PREDICTIVE FACTORS OF HELP SEEKING FOR MENTAL HEALTH SUPPORT AMONG LATINX MALE COLLEGE STUDENTS

by

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We respectfully acknowledge the University of Arizona is on the land and territories of Indigenous peoples. Today, Arizona is home to 22 federally recognized tribes, with Tucson being home to the O'odham and the Yaqui. Committed to diversity and inclusion, the University strives to build sustainable relationships with sovereign Native Nations and Indigenous communities through education offerings, partnerships, and community service.

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

ABSTRACT

The need for mental health services for Latinx communities is growing due to shifting demographics in the United States and increased immigration from Latin America (Provencio Vasquez et al., 2011; Torres & Vallejo, 2015). Unfortunately, Latinx people in the U.S. face disparities in both access to and quality of mental health treatment (Davis & Liang, 2015; Provencio Vasquez et al., 2011). These disparities are due to structural barriers, including systemic racism and varying levels of immigration status (Goodman & Gorski, 2015; Marquez Kiyama et al., 2015; Martinez Tyson et al., 2016).

The aim of the present study was to gather data about Latinx male college students' help seeking attitudes and intentions at a large predominantly white institution (PWIs) in the United States. Another aim was to examine Latinx male college students' preference for culturally competent mental health counseling from a critical race theory (CRT) framework. Because cultures and sociocultural identities are diverse and continuously evolving, striving toward culturally responsive practices and services must also evolve (Asumah & Nagel, 2014). With the growing population of Latinx college students, the college environment is an important environment to explore the relationship between Latinx college students and mental health supports (Hope et al., 2018).

In this study, an online survey examined the relationship between the predictor variables—mental health symptoms, stigma toward help seeking for mental health support (*attitudes* and *self-stigma*), masculinity ideologies (*restrictive emotionality*, *machismo,* and *caballerismo*), and importance of applying culturally relevant support services (using critical race theory) in mental help supports—and the criterion variable—intention of young adult Latinx male college students to seek help for mental health support.

Results of the hierarchical regression conducted with SPSS revealed that attitudes toward mental health support (as measured by the Attitudes Toward Seeking Professional Psychological Help-Short Form or ATSPPH-SF) had predictive power for the intent to seek help among Latinx male college students (B = .880, p = .019). Specifically, higher scores on the ATSPPH-SF were associated with greater intent to seek help for emotional problems and suicidal ideation. No other variables in the full regression model had predictive power for the intent to seek help (p > .05).

The results of the present study have several implications for universities and colleges. Mental health and wellness are growing concerns for Latinx college students, and college mental health professionals need to be prepared to address these concerns (Hope et al., 2018). As such, the results of the present study can be used by mental health professionals and administrations to better understand the help seeking behaviors of Latinx male college students at their universities. Attitudes toward mental health was found to be a significant predictor of help seeking intention among the sample of Latinx male college students. As such, college mental health professionals and administrators may endeavor to create marketing materials, workshops, and sessions that address and improve attitudes toward mental health and help seeking for mental health concerns.

CHAPTER I

INTRODUCTION

This chapter provides an overview of the factors that contribute to Latinx male college students seeking (or not seeking) mental health support. The chapter begins with an overview of the literature. Specifically, the increase in the Latinx populations in the United States generally as well as the help seeking behaviors of Latinx men in particular. The conceptual framework for the study is the intersection of cultural identities, systemic racism, and intentions to seek mental health support. Focused on the decision of Latinx male college students to seek (or not seek) mental health support, the study examined key factors such as mental health symptoms, stigma toward seeking mental health support (*attitude* and *self-stigma*), ideologies about masculinity, and need for applying culturally relevant support services (using critical race theory). As part of the extant literature, the chapter highlights the significance of the current study and its importance to mental health professionals and educators. The chapter concludes with the purpose of the study, including the research question.

Overview of the Literature

The need for mental health services for Latinx communities is growing due to shifting demographics in the United States and increased immigration from Latin America (Provencio Vasquez et al., 2011; Torres & Vallejo, 2015). Population projections suggest that Latinx youth are the fastest growing population in the U.S. (Conception et al., 2019). In fact, the Latinx population in the U.S. grew by 55.6% between the years 2000 and 2010 (Limon et al., 2016; Torres & Taknint, 2015). The Centers for Disease Control and Prevention (CDC) have predicted that by the year 2050, one in every four persons living in the United States will be Latinx (Alvarez et al., 2004; Provencio Vasquez et al., 2011).

Unfortunately, Latinx people in the U.S. face disparities in both access to and quality of mental health treatment (Davis & Liang, 2015; Provencio Vasquez et al., 2011). These disparities are due to structural barriers, including systemic racism and varying levels of immigration status (Goodman & Gorski, 2015; Marquez Kiyama et al., 2015; Martinez Tyson et al., 2016). In 2001, the U.S. Department of Health reported that fewer than 1 in 11 Latinx people with mental illness (PWMI) sought services from a mental health professional. Underutilization of mental health support is exacerbated in Latinx men, whose masculine ideologies may hinder help seeking (Davis & Liang, 2015). Even when Latinx men proactively seek help for mental health concerns, the quality of services is negatively impacted by inadequate partnerships between primary care physicians and mental health professionals, unavailability of culturally competent health care providers, and missed opportunities to collaborate with local social supports (Peifer et al., 2000). With disproportionate rates of mental health conditions among Latinx children and adolescents (Provencio Vasquez et al., 2011), there is a clear need for research to improve the access to and quality of mental health treatments.

According to the National Alliance on Mental Illness (NAMI, 2020), there are many mental health professionals who can help clients and patients achieve their mental health outcomes. The present study will use the terminology *mental health professionals* to include psychologists, counselors (including pastoral counselors), clinicians, therapists, clinical social workers, psychiatrists, psychiatric or mental health nurse practitioners, psychiatric pharmacists, and certified peer specialist (NAMI, 2020). These professionals may work in a variety of settings, including inpatient facilities—hospitals and psychiatric facilities and outpatient facilities—community mental health clinics, schools, and private practices. For this reason,

mental health professional is used in this study to capture the diversity of practitioners who could provide mental health services to the Latinx population.

Another complexity is that while the term Latinx is used broadly to describe a group of people, this is not a monolithic group (Concepcion Zayas et al., 2019; Weinick et al., 2004; Zack Ishikawa, 2010). For instance, many Latinx children and adolescents are U.S. born—many have lived in the U.S. for generations, while others are born in other parts of the Americas before immigrating to the U.S. Furthermore, immigration patterns differ by country of origin, and the Latinx population is diverse in race, socioeconomic statues, educational levels, citizenship statuses, and geographic locations. These differences must be explored and considered if mental health professionals are to be competent in offering guidance and support. Otherwise, misunderstandings of these variations can lead to incorrect diagnosis and treatment due to a lack of cultural awareness (Concepcion Zayas et al., 2019).

