

2013

# Seeking help for psychological distress: The role of acculturation, family relationships, coping, and stigma among Latin Americans in canada

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SEEKING HELP FOR PSYCHOLOGICAL DISTRESS: THE ROLE OF  
ACCULTURATION, FAMILY RELATIONSHIPS, COPING, AND STIGMA AMONG  
LATIN AMERICANS IN CANADA

By

Alma E. Roldan-Bäu

A Dissertation  
Submitted to the Faculty of Graduate Studies  
through Psychology  
in Partial Fulfillment of the Requirements for  
the Degree of Doctor of Philosophy at the  
University of Windsor

Windsor, Ontario, Canada

2013

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Seeking Help for Psychological Distress: The Role of Acculturation,  
Family Relationships, Coping, and Stigma among Latin Americans in Canada

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## DECLARATION OF ORIGINALITY

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## ABSTRACT

The present research investigated help-seeking intentions among Latin American adults living in Canada. Path analysis was utilized to test the utility of the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980) to explain help-seeking in this population. The impact of various additional variables, including stigma, perceived barriers, and cultural variables (e.g., familism, acculturation, coping) was also examined. The sample consisted of 223 Latin American adults living in Canada. Participants had the option to complete the study questionnaire online or in a paper format and in their language of choice (i.e., English or Spanish). Qualitative data were collected using an open-ended question asking participants about any previous experience with mental health services. Consistent with the TRA, the results demonstrated that both attitudes toward help-seeking and subjective norms were correlated with help-seeking intentions. The final respecified path model provided a good fit of the data and suggested important roles for multiple variables, including familism, acculturation, and collective coping. This model also suggested that subjective norms play an important role as a mediator of the effects of attitudes and acculturation on help-seeking intentions. Qualitative results revealed several themes related to help-seeking. A large number of respondents reported positive experiences with help-seeking. However, some participants reported negative experiences. One factor that emerged as a barrier to help-seeking was the disregard of cultural issues in psychotherapy. Thus, both quantitative and qualitative results suggest an important role for cultural factors in the help-seeking process. Overall, the findings of the current study contribute to our understanding of the antecedents that impact help-seeking among Latin Americans in Canada. Future directions and clinical implications are discussed.

## ACKNOWLEDGEMENTS

This project could not have been possible without the help of countless individuals. I am grateful to have had the opportunity to work with the Latin American community in Canada.

Thank you to my supervisor, Dr. Ben Kuo, for his dedication, mentorship and guidance. He believed in my project and allowed me to find my own path. Thank you to my committee members, Dr. Hakim-Larson, Dr. Towson, Dr. Yun and Dr. Grau, for their attention to detail, and their thoughtful feedback and encouragement throughout this entire process. I would also like to thank the members of the Multicultural Clinical and Counselling Research Lab for their helpful suggestions and feedback. I am thankful to Sherri Simpson for her IT help creating my bilingual online study questionnaire. I would like to thank Dr. Scott Miller and Joanna Kraft at the University of Windsor and Dr. Monique Herbert at the University of Toronto for their help with statistical analysis. Thank you to Barb Zakoor for her assistance with paperwork and for answering my countless questions.

Thank you to my family and friends who helped with data collection. I am thankful to individuals at the Bethel Baptist Church, the Nazaret Baptist Church, the San Lorenzo Latin American community centre and the Catholic Crosscultural Services for their assistance with data collection. I am extremely grateful to all the research participants who took the time to complete my survey.

Thank you to my parents and brothers for their support, love and for believing in me. My parents emigrated from El Salvador to provide my brothers and me with a better life. They have instilled in us the importance of family, hardwork and perseverance. Without their many sacrifices I would not be where I am today. Finally, I would like to thank my husband, Christian, who is my rock and my best friend. I could not have done this project without your love and support.

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## CHAPTER I

### Introduction

Despite advances in psychological and mental health treatment quality and efficacy (Corrigan, 2004; Wampold, 2001), the majority of individuals (60-75%) suffering from mental illness do not seek treatment (Corrigan, 2004; Kessler et al., 2001; Vasiliadis, Lesage, Adair, & Boyer, 2005). This underutilization of mental health services is even more significant among individuals of ethnic minority backgrounds (Leong & Lau, 2001; Leong, Wagner, & Tata, 1995; Snowden & Yamada, 2005; Whitley, Kirmayer, & Groleau, 2006). From an economic perspective, the cost of mental illness in Canada due to disability and decreased workplace productivity has been estimated to be over \$15 billion a year (Dewa, Chau, & Dermer, 2010). Given the staggering costs of mental illness, research efforts that attempt to identify the barriers to seeking mental health services among Canadians are warranted.

Research in the United States has consistently shown that despite similar rates of mental illness, Latino-, Asian- and African-Americans are significantly less likely than White Americans to use mental health treatments (Snowden & Yamada, 2005; U.S. Department of Health and Human Services, 2001). Similarly, research in Canada has also suggested that immigrants from non-European countries tend to underutilize mental health services (Kirmayer et al., 2007; Whitley et al., 2006). Unfortunately, research on the use of mental health services among ethnic minorities living in Canada is limited (Agic, 2004). The majority of studies on ethnic minority mental health and help-seeking have been conducted in other countries, such as the United States, Australia, and England (Agic, 2004), although there are some notable exceptions (Kuo, Kwantes, Towson, & Nanson, 2006; Morgan, Ness, & Robinson, 2003). For instance, Kuo et al. (2006)

examined help-seeking attitudes in an ethnically diverse sample of Canadian university students. The authors found that Caucasian students reported more positive attitudes toward help-seeking than ethnic minority students. Thus, there has been an increased call from both researchers and clinicians for more empirical investigations focusing on ethnic minority mental health within the Canadian context.

Even though Latin Americans represent a growing immigrant population both in the United States and in Canada (Statistics Canada, 2007; U.S. Census Bureau, 2003), they remain an under-researched ethnic group in Canada, and little empirical information exists on their mental health concerns. Given the increasing Latin American population and the stressors associated with immigration in North America (Beiser, 2005; Bledsoe, 2008; Collins & Arthur, 2005), it is crucial that research efforts focus on their immigrant experience and health care needs within Canada. Thus, the present study attempts to address this current gap in the literature.

Path analysis was utilized in the present study to examine the ability of the Theory of Reasoned Action (Ajzen & Fishbein, 1980) to explain help-seeking intentions among Latin Americans living in Canada. This study also explored the role of stigma, perceived barriers and various cultural variables (e.g., familism, acculturation, culture-based coping) as antecedents in the help-seeking process. In addition, thematic analysis of participants' responses to an open-ended question on help-seeking was utilized to gain a greater understanding of their attitudes towards, and past experiences with, help-seeking for psychological distress in Canada.

### **Latin Americans in Canada and the United States**

In the United States, Latin Americans are the largest ethnic minority group and account for 13.4% of the total U.S. population (U.S. Census Bureau, 2003). It has been

projected that by 2020, Latin Americans will comprise 17.8% of the total U.S. population (U.S. Census Bureau, 2003). Furthermore, according to Statistics Canada (2007), Latin Americans comprised the 5<sup>th</sup> largest minority group in Canada, and in 2006 were the third-largest group of recent immigrants (10.8% of newcomers).

Differences exist between the Latin American population in the United States and Canada. In the U.S., the majority of Latin Americans are of Mexican, Puerto Rican, and Cuban descent and most have lived in the U.S. for multiple generations (Organista, 2007). In contrast, the three largest groups of Latin Americans in Canada are from El Salvador, Mexico, and Chile with the majority being first generation immigrants (73%) who emigrated after 1980 (Lindsay, 2007). Latin American immigrants in Canada have arrived in various migration waves, often in response to political conflict, violence, and civil war in a particular country (Riano-Alcala, 2008; Simmons, 1993). For instance, violence in Chile by the Pinochet government in the 1970's led to the first wave of Latin American immigrants to Canada (Simmons, 1993). Similarly, the military dictatorship and civil war in El Salvador in the 1980's resulted in the second wave of Latin American immigrants to Canada (Simmons, 1993). More recently, additional waves of immigrants have arrived in Canada from other Latin American countries including Mexico, Colombia, and Peru (Saphir, 2008). Thus, the majority of Latin American immigrants have arrived in Canada as refugee claimants in response to violence and political conflict, and many of these individuals have experienced trauma and persecution in their countries of origin (Saphir, 2008).

Regardless of country of origin, Latin Americans share a common language and similar cultural characteristics (Marín & Marín, 1991; U.S. Department of Health and Human Services, 2001). For example, Latin Americans have been shown to share similar

values and beliefs with regard to family support, loyalty, and obligations (Sabogal, Marín, Otero-Sabogal, & Marín, 1987; Steidel & Contreras, 2003). Several terms have been utilized in the literature to refer to this population, including Hispanic, Latino, and Latin American. The term “Latin American” refers to individuals from Mexico, South and Central America, Cuba, Puerto Rico, Dominican Republic and any other groups of Spanish culture origin, regardless of race (Marín & Marín, 1991), and is the term used by Statistics Canada (Lindsay, 2007). This study will primarily use the term Latin American, unless referring to previous research that has used a different term (e.g., Mexican American) or to specific measures (e.g., Latino Cultural Orientation).

### **Latin Americans and Help-Seeking for Psychological Distress**

Latin Americans, similar to other ethnic minority groups, may be in great need of mental health services as a result of stress due to discrimination, and higher rates of poverty and unemployment than White Americans (Bledsoe, 2008; Garcés, Scarinci, & Harrison, 2006; U.S. Department of Health and Human Services, 2001). In fact, several epidemiological studies in the United States have reported that Latin Americans have equal or higher prevalence rates of mental illness compared to White Americans (Bledsoe, 2008; Kouyoumdjian, Zamboanga, & Hansen, 2003; U.S. Department of Health and Human Services, 2001). In addition, recent studies have further suggested that Latin Americans may experience higher rates of psychological distress than other ethnic minority groups, and that the rates of distress may be even higher for Latin Americans of low socioeconomic status (Bledsoe, 2008; U.S. Department of Health and Human Services, 2001). Furthermore, some studies have found that certain Latin American subgroups are in greater need of mental health services as compared to other Latin American subgroups (Prilleltensky, 1993; U.S. Department of Health and Human

Services, 2001). For example, a Canadian study reported that Central American refugees who have experienced war-related trauma and terror in their countries of origin may be at higher risk for post-traumatic stress symptoms and may experience greater difficulty adjusting to their new country (Prilleltensky, 1993). However, despite the growing evidence indicating a need for mental health services among Latin Americans, this population tends to underutilize mental health services compared to non-Latino White Americans (Cabassa, Zayas, & Hansen, 2006; Keefe, 1982; Rogler & Cortes, 1993; U.S. Department of Health and Human Services, 2001).

One emerging area of research has focused on trying to understand the help-seeking process for mental health problems among immigrant populations, including Latin Americans. Instrumental barriers, such as lack of transportation, health insurance, or child-care have been hypothesized as explanations for the lower rates of help seeking behaviours among this population (Ruiz, 1993). However, studies that have attempted to control for instrumental barriers, such as accessibility to mental health services, have found that ethnic minorities, including Latin Americans, are still less likely to seek help compared to White individuals (Fiscella, Franks, Doescher, & Saver, 2002; Kirmayer et al., 2007; Steele, Glazier, & Lin, 2006; U.S. Department of Health and Human Services, 2001). These findings suggest the presence of additional barriers to help-seeking for Latin Americans. Converging evidence has suggested that internal psychological factors, such as attitudes toward help-seeking and stigma, are likely to play a significant role in the decision to seek help for mental health concerns among Latin Americans (Alvidrez, 1999; Cabassa & Zayas, 2007). Thus, the impact of psychological, cultural, and physical barriers on help-seeking among this population was explored in the present study.



## **The Impact of Psychological Antecedents on Help-seeking**

Help-seeking research has focused on identifying the factors that impede or facilitate help-seeking for psychological distress (Vogel, Wester, Wei, & Boysen, 2005). A common research approach in this area is to investigate the influence of various psychological factors on help-seeking attitudes and intentions to seek help (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Rickwood & Braithwaite, 1994). Using this approach, a number of psychological variables, such as attitudes toward seeking psychological help and stigma, have been shown to significantly impact the help-seeking process (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995). In addition, previous empirical studies have identified psychological distress as an important predictor of help-seeking among college students and community samples alike, such that greater psychological distress is associated with greater intentions to seek help (Cabassa, Zayas & Hansen, 2006; Cramer, 1999). Moreover, using this approach several demographic variables, such as gender and previous use of mental health services, have been identified as playing an important role in predicting individuals' decision to seek help. Past research, for instance, has shown that women are more likely than men to seek help for psychological problems (Andrews, Issakidis, & Carter, 2001; Moller-Leimkuhler, 2002). Some researchers have suggested that gender differences in help-seeking may be explained by traditional gender roles that make asking for help and the expression of emotional distress more difficult for men than for women (Moller-Leimkuhler, 2002; Vogel & Wester, 2003). Past studies have also suggested that previous use of mental health services was associated with greater intentions to seek help among Latin Americans (Alvidrez, 1999; Cabassa, Zayas, & Hansen, 2006). Thus, these three

variables, psychological distress, gender, and previous use of mental health services, were included as covariates in the present study.

Although these research studies have provided valuable empirical data relating to the help-seeking process, this research approach has resulted in many inconsistent findings (Vogel et al., 2005). Two recommendations have been proposed by help-seeking researchers to help clarify past inconsistencies and to further the help-seeking literature (Cramer, 1999; Vogel et al., 2005). First, future studies should use theoretical models of help-seeking to help ground the research questions. And second, researchers should use more sophisticated statistics, such as path analysis, that allow one to examine the direct and indirect effects of multiple variables on help-seeking simultaneously. Accordingly, the present study examined help-seeking among Latin Americans by using an established theoretical model of behaviour and by employing path analysis statistics to explore both the direct and indirect relationships among variables. The literature on various help-seeking models will be reviewed in the following section of this chapter.

### **Theory Driven Help-Seeking Research**

Several theoretical models have been developed in an attempt to understand and predict health-related behaviours, including seeking help for psychological distress and mental health problems (Ajzen & Fishbein, 1980; Andersen, 1995; Janz & Becker, 1984). Three models that have generated a great deal of research will be reviewed in this section: The Health Belief Model, Andersen's Behavioural Model, and the Theory of Planned Behaviour.

The Health Belief Model was developed in the 1950's to help understand why individuals failed to use preventive health initiatives, such as immunization and other health screenings (Becker & Maiman, 1975). This model proposes that perceived

susceptibility, perceived severity, perceived benefit, perceived barriers, and cues to action (i.e., internal or external stimulus) all influence whether or not a person will engage in a given health behaviour. This model was later adapted by Janz and Becker (1984) to address other health-related behaviours, including the use of health care services.

Although this model has generated a great deal of research (Brannon & Feist, 2000), it has been criticized for various reasons. Poss (2001), for instance, criticized this model because it only focuses on the direct effects on behaviour and because many of the variables are difficult to operationalize.

Andersen developed the Behavioural Model in the 1960's to help understand why families use health services (Andersen, 1995). Although the original model was developed to try to understand why families seek help, the focus was later changed to the level of the individual because of difficulties developing measures at the level of the family. The model suggests that a person's use of health services is influenced by his or her predisposition to use services, by factors that enable or impede use, and by his or her need for care (Andersen, 1995). Andersen proposed that predisposing factors influence enabling factors, which then influence need, and finally influence use of health services. Examples of predisposing factors are: demographics (e.g., age, gender), health beliefs and attitudes, and social factors such as ethnicity, education level, and religion. Enabling factors include personal and family resources, such as insurance, income, social support, available community services as well as perceived barriers. Social relationships are also included under enabling factors. Perceived need includes perceived health and whether the person deems his or her symptoms important or serious enough to seek formal help. Health behaviours include diet and exercise, and use of health services. This model has been modified for ethnically diverse homeless populations and is referred to as the

Gelberg-Andersen Behavioural Model for Vulnerable Populations (Gelberg, Andersen, & Leake, 2000). This model was used in a recent study to explore the predictors of health services utilization among homeless women in the U.S. (Stein, Andersen, & Gelberg, 2007). The study demonstrated that barriers to care, such as travel time and cost of treatment, predicted greater illness and lower preventive and outpatient service use in this population.

The Theory of Planned Behaviour (TPB; Ajzen, 1991) is a more recent version of the Theory of Reasoned Action (Ajzen & Fishbein, 1980) that includes an additional variable, perceived behavioural control (PBC). PBC has been defined as “the perceived ease or difficulty of performing the behaviour and it is assumed to reflect past experiences as well as anticipated impediments and obstacles” (Ajzen, 1991, p. 188). Although the PBC construct has been shown to play an important role in predicting various behaviours (Ajzen, 1991; Armitage & Conner, 2001), it is not without controversy (Ajzen, 2002). Studies have shown, for example, that PBC is a multidimensional construct that is composed of both perceived difficulty of the behaviour and perceived control over the behaviour (Ajzen, 2002; Armitage & Conner, 2001; Conner & Armitage, 1998; Terry & O’Leary, 1995). To date, there is little consensus on how best to operationalize and measure this construct (Conner & Armitage, 1998), and PBC measures have often lacked internal consistency (Ajzen, 2002). Moreover, research has shown that the relative importance of the PBC construct varies across situations and behaviours (Ajzen, 1991; Albarracin et al., 2001; Schomerus et al., 2009). A somewhat distinct, but related term to PBC is perceived barriers. According to Ajzen (1991, 2002), PBC is influenced by control beliefs, which are beliefs about the availability of resources and opportunities, as well as beliefs about the presence of obstacles. Perceived barriers is a construct that is

part of other behavioural models, including the Health Beliefs Model (Janz & Becker, 1984) and the Gelberg-Andersen Behavioural Model for Vulnerable Populations model (Gelberg et al., 2000), and has recently been shown to play an important role in predicting help-seeking intentions and behaviours among Chinese adults (Mo & Mak, 2009) and homeless American women (Stein, Andersen, & Gelberg, 2007). Accordingly, the impact of perceived barriers will be assessed in the present study. Therefore, a decision was made by the researcher to use the Theory of Reasoned Action (TRA) with the addition of perceived barriers in the present study, rather than using the more recent TPB model. The evidence supporting this model will be reviewed in the following section.

### **Theory of Reasoned Action**

The Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980) is based on the assumption that individuals use information available to them to make rational decisions about whether or not to engage in a particular behaviour. The TRA postulates that a person's intention to perform (or not perform) a behaviour is the immediate determinant of the actual behaviour. Intentions have been defined as "the motivational factors that influence a behaviour; they are indications of how hard people are willing to try, of how much of an effort they are planning to exert, in order to perform the behaviour" (Ajzen, 1991, p. 181). As such, stronger intentions are expected to lead to increased performance of the behaviour in question. Literature reviews have confirmed that intentions are good predictors of actual behaviour across various behavioural outcomes (Ajzen, 1991; Ajzen & Fishbein, 1980; Albarracín, Johnson, Fishbein, & Muellerleile, 2001). Intentions to perform a behaviour, in turn, are determined by an individual's attitudes toward the behaviour and his or her subjective norms. Attitudes toward a behaviour refer to a person's favourable or unfavourable evaluation or appraisal of the behaviour in question,

such that more positive attitudes toward a behaviour are expected to result in greater intentions to perform the behaviour. Subjective norms, on the other hand, refer to an individual's perception of social pressure to perform, or not perform, a given behaviour. If an individual perceives that significant others approve or disapprove of a given behaviour, they would be either more or less likely to intend to perform this behaviour.

Researchers have found the TRA model to be useful for predicting various health-related behaviours, including the use of mammograms (Montaño, Thompson, Taylor, & Mahloch, 1997) and condoms (Albarracín et al., 2001; Sheeran & Taylor, 1999).

Although the majority of studies on the TRA model have focused on preventive health behaviours, the TRA has recently been employed to examine help-seeking for mental health problems (Codd & Cohen, 2003; Vogel et al., 2005; Vogel, Wade, & Hackler, 2007).

Vogel et al. (2005), for instance, utilized the TRA to examine the impact of several psychological factors and to test the mediating role of attitudes toward seeking professional help between these different psychological factors and intentions to seek help. Specifically, the authors tested the following psychological and demographic factors: social stigma, treatment fears, self-disclosure, self-concealment, anticipated risk, anticipated utility, social norms, distress, social support, previous therapy, and gender. Using structural equation modeling to test the mediation model, Vogel et al. reported that several psychological factors (i.e., social support, anticipated utility of therapy, social stigma and social norms) and previous counselling experience predicted attitudes toward seeking professional psychological help. Attitudes toward seeking professional psychological help in turn predicted intentions to seek counselling for interpersonal and drug problems among college students.

In a second study, Vogel et al. (2007) used the TRA to explore the impact of public and self-stigma on attitudes toward help-seeking and intentions to seek help. Stigma refers to a cognitive process based on stereotypes and negative attitudes toward people with mental illness (e.g., the belief that all people with mental illness are violent), which can result in discriminatory actions against people with mental illness (Corrigan, 1998, 2004). Corrigan (2004) distinguished between public stigma and self-stigma. Public stigma refers to the general populations' negative views and opinions of individuals with mental illness, while self-stigma refers to negative opinions that an individual with mental illness holds toward him- or herself (Corrigan, 1998, 2004). That is, self-stigma refers to an internalization of public stigma, and can result in diminished self-esteem, self-efficacy, and self-confidence (Corrigan, 1998). Using structural equation modeling, Vogel et al. (2007) reported that the relation between public stigma and intentions to seek help was mediated by self-stigma and attitudes toward help-seeking. That is, public stigma influenced self-stigma, which then influenced attitudes toward help-seeking, which in turn influenced intentions to seek help. Thus, the application of the TRA theoretical model to help-seeking represents a new and promising area of research in the study of help-seeking. In light of the recent support for the TRA, the present study represents an effort to extend the cumulative help-seeking research based on the TRA model.

The subsequent sections will provide an overview outlining measurement of attitudes toward help-seeking and subjective norms, the two determinants of intentions to seek help according to the TRA, as well as review the empirical evidence supporting the impact of these two variables on help-seeking among Latin Americans.

### **Attitudes Toward Seeking Professional Help and Intentions to Seek Help**

According to the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980), a person's intentions to perform a given behaviour are a function of two components, attitudes and subjective norms. Attitudes are defined as "the individual's positive or negative evaluation of performing the behaviour" (p. 6). Attitudes toward a behaviour, in turn, are based on an individual's beliefs that performing the behaviour will lead to certain outcomes, and the evaluation of these outcomes (i.e., advantages and disadvantages of performing the behaviour) (Ajzen & Fishbein, 1980; Albarracín et al., 2001).

Meta analyses have confirmed the significant role of attitudes in predicting intentions to perform a behaviour (Albarracín et al., 2001; Armitage & Conner, 2001). In general, more positive attitudes toward a given behaviour lead to greater intentions to perform the behaviour in question. For instance, Albarracín et al. (2001) reported that across 96 data sets, more positive attitudes about condom use predicted greater intentions to use condoms, which in turn, predicted actual condom use.

Similarly, empirical studies have provided support for the role of attitudes on the decision to seek psychological help. In general, attitudes towards seeking mental health services have been measured using the Attitudes Toward Seeking Professional Psychological Help scale (ATSPPH; Fisher & Turner, 1970) that assesses four dimensions of attitudes: recognition of need for psychological help, stigma tolerance, interpersonal openness, and confidence in mental health professionals. The intention to seek psychological help has usually been measured by assessing *willingness to seek help* for a psychological problem from a mental health professional. Studies have confirmed the validity of using willingness to perform a behaviour as a measure of a person's



intention to perform the given behaviour, and that intentions are adequate predictors of actual behaviour (Albarracín et al., 2001; Fishbein, 2008). As noted earlier, research has consistently shown that attitudes towards mental health services influence intentions to seek help, such that individuals with more positive attitudes toward help-seeking are more likely to seek help for psychological problems (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Rickwood & Braithwaite, 1994).

### **Attitudes Toward Seeking Professional Help and Help-Seeking Among Ethnic Minority Populations**

Attitudes also play a significant role in predicting intentions to seek help among ethnic minorities (Alvidrez, 1999; Kim & Omizo, 2003). Research efforts have focused on exploring the impact of culture on attitudes toward help-seeking and how this influence then impacts help-seeking. For example, ethnic minority research has shown that greater adherence to Asian values was related to more negative attitudes toward help-seeking and lower intentions to seek help (Kim & Omizo, 2003; Liao et al., 2005). That is, cultural values influence attitudes toward help-seeking among Asian American students, which in turn, influence their intentions to seek help.

For Latin Americans, traditional cultural values and attitudes may also impede help-seeking for psychological distress. For instance, Alvidrez (1999) investigated the impact of previous exposure to mental health services, family attitudes, stigma and beliefs about the causes of mental illness on help seeking in a sample of Latin American, African American and White women ( $N = 187$ ). The results showed that despite similar socioeconomic status and psychiatric symptoms, African American and Latin American women were less likely to make a mental health visit compared to White women, with Latin American women having a particularly low rate of service use. In terms of family

attitudes, Latin American women were more likely than White women to agree with the statement that personal problems should not be talked about outside the family. In addition, although stigma did not yield significant results for Latin American women, the author noted that a follow-up qualitative study suggested that stigma was indeed a significant barrier to help-seeking for these women. These findings suggest that lower rates of help-seeking among ethnic minority women may be due to more negative attitudes toward help-seeking and mental health.

Nadeem et al. (2007) also examined the impact of stigma-related beliefs and concerns on mental health services use among U.S.-born White, U.S.-born and immigrant Black and Latina low-income women. The authors reported that stigma and negative attitudes played an important role in the understanding of mental health use among the women. For instance, among the women without depression, immigrant Black and Latina women were more likely to report stigma related concerns than U.S.-born White women. Furthermore, when the authors assessed whether women with depression wanted treatment, having stigma concerns was related to lower desire for treatment among immigrant women of ethnic minority groups (across the two different ethnic groups due to small sample sizes) but not for U.S.-born Whites or U.S.-born persons from ethnic minority groups. That is, stigma seemed to be a more significant barrier of intentions to seek help for immigrant women from ethnic minority groups compared to the other non-immigrant women.

Overall, empirical evidence supports the importance of attitudes in the decision to seek psychological help. Research has shown that attitudes toward psychological help mediate the relations between various psychological variables and intentions to seek help among White and Asian American individuals. Although this relation likely holds true for

Latin Americans as well, few empirical investigations have tested this directly. Moreover, some evidence points to the important role of stigma in the decision to seek help among Latin Americans. However, empirical studies examining the impact of stigma on help-seeking attitudes and intentions to seek help in this population are generally lacking. One possible explanation for this gap in the literature may be that until recently most stigma measures lacked adequate psychometric properties. In this proposed research, a newly developed and validated stigma measure (i.e., the Perceptions of Stigmatization by Others for Seeking Help scale: Vogel, Wade, & Ascherman, 2009) was utilized to further examine the impact of stigma on help-seeking among Latin Americans.

### **Subjective Norms: Definition, Theory, and Measurement**

According to the TRA model, both attitudes and subjective norms predict intentions to perform a given behaviour. Ajzen and Fishbein (1980) defined subjective norms as a person's "perception that most people who are important to him think he should (or should not) perform the behavior in question" (p. 57). In other words, subjective norms refer to a person's perceived social pressure from important referents. The usefulness of 'norms' in psychology research, however, has been questioned due to vague and inconsistent definitions of the construct (Cialdini, Reno, & Kallgren, 1990; Lapinski & Rimal, 2005). Cialdini et al. (1990) attempted to clarify the definition of normative influences on behaviour, which they referred to as social norms, and proposed two different types of social norms. The first type of social norm is referred to as *descriptive norms*, which specify what most people typically do (i.e., how others behave) in a given situation. *Injunctive norms*, on the other hand, specify what people approve or disapprove of in a given culture. Therefore, the subjective norm construct defined by

Ajzen and Fishbein (1980) can also be described as injunctive norms (Cialdini et al., 1990).

In contrast to attitudes, the impact of subjective norms on intentions to perform a given behaviour has not been well established (Armitage & Conner, 2001). A meta-analysis of the TRA research suggested that attitudes toward the behaviour in question have a robust effect on intentions to perform the behaviour, but that subjective norms, on the other hand, seem to be the weakest component of the TRA model (Armitage & Conner, 2001; Godin, Maticka-Tyndale, Adrien, & Manson-Singer, 1996). Some researchers have interpreted these findings as meaning that social pressures are less important as determinants of intentions to perform a given behaviour compared to attitudes toward the behaviour. As a result, some studies have removed subjective norms from their analyses and have focused mainly on attitudes as the sole predictor of intentions (Sparks, Shepherd, Wieringa, & Zimmermanns, 1995; Vogel et al., 2007). Armitage and Conner (2001), however, suggested that inadequate measurement of the subjective norm construct might account for the weaker effects of subjective norms on intentions to perform a behaviour. For example, the majority of researchers have used single items to assess subjective norms, instead of more reliable multiple items scales (Armitage & Conner). Armitage and Conner investigated this possibility by comparing the effect on intention to perform a behaviour (across various behaviours) of single-item versus multiple-item measures of subjective norms. The authors reported that multiple-item measures of subjective norms, compared to single-item measures, had stronger correlations with intentions to perform the behaviour in question.

A second possible explanation for the weaker effect of subjective norms on intentions compared to attitudes is that there may be individual differences in the

importance of social influences (Armitage & Conner, 2001; Lapinski & Rimal, 2005). For instance, some studies have suggested that subjective norms may play a larger role in predicting intentions to perform a behaviour among individuals with stronger interdependent self-construal compared to more independent self-construal (Park & Levine, 1999; Trafimow & Finlay, 1996). According to cross-cultural researchers, the meaning of the *self* varies across cultures (Markus & Kitayama, 1991; Triandis, 1996). In collectivistic cultures, for example, the self is defined as interdependent, or as part of a collective (e.g., family or members of the in-group), where the goals of the in-group are placed before personal goals, and norms, duties and obligations dictate social behaviour (Triandis, 1996). Examples of collectivistic cultures include Asian, African and Latin American cultures. In contrast, in individualistic cultures, the self is defined as independent and autonomous, where personal goals are placed before the goals of the collective and behaviour is mainly shaped by attitudes (Triandis). Furthermore, Triandis suggested that although social behaviour is a function of both attitudes and norms, their relative importance may differ for persons from collectivistic cultures compared to persons from individualistic cultures, such that individuals from collectivistic cultures may place more importance on social norms than personal attitudes as determinants of their behaviour. Some empirical evidence exists to support Triandis' assertion and will be discussed in the following section pertaining to research in the area of help-seeking for psychological distress.

