the exosystem for many in this group, the macrosystem must be examined for how it contributes to this structure. Global institutions perpetuate an economic system which privileges few and oppresses many, and keeps some areas poor and violent. This system is not frequently challenged, particularly in psychology. For many it is so distal that it is seen as a natural reality, or an individual choice, rather than a pervasive and active system of oppression that is maintained by us all because it is threatening, not readily visible, and seldom acknowledged.

Aspects of the macrosystem socialize us to think and act in certain ways. In the U.S. specifically, many of us share a narrative of the U.S. as historically warm and open to the immigrant cause, and the refuge for the oppressed masses. Nonetheless, there continue to be shared and strong beliefs that immigrants take jobs from citizens, compromise the economy, and contribute to poverty and violence, and that these “realities” compromise the American value for
immigration. At one community conversation held at the First Church in Jamaica Plain, these beliefs were openly discussed and questioned by the community (Chomsky, 2007). These narratives contribute to the anti-immigration sentiment in the United States. That then shapes U.S. immigration policy, which maintains a system of masses of oppressed persons seeking opportunities and freedom in areas with concentrated wealth, and areas with wealth invested in keeping those resources (Chomsky, 2007). This dynamic is a powerful force which exists at the macrosystem and profoundly impacts the distribution of resources, the power of individuals to shape their life and destiny, and implications for human rights.

These inequities are visible at the global level, but they are also visible at the national and local level as part of an ideology that power differentials and structural inequalities are natural and a reflection of individual capabilities and traits. This ideology is pervasive in our every day lives where it leads to unquestioned health disparities, zoning restrictions, and educational inequalities. Those individuals who live in poverty are affected psychologically by a sentiment that they have created their own destiny, are are equally able to rise above it. The macrosystem is in many ways so removed from day to day experience, that it is difficult to see and thus question. However, we must question this narrative that does not consider the structural forces which create and perpetuate class distinction and racism. We must challenge this narrative and question in what ways does it impact individual psychology and potential.

At a macrosystem level, one must recognize the profound impact of racial and ethnic discrimination on people’s lives and wellbeing, and Latinos in the U.S. face many challenges related to living as ethnic minorities and sometimes as immigrants or children of immigrants. Historically, many Latinos have a history as a subjugated and colonized people; this mentality impacts the psychology of persons by effecting the perception of oneself, others, and the world
as a just place (Comas-Diaz, 2007). Often, this mentality and experiences with racism and discrimination lead to changes in the sense of trust, power, and safety, and can create shame, rage, fear, and depression which are visible at the individual level (Comas-Diaz, 2007).

**Limitations**

Perhaps the most salient limitation to this study is the issue of to what extent a secondary analysis of qualitative data is useful. Consultation can be helpful in terms of cross-checking results of the secondary analysis with the researcher who obtained the data directly, however there are still methodological considerations to be considered, such as whether qualitative data can be contextualized and interpreted by those who were not present while it was gathered. Because the researchers who analyzed data for this study were not present for its gathering, we cannot comment on the quality of the original work or a deep contextual understanding of the narrative at the moment it was gathered. For example, interactions between the researcher and the researched, such as non-verbal cues, could not be observed or experienced. This may have included effects of power differentials related to differences in gender, age, education, status, etc., on the ways in which data was reported or not reported.

Despite these limitations, the study sought to use a secondary qualitative analysis on transcribed verbal language to answer the research questions. As another limitation, this researcher is not a fluent Spanish speaker, yet I wanted to explore transcribed data which was mostly written in the Spanish language. Therefore the analysis was completed, translated, and interpreted mostly by two co-researchers who do understand the Spanish language. The reader would be wise to question whether this process adequately captured what the participant
attempted to communicate. It is possible that meanings may have been subtly skewed in translation, due to some of the limitations of English in communicating emotional expressions.

Contributions

**Exploration of participants and personal narratives of mental health.** To summarize, results support illness narratives as complex, constructed, contextual, and interactional (Shweder et al., 1997; Ratner, 2006; Grzywacz & Fuqua, 2000; Kleinman, 1988). This research examined the intersection of personal narratives of mental health with social forces. The results illustrate that while distress and mental illness are typically assessed at an individual level, individual narratives reflect those social forces which shape our lives. Constructs of allocentrism and idiocentrism were used to organize some of the naturally occurring perspectives which emerged from individual narratives, and they do capture aspects of individuals’ experiences. Including constructs of idiocentrism and allocentrism had utility to expand assessment beyond the more traditionally accessible individual symptomology, and into relevant contextual and socio-cultural values. This raises our awareness of non-Western values and non-dominant worldviews, which have been lacking in psychological theories and practice (Sue et al., 1996). Nonetheless, in this study, these constructs were less useful in isolation.

