Factors Influencing the Use of Mental Health Resources Among Hispanic/Latinx Adults in the United States
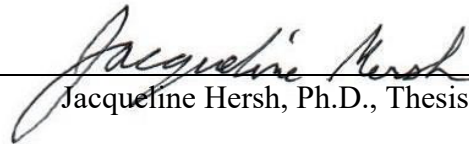
by

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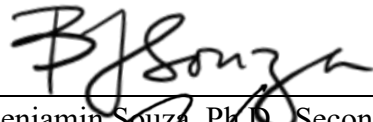in partial fulfillment of the requirements for the degree of

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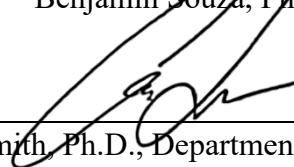
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Abstract

Mental illness is pervasive for all people in the U.S., but treatment seeking behaviors and resources are especially lacking for some. The Hispanic/Latinx community experiences more treatment disparity compared to other groups. There are significant barriers that they face, such as stigma and lack of resources. This study aimed to answer the questions of which barriers are more pertinent and which variables about a person can predict ratings of barriers. We hypothesized that there would be higher rated barriers and that certain demographic variables such as age, gender and beliefs would relate to certain barriers. In the current study, a survey (in either English or Spanish) was provided asking various questions about barriers and people's views on therapy, as well as demographic questions. It was concluded that finance/cost, trust in clinicians and availability of providers were rated the highest. Additionally, six predictor variables did significantly predict ratings of barriers, such as negative community views leading to higher ratings of finance/cost. Future implications for how this study can enact change are discussed.

Factors Influencing the Use of Mental Health Resources Among Hispanic/Latinx Adults in

the United States

Individuals of Hispanic and/or Latinx origin make up a significant portion of the

population of the United States. Hispanic is defined as an individual of Spanish-speaking

origin, while Latino/a/x refers to an individual from Latin America or the Caribbean (Cuncic,

2020). In 2002, Hispanics became the largest minority group in the United States (U.S.),

making up 13% of the entire country's population (Internian & Diaz-Martinez, 2007).

According to the U.S. Census Bureau (2019), in 2019 that number reached 18.5%, which is a

total of over 60 million Hispanic and/or Latinx individuals in the United States. Additionally,

according to the National Alliance on Mental Illness (NAMI, 2021), in the United States, 1 in

5 adults (51.5 million people) experienced mental illness in 2019; out of this population, 18%

were of Hispanic and/or Latinx origin, and only 33.9% received treatment. Given the

statistics, over 9 million Hispanic/Latinx individuals experience mental illness each year, but

almost 7 million are left untreated or without support (NAMI, 2021).

Mental illness has an enormous impact on the overall well-being of an individual. For

instance, people living with mental illness are at higher risk for other physical diseases such

as cardiovascular and metabolic diseases. Not only that, they also have a higher rate of

substance use, unemployment, school dropout, hospitalizations, homelessness, and

incarceration (NAMI, 2021). Management of mental illness may require additional resources

such as time and money. As if those weren't enough, Hispanic/Latinx individuals are also

vulnerable to psychological distress due to the possible experience of immigration and

acculturation, including being in an unfamiliar environment, language barriers, and an

inability to communicate with their community/neighborhood, which could lead to social

isolation (Guzman et al., 2015). In addition, individuals are often exposed to violence,

discrimination, trauma, and are faced with a clash of cultures between the traditional

collectivist/community-based one in Hispanic/Latinx culture and the individualistic one of

the U.S. (Guzman et al., 2015). Despite experiencing similar rates of mental illness (or more)

compared to most non-Hispanic White adults in the United States and the additional

aforementioned stressors, Hispanic/Latinx individuals are less likely to receive treatment

than non-Hispanic White individuals (Guzman et al., 2015). These unique stressors could

potentially be a contributing factor to the lower treatment rate. Previous research has been

conducted to consider the reasons for the disparity in treatment seeking behaviors among

Hispanic/Latinx individuals, and several barriers have been identified.

Barriers to Treatment for Hispanic/Latinx Populations

Knowledge and the Experience of Symptoms

Hispanic individuals were found to have less knowledge regarding what mental

illness is, treatment services that are available and how to access them, and what the

treatment options are (Guzman et al., 2015). This general lack of knowledge, and more

specifically, the lack of knowledge about the severity of one's disorder, can lead to being less

likely to seek out psychological services and/or receive help. As suggested by Guzman and

colleagues (2015), if one perceives their mental health to be worse and their disorder to be

significant, they are more likely to seek treatment. Another factor that impacts whether one

seeks treatment or not is that many Hispanic individuals are more likely to describe physical

somatic symptoms rather than psychological ones and prefer to speak to their primary care

provider rather than a mental health professional (Guzman et al., 2015).

Access to Resources

A common barrier to treatment is a lack of resources and services that are available where individuals are living. Hispanic neighborhoods have significantly less mental health clinics (Guzman et al., 2015); there are also less qualified and less culturally appropriate services that are available to them, which decreases the likelihood of treatment being sought. Access to adequate transportation may also be a barrier to utilizing services (Guzman et al., 2015). Hispanic/Latinx individuals are more likely to seek mental health services with their primary care physician and therefore, having access to treatment in this setting is a crucial variable in whether they seek treatment or not (Interian & Martínez, 2006).

Language

There is a lack of bilingual mental health providers and services available, which can lead to individuals who are not proficient in English to not understand treatment or service options. Thus, they are less likely to seek care (Guzman et al, 2015). Furthermore, the language barrier results in less trust between an individual and the clinician, as the quality of communication is poorer (Sewell, 2015). Even in instances where an interpreter/translator is present, many feel uncomfortable because of the presence of a third party (Sewell, 2015).

Trust

Trust in one's physician or clinician is imperative to seeking help. There is a disparity between White people and Black people and Hispanics/Latinxs in regard to trust in medical resources. Overall, minority populations such as Hispanic/Latinx and Black individuals experience more mistrust than White individuals. More specifically, again when compared to White people, Latinx folks have the least amount of trust, even less than Black people. (Sewell, 2015). One possible reasons is that due to medical abuses in the past, there may be a collective memory of mistrust in the Hispanic/Latinx community (Sewell, 2015).

Financial

The cost of treatment can be a barrier to accessing services. Individuals may have insufficient funds and/or insurance to cover these services. Healthcare visits would then have to be limited (Guzman et al., 2015).