Latinx people experience mental health concerns at a rate similar to other Black, Indigenous, and People of Color (BIPOC), but they underutilize mental health services when compared to other BIPOC and White people (Berdahl & Torres Stone, 2009; Cabassa, 2007; Defreitas et al., 2018; Martinez Tyson et al., 2016). Some of the reasons include barriers to English as a second language, their legal status in the U.S., limited access to healthcare coverage as well as acculturation, racism, and discrimination (Peifer et al., 2000; Zack Ishikawa et al., 2010). There is also variation in use of mental health services and help seeking behaviors within the Latinx communities by gender identity.

There are gender differences in help seeking behaviors such as relying on others, asking for help, admitting to a problem, and willingness to express emotions (Cole & Ingram, 2020). In particular, men are more likely than women to have negative perceptions toward mental health

treatments and are therefore less likely to utilize mental health services. This trend is exacerbated among BIPOC men (Cabassa, 2007). In fact, studies have found that even when controlling for the presenting mental health concern, Latinx men are less likely than Latinx woman to utilize mental health services from a mental health professional or primary care physician (Cabassa, 2007; Peifer et al., 2000; Zack Ishikawa et al., 2010).

Systemic barriers also contribute to the underutilization and treatment disparities among Latinx men. In addition to systemic racism, there are unique variables that may contribute to Latinx men underutilizing mental health services. Embedded within these variables are potentially problematic conceptions of masculinity. Levant and Richmond (2007) defined masculinity ideologies as "an individual's internalization of cultural belief systems and attitudes toward masculinity and men's roles, [which] informs expectations for boys and men to conform to certain socially sanctioned masculine behaviors and to avoid certain proscribed behaviors" (p. 131). Research has suggested that men who score highest on measures of traditional masculinity tend to have more negative views toward seeking mental health support (Davis & Liang, 2015). An underlying reason for the negative attitudes is the stigma associated with mental health problems.

Stigma has been a well-documented reason that people are unwilling to seek mental health services (Cabassa, 2007; Cole & Ingram, 2020). However, there are ways to address the stigma of mental health services that can increase utilization of mental health services. Some of these factors may include assurance of confidentiality, articulation of the need and benefits of mental health care, normalization of mental health problems, and increased confidence in one's health care provider (Zack Ishikawa et al., 2010). For Latinx men and other BIPOC groups, confidence in health care providers is linked to increased cultural competence rooted in a social

justice lens (Goodman & Gorski, 2015). Social justice is the belief that everyone deserves equitable social rights and opportunities. Gaining access to culturally appropriate, and high-quality mental health care will be vital for Latinx populations (Conception et al., 2019). As such, a social justice lens requires culturally competent counseling that transforms and/or abolishes oppressive practices, policies, and procedures that cause harm to marginalized clients (Goodman & Gorski, 2015). Unfortunately, there continue to be significant cultural concerns about whether mental health professionals are competent to deliver culturally appropriate mental health services to Latinx people in clinical settings.

Consequently, the current study examined mental health symptoms, stigma toward seeking mental health support (*attitude* and *self-stigma*), and importance of applying culturally relevant support services (using critical race theory) within mental health support systems. Because cultures and sociocultural identities are diverse and continuously evolving, striving toward culturally responsive practices and services must also evolve (Asumah & Nagel, 2014). With an increasing population of Latinx college students, the college environment may serve as an appropriate environment to explore the relationship between Latinx college students and mental health supports (Hope et al., 2018). The current study sought to survey Latinx college students with an emphasis on transformative participation. Transformative participation occurs when research elicits change from within communities, such as alleviating problems and suffering, including oppression. Transformative practices can be hindered when communities are not included in research about and allegedly for those communities (Goodman & Gorski, 2015). As such, the current study utilized an 8-member advisory board consisting of Latinx males aged 23 – 27. This advisory board provided guidance and feedback on the design of the study, the methodology and measurements, and the recruitment of participants.

Statement of the Problem

There are compelling reasons to study Latinx college students with respect to cultural identity, systemic racism, and mental health support. Perhaps the most significant reason is that the current sociopolitical climate has included resistance to Latinx immigration and increased animosity and racism toward this group in the U.S. (Hwang & Goto, 2009). Defreitas et al. (2018) suggested that it is important for mental health professionals to understand mental health stigma as it relates to people of color due to historic mistrust of mental health services and therapy. Terminology such as *twice disadvantaged*, *twice penalized*, and *double jeopardy* have been used to describe the discrimination faced by people with multiple marginalized identities. For example, women and racially minoritized groups with mental health symptoms and disabilities often experience multiple forms of discrimination in society (Alston & Bell, 1996; Ferraro & Farmer, 1996; O'Hara, 2004). Given multiple forms of discrimination, it is imperative for mental health professionals to understand unique—but varied—considerations for Latinx college students with mental health symptoms and how these various concerns intersect to exacerbate mental health problems and impact help seeking behavior.

Another reason for this study is that mental health fields, including psychology, counseling, and social work must increase their focus on diversity, multiculturalism, and social justice. Specifically, it is critical to understand how sociocultural identities, including race/ethnicity, relate to help seeking as well as positive mental health outcomes. Culture is a primary factor in the formation of a person's sense of self because it defines the norms, symbols, and behaviors that people utilize to navigate the world (Williams, 2006). Within a country, race, or community, people may belong to multiple sociocultural groups and negotiate multiple cultural expectations on a daily basis (Asumah & Nagel, 2014). Crenshaw's (1989) concept of

intersectionality is foundational to understanding that every person has several cultural identities, each of which are a site of privilege or oppression. Intersectionality is particularly relevant to understanding the decision of Latinx men to utilize (or not utilize) mental health services given the cultural stigma of mental illness (Berdahl & Torres Stone, 2009; Cabassa, 2007; Defreitas et al., 2018; Martinez Tyson et al., 2016).

It is also important to examine patterns in mental health seeking during developmental transitions, such as the shift to emerging adulthood during the college years. This shift can be a stressful period of time, and Latinx college students face unique mental health needs. In particular, Keels (2013) stated that Latinx students who attend Predominantly White Institutions (PWIs) experience greater stigma, less institutional support, and less social support than their White peers. These added stressors may make it more difficult for these students to persist academically (Hope et al., 2018; Keels, 2013). The study conducted by Anguiano et al. (2020) suggested that Latinx college students can feel "out of place" if their cultural and ethnic identities and experiences are not validated.

Within the college context, Gonzalez (2015) outlined additional barriers that Latinx students may face, including individual barriers, relational barriers, and systemic barriers. Individual barriers include skills and abilities related to academic readiness. Relational barriers include the ability for close others (e.g., family, friends, community members) to assist with college access. Systemic barriers are macro level institutional and societal barriers (e.g., institutional policies, procedures, and practices, availability of resources and support), which are impacted by the process of *acculturation* and racist practices. These barriers all relate to systemic factors, including oppression and discrimination rooted in racism.

