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Latino/a help-seeking behavior and endorsement of common factors

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Latino/a help-seeking behavior and
endorsement of common factors

by

Sara Lynne Schwatken

A thesis submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of
MASTER OF SCIENCE

Major: Psychology

Program of Study Committee:
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ABSTRACT

Reasons for underutilization of mental health services by the Latino/a population have been examined in previous research. In the current study, I explored Latino/as college students' perceptions of the common factors in therapy and how these perceptions explain willingness to seek professional mental health services. A comparison group of European American college students was utilized to examine similarities and differences between racial groups. No statistically significant differences were noted between groups for the perceived helpfulness of the common factors. However, perceptions of helpfulness significantly accounted for more variance in willingness to seek help for Latino/as (15%) than European Americans (5%) when controlling for previous therapy experiences.

CHAPTER 1: OVERVIEW

Latino/as underutilize professional mental health services at a more extensive rate than most other racial groups in the United States (Flaskerud, 1986; Sue et al., 1994; Echeverry, 1997). This finding has also been found within Latino college students (Kearney, Draper, & Baron, 2005) and in Latino/a community samples (Flaskerud, 1986; Aguilera & Lopez, 2008). This situation is troubling as Latino/as are the largest and fastest growing population group in the United States, projected to account for 25% of the U.S. population by the year 2030 (US Census Bureau, 2009).

Researchers have examined possible explanations for this lack of utilization. Their findings can be categorized into three main areas: structural barriers, client and cultural factors, and attitudes toward treatment. Structural barriers to help-seeking can include geographic barriers, service costs, client and counselor time constraints, and a lack of bi-cultural services or Spanish speaking personnel (Echeverry, 1997).

Client factors such as age, gender, education, legal status and cultural factors such as religious beliefs, acculturation, national origin, English proficiency, and resource preferences, have been shown to affect Latino/as' willingness to seek help (Chiang, Hunter, & Yeh, 2004). Although the research on help-seeking behavior in relation to client age, gender, and national origin is equivocal, researchers generally agree that higher educational attainment and acculturation increases help-seeking behavior (Portes, Kyle, & Eaton, 1992; Alegria et al., 1991; Vega & Lopez, 2001; Echeverry, 1997; West, Kantor & Jasinski, 1998).

To a lesser extent, researchers have examined Latino/as' beliefs about mental health treatment; for example, attitudes toward the treatment of depression (Cabassa, 2007). Few researchers have investigated factors related to Latino/as' general expectations and

preferences surrounding the therapy process. No research to date has investigated the extent to which Latino/as perceive the common factors paradigm as helpful to them if they were to seek professional help.

Investigators generally agree that common factors are most responsible for producing positive client change in therapy, as compared with the specific factors found in different orientation-based interventions (Rosenzweig, 1936; Smith & Glass, 1977; Shapiro & Shapiro, 1983; Wampold, Mondin, Moody, Stich et al., 1997). However, whether common factors operate as positive change mechanisms for clients from racially diverse groups in the way they have been shown to for an essentially European American client population has yet to be demonstrated. A reasonable first step toward this goal would be to examine how Latino/as perceive common factors as helpful characteristics of therapy and how their perceptions of common factors relate to help seeking behaviors.

My goal, in the present study, is to examine two areas of interest. First, to what extent do Latino/as endorse the common factors, as outlined by Lambert and Ogles (2003), found in all therapies? Second, in what way does the endorsement of these factors relate to Latino/as help seeking behavior? Latino/as who do not perceive the common factors as potentially helpful may be less willing to seek counseling. A greater endorsement of common factors as being potentially therapeutic may increase the willingness of Latino/as to seek mental health services if needed.

CHAPTER 2: LITERATURE REVIEW

Researchers have found that Latino/as underutilize mental health services at a greater rate than European Americans (Sue et al., 1994; Echeverry, 1997). Some researchers have indicated that Latino/as utilize mental health services at a lower rate than both European Americans and other major ethnic groups (Flaskerud, 1986). For example, in a major review of epidemiological studies, Cabassa, Zayas, and Hansen (2006) examined 16 articles depicting Latino/a utilization of mental health services. The review overwhelmingly indicates that Latino/as underutilize mental health services compared to European Americans and rely heavily on primary care for mental health treatment. This pattern holds true for Latino/as when they present with issues such as eating disorders (Cachelin & Striegel-Moore, 2006), domestic abuse (Ingram, 2007), teen dating violence (Ocampo, Shelley, & Jaycox, 2007), distress from a care-giving role (Valle, Yamada, & Barrio, 2004), and childhood ADHD (Eiraldi, Mazzuca, Clarke & Power, 2006). Additionally, Latino/a students also underutilize mental health services in college counseling centers (Kearney, Draper & Baron, 2005).

However, these findings are not as clear cut as they may seem. The term “Latino/a” refers to individuals whose national heritage derives from Mexico, Puerto Rico, Cuba, the Dominican Republic, and Central and South American countries. Although the term includes a large number of individuals and groups, it fails to take into account the inherent cultural differences among these individuals who hail from geographically different regions. Help-seeking behavior can vary greatly depending on the geographic region and cultural heritage of the individual. Cuban Americans and Puerto Rican Americans have been found to be the groups of Latino/as most likely to utilize mental health services whereas Mexican immigrants and Mexican Americans are the least likely to utilize traditional mental health outpatient

services (Vega, Kolody, & Aguilar-Gaxiola, 2001). The variability in Latino/a willingness to seek help has yet to be fully understood due to the fact that the majority of studies looking at help-seeking behavior for this population have used general Latino/a samples. This limitation notwithstanding, investigators generally agree that all Latino/a American groups utilize services at a lower rate than European Americans.

Researchers and clinicians alike are interested in understanding why this phenomenon of underutilization occurs. To this point, research has primarily been conducted to determine the structural barriers or client-specific cultural variables that may inhibit Latino/as from seeking professional mental health services. Although valuable, this line of research does not parallel the help-seeking research being conducted with predominantly European American samples. A major difference in the research being conducted with these two groups is the predictive variables chosen to explain utilization of services or willingness to seek services. As mentioned above, structural barriers and cultural factors have been used to predict or explain the underutilization of Latino/as in the mental health field. Conversely, perceptions, attitudes and expectations have been the primary targets of interest in predicting help-seeking for the European American population. Because of this disparity, the current study was designed to fill the void in the Latino/a help seeking literature by assessing Latino/a help-seeking behavior, specifically willingness to seek professional services, in a similar fashion to what has been studied in primarily European American samples and by using a European American sample for comparison.

Help-Seeking Behavior for European Americans

A number of theories have been developed to explain help-seeking behavior and have been tested using predominantly European American samples. One commonly referenced

theory views help-seeking behavior as a basic approach/avoidance conflict (Kushner & Sher, 1989). In this conflict, factors that increase the likelihood of seeking help, such as anticipated benefits of therapy and perceived reduction of distress, are pitted against factors that decrease the likelihood of seeking help, such as perceived stigma or costs. Therapy is sought when approach factors outweigh avoidance factors. The approach/avoidance theory can explain how an individual who is under distress and understands the benefits of therapy may decide against utilizing professional services.

Vogel, Wester, and Larson (2007) summarized five main conceptual factors (social stigma, treatment fears, fear of emotion, anticipated utility and risks, and self-disclosure) that have been empirically tested and shown to negatively influence the decision to seek help. Social stigma, defined as the fear that others will judge persons negatively if they seek help for a problem, has been demonstrated to predict attitudes toward seeking help and future willingness to seek help (Deane & Todd, 1996; Komiya et al., 2007; Deane & Chamberlain, 1994).

Treatment fears include concern for how a helper will act toward the client, fear of the helper's opinion of the client's decision to seek help, or fear of being coerced by the helper (Vogel, Wester & Larson, 2007a). An individual's avoidance of therapy may also be related to a fear of expressing intense emotion that might result in a negative experience in counseling. Vogel and his colleagues (2007a) further point to anticipated utility and risks as factors associated with the decision to seek help. Anticipated utility is the perceived usefulness of therapy. Anticipated risk is an individual's perception of the potential dangers of opening up to another person (Vogel & Wester, 2003). Anticipated risks and benefits have been found to mediate the relationship between emotional expression and attitudes toward

treatment as well as intentions of seeking professional help (Vogel, Wade, & Hackler, 2008). Last, self-disclosure has also been linked to help seeking behavior. Kelly and Achter (1995) and Cepeda-Benito and Short (1998) found that concealment of distressing personal information was inversely related to past help-seeking behavior and current help-seeking intentions.

Factors that increase the likelihood of professional help-seeking include perceiving one's problems as more severe than the problems of others (Goodman, Sewell, & Jampol, 1984), believing a decision to seek therapy will reduce distress in one's life, and possessing a supportive social network that encourages help-seeking (Mechanic, 1975; Rickwood & Braithwaite, 1994).

Vogel, Wester, Wei, and Boyson (2005) found that social stigma, self-disclosure, anticipated utility, social norm, social support, and previous counseling experiences influenced help-seeking intentions. Attitudes towards counseling mediated the relation between these six observed psychological factors and help-seeking intent, indicating that potential clients chose not to seek help if they held negative attitudes toward counseling.

Adult attachment (Shaffer, Vogel, & Wei, 2006), self-stigma (Vogel, Wade, & Haake, 2006), and the influence of television portrayals of psychologists (Vogel, Gentile, & Kaplan, 2008) have also been found to influence attitudes, expectations, and intentions to seek counseling. The social network of an individual can also impact the aforementioned factors related to help-seeking. Vogel et. al., (2007) found that individuals who were prompted to seek help or knew someone who had sought help were more likely to have positive attitudes toward help-seeking and held higher expectations regarding mental health services.

This review of the help-seeking literature, although not comprehensive, provides a basic understanding of the various facets of help-seeking attitudes and intentions. However, research covering aspects of help-seeking has been primarily investigated using European American samples, and few studies have explicitly explored differences among racially diverse groups in relation to the factors that influence help-seeking behavior. At this point, it is unknown if the common factors outlined previously operate similarly for Latino/a Americans as they do for European Americans. Although it is beyond the scope of the current study to replicate previous findings with a Latino/a population, this study will examine a few of these variables as well as Latino/as' perceptions of helpfulness of therapy and these perceptions' relation to willingness to seek help.

Help-seeking behavior for Latino/as

In the past few decades research on the help-seeking behavior of Latino/as has emerged. This research falls mostly into one of three areas: structural barriers, client and cultural factors, and, to a lesser extent, attitudes toward treatment. No overarching framework has been developed or incorporated for research on help seeking within the Latino/a population. There is a clear need to better understand why this population underutilizes professional mental health services.

Structural Barriers: Structural, organizational, or logistical barriers may contribute to the underutilization of professional mental health services by Latino/as. Common structural barriers include inconvenient locations of mental health service agencies, high costs of services for the uninsured, an inconvenient schedule of services (e.g., 9AM to 5PM clinical workday), a lack of culturally sensitive and relevant services, and a lack of Spanish-speaking

personnel (Echeverry, 1997). Each of these elements has been examined as a barrier to help-seeking for Latino/as.

The geographic location of service providers is a considerable barrier that affects many Latino/a individuals. Transportation costs, travel distance for those living in rural communities and the embarrassment of using public transportation, or transporting a friend or family member that is visibly disturbed or difficult to manage may all be deterrents from seeking help (Echeverry, 1997). Service locations outside of the community may cause Latino/as to feel less comfortable with seeking counseling given their familiarity and investment with their home community. For example, Latino/as who reside in established immigrant communities were more likely to use mental health services than Latino/a adults who reside in newly established communities (Aguilera & Lopez, 2008). Last, Latino/as may not know where to seek treatment for mental health problems, also affecting the utilization rates for this population (Cabassa, Zayas, & Hansen, 2006).

Another structural barrier is the high cost of mental health services. The U.S. Census Bureau (2009) estimates that 21.5% of Hispanics are living in poverty compared to 7.8% of European Americans. Moreover, Hispanics only comprise 15% of the population but represent 25% of those living in poverty. The number of uninsured Latino/as is an even greater concern in relation to help-seeking behavior; fewer than two out of every three Latino/as have health insurance. If the financial burden for mental health care is too great the likelihood that Latino/as will utilize mental health care is low. An inconvenient schedule of services is another logistical barrier affecting service usage for the Latino/a population. Newly immigrated Latino/as, who may be working multiple jobs to support their families, may find it difficult to access counseling during the workday.

Two of the most agreed upon structural factors that prohibit help-seeking for the Latino/a population is the sparse availability of culturally relevant services and Spanish-speaking personnel (Echeverry, 1997). Newly immigrated Latino/as prefer to utilize counseling services that embody the values and worldviews held by their indigenous culture. In most areas of the U.S., the choice to see mental health professionals who share similar cultural backgrounds and worldviews with Latino/as is nonexistent. The lack of Spanish-speaking personnel in the mental health care field is also a critical issue. Even if a Latino/a is fluent in English, when discussing distressing personal information the individual may feel more comfortable speaking in Spanish to another Spanish speaking individual. The lack of Spanish-speaking therapists in the field, and especially in college counseling centers, could also account for the underutilization of mental health services (Echeverry, 1991).

Other structural barriers exist for Latino/as. Williams et al. (2001) identified political barriers to mental health services for Latino/as. Focus groups of Latino/as expressed the idea that they were not represented in the city and did not expect their mental health needs to matter. Others believed that Latino/as are fearful of asking for help because having sought counseling might jeopardize the possibility of “getting their papers.” Latina immigrant women were reluctant to seek help for domestic abuse due to fears of deportation or the potential loss of legal status which was dependent upon their husbands (Bauer et al., 2000).

The perception of such socio-cultural barriers may have a greater effect on service usage than actual structural barriers inherent in the mental health system. Latino/as perceive that counseling services do not apply or are not worth the inconveniences and risks inherent in pursuing them (Atkinson, Morten, & Sue, 1998; Thorn & Sarata, 1998).

In my study, I do not predict that structural barriers will play a significant role in the utilization of mental health services by Latino/as. I will be utilizing college student perceptions of seeking help from the college counseling center. Because I've chosen this population, many of the structural barriers discussed above (e.g., transportation, cost, and availability of services) should play less of a role in Latino/a willingness to seek help but will be briefly examined as potential control variables in this study. However, other barriers such as language barriers and socio-cultural barriers may play a part in willingness to seek help within the Latino/a population. In the next section, I will discuss factors inherent to the individual in his or her decision to seek counseling.

Client Factors: A subset of research on Latino/a help-seeking behavior has focused on client and cultural factors that affect the decision to seek therapy. Client factors suggested as possible barriers to help-seeking include age, sex, and educational level. Cultural factors such as religious beliefs, national origin, resource preference, and acculturation may have an even greater impact on Latino/as' willingness to seek help.

Age, Sex, Educational level: Investigators have suggested that age can be predictive of intent to seek professional mental health services among Latino/as; both younger Latino/a adults (Portes, Kyle, & Eaton, 1992) and older Latino/a adults (Alegria et al., 1991) tend to use mental health services more frequently than middle aged Latino/a adults. This variability may be accounted for by ethnicity; that is, older individuals from Puerto Rico may be more willing to seek help while older individuals from Mexico may be less willing to seek therapy.

A differential willingness to seek therapy between the sexes exists; Latinas are up to three times more likely to use mental health services than Latinos (Vega & Lopez, 2001; see Cabassa, et al., 2006 for a review). Researchers suggest this finding is indicative of Latino

perceptions that seeking mental health treatment is emasculating (Echeverry, 1997).

However, in a study conducted by Cabassa, (2007), when presented with a case vignette of a Latino suffering from depression, the majority of male participants felt as though they could identify with the protagonist and would seek help in his situation. A more likely reason women are found to seek mental health services at a greater rate can be explained by recent epidemiological studies which indicate that Latinas may be at greater risk for mental health difficulties. Specifically, Latina women have a higher chance of experiencing depression than Latino men (Riolo et al., 2005). This finding would be consistent with the rates seen in European Americans (Kessler et al., 2005) as well as the long standing and well known epidemiological finding that European American women are several times more likely to seek therapy than European American men. (Vega & Lopez, 2001).

Educational level is a factor suggested to affect help-seeking behavior. However, this variable can easily interact with income, knowledge of resources, acculturation, and English proficiency in the decision to seek professional help (Echeverry, 1997). Because educational level is commonly and highly correlated with income, individuals who do not receive high school diplomas (and therefore many not find employment with health insurance) may find it hard to finance personal therapy. The Latino/a population may be especially vulnerable to help-seeking barriers related to educational level considering Latino/as have the lowest educational levels of all racial groups in the United States (Alegria et al., 2002; Zea, Jarama & Trotta-Bianchi, 1995).

Cultural factors: Religious beliefs may dissuade individual from seeking services if psychic distress is viewed as a burden meant to be borne. In instances such as this, an individual may choose to seek help or support from a folk healer or religious official.

Additionally, when Latino/a adults are experiencing mental health difficulties, often this distress will manifest itself somatically. To seek help for a medical complaint is more socially acceptable than seeking help for an emotional disturbance, especially if the person has strong religious convictions (Echeverry, 1997).

The national origin of a potential client also influences help-seeking behavior. Individuals who have been acclimated to seeking help or have the resources to do so are likely to be more willing to seek professional mental health services in the future. Depending upon the Latin American country from which individuals or their family members have immigrated, the individual could be more or less likely to seek help. Puerto Ricans tend to seek mental health assistance more often, whereas Mexican Americans utilize services less frequently (Alegria et al., 2002). Echeverry (1997) further suggests that a potential client may decide not to seek services if he or she encounters service intended primarily for another Latino/a ethnic group. For example, an individual from Cuba may choose not to utilize a community mental health center if it primarily provides services for Mexican Americans. The individual may feel as if his or her particular problems would not be understood in the context of another national worldview. This example outlines the difficulties of providing services and attracting clients from all subgroups of the Latino/a population.

An even larger barrier to help-seeking is the variety of resource preferences held in this population. When experiencing psychological distress, a Latino/a has a number of choices for help in alleviation of distressing emotions, or an individual may choose to rely on herself to get through difficult times. In a sample of Puerto Rican Americans, individuals who endorsed self-reliant attitudes were 40% less likely to seek professional services than individuals who felt they did not have to solve emotional problems on their own (Ortega &

Alegria, 2002). For individuals that do turn to an external source, the literature suggests that Latino/as are more likely to seek support from their social support network versus more formal mental health services (Cabassa et al., 2006; Chiang, Hunter, & Yeh, 2004). One reason for this is that many Latino/a cultures have a collectivist orientation. This worldview has been described as being “particularly concerned with harmony in their interpersonal relationships, very attentive and responsive to the needs of others, and often willing to sacrifice their individual goals to promote the collective, be it a family, neighborhood, tribe, or nation” (pg 547; Kaniasty & Norris, 2000). If an individual identifies heavily with a collectivist culture, that individual might not feel comfortable seeking support outside of their immediate network or community. Instead, she would to turn to a friend, family member, or community member in times of need. Further, these individuals who place family first would feel disrespectful discussing personal matters, especially if they concern the family, to an “outsider” or therapist.

Researchers have even suggested that Latino/as may not utilize mental health services as frequently as European Americans because the Latino/a worldview is more interpersonal in nature (as compared to the intrapersonal nature of European Americans). Thus, Latino/as receive support from informal sources whereas European Americans are more likely to receive support by seeking therapy. However, this finding does not seem to enjoy much empirical support. For example, in a study examining help-seeking comfort in emergency and non-emergency situations, the comfort of certain racial groups (e.g., African Americans and European Americans) with help-seeking decreased during a time of non-emergency while Latino/a Americans comfort with help-seeking remained at a level similar to their reported comfort during an emergency situation (Kaniasty & Norris, 2000).

Although Latino/as appear to be comfortable with seeking help from an informal source, the Latino/a sample in the Kaniasty and Norris (2000) study reported receiving less social support than their racial counterparts during both emergency and non-emergency circumstances, demonstrating that Latino/as do not perceive themselves as routinely having adequate levels of support to cope with traumatic and distressing events. Other researchers have discovered similar results; having a large social support network did not increase social support utilization in Latina dementia caregivers (Valle, Yamada, & Barrio, 2004).

Constantine, Wilton, and Caldwell (2003) found that having a social support network or being satisfied with the network did not moderate the relationship between psychological distress and willingness to seek mental health services. These latter findings illustrate that although some Latino/as may have large and high quality support networks; these sources of support are being underutilized. Not only do Latino/as underutilize formal support systems, it appears that Latino/as' psychological needs are also not being met by informal supports.

