MENTAL HEALTH SERVICE UTILIZATION IN LATINO COLLEGE STUDENTS:
A MIXED METHODS STUDY

A thesis submitted in partial fulfillment of the requirements
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Psychology, Clinical Psychology

by

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DEDICATION

“A good head and good heart are always a formidable combination.”

– Nelson Mandela

This thesis is dedicated to my mother, father, and brothers for teaching me the value of dedication, motivation, passion, curiosity, hard work, and kindness. I am also dedicating this thesis to my friends and family for endless support, and to my undergraduate (Dr. L Mark Carrier and Dr. Larry Rosen) and graduate (Dr. Scott W. Plunkett) research advisors. To all of the above mentioned individuals, thank you for supporting and nurturing my goals, and leading me to a path where I may continue to develop not only a good head, but also a good heart. Also, thank you for my animal moral support team: Sophie, Hoody, and Luna.
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ABSTRACT

MENTAL HEALTH SERVICE UTILIZATION IN LATINO COLLEGE STUDENTS:
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Literature suggests that mental illness, particularly depression and trauma, is extremely prevalent in Latino populations, with low rates of psychological service use. The purpose of this study was to examine factors that would decrease or increase the use of mental health services in Latino populations. The data for this thesis came from: (1) 563 Latino college students were sampled via a confidential, online survey at a Southern California university; and (2) 90 Latino college students who participated in eight focus groups. Results correspond to prior literature, as only 21.0% of survey respondents stated they may want to receive counseling in the future, and participants endorsed many negative attitudes toward psychological help. Participants who were interviewed suggested that the barriers that keep Latinos from seeking services include stigma, time, finances, and cultural factors (e.g. espiritualismo, familismo, machismo/marianismo, confianza, etc). Participants suggested outreach via media (e.g. fliers, telenovelas, etc) to increase awareness of mental health services and decrease stigma regarding using mental health services, as a way to facilitate treatment. Implications for community leaders, educators, practitioners, and policy-makers will be discussed.
CHAPTER I
INTRODUCTION

Statement of the Problem

According to Kessler, Chiu, Demler, and Walters (2005), 50% of all psychiatric disorders begin by the age of 14, and this number increases to 75% by age 24. Mental illness is the largest cause of disability worldwide (World Health Organization, 2011). In the United States, 60% of all adults with a mental illness did not utilize a mental health service in 2011 (Substance Abuse and Mental Health Services Administration, 2012). Untreated mental illness can lead to stalking (Sheridan, Blaauw, & Davies, 2003), suicide, and homicide (Hiroeh, Appleby, Mortensen, & Dunn, 2001). Also, untreated mental illness carries serious societal consequences, as severe mental illness is estimated to cost 193.2 billion dollars every year in lost wages in the United States.

College students are a population that are at risk for the development of a serious mental illness due to the stressors that accompany attending a university, as well as numerous transitions that occur during this developmental stage such as identity exploration, developing romantic relationships, moving, and working (Arnett, 2011; Hill, Jackson, Roberts, Lapsley, & Brandenberger, 2011). Levine and Cureton (1998) noted that college students are “overwhelmed and more damaged than in the past” (p. 95). The Center for Collegiate Mental Health (2013) noted increases in hospitalization (7% to 10.3%), non-suicidal self-injury (21.8% to 23.2%), and serious harm to others (2.2% to 3.4%) in college student populations from 2010 to 2013. In addition to being a high-risk population, college students also severely underutilize available mental health services (Rosenthal & Wilson, 2008), with ethnic minority college students showing the highest
need (Eaton et al., 2006), and least amount of use (Boone et al., 2011).

In the United States, the most rapidly increasing ethnic minority group is Latinos (Pew Hispanic Center, 2011), constituting the largest ethnic minority group in the United States (U.S. Census, 2014). Latinos utilize mental health services at even lower rates (50% less) than Caucasians (Agency for Healthcare Research and Quality, 2010). Also, Latinos are now attending college at historically high rates (Fry, 2002; Ganderton & Santos, 1995). Given that Latinos as well as college students utilize mental health services less than other ethnic groups and age groups, Latino college students are especially at risk of underutilizing mental health services.

Purpose

The purpose of this study is to examine factors that would facilitate or decrease mental health service utilization in the Latino college student population. This study used a mixed methods design because it is often difficult to capture the experiences of diverse groups using quantitative methods alone (Vega, Kolody, & Aguilar-Gaxiola, 2001). It is imperative that studies be conducted to facilitate Latino emerging adults’ use of mental health care. The Surgeon General (2001) stated that addressing ethnic disparities in mental health service utilization is a top priority in research. Because emerging adulthood is a formative and sensitive developmental period, it is important to seek treatment for mental health disorders during this time. Further, multiple studies suggested that Latino emerging adults have exceedingly high rates of psychopathology (Cheng, Kwan, & Sevig, 2013; Frerichs, Aneshensel, & Clark, 1981; Reyes-Rodriguez, Franko, Matos-Lamourt, Bulik, Von Holle, Cámara-Fuentes et. al, 2010) and low rates of mental health service utilization (Alvidrez, 1999). Despite this, few studies have examined ways to
increase participation in seeking help for mental disorders in this extremely vulnerable population. Thus, this study is being conducted in order to illuminate several factors that could potentially result in a positive experience for Latinos who wish to seek help, in addition to being used as an educational tool for Latinos who may not know how to begin seeking help, and also as an informative tool for clinicians and researchers.

**Definitions**

- Emerging adulthood references the period of development following adolescence and ending in maturity (18-25 years of age) (Arnett, 2011).

- Latino, or Hispanic, refers to a heterogeneous group with shared cultural and ethnic experiences (Marin & Marin, 1991). For the purpose of this study, Latino refers to individuals from Latin American nations (e.g., Mexican, Cuban, Puerto Rican, Central American, and South American) and/or the United States who ethnically identify as Latino or Hispanic.

- Mental health services refer to any form of treatment from psychiatrists, non-psychiatric mental health specialists (e.g., psychologists, social workers, marriage and family therapists), or mental health hotline workers (Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005).

- Public stigma refers to the presence of negative perceptions by members of the public about a person’s mental health status or mental health service utilization (Vogel, Wade, & Hackler, 2007).

- Self-stigma is similar to public stigma, in that often occurs when an individual has internalized the opinions made by the public surrounding mental illness and mental health service utilization (Corrigan, 2004). Thus, self-stigma refers to the presence of
negative perceptions held by individuals about themselves, indicating they are worthless, unacceptable, or inappropriate if they are mentally ill or are seeking services (Vogel et al, 2007).

Assumptions

This research study was created based upon the following assumptions. First, Latino college students will participate in this study without pressure or coercion from researchers. Verbal instructions and consent forms emphasized that participants were free to leave at any time, and participants were made aware in their classes that they could participate in a number of different studies or complete an alternate assignment. All research assistants were trained by the primary investigators to ensure a comfortable environment free from pressure to participate.

Next, it was assumed that participants would be able to read English, understand the items on the questionnaire, and be able to speak English in focus group interviews. This assumption was made since all the participants were attending a university in Southern California where English is the language of instruction.

It was also assumed that participants would answer the survey questions and focus group questions completely and honestly. The survey data collected for this study were anonymous and confidential, reducing the possibility of engendering socially desirable answers from participants. Although the focus groups were face-to-face, every effort was made to avoid participants responding dishonestly. For example, participants were frequently told there is no wrong or right answer and every opinion is valued.

Next, it was assumed that the measures used in the study were appropriate for Latino college students. This assumption was made because the measures have been used
with other samples of Latino adolescents, college students, and emerging adults. The measures were found to be reliable in these studies, and it was assumed they were valid since the measures related to other measures as hypothesized.

Also, it was assumed that no errors were made in transcription of the focus groups. The principal investigator trained the research assistants who transcribed the audios of the focus groups. Further, all focus group transcriptions were double-checked for accuracy after completion. Finally, it was assumed that no errors were made while developing focus group themes because themes were derived from trained research assistants in consultation with the principal investigator.
CHAPTER II

REVIEW OF LITERATURE

Latinos in the United States

Latino is a term used to describe a heterogeneous and racially diverse group descending from Latin America (Fisher, 1996; Fraga & Garcia, 2010). The Latino population in America is growing rapidly and exceeding U.S. Census Bureau projections, with 54 million individuals identifying as Latino as of July 2013, constituting 17% of the United States (U.S. Census Bureau, 2014). Most recent estimates anticipate that by 2060, this number will grow to 128.8 million individuals, constituting 31% of the nation’s population (U.S. Census Bureau, 2014). Ethnographers theorize that the driving forces behind the United States population growth are immigrants and U.S.-born immigrant children, as this group accounted for 51% of the U.S. population increase from 1960 to 2005 (Passel & Cohn, 2008).

In 2014, the census reports showed that Latinos made up the largest ethnic minority group in the United States (U.S. Census Bureau, 2014). Most (i.e., 64%) Latinos are of Mexican origin, with the remaining 36% being comprised of Puerto Ricans (9.4%), Salvadorans (3.8%), Cubans (3.7%), Dominicans (3.1%), Guatemalans (2.3%), and other Central American, South American, or Latino countries (U.S. Census Bureau, 2012).

As stated above, the Latino population is the fastest growing group in the United States. Thus, there is a salient need for research regarding positive mental health outcomes for this widely expanding population. The present study seeks to contribute to the scholarly literature regarding Latino emerging adults, and is concentrated on Latino university students at a comprehensive public university in Los Angeles County. The
university is designated as a Hispanic-Serving Institution.

**Prevalence of Mental Disorders in the United States**

The American Psychiatric Association (2001) understands mental illness as substantial behavioral patterns in an individual causing distress or dysfunction. In a nationally representative sample of English speaking adults in the United States, researchers found that nearly half (i.e., 46.4%) of the 9,282 subjects met criteria for a DSM-IV (American Psychiatric Association, 2001) diagnosis (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). Lifetime prevalence rates for major depressive disorder were the most predominant, with 16.6% of the sample meeting criteria, followed by alcohol abuse (13.2%), specific phobia (12.5%), and social phobia (12.1%). Further, 28.8% of the sample met criteria for any anxiety disorder, making anxiety disorders the most prevalent set (i.e., family) of psychiatric illnesses in the United States. Anxiety disorders are closely followed in prevalence by impulse-control disorders (24.8%), mood disorders (20.8%), and substance use disorders (14.6%). As previously stated, 46.4% of the sample met the criteria for any disorder. In addition, 27.7% of the sample met criteria for two or more disorders in their lifetime, and 17.3% of the representative sample met criteria for three or more lifetime psychiatric diagnoses (Kessler et al., 2005).

**Prevalence of Mental Disorders in Latinos**

Prior research on mental illness prevalence in Latino communities has suggested a theory called the “immigrant paradox,” which refers to the idea that being a foreign-born Latino may serve as a barrier against the development of mental illness (Alegria et al., 2008). The idea that a recent immigration status may serve as a protective factor against
the development of mental illness is paradoxical in nature, as many individuals anticipate immigration to be a highly stressful event (Falconer, Nussbeck, & Bodenmann, 2013). This may be especially true since recent immigrants to the United States face serious risk factors for the onset of illness, such as low socioeconomic status, discrimination, and language barriers (Finch, Hummer, Kolody, & Vega, 2001; Magana & Hovey, 2003; U.S. Department of Health and Human Services, 2001). Thus, as a probable result of the immigrant paradox, prevalence rates of mental disorders in Latinos vary dramatically.

Alegría et al. (2008) combined the National Comorbidity Survey Replication (NCS-R) and the National Latino and Asian American Study (NLAAS) to examine prevalence rates of mental illness in Latino groups. The World Health Organization’s Composite International Diagnostic Interview, which produces DSM-IV (American Psychiatric Association, 2001) diagnoses, was administered face-to-face or via telephone to English and Spanish speaking adults. The NLAAS dataset consisted of 2,554 Latino respondents of Mexican, Puerto Rican, Cuban, Dominican, Colombian, Salvadoran, Ecuadorian, Guatemalan, Honduran, Peruvian, and Nicaraguan descent, while the NCS-R was used to analyze 4,222 non-Latino Caucasian individuals. Results from the combined dataset suggested that Latinos born in the United States experienced higher rates of psychiatric illnesses than their foreign-born counterparts, but experienced lower rates of psychopathology than non-Latino Caucasians.

