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Remedios: Coping with Mental Distress among Mexican Americans in the Rio Grande Valley

Romeo Escobar, PhD, LCSW, ACSW[1*], Irán Barrera, PhD, LCSW[2], Denise A. Longoria, PhD, LCSW-S[1], John Gonzalez, PhD, LMSW[1], & Isaias Melgoza, LMSW[3]

[1]*School of Social Work, University of Texas Rio Grande Valley, 1201 W University, Edinburg, Texas 78539-2999, Social Work and Occupational (SWOT) 1.204, United States.*

[2]*Associate Professor, Department of Social Work Education, Fresno State University, 5310 N. Campus Drive, M/S PH102, United States.*

[3] *CIMA Hospice, Edinburg, Texas.*

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[*]**Corresponding Author:** Romeo Escobar, PhD, LCSW, ACSW, Assistant Professor, School of Social Work, University of Texas Rio Grande Valley, 1201 W University, Edinburg, Texas 78539-2999, Social Work and Occupational (SWOT) 1.204. E-mail: romeo.escobar@utrgv.edu

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Abstract

The Latino population continues to increase, with estimates of 60 million living in the United States. Of the Hispanic population, 19% live in poverty. This may be a problem because according to research, living in poverty affects people's social networks and self-worth negatively and is strongly associated with psychological issues. This study examined the perceptions of practitioners of mental health treatment of Mexican Americans who were experiencing mental distress and were residing in the U.S.- Mexico border. Findings suggest clients self-diagnose and try medications (usually purchased in Mexico) that were recommended to them by family members and/or social networks. Additionally, the family and social network behave like their own health/mental health care network, a manifestation of the Mexican American value that one should take care of one's own. Loved ones provide these suggestions or *consejos* to help those struggling with mental stress manage their mental health. Professional mental health care is usually the last resort, which clients consider only after other options have been exhausted. This study reveals a need to explore the so-called family and social network health care system within this culture.

Keywords: Mental health, Mexican Americans, family and social networks, South Texas Border

Introduction

A profile of Hispanics/Latinos from the U.S. Department of Health and Human Services (2021) reported that the U.S. Census Bureau estimates of 2019 were that 60.5 million Hispanics live in the United States. Hispanics make up 18.4 percent of the U.S. population with Mexican Americans as the largest group of Hispanics at 61.4 percent [1]. In 2017, 19% of all Hispanics were living in poverty compared to 13% of all Americans [2]. This is an alarming finding because according to research, people living in poverty affects their social networks and their sense of self negatively [3]. Additionally, there is a strong association with psychological problems [4].

Research findings on Latino Americans' mental health service utilization has consistently indicated barriers that exist which affect the ability in accessing economic, cultural, and structural resources. According to research findings from Barrera and Longoria [5], Marin et al., [6], and Atdjian and Vega [7], these barriers include level of acculturation, language, availability of services, affordability, accessibility, lack of health insurance, unfamiliarity with health systems, and eligibility criteria. Additionally, the practitioners' unfamiliarity with cultural nuances and the understanding of which is critical in diagnosis and treatment of illness was also found by the researchers [5,6,8]. Considering these facts, this study examined practitioners' understandings of mental health treatment of Mexican Americans experiencing mental distress living in the Rio Grande Valley.

Service Utilization

According to Chang and Biegel [9], Alegria et al. [10], and Blanco et al. [11] found that Latinos underutilize mental health care. Chang and Biegel [9] examined factors affecting use of mental health services and dropouts from mental health services among Latino Americans with mental health issues. Findings from this study included, being older, having health insurance, having self-perceived need for mental health services, having mental health service need perceived by others and a greater number of probable psychiatric disorders were associated with the use of mental health services among Latinos with mental health issues. Regarding dropping out of mental health services, factors included being younger, not having health insurance, and having a lower level of family support. The findings also suggest that education is needed to help Latino Americans recognize the need for mental health services.

Escobar et al. [12] explored the challenges Mexican Americans face when accessing mental health care service utilization along the South Texas-Mexico border. Researchers held focus groups with mental health treatment providers. Among the challenges identified were limited access to insurance, a minimal knowledge of mental health, lack of family involvement, having few providers, medication management issues, stigma, and culture.

In another study, Gonzalez et al. [13] explored factors that led older Mexican Americans to mental health treatment. They found

overarching themes were culturally responsive agencies and sustained relationships as pathways to service utilization characterized as professional, as well as close and family-like interactions. Family members and health care providers were also significant in facilitating utilization.