Latino/as' level of acculturation or enculturation can also influence their utilization of professional services. Acculturation is the extent to which an individual identifies with the host culture, which in the U.S. is, the European American majority culture. Enculturation refers to the extent to which one identifies with his or her indigenous culture (Kim & Abreu, 2001). Numerous empirical studies articulate the role of acculturation in help-seeking behavior. Low levels of acculturation (i.e. low levels of identification with European American culture) correlate with a lesser intent to seek mental health services. In situations of intimate partner violence, although Latinas underutilized both formal and informal supports as compared with European Americans, women who were more acculturated were more likely to seek professional help (West, Kantor, & Jasinski, 1998). Lipsky and

colleagues (2006) found that low acculturation was linked to low allied health care utilization rates for abused Hispanic women. Acculturation also affects Latino/a youth. Ho, Yeh, McCable, & Hough (2006) found that parental acculturation partially mediated the relationship between race and service use. These results explain how individuals who are second, third, or even fourth generation U.S. citizens would still choose not to seek mental health services. If, individuals do not receive the mental health care they need as children, the likelihood the individual will seek professional services as adults is low, despite the acculturation level of the individual. Enculturation has also been shown to be a predictor of help-seeking behavior for other diverse populations. In a sample of Asian American college students, enculturation was inversely related to help-seeking attitudes (Kim, 2006). However, in a similar study sampling Mexican American college students, enculturation was not found to be a factor in help-seeking attitudes or behaviors (Miville & Constantine, 2006). My study will address Latino/as' level of acculturation and enculturation and determine whether either of these constructs affects willingness to seek professional help in a college sample.

A variety of other cultural factors have been proposed to hinder help-seeking behavior in the Latino/a population. For example, guilt, stigma, and shame are commonly referenced factors that are presumed to operate as more severe deterrents to help-seeking behavior in this population (Chiang, Hunter, & Yeh, 2004). However, Alvidrez (1999) found that concerns related to social stigma were the lowest for Latinas in comparison to African American and European American young women. Rather, a significant predictor of intent to seek mental health services for Latinas was exposure to the mental health profession as measured by the frequency and duration of a friend or family member utilizing mental health services. This finding suggests that the behavior of proximal others (those considered to be

more like me than strangers) can positively influence Latino/as decision to seek therapy. Perhaps Alvidrez's finding indicates that the indirect exposure to therapy by a friend or family member reduces perceptions of stigma associated with seeking professional help. Although structural barriers, client factors, and cultural factors have been shown to affect mental health service utilization, these factors alone are not an exhaustive list of predictors of Latino/a help-seeking behavior.

Attitudes Toward Counseling: An additional area of the help-seeking literature concerns attitudes toward treatment and seeking professional help. If an individual feels seeking therapy would be a sign of weakness, embarrassing, or culturally insensitive she may develop a negative attitude towards seeking counseling and subsequently choose not to seek professional help. Research on this topic with the Latino population is much rarer than research examining structural or client factors. Research indicates that African Americans and Latino/as have more negative attitudes towards seeking mental health services (Leong, Wagner, & Tata, 1995). Bauer et al. (2000) reported that Latina immigrants had the assumption that interactions with health care professionals would be "marred by racial and ethnic prejudice" and because of this were reluctant to seek professional help for fear of being mistreated and disempowered.

The sex of Latino/a individuals can influence attitudes toward mental health services and help seeking. Chiang et al. (2004) found sex differences in Latino/as' attitudes towards counseling with Latinas possessing less favorable attitudes towards counseling than Latinos. This finding is counterintuitive to the literature predicting women are more likely than men to seek professional help (Vega & Lopez, 2001). Chaing et al. suggest that Latina college students may more strongly identify with their indigenous, collectivist culture and therefore

have positive sources of support within their family and community and not see counseling as the preferred or appropriate source of help in times of distress. Conversely, Latinos, struggling with racial discrimination and a less positive identification with their indigenous culture, may not have the same supportive network. In this case, Latino men would have less negative (and possibly more positive) attitudes towards counseling because an individualistic coping orientation promotes professional therapy as a legitimate and appropriate source of help.

However, evidence for sex differences in attitudes toward counseling may be equivocal. In a sample of young adults, men were less likely to endorse positive attitudes toward mental health treatment than females (Gonzalez, Alegria, & Prihoda, 2005), yet Cabassa, Lester, and Zayas (2007) indicated that Latino immigrants had more favorable attitudes towards counseling than their female counterparts. Regardless of the inconsistency of attitudes between and even within the sexes, all Latino/as rated familial and social support more favorably in comparison with attitudes toward professional counseling (Chiang et al., 2004). It is possible that acculturation or enculturation could mediate or moderate the relationship between sex and attitudes toward help-seeking; this could be why previous research has found differential support for women and men's attitudes toward treatment or help-seeking.

More recent research suggests attitudes toward seeking mental health treatment can also be influenced by the psychological problem at hand. Cabassa (2007) and Cabassa et al. (2007) completed a series of studies examining Latino/a immigrants' attitudes toward seeking professional counseling for depression. Participants reported a preference for counseling over anti-depressant medication and strongly agreed that counseling is effective in restoring a

depressed individual to normal functioning (Cabassa & Zayas, 2007). Although perceptions of depression treatments were positive, Latino/a immigrants preferred to first rely on informal sources, with only 18% ranking formal mental health sources as their first help-seeking choice and 70% ranking informal sources (primarily family members) as their first choice (Cabassa, 2007). Structural barriers such as lack of insurance, language problems, and not knowing where to seek services tended to inhibit intent to seek help for immigrant men in this sample. Last, a lack of knowledge regarding mental health treatments or knowledge about what to expect from therapy may decrease the likelihood of actively seeking mental health services.

Much could be contributed to this area of Latino/a help-seeking knowledge. My study aims to build on the foundation of research on Latino/as' attitudes toward therapy as a potential factor influencing this group's willingness to seek professional mental health services. One area that has yet to be explored either in this population or in the majority European American population, is perceptions of helpfulness of the specific aspects of therapy. In other words, I am interested in understanding how helpful Latino/as perceive the traditional Western approach to therapy to be and whether these perceptions influence their willingness to seek help.

Common Factors Model of Therapy

In applied psychology, hundreds of distinct therapies have been developed and used in the treatment of clients. Each system of therapy has its own assumptive world, theoretical orientation, change mechanisms, strategies, and techniques (Hansen & Friemuth, 1997). Many therapies fall under one of five major categories: psychoanalytic, psychodynamic,

humanistic, behavioral, or cognitive, and each operates under the assumption that the specific factors inherent in their therapy are what produce client change.

The suggestion that the effect of factors common to all therapies was responsible for the improvement of clientele was first raised by Rosenzweig (1936), who quoted the Dodo bird from *Alice in Wonderland* to describe the idea that: "Everybody has won, and all must have prizes." Rosenzweig stated that all therapies can assist in client improvement and each therapy has its merits, not because of its specific ingredients but because of its commonalities with other therapies.

Subsequent researchers built upon Rosenzweig's prescient conceptualization to begin providing evidence for a common factors model. Frank and Frank (1961) proposed that all psychotherapies share four common features: 1) a supportive therapeutic alliance; 2) a helpful setting; 3) the use of a specific framework from which the therapist operates; and, 4) a jointly agreed upon approach to solving the patient's problem. Luborsky and colleagues (1975) examined comparison studies to determine which of the many different therapies best improved client outcome. They found non-significant differences in outcomes for patients in different therapy conditions, indicating that any specific therapy had less of an effect on client outcome than simply being in therapy.

Smith and Glass (1977) conducted a classic meta-analysis of outcome studies, revealing that 75% of patients who were in a therapy treatment showed improvement. Smith (1980) replicated this study with a more sophisticated methodology, finding that 80% of clients in the treatment conditioned improved, with an effect size of .85, as compared with clients in a waitlist condition. Others' research has supported the common factors model (Lambert & Ogles, 2003; Shapiro & Shapiro, 1982).

Elliott (1985) was one of the first researchers to delineate therapeutic events and test them empirically. He devised two super-clusters of helpful events, labeled the task and interpersonal clusters. The task cluster consists of factors focused on treating the presenting problem and includes four sub-clusters labeled as: new perspective, problem solution, clarification of problem, and focusing attention. The interpersonal cluster also included four sub-clusters: understanding, client involvement, reassurance, and personal contact. Each of these clusters involves aspects of the client experiencing helpful contact from the therapist. Although Elliott did not directly examine common factors, his study was among the first to empirically test aspects of therapy distinct from specific factors as outlined by particular orientations.

Later, Grencavage and Norcross (1990) reviewed and coded 50 publications to find a consensus on the common factors across therapies. They indicated that common factors can fall into one of five categories: client characteristics, therapist qualities, change processes, treatment structure, and therapeutic relationship. Common factors found in the client characteristics category included the presence of positive expectations, a distressed or incongruent client, and a patient who actively seeks help. This sub-cluster was a novel idea, breaking from the traditional characteristics described by Frank and Frank (1961), as these factors explained what is also shared or common among clients who have sought therapy.

Client factors, as outlined by Grencavage and Norcross (1990), have subsequently been discussed in the literature as expectancies. Expectancies have recently been considered a major common factor that can affect change processes more so than other proposed common factors (Hubble, Duncan, Miller, 1999). Because client factors or expectancies are key in client improvement, research has examined client expectancies as a function of not

only change, but willingness to seek help. This examination is especially needed for the Latino/a population because no research to date has examined Latino/a expectancies related to other common factors. My study will be the first to address Latino/as expectancies about the common factors inherent in therapy. Specifically, I will examine Latino/as endorsement of common factors as potentially helpful if they were to seek professional mental health services.

Therapist qualities concern generally positive descriptors, such as cultivating hope/enhancing expectancies, having warmth and a positive regard, having empathetic understanding, being a socially sanctioned healer, and being accepting.

The change processes category was comprised of 26 factors that described insight and action factors in the therapeutic process. For instance, fostering of insight/awareness, feedback/reality testing, and tension reduction were all factors that fell under this category. The fourth major category concerned the structure of the therapy setting. Therapy structure factors include the use of techniques, a focus on exploration of emotional issues, a healing setting, and an explanation of therapy and participants' roles in therapy. Last, factors under the therapeutic relationship category commonly included the development of the alliance, engagement, and transference.

Similarities can be found between Elliott's (1985) taxonomy and Grencavage and Norcross' (1990) categories. Therapist qualities and the therapeutic relationship are major categories in both classifications as well as factors related to insight and healing. Wampold, Mondin, Moody, Stich, Benson, and Ahn (1997; see APA cite for 6+ authors) and Messer and Wampold (2002) found that therapist variables prevail over the specific factors in therapy. However, these classifications do not describe common factors as to their order of

occurrence in the therapeutic process. Further, there is little differentiation between insight and action factors. Although insight and action may occur together in therapy, the reverse is not certain, and each type of factor can also occur separately (Hill, 2001). A better classification system was needed to understand both when common factors occur in therapy and what type of change process is occurring for each factor.

By far, Lambert and Ogles (2003) have offered the most comprehensive classification of common factors. These researchers categorized factors into three main areas, stipulated when common factors occurred in therapy, and identified the type of change process occurring for each factor. Their therapeutic sequence of common factors included support factors, learning factors, and action factors. The support category included factors pertaining to therapist qualities and the therapeutic alliance. Learning factors are representative of insight and educational aspects of the therapeutic process, and action factors are representative of the active participation by both the therapist and client in the solving of client problems. Insight is often used as a term for the learning stage and common factors within it; therefore, insight will be used as the descriptor for this category in the remainder of the paper.

In most therapies, each of the categories follows sequentially after the other, in that insight factors will not occur until after support factors have been utilized. Although each factor can be utilized at any point in therapy, many training models follow the support, insight, action sequence (e.g., Hill, 2006). Because Lambert and Ogles' (2003) model is the most comprehensive and well-respected classification of common factors, I will utilize their model in my study.

My study will sample Latino/a college students to determine if the factors grouping (support, insight, or action) or certain individual factors are endorsed as potentially helpful at a different degree than any other grouping or specific factor. I will also utilize a control sample of European American college students to determine whether Latino/as endorse certain factors (such as factors related to the therapeutic alliance) to a different degree than their majority culture counterparts. Understanding Latino/as' perceptions of common factors helpfulness may also shed light on Latino/as' help seeking behaviors.

Support factors are the most researched factors in the common factors literature. In Lambert and Ogles (2003) a list of support factors includes those related to the therapist, therapeutic alliance, and the therapeutic experience of the client. Therapist factors include professional expertness, warmth, respect, empathy, acceptance, and genuineness. If a therapist is able to convey that he or she is not only knowledgeable but empathetic, client outcomes are expected to be positive regardless of the specific interventions used or orientation from which the therapist is operating (Prochaska & Norcross, 2001). Najavits and Strupp (1994) have confirmed this relation; specifically, therapist warmth and affirmation increase positive client outcomes.

Support factors categorized in the therapeutic alliance include the development of a positive relationship, identification with the therapist, active participation by both the therapist and the client, and the building of trust within the relationship (Lambert & Ogles, 2003). Although building a therapeutic alliance is more highly emphasized in certain schools of therapy, each type of therapy utilizes relationship-building skills and factors as a prerequisite or vehicle for change (Prochaska & Norcross, 2001). Client factors, or experiences as a function of the therapist's support, are also considered common factors. For

example, if the therapeutic relationship is constructive, a client is likely to experience a release of tension, diminished feelings of isolation, and emotional catharsis (Frank & Frank, 1961).

Latino/as will likely endorse items related to support as potentially helpful. As will be discussed below, Latino/a culture is collectivistic, in which relationships are held in high regard. Latino/as may value the interconnectedness and support of another individual as factors potentially beneficial if they were to seek professional mental health services. Outcome studies provide support for this hypothesis. A strong therapeutic alliance has been correlated with greater satisfaction with services in Latinas (Paris et al., 2005) and has been found to account for 45% of the variance of therapy effectiveness in a sample of Latino/as in Puerto Rico (Bernal, Bonilla, Padilla-Cotto, & Perez-Prado, 1998).

Sequentially, once a relationship has been established by the use of support factors, learning or insight factors are utilized. Wampold, Imel, Bhati, and Johnson-Jennings (2007) proposed that “insight involves obtaining a functional understanding of one’s problem, complaint, or disorder through the process of psychotherapy and that insight is a beneficial common factor present in and critical to all psychotherapy orientations” (pg 119). Items in Lambert and Ogles’ (2003) framework include factors considered to provide enlightenment or knowledge to the client about his or her presenting problem, situation, or personality. Insight, feedback, affective experience, and the exploration of the client’s internal frame of reference are a few examples of these factors.

Researchers examining the construct of insight have found that individuals who are more insightful will benefit from therapy to a greater degree than individuals who lack insight. However, in reviewing the literature, Connolly, Gibbons, Crits-Christoph, Barber,

and Schamberger (2007) suggest that client improvement is related to the gain in insight over the course of treatment, not how insightful the client was pre-treatment. The Connoley et al. findings suggest that the interventions used within therapy to foster insight are related to client change. Overall, less empirical research has been completed in this area due to the difficult nature of researching insight in therapy (Wampold, Imel, Bhati, & Johnson-Jennings, 2007).

Researchers suggest that insight oriented interventions may not be especially effective or relevant for Latino/a individuals. Some suggest that because the root of Latino/a mental illness, such as depression, is often due to external factors such as racial discrimination, financial concerns, and acculturative stress (Santiago-Rivera et al., 2008), interventions targeting the cognitive or abstract nature of the presenting concern may not effectively produce change. Although a few researchers have insisted on the inappropriateness of the non-directive techniques seen in insight-oriented therapies (Valdes, 1983; Garzon & Tan, 1992), in actuality, there is no empirical support for this assertion (Rosenthal, 2003). Alternatively, Latino/as preference for more concrete therapies or therapeutic interventions may be a factor of socioeconomic status (Javier, 1990); for example, insight therapies may be a poor treatment choice for a Latina who is struggling to put food on the table for her children. My study will be the first to address to what degree Latino/as find insight factors to be potentially helpful in therapy.

The final category, action factors, encompasses factors related to the active solving of the client's problems (Lambert & Ogles, 2003). Behavioral regulation, mastery efforts, reality testing, and working through problems are action factors used regularly in the later sessions of therapy. Action factors do occur in most therapies -- even the strictly "talk

therapies” include action factors. For example, encouragement of facing fears and modeling are often utilized in humanistic therapies (Prochaska & Norcross, 2001). Action factors are typically examined in manualized treatment research.

Latino/as are predicted to endorse action factors as potentially beneficial. Rosenthal (2003) suggests Latino/as may benefit most from behavioral (or action) interventions because of past literature indicating a potential fit with Latino/as’ cultural values and psychological orientation. Although no research to date has examined the connection between action factors and Latino/a expectancies, outcome studies point to the possible utility and preference for action factors. Behavioral interventions have been shown to be effective for Latino/a youth (see Rosenthal, 2003 for review). Researchers have also provided strong empirical support for cognitive behavioral approaches (Voss Horrell, 2008) and behavioral activation therapies (Santiago-Rivera et al., 2008) for the Latino/a population. These findings suggest Latino/as may highly endorse action factors as potentially helpful. However, the reported efficacy for behavioral therapies may be due to the convenience of researching manual-based therapies (vs. insight or “talk” therapies), rather than evidence for behavioral interventions as preferable treatment for Latino/a individuals. My study will clarify whether or not Latino/as do have a preference for behavioral or action interventions.

In sum, the common factors model, emphasizing the role of shared therapeutic variables over the role of orientation-specific techniques (Ahn & Wampold, 2001; Wampold, 2001; Luborsky et al, 2002; Lambert & Bergin, 2003) has moved the profession from an outcome-oriented view to a process or process-into-outcome understanding of therapeutic change. What has yet to be explored is whether common factors are relevant to the Latino/a population as being potentially helpful to them if they were to enter therapy.

Research Questions

A brief review of the literature reveals a modest collection of research concerning the attitudes of Latino/as towards professional help-seeking and psychological treatment. What has yet to be explored are the expectations of Latino/as as to what occurs in therapy. Specifically, to what extent does this population find the typical approach of common factors to be potentially helpful? In the present study, I aim to assess the expectations and preferences of Latino/as concerning the use of a common factors approach in therapy. The use of a generally accepted set of common factors in therapy is in and of itself a potential factor affecting the help-seeking behavior of this population that traditionally underutilizes mental health services. More specifically, do Latino/a college students perceive the therapeutic common factors to be helpful in dealing with their psychological difficulties and does this perception influence their help-seeking behavior? Furthermore, do these perceptions differ from European American college students?

To assess Latino/as' perceptions of helpfulness of the common factors in therapy, I posed three exploratory questions:

1. Does confirmatory factor analysis indicate adequate or robust goodness-of-fit indices for the conceptual common factors categories as outlined by Lambert and Ogles (2003; support, learning, action) vis a vis college students' endorsement of helpfulness for these items?
2. How helpful do Latino/as perceive Lambert and Ogles' (2003) common factors in therapy to be?

3. Do the overall and subscale ratings of Latino/as on perceived helpfulness of common factor categories (i.e., support, learning, action or a new factor structure) differ from those of European Americans?

No research to date has explicitly explored Latino/as' preferences or expectancies of the common factors in therapy. However, Latino/as will likely endorse certain common factors as being more helpful in comparison to other common factors in therapy. Outcome studies indicate Latino/as may endorse support and action factors more highly than insight factors. Therapeutic alliance has been shown to influence both the effectiveness and satisfaction with therapeutic services for Latino/as (Paris et al., 2005; Bernal, Bonilla, Padilla-Cotto, & Perez-Prado, 1998). Therapies and interventions utilizing action factors (such as cognitive behavioral therapy and behavioral activation) have also received good empirical support for effectiveness with Latino/as (Voss Horrell, 2008; Santiago-Rivera et al., 2008; Rosenthal, 2003). Because therapies often utilizing support and action factors have been shown effective, it is likely Latino/as may endorse these factors as potentially helpful if they were to seek therapy.

Conversely, although there is no empirical support for this assertion, many authors suggest that therapies utilizing insight factors are not recommended for treatment with Latino/as because non-directive therapies do not address the very real, external issues (such as discrimination and acculturative stress) Latino/as face (Valdes, 1983; Garzon & Tan, 1992; Santiago-Rivera et al., 2008) and do not address the action-oriented perspectives associated with this cultural group (Sue & Sue, 2007). Due to these concerns, I do not expect insight factors to be highly endorsed in my study. However, these hypotheses are tentative

and exploratory in nature as little empirical support in the literature exists to guide hypotheses.