Further, multiple studies suggest that mental disorder prevalence in Latino immigrants increases with the length of their stay in the United States (Vega et al., 1999). For example, recent immigrants of Mexico (i.e., individuals who have immigrated from Mexico within the last 13 years or sooner) experienced significantly lower rates of
psychiatric distress and mental disorders than Mexican-Americans and U.S.-born Puerto Ricans (U.S. Department of Health and Human Services, 2001). United States nativity is associated with a number of high risk behaviors, such as eating more high-calorie food, consuming more alcohol and tobacco products, practicing riskier sexual behaviors, and being less physically active (Vega, Rodriguez, & Gruskin, 2009). Thus, researchers theorize that Latinos growing up in the United States, and non-recent immigrants to the United States, may be engaging more in these high-risk behaviors. The aforementioned theory would account for the lower rates of psychopathology among recent immigrants, and higher or equal rates of psychopathology among US-born Latinos, when compared to Caucasians, and other U.S.-born ethnic groups (Abraido-Lanza, Chao, & Florez, 2005).

As stated, many studies suggest that Latinos experience even higher rates of psychiatric distress than their non-Latino counterparts. The Centers for Disease Control and Prevention (2010) reported that Latinos were more likely to report having major depression than Caucasians. Many studies suggest that Latinos in the United States also experience higher rates of post-traumatic stress disorder and suicidal ideation. In a sample of 677 patients seen in a trauma center, Shih, Schell, Hambarsoomian, Marshall, and Belzberg (2010) found that Latino patients were twice as likely to develop post-traumatic stress disorder than Caucasians. One study suggested that Latino Vietnam veterans also have higher rates of post-traumatic stress disorder and experience a greater severity of symptoms than Caucasians (Ortega & Rosenheck, 2000)

Also, recent studies suggest, possibly explained by the aforementioned immigrant paradox, that severe mental illness is rising sharply in Latinos, and particularly, in younger Latinos (McLaughlin, Hilt, & Nolen-Hoeksema, 2007). The Centers for Disease
Control and Prevention (CDC, 2005) reported that 47% of Latina high school students experience hopelessness at greater rates non-Latino high school students. Hopelessness is understood to be a significant and reliable predictor of suicidality (Beck, Brown, Berchick, Stewart, & Steer, 2014). Additionally, 18% of Latino adolescents reported that they considered committing suicide, with Latina high school students attempting suicide at much higher rates (14%) than Caucasian students (7.7%) or African American students (9.9%) (CDC, 2005). More recent reports continued to reflect this trend, with 13.5% of Latina high school students attempting suicide, while only 8.8% of African American high school students and 7.9% of other non-Latino high school students attempting suicide (CDC, 2011).

Multiple studies have indicated that Latina adolescents suffer from more severe depressive symptoms and/or greater rates of major depression than any other ethnic group (Centers for Disease Control and Prevention, 2005; Eaton et al., 2006; Joiner, Perez, Wagner, Berenson, & Marquina, 2001; Knopf, Park, & Mulye, 2008; Paxton, Valois, Watkins, Huebner, & Drane, 2007; Roberts, Roberts, & Chen, 1997; Siegel, Aneshensel, Taub, Cantwell, & Driscoll, 1998; Zayas, Lester, Cabassa, & Fortuna, 2005). Although Latinos are at heightened risk for the development of psychopathology due to sociocultural factors, some studies suggested that this population is at a higher risk for developing depression even when controlling for income and social status (Siegel et al., 1998). In addition to depression, Latino adolescents are more likely than other ethnic groups to be diagnosed with a psychotic disorder, anxiety disorder, or adjustment disorder (Yeh et al., 2002).
Further, one study conducted by Vernon and Roberts (1982) compared treated and untreated psychiatric distress in 219 Caucasians, 187 African Americans, and 122 Mexican-Americans. They found similar results in adults. Specifically, the investigators found greater depression, depressive symptomatology, and diagnosed psychiatric illnesses in the Mexican-American study participants. Karno et al. (1987) also found that Mexican-Americans experience more psychopathology, reporting that Mexican-American men experienced more alcohol abuse and alcohol dependence than other ethnicities, and Mexican-American women experienced high rates of phobia.

Many studies note that these prevalence rates may be increased due to societal and contextual factors, like poverty, immigration, or neighborhood violence (Suarez-Orozco, Suarez-Orozco, & Todorova, 2008). These factors may help to explain why Latinos have higher rates of traumatic experiences (Kulka et al., 1990; Perilla, Norris, & Lavizzo, 2002) and psychiatric distress (Cheng, Kwan, & Sevig, 2013; Frerichs, Aneshensel, & Clark, 1981; Reyes-Rodríguez, Franko, Matos-Lamourt, Bulik, Von Holle, Cámara-Fuentes et. al, 2010) than other ethnic groups.

**Prevalence of Mental Disorders in Emerging Adults**

The period following adolescence, often referred to as emerging adulthood (age 18-25; Arnett, 2011), is a period of extreme development and vulnerability. Kessler et al. (2005) reported that 50% of all diagnosed mental disorders developed by the age of 14, and this number increased to 75% by the age of 25. Emerging adults are a particularly high-risk group for having mental health issues (e.g., depression) as they undergo stress resulting from numerous transitions during this time period. Multiple studies reported that emerging adults face significant intrapersonal (e.g., identity exploration), interpersonal
(e.g., romantic relationships), and extra personal (e.g., school, work, residence) struggles (Arnett, 2011; Hill, Jackson, Roberts, Lapsley, & Brandenberger, 2011). Depressive symptoms during emerging adulthood have been related to numerous detrimental outcomes such as increased risk of alcohol-related problems (Weitzman, 2004), personality disorders (Aalto-Setälä et al., 2001), and worse self-mastery (Reinherz, Giaconia, Hauf, Wasserman, & Silverman, 1999).

The mental health needs of emerging adults, particularly college students, are increasing in severity. Multiple universities report a transformation in psychological needs of college students, with services shifting from typical adjustment counseling to psychiatric disorders (Gallagher, Gill, & Sysko, 2000; Gallagher, Sysko, & Zhang, 2001; Pledge, Lapan, Heppner, & Roehlke, 1998; O’Malley, Wheeler, Murphey, & O’Connell, 1990; Robbins, May, & Corazzini, 1985; Stone & Archer, 1990). For example, in the past 5 years, 71% of college counseling centers reported that individuals sought services for a learning disability, 51% for self-injury, 49% for illicit drug use, 45% for alcohol use, 38% for eating disorders, 34% for childhood sexual abuse, and 33% for sexual assault on campus (Gallagher et al., 2001). Further, nearly all (89%) counseling centers at universities had to hospitalize a student for psychological reasons, and 10% experienced a completed student suicide (Gallagher et al., 2001).

**Prevalence of Mental Disorders in Emerging Adult Latinos**

Because college students are a particularly vulnerable population, Latino university students represent a subset of this sample that is at an even greater risk. For example, studies have found that female Latina college students experienced more major depression (Gomez, Miranda, & Polanco, 2007) and depressive symptoms than other men
and women in other ethnic groups (Granillo, 2012). Del Pilar (2009) found that 26.9% of Latinos had a history of depression and 14.3% had extremely high rates of suicidal ideation. Similarly, Chesin and Jeglic (2012) found that 20% of Latina undergraduates reported current suicidal ideation, with 15% reporting that they had attempted suicide in the past. Further, in Del Pilar’s (2009) study, 4% of Latino college students had been hospitalized for psychiatric reasons, compared to only 2% of non-Latino students. Multiple studies suggested that the higher prevalence of mental health concerns in Latino emerging adults was due to predisposing risk factors that Latino adults in general face, such as racial discrimination (Finch et al., 2000; Singh & Siahpush, 2001), social inequity, economic inequity (Nadeem, Lange, Edge, Fongwa, Belin, & Miranda, 2007), trauma exposure (Kulka et al., 1990; Perilla et al., 2002), and unsafe neighborhoods (Pitts & Phillips, 2002).

**Costs and Harms of Mental Disorders in the United States**

Conservative estimates for the cost of mental disorders in the United States report that the nation currently loses 300 billion dollars annually on both direct and indirect costs stemming from mental illness (Insel, 2008). Direct costs describe actual money spent on mental health care and treatment costs, such as medication, residential treatment, hospitalization, or visits to community mental health centers (Druss & Rosenheck, 1999). Indirect costs are caused by losses and disabilities in the workforce that are a result of the diagnosed disorder. Indirect costs, which are implicated more often in the literature, include governmental support, a reduction in available workers, reduced educational status, homelessness, and incarceration (Insel, 2008). Indirect costs also include frequent emergency room visits due to various physical disorders that are exacerbated by, or
caused by, mental illness (Phelan, Stradins, & Morrison, 2001).

Poisal et al. (2007) estimated that in 2006, health care costs had grown to 16% of the gross domestic product of the United States, which they predicted to be 20% by 2016. Further, mental disorders accounted for 6.2% of these health care expenditures. The economic losses caused by mental illness in the United States surpassed the health costs for chronic respiratory disease, cancer, diabetes, and pulmonary diseases (Bloom et al., 2011). An and Zhu (2014) monitored health care expenditures on mental illness from 1996 through 2011 via the Medical Expenditure Panel Survey. Services used in this study include emergency room visits, outpatient hospital services, office visits, and prescriptions. The average per-capita expense of mental illness in the United States from 1996-2011 was $1,156 dollars, with out-of-pocket expenses comprising 29.2% of this total.

Depression is the leading cause of disability in the world (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006; WHO, 2011). Individuals diagnosed with depression have higher rates of work place absences and are reported to be less productive while at work (Kessler, Ames, Loepke, McKenas, Richling, Stang, & Ustun, 2004). In general, mental illness is expensive to the country as a whole. Substance use disorders cost the United States 500 billion dollars every year through medical costs, criminal justice costs, and loss of earnings (Jason & Ferrari, 2010). According to Greenberg et al. (2003), anxiety disorders in the United States cost $42 billion every year due to decreased work productivity and psychiatric and medical treatment.

Other estimates of income loss as a result of a psychiatric disorder suggested that individuals could lose up to 21% of possible earnings (Frank & Gertler, 1991; Miller &
Kelman, 1992). Individuals diagnosed with schizophrenia lost 10-35% of possible income, while individuals with anxiety disorders and antisocial personality disorder lost 3-10% of possible income. Some researchers suggest that mental illness can result in a loss of possible new employment. Ettner (2000) found that the probability of being hired was reduced for the mentally ill. Marcotte and Wilcox-Go (2001) found that each year 5-6 million individuals (16-54 years of age) cannot find a job, do not seek jobs, or lose their jobs, as a direct result of mental illness.

Finally, lost earnings and government expenses are not the only costs of a diagnosed mental disorder. Individuals diagnosed with depression had higher mortality rates (Carney, Freedland, Miller, & Jaffe, 2002), with depression negatively impacting the course of diseases such as cancer, heart disease, diabetes, or HIV (Katon, 2003). Further, parents or other caregivers of mentally ill individuals often experience deficits in their own health as a result of caring for their mentally ill family member (National Alliance for Caregiving and AARP, 2009).

Costs and Harms of Mental Disorders in Latinos

Mental illness has numerous costs in Latino families as well. Due to the high value of family in the Latino culture (Halgunseth, Ispa, & Rudy, 2006; Smokowski & Bacallao, 2007), caregiver burden is an associated risk of having a mental disorder. Studies have suggested that Latino caregivers, although more positive and supportive than caregivers of other cultures (Kopelowicz et al., 2002; Milstein, Guarnaccia, & Midlarsky, 1996), still experience caregiver burden at levels equal to Caucasians (Jenkins & Schumacher, 1999; Struening, Stueve, Vine, Kreisman, Link, & Herman, 1995). Magana (2006) found that Latino caregivers of individuals with Alzheimer’s, dementia,
or intellectual developmental disorder suffered from higher levels of psychiatric distress than Caucasian caregivers. Magana, Ramirez Garcia, Hernandez, and Cortez (2007) studied 85 Latino families in Texas, Wisconsin, and Southern California. They found that rates of depressive symptoms were higher in Latino caregivers (40%) of individuals diagnosed with schizophrenia than in the general Latino population (20%). Similarly, in a study of 30 chronically mentally ill Puerto Rican immigrants living in New York, Swerdlow (1992) found that the chronic nature of mental illness creates an economic burden to the individual, the individual’s family, and society.

Compared to Caucasi ans, Latino men and women work fewer hours per week, have greater rates of unemployment, work fewer weeks per year, and earn less money (Altonji, Blom, & Meghir, 2012). Thus, Latinos experience the same detrimental effects of mental illness on social or occupational functioning as other ethnic groups, but at greater rates, as they are at a disadvantage in the workforce. For example, Chatterji, Alegria, and Takeuchi (2009) found that Latina women had an 11-14% worse chance of employment if they were recently diagnosed with a mental disorder. Further, a qualitative analysis of Latinas’ mental health utilization revealed that Latina women felt that missing work to treat a mental disorder was not possible due to employer discrimination (Kaltman, Hurtado de Mendoza, Gonzales, & Serrano, 2014).