Cultural Beliefs/Stigma

Stigma can have a huge impact on mental health participation because seeking mental health resources is often viewed negatively. This stigma can be observed through discriminatory behavior and stereotypes, the actions and attitude of a practitioner, one's society and one's family. If someone is afraid of being stigmatized, they are less likely to seek mental health services in order to avoid prejudice (Fripp & Carlson, 2017). Stigma surrounding mental health and treatment as well as the distrust in health services can contribute to a lack in treatment-seeking behaviors (Guzman et al., 2015). Many Hispanics believe that mental illness is associated with being "crazy," services would not be effective, and that these are private matters that should not be discussed (Guzman et al., 2015). In addition, shame associated with stigma, disapproval by family members, and religious beliefs are all factors that could be interfering with interest in psychological services. Furthermore, the gender gap can be influenced by the idea of *machismo*, which includes that men do not need to seek help, and *marianismo*, which describes how women are expected to be self-sacrificing. There is also a belief, known as *familismo*, which suggests that individuals should seek help from family members before anyone else (Guzman et al., 2015).

Demographics

There are some demographic variables that influence how an individual rates a barrier. As cited by Guzman and colleagues (2015), among Hispanic/Latinx individuals,

being male, and over the age of 65 was associated with reduced likelihood of accessing

mental health treatment. In addition, immigration status can affect the likelihood of seeking

services, as those who are undocumented may fear revealing their status (Guzman et al.,

2015).

Limitations to Past Research

Of note, there are limitations to the previous studies. In general, there is not as much

research on racial and ethnic minority (REM) populations as there are for White individuals.

Even within the REM populations, there is a higher volume of research in regard to Black

populations compared to Hispanic/Latinx. To be even more specific, within the

Hispanic/Latinx community, there are different countries of origin that could contribute to

differences in any of the barriers due to for instance, a difference of culture, language, and

beliefs. Furthermore, a majority of the studies were conducted in English, which leaves out a

significant portion of the Hispanic/Latinx community who only speak Spanish or have low

English proficiency skills (Sewell, 2015).

Additionally, more research needs to be done on the specific cultural beliefs that

influence the stigma surrounding mental health, and the specific beliefs on what constitutes

poor versus good mental health. Subgroups within Hispanic/Latinx communities should also

be considered, including differences that may arise between countries of origin (Guzman et

al., 2015). In fact, the subpopulation or country of origin among Hispanic/Latinx

communities will be explored in our study. This can provide insight as to differences

between differing cultures and countries.

Finally, although many barriers were theorized in the literature, there is a lack of knowledge directly from Hispanic/Latinx individuals about which factors are considered the most debilitating or common.

Current Study

In our study, we assessed which of the barriers are the most prevalent in terms of influencing whether Hispanic/Latinx individuals seek and/or continue with psychotherapy treatment, as well as examining whether demographic variables correlated with these particular barriers. Building off of past study limitations, diversity and inclusion were highlighted by providing the survey in both English and Spanish and giving participants the ability to choose in what language they completed the survey. In addition, country of origin, language fluency, and gender identity were assessed.

Consistent with previous research, we hypothesized that there would be various factors that influence Hispanic/Latinx individuals' desire to seek or stay in psychological treatment. With this study, we aimed to compare the different potential barriers and answer the question of whether some barriers are more prevalent or influential than others. The goal was to identify which barriers would be most important for clinicians to target in order to better serve the Hispanic/Latinx community. Based on previous research, we expected that age and gender may be demographic factors that would influence results, with older age and cis-male gender identity associated with less mental health resource use (Guzman et al., 2015); thus, we expect some barriers may be more prevalent for these groups, although based on past research, it is unclear which. Residency status can also impact the results, as undocumented immigrants may be more likely to resist seeking services for fear of deportation if asked to show their documents (Guzman et al., 2015). Other barriers that have

been identified are lack of family knowledge and education, lack of availability of resources, language and financial barriers, and a reliance on primary care physicians (Guzman et al., 2015). These factors may be relevant, but it is unclear based on the literature which ones are going to be influential for the Hispanic/Latinx community.

Methods

Participants

In order to be included in the study, participants had to be living in the United States, identify as Hispanic and/or Latinx, and had to be at least 18 years old. The questionnaire was provided in both English and Spanish, meaning that people who spoke either language could be included. We recruited 100 participants from Prolific (51 female, 46 male, 2 non-binary and 1 self-identify), an online service where our survey was uploaded and then participants can complete it. Each participant was paid $2.40.

The mean age of the participants was 30.1, with a range of 18-68 years old. Participants were asked to fill in their race. In response to this question, half of the participants (50%) identified as White, 14% identified as Hispanic, 10% as Latino/a/e/x, 7% as a combination of White and Hispanic and/or Latino/a/e/x, 6% as Mixed race, 5% as Indigenous/Native American, 4% as both Hispanic and Latino/a/e/x, and the rest consisted of 2 participants who identified their race as Mexican, 1 as Black and 1 as Asian. Regarding ethnicity (which was a check all that apply question with a write in option), 49% identified as solely Hispanic, 30% identified as both Hispanic and Latino/a/e/x, 17% identified solely as Latino/a/e/x, 3% self-identified (with 2 participants writing in Chicano/a and 1 participant writing in Mexican), and 1% identified as Hispanic and self-identified as Mexican.

Regarding employment status, 61% were employed, 23% were unemployed, and 16% were

out of the labor force (for example a homemaker or student).

     In terms of annual income level, 28% of participants were in a bracket of $20,000-

$39,999, 17% in the bracket of $40,000-$59,999, 16% in the bracket of less than $10,000,

14% in the bracket of $10,000-$19,999, 13% in the bracket of $60,000-$79,999, 7% in the

bracket of $100,000-$199,999, and 5% in the bracket of $80,000-$99,999. When asked about

highest level of education, 41% of participants selected bachelor's degree as their highest

education level, 20% selected high school diploma, 20% selected some college with no

degree, 9% selected associates degree, 6% selected master's, 2% selected post high school

certificate, 1% selected some high school with no diploma, and another 1% selected

doctorate degree.

     We asked about religious identity with a free, write-in question and the responses

were 28% none, 23% Christian (including specifications of Protestant and Pentecostal), 20%

Catholic, 15% Agnostic, 8% Atheist, 3% Spiritual, 2% Other (including Pagan, and believing

in God but not necessarily religious), and 1% Jehovah's Witness. Participants answered what

their first and/or native languages were and 63% indicated English, 20% indicated English

and Spanish, 16% indicated Spanish, and 1% indicated English, Spanish and Other (which

was classical Hebrew). Regarding fluency in language, participants indicated other languages

that they were fluent in; 39% said Spanish, 36% said none, 15% said English, 4% said

Spanish and English, 3% said a combination of various languages such as Spanish, Italian,

and 3% said a singular other language such as Japanese, French or German.

     Regarding marital status, 69% of participants were single, 25% were married, 5%

were other (which included dating, long term relationship and engaged), and 1 participant

was divorced. We also asked participants which US state they lived in; 35% reported

California, 19% reported Texas, 12% reported Florida, 7% reported New York, 6% reported

Illinois and the rest included a total of 13 other states such as Georgia, New Mexico and

Wisconsin.