My study is the first to examine Latino/as' expectations of the potential helpfulness of common factors in therapy. It will also be the first to address how Latino/as' perceptions of the helpfulness of common factors in therapy influence their help-seeking behavior. To obtain these answers, I will pose an additional research question:

4. To what extent do Latino/as perceptions of the helpfulness of the common factors in therapy account for variance in their willingness to seek help above and beyond variance accounted for by relevant demographic variables?

As I have discussed previously, many structural, client, and cultural factors have been shown to influence Latino/as' willingness to seek professional help. Less research has looked specifically at expectations related to counseling. Although my research questions are exploratory in nature, it is likely that individuals who report greater levels of perceived helpfulness of the common factors will display a greater willingness to seek help.

CHAPTER 3: PILOT STUDY

METHOD

As no measures currently exist to examine the perceived helpfulness of common factors and their elements, I developed a new scale to measure these perceptions. In addition to factor analytic examination of the common factor items, this pilot study will answer my first research question: *Does confirmatory factor analysis indicate adequate or robust goodness-of-fit indices for the conceptual common factors categories as outlined by Lambert and Ogles (2003; support, learning, action) vis a vis college students' endorsement of helpfulness for these items?*

Participants and Procedures

This study was approved by the Institutional Review Board at Iowa State University on 10/11/2010; IRB Identification Number 10-406. Materials regarding IRB approval are included in the appendix. Participants for the pilot study were drawn from introductory psychology and communication studies courses at Iowa State University (Psychology 101, Communication Studies 101, Psychology 230 and Psychology 280). To fulfill research course requirements, 776 students elected to participate in the pilot study. Subjects with 10% or more of their survey incomplete ($n = 18$) were dropped from the study, leaving 758 participant responses used in the analysis (333 Male, 419 Female, 6 No Response). The 10% criterion was used based on recommendations of Tabachnick and Fidell (1996) who recommend removing missing data (verses replacing data) when an appropriate number of responses will not be lost. Because the pilot study was not concerned with descriptive data, the individuals who chose not to respond were retained in the study. The majority of

participants were White¹ (84.4%), 4.1% were African American, 2.5% were Asian American or Pacific Islander, 1.6% were Latino/a, 1.7% identified as multiracial, and 1.1% indicated “other” as their racial background. Additionally, 4% of participants reported being international students.

With respect to grade levels, 52.2% were first year students, 27.8% of participants were sophomores, 13.1% were juniors, and 6.5% were seniors. Three participants (.4%) chose not to indicate their year in school.

The data collection for the pilot study was conducted as part of the scale validation procedures in the department of psychology. As part of course requirements, students in introductory psychology courses at ISU are required to obtain a certain number of research credits. One option students have to fulfill research credits is to complete a research session for scale validation. Scale validation sessions are run each semester for psychology faculty and graduate students to collect data from a large sample of students to provide information for preliminary analyses for new or seldom used measures. Faculty and graduate students can submit measure(s) and all items for all measures, as well as a brief demographic questionnaire, which are administered to participants. Introductory psychology students are recruited to participate in scale validation through an online research sign-up system. If students chose to participate in scale validation, they were directed to a web-based survey site to complete an online informed consent, survey measures, and were provided with debriefing information.

¹The term “White” will be used in the methods and results section of both the pilot and main study to accurately reflect the classification used by Iowa State University in the reporting of race. This term corresponds to the racial classification of “European American”, as suggested for use by the American Psychological Association.

Measure

Item Development: Participants' perceptions of the common factors found in most Western therapies was measured using a 32-item scale created for this study and was titled *Perceived Helpfulness of the Common Factors in Therapy (PHCFT)*. The items were drawn from the taxonomy of factors outlined in the *Handbook of Psychotherapy and Behavior Change* (Lambert & Ogles, 2003). The taxonomy includes three categories: Support, Insight, and Action. Under Lambert and Ogles' (2003) taxonomy, 12 items represent the support factors, 10 items represent insight factors, and 10 items represent action factors. One survey item was based upon each item in the taxonomy to ensure all aspects of the taxonomy were included. Each item was transformed into a statement representing the active or dynamic process of the common factor. In other words, items were developed to represent what each common factor would look to a potential client in therapy. For example, for the common factor "advice," an item was created to portray the experience of a client receiving advice from their therapist. Using an active voice, the item included in the measure then became "To be able to receive advice from the therapist."

The scale consists of 12 support items, 10 insight items and 10 action items to appropriately reflect Lambert and Ogles categorization of the common factors. I and two psychology faculty members then examined the statements to ensure readability as well as consistency among the items. Additional example items include "Have a trusting relationship with your therapist" (representing "trust" in the taxonomy), "Learn new things about yourself" (representing "cognitive learning" in the taxonomy) and "Decrease some of your problematic behaviors" (representing "behavioral regulation" in the taxonomy) which represent a support, learning, and action factor, respectively. The items on the PHCFT are in

Likert format; participants are asked to indicate how helpful they perceive each common factor to be if they were to seek professional mental health services. Polar anchors range from 1 (*not helpful*) to 5 (*very helpful*).

RESULTS

Factor Analyses of the PHCFT

Lambert and Ogles' (2003) taxonomy of common traits found in therapy includes three categories: Support, Insight, and Action. To determine if Lambert and Ogles' categorization fit for students' perceptions of these items, a confirmatory factor analysis (CFA) was conducted on the items from the PHCFT. A full information maximum-likelihood (FIML) estimation method was utilized using LISREL 8.80 (2006). I used three indices suggested by Hu and Bentler (1999) to determine model fit: comparative fit index (CFI > .95); the Root-Mean-Square Error of approximation (RMSEA < .06); and, the Standardized Root-Mean Square Residual (SRMR < .08). Results of the CFA suggest an acceptable fit of the data to Lambert and Ogles categorization, $\chi^2(461, N = 758) = 2784.35$ $p < .001$, CFI = .98, RMSEA = .077, SRMR = .05. Weston and Gore (2006) suggests that it is more difficult to find a good fit with a CFA; therefore having a RMSEA with < .08 is acceptable. While the chi-square statistic was significant, indicating a poor fitting model, this statistic is a stringent test which attempts to predict a perfect model – an almost impossible feat with a confirmatory factor analysis.

Because the CFA indicated that the model only acceptably fitting the data versus robustly fit the data, additional models were explored to determine if the PHCFT has a more robust factor structure with a different model. To find potential models, an exploratory factor analysis (EFA) using principle axis factoring (PAF) was conducted to determine the best

factor structure for the items from the PHCFT. The 758 participant data set was split in two; with 379 participants per data set to provide a secondary group to cross-validate the new factor structure with a CFA. Using the first data set, a parallel analysis was used to determine the number of factors to extract. A number of researchers suggest using a parallel analysis is a more reliable way to examine the number of factors to extract because it allows the viewer to determine how many factors account for more variance than what would be expected by chance (Brown, 2006; Russell, 2002). The parallel analysis indicates factor extractions based on 1,000 random permuted data sets. By comparing the scree plot and eigenvalues of the parallel analysis and actual data, factors in the data with eigenvalues greater than eigenvalues in the parallel analysis should be extracted (Brown 2006).

A number of principal axis factoring (PAF) analyses were conducted to find the best fit for the data. First, an unrotated PAF indicated that three factors explained more variance than due to chance alone (as compared to the parallel analysis). To account for an eigenvalue potentially falling on the parallel analysis line, two-, three- and four-factor solutions were explored using both Varimax and Promax rotations. The most interpretable model was found using a four-factor solution with the Promax rotation. Four considerations were taken into account to make this decision. First, items must have had a factor loading of .40 or greater and cross-loadings on other factors of less than .25 based on the factor pattern matrix. Tabachnick and Fidell (1996) suggest that loadings of .32 or greater be retained, but encourage researchers to determine the best cutoffs for loadings and cross-loadings for interpretability. I selected .40 factor loading and .25 cross-loading cutoffs because these criteria appropriately differentiated factors with clear factor loadings. This procedure

eliminated solutions with a Varimax rotation and the two-factor solution with Promax rotation (as the majority of items loaded highly on one or more factors).

Second, reliability analyses were conducted for the new three- and four-factor scales to determine if one factor structure provided more reliable scales than the other. Each reliability analysis conducted for three- and four-factor solutions with a Promax rotation indicated the scales were adequately reliable (lowest reliability of a subscale was $\alpha = .77$). Third, correlations between the factors for both the three- and four-factor solutions with Promax rotation were conducted. Correlations among factors ranged from $r = .55$ to $r = .74$ for the three-factor solution and from $r = .55$ to $r = .75$ for the four-factor solution; indicating factors in both solutions are comparably correlated.

Fourth, qualitative considerations of item content in each factor and the desire to have factors with no less than three items were also weighed. The four factor solution provided a factor structure with the first factor containing 11 items, with the other three factors each containing three items. Twelve items were removed from the original scale for loading highly (above .25) on two or more factors; the final measure contains 20 items.

To determine if this obtained four-factor solution would be robust under cross validation, a CFA was conducted with the second sample of data. In addition, the new three-factor model (with different item loadings than the original three factor model), as well as the one-factor model were also analyzed using a CFA to provide fit comparisons to the four-factor model.

Using a maximum-likelihood estimation method, the three-factor solution did not adequately fit the data; $\chi^2(347, N = 379) = 2039.53, p < .001, CFI = .98, RMSEA = .077, SRMR = .051$). Additionally, to determine if a one-factor solution would be a better fit for

the data, a PAF and CFA were conducted. The PAF indicated that all items loaded highly on one factor (lowest factor loading was .56); however, the CFA indicated the one factor solution was not a good fit for the data. Results of the CFA did not meet the criteria outlined by Hu and Bentler (1999); $\chi^2(464, N = 379) = 1824.50, p < .001, CFI = .98, RMSEA = .084, SRMR = .051$).

The four-factor solution provided a robust fit based on the recommendations of Hu and Bentler (1999); $\chi^2(164, N = 379) = 702.47, p < .001, CFI = .99, RMSEA = .052, SRMR = .045$). Thus, the new four-factor solution will be adopted and used throughout the remainder of the pilot and main study.

Reliabilities and Descriptive Data

To reflect the item content of the new scales of the PHCFT, new names were developed for each factor. The first factor, containing 11 items, was termed *Therapeutic Work*. Items in this scale reflect specific interventions, techniques, activities and experiences related to the work which occurs in therapy. For example, items such as “To be able to work through some of your personal difficulties” and “To be able to receive advice from your therapist” are items which loaded highly on this factor. The total sample, as well as the split of sample one and sample two provided evidence for the high reliability of this scale. The total sample reliability was $\alpha = .94$ with sample one and two reflecting similar reliabilities; $\alpha = .93$ and $\alpha = .95$, respectively. The *Therapeutic Work* subscale is comprised of items from all three categories of common factors (support, insight, and action) originally created from Lambert and Ogles (2003) taxonomy. The top loading item (.85) on this scale was an action item, “To be able to work through some of your personal difficulties,” followed by three insight items.

The second factor, labeled *Alliance*, represents three items concerning the therapist and the relationship. Items included in this scale were: “To be able to have a positive relationship with your therapist,” “To experience a strong working relationship with the therapist” and “Having a trusting relationship with the therapist.” The total sample reliability was $\alpha = .88$ with sample one and two reflecting similar reliabilities; $\alpha = .86$ and $\alpha = .90$, respectively. All three items on the *Alliance* subscale are items originally found in the support category of common factors by Lambert and Ogles (2003), indicating some stability between the authors’ conceptual grouping how participants grouped the common factors.

Use of Therapy was the term labeled for the third factor also containing three items. Items in this scale represent aspects of how therapy is structured and how the relationship is used in and outside of therapy. Items in this scale include “To have therapy sessions follow a structured format,” “To see the therapist as a person to model yourself after” and “To model your relationships with the therapist to other relationships in your life.” The total sample reliability was $\alpha = .77$ with sample one and two reflecting similar reliabilities; $\alpha = .72$ and $\alpha = .81$, respectively. This subscale was comprised of one support item and two action items from Lambert and Ogles (2003) taxonomy.

The last factor, termed *Experiential Processing*, contains three items related to the experience of emotion and working through problematic experiences. For example, items which loaded highly on this factor include “To have a release of pent-up emotions,” “To have a place to experience your emotions” and “To reduce feelings of isolation.” The total sample reliability was $\alpha = .78$ with sample one and two reflecting similar reliabilities; $\alpha = .76$ and $\alpha = .79$, respectively. One item from each of Lambert and Ogles (2003) categories (support, insight, action) were included in this new subscale.

Table 1 illustrates the categorization of items from the original conceptualization of Lambert and Ogles (2003) taxonomy and the comparison to the new factor structure. The *Alliance* subscale was the only scale that retained items from only one category (support) of the original categorization by Lambert and Ogles. Each of the other subscales drew from two or more of Lambert and Ogles (2003) categories. I will explore the differences between the new factor structure and Lambert and Ogles (2003) taxonomy in the discussion.

The total scale reliability was $\alpha = .95$ for the total sample with split sample alphas of $\alpha = .94$ and $\alpha = .96$. Because of this high total scale reliability, bivariate correlational analyses were conducted to examine the relationship among the subscales. A Bonferroni adjustment of .01 (.05/5) was utilized to account for effects due to chance. Results indicated that each scale correlated highly with the total scale; correlations ranged from $r = .74, p < .001$ (Use of Therapy) to $r = .97, p < .001$ (Therapeutic Work). Scales were also correlated moderately to highly with one another; ranging from $r = .50, p < .001$ to $r = .74, p < .001$. All correlations can be found in Table 2 for the total sample. The high correlations among the subscales indicate the factors are likely highly collinear. The mean score for the total sample was 67.22, out of a possible range of 20-100 ($SD = 14.98$) with subscale means of 38.70 (Therapeutic Work; $SD = 8.74$), 10.24 (Alliance; $SD = 2.98$), 8.44 (Use of Therapy; $SD = 2.72$) and 9.83 (Experiential Processing; $SD = 2.61$) each in a possible range of 3-15.

Table 1.

Comparison of item categorization for original and new proposed factor structure of the PHCFT²

Original	New	Factor Loading
Support	Therapeutic Work	
1. To have a release of pent-up emotions	1. To be able to work through some of your personal difficulties	.85
2. To feel the therapist is similar to you	2. To develop an understanding or rationale of your problematic experiences	.84
2. To reduce feelings of isolation	3. To gain insight into your problematic experiences	.84
4. To be able to have a positive relationship with the therapist	4. To be able to receive feedback from the therapist	.83
5. Having the therapist reassure you about your difficulties	5. To increase your expectations of your personal effectiveness	.82
6. To have a release of tension	6. To understand your problematic experiences and how they relate to each other	.81
7. Having a trusting relationship with the therapist	7. Having the therapist provide encouragement to face your fears	.81
8. To experience a strong working relationship with your therapist	8. To be able to receive advice from the therapist	.80
9. Active participation by both you and the therapist	9. To learn new things about yourself	.79
10. Having a therapist with expertise	10. To increase the feeling that you can master aspects of your life	.78
11. To have the session follow a structured format	11. To develop the ability to control your unwanted thoughts	.72
12. Having a therapist who is warm, empathetic, accepting, genuine, and respectful		

² *Note:* Terms in bold represent the subscale names. Twelve items were deleted from the original scale for loading highly (over .25) on two or more factors based on the 4-factor PAF solution.

*Comparison of item categorization for original and new proposed factor structure of the PHCFT
(continued)*

Insight	Alliance	
1. To have a place to experience your emotions	1. Having a trusting relationship with the therapist	.92
2. To increase your expectations of your personal effectiveness	2. To be able to have a positive relationship with the therapist	.88
3. To understand your problematic experiences and how they relate to each other	3. To experience a strong working relationship with the therapist	.87
4. To learn new things about yourself	Use of Therapy	
5. To feel you have learned new techniques for managing interpersonal relationships	1. To model your relationship with the therapist to other relationships in your life	.89
6. To develop a framework for the way you think and feel	2. To see the therapist as a person to model yourself after	.82
7. To be able to receive advice from your therapist	3. To have the session follow a structured format	.70
8. To develop an understanding or rationale of your problematic experiences	Experiential Processing	
9. To be able to receive feedback from the therapist	1. To have a place to experience your emotions	.84
10. To gain insight into your problematic experiences	2. To have a release of pent-up emotions	.81
Action	3. To decrease some of your problematic behaviors	.71
1. To decrease some of your problematic behaviors		
2. To have a place to test out your thoughts and feelings		
3. Having a place to reward your successes in therapy		
4. To increase the feeling that you can master aspects of your life		
5. To develop the ability to control your unwanted thoughts		

Comparison of item categorization for original and new proposed factor structure of the PHCFT (continued)

6.	To be able to work through some of your personal difficulties
7.	To model your relationship with the therapist to other relationships in your life
8.	To gain the ability to take more risks in your personal life
9.	Having the therapist provide encouragement to face your fears
10.	To see the therapist as a person to model yourself after

Table 2

Correlations among subscales of the PHCFT

Variable	1	2	3	4	5
1. Total	--				
2. Therapeutic Work	.97**	--			
3. Alliance	.83**	.74**	--		
4. Use of Therapy	.74**	.60**	.58**	--	
5. Experiential Processing	.79**	.72**	.55**	.50**	--

Note: * $p < .05$ ** $p < .001$

CHAPTER 4: MAIN STUDY

METHOD

Participants and Procedures

Participants for the main study were drawn from Iowa State University's Office of the Registrar's database on the basis of individuals who self-identify as Latino/a or White. The Registrar maintains a database of information on all enrolled students. Names and emails of individuals who self-identify as Latino/a or White were requested to recruit these groups of students to participate in my study. The Registrar provided a list of 811 Latino/a students and 21,075 White students. Because the pool of White students was vastly larger than the sample of Latino/a students, a random sample of 800 White students was created to provide equivalent sample sizes for both ethnic groups of interest in this study using a random number generator in Microsoft Excel (2010). In sum, 1,611 students were contacted to participate in the study. Of the 1,611 students contacted 243 students (15.08%) initiated participation in this study. After removing incomplete responses ($n = 26$) as recommended by Tabachnick and Fidell (1996), the sample size was 217 subjects. I discuss data cleaning procedures later in the results section. Six participants (2.8%) indicated they were bi-racial (specifying Latino/a and one or more other racial identities), 101 participants (46.5%) reported identifying as Latino and 110 participants (50.7%) identified as White. Because I am specifically examining Latino/a and White perceptions of therapy and willingness to seek help, only Latino/a and White participants' responses were used in this study; the six individuals who reported they were biracial were removed from the study.

Thirty-six White participants were males and 74 were females. When compared with the general University population, a chi-square test resulted in a significant difference

between my sample and the population from which it was drawn; $\chi^2(1, N = 110) = 23.10, p < .001$. This same significant difference was also found among Latino/a participants (41 males, 60 females); $\chi^2(1, N = 101) = 5.45, p = .02$. These results indicate that for both groups significantly more women chose to participate in my study than men.

The average age of participants was 22.39, with a range of ages of 18-54. Fifty participants (23.0%) were seniors, 48 (22.1%) were freshmen, 44 (20.3%) were juniors, 38 (17.5%) were sophomores, 34 (15.7%) were graduate students and 3 individuals chose not to identify their year in school. When compared to the general University population no differences were found between my sample and the population from which it was drawn when submitted to chi-square analyses. Similar distributions of educational cohorts were found between my sample and the University population for both Whites [$\chi^2(4, N = 110) = .78, p = .94$] and Latino/as [$\chi^2(4, N = 101) = 5.63, p = .22$].

Participants were contacted through their Iowa State email address and asked to follow a link to the online survey. The online survey included a brief demographic questionnaire and materials related to seeking professional mental health services. Completion of the survey was estimated to take no longer than 45 minutes, and those who chose to participate were eligible to be entered into a raffle to win one of ten, \$10.00 gift cards to Amazon.com.

Researchers have explored both online formatting of survey materials as well as procedural steps to increase response rate of online studies. I followed a number of recommendations in this study to obtain the maximum possible responses from this study population. First, I personalized all emails. Personalization has been shown to improve responses on web surveys (Heerwegh, 2005) and does not appear to influence social

desirability (Herrwegh & Loosveldt, 2006). Personalization of invitations to participate also poses no risk to keeping the collected data de-identifiable. Secondly, shorter surveys tend to elicit higher unit-response rates and combats low topic salience (Marcus, et al., 2007). Therefore, the number of items on the instruments were capped at 76 items for Latino/a participants, with European American participants receiving a slightly shorter survey capped at 72 items.