### **Subjective Norms and Help-Seeking for Psychological Problems**

To date, a small number of studies have examined the impact of subjective norms on intentions to seek help for psychological problems (Codd & Cohen, 2003; Halgin, Weaver, Edell, & Spencer, 1987; Vogel et al., 2005). For example, Vogel et al. (2005)

employed the TRA to gain a better understanding of help-seeking behaviour for psychological distress using a sample of American university students. The authors examined the impact of subjective norms and attitudes, as well as various psychological variables, including social stigma and self-concealment, on intentions to seek help for psychological problems. The authors referred to subjective norms as 'social norms' and used a single item to assess the subjective norm construct, as described by Bayer and Peay (1997) and Ajzen and Fishbein (1980). Using structural equation modeling to test the mediation model, Vogel and colleagues reported that attitudes toward seeking professional psychological help mediated the relationship between several psychological factors (i.e., social norms, social support, anticipated utility of therapy, social stigma) and willingness to seek counselling for interpersonal and drug problems among college students. Contrary to the TRA, social norms were not found to have a direct effect on intentions to seek counselling for psychological problems in this sample.

Codd and Cohen (2003) investigated intentions to seek help for alcohol abuse among college students using the TRA model. In contrast to Vogel et al. (2005), the study's results revealed that both attitudes toward seeking help and subjective norms significantly predicted intentions to seek help for alcohol abuse. Intentions to seek help, attitudes toward seeking help and subjective norms were all assessed using a single item, as described by Ajzen and Fishbein (1980). When comparing the relative effect of attitudes toward seeking help and subjective norms, the authors reported that attitudes toward seeking help appeared to have a greater impact on intentions to seek help. Furthermore, when the authors controlled for alcohol use among the college students, attitudes toward seeking help was the only significant predictor of intentions to seek help. The authors believed that the TRA provided an adequate framework to investigate help-

seeking behaviour and interpreted the study's results as demonstrating that attitudes play a more important role in predicting intentions to seek help than subjective norms. Even though these authors developed the study variables (i.e., intentions, attitudes, and subjective norms) using the methodology described by Ajzen and Fishbein (1980), they expressed concerns regarding the limitations of using single items to assess these constructs and suggested that the model could be strengthened by developing additional approaches to measure these constructs. Thus, a multi-item measure of subjective norms was used in the present study.

Research on the TRA among ethnic minority populations appears to provide support for Triandis' (1996) assertion that the relative importance of attitudes and subjective norms may vary across different cultures. For example, Kim and Park (2009) adapted the TRA model to examine the relation between Asian values and help-seeking intentions among Asian American college students. Specifically, the authors tested a mediation model to explore whether the relation between Asian values and intention to see a counselor was mediated by attitudes toward seeking professional psychological help and subjective norms. Subjective norms were assessed by asking participants to rate the normative beliefs of important referents, such as their father, mother, siblings, relatives, ancestors and professors in relation to seeing a counselor (e.g., My father believes that I should/should not see a professional counselor when personal problems arise) and the participant's motivation to comply with each referent's view on mental health services. The results of Kim and Park's study demonstrated that perceived subjective norms relating to the acceptability of help-seeking mediated the relationship between Asian values and help-seeking intentions among Asian American students. That is, stronger endorsement of Asian values was associated with negative subjective norms related to

seeing a professional counselor, and negative subjective norms, in turn, were associated with less willingness to see a counselor. In contrast, attitudes toward seeking professional psychological help were not found to significantly mediate the relation between Asian values and intentions to seek help. The study findings suggest that social influences, as assessed by subjective norms, play an important role in the link between Asian values and help-seeking intent among Asian American students.

Similarly, Barksdale and Mollock (2009) tested a culturally modified help-seeking model among African American college students. Specifically, the authors tested the ability of the TRA model to predict help-seeking intentions among African American students. The authors tested the ability of their culturally modified subjective norms relating to help-seeking (e.g., perceived family and peer norms) to predict intentions to seek help. The role of attitudes, however, was not explored in this study. The authors reported that both perceived family and peer social norms were negatively associated with help-seeking intentions. However, hierarchical regression analysis revealed that, when other variables were held constant, perceived family norms were the only significant predictor of help-seeking intentions among African American students. This study provides support for a central role of the family among African Americans and suggests that perceived family norms influence the underutilization of mental health services among individuals of this cultural group.

These studies demonstrate the usefulness of the TRA in explaining help-seeking intentions among diverse populations and provide support for the assertion that the relative importance of attitudes and subjective norms may be influenced by cultural characteristics. Additionally, it is important to note that Kim and Park (2009) and Barksdale and Mollock (2009) incorporated the TRA using diverse ethnic samples as well



as using culturally expanded subjective norms. As such, this construct was adapted to reflect the important referents (i.e., family, friends, church members) of the particular cultural group being studied. This approach was employed in the present study to examine the influence of subjective norms on intentions to seek help among Latin Americans.

### **Subjective Norms and Help-Seeking Among Latin Americans**

A review of the literature revealed only one published study that had applied the TRA to explore help-seeking intentions for mental health problems among Latin Americans. Based on the TRA, Cabassa and Zayas (2007) tested the effect of attitudes toward seeking depression treatment and subjective norms on intentions to seek treatment for depression among adult Latin Americans. The study's sample consisted of 95 adult Latin American primary health clinic patients, predominantly of Mexican origin. The sample also included a small number of Central American, Caribbean, and South American individuals. The authors presented the participants with a vignette depicting an individual experiencing a major depression disorder episode and asked the participants about what their intentions would be regarding seeking help from both informal (i.e., family, friends or religious leader) and formal (i.e., general medical provider, psychiatrist or other mental health provider) sources of care if they were facing a similar situation. The authors reported that after controlling for demographic variables such as age and gender, intentions to seek formal sources of care for depression were predicted by both subjective norms of family and attitudes toward mental health providers. This study suggested that the TRA can be successfully applied to Latin American individuals to investigate intentions to seek help for mental illness and that both attitudes and subjective norms are important in determining help-seeking among this population.

Research outside of help-seeking for psychological distress also provides additional support for the role of subjective norms in predicting intentions to perform a behaviour among Latin Americans. For instance, Flores, Tschann and Marin (2002) used a culturally expanded version of the TRA to examine how Latina adolescents' intentions to have sex in the coming month were influenced by attitudes toward having sex and by their perception of social norms of important referents (e.g., father, mother, cousin, best friend) about having sex. The sample consisted of Mexican and Central American adolescents, ages 14-19. The study's results showed that social norms alone predicted intentions to have sex in the next month among Latina adolescents. That is, social norms of important referents appeared to be more important in predicting intentions to have sex among Latina adolescents than individual attitudes about having sex. The authors hypothesized that these findings might be due to collectivistic Latin American cultural values and higher familism in this population.

Additional support for the importance of normative influence in the lives of Latin Americans comes from research examining the impact of social networks on help-seeking. Several researchers have suggested that social networks influence the help-seeking process (Cauce et al., 2002; Pescosolido et al., 1998; Rogler & Cortes, 1993). Pescosolido et al. (1998) stated that most of the research on the influence of the social networks focused on the size of the network without taking into account the beliefs and values of the social network. For example, members of one's social network may hold views that are congruent or incongruent with formal help-seeking and may influence help-seeking behaviour accordingly. As a result, social networks can facilitate or impede help-seeking for psychological distress. Pescosolido et al. (1998) used data from the 1989 Mental Health Care Utilization Among Puerto Ricans Study to investigate the influence

of social networks on service use for mental health problems. The authors found that larger, more supportive social networks among low-income Puerto Ricans decreased the use of formal help-seeking for mental health problems. These findings provide additional evidence for the importance of social influences on help-seeking among Latin Americans. Thus, the present study further explored the impact of social influences on help-seeking by examining the impact of subjective norms on intentions to seek help for psychological problems among Latin Americans in Canada.

In addition to psychological variables, cultural variables have also been implicated in the decision to seek psychological help among ethnic minority individuals. Therefore, the present study aimed to extend the TRA model of help-seeking by additionally testing the role of various critical cultural variables in the decision to seek psychological help among Latin Americans living in Canada.

### **The Impact of Culture on Help-Seeking among Latin Americans**

Researchers and clinicians have suggested that cultural values play an important role in help-seeking for psychological problems among Latin Americans (Altarriba & Bauer, 1998; Frevert & Miranda, 1998). Broadly speaking, culture has been defined as “all those things that people have learned to do, believe, value, and enjoy. It is the totality of the ideals, beliefs, skills, tools, customs and institutions into which each member of society is born” (Sue & Sue, 2008, p. 140). According to the cultural barrier theory, certain values, beliefs and behaviours in the Latin American culture are incompatible with the values underlying American and Canadian mental health services, which result in reduced help-seeking for mental illness by this population (Alvidrez, 1999; Bledsoe, 2008; Leong et al., 1995). Rogler (1989), for instance, suggested that various Latin American cultural values could lead to distrust of mental health services and impede

formal help-seeking. These values include *machismo* (pride in manliness/gender roles), *personalismo* (trust in the immediate person rather than the institution), *verguenza* (sense of shame), and familism (values pertaining to family cohesion and loyalty).

Furthermore, other researchers have also speculated that Latin American cultural values influence the coping strategies used by Latin Americans to deal with psychological distress (Altarriba & Bauer, 1998; Frevert & Miranda, 1998). For example, Latin Americans may have access to a number of alternative resources such as family supports, religious leaders, and folk healers that can help them cope with psychological distress (Falicov, 1998; Prieto, McNeill, Walls, & Gómez, 2001). Moreover, others have suggested that strong extended family often represents a way of coping with emotional problems by Latin Americans. As a result, Latin Americans will seek help from a mental health professional only as a last resort when informal sources have failed to provide relief (Echeverry, 1997; Keefe & Casas, 1980; Leong et al., 1995).

In general, empirical research testing the impact of cultural values on Latin American help-seeking for psychological distress is sparse. In fact, one of the major limitations of many studies with ethnic minority populations is that researchers often fail to include validated measures of specific cultural variables in their studies, such as cultural beliefs and norms (Betancourt & López, 1993; Castro & Alarcón, 2002; U.S. Department of Health and Human Services, 2001). Not including specific measures of cultural norms and beliefs limits the understanding of within- and between- group differences in the findings and may result in perpetuating cultural stereotypes (Betancourt & López, 1993; Castro & Alarcón, 2002; Hunt et al., 2004). Thus, one of the goals of the present research was to address this gap in the literature.

### **Culturally Modified Help-Seeking Models**

As presented above, cumulative research has indicated that cultural factors influence behaviour (Berry, 1997; Betancourt & López, 1993; Bledsoe, 2008; Sue & Sue, 2008). Despite this evidence, many theoretical models in psychology continue to ignore the impact of culture (Betancourt & Lopez, 1993) and have been criticized for being “culturally blind” (Castro & Alarcon, 2002, p. 783). Researchers have recommended that ethnic minority research incorporate specific cultural variables into existing psychological theories (Betancourt & Lopez, 1993; U.S. Department of Health and Human Services, 2001). Doing so will aid the understanding of both universal and culture-based psychological processes (Betancourt & Lopez, 1993). Accordingly, some multicultural researchers have stressed the importance of adapting current help-seeking models based on culturally relevant variables to improve the understanding of this process (Ashing-Giwa, 1999; Castro & Alarcón, 2002; Pescosolido, Wright, Alegría, & Vera, 1998). To date, only a small number of help-seeking studies have followed this recommendation (for examples see Kim & Park, 2009; Liao, Rounds, & Klein, 2005; Morgan et al., 2003).

Liao et al. (2005) evaluated how well Cramer’s (1999) help-seeking model generalized to Asian American students, and whether acculturation improved the model fit for this population. Cramer’s help-seeking model proposes that self-concealment and social support impact attitudes toward help-seeking and psychological distress, and these in turn impact individuals’ intentions to seek help. The authors reported that Cramer’s help-seeking model did generalize to Asian students. However, the addition of acculturation significantly improved the fit of the model for the Asian participants and provided a fuller understanding of the help-seeking process among Asian individuals.

In a second example, Kim and Park (2009) culturally adapted the TRA model to examine the relation between Asian values and help-seeking intentions among Asian American college students. This study demonstrated that including a measure of Asian values improved the explanatory value of the TRA model. Specifically, the study's findings suggest that social influences, via subjective norms, play an important role in the association between Asian values and help-seeking intentions among Asian American students. The study also demonstrated that the TRA can be successfully adapted to provide a culturally-relevant model of help-seeking.

Taken together, these studies demonstrate how adapting current help-seeking models by including cultural variables can provide additional information about help-seeking among ethnic minority individuals. That is, the decision to seek help for mental health problems among ethnic minority individuals is likely influenced by *both* psychological and cultural factors. Thus, the present study contributed to this growing area of research by extending the TRA to examine the impact of both psychological and cultural variables on help-seeking among Latin Americans in Canada.

The subsequent sections will focus on three critical cultural variables hypothesized to impact help-seeking among Latin Americans: acculturation, familism, and culture-based coping strategies. The literature pertaining to the relationship between each of these cultural variables and help-seeking will be reviewed.

### **Acculturation: Definition**

Acculturation is a significant cultural variable in immigrant and cross-cultural research (Berry, 1997; Kim & Abreu, 2001; Ryder, Alden, & Paulhus, 2000).

Acculturation has been defined as “phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent

changes in the original culture patterns of either or both groups” (Redfield, Linton & Herskovits, 1936, p. 149, as cited by Berry, 1997). The classic definition of acculturation implies changes in both groups although most theories and measures have focused on changes in the group being acculturated to the dominant culture group (Berry, 1997). Furthermore, Graves (1967) coined the term *psychological acculturation*, which refers to acculturation changes at the individual level. Distinguishing between individual-level and group-level acculturation is important because the acculturation changes experienced by an individual of a given ethnic group may be different from the changes experienced by the group as a whole (Berry, 1997). The present paper will focus on acculturation at the individual level.

Acculturation examines what happens when an individual from one culture is being exposed to a new culture and attempts to adapt to that culture (Berry, 1997; Ryder et al., 2000). Exposure to a new culture may involve changes and adaptation in many domains, including self-identity, beliefs, behaviours, and attitudes (Kim & Omizo, 2003; Ryder et al., 2000). Similarly, Cuellar et al. (1995) proposed that the acculturation process involves changes in behaviour, affect, and cognition. Behavioural changes include changes in language use and cultural expressions, as well as food or music preferences. Affective changes include changes in how a person feels about important aspects of their self-identity or emotional reactions to important cultural symbols. Finally, cognitive changes include alterations in beliefs, attitudes, values, and norms due to cultural transition.

### **Acculturation: Theory and Measurement**

The definition of acculturation has been revised and expanded over the years beyond Redfield et al.’s (1936) original definition. Consequently, many models exist that

attempt to explain this complex process. Two theoretical models have dominated acculturation research: the unidimensional and the bidimensional models of acculturation.

The first model of acculturation is the unidimensional model (Kim & Omizo, 2003). From this perspective, change from the culture of origin (often described as the heritage culture) toward the mainstream culture occurs along a single linear continuum. For example, an immigrant is assumed to adopt the dominant culture's values and behaviours while simultaneously discarding the values and behaviours of their culture of origin. Assimilation is the term often used to describe the process of discarding the original culture while adopting the dominant culture. The degree of cultural change in the acculturating individual ranges somewhere between two extremes, complete identification with the heritage culture to complete identification with the mainstream culture. Biculturalism is assumed to be the midpoint between the two extremes. Based on the unidimensional model, researchers have used either proxy measures of acculturation or unidimensional self-report measures of acculturation (Ryder et al., 2000). For instance, a large number of studies have used demographic variables, such as generational status, age of migration, years lived in the new country, as proxy measures of acculturation (Dinh, Castro, Tein, & Kim, 2009; Lara et al., 2005). The underlying assumption of using demographic variables is that greater exposure to the new culture signifies greater adaptation to the new culture. Although the use of demographic variables is easy and efficient, this approach has been criticized for being too simplistic and for not taking into account individual differences in the rate of acculturation, such as premigration exposure to the mainstream culture or current level of contact with the mainstream culture (Cabassa, 2003; Kim & Abreu, 2001). Overlooking individual differences could lead to generalizations and stereotypes of a given cultural group (Kim & Abreu, 2001).



Furthermore, other researchers have relied on unidimensional self-report measures of acculturation to assess cultural changes in immigrants (see Gil, Wagner, & Vega, 2000; Rodríguez & Kosloski, 1998). Unidimensional measures of acculturation assume that acculturation change occurs along a single continuum, with high heritage culture adherence on one end and high host culture adherence on the other. Although this approach is considered an improvement over the use of demographic variables, it is not without criticism (Ryder et al., 2000). For instance, unidimensional self-report measures are unable to distinguish between people who are bicultural (equal adherence to both cultures) and people who identify with neither culture, as both groups would end up in the middle of the continuum (Ryder et al., 2000).

In contrast to the unidimensional approach of acculturation, theorists have developed the bidimensional model of acculturation. Proponents of this model argue that changes in heritage culture and mainstream culture may be assessed independently of each other (Kim & Abreu, 2001; Ryder et al., 2000). From this perspective, individuals may adopt certain aspects of the mainstream culture while retaining other aspects of their heritage culture (Ryder et al., 2000).

One of the most researched bidimensional models of acculturation is Berry's model of acculturation (1980, 1997). According to Berry, there are two important issues faced by individuals. The first is the extent of cultural maintenance of one's original heritage culture that the individual desires, and the second is the individual's extent of contact and participation with other (host) cultural groups. Based on these two issues, Berry proposed four different acculturation strategies. Assimilation is the strategy used by an individual who has chosen low heritage cultural maintenance and high contact and participation with the mainstream culture. That is, the individual has given up his or her

culture of origin and has adopted aspects of the new culture. Integration is the strategy used by an individual who has chosen both high heritage cultural maintenance and high mainstream cultural contact and participation. Integration is related to biculturalism such that the individual has retained certain aspects of their culture of origin and has also adapted to the new culture. Separation involves high heritage cultural maintenance with low contact and participation with the dominant culture. And finally, marginalization involves neither maintenance of one's heritage culture nor contact and participation with the dominant cultural group. Marginalization and separation are not always adopted by choice but instead may reflect societal circumstances and policies, such as segregation or discrimination (Cuéllar, Arnold, & Maldonado, 1995; Lara et al., 2005; Marín, 1992). Although Berry's conceptual model has contributed significantly to the understanding of the acculturation process, researchers have questioned the validity of using four separate acculturation categories (Ryder et al., 2000). Instead, researchers have suggested that a more valid and comprehensive approach would involve assessing each of the acculturation dimensions (i.e., heritage cultural adherence and mainstream cultural adherence) separately (Ryder et al., 2000).

Both the unidimensional and the bidimensional models of acculturation have generated substantial research and contributed to a greater understanding of the acculturation process (Ryder et al., 2000). However, the bidimensional approach provides a more valid and in-depth account of the acculturation process that takes into account individual differences in adaptation to the mainstream culture (Ryder et al., 2000). For instance, Ruelas et al. (1998) investigated the role of acculturation on perceived counselor credibility in a sample of Mexican American students. Counselor credibility was assessed across four different helping styles with the use of vignettes. Acculturation was assessed

using both a unidimensional and a bidimensional approach. When using the unidimensional approach of acculturation, the results showed that perceived counselor credibility, regardless of helping style, decreased as adherence to American culture increased (i.e., assimilation). However, when the authors used the bidimensional approach, and assessed both Mexican cultural adherence and American cultural adherence independently, the results demonstrated that a decrease in Mexican cultural adherence was associated with lower perceived counselor credibility. In contrast, American cultural adherence was not associated with counselor credibility. The authors concluded that using the unidimensional approach alone would have provided an incomplete picture of the reality by ignoring the positive effects of the Mexican culture on perceived credibility. Thus, this present study adopted a bidimensional approach to assess acculturation as it provides a richer and a more concise reflection of the acculturation process as compared to the unidimensional approach.

### **Acculturation and Help-Seeking among Latin Americans**

The cultural barrier theory (Leong et al., 1995) predicts that greater adherence to Latin American cultural values interferes with help-seeking for psychological distress among Latin Americans. To date, empirical studies that have tested the relationship between acculturation and help-seeking attitudes and intentions to seek help for psychological distress among this population have generated inconsistent findings.

Early studies by Wells and colleagues (1987, 1989) suggested that acculturation played a significant role in help-seeking among Mexican Americans. The authors assessed acculturation level using a unidimensional measure of acculturation. The authors found that less acculturated Mexican Americans reported significantly lower rates of using mental health care services than more acculturated Mexican Americans (1989) and

non-Hispanic Whites (1987). These differences remained significant even after controlling for demographic and economic factors, health status, and insurance coverage. However, there was no difference in the use of general medical health services among the three groups.

More recently, Miville and Constantine (2006) investigated the role of acculturation and perceived social support in predicting help-seeking attitudes and past help-seeking behaviours among Mexican American college students. The authors assessed acculturation using a bidimensional measure of acculturation. The study found that neither Mexican cultural orientation nor American cultural orientation predicted attitudes toward seeking professional help among the Mexican student sample. However, greater American cultural orientation was positively correlated with past help-seeking behaviour (i.e., seeking counselling in the past year), whereas there was no relation between Mexican cultural orientation and past help-seeking behaviour. This study suggests that acculturation might not have affected the participants' help-seeking attitudes but did influence their help-seeking behaviour.

Ramos-Sanchez and Atkinson (2009) also studied the relationship between acculturation, gender, and cultural values on help-seeking attitudes and intentions to seek help in a sample of Mexican American community college students. The authors assessed acculturation using a bidimensional approach. In contrast to Miville and Constantine's (2006) findings, the study showed that higher Mexican cultural orientation predicted more positive attitudes toward seeking professional psychological help. American cultural orientation, on the other hand, was not related to attitudes toward professional psychological help-seeking. Furthermore, generational status of the participants was related to both attitudes and intentions to seek help, such that individuals with lower

generation status, and possibly higher adherence to Mexican culture, reported more positive attitudes toward seeking professional psychological help and more willingness to seek help. The authors hypothesized that certain aspects of Mexican culture not directly assessed in their study, such as respect for authority figures and educated professionals, may have motivated the use of mental health services among Mexican Americans with stronger Mexican cultural orientation.

Finally, in an unpublished dissertation, Herrera (2006) applied structural equation modeling statistics to explore the direct and indirect effects of acculturation on willingness to see a counselor in a sample of Mexican college students. Herrera's study showed that neither American nor Mexican cultural orientation had a direct effect on willingness to see a counselor among the Mexican students. However, the findings revealed that American cultural orientation had a significant indirect effect on willingness to see a counselor, such that students with greater American cultural orientation reported less shame, which in turn, was associated with greater willingness to see a counselor. A similar relationship was found for Mexican cultural orientation. That is, students with stronger Mexican cultural orientation also reported less shame, which was then associated with greater willingness to see a counselor. Herrera's study highlights the importance of examining the indirect effects as well as the direct effects predictors have on willingness to seek help.

While several cultural researchers have written about the impact of acculturation on help-seeking among Latin Americans (Bledsoe, 2008; Mezzich, Ruiz, & Muñoz, 1999; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999), the cumulative empirical studies have not yielded consistent results. Thus, more research is needed to help clarify past inconsistencies. To date, the majority of acculturation research has focused on the direct

effects of acculturation on various outcome variables, such as help-seeking attitudes (Lara et al., 2005). Lara and colleagues (2005) recommended that future acculturation studies should use more complex statistical approaches (e.g., path analysis) to explore mediation and indirect effects, in addition to direct effects between variables. Consistent with this recommendation, research with Asian Americans has shown that acculturation has an indirect effect on willingness to seek help mediated by attitudes toward help-seeking (Kim & Omizo, 2003; Liao et al., 2005). Moreover, acculturation studies of Latin Americans thus far have mainly focused on Mexican Americans and have not adequately included other Latin American subgroups (Lara et al., 2005). The present study employed a bidimensional measure of acculturation to explore the relationship between acculturation and attitudes toward seeking professional psychological help and intentions to see a counselor among Latin Americans. Further, the present study used path analysis statistics to explore the direct, indirect, and mediational effects between variables in a diverse sample of Latin American adults.

### **Familism: Definition**

Latin Americans are a heterogeneous group of individuals from diverse backgrounds, in terms of country of origin and race. Despite these differences, Latin Americans share similar attitudes towards the family (Sabogal et al., 1987). Although familial relationships are important in most cultures, there appear to be differences in expectations, values, and beliefs about the role of the family across cultures (Luna et al., 1996; Sue & Sue, 2008). Traditional Latin American culture influences family values, which include family unity, respect for and loyalty to the family, and cooperation among family members (Sue & Sue, 2008). Families tend to be hierarchical whereby older individuals demand more respect than younger ones. This value influences child rearing

practices and intergenerational relationships (Hines, Garcia-Preto, McGoldrick, & Almeida, 1992), within which obedience is valued and loyalty to the family is emphasized. Latin American culture also influences family structure such that families tend to include extended family members resulting in families that are larger than typical North American families (Sue & Sue, 2008). Within these large families, reciprocal relationships of mutual obligations are expected. The family experience for Latin Americans is often characterized by positive affect, high cohesion, and collaborative problem-solving processes and support (Merali, 2005). For many Latin Americans, the family serves as an emotional support system that functions as a protective factor against many stressors (Sabogal et al., 1987).

Familism, which is often described as a strong identification and attachment with one's family that involves feelings of loyalty and reciprocity, is considered to be one of the most important Latin American cultural values (Frevert & Miranda, 1998; Marín & Marín, 1991; Sabogal et al., 1987). The familism construct is multidimensional and is comprised of at least three different dimensions: attitudinal, behavioural, and structural (Valenzuela & Dornbusch, 1994). Attitudinal familism involves values and beliefs regarding the role played by the family. Behavioural familism refers to the behaviours based on the beliefs mentioned above, such as calling family members or helping family when in need. Structural familism, in turn, refers to the presence or absence of extended family members in the person's immediate environment (e.g., the number of relatives within driving distance). The majority of research on familism has focused on the attitudinal component because of its relationship with psychological functioning (Gil et al., 2000; Villarreal, Blozis, & Widaman, 2005). For example, in a longitudinal study Gil et al. (2000) investigated the role of acculturation and attitudinal familism on alcohol use

among immigrant and U.S.-born Latin American adolescent males. The study revealed that lower attitudinal familism was associated with higher rates of alcohol use in both the immigrant and U.S.-born Latin American subsamples. The authors suggested that family values were protective factors against substance use among Latin American adolescents and that the deterioration of these values was associated with increased alcohol use. The following literature review will focus on attitudinal familism specifically.

### **Measurement of Familism**

Even though most researchers agree on the significance of familism in the lives of Latin Americans (Alvidrez, 1999; Dinh et al., 2009; Frevert & Miranda, 1998), there is little consensus on how best to measure this construct (Villarreal et al., 2005). As a result, many different models and measures of familism have been used (Gil et al., 2000; Sabogal et al., 1987; Steidel & Contreras, 2003). Some researchers have examined the validity of multidimensional measures of familism (Sabogal et al., 1987; Steidel & Contreras, 2003), while others have explored individual components deemed to be important for Latin Americans, such as family support (Miville & Constantine, 2006), family cohesion (Mulvaney-Day, Alegría, & Sribney, 2007), and the significance of family (Gaines et al., 1997). However, researchers have suggested that multidimensional familism scales provide a more comprehensive and valid understanding of the familism construct (Steidel & Contreras, 2003; Villarreal et al., 2005). Thus, this review will focus on two multidimensional familism scales that have been demonstrated to possess adequate psychometric properties with diverse Latin American samples (Sabogal et al., 1987; Steidel & Contreras, 2003).

Sabogal and colleagues' (1987) scale is one of the most researched multidimensional familism scales. The authors tested the reliability and validity of their



Familism scale using a large sample ( $n = 452$ ) of Mexican, Cuban, Central American, and South American immigrants living in the United States compared to a sample ( $n = 227$ ) of White Americans. Based on their findings, the authors described three dimensions of attitudinal familism: a) Family obligations, b) Perceived support from family, and c) Family as referents. The family obligations factor includes items based on perceived obligations to provide material and emotional support to extended family members. The perceived support from family factor involves items assessing perception of family members as reliable sources of support in times of need. The Family as Referents factor includes items relating to seeing family members and relatives as behavioural or attitudinal social referents. All three factors were identified in the entire sample regardless of the participants' country of origin. Further, all Latin American participants reported similar levels of agreements with two of the factors, Perceived Family Support and Family as Referents. However, for Family Obligations, Cuban and Central American individuals reported similar levels of endorsement while Mexican Americans reported a lower level of endorsement on this factor. Overall, all Latin American groups scored higher on all three of the familism subscales (Family Obligation, Perceived Support from Family, and Family as Referents) than the non-Hispanic White sample (Sabogal et al.).

Sabogal et al. (1987) further tested the validity of their scale by exploring the relation between the three familism factors and acculturation and several demographic variables (i.e., generation status, number of years lived in Latin America). Using a unidimensional scale of acculturation based on language proficiency and preference, Sabogal et al. (1987) found that Latin Americans with lower levels of acculturation reported higher levels of agreement with family obligations and family as referents as compared to more acculturated Latin Americans. Furthermore, first generation

immigrants and those who had spent their first 15 years of life in Latin America, regardless of country of origin, reported higher levels of agreement with family obligations and family as referents than second generation immigrants. In contrast, the third factor (perceived family support) was elevated across all Latin American groups and was not affected by acculturation level, generation status, or country of birth. In addition, regardless of acculturation level (i.e., both low and high acculturation groups), the Latin American participants reported significantly greater agreement with perceived family support than the non-Latin American White participants. The authors interpreted these findings to mean that certain aspects of familism (i.e., family obligations and family as referents) decrease as individuals adapt to American culture, while other aspects of familism (i.e., perceived family support) remain important in the lives of Latin Americans, regardless of acculturation level.