We asked various questions regarding immigration and citizenship status. A large

majority (93%) of our participants were born in the U.S. For the participants who were born

in the US, we asked about which generation immigrated. A majority (57%) said parents,

12.9% said great grandparents, 10.8% said grandparents, 10.8% had mixed generational

responses (e.g. Parents and Grandparents), 4.3% were not sure or said that this does not apply

to them, 3.2% said that they themselves did, and 1.1% said great great grandparents.

Regarding country of origin, 51.6% said Mexico, 18.3% had origins in more than one

country, 10.8% were from various countries such as Peru, Guatemala or Colombia

(singularly), 6.5% from Puerto Rico, 5.4% from El Salvador, 4.3% said that they were not

sure, and 3.2% from Cuba. For the 7 people who were not born in the U.S., 6 were from

Mexico and 1 was from El Salvador. In addition, 6 were US citizens and 1 was a permanent

resident.

Materials

Survey Items. Participants completed survey items first regarding their experience

with therapy (whether they received therapy before, and if yes, how it went) and whether

certain identified barriers influenced their ability or desire to seek therapy. One example of

these questions was "Have you ever received psychological therapy services before?"

Another example was "If you have not received therapy before, why not?" The main part of

our survey was where participants were provided with the various barriers and asked to rate

on a sliding visual analog scale (VAS) from "Not at All" to "Extremely" whether these barriers impacted their interest in or ability to seek therapy. An example of these questions was "How influential, if at all, were these factors in impacting your interest in or ability to seek therapy or remain in treatment? - Language barriers, Not at all -------- Extremely." Similar barriers were presented in a question regarding if the participant had not received therapy before. Some final open-ended questions were asked regarding how the participants and their families/communities viewed therapy. An example of one of these questions was "What are your personal beliefs surrounding mental health and therapy?" See Appendix A for the full survey.

Demographic Questionnaire. Participants completed a demographics section second. They were asked their age, race, ethnicity, native/first language(s), gender identity, immigration status/citizenship status, country of origin, which state and county they live in (to be able to determine the rurality of the location), highest level of education, job, income, marital status, and religious identity. This data was collected to assess whether these factors were associated with the barriers included. See Appendix B for the questionnaire.

Validity Check Items. In order to ensure that participants were paying attention to the material presented in the survey, four validity checks were spread out throughout the survey. The first validity check was found in the survey items section near the middle. Participants were asked to select "white elephant" in a set of animal and color combinations. The second validity check was found after the VAS questions regarding the barriers; participants were asked to select "strongly disagree" from a list of choices. The third validity check was at the end of the survey items section; participants had to select what the image of an eggplant is called. Finally, the fourth validity check was found in the demographic

questionnaire section. Participants were asked to select "strongly agree" from a list of choices. All participants successfully completed all validity check items. These items can be seen within the questionnaires in Appendices A and B: validity items are in italics.

Procedure

The Institutional Review Board at Appalachian State University approved all study procedures (see Appendix C for approval). Participants were recruited through Prolific. After reviewing a consent form (see Appendix D for this form both in English and Spanish), consenting participants volunteered to complete the online survey in exchange for monetary compensation. The survey consisted of questions regarding psychological therapy and then a demographic questionnaire section. To begin with, participants chose if they wanted to complete the survey in English or Spanish. Following this, there was a question regarding whether or not the participant had engaged in psychological therapy before. Based on the answer to this question, the participant was presented with more questions detailing their experience in therapy and the barriers that persisted with initiating or remaining in treatment, or with questions regarding barriers and/or reasons as to why they had not engaged in therapy before. Following this, there were a series of demographic questions that all participants were asked to complete. The participants completed the survey, were thanked for their contribution, and then were given monetary compensation through the Prolific website.

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Data Analysis Plan

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For this study, both quantitative and qualitative data was collected. Data was collected through Prolific and then recorded in Qualtrics. The main questions being assessed were, what barriers exist and what personal information or beliefs from the participants would relate to the barriers. The quantitative data consisted of responses that were either

numbers or multiple-choice responses, which we then coded, regarding various demographic variables, and qualitative data consisted of text response write-in questions. When possible, for simplicity and looking at overarching patterns in responses, categories of these responses were created for the qualitative data (e.g., positive, negative, mixed, not sure). Once categories were created, a group of eight independent raters (undergraduate research assistant students) then coded the qualitative data into the provided categories. The researcher then did the same. When there were discrepancies in codes, the researcher, director and two graduate-level students discussed and voted to decide the code. Then, the barriers were ranked based on the means (as well as an ANOVA test to see the significant differences between the barriers) and two MANCOVA tests were run to see which variables correlated and/or significantly predicted which barriers. For text-response questions that have no coding, a basic calculation of percentages of the responses was used.

Results

Quantitative Data

We assessed whether certain barriers were more prevalent than others by looking at the means of the barriers in terms of how each of them was rated. We tested a total of nine barriers (finance/cost, language, access to transportation, access to childcare, stigma, cultural beliefs, trust in clinicians, knowledge of therapy/resources and availability of providers). Each barrier was broken into two parts, which were how that barrier impacted their interest and/or ability to seek treatment and then how that barrier impacted their desire to remain in treatment. Participants were asked to rate (on a visual analog scale that equated to 0-10) how much that barrier impacted those various behaviors. The top three barriers were: finance/cost in terms of affecting the interest/ability to seek treatment ($M = 7.16$, $SD = 3.33$) and

finance/cost in terms of affecting the desire to remain in treatment ($M = 6.72$, $SD = 3.34$),

trust in clinicians in terms of affecting the interest/ability to seek treatment ($M = 5.81$, $SD =$

3.38) and trust in clinicians in terms of affecting the desire to remain in treatment ($M = 5.77$,

$SD = 3.32$), availability of providers in terms of affecting the interest/ability to seek treatment

($M = 5.78$, $SD = 3.36$) and availability of providers in terms of affecting the desire to remain

in treatment ($M = 5.24$, $SD = 3.35$). The rest of the ranking of the barriers for interest/ability

to seek therapy can be found in Table 1, and for desire to remain in treatment in Table 2.

      To further investigate the differences between people's ratings of the barriers, we

conducted a repeated measures ANOVA on people's responses for the nine barriers for

interest/ability to seek treatment. This analysis found that, on average, people rated some of

the barriers as higher than others, $F(8, 752) = 47.4$, $p < .001$. Follow up analysis showed that

finance/cost (being the highest) was significantly higher than the second highest rated barrier

(trust in clinicians), $p = .030$. However, trust in clinicians was not significantly higher from

the next rated barrier (availability of providers), $p = 1.000$. The lowest rated barrier, which

was access to childcare, was significantly lower than all the other barriers, $p < .001$.

      We then conducted the same test (repeated measures ANOVA) on people's responses

to the nine barriers for desire to remain in treatment. This analysis found that, on average,

people rated some of the barriers as higher than others, $F(8, 752) = 42.7$, $p < .001$. Although

finance/cost was still the highest rated barrier, it was not significantly higher than the next

rated one (trust in clinicians), $p = .176$. In addition, trust in clinicians was not significantly

higher than the next rated barrier (availability of providers), $p = .835$. The lowest rated

barrier was still access to childcare and it was significantly lower than all the other barriers, p

$< .001$.