Next, a clear description of the prize draw incentive was outlined for participants. Although immediate incentives result in increased response rates in non-web based studies (Church, 1993), it appears that immediate incentives have no advantages to promised incentives (Bosnjak & Tuten, 2003). Tuten, Galesic, and Bosnjak (2004) proposed that one reason promised incentives such as prize draws are equally effective at obtaining moderate response rates is that individuals may be accustomed to expect prize draw incentives.

Last, potential participants received two reminder emails asking them to complete study materials. Klofstad, Boulianne, and Basson (2008) found that when including a reference to future email reminders in the original email invitation to participate, an increase of 7.2% in response rate was found for students.

In summary, potential participants received a total of three personalized emails. The first invited students to participate in the study, briefly outlined procedures and requirements, and indicated they would receive additional email reminders to participate. The second and third emails briefly and kindly thanked those that have participated and gently reminded students who had not that their participation in this study would be greatly appreciated. This number of contacts is usual in psychological research and represents neither intrusiveness nor an overly extended approach. The response rate after all three emails was 15.08%. This

response rate is low; however, email recruitment methods tend to provide slightly lower rates than paper-and pencil survey mailings (Singh, Taneja & Mangalaraj, 2009).

After completion of the survey materials, participants were informed that their participation had made them eligible to register for the prize drawing. Participants were given a code which they were instructed to send to the primary researcher along with their name and email address in order to be put into the raffle pool. Participants were given the chance of sending this information through email, the United States Postal Services, or through ISU campus mail. This information was in no way connected to their survey responses. Following completion of the survey, participants were debriefed via a written statement and contact information was provided for the Student Counseling Services on campus should participants feel a need for counseling services after completing study materials.

After completion of the study, names were randomly drawn and winners contacted through their ISU or provided email to notify them of their win. Winning participants were asked to provide a mailing address or valid email address to send the gift certificate and were again thanked for their participation. All information related to the prize drawing was then destroyed via shredding; any other paper or electronic records will be kept on file for a minimum of five years in accordance with American Psychological Association policy and ethical code (APA, 2002).

Measures

The measures used in this study can be found in the Appendix.

Demographic Questionnaire: Latino/a participants received a 21 item demographic survey in which they were asked to report their age, sex, year in school, generational status, and specific Latino/a-ethnic ethnicity. Participants were also asked to answer questions

related to mental health service use and their perceptions of this experience. For example, participants were asked to report if they are currently, or have in the past sought help from a mental health professional, how helpful this experience was, how aware they feel they are about what happens in therapy, how likely they are to seek counseling in the future, if the times that a typical counseling center would operate would be convenient to their schedule, and if having a Spanish-speaking therapist would influence their decision to seek help. Additionally, a one-item open-ended request for participants' description of what they believe happens in therapy was included. This open-ended question was included as purely supplementary data and will not be analyzed in the current study. Additionally, a two-item measure examining participants' level of acculturation and enculturation was included in the demographic materials.

European Americans received a slightly modified version of this survey (17 items); specifically, European American participants were not asked about their Latino/a-specific ethnic background. Participants were asked to what extent they identify with both the majority or minority culture(s). Participant responses can be grouped in four main categories based on these two items: high identification with both majority and minority culture, low identification with both majority and minority culture, high identification with majority culture and low identification with minority culture, and low identification with majority culture and high identification with minority culture. This method has been used to examine cultural orientation with minority groups (Bennett & BigFoot-Sipes, 1991; Oetting & Beauvais, 1991).

Perceived Helpfulness of the Common Factors in Therapy (PHCFT): Perceptions of the helpfulness of the common factors in therapy was measured using the PHCFT. This

scale was based on the taxonomy of common factors found in *Handbook of Psychotherapy and Behavior Change* (Lambert & Ogles, 2003). Items were created to reflect each of the common factors listed in Lambert and Ogles (2003) taxonomy: support, insight, and action stages of therapy. In the previous pilot study, a new four-factor solution was found to best represent participants' perceptions of helpfulness of the common factors of therapy. The first factor, termed Therapeutic Work, contains 11 items related to the specific interventions, techniques, activities and tasks which occur within the therapy setting. Sample items include "To be able to receive feedback from the therapist" and "To develop the ability to control your unwanted thoughts." Chronbach reliability estimates for the Therapeutic Work subscale was $\alpha = .94$ for the participant data used in the primary study (non-pilot). The other three subscales each include three items. The second subscale, Alliance, reflects items related to the therapist and relationship in therapy. Items include "To be able to have a positive relationship with the therapist" and "Active participation by both you and the therapist." The alpha reliability coefficient for the Alliance subscale was $\alpha = .90$. Use of Therapy is the third factor and relate to how therapy is structured and how the relationship is used in and outside of the therapy setting. Sample items in this scale include "Having a place to reward your successes in therapy" and "To model your relationships with the therapist to other relationships in your life." The alpha reliability coefficient for the Use of Therapy subscale was $\alpha = .78$. Last, the Experiential Processing subscale contains items concerning the experiencing of emotion and the working through of problematic experiences. Example items include "To reduce feelings of isolation" and "To have a place to experience your emotions." The alpha reliability coefficient for the Experiential Processing subscale was $\alpha = .85$.

When internal consistency of the total and subscales of the PHCFT were examined in the current sample for each group, results indicated similar results. The total scale reliability was $\alpha = .96$ for Latino/as and $\alpha = .95$ for Whites. Additionally, reliabilities only differed slightly between groups for each subscale: Therapeutic Work ($\alpha = .95$ for Latino/as, $\alpha = .94$ for Whites), Alliance ($\alpha = .93$ for Latino/as, $\alpha = .88$ for Whites), Use of Therapy ($\alpha = .78$ for Latino/as, $\alpha = .78$ for Whites), Experiential Processing ($\alpha = .88$ for Latino/as, $\alpha = .81$ for Whites). The items on the PHCFT are in Likert format; participants are asked to indicate how helpful they perceive each common factor to be if they were to seek professional mental health services. Polar anchors range from 1 (*not helpful*) to 5 (*very helpful*).

Inventory of Attitudes Toward Seeking Help Scale (IASMHS): Participants willingness to seek help was measured by the IASMHS (Mackenzie, Knox, Gekoski & Macaulay, 2004). This 24-item Likert scale is an adaptation of the Attitudes Toward Seeking Professional Psychological Help Scale developed by Fisher and Turner (1970). Factor analysis revealed three consistent factors: Psychological Openness, Help-Seeking Propensity, and Indifference to Stigma (Mackenzie, Knox, Gekoski & Macaulay, 2004). The Psychological Openness scale indicates the extent to which an individual is open to their psychological problems and possibility of seeking help; the Help-Seeking Propensity scale taps an individual's willingness to seek professional help; and the Indifference to Stigma scale represents a participant's concern with other's reactions if they were to seek professional mental health services (Mackenzie et al., 2004). Items for each of the subscales include: "There are experiences in my life I would not share with anyone" (reverse coded), "It would be relatively easy for me to find the time to see a professional for psychological

problems,” and “Had I received treatment for psychological problems, I would not feel that it ought to be ‘covered up.’”

The full scale has been demonstrated to have a strong internal reliability of $\alpha = .87$ and each of the subscales reliability ranges from $\alpha = .76$ to $.82$. Test-retest coefficients (over periods ranging from five days to two months) have been reported ranging from $r = .64$ (Help-Seeking Propensity) to $.91$ (Indifference to Stigma) with the full scale having a test-retest reliability of $r = .85$ (Mackenzie et al., 2004). Concerning construct validity, the IASMHS has also been correlated with intentions to seek counseling ($r = .33, p < .01$) and past use of psychological services ($r = .21, p < .01$) in a community sample (Mackenzie et al., 2004). The sample in the current study demonstrated strong internal reliability for the IASMHS with a total scale reliability of $\alpha = .87$ and subscale reliabilities of $\alpha = .79$ (Psychological Openness), $\alpha = .80$ (Help-Seeking Propensity) and $\alpha = .76$ (Indifference to Stigma).

To date, reliability analyses on the IASMHS have not been conducted on a Latino/a population, so I examined alpha coefficients separately by racial group. When reliabilities were examined for European Americans and Latino/as, total internal consistency was $\alpha = .85$ for Latino/as and $\alpha = .89$ for Whites. Subscales also slightly differed between groups for each subscale: Psychological Openness ($\alpha = .72$ for Latino/as, $\alpha = .83$ for Whites), Help-Seeking Propensity ($\alpha = .78$ for Latino/as, $\alpha = .81$ for Whites) and Indifference for Stigma ($\alpha = .75$ for Latino/as, $\alpha = .76$ for Whites). Although slightly lower internal consistency reliability alphas were shown for Latino/as than Whites, the reliabilities reported in this study are sufficient for research-based use of the IASMHS with Latino populations. Eight items were reverse coded

as indicated by the authors of the scale (Mackenzie et al., 2004) so that higher scores reflect more positive attitudes toward seeking professional mental health services.

RESULTS

The main goal of my study was to examine Latino/a and White participants' perceptions of the helpfulness of the common factors in therapy and to determine if these perceptions influence their willingness to seek professional mental health services. Before answering these questions, I will describe my Latino/a sample in greater detail and provide descriptive data on the mental health utilization questions as well as descriptive data exploring relations among the primary variables of interest in my study.

Preliminary Analyses

Data Cleaning

To prepare the data for analyses, I undertook a three step process. First, twenty-six participants (10.7%) were removed from the data set for not completing a sufficient number of questions on key instruments (missing more than 10%). Second, missing values on the PHCFT and IASMHS scales were replaced by the mean value of that item for all participants. This procedure has been recommended as a more stringent method to replace missing data due to the fact greater constraints will be placed on the item's potential variance (Tabachnick & Fidell, 1996). No identifiable pattern was noted for missing values on the PHCFT and IAMHS scales. Third, four outliers on the PHCFT and two outliers on the IASMHS were detected by examining the box plots for each scale. However, the 5% trimmed mean for each scale was within .10 point of the observed mean; indicating the outliers has very little effect on the mean. Because of this, these outliers were left in the data set.

Latino/a Participant Demographics

With respect to generational status, the majority of Latino/a participants indicated they were second generation (45.2%), followed by first (18.3%), fifth (17.2%), third (10.8%), and fourth generation (4.3%). An additional 4.3% of Latino/a participants indicated they were international students. Of the total 13 international student participants the majority are studying abroad from Puerto Rico (10). An additional two participants' country of origin was Mexico and one participant's country of origin was a Central or South American country.

The average age of participants when they immigrated to the United States was 11.28 years, with a range of reported ages from 1 to 30. Of the Latino/a participants born in the United States (second generation and after), the majority indicated they were of Mexican ancestry (61.0%), followed by Central or South American ancestry (7.8%), Puerto Rican ancestry (6.5%), and one participant (1.2%) reporting Cuban ancestry.

Latino/a participants' mean rating of acculturation was 4.73 (with a standard deviation, SD, of 1.66) on a 1-7 Likert point scale indicating a moderate identification and/or commitment with Latino/a culture. The most frequent response was a 4, or "moderate" identification anchor, (24.8%) followed by 7, or "very high" identification anchor (20.8%). Latino/a participants' mean rating of enculturation was 4.46 (SD = 1.71) on a 1-7 Likert point scale, again indicating a moderate identification and/or commitment to majority (White) culture. The most frequent response was a 6, or "high" identification anchor (28.7%) followed by 4, or "moderate" identification anchor (18.8%).

Mental Health Utilization Participant Demographics and Descriptive Analyses

Of the total 211 participants, 24 participants report being in therapy at the time of data collection, 12 of which indicate this experience as being “very helpful.” An additional eight participants find their experience to be “somewhat helpful”, three report neutral feelings about their experience, and one participant finds their experience to be unhelpful. Eight-two (38.9%) of participants report having sought therapy in the past. Participants who have previously sought services appear to have had overall positive experiences with therapy, with the most frequent response (39.0%) being “somewhat helpful”, followed by “very helpful” (32.9%), a “neutral” experience (14.6%), “not helpful” (8.5%), or “somewhat unhelpful” (4.9%). Participants who had sought therapy in the past at time of data collection were asked if they would seek professional mental health services in the future if they felt the need. The majority of participants reported “yes” they would seek help in the future (81.9%) with a minority of participants reporting “no” (18.1%).

Participants who had not sought therapy in the past and were not currently in therapy at time of data collection were asked how aware they feel they are of what occurs in therapy. The most frequent response was “somewhat aware” (52.5%) followed by “somewhat unaware” (20.0%), “very aware” (12.5%), “undecided” (9.2%), and “very unaware (5.5%).” These participants were also asked to answer a Likert-point question indicating how likely they would be to seek professional mental health services in the future if they felt the need. A range of responses were reported, approximately a quarter of participants reported they would be “somewhat likely” (25.4%) to seek services, followed by “undecided” (24.6%), “very unlikely” (23.8%), “somewhat unlikely” (23.0%), and “very likely” (3.3%).

All participants were asked to indicate how convenient the hours of service of college counseling centers (including the ISU counseling center) are for participants to be able to seek services. They were also asked if the availability of a Spanish-speaking therapist would influence their willingness to seek services. A range of responses were reported for the hours of convenience question. The most frequent response was “somewhat convenient” (35.5%), followed by “somewhat inconvenient” (24.2%), “neutral” (18.5%), “very convenient” (12.8%), and “very inconvenient” (9.0%). Only one participant (0.5%) indicated s/he would only be likely to seek services if a Spanish-speaking therapist were available, 10.4% indicated they would be more likely to seek services whereas the majority of participants (73.9%) indicated that having a Spanish-speaking therapist would not influence their decision to seek therapy. An additional 15.2% of participants also indicated they would not be influenced, but would be more likely to seek services if their therapist only spoke English.

The breakdown of mental health utilization questions by racial group can be found in Tables 3 and Table 4. In order to detect any differences between the groups on these items, chi-square analyses for dichotomous variables and univariate analyses of variance for continuous variables were conducted to determine significant differences. A Bonferroni adjustment with an adjusted alpha of .006 (.05/8) was used to account for effects due to chance. Results indicated there were two significant differences between groups; significantly more White participants were currently in therapy at the time of data collection than Latino/a participants $\chi^2(df=1) = 7.93, p = .005$. Additionally, significantly more Latino/a participants indicated they would seek therapy if they have a Spanish-speaking therapist $F(N=211) = 8.39, p = .004, \eta^2 = .04$. According to the general rule of thumb

(partial eta-squared effects are small .01, medium .06, large .16), this statistically significant finding has a small to medium effect size.

Descriptive Data

Means, standard deviations, medians, and ranges for the total and subscale scores of the IASMHS for each group can be found in Table 5. Independent sample univariate tests, with a Bonferroni adjustment of .0125 (.05/4), found no significant differences between Latino/as and Whites on the total or subscale scores of the IASMHS. The difference in means between groups was less than three points for the total and subscale scores, suggesting little difference in attitudes toward seeking help between these two racial groups.

Table 3

Descriptive Data of Dichotomous Mental Health Utilization Items by Racial Group

Variable	<i>n</i>	<i>Yes</i>	<i>No</i>	χ^2	<i>df</i>	<i>p</i>
Current Therapy						
Latino/a	101	5	96	7.93**	1	.005
White	110	19	91			
Past Therapy						
Latino/a	101	38	63	.13	1	.72
White	110	44	66			
Future Help						
Latino/a	39	30	9	1.24	1	.26
White	44	38	4			

Note: * $p < .05$ ** $p < .006$ Future Help = if in past or current therapy would you seek help in the future.

Table 4

Descriptive Data of Mental Health Utilization Items by Racial Group

Variable	n	# Selecting Each Rating					F-value	p	η^2
		5	4	3	2	1			
Helpfulness of Experience									
Latino/a	38	11	17	5	1	4	.72	.405	.03
White	44	16	15	7	3	3			
Awareness									
Latino/a	58	9	32	5	7	5	1.09	.298	.01
White	62	6	31	6	17	2			
Likelihood to Seek Help									
Latino/a	58	2	18	13	10	15	.43	.512	.01
White	64	2	13	17	18	14			
Convenience of Services									
Latino/a	101	14	44	17	19	7	5.31*	.022	.03
White	110	13	31	22	32	12			
Spanish Speaking Therapist									
Latino/a	101	--	1	20	65	15	8.39**	.004	.04
White	110	--	0	2	91	17			

Note: * $p < .05$ ** $p < .006$ Helpfulness of Experience = if in past or current therapy, how helpful was this experience; 5 = very helpful, 4 = somewhat helpful, 3 = neutral, 2 = not helpful, 1 = somewhat unhelpful. Awareness = how aware participants are who have not had any therapy experience; 5 = very aware, 4 = somewhat aware, 3 = neutral, 2 = somewhat unaware, 1 = very unaware. Likelihood to Seek Help = how likely participants are to seek help who have not had any therapy experience; 5 = very aware, 4 = somewhat aware, 3 = undecided, 2 = somewhat unaware, 1 = very unaware. Convenience of Services = how convenient hours of services at college counseling centers are; 5 = very convenient, 4 = somewhat convenient, 3 = neutral, 2 = somewhat inconvenient, 1 = very inconvenient. Spanish Speaking Therapist = would having a Spanish speaking therapist influence your decision to seek counseling services; 4 = yes, only seek services with a Spanish-speaking therapist, 3 = Yes, more likely to seek services, 2 = no, would not influence decision, 1 = no, more likely to seek services if therapist only spoke English.

The combined overall total scale mean was 82.86 (SD = 15.13) with subscale means of 27.10 (SD = 6.5; Psychological Openness), 27.96 (SD = 5.98; Help-seeking Propensity), and 27.79 (SD = 6.07; Indifference to Stigma). The means reported in this study are higher

than the means reported in the original community sample by (Mackenzie et al., 2004); the total scale mean in the sample was 69.19 with subscale means ranging from 21.79 to 23.98 (Mackenzie et al., 2004). Higher means in the present study may indicate more positive attitudes toward seeking professional psychological help for a university sample than for a community sample. Descriptive data for the IASMHS, PHCFT and other continuous variables of interest can be found in Table 5.

Correlations among measures: Bivariate correlation analyses by racial group were conducted. Results for Latino/a participants are in Table 6 and results for White participants in Table 7. A Bonferroni adjustment was utilized with an adjusted alpha of .006 (.05/9) to account for correlations due to chance from the 9 variables examined with Latino/a participants. The total and subscale scores of the PHCFT correlated moderately to highly with each other, correlations ranged from $r = .48, p < .001$ to $r = .98, p < .001$. The total and subscale scores of the IASMHS correlated moderately to highly as well; statistically significant correlations ranged from $r = .54, p < .001$ to $r = .88, p < .001$. The Help-Seeking Propensity subscale did not correlate with the Indifference to Stigma subscale at the adjusted significance level. Additionally, the total scale as well as the Therapeutic Work subscale and Alliance subscale of the PHCFT correlated moderately with the Help-Seeking Propensity subscale of the IASMHS; correlations ranged from $r = .37, p < .001$ to $r = .39, p < .001$.

Correlations among study measures and subscales for White participants followed a similar pattern. The total and subscale scores of the PHCFT and IASMHS each correlated moderately to highly with each other. Correlations for the PHCFT ranged from $r = .53, p < .001$ to $r = .96, p < .001$ and correlations for the IASMHS ranged from $r = .46, p < .001$ to $r = .87, p < .001$.

Table 5

Descriptive Data of Continuous Study Variables by Racial Group

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	<i>Median</i>	<i>Range</i>
Acculturation					
Latino/a	101	4.73	1.66	5.00	1-7
White	110	4.32	1.71	5.00	1-7
Enculturation					
Latino/a	101	4.46	1.71	5.00	1-7
White	110	3.13	1.48	3.00	1-7
Perceptions of Helpfulness Total (PHCFT)					
Latino/a	101	69.79	16.05	73.00	27-135
White	110	68.90	14.84	70.00	21-100
Therapeutic Work (PHCFT)					
Latino/a	101	40.63	9.37	43.00	11-55
White	110	40.00	8.79	41.00	11-55
Alliance (PHCFT)					
Latino/a	101	10.72	3.10	12.00	3-15
White	110	10.36	2.84	10.66	3-15
Use of Therapy (PHCFT)					
Latino/a	101	8.38	2.75	8.00	3-15
White	110	8.00	2.81	8.00	3-15
Experiential Processing					
Latino/a	101	10.06	2.84	10.00	3-15
White	110	10.53	2.83	11.00	3-15
Willingness to Seek Help Total (IASMHS)					
Latino/a	101	81.41	14.32	81.00	37-113
White	110	84.18	15.79	83.87	37-114
Psychological Openness (IASMHS)					
Latino/a	101	26.28	6.02	26.00	11-39
White	110	27.86	6.87	28.00	9-40
Help-Seeking Propensity (IASMHS)					
Latino/a	101	27.78	5.77	27.00	10-39
White	110	28.13	6.17	28.00	12-40
Indifference to Stigma (IASMHS)					
Latino/a	101	27.36	6.13	27.00	14-40
White	110	28.20	6.02	29.00	14-40

Note: PHCFT = Perceived Helpfulness of Common Factors in Therapy, IASMHS = Inventory of Attitudes to Seek Mental Health Services.