There are also associated physical health concerns as a consequence of mental illness in the Latino community. In the general population, it has been shown that depression precedes and often exacerbates stroke, diabetes, and various forms of heart disease (Eaton, Armenian, Pratt, Ford, 1996; Jonas & Lando, 2000; Ladwig, Roll, Breithardt, Budde, & Borggrefe, 1994). Black, Markides, and Ray (2003) found that
depressive symptomatology was associated with negative health outcomes in Mexican Americans with diabetes. These individuals developed secondary medical problems, had greater disability levels, and utilized more public health care. Further, in individuals suffering from both diabetes and depression, mortality rates were triple that of individuals diagnosed with diabetes with no depression (Black, Goodwin, & Markides, 1998).

**Costs and Harms of Mental Disorders in Emerging Adult Latinos**

Mental illness is also associated with costs to emerging adults. Levine and Cureton (1998) reported that university students are overwhelmed, stressed, and damaged. Kitzrow (2003) reported that many individuals in the United States would have graduated from college if they had not been diagnosed with a psychiatric disorder. Anxiety disorders, mood disorders, substance abuse, and conduct disorders were the greatest predictors of academic failure of university students (Kessler et al., 1995). Additionally, mental health in emerging adulthood predicts substance use, academic achievement, employment, and social outcomes in later life (Ettner, Frank, & Kessler, 1997; Kessler et al., 2001; Kessler et al., 2005; Weitzman, 2004).

In addition to the aforementioned consequences of psychological illness in emerging adults, Latino college students are also uniquely at risk for experiencing low academic achievement as a result of stress and mental illness. Crockett et al. (2007) described the relationship between acculturative stress and mental illness. Acculturative stress is understood as the stress caused by individual’s attempts to adjust, assimilate, and adapt to the predominant culture (Driscoll & Torres, 2013). Crockett and colleagues (2007) found that Latino college students experience significant levels of acculturative stress, and that these levels of stress significantly predict poor psychological functioning,
such as depression and anxiety. Both general stress and acculturative stress have been illustrated to lead to psychological dysfunction in Latino college students, and this dysfunction results in lowered academic achievement and performance (Zajacova, Lynch, & Espenshade, 2005).

Further, Latino college students may also be uniquely at risk for heightened suicide attempts. The Centers for Disease Control and Prevention (2008) indicated that emerging adult ethnic minority individuals were at great risk for suicidal behavior. Studies have indicated that racial discrimination in Latino college students may lead to post-traumatic stress disorder, substance abuse disorders, and subsequently, suicide attempts (Flores, Tschann, Dimas, Pasch, & de Groat, 2010). Gomez, Miranda, and Polanco (2011) found that racial/ethnic discrimination and acculturative stress were significantly associated with suicide attempts in Mexican-American emerging adults.

Thus, it is clear that Latino emerging adults are at a heightened risk for developing psychopathology, and that this psychopathology is related to many detrimental outcomes. Numerous mental health service agencies are available to decrease mental illness and/or decrease the associated harms from mental illness, yet many Latinos do not seek out mental health services. Identifying the reasons why can be beneficial to the individuals as well as society.

**Barriers of Mental Health Help-Seeking in the United States**

Kessler, Zhao, Katz, Kouzis, Frank, and Edlund (1999) found that only 25% of individuals meeting criteria for a DSM-III-R psychiatric disorder were receiving psychological help. Kessler et al. (2001) estimated that 50-60% of individuals who need psychiatric help do not seek it. Several general barriers to seeking mental health
counseling in the United States have been identified in the literature. For example, stigma, financial barriers, and fears have all been implicated as factors that may decrease an individual’s willingness and desire to seeking psychological counseling (Sareen et al., 2007).

Both public and self-stigma have been implicated as a barrier to therapeutic treatment in the United States. Public stigma is defined as a general negative view by the public towards individuals with mental illness (Vogel, Wade, & Hackler, 2007). Weiner et al. (1988) reported that many individuals believe people with mental illnesses are responsible for their mental illness, and thus they blame people for their psychiatric problems and respond negatively to their concerns. In addition, some people believe individuals with mental illness are dangerous (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Corrigan et al., 2002; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999), and it is suggested that individuals with mental illness may not seek counseling so they will not be perceived as dangerous to others. Further, many individuals do not seek treatment due to concerns that loved ones will negatively respond to their desire to seek treatment or have negative attitudes toward mental health services (Leaf, Livingston, Tischler, Weissman, Holzer, & Myers, 1985; Kessler et al., 2001).

Self-stigma, often a result of internalized public stigma, is defined as the private beliefs of individuals that they are unacceptable in society and not worthy of help (Vogel, Wade, & Haake, 2006). Many individuals do not seek treatment due to both public and self-stigma regarding mental illness (Leaf et al., 1985). Hadas and Midlarsky (2000) sampled 319 mentally ill older adults and found that they personally believed they were responsible for creating and also alleviating their psychiatric distress.
Many studies implicate economic barriers. In a study of 8,098 Americans aged 15-54, 46% cited financial barriers as prohibiting them from seeking psychological care (Kessler, Foster, Saunders, & Stang, 1995). Also, 36.2% of the sample reported that health insurance would not cover their treatment, and 44.3% of the sample stated that psychological counseling was simply too expensive.

Even patients with adequate health insurance have a difficult time accessing treatment. In a study conducted at Harvard University (Boyd, Linsenmeyer, Woolhandler, Himmelstein, & Nardin, 2011), confederates posed as Blue Cross PPO patients. Out of 64 centers contacted, only 12.5% accepted insurance, and only 6.2% were able to offer an appointment in less than two weeks.

In addition to stigma and finances, fear also plays a role in resistance to seek mental health counseling. Sareen et al. (2007) conducted a study of 5,384 people from the United States, 6,261 people from Canada, and 6,031 people from the Netherlands. They found that across all sites, including the United States, people endorsed the following reasons for not seeking mental health counseling: financial barriers, fear of involuntary hospitalization, fears that their disorder will embarrass them, or fears that treatment will be futile. Sareen et al. also found that individuals with mood disorders and substance use disorders were most likely to believe they would be hospitalized against their will, due to past experiences or lack of knowledge. They also found that individuals diagnosed with an anxiety disorder in the past year were likely to resist treatment as they did not believe it would work. This finding might suggest a lack of knowledge in the general community about the prognosis of common and treatable psychiatric disorders. In addition, researchers found that individuals with substance use disorders were most likely to report
embarrassment as a barrier to receiving mental health services (Sareen et al., 2007; Wells, Robins, Bushnell, Jarosz, and Oakley-Brown, 1994).

Finally, attitudinal factors play a role in a resistance to seek mental health counseling. Many people believe that mental health issues are simply problems that they should solve on their own, or that the problems will dissipate on their own (Saldivia et al., 2004; Wells et al., 1994). Many individuals diagnosed with a mental illness report waiting for symptoms to dissipate without treatment, or they use self-help books to treat their mental illness (den Boer, Wiersma, van den Bosch, 2004).

In summary, there are several perceived and reported barriers to accessing mental health counseling in the United States, which, as will be discussed in greater detail later, lead to detrimental outcomes. Adults in the United States endorsed both structural (e.g., financial) and attitudinal (e.g., public or private stigma) barriers to accessing mental health care, suggesting the issue is complex and multi-faceted. These barriers become more complicated when applying the issue to Latino and emerging adult Latinos.

**Barriers of Mental Health Help-Seeking in Latinos**

In addition to the factors faced by the general population, Latinos living in the United States represent a distinct group with unique barriers that prevent access to mental health counseling. The Latino population in the United States is extremely heterogeneous; thus, results from studies may not be generalizable across all Latino cultures. For example, it has been established that Mexican-Americans, particularly Mexican-American immigrants, severely underutilize mental health services (Alegria et al., 1991), while Cubans and Cuban Americans are very likely to use mental health services (Portes, Kyle, & Eaton, 1992). The Epidemiological Catchment Area study
showed that a third of Mexican Americans diagnosed with a psychiatric disorder did not receive mental health services (Hough, 1983). Specifically, in Los Angeles, 51% of Mexican-Americans did not receive any care for their psychiatric problems (Hough, 1983). Vega et al. (1999) found even lower rates of mental health service utilization by Mexican Americans. Specifically, they found that 71% of Mexican Americans with a diagnosable disorder did not receive mental health counseling, which rose to 86% when including immigrants. Only 8% of Mexican Americans in Los Angeles were found to be using mental health services, with Mexicans born in the United States diagnosed with two or more disorders being most likely to use services (Vega et al., 1999).

Common barriers Latinos perceive to seeking mental health services include language and culture, stigma, finances, and the culture of the United States’ mental health care system. Language often acts as a barrier for Latinos in the United States seeking mental health services (Seijo, Gomez, & Freidenberg, 1991). Aside from language, many researchers suggest there are unique cultural barriers that keep Latinos from seeking mental health services (Jakobsons & Buckner, 2007; Kouyoumdjian, Zamboanga, & Hansen, 2003). Cultural barriers included feeling uncomfortable discussing mental health problems with a professional (Frevert & Miranda, 1998). Older literature has suggested that Latinos in the United States preferred using curanderos (i.e., indigenous healers) as a form of mental health care for psychiatric problems (Kiev, 1968). Another cultural value that has been discussed in the literature is familismo (i.e., a strong value of family orientation and commitment; Toro-Morn, 2012). Specifically, since Latinos are family-oriented, they may rely upon large kinship networks (as opposed to clinicians) to provide mental health support (Antshel, 2002; Cheung, 1991; Martinez, 1993).
As with their non-Latino counterparts, Latinos with mental health issues also face stigma. The Latino values of marianismo and machismo (i.e., female and male gender roles in Latin American culture) suggest it is important that women “suffer silently” to care for their families (Sarmiento & Cardemil, 2009), and men are expected to be strong to care for their families (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006; Santiago-Rivera, Arrendondo, & Gallardo-Cooper, 2001). Individuals in communities where these values prevail may face stigma from family and friends. Similarly, there is a public perception in the Latino community that psychiatric illness indicates weakness (Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007; Frevert et al., 1998). Self-stigma and embarrassment also occur due to internalization of cultural values. For example, if one feels that they are betraying the values of familismo, they may feel they are unworthy of dignidad/respeto (dignity/respect) and not seek proper services (Abdullah & Brown, 2011). In a qualitative study that did not explicitly ask about stigma, 73% of Latino adults openly noted that stigma was one reason they did not adhere to medications for psychiatric issues (Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007).

Mexican and Mexican American individuals also cited financial issues as barriers to receiving mental health counseling, with insufficient insurance being a large factor (Padgett, Patrick, Burns, & Schlesinger, 1994). Latinos in the United States often lack insurance (Alegria et al., 2002), and according to Angel and Angel (1996) Latinos do not have health insurance at far greater rates than any other ethnic groups in the United States. Further, many Latinos, especially with low incomes, struggle to find time to leave work, transportation to therapy (Acosta, 1980), or time away from family responsibilities.
Problems with the United States’ mental health system are also implicated as a barrier to Latinos seeking mental health counseling. The United States health care system is described as individualistic and sterile, while Latinos value collectivism and *familismo* (Andrés-Hyman et al., 2006). Many scholars have suggested adding a family component to therapy to enhance Latino participation, as individual therapy and the emphasis on the self may cause a lack of interest in seeking treatment for Latinos (Antshel, 2002; Comas-Díaz, 2006; Lau, 2006). The lack of cultural adaptability in current psychiatric treatment may suggest to Latinos a disregard for culture and treatment, thus decreasing interest in seeking treatment (Abdullah & Brown, 2011). Further, many Latinos living in low-income areas may be dissatisfied by the quality or accessibility of treatment. For example, 40% of Latinos live in impoverished communities (Santiago & Wilder, 1991). Poorer communities may be less likely to have adequate availability of mental health practitioners.

In a study of 695 Latinos in the United States, Alegria et al. (2002) found that Latinos, on average, were younger than Caucasians, had received less education, and did not have insurance. Alegria et al. indicated that regardless of income, when compared to other ethnicities, Latinos face unique barriers, such as being uncomfortable speaking in English, physically accessing services in their neighborhoods, and different conceptualizations of psychiatric illness. These barriers are supported by the work of other researchers (Gloria & Rodriguez, 2000). Lack of knowledge is another general issue Latinos face when seeking mental health services. For example, many Mexican Americans stated that they are unaware of how to find a mental health practitioner
Less than 20% of U.S.-born Latinos sought mental health care, even at the offices of general practitioners, and this number decreased to 9% when seeking a mental health care setting (Vega et al., 1999). Further, individuals from ethnic minority groups experienced lack of insurance, transportation, and stigma barriers at greater rates than Caucasian individuals (Padgett et al., 1994; Norquist & Wells, 1991). Thus, there is a significant need for research that will determine effective ways to assist Latinos in accessing mental health services.