In an attempt to expand on Sabogal and colleagues' work and to address some of the previous limitations of earlier scales, Steidel and Contreras (2003) developed a new familism scale, the Attitudinal Familism scale. Specifically, Steidel and Contreras expanded the definition of Familism to include the following dimensions: a) Subjugation of self to the family, such that the individual sacrifices their own needs and goals if they interfere with the family's needs and goals, b) Familial interconnectedness, which includes a strong emotional and physical bond with family members, c) Belief in familial reciprocity in times of need, and d) Familial honour, which involves protecting the family name or honour. Steidel and Contreras confirmed the presence of these four factors using a community sample of Latin Americans ( $N = 125$ , 86% of Puerto Rican background) and reported adequate reliability scores. To test the validity of the scale, the authors examined correlations between the Familism scale and acculturation and generation status. The

authors used a bidimensional measure of acculturation. As expected, the overall Familism score was negatively correlated with higher American cultural orientation and positively correlated with higher Latin American cultural orientation. A similar pattern of correlation was found with two of the subscales, Familial Honour and Interconnectedness. In contrast, two of the subscales, Familial Support and Familial Honour were not correlated with acculturation. These findings are consistent with Sabogal's (1987) previous findings on Family Support, which was found not to be affected by levels of acculturation.

Despite differences in how the familism construct might have been conceptualized and measured, research findings consistently point to higher familism scores among Latin Americans than their White American counterparts (Ramirez et al., 2004; Sabogal et al., 1987; Valenzuela & Dornbusch, 1994). These findings provide support for the importance of familism as a core Latin American cultural variable.

### **Familism and Help-Seeking Among Latin Americans**

Familism may also play an important role in help-seeking attitudes and behaviours among Latin Americans. Some researchers have posited that the Latin American family believes that mental illness is best treated within the family and that family members would not approve of a family member seeking help (Frevert & Miranda, 1998; Whitley et al., 2006). From a family-oriented and collectivistic perspective, Latin American individuals may be more likely to seek help from other family members and may feel guilty about seeking help outside the family (Altarriba & Bauer, 1998; Frevert & Miranda, 1998). For example, Alvidrez (1999) reported that Latin American women were more likely to endorse the belief that problems should not be talked about outside of the

family than Black and White women. However, only a few empirical studies have explored the relationship between familism and mental health services use.

Ramos-Sanchez and Atkinson (2009) investigated acculturation and Latin American cultural values as predictors of help-seeking attitudes and willingness to see a counselor in a sample of Mexican American college students. Familism was one of the Latin American cultural values assessed in that study although the scale used had a weak reliability ( $\alpha = .65$ ). The authors reported that familism was not correlated with attitudes toward seeking help but was negatively correlated with intentions to seek help. That is, higher levels of familism were associated with less willingness to seek help. Hierarchical regression analysis, however, showed that after controlling for demographic variables such as gender and generation status, familism was not a significant predictor of intentions to seek help. Moreover, in an unpublished dissertation, Garcia (2008) examined the relationship between various variables including familism and attitudes toward seeking professional psychological help in a sample of Puerto Rican and Dominican college students. Garcia used Steidel and Contreras' (2003) multidimensional familism scale. The findings showed that one of the subscales of the attitudes toward seeking professional help (i.e., stigma tolerance) was negatively correlated with one of the subscales of the familism scale (i.e., parental honour). That is, higher agreement with parental honour was associated with less stigma tolerance, and thus, more negative attitudes.

In addition, Miville and Constantine (2006) assessed familism by focusing on the subcomponent of perceived family support. The authors investigated the role of acculturation and perceived social support from various sources (i.e., family, friends and

significant others) on attitudes toward seeking professional help. The results revealed that greater perceived family support was associated with negative attitudes toward seeking professional help among Mexican American students.

In sum, there is some evidence to suggest that higher levels of familism may be associated with negative attitudes toward help-seeking and less willingness to seek help among Latin American individuals, although more research is needed. Therefore, the present study explored this issue further by adopting a multidimensional measure of familism to investigate the direct and indirect effects of family on help-seeking attitudes, subjective norms, and intentions to seek help among Latin Americans.

### **Coping Theory**

Coping research has been influenced significantly by the work of Lazarus and colleagues. Lazarus and colleagues' research in the 1950's and 60's reported that a given stressor did not always produce the same effect across people, and emphasized the importance of individual differences in cognitive processes that mediated the relationship between a stressor and a given reaction (Folkman & Lazarus, 1980; Lazarus, 1993; Lazarus & Folkman, 1987). As such, a person's appraisal of a given situation plays a pivotal role in their reaction to stress (Lazarus, 1993). Based on this model, a widely accepted definition of coping is the "thoughts and behaviours that people use to manage the internal and external demands of situations that are appraised as stressful" (Folkman & Lazarus, 1980, p.141). From this perspective, coping is viewed as a process where a person can alter his or her situation and/or alter how he or she interprets the situation. Lazarus and colleagues labeled changing the situation and engaging in coping actions as problem-focused coping, while changing the appraisal of the situation was labeled as emotion-focused coping. Lazarus' model has provided a useful conceptual model of

stress and coping and has generated a significant amount of research over the last 30 years (Endler & Parker, 1990; Folkman & Moskowitz, 2004). However, multicultural researchers have criticized this model for focusing too much on individualistic Western values and for failing to capture the diversity of coping strategies used by individuals from different cultural backgrounds (Dunahoo, Hobfoll, Monnier, Hulsizer, & Johnson, 1998; Kuo, 2011; Wong, Wong, & Scott, 2006).

### **Culture-Based Coping Among Ethnic Minority Populations**

Lazarus' model of coping focuses on the person-environment fit and emphasizes self-determined cognitive or behavioural responses to stressors. This model of coping is consistent with North American values that emphasize independence and individualism (Dunahoo et al., 1998; Wong et al., 2006). Although coping is universal, multicultural researchers have posited that individuals from collectivistic cultures, such as Asian, Latin American and African cultures, may utilize coping strategies that are more consistent with their interdependent tendencies and collectivistic cultural values and social norms (Kuo, 2011; Wong et al., 2006). Moreover, there have been some recent efforts to develop theoretical models of coping that consider the impact of culture on stress and coping. For example, Chun, Moos and Cronkite (2006) described a conceptual framework based on Moos' Transactional Theory of Coping (1984) that depicts the influence of culture on coping and stress. Specifically, Moos' theory describes the impact of cultural factors (i.e., individualism and collectivism) on various dimensions involved in the coping process, such as cognitive appraisals, coping skills and coping outcomes. According to this theory, for example, culture may influence how a stressful situation is construed, as well as the specific coping goals involved (e.g., reduce personal distress

versus maintain in-group harmony) and the coping strategies used to deal with a given stressor (Chun, Moos, & Cronkite, 2006).

Converging empirical evidence supports the impact of culture on coping. Wasti and Cortina (2002) investigated cross-cultural coping responses to workplace harassment among women from three different cultures (Anglo American, Latin American, and Turkish women). The study found that the women used the same coping strategies (i.e., avoidance, denial, negotiation, advocacy seeking, and social coping) to cope with workplace harassment across the three cultural groups. However, the results showed that Latin American and Turkish women engaged in more avoidance coping than Anglo American women. Further, Latin American women used more denial and less advocacy seeking (e.g., making a complaint or reporting the assailant) as compared to the Anglo American women. The authors interpreted the higher use of avoidance and denial strategies and the lower use of advocacy seeking among Latin Americans as a result of a greater emphasis on collectivistic cultural orientation and social harmony among this population in times of conflict and confrontation.

Moreover, recent studies have explored the role of specific cultural constructs, such as self-construal or acculturation, in explaining cultural differences in coping. A study by Lam and Zane (2004) investigated ethnic differences in coping with interpersonal stressors between Asian Americans and White Americans and tested the mediational role of self-construal (i.e., independent and interdependent self-construal) in the coping process. The authors applied Rothbaum and colleagues' (1984) theory of primary and secondary control coping. Primary control coping refers to changing the environment to fit one's needs, while secondary control coping refers to changing one's feelings and thoughts to adjust to the environment. The results showed that primary

control coping was preferred over secondary control coping among both Asian Americans and White Americans. However, there were also significant ethnic differences. Asian Americans were less oriented toward primary control coping and more oriented toward secondary control coping than White Americans. The authors then tested whether self-construal (i.e., independent versus interdependent self-construal) mediated the relation between ethnicity and coping. The results indicated that independent self-construal mediated the relation between ethnicity and primary control coping, such that greater orientation toward an independent self-construal fully accounted for the greater use of primary control coping among White Americans compared to Asian Americans. Similarly, interdependent self-construal partially mediated the relation between ethnicity and secondary control coping. That is, greater orientation toward an interdependent self-construal partially accounted for the greater use of secondary control coping among Asian Americans compared to White Americans. In addition, in Kuo, Roysircar, and Newby-Clark's (2006) study, less acculturated Asian students were found to engage in greater use of collectivistic coping strategies compared to more acculturated Asian students. Collectivistic coping strategies were defined by the authors as coping strategies based on group-referencing (e.g., referring to one's family or ethnic group) and cultural values. These studies provide compelling evidence for cultural differences in coping and suggest that cultural variables (i.e., self-construal, acculturation) may explain between- and within-group differences in coping strategies used by ethnic minority individuals. Given this evidence, researchers have urged that an integrative approach including *both* conventional (i.e., problem- and emotion-focused coping) and collectivistic coping strategies is needed to further elucidate the *etic* (universal) and *emic* (culture-based) dimensions of coping (Chun et al., 2006; Kuo, 2011).



To date, the majority of studies on the impact of culture on coping have focused on Asian American individuals (Kuo, 2011). However, a small but growing number of studies have examined the impact of culture on coping among Latin Americans. These studies will be discussed in greater detail below.

### **Culture-Based Coping Among Latin Americans**

Some research efforts have focused on culture-based coping strategies used by Latin Americans. Two coping strategies that have received some empirical attention in the literature are religious coping and the use of family supports (Campbell et al., 2009). For example, Abraido-Lanza, Guier, and Revenson (1996) conducted a qualitative study to explore the coping strategies used by Latin American women coping with arthritis. The results indicated that over one-third of the research participants used prayer and religion as a coping strategy. In a more recent study, Abraido-Lanza, Vasquez, and Echeverria (2004) further explored the coping strategies used by Latin American women with arthritis. The authors reported that religious coping (e.g., praying, seeking God's help, or putting faith in God) was an important coping strategy used by the participants. Path analysis revealed that religious coping was associated with active but not passive coping in the sample, and that religious coping was associated with greater psychological well-being (Abraído-Lanza, Vásquez, & Echeverría, 2004). In addition, studies that have examined ethnic difference in religiosity and religious coping among female White American and Latina family caregivers of relatives with dementia have reported that Latina caregivers rated religion as more important, and used more prayer and religious coping, than White American caregivers (Coon et al., 2004; Mausbach, Coon, Cardenas, & Thompson, 2003). Moreover, Farley and colleagues (2005) examined the coping strategies used by Mexican immigrants and non-Hispanic White Americans. The study

revealed that Mexican immigrants were more likely to use positive reframing, denial and religion, and less likely to use substance abuse and self-distraction as coping strategies compared to non-Hispanic White Americans.

Family support has also been identified as a significant coping strategy used by Latin Americans. Although the use of social support is universal, there is some evidence to suggest that Latin Americans may use family supports in a qualitatively different manner than other ethnic groups (Campbell et al., 2009). For instance, Guarnaccia and colleagues (1992) examined coping strategies used by caregivers of family members with mental illness. The authors reported that Latin Americans were more likely than European and African American individuals to turn to family members for support and advice. Moreover, Chiang and colleagues (2004) reported that Latin American students were more likely to cope by seeking support from their parents than Black students. These studies provide support for the influence of culture on coping strategies and suggest that the use of religious coping and family supports are important in the lives of Latin Americans.

### **Culture-Based Coping and Help-Seeking among Latin Americans**

Some multicultural researchers have hypothesized that Latin American cultural values that emphasize interdependent coping strategies may impede the use of formal help-seeking for psychological problems (Frevort & Miranda, 1998; Leong et al., 1995). That is, it may be more culturally appropriate for Latin Americans to cope with psychological distress by using sources of help other than formal help, such as informal resources through family and friends (Constantine, Wilton, & Caldwell, 2003; Rogler & Cortes, 1993). In an exploratory study, Chiang, Hunter and Yeh (2004) examined coping attitudes and strategies in a sample of Black ( $n = 75$ ) and Latin American ( $n = 55$ ) college

students. The authors employed the Coping Attitudes, Sources and Practices Questionnaire (CAS PQ: Yeh & Wang, 2000 as cited by Chiang et al., 2004), a coping questionnaire developed based on Asian collectivistic and interdependent coping attitudes and practices. Both samples reported using similar coping sources (i.e., talking with a friend, parents or significant other). However, Latin Americans were more likely to talk to their parents than Black students when dealing with academic, personal and interpersonal stressors. The authors also investigated the students' attitudes toward seeking professional counselling and seeking support from others in their support networks. Both Black and Latin American students had unfavourable attitudes toward counselling and both preferred coping strategies involving family, friends, and significant others.

There is some evidence to suggest that Latin Americans with strong social support networks may delay seeking formal help and may do so as a last resort. McMiller and Weisz (1996) investigated help-seeking pathways among African-American, Latin American, and White American families. Compared to White American parents, Latin American parents were less likely to contact professionals when seeking advice or help regarding their children's problems and more likely to contact family or other community sources instead. In addition, Pescosolido et al. (1998) reported that larger, more supportive social networks among low-income Puerto Ricans actually decreased the use of formal help-seeking for mental health problems. Similarly, Constantine, Wilton, and Caldwell (2003) investigated the role of social support and psychological distress on willingness to seek psychological help among Black ( $n = 96$ ) and Latin American ( $n = 62$ ) college students. The authors reported that higher satisfaction with social supports

predicted less willingness to seek counselling for mental health problems among Black and Latin American students.

On the other hand, Moore and Constantine (2005) examined coping strategies among African, Asian, and Latin American international students using the Collectivistic Coping Styles Measure (CCSM), a coping scale designed based on collectivistic and interdependent cultural values. The scale consists of two subscales, social support seeking and forbearance. Forbearance was defined as “the tendency to minimize or conceal problems or concerns so as not to trouble or burden others” (p. 331). Participants were asked to think about a recent problem and to rate the extent to which they used each of the two coping strategies. Moore and Constantine’s study results showed that social support seeking was positively correlated with attitudes toward seeking professional help while forbearance was negatively correlated with help-seeking attitudes across all three ethnic groups. Comparisons between ethnic groups were not possible due to small sample sizes. Thus, additional research is needed to help clarify the role of social support on help-seeking among Latin Americans.

In addition to family and social support, researchers have suggested that religion and religious coping may play an important role in Latin American help-seeking (Altarriba & Bauer, 1998; Frevert & Miranda, 1998). To date, the roles of religion and religious coping have been understudied in psychology research (Pargament, Smith, Koenig, & Perez, 1998) and little is known about the role these variables play in help-seeking for mental illness. Some researchers have reported that highly religious individuals may be less likely to seek help from mental health professionals (Neighbors, Musick, & Williams, 1998), while other researchers have reported that individuals who sought help from their priests were more likely to seek help in general (Sørgaard,

Sørensen, Sandanger, & Ingebrigtsen, 1996). With regard to Latin Americans, some researchers have suggested that individuals who identify themselves as more religious and use religious coping may be more willing to seek help from religious leaders than from formal psychological services (Altarriba & Bauer, 1998). Few empirical studies, however, have tested this possibility. One study, for example, reported that Latin American women who endorsed religious or supernatural causes for mental illness were less likely to use mental health services (Alvidrez, 1999). In contrast, in an unpublished dissertation, Ramos-Sanchez (2001) investigated the impact of acculturation, Latin American cultural values, and religiosity on attitudes toward seeking help and willingness to seek counselling for interpersonal, intrapersonal or academic/career concerns among Mexican American students. Religiosity was not correlated with attitudes toward seeking professional help but was positively correlated with willingness to see a counselor for interpersonal and academic concerns. Hierarchical regression analysis revealed that religiosity was a significant predictor of willingness to seek help for interpersonal problems even after controlling for various other variables.

Many questions remain about the culture-based coping strategies used by Latin Americans and how these may influence help-seeking for psychological distress. The present study aimed to address this gap in the literature by examining coping strategies used by Latin Americans living in Canada, and by directly testing the relationship between coping and help-seeking among Latin Americans. Furthermore, in order to gain a greater understanding of coping among ethnic minorities, it is essential that coping research efforts use an integrated approach incorporating both conventional and culture-based coping (Kuo, 2011). Thus, this approach was used in the present study to examine coping among Latin Americans, an understudied cultural group in Canada.

## The Present Study

The present study employed an established theoretical model, the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980), to examine help-seeking among Latin Americans, an under-researched ethnic minority group in Canada. Given that the application of the TRA to the area of help-seeking represents a new and thriving area of research, this study aimed to contribute to this emerging body of knowledge. Second, this study utilized path analysis to examine the generalizability of the TRA model to Latin Americans in Canada. This statistical approach allowed the testing of both the direct and indirect effects of multiple variables on help-seeking simultaneously. Third, using the TRA, the present study aimed to extend Vogel's (2007) study by examining the impact of stigma on both attitudes and subjective norms, given that subjective norms is a variable hypothesized to be important in the decision to seek help among Latin Americans (Cabassa & Zayas, 2007; Pescosolido et al., 1998). This study also addressed past criticisms of single item subjective norms scales (Codd & Cohen, 2003) by using a multi-item subjective norms scale. Fourth, in response to multicultural researchers' recommendations on how to improve research with ethnic minorities (Castro & Alarcón, 2002; U.S. Department of Health and Human Services, 2001), the present study examined the impact of *both* psychological and cultural variables (i.e., familism, culture-based coping, and acculturation) on help-seeking among Latin Americans and, by doing so, tested expanded TRA models. This study also examined the impact of perceived barriers on help-seeking among Latin Americans, such as their knowledge about available services and language problems. Finally, qualitative data were collected using an open-ended question to gain further understanding of the help-seeking process for this population. Thematic analysis (Braun & Clarke, 2006) was utilized to analyze the

qualitative data. By examining the psychological, cultural, and physical barriers to help-seeking, and by utilizing both quantitative and qualitative approaches, this study aimed to provide a greater understanding of intentions to seek help for psychological distress among Latin Americans living in Canada.

### **Research Questions and Study Variables**

The purpose of the present study is to extend the existing help-seeking literature by evaluating the generalizability of the Theory of Reasoned Action (TRA) model of psychological help-seeking in a sample of Latin American adults living in Canada, and by testing whether a culturally expanded model of the TRA could provide an improved explanatory framework of psychological help-seeking for this population. Specifically, the research questions are: “To what extent does the TRA explain help-seeking intentions among Latin Americans in Canada” and “To what extent do psychological and culturally-relevant variables improve the TRA’s ability to explain help-seeking intentions among Latin Americans in Canada.”

The outcome variable in the present study is *intentions to seek help for psychological distress*. The predictor variables in this study include *attitudes toward help-seeking, subjective norms, stigma, culture-based coping, acculturation* (Latino and Canadian cultural orientations), and *familism*. Furthermore, *gender, previous counselling experience, and psychological distress* were tested as potential moderators because previous research has suggested that these variables impact the help-seeking process (Alvidrez, 1999; Salant & Lauderdale, 2003). See Table 1 for the definition of variables and a summary of the hypothesized relationships.

In addition, participants were asked to report potential barriers to help-seeking, such as their knowledge about available treatments or transportation difficulties. These

barriers were included for exploratory purposes; thus, specific hypotheses were not proposed. Finally, an open-ended question was included to further assess Latin Americans' attitudes toward mental health services. The question was, "Have you or your family ever had an experience with mental health services and can you tell me about it? What was it like?"



Table 1

*Definition of Variables and Summary of Hypothesized Roles*

Variable	Definition	Hypothesized Role	Measure
Stigma	A cognitive process based on stereotypes and negative attitudes toward people with mental illness.	Predictor	Perceptions of Stigmatization by Others for Seeking Help (PSOSH; Vogel et al., 2009)
Latin American culture-based coping	Coping strategies influenced by Latin American collectivistic cultural values.	Predictor	Collective coping (CC) scale of Cross-Cultural Coping Scale (CCCS; Kuo, Roysircar, & Newby-Clark, 2006); Religious coping (RC)
Latino Cultural Orientation	Degree of cultural orientation and adherence to Latin American culture.	Predictor	Latino cultural orientation (LCO) scale of Acculturation Rating Scale for Mexican Americans-II (ARSMA-II; Cuellar et al., 1995)
Canadian Cultural Orientation	Degree of cultural orientation and adherence to Canadian culture.	Predictor	Canadian cultural orientation (CCO) scale of Acculturation Rating Scale for Mexican Americans-II (ARSMA-II; Cuellar et al., 1995)
Familism	Attitudes toward family relationships that involve feelings of loyalty and reciprocity.	Predictor	Attitudinal Familism Scale (AFS; Steidel & Contreras, 2003)
Attitudes toward help-seeking	Favourable or unfavourable evaluations toward seeking professional psychological help for emotional or psychological difficulties.	Mediator	Attitudes toward seeking professional psychological help (ATSPPH; Fischer & Farina, 1995)

Table 1 Continued

Variable	Definition	Hypothesized Role	Measure
Subjective Norms	Perceived social pressure from important individuals in one's life.	Mediator	Subjective Norms (SN; Ajzen & Fishbein, 1980)
Psychological Distress	A range of feelings and emotions in response to internal conflict or stressful situations.	Moderator	Brief Symptom Inventory (BSI; Derogatis, 2000)
Previous counselling experience	Participants are asked to state (Yes or No) whether they have previously sought psychological counselling.	Moderator	Demographic questionnaire
Gender		Moderator	Demographic questionnaire
Intentions to seek help for psychological distress	An individual's intentions to seek professional psychological help for personal and emotional problems.	Outcome	Intentions to Seek Counselling (ISCI; Roberston & Fitzgerald, 1992)

### **Hypothesized Help-Seeking Path Models**

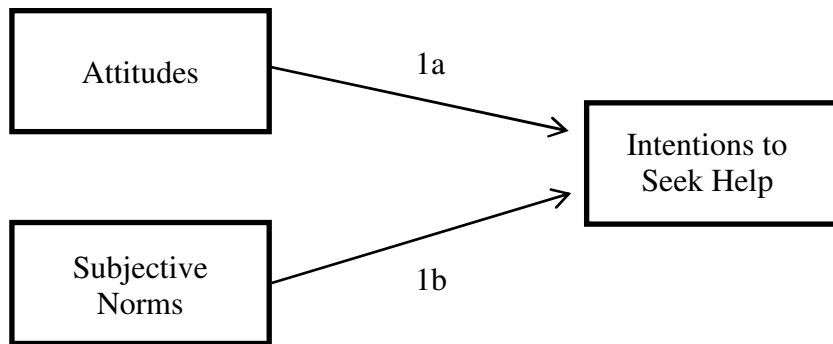
Figure 1 illustrates the TRA model (hypothesized Path Model 1) that was tested for its ability to explain intentions to seek help among Latin Americans living in Canada. Based on this model, the following hypotheses were proposed:

1. *Consistent with the TRA model, attitudes toward help-seeking (1a) and subjective norms (1b) will be positively related to intentions to seek help.*

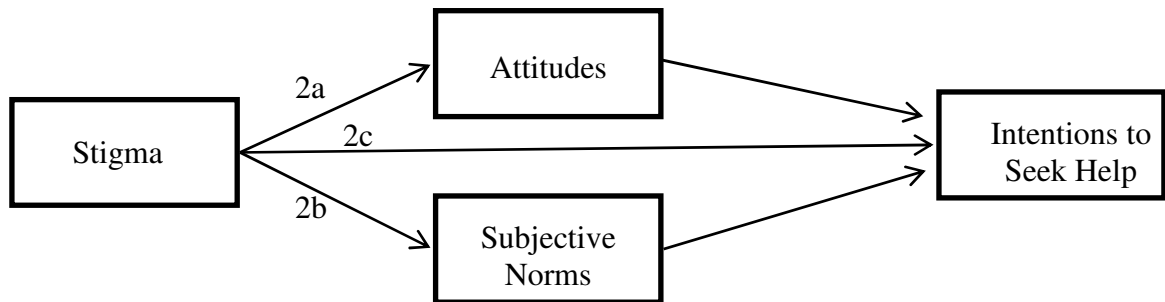
Figure 2 illustrates an expanded TRA model that includes stigma as a predictor of attitudes toward help-seeking, subjective norms and intentions to seek help (hypothesized Path Model 2). This model represents an extension of Vogel and colleagues' (2007) study. Therefore it was predicted that:

2. *Higher stigma will be negatively related to attitudes toward help-seeking (2a), subjective norms (2b), and intentions to seek help (2c).*
3. *Consistent with the TRA model, attitudes toward help-seeking (3a) and subjective norms (3b) will mediate the effect of stigma on intentions to seek help.*

Figure 3 illustrates a culturally expanded TRA model that includes three cultural variables (acculturation, familism and coping) hypothesized to impact help-seeking among Latin Americans (hypothesized Path Model 3). Given the limited number of empirical studies that have integrated help-seeking with Latin American cultural variables, the following hypotheses were mainly based on research with other ethnic minority groups (Kim & Omizo, 2003; Liao et al., 2005), as well as the cultural barrier theory (Leong et al., 1995) and theoretical suppositions (Bledsoe, 2008; Frevert & Miranda, 1998) that suggest that traditional Latin American values are inconsistent with the values underlying Canadian mental health services.



*Figure 1.* Hypothesized Path Model 1: The Theory of Reasoned Action (Ajzen & Fishbein, 1980). The numbers 1a and 1b represent the hypothesized pathways.



*Figure 2.* Hypothesized Path Model 2: Expanding the TRA to include Stigma. The numbers 2a, 2b, and 2c represent the hypothesized pathways.

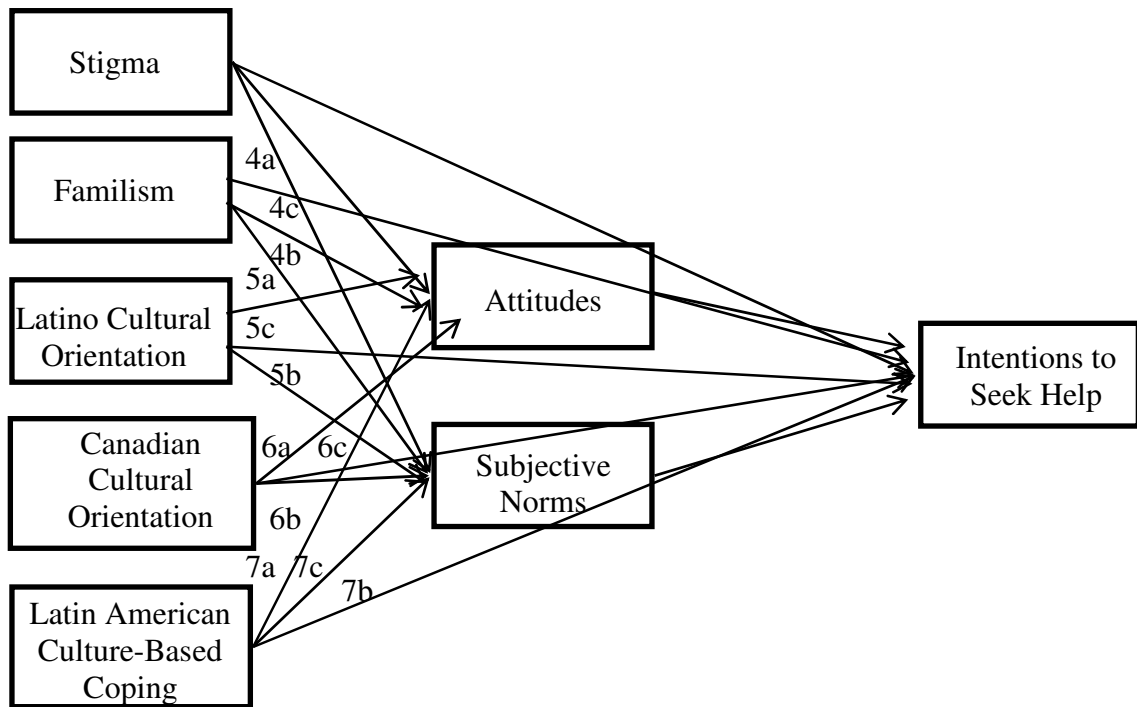
Thus, based on the Hypothesized Path Model 3 (see Figure 3), it was predicted that:

4. *Familism will be negatively related to attitudes toward help-seeking (4a), subjective norms (4b), and intentions to seek help (4c).*
5. *Latino cultural orientation will be negatively related to attitudes toward help-seeking (5a), subjective norms (5b), and intentions to seek help (5c).*
6. *Canadian cultural orientation will be positively related to attitudes toward help-seeking (6a), subjective norms (6b), and intentions to seek help (6c).*
7. *Latin American culture-based coping will be negatively related to attitudes toward help-seeking (7a), subjective norms (7b), and intentions to seek help (7c).*
8. *Consistent with the TRA model, attitudes toward help-seeking (8a), and subjective norms (8b), will mediate the effect of the cultural variables (familism, acculturation and coping) on intentions to seek help.*

In addition to the hypothesized path models, it was predicted that the addition of cultural variables to the TRA model would improve the ability of the model to explain help-seeking among Latin Americans. As noted earlier, given that previous research has found that women (Andrews, Issakidis, & Carter, 2001; Moller-Leimkuhler, 2002), individuals who have previously sought psychological treatment (Alvidrez, 1999; Cabassa, Zayas, & Hansen, 2006) and those experiencing greater psychological distress were more likely to seek help (Cabassa, Zayas, & Hansen, 2006; Cramer, 1999), it was also hypothesized that gender, previous counselling experience, and psychological distress would play important roles as moderators. Thus, the following hypotheses were also proposed:

9. *Cultural variables (familism, coping, and acculturation) will improve the fit of the TRA model among Latin Americans.*

10. *Gender, previous counselling experience, and psychological distress will each moderate the effect of the predictor variables on intentions to seek help.*



*Figure 3.* Hypothesized Path Model 3: Testing a Culturally-Expanded TRA model. The numbers 4 through 7 (a, b, and c) represent the hypothesized pathways.



## CHAPTER II

### Method

This chapter outlines the study participants, recruitment and administration methods, measures, and the qualitative analysis procedure.