Again, the Help-Seeking Propensity subscale of the IASMHS was correlated with the Therapeutic Work and Alliance subscales as well as the total score of the PHCFT (correlations ranged from $r = .30, p < .001$ to $r = .39, p < .001$. Unlike for Latino/a participants, the Experiential Processing subscale also correlated with the Help-Seeking Propensity subscale ($r = .34, p < .001$). Additionally, after the Bonferroni adjustment the Alliance subscale of the PHCFT correlated with the Psychological Openness subscale of the IASMHS ($r = .32, p < .001$) and the total score ($r = .37, p < .001$). Lastly, White participants data also demonstrated a correlation between the total PHCFT and total IASMHS ($r = .26, p < .001$).

Main Analyses

Question 2: How Helpful do Latino/as perceive the common factors in therapy to be?

No previous research has examined how Latino/as perceive the helpfulness of the common elements of therapy. The second question I addressed in this study was to determine if Latino/as perceive those therapeutic events and characteristics that occur in almost every Western therapy setting to be potentially helpful if they were to seek therapy. As the anchors of the Likert scale are qualitatively successive and offer a threshold of helpfulness endorsement (3 = somewhat helpful), any item or subscale mean score at or above this anchor for the Latino/a sample is viewed as being "helpful" to this population. Table 8 contains the means, standard deviations, and percentage of participants selecting each response for the total sample and Latino/as and White participants separately.

Table 6

Correlations among Study Measures and Mental Health Questions for Latino/as

Variable	1	2	3	4	5	6	7	8	9
1. PHCFT	--								
2. PHCFT – TW	.98***	--							
3. PHCFT – A	.84***	.77***	--						
4. PHCFT – UT	.70***	.58***	.52***	--					
5. PHCFT – EP	.85***	.81***	.60***	.48***	--				
6. IASMHS	.12	.17	.20*	-.12	.02	--			
7. IASMHS – PO	.11	.14	.19	-.11	.04	.88***	--		
8. IASMHS – HSP	.37***	.39***	.38***	.18	.23*	.74***	.54***	--	
9. IASMHS – IS	-.18	-.12	-.07	-.33***	-.22*	.77***	.56***	.27**	--

Note: * $p < .05$ ** $p < .01$ *** $p < .006$ PHCFT = Perceived Helpfulness of Common Factors in Therapy. IASMHS = Inventory of Attitudes Toward Seeking Mental Health Services. TW = Therapeutic Work subscale. A = Alliance subscale. UT = Use of Therapy subscale. EP = Experiential Processing Subscale. PO = Psychological openness subscale. HSP = Help seeking propensity subscale. IS = Indifference to stigma subscale.

Table 7

Correlations among Study Measures and Mental Health Questions for Whites

Variable	1	2	3	4	5	6	7	8	9
1. PHCFT	--								
2. PHCFT – TW	.96***	--							
3. PHCFT – A	.82***	.70***	--						
4. PHCFT – UT	.68***	.55***	.53***	--					
5. PHCFT – EP	.77***	.68***	.59***	.32***	--				
6. IASMHS	.26***	.25**	.37***	.01	.23*	--			
7. IASMHS – PO	.25**	.25**	.32***	-.02	.22*	.87***	--		
8. IASMHS – HSP	.33***	.30***	.39***	.06	.34***	.83***	.60***	--	
9. IASMHS - IS	.07	.05	.21*	-.003	.004	.78***	.51***	.46***	--

Note: * $p < .05$ ** $p < .01$ *** $p < .006$ PHCFT = Perceived Helpfulness of Common Factors in Therapy. IASMHS = Inventory of Attitudes Toward Seeking Mental Health Services. TW = Therapeutic Work subscale. A = Alliance subscale. UT = Use of Therapy subscale. EP = Experiential Processing Subscale. PO = Psychological openness subscale. HSP = Help seeking propensity subscale. IS = Indifference to stigma subscale.

Overall, the range of mean responses on the 5 point Likert-scale ranged from 2.56-3.90 signifying items on the scale were generally found to be somewhat helpful. The highest rated item on the PHCFT was a Therapeutic Work item, “To be able to work through some of your personal difficulties.” Other top items included “To be able to receive feedback from the therapist” and “To gain insight into your problematic experiences.” Lowest rated items (although still rated as slightly helpful) included “To see the therapist as a person to model yourself after” and “To have the therapy sessions follow a structured format.” The three lowest rated items were the items composing the Use of Therapy subscale indicating that participants are less concerned about the structure and modeling behaviors associated with therapy than other common factors.

For Latino/as, the mean endorsement of the common factor items, for the majority of items (17 of 20), was 3 or above suggesting this group perceived the common factors to be at least somewhat helpful. However, the three item means not rated three or above were still rated as “slightly helpful;” item means for the lowest rated items ranged from 2.64-2.98. Subscale means were divided by the number of items in each scale to provide a mean rating congruent with the Likert scale presented to participants. The total scale mean was computed by adding the four subscale means and dividing by the number of items for the scale to provide a mean score harmonious with the helpfulness anchors of the scale. Results of these calculations can be found in Table 9.

Examination of the means for the total and subscale scores indicates that Latino/as do perceive the total scale representing all common factors in therapy as well as the Therapeutic Work, Alliance, and Experiential Processing subscales to be at least somewhat helpful if they were to seek therapy. The Therapeutic Work subscale was endorsed to the highest degree of

helpfulness ($M = 3.69$, $SD = 0.85$) followed by the Alliance ($M = 3.57$, $SD = 1.03$), Experiential Processing ($M = 3.35$, $SD = 0.95$) and Use of Therapy ($M = 2.79$, $SD = 0.92$) subscales.

Table 8

Descriptive Statistics for Perceived Helpfulness of Common Factors in Therapy³

Item	<i>M</i> (<i>SD</i>)	% Selecting Each Rating				
		1	2	3	4	5
12. To be able to work through some of your personal difficulties (TW)	3.90 (.96)	1.9	7.6	17.5	45.0	28.0
Latino/a	3.88 (1.02)	2.0	9.9	16.8	40.6	30.7
White	3.91 (0.90)	1.9	5.5	18.2	49.1	25.5
17. To be able to receive feedback from the therapist (TW)	3.82 (0.97)	1.4	9.0	21.8	41.1	26.1
Latino/a	3.84 (1.00)	1.0	9.9	22.8	36.6	29.7
White	3.80 (0.95)	1.8	8.2	20.9	46.4	22.7
19. To gain insight into your problematic experiences (TW)	3.75 (1.02)	2.4	10.4	21.3	38.9	25.1
Latino/a	3.71 (1.09)	2.0	15.8	17.8	35.6	26.7
White	3.80 (0.96)	2.7	5.5	24.5	41.9	23.6

³ Note: $N = 211$. Items ranked from not at all helpful to extremely helpful. Item numbers refer to the order they were presented to participants. 1 = *not at all helpful*, 2 = *slightly helpful*, 3 = *somewhat helpful*, 4 = *very helpful*, 5 = *extremely helpful*. TW = Therapeutic Work item, A = Alliance item, UT = Use of Therapy item, EP = Experiential Processing Item. Selected responses may not sum to 100% in cases where missing data was replaced by the mean of the item for the total sample.

Descriptive Statistics for Perceived Helpfulness of Common Factors in Therapy (continued)

16. To develop an understanding or rationale of your problematic experiences (TW)	3.69 (1.03)	2.4	12.3	22.3	39.3	23.2
Latino/a	3.67 (1.07)	2.0	15.8	18.8	39.6	23.8
White	3.71 (1.01)	2.7	9.1	25.5	39.1	22.7
11. To learn new things about yourself (TW)	3.66 (1.06)	2.8	12.8	23.2	37.0	23.7
Latino/a	3.69 (1.05)	2.0	13.9	20.8	38.6	23.8
White	3.63 (1.08)	3.6	11.8	25.5	35.5	23.6
15. To be able to receive advice from the therapist (TW)	3.66 (1.05)	3.3	12.3	20.9	42.2	21.3
Latino/a	3.75 (0.97)	1.0	11.9	20.8	43.6	22.8
White	3.57 (1.11)	5.5	12.7	20.9	40.9	20.0
6. Having a trusting relationship with the therapist (A)	3.66 (1.10)	3.8	12.3	23.2	35.5	25.1
Latino/a	3.66 (1.15)	4.0	13.9	22.8	30.7	28.7
White	3.71 (1.05)	3.5	10.9	23.6	40.0	21.8
5. To increase the feeling that you can master aspects of your life (TW)	3.62 (1.00)	2.8	11.4	25.6	41.7	18.5
Latino/a	3.63 (0.92)	1.0	12.9	22.8	48.5	14.9
White	3.60 (1.08)	4.5	10.0	28.2	35.5	21.8

Descriptive Statistics for Perceived Helpfulness of Common Factors in Therapy (continued)

13. To increase your expectations of your personal effectiveness (TW)	3.57 (0.99)	3.3	10.4	28.0	41.5	16.1
Latino/a	3.63 (0.97)	1.0	12.9	26.6	40.6	18.8
White	3.51 (1.01)	5.5	8.2	29.1	42.7	13.6
4. To be able to have a positive relationship with the therapist (A)	3.56 (1.09)	3.3	14.2	28.0	31.8	22.7
Latino/a	3.58 (1.10)	3.0	14.9	26.7	31.7	23.8
White	3.55 (1.09)	3.6	13.6	29.1	31.8	21.8
8. To understand your problematic experiences and how they relate to each other (TW)	3.56 (1.01)	4.7	18.0	29.9	35.5	11.4
Latino/a	3.60 (1.05)	4.0	10.9	25.7	39.6	19.8
White	3.53 (0.98)	3.6	13.6	29.1	31.8	21.8
10. To develop the ability to control your unwanted thoughts (TW)	3.55 (1.12)	4.3	16.1	20.9	37.9	20.9
Latino/a	3.58 (1.13)	5.0	15.8	15.8	42.6	20.8
White	3.52 (1.11)	3.6	16.4	25.5	33.6	20.9
1. To have a release of pent-up emotions (EP)	3.53 (1.07)	4.3	13.7	24.2	40.3	17.5
Latino/a	3.46 (1.04)	4.0	14.9	27.7	38.6	14.9
White	3.60 (1.09)	4.5	12.7	20.9	41.8	20.0

Descriptive Statistics for Perceived Helpfulness of Common Factors in Therapy (continued)

18. Having the therapist provide encouragement to face your fears (TW)	3.52 (1.08)	2.4	8.5	22.7	39.3	27.0
Latino/a	3.62 (1.06)	2.0	15.8	21.8	38.6	21.8
White	3.43 (1.10)	7.3	9.1	33.6	33.6	16.4
3. To decrease some of your problematic behaviors (EP)	3.43 (1.07)	4.3	17.1	25.1	38.9	14.7
Latino/a	3.32 (1.10)	5.9	19.8	22.8	39.6	11.9
White	3.53 (1.03)	2.7	14.5	27.3	28.2	17.3
2. To have a place to experience your emotions (EP)	3.35 (1.11)	8.1	12.3	30.3	35.5	13.7
Latino/a	3.29 (1.00)	5.0	15.8	33.7	36.6	8.9
White	3.40 (1.21)	10.9	9.1	27.3	34.5	18.2
9. To experience a strong working relationship with the therapist (A)	3.31 (1.04)	4.7	18.0	29.9	35.5	11.4
Latino/a	3.48 (1.06)	4.0	15.8	24.8	39.6	15.8
White	3.16 (1.01)	5.5	20.0	34.5	31.8	7.3
14. To model your relationship with the therapist to other relationships in your life (U)	2.83 (1.09)	11.4	28.9	30.3	23.2	5.7
Latino/a	2.98 (1.07)	7.9	25.7	33.7	23.8	7.9
White	2.69 (1.09)	14.5	31.8	27.3	22.7	3.6

Descriptive Statistics for Perceived Helpfulness of Common Factors in Therapy (continued)

7. To have the therapy sessions follow a structured format (U)	2.80 (1.08)	11.4	30.3	31.3	20.4	6.2
Latino/a	2.76 (1.02)	9.9	32.7	31.7	20.8	4.0
White	2.83 (1.14)	12.7	28.2	30.9	20.0	8.2
20. To see the therapist as a person to model yourself after (U)	2.56 (1.17)	21.8	28.4	27.0	16.1	6.2
Latino/a	2.64 (1.21)	21.8	24.8	27.7	18.8	6.9
White	2.49 (1.14)	21.8	31.8	26.4	13.6	5.5

Table 9

Mean Ratings of Helpfulness of the Common Factors in Therapy

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	<i>Median</i>
PHCFT – Total				
Latino/a	101	3.49	0.80	3.65
White	110	3.44	0.74	3.50
Therapeutic Work				
Latino/a	101	3.69	0.85	3.91
White	110	3.64	0.80	3.73
Alliance				
Latino/a	101	3.57	1.03	4.00
White	110	3.45	0.95	3.55
Use of Therapy				
Latino/a	101	2.79	0.92	2.67
White	110	2.67	0.94	2.67
Experiential Processing				
Latino/a	101	3.35	0.95	3.33
White	110	3.51	0.94	3.67

Note: PHCFT = Perceived Helpfulness of Common Factors in Therapy. Subscale means were divided by the number of items in each scale to provide a rating congruent with the 5-point Likert scale presented to participants. Any subscale mean score at or above 3 is viewed as being "helpful"

For comparison, the mean values of the total and subscale scores of the PHCFT for White participants can also be found in Table 9. As can be seen, little difference was noted between the mean values of each scale for Latino/a and White participants. Univariate analyses of variance were conducted with a Bonferroni adjustment of $\alpha = .01$ (.05/5) to determine if there were any statistically significant differences between groups. No significant differences were found for the total ($F[N=211] = .14, p = .71$) or subscale mean scores (f -tests ranged from $F[N=211] = .16, p = .69$ to $F[N=211] = 1.31, p = .25$). However, the ranking of subscale means was different from Latino/a participants; the highest mean for White participants was for the Therapeutic Work subscale followed by the Experiential Processing, Alliance, and Use of Therapy subscales. The Use of Therapy subscale did not meet the criteria for helpfulness for either group indicating these common factors are not perceived as particularly helpful aspects of therapy. In sum, Latino/as perceive the Therapeutic Work, Alliance, and Experiential Processing common factors to be at least somewhat helpful if they were to seek professional mental health services.

Question 3: Do Latino/as' overall and subscale ratings of perceived helpfulness of common factor categories (i.e., support, learning, action or a new factor structure) differ from those of European Americans when submitted to a multiple group factor analysis? A multiple group confirmatory factor analysis using LISREL 8.8 was conducted to determine if the factor structure for the PHCFT found in the pilot study was a robust fit for both Latino/as and White participants. First, a CFA was conducted in which the four-factor structure was specified for both groups but with no constraints on the parameters. The non-constrained four-factor model resulted in the following fit: $\chi^2(328, N = 211) = 1688.44, p < .001, CFI = .99, RMSEA = .06, SRMR = .09$. This model was then used as a baseline.

A second CFA was run in which all item paths were constrained to the factor they were found to load highly on in the pilot study for the four-factor model; $\chi^2(348, N = 211) = 1915.52$ $p < .001$, CFI = .98, RMSEA = .09, SRMR = .26.

To examine if the more- and less-constrained models were significantly different for the groups, a Satorra-Bentler scaled chi-square test was conducted. Results showed that the models were significantly different (Satorra-Bentler Scaled Difference = -39.21, $df = 20$, $p < .001^4$), indicating the factor structure is not invariant between Latino/as and Whites. Areas of poor fit were examined and constraints were freed until a model was found that fit appropriately. To accomplish this, modification indices were examined for any item that exceeded the critical value of 3.84 (a chi-square statistic with one degree of freedom) and was freed. This procedure was repeated until all items displayed a modification index of less than 3.84. In sum, constraints on 14 of the 20 items were freed.

Factor loadings for both groups can be found in Table 10. Items with asterisks represent items that were variant between groups. Ten of the 11 items in the Therapeutic Work subscale were freed indicating the groups factor paths were significantly different for Latino/as and Whites on this subscale. Factor loadings were greater for Latino/as than Whites on nine of the ten variant items in this subscale. Additionally, one Alliance item, one Use of Therapy item, and two Experiential Processing items were also found to have variant paths. Latino/as displayed greater factor loadings on two of these four additional variant items.

⁴ A negative scaled difference statistic is found when both models have a poor fit to the data, the Satorra-Bentler test cannot conduct the test for significance when this is the case. Significance was computed using a Chi-Square difference calculator after the analysis.

Table 10

Fit for Multiple Group and Single Group Confirmatory Factor Analyses

Item	Factor Loading	
	Latino/a	White
Therapeutic Work		
1. To increase feelings you can master aspects of your life.*	.79	.54
2. To understand your problematic experiences and how they relate to each other*	.90	.99
3. To develop the ability to control your unwanted thoughts	.71	.75
4. To learn new things about yourself*	.81	.67
5. To be able to work through some of your personal difficulties*	.92	.81
6. To increase your expectations of your personal effectiveness*	.87	.48
7. To be able to receive advice from the therapist*	.80	.62
8. To develop an understanding or rationale of your problematic experiences*	.90	.72
9. To be able to receive feedback from the therapist*	.89	.76
10. Having the therapist provide encouragement to face your fears*	.82	.47
11. To gain insight into your problematic experiences*	.93	.58
Alliance		
1. To be able to have a positive relationship with the therapist*	.90	.84
2. Having a trusting relationship with the therapist	.97	.91
3. To experience a strong working relationship with the therapist	.92	.90
Use of Therapy		
1. To have the therapy sessions follow a structured format	.68	.62
2. To model your relationship with the therapist to other relationships in your life	.84	.89
3. To see the therapist as a person to model yourself after*	.83	.95
Experiential Processing		
1. To have a release of pent-up emotions	.91	.87
2. To have a place to experience your emotions*	.88	.54
3. To decrease some of your problematic behaviors*	.87	.92

Note: Asterisks indicate items which were variant between groups.

Because over half of the items were variant for Latino/as and Whites, it was deemed appropriate to examine if the original four-factor model found in the pilot study was an adequate fit for either Latino/as and Whites. A CFA for the four-factor model for Latino/as demonstrated a robust fit to the data; $\chi^2(164, N = 101) = 987.67$ $p < .001$, CFI = .99, RMSEA = .06, SRMR = .06. However, the CFA for Whites for the four-factor model did not demonstrate an adequate fit; $\chi^2(164, N = 110) = 700.78$ $p < .001$, CFI = .99, RMSEA = .07, SRMR = .09. These results indicate that the four-factor model found in the pilot study also is appropriate for Latino/as in the main study but does not fit adequately for Whites in the main study.

To examine the potential factor structure of the PHCFT for Whites in the main study an EFA was conducted using a parallel analysis. As in the pilot study, the parallel analysis indicates factor extractions based on 1,000 random data sets. By comparing the scree plot and eigenvalues of the parallel analysis and actual data, factors in the data with eigenvalues greater than eigenvalues in the parallel analysis should be extracted (Brown 2006). This analysis indicated one factor should be extracted. However, to account for a factor potentially falling on the parallel analysis line, one-, two-, three-, and four-factor solutions were explored using both Varimax and Promax rotations. Additional models also allowed for further comparisons. The most interpretable model was found using a three-factor solution with the Promax rotation. Four considerations were taken into account to make this decision. First, items must have had a factor loading of .40 or greater and cross-loadings on other factors of less than .25 based on the factor pattern matrix. This procedure eliminated solutions with a Varimax rotation and the one- and two-factor solution with Promax rotation (as the majority of items loaded highly on one or more factors).