Racism experienced by Latinx students in institutions of higher education may include overt and covert racial incidents and slurs (Vachuska & Brudvig, 2018). Such incidents may create a hostile and less welcoming campus climate compared to the experience of their White peers (Anguiano et al, 2020; Hernandez et al. 2013; Marquez Kiyama et al., 2015). Examples of such incidents may include racial microaggressions and stereotyping (Hope et al., 2018; Marquez Kiyama et al., 2015; Solórzano, 1998), prejudice and discrimination, and low expectations from professors and peers (Marquez Kiyama et al., 2015). All of these experiences may have a negative impact on the mental health of Latinx college students.

Significance of the Study

The college environment serves as an appropriate environment to explore the relationship between Latinx college students and mental health supports. Adolescents and young adults present the highest prevalence of mental health concerns when compared to other age groups, yet they also are the least likely to seek help (Aguirre Velasco et al., 2020; Wilson et al., 2005). Because mental health and wellness are growing concerns for Latinx students in college settings (Hope et al., 2018), it is important for mental health professionals to be prepared to address these concerns.

Mental health professionals must understand the factors, including mental health stigma and help seeking behaviors that affect the access to and quality of mental health supports. In particular, it is imperative that mental health professionals understand their clients' sociocultural identities in unique ways. This is important because there is considerable diversity within and across races, ethnicities, and sociocultural heritages and experiences and other cultures and subcultures often exist within larger cultures, such as Latinx communities (Asumah & Nagel, 2014; SAMHSA, 2014). Mental health professionals who center culture in their approach must

understand and respect their client's sociocultural identities and the manner in which those identities affect and are impacted by external forces (SAMHSA, 2014). Asumah and Nagel (2014) suggested that mental health professionals who possess culturally responsive skills can positively affect helping seeking behavior, including the access to and quality of mental health supports. As such, integrating a critical race theory (CRT) approach into counseling will enable mental health professionals at college settings to adequately support students with minoritized identities, including Latinx clients.

Conceptual Framework

The conceptual framework for the present study is the intersection of cultural identities, systemic racism, and intentions to seek mental health support. For this reason, the present study had four broad categories of variables related to (a) culturally relevant support services (using a critical race theory framework), (b) mental health stigma, and (c) masculinity ideologies, and (c) intention to seek mental health support. Each area may contribute to a better understanding of the decision of Latinx male college students to seek (or not seek) mental health supports.

Critical Race Theory

Critical Race Theory (CRT) originated in U.S. law schools in the 1970s to acknowledge race as a central component of the U.S. legal system (Crenshaw, 1989; Crenshaw, 1991; Crenshaw et al., 1995; Delgado & Stefancic, 1993; Martinez, 2014; Villalpando, 2004). Influenced by civil rights scholarship and feminist thought, CRT leans into the examination of power, race, and racism to address how power imbalances are racialized. At its core, CRT challenges "color blindness" (race neutrality) and argues that "ignoring racial difference maintains and perpetuates the status quo with its deeply institutionalized injustices to racial minorities" (Olson, 2003, p. 211). In short, CRT raises awareness of historical and cultural

contexts in an effort to make visible and eliminate racism as part of a larger goal to abolish all forms of subordination (Crenshaw et al., 1995; Martinez, 2014).

CRT was originally founded on five themes (Martinez, 2014; Solórzano, 1998):

1. Racism is a central, permanent, and "normal" component of U.S. culture that intersects with other forms of subordination. As such, people of color have experiential knowledge through lived experiences with systems of racism and oppression.
2. The experiential knowledge of people of color as detailed through narrative is central to understanding racial realities within the U.S. culture.
3. CRT offers a challenge to the dominant claims of race neutrality, equal opportunity, color blindness, and merit.
4. CRT values taking an interdisciplinary perspective in order to analyze race in both historical and contemporary contexts.
5. CRT makes a deliberate commitment to social justice.

The five themes of CRT have been applied to unmask the minoritized status stressors, including how these stressors impact academic persistence and well-being (Anguiano et al, 2020; Marquez Kiyama et al., 2015). CRT centers race and racism as central elements of the educational system and highlights that racism is embedded in every aspect of colleges and universities in the United States (Anguiano et al, 2020; Marquez Kiyama et al., 2015; Villalpando, 2004). CRT is a theoretical tool that can be used to uncover overt and covert patterns, practices, and policies that endorse racial inequality. Dismantling systems of oppression can result in the removal of barriers for Latinx students in higher education (Villalpando, 2004).

The present study utilized the Critical Race Theory Measurement (CRTM), which draws from six CRT constructs: (1) Endemic Racism, (2) Race as a Social Construct, (3) Differential Racialization, (4) Interest Convergence/Material Determinism, (5) Racial Narratives, and (6) Intersectionality (Campbell, 2014). The rationale for the present study is to better understand the need for more culturally relevant support services based on critical race theory constructs and how this need may impact the decision of Latinx men to seek (or not seek) mental health support. Furthermore, the present study is designed to examine how perceptions of the need for more culturally relevant support systems intersect with the stigma of seeking mental health support among Latinx men.

Mental Health Stigma and Help Seeking

Mental health stigma research has become prevalent in the last ten years due to increased awareness of mental illness and the harmful impact of stigma on seeking mental health support. Mental health stigma is defined broadly as the "negative stereotyping, biases, and discrimination often directed at people with mental illness" (Boyd & Deforge, 2014, p. 17). While stigma comes from attitudes and discrimination in the environment, *internalized stigma*—or *self-stigma* —is when people apply the negative stereotypes, biases, and discrimination to themselves. Social scientists have developed frameworks for understanding self-stigma and its impact on help seeking behavior.

Fox and colleagues (2017) developed the Mental Illness Stigma Framework (MISF) to integrate existing definitions and conceptualizations of mental health stigma. The Mental Illness Stigma Framework extended earlier work by Griffiths et al. (2008) to differentiate perceived stigma versus personal stigma. According to these researchers, personal stigma is defined as an individual's own beliefs, feelings, and behaviors about people with mental illness (Griffiths et

al., 2008). In contrast, perceived stigma is a person's beliefs about negative attitudes others may hold toward those with mental illness. As such, the concept of *personal stigma* is more related to *internalized stigma* or *self-stigma*.

Griffiths and colleagues (2008) conducted a study utilizing the Personal and Perceived subscales of the Depression Stigma Scale (DSS). In their study, *personal stigma* was higher for participants who were older, who did not possess post-secondary education, and who identified as men. *Personal stigma* was also higher for participants who had less exposure to mental health—those who had not previously experienced a mental illness, or those who had not reported mental illness in their close relationships, or those who had not sought any mental health treatment. Demographic data such as gender and age explained 22% of the variance in personal stigma (Griffiths et al., 2008). Building upon previous research, the present focused on *personal stigma* as a measure of *internalized stigma* or *self-stigma*. The term *self-stigma* was used instead of personal stigma because it corresponded with the use of the 10-Item Self-Stigma of Help Seeking Scale (SSOSH) (Porcari et al., 2017; Vogel et al., 2006).