#### Participants

The present study included a convenience sample of 246 Latin American adults living in Canada. Two participants did not meet the inclusion criteria for the study and were excluded. Specifically, one participant was excluded because he was born in Spain and did not self-identify as Latino/Latin American/Hispanic (based on the items on the acculturation measure). A second participant was also excluded because his parents were from Jamaica and he did not self-identify as Latino/Latin American/Hispanic. In addition, participants who failed to complete at least one measure were excluded from the study. To assess for potential differences between respondents who completed and those who did not complete the questionnaire, respondents with missing data ( $n = 20$ ) were compared with respondents without missing data ( $N = 224$ ) on all demographic variables. The two groups were not found to differ significantly on any of the demographic variables tested (i.e., gender, generation status, immigrant status, education level, format of questionnaire, language of questionnaire, religious status), except for age. Specifically, participants with missing data were more likely to be older individuals ( $M = 56.1$ ,  $SD = 14.90$ ) than the participants who completed the questionnaire ( $M = 46.1$ ,  $SD = 15.14$ ),  $t(241) = 2.81$ ,  $p = .005$  (effect size,  $d = .36$ ). During data cleaning and testing of statistical assumptions, one participant was identified as an outlier and was dropped from further analysis. This led to a final sample size of 223 participants in the present study.

The sample consisted of 223 Latin American adults (63.7% females, 36.3% males), ranging in age from 18 to 78. See Table 2 for a summary of the demographic characteristics. One hundred and fifty five (69.5%) of the participants completed the questionnaire in the paper-and-pencil format, whereas 68 (30.5%) completed the questionnaire online. One hundred and forty seven (65.9%) of the participants completed the Spanish version of the questionnaire, whereas 76 (34.1%) completed the English version. The majority of the participants (88.8%) were born outside of Canada in various Latin American countries (see Table 2 for the specific countries of origin). In terms of generation status, 72.2 % of the sample identified themselves as 1<sup>st</sup> generation (born outside of Canada and immigrated to Canada after the age of 12), 15.2 % identified as 1.5 generation (born outside of Canada and immigrated to Canada before the age of 12), and 10.8% identified as 2<sup>nd</sup> generation status (born in Canada and have at least one parent who was born outside of Canada). Finally, the majority of the sample identified themselves as Canadian citizens (78.5%). With regard to relationship status, one hundred and thirty-seven (61.4%) of the participants reported being married or in a common-law relationship, 51 (22.9%) identified as single, 30 (13.5%) identified as divorced/separated, and 4 (1.8%) identified as widowed. Approximately 50% of the sample was employed full-time, 12.7% were employed part-time, 8.1% were unemployed, 9.0% were retired, and 13.4% held student status. In terms of religion, most participants identified as Catholic (61%) or non-Catholic Christian (27.8%). The frequency of church/religious service attendance varied widely from more than once a week (16.1%) to never (14.3%). Educational level of the study participants varied from incomplete primary school to graduate/professional degree, with most participants having completed a 2-year college

degree (26.5%) or a university degree (35.4%). Seventy-three (32.7%) participants had sought mental health services and 149 (66.8%) had not.

Table 2

<i>Demographic Characteristics (N = 223)</i>		
	<i>N</i>	<i>%</i>
Gender		
Men	81	36.3
Women	142	63.7
Format		
Paper-and-Pencil	155	69.5
Online	68	30.5
Language of Survey		
English	76	34.1
Spanish	147	65.9
Age ( <i>Mean</i> = 46.19, <i>SD</i> = 15.17)		
30 or less	44	19.7
31-50	82	36.8
51 or older	96	43
Missing	1	0.4
Place of Birth		
Canada	23	10.3
Foreign Born	198	88.8
Missing	2	0.9
Country of Birth (other than Canada)		
Argentina	8	3.6
Bolivia	1	0.4
Chile	15	6.7
Colombia	29	13
Costa Rica	2	0.9
Cuba	3	1.3
Ecuador	9	4
El Salvador	74	33.2
Guatemala	6	2.7
Honduras	1	0.4
Italy	3	1.3
Mexico	11	4.9
Nicaragua	4	1.8
Peru	11	4.9
Uruguay	17	7.6
Venezuela	3	1.3
Missing	2	0.9

Table 2 Continued

<i>Demographic Characteristics (N = 223)</i>		
	<i>N</i>	<i>%</i>
Years in Canada (Foreign Born)		
Less than 10 years	46	23.2
10 to 20 years	30	15.2
More than 20 years	121	61.1
Missing	1	0.5
Generation Status		
1st generation	161	72.2
1.5 generation	34	15.2
2nd generation	24	10.8
Foreign student	4	1.8
Immigration Status		
Canadian citizen	175	78.5
Permanent resident	27	12.1
Refugee	16	7.2
Other	5	2.2
Reasons for Immigrating to Canada <sup>a</sup>		
Voluntary	71	31.8
War	47	21.1
Political Oppression	37	16.6
Poverty/Economic Reasons	5	2.2
Other	35	15.7
N/A or Missing	28	12.5
Relationship Status		
Single	51	22.9
Common-law	9	4
Married	128	57.4
Divorced/separated	30	13.5
Widowed	4	1.8
Missing	1	0.4

<sup>a</sup> Many participants born in Canada indicated that this question was not applicable to them.

Table 2 Continued

<i>Demographic Characteristics (N = 223)</i>		
	<i>N</i>	<i>%</i>
Employment Status <sup>b</sup>		
Full-time	102	45.7
Part-time	28	12.7
Unemployed	18	8.1
Student	18	8.1
Retired	20	9.0
Full-time and Part-time	3	1.3
Student and Part-time	12	5.4
Student and Unemployed	1	0.4
Retired and Part-time	1	0.4
Missing	20	9.0
Religion		
Catholic	136	61
Non-Catholic Christian	62	27.8
Jewish	1	0.4
Muslim	1	0.4
Other <sup>c</sup>	22	9.9
Church/Religious Service Attendance		
More than once a week	36	16.1
Once a week	66	29.6
Once a month	19	8.5
A few times a year	47	21.1
Once a year	10	4.5
Never	32	14.3
Education Level		
Primary school incomplete	2	0.9
Primary school	11	4.9
High school	42	18.8
2-year College	59	26.5
University Degree	79	35.4
Graduate or Professional degree	30	13.5

<sup>b</sup> Participants were instructed to endorse all employment descriptors that applied to them.

<sup>c</sup> Two participants identified as atheists and 9 participants indicated that they had no religion. The remaining participants did not provide further information.

Table 2 Continued

<i>Demographic Characteristics (N = 223)</i>		
	<i>N</i>	<i>%</i>
Father's Education Level		
Primary school incomplete	14	6.3
Primary school	63	28.3
High school	55	24.7
2-year College	31	13.9
University Degree	37	16.6
Graduate or Professional degree	22	9.9
Missing	1	0.4
Mother's Education Level		
Primary school incomplete	19	8.5
Primary school	64	28.7
High school	68	30.5
2-year College	32	14.3
University Degree	25	11.2
Graduate or Professional degree	13	5.8
Missing	2	0.9
Previous Mental Health Services		
Yes	73	32.7
No	149	66.8
Missing	1	0.4

## **Recruitment and Administration Procedures**

Kline (2005) suggests that in most cases a sample size of at least 200 is necessary to ensure adequate model estimation using path analysis statistics. Moreover, Kline also recommends that model complexity (i.e., number of parameters) be taken into account such that the ratio of the number of cases to the number of parameters should not be less than 5:1. Based on these criteria, a sample size of 200 was deemed appropriate for the present study. Therefore, multiple recruitment procedures were used to obtain the required sample size. Prior to data collection, the research proposal was approved by the Research Ethics Board (REB) at the University of Windsor.

One method of recruitment was through Latin American cultural and religious organizations in Toronto and in other cities across Canada (e.g., San Lorenzo Latin American Community Centre, Catholic Crosscultural Services, Bethel Baptist Church, Bautista Nazaret Church). Specifically, organization directors (or Church ministers, priests, etc.) were contacted and were asked to promote the study within their organizations by forwarding recruitment emails or making announcements. In addition, permission was requested from these individuals to attend their organization and recruit participants in person. Participants had the option to complete a paper-and-pencil version of the questionnaire in English or in Spanish or to complete an electronic version of the survey online with the information of the website provided to them by the researcher. Participants were also recruited through the “snowball” technique, including emailing online networking sites (e.g., Facebook) and asking family and friends to tell their significant others about the study. The “snowball” technique also involved the researcher of this study emailing her personal contacts who met the study’s inclusion criteria. These



individuals were then asked to forward the recruitment information to other potential participants.

Recruitment through online social networking sites involved contacting organizers of Latin American groups for permission to post the study information on their group sites or to email their group members about the study with the website link provided. As a token of appreciation for participating in the study, all participants were provided with the option to enter in a draw for one iPod Nano, and four \$25 gift certificates for Walmart. This option was provided by informing the participants verbally if they were completing the paper-and-pencil version on site or by providing them with a link on the online version of the study.

Web-based approaches to recruit research participants have several advantages including reduced costs in the use of lab space, printing paper and mailing, automatically saving of data in an electronic form, and obtaining larger samples with heterogeneous demographics (Birnbaum, 2004). However, web-based approaches are not without drawbacks. One potential drawback is the possibility of multiple submissions by the same individual (Birnbaum, 2004). Although Birnbaum (2004) believes multiple submissions by the same individual are a rare occurrence, he offered several recommendations to address this possibility. For example, Birnbaum suggested including instructions asking participants to complete the survey only once, and permitting participation in the study with the use of a password. These recommendations were implemented in the present study. A second potential drawback to web-based approaches is the possibility of self-selection of participants, which may not generalize to the general population. One possible solution to this problem implemented in the present study was to use multiple recruitment methods. For instance, the paper-and-pencil approach allowed respondents

who do not have access to computers and/or internet, or who would prefer to complete a paper version of the survey, to participate in the study. Thus, both a web-based survey and a paper-and-pencil approach were used in the present study.

Participants were given the option of completing the survey in English or in Spanish. Two of the measures (ARSMA-II: Cuellar et al., 1995; Attitudinal Familism Scale: Steidel & Contreras, 2003) were published in both English and Spanish versions. The remaining measures were translated into Spanish by the researcher along with two additional bilingual translators using the back-translation technique, as recommended by Brislin (1986). Specifically, the English survey was translated into Spanish by a bilingual individual, and then the survey was back-translated into English by another bilingual individual. Discrepancies between the original measure and the translated versions were resolved through discussion by the three bilingual translators. Special care was taken to ensure that the measures could be understood by participants from various Latin American subgroups (e.g., Central versus South Americans) and that region-specific phrases and terminology were avoided.

Prior to completing the survey, participants were asked to read a letter of information for consent to participate; the letter outlines the terms of the research study (See Appendix A for the English version of the letter of consent). Once the participant completed the questionnaire or exited the online study, a debriefing letter was provided to them describing the study in greater detail, relevant literature references for the study, participants' rights, and estimated date of announcing the study results. The letter also included contact information for the primary researcher and her research supervisor and information for community support services. Participants were encouraged to ask

questions or make comments during the process of the research. Participants were also provided with information about participating in the optional prize draw.

### **Measures**

Participants were given the option to complete either a paper-and-pencil or web-based survey in the language of their choice (See Appendices B and C for the English and Spanish versions of survey, respectively). The majority of the measures used in the present study were obtained from published articles. Certain measures were adapted for the present study and whenever possible these modifications were made with permission from the authors of the measures. The Brief Symptom Inventory (BSI: Derogatis, 2000) is under copyright. Permission to use this measure was purchased from Pearson Education Inc. The battery of measures consisted of the following:

- a) Demographic Questionnaire
- b) Attitudes Toward Seeking Professional Psychological Help-Shortened Form (Fischer & Farina, 1995)
- c) Subjective Norms (developed based on guidelines described by Ajzen & Fishbein, 1980; Trafimow, 2007)
- d) Intentions to Seek Counseling (Robertson & Fitzgerald, 1992)
- e) Perceptions of Stigmatization by Others for Seeking Help (Vogel et al., 2009)
- f) Acculturation Rating Scale for Mexican Americans-II (Cuéllar et al., 1995)
- g) Cross-Cultural Coping Scale (Kuo, Roysircar, & Newby-Clark, 2006)
- h) Attitudinal Familism Scale (Steidel & Contreras, 2003)
- i) Brief Symptom Inventory (Derogatis, 2000)
- j) Perceived Physical Barriers to Help-seeking

**Demographic Questionnaire.** The demographic questionnaire included the following questions: age, gender, educational attainment, country of birth, income level, generational status and age of migration, religion and level of religious involvement, educational attainment of mother and father, previous counselling experience, reasons for immigration (e.g., voluntary, political reasons), and employment status.

**Attitudes Toward Seeking Professional Psychological Help-Short Form**

**(ATSPPH-SF: Fischer & Farina, 1995).** The ATSPPH-SF is a widely used measure of attitudes toward seeking professional help for psychological problems. The ATSPPH-SF is a shortened form of the original 29-item scale, Attitudes Toward Seeking Professional Psychological Help scale (ATSPPH; Fischer & Turner, 1970). The original scale was developed to assess four dimensions of attitudes: a) recognition of need for psychological help, b) stigma tolerance, c) interpersonal openness, and d) confidence in mental health professionals.

The ATSPPH-SF consists of 10 items and produces a single score indicating a person's overall help-seeking attitude. A sample item is "*If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.*" Participants are asked to rate their level of agreement with each statement using a 4-point Likert scale ranging from 0 to 3, such that 0 = *Disagree*, 1 = *Partly Disagree*, 2 = *Partly Agree*, and 3 = *Agree*. Higher scores reflect more favourable attitudes toward seeking professional psychological help. Internal consistency of the 10 items was reported to be .84, while the test-retest reliability was .80. Correlation between the original 29-item scale and the new 10-item scale was .87, indicating good convergent validity (Fischer & Farina, 1995). Further, construct validity was established by showing that the scale correlated with previous use of professional help for a problem among

individuals experiencing a serious emotional or personal problem (Fischer & Farina, 1995). The ATSPPH-SF has been used in several studies of ethnic minority individuals including Asian participants ( $\alpha = .85$ ; Kim & Omizo, 2003) and Latin American participants ( $\alpha = .78$ ; Miville & Constantine, 2006). In the present study, the internal consistency for the scale was adequate for the English subsample ( $\alpha = .77$ ), Spanish subsample ( $\alpha = .68$ ), and the overall combined sample ( $\alpha = .72$ ). See Table 3 for the internal consistency for the study variables.

**Subjective Norms.** Fishbein and Ajzen (1980; 2010) have described specific guidelines on how to measure subjective norms. According to the authors, subjective norms can be assessed in two ways. The first approach involves asking participants a single general question, such as “Most people who are important to me think I should (or should not) perform the given behaviour.” However, this approach has been criticized for being psychometrically weak as it relies on a single item (Armitage & Conner, 2001). The second approach put forth by the authors involves asking the participants to rate the beliefs of *specific* individuals or groups (e.g., parents, siblings). This second approach was adopted for the present study.

Subjective norms of important referents related to seeking professional psychological help were assessed using six items. The scale consists of a 7-point Likert scale ranging from -3(*extremely unlikely*) to 3(*extremely likely*), as recommended by Ajzen and Fishbein (1980). Based on a review of the literature on the impact of subjective norms in the lives of Latin Americans (Cabassa & Zayas, 2007; Flores, Tschann, & Marin, 2002), the following referents were included in the present study: significant other/spouse, immediate family, extended family, friends, and important others in his/her

life. A sample item is, “My immediate family (parents and siblings) think I should seek help from a professional counselor if I were experiencing a persistent personal problem in my life.” These questions were developed using guidelines described by Ajzen and Fishbein (1980) and Trafimow (2007). Subjective norms were calculated by summing participants’ responses across the different referent groups, with higher scores signifying more positive subjective norms related to seeking help from a mental health professional.

Similar methodology has been used in other studies assessing subjective norms among Asian Americans (Kim & Park, 2009) and Latin Americans (Cabassa & Zayas, 2007; Flores et al., 2002). Specifically, Cabassa and Zayas (2007) assessed the role of the subjective norms of family and friends towards help-seeking among Latin Americans. Unfortunately, the two studies using Latin American samples (Cabassa & Zayas, 2007; Flores et al., 2002) did not report scale reliability for their samples. However, Kim and Park (2009) reported adequate reliability scores for normative beliefs ( $\alpha = .78$ ) among Asian American students using a similar methodology. In the present study, the subjective norms scale demonstrated excellent internal consistency for the English subsample ( $\alpha = .93$ ), Spanish subsample ( $\alpha = .95$ ), and the overall combined sample ( $\alpha = .94$ ).

**Intentions to Seek Counseling Inventory (ISCI: Robertson & Fitzgerald, 1992).** The ISCI was developed by modifying Cash et al.’s (1975) Personal Problem Inventory. The ISCI lists common personal problems that are frequently cited as reasons for seeking professional psychological services, such as relationship difficulties, depression, self-understanding, and loneliness. For each personal problem, participants are asked to rate how likely they would be to seek professional psychological services if they were experiencing that problem using a 6-point Likert scale (1= *very unlikely*, 2 =

*unlikely*, 3 = *doubtful*, 4 = *possibly*, 5 = *likely*, 6 = *very likely*). The ratings are summed to give a total score, with higher scores indicating greater likelihood to seek professional psychological help. Factor analysis of the ISCI yielded three factors: Psychological and Interpersonal Concerns (10 items,  $\alpha = .90$ ), Academic Concerns (4 items,  $\alpha = .71$ ), and Drug Use Concerns (2 items,  $\alpha = .86$ ) (Cepeda-Benito & Short, 1998). Internal consistency has been reported as ranging from .84 to .89 (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995). In terms of construct validity, the ISCI scale has been shown to detect differences in college students' intentions to seek help when the therapists were presented as more or less attractive (Cash et al., 1975). Furthermore, higher ISCI scores have been shown to correlate with increased problem severity (Lopez et al., 1998) and more positive attitudes toward seeking help (Kelly & Achter, 1995). Adequate psychometric properties have been reported among ethnic minority samples. For example, in an unpublished dissertation, Venza (2002) reported good overall scale reliability ( $\alpha = .90$ ) in a sample of Latin American, African and European students. Further, Barksdale and Mollock (2009) reported good scale reliability for the ISCI in a sample of African Americans. Specifically, reliability alphas were:  $\alpha = .91$  for psychological concerns,  $\alpha = .86$  for academic concerns,  $\alpha = .98$  for drug use, and  $\alpha = .93$  for the entire scale. In the present study, the items involving academic concerns were excluded because the sample included many non-student participants. Moreover, the items reflecting conflict with "parents" were re-worded to conflict with "family" to ensure that this personal problem was applicable to all participants. In the present study, the internal consistency was excellent for the English subsample ( $\alpha = .93$ ), Spanish subsample ( $\alpha = .94$ ), and the overall combined sample ( $\alpha = .94$ ).

**Perceptions of Stigmatization by Others for Seeking Help (PSOSH: Vogel et al., 2009).** The PSOSH is a newly developed stigma scale that examines an individual's perceived stigma in his or her social network. Participants are given the following instructions, "Imagine that you had a problem that needed to be treated by a mental health professional. If you sought mental health services, to what degree do you believe that the people you interact with would \_\_\_\_\_." Sample items include "react negatively to you" and "think you posed a risk to others." Participants respond to each of the five items on a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*a great deal*), with higher scores reflecting greater stigma by individuals in the participant's immediate social circle. Across four samples, the authors reported internal consistencies ranging from .84 to .89 and adequate test-retest reliability of .77. In terms of construct validity, the PSOSH scale was found to be related to, but distinct from, other measures of stigma and help-seeking attitudes. Moreover, the authors of the scale also reported adequate psychometric properties among ethnic minority samples. Internal consistencies across various ethnic groups were .90 for African Americans, .90 for Latin Americans, .88 for Asian Americans and .89 for Native Americans. In the present study, the internal consistency was excellent for the English subsample ( $\alpha = .91$ ), Spanish subsample ( $\alpha = .93$ ), and the overall combined sample ( $\alpha = .92$ ).

**Acculturation Rating Scale for Mexican Americans-II (ARSMA-II: Cuellar et al., 1995).** The ARSMA-II is a revised scale of the original ARSMA scale (Cuellar, Harris & Jasso, 1980). The ARSMA-II, similar to the original ARSMA measure, is a bilingual (English and Spanish) multidimensional measure that includes items assessing four factors: a) language use and preference; b) ethnic identity and classification; c) cultural heritage and ethnic behaviours; and d) ethnic interactions. One of the major



differences between the two scales is that the original ARSMA was a unidimensional scale and assessed the four factors using one scale. In contrast, the ARSMA-II is a bidimensional measure of acculturation, meaning that these four factors are assessed using two separate scales, one for Mexican culture and one for American culture. The ARSMA-II, similar to the ARSMA, assesses mainly behavioural aspects of acculturation but also includes some affective items related to self-identity. Moreover, the scale attempts to measure the four modes of acculturation described by Berry (1980): Assimilation, Integration, Separation, and Marginalization.

The ARSMA-II consists of two scales. The first scale assesses Mexican and American cultural orientations and yields scores for two acculturation modes, assimilation and integration. The second scale is the Marginality scale, which yields scores for the two other acculturation modes, separation and marginalization. However, the authors of the ARSMA-II (Cuellar et al., 1995) recommended that the Marginality scale be used with caution as the scale is experimental and its validity has not been established. Therefore, only the first scale of the ARSMA-II was used in the present study. This scale consists of two subscales, a 17 item Mexican Orientation Scale (MOS), and a 13 item Anglo Orientation Scale (AOS). The 30 items on this scale are scored using a 5-point likert scale, ranging from 1 (*not at all*) to 5 (*extremely often or almost always*). Examples of items include, “My friends are of Anglo origin,” and “My friends are of Mexican origin.” The scale yields two scores, MOS and AOS, with higher scores indicating greater orientation in the respective culture. The MOS score is calculated by summing the responses in the MOS subscale and dividing by the number of items in the subscale to obtain a mean score. The same format is used to calculate the AOS score. In addition, a linear acculturation score (ranging from very Mexican oriented to very Anglo

oriented) can also be calculated by subtracting the MOS mean from the AOS mean score. High scores on both the MOS and AOS are indicative of biculturalism.

In the original study, the ARSMA-II was found to have coefficient alphas of .88 for MOS and .83 for AOS, and a 1-week test-retest reliability coefficient of .96 for MOS and .94 for AOS (Cuellar et al., 1995). Concurrent validity was established using the original ARSMA measure with a correlation coefficient of .89. Further, construct validity was established by the scale's ability to predict acculturation level across five generations of Mexican Americans.

Although the ARSMA-II scale was developed for Mexican Americans, the scale has also been adapted for the use with other Latin American subgroups. For example, Garcia and colleagues (2005) used the ARSMA-II with a mixed sample of Latin American women (i.e., Mexican, Central American, and Caribbean) to explore the relation between acculturation and the reporting of intimate partner violence among Latin American women. Unfortunately, the authors did not report reliability coefficients for their sample. Gamst and colleagues (2002) also employed the ARSMA-II in a mixed sample of Latin American outpatients (i.e., Mexican, Central American, South American, and Cuban) and reported good internal consistency reliability (MOS  $\alpha=.89$  and AOS  $\alpha=.94$ ), providing support for the use of the ARSMA-II with other Latin American subgroups.

In the present study, slight wording changes were made in the items of the ARSMA-II. The term "Anglo" in the original scale was changed to "European Canadian" and the term "Mexican" was changed to "Latino(a)/Hispanic" in order to reflect the Canadian context of the study and the demographics of the target participants. As such,

for this study AOS and MOS scales are referred to as Canadian cultural orientation (CCO) and Latino cultural orientation (LCO), respectively. In the present study, the ARSMA-II demonstrated good internal consistency for the English subsample (LCO  $\alpha = .86$  and CCO  $\alpha = .80$ ), Spanish subsample (LCO  $\alpha = .83$  and CCO  $\alpha = .84$ ), and the overall combined sample (LCO  $\alpha = .85$  and CCO  $\alpha = .84$ ).

**Cross-Cultural Coping Scale (CCCS: Kuo, Roysircar & Newby-Clark, 2006).**

The CCCS is a scenario-based coping measure designed to assess both individualistic and collectivistic coping strategies. The scale is comprised of three subscales: Collective coping (e.g., “I take the course of action that is most acceptable to my family”), Engagement coping (e.g., “I put extra effort or work extra hard to resolve the problem”), and Avoidance coping (e.g., “I try to block out or forget about what’s bothering me”). The original scale consists of 20 items, plus six additional items that were included later by the test developers to increase the reliability of the subscales. Participants are asked to imagine being in a hypothetical stressful situation (i.e., dealing with symptoms associated with depression) and then rate the likelihood of using various methods of coping in dealing with the described situation using a 6-point Likert scale ranging from 0 (*very inaccurate*) to 6 (*very accurate*). Responses are summed such that higher scores reflect greater endorsement of a given coping strategy.

The CCCS has been tested on ethnically diverse samples, including Asian and White individuals (Kuo et al., 2006; Wester et al., 2006). Adequate reliability has been reported across various samples, with Cronbach’s alphas of .78 and .80 for Collective coping (CC), .68 and .77 for Avoidance Coping (AC), and .63 and .65 for Engagement coping (EC). Test-retest reliability over a 4-week period was .88. Validity was established through correlations between the CCCS scores and measures of acculturation. Less

acculturated individuals reported greater collective coping than more acculturated individuals. This measure was deemed appropriate for use with the present sample because of adequate psychometric properties with other ethnic minority individuals in Canada and the United States.

Since the original CCCS measure was developed based on adolescent and university student samples, some modifications in certain items of the scale were needed in order to better reflect the characteristics of the sample in the present study. Specifically, items involving “parents” were changed to “family.” In addition, one item describing “Chinese values” was changed to “Latino values.” Furthermore, based on review of the literature on important Latin American coping strategies (Abraído-Lanza et al., 1996; Abraído-Lanza et al., 2004; Guarnaccia et al., 1992), four extra items involving religious coping (RC) were included, “I put my trust in God,” “I seek God’s help,” “I try to find comfort in my religion,” and “I seek advice or help from my religious leader.” These changes were made with the permission of the author of the measure. In the present study, the CCCS scales demonstrated adequate to good internal consistency for the English subsample (CC  $\alpha = .75$ , EC  $\alpha = .73$ , AC  $\alpha = .76$ , RC  $\alpha = .90$ ), Spanish subsample (CC  $\alpha = .71$ , EC  $\alpha = .77$ , AC  $\alpha = .70$ , RC  $\alpha = .80$ ), and the overall combined sample (CC  $\alpha = .73$ , EC  $\alpha = .76$ , AC  $\alpha = .71$ , RC  $\alpha = .85$ ).

**Attitudinal Familism Scale (AFS: Steidel & Contreras, 2003).** The Attitudinal Familism Scale is a bilingual (English and Spanish) 18-item scale composed of 4 subscales that was adopted in the present study to measure Latin American familism. First, the *Subjugation of Self to the Family* subscale has to do with individuals sacrificing their own needs and goals if they interfere with the family’s needs and goals. Second, the *Familial Interconnectedness* subscale refers to a strong emotional and physical bond with

one's family members. Third, the *Familial Support* subscale refers to a belief in familial reciprocity in times of need. Fourth, the *Familial Honour* subscale involves protecting the family name or honour. Examples of items include, "A person should rely on his or her family if the need arises" and "A person should feel ashamed if something he or she does dishonours the family." The scale is scored on a 10-point Likert scale ranging from 1 (*strongly disagree*) to 10 (*strongly agree*). An overall familism score was computed by calculating a mean score where higher scores reflect higher levels of attitudinal familism.

Steidel and Contreras (2003) confirmed the four factors using a community sample of Latin Americans ( $N = 127$ , 86% of Puerto Rican background). The authors reported adequate reliability (Cronbach's alphas): .83 for the overall Familism scale, .72 for *Familial Support*, .69 for *Familial Interconnectedness*, .68 for *Familial Honour*, and .56 for *Subjugation of Self for Family*. Validity was established by correlating the Familism scale with acculturation. As expected, the overall Familism score was negatively correlated with higher American cultural orientation and positively correlated with higher Latin American cultural orientation.

In an unpublished dissertation, Steidel (2006) tested the reliability and validity of the Attitudinal Familism scale in a sample of Latin Americans ( $N = 129$ ) from diverse ethnic backgrounds including Puerto Rico, Mexico, Peru, and Guatemala. Cronbach's alphas for the attitudinal familism factors were: .87 for the overall familism scale, .77 for *Familial Support*, .82 for *Familial Interconnectedness*, .61 for *Familial Honour*, and .68 for *Subjugation of the Self for Family*. Further, the scale had good reliability for both the English ( $\alpha = .87$ ) and the Spanish subsample ( $\alpha = .87$ ). In terms of validity, familism was correlated with acculturation scores such that highly acculturated participants reported

lower overall attitudinal familism scores. In the present study, the familism scale demonstrated good internal consistency for the English subsample ( $\alpha = .86$ ), Spanish subsample ( $\alpha = .82$ ), and the overall combined sample ( $\alpha = .84$ ).

**Brief Symptom Inventory-18 (BSI-18; Derogatis, 2000).** The BSI-18 is a shortened version of the original Brief Symptom Inventory (BSI; Derogatis, 1983). The BSI-18 asks participants to rate their degree of distress regarding a range of symptoms over the past week. Items are rated on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). The BSI-18 is comprised of three dimensions: Somatization (SOM), Depression (DEP) and Anxiety (ANX) each with six items, as well as an overall score of psychological distress based on a total of all 18 items, the Global Severity Index (GSI). Item responses are summed such that higher scores indicate greater distress.

Derogatis (2000) reported adequate internal consistency for the GSI ( $\alpha = .89$ ) as well as for the three dimensions of SOM ( $\alpha = .74$ ), DEP ( $\alpha = .84$ ) and ANX ( $\alpha = .79$ ). Studies have demonstrated adequate validity and reliability in Asian (Lee & Liu, 2001) and Latin American populations (Dunn & O'Brien, 2009; Thoman & Surís, 2004). For instance, in a sample of 126 Central American individuals living in the United States, Dunn and O'Brien (2009) reported adequate internal consistency (Cronbach's alphas ranged from .77 to .81). In the present study, the internal consistency for the BSI-18 was excellent for the English subsample ( $\alpha = .92$ ), Spanish subsample ( $\alpha = .93$ ), and the overall combined sample ( $\alpha = .93$ ).