Second, qualitative considerations of item content in each factor and the desire to have factors with no less than three items were weighed. This eliminated the four factor solution with Promax rotation as two of the factors contained only two items after removing high cross-loading items. Third, reliability analyses were conducted for the new three-factor scales. The reliability analysis conducted for three-factor solution with a Promax rotation indicated the scales were adequately reliable (lowest reliability of a subscale was $\alpha = .78$). Fourth, correlations between the factors were examined. Correlations among factors ranged $r = .36$ to $r = .63$, $p < .001$ for the three-factor solution, indicating scales are related but not redundant.

The new three-factor solution for Whites contains eight items for the first factor and three items for both the second and third factor. Six items were removed for loading highly on one or more factors. Items in the first factor were all Therapeutic Work subscale items from the original first factor in the pilot study. The second factor contained two items from Experiential Processing subscale and one item from the Alliance subscale. Last, items in the third factor were all Use of Therapy items. Of note, the majority of items in the original Alliance subscale loaded highly on two or more factors and were therefore removed; however, the Therapeutic Work subscale remained close to intact and Use of Therapy subscale remained untouched. It appears that a major cause for the inadequate fit of the original model for Whites was the item overlap on the six items removed from the scale. Comparisons of the original factor structure and the new factor structure for Whites can be found in Table 11. A closer examination of this new factor structure for Whites is beyond the scope of this study. Additionally, an additional sample of White participants would need to be taken to conduct a CFA to verify this new factor structure or to determine if the original

factor structure would be a better fit for a new White sample. This is also beyond the scope of this study, but will be discussed as recommendations for future research in the discussion section.

Table 11.

Comparison of item categorization for four-factor model and new proposed factor structure of the PHCFT for Whites⁵

Original	New
Therapeutic Work	Factor 1
1. To be able to work through some of your personal difficulties	1. To understand your problematic experiences and how they relate to each other
2. To develop an understanding or rationale of your problematic experiences	2. To develop the ability to control your unwanted thoughts
3. To gain insight into your problematic experiences	3. To be able to work through some of your personal difficulties
4. To be able to receive feedback from the therapist	4. To increase your expectations of your personal effectiveness
5. To increase your expectations of your personal effectiveness	5. To develop an understanding or rationale of your problematic experiences
6. To understand your problematic experiences and how they relate to each other	6. To be able to receive feedback from the therapist
7. Having the therapist provide encouragement to face your fears	7. Having the therapist provide encouragement to face your fears
8. To be able to receive advice from the therapist	8. To gain insight into your problematic experiences

⁵ *Note:* Terms in bold represent the subscale names. Six items were deleted from the original scale for loading highly (over .25) on two or more factors based on the 3-factor PAF solution.

Comparison of item categorization for four-factor model and new proposed factor structure of the PHCFT for Whites (continued)

9. To learn new things about yourself

Factor 2

10. To increase the feeling that you can master aspects of your life

1. To have a release of pent-up emotions

11. To develop the ability to control your unwanted thoughts

2. To have a place to experience your emotions

3. To be able to have a positive relationship with the therapist

Alliance

1. Having a trusting relationship with the therapist

Factor 3

2. To be able to have a positive relationship with the therapist

1. To model your relationship with the therapist to other relationships in your life

3. To experience a strong working relationship with the therapist

2. To see the therapist as a person to model yourself after

Use of Therapy

3. To have the session follow a structured format

1. To model your relationship with the therapist to other relationships in your life

2. To see the therapist as a person to model yourself after

3. To have the session follow a structured format

Experiential Processing

1. To have a place to experience your emotions

2. To have a release of pent-up emotions

3. To decrease some of your problematic behaviors

Question 4: To what extent do Latino/as' perceptions of the helpfulness of the common factors in therapy account for variance in willingness to seek help above and beyond variance accounted for by relevant demographic variables? Before determining if Latino/as' perceptions of helpfulness predict willingness to seek help, the data from Latino/a participants was tested for normality and bivariate correlations were conducted to determine what demographic variables and/or cultural factors were deemed relevant to control for in the regression analyses. Hierarchical regression analyses were conducted for Latino/as as well as Whites for comparison.

Tests of Normality: To determine if the data met the assumptions of normality needed to conduct regression analyses, the residuals of the data were examined for skewness and kurtosis. By dividing the skewness statistic by the residual skewness standard error and comparing the resulting z -score to the critical value of 1.96, it was determined the total IASMHS scale met the assumptions for normality for Latino/as (z -score = -0.67) and Whites (z -score = -1.30). The Help-Seeking Propensity subscale also met these assumptions for Latino/as (z -score = 0.25) and Whites (z -score = -1.42). Kurtosis was examined by dividing the kurtosis statistic by the residual kurtosis standard error and comparing the resulting z -score to the critical value of 1.96. Both the IASMHS and the Help-Seeking Propensity subscale met these criteria; z -scores were 0.89 and 0.48 for Latino/as and -0.61 and -0.55 for Whites, respectively. Results of these tests indicate the data met the assumptions of normality.

Bivariate Correlations: A number of variables have been predicted in the literature to account for Latino/a help-seeking behavior. For example, sex, level of acculturation and enculturation, and structural barriers (such as not perceiving the hours of operation to be

convenient and not being able to seek help from a Spanish-speaking therapist) have been discussed in the help-seeking literature. Additionally, having been in therapy may predict one's willingness to seek help in the future and was found to correlate with the IASMHS (MacKenzie et. al., 2004). Bivariate correlations were conducted for both Latino/a and White participants to determine which of these proposed variables demonstrate a significant relationship with the PHCFT and IASMHS. The variables "sex," "current therapy," and "past therapy" were dummy coded 0 (male, no) and 1 (female, yes) to be included in these analyses. The previous bivariate correlational analyses presented above indicated that the subscales and total score of the PHCFT were correlated only with the Help-Seeking Propensity subscale of the IASMHS for Latino/a participants ($r = .37, p < .001$). Because of this, the Help-Seeking Propensity subscale will be used as a criterion variable in the regression analyses. This particular subscale also allows for a more accurate analysis of participants' willingness to seek help than by simply examining overall attitudes toward seeking help as measured by the total score of the IASMHS. Thus, the Help-Seeking Propensity subscale was included in the bivariate analyses to also examine which of the demographic/cultural variables were related to this criterion. A Bonferroni adjustment of .005 (.05/11) was utilized for both groups to account for significant findings due to chance.

For Latino/a participants, having been in therapy in the past was significantly correlated with the total ($r = .30, p < .001$) and Help-Seeking subscale ($r = .30, p < .001$) scores of the IASMHS. These relations were also significant for White participants, past therapy was correlated with the total ($r = .42, p < .001$) and Help-Seeking Propensity subscale ($r = .45, p < .001$). Additionally, having been in therapy at the time of data collection was also correlated with the Help-Seeking Propensity subscale ($r = .27, p < .001$)

for Latino/a participants. No other predicted demographic or cultural variable was correlated with participants' willingness to seek help. All bivariate correlations are reported in Table 12 for Latino/as and Table 13 for Whites.

Regression Analyses

I conducted hierarchical regression analyses to determine if perceptions of helpfulness of the common factors in therapy accounted for variance above that due to related demographic variables. Four regression analyses were conducted to examine the effect on the two criterion variables, examined separately, (the total score of the IASHMS and the Help-Seeking Propensity subscale) for both the Latino/a and White groups. Bivariate correlational analyses indicated that being in therapy at the time of data collection and/or having been in therapy in the past were related to attitudes toward seeking professional help (total score on the IASMHS) as well as willingness to seek help (Help-Seeking Propensity subscale of the IASMHS). Both of these variables were entered in the first and second step as control variables in each regression equation followed by the total score of the PHCFT in the second step. Because subscale scores were moderately to highly correlated, the total score was utilized as the predictor variable in order to eliminate the likely problem of collinearity of using the subscales of the PHCFT to predict help-seeking attitudes. In the third step each previously mentioned variable was included with the addition of three interaction terms to examine any potential interaction effects among the PHCFT and experiences with therapy. The interaction terms consisted of the interaction between current and past therapy, current therapy and the PHCFT as well as past therapy and the PHCFT.

Table 12

Correlations among Study Measures and Selected Demographic Variables for Latino/as

Variable	1	2	3	4	5	6	7	8	9	10	11
1. PHCFT	--										
2. IASMHS	.12	--									
3. IASMHS - HSP	.37***	.74***	--								
4. Sex	.32***	.09	.18	--							
5. SES	-.02	.04	-.07	.19	--						
6. Acculturation	.21*	.07	.07	.18	.01	--					
7. Enculturation	-.04	.11	.04	-.09	.12	-.27**	--				
8. Current Therapy	-.04	-.07	-.04	.10	-.17	-.02	-.14	--			
9. Past Therapy	-.04	.30***	.30***	.06	-.03	.06	-.03	-.01	--		
10. Hours/Convenience	-.03	.05	.08	.04	-.07	-.12	-.10	-.04	.01	--	
11. Spanish-Speaker	-.08	.10	.02	-.13	.17	-.44***	.15	.12	.18	.19	--

Note: * $p < .05$ ** $p < .01$ *** $p < .005$ PHCFT = Perceived Helpfulness of Common Factors in Therapy. IASMHS = Inventory of Attitudes Toward Seeking Mental Health Services. HSP = Help-Seeking Propensity Subscale of the IASMHS. Dummy Coded: Sex: 0 = male, 1 = female. Latino/a Ethnicity = Specific Latino/a ethnic background of participant. Current Therapy: 0 = no, 1 = yes. Past Therapy: 0 = no, 1 = yes. Hours/Convenience = How convenient are the hours of college counseling centers. Spanish-Speaker = preference for a Spanish-speaking therapist.

Table 13

Correlations among Study Measures and Selected Demographic Variables for Whites

Variable	1	2	3	4	5	6	7	8	9	10	11
1. PHCFT	--										
2. IASMHS	.26***	--									
3. IASMHS - HSP	.33***	.83***	--								
4. Sex	.22*	.22*	.20*	--							
5. SES	.06	.04	.10	.06	--						
6. Acculturation	-.04	-.17	-.08	.15	.11	--					
7. Enculturation	.08	-.05	.001	.28***	-.14	.27***	--				
8. Current Therapy	.14	.24*	.27***	.04	.23*	.10	.04	--			
9. Past Therapy	.24*	.42***	.45***	.13	.15	.06	.05	.41***	--		
10. Hours/Convenience	-.02	.01	-.04	.07	-.05	-.05	-.14	.04	.16	--	
11. Spanish-Speaker	.13	-.03	-.02	-.004	.05	.24*	-.22*	.09	.00	.08	--

Note: * $p < .05$ ** $p < .01$ *** $p < .005$ PHCFT = Perceived Helpfulness of Common Factors in Therapy. IASMHS = Inventory of Attitudes Toward Seeking Mental Health Services. HSP = Help-Seeking Propensity Subscale of the IASMHS. Dummy Coded: Sex: 0 = male, 1 = female. Latino/a Ethnicity = Specific Latino/a ethnic background of participant. Current Therapy: 0 = no, 1 = yes. Past Therapy: 0 = no, 1 = yes. Hours/Convenience = How convenient are the hours of college counseling centers. Spanish-Speaker = preference for a Spanish-speaking therapist.

Regression 1: In the first regression explaining the total score of the IASMHS, or overall attitudes toward seeking help, the model in Step 1 was significant for Latino/a participants, $R^2 = .09$, $F(2, 101) = 4.97$, $p = .009$. Results of the analysis can be found in Table 14. Only having been in therapy in the past was a significant predictor of attitudes toward seeking professional mental help services; $t = 3.07$, $p = .003$. The model in Step 2 was also significant ($R^2 = .011$, $F(2, 101) = 3.91$, $p = .011$); however, the change in R^2 was not ($\Delta R^2 = .02$, $F(2, 101) = 1.72$, $p = .19$) suggesting that the addition of the PHCFT did not predict a statistically significant amount of additional variance in attitudes toward seeking help. The model in Step 3 was not significant and no additional variance was explained by the addition of the interaction terms ($\Delta R^2 = .01$, $F(3, 101) = .25$, $p = .86$). No variable entered in the third step was a significant predictor of overall attitudes toward seeking help.

Regression 2: The same three-step regression was conducted for White participants, results can be found in Table 15. The model in Step 1 was also significant for this group $R^2 = .18$, $F(2, 110) = 11.91$, $p < .001$; past therapy was the only significant predictor $t = 4.08$, $p < .001$. The overall model in Step 2 was significant $R^2 = .21$, $F(2, 110) = 9.34$, $p < .001$; however, the change in R^2 was not ($\Delta R^2 = .03$, $F(2, 110) = 3.63$, $p = .06$) suggesting that the addition of the PHCFT did not predict a statistically significant amount of additional variance in attitudes toward seeking help for White participants. The model in Step 3 was significant $R^2 = .24$, $F(2, 110) = 13.61$, $p < .001$; however, the change in R^2 was not ($\Delta R^2 = .03$, $F(2, 110) = 2.54$, $p = .11$). No predictor variable was statistically significant and the addition of the interaction terms did not explain any additional variance.

Table 14

Results of Hierarchical Linear Regression Predicting Attitudes Toward Seeking Mental Health Services (IASMHS) for Latino/as

Predictor	R^2	ΔR^2	B	B 95% CI	SE	β	t
Step 1	.09**	.09**					
Current Therapy			.58	[-.99, 2.15]	.79	.07	.73
Past Therapy			1.09	[.39, 1.79]	.35	.30	3.07**
Step 2	.11**	.02					
Current Therapy			.53	[-1.03, 2.10]	.79	.07	.68
Past Therapy			1.10	[.40, 1.80]	.35	.30	3.13**
PHCFT-Total			.28	[-.14, .71]	.21	.13	1.31
Step 3	.12	.01					
Current Therapy			2.39	[-10.69, 15.47]	6.59	.29	.36
Past Therapy			1.38	[-1.74, 4.50]	1.57	.38	.88
PHCFT-Total			.33	[-.25, .91]	.29	.15	1.13
Current x Past			-.90	[-4.66, 2.87]	1.90	-.07	-.47
Current x PHCFT			-.77	[-4.86, 3.33]	2.06	-.31	-.37
Past x PHCFT			-.06	[-.93, .81]	.44	-.06	-.14

Note: $N = 101$. ** $p < .01$

Table 15

Results of Hierarchical Linear Regression Predicting Attitudes Toward Seeking Mental Health Services (IASMHS) for Whites

Predictor	R^2	ΔR^2	B	B 95% CI	SE	β	t
Step 1	.18**	.18**					
Current Therapy			.38	[-.61, 1.37]	.50	.07	.78
Past Therapy			1.57	[.81, 2.33]	.39	.39	4.08**
Step 2	.21**	.03					
Current Therapy			-.34	[-1.32, .64]	.49	.06	.69
Past Therapy			-1.42	[2.19, .65]	.39	.35	-3.66**
PHCFT-Total			.45	[-.02, .92]	.24	.17	1.91
Step 3	.24**	.03					
Current Therapy			7.41	[.34, 14.48]	3.57	1.43	2.08
Past Therapy			-.44	[-5.29, 4.41]	2.44	-.11	-.18
PHCFT-Total			.48	[-.06, 1.03]	.23	.18	1.76
Current x Past			-1.18	[-3.54, 1.18]	1.19	-.21	-.99
Current x PHCFT			-1.68	[-3.51, .16]	.93	-1.20	-1.81
Past x PHCFT			.52	[-.79, 1.87]	.67	.51	.81

Note: $N = 110$. ** $p < .01$

Regression 3: A hierarchical regression analysis was conducted to determine if perceptions of helpfulness of the common factors explain additional variance above the variance accounted for by having previously sought help or currently seeking help on the Help-Seeking Propensity scores of participants. Results of this analysis for Latino/a participants can be seen in Table 16. The overall model in Step 1 was significant; $R^2 = .09$, $F(2, 101) = 4.97$, $p = .009$. Only having previously been in therapy was a significant predictor $t = 3.13$, $p = .002$ of willingness to seek help in the first step. The overall model was significant in Step 2 ($R^2 = .24$, $F(2, 101) = 10.09$, $p < .001$) as was the change in R^2 ($\Delta R^2 = .15$, $F(2, 101) = 18.54$, $p < .001$). Past therapy and the PHCFT were significant predictors in Step 2; $t = 3.54$, $p = .001$ and $t = 4.31$, $p < .001$, respectively. The perceived helpfulness of elements of the common factors in therapy accounted for an additional 15% of the variance in willingness to seek help for Latino/a participants. The overall model in Step 3 was significant $R^2 = .25$, $F(2, 101) = 5.05$, $p < .001$; however no additional significant variance was explained by the addition of the interaction terms ($\Delta R^2 = .01$, $F(3, 101) = .25$, $p = .86$). The only significant predictor in Step 3 was the total score of the PHCFT; $t = 3.34$, $p < .001$.

Regression 4: The same model was tested for White participants in the fourth regression analysis and the results can be viewed in Table 17. The overall model in Step 1 was significant, $R^2 = .21$, $F(2, 110) = 14.58$, $p < .001$; however, only having been in therapy previously was a significant predictor $t = 4.37$, $p < .001$. The overall model in Step 2 was also significant ($R^2 = .26$, $F(2, 110) = 12.64$, $p < .001$) as was the change in R^2 ($\Delta R^2 = .05$, $F(2, 110) = 7.11$, $p = .01$). Both having been in therapy previously ($t = 3.86$, $p < .001$) and having greater perceptions of helpfulness of the common factors ($t = 2.67$, $p = .01$) were significantly predictive of willingness to seek help. The addition of the PHCFT accounted for

an additional 5% of the variance in willingness to seek help after controlling for history of receiving therapy. The overall model in Step 3 was significant $R^2 = .29$, $F(2, 101) = 6.96$, $p < .001$; however no additional significant variance was explained by the addition of the interaction terms ($\Delta R^2 = .03$, $F(3, 110) = 1.20$, $p = .31$). The only significant predictor in Step 3 was the total score of the PHCFT; $t = 2.21$, $p = .02$.

Results of the hierarchical regression analyses indicated that perceptions of helpfulness of common aspects of therapy are significant predictors of one's willingness to seek help, but not overall attitudes toward seeking professional mental health services. Having previously sought therapy accounted for a greater amount of variance in this prediction equation for Whites (21%) than Latino/as (9%). However, total variance explained was similar for both Whites and Latino/as when the PHCFT was entered into the equation; the total model accounted for 26% of the variance for Whites and 24% of the variance for Latino/as. However, Latino/as' perceptions of helpfulness of the common factors accounted for more of the variance in willingness to seek help than this variable did for Whites. This suggests that perceptions of the helpfulness of common factors in therapy may be a stronger predictor of help-seeking for Latino/as than the majority population. Also, the addition of the interaction terms did not significantly explain any additional variance when added to any of the regression equations. These results suggest that no interaction effects among variables were present among the independent variables used in the prediction of overall attitudes toward help-seeking or willingness to seek help.

Table 16

Results of Hierarchical Linear Regression Predicting Help-Seeking Propensity (HSP- IASMHS) for Latino/as

Predictor	R^2	ΔR^2	B	B 95% CI	SE	β	t
Step 1	.09**	.09**					
Current Therapy			-.14	[-.77, .50]	.32	-.04	-.43
Past Therapy			.45	[.16, .73]	.14	.30	3.13**
Step 2	.24**	.15**					
Current Therapy			-.08	[-.66, .50]	.29	-.03	-.28
Past Therapy			.47	[.21, .73]	.13	.31	3.54**
PHCFT-Total			.34	[.19, .50]	.08	.38	4.31**
Step 3	.25**	.01					
Current Therapy			-1.01	[-5.88, 3.87]	2.45	-.30	-.41
Past Therapy			.65	[-.52, 1.81]	.59	.44	1.10
PHCFT-Total			.36	[.15, .58]	.11	.41	3.34**
Current x Past			-.57	[-1.98, .83]	.71	-.11	-.81
Current x PHCFT			.35	[-1.18, 1.87]	.77	.35	.45
Past x PHCFT			-.05	[-.37, .28]	.16	-.11	-.28

Note: $N = 101$. ** $p < .01$ *** $p < .001$

Table 17.