**Barriers of Mental Health Help-Seeking in Emerging Adult Latinos**

Research suggests that Mexican American college students feel a great deal of stress as a result of acculturation (Gloria & Rodriguez, 2000). According to Pomales and Williams (1989), levels of acculturation may act as a barrier to seeking mental health counseling since less acculturated individuals face more difficulty finding counselors as trustworthy.

Lack of social support on the college campus also may act as a barrier toward seeking mental health counseling (Gloria & Robinson Kurpius, 1996). As stated previously, Latinos may feel disenfranchised with mental health services if they do not take culture into account. Thus, college campuses and support for the culture on college campuses may increase utilization of therapy, while a perceived lack of support may decrease utilization rates. In a study of 162 Mexican American college students, social support significantly predicted positive attitudes toward receiving mental health services (Miville & Constantine, 2006).

Further studies on help seeking and access to mental health care in general
university student populations have shown that financial barriers, stigma, privacy concerns, and lack of time are significant barriers to receiving treatment (Givens & Tjia, 2002; Megivern, Pellerito, & Mowbray, 2003; Mowbray et al., 2006). Additionally, even though college students often have universal health coverage through student fees, they still have extremely low levels of service use due to lack of knowledge or negative attitudes (Eisenberg, Golberstein, & Gollust, 2007). For example, some students report that they do not believe therapeutic treatment or medication is helpful, and that their mental health issues are not abnormal considering stress from college (Eisenberg et al., 2007).

Thus, since college students severely underutilize mental health services, and Latinos also severely underutilize mental health services, Latino college students may be a particularly vulnerable population.
CHAPTER III

METHODOLOGY

Procedures

The present study is a mixed-methods investigation utilizing both quantitative survey data and qualitative focus group data. Data for the quantitative portion of this thesis were collected using an online survey system (Qualtrics). The institutional review board approval was obtained from California State University Northridge prior to data collection.

Subjects were recruited from lower-division courses through the university’s psychology subject pool. Students received course credit for participating and were not penalized for declining to participate. Students who declined to participate in the present project were allowed to choose from any other research project being conducted that semester, or they were allowed to complete an alternative assignment. All data were kept on password-protected computers in a locked research lab. No identifying data were retained about the participants.

Survey Data

Self-report survey data collection occurred during Fall 2013. Students signed up to participate in the study online, and they were then directed to complete the self-report survey located on Qualtrics.com. The survey took approximately 12 minutes for participants to complete. Survey participants were required to be 18-29 years old to participate in the study. For the present study, data from Latinos aged 18-25 were used. After data collection, survey responses were downloaded, and SPSS 22 (Statistical Package for the Social Sciences) was utilized to store and analyze data.
Focus Group Data

Eight focus groups (40-70 minutes in length) were conducted over a two-week period in Fall 2014. Students were allowed to participate in the focus groups if they were 18-25 years of age and self-identified as Latino. The primary investigator scheduled the focus groups with 8-12 Latino students each ($N = 90$ total). Participants were grouped into focus groups that were somewhat homogenous: (1) students and parents born in Mexico, (2) students born in the USA while parents were born in Mexico, (3) students and parents born in any Central American country, (4) students born in the USA while parents were born in any Central American country, (5) students born in the USA while parents were born in any South American country, (6 and 7) Latino/a students born in the USA with one or more parents born in the USA, and (8) Latino/a students not fitting the aforementioned categories.

Two moderators facilitated each focus group: (1) a 2nd year graduate student in clinical psychology (Latina/o origin, bilingual in Spanish and English, female, 25 years old), and (2) the primary investigator (i.e., 2nd year graduate student in clinical psychology, Caucasian, female, 23 years old). In addition to the moderators, a graduate or undergraduate student attended each focus group as a note-taker. All three researchers were trained in conducting focus groups and taking notes, and all three completed the NIH Human Participants Protection Education for Research Teams certification.

A scripted and rehearsed focus group was conducted after participants consented to participate. The following questions were asked: (1) “Do you think (insert group; e.g., Mexican Americans, Guatemalans, Latino/as) in the United States seek psychological help? Why or why not?” (2) “What barriers do you think might keep (insert group; e.g.,
Mexican Americans, Guatemalans, Latino/as) from seeking psychological help?” (3) “What kinds of psychological problems, mental health issues, or challenges might (insert group; e.g., Mexican Americans, Guatemalans, Latino/as) seek help for? And, who do you think they might seek help from?” (4) “What do you think would increase the chances that (insert group; e.g., Mexican Americans, Guatemalans, Latino/as) would utilize a mental health professional or therapy?” (5) “What services are available to young adults to deal with psychological problems? On campus? Off campus?” In addition to the questions, the script also included non leading probes such as, “Can you tell me more about that,” “Can you please elaborate,” and “Who else can offer an opinion?”

Two digital voice recorders were used to audio-record the sessions. The audio recordings were temporarily stored in a locked research lab on a password-protected computer. Only NIH-ethics-certified research assistants had access to the recordings and transcriptions. Undergraduate and graduate research assistants transcribed and verified the focus groups. Once the audios were transcribed and verified for accuracy, they were erased.

The primary investigator coded and analyzed the data for emerging themes. After the focus groups occurred, the two moderators and one note-taker met to exchange notes and identify emerging themes. Finally, themes across all focus groups were combined. The primary investigator then read through each focus group transcript and performed initial open coding for pre-identified themes while also searching for any possible unidentified patterns. Next, focused coding was used to prune themes and explain how the themes may be caused or related.
Sample Characteristics

Survey Data Sample

Survey data from the larger study were collected from 1119 undergraduate students. Data from 563 Latinos, 18-25 years of age ($M = 19.01$), were retained for this study. Most (i.e., 77.4%) were female participants; only 22.6% were male participants. Slightly over half (i.e., 54.4%) were freshman in college; with 26.5% sophomores, 16.2% juniors, 2.7% seniors, and 13.6% unknown. The majority (i.e., 70.1%) reported living at home with at least one parent.

Most (i.e., 87%) of the participants were born in the United States, with 6.6% born in Mexico, 1.2% in El Salvador, and the remaining 5.2% from other countries. The most common birth country for the mothers of participants was Mexico (59.5%), followed by El Salvador (16.2%), and the United States (11.1%). The most common birth country for the fathers of participants was Mexico (63.6%), followed by El Salvador (12.3%), United States (7.3%), and Guatemala (7.1%). The other mothers and fathers originated from fifteen other countries (i.e., Argentina, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, Honduras, Iran, Nicaragua, Peru, Philippines and Puerto Rico). In regards to generational status, 12.8% of the sample identified as first generation Americans (i.e., participants and parents born in another country), 73.3% of the sample identified as second generation Americans (i.e., participant born in the United States, parents born in another country), 9.6% of the sample identified as “2.5 generation” (i.e., subject born in the United States, one parent born in another country), and finally, 4.3% of the sample were third generation Americans (i.e., participant and parents born in the United States).
Focus Group Sample

Data were collected from 90 undergraduate students, ranging in age from 18 to 23 (M = 18.9) years. The majority (i.e., 62.2%) of participants identified as women, with men representing 37.8% of the sample. Most of the participants were freshman in college (48.9%), with 35.6% sophomores, 13.3% juniors, and 2.2% seniors.

Birth countries of students who completed the survey follow: 77.8% were born in the United States, 16.7% were born in Mexico, 3.3% were born in Guatemala, 1.1% were born in Colombia, and 1.1% were born in El Salvador. Among parents, 44.4% of the participants’ mothers were born in Mexico, 20% in the United States, 14.4% in Guatemala, 13.3% in El Salvador, 2.2% in Honduras, and 1.1% each from Colombia, Cuba, Italy, Peru, and Puerto Rico. Most (i.e., 57.8%) of the participants’ fathers were born in Mexico, 12.2% in El Salvador, 11.1% in Guatemala, 10.0% in the United States, 2.2% in Colombia, 2.2% in Ecuador, and 1.1% each from Bolivia, Chile, Cuba, and Peru.

Measurement

Demographic variables were measured using standard items about age, ethnicity, birth country, gender, university classification, etc. Other variables were measured using self-report instruments used in other studies.

Self-Stigma of Seeking Help

The 10-item Self-Stigma of Seeking Help Scale (Vogel et al., 2006) was used to measure personal stigma an individual may feel regarding seeking help from a therapist. A sample item follows: “It would make me feel inferior to ask a therapist for help.” The response choices follow: 1 = strongly disagree, 2 = disagree, 3 = agree & disagree equally, 4 = agree, and 5 = strongly agree. A Cronbach’s alpha of .74 was found in the
present study.

**Public Stigma for Help-Seeking**

The 12-item Perceived Devaluation Discrimination Scale (Link et al., 1987) was used to measure the amount individuals feel other people will discriminate against them for using mental health services. A sample item follows: “Most people would willingly accept a former psychiatric patient as a close friend.” The response choices follow: 1 = *strongly disagree*, 2 = *disagree*, 3 = *somewhat disagree*, 4 = *somewhat agree*, 5 = *agree*, and 6 = *strongly agree*. A Cronbach’s alpha of .83 was found in the present study.

**Attitudes toward Seeking Help**

The 10-item Attitudes towards Seeking Professional Help Scale (Fischer & Farina, 1995) was used to measure personal opinions an individual has towards counseling. A sample item follows: “If I believed I was having a mental breakdown, my first inclination would be to get professional attention.” The response choices follow: 1 = *disagree*, 2 = *partly disagree*, 3 = *partly agree*, and 4 = *agree*. A Cronbach’s alpha of .73 was found in the present study.

**Intention to Seek Counseling**

Intention to seek mental health counseling was measured by the 17-item Intention to Seek Counseling Inventory (Cash et al., 1975). Sample items follow: “Weight control,” “difficulty sleeping,” or “relationship differences.” The response choices follow: 1 = *very unlikely*, 2 = *unlikely*, 3 = *likely*, and 4 = *very likely*. A Cronbach’s alpha of .91 was found in the present study.
CHAPTER IV
RESULTS

Survey Data Results

Descriptive analyses were conducted using SPSS 22.0 for Mac. Descriptive analyses were run to explore attitudes and opinions held by participants towards factors related to mental health service utilization.

Self-Stigma

First, participants’ responses on the self-stigma scale were examined (see Table 1). Responses of “agree” and “strongly agree” were collapsed together. Also, “disagree” and “strongly disagree” were collapsed together. The items in Table 1 were ordered from low to high on “strongly agree or agree” percentages.

<table>
<thead>
<tr>
<th>Items</th>
<th>Strongly Agree or Disagree</th>
<th>Agree &amp; Disagree Equally</th>
<th>Strongly Agree or Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeking psychological help would make me feel less intelligent.</td>
<td>78.0%</td>
<td>14.4%</td>
<td>7.2%</td>
</tr>
<tr>
<td>If I went to a therapist, I would be less satisfied with myself.</td>
<td>74.2%</td>
<td>18.1%</td>
<td>7.6%</td>
</tr>
<tr>
<td>It would make me feel inferior to ask a therapist for help.</td>
<td>65.0%</td>
<td>23.4%</td>
<td>11.0%</td>
</tr>
<tr>
<td>I would feel inadequate if I went to a therapist for psychological help.</td>
<td>52.8%</td>
<td>30.9%</td>
<td>16.2%</td>
</tr>
<tr>
<td>My self-esteem would increase if I talked to a therapist.</td>
<td>25.0%</td>
<td>41.2%</td>
<td>16.6%</td>
</tr>
<tr>
<td>I would feel worse about myself if I could not solve my own problems.</td>
<td>53.6%</td>
<td>24.7%</td>
<td>21.0%</td>
</tr>
<tr>
<td>My self-confidence would remain the same if I sought professional help for a problem I could not solve.</td>
<td>28.4%</td>
<td>37.3%</td>
<td>33.4%</td>
</tr>
<tr>
<td>My view of myself would not change just because I made the choice to see a therapist.</td>
<td>31.0%</td>
<td>31.8%</td>
<td>36.8%</td>
</tr>
<tr>
<td>My self-confidence would NOT be threatened if I sought professional help.</td>
<td>27.0%</td>
<td>23.1%</td>
<td>49.8%</td>
</tr>
<tr>
<td>I would feel okay about myself if I made the choice to seek professional help.</td>
<td>15.8%</td>
<td>23.8%</td>
<td>60.4%</td>
</tr>
</tbody>
</table>

Only a small percentage of participants agreed or strongly agreed that seeking psychological help from a therapist would make them feel inadequate (16.2%), less intelligent (7.2%), inferior (11.0%), or less satisfied with themselves (7.6%). Only a small percentage of participants agreed or strongly agreed that that their self-esteem
would increase if they talked to a therapist (16.6%) or that they would feel worse about themselves if they could not solve their own problems (21.0%).