Stigma associated with mental health concerns has been linked to negative attitudes about seeking mental health support (Vogel et al., 2006). Put simply, people who have a higher degree of self-stigma toward mental health are more likely to view help seeking as a sign of personal weakness (Picco et al., 2016). For this reason, the current study examined attitudes toward help seeking for mental health support using the 10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF) developed by Fischer and Farina (1995). Taken together, the two measures of SSOSH and ATSPPH-SF assessed self-stigma and attitudes toward seeking mental health support, respectively.

Masculinity Ideologies and Help Seeking

Research has suggested that masculinity impacts help seeking behavior. Men who score high on measures of traditional masculinity, tend to have more negative views toward help seeking behaviors for mental health concerns (Davis & Liang, 2015). Levant and Richmond (2007) defined masculinity ideologies as, "an individual's internalization of cultural belief systems… to conform to certain socially sanctioned masculine behaviors and to avoid certain proscribed behaviors" (p. 131). Davis and Liang (2015) explored gender role conflict (GRC) to explain the psychological distress that occurs when one does not live up to the rigid constraints of heteronormative masculinity. Ideologies about masculinity vary by cultural group, and the present study focused on masculinity in Latinx populations.

Hegemonic masculinity in Latinx populations, particularly Mexican culture, has been described as *maschismo* or *caballerismo*. *Machismo* is broadly associated with hyper-masculine, sexist, and chauvinistic attitudes and behaviors of Latinx men. *Caballerismo* refers to a code of masculine chivalry. *Caballerismo* is multidimensional but is still situated under an umbrella of masculinity. Talking about and seeking help for psychological concerns may or may not fit within *machismo* or *caballerismo* values. To assess ideologies of masculinity among Latinx men, the current study utilized the 9-item Gender Role Conflict Scale-Restrictive Emotionality subscale (GRCS-RE) (Blazina et al., 2005) and the 20-item Machismo and Caballerismo Scale (Arciniega et al., 2008).

Intention to Seek Mental Health Support

According to Rickwood and Thomas (2012), help seeking for mental health concerns has received ample attention in research, policy and practice. However, progress has been hindered by an inability to develop a standard operational definition of help seeking behavior. The lack of a clear definition is concerning because research on help seeking behavior is critical to address

the reasons many people do not seek professional help for mental health concerns (Rickwood &Thomas, 2012).

Understanding help seeking behavior is fundamental to increasing utilization of mental health services (Wilson, et al., 2005). Examples of help seeking behavior may include relying on others, asking for help, admitting to a problem, and expressing emotions related to the problem (Cole & Ingram, 2020). Aguirre Velasco et al. (2020) stated that the common element of help seeking is communicating one's needs. Similarly, Rickwood and Thomas (2012) defined help seeking as "an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns" (p. 180). Rickwood and Thomas went on to describe two types: formal and informal. Formal help seeking is assistance from professionals who are credentialed and officially recognized, while informal help seeking is assistance from social networks—friends and family—individuals who have a personal relationship with the help seeker (Rickwood &Thomas, 2012). To measure help seeking, both formal and informal, the current study used the 22-item General Help seeking Questionnaire-original version (GHSQ) (Deane et al., 2001; Wilson et al., 2005)

Purpose of the Study

Research suggests that Latinx college students encounter barriers to accessing and receiving quality mental health services from mental health professionals. In response, research on culturally responsive interventions may offer solutions to address disparities in access and therapeutic outcomes for Latinx clients (Benuto & O'Donohue, 2015). To further understand how universities and colleges can better serve Latinx college students, additional research must be conducted. With this in mind, the current study adds to that understanding. To achieve this purpose, the following research question was examined:

To what extent does mental health stigma, masculinity ideologies, and culturally relevant support services predict the intention of Latinx male college students to seek mental health support?

The variables were measured in the following ways:

- Mental health symptoms as measured by the Mental Health Inventory-5 (MHI-5).
- Mental health stigma as measured by two variables: self-stigma was measured by the 10-Item Self-Stigma of Seeking Help Scale (SSOSH), and attitudes toward help seeking was measured by the 10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF).
- Masculinity ideologies as measured by three variables: restrictive emotionality was measured by the 9-item Gender Role Conflict Scale- Restrictive Emotionality (GRCS-RE) subscale and Machismo and Caballerismo were measured by the two subscales of the 20-item Machismo and Caballerismo Scale.
- Need for culturally relevant support services as measured by the 19-item Critical Race Theory Measurement (CRTM).
- Intention to seek mental health support as measured by the 22-item General Help seeking Questionnaire-Original Version (GHSQ).

Conclusion

The existing literature indicated a variety of factors impact the utilization of mental health support among Latinx male college students. In response, the current study sought to investigate the intersection of cultural identities, racial discrimination, and intention to seek mental health support. The findings from the current study offer implications for developing

culturally-responsive treatment interventions that utilize critical race theory concepts. In the next chapter, a review of the literature related to the current study will be presented.

CHAPTER II

LITERATURE REVIEW

This chapter presents extant literature related the heterogeneity of Latinx populations, including population specific terminology, barriers to mental health, mental health stigma, help seeking behavior, culturally responsive concepts and interventions, and critical race theory as a framework applied to mental health settings. In particular, this chapter summarizes interdisciplinary cultural and conceptual frameworks that relate to how and why these constructs are operationalized and relevant to the present study.

Heterogeneity of Latinx Populations

Latinx people in the U.S. are markedly heterogeneous, representing 23 countries and speaking more than 12 languages and dialects (Ruiz & Steffen, 2011). Latinx populations should be a priority group for mental health professionals because demographics in the United States are shifting due to increases in immigration from Latin America (Provencio Vasquez et al., 2011; Torres & Vallejo, 2015). Population projections have suggested that Latinx youth are the fastest growing population in the U.S. (Conception et al., 2019); the Latinx population in the U.S. grew by 55.6% between the years 2000 and 2010 (Limon et al., 2016; Torres & Taknint, 2015). The Centers for Disease Control and Prevention (CDC) have predicted that by the year 2050, one in every four persons living in the United States will be Latinx (Alvarez et al., 2004; Provencio Vasquez et al., 2011). Research often describes these populations homogeneously. However, it is important to note that while Latinx is used broadly to describe a group of people, it is not a term that reflects a monolithic group. Many Latinx children and adolescents are U.S. born and part of families who have lived in the U.S. for generations. In contrast, others are first generation U.S.

citizens or born in other parts of the Americas before immigrating to the U.S. from a variety of countries.