Results of Hierarchical Linear Regression Predicting Help-Seeking Propensity (HSP- IASMHS) for Whites

Predictor	R^2	ΔR^2	B	B 95% CI	SE	β	t
Step 1	.21**	.21**					
Current Therapy			.21	[-.17, .59]	.19	.10	1.09
Past Therapy			.65	[.35, .94]	.15	.41	4.37***
Step 2	.26**	.05**					
Current Therapy			.18	[-.18, .55]	.19	.09	.99
Past Therapy			.57	[.28, .86]	.15	.36	3.86***
PHCFT-Total			.24	[.06, .42]	.09	.23	2.67**
Step 3							
Current Therapy	.29**	.03	2.47	[-.21, 5.15]	1.35	1.21	1.83
Past Therapy			-.16	[-2.0, 1.67]	.93	-.10	-.18
PHCFT-Total			.23	[.02, .44]	.10	.22	2.21*
Current x Past			-.57	[-1.47, .32]	.45	-.26	-1.27
Current x PHCFT			-.50	[-1.20, .20]	.35	-.92	-1.43
Past x PHCFT			.22	[-.29, .72]	.25	.52	.39

Note: $N = 110$. ** $p < .01$ *** $p < .001$

CHAPTER 5: DISCUSSION

My study was the first to examine Latino/a college student perceptions of the common factors in therapy and how these perceptions relate to attitudes toward help-seeking. To do this, I explored a number of questions. Additionally, a comparison group of European American college students was also utilized to ascertain if the findings of my study are unique to Latino/as or similar to those obtained with a majority culture sample.

Pilot Study

I created the PHCFT for use in this study to measure perceptions of helpfulness of the common factors that occur across all Western-therapeutic orientations. Items were created for this scale based on the taxonomy of common factors outlined by Lambert and Ogles (2003). One item was created for each factor listed in their taxonomy, which included items related to the temporal stages of therapy; support, insight and action. My first interest was in determining whether the conceptual factors outlined by Lambert and Ogles empirically held together, during confirmatory factor analysis, when the elements within those factors were rated by college students as to their helpfulness. Results of this analysis indicated that Lambert and Ogles' conceptual factor structure possessed an adequate, but not optimal fit to the data.

A four-factor model provided a better fit for the data. Participants appeared to group the common factors in therapy (*vis a vis* the perceived helpfulness of these factors) differently than how mental health professionals have classically grouped the common aspects of therapy. A key point to note is that my study was concerned with the perceived helpfulness of these factors rather than on factor analyzing Lambert and Ogles' (2004) specific taxonomical structure. The finding that the perceptions of helpfulness of common

factor items do not perfectly represent the support, insight and action categorization does not provide evidence for an incorrect or mis-specified taxonomy of Lambert and Ogles (2004). Instead, my findings simply show that individuals tend to organize their perceptions of helpfulness of these items in a different categorization than the items are grouped by Lambert and Ogles according to their temporal occurrence in therapy.

An exploratory factor analysis, later verified by a confirmatory factor analysis, provided a new four-factor structure for the perceptions of helpfulness of the common factors in therapy. Therefore, for the instrument, I created new subscale names to reflect the item content in each factor. I categorized these new subscales for the PHCFT as *Therapeutic Work*, *Alliance*, *Use of Therapy* and *Experiential Processing*.

Interestingly, participants grouped their perceptions of helpfulness of the Lambert and Ogles common factors into categories that may actually more closely align with Elliot's (1985) taxonomy of factors. Elliot divides common factors into two super clusters: *Task* and *Interpersonal*. In the *Task* cluster, the most salient sub-cluster was New Perspective, or events that allow the client to form insight or new awareness. Other sub-clusters include Problem Clarification, Focusing Awareness and Problem Solution. Each of these task clusters appears to represent items that fall under the *Therapeutic Work* subscale of the PHCFT. In other words, in Elliot's model, the actual events or tasks of therapy appear to be grouped by potential clients into one factor. The other super cluster, *Interpersonal*, contains the sub-clusters of Understanding, Client Involvement, Reassurance, and Personal Contact. The Understanding, Reassurance, and Personal Contact clusters appear to more closely align with the *Alliance* and to some extent, the *Use of Therapy* subscales in the current study.

Common factors related to the alliance and interpersonal dynamics of therapy in the current study are grouped similarly to Elliot's super cluster.

All *Alliance* items were items from the original Lambert and Ogles classification of support factors, suggesting that aspects of therapy related to the therapeutic alliance and receiving support from the therapist have similarly rated perceptions of helpfulness. Many authors have suggested that support/alliance factors lead to positive outcomes (Prochaska & Norcross, 2001; Najavits & Strupp, 1994) as well as a reduction in tension, feelings of isolation, and the experience of emotional catharsis (Frank & Frank, 1961). Support factors have been the most researched common factor grouping in process and outcome literature, and studies have consistently emphasized the importance of a strong therapeutic bond in therapeutic situations. Participants in the current study also appear to group these factors as being potentially helpful to them if they were to seek professional mental health services.

The *Use of Therapy* subscale contained items related to how therapy could be structured and applied to clients' lives. This scale was comprised of both action factors and one support factor, with structure and modeling behaviors found in therapy being grouped together by participants. The *Emotional Processing* subscale contained items related to the active experiential work involved in the experience of emotions and behaviors. This grouping of items, concerning the working through of emotions, is an interesting concept; individuals appear to differentiate overall tasks of therapy from the emotional processing tasks of therapy. This indicates that college students view the emotional working through of distressing problems as a separate category of perceived helpfulness of the common factors.

Main Study

My main study addressed the remainder of my research questions of interest. Specifically, do Latino/as perceive the common factors to be potentially helpful? Does the factor structure of perceived helpfulness obtained with Latino/as differ from European Americans? And, do these perceptions predict willingness to seek professional mental health services? Before addressing these questions, descriptive analyses of participants' responses related to the mental health utilization and perceptions as well as those of the measures were conducted.

Mental Health Utilization and Data on the Study Measures

At the time of data collection, a sizable percentage of participants were in therapy (11.4%) and/or had been in therapy in the past (38.9%). These higher utilization rates appear to be found in other help-seeking research (Mohr & colleagues, 2010). An examination of data indicated that no self-selection bias with respect to participating in my study was in operation for individuals who had previously had, versus not had, therapy. Also, no differential rating of helpfulness was found between persons who had or had not had therapy services and no difference between likelihood of seeking help in the future was found between individuals rating themselves as highly aware (or unaware) of what happens in therapy.

Results of the chi-square and univariate tests comparing Latino/as and European Americans showed that significantly more European Americans were in therapy at the time of data collection and significantly more Latino/as would be more likely to seek help were a Spanish-speaking therapist available. The first significant finding may suggest a greater comfort with seeking help in the European American college student population than the

Latino/a college student population as has been suggested in previous research examining differences in utilization rates for European American and Latino/a college students (Kearney, Draper, & Baron, 2005). However, because there was not a statistically significant difference in having sought help in the past between groups it is not likely that is the case for this sample. I also expected that Latino/as would be more influenced than European Americans to seek help if their therapist spoke Spanish due to the likelihood that significantly more Latino/as than European Americans speak Spanish.

No statistically significant group differences were noted for the total or subscale scores of the PHCFT or IASMHS. Latino/a and European American participants similarly endorsed perceptions of helpfulness of the common factors as well as attitudes toward seeking mental health services. A few differences between groups in the pattern of correlations among measures were identified. For Latino/as, only the total score of the PHCFT, the Therapeutic Work subscale and Alliance subscale were significantly correlated with the Help-Seeking Propensity subscale of the IASMHS. This finding suggests that perceptions of helpfulness for Latino/as are significantly related to willingness to seek help. European American participants also demonstrated this relation. However, they also demonstrated additional statistically significant relations between the total score of the PHCFT and Alliance subscale and the total score of the IASMHS, as well as a relation between the Alliance subscale of the PHCFT and the Psychological Openness subscale of the IASMHS. European Americans' perceptions of helpfulness of the common factors in therapy may be more broadly related to their overall attitudes toward seeking professional mental health services. Additionally, having a higher degree of psychological openness appears to relate to a greater endorsement of Alliance items, perhaps suggesting European Americans

who are more open would perceive common factors related to the therapeutic relationship to be more helpful than other factors if they were to seek help.

Perceptions of Helpfulness of the Common Factors in Therapy

With the first question addressed in the main study, I established the degree of perceived helpfulness of the common factors in therapy for Latino/as. The Likert scale polar anchors of “not helpful” to “very helpful” provide a qualitatively successive rating of the helpfulness of the individual common factors and subscales of the PHCFT. Any item or scale rated above a three (or a “somewhat helpful” endorsement) was considered to be perceived as helpful by the Latino/a population. Examination of the ratings indicated vastly positive perceptions of helpfulness for the items in the PHCFT. Seventeen of the 20 items in the scale met the threshold of being perceived as at least somewhat helpful. The three items that did not reach this threshold were items that composed the Use of Therapy subscale. Although still rated as at least “slightly helpful,” items related to the structure of therapy and modeling behaviors do not appear to be perceived as more helpful aspects of therapy. As a result, the Use of Therapy subscale was the lowest rated scale and did not meet the threshold for helpfulness.

Every other subscale on the PHCFT as well as the total score average did meet the threshold for a helpfulness rating of three or above. For Latino/a participants, the Therapeutic Work subscale received the highest rating followed by the Alliance and Experiential Processing subscales. Taken literally, this ranking of the subscales could suggest that Latino/as perceive the actual work of therapy to be the most potentially helpful aspect of the experience. However, these subscale ratings were all within .40 points of each other (.08 standard deviations) suggesting that each of these three scales were similarly rated as helpful.

Examination of the new subscales of the PHCFT, in comparison to the original categorization of common factors by Lambert and Ogles (2003), provides additional information regarding the helpfulness of common factors for the Latino/a population. The Therapeutic Work subscale is composed of items from all of the original categorizations of common factors in therapy (support, insight and action groupings). Because this scale includes items from all three categorizations and it met the threshold for helpfulness, this result provides some initial support for Latino/as' positive endorsement of common factors related to the support, insight, and action stages of therapy.

My study also provided specific support for Latino/as' positive endorsement of the support factors in therapy. Authors have previously suggested that Latino/as would be likely to endorse items related to the support category of common factors in therapy due to the importance placed on the relationships in Latino/a culture (Paris et al., 2005; Bernal, Bonilla, Padilla-Cotto, & Perez-Prado, 1998). All support items retained in the new PHCFT scale were endorsed as being at least somewhat helpful. Further support for Latino/a endorsement of support factors is found in the Alliance subscale. The Alliance subscale is composed of support items from the original categorization and met the threshold criteria of helpfulness as well.

Prior literature has also suggested that Latino/as would not find the common factors related to the insight stage of therapy to be potentially helpful (Valdes, 1983; Garzon & Tan, 1992). Insight factors retained from the original scale (which can be found in both the Therapeutic Work and Experiential Processing subscales) were all endorsed as being at least somewhat helpful. Two of the three top-rated items in the PHCFT were originally categorized as insight items, suggesting that not only do Latino/a college students find insight

factors to be potentially helpful, but gaining insight in therapy may be perceived as being one of the most helpful aspects of the experience. This finding may be the result of sampling a Latino/a college student population in which acculturation levels may be higher than in the general adult population. My sample reported a moderate identification with majority culture; however, the most frequent response was a “high” identification with majority culture. More highly acculturated individuals may have more favorable opinions of insight factors because of their higher identification with European American culture in which insight, self-focus, or self-awareness is more highly valued. Additional research with a community sample would be needed to further explore preferences for insight interventions in the Latino/a population.

Action factors were proposed from prior literature as being potentially helpful for Latino/as (Voss Horrell, 2008; Santiago-Rivera et al., 2008). The majority of items retained in the PHCFT from the original classification of action factors were considered to be at least somewhat helpful. However, two of the three action items composing the Use of Therapy subscale did not meet the threshold criteria of helpfulness. Both of these items concerned the modeling behaviors of using the therapist or alliance as a model for other relationships in an individual’s life. This indicates that Latino/as may not find the action factors related to modeling to be particularly helpful if they were to seek professional mental health services. Latino/a college students may prefer to simply be told how to improve their lives versus indirectly being shown how to do this through modeling. Alternatively, one reason for this result may be that Latino/as would not want to model behaviors in other relationships on the therapeutic alliance because the relationship could be culturally different than other relationships in their lives. The chances a Latino/a client would be matched with a European American therapist are much higher than being able to be able to see a Latino/a therapist

(APA, 2009); Latino/as may not see value in modeling themselves or their relationships after a therapist who is culturally different. On the other hand, European American participants also did not rank these particular items highly; indicating that all potential clients may not find modeling behaviors to be potentially helpful if they were to seek therapy. All potential clients may instead prefer to be instructed on how to improve their lives versus learning through modeling. Additional research is needed to determine whether modeling is perceived as unhelpful because therapist and client cultural differences are too great or for a variety of other reasons.

European American participants' responses were also examined in comparison to Latino/as' responses to illustrate any differences between the racial groups in perceptions of helpfulness. Univariate tests showed no significant differences between groups on the total or subscale scores of the PHCFT. Latino/as endorse the common factors to a similar degree as European Americans in terms of helpfulness. The three subscales which met the threshold criteria for helpfulness were each within .20 points of each other (.08 standard deviations); suggesting a similar degree of perceived helpfulness for these groupings of common factors. The overall result of these findings indicates Latino/as and European Americans similarly perceive the Therapeutic Work, Alliance, and Experiential Processing common factors in therapy to be at least somewhat helpful if they were to seek professional mental health services.

PHCFT Factor Structure for Latino/as and European Americans

The PHCFT was developed on a primarily European American sample in the pilot study. The next step in understanding Latino/as' perceptions of the common factors in therapy was to determine whether the factor structure of the PHCFT held true for this

population. Results of the multiple group factor analysis did not demonstrate factor invariance between Latino/as and European Americans. Constraints on over half the items were freed until all remaining paths were invariant. Fourteen of the 20 items on the PHCFT were found to vary between groups. The majority (ten) of these items were all items from the Therapeutic Work subscale. Paths for these items appear to be different for Latino/as and European Americans.

At first glance, this finding suggested that Latino/as do not group the common factors in therapy in the same way as European Americans. However, when examining the factor loadings for each group on the Therapeutic Work subscale, the factor loadings for nine of the ten variant items in the Therapeutic Work subscale were larger for Latino/as than for European Americans. This qualitative examination provides some support for stronger, or more appropriate, pathways for Latino/as than European Americans for items on the Therapeutic Work subscale. Results from the confirmatory factor analyses supported this finding. The model in the CFA for Latino/as was deemed a good fit; however, the same model for European Americans was not found to be an adequate fit. This additional evidence highlighted that the factor structure did hold true for the Latino/a group but not for the European American group in the main study.

The result that the Latino/a college student population groups the common factors in the same way as the original group in the pilot study is a highly encouraging finding. Latino/as appear to group their perceptions of the common factors in a similar fashion to the majority group. Because of this, future researchers will be able to further explore perceptions of helpfulness of the common factors in therapy as a potential research variable for both Latino/as and European Americans. As I look ahead to my last research question of interest,

this finding can be utilized to aid in my understanding of individual's willingness to seek professional mental health services.

The confirmatory factor analysis for European American participants in the main study did not result in an adequate fit for the proposed factor structure found in the pilot study. This suggests that for this particular majority group sample, the factor structure does not represent how these individuals would group the common factors in therapy. A number of items of the PHCFT loaded highly on one or more factors; this item overlap is the likely cause for the inadequate fit for the original model in this sample. For example, the majority of items of the Alliance subscale loaded highly on two or more factors, eliminating the use of this subscale. Nonetheless, the EFA conducted to examine a potential new factor structure was purely exploratory to provide supplemental data as a way of explaining the result that this European American sample did not confirm the factor structure found in the pilot study. Additional research with new European American samples would be needed to verify or confirm either the original factor structure or this new factor structure before any additional conclusions could be drawn.

I expected that the European American sample would provide additional confirmatory evidence for the factor structure discovered in the pilot study. One reason this finding was not found could have been due to differences between the European American participants in the pilot and main study. Participants in the main study may have had significant differences in experiences related to counseling than participants in the pilot study. Unfortunately, no data is available for participants in the pilot study regarding their mental health service utilization. If this data were available, I could determine if having been in therapy in the past has an effect on the factor structure. As discussed above, a fair percentage of participants in

the current study have been in therapy in the past or were in therapy at the time of data collection. Having this experience may lead to different groupings of perceptions of the common factors.

This may be especially true for individuals who were in therapy at the time of data collection. As significantly more European American participants were in therapy at the time of data collection than Latino/as, this may also be the reason why differences were found between the European American samples but no differences were found between the first European American sample and the Latino/a sample. Perceptions of helpfulness may be more fluid or not fully formed by the individual while in, or experiencing, the dynamic process of therapy. Conversely, for individuals having never been in therapy or in therapy in the past, perceptions of helpfulness may be better defined. Therefore, if more European Americans were in therapy at the time of data collection in the main study than in the pilot study, this may be a potential reason for why more overlap on PHCFT items were found in the main study for European Americans.

Perceptions of Helpfulness as a Predictor of Attitudes and Willingness to Seek Help

A number of regression equations were conducted to examine my last research question of interest; “to what extent do Latino/as’ perceptions of the helpfulness of the common factors in therapy account for variance in willingness to seek help above and beyond variance accounted for by relevant demographic variables?” Past literature has suggested that structural barriers such as mental health centers having inconvenient times of service or not having access to a Spanish-speaking therapist (Echeverry, 1997), as well as client factors, such as one’s sex (Vega & Lopez, 2001), level of acculturation or enculturation (Lipsky et. al., 2006; Ho et. al., 2006) or having been in therapy in the past

(McKenzie et. al., 1999) could influence one's willingness to seek help. Only having been in therapy in the past demonstrated a relation to the criterion variables of interest: overall attitudes toward seeking professional mental health services and help-seeking propensity (i.e., willingness to seek help). Having been in therapy at the time of data collection also demonstrated a relation to the criterion variables for European American participants. Therefore, both variables were included as control variables in the regression analyses for both groups.

To examine the predictive power of one's perceptions of helpfulness of the common factors of therapy on overall attitudes toward seeking mental health services, a hierarchical regression was conducted for both ethnic groups. Neither group demonstrated a statistically significant increase in the amount of variance explained when predicting overall attitudes. Having been in therapy in the past was the only significant predictor in these equations for both groups. Nine percent of the variance in attitudes was explained by having been in therapy in the past for Latino/as and eighteen percent was explained for European Americans. Although not a large percentage of the variance is explained by this variable, twice as much variance in overall attitudes toward seeking help is accounted for by having been in therapy in the past for the European American college students compared to Latino/a college students. This finding is in line with the original validation data on the IASMHS; 54% of participants in the community sample had sought professional health for mental health concerns from a primary care physician or mental health professional. Past use of professional help was also correlated with the Psychological Openness ($r = .34$), Help-Seeking Propensity ($r = .34$), and total score of the IASMHS ($r = .33$; MacKenzie et. al., 1999). Using this data, a simple calculation would indicate that approximately 12% of the

variance in the IASMHS could be explained by use of past mental health services for a predominantly European American sample.

A second set of regression equations were conducted to examine this predictor in relation to the new criterion of the Help-Seeking propensity subscale. Both groups demonstrated a statistically significant increase in the amount of variance explained when predicting the specific attitude of willingness to seek help. Again, having been in therapy in the past was a significant predictor for both groups; nine percent of the variance was explained in the first step for Latino/as, and 21% was explained for Whites. Interestingly, adding perceptions of helpfulness of the common factors in the second step explained an additional 15% of the variance for Latino/as (for a total of 24% explained) and only an additional five percent for European Americans (for a total of 26% explained). Perceptions of helpfulness appear to be a stronger predictor of willingness to seek help for Latino/as than European Americans, whereas having been in therapy in the past appears to be a stronger predictor for the latter group.

The finding from the prior question regarding the factor structure for both groups provides additional support for this question's result. Latino/as' responses fit the factor structure found in the pilot study, indicating these items or factors are better able to be distinguished as separate entities and are able to account for more variance in the prediction equation. On the other hand, a great amount of item overlap was found for the European American sample in the main study, limiting the amount of variance that can be explained for this group. Also of note, Latino/a college students did not endorse perceptions of helpfulness to a higher degree than European American college students; however, their perceptions appear to have a greater influence on willingness to seek help than the majority population.