Gonzalez et al. [14] studied motivations for mental health service use by older Mexican American women experiencing psychological distress. Qualitative interviews identified relevant themes that emphasized relational constructs with providers, peers, and family. Researchers also found perceived effectiveness of solution-driven group-based care and the integration of sociocultural norms into treatment. Disentangling mental health experiences through cultural tailoring services helps address unique needs in late life. This study highlights the relevance of personal, cultural, and clinical preferences for care in treatment engagement and adherence.

Complementary Medicine

Many Mexican Americans incorporate complementary medicine as part of their health care practices, but only a few individuals share this information with their primary physicians and/or other health care providers. Fowler et al. [15] studied Hispanic parents' beliefs about and approaches to their child's health. This study provided an updated understanding of folk and traditional medicine (FTM) among Hispanic parents in the United States. A significant finding was 84% of participants believed in one or more folk illnesses. In the sample, foreign-born participants are more likely than U.S. born to endorse folk illness beliefs. Eighty-three percent of the participants had used cultural remedies for their children. Only 15% of the participants had discussed such folk practices with their child's provider. And 86% of the participants felt comfortable talking to a child's physician [15]. According to Nguyen et al. [16], they found that more Mexican Americans patients (range of 66.7 - 73.7%) described complementary alternative medicine practitioners as being closer to their cultural traditions than non-Hispanic Whites (11.8%).

Border Health Care

People who reside in the U.S.–Mexico border often rely on care for their health from both sides of the border, regardless of enrollment of health insurance.

Rio Grande Valley (RGV), bordered by Mexico, is a region characterized by a long history of a close and interdependent relationship with Mexico with shared families, traditions, values, activities, and businesses; until a few decades ago, the border was relatively porous. Many still consider RGV and its close Mexican cities to be one region [17].

Shen et al. [18] studied access to healthcare for Hispanics on the U.S.-Mexico border. They found that Hispanics in the region had lower odds of having health insurance and access to doctors. After looking at county level data of the health care system, they concluded that Hispanics living on the U.S.- Mexico border had less access to healthcare when compared to Hispanics that do not live on the border.

To better assess the different types of treatment for mental health among Mexican Americans in the Rio Grande Valley region, researchers in the present study examined mental health care practitioners' perceptions of clients' help-seeking behavior regarding mental distress. Practitioners were asked this question: "What kinds of treatment do they (clients) receive before entering/receiving mainstream mental health treatment?"

Methods

Using a qualitative approach, this study focused on how Mexican Americans perceive mental illness and find meaning for their mental distress. Based on Padgett's recommendations [19], a qualitative methodological approach was implemented using focus groups to study the help-seeking behaviors regarding mental distress among Mexican Americans living in the Rio Grande Valley. Carlson and Hackett [20] also recommended using focus groups for this type of study. As one of the first steps to initiate this study with this hard-to-reach population, researchers decided to obtain information from professionals who provide mental health treatment to the Mexican American population. The emphasis of the focus groups in the study was to gather practitioners' perceptions of clients' mental health experiences.

The researchers organized three focus groups in communities of the Rio Grande Valley region. These communities were McAllen/Edinburg, Harlingen, and Brownsville. Researchers recruited 25 mental health practitioners (N = 25) from these three communities to attend one of the three focus groups. These practitioners were recruited due to their firsthand knowledge of clients' mental distress. Additionally, researchers conducted in-depth interviews with three of these recruited practitioners. The recruited practitioners were comprised of 21 Mexican Americans, three non-Hispanic whites, and one Asian American. The educational level consisted of fourteen practitioners with a degree in social work, five practitioners had a psychology degree, and six practitioners had a graduate degree in a related field. All 21 Mexican American practitioners were bilingual in English and Spanish. The remaining practitioners were monolingual in English. All 25 practitioners indicated their clients were bilingual in English and Spanish. All practitioners were encouraged to participate in discussions as the purpose of the focus groups was to gather ideas from different perspectives.

The Rio Grande Valley is primarily comprised of Mexican Americans. Most of the inhabitants are bilingual in English and Spanish, and many switch between the two languages comfortably. Most of the mental health practitioners selected for the study were also bilingual in English and Spanish. Generally, focus groups should occur in nonthreatening environments among individuals sharing certain characteristics. This will allow opportunity for an effective good group dynamic to occur and greater self-disclosure [20]. Based on the clinicians' preference, the three focus groups were held in locations that were geographically convenient for the practitioners. Informed consent was obtained from all participants in the study by the researchers.