Approximately one third of the sample (33.4%) agreed or strongly agreed their self-confidence would remain the same if they sought professional help for a problem they could not solve. Also, 36.8% agreed or strongly agreed with the following statement, “my view of myself would not change just because I made the choice to see a therapist.” Approximately half of the sample (49.8%) felt their self-confidence would not be threatened if they sought professional help. And finally, 60.4% of the participants reported they would feel okay if they made the choice to seek professional help.

**Public Stigma**

Participants’ responses on the public-stigma scale were examined (see Table 2). Responses of “agree” and “strongly agree” were collapsed together. Also, “disagree” and “strongly disagree” were collapsed together. A small percentage of Latino participants agreed or somewhat agreed that (1) most people feel receiving mental health treatment is a sign of personal failure (21.6%), and (2) most people think less of a person who has received mental health treatment (21.2%). However, the majority of the sample agreed or somewhat agreed that most people (1) would willingly accept a person who has received mental health treatment as a close friend (71.9%), (2) believe a person who has received mental health treatment is just as intelligent as the average person (74.4%), (3) believe a person who has received mental health treatment is just as trustworthy as the average person (73.3%), and (4) would treat a person who has received mental health treatment just as they would treat anyone (74.3%).
Table 2  
*Latino Students' Perceptions Toward Public Stigma for Help-Seeking (N = 563)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree or Disagree</th>
<th>Somewhat Disagree</th>
<th>Somewhat Agree</th>
<th>Strongly Agree or Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most people feel that receiving mental health treatment is a sign of personal failure.</td>
<td>35.7%</td>
<td>35.5%</td>
<td>16.5%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Most people would not hire a person who has received mental health treatment to take care of their children, even if he or she had been well for some time.</td>
<td>54.6%</td>
<td>24.0%</td>
<td>11.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Most people think less of a person who has received mental health treatment.</td>
<td>38.5%</td>
<td>35.0%</td>
<td>15.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Most employers will pass over the application of someone who has received mental health treatment in favor of another applicant.</td>
<td>48.8%</td>
<td>27.2%</td>
<td>11.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Most employers will hire a person who has received mental health treatment if he or she is qualified for the job.</td>
<td>10.3%</td>
<td>19.2%</td>
<td>35.3%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Most people would accept a person who has fully recovered from a mental illness as a teacher of young children in a public school.</td>
<td>11.3%</td>
<td>20.2%</td>
<td>27.4%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Most people in my community would treat a person who has received mental health treatment just as they would treat anyone.</td>
<td>3.3%</td>
<td>11.9%</td>
<td>28.1%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Most people would willingly accept a person who has received mental health treatment as a close friend.</td>
<td>5.2%</td>
<td>14.4%</td>
<td>24.5%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Most people believe that a person who has received mental health treatment is just as intelligent as the average person.</td>
<td>4.1%</td>
<td>12.4%</td>
<td>26.5%</td>
<td>47.9%</td>
</tr>
<tr>
<td>Most people believe that a person who has received mental health treatment is just as trustworthy as the average person.</td>
<td>4.6%</td>
<td>14.6%</td>
<td>25.2%</td>
<td>48.1%</td>
</tr>
</tbody>
</table>

Only 17.2% of the Latino respondents agreed or somewhat agreed that most employers would pass over an applicant who has received mental health treatment in favor of another applicant, yet 29.5% agreed or somewhat agreed that most employers would hire a person who has received mental health treatment if he or she is qualified for the job. Most (i.e., 63.1%) of the Latino respondents agreed or somewhat agreed that most people would accept a person who has fully recovered from a mental illness as a teacher of young children in a public school. Yet only 17.2% felt that most people would not hire a person who has received mental health treatment to take care of their children, even if he or she had been well for some time.
Perceptions Toward Seeking Psychological Help

Participants’ responses on the perceptions toward seeking psychological help scale were examined (see Table 3). Items in Table 3 were ordered from low to high on “agree” percentages.

Table 3
Latino Students’ Perceptions Toward Seeking Psychological Help (N = 563)

<table>
<thead>
<tr>
<th>Items</th>
<th>Disagree</th>
<th>Partly Disagree</th>
<th>Partly Agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I believed I was having a mental breakdown, my first inclination would be to get professional attention.</td>
<td>20.2%</td>
<td>33.2%</td>
<td>21.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>I would want to get psychological help if I were worried or upset for a long period of time.</td>
<td>13.7%</td>
<td>37.1%</td>
<td>40.0%</td>
<td>0.7%</td>
</tr>
<tr>
<td>If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.</td>
<td>19.9%</td>
<td>38.4%</td>
<td>30.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>I might want to have psychological counseling in the future.</td>
<td>26.5%</td>
<td>35.0%</td>
<td>19.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.</td>
<td>29.1%</td>
<td>42.3%</td>
<td>14.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.</td>
<td>1.6%</td>
<td>48.3%</td>
<td>28.6%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.</td>
<td>2.5%</td>
<td>17.9%</td>
<td>44.4%</td>
<td>28.1%</td>
</tr>
<tr>
<td>A person should work out his or her own problems; getting psychological counseling would be a last resort.</td>
<td>0.9%</td>
<td>25.4%</td>
<td>29.5%</td>
<td>32.5%</td>
</tr>
<tr>
<td>Personal and emotional troubles, like many things, tend to work out by themselves.</td>
<td>0.9%</td>
<td>19.4%</td>
<td>38.7%</td>
<td>33.7%</td>
</tr>
<tr>
<td>There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.</td>
<td>0.5%</td>
<td>8.2%</td>
<td>18.1%</td>
<td>47.6%</td>
</tr>
</tbody>
</table>

When asked about solving emotional problems alone, only a small percentage of participants agreed or partly agreed that a person is more likely to solve an emotional problem with professional help than alone (16.5%). Also, only a small percentage of participants agreed or partly agreed that (1) they might want to have psychological counseling in the future (21.0%), (2) if they were having a mental breakdown, their first inclination would be to get professional attention (21.5%), and (3) if they were experiencing a serious emotional crisis in their life, they would be confident they could
find relief in psychotherapy (31.1%). Nearly half of the respondents agreed or partly disagreed that they would want to get psychological help if they were worried or upset for a long period of time (40.7%), and that the idea of talking about problems with a psychologist struck them as a poor way to get rid of emotional conflicts (46.0%).

Over half of the sample agreed or partly agreed that people should work out their own problems, and that getting psychological counseling would be a last resort (62.0%). Similarly, over half of participants agreed or partly agreed that there is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help (65.7%). Finally, nearly three-quarters of the sample agreed or partly agreed that personal and emotional troubles, like many things, tend to work out by themselves (72.4%), and that due to the time and expense involved in psychotherapy, it would have doubtful value for a person like themselves (72.5%).

**Intention to Seek Counseling**

Participants’ responses on their intention to seek counseling for specific problems were analyzed (see Table 4). Items in Table 4 were ordered from low to high on “very likely” percentages. Over half of the sample stated they would be likely or very likely to seek help for depression (69.2%), drug problems (56.5%), excessive alcohol use (56.7%), and conflict with parents (52.5%). Less than half of the sample stated they would be likely or very likely to seek help for loneliness (48.9%), self-understanding (49.2%), inferiority feelings (46.7%), relationship differences (48.6%), difficulty in sleeping (42.1%), speech anxiety (41.9%), academic work procrastination (38.9%) test anxiety (38.5%), concerns about sexuality (36.2%), choosing a major (38.3%), weight control (33.6%), difficulties dating (25.8%), and difficulties with friends (28.1%).
Table 4
Latino Students' Intention to Seek Counseling (N = 563)

<table>
<thead>
<tr>
<th>How likely would you be to seek counseling if you were experiencing these problems?</th>
<th>Very Likely</th>
<th>Likely</th>
<th>Unlikely</th>
<th>Very Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>13.9%</td>
<td>34.6%</td>
<td>16.2%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Drug problems</td>
<td>30.7%</td>
<td>33.9%</td>
<td>12.3%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Excessive alcohol use</td>
<td>28.4%</td>
<td>28.1%</td>
<td>14.2%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Conflict with parents</td>
<td>19.0%</td>
<td>17.9%</td>
<td>27.7%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Loneliness</td>
<td>20.4%</td>
<td>17.1%</td>
<td>30.2%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Self-understanding</td>
<td>22.2%</td>
<td>16.3%</td>
<td>27.5%</td>
<td>32.9%</td>
</tr>
<tr>
<td>Inferiority feelings</td>
<td>27.4%</td>
<td>14.7%</td>
<td>25.4%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Relationship differences</td>
<td>18.7%</td>
<td>13.3%</td>
<td>32.3%</td>
<td>35.3%</td>
</tr>
<tr>
<td>Difficulty in sleeping</td>
<td>22.9%</td>
<td>11.9%</td>
<td>33.9%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Speech anxiety</td>
<td>25.2%</td>
<td>11.2%</td>
<td>32.5%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Academic work procrastination</td>
<td>22.6%</td>
<td>10.5%</td>
<td>38.2%</td>
<td>28.4%</td>
</tr>
<tr>
<td>Test anxiety</td>
<td>28.1%</td>
<td>10.3%</td>
<td>32.9%</td>
<td>28.2%</td>
</tr>
<tr>
<td>Concerns about sexuality</td>
<td>38.0%</td>
<td>10.1%</td>
<td>25.2%</td>
<td>26.1%</td>
</tr>
<tr>
<td>Choosing a major</td>
<td>32.9%</td>
<td>9.2%</td>
<td>29.1%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Weight control</td>
<td>33.9%</td>
<td>9.2%</td>
<td>32.1%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Difficulties dating</td>
<td>36.9%</td>
<td>7.3%</td>
<td>36.6%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Difficulty with friends</td>
<td>34.8%</td>
<td>5.7%</td>
<td>36.1%</td>
<td>22.4%</td>
</tr>
</tbody>
</table>

Focus Group Results

Participants responded to six focus group questions. Characteristics of each focus group is presented in Table 5.

Table 5
Focus Group Characteristics

<table>
<thead>
<tr>
<th>Group</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group size</td>
<td>n = 12</td>
<td>n = 10</td>
<td>n = 10</td>
<td>n = 12</td>
<td>n = 11</td>
<td>n = 11</td>
<td>n = 12</td>
<td>n = 12</td>
</tr>
<tr>
<td>Sex</td>
<td>5 M, 7 F</td>
<td>4 M, 6 F</td>
<td>6 M, 4 F</td>
<td>4 M, 8 F</td>
<td>3 M, 8 F</td>
<td>3 M, 8 F</td>
<td>6 M, 6 F</td>
<td>3 M, 9 F</td>
</tr>
<tr>
<td>Country of origin</td>
<td>Central America</td>
<td>Central America</td>
<td>Latino Mixed</td>
<td>South America</td>
<td>Mexico</td>
<td>Mexico</td>
<td>Latino Mixed</td>
<td>Latino Mixed</td>
</tr>
<tr>
<td>Generation status</td>
<td>1st</td>
<td>2nd</td>
<td>2.5-3rd</td>
<td>2nd</td>
<td>1st</td>
<td>2nd</td>
<td>2.5-3rd</td>
<td>2.5-3rd</td>
</tr>
<tr>
<td>Date</td>
<td>10/14/14</td>
<td>10/14/14</td>
<td>10/16/14</td>
<td>10/17/14</td>
<td>10/17/14</td>
<td>10/21/14</td>
<td>10/17/14</td>
<td>10/21/14</td>
</tr>
<tr>
<td>Minutes</td>
<td>41:07</td>
<td>38:48</td>
<td>50:28</td>
<td>39:49</td>
<td>52:16</td>
<td>45:07</td>
<td>43:30</td>
<td>41:54</td>
</tr>
</tbody>
</table>

Note. M = Male, F = Female

Question 1

First, participants were asked to respond to the following: “Do you think (insert group) in the United States seek psychological help? Why or why not?” Table 6 shows the themes that were identified in each focus group (denoted with “✓”). The last column shows what percentage of focus groups mentioned the theme.
Table 6
Responses to Question: “Do you think (insert group) in the United States seek psychological help? Why or why not?”

<table>
<thead>
<tr>
<th>Themes</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>75.0%</td>
</tr>
<tr>
<td>No, due to pride</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>87.5%</td>
</tr>
<tr>
<td>No, people can help themselves</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>No, it is not traditional</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>No, due to <em>familismo</em> or reliance upon family</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>No, due to resources</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>Time</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Income</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>Language</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Transportation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>No, due to stigma</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>50.0%</td>
</tr>
<tr>
<td>No, due to lack of awareness</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>No, due to trust/confianza</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>No, due to <em>espiritualismo</em></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
<td>No, due to <em>machismo/marianismo</em></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
<td>No, due to media representation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>No, due to <em>fatalismo</em></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

✓ indicates the theme was mentioned in the focus group.