It is also important to note that immigration patterns differ by country of origin. Latinx people trace their origins to a variety of nations including Mexico, Spanish-speaking Central and South American countries Portuguese-speaking Brazil, Puerto Rico, Cuba, and the Dominican Republic (Alvarez et al., 2004; Hayes-Bautista & Chapa, 1987; Page, 2013). In the U.S., Mexican Americans comprise the largest Latinx sub-group followed by—in order—Puerto Ricans, Cubans, Salvadorans and Dominicans (Ruiz & Steffen, 2012). Consequently, much of the research literature has focused on the Mexican American experience, even as pan-ethnic terminology such as *Latino* have become more common (Teruya & Bazargan-Hejazi, 2013; Torres, 2004). The term Latino is used to capture other countries of origin often grouped by geographic regions—Central and South American and "other Hispanic origins," including Caribbean countries (Torres, 2004). For instance, people from El Salvador represent the largest group from South America (Page, 2013; Torres, 2004). Variation also exists in where Latinx populations settle. Some Latinx sub-groups are regionally clustered in the U.S.—Cubans are concentrated in Florida, Mexicans are concentrated in the Southwest, and Dominicans are concentrated in the New York and New England states—however, population growth and migration is becoming more disbursed throughout the U.S. (Ruiz & Steffen, 2012; Torres, 2004).

Torres summarized three overarching issues that contribute to the heterogeneity of the Latinx population: distinct immigration patterns, varying sub-group experiences in the U.S., and research findings that vary by sub-group. Some across group inferences have been made, and research has summarized Latinx immigration patterns as being economic or political in motivation. Yet, varying laws, norms, and sociopolitical responses to Latinx sub-groups further

impact the migration patterns and treatment of these groups. As such, researchers caution against a 'one-size-fits-all' to understand the experience of Latinx people (Torres, 2004).

Immigration

People who emigrate from their home countries for economic reasons tend to be seeking better and more permanent opportunities are referred to as *immigrants* (Torres, 2004). In contrast, people who emigrate from their home country due to political reasons with the chance of returning to that country when conditions improve are referred to as *refugees*. With varying reasons for coming to the U.S., there are some key differences in immigration patterns among Latinx populations.

Mexicans constitute most of the immigrant population into the U.S. Mexico is a rapidly developing industrialized country (Wilson, 2007). However, stark wage differences between Mexico and the U.S. account for part of the reason behind economic immigration of Mexicans to the U.S. The increase in Mexican immigration is one of the consequences of the North American Free Trade Agreement (NAFTA). This trade agreement resulted in a three-fold increase in U.S. import of corn, a 50% drop in price, and economic pressure on poor farmers to produce at a level that is not sustainable. This has contributed to workers immigrating to the U.S., creating social networks that serve as gateway locations where Mexican immigrants tend to congregate. As people immigrate, contacts in these gateway locations help Mexican immigrants find housing and employment. In this regard, the pattern of immigration becomes self-reinforcing, changing social, economic, and cultural life in both Mexico and the U.S. (Goldman et al., 2014).

Similar to Mexicans, research has suggested that Puerto Ricans immigrate to the U.S. for economic reasons. Puerto Ricans are a unique sub-group under the Latinx umbrella because Puerto Rico is a U.S. territory. This means that Puerto Ricans can utilize their status as U.S.

citizens to move freely between the island and the U.S. mainland (Torres, 2004). Research has suggested that economic reasons have constituted the primary motivation for Puerto Ricans relocating to the mainland. The political relationship between the U.S. and Puerto Rico has created opportunities for Puerto Ricans who move to the U.S. to remain culturally and physically connected to their homeland (Torres, 2004).

Immigration from countries such as Cuba, the Dominican Republic and Central and South American countries has often been for political reasons. Cuban immigration was initially sparked by political reasons following the revolution of 1959, led by Fidel Castro. Other factors impacting Cuban immigration included the Cuban Missile Crisis (1962), freedom flights in the 1960s and 1970s, and the Mariel boatlift in 1980. The political relationship between the U.S. and Cuba has enabled Cubans to enter as political exiles—a status that provides access to more services and protection than other Latinx immigrants. Similarly, Dominicans have tended to immigrate for both political and economics reasons, with immigration numbers rising after the 1961 assassination of Dominican dictator Rafael Trujillo (Torres, 2004).

War and militarization have contributed to immigration from Central and South American countries. Specifically, war and militarization contributed to Latinx immigration from Nicaragua, El Salvador, Guatemala, and Panama. However, other Central and South American countries with more stable governments—Costa Rica, Honduras, Belize, and most South American countries—still experience economic crises that result in Latinx immigrants seeking better financial opportunities in the U.S. The larger point is that immigration data aggregated under a pan-ethnic umbrella may be problematic (Torres, 2004). Instead, it is important for research to consider in-depth information about each sub-group within the Latinx umbrella. This is true for understanding the heterogeneity of Latinx college students.

Latinx College Students

Most traditional college-age Latinx students are U.S. born (Concepcion Zayas et al., 2019). As of 2011, Latinx students made up 17% of all traditional-age college students (18-24 years old), compared to 11% in 2006. Latinx students attend 2-year colleges at a higher rate than other racial groups—representing 25% of the student population at 2-year colleges and 13% at 4-year universities (Crisp et al., 2015). Unfortunately, higher education institutions tend to retain and graduate Latinx students at a lower rate as compared to other racial groups (Crisp et al., 2015). While much of the literature has focused on the largest sub-group populations (i.e., Mexican, Puerto Rican), it is important to consider how immigration patterns from other countries may relate to college success (Page, 2013; Torres, 2004). The rate at which Colombians (32%) and Peruvians (30%) earn bachelor's degrees is higher than the rate of the total U.S. population. Other sub-groups (e.g., Mexicans and Salvadorans) have rates of degree completion that are lower than those of other Latinx populations (Crisp et al., 2015). When examining college enrollment by sub-group, the data shows that Mexicans have the lowest college completion rates—far behind Puerto Ricans, Cubans, and South and Central Americans (Gloria et al., 2005). One reason for the lower academic success of Mexican youth may be due to their documentation status, racism, and negative stereotypes toward this sub-group in particular (Teruya & Bazargan-Hejazi, 2013).

In sum, the Latinx population is diverse in race, acculturation levels, immigration patters, socioeconomic statuses, educational levels, citizenship statuses, and geographic locations within the U.S. (Alvarez et al., 2004; Concepcion Zayas et al., 2019; Torres, 2004). These differences must be explored and considered as mental health professionals offer guidance and support to

these groups; misunderstandings of these variations can lead to incorrect diagnosis and treatment (Concepcion Zayas et al., 2019; Martinez Tyson et al., 2016).