**Perceived Physical Barriers to Help-Seeking.** Additionally, participants were asked to respond to questions pertaining to their perception of physical barriers to help-seeking. This measure was developed based on the researcher's review of the literature on potential physical barriers (Cabassa & Zayas, 2007; Mo & Mak, 2009). The scale

consisted of six items. Participants were asked how the following barriers may impact their decision to seek help: cost of treatment, transportation difficulties, not knowing where to seek appropriate treatment, ability of mental health professional to speak Spanish, and discrimination. In the present study, this scale demonstrated adequate internal consistency for the English subsample ( $\alpha = .72$ ), Spanish subsample ( $\alpha = .78$ ), and the overall combined sample ( $\alpha = .74$ ).

Table 3  
Internal Consistency Reliability ( $\alpha$ ) of  
All the Measures in the Study

Measure	Alpha( $\alpha$ )
ATSPPH	.72
SN	.94
ISCI	.94
PSOSH	.92
CCO	.84
LCO	.85
CC	.73
AC	.71
EC	.76
RC	.85
AFS	.84
BSI	.93
PB	.74

*Note.*  $N = 223$ . ATSPPH = Attitudes Toward Seeking Professional Psychological Help; SN = Subjective Norms; ISCI = Intentions to Seek Psychological Help; PSOSH = Perceptions of Stigmatization by Others for Seeking Help; CCO = Canadian Cultural Orientation; LCO = Latino Cultural Orientation; CC = Collective Coping; AC = Avoidance Coping; EC = Engagement Coping; RC = Religious Coping; AFS = Familism; BSI = Brief Symptom Inventory; PB = Perceived Barriers. The internal consistency alpha values are for the combined overall sample (both English and Spanish subsamples).



### **Analysis of Responses to the Open-Ended Question**

Thematic analysis was used to analyze participants' responses to an open-ended question on help-seeking for psychological distress. Thematic analysis is a qualitative approach used to identify repeated patterns and themes across a data set (Braun & Clarke, 2006). The data set for the present study consisted of participants' responses to the following question: "Have you or your family ever had an experience with mental health services and can you tell me about it? What was it like?" Of the 223 participants, 77 participants provided responses to this question, and these were used in the analysis.

The analysis used in the present study was based on the guidelines recommended by Braun and Clarke (2006) which involved making decisions across multiple steps of analysis. First, themes were identified based on both theoretical importance and prevalence within the data. Second, themes were identified using both inductive (i.e., based on the data itself) and deductive (i.e., based on theory) approaches. And third, thematic analysis focused on the semantic meaning of the data, where the analysis focused on the description, organization and interpretation of the surface level of the data.

The specific steps involved in the qualitative analysis were the following as recommended by Braun and Clarke (2006). The first step involved translating any answers provided in Spanish into English. All the answers were then read and re-read to generate initial codes in a systematic fashion across the entire data set. In order to establish coding reliability, a second coder who is experienced in qualitative analysis independently coded 20 randomly chosen responses. Inter-coder reliability was calculated as described by Boyatzis (1998) and was found to be 89%. Discrepancies were reviewed and discussed by both coders. The second step involved grouping codes into potential themes. In the third step, codes and themes were reviewed, reorganized and redefined.

The data were coded manually by writing directly on printed copies of the text, and organized using Microsoft Word documents and a white-board. Thematic maps were also used to help organize themes, as described by Attride-Stirling (2001). Subsequently, appropriate excerpts were chosen from the data that exemplified each theme. For each excerpt, basic demographic information of the participant and the language in which the response was provided (English versus Spanish) were included.

## CHAPTER III

### Results

Path analysis was conducted using AMOS (Analysis of Moment Structures, Version 20; Arbuckle, 2006) with the maximum likelihood estimation method (Kline, 2005) to evaluate the fit of the TRA theoretical model (Ajzen & Fishbein, 1980; as shown in Figure 1). That is, to assess whether the TRA model provided an adequate explanation of help-seeking for psychological problems among Latin American individuals living in Canada. Path analysis was then performed on the expanded models of help-seeking (Figure 2 and Figure 3) that included psychological and cultural variables to test whether these variables provided improved explanations of help-seeking for psychological problems among Latin Americans. All models were assessed using multiple model-fit indices, as recommended by Kline (2005). In addition, the impact of three covariates was assessed: gender, previous use of mental health services, and psychological distress.

### Data Screening

The data were screened for missing values and violations of statistical assumptions as outlined by Tabachnick and Fidell (2007). Missing value analysis revealed that less than 10% of the data were missing at random. The one exception was the Income variable where 17% of the sample failed to report income. Furthermore, visual inspection of this variable revealed that many participants appeared to provide yearly income instead of monthly values. For these two reasons, this variable was not included in further analyses. Instead, the participants' education level and their parents' education level were used to approximate socioeconomic status. For the remaining variables, missing data were substituted by using variable means at the item-level because less than 10% of the data were missing (Tabachnick & Fidell, 2007). Normality was

investigated by using histograms, skewness and kurtosis values, and inspecting normality probability plots. A square root transformation was used for the stigma and psychological distress (BSI) variables because they were severely positively skewed (Tabachnick & Fidell, 2007). Standardized scores, or  $z$  scores  $> 3.29$  (Tabachnick & Fidell, 2007), and histograms were used to identify univariate outliers. Five univariate outliers were identified. Regression analysis was conducted with and without these outliers to assess their impact. Since these values were not found to significantly alter the regression equation, it was decided not to delete these values. However, one multivariate outlier was identified using Mahalanobis distance ( $\chi^2 = 27.9, p < .001$ ), and this case was deleted. The presence of influential cases was assessed by calculating Cook's distance (values  $> 1$ ) and standardized Dffit (values  $> \pm 2$ ). No influential cases were identified. Analysis of residual and bivariate scatterplots indicated that the assumptions of linearity and homoscedasticity were met. Inspection of intercorrelations between variables, condition indexes and tolerance values revealed that the assumptions of multicollinearity and singularity were met. Finally, the Durbin-Watson statistic indicated that the assumption of the independence of errors was also met.

### **Descriptive Statistics and Exploratory Analyses**

Descriptive statistics and bivariate correlations among the main study variables are presented in Table 4. As expected, attitudes toward help-seeking and subjective norms were significantly correlated with intentions to seek help. These correlations were in the expected direction in that more positive attitudes and subjective norms were associated with increased intentions to seek help. Most correlations were in the expected direction except for the relation between intentions to seek help and perceived physical barriers. It was expected that higher perceived physical barriers would be associated with lower

intentions to seek psychological help. Instead, the opposite relationship was found. Thus, this variable was not included in the hypothesized path models. Potential explanations for this finding will be explored in the subsequent chapter of this document.

The effect of the demographic variables on the dependent variable, intentions to seek psychological help, was then examined. Because of the large number of categories for some of the demographic variables (e.g., relationship status), categories with a small sample size were grouped to increase the power of the means comparison analysis. Specifically, the effect of the questionnaire format (online versus paper), language of the questionnaire (English versus Spanish), age (30 years or less, 31-50 years old, 51 years and older), born in Canada (yes or no), generation status (first generation, 1.5 generation, second generation), immigrant status (Canadian citizen, permanent resident, refugee/other), relationship status (single, common-law/married, divorced), employment (full-time, part-time, unemployed, student, retired), church attendance frequency (once a week or more, once a month/a few times a year, once a year, never), education level (high school degree or lower, 2 year college degree/university degree, graduate or professional degree), father's education, and mother's education on the dependent variable were investigated. The results from independent *t*-tests and one-way ANOVA revealed no significant effect of format ( $t(220) = -.33, p > .05$ ), language ( $t(221) = .14, p > .05$ ), age ( $F(2,220) = .83, p > .05$ ), born in Canada ( $t(219) = -.52, p > .05$ ), generation status ( $F(2, 216) = 1.87, p > .05$ ), immigrant status ( $F(2, 220) = 1.62, p > .05$ ), relationship status ( $F(2, 215) = .42, p > .05$ ), employment ( $F(4, 193) = 1.51, p > .05$ ), church attendance frequency ( $F(3, 206) = 1.46, p > .05$ ), education level ( $F(2, 220) = .16, p > .05$ ), father's education ( $F(2, 219) = 1.51, p > .05$ ), or mother's education ( $F(2, 218) = .58, p > .05$ ) on intentions to seek help for psychological distress.

Independent *t*-tests were also performed to determine whether significant differences in the dependent variable existed due to the hypothesized covariates (gender, previous use of mental health services, and psychological distress). A dichotomous variable was created for psychological distress as recommended by the test developer (Derogatis, 2000), such that respondents with T-scores greater than 63 on the Global Severity Index (GSI) were identified as experiencing significant psychological distress (based on community norms). The results revealed that female participants ( $M = 51.45$ ,  $SD = 20.59$ ) reported greater intentions to seek help than male participants ( $M = 45.46$ ,  $SD = 20.94$ ),  $t(221) = -2.07$ ,  $p = .04$ ,  $d = .28$ . Further, participants who had previously used mental health services ( $M = 56.15$ ,  $SD = 18.60$ ) reported greater intentions to seek help compared to participants who had not used mental health services ( $M = 45.70$ ,  $SD = 21.04$ ),  $t(220) = 3.61$ ,  $p < .001$ ,  $d = .53$ . And finally, participants reporting greater psychological distress ( $M = 57.34$ ,  $SD = 17.77$ ) reported greater intentions to seek help than participants reporting less psychological distress ( $M = 46.82$ ,  $SD = 21.18$ ),  $t(221) = -3.25$ ,  $p = .001$ ,  $d = .54$ . These findings provide support for the inclusion of these covariates in the hypothesized path models.

Table 4  
Correlations among model variables, Means, and Standard Deviations

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	M	SD
1. ATT	---	.26**	-.21**	-.04	.14*	-.03	-.13	-.08	-.09	-.02	-.01	.21**	.11	-.27**	.10	1.93	.54
2. SN	---	---	.01	.12	-.28**	.14*	-.14*	.02	-.04	.11	.04	.22**	.14*	-.19**	-.12	27.92	11.88
3. FAM	---	---	---	.15*	-.13	.42**	.08	.20**	.31**	-.01	.10	-.01	-.07	.06	-.07	7.10	1.31
4. LCO	---	---	---	---	-.25**	.39**	.12	.12	.32**	.02	-.15*	.14*	-.01	.08	.10	4.02	.66
5. CCO	---	---	---	---	---	-.17*	.10	-.06	-.19**	-.05	.06	.06	-.03	-.11	.08	3.28	.77
6. CC	---	---	---	---	---	---	.29**	.35**	.40**	.12	-.01	.00	.04	.08	.09	21.69	7.32
7. EC	---	---	---	---	---	---	---	.30**	.02	-.03	.07	-.06	-.14*	.14*	.10	28.24	6.00
8. AC	---	---	---	---	---	---	---	---	.11	.10	.18**	.01	.22**	.01	-.01	20.47	7.91
9. RC	---	---	---	---	---	---	---	---	---	.01	-.02	-.03	-.01	.06	.11	11.28	6.10
10. PB	---	---	---	---	---	---	---	---	---	---	.31**	.29**	.16*	-.09	.09	13.53	5.47
11. Stigma	---	---	---	---	---	---	---	---	---	---	---	.04	.13	-.01	-.04	2.79	.71
12. ISCI	---	---	---	---	---	---	---	---	---	---	---	---	.23**	-.24**	.14*	49.28	20.88
13. BSI	---	---	---	---	---	---	---	---	---	---	---	---	---	-.40**	.11	3.16	1.80
14. PMH	---	---	---	---	---	---	---	---	---	---	---	---	---	---	-.11	1.67	.47
15. Gender	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	n/a	n/a

Note. ATT = Attitudes toward seeking professional psychological help; SN = Subjective norms; FAM = Familism; LCO = Latino Cultural Orientation; CCO = Canadian Cultural Orientation; CC = Collective coping; EC = Engagement coping; AC = Avoidance coping; RC = Religious coping; PB = Perceived Barriers; ISCI = Intentions to seek psychological help; BSI = Psychological Distress; PMH = Previous Use of Mental Health Services.  
\*  $p < .05$ , \*\*  $p < .01$ .

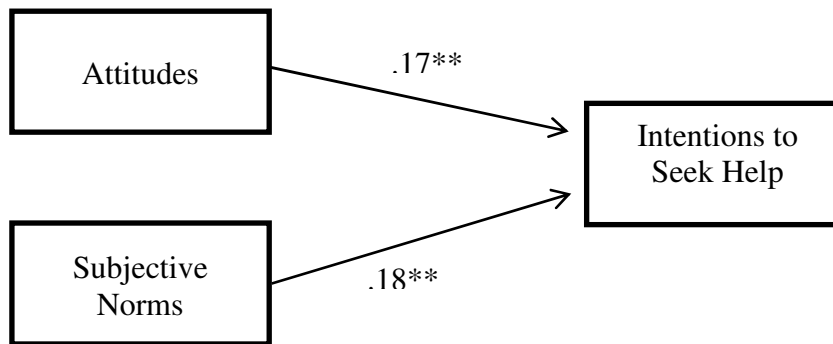
## Main Analysis

### Hypothesized Model 1

Path analysis was used to evaluate the fit of path model 1, the TRA model (Ajzen & Fishbein, 1980). The goodness of fit between the hypothesized model and the sample data was assessed by examining various fit indices, as recommended by Byrne (2010) and Kline (2005). All the models were assessed using the chi-square ( $\chi^2$ ) statistic, which tests the null hypothesis that the model fits the data perfectly. In path analysis, a non-significant  $\chi^2$  is desired because it indicates that the hypothesized model fits the data, whereas a significant  $\chi^2$  suggests that the model does not fit the data (Byrne, 2010). Although the  $\chi^2$  statistic is widely used, additional fit indices were also used to assess overall model fit because the  $\chi^2$  statistic is overly sensitive with large sample sizes (Byrne, 2010; Kline, 2005). These model-fit indices included: root-mean-square error of approximation (RMSEA; Steiger, 1990), standardized root-mean-square residual (SRMR; Bentler, 1995), goodness-of-fit index (GFI; Joreskog & Sorbom, 1993), and the comparative fit index (CFI; Bentler, 1990). Hu and Bentler (1999) recommend that RMSEA values  $\leq 0.06$  suggest good fit, while others suggest that values between .05 and .08 suggest mediocre fit and values of  $\geq .10$  suggest poor fit (Browne & Cudeck, 1993; McCallum, Browne, & Sugawara, 1996). SRMR values less than .10 are recommended (Hu & Bentler, 1999; Kline, 2005), while GFI and CFI values ranging from .90 to .95 are indicative of a good fit (Hu & Bentler, 1999).

The path model for Model 1 is displayed in Figure 4, along with the standardized regression weights. Consistent with hypotheses 1a and 1b, the model demonstrated that both attitudes toward seeking professional help and subjective norms were significantly





*Figure 4.* Hypothesized Path Model 1 results. Standardized path coefficients are shown.  
\*\*  $p < .01$ .

correlated with intentions to seek help, as predicted by the TRA model. Specifically, more positive attitudes and subjective norms were associated with increased intentions to seek help. The squared multiple correlations ( $R^2$ ) for the endogenous variables and the model fit indices are shown in Table 5 and Table 6, respectively. The squared multiple correlation ( $R^2$ ) for intentions to seek help was low ( $r^2 = .06$ ), indicating that the proportion of variability in the data set that is accounted for by this model is low (see Table 5). The fit indices were then assessed. The chi-square fit index was  $\chi^2(1) = 12.62$ ,  $p < .001$ , suggesting that the fit of the model is not adequate. According to Byrne (2010), however, these results are not totally unexpected with large sample sizes given this test's sensitivity to sample size. Thus, the remaining fit indices were examined. The GFI value of .96 suggested good fit, whereas the remaining fit indices suggested poor model fit: CFI = .56, RMSEA = .23, and SRMR = .10

Byrne (2010) recommends assessing both the modification indices and the standardized residuals in order to detect model misspecification. Modification indices (MI) represent the drop in  $\chi^2$ , or improvement in fit, if the parameter were freely estimated in future runs of the model (Byrne, 2010). Standardized residuals represent “estimates of the number of standard deviations the observed residuals are from the zero residuals that would exist if the model fit were perfect” (Byrne, 2010, p. 86). That is, they represent the discrepancy between the covariance matrix of the hypothesized model and the covariance matrix of the sample (Byrne, 2010). Values greater than 2.58 are considered large (Joreskog & Sorbom, 1993). Examination of both MI and standardized residuals for model revealed elevated values for the inclusion of a covariance pathway between attitudes and subjective norms to improve model fit. However, this path was not

Table 5  
*Squared Multiple Correlations ( $R^2$ ) for Endogenous Variables*

Endogenous Variables	$R^2$				
	Model 1	Model 2	Model 3	Model 4	Model 5
Intentions to Seek Help	.06	.06	.13	.16	.15
Attitudes	--	.00	.13	.13	.10
Subjective Norms	--	.00	.18	.18	.23

*Note.* Model 1 = Hypothesized Model 1, Model 2 = Hypothesized Model 2, Model 3 = Hypothesized Model 3, Model 4 = Hypothesized Model 3 plus three covariates (gender, psychological distress, and previous use of mental health services), Model 5 = Final respecified model.

Table 6  
*Fit Indices of Study Models*

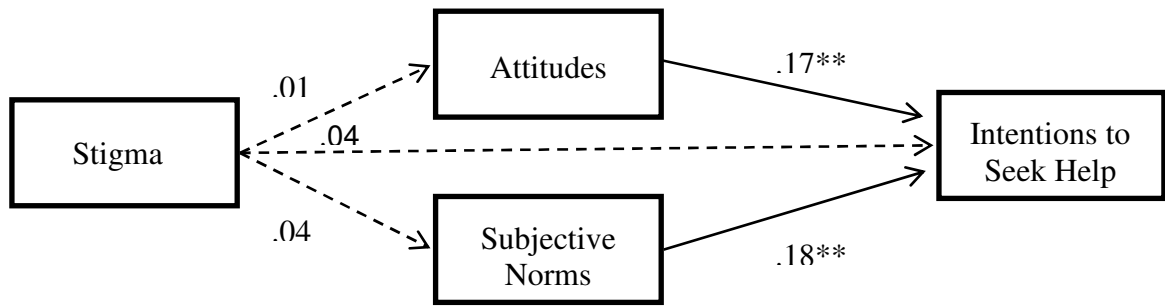
	$\chi^2$	<i>df</i>	<i>p</i>	GFI	CFI	RMSEA	SRMR
Model 1	12.62	1	<.001	.96	.56	0.23 [.13, .35]	.10
Model 2	12.7	1	<.001	.97	.52	0.23 [.13, .35]	.08
Model 3	253.34	29	<.001	.80	.20	0.19 [.16, .21]	.15
Model 4	469.41	91	<.001	.79	.18	0.15 [.14, .17]	.13
Model 5	55.93	30	<.001	.95	.89	0.06 [.04, .08]	.08

*Note.* Model 1 = Hypothesized Model 1, Model 2 = Hypothesized Model 2, Model 3 = Hypothesized Model 3, Model 4 = Hypothesized Model 3 plus three covariates (gender, psychological distress, and previous use of mental health services), Model 5 = Final respecified model. RMSEA values in brackets represent 90% confidence intervals.  $\chi^2$  = chi-square statistic, with degrees of freedom and p-value; GFI = goodness-of-fit index; CFI = comparative fit index; RMSEA = root-mean-square error of approximation; and SRMR = standardized root-mean-square residual.

added because this would make the hypothesized model just-identified (i.e., zero degrees of freedom), and thus, it would not be possible to generate goodness of fit tests for this model (Garson, 2012).

### **Hypothesized Model 2**

Path analysis was used to test whether the addition of stigma improved the fit of the original path model. Hypothesized path model 2 is displayed in Figure 5, along with the standardized regression weights. Solid arrows represent significant pathways, while dashed arrows represent non-significant pathways. This model demonstrated that both attitudes and subjective norms remained significant predictors of intentions to seek help. Contrary to hypotheses 2a, 2b and 2c, however, stigma was not found to be significantly correlated to any of the study variables. The  $R^2$  for this model remained low at .06. See Table 5 for the  $R^2$  for all the endogenous variables. Inspection of the fit indices suggested poor model fit. Since the stigma variable did not have a significant effect on the other variables in the model, the fit indices for this model remained similar to model 1 (See Table 6 for fit indices). Moreover, the MI's and standardized residuals were similar to model 1, suggesting a covariance between attitudes and subjective norms.



*Figure 5.* Hypothesized Path Model 2 results. Standardized path coefficients are shown. Solid lines represent significant pathways, while dashed lines represent non-significant pathways.

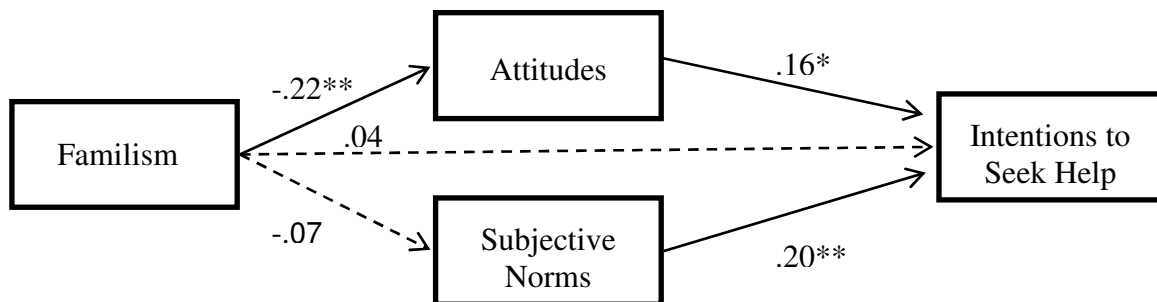
\*\*  $p < .01$ .

### Hypothesized Model 3

Path analysis was used to test whether the hypothesized path model 3 that included additional psychological and cultural variables (e.g., familism, acculturation) improved the fit of model 1. Although the effect of all the variables was tested simultaneously, the effect of each individual variable is displayed separately in Figures 6 through 12 for clarity purposes. The overall model is displayed in Figure 13. Standardized regression weights are displayed in each figure. Solid arrows represent significant pathways, while dashed arrows represent non-significant pathways. The  $R^2$  for the overall model is displayed in Table 5. This model demonstrated greater explanatory value than models 1 and 2. Consistent with hypothesis 4a, this model demonstrated that higher familism was associated with more negative attitudes toward seeking professional help. However, contrary to hypotheses 4b and 4c, familism was not significantly correlated with either subjective norms or intentions to seek help. Contrary to hypotheses 5a, 5b, and 5c, higher Latino cultural orientation (LCO) was not associated with lower attitudes, subjective norms or lower intentions to seek help. Instead, the model revealed that Latino cultural orientation was not significantly correlated with attitudes or subjective norms, and that higher Latino cultural orientation was associated with *greater* intentions to seek help. Consistent with hypotheses 6a and 6c, higher Canadian cultural orientation (CCO) was associated with more positive attitudes toward help-seeking and greater intentions to seek help. However contradicting hypothesis 6b, higher Canadian cultural orientation was associated with more negative subjective norms. Hypotheses 7a, 7b, and 7c predicted that higher Latin American culture-based coping would lead to lower attitudes, subjective norms and intentions to seek help. Latin American culture-based coping was assessed using both the Collective Coping and the Religious Coping variables. For the Collective

Coping variable, the data did not support hypotheses 7a, 7b, and 7c. Contrary to hypotheses 7a and 7b, higher levels of collective coping were associated with more positive attitudes and subjective norms. Collective coping was not significantly correlated with intentions to seek help, contradicting hypothesis 7c. In terms of Religious Coping, the data did not support hypotheses 7a and 7c. However, consistent with hypothesis 7b, higher religious coping was associated with lower levels of subjective norms. Model 3 also tested the effect of engagement coping and avoidance coping, although specific hypotheses were not proposed for these variables due to lack of empirical data in this area. The data revealed that higher levels of engagement coping were associated with lower attitudes and subjective norms. There was no significant relationship between engagement coping and intentions to seek help. Finally, avoidance coping was not significantly associated with attitudes, subjective norms or intentions to seek help.

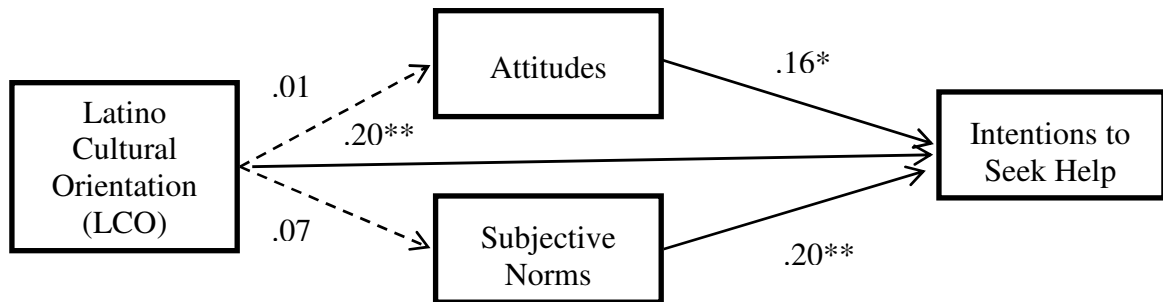
Hypotheses 8a and 8b predicted that attitudes and subjective norms would mediate the effect of the various variables on intentions to seek help. This possibility was assessed in the final model (Model 5). In terms of model fit, the fit indices for this model were  $\chi^2(29) = 253.44$ ,  $p < .001$ , GFI = .80, CFI = .20, RMSEA = .19, and SRMR = .15 (See Table 6). These values are suggestive of poor model fit. Examination of the MI values and standardized residuals revealed various potential pathways to improve model fit. These possibilities were explored following the inclusion of the hypothesized covariate variables in Models 4 and 5.



*Figure 6.* The Effect of Familism in Path Model 3. Standardized path coefficients are shown. Solid lines represent significant pathways, while dashed lines represent non-significant pathways.

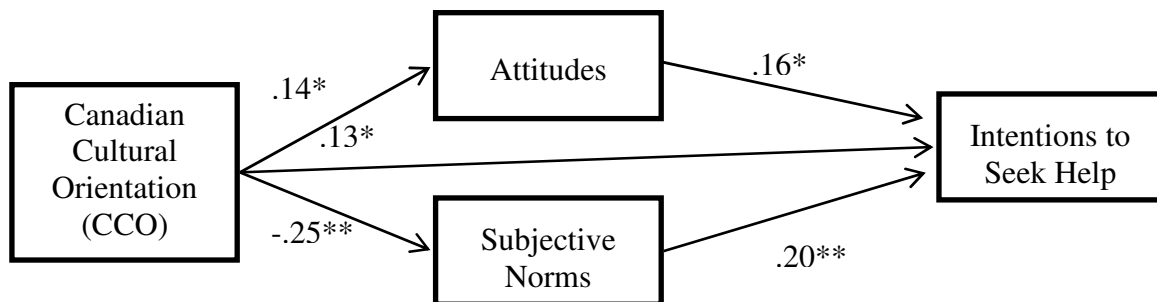
\*  $p < .05$  and \*\*  $p < .01$ .





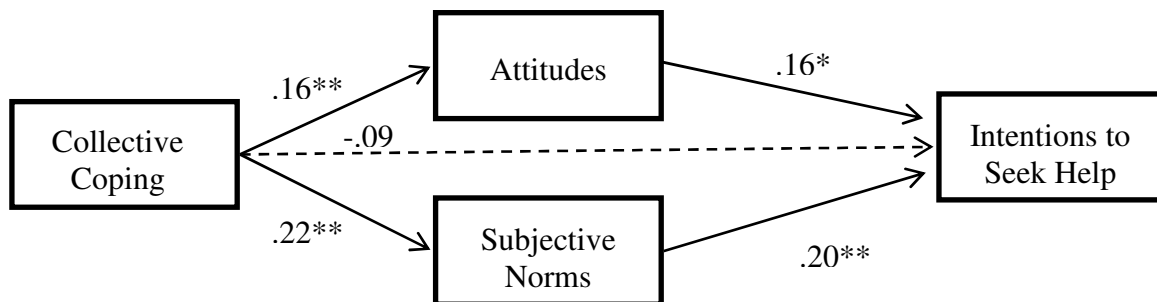
*Figure 7.* The Effect of Latino Cultural Orientation in Path Model 3. Standardized path coefficients are shown. Solid lines represent significant pathways, while dashed lines represent non-significant pathways.

\*  $p < .05$  and \*\*  $p < .01$ .



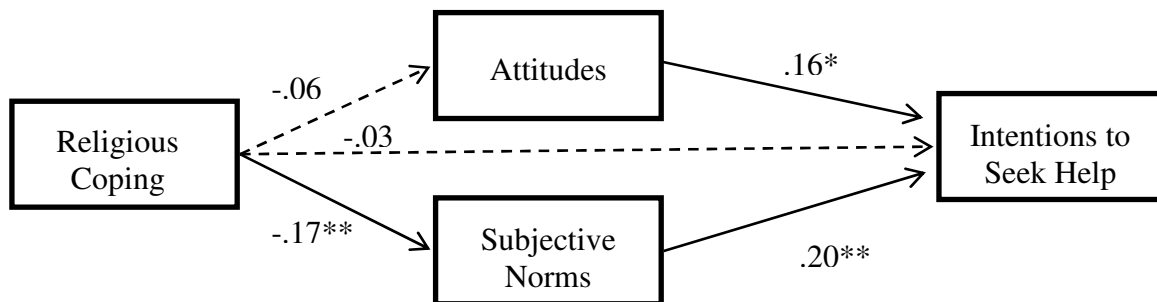
*Figure 8.* The Effect of Canadian Cultural Orientation in Path Model 3. Standardized path coefficients are shown. Solid lines represent significant pathways, while dashed lines represent non-significant pathways.

\*  $p < .05$  and \*\*  $p < .01$ .

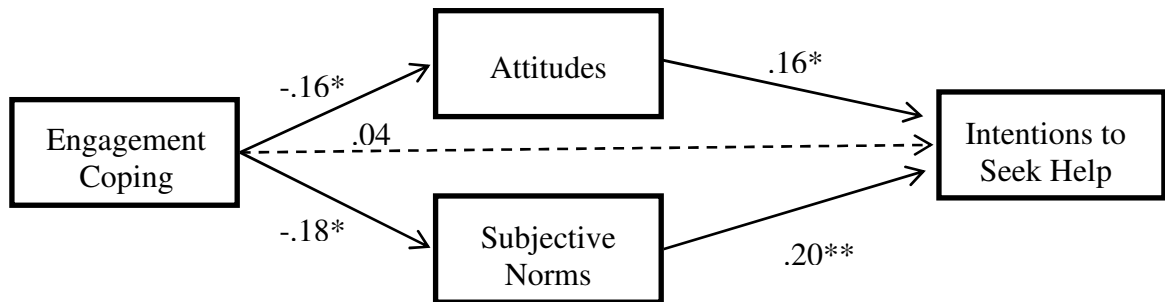


*Figure 9.* The Effect of Collective Coping in Path Model 3. Standardized path coefficients are shown. Solid lines represent significant pathways, while dashed lines represent non-significant pathways.