In six out of eight focus groups (i.e., 75%), at least one participant stated that members of their group would seek psychological help. As an illustration, a male Latino reported, “*I think they could seek help if the problem is too out of control. For example, like addiction, they would seek help for that*”. A 1*/st* generation, female, Mexican participant agreed, “*I honestly think that if the Mexican Americans are willing to accept the fact that they need the help, they will seek it. But, I mean, it’s pretty rare because like he said we have too much pride built up. We believe that we can solve it on our own. I do believe that if there is a certain amount of acceptance, that, you know, we do need help, we will seek the help*”.

In every focus group, at least one participant stated members from their group would not seek psychological help. Various reasons were provided. A 2*/nd* generation, male, Central American participant stated, “*Um, I think the thing is that some people see it as a joke. Why spend money on this when I can pay my bills, or my car, or something like that. It’s also um, it’s kind of a joke. Some people are like, ‘why are you doing that?’*”,...
and they really need it but the family is like ‘you can talk to your mom’ or something like that. They won’t take it serious when it’s a really serious topic.”

Slightly over 60% of the focus groups reported that Latinos in the United States would not seek psychological help due to traditions and/or the idea that people could help themselves. Regarding traditions, a 2nd generation, Mexican, female participant reported, “I don’t, like, really, like think that Latinos seek for psychology help. Because it’s like, ‘oh no you’ll be fine’, just like, we have like, our own remedies. Oh, my grandma taught me this. It’s like down from generations.” A first-generation, female, Mexican stated, “I think back in our homeland, they don’t really have this big thing about psychiatrists. There’s, like, our dentists or doctors, but not really psychiatrists. So I feel like it’s not in their culture, not in their culture basically, but it’s like they weren’t raised that way. To like think, ‘Oh, um, I don’t know, I’ve been thinking this way, so maybe I can see a psychiatrist’. They don’t really have that, maybe they take it as a joke. I think it’s taken as a joke more often.”

Familismo and/or reliance upon family was cited by participants in over 60% of the focus groups. A 2nd generation, Central American, male student said, “We’re really family oriented, so we keep everything in a circle, and we vent with our family members, like our mother or father. But uh, we don’t seek help, ‘cause then we, ah, we see it as a force of weakness”. Another male Latino echoed this sentiment, stating, “I think because Latino families tend to stay close to each other, or at least the immediate family stays close, um, there is a tendency for those Latino children or whatever to seek help from their parents or whoever their immediate relatives are instead of seeking psychiatric help. Because they’re already close-knit to them so there is just that familiarity, so you
just have that trust to talk to your immediate relatives about your problems.”

Participants in slightly over 60% of the focus groups reported that Latinos in the United States would not seek psychological help due to resources. For example, common themes included lack of time (37.5%), lack of income (62.5%), language issues (12.5%), and transportation issues (12.5%). Participants in half of the focus groups reported that Latinos in the United States would not seek psychological help due to stigma. One 3rd generation Latina remarked, “I think there’s a heavy stigma against it, or like, uh, like that’s a bad thing. It’s not really considered an illness.”

Participants in 37.5% of the focus groups stated that Latinos in the United States would not seek psychological help due to a lack of awareness and cultural values like confianza. One male, Latino student, when asked why a Latino individual would or would not seek mental health counseling, stated, “I think it’s all about that trust. ‘Cause, you know, not letting too many people know about your issues. It’s that trust, you know trusting someone.”

Participants in 25% of the focus groups cited espiritualismo and machismo/marianismo as reasons Latinos in the United States would not seek psychological services. Regarding machismo and marianismo, a male Latino stated, “I think that in terms of males, for them to seek help is, at least for the Latinos, um, showing weakness. And, uh, that's stigmatized in men. And for females, they are afraid. Because, um, because they’re suppose to be the weaker sex, so to them having these problems, they feel like it’s normal”. Further, a 2nd generation, male, South American student remarked that, “my family would look at it, as why would you go to one. Handle your own stuff. Man up to it.”
Finally, participants in 12.5% of the focus groups noted media representation or fatalismo as reasons Latinos in the United States would not seek psychological services. One 1st generation, male, Mexican student suggested, “I think it’s kind of rare to see those cases [of Latinos seeking help]. If you see any, um, it’s through the media or they’re like TV shows.”

**Question 2**

Participants were asked to respond to the following: “What do you think might keep (insert group; e.g., Mexican Americans, Guatemalans, Latino/as) from seeking psychological help?” Table 7 shows the themes that were identified in each focus group (denoted with “✓”). The last column shows what percentage of focus groups mentioned the theme.

<table>
<thead>
<tr>
<th>Themes</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>100.0%</td>
</tr>
<tr>
<td>Time</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>87.5%</td>
</tr>
<tr>
<td>Income</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>100.0%</td>
</tr>
<tr>
<td>Transportation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>75.0%</td>
</tr>
<tr>
<td>Language</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>Stigma</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>87.5%</td>
</tr>
<tr>
<td>Pride</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>75.0%</td>
</tr>
<tr>
<td>Familismo</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>75.0%</td>
</tr>
<tr>
<td>Lack of awareness</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>Fear of punishment for documentation status</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Fatalismo</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>25.0%</td>
</tr>
<tr>
<td>Media representation</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>25.0%</td>
</tr>
<tr>
<td>Nothing</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
<td>Confianza</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Resilience</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Intimidating</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Not traditional</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

✓ indicates the theme was mentioned in the focus group.

Participants in every focus group reported that resources would keep Latinos from seeking psychological help, citing income issues (100%), time constraints (87.5%), transportation (75%), and language barriers (62.5%). Many Latino students made
comments similar to this 1st generation, male Central American remarked,

“Transportation and time can be a part of it because some of the parents work two jobs. They both work so they don’t have the time to, like, take us to the place, or take their time out just to be with us, or to be able to come, so they tend to just leave it like it is.” When asked what would keep Latinos in the United States from seeking help, a female Latina student stated, “I think it has to do with time. I don’t know, like the females have to be always busy. Especially, like, when they have kids. They’re always worrying about getting ready for dinner. Just doing chores all day”, and a male stated, “I think that some people would avoid seeing them, [or] seeking professional help because of lack of capital. Some people don’t make a lot of money. Most Latinos don’t have great jobs. They work factory jobs, and some of them don’t even have insurance, because factories don’t even have benefits. So how can they even afford to go?”

In regards to language, one male Latino participant stated, “I think if some Latinos were to go and try to talk to a professional and they’re not full-on speaking English, I think they’re embarrassed and probably more frustrated on how to express themselves in that language. So they’re probably thinking, ‘what’s the point if I can’t even express myself when I go to a professional? How are they really going to help me if I can’t figure out how I feel? Or I don’t know what’s going on with me?’”

Participants in 87.5% of the focus groups reported stigma as a factor that would keep Latinos from seeking psychological services. A 1st generation, male, Central American suggested, “The stereotypes are, you know, like, very important in our culture. Like a person that’s mentally ill, if you go to our culture, we don’t see them as a normal person who needs help. We seem them as a crazy person different from the people of the
community. And we, yeah, just push them away.” A 3rd generation, male, Latino stated, “We do not wanna [sic] be looked at as crazy, and on top of that, sometimes families can overblow it. Like they could think too much of someone going to get psychological help, and that would be something that would stop a child or someone else from going and getting it.”

Participants in 75.0% of the focus groups mentioned pride and familismo as reasons Latinos would not seek psychological help. A 2nd generation, male, South American implicated familismo by stating, “Well my mom can’t really even talk to people she doesn’t know. She talks to within family lines, like my tias and my tios, and stuff like that. And like, it’s just like, like we just keep it within our family, I guess. And maybe once in a while, if your friends understand, you can say it to your friends. But, um, most of the times it’s family wise.” Further, lack of awareness of services was implicated in 62.5% of focus groups.

At least one participant in 75% of the focus groups suggested that fear of punishment for documentation status would keep Latinos from seeking psychological help. One male Latino stated, “I think part of it is also the fear of getting caught, because possibly, you are undocumented. But you also need that psychological help. And if you go to seek help from a professional, they’re going to find out. [They think] ‘oh, I’m undocumented. I’m going to get sent back to whatever country I’m from. And there goes my life in the United States.’ So, there’s that fear too.” A 1st generation, male, Mexican stated, “I think it could also have to do with a lot of Mexicans come to the country as immigrants and they are not here legally, and they are trying to keep a low profile, and like, try to like, stay under the radar, you know. Still get good money and a better life for
their kids or future families, so they might have a reason why they don’t seek it, ‘cause they’re trying to be, like under the radar. [They] don’t let people know who they are or how they even got here.”

Fatalismo and media representation were mentioned in 25.0% of the focus groups. One 1st generation, male, Central American remarked, “If they’re going, some people would find out, and they’d think, ‘oh, you just want to pay someone a whole bunch of money to tell you what we’re telling you right now.’ Some people get discouraged to look for help because they’re like, ‘oh yeah, that’s true’, they’re like, ‘if something is wrong with me I can go to a regular doctor and get medicine instead of paying an hour for someone telling me, ‘oh how do you feel?’ Because that’s how the film projects a therapist. You sit down in a chair and they are like, ‘so how do you feel,’ so people are like ‘why do I want to waste money on that?’” Participants in 25% of the focus groups also mentioned nothing would keep Latinos from seeking mental health counseling.

Finally, participants in 12.5% of the focus groups cited confianza, resilience, that the experience is intimidating, or that therapy is not traditional as reasons Latinos may not seek mental health counseling. In regards to resilience, a 1st generation, male, Mexican participant stated, “I think what, like, what needs to be taken into account is American people and Mexicans- like, they deal with stuff differently. Mexicans, I think they have more of a higher tolerance for a certain level of, you know, stuff that happens to them. They’ve just been through more stuff, they’ve just moved countries, so, uh I think they’re more like, they can just tough it out. That’s the really, like, Mexican way of, like, growing up. You get cut, you get hurt, you know, tough it out.”
Question 3

Participants were asked to respond to the following: “What kinds of psychological problems would (insert group) get help for?” Table 8 shows the themes that were identified in each focus group (denoted with “✓”). The last column shows what percentage of focus groups mentioned the theme.

Table 8
Responses to Question: “What kinds of psychological problems would (insert group) get help for?”

<table>
<thead>
<tr>
<th>Themes</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>87.5%</td>
</tr>
<tr>
<td>PTSD</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>Sexual Violence</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Immigration</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Depression</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>87.5%</td>
</tr>
<tr>
<td>Stress</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Substance abuse</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>75.0%</td>
</tr>
<tr>
<td>Family problems</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>75.0%</td>
</tr>
<tr>
<td>Family separation</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Acculturative difficulties</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Anxiety</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Insomnia</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>They will not seek help</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Death in the family</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Schizophrenia</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

✓ indicates the theme was mentioned in the focus group.

Depression was implicated in 87.5% of the focus groups. One 2nd generation, male, South American stated, “I feel like they are depressed some of the times. Like right now, my mom, she quit her job because she is so depressed at the job she worked at. And it is already minimum wage job, so it wasn’t worth it, right? So she is depressed about that, so, like, now my mom won’t pay the bills and stuff”.

Participants in the focus groups mentioned other problems Latinos may seek counseling for, such as trauma (87.5%) and stress (87.5%). Two 2nd generation, female, Latinas mentioned trauma related to coming to America. One stated, “It could also be trauma. I do not know what that falls under, but especially if they are like immigrants, or
they started off as immigrant, and they had to come here, and the journey they had to go through. And who knows what they had to go through to get here. Some people get caught or they get their stuff stolen. I know my mom went to jail, and stuff like that, so that could be a contributing factor to it, to why they have problems in their daily lives. ‘Cause it comes back to them and it does not go away.” The other Latina student stated, “There could be some trauma with the immigrants, especially because when they do cross the boarders, not all of them can necessarily make it through. Some of them will get caught and sent to jail- even killed on the way. And not all immigrants are able to bring their entire family, so they would have to leave some family members behind. This will cause them having to suffer from having to leave their family members behind.”

A 1st generation, male Mexican commented on trauma from abuse and stated, “Um, coming from Mexico, um, there, uh, alcoholism in the family is a big, it’s a HUGE problem, also like child abuse in the family because of alcoholism is a HUGE problem. They even have like, a, uh, uh special line for like domestic abuse and it’s really encouraged to seek out help when that’s the case. Even when you witness someone that is being abused and like has alcoholism in their family, it is recommended that you call anonymously and, you know, alert the authorities about what’s going on. In, you know, a household that has alcoholism or child abuse. Those are big problems in Mexico.”