Two of the focus groups were held in agency facilities and one was held on campus in the Department of Social Work at the University of Texas Pan American (UTPA), which is now University of Texas Rio Grande Valley. All the focus groups were held in conference rooms. All participants sat around the conference room table where they could see each other during the process of the focus groups.

Two moderators took responsibility in facilitating the focus groups in the preferred language of the participants, which was either English, Spanish, or a combined English and Spanish group. The moderators had experience in facilitating focus groups and discussions averaged approximately 60 minutes. Each of the focus groups were recorded for transcription purposes [20]. The researchers had a list of semi-structured guiding questions to probe for examples, clarify, and obtain additional details from the participants. These semi-structured questions focused on Mexican Americans' attempts to alleviate mental distress before attending formal mental health services. Focus group questions centered on Mexican Americans' attempts to alleviate mental distress before attending formal mental health services. Kleinman's explanatory model [21] which is used frequently to examine help-seeking behaviors and culture served as a guide to formulate these questions.

Based on Kleinman's explanatory model [21], the model encompasses the notions a person has about an episode of illness and its treatment as delivered by all those who engage in the clinical process. These types of models examine people's cognitive processes based on their cultural knowledge, beliefs they have about their illness (general health and mental health) and idiosyncratic experiences.

These are beliefs that individuals hold based on their culture and social network. These elements guide the interpretation and action concerning health. Individuals form explanatory models to cope with a specific health problem, and these explanatory models determine what important clinical evidence is and how it is organized and interpreted for treatment approaches. Explanatory models assist patients and families in making sense of illness episodes [21].

Ethnographic content analysis [22] was used by researchers to analyze the transcripts. The analysis focused on the collection of narratives, identifying concepts, and emergent patterns and categories which was done through repeated study of the content or text. Ethnographic analysis of the content was achieved through a recursive and reflexive movement between the researchers' interpretation of the narratives and the narratives itself. The purpose of this process was to come up with a systematic and analytic manner, but not rigid, to be able to attain a clear description and definition. The process of qualitative document analysis according to Altheide [22] includes examining the content of the narratives to permit emergence, refinement, or collapsing of additional categories.

The analysis of the content began right after the focus group discussions. The researchers did not have a need to make any adjustments to the guiding questions or research protocol. They performed all the content analysis, including conceptual refinement, identification of pertinent categories and integrated and interpreted the study findings.

Using ethnographic content analysis allowed the researchers to organize the perceptions of the practitioners' clients' experiences of mental distress, specifically types of treatment(s) utilized before seeking formal care. For this analysis, the researchers used the question "What kind of treatment do they receive?" The data from the transcript was reviewed by the researchers and their assistants, and they were able to categorize the types of mental health treatments clients received before seeking mainstream mental health treatment. Each transcript was independently coded by four coders using the categories identified by the research team. The researchers and their assistants then met to discuss any similarities and possible connections with the types of treatment identified during the focus groups discussions. Any discrepancies in coding were adjusted through these discussions. All codes and their meanings identified by the researchers are presented in the results section for each category. The prevalence of mental distress was not a concern of this study.

To augment the trustworthiness of the narratives that were collected, the researchers met with three participants of the focus groups to interview them for approximately 30 minutes for an opportunity for "member checking". According to Padgett [19], member checking, or returning to the field to verify the analysis, assures the interpretation of the analysis by the researchers is on the right track. Additionally, member checking was also conducted with some of the focus group participants by asking them for clarification to some of the questions asked by the researchers regarding different types of treatment that surfaced from the transcriptions and/or interview recordings.

Focus group participants were asked to reply to questions from their personal experiences in working with Mexican Americans who either had no prior mental health treatment/knowledge or were receiving mental health services for the first time. This afforded an opportunity for participants to impart with the researchers their clients' overall perception of issues related to mental health treatment without their clients providing "tainted" information. By engaging in this process, if participants reflected on those Mexican American clients who had prior mental health treatment, it lessened the possibility the client had knowledge of mainstream mental health language and experiences. The moderators continuously reminded participants of these criteria to ensure accuracy of the data.