Next, we looked to see which factors were associated with the nine different barriers. Specifically, we conducted a MANCOVA test examining the relationship between the 14 predictor variables (gender, age, first language, immigration generation, religion, number of therapy sessions attended, family views on therapy, community views on therapy, whether one has concerns about how others would respond if they sought therapy, personal beliefs surrounding mental health/therapy, whether having a therapist that is the same race and/or ethnicity as them would matter, education level, income and relationship status) and the nine barriers for interest/ability to seek treatment. When focusing on the multivariate test, the only predictor variable that was significantly related to people's responses to all the barriers was whether one has concerns about how others would respond if they sought therapy, $F(9, 72) = 2.44$, $p = .018$. When examining the univariate tests for concern about other's views, this variable was only significantly related to the stigma barrier, $F(1, 80) = 8.72$, p .004. Specifically, people who reported being more concerned about other's response gave higher ratings to the stigma barrier question. To further explore the results, we examined the remaining univariate tests for all variables. This revealed that family views on therapy was significantly related to the access to transportation barrier, $F(1, 80) = 5.04$, $p = .028$, such that people who said that their family had more positive views of therapy reported higher ratings of this barrier. In addition, whether having a therapist that is the same race and/or ethnicity as them would matter was significantly related to the cultural beliefs barrier, $F(1, 80) = 7.01$, $p = 0.10$, such that people who expressed more of a desire to have a therapist that is the same race and/or ethnicity reported higher ratings for this barrier.

We then conducted the same test (MANCOVA) examining the relationship between the 14 predictor variables and the nine barriers for the desire to remain in treatment. When

focusing on the multivariate test, the only predictor variable that was significantly related to people's responses to all the barriers was personal beliefs surrounding mental health/therapy, $F(9, 72) = 2.56$, $p = .013$. When examining the univariate tests for personal beliefs, this variable significantly related the knowledge of therapy barrier, $F(1, 80) = 7.44$, p .008, the trust in clinicians barrier, $F(1, 80) = 5.25$, p .025 and the cultural beliefs barrier, $F(1, 80) = 4.64$, p .034. Specifically, those who reported more negative personal views had higher ratings of the knowledge of therapy barrier, the trust in clinicians barrier and the cultural beliefs barrier. To further explore the results, we examined the remaining univariate tests for all the variables. This revealed that community views on therapy was significantly related to the finance/cost barrier, $F(1, 80) = 5.62$, $p = .020$, such that people who reported that their community had more negative views gave higher ratings to this barrier. In addition, concern about other's views significantly related to the trust in clinicians barrier, $F(1, 80) = 5.25$, $p = .025$ and the stigma barrier, $F(1, 80) = 7.32$, $p = .008$, such that those who expressed more concern gave higher ratings to both of these barriers. It was also found that whether having a therapist that is the same race and/or ethnicity as them would matter significantly related to the cultural beliefs barrier, $F(1, 80) = 9.45$, $p = .003$, such that those who expressed more of a desire to have a therapist who is the same race and/or ethnicity gave a higher rating to this barrier. Technically it was not significantly related to the availability of providers barrier, however it was extremely close to being significant, $F(1, 80) = 3.73$, $p = .057$, such that those who expressed more of a desire to have a therapist who is the same race and/or ethnicity gave a higher rating to this barrier. Finally, we found that the number of therapy sessions attended significantly related to the access to childcare barrier, $F(1, 80) = 3.96$, $p = .050$, such that

those who attended more sessions gave a higher rating to this barrier (although the highest rating was for the second highest amount of sessions, 26-50).

Qualitative Data

For the qualitative data, multiple write-in response questions were asked regarding beliefs about mental health and therapy. We conducted analyses on the participants' qualitative responses. When responding to the question, "How does your family view therapy/mental health?", 49.5% provided responses that suggested family members held an exclusively positive view of therapy and mental health, while 23.2% indicated family had mixed feelings/reactions, and 18.2% provided responses suggesting family had exclusively negative views (out of 99 responses). When responding to the question, "How does your community and/or culture view therapy/mental health?", 47% of responses suggested the community/culture held exclusively negative views, while 26% of participant responses suggested exclusively positive views, and 15% had mixed feelings. When responding to the question, "Do you have any concerns for how your family, friends, community, etc. would respond if you were to receive therapy/are currently receiving therapy? Why or why not?", a large majority (71%) indicated no or that they do not care, 22% said yes, and 6% were neutral or indifferent (e.g., "I'm not sure"). When responding to the question, "What are your personal beliefs surrounding therapy/mental health?", a majority (76%) said it was positive or necessary, 14% had mixed feelings and 4% had negative feelings. When responding to the question, "Overall, how would you describe/rate your experience in therapy?", a majority (57.6%) said it was good or helpful, 16.9% said it was okay or average, 15.3% had mixed feelings and 10.2% had a negative experience (out of 59 responses). When responding to the question, "About how many of these therapy sessions did you attend?", 31% said 2-6

sessions, 24.1% said 7-12 and 15.5% said above 50 (out of 58 responses). When responding to the question, "Would you consider using therapy services again? Please explain why or why not.", a majority (77.1%) said yes, 16.7% said maybe and 4.2% said no (out of 48 responses). When responding to the question, "Do you feel that having a professional who is the same race and/or ethnicity as you contributes to your interest in staying in treatment/seeking treatment? Why or why not?", 47.5% said no, 32.2% said yes and 16.9% said maybe (out of 59 participants).

For the following questions, write-in text responses were analyzed, and each response could contain more than one answer. When responding to the question, "Are there any other factors that weren't mentioned previously that contribute to your interest in seeking and/or staying in therapy?", a majority of participants said no (74%), however, out of the other barriers that were identified, the three most common were gender/sexuality (8%), social anxiety/other mental health challenges (6%) and that they don't feel comfortable or feel it will help (5%). When responding to the question, "Why did your previous therapy sessions end?", the three top answers (out of 48 responses) were that they wanted to stop or didn't like it/felt uncomfortable (29.2%), couldn't keep paying or a financial strain (20.8%) and that it was no longer necessary, or they got better (18.8%). When responding to the question, "Why have you not received therapy before?", the top three answers (out of 41 responses) were that they could cope or it was not necessary (53.7%), cost (34.1%) and stigma or concern for what others would think (19.5%). When responding to the question, "Have you ever experienced mental health concerns or felt that you had a reason to seek therapy? - Yes (please specify what were those concerns/reasons)", the top three answers (out of 65

responses) were depression (47.7%), anxiety/fears/phobias/social anxiety (38.5%) and suicidal thoughts/ideations/behaviors (13.8%).