Participants in 37.5% of focus group stated they, or members of their community, might seek counseling for family separation or acculturative difficulties. One 2nd generation, male, South American student stated, “I would have to say separation of family. Like my Aunt, I mean she might need help, because my Aunt feels lonely without her son, that’s over there in Colombia.”
One 2nd generation, female, Mexican commented on acculturative stress, stating, "I believe stress. Not just from school, but everything. Things go down in the community. Things go down with other Latinos who think you're whitewashed, putting you down for being Hispanic, when they're Hispanic as well." Another 3rd generation, female, Latina student remarked, "Also when they are trying to be a part, like going to school, and they are trying to be a part of the community, and they are having trouble with it because they can't make friends. So they are having trouble fitting in, because they just came [to America], and they may speak a different language than other people, so they may want to stay secluded to Hispanic people and speak to them rather than going out and speaking to other people."

Participants in 25% of the focus groups noted that Latinos might seek help for anger issues. Only 12.5% of focus groups (one out of eight) added that individuals in their community might seek help for suicide, death in the family, or schizophrenia.

**Question 4**

Participants were asked to respond to the following: "If (insert group) got help, who do you think they might seek help from?" Table 9 shows the themes that were identified in each focus group (denoted with "✓"). The last column shows what percentage of focus groups mentioned the theme.

Participants in 100% of the focus groups mentioned that Latinos would seek help from their friends or neighbors, and 87.5% would seek help from family. One 1st generation, Latina, Mexican stated, "Problems are shared in between comadres and compadres. So I don't think there would be like, 'Oh I'm going to go talk to the psychologist because of this or that'. I don't picture that. I picture them calling their
comrade while staring at beans or whatever. Or if not, they’ll probably like, you know, if
you’re really religious you’ll probably pray, like, your problems away.”

Table 9
Responses to Question: “If (insert group) got help, who do you think they might seek help from?”

<table>
<thead>
<tr>
<th>Themes</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends/neighbors</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>100.0%</td>
</tr>
<tr>
<td>Family</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>87.5%</td>
</tr>
<tr>
<td>Religious figures/religion</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>75.0%</td>
</tr>
<tr>
<td>Teacher</td>
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<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>37.5%</td>
</tr>
<tr>
<td>Psychologist</td>
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<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>37.5%</td>
</tr>
<tr>
<td>Latino psychologist</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25.0%</td>
</tr>
<tr>
<td>School psychologist</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5%</td>
</tr>
<tr>
<td>Non-specific psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Primary care physician</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>25.0%</td>
</tr>
<tr>
<td>A professional (non-specific)</td>
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<td>✓</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>25.0%</td>
</tr>
<tr>
<td>Counselor</td>
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<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Support groups</td>
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<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25.0%</td>
</tr>
<tr>
<td>Mental health practitioner</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5%</td>
</tr>
<tr>
<td>Folk cures</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5%</td>
</tr>
<tr>
<td>Coach</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5%</td>
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<tr>
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</tr>
<tr>
<td>Non-profit organization</td>
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<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<td>12.5%</td>
</tr>
<tr>
<td>Hotline</td>
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<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>12.5%</td>
</tr>
</tbody>
</table>

✓ indicates the theme was mentioned in the focus group.

Regarding friends, one 1st generation, male, Mexican stated, “The way I see it, is like, if you go to your friend, a Hispanic friend, Mexican friend. Okay, they know what you’re going through. They know your background, they know your family, they know your struggle. But you go to, let’s say, a white counselor, psychologist. To me, I feel, because I’ve never been to one, but I feel they’d be like, ‘how do you feel?’; like, ‘tell me what’s going on.’ It’s like, they’d give you what they think, but in reality, I don’t think they know what you’re going through. Because they’ve never been through it. Or, like, because I feel like they’ve been through... they’ve had a better life than some other Mexicans or Hispanics.”

Participants in 75% of the focus groups mentioned religion, or seeking religious figures, when asked who Latinos would seek help from. One 3rd generation, female, Latina stated, “Aye no, we wouldn’t. A majority of the Hispanic people wouldn’t even
seek, well, especially the elderly people, would not seek for help, or professionalism, or in the medical field. In fact, they would seek help for themselves through their religious beliefs. They would be like, say, with religious beliefs, think like God would help them and stuff like that, and I think that’s a major part of them. Um, you know, with people of the Latino community. So, I would say no, hardly anyone would seek for help in a professional. I agree, I agree to some aspects where people say to their close families, to close individuals, but not to the actual professional therapy, medical and stuff like that.”

Participants in 37.5% of the focus groups noted Latinos would seek help from a psychologist, while participants in 25.0% of the focus groups said they would seek help from a Latino psychologist, 12.5% would seek help from a school psychologist, and 12.5% mentioned non-specific psychologists. One male Latino remarked, “I think if they were to seek professional help, I think they would want to see someone like them. So, if it was a male Latino, he would try to seek a Latino male psychologist, if that was possible. Um, and then, the same thing with a female. A female would seek a Latino, uh, psychologist. Because they understand what they’re going through. It’s, uh, just a living in a, uh country that’s maybe not theirs. And even if it is theirs, the culture is a little different.” Participants in 12.5% of the focus groups cited primary care physicians, non-specific professionals, counselors, or support groups as people/places Latinos in the United States would seek help from. Also, mental health practitioners, folk cures, coaches, significant others, non-profit organizations, and hotlines were cited in 12.5% of the focus groups. Also, teachers were brought up in 37.5% of focus groups.

**Question 5**

Participants were asked to respond to the following: “What do you think would
increase the use of mental health resources for (insert group)?” Table 10 shows the themes that were identified in each focus group (denoted with “✓”). The last column shows what percentage of focus groups mentioned the theme.

Table 10

<table>
<thead>
<tr>
<th>Themes</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normalize mental health issues</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>100.0%</td>
</tr>
<tr>
<td>Provide information/advocacy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>87.5%</td>
</tr>
<tr>
<td>Reduce stigma</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>62.5%</td>
</tr>
<tr>
<td>Advertise with media (e.g. commercials, radio ads, flyers)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>62.5%</td>
</tr>
<tr>
<td>Community outreach</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>50.0%</td>
</tr>
<tr>
<td>Community workshops/health fairs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>50.0%</td>
</tr>
<tr>
<td>Service providers working in the community</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>50.0%</td>
</tr>
<tr>
<td>Spanish services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>37.5%</td>
</tr>
<tr>
<td>Free services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25.0%</td>
</tr>
<tr>
<td>Offer services in schools</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25.0%</td>
</tr>
<tr>
<td>More Latino psychologists</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25.0%</td>
</tr>
<tr>
<td>Group therapy</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5%</td>
</tr>
</tbody>
</table>

✓ indicates the theme was mentioned in the focus group.

Normalizing mental health issues was noted as a factor that would increase mental health service utilization in Latinos by participants in 100% of the focus groups.

Participants specifically cited providing information and advocacy (87.5%) and reducing stigma (62.5%) as ways to normalize mental health issues. A 2nd generation, male, Mexican remarked upon providing information/advocacy, stating, “Knowing really what it is, or knowing it’s not what we think it is. Someone said earlier, it’s only for people going crazy, or if not, already crazy. I think we need to educate ourselves and our community that it’s not that. Only in television and stuff, the only ones going there are called crazy. You hear all these things, and see all these things, and it becomes truth to you. So I think we need to educate that it’s for everybody, it’s not just because we think you’re gonna [sic] go crazy, you know what I mean? Basically just educating us more than we already are.”
A 2<sup>nd</sup> generation, female, Central American commented on reducing stigma, stating, “Maybe a social acceptance, maybe they see it, as a sign of weakness. Like, ‘why am I going to go seek help?’ If it was seen as more acceptable they might be prone to go. If I go, they’re gonna [sic] make fun of me, so why would I go?” Further, a 2<sup>nd</sup> generation Mexican student stated, “I feel like as Mexicans we have to, um, tell like the family like ‘Oh I’ve gone already, you should go. Just try it out. It worked for me it may work for you.’ But you need someone in your same culture to tell another person in the same culture so they can go. Because they’ll trust you more”.

Participants in 62.5% of the focus groups stated advertising using media would increase use of mental health services by Latinos. One 1<sup>st</sup> generation Mexican stated, “I guess having it through media because Mexican people worship TV. [Group laughs] Yeah, they like gossip TV. So I think that could encourage them too, maybe if it was seen more on like telenovelas they would probably be like, ‘oh she’s doing it I probably should to’.” A 2<sup>nd</sup> generation, male, South American student remarked, “Probably more fliers, or like, more online stuff, or like, like in the news, like in the Hispanic news. It could be everywhere around us like in a way, they could like, it’s always going to be there. Like you can convince them, convince them, that like there is all this stuff everywhere around.” Another 2<sup>nd</sup> generation, male, South American stated, “I think like, the Latinos should do, like, a commercial showing like a Latino, like a telemundo commercial. I think that would be the only way. I would never see any other way”.

Participants in half of the focus groups reported that community outreach, community workshops, health fairs, and service providers working in the community would increase the use of mental health resources by Latinos. A 1<sup>st</sup> generation Mexican
student noted community outreach, stating, “I feel like apart from spreading the word out, um, you know, um, I think, because we love our culture. So, I think maybe tying in something that would lure us in. Because as a Mexican American, living in the US, I still see psychologist as the American way. So I feel that if somehow, I don't know, if there was something that would lure me in, I would feel more comfortable into going and actually participating.”

Participants in 37.5% of the focus groups noted that providing services in Spanish would increase the use of mental health services. A 1st generation, female, Central American participant suggested “Letting them know as well that even though the info is being held out in Spanish, that once they get there, someone will help them out in Spanish. Although sometimes people get information in Spanish, they get there, but clerks or something don’t know Spanish, so it’s hard for them. Once they get there [they need] to receive help in Spanish as well.” A 2nd generation, male, South American commented, “[Seeking help] kinda [sic] intimidates them. Like, my mom goes to the doctor, and has a hard time describing what she’s feeling to a doctor who barely speaks Spanish”.

Offering free services, services in schools, and increasing Latino psychologists working in the field would increase use of mental health services for Latinos, according to participants in 25% of the focus groups. Regarding increasing Latino psychologists, a 2nd generation, male, South American stated, “Having more Hispanic professionals in the field will help too, because many Hispanics don't feel comfortable talking to a person of a different race”. One 2nd generation, female, Mexican student remarked upon free services, stating, “Like they all say, it does have to do with the money. Us Hispanics don't like to spend money. So we have to find anything that's cheapest or that's free. At the
stores, what do we find? Especiales. Or, you know, everything where we go is the cheap stuff. So if that's free then the majority would go. But if it’s not, nobody would waste time and put money where they could talk to their uncle or sister”.

Finally, participants in one focus group noted offering group therapy as something that would increase the use of mental health services for Latinos.

**Question 6**

Participants were asked to respond to the following: “What services are you aware of to help with psychological problems? On campus? Off campus?” Table 11 shows the themes that were identified in each focus group (denoted with “✓”). The last column shows what percentage of focus groups mentioned the theme.

<table>
<thead>
<tr>
<th>Themes</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free counseling on campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>100.0%</td>
</tr>
<tr>
<td>Not aware of anything on/off campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>62.5%</td>
</tr>
<tr>
<td>Hotlines off campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>50.0%</td>
</tr>
<tr>
<td>Kaiser/hospitals</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>50.0%</td>
</tr>
<tr>
<td>Internet</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>50.0%</td>
</tr>
<tr>
<td>Peer groups on campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Religious figures off campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Friends/family off campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Off campus community agencies</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Learning disability center</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>37.5%</td>
</tr>
<tr>
<td>Primary care physician off campus</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
<td>Local schools offering counseling</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
<td>Free group counseling on campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
<td>Free workshops on campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
<td>Free massages on campus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25.0%</td>
</tr>
<tr>
<td>Physical therapy on campus</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Off campus insurance</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>Health center at work</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
<tr>
<td>CSUN Helpline</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

✓ indicates the theme was mentioned in the focus group.

Participants in every focus group stated that they were personally aware of free counseling offered at the university’s counseling center. Participants in 62.5% of the focus groups mentioned they were not aware of any psychological services off campus.
One 1st generation, female, Mexican participant remarked, “Well I just know about the, here, at CSUN. At the places at CSUN. And I live where- an area where it’s a pure Latino’s community. And, honestly, I don't know of no places around the community that offer those, these types of help. I don’t know where to go”. A 1st generation Central American student commented, “I don’t think we’re aware of other services, like most of us know services because they informed us of it during school. If we weren’t informed we wouldn’t know. I think it helped to inform everyone of services available”.

Participants in 50% of the focus groups cited off-campus hotlines, the Internet, Kaiser Permanente or other hospitals as places where individuals could receive help for psychological problems. One 1st generation, female, Central American student stated, “I mean, it’s through Kaiser, it’s through a hospital, but I know hospitals offer it. I know hospitals offer it”. One 1st generation, female, Mexican student remarked, “They have suicidal hotlines. And, like, Kaiser Permanente, they offer the services and you don’t have to pay for it, you are paying for it, but not up front”.