Population Specific Terminology

The language and terminology used to describe individuals who trace their heritage to Latin America has changed over time. In 1978, the term *Hispanic* was coined by the Federal Office of Management and Budget to identify and quantify the growing immigrant population from Latin America. The term *Hispanic* was meant to describe people who spoke Spanish and could trace their lineage to Spain, irrespective of their racial identity. *Hispanic* derives from the Latin word *Hispania*, which became *España* (Spain). In the late 1970s and 1980s, *Hispanic* became the official classification used for the U.S. Census and other governmental agencies (Cardemil et al., 2019; Noe-Bustamante et al., 2020; Salinas & Lozano, 2017).

Although *Hispanic* was the official term of the U.S. government, many immigrants from Latin America preferred to identify with their country of origin (e.g., Cuban American, Mexican American, and Puerto Rican). Of particular note for Mexican Americans was the use of Ch*icano/Xicano* and *Chicana/Xicana*—terms that have a purposefully political meaning (Cardemil et al., 2019; Rios, 2008; Urrieta, 2004). The Chicano Movement of the 1960s sought to challenge the status quo and reject the notion of second-class citizenship felt by Mexican Americans (Chávez, 2013; Garcia, 2015; Urrieta, 2004). *Chicano* was a term that was typically used by low-income groups to assert pride. The term was used politically "to express the militant demands for civil rights, ethnic pride, and community empowerment" (Garcia, 2015, p. 2). People who prefer the terms *Xicano*/*Xicana* often view themselves as ideologically distinct from earlier *Chicano*/*Chicana* activists and scholars. The terms *Xicano*/*Xicana* recognizes the multidimensionality and intersecting nature of sociocultural identities (e.g., race/ethnicity,

gender, class, sexuality). As such, many people in the community began to resist the term *Hispanic* because of its strong connection to Spain, and a history of colonization (Noe-Bustamante et al., 2020).

In the 1990s, *Latino* emerged as a descriptor of immigrants originating from Latin America. *Latino* was first used in the U.S. Census in 2000 (Cardemil et al., 2019; Noe-Bustamante et al., 2020). The term *Latino* detached from Spanish origins—Spanish speaking and/or having roots from Spain. This term could be used to describe all Latin American people, including people from non-Spanish speaking countries (i.e., Belize, Brazil, French Guiana, Guyana, and Suriname) (Cardemil et al., 2019; Salinas & Lozano, 2017). A key similarity between *Hispanic* and *Latino* is they are both pan-ethnic terms that refer to a cultural and ethnic group, not a race (Salinas & Lozano, 2017). However, the term *Latino* also carried political meaning, as it represented a chance to reject the term *Hispanic*, which many people felt had been imposed on them by the U.S. government. Consequently, using the terms *Latino* and *Latina* reinforced a gender binary because identifying with one of these terms automatically assigns the person an identity of "male" or "female." The masculine form, *Latino*, has been used to describe all groups of people, even if as few as one male identified person were a component of the group, thereby reinforcing patriarchal ideologies (Cardemil et al., 2019).

In recent years, there has been a growing concern of gendered terms such as *Latino* and *Latina* reinforcing cisgender heteronormative constructs, thus excluding people who identify outside of the gender binary (Cardemil et al., 2019; Salinas & Lozano, 2017). In response, more inclusive terms emerged: *Latinx*, *Latin@*, *Latine*, and *LatinU*. The term *Latinx* has been most widely used in academic communities to challenge the limitations of binary gendered constructs. The intent of the term *Latinx* is to build unity and affirm all members of these populations, and to

call attention to the historical and present imperialism, marginalization and violence associated with the gender binary (Cardemil et al., 2019; Noe-Bustamante et al., 2020). An added layer is the way in which *Latinx* is Indigenized. The use of the letter "x" has been connected to Indigenous languages. The "x" marks the Indigenous mythical homeland of Aztlán—a representation of land that was occupied by native people prior to Spanish colonization (i.e., the U.S. Southwest). As such the "x" "confronts the history of violent colonization and systemic marginalization faced by Indigenous people throughout the Americas (Salinas, 2020). *Latinx* was officially added to the Merriam-Webster dictionary in 2018 (Cardemil et al., 2019; Noe-Bustamante et al., 2020).

However, the use of the term *Latinx* is not without its critics. The term has not been widely accepted within the population of people who identify with Latin American heritage. Some people have criticized the term as intellectually off-putting and inconsistent with traditional Spanish grammar, overly reductive in describing diverse populations, and minimizing critical gender-related struggles of cisgender women (Cardemil et al., 2019). According to a recent Pew Report, one-in-four people of Latin American descent (23%) in the U.S. were aware of the term *Latinx*, but only about 3% used the term to describe themselves. Participants in this Pew Report—all of whom identified as having Latin American descent—were given the chance to respond to an open-ended question about the meaning of the word *Latinx*. Their responses were coded into the following descriptions: 42% as gender-neural; 12% as a word they disagree with or dislike; 12% as descriptive of people who are *Hispanic* or *Latino*; 9% as an LGBTQ-inclusive term; 6% as a new or replacement term, and 6% unsure or no response. The researchers did not show the percentages for participants who "refused" to respond. Age appeared to be a significant factor. The median age of those who had heard of *Latinx* was 29 years old, compared

with 43 years old for those who had not heard of the term *Latinx*. Other important factors were nativity—participants born in the U.S. were more likely to know the term *Latinx*. Furthermore, participants who had some college experience or were college graduates were more likely to know the term compared with participants who had no college experience. Participants who spoke primarily English were more likely to know the term *Latinx*. The Pew Report suggested that the term *Hispanic* is still the preferred term overall with fewer participants preferring *Latinx*. Of the participants who had heard of the term *Latinx*, 10% stated they prefer the term Latinx. Even among those aware of Latinx, the terms *Hispanic* (50%) and *Latino* (31%) were preferred among those surveyed (Noe-Bustamante et al., 2020).

Hayes-Bautista and Chapa (1987) stated that the only unifying factor that denotes Latinx as a pan-ethnic term is a connection to and origin from a Latin American country. In addition, the major conceptual rationale for identification of this group has been both political and geographic. Confusion over categorization has occurred through conflation of nationality (e.g., Mexican, Puerto Rican, Salvadoran) and race (e.g., Mestizo, Indigenous, Asian, Black, White); although, racial categorization of this group has not occurred since 1940 (Hayes-Bautista and Chapa, 1987). The terminology used to describe this population is complicated, nuanced, and inscrutable. While there is no consensus on terminology within the group of study, given the setting (research university), age group (college students), and values (i.e., inclusivity) of the present study, the term *Latinx* will be used henceforth.

Overview of Barriers to Mental Health for Latinx College Students

Research has consistently demonstrated that Latinx people living in the U.S. are reluctant to seek mental health support from a mental health professional (Berdahl & Torres Stone, 2009; Defreitas et al., 2018). When it comes to seeking mental health treatment, fewer than 1 in 20

Latinx people seek services from a mental health professional, and fewer than 1 in 10 seek services from a general health care provider (Berdahl & Torres Stone, 2009). These statistics are particularly worrisome because it means that Latinx people are less likely to be diagnosed with mental health problems, such as depression, despite evidence of higher population rates of depressive symptoms than their White counterparts (Ruiz & Steffen, 2012).