Discussion

This study aimed to identify what barriers exist to mental health treatment for Hispanic and/or Latinx adults in the United States, and which of these barriers are more influential than others. In addition, we aimed to analyze how different demographic and other qualitative information regarding views on therapy correlated with and explained/predicted the various barriers. We hypothesized that several barriers based on past research would relate to willingness to seek or stay in treatment (i.e., knowledge, language, trust, finance/cost, access to resources, stigma, cultural beliefs, access to childcare, and availability of providers) and that certain demographic variables (i.e., age, gender, residency status) would correlate or predict with these barriers. This study was exploratory in nature, meaning that there were not specific hypotheses of our outcomes we were looking for, but rather questions to be answered. However, we had general hypotheses and they were that certain barriers would indeed be more pertinent to participants than others and that certain demographics and beliefs from participants would influence these results. A more conservative test (MANCOVA) was utilized to ensure that what showed up as significant could indeed be classified as true, rather than a coincidence.

After running all of the tests, overall, we found that there were barriers that were rated higher than others, and we did see some demographic variables correlate and explain why certain barriers do exist. The barriers that were rated the highest overall were Finance, Trust in clinicians and Availability of providers. In terms of the barriers that were related to interest/seeking behaviors, there was a significant difference between finance and trust in

clinicians, but not between trust in clinicians and availability of providers. In terms of the barriers that were related to remaining in treatment behaviors, there was not a significant difference between the top three barriers. For both seeking and remaining in treatment, access to childcare was rated as the lowest barrier and was significantly different than all the other barriers.

    We also found that whether one has concerns about how others would respond if they sought therapy significantly relates and is a predictor in general for all the barriers for interest/ability to seek treatment, and personal beliefs significantly relates and is a predictor in general for all the barriers for desire to remain in treatment. More specifically, with the barriers for interest/ability to seek treatment, if one has more concerns of how what others will think about them seeking therapy, they give higher ratings to the stigma barrier. If one's family viewed therapy in a more positive way, they rated access to transportation as more of a barrier. Finally, people who expressed more of a desire to have a therapist that is the same race and/or ethnicity as them gave higher ratings to the cultural beliefs barrier. More specifically for the barriers for the desire to remain in treatment, if people had more negative personal views of therapy, they give higher ratings to the barriers knowledge of therapy, trust in clinicians and cultural beliefs. Those who said that their community had more negative views of therapy rated the finance/cost barrier higher. People who expressed higher levels of concern of how others would think rated the barriers trust in clinicians and stigma higher. Those who expressed more of a desire to have a therapist who is the same race and/or ethnicity as them rated the cultural beliefs barrier higher. Although it was not technically significant, what was very close to being significant was that those who expressed more of a desire to have a therapist who is the same race and/or ethnicity as them rated the availability

of providers barrier higher. Finally, we found that people who attended more therapy sessions rated the access to childcare barrier higher (although the second-highest amount, 26-50 sessions, was the highest).

In terms of the barriers that were rated the highest (cost, trust in clinicians and availability of providers), this does make sense. Previous literature indicates that these are prevalent barriers, especially for Hispanic/Latinx populations due to the fact that in Hispanic/Latinx communities often lack in mental health resources and experience more lack of trust compared to other minority groups and White individuals in the United States (Guzman et al, 2015). Cost seemed to be the most universal barrier in that there was not one predictor variable among the participants, yet it was rated the overall highest. This seems to indicate that cost is something everyone is worried about and this is due to the fact that therapy is expensive, and people obviously worry about money, especially for something they may not see as necessary. Personal beliefs and concern for other's beliefs were the two variables that predicted the most barriers. The way that one views the topic of mental health and therapy is going to significantly impact their actions, and it would make sense that if one is more concerned about others, they are going to worry more about stigma and so forth. If someone wishes to have a therapist who is of the same race and/or ethnicity as them, then it makes sense why they would be more affected by cultural beliefs, indicating that they are aware of the discrepancies between views that different cultures have, and would want someone who understands this phenomenon. If people are attending more therapy sessions, then they are probably going to need more access to childcare, if they have children, so that is why they rated access to childcare higher than other participants. People who stated that their community had more negative views of therapy also rated the finance/cost barrier

higher. This could be due to the fact that the community may have those negative views because there may be less access to resources or knowledge, which is why the person may be more concerned with how much it costs. The result that is a little harder to explain is the fact that people whose family views therapy in a more positive way gave a higher rating to access to transportation being a barrier. It is unclear why this is the case and future research should examine this link further.

The sample size of this study was admirable but could have been higher. One of the biggest limitations that we saw was that our sample may not have been as representative or diverse as we would have liked. Most of our sample was younger, had English as their first language or one of their first languages, were born in the U.S. and had older generations who immigrated. Because of this, some barriers that were expected to rate higher did not, for example, language. We used Prolific as our means of recruiting participants and using this service requires a level of proficiency and resources that not everyone may have, especially those who may be more prone to certain barriers such as language, cost or knowledge/access to resources. This made our study not as representative of Hispanic/Latinx individuals who experience more difficulties due to just having immigrated here, and so on. However, on the other hand, it does ensure that we don't make generalizations on the community as a whole and understand that there is variability.

Another limitation could be that some of the more qualitative questions were asking two different questions in one (i.e., "About how many of these therapy sessions did you attend and how often were they?"), which made answers a little bit more difficult to code into categories and analyze the data. Finally, another limitation is that our data is not compared

directly to the data from people of other backgrounds, which makes it harder to see whether these responses are unique to Hispanic/Latinx individuals.

To fix some of these limitations in the future, future studies could recruit a larger sample size. This would hopefully catch some more variability in identities and levels of proficiency with language. Future studies could also expand the survey beyond online data collection and, for example, recruit participants from community health centers, or places/organizations that specifically help immigrants to obtain a more representative sample. In addition, it may be helpful to reword or separate out some questions to make them have more a clear and codable answer (i.e., one question could be "How many therapy sessions have you attended" and a separate question could be "How often were these therapy sessions?"). Furthermore, future studies could compare the data with Hispanic/Latinx individuals directly with other groups of people to find out unique responses/challenges for Hispanic/Latinx individuals.

Besides these, there are some future directions for this study that would further knowledge on the subject. Participants identified other barriers that we did not mention, for example, having a minority gender identity or sexuality leads to fears of discrimination and less treatment seeking behaviors. It could be interesting and important to explore these other barriers to see if we are missing ones that are causing people to struggle and not leave them out. There could also be other studies that specifically focus in on some of the barriers and figure out the causal relationship between them. For example, if we now know that higher rates of worry about others' perception relates to higher barriers relating to stigma, more investigations can be conducted to find out more about this relationship and what views exactly cause certain perceptions/feelings. In addition, we broke up the barriers into seeking

behaviors versus remaining and there were some differences in the responses people gave between them. It could be interesting to explore more with seeking versus remaining to see if there are significant differences between them.