Participants in 37.5% of the focus groups noted that peer groups on campus, religious figures off campus, friends and family off campus, and off campus community agencies were places that individuals could go if they were in need of psychological assistance. One Latino male stated, “I would rely more on family to help me with issues, and I don’t really know of any resources available”. Free workshops on campus, free massages on campus, physical therapy on campus, off-campus insurance, off-campus health centers at work, and the CSUN helpline were mentioned in 12.5% of focus groups.
CHAPTER V

DISCUSSION

The purpose of this mixed methods study was (1) to identify reasons that Latinos may not value or seek mental health counseling, and (2) to identify ways that Latinos would suggest overcoming these barriers. Results from the self-report surveys and focus groups suggested numerous barriers. Also, results from the focus groups provided ways to address these barriers and increase psychological service utilization in Latino communities.

Discussion of the Findings

In general, the majority of Latino participants reported little self-stigma and public stigma when answering questions in the self-report survey. However, the focus group data indicated that self and public stigma were fairly predominant in the Latino communities, which coincides with the literature (e.g., Abdullah & Brown, 2011). This discrepancy might be due to how the questions were asked on both the surveys and in the focus groups. For example, in the focus groups, respondents were asked very broad questions that were directed toward members of the community (e.g., “Do you think (insert group) in the United States seek psychological help? Why or why not?”). In contrast, the survey questions administered were very specific to personal flaws related to seeking services (e.g., I would feel inadequate, less intelligent, or inferior for seeking help). In other words, when responding to the survey, subjects did not indicate that they would necessarily feel less intelligent or that their self-esteem would change as a result of seeking mental health counseling. Yet, in the focus groups, there were concerns that the community would view a person as “crazy” or “weak” if they had to see a therapist.
Thus, the survey questions were asking about more pointed constructs of stigma than the broad questions utilized in the focus groups.

Further, the questions on the survey regarding public stigma were not directed specifically toward Latinos (e.g., “Most people believe that a person who has received mental health treatment is just as intelligent as the average person”). Participants were instructed to rate the degree to which they agreed with the statements, and all of the statements include the phrase “most people.” As Latinos are not a majority group, and participants were not specifically asked about Latino communities, they may have been imagining a general perception, rather than a Latino perception. This may also explain some of the discrepancy regarding stigma in survey data and stigma in focus groups.

The focus group data were more consistent with the scale that asked about perceptions toward seeking mental health counseling. This may be particularly true when participants were asked whether they would seek psychological help in the survey; only 20-50% of the participants would consider psychological help based on the particular type of problem.

Many of the participants in the focus group mentioned stigma as well as cultural values (e.g., confianza, familismo, fatalismo, marianismo/machismo, espiritualismo) that may keep Latinos from seeking services. This corresponds with survey data, as over half of the respondents thought that getting psychological counseling would be a last resort, and that there was something admirable in the attitude of a person who was willing to cope with his or her conflicts and fears without resorting to professional help. Also, nearly 75% of the sample in the survey data stated that their problems would work themselves out.
Also, various resource issues (e.g., documentation status, transportation issues, childcare issues, low income, language barriers) were mentioned in focus groups. Nearly 75% of survey data respondents agreed that they felt psychotherapy would not be valuable due to the time and expense involved. These barriers have been noted in other studies on accessing mental health services and/or being involved in educational systems. Also, these barriers correspond to literature that shows that Latinos are more likely to live in impoverished areas where there are fewer mental health services available.

One of the explanations for the small percentage of respondents who would seek help may come from the responses in both the survey data and in the focus groups. When asked on self-report scales which issue participants would potentially seek psychological services for, the top issue was depression (69.2% would seek services). Specifically, over 50% of the participants would seek psychological services on only three other issues: excessive alcohol use (56.7%), drug problems (56.6%), and conflict with parents (53.5%). The focus group data found similar results. Specifically, participants in most focus groups mentioned that they or members of the community would seek psychological services for depression (87.5%), substance use issues (75.0%), and family problems (75.0%). The issue most frequently endorsed as a problem Latinos would seek help from in the focus groups, that is trauma, was not inquired about in survey data, but illuminates a salient problem in Latino communities.

Thus, results suggest that although few Latinos would seek psychological help, if they are going to seek treatment, they would be most likely to seek treatment for depression, substance abuse, and family problems. As stated previously, depression is the leading cause of disability worldwide, and is even more prevalent in Latinos that other
ethnic groups in the United States. Further, depression and alcohol abuse are commonly portrayed in mass media, which coincides with focus group respondents frequently discussing the importance of telenovelas and other media in their communities.

Limitations and Research Implications

This thesis will add to the understanding of mental health service utilization in Latino college students, but certain limitations to the study do exist. First, the sample is limited to Latino students attending a university in Los Angeles County, which may limit generalizability. For example, Latinos at the university where data were collected were primarily Mexican or Central American origin. A university on the East Coast, such as a school in New York or Florida, may have a much larger Puerto Rican or Cuban sample. Further, this study collapses various Latino origins into one homogenous group in the results, which would not take intra-group differences into account in the analyses.

Further, this study only adds to the knowledge of Latino emerging adults in college. Many Latino emerging adults are not enrolled at a university, and further research must be conducted to identify barriers and facilitators for mental health counseling in these groups. For example, every student in this study was eligible for free counseling through the university counseling services. Thus, the results of this study may vary when looking at Latinos who are not enrolled at a university.

Another possible limitation to this study is the contrast between quantitative data regarding stigma and qualitative data regarding stigma. As discussed, stigma was a frequent theme in the focus groups, but participants did not generally endorse stigma toward mental health in the survey portion of the study. It may be of interest in future studies to conduct interviews regarding the structure of these scales, as they may not be
completely measuring Latino perceptions of private or public stigma.

Finally, this study did not take acculturation into account. Although generational status was collected, scales regarding acculturation were not administered. Level of acculturation may influence the results of the study, and generational status is not a perfect indicator of acculturation. On related note, it is also possible the documentation status of participants might influence the results, however documentation status was not asked on the demographic forms. Future studies might consider ways to glean documentation status while still protecting participants’ anonymity and/or legal status.

**Implications**

The results indicated a variety of barriers that Latinos face when seeking mental health treatment. The focus group data also indicated a variety of ways to combat these barriers, which could lead to good interventions. These results are relevant for clergy, policy makers, mental health practitioners, community leaders, and educators.

Religion is distinctly important in Latino communities. When asked who Latinos would seek help from, participants in 75% of the focus groups stated they would seek psychological help from religious figures or prayer. Since many members of the community turn to clergy, it may be of value for clergy members in Latino communities to keep themselves educated about problems commonly faced by Latinos (e.g., depression, substance abuse, family conflict, and trauma), and have referrals to local mental health services in parishes or church rectories and entrances.

Participants in every focus group stated that one way to increase mental health service use in their community would be to normalize mental illness and mental health service use, and participants in 87.5% of the focus groups stated that one way to do this
would be through increasing awareness of services. Thus, it may be of interest for local practitioners and educators to reach out to churches regarding mental health services, or to hold workshops or therapy groups in church halls. In this way, mental health practitioners can acknowledge the importance of *espiritualismo*, while also providing local services, which participants in 50% of the focus groups indicated would increase mental health service use in Latino communities.

Focus groups also frequently mentioned television and other advertising techniques when asked about how to promote mental health service use. Participants in over 60% of focus groups stated ways to increase the use of mental health services by Latinos would include advertising through public service announcements, commercials on television, radio commercials, and through fliers. Participants stated that members of their community did not know where services were located, as 62.5% of participants reported that they were not aware of any counseling services outside of the university’s counseling center. Thus, it may be valuable for community leaders and mental health practitioners in Latino communities to advertise their services in these ways. One participant remarked that they receive a number of fliers under their windshields or taped to their door, but has never seen advertising for a psychologist through this medium. Further, another participant suggested airing commercials aimed at de-stigmatizing mental illness or advertising for local mental health practitioners in Spanish on *Univision* or during popular *telenovelas*. One participant even suggested that television shows themselves may play a role in negative perceptions of seeking psychological help, as individuals in Spanish-language television series do not seek treatment until they have “gone crazy.” Therefore, this participant suggested that it may be helpful to portray
mental health help-seeking on television as proactive, so it can be seen in a positive light by the Latino community.

Further, through identifying cultural barriers to receiving mental health treatment, practitioners may actually use these cultural values to enhance therapy for Latino groups, thus increasing the adoption of therapy in the community. For example, confianza, familismo, and machismo were identified as factors that keep Latinos from seeking help, but these factors may actually be restructured to benefit practitioners. Some practitioners have noted in parent education groups, that parents do not like teaching their male children to do household chores due to strict gender roles and the concept of machismo. Thus, practitioners working with Latinos could reframe the idea of teaching household chores to sons can help make him independent and self-reliant, and he does not have to marry simply to have a woman care for him.

Similarly, practitioners and community leaders may be interested in creating a targeted ad campaign for specific Latino communities. A campaign showing a Latino man taking his son to therapy, with a slogan about how the man is strong for seeking outside help to take care of his family, thus addressing both familismo and machismo, and using these former barriers as facilitators for treatment. As participants believed that seeing more Latinos using services would increase utilization, it could be helpful to show a family like this in advertisements or on billboards. Future research should be conducted to examine the efficacy and feasibility of this campaign.

Further, confianza was mentioned as a barrier to treatment in several groups. Many individuals stated they did not trust practitioners or feel comfortable sharing their opinions and feelings with strangers. With this knowledge, educators have an excellent
opportunity to promote positive images of respectful and trustful therapeutic relationships. For example, school counselors, psychologists, administrators, and teachers should be mindful to not talk about students while other students are in their office. This may increase a sense of trust by Latino youth of authority figures in the helping professions by modeling traits of confianza.

Lack of awareness was implicated in 62.5% of focus groups as a barrier for Latinos receiving treatment, and 87.5% of participants stated that more Latinos would seek therapy if they were provided with information. Some focus group respondents reported there is a perception in their community that psychologists and other individuals in the helping profession are just people that you pay to talk to. Thus, it would be important for individuals working in helping professions to explain the value of therapy and the benefits individuals may receive, that would differentiate it from talking to a family member or friend. Similarly, it is important to Latinos that services are often offered on free or sliding scales. In Los Angeles County, there are many free and sliding scale therapists and agencies, but participants in 62.5% of the focus groups stated they were unaware of counseling services outside of the university. Therefore, individuals offering free or sliding scale therapy could ask members of their communities about effective ways to advertise their services.

Further, many participants stated services should be offered in Spanish. On a related note, it may be of value to practitioners to use culturally-adapted, or culturally-specific interventions, as opposed to merely using translated programs normed on non Latino populations. For example, Hinton, Hofmann, Rivera, Otto, and Pollack (2011) conducted a clinical trial examining a culturally-adapted cognitive-behavior therapy for
treatment resistant PTSD in Latina women. In this therapy, the researchers identified cultural values that enhanced therapy for this group. They articulated that a therapist administering a culturally-adapted treatment would demonstrate they feel *respeto* for their clients and they have knowledge of the Latino culture, and in turn, the client may acquire more benefits from therapy, as the skills and analogies are taught to them in ways that are more familiar and easy to understand and relate to. Future studies should investigate how many therapists in Latino communities utilize culturally-adapted therapeutic techniques in comparison to simply offering general services in Spanish. Even further studies may then compare symptoms in individuals receiving a culturally-adapted therapy to individuals receiving Spanish-language therapy that is not culturally adapted (e.g., CA-CBT vs. CBT).

In most of the focus groups, trauma was mentioned as a potential issue for which individuals may seek help. Thus, a recommendation for researchers using the Intention to Seek Counseling Inventory (Cash et al., 1975) might be to add trauma as one of the items in the scale. Likewise, for researchers using similar measures, the results of this study would indicate that trauma, depression, substance use, and conflict with family should all be included as potential problems where Latinos would potentially seek services.

**Conclusion**

Given that Latinos are a group at high-risk for psychopathology with low mental health service utilization rates, and this phenomenon is also identified in college students, this mixed methods study sought to examine ways to increase mental health service use in Latino college students. Results suggested various factors that contribute to the lack of therapy utilization, such as public stigma in Latino communities, cultural values, a lack of
awareness of services, and a lack of capital and resources (e.g. time, money, English ability, documentation status). Factors that may facilitate the use of mental health counseling included normalizing mental health issues, advertising with media, having local service providers, providing free services, and engaging in community outreach. Future research should be conducted to examine the feasibility of the suggestions made by focus group participants. This information is of importance to physicians, educators, mental health practitioners, policy makers, and community leaders working with Latinos.
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