An unexpected finding from these analyses was that perceptions of helpfulness of the common factors in therapy did not predict overall attitudes toward seeking help. The IASMHS (criterion variable) is comprised of three subscales; Psychological Openness, Help-Seeking Propensity, and Indifference to Stigma. Only Help-Seeking Propensity was correlated in previous analyses with the PHCFT; indicating perceptions of helpfulness of therapy does not appear to be related to one's openness or sense of stigma related to seeking help. Both of these variables may actually be additional predictor variables in one's willingness to seek help and have been explored in this fashion in the help-seeking literature with a primarily European American sample (Vogel, Wade & Hackler, 2007; 2008). Although an interesting finding, the more important aspect to note is that perceptions of helpfulness did predict willingness to seek help, as was hypothesized. The addition of interaction terms did not explain any additional variance.

Implications

In this study, I was the first to measure not only a culturally diverse group, but the majority group's perceptions of helpfulness of the common factors in therapy. Previous research has examined attitudes toward treatment as well as barriers to help seeking. However, no one has yet examined how helpful individuals perceive what actually occurs in all Western therapeutic approaches to psychotherapy. This study provided evidence for overwhelmingly positive perceptions of the common factors in therapy for both racial groups examined. On a whole, this indicates that individuals generally would find what occurs in therapy to be at least somewhat helpful to them if they were to seek professional mental health services. Common factors have primarily been discussed from the perspective of the therapist or orientation; this study is also the first to illustrate how potential clients feel about

what occurs in therapy. This study can be the first step in better understanding client preferences and perceptions of what would provide the most beneficial experience in therapy. The results of this study are encouraging in this regard; potential clients tend to find the change mechanisms inherent across therapies to be potentially helpful.

Another positive result found in this study was the finding that Latino/as' and European Americans' overall perceived helpfulness of the common factors were rated and ranked similarly. A few authors have suggested that the low mental health service utilization rate found in the Latino/a population may be the result of Latino/as not finding value in this type of support; and instead opting for other sources of support such as friends and family (Cabassa et al., 2006; Chiang, Hunter, & Yeh, 2004) or community figures (Echeverry, 1997). This study provides evidence that Latino/as would find therapy to be potentially helpful and find the common factors of therapy to be as helpful as European Americans.

The common factors in therapy have largely been discussed from a Euro-centric view of counseling and psychotherapy. Some question has been raised about the appropriateness of traditional therapy interventions for various cultural or racial groups, including Latino/as (Valdes, 1983; Garzon & Tan, 1992). Results of this study indicate that overall, Latino/a college students perceive the common factors in therapy to be at least somewhat helpful which provides initial evidence for the appropriateness of traditional Euro-centric approaches to therapy with Latino/a college students. Additional process and outcome research would be needed to verify this assertion. Until that research can be completed, clinicians can have some assurance that the traditional approaches to therapy (as discussed from a common factors model) are perceived as being helpful by this diverse group, indicating they will likely "buy into" the approach used by the therapist. The only factors that appeared to not be

perceived of as helpful were factors related to modeling behaviors and the structure of therapy. However, these factors were also not endorsed as particularly helpful by European Americans. Because of this, clinicians may want to keep in mind that all college students may not find these to be particularly helpful aspects of therapy.

Unlike previous research, the structural and client or cultural variables did not play a significant role in predicting one's willingness to seek professional mental health services for the college students sampled in my study. The majority of the literature examining Latino/as' underutilization of services and help-seeking behavior has focused on those variables related to the cultural differences between this group and the majority population. The demographic, cultural, and structural barriers observed in this study did not appear to play a role in attitudes toward seeking help or in help-seeking propensity for a college student sample. The fact that these variables were not salient for this Latino/a sample may indicate that research looking at this group (and other culturally diverse groups) may need to also look elsewhere for reasons for underutilization, especially in college student samples. In my study, perceptions of helpfulness for what occurs in therapy were a much stronger predictor for willingness to seek help than any other relevant variable.

This finding highlights the need for investigators to integrate the diverse lines of help-seeking literature for the Latino/a and European American populations. The vast majority of research using a predominately Latino/a sample has not incorporated the wide body of knowledge available from research on European Americans. Instead, research in this field has focused on variables of dissimilarity to explain lack of utilization. The entirety of the research also has not included a European American sample to be able to compare and contrast variables of interest. While researchers have suggested a number of variables to be

potential barriers to help-seeking for Latino/as, it is unclear if these barriers would also be relevant for European Americans or to what degree these variables impact help-seeking in relation to other variables. Future researchers are also encouraged to examine potential mediating or moderating variables that could be present to further explain similarities and differences between culturally or racially diverse groups. For example, Latino/as' level of acculturation may be a moderator in the relationship between structural or cultural barriers and seeking help in a community sample.

My study highlighted that many of the proposed variables for Latino/as were not relevant for this college student sample; utilizing a European American college student sample allowed for an in-depth examination of similarities and differences between groups. Of greatest importance, this study illustrated how significant a predictor Latino/as' perceptions of the common factors in therapy are in this group's willingness to seek professional mental health services. This variable was the greatest predictor in the variables examined and provides one strong explanation for why Latino/as decide (or decide not to) seek professional help.

Limitations

One limitation of my study is the small sample size used in the main analyses. Although Latino/as were oversampled for this study, only 101 surveys for Latino/as, and 110 surveys for European Americans were utilized for the analyses. Each analysis in the current study provided significant results. However, having a larger sample in the main study may have provided more robust statistical findings. The small sample size may specifically affect the ability to detect or confirm factor structures. Although Monte Carlo studies have indicated that stable factor structures can be obtained with as few as three subjects per item

(Fassinger, 1987), Tinsley and Tinsely (1987) recommend that 5-10 participants per item should be recruited. To perform the appropriate analyses in a conservative manner (i.e., 10 participants per item), a sample of 310 participants per group would be needed. A response rate of 38% would have been needed to meet this criterion from the available 811 Latino/as students enrolled at Iowa State University at the time of data collection. That being said, the Latino/a group was able to meet the criteria for an adequate goodness of fit when subjected to a confirmatory factor analysis to verify the factor structure of the PHCFT found in the pilot study.

Additionally, a new sample of European American participants would have been required to more fully explore the correct factor structure of the PHCFT for this population. Having a secondary sample of European Americans in the main study would have allowed for a confirmatory factor analysis of the three-factor model explored using an exploratory factor analysis.

The small sample size may be a result of the email-recruitment sampling method used in the current study. Although a number of steps were taken to increase response rates (personalization of emails, reminder emails and a raffle), the main study had only a 15.08% response rate. Singh, Taneja and Mangalaraj (2009) suggest recruitment through email is one of the least reliable methods of collecting data due to potential participants not receiving the email, the vast number of recruitment requests a potential participant receives, or the study having low topic interest for the wide variety of individuals contacted. The authors also found that recruitment through email only resulted in a 4.18% response rate.

A number of explanations may be feasible for the low response rate in my study. For example, the topic may not have sparked interest for many students. Low topic salience for

potential participants has been associated with a reduced response rate (Sheehan & McMillan, 1999). Researchers have also suggested that potential participants receive so many email requests to participate in academic or market research that many will not be enticed to participate in any one given study. This effect can be even greater when the incentive to participate is not perceived as valuable enough for their sacrifice of time (Singh, Taneja & Mangalaraj, 2009). The participant pool for my study consisted of college students at a large research university. Many of the students are likely to receive numerous invitations to participate in research in a given academic semester. Participants also may not have been enticed to participate in the study for a relatively small prize (a chance to win one of ten, ten dollar gift cards), especially considering many invitations for research in the University can come with the incentive of earning course credit. Lastly, additional recruitment methods or sampling outside of the university would have provided a larger sample in the current study.

Another limitation of the current study is that the PHCFT scale was developed solely based on common factors found in Lambert and Ogles' (2004) taxonomy. One item per common factor was developed; however, because I was interested in understanding perceptions of common factors (versus confirming the factor structure of Lambert and Ogles), it would have been beneficial to develop additional items. For instance, because the factor structure found in the pilot study more similarly represented Elliot's (1985) taxonomy, drawing items from this taxonomy as well would have been constructive. Creating as many items as possible from all available taxonomies would have freed me from the assumption that college students' groupings of the perceptions of helpfulness of common factors would be theoretically based. Also, drawing from other taxonomies would have accounted for potential common factors not included in Lambert and Ogles' (2003) taxonomy.

An additional limitation was that my sample was not fully representative of the University population from which it was drawn. Significantly more women chose to initiate participation in my study than men, limiting the degree to which I can generalize my findings to males in the college population. Greater participation by women has been found in prior help-seeking research (MacKenzie et. al, 2006) suggesting that women may have a greater degree of comfort or less stigma responding to mental health questions than men. Additional research with more representative demographics of the population from which the sample is drawn would allow for a broader generalization regarding perceptions of therapy and help-seeking behavior.

Lastly, no information was available regarding the demographic and mental health utilization variables in the pilot study. Because of this, it is unclear what differences may have been present between European Americans in the pilot and main study. Having this information would have allowed for a more thorough exploration of why the factor structure of the PHCFT was not confirmed in the second European American sample.

Directions for Future Research

The current study provided much information that was previously unavailable for the Latino/a population regarding perceptions of therapy, as well as these perceptions' predictive value for willingness to seek professional mental health services. Using this information, it would be beneficial for future research on Latino/a help-seeking to incorporate perceived helpfulness as a predictive factor when examining other variables of interest. Previous research with this population has primarily focused on the structural and/or client or cultural variables that may act as barriers to help-seeking. A more holistic approach to examining help-seeking behavior with this population is needed in which structural barriers, client

factors, and expectations/perceptions of therapy are incorporated in the prediction of help-seeking behavior. In the future, investigators should integrate what we know about the specific barriers for the Latino/a group and what we know about help-seeking from the predominantly European American research.

As discussed above, future researchers may want to include all potential variables discussed in the Latino/a help seeking literature (structural, client, and cultural variables) as well as variables discussed in the European American literature (stigma, disclosure, expectations) into a regression equation to determine which variables are most salient for each population in terms of help-seeking behavior. Moderating variables should also be considered in these analyses. For instance, level of acculturation or enculturation as well as other cultural variables may act as moderators in the relationship between proposed variables and help-seeking behavior. Additionally, more representative samples of groups should be utilized, including community samples and diverse geographic locations, which would allow for a broader interpretation of how perceptions of helpfulness of the common factors of therapy predict willingness to seek help for all individuals, not just those in a university setting.

Future research would also be needed to examine the disparity found in the factor structure of the PHCFT between the pilot and main sample of European Americans. Additional research with a new sample of participants is needed to verify the factor structure of the PHCFT for European Americans. The use of a community sample would also be beneficial to explore the norms for perceptions of common factors for non-college student adults.

With the results of this study in mind, future researchers would also be encouraged to consider conducting applied research regarding perceptions of helpfulness of therapy and willingness to seek help. My study provided evidence that one's willingness to seek help can be, in part, explained by perceptions of helpfulness of what occurs in therapy. In other words, the more positive perceptions of therapy the more willing someone may be to seek help. Future research could then focus on attempts to increase positive perceptions of helpfulness of therapy. Researchers have suggested that for Latino/as, having a close friend or family member who has sought help is associated with a greater intent to seek help for the potential client. Testimonials or statements of support by trusted individuals may be one method for increasing positive perceptions of therapy and could be examined in future research.

CHAPTER 6: REFERENCES

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APPENDIX

IRB APPROVAL

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office for Responsible Research
Vice President for Research
1138 Pearson Hall
Ames, Iowa 50011-2207
515 294-4566
FAX 515 294-4267

Date: 10/12/2010

To: Sara Schwatken
W112 Lagomarcino Hall

CC: Dr. Loreto Prieto
W218 Lagomarcino Hall

From: Office for Responsible Research

Title: Help-Seeking Behavior and Endorsement of Common Factors in Therapy

IRB Num: 10-406

Approval Date: 10/11/2010

Continuing Review Date: 10/3/2011

Submission Type: New

Review Type: Expedited

The project referenced above has received approval from the Institutional Review Board (IRB) at Iowa State University. Please refer to the IRB ID number shown above in all correspondence regarding this study.

Your study has been approved according to the dates shown above. To ensure compliance with federal regulations (45 CFR 46 & 21 CFR 56), please be sure to:

- **Use only the approved study materials** in your research, including the recruitment materials and informed consent documents that have the IRB approval stamp.
- **Obtain IRB approval prior to implementing any changes** to the study by submitting the "Continuing Review and/or Modification" form.
- **Immediately inform the IRB** of (1) **all serious and/or unexpected adverse experiences** involving risks to subjects or others; and (2) **any other unanticipated problems** involving risks to subjects or others.
- **Stop all research activity if IRB approval lapses**, unless continuation is necessary to prevent harm to research participants. Research activity can resume once IRB approval is reestablished.
- **Complete a new continuing review form** at least three to four weeks prior to the **date for continuing review** as noted above to provide sufficient time for the IRB to review and approve continuation of the study. We will send a courtesy reminder as this date approaches.

Research investigators are expected to comply with the principles of the Belmont Report, and state and federal regulations regarding the involvement of humans in research. These documents are located on the Office for Responsible Research website <http://www.compliance.iastate.edu/irb/forms/> or available by calling (515) 294-4566.

Upon completion of the project, please submit a Project Closure Form to the Office for Responsible Research, 1138 Pearson Hall, to officially close the project.

STUDY MEASURES*Demographic Questionnaire*

How old are you?

What is your sex?

- a. Male
- b. Female

Please mark your current year in school

- a. Freshman
- b. Sophomore
- c. Junior
- d. Senior
- e. Other: (please specify) _____

What generation are you? (*Only for Latino/a participants*)

- a. 1st generation – You were born in a country other than the US and then moved to the US.
- b. 2nd generation – You were born in the US but one or both of your parents were born in another country.
- c. 3rd generation – You and both your parents were born in the US but two or more of your grandparents were born in another country.
- d. 4th generation – You and your parents were born in the US and one grandparent was born in another country.
- e. 5th generation – You, your parents, and all of your grandparents were born in the US.
- f. International student – You entered the US for educational purposes and you are not permanent resident of the US.

On the last question, if you indicated you are not an international student, please mark the Latino subgroup to which you most readily identify. *If you are an international student please do not answer this question. (Only for Latino/a participants)*

- a. Mexican heritage
- b. Cuban heritage
- c. Puerto Rican heritage
- d. Central American or South American heritage (please specify) _____

If you are an international student, please mark your country of origin. *Please skip this question if you are not an international student. (Only for Latino/a participants)*

- a. Mexico
- b. Cuba
- c. Puerto Rico
- d. Central American or South American country (please specify) _____

If you are a first generation immigrant intending to stay in the US, at what age did you immigrate to the US? *(Only for Latino/a participants)*

Please circle the number that best identifies your degree of commitment to (or identity with) the Latino American and European American (White) cultures.

My level of commitment/identity to Latino American culture:

1	2	3	4	5	6	7
None	Low	Moderate	High	Very High		

My level of commitment/identity to European American (White) culture:

1	2	3	4	5	6	7
None	Low	Moderate	High	Very High		

With which religious denomination do you affiliate?

- a. Christian – Catholic
- b. Christian – Protestant
- c. Christian – LDS or Other
- d. Jewish
- e. Hindu
- f. Buddhist/Taoist
- g. Muslim
- h. Atheist or Agnostic
- i. Other: (please specify) _____

In terms of income and socio-economic status, how would you categorize your parents?:

- a. Lower
- b. Lower middle
- c. Middle
- d. Upper middle
- e. Upper
- f. Other: (please specify) _____

General Mental Health Questions

Are you currently receiving help from a mental health provider (e.g., psychologist, counselor, social worker, etc.)?

- a. Yes
- b. No

If “yes”, how helpful was this experience? *Please only respond to this question if you are currently receiving help from a mental health provider.*

- a. Very helpful
- b. Somewhat helpful
- c. Neutral
- d. Somewhat unhelpful
- e. Not helpful

Have you ever sought counseling or therapy from a mental health professional in the past for a personal problem? (e.g., psychologist, counselor, social worker, etc.)

- a. Yes
- b. No

If “yes”, how helpful was this experience? *Skip this question if you have NOT sought treatment in the past.*

- a. Very helpful
- b. Somewhat helpful
- c. Neutral
- d. Somewhat unhelpful
- e. Not helpful

If you are not currently seeking help nor have sought help previously, how aware do you feel you are about what happens during therapy? *Please only respond to this question if you have not sought treatment in the past and are not currently receiving help from a mental health provider.*

- a. Very aware
- b. Somewhat aware
- c. Undecided
- d. Somewhat unaware
- e. Very unaware

If “yes” to question 12 and/or 14, would you seek help from a mental health provider in the future? *Please only respond to this question if you have sought help previously or are currently receiving help from a mental health provider.*

- a. Yes
- b. No

If you are neither currently seeking help nor have sought help previously, how likely are you to seek help from a mental health provider (e.g., psychologist, counselor, social worker, etc.)? *Please only respond to this question if you have not sought treatment in the past and are not currently receiving help from a mental health provider.*

- a. Very likely
- b. Somewhat likely
- c. Undecided
- d. Somewhat unlikely
- e. Very unlikely

Please describe your own perceptions of what happens during therapy below:

Most mental health agencies are open Monday through Friday 8:00am to 5:00pm. If you were to seek help at such an agency, would you find the hours the agency is open convenient for your schedule?

- a. Very convenient
- b. Somewhat convenient
- c. Neutral
- d. Somewhat inconvenient
- e. Very inconvenient

Would having a Spanish speaking therapist influence your decision to seek counseling services?

- a. Yes, I would only seek services if my therapist could speak Spanish
 - b. Yes, I would be more likely to seek services if my therapist could speak Spanish
 - c. No, having a Spanish speaking therapist would not influence my decision.
 - d. No, I would be more likely to seek services if my therapist only spoke English.
-

Perceived Helpfulness of the Common Factors In Therapy (PHCFT)

To what extent do you believe the following items would be helpful to you if you were to participate in professional counseling?

1	2	3	4	5
Not at all Helpful	Slightly Helpful	Somewhat Helpful	Very Helpful	Extremely Helpful

1. To have a release of pent-up emotions
2. To have a place to experience your emotions
3. To decrease some of your problematic behaviors
4. To feel the therapist is similar to you.
5. To reduce feelings of isolation
6. To increase your expectations of your personal effectiveness
7. To be able to have a positive relationship with the therapist
8. To have a place to test out your thoughts and feelings
9. Having the therapist reassure you about your difficulties
10. To have a release of tension
11. Having a place to reward your successes in therapy.
12. To increase the feeling that you can master aspects of your life
13. To understand the way you think and feel
14. Having a trusting relationship with the therapist
15. To have the therapy sessions follow a structured format
16. To understand your problematic experiences and how they relate to each other
17. To experience a strong working relationship with the therapist
18. To develop the ability to control your unwanted thoughts
19. To learn new things about yourself
20. Active participation in the sessions by both you and the therapist
21. Having a therapist with expertise
22. To be able to work through some of your personal difficulties
23. To feel you have learned new techniques for managing interpersonal relationships.
24. To model your relationship with the therapist to other relationships in your life
25. To be able to receive advice from the therapist
26. To develop an understanding or rationale of your problematic experiences
27. To be able to receive feedback from the therapist
28. To gain the ability to take more risks in your personal life
29. Having the therapist provide encouragement to face your fears
30. To gain insight into your problematic experiences
31. To see the therapist as a person to model yourself after
32. Having a therapist who is warm, empathetic, accepting, genuine, and respectful

Note: Original developed for this study. All items were given to all participants in the pilot and main study.

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)⁶

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and mental health counselors). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns*, *emotional problems*, *mental troubles*, and *personal difficulties*.

For each item, indicate to what extent you *disagree* (1) or *agree* (5) with each statement listed below.

1	2	3	4	5
Disagree		Undecided		Agree

1. There are certain problems which should not be discussed outside one's immediate family.
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.
6. Having been mentally ill carries with it a burden of shame.
7. It is probably best not to know *everything* about oneself.
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.
9. People should work out their own problems; getting professional help should be a last resort.
10. If I were to experience psychological problems, I could get professional help if I wanted to.
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.
12. Psychological problems, like many things, tend to work out by themselves.
13. It would be relatively easy for me to find the time to see a professional for psychological problems.
14. There are experiences in my life I would not discuss with anyone.
15. I would want to get professional help if I were worried or upset for a long period of time.
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.

⁶ *Note:* Taken from Mackenzie, Knox, Gekoski & Macaulay (2004)

Inventory of Attitudes Toward Seeking Mental Health Services (continued)

17. Having been diagnosed with a mental disorder is a blot on a person's life.
 18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.
 19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.
 20. I would feel uneasy going to a professional because of what people would think.
 21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.
 22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
 23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."
 24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.
-