Perhaps, the most important future direction from this study is to not only figure out the barriers and see the relationships, but to take this knowledge and actually try to fix the problem. If we now know, based on this sample, that finance/cost, trust in clinicians and availability of providers are the most pertinent barriers, then studies or actions can be taken to figure out how to solve these problems. How to possibly reduce cost or receive insurance coverage, how to build trust between clinicians and clients which could be implemented in how clinicians are trained, and how to provide more providers and resources to underserved communities.

This study demonstrated that there indeed are treatment disparities among Hispanic/Latinx adults in the United States and more work needs to be done to help reduce this. It showed us exactly what the barriers are and answered our question of which ones may be more of a concern for this specific community: finance/cost, trust in clinicians and availability of providers. It also answered our question of what variables about a person may be predictors for barriers, for example, one's personal views does impact their behavior and is a barrier for remaining in treatment. Now that we know more about the problem, it is time to take this knowledge, make real change and put an end to the treatment disparity for this rich and vibrant community.

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Table 1

Interest/Seeking

Estimated Marginal Means - Barriers

			95% Confidence Interval	
Barriers	**Mean**	**SE**	**Lower**	**Upper**
Knowledge of therapy	4.811	0.337	4.141	5.48
Language	2.453	0.341	1.776	3.13
Access to transportation	3.653	0.381	2.895	4.41
Availability of providers	5.779	0.345	5.095	6.46
Access to childcare	0.758	0.212	0.337	1.18
Finance/cost	7.158	0.344	6.476	7.84
Trust in clinicians	5.811	0.346	5.124	6.50
Cultural beliefs	3.484	0.344	2.801	4.17
Stigma	4.253	0.377	3.505	5.00

Table 2

Desire to remain

Estimated Marginal Means - Barriers

Barriers	Mean	SE	95% Confidence Interval	
			Lower	Upper
Knowledge of therapy	4.653	0.337	3.983	5.32
Language	2.958	0.352	2.259	3.66
Access to transportation	3.611	0.357	2.902	4.32
Availability of providers	5.242	0.343	4.561	5.92
Access to childcare	0.958	0.224	0.513	1.40
Finance/cost	6.716	0.344	6.033	7.40
Trust in clinicians	5.768	0.339	5.096	6.44
Cultural beliefs	3.505	0.347	2.816	4.19
Stigma	3.642	0.366	2.915	4.37

Appendix A

Survey Items

1. Have you ever received psychological therapy services before? This is defined as meeting with a specialized provider such as a therapist, clinician and/or counselor to focus on mental health concerns. Mental health concerns can be defined as any health conditions that involve a change in your emotions, behavior, or thinking and cause significant distress and/or decrease functioning in everyday life.

    Note: For remaining questions, the term "therapy" will be used to refer to psychotherapy, mental health treatment, and/or psychological therapy services.
    a. Yes
    b. No
    c. Other (write in)
2. Are you currently utilizing therapy?
    a. Yes
    b. No
    c. Other (write in)
3. If you have received therapy before, about how many of these sessions/meetings did you attend? (write in)
    a. If you are currently utilizing therapy, how often do you participate in these services? (write in)
4. If you are no longer receiving therapy, why did it end? (write in)
5. If you have not received therapy before, why not? (write in)
6. If you did receive therapy, what was your experience like? (write in)
7. Would you seek therapy again? (write in)
8. Was the professional (e.g., clinician, therapist, and/or counselor) the same race and/or ethnicity as you? (write-in)
    a. Was having a professional who identifies as the same race and/or ethnicity as you something you looked for? If so, how hard was it to find? (write in)
9. Do you feel that having a professional who is the same race and/or ethnicity as you would contribute to your interest in staying in treatment/seeking treatment? (write in)
10. *Please select "white elephant"*
    a. *Blue Zebra*
    b. *Yellow Monkey*
    c. *White Elephant*
    d. *Red Tiger*
11. (If you have received therapy): How influential, if at all, were these factors in impacting your interest in or ability to seek psychotherapy, or remain in treatment? (visual analog sliding scale from: Not at all------------Extremely) (duplicate)
    a. Knowledge of therapy (e.g., knowledge of available services/resources, general knowledge about psychology, mental health concerns)
        i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely
        ii. Impact on remaining in therapy   Not at all--------Extremely
    b. Language barriers
        i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

  c. Access to transportation

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

  d. Availability of providers

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

  e. Access to childcare

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

  f. Finances/Cost of services

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

  g. Trust in clinicians

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

        iii.   How (if at all) has your race and/or ethnicity has contributed to this (write in)

  h. Cultural Beliefs

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

  i. Stigma- the process of stigmatization can be defined as "a complex process of social control in which labeling, stereotyping and negative attitudes towards a person, based on a condition or behavior often lead to status loss, rejection or discrimination" (Rivera-Segarra et al., 2018). Stigma can occur at the individual, interpersonal and/or structural level.

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

  j. Other (please specify): (write in)

12. (If you haven't received therapy) How influential, if at all, were these factors in your interest in or ability to seek therapy? (sliding scale, Not at all-------------Extremely)

  a. Knowledge of therapy (e.g., knowledge of available services/resources, general knowledge about psychology, mental health concerns)

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely

  b. Language barriers

        i.   Impact on interest in therapy or ability to seek therapy   Not at all ------ --Extremely

        ii.   Impact on remaining in therapy   Not at all--------Extremely
- c. Access to transportation
  - i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely
  - ii. Impact on remaining in therapy   Not at all--------Extremely
- d. Availability of providers
  - i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely
  - ii. Impact on remaining in therapy   Not at all--------Extremely
- e. Access to childcare
  - i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely
  - ii. Impact on remaining in therapy   Not at all--------Extremely
- f. Finances/Cost of services
  - i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely
  - ii. Impact on remaining in therapy   Not at all--------Extremely
- g. Trust in clinicians
  - i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely
  - ii. Impact on remaining in therapy   Not at all--------Extremely
  - iii. Do you feel that your race and/or ethnicity has contributed to this trust or mistrust (write in)
- h. Cultural Beliefs
  - i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely
  - ii. Impact on remaining in therapy   Not at all--------Extremely
- i. Stigma- the process of stigmatization can be defined as "a complex process of social control in which labeling, stereotyping and negative attitudes towards a person, based on a condition or behavior often lead to status loss, rejection or discrimination" (Rivera-Segarra et al., 2018). Stigma can occur at the individual, interpersonal and/or structural level.
  - i. Impact on interest in therapy or ability to seek therapy   Not at all --------Extremely
  - ii. Impact on remaining in therapy   Not at all--------Extremely
- j. Other (please specify): (write in)

13. *Please select "strongly disagree"*
- a. *Strongly disagree*
- b. *Disagree*
- c. *Neutral*
- d. *Agree*
- e. *Strongly agree*