Findings

Researchers examined the perceptions practitioners in South Texas have of their Mexican American clients' help-seeking behaviors to manage or treat mental health issues. Practitioners were asked, "What kinds of treatment did they (clients) receive before entering mental health treatment?" The focus of this study was on what clients did and who they received help from before seeking assistance from mainstream mental health professionals (e.g., psychologists). Practitioners indicated that clients would first turn to their family, friends, medical regimens from those they know, herbs, and other complementary alternatives before seeking assistance from mental health practitioners. An overarching theme identified by the researchers was that clients were seeking a remedy (*remedio*) for their mental distress. Participants described the *remedio* as a quick fix with an affordable solution to their mental distress; these *remedios* were often given by family (including extended) and social networks (*compadres or comadres,* godmother or godfather, or the in-laws of each spouse). One practitioner noted, "It really has to do with receiving a quick fix, an herb, a *consejo* (advice) from a priest or a *consejo* about treatment from the *comadre* (in-law)." The remedies were often given from people with direct experience with mental distress or knowledge of someone's experience with mental distress and mental health treatment.

Family and Social Networks

Practitioners reported that many clients obtain information about the treatment of mental distress from family members and their social networks (e.g., *compadres*). The information given by family and social networks are derived from personal experiences with mental distress treatment and/or observations of loved ones who experience mental distress. One practitioner reported, "relatives might say, I see this in you, and it"—referring to medications—"really worked for me, so I think you should take it." Another practitioner noted that clients make help-seeking decisions based on "the advice or recommendations from family or a trusted neighbor and they end up taking the neighbor's medication." Another participant shared, "the relative or somebody they knew and trusted took it, and it worked for them, so they start experimenting with the medications." Practitioners also mentioned that many clients received their "diagnosis" from family and social networks, which often resulted in receiving parents' and family members' own medication regimen for that diagnosis. One practitioner stated that one of her female clients "gives medications to all of her kids" based on recommendations from someone they trust in the community and will go to Mexico to buy the medications.

Cross-Border Utilization

Practitioners reported that many clients cross the border into Mexico for medications for their mental distress. One practitioner reported that a client stated to him, "*Me dijo la comadre* for me to take this medication [My in -law told me to take a certain medication], so I'll go to Mexico and ask for it." Another practitioner stated, "...they go to Matamoros (Mexico) to get medications over there." Prescriptions are not required, and it is easy to purchase medications recommended by friends. According to practitioners, clients will sometimes receive a prescription from their primary care provider in the U.S. and then go to Mexico to fill it, given the lower costs of medications in Mexico.

Complementary Remedies

Complementary alternative treatments include visiting *curanderos* (folk healers) and using herbs or teas from a *yerberia* (herb store) to cure specific mental ailments. One practitioner noted, "Individuals that are traditional will go to *yerberias* and will try teas to help with anxiety instead of using medications." Another practitioner reported, "to help with clients' mental distress, sometimes they will go to a spiritual healer, pastor or *curandero* to help with the treatment of symptoms."

Curandero/a **(folk healer):** One practitioner reported that some clients seek "a *curandero* to help them sleep or take the spell away that's causing mental distress," because clients often complain about *mal ojo* (evil eye), a cultural belief, that other individuals are causing ill will to another individual that results in the latter's experience of pain, anxiety, and/or insomnia. The *curandero* will *curar*, or cure, the client by rubbing an egg over the ill client's body while saying a prayer. However, practitioners stated that clients would first go to family members who know how to perform the egg curing ritual before seeking an outside healer; this is usually a family elder. One practitioner commented:

- I don't even think it is "a curandero;" it's always (somebody) someone, a tia, grandma or someone in the family. It is usually someone that always has done it within the family or social network, someone that could help.

Practitioners noted that some family members "can heal clients suffering from *susto* (fear) and perform *barridas*," which is a type of cleansing technique in which branches of herbs are used to heal the client from mental distress.

Tecitos **(Teas):** Practitioners discussed the use of *tecitos* (teas) as another *remedio*. One practitioner reported, "because they don't want to put their children on medication, clients will give teas to their children, and they will also use them for their anxiety." Another practitioner stated, "*se ponen nerviosos y toman te de manzanilla y te quien sabe que mas y te de quien sabe que tanto*" (they get nervous and drink chamomile tea and other types of teas).

Religion/Spiritual. Practitioners reported using religious services if herbs and teas did not work for mental distress, "If the herbs are not working, then they go talk to a priest or a minister and will not go to a professional counselor." Practitioners believe that many of their clients turn to their religion for healing services because of their affordability: "they can see a preacher free of charge." Practitioners reported that clients would also perform *Mandas* or religious promises to deal with their mental distress. *Mandas* can be as simple as "the offering of hair or a different kind of offering to a certain saint or performing a walking pilgrimage to the church shrine of San Juan to get over their illness." These beliefs are an extension of religion and spiritual healing.