A major contribution of this study was actually in illuminating people’s voices, experiences, and their constructed and contextual realities. This study gives some space for individual stories and narratives of psychological suffering to be heard. These narratives have been valuable in understanding the complex ways in which these individuals understand their own psychological distress and perceptions of healing. The study captures those issues which play a major role in the lives of the people actually seeking mental health care. Just some of
these issues include separation from family, fears of deportation, and lack of support and resources. Some of these stories reflect dominant themes in psychological theory, and some of these stories present marginalized experiences and perspectives. All of these stories are unique and contribute much to the study and our awareness as mental health practitioners.

The individual has been the focus of traditional psychological theories about human development, identity, and illness. As psychological research and interventions continue to target distress at an individual level; its social aspects and nature are less frequently visible, due to the predominately individualized approach to psychology. Feminist, cultural, and critical models of psychology have challenged these models and stressed the contextualization of psychological distress. In this study, I have examined individual voices, and through an ecological analysis attempted to increase the visibility of social forces on those individuals’ experiences.

The study has illustrated ways that not only individual values, but also interpersonal dynamics, cultural values, and sociopolitical climate, shape personal experiences of mental health and distress. With this, the study stands alongside other multicultural, critical, and feminist models to offer an ecological analysis of participants’ data in a way that is respectful of the context and realities of their lives. This study widens an understanding of the variety of experiences of stress and illness that exist for persons, challenging traditional assumptions of intrapersonal forces, and acknowledging the role of interpersonal and social processes as an influence on mental health. The study reminds us that mental health care can be better tailored to the needs of those who we serve, by hearing their voices and understanding the context within which they are part. In this way, mental health assessment and treatment can be more closely oriented to personal and social wellness.
An ecological analysis demonstrates ways in which health and wellness are influenced by the many systems we are part of. Contextual factors influence individual psychologies in many ways, including through the resources we have access to, the power we have to shape our lives, our expectations and beliefs about ourselves and others. The effects can work toward health and wellness, or against it. For example, for these individuals who are part of the system of the Martha Eliot Health Center, they can access feelings of support, community, and acceptance. In other ways, the Martha Eliot system has restricted who has access to care, blocked some from accessing care, and dictated who can provide that care and what it should look like. These systems are dynamic in that they hold powerful forces which can be beneficial to the person, and in other ways detrimental. In either direction, they are a strong influence on our lives. In the same way, the individual can affect the system in health promoting and health defeating ways.

**Implications for theory.** Personal narratives of mental health offered individual explanations of distress. Simultaneously, the individual is always developing, inextricably linked to his or her environment, part of multiple and dynamic systems, and shaped alongside historical forces. Social systems impact the individual and his or her access to health, although we do not always know it. From an ecological lens, individual symptoms are social symptoms, and systems of oppression play out in individuals’ daily lives as psychological suffering. Psychological suffering and distress, through systems of oppression, keep people unwell.

In this study, when we ask how do we give people the capacity and ability for healthy functioning, we hear about the need for connection, supports, community, physical health, and access to safe communities and relationships. In this study, participants are already aware of what they need. As psychologists, we tell people that they have an inborn ability to heal and transform themselves. However, what does it mean that the most basic threads of life are not
accessible to the majority of these participants? What does it mean that there are external barriers to individual wellness, and that people cannot access the resources they need to be healthy? What does it mean when the social systems we live and participate in, are the same ones which function to keep people oppressed? What does it mean when the status quo maintains oppression and inequity? It means that health and psychological wellbeing itself is preferential to those with means, resources, privilege, and power.

This study thus proposes that if the goal of psychology is to maximize human health, wellness, and developmental potential, we must seriously reconsider a focus on the individual and a disregard for context. When individual lives are examined, they must be viewed as embedded within larger contextual systems. External systems and dimensions profoundly affect individual experience through our development, resources, resilience, perspective, realities, and orientation. Our informants know what they need for healing. Nonetheless, they report that it has been very difficult to reach or maintain wellness. Systemic barriers inhibit and block access to the resources people know they need for healing.