14. Have you ever experienced mental health concerns or felt that you had a reason to seek therapy? (if have not been in therapy before)/ Why did you seek therapy (if yes)
- a. Yes (explain what were those concerns/reasons)
- b. No

       c.   Prefer not to disclose

15. If you had a concern with your mental health, which would you be most likely to seek help from? (Family, friends, religious, regular physician, mental health professionals)- please rank the following options with your first choice being ranked as number 1.
    a. Family
    b. Friends
    c. Religious leaders
    d. Regular physician/healthcare provider
    e. Mental health professional (e.g., clinician, therapist, and/or counselor)
    f. Other (write in)
    g. Not applicable (for each option)
16. How does your family view therapy? (write in)
17. How does your community and/or culture view therapy? (write in)
18. Do you have any concerns for how your family, friends, community, etc. would respond if you were to receive therapy? (write in)
19. What are your personal beliefs surrounding mental health and therapy? (write in)
20. Are there any other factors that contribute to your interest in seeking therapy or staying in treatment? (e.g., sexual orientation, religion) (write-in)
21. *What is this called (validity question, picture of an eggplant)*
    a. *Brinjal*
    b. *Eggplant*

Appendix B

Demographic Questionnaire

1. What is your current age? (write in)
2. Race is identified as a person's classification based on physical appearance and ancestral background/heritage. Examples may include White, Black, American Indian or Alaska Native, Asian, or Native Hawaiian or Other Pacific Islander.
   a. What is your race? (write in)
3. Ethnicity is defined as an indicator of one's cultural markers rather than physical appearance. This can include a group that shares a common and distinctive culture, language, religion, background, ethnic traits, association, or allegiance
   a. What is your ethnicity? (check all that apply)
      i. Hispanic
      ii. Latinx
      iii. Self-identify (write in)
4. What is your native/first language? Check all that apply.
   a. English
   b. Spanish
   c. Portuguese
   d. Other (write in)
5. Do you speak any other languages fluently? (write in). If yes, what language(s)? (write in)
6. What is your current gender identity?
   a. Female
   b. Male
   c. Non-binary
   d. Self-identify (write in)
   e. Prefer not to answer
7. *Please select "Strongly agree"*
   a. *Strongly disagree*
   b. *Disagree*
   c. *Neutral*
   d. *Agree*
   e. *Strongly agree*
8. What is the highest degree or level of school you have completed?
   a. No schooling completed
   b. Pre-school to 8th grade
   c. Some high school, no diploma
   d. High school diploma, GED, or alternative credential
   e. Some college or university credit (no degree)
   f. Post high school certificate/credential
   g. Associates degree (for example: AA, AS)
   h. Bachelor's degree (for example: BA. BS)
   i. Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)
   j. Doctorate degree (for example, PhD, MD, EdD)
   k. Other (write in)
9. What is your current job?

     a. Write in
     b. Unemployed
     c. Out of labor force (eg. homemaker, student, receiving public assistance)

10. What is your yearly income? (Including your own income and/or anyone else that supports you financially)
     a. <$9,999
     b. $10,000 to $19,999
     c. $20,000 to $39,999
     d. $40,000 to $59,999
     e. $60,000 to $79,999
     f. $80,000 to $99,999
     g. $100,000 to $199,999
     h. >$200,000

11. What is your marital status?
     a. Married
     b. Single
     c. Separated
     d. Divorced
     e. Widowed
     f. Other (write in)

12. If applicable, what is your religious identity? (write in)

These next set of questions are only being asked with the intention of providing more demographic information for the study. Your answers are anonymous and have no way of being traced back to you in any way (we are not collecting names or IP addresses) and will not be used against you.

13. Which U.S. state do you live in? (write in)
     a. Which county do you live in? (write in)

14. Were you born in the U.S.? (Yes, no, other, prefer not to answer)
     a. (If no) Which country did you immigrate/move from? (write in)

15. (If yes), Which generation immigrated/moved to the U.S.? (Examples may include parents, grandparents, great-grandparents, etc.) (write in)

16. What country did your direct relatives immigrate/move from? (write in)

17. Immigration status (confidential/anonymous) (if no born in US)
     a. What is your immigration status?
          i. U.S. citizen
          ii. Permanent resident
          iii. Asylee or refugee
          iv. Asylum applicant
          v. Self-identify (write in)
          vi. Prefer not to answer

Appendix C

To: Hannah Apostolico
Psychology
CAMPUS EMAIL

From: IRB Administration
Date: 7/29/2021
RE: Notice of Exempt Research Determination
Agrants #:
Grant Title:

STUDY #: 21-0271
STUDY TITLE: Barriers to Psychological Treatment Among Hispanic/Latinx Adults in the US

Exemption Category: 2.Survey, interview, public observation

NOTE: This project, like all exempt and non-exempt research with human subjects at Appalachian State University, is subject to other requirements, laws, regulations, policies, and guidelines of Appalachian State University and the state of North Carolina. As of August 24, 2020 and until further notice, this includes the requirement by the Office of Research to pause in-person research projects until it receives an additional review to ensure the existence of an adequate COVID-19 mitigation protocol. Please see the full requirement on the Research Protections website.

This study involves no more than minimal risks and meets the exemption category or categories cited above. In accordance with the 2018 federal regulations regarding research with human subjects [45 CFR 46] and University policy and procedures, the research activities described in the study materials are exempt from IRB review.

What an exempt determination means for your project:

1. The Office of Research Protections staff have determined that your project constitutes research with human subjects, but that your research is exempt from the federal regulations governing human subjects research, per 45 CFR 46.104.
2. Because this research is exempt from federal regulations, the recruitment and consent processes are also exempt from Intuitional Review Board (IRB) review. This means that the procedures you described and the materials you provided were not reviewed by the IRB, further review of these materials are not necessary, and that you can change the consent procedures without submitting a modification.
3. **You still need to get consent from adult subjects and, if your study involves children, you need to get assent and parental permission.** At the very least, your consent, assent, and parental permission processes should explain to research subjects: (a) the purpose, procedures, risks, and benefits of the research; (b) if

compensation is available; (c) that the research is voluntary and there is no penalty or loss of benefits for not participating or discontinuing participation; and (d) how to contact the Principal Investigator (and the Faculty Advisor if the PI is a student). You can also use exempt research consent template, which accounts for all of these suggested elements of consent: https://researchprotections.appstate.edu/human-subjects-irb/irb-forms.

- o **Please note that if your consent form states that the study was "approved by the IRB" this should be removed. You can replace it with a sentence that says that the study was determined to be exempt from review by IRB Administration. In addition, be sure that the number you have listed for the IRB is 828-262-2692**

4. **Special procedures and populations for which specific consent language is suggested.** Research involving children, research that uses the SONA database for recruitment, research with students at Appalachian State University, or research that uses MTurk for recruitment should use the specific language outlined by The Office of Research Protections on our website.