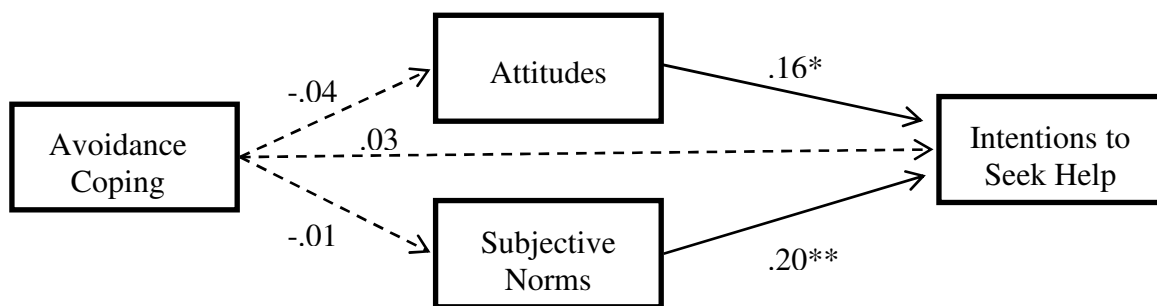
\*  $p < .05$  and \*\*  $p < .01$ .



*Figure 10.* The Effect of Religious Coping in Path Model 3. Standardized path coefficients are shown. Solid lines represent significant pathways, while dashed lines represent non-significant pathways.  
\*  $p < .05$  and \*\*  $p < .01$ .

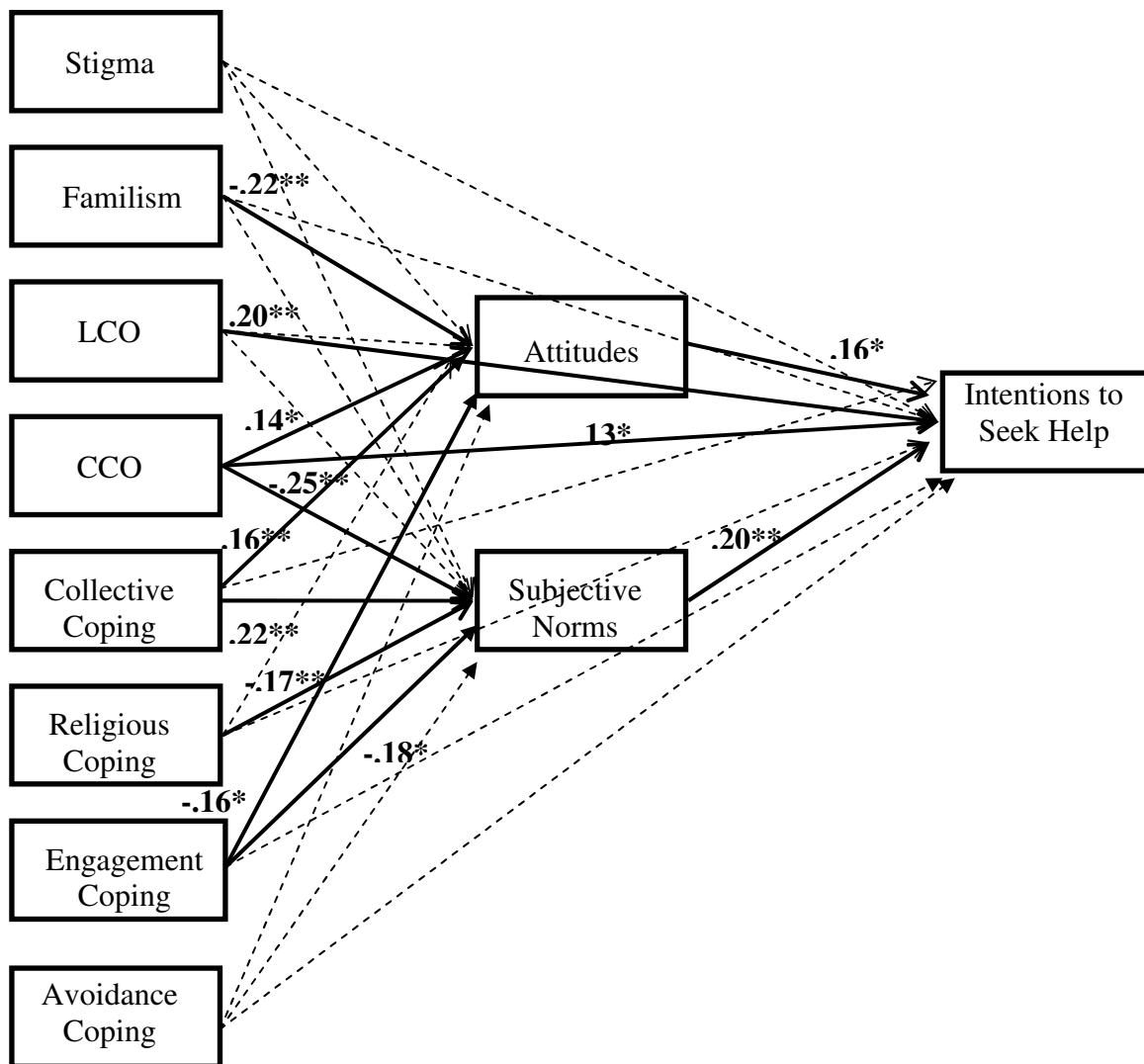


*Figure 11.* The Effect of Engagement Coping in Path Model 3. Standardized path coefficients are shown. Solid lines represent significant pathways, while dashed lines represent non-significant pathways.  
\* $p < .05$  and \*\* $p < .01$ .



*Figure 12.* The Effect of Avoidance Coping in Path Model 3. Standardized path coefficients are shown. Solid lines represent significant pathways, while dashed lines represent non-significant pathways.

\*  $p < .05$  and \*\*  $p < .01$ .



*Figure 13.* Hypothesized Path Model 3 results demonstrating the effect of all the variables tested. LCO = Latino Cultural Orientation and CCO = Canadian Cultural Orientation. Solid lines represent significant pathways, while dashed lines represent non-significant pathways. Standardized path coefficients are only displayed for significant pathways. See Figures 6 through 12 for standardized path coefficients for both significant and non-significant pathways.

\*  $p < .05$  and \*\*  $p < .01$ .

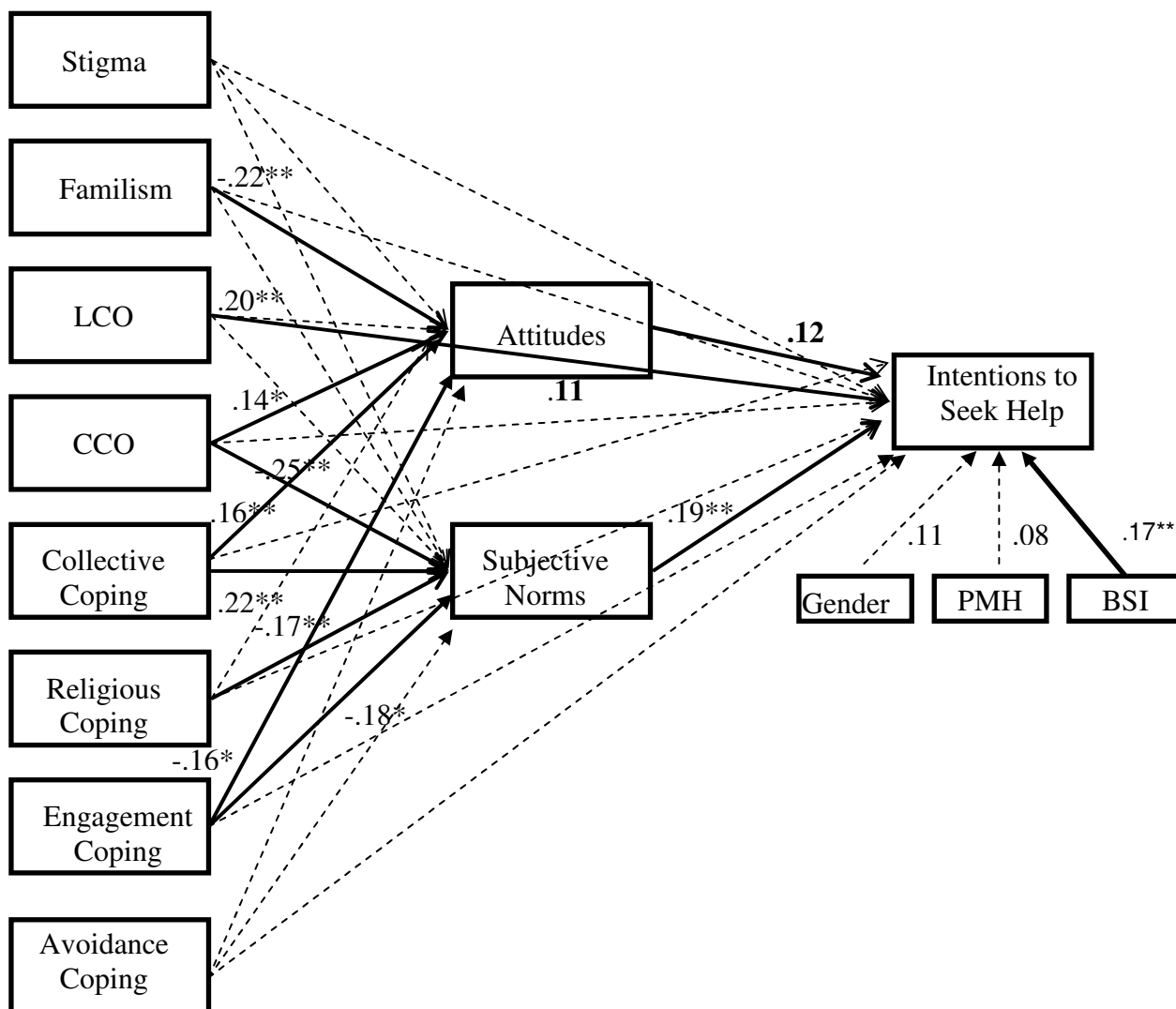
#### Model 4

Path analysis was used to assess the effect of the three hypothesized covariates, gender, previous use of mental health services and psychological distress, on intentions to seek help. The model is displayed in Figure 14, with the standardized regression weights displayed in the figure. Solid arrows represent significant pathways, while dashed arrows represent non-significant pathways. The  $R^2$  for the overall model is displayed in Table 5. This model demonstrated a small increase in explanatory power for intentions to seek help compared to model 3. Consistent with hypothesis 10, psychological distress had a significant effect on intentions to seek help. Contrary to this hypothesis, however, neither gender nor previous use of mental health services had a significant effect on intentions to seek help (see Figure 14 for standardized regression weights). Furthermore, the majority of the pathways in this model remained the same as Model 3 (Figure 13). However, there were some notable differences, as depicted in Figure 14 (see numbers in bold). In this model, attitudes toward help seeking did not significantly affect intentions to seek help,  $p = .07$ . This is in contrast to the TRA model. In addition, Canadian cultural orientation (CCO) did not significantly affect intentions to seek help either,  $p = .08$ .

In regard to model fit, the fit indices for this model were  $\chi^2(91) = 469.41$ ,  $p < .001$ , GFI = .79, CFI = .18, RMSEA = .15, and SRMR = .15 (See Table 6). These values are suggestive of poor model fit.

Multi-group analyses for the hypothesized covariates were not possible in this study due to the relatively small sample size for the different groups (e.g., male versus female).





*Figure 14.* Path Model 4 results demonstrating the effect of the study covariates. LCO = Latino Cultural Orientation, CCO = Canadian Cultural Orientation, PMH = previous use of mental health services, and BSI = psychological distress. Solid lines represent significant pathways, while dashed lines represent non-significant pathways. Standardized path coefficients are displayed for the three hypothesized covariate variables, as well as for all the pathways that were significant in Model 3. The two numbers in bold represent pathways that are different than the pathways found in Model 3.  
\*  $p < .05$  and \*\*  $p < .01$ .

### **Model 5: Respecified Model**

Given the poor fit of the hypothesized path models, model respecification was undertaken, as recommended by Byrne (2010). Specifically, the modification indexes (MI's) and standardized residuals were examined to determine areas of model misspecification. In addition, non-significant pathways were trimmed.

Modification indices (MI) represent the drop in  $\chi^2$ , or improvement in fit, if the parameter were freely estimated in future runs of the model (Byrne, 2010). One rule of thumb for MI's is to add the parameter with the largest MI and then see the effect on model fit (Garson, 2012). This step can be repeated several times as long as the changes make theoretical sense (Byrne, 2010; Garson, 2012). Standardized residuals represent the difference between the observed residuals and the expected residuals if the model fit were perfect (Byrne, 2010). Values greater than 2.58 are considered large (Joreskog & Sorbom, 1993). Non-significant pathways should be trimmed one pathway at a time and the model fit should be re-tested after each step (Garson, 2012).

Analysis of the MI's and standardized residuals resulted in various new pathways. Covariances between collective coping and familism, collective coping and Latino cultural orientation, collective coping and religious coping, and between Latino cultural orientation and religious coping were added. These pathways made theoretical sense as individuals who engage in collective coping may be more likely to adhere to Latin American cultural values (familism, Latino cultural orientation and religious coping). Similarly, a relation between religious coping and Latino cultural orientation also makes sense. A covariance was added between previous use of mental health services and psychological distress, as well as pathways from previous use of mental health services and subjective norms and attitudes. That is, it makes theoretical sense that previous use

of mental health services will affect an individual's attitudes and subjective norms, as well as their level of psychological distress. Finally, a pathway was added from attitudes to subjective norms. This pathway was deemed reasonable given that Ajzen and Fishbein's original model (1980) suggested that attitudes and subjective norms influence each other. Subsequently, all non-significant pathways were trimmed. As a result, several variables were trimmed from the model, including stigma, avoidance coping, engagement coping, and religious coping. The final respecified model is displayed in Figure 15.

The final model demonstrates that both attitudes and subjective norms influenced intentions to seek help, as hypothesized in the present study and consistent with the TRA model. The model also suggests that attitudes had an indirect effect on intentions to seek help via subjective norms. Furthermore, higher levels of familism were associated with more negative attitudes toward seeking help. Additionally, greater collective coping was associated with more positive subjective norms, while greater Canadian cultural orientation was associated with lower subjective norms. The model also revealed that Latino cultural orientation had a direct effect on intentions to seek help such that greater Latino cultural orientation was associated with stronger intentions to seek help. Furthermore, familism and collective coping, as well as Latino cultural orientation and collective coping, were found to co-vary. In terms of the three hypothesized covariates, psychological distress was the only variable that had a direct effect on intentions to seek help. The model suggested that gender influenced subjective norms, such that women were more likely to report more negative subjective norms. Moreover, previous use of mental health services was associated with more positive attitudes and subjective norms.

The fit indices for the respecified model were  $\chi^2(30) = 55.93, p < .001, GFI = .95, CFI = .89, RMSEA = .06, and SRMR = .08$ , suggesting good fit with the data. This model

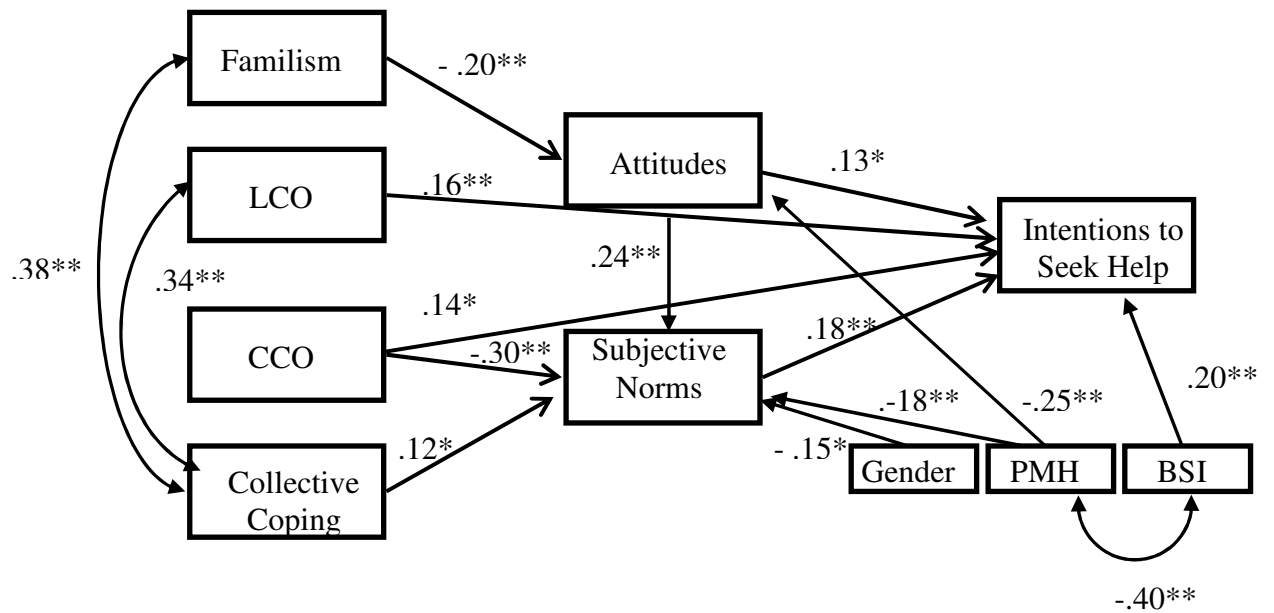
explained 15% of the variance of intentions to seek psychological help (see Table 5 on page 98).

### **Mediation Analysis**

It was hypothesized that attitudes towards help-seeking and subjective norms would mediate the effect of the cultural variables on intentions to seek help (hypotheses 8a and 8b, respectively). Mediation analysis was conducted using the bootstrapping method on AMOS, as described by Kenny (2012) and Kline (2005). Specifically, the bootstrapping procedure involved creating 1000 bootstrap samples and using these samples to obtain confidence intervals and standard errors to determine the significance of the indirect effects. If the 95% confidence does not contain zero then the indirect effect is significant at the .05 level (Shrout & Bolger, 2002). The path diagram for the respecified model indicated that higher Canadian cultural orientation (CCO) was associated with more negative subjective norms, which was predictive of lower intentions to seek help. Consistent with hypothesis 8b, bootstrapping (with 1000 bootstrap samples) revealed that the total indirect pathway from Canadian cultural orientation to intentions to seek help was significant (95% CI = -3.087 to -3.71), indicating that subjective norms mediated this effect. Interestingly, this indirect pathway is in the opposite direction of the direct pathway from Canadian cultural orientation and intentions to seek help, suggesting an inconsistent mediation (MacKinnon et al., 2007). In other words, Canadian cultural orientation may have opposing direct and indirect effects on intentions to seek help. Potential explanations for this finding are discussed in the subsequent chapter.

Given that the respecified model also indicated an indirect pathway from attitudes to intentions to seek help, exploratory analysis was conducted to test whether subjective norms mediated this pathway as well. Bootstrapping revealed that the total indirect

pathway from attitudes to intentions to seek help was significant (95% CI = .492 to 3.74), suggesting that subjective norms mediated this effect. Thus, positive attitudes were associated with more positive subjective norms, which were predictive of greater intentions to seek help. On the other hand, contrary to hypothesis 8a, the path diagram for the respecified model did not suggest a mediating role for attitudes toward help-seeking.



*Figure 15.* Respecified Path Model 5 results. Standardized path coefficients are shown. LCO = Latino Cultural Orientation, CCO = Canadian Cultural Orientation, PMH = previous use of mental health services, and BSI = psychological distress.  
 $* p < .05$  and  $** p < .01$ .

### **Summary of Path Analysis**

The results of the present study revealed that the TRA model (hypothesized model 1) did not adequately fit the data. Despite the poor fit of this model, the specified relations between attitudes and intentions to seek help and subjective norms and intentions to seek help were found to be significant and in the expected direction consistent with the TRA model.

The hypothesized model 2, which expanded the TRA model to include stigma, was also found to have a poor fit with the data of the present study. Moreover, stigma was not found to have a significant relation with any of the variables in the model. Inclusion of the cultural variables (hypothesized Model 3) and the covariates (Model 4) significantly improved the proportion of the variance accounted for by the model. However, both models still showed poor fit with the data.

Finally, the respecified model (model 5) was established by examining the modification indexes and standardized residuals, by trimming non-significant pathways, and by considering the theoretical implications of each step. The final respecified, culturally-expanded model provided a good fit of the data. In addition, both attitudes and subjective norms were found to be significant predictors of intentions to seek help, consistent with the TRA. This model also suggested important roles for the three hypothesized covariates and for various cultural variables, including familism, collective coping and acculturation levels. Finally, mediation analysis revealed that subjective norms mediated the relation between Canadian cultural orientation and intentions to seek help, as well as the relation between attitudes and intentions to seek help.

## **Results of the Analysis of the Responses to the Open-Ended Question**

Qualitative analysis using thematic analysis (Braun & Clarke, 2006) was carried out to provide further information concerning help-seeking for psychological distress among Latin Americans living in Canada. Qualitative data consisted of the participants' written responses to the open-ended question included at the end of the study questionnaire. The question was: "Have you or your family ever had an experience with mental health services and can you tell me about it? What was it like?" Out of the 223 participants, 77 participants (34.5%) provided responses to the open-ended question. Although some respondents provided detailed responses, the majority answered in a few words (e.g., "helpful," "bad experience") or in a few sentences. Basic demographic information and the language in which the response was written (English versus Spanish) are indicated for each excerpt.

Thematic analysis resulted in four major themes: a) quality of previous experience with mental health services; b) importance of cultural values and cultural understanding in treatment; c) diverse attitudes toward medication; and d) the role of religion in help-seeking.

### **Quality of Previous Experience with Mental Health Services**

**Positive Experiences.** Over 80% of the respondents commented on the quality of their own or their family's previous experience with mental health services. Of these respondents, approximately 70% reported a positive experience. Many respondents commented on the positive therapist/clinician characteristics, such as patience, acceptance and understanding, that they appreciated in treatment.

"Very professional and patient. They [the therapists] listen and help you get to the bottom of the problem." (66-year-old woman; Spanish)



“Yes I went through some depression and I sought help. I found I was able to talk to someone that was not my family or friends, which allowed me to open up more. I didn't feel like I was being judged and felt I could speak my mind. It allowed me to understand my feelings somewhat. I stopped going but I wish I didn't because it helped me a lot.” (23-year-old woman; English)

In terms of what was helpful in receiving treatment, consistent with previous research on Latin American help-seeking (Bledsoe, 2008; Kouyoumdjian, 2003), many participants in the current study commented on how they valued a more direct therapy approach that included advice giving and problem solving.

“Family therapy was very useful for us and helped us find solutions to certain problems in a way that was successful for our family.” (50-year-old woman; Spanish)

“My experience has been good. They [the therapists] help us resolve problems in a more certain manner and help us feel better about ourselves.” (44-year-old woman; Spanish)

In addition to problem-solving, many participants also commented on gains in psychological well-being through receiving counselling, including improved self-esteem and self-efficacy, as well as feeling supported by the clinician.

“My experience was that I was a bit weak, depressed, cried often, and did not want to accept everything that was happening to me. After seeking professional help, I feel more sure of myself, I learned to love myself first, and to accept and face things without fear and to try to be happy with what I have.” (47-year-old woman; Spanish)

“I suffer from depression and am currently on medication. I feel much better after visiting my doctor. My experience has been very positive and I feel greatly supported. If it wasn't for the support I receive from this professional, I may not be alive today.” (59-year-old man; Spanish)

**Negative Experiences.** Approximately 30% of the respondents reported negative experiences with mental health services. Many participants reported that treatment had not been helpful but often did not report why, while others focused on negative therapist characteristics or issues of distrust.

“...I tried therapy once here [in Canada] and I found it robotic and cold.” (31-year-old woman; English)

“Uncomfortable, I feel that [the therapist’s] questions were more to judge me, or to know whether I was telling the truth, than to help me.” (30-year-old woman; Spanish)

An additional theme that emerged in relation to negative treatment experiences was the role of cultural issues, which will be explored in greater depth as a separate theme.

### **Importance of Cultural Values and Cultural Understanding in Treatment**

The consideration of cultural values played an important role in the outcome of treatment for approximately 20% of the respondents of the open-ended question in the study. Some participants appreciated the fact that cultural issues were taken into account in the therapy and reported that this had influenced their experience with mental health services. In contrast, some respondents indicated that ignorance and misunderstanding of cultural values or cultural stereotypes had a negative effect on treatment outcome for them.

“I have been in [to therapy] on three different occasions. The situation involving my children went very well. The children and I were treated well and cultural issues were taken into account. However, when I had to go in for marital problems it was somewhat difficult because I was a woman. The therapist took the male side of things and assumed I was a submissive woman. None of the times was with a Latino therapist, thus it’s possible that Latino therapists may understand us better in terms of immigrant and cultural issues, ethics and values. However, it is very difficult to find a good Latino therapist.” (43-year-old woman; Spanish)

“I have had professional help during hard times, sometimes I did find that it was helpful and sometimes I did not. I think most of the times I didn't find help was because of the lack of understanding of my cultural background [by] the professional helping me.” (58-year-old woman; English)

Other participants commented that the lack of understanding of cultural issues or a clash in cultural values between the therapist and them had resulted in inappropriate or

unhelpful advice, feeling disrespected by the therapists, and even becoming distrustful of the therapy process.

“If the counsellor is North American/Caucasian, they have very different values than Hispanics. We [Hispanics] always try to protect the family above all else. They suggest that children should be allowed to make mistakes and that this is how they will learn but when these problems arise, it is usually the mother that carries the heaviest burden. The solution that they [the therapists] provide is to tell [your children] to “leave the house now that you are of age”, but that is not the solution to the problem.” (52-year-old woman; Spanish)

“Somewhat positive but with much distrust in the health care system especially in the area of mental health. I believe that there is a lack of ethnic understanding and disrespect towards cultural issues, as well as a great deal of prejudice against Latin American individuals.” (45-year-old woman; Spanish)

### **Diverse Attitudes Toward Medication**

Some participants reported that they had a positive experience with medication and found it helpful (approximately 5% of the respondents). However, other participants reported that medication alone was not enough and that they also valued psychotherapy treatment (approximately 5% of the respondents). In addition, some participants reported negative attitudes toward medication in general and concerns that the Canadian/North American mental health system was too focused on medical solutions as opposed to psychotherapy.

“Very traumatic [experience] in the hospitals because the mentally ill are discriminated against and mocked in this establishment. There is little respect towards them. Psychiatrists (not all of them) don’t care about their patients, psychotherapy does not exist for them and medication is seen as the only option. I have found the best psychiatrist with whom I am doing psychotherapy, who cares about me and all his patients. Because of this, I feel better every day. Few remain like him.” (48-year-old woman; Spanish)

“I don’t think that I or my family have had any contact with mental health services, however I did my practicums/internships for my BA [degree] in a psychiatric hospital and under certain circumstances I disagreed with the diagnostic criteria for patients without psychotic symptoms. I believe that here in North America the medical model is very powerful, psychiatry and the use of medication for mood disorders for example, compared to psychological

treatments. Or if psychological treatments do have power, I don't want to imagine the cost of an appointment with a good psychologist or analyst. Anyway I have not tried to seek psychological help but I would prefer to be analyzed by a psychoanalyst, but I've heard that this is very costly." (27-year-old woman; Spanish)

### **The Role of Religion in Help-Seeking**

Previous research exploring the role of religion and religious coping on help-seeking has resulted in mixed findings. Some researchers have suggested that religious coping may impede formal help-seeking, whereas others have suggested the opposite. Examples of both instances were found in the present sample. Approximately 10% of the respondents mentioned religion or religious coping in relation to help-seeking. For some participants their religious beliefs did not impede help-seeking and many believed that treatment was helpful because of their faith in God.

"My experience with mental health services following an accident at work has helped me a great deal and I still continue with treatment trusting in scientific advances with which I hope to be able to become the normal person I was before. I hope and trust in God that this will be so." (52-year-old man; Spanish)

"It really helped me understand what was happening and gave me tools to deal with the crisis (anxiety, panic attacks, depression) I was dealing with and I now have a better idea of the services available, and this, along with my strong convictions and faith in God, made me realize that I am not alone and that this is a disease that does not go away by itself." (41-year-old woman; Spanish)

On the other hand, some participants reported turning to religion, prayer and support from fellow church members as an *alternative* to formal help-seeking.

"First, I place the problem or situation in God's hands. I ask that my family and friends pray for me." (49-year-old woman; Spanish)

"Ever since I was 16 I was diagnosed with depression, though I showed symptoms from before. Since it wasn't something my family really knew about, they had negative ideas about depression, those symptoms were never detected. Since then it has been a struggle but I am fulfilled and satisfied with my life. I know I have a long road ahead and maybe this is something I will have to deal with for the rest of my life but I know that I can do it with the help of my family, church and most importantly God." (30-year-old woman; English)

### **Summary of Thematic Analysis of the Open-Ended Responses**

Thematic analysis of the open-ended question revealed several themes relevant to the present study. The findings revealed that a large number of respondents reported a positive experience with previous mental health services. Participants focused on positive therapist/clinician characteristics, the role of problem-solving, and some participants reported other gains such as an increase in self-esteem, self-efficacy, and support. However, some participants reported negative experiences with mental health services and reported that it was an unhelpful experience. For instance, some identified negative therapist/clinician characteristics that made the experience unpleasant. One factor that seemed to impact the outcome and perception of psychological treatment by Latin Americans was the extent to which cultural values were considered in the treatment process. Many participants reported that the consideration of cultural values in treatment was important. Ignoring or misunderstanding of cultural values, on the other hand, resulted in a negative experience for them and was identified as a barrier to help-seeking. Although some respondents found medication treatment helpful, others expressed concern about the over-emphasis on medication over psychotherapy in current psychological and psychiatric treatment. Religion and religious coping was reported by some participants. For some participants, religion played an important role in addition to seeking help, whereas for others religion was reported as an alternative to formal help-seeking.