With a perspective of individual symptoms as social symptoms, change at the individual level is not sufficient. We can also question whether it is ethical, which is an important question yet beyond the scope of this project. This perspective challenges many of the core assumptions in traditional psychological theory and practice. The notion that the experience of psychological distress emerges from an interaction between intrapsychic, social, and cultural components was supported in this study, paralleling feminist-ecological models and Kleinman’s anthropological scholarship in illness. Traditional psychological theories are insufficient when they do not recognize the power of those cultural systems and contextual forces that influence us. A dialogue
which makes these forces visible and encourages a critical discussion is the first step. Using these ideas to inform action and transform intervention is the next.

**Bridging theory and practice.** This research encourages the profession and dominant perspectives of mental health and illness to benefit from integration of other non-Western and non-dominant experiences. Worldview has been an important first step to critically examine mental health interventions toward a goal of culturally sensitive treatments and philosophical rationally for treatment. In practice, mental health professionals can be sensitive to the diverse ways of understanding the self; as allocentric and relationally situated, or as idiocentric and prioritizing individual states and attributes. In this study, constructs of allocentrism and idiocentrism were useful as a way to understand individual narratives, and as constructs which remind us of the importance of valuing relational themes. In addition, the study supported an orthogonal perspective on relationality, where an individual’s identity and experience can be allocentric and idiocentric, to different degrees and in different ways across different contexts.

To this end, clinicians may benefit from using open-ended interview and questions as a method for encouraging examination of the relational and contextual themes in individual narratives of mental health. In this approach, the patient is seen as unique and encouraged to verbalize his or her own perspective and self-conceptualization of mental anguish and primary problems. The person’s own conceptualization of their problem is as integral a part of assessment as other clinical symptom indicators, and this leads to an assessment that is respectful not only of clinical symptoms, but of the person’s lived experience. The clinician considers the impact of cultural variables and values, and also the person’s unique experience of distress, for a valid and useful conceptualization of the problem. When the clinician can better understand the client’s subjective experience and values, assessment is closer to being culturally valid. In
addition, the practitioner should be aware of the ways that the individual may affect or deviate from the social and cultural systems. As one example, Latinos are sometimes grouped simplistically and in a way that does not account for variability within research and even clinical practice. Although all these individuals had identified as Latina/o, an obvious breadth of worldviews and experiences were described.

Another implication suggests that assessment is limited if it stops only at individual symptoms. Many systems of care target symptom reduction and relief, and this is what many psychologists are trained to do within a medical model. However, symptoms may not always match the perceived cause, or what the person is hoping for in treatment. Given research that suggests interventions may be seen as most effective when they match the person’s perceived causation and subjective beliefs (e.g. Lewis-Fernandez & Diaz, 2002), clinicians should be wary of chasing symptoms and losing site of the context within which symptoms were created in the first place.

A major finding of this study was that while distress often manifested as an internal and private experience, the cause for individual distress was most often explained as interpersonal, contextual, and socio-cultural. This makes sense as human problems have an individual part, because the person directly experiences the suffering, and a social part, as individual problems often originate in social context. This study gives recognition to the individual and contextual sides of suffering, and the tools that may be helpful in solving these problems. This study illustrates that individuals use many perspectives to understand the experience of illness, and paths toward coping and healing are both individual and social. It was a common group experience that having relationships maintains health and supports healing, and not having relationships, or having strained relationships (due to conflict or distance), causes suffering. This
challenges psychological theory, and those of us who apply theory to human lives, to be open to and actively looking for social and contextual influences of individual health, and using those systems to promote health.

The results of this study have implications for working toward advocacy and social justice in psychology. The study calls for action to address the needs of marginalized groups, whose voices do not tend to be represented by dominant political forces. Change can begin locally at the individual or community level. To encourage these connections, we can look at empowering the individual and changing the system. The interventions which make sense within this framework include redefining the therapeutic relationship, clinical training, enhancing belongingness in communities, encouraging open dialogue to make social problems visible, advocacy, and redefining community values and possibilities.

From this standpoint, the role of psychologists can be to foster an egalitarian and collaborative relationship, in which both persons give information and resources, and both determine goals and decisions (Prilleltensky & Gonick; 1994). This relationship must value the systems and identities with which individuals identify, for example, racial and ethnic groups, nationality, gender, sexual orientation, socioeconomic resources, ability and disability. There will always be an individual aspect to psychology, because that is where we find suffering and individuals trying their best to cope. Any solution to the problem however must target where the suffering originates, within social ills. For this reason, in psychology, clinicians need training and mentorship in aspects of advocacy where they will be able to work toward these changes. Advocacy must be recognized as integral part of applied psychology, not as a fringe skill or beyond the realm of the field. In order to match this vision of therapeutic relationship, the
practitioner must demonstrate cultural competence, comfort with an egalitarian relationship, a critical voice, and a willingness to advocate.