Other Remedies

Practitioners noted other remedies that clients reported using after all other remedies failed, including illegal drugs and solutions from media, particularly television. Practitioners stated, "Individuals are medicating with alcohol, or they are medicating with illegal drugs or sleeping pills." One practitioner reported a client stating, "I've tried smoking marijuana every day, but it is not working." Another practitioner added, "a lot of them use street drugs like Xanax or whatever they buy from the streets to medicate themselves."

Practitioners reported that clients would rely on television shows and radio stations for information in self-diagnosis and medical treatment. "Sometimes individuals look for treatment through TV programs because there are a lot of television programs that have doctors or psychic readers or someone that is selling 'miracle' cream that they can buy to help with their suffering." Clients are known to also listen to radio programs to find remedies for their emotional problems. "Mexican stations receive lot of calls asking for help or to refer them to types of treatments or they are simply also looking for merchandise to buy for a quick fix."

Discussion

According to Guzman et al. [23], the underusage of mental health services within Mexican Americans and their growing substance abuse problems, especially among adolescents, together form a worrisome public health concern for the United States. Findings also suggest that clients self-diagnose and self-medicate using medications bought in Mexico that were recommended to them by family members and/or social networks. These practices can be very harmful as the medications' purpose and side effects are unknown. One of the authors of this study found in his former private practice, that many of the clients receiving psychotherapy were also taking medications from Mexico without knowing their side effects (the packaging materials of the medications often state notes such as "*para dormir*," which means "for sleep."

There are two paradigmatic perspectives at play between those who self-medicate and those who begin with a complementary alternative solution. It also seems that there are two paradigms between those who manage their mental health through self-medications and those who do not take medications. These are different from those who self-medicate for their mental distress, those who do not often begin with teas/herbs, then to religion, and lastly to illegal drugs and media for further assistance. They turn to various media to supplement whatever information has already been passed down to them from family, friends, and the larger social network. Since many Mexican Americans are using media to learn about symptomology, diagnosis, and medications to help with their symptoms, then there needs to be a better understanding of mental health literacy together with mental health care seeking-behavior within Mexican Americans residing on the South Texas border.

Given that most Mexican Americans begin their self-care for mental health concerns by turning to their family and social network, these resources behave like the patients' own health care network or mental health care system, an outworking of this population's value that people should take care of their own. The family and social network provide these suggestions or *consejos* to help their loved one cope with their mental distress, leaving professional care providers as the last resort after other options were exhausted. This study thus points to the need for a more thorough exploration of this so-called family and social network health care system within this culture.

Lastly, practitioners describe the clients' explanatory model of help-seeking as informed by the family and social networks. In other words, clients do not seek mainstream mental health care treatment until all other remedies have failed. One practitioner noted: "If those specific remedies don't work, then they seek treatment from a practitioner only after already having exhausted their friends and family, networks, medical advice and the herbal treatments." Another practitioner reported, "Clients will first seek any treatment method from their family. If that was not successful, then they move into trying herbs or what their friends are experimenting with for symptoms like theirs; after following those medical regimens and experiencing failure, then the client seeks their doctor, consequently followed with referrals to mental health professionals." As a result, further research is needed to advance the knowledge surrounding the family's role and social networks in mental health care among Mexican Americans.

Recommendations

The United States is composed of multiethnic, multiracial populations that have distinct health beliefs and cultural practices, resulting in several challenges to health care delivery [5]. Additionally, Gonzalez et al. [14] suggested that culture is a critical element in medical compliance. Therefore, the first recommendation is to address the role of culture, specifically *familismo* (familism), in mental health treatment with Mexican Americans. The second recommendation is to ensure that professionals in the field of mental health working with Mexican American clients are trained and educated on the clients' use of religious and/or other spirituality practices. Next, it is recommended to provide outreach using mavens, which refers to individuals who are readily available to disperse information and advice through oral communication within the community. According to Klein et al. [24], relying on promotoras within informal

networks can help promote pro-social information and behavior as well as increase help-seeking from formal sources. Outreach would include education about the dangers of self-medicating. The final recommendation is that mental health organizations at different levels (local and state) should collaborate with local television networks and media to promote mental health literacy in both English and Spanish. These recommendations are critical in attaining the goal of reducing disparities in mental health treatment among minority groups.

Conflict of interest: The authors declare no conflict of interest.

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