Given the increase in the population of Latinx college students, the college environment may serve as an appropriate environment to explore the relationship between Latinx college students and mental health services. Because mental health and wellness are growing concerns for Latinx students in college settings (Hope et al., 2018), it is important for mental health educators and professionals to be prepared to address these concerns. Gonzalez (2015) outlined many barriers that Latinx college students may face, including individual barriers—skills and abilities related to academic readiness, relational barriers—ability for close others (e.g., family, friends, community members) to assist with college access, and systemic barriers—macro level institutional and societal barriers (e.g., institutional policies, procedures, and practices, availability of resources and support).

Individual and Relational Barriers

Individual barriers relate to inadequate academic preparation, including English-language skills, math skills, and study skills. While not all Latinx college students face these barriers, even high-achieving Latinx students are less likely than similarly performing peers from other racial/ethnic groups to complete college applications (Gonzalez, 2015). Individual barriers can result in decreased levels of confidence, self-efficacy, motivation, and intent to persist (Gonzalez, 2015; Marquez Kiyama et al., 2015), which can impact mental health outcomes.

Relational barriers are created when key persons in the student's life are unable to assist with college access. Key persons may include family, friends, and community members. Key barriers articulated in the literature include low levels of family access to college planning information and materials, uncertainty about the cost of college, lack of awareness about college application steps and processes, and less parent/guardian involvement due to language and time limitations (Gonzalez, 2015).

In addition, Marquez Kiyama, et al. (2015) note that pressure to fulfill family obligations at the expense of school or course work could constitute a unique barrier. Therefore, relational barriers may be connected to the cultural concept of *familismo* (Marquez Kiyama, et al., 2015; Wing Sue et al., 2019). *Familismo* means that family unity, respect (i.e., *respeto*), and tradition are an important aspect of life; cooperation among family members is important. Moreover, loyalty and placing the needs of close friends and family before individual needs is valued (Wing Sue et al., 2019).

Systemic Barriers

A key systemic barrier that has been examined in literature is the complex process of *acculturation*, defined as the process of internalizing values, beliefs, and traditions of the larger society. *Acculturation* has been described as a powerful force in the development of identity for BIPOC, particularly immigrants. Research has indicated that Latinx people who have been exposed to the values, beliefs, and standards of the larger White/Western U.S. culture may become increasingly Westernized (Wing Sue et al., 2019). One critique is literature on *acculturation* has not taken socioeconomic status into consideration as a prominent factor. For instance, Latinx immigrants may be forced to adopt less healthy lifestyle or habits of lower-income Americans when immigrating to the United States (Goldman et al., 2014). Additionally,

the acculturative stress hypothesis suggests that Mexican immigrants in particular are viewed by U.S. society as low status, and as such face discrimination and chronic stress. Poorer living and working conditions may expose Mexican immigrants to infections disease, environmental toxins, injury, and other health risks (Goldman et al., 2014). These factors may contribute to evidence that as Latinx immigrants acculturate to the societal conditions in the U.S., their mental health tends to worsen (Acevedo et al., 2007; Goldman et al., 2014). *Acculturation* is likely inextricably linked to other systemic barriers, namely racism, which can lead to psychological distress and mental health problems (Acevedo et al., 2007; Marquez Kiyama et al., 2015).

Researchers have attempted to explore the link between macro level institutional and societal barriers (i.e., racism) and micro level outcomes (e.g., college access and success). While researchers have often included systemic barriers as part of the context (i.e., environmental), the focus on macro level institutional variables are less often the focal point of investigation (Gonzalez, 2015; Rios-Aguilar & Marquez Kiyama, 2012). For instance, it is important to consider the impact of institutional policies and procedures, such as tracking Latinx students to lower-level courses or poor outreach and communication with Latinx families. Researchers have also noted the absence of quality college preparation programs, rising costs of college, and specific barriers for undocumented students (Gonzalez, 2015).

Overview of Barriers to College Success for Latinx College Students

Latinx college students face unique but varied inequities when it comes to college access and success. Research has found Latinx college students to be less likely to successfully matriculate through college, select a competitive college or university, enroll in coursework full-time, and earn a bachelor's degree than their White counterparts (Marquez Kiyama, et al., 2015). Data suggest that in the 1990s and early 2000s nearly half of Latinx students enrolled in college

immediately after secondary school; however, enrollment was lowest at research intensive schools (Gloria et al., 2005). Once Latinx students enroll at college—specifically predominantly White Institutions (PWIs)—they many face barriers specific to the college environment. With the limited number of Hispanic-Serving Institutions, Latinx students in the U.S. generally attend PWIs (Anguiano et al., 2020). PWIs are institutions historically built by and for middle- and upper-class White communities. Latinx students at PWI institutions may be hindered by an incongruence between their culture and the culture of the campus (Marquez Kiyama et al., 2015). Specifically, Latinx college students attending PWIs may face marginalization and social exclusion within both academic and co-curricular environments within these institutions (Anguiano et al., 2020; Hernandez et al., 2013). These students are at a high likelihood to experience stress, anxiety, and depression as a result of racial hostility on these campuses (Hope et al., 2018; Hwang & Goto, 2009). Keels (2013) stated that Latinx students who attend PWIs experience greater stigma, less institutional support, and less social support than their White peers. These added stressors may make it more difficult to persist academically (Hope et al., 2018; Keels, 2013). The study conducted by Anguiano et al. (2020) suggested that Latinx college students can feel "out of place" if their cultural and ethnic identities and experiences are not validated within the institutional environment.

Racism experienced by Latinx students in institutions of higher education may include overt and covert racial incidents and slurs (Vachuska & Brudvig, 2018). This can create a less than welcoming campus climate (Anguiano et al, 2020; Hernandez et al. 2013; Marquez Kiyama et al., 2015) with racial microaggressions and stereotyping (Hope et al., 2018; Marquez Kiyama et al., 2015; Solórzano, 1998), prejudice and discrimination, exclusion from curriculum, and low expectations from professors and peers (Marquez Kiyama et al., 2015). Researchers have

documented several instances of both explicit and implicit racism at the University of Wisconsin-Madison (Vachuska & Brudvig, 2018). In their study examining physical, verbal, and virtual instances of racism, several hundred students of color voluntarily shared stories that referred to specific instance of racism or exclusion experienced on campus. In one story, a Latinx student shared, "Not once have I seen a Hispanic professor. The only Hispanic faculty I have seen are three custodians in my residence hall" (Vachuska & Brudvig, 2018, p. 8). Beyond overt racism and lack of representation, many students of color expressed that they had been barred from opportunities due to racism (Vachuska & Brudvig, 2018).