Health providers can encourage dialogue about the ways in which structural systems, sociopolitical forces, power dynamics, and context influences individual health. Individuals can be educated about structural systems, and ways they might choose to influence the system with their voice. We must continue dialogue both in and out of the therapeutic relationship, to make social problems and dynamics visible. This includes an acknowledgment of their historical roots, and the legacy of unequal distribution of resources that continues. This might have to begin with those who have the power and privilege to speak critically to do so in a public forum. This can happen in churches, schools, through civic organizations, or it can occur in politically neutral spaces in the community. As dominant forces are made visible, non-dominant voices can also be spoken. This allows space for multiple perspectives and possibilities, and for those non-dominant voices to become stronger and shared. By creating new narratives and perspectives, as well as a vision of possibilities, communities begin to shift entrenched systems of influence. In many ways, the community in Jamaica Plain has a long legacy of modeling such open dialogue and community based conversations and initiatives.

Many participants expressed longing for a sense of community and belongingness. Many believe that collective belonging is also the key to health. The participants’ experience matches the literature on the role of belongingness in increased life satisfaction and decreased loneliness (Prezza et al., 2001), and access to support and wellbeing (Cicognani et al., 2001). Individuals can impact their systems toward this end, and should be encouraged to so. Individuals can be educated about structural systems, and encouraged to influence the system with their voice. Mental health workers can model this advocacy themselves. Mental health workers can
encourage individual participation in civic organizations and community, to promote the collective unity. Therapeutic groups might also be useful in this way, with a goal toward collective unity toward a valued local cause, rather than or in addition to symptom reduction. This is also in line with other research that has emphasized that treatments are most effective when they match the culture and values of the person, specifically self-orientation as a cultural variable (LaRoche et al., 2006). Health organizations can work to establish stronger relationships with other community organizations and disciplines, to facilitate such connections. Encouraging patients to give to community systems, such as the health center, with their activism, feedback, participation, and decision making, allows one to feel part of a larger and stable structure.

**Lessons learned**

In this last piece of my discussion, I will comment on the process of my dissertation study through my own experience. I was excited to work on this project, inspired by my two years of training at Martha Eliot, where I developed a commitment to community mental health and social justice advocacy. My proposal began as an examination of the self-orientations of allocentrism and idiocentrism, how these orientations are represented in people’s lived experience, and whether they are a useful construct for counseling psychology. I decided on a mixed-methodology toward this examination, but as I wrote and read more of the literature in this area, what continued to interest me most was those very personal ways we all interpret health, wellness, and illness. My questions targeted the experience of illness for this participant group.

Throughout the study, although quantitative information described the participants and group’s relationality in a standardized and comparable way, what was most useful was the
information and themes discussed in this study gathered from participants directly. It would not have been possible to gather the richness of individual stories, experiences, and meanings, using quantitative measurements of relationality alone. I would have missed the meaning in context, which has clearly had an impact on the individuals’ experience of illness and distress.

The tensions between a positivist and postmodern perspective have emerged in my own writing and experience of the project. While my epistemological point of view and my questions were postmodern in nature, my language and writing often reflected a positivist and quantitative approach. My committee was helpful to me in sharing this observation, which I was then able to observe for myself. The process illustrated the ways in which although my thinking was more postmodern, the positivist tradition remains a dominant force in my training and socialization. In this way, it was not easy to see at times, and in shifting between positivist and post-positivist thinking and writing this paralleled other aspects of this study, such as those contextual forces which are not easily observable but directly shape our experience and worldview.

In summary, in Chapter 4, individual voices could be heard describing unique experiences of distress. From a mainstream psychological perspective, human distress is conceptualized as an individual experience. Through the feminist ecological model, these narratives were analyzed within multiple contexts. From a critical standpoint, and using a feminist ecological model, human distress is inextricably linked to and originating from social ills and oppressive systems. The influences and effects of power and oppression are not necessarily conscious for individuals, but they are there and profoundly affect the daily lives of individuals, often in the form of psychological distress. Presenting this information from the model was more challenging than I initially would have thought. Similar to the tensions I spoke to with quantitative and qualitative methodologies, I found myself valuing an ecological
perspective yet struggling to fully step into that perspective. I end this project with an
acknowledgment of these very real tensions, which are documented both in my dissertation
and my own experience of the process.
References


Chomsky, A. (2007, October). 21 Myths about immigration. Lecture conducted from First
Church in Jamaica Plain, Unitarian Universalist Parish Hall, Jamaica Plain, MA.


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533-556.