## CHAPTER IV

### Discussion

The purpose of the present study was to examine the ability of the TRA model to explain intentions to seek help for psychological distress in a sample of Latin American individuals living in Canada. Given that theoretical and empirical literature has implicated cultural variables as playing an important role in the decision to seek help (Cabassa & Zayas, 2007; Frevert & Miranda, 1998), an additional aim of the present study included testing whether culturally-expanded TRA models provided improved explanatory frameworks for help-seeking among Latin Americans. Moreover, qualitative analysis was included to gain further information on Latin Americans' attitudes towards and experience with help-seeking for psychological distress.

This chapter presents a summary and discussion of the results for the hypothesized path models tested and the qualitative findings. Specifically, the effect of attitudes and subjective norms, stigma, cultural variables, and additional barriers on help-seeking intentions are discussed. Furthermore, the limitations of the study, directions for future studies, and the implications of the findings are also discussed.

#### **The Theory of Reasoned Action (TRA) Model**

The TRA model (Ajzen & Fishbein, 1980) proposes that intentions to seek help for psychological distress are influenced by attitudes toward seeking help and subjective norms. One of the aims of the present study was to assess whether the TRA explained help-seeking intentions among Latin Americans. Although the results from this study showed that the TRA did not adequately fit the data, the relations between the variables in the model were in the predicted direction (see Figure 4 on page 94). Consistent with the TRA, more positive attitudes toward help-seeking and more positive subjective norms

were both associated with greater intentions to seek help for psychological distress in the present sample.

The relation between attitudes toward help-seeking and intentions to seek help found in the present study is consistent with a number of previous research studies (e.g., Cabassa & Zayaz, 2007; Cepeda-Benito & Short, 1998; Cramer, 1999; Kelly & Achter, 1995; Kim & Omizo, 2003; Liao et al., 2005). That is, an individual's favourable attitudes toward mental health treatments are important antecedents to seeking appropriate treatment for psychological distress.

Research studies examining the importance of subjective norms as antecedents of intentions to seek help have resulted in mixed findings. For instance, Vogel and colleagues reported in their study with American college students that subjective norms did not have a direct impact on intentions to seek help (Vogel et al., 2005) and excluded this variable from a subsequent study that utilized the TRA model (Vogel et al., 2007). On the other hand, Kim and Omizo (2003) reported that subjective norms, but not attitudes, mediated the effect of Asian values on intentions to seek help in a sample of Asian American college students. To the best of this author's knowledge, only one other study has investigated the impact of both attitudes and subjective norms on help-seeking intentions among Latin Americans. Cabassa and Zayas (2007) found that *both* attitudes and subjective norms predicted intentions to seek help in a sample of Latin American outpatients. Interestingly, the results of the present study are consistent with Cabassa and Zayas' study, providing additional support for the impact of subjective norms in the decision to seek help for Latin Americans. Moreover, subjective norms were found to be more strongly correlated with intentions to seek help than attitudes in three of the five models tested in the current study (see Figures 13, 14, and 15 on pages 108, 110, and 115,

respectively). These findings suggest that for Latin Americans subjective norms may be more salient than attitudes when deciding whether or not to seek mental health treatment. These findings are consistent with a prior study of Latin American adolescents that showed subjective norms to be more important than individuals' attitudes in relation to their intentions to engage or not engage in sexual behaviour (Tschann & Marin, 2002).

In addition to the direct effect of attitudes on intentions to seek help, the final respecified model (see Figure 15) showed that more positive attitudes indirectly influence intentions to seek help. That is, more positive attitudes are associated with more positive perceived subjective norms, which in turn, are associated with greater intentions to seek help for psychological distress. Moreover, the findings showed that subjective norms were a significant mediator in this indirect pathway. These findings point to the important influences of key social referents (i.e., family, parents, siblings) for Latin Americans as a mechanism to explain the effect of attitudes on intentions to seek help.

Taken together, the results of the present study suggest that social norms are highly important in the decision to seek psychological help for Latin Americans. These results are consistent with previous theoretical and empirical literature that suggests that Latin American culture is collectivistic and that interdependence and family cohesion are highly valued (Cabassa & Zayas, 2007; Frevert & Miranda, 1998; Sabogal et al., 1987). From a collectivistic perspective, Latin Americans may be motivated to maintain harmonious interpersonal relationships by conforming to important referents' expectations. In other words, when the subjective norms of important referents are inconsistent with seeking psychological help, Latin American individuals may feel reluctant to seek treatment. Therefore, the current findings further exemplify how Latin



Americans' intentions to seek help may be part of a social process that is influenced by the advice and perceived opinions of others within one's social network.

### **The Effect of Stigma on Help-Seeking Intentions**

The second model tested in the present study attempted to replicate Vogel and colleagues' (2007) findings based on American college students which implicated stigma as a significant predictor of help-seeking for their sample. The study showed that college students' attitudes toward help-seeking mediated the effect of stigma on their intentions to seek help. In contrast to their findings, in the present study stigma was not found to be significantly correlated with intentions to seek help or with any of the other TRA variables (see Figure 5 on page 98).

While the theoretical literature suggests that stigma is a significant barrier to help-seeking for Latin Americans (Bledsoe, 2008; Frevert & Miranda, 1998; Kouyoumdjian, 2003), the results of the few existing empirical studies on stigma have been mixed. For instance, Nadeem (2007) reported that immigrant Latin American women were more likely to report stigma concerns about mental health treatment compared to U.S.-born White women. In contrast, Alvidrez (1999) found that Latin American women were less likely to report stigma concerns associated with mental health treatment compared to African- and European-American women. One possible explanation for the lack of relationship between stigma and help-seeking intentions in the present study is that compared to the other psychological variables tested, stigma does not play a significant role as a barrier to help-seeking for mental health concerns among Latin Americans.

The present study utilized a stigma measure (i.e., Perceptions of Stigmatization by Others for Seeking Help: Vogel et al., 2009) that examines an individual's perceived stigma within his or her social network. Given the importance of one's social network

within Latin American culture (Kouyoumdjian et al., 2003; Sabogal et al., 1987), the lack of significant findings for stigma is surprising. Specifically, this measure asked participants to rate the perceived judgment of *people with whom they interact*. For many Latin Americans, important referents within their social networks include immediate and extended family members (Sabogal et al., 1987) specifically. Therefore, it is possible that asking participants about the opinions of others with whom they interact was too general and did not reflect the opinions of important referents in their lives.

Alternatively, it is also possible that the specific type of stigma being assessed in the present study (i.e., the perceptions of others within one's social network) does not play a significant role in help-seeking for this sample, as opposed to other types of stigma such as self-stigma. Self-stigma has been defined as a negative perception that an individual has towards him or herself for seeking psychological help that includes feelings of shame and low self-esteem (Vogel et al., 2007). For instance, in a qualitative study Interian et al. (2007) reported that self-stigma was identified as a significant barrier to mental health treatment in a sample of depressed Latin American outpatients. Specifically, the sample indicated that they viewed seeking depression treatment as a sign of weakness, as a personal failure, and as an inability to cope with life's problems. Thus, cultural beliefs about 'suffering with dignity' and expectations of strength and forbearance in the face of distress (Abdullah & Brown, 2011; Moore & Constantine, 2006) may result in self-stigma associated with seeking help, which then impedes help-seeking among Latin Americans.

### **The Effect of Cultural Variables on Help-Seeking Intentions**

The present investigation addressed gaps in previous cultural research by examining the effect of various cultural variables on help-seeking intentions in a sample

of Latin Americans. Specifically, the effect of acculturation, familism, and coping strategies was assessed in three of the path models tested (see Figures 13, 14, and 15 on pages 108, 110, and 115, respectively).

**The Effect of Acculturation on Help-Seeking Intentions.** The current investigation examined the effect of Latino and Canadian cultural orientation on intentions to seek help in the present sample. Contrary to the study's hypothesis, the results of this investigation showed that higher Latino cultural orientation was associated with greater intentions to seek help. Moreover, Latino cultural orientation was not associated with either attitudes toward seeking or subjective norms. These findings are contrary to the cultural barrier theory proposed by Leong and colleagues (1995) which posited that individuals reporting greater Latino cultural orientation would be less likely to seek help for psychological distress. However, our findings are consistent with a recent study (Ramos-Sanchez & Atkinson, 2009) which found greater Latino cultural orientation and lower generation status (i.e., more recent immigrants) to be associated with more positive attitudes and greater intentions to seek help in a sample of Latin American outpatients. The authors posited that their findings may have been due to Latin American cultural values not assessed in their study, such as respect for authority figures. In support of this possibility, Reulas et al. (1998) reported that Latin Americans with higher levels of Latino cultural orientation rated counsellors more favourably in terms of expertise and trustworthiness. Thus, this possibility necessitates further investigation.

As hypothesized, Canadian cultural orientation was associated with greater intentions to seek help. On the other hand, contrary to the study hypotheses, Canadian cultural orientation was associated with negative subjective norms, and was not associated with attitudes toward help-seeking. Furthermore, mediation analysis revealed

that subjective norms were a significant mediator in the indirect pathway from Canadian cultural orientation to intentions to seek help. It is interesting to note that the direct and indirect effects of Canadian cultural orientation on intentions to seek help were in the opposite direction from what was predicted. This type of mediation has been referred to as an inconsistent mediation (MacKinnon et al., 2007). Specifically, greater Canadian cultural orientation was associated with greater intentions to seek help, while greater Canadian cultural orientation was also associated with more negative perceived subjective norms, which in turn, predicted lower intentions to seek help. Given the competing effects, it is possible that the overall effect of Canadian cultural orientation on intentions may be minimal, which may explain previous inconsistent findings in this area of research. Previous researchers have tended to examine the direct effects of acculturation on either attitudes or intentions to seek help (Miville & Constantine, 2006; Ramos-Sanchez & Atkinson, 2009) without testing the possibility of a mediation model. The present findings highlight the importance of including potential mediating variables when examining the antecedents of the help-seeking process.

The acculturation construct is a multidimensional construct that includes cultural identity, behaviours, language preference, and values (Cuellar et al., 1995). Thus, one possible explanation for the seemingly opposite effects is that certain components of the acculturation variable may be associated with greater intentions to seek help, while other components may be related to negative perceived subjective norms. For example, as an individual's cultural competence in Canadian society increases (i.e., English language competence, knowledge of appropriate services), he or she may be more willing to seek out mental health treatments. On the other hand, individuals with greater cultural competence in Canadian society may endorse traditional Latin American values less than

others in their social networks and may therefore perceive the opinions of these social referents as more negative. At this point, this interpretation is speculative. Unfortunately, the acculturation measure used in the present study did not directly assess adherence to Latin American values but instead focused on behaviours (i.e., language use, music/food preferences) and cultural identity (Cuellar et al., 1995). A relatively recent study, however, showed that assessing both behavioural acculturation and adherence to cultural values is important. Liao et al. (2005) reported that adherence to Asian values explained a greater proportion of the variance in attitudes toward help-seeking than behavioural acculturation alone in a sample of Asian American students. Thus, future studies examining Latin American acculturation should also include a measure of adherence to Latin American cultural values.

In sum, the results based on the Latino and Canadian cultural orientation variables suggest that the effect of acculturation on help-seeking intentions among Latin Americans may be more complex than initially proposed by the cultural barrier theory (Leong et al., 1995).

**The Effect of Familism on Help-Seeking Intentions.** Familism, which refers to values pertaining to family cohesion and loyalty, is often described as one of the most important Latin American cultural values (Sabogal et al., 1987). Consistent with the hypothesis of this study, higher levels of familism were associated with more negative attitudes toward help-seeking. These findings are in line with results reported by Garcia (2008) and Miville and Constantine (2006) noting that higher levels of familism were associated with more negative attitudes toward help-seeking among Latin American college students. In contrast to these studies, Ramos-Sanchez and Atkinson (2009)

reported that familism was not a significant predictor of either attitudes toward help-seeking or intentions to seek help in a sample of Mexican American college students. These three studies assessed the direct impact of familism on help-seeking attitudes or intentions to seek help using hierarchical regression. To the best of this author's knowledge, the present study is the first to investigate the impact of familism on both attitudes and intentions to seek help using path analysis. The path analysis statistical approach used in the current investigation allowed for both the direct and indirect effects of familism on intentions to seek help to be assessed simultaneously. The results from the present study suggest that familism has an *indirect* effect on intentions via attitudes toward help-seeking (see Figures 13, 14, and 15 on pages 108, 110, and 115, respectively) and help shed light on the impact of familism on intentions to seek help.

It may be that Latin Americans reporting higher familism in the present study perceived their families as more supportive and thus viewed help-seeking from mental health services as unnecessary or unhelpful. For example, greater perceived family support has been shown to be associated with negative attitudes toward help-seeking (Miville & Constantine, 2006). Moreover, greater familism and familism cohesion has been shown to have protective benefits against various stressors faced by Latin American adolescents and families (Gil & Vega, 1996; Gil et al., 2000). In other words, many Latin Americans may rely on close family relationships as their primary or main source of support. Alternatively, another possibility is that Latin American individuals endorsing higher levels of familism may hold negative attitudes toward help-seeking because they place greater importance on family privacy and may feel more distrustful towards mental health services. For instance, some Latin American individuals believe that mental illness is best treated within the family (Frevert & Miranda, 1998) and that problems should not

be discussed outside the family (Alvidrez, 1999). Thus, cultural values emphasizing family privacy and cohesion may serve as an impediment for help-seeking for some Latin American individuals.

**The Effect of Coping on Help-Seeking Intentions.** The effect of various coping strategies (engagement, avoidance, collective, and religious coping) on help-seeking intentions was also explored in three path models tested in this study. Models 3 and 4 (see Figures 13 and 14 on pages 108 and 110, respectively) showed that engagement coping (i.e., problem-focused coping) was associated with negative attitudes toward help-seeking and negative subjective norms, whereas avoidance coping was not significantly related to either attitudes or subjective norms. Given the dearth of research in this area, no a priori hypotheses were advanced involving these two coping strategies. The engagement coping scale consisted of items referring to problem solving/direct action, personal adjustments in the face of stress, and self-reliance (Kuo, Roysircar, & Newby-Clark, 2006). One possible explanation for the current findings is that individuals who reported greater engagement coping may be more self-reliant and independent when dealing with stressful situations, and thus hold negative attitudes toward seeking help. Alternatively, it is also possible that Latin Americans who reported greater engagement coping strategies might also have endorsed higher levels of forbearance, a Latin American value not assessed in the present study. Forbearance within collectivistic cultures refers to a tendency to sacrifice oneself and endure distress by relying on oneself, so as not to burden others (Moore & Constantine, 2006). Indeed, one study demonstrated that greater forbearance among ethnic minority students, including Latin Americans, was associated with more negative attitudes toward seeking professional help (Moore & Constantine, 2006). Further research focusing on the relationship between additional Latin American cultural values

and coping, and on the effect of these coping strategies on help-seeking attitudes and intentions, is needed.

Religious coping was also identified as a significant antecedent to help seeking intentions in path models 3 and 4 (see Figures 13 and 14 on pages 108 and 110, respectively). As hypothesized, these models indicated that greater religious coping was associated with more negative subjective norms, suggesting that religious coping *indirectly* impedes formal help-seeking among Latin Americans. In contrast to the study hypotheses, however, religious coping was not associated with either attitudes toward help-seeking or intentions to seek help. Although previous studies have examined the impact of religious beliefs on help-seeking (Alvidrez, 1999; Ramos-Sanchez, 2001), to this author's knowledge this study was the first to investigate the impact of religious coping on attitudes, subjective norms, and intentions to seek mental health services. The findings in the present investigation suggest that individuals who reported higher levels of religious coping perceived more negative subjective norms relating to seeking professional help among important referents in their lives, and that these negative subjective norms in turn were associated with lower intentions to seek help. It may be that individuals who reported higher levels of religious coping were more religious in general, engaged in more organized religious activities, and tended to perceive greater negative subjective norms relating to help-seeking within their religious communities. These findings suggest that religious coping may be an indirect impediment to help-seeking for some Latin American individuals.

Results from the qualitative responses provide further insight into the relation between religious coping and help-seeking among Latin Americans. For some participants in this study, religious beliefs and religious coping did not impede their use



of mental health treatments. For instance, some respondents commented that in their opinion their psychological treatment had been effective because of prayer and their faith in God. In contrast, other participants reported turning to religion and religious coping as an *alternative* to seeking psychological treatments. In this case, religious coping appears to function as an impediment to seeking formal psychological treatment. The effect of religious coping on the decision to seek help is an emerging area of research and the factors and circumstances that help determine whether religious coping impedes or facilitates seeking mental health treatment among Latin Americans require further study. Future studies should investigate the effect of religious coping and religious beliefs on both formal and informal help-seeking strategies used by Latin Americans to cope with distress.

Collective coping, as defined in the present study, is based on group-referencing (e.g., one's family, ethnic group) behaviours and cultural values. Based on the theoretical literature (Frevert & Miranda, 1998; Leong et al., 1995), it was hypothesized that collective coping would likely impede help-seeking among Latin Americans. Counter to this hypothesis, the results of the present study showed that collective coping was actually associated with positive attitudes toward help-seeking (see Figures 13 and 14 on pages 108 and 110, respectively) and with positive subjective norms (see Figure 15 on page 115). On the other hand, collective coping was not found to be associated with intentions to seek help. These findings are in line with Moore and Constantine's (2005) study that showed that collective coping, as assessed by social support seeking, was positively correlated with attitudes toward help-seeking in a sample of Mexican American students. Furthermore, the present findings are unique in that they also suggest that collective coping may have an indirect facilitative effect on the help-seeking process via subjective

norms as well. In other words, Latin Americans who employed collective coping strategies reported more positive attitudes and subjective norms related to help-seeking, and these attitudes and subjective norms in turn influenced intentions to seek help.

Family support plays an important role in the lives of most Latin Americans (Mulvaney-Day et al., 2007; Sabogal et al., 1987). However, the type of support may differ within families. For instance, some individuals may prefer behavioural support (e.g., monetary support, childcare) as opposed to emotional support from family members. Both behavioural and emotional support have been shown to be important in the lives of Latin Americans (Mulvaney-Day et al., 2007). Thus, it may be that individuals who reported greater collective coping (i.e., talking to and seeking advice from family and friends) were more likely to seek emotional support from family members. Individuals who seek emotional support from their family, as opposed to those who prefer behavioural supports, may differ on some other personal characteristic not assessed in the present study, such as self-concealment. Past research has shown that individuals with lower levels of self-concealment tend to seek out greater social support (Cramer, 1999). Therefore, these individuals may feel more comfortable about disclosing their psychological distress to others and thus hold more positive attitudes toward help-seeking for psychological distress.

Finally, in the re-specified path model (see Figure 15), two Latin American cultural variables, familism and Latino cultural orientation, were found to co-vary with collective coping. In other words, Latin Americans who endorsed values consistent with familism and Latino cultural orientation were more likely to engage in collective coping strategies when dealing with their mental illness concerns (i.e., depression symptoms as described in the study vignette). These findings correspond with previous research

emphasizing the effect of culture on coping (Chun et al., 2006; Kuo, 2011) and provide additional support for the use of culture-based coping strategies among Latin Americans.

### **The Effect of the Study Covariates on Help-Seeking Intentions**

The effect of three covariates (psychological distress, gender and previous use of mental health services) on help-seeking intentions was assessed in the current investigation. Consistent with the present study's hypothesis, greater psychological distress was associated with stronger intentions to seek help. This finding is in accordance with previous research in this area (Cepeda-Benito & Short, 1998; Cramer, 1999). In contrast to previous research (Alvidrez, 1999; Andrews et al., 2001), however, gender was not associated with either intentions to seek help or attitudes toward help-seeking. On the other hand, gender was associated with subjective norms such that women reported more negative subjective norms. Within traditional Latin American families, women often play an important role as care-takers and may be socialized to cope with their own distress by drawing upon inner strength for the sake of the family (Abraido et al., 1996). Thus, one possibility may be that some Latin American women may internalize some of these expectations and may perceive important others as having negative opinions about seeking formal help for psychological distress. Finally, previous mental health use was not associated with intentions to seek help or subjective norms. However, consistent with previous studies (Alvidrez, 1999), previous mental health treatment was associated with more positive attitudes toward help-seeking. The qualitative data from the present study provided further support for this relation and showed that most respondents who had previously sought mental health treatment reported positive attitudes towards the process.

### **Additional Barriers to Help-Seeking**

In addition to the psychological and cultural variables assessed, the effect of various structural and physical barriers was also investigated in the present study. These barriers included cost of treatment, transportation difficulties, ability of a therapist to speak Spanish, and fear of discrimination. Contrary to the study's hypotheses, the bivariate correlations revealed that these physical barriers were positively correlated with intentions to seek help among Latin Americans. One possibility is that these physical barriers may become more salient for individuals who are seriously contemplating seeking out mental health services (higher score on intentions to seek help), as compared to those who have low intentions to seek mental health services. That is, individuals who are actively trying to find treatment may be more aware of the barriers associated with this process, such as the cost of treatment, transportation difficulties, and language barriers. Subsequent research should explore this possibility further among Latin Americans.

Results from the qualitative data suggested additional barriers to help-seeking as perceived by Latin Americans. Although the majority of respondents reported a positive experience with mental health services, some respondents indicated that therapists' lack of cultural understanding resulted in their negative experiences and outcomes. In particular, some participants reported feeling misunderstood or judged by their therapists, while others found the therapist's advice inappropriate or unhelpful because cultural values had been overlooked. Moreover, other respondents indicated that treatment options involving medication, as opposed to psychotherapy, were at times overemphasized by clinicians. These findings highlight the importance of developing and implementing mental health services that are culturally competent. Culturally competent care has been

defined as “a system that acknowledges the importance and incorporation of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs” (Sue et al., 2009 p. 528). Many multicultural scholars (Collins & Arthur, 2010; Hernandez et al., 2009; Sue et al., 2009; Whaley & Davis, 2007) have indicated that culture influences many aspects of treatment, including problem identification and definition as well as preferred treatment options, and that ignoring or overlooking cultural issues in psychological treatment can lead to improper treatment and may perpetuate disparities in access to mental health services.

### **Limitations of the Present Study**

The present study investigated the effect of various psychological and cultural variables on help-seeking intentions among Latin Americans living in Canada. The findings identified multiple variables as important antecedents to help-seeking intentions for this population. Despite these contributions, the findings of the present study should be viewed in the context of several methodological limitations.

The outcome measure used in the study was intentions to seek help and was developed based on the TRA model (Ajzen & Fishbein, 1980). The TRA model suggests that intentions to seek help are the direct predictors of help-seeking behaviour. However, the research design of the current investigation was cross-sectional and thus future help-seeking behaviour was not assessed. Therefore, a fruitful avenue for future studies would be to conduct a longitudinal study so that the effect of the psychological and cultural antecedents on both help-seeking intentions and future help-seeking behaviour can be assessed simultaneously. Such a study would help clarify the temporal relationship between these important antecedents and help identify additional barriers to actual help-

seeking behaviour. That is, an individual's intentions to seek help may change over time and other factors may impede an individual from acting on their intentions. For instance, individuals may report high intentions to seek help for psychological distress but may then encounter difficulties navigating the Canadian healthcare system, which would impede them from seeking appropriate treatment.

The final re-specified path model in the present study fit the data well and identified various cultural variables, including familism and collective coping, as important antecedents to help-seeking intentions in the current sample. However, because this model was statistically derived and generated post-hoc, future replication of this model is needed to determine the validity of the model and its various pathways. Specifically, Kline (2005) recommends that post-hoc models should be replicated using different samples and compared to other potential equivalent models. Furthermore, although the final model pointed to various significant pathways in the model and fit the data, the proportion of the variance explained was small (i.e.,  $R^2 = 15$ ). These findings suggest that there are additional variables not included in this model that could have impacted this complex help-seeking process among Latin Americans. This possibility is discussed further in a later section of this chapter.

In addition, the measure of stigma used in the present study is a relatively new measure of the construct (Vogel et al., 2009), and it assesses stigma within the limited scope of one's immediate social group. While this measure demonstrated adequate reliability in the present sample, closer inspection of the data revealed skewed responses such that the majority of the sample reported little or no stigma concerns related to seeking mental health services. While one possible interpretation could be that stigma was truly not a significant concern for the participants, it is also possible that this

response style may reflect psychometric limitations of the measure. For example, social desirability factors may have impacted the respondents' willingness to acknowledge the presence of stigma, in relation to their decision to seek help. However, social desirability was not assessed or controlled in the present investigation. Alternatively, it is possible that individuals who experience significant levels of stigma toward mental illness might have chosen not to participate in the present study. An additional possibility could be that different aspects of stigma (i.e., social- and self-stigma: Vogel et al., 2009), not assessed in the present study, may have played a more important role in Latin Americans' decision to seek help. Thus, future avenues of inquiry might include measures that assess stigma multi-dimensionally in order to determine the relative importance of these different dimensions of stigma.

Participants in the present study had the option to complete the study questionnaire in their language of choice (i.e., Spanish or English). Thus, it is possible that language may have primed specific cultural beliefs and attitudes. For example, Lechuga and Wiebe (2009) showed that the language of the study (i.e., Spanish or English) in a sample of Mexican Americans primed cultural attitudes and influenced participants' reported intentions to use condoms. However, this possibility is not likely in the present study as the language of the questionnaire was not found to have a significant effect on intentions to seek help among the study participants.

Finally, the sample included in the present study consisted of adult Latin Americans (average age of 46 years) living in Canada and the majority of the participants chose to complete the survey in the Spanish paper-and-pencil version of the questionnaire. As such, this sample represents a unique and often hard to reach population. However, the generalizability of the findings to other Latin American

populations within Canada is unclear, such as younger adults or adolescents who might prefer to complete the survey in English with the online version of the questionnaire. Furthermore, given that most participants completed the paper-and-pencil format in cultural and religious centres in the Toronto area, it is not known how well these findings would generalize to other Latin Americans in Canada living outside the Toronto/Ontario area. Moreover, the sample size consisted of over 200 Latin American individuals, as recommended by Kline (2005) to ensure adequate power for path analysis. However, the sample size was not large enough to allow for multi-group comparisons of the covariate variables (i.e., males versus females) across different path models to assess for moderation, as recommended by Holmbeck (2003). Future studies should include a more diverse sample of Latin Americans living in various provinces in Canada and aim for a larger sample size.

### **Recommendations for Future Research**

A re-specified, culturally-expanded model of help-seeking was identified in the present investigation. As noted earlier, this model should be replicated with different Latin American samples before its validity can be established. Moreover, subsequent research may benefit from testing competing theoretical models or integrating established models of help-seeking to shed further light on the predictors and the barriers to help-seeking for Latin Americans. One possibility might be to include variables from Andersen's behavioural model such as health beliefs and the perceived severity of illness (Andersen, 1995). Including these variables might be fruitful given that past research has suggested that beliefs about the causes of mental illness influence help-seeking among Latin Americans (Alvidrez, 1999) and that interpretations relating to problem severity are influenced by cultural factors (Cauce, 2002).



In addition, the present study suggested an important role for social influences on help-seeking among Latin Americans, as represented by the measure of subjective norms. In contrast to many of the previous studies in this area, the present study focused on assessing the perceived subjective norms of specific, social referents (i.e., parents, siblings) in the participant's life. Using this approach, subjective norms were identified as an important antecedent to help-seeking intentions for the present sample. Furthermore, this study also identified collective coping (i.e., seeking support from family members, behaving in a manner consistent with Latin American cultural values) as an important antecedent to subjective norms. Therefore, one possible avenue for future studies may be to explore the effect of emotional and structural support from these important referents on the help-seeking process. Previous research, for instance, has shown that social support is an important indirect predictor of help-seeking intentions (Cramer, 1999). Specifically, higher levels of social support result in lower levels of psychological distress, which in turn result in lower intentions to seek help. Moreover, Latin Americans often turn to their families for support during times of stress (Kouyoumdjian et al., 2003; Pescosolido et al., 1998) and may seek formal help only after they have consulted with these informal sources (Cabassa & Zayas, 2007). Thus, assessing the effect of emotional and structural social support may provide further understanding into both the formal and informal help-seeking strategies employed by Latin Americans when coping with psychological distress.

Furthermore, the present study included an open-ended question at the end of the survey in order to provide additional information on the use of mental health services among Latin Americans. This question provided invaluable insight into the participants' attitudes toward help-seeking and into the barriers associated with seeking mental health

treatment. For example, the present sample reported that a clinician's lack of cultural understanding impacted treatment outcome. Because this is an emerging area of research, future studies would benefit from including a larger number of open-ended questions. Specifically, it might be useful to ask participants about their perceived barriers to help-seeking, their beliefs about the causes of mental illness, and their use of informal resources to cope with mental health concerns. Such avenues of inquiry will help further identify the needs of the Latin American community in Canada and help ensure culturally competent treatment options for mental health issues for this population.

Finally, the present investigation did not make a distinction between different types of formal care, such as psychiatric versus psychological treatment options. This is an important distinction within the Canadian healthcare system as most psychiatric services are paid for by the Canadian healthcare system while most psychological services are not. In other words, these different treatment options may be differentially impacted by various barriers, such as long wait lists or the financial costs of treatment. Thus, future studies may benefit from investigating the variables that impact the use of different mental health treatment options in Canada.

### **Clinical Implications**

The findings in the present study showed that psychological factors, such as attitudes toward help-seeking and subjective norms, influence help-seeking intentions among Latin American adults. Moreover, subjective norms, or the perceived opinions of important social referents, appear to be more important than an individual's attitudes when deciding whether or not to seek help. Furthermore, the results suggest that familism, a Latin American cultural value related to family support and cohesion, also influenced the help-seeking process. That is, in the present study, higher levels of

familism were associated with more negative attitudes toward seeking help. Taken together, these findings suggest that the decision to seek help by Latin Americans is a social process that is influenced by the opinions and expectations of important referents and by cultural values. These findings suggest that educational and outreach mental health initiatives geared toward the Latin American community may benefit from targeting both an individual's attitudes and perceptions of mental illness and treatment services, as well as negative perceptions or attitudes within the individual's family or social network.