5. **Study changes that require you to submit a modification request**: most changes to your research will not require review by the Office of Research Protections. However, the following changes require further review by our office:

- the addition of an external funding source;
- the addition of a potential for a conflict of interest;
- a change in location of the research (i.e., country, school system, off site location);
- change in contact information for the Principal Investigator,
- the addition of non-Appalachian State University faculty, staff, or students to the research team, or
- **Changes to study procedures.** If you change your study procedures, you may need to submit a modification for further review. Changes to procedures that may require a modification are outlined in our SOP on exempt research, a link to which you can find below. Before submitting a modification to change procedures, we suggest contacting our office at irb@appstate.edu or (828) 262-2692 to confirm whether a modification is required.

Investigator Responsibilities: All individuals engaged in research with human participants are responsible for compliance with University policies and procedures, and IRB determinations. The Principal Investigator (PI), or Faculty Advisor if the PI is a student, is ultimately responsible for ensuring the protection of research participants; conducting sound ethical research that complies with federal regulations, University policy and procedures; and maintaining study records. The PI should review the IRB's list of PI responsibilities.

To Close the Study: When research procedures with human participants are completed, please send the Request for Closure of IRB Review form to irb@appstate.edu.

If you have any questions, please email IRB@appstate.edu or contact the Director of Research Protections at (828) 262-2692.

Best wishes with your research.

Important Links for Exempt Research:

Note: If the link does not work, please copy and paste into your browser, or visit https://researchprotections.appstate.edu/human-subjects.

1. Standard Operating Procedure for exempt research (#9): https://researchprotections.appstate.edu/sites/researchprotections.appstate.edu/files/sop_9_approved_1.21.2019.pdf

2. PI responsibilities: https://researchprotections.appstate.edu/sites/researchprotections.appstate.edu/files/PI%20Responsibilities.pdf

3. IRB forms: http://researchprotections.appstate.edu/human-subjects/irb-forms

CC:
Benjamin Souza, Languages, Literatures & Cultures
Emma Walker, Psychology

Appendix D

Consent to Participate in Research
Principal Investigator: Hannah Apostolico
Contact Information: apostolicohs@appstate.edu
Faculty Advisor: Jacqueline Hersh, Ph.D. (hershjr@appstate.edu, 828-262-6969)

You are invited to participate to take part in a research study looking at factors influencing the use of mental health care resources among Hispanic/Latinx adults in the US. If you take part in this study, you will be one of about 100 people aged 18 years of age or older. By doing this study, we hope to learn more about the use of mental health care. In this study, you will answer questions about your interest in and/or experience with mental health resources. You will also be asked questions about your age, gender, race/ethnicity, immigration status (of note, there is a "prefer not to answer" option), and education level. Your responses in this survey will be anonymous. This means that no one, not even members of the research team, will know that the information you gave came from you. Participation in this study is expected to take between 10-18 minutes.

There are few foreseeable risks to participating in this study. It is possible that you could reflect upon your responses to the survey and regret not seeking and/or staying in treatment. This is equivalent to the risk encountered in daily life (e.g., reading a story about an individual who is in treatment, viewing an ad for psychological help). Additionally, you may feel uncomfortable answering questions about your immigration status. To mitigate this risk, the survey is anonymous, and your answers will not be shared with anyone. Your Prolific ID will be collected in order to access your demographic information to determine eligibility for participation. However, your Prolific ID will not be stored with your responses.

You will be compensated $2.25 for your participation in this study. While you will not directly benefit from participating in this study, your responses will help increase our knowledge about interest and experiences with mental health resources.

Appalachian State University's Institutional Review Board has determined this study to be exempt from IRB oversight. Participation in this study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. If you cease your participation before completing the study, you will not, however, receive compensation.

If you have questions about this research study, you may contact Hannah Apostolico (apostolicohs@appstate.edu) or Jacqueline Hersh, PhD at hershjr@appstate.edu. Questions regarding the protection of human subjects may be addressed to the IRB Administrator, Research and Sponsored Programs, Appalachian State University, Boone, NC 28608 (828)262-2692, irb@appstate.edu.

By continuing to the research procedures, I acknowledge that I am at least 18 years old, have read the above information, and agree to participate.

Consentimiento para participar en la investigación
Investigador principal: Hannah Apostolico
Información de contacto: apostolicohs@appstate.edu
Asesor de la facultad: Jacqueline Hersh, Ph.D. (hershjr@appstate.edu, 828-262-6969)

Se le invita a participar en un estudio de investigación que analiza los factores que influyen en el uso de los recursos de salud mental entre adultos hispanos/latinx en los Estados Unidos. Si participa en este estudio, será una de las 100 personas de 18 años o más. Al hacer este estudio, esperamos aprender más sobre el uso de la atención de salud mental. En este estudio, usted responderá a preguntas sobre su interés y/o experiencia con recursos de salud mental. También se le harán preguntas acerca de su edad, género, raza/etnia, estatus migratorio (por nota, hay una opción "Prefiere no contestar"), y nivel educativo. Sus respuestas en esta encuesta serán anónimas. Esto significa que nadie, ni siquiera los miembros del equipo de investigación, sabrá que la información que usted dio vino de usted. Se espera que la participación en este estudio vaya a tomar entre 10-18 minutos.

La participación en este estudio conlleva pocos riesgos previsibles. Es posible que usted pueda reflexionar sobre sus respuestas a la encuesta y lamentar no buscar y/o permanecer en el tratamiento. Esto es equivalente al riesgo que se encuentra en la vida diaria (por ejemplo, leer una historia sobre un individuo que está en tratamiento, ver un anuncio de ayuda psicológica). Además, usted puede sentirse incómodo respondiendo a preguntas sobre su estado migratorio. Para mitigar este riesgo, la encuesta es anónima y sus respuestas no se compartirán con nadie. Su Prolific ID será recopilada para acceder a su información demográfica para determinar la elegibilidad para participar. Sin embargo, su Prolific ID no se almacenará con sus respuestas.

Se le compensará $2.25 por su participación en este estudio. Aunque no se beneficiará directamente de participar en este estudio, sus respuestas ayudarán a aumentar nuestro conocimiento sobre el interés y las experiencias con los recursos de salud mental.

La Junta de Revisión Institucional de la Universidad de Appalachian State ha determinado que este estudio está exento de la supervisión del IRB. La participación en este estudio es completamente voluntaria. Incluso si decide participar ahora, puede cambiar de opinión y detenerse en cualquier momento. Si usted deja de participar antes de completar el estudio, no recibirá, sin embargo, compensación.

Si tiene preguntas sobre este estudio de investigación, puede ponerse en contacto con Hannah Apostolico (apostolicohs@appstate.edu) o Jacqueline Hersh, PhD en hershjr@appstate.edu. Las preguntas relativas a la protección de los sujetos humanos pueden dirigirse al Administrador del IRB, Programas de Investigación y Patrocinado, Universidad de Appalachian State, Boone, NC 28608 (828)262-2692, irb@appstate.edu.

Al continuar con los procedimientos de investigación, reconozco que tengo al menos 18 años de edad, he leído la información anterior y acepto participar.