Furthermore, both the quantitative and qualitative results in the current study suggest that cultural factors are important in understanding the help-seeking process for Latin Americans. Research on culturally competent treatments has shown that treatment approaches geared towards specific ethnic groups, as opposed to non-specific treatments, are more successful in improving treatment usage and in reducing disparity in access to care (Collins & Arthur, 2010; Hernandez et al., 2009). The development of culturally competent treatment options requires ongoing community participation to ensure that services are adapted to meet the community's needs (Hernandez et al., 2009). Given that the majority of psychological treatments in North America tend to favour individualism and autonomy as opposed to collectivism (Sue & Sue, 1998), treatment options may benefit from considering the potential impact of collectivistic cultural values. For instance, treatment options that allow for a greater involvement of informal supports, such as family or other important social referents, may be preferred by some Latin American individuals. Additionally, the findings of the present investigation further highlight the importance of attending to cultural issues in psychological treatment and ensuring that clinicians are trained to provide culturally-competent services. At the level of the

clinician, cultural competence involves self-awareness, awareness of the client's culture, and awareness of appropriate interventions (Sue & Sue, 1998), as well as developing a culturally-sensitive working alliance (Collins & Arthur, 2010). This approach would ensure that cultural issues are taken into account, that treatment is not based simply on cultural stereotypes, and that treatment is adapted in a flexible manner to each individual.

### **Summary and Conclusion**

The present study used path analysis to examine the ability of the TRA model (Ajzen & Fishbein, 1980) to explain help-seeking intentions among Latin Americans. Consistent with the TRA, the results showed that both attitudes and subjective norms influenced help-seeking intentions in the present sample. Moreover, the findings showed that the decision of whether or not to seek help is for Latin Americans part of a social process where important social referents' opinions are considered. The present study contributes to the literature on the usefulness of the TRA model in explaining help-seeking, as well as to the literature on important antecedents to help-seeking for Latin Americans. Furthermore, the final re-specified model suggests an important role for various Latin American cultural values, including familism and collective coping, as antecedents to help-seeking intentions. Therefore, the current findings also contribute to the literature on the impact of cultural variables on help-seeking among Latin Americans. Finally, this research study included an open-ended question to gain a greater understanding of Latin Americans' attitudes toward help-seeking. Participants reported both positive and negative experiences with mental health services. One factor that appeared to influence participants' experience with mental health services was the extent to which cultural issues were considered in the treatment process. That is, overlooking or misunderstanding cultural issues and values was related to negative experiences for some

participants. Taken together, the present study provides a new understanding of the ways in which psychological and cultural variables influence help-seeking for psychological distress among Latin Americans. Given that this is the first study to examine help-seeking intentions among Latin Americans living in Canada, more research is needed in this area to ensure that the needs of this community are met and that culturally competent services are available for Latin Americans, as well as for other ethnic minority groups, living in Canada

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## APPENDICES

### Appendix A



## LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: Latino Canadians' Attitudes Toward Mental Health Services.

You are asked to participate in a research study conducted by graduate student, Alma Roldan (PhD Student), under the supervision of Dr. Ben C.H. Kuo (Associate Professor), from the Department of Psychology at the University of Windsor in Windsor, Ontario. The results of this study will contribute to Alma Roldan's dissertation project. The Research Ethics Board (REB) at the University of Windsor has reviewed and given clearance for this research study to take place.

If you have any questions or concerns about the research, please feel free to contact Alma Roldan, M.Sc. at roldana@uwindsor.ca or Dr. Ben Kuo, Certified Psychologist, at benkuo@uwindsor.ca or (519) 253-3000 ext. 2238.

### PURPOSE OF THE STUDY

This study is designed to assess the influence of various psychological and cultural factors on Latinos' attitudes toward psychotherapy and mental health services. Research in this area is important, as there is currently little knowledge about Latino-Canadians' opinions of mental health services.

### PROCEDURES

If you volunteer to participate in this study, you will be asked to:

- Read through this consent form to decide whether you would like to participate in the study.
- Keep a copy of this form for your records.
- Please follow the instructions at the beginning of each survey before completing the surveys and answer the questions as openly and honestly as possible

You will be given the option to complete the study in English or Spanish. This study should take about 30 to 40 minutes or less to complete. Once you have completed the survey, you will be provided with a research summary and a list of local resources.

### POTENTIAL RISKS AND DISCOMFORTS



There are minimal risks anticipated with participating in the present study. However, should you experience any distress or discomfort as a result of taking part in the study, please follow these links: For a list of Canadian Mental Health Association offices, visit <http://www.cmha.ca/bins/index.asp>. For a list of distress lines across Canada, visit <http://www.casp-acps.ca/crisiscentres.asp>.

#### POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Your participation in this study will contribute to knowledge about Latino Canadians' attitudes and beliefs relating to psychotherapy and mental health services. Such knowledge will help identify barriers to mental health service utilization among this population, as well as inform the development and implementation of culturally appropriate mental health interventions.

#### COMPENSATION FOR PARTICIPATION

At the end of the survey you will have the option to enter a draw for **1 iPod nano** and **4 \$25 gift certificates for Walmart Canada**.

#### CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. You will not be asked to provide your name when answering the questionnaire. The data for the online survey will be kept in a secure database accessed only by the principal investigator and the faculty supervisor. All data records will be destroyed five years after the study is completed. At that time, written materials will be shredded, and electronic files will be permanently deleted.

#### PARTICIPATION AND WITHDRAWAL

You can decide whether or not you wish to participate in this study. If you volunteer to be in this study, you may withdraw at any time before submitting your answers without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. However, once you have submitted your survey, it is no longer possible to withdraw your responses because they will be stored in a non-identifiable database. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

#### FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS

When this research study is finished, we will write a summary of the study results that you can access through the following website: [www.uwindsor.ca/reb](http://www.uwindsor.ca/reb). (You will need to click on "Study Results: Participants/Visitors"). The results are expected to be posted by February 2012.

#### SUBSEQUENT USE OF DATA

This data may be used in subsequent studies. These data may be used by the researcher for subsequent publications but will not deviate from the purpose described in this form.

#### RIGHTS OF RESEARCH SUBJECTS

The Research Ethics Board (REB) at the University of Windsor has reviewed and given clearance for this research study to take place. You may withdraw your consent at any time and drop out of the study without penalty. If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e mail: ethics@uwindsor.ca.

#### CONSENT OF RESEARCH SUBJECT

I understand the information provided for the study Latino Canadians' Attitudes Toward Mental Health Services as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study.

#### SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

Dr. Ben Kuo	March 16, 2011
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Alma Roldan	March 16, 2011
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**Please keep a copy of this form for your records.**

## Appendix B

### Demographic Questionnaire

Please complete the following information as accurately as possible.

1. Gender (specify if necessary)
  - Male
  - Female
2. Age \_\_\_\_\_
3. What country were you born in? \_\_\_\_\_
4. If you were born outside of Canada, how many years have you lived in Canada? \_\_\_\_\_
5. a) Where was your father born? \_\_\_\_\_
- b) Where was your mother born? \_\_\_\_\_
6. If you were born outside of Canada, please indicate your **main** reason for immigration:
  - Voluntary (ie., a better life, more opportunities, etc).
  - War
  - Political oppression/persecution
  - Poverty
  - Other: \_\_\_\_\_
7. Current Immigration Status
  - Canadian Citizen
  - Landed Immigrant
  - Refugee
  - Other: \_\_\_\_\_
8. What is your generation status in Canada?
  - 1<sup>st</sup> generation (born outside of Canada & immigrated to Canada **after** the age of 12)
  - 1.5 generation (born outside of Canada & immigrated to Canada **before** the age of 12)
  - 2<sup>nd</sup> generation (born in Canada & at least one of your parents was born outside of Canada)
  - 3<sup>rd</sup> generation (born in Canada and both parents were born in Canada)
  - Beyond 3<sup>rd</sup> generation or later (you, your parents and grandparents were born in Canada)
  - I am an international student who was born outside of Canada
9. Current Relationship Status:
  - Single
  - Married
  - Common-Law/Cohabiting
  - Separated or Divorced
  - Widowed
10. Employment Status (choose all that apply):
  - Full-time
  - Part-time
  - Unemployed
  - Student
  - Retired

11. What is your estimated highest level of education completed (specify if necessary):

- No schooling or did not complete elementary school
- Elementary School Education
- High School
- Completed 2 year college program
- Completed University degree
- Completed graduate or professional school

12. Highest level of your father's education:

- No schooling or did not complete elementary school
- Elementary School Education
- High School
- Completed 2 year college program
- Completed University degree
- Completed graduate or professional school

13. Highest level of your mother's education:

- No schooling or did not complete elementary school
- Elementary School Education
- High School
- Completed 2 year college program
- Completed University degree
- Completed graduate or professional school

14. Religious Affiliation:

- Catholic
- Christian (Baptist, Protestant, etc)
- Jewish
- Muslim
- Other: \_\_\_\_\_

15. How often do you attend church, temple or other religious meetings:

- More than once a week
- Once a week
- Once a month
- A few times a year
- Once a year
- Never

16. Postal Code of primary (ie., permanent) Canadian residence: \_\_\_\_\_

17. What is your estimated family monthly income (in Canadian dollars)? \$ \_\_\_\_\_

18. Have you ever used mental health services (eg., psychotherapy, counselling, etc)

- Yes
- No

### Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPH-SH)

Below are a number of statements pertaining to psychology and mental health issues. Use the rating scale below to **circle the number that best describes your opinion**. There are no “wrong” answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item.

Disagree                  Partly Disagree                  Partly Agree                  Agree  
 0-----1-----2-----3

	Disagree	Partly Disagree	Partly Agree	Agree
1. If I believed I was having a mental breakdown, my first inclination would be to get professional help.	0	1	2	3
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	0	1	2	3
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	0	1	2	3
5. I would want to get psychological help if I were worried or upset for a long time.	0	1	2	3
6. I might want to have psychological counselling in the future.	0	1	2	3
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.	0	1	2	3
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	0	1	2	3
9. A person should work out his or her own problems; getting psychological counselling would be a last resort.	0	1	2	3
10. Personal and emotional troubles, like many things, tend to work out by themselves.	0	1	2	3





**Brief Symptom Inventory-18 (BSI-18)**

The BSI-18 (Derogotis, 2000) is under copyright and cannot be reproduced in any form or by any means without the permission of the publisher, Pearson Education Inc.



### Intentions of Seeking Counseling Inventory (ISCI)

The following list states a number of reasons why people decide to seek therapy. Read each item carefully and **imagine** that you were experiencing the same problem. Please indicate how likely you would be to seek therapy if you were experiencing the same problem using the following scale:

Very Unlikely      Unlikely      Doubtful      Possibly      Likely      Very Likely  
 1-----2-----3-----4-----5-----6

Remember, there are no “wrong” answers. Please circle the response that seems to best apply to you. It is important that you answer every item.

	Very Unlikely	Unlikely	Doubtful	Possibly	Likely	Very Likely
1. Weight control	1	2	3	4	5	6
2. Excessive alcohol use	1	2	3	4	5	6
3. Relationship difficulties (ie., romantic partner)	1	2	3	4	5	6
4. Concerns about sexuality	1	2	3	4	5	6
5. Depression	1	2	3	4	5	6
6. Conflict with family	1	2	3	4	5	6
7. Speech Anxiety	1	2	3	4	5	6
8. Difficulties dating	1	2	3	4	5	6
9. Difficulty sleeping	1	2	3	4	5	6
10. Drug Problems	1	2	3	4	5	6
11. Feelings of Inferiority	1	2	3	4	5	6
12. Difficulties with friends	1	2	3	4	5	6
13. Self-understanding (ie., personal growth)	1	2	3	4	5	6
14. Loneliness	1	2	3	4	5	6
15. Anxiety	1	2	3	4	5	6

### Perceptions of Stigmatization by Others for Seeking Help (PSOSH)

Please **imagine** that you had a problem that needed to be treated by a mental health professional. Use the following to scale to respond to the following question:

If you sought mental health services, to what degree do you think that people you interact with would \_\_\_\_\_

	Not At All	A Little	Some	A Lot	A Great Deal
1. React negatively to you	1	2	3	4	5
2. Think bad things of you	1	2	3	4	5
3. See you as seriously disturbed	1	2	3	4	5
4. Think of you in a less favourable way	1	2	3	4	5
5. Think you posed a risk to others	1	2	3	4	5

### Physical Barriers

Please indicate whether the following would impact your decision to seek help from a mental health professional if you were experiencing a persistent emotional or personal problem:

	Not At All	A Little	Some	A Lot	A Great Deal
1. Cost of treatment	1	2	3	4	5
2. Transportation difficulties	1	2	3	4	5
3. Not knowing where to seek appropriate treatment	1	2	3	4	5
4. Ability of the mental health professional to speak Spanish	1	2	3	4	5
5. Discrimination	1	2	3	4	5
6. Other (please specify):	1	2	3	4	5

### Acculturation Rating Scale for Mexican Americans-II (ARSMA-II)

Please read each statement carefully and indicate your response according to the following scale:

Not at all                      Very little or Not very often                      Moderately                      Much or Very often                      Extremely often or Almost always  
 1-----2-----3-----4-----5

There are no wrong answers. It is important that you answer every item.

	Not at all	Very little or not very often	Moderately	Much or Very often	Extremely often or Almost always
1. I speak Spanish	1	2	3	4	5
2. I speak English	1	2	3	4	5
3. I enjoy speaking Spanish	1	2	3	4	5
4. I associate with European Canadians	1	2	3	4	5
5. I associate with Latinos/Hispanics	1	2	3	4	5
6. I enjoy listening to Spanish language music	1	2	3	4	5
7. I enjoy listening to English language music	1	2	3	4	5
8. I enjoy Spanish language TV	1	2	3	4	5
9. I enjoy English language TV	1	2	3	4	5
10. I enjoy Spanish language movies	1	2	3	4	5
11. I enjoy English language movies	1	2	3	4	5
12. I enjoy reading (e.g., books) in Spanish	1	2	3	4	5
13. I enjoy reading (e.g., books) in English	1	2	3	4	5
14. I write (e.g., letters, emails) in Spanish	1	2	3	4	5
15. I write (e.g., letters, emails) in English	1	2	3	4	5
16. My thinking is done in the Spanish language	1	2	3	4	5
17. My thinking is done in the English language	1	2	3	4	5
18. My contact with my (or my family's) country of origin has been	1	2	3	4	5
19. My contact with Canada has been	1	2	3	4	5
20. My father identifies or identified himself as Latino/Hispanic	1	2	3	4	5
21. My mother identifies or identified herself as Latina/Hispanic	1	2	3	4	5
22. My friends, while I was growing up, were of Latino/Hispanic origin	1	2	3	4	5
23. My friends, while I was growing up, were of European Canadian origin	1	2	3	4	5
24. My family cooks Latino/Hispanic foods	1	2	3	4	5
25. My friends now are of Latino/Hispanic origin	1	2	3	4	5
26. My friends now are of European Canadian origin	1	2	3	4	5
27. I like to identify myself as Canadian	1	2	3	4	5
28. I like to identify myself as Latino(a)/ Hispanic	1	2	3	4	5
29. I like to identify myself as Latino-Canadian	1	2	3	4	5
30. I like to identify myself as European Canadian	1	2	3	4	5

### Cross-Cultural Coping Scale (CCCS)

Please **imagine** yourself being in the situation described below. Then carefully read and respond to the following statements. Rate how well the statements describe what you would do if the situation were to happen to you. There are no right or wrong answers.

Use the following scale to indicate your answers:

Very Inaccurate      Somewhat Inaccurate      Inaccurate      Somewhat Accurate      Accurate      Very Accurate  
 0-----1-----2-----3-----4-----5

**Please read this description before answering the questions:**

*Lately you have been feeling quite sad and stressed and find it hard to get motivated to do anything. You have noticed changes in your appetite and have experienced difficulties sleeping and have lost interest in activities you usually enjoy. You have also been feeling more tired and irritable than usual. You are having difficulties concentrating and your performance at work/school has suffered because of your emotional difficulties.*

***If this were to happen to you, how likely would you be to use the following methods to deal with this stressful situation?***

	Very Inaccurate	Somewhat Inaccurate	Inaccurate	Somewhat Accurate	Accurate	Very Accurate
1. I think about the situation carefully and think of options before I decide what to do.	0	1	2	3	4	5
2. I deal with the problem by doing what my family may do or say with regard to the situation	0	1	2	3	4	5
3. I look for something good or positive in this difficult situation.	0	1	2	3	4	5
4. I take the course of action that seems most acceptable to my Latino values.	0	1	2	3	4	5
5. I engage in activities that will help me relax or feel better (e.g., sports, listening to or playing music, getting online).	0	1	2	3	4	5
6. I just accept the fact that this happens and tell myself that I can't do much about it.	0	1	2	3	4	5
7. I hold firmly to my position and face the problem.	0	1	2	3	4	5
8. I get involved in other activities to keep my mind off the problem (e.g., study harder so as not to think about the problem).	0	1	2	3	4	5
9. I put my trust in God.	0	1	2	3	4	5
10. I turn to friends who have similar ethnic/cultural or language background as me to obtain information or resources in dealing with my problem.	0	1	2	3	4	5

	Very Inaccurate	Somewhat Inaccurate	Inaccurate	Somewhat Accurate	Accurate	Very Accurate
11. I rely on myself to take action (e.g., finding out solutions) to deal with the situation.	0	1	2	3	4	5
12. I engage in activities my family would not approve of to ease my anxiety or nervousness, such as smoking, drinking and doing drugs.	0	1	2	3	4	5
13. I try to block out or forget about what's bothering me.	0	1	2	3	4	5
14. I talk with and get help from other members of my family (e.g. siblings, cousins, aunts, uncles).	0	1	2	3	4	5
15. I seek God's help.	0	1	2	3	4	5
16. I tell myself that my problems will go away on their own.	0	1	2	3	4	5
17. I take the course of action that seems most acceptable to my family.	0	1	2	3	4	5
18. I turn to friends who have similar ethnic/cultural or language background as me to get their understanding and support.	0	1	2	3	4	5
19. I talk with and get help from my family	0	1	2	3	4	5
20. I keep my emotions to myself and do not show them.	0	1	2	3	4	5
21. I choose to resolve my problems in ways that would attract the least attention to me.	0	1	2	3	4	5
22. I seek advice and help from someone else whom I consider to be wiser than me (e.g. parents, elders or teachers).	0	1	2	3	4	5
23. I put extra effort or work extra hard to resolve the problem.	0	1	2	3	4	5
24. I come up with a plan before tackling the situation.	0	1	2	3	4	5
25. I trust my personal strengths and believe in myself in resolving the problem.	0	1	2	3	4	5
26. I try to make myself feel better by telling myself that the problem is not as bad as it appears.	0	1	2	3	4	5
27. I give up trying to solve the problem.	0	1	2	3	4	5
28. I try to find comfort in my religion.	0	1	2	3	4	5
29. Instead of dealing with the problem, I find myself daydreaming more.	0	1	2	3	4	5
30. I seek advice or help from my religious leader (e.g., priest, minister).	0	1	2	3	4	5



### Appendix C

#### Cuestionario de Datos Personales

Por favor consteste las siguientes preguntas con el mayor cuidado posible.

1. Sexo  Masculino  Femenino
2. Edad \_\_\_\_\_
3. En que país nació? \_\_\_\_\_
4. Si Usted nació fuera de Canadá, ¿cuantos años ha vivido en Canadá? \_\_\_\_\_
- 5.a) Donde nació su padre? \_\_\_\_\_
- b) Donde nació su madre? \_\_\_\_\_
6. Si Usted nació fuera de Canadá, indique la razón **principal** por qué usted inmigró a Canadá:
- Voluntariamente (por ejemplo, en busca de una mejor vida, mejores oportunidades).
- Guerra
- Opresión política
- Pobreza
- Otra Razón: \_\_\_\_\_
7. Estado Migratorio en Canadá:
- Ciudadano
- Residente Permanente
- Refugiado
- Otro: \_\_\_\_\_
8. ¿Cual es su generación en Canadá?
- 1.5 generación (inmigró a Canadá **antes** de los 12 años)
- 1a generación (inmigró a Canadá **despues** de los 12 años)
- 2a generación (nació en Canadá y por lo menos uno de sus padres nació fuera de Canadá).
- 3a generación (nació en Canadá y sus dos padres nacieron en Canadá)
- Despues de la 3a generación (usted, sus padres y abuelos nacieron en Canadá)
- Soy estudiante internacional y nací fuera de Canadá
9. Estado Civil:
- Soltero(a)
- Casado(a)
- Acompañado(a) (unión libre)
- Separado(a) o Divorciado(a)
- Viudo(a)
10. Estado de empleo (marque todos los que se le apliquen):
- A tiempo completo
- A tiempo parcial
- Desempleado
- Estudiante
- Jubilado

11. ¿Cuál es su nivel de estudio?

- No escuela o primaria incompleta
- Escuela primaria
- Escuela Secundaria
- Escuela técnica/vocacional
- Diploma/grado universitario
- Postgrado universitario

12. ¿Cuál es el nivel de estudio de su padre?

- No escuela o primaria incompleta
- Escuela primaria
- Escuela Secundaria
- Escuela técnica/vocacional
- Diploma/grado universitario
- Postgrado universitario

13. ¿Cuál es el nivel de estudio de su madre?

- No escuela o primaria incompleta
- Escuela primaria
- Escuela Secundaria
- Escuela técnica/vocacional
- Diploma/grado universitario
- Postgrado universitario

14. Religión:

- Católico(a)
- Cristiano(a) (Bautista, Protestante, etc)
- Judío(a)
- Musulmán
- otro: \_\_\_\_\_

15. ¿Cada cuanto va a la iglesia/templo/ sinagoga, etc?

- Más de una vez a la semana
- Una vez a la semana
- Una vez al mes
- Un par de veces al año
- Una vez al año
- Nunca

16. Código postal Canadiense: \_\_\_\_\_

17. Aproximadamente, ¿cuanto es el ingreso familiar por mes (en dólares Canadienses)?

\$ \_\_\_\_\_

18. ¿Alguna vez ha usted usado servicios de la salud mental (por ejemplo, psicoterapia, consejería, etc)?

- Sí
- No



**Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPP-SH)\_Spanish**

Los siguientes son una serie de declaraciones acerca de la psicología y la salud mental. Por favor use la escala mostrada y **marque el número que mejor describa su opinión**. No hay respuestas “incorrectas”. Por favor trate de contestar todas las oraciones.

**No** estoy de acuerdo                      A veces **no** estoy de acuerdo                      A veces **sí** estoy de acuerdo                      **Sí** estoy de acuerdo  
 0-----1-----2-----3

	No estoy de acuerdo	A veces no estoy de acuerdo	A veces sí estoy de acuerdo	Sí estoy de acuerdo
1. Si yo creo que estoy teniendo una crisis emocional, mi primer impulso sería buscar ayuda profesional.	0	1	2	3
2. La idea de hablar con un psicólogo sobre mis problemas me parece una mala manera de resolver los problemas emocionales.	0	1	2	3
3. Si en este momento, yo estuviera pasando por una crisis emocional grave en mi vida, yo tendría confianza que la psicoterapia me ayudaría.	0	1	2	3
4. Yo admiro la actitud de una person que está dispuesta a enfrentar sus conflictos y problemas emocionales sin buscar ayuda profesional.	0	1	2	3
5. Yo buscaría ayuda psicológica si me sintiera preocupado(a) o molesto(a) por un tiempo prolongado.	0	1	2	3
6. Es posible que en el futuro yo decida obtener consejería psicológica.	0	1	2	3
7. No es probable que una persona con problemas emocionales los pueda solucionar sin ayuda profesional.	0	1	2	3
8. Tomando en cuenta el tiempo y costo involucrados en la psicoterapia, dudo que este tipo de tratamiento tenga alguna utilidad para una persona como yo.	0	1	2	3
9. Una persona debe solucionar sus problemas por si misma; el buscar ayuda psicológica sería el último recurso.	0	1	2	3
10. Como muchas otras cosas, los problemas personales y emocionales tienden a resolverse por sí mismos.	0	1	2	3

### Subjective Norms (SN)\_Spanish

Por favor indique que tan de acuerdo está con las siguientes declaraciones. Por favor use la escala mostrada y **marque el número que mejor describa su opinión**. Por favor conteste todas las preguntas.

Muy Improbable			Neutral			Muy Probable
-3	-2	-1	0	1	2	3

Si usted estuviera experimentando **un problema personal serio y prolongado** en su vida, ¿como calificaría las siguientes declaraciones acerca de la búsqueda de ayuda de un consejero profesional?:

1. La mayoría de las personas que son importantes en mi vida pensarían que yo debería buscar ayuda de un consejero.	-3	-2	-1	0	1	2	3
2. Mi familia inmediata (mis padres y hermanos) pensarían que yo debería buscar ayuda de un consejero.	-3	-2	-1	0	1	2	3
3. Mi pareja/esposo(a) pensaría que yo debería buscar ayuda de un consejero.	-3	-2	-1	0	1	2	3
4. Mi familia extendida (mis primos, tias, tios, etc) pensarían que yo debería buscar ayuda de un consejero.	-3	-2	-1	0	1	2	3
5. Mis amigos pensarían que yo debería buscar ayuda de un consejero.	-3	-2	-1	0	1	2	3
6. Las personas en mi vida cuya opinión valoro pensarían que yo debería buscar ayuda de un consejero.	-3	-2	-1	0	1	2	3



**Brief Symptom Inventory-18 (BSI-18)**

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### Intentions of Seeking Counseling Inventory (ISCI)\_Spanish

La siguiente lista indica una serie de razones por las que una persona decide buscar tratamiento psicológico. Por favor lea cada razón e **imagínese** que usted está teniendo ese mismo problema. Por favor indique, usando la siguiente escala, la probabilidad de que usted buscaría tratamiento si tuviere el mismo problema:

Muy Improbable    Improbable    Dudoso    Posiblemente    Probable    Muy probable  
 1-----2-----3-----4-----5-----6

Recuerde que no hay respuestas incorrectas. Marque el número que mejor indique su opinión. Por favor conteste todas las proposiciones.

	Muy Improbable	Improbable	Dudoso	Posiblemente	Probable	Muy Probable
1. Control de peso.	1	2	3	4	5	6
2. Consumo excesivo de alcohol	1	2	3	4	5	6
3. Problemas con su esposo(a) ó pareja	1	2	3	4	5	6
4. Preocupación acerca de la sexualidad.	1	2	3	4	5	6
5. Depresión.	1	2	3	4	5	6
6. Conflictos con la familia.	1	2	3	4	5	6
7. Ansiedad para hablar en público.	1	2	3	4	5	6
8. Problemas en la búsqueda de novio(a) o pareja.	1	2	3	4	5	6
9. Dificultad para dormir.	1	2	3	4	5	6
10. Problemas con las drogas.	1	2	3	4	5	6
11. Sentimientos de inferioridad.	1	2	3	4	5	6
12. Dificultades con los amigos.	1	2	3	4	5	6
13. Comprensión de sí mismo (es decir, el crecimiento personal).	1	2	3	4	5	6
14. Soledad.	1	2	3	4	5	6
15. Ansiedad	1	2	3	4	5	6

### Perceptions of Stigmatization by Others for Seeking Help (PSOSH)\_Spanish

Por favor imagínese que usted tuviera un problema que necesitaba ser tratado por profesional de la salud mental. Por favor use la siguiente escala para contestar las siguientes preguntas:

**Si usted buscara tratamiento para la salud mental, ¿como reaccionarían las personas cercanas a usted?**

	Para nada	Muy poco	Poco	Bastante	Muchísimo
1. Reaccionarían negativamente hacia usted.	1	2	3	4	5
2. Pensarían cosas malas de usted.	1	2	3	4	5
3. Lo vieran como alguien con trastornos mentales graves.	1	2	3	4	5
4. Pensarían de usted de una manera menos favorable.	1	2	3	4	5
5. Pensarían que usted representa un peligro para los demás.	1	2	3	4	5

### Physical Barriers\_Spanish

Por favor indique si las siguientes condiciones afectarían su decisión de buscar la ayuda de un profesional de la salud mental:

	Para nada	Muy poco	Poco	Bastante	Muchísimo
1. El costo de los servicios.	1	2	3	4	5
2. Dificultad para transportarse.	1	2	3	4	5
3. No saber dónde encontrar los servicios apropiados.	1	2	3	4	5
4. Disponibilidad de un profesional de salud mental que hable español.	1	2	3	4	5
5. La discriminación.	1	2	3	4	5
6. Alguna otra cosa (por favor especifique): _____	1	2	3	4	5







	Muy Inexacto	Un Poco Inexacto	Inexacto	Un Poco Exacto	Exacto	Muy Exacto
12. Hago actividades que mi familia no aprobaría para aliviar mi ansiedad y nerviosismo, tales como fumar, beber y consumir drogas.	0	1	2	3	4	5
13. Trato de bloquear u olvidar lo que me está molestando.	0	1	2	3	4	5
14. Busco ayuda de otros miembros de mi familia (por ejemplo, hermanos, primos, tías, tíos)	0	1	2	3	4	5
15. Busco la ayuda de Dios.	0	1	2	3	4	5
16. Me digo que mis problemas se resolverán por sí mismos.	0	1	2	3	4	5
17. Hago lo que parece más aceptable para mi familia.	0	1	2	3	4	5
18. Busco amigos que son de mi mismo origen étnico o cultural (o que hablan mi mismo idioma) para obtener su comprensión y apoyo.	0	1	2	3	4	5
19. Hablo con mi familia y pido ayuda.	0	1	2	3	4	5
20. Oculto mis emociones.	0	1	2	3	4	5
21. Resuelvo mis problemas de la manera más discreta posible.	0	1	2	3	4	5
22. Busco consejo y ayuda de alguien a quien yo considero más sabio que yo (por ejemplo, padres, maestros, adultos mayores).	0	1	2	3	4	5
23. Pongo extra esfuerzo o trabajo más duro para resolver el problema.	0	1	2	3	4	5
24. Pienso en un plan antes de tratar de resolver la situación.	0	1	2	3	4	5
25. Confío en mis puntos fuertes y creo que yo mismo puedo resolver el problema.	0	1	2	3	4	5
26. Trato de sentirme mejor, diciéndome que el problema no es tan malo como parece.	0	1	2	3	4	5
27. Me doy por vencido tratando de resolver el problema.	0	1	2	3	4	5
28. Trato de encontrar consuelo en mi religión.	0	1	2	3	4	5
29. En lugar de tratar con el problema, me dedico a soñar despierto.	0	1	2	3	4	5
30. Busco consejo y ayuda de mi líder religioso (sacerdote, pastor, etc).	0	1	2	3	4	5

Si usted y/o su familia han tenido contacto con los servicios de salud mental, ¿Cual fue su experiencia?

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*~Muchas gracias por su participación!~*

**VITA AUCTORIS**

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