Overview of Seeking Mental Health Support among Latinx College Students

There are compelling reasons to study Latinx college students with respect to identity, racial discrimination, and mental health outcomes. Sociopolitical concerns such as resistance to Latinx immigration have likely increased animosity and racism toward this group in the United States (Hwang & Goto, 2009). Additionally, DeFreitas et al. (2018) suggested that it is important for mental health professionals to understand mental health stigma as it relates to people of color due to elevated levels of stigma toward those with mental illness and toward therapy. As such, therapeutic interventions must be culturally relevant and intersectional in order to best support the growing Latinx population. Give the implications of the present study, it is important to note that campus racial climate is a particularly salient factor impacting the well-being of Latinx college students.

Negative Attitudes about Help Seeking

Mental health stigma and help seeking behavior are two inextricably linked concepts. Barriers to mental health and the consequences of stigma, can prevent people from seeking out assistance with their mental health concerns. In fact, Rickwood et al. (2005) found that the lack

of emotional competence, negative beliefs about help seeking, and stigma were the main factors preventing young people from seeking help for mental health concerns. Several systemic reviews have uncovered stigma as a core contributing factor to help seeking behavior (Aguirre Velasco et al., 2020). Aguirre Velasco et al. (2020) and Cole and Ingram (2019) stated that stigma is one of the most significant barriers to formal help seeking for men. In fact, studies have found that even when controlling for presenting mental health concerns, Latinx men are less likely than Latinx woman to utilize mental health services from a mental health professional or primary care physician (Cabassa, 2007; Peifer et al., 2000; Zack Ishikawa et al., 2010).

Aguirre Velasco et al. (2020) stated that help seeking for mental health requires individuals to communicate their need for personal and psychological assistance. Rickwood and Thomas (2012) defined help seeking for mental health to be "an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns" (p. 180). Rickwood and Thomas described two types: formal and informal. Formal help seeking is assistance from professionals who are credentialed and officially recognized. Informal help seeking is assistance from social networks—friends and family—individuals who have a personal relationship with the help seeker (Rickwood &Thomas, 2012). To understand help seeking behaviors, it is important to consider both formal and informal assistance.

Aguirre Velasco et al. (2020) conducted a review of literature on help seeking for adolescents (ages 10 to 19 years). Help seeking was defined as "the action of actively searching for help for mental health problems, including informal sources (family, friends, sporting coaches, online communities) or formal sources (general professional, mental health professionals, social workers, teachers etc.), based on interpersonal social abilities" (Aguirre Velasco et al., 2020, p. 2). A total of 90 studies were reviewed. Of the 90 studies, barriers to help

seeking were categorized into the following order: stigma (n = 30), family beliefs (n=15), mental health literacy (n=14), the need for autonomy (n=12), and other barriers (n=8) such as cost, transportation, and wait time.

Another study by Cabassa (2007) examined help seeking among 56 Latinx men. The participants were predominantly Mexican (80%) with a mean age of 30. The participants in this study were asked to rank order their top three help seeking preferences for a situation that was presented in a vignette. The choices were as follows: (a) deal with the situation by themselves; or talk to a (b) family member; (c) friend; (d) religious leader (e.g., priest minister or rabbi); (e) doctor; (f) psychiatrist, or (g) other mental health professional (e.g., social worker, counselor, psychologist). Results of the study suggested that Latinx men search for help first within their social networks (i.e., informal sources; 70%) before seeking help from formal sources. Social networks may influence how Latinx men cope with distress and can facilitate pathways that lead to the use of formal sources of help, or they could delay and/or discourage the use of formal sources. Additional research is needed in order to understand the influence of social networks on pathways to formal help seeking (Cabassa, 2007).

Cole and Ingram (2019) as well as Davis and Liang (2015) explored the role of masculinity in help seeking behaviors among Latinx men. Ideologies about masculinity vary by cultural group, so an intersectional approach is necessary to examine masculinity in Latinx populations. Levant and Richmond (2007) defined masculinity ideologies as, “an individual’s internalization of cultural belief systems and attitudes toward masculinity and men’s roles, [which] informs expectations for boys and men to conform to certain socially sanctioned masculine behaviors and to avoid certain proscribed behaviors” (p. 131). Research has suggested

that men who score high on measures of traditional masculinity, tend to have more negative views toward help seeking behaviors for mental health concerns (Davis & Liang, 2015).

Davis and Liang (2015) explored the role of gender role conflict (GRC) in help seeking attitudes. GRC was developed as a concept to explain the psychology distress that occurs when one does not live up to the rigid constraints of heteronormative masculinity. These researchers described GRC through four dimensions: (1) success, power, and competition (SPC), (2) restrictive emotionality (RE), (3) restrictive affective behavior between men (RABBM), and (4) conflict between work and leisure (CBWL). Research has identified an association between GRC and help seeking behavior. Berger et al. (2005) conducted a study in which they surveyed men (White, Black, and Latinx) about help seeking to determine if age is a significant factor in help seeking behavior among these populations. These researchers found that higher levels of GRC (on the restrictive affectionate behavior between men dimension only) and a traditional masculinity ideology are associated with negative attitudes toward help seeking from formal sources. This result highlighted that GRC and traditional masculine ideology are two separate concepts and that a traditional masculine ideology is a better predictor of negative attitudes toward formal help seeking. These researchers also found that older men had a more positive attitude toward formal help seeking than younger men (Berger et al., 2005).

Hegemonic masculinity in Latinx populations, particularly Mexican culture, has been described as *maschismo* or *caballerismo*. *Machismo* is broadly associated with hyper-masculine, sexist, and chauvinistic attitudes and behaviors of Latinx men. However, some studies suggested this concept is a myth, or at least limited (Arciniega et al., 2008; Davis & Liang, 2015). Research has shown that Latinx men are socialized to be collaborative and connected to their emotions. As such, the term *caballerismo* was introduced as a more nuanced way to describe Latinx

masculinity (Arciniega et al., 2008). *Caballerismo* originated from the Spanish words for horse (*caballo*) and horseman (*caballero*) and refers to a code of masculine chivalry. Originally a term to denote status—someone who could afford land and horses—the term has come to mean a gentlemen with proper, respectful manners, living by a code of masculine-based chivalry (Arciniega et al., 2008). As such, *caballerismo* is multidimensional, but is still situated under an umbrella of masculinity. Talking about and seeking help for psychological concerns may or may not fit within *machismo* or *caballerismo* values. Research has drawn links to *machismo* and *caballerismo* to racism and gender role conflict (Davis & Liang, 2015).

Unfortunately, the role of masculinities in men has contributed to the underutilization of mental health services. Seeking formal mental health services may be seen as weak and/or counter to masculine socialization (Davis & Liang, 2015). Men may also prefer to utilize informal sources-social networks (Cabassa, 2007). Zack Ishikawa et al. (2015) conducted a qualitative study of 13 Latinx men and women about formal and informal sources of emotional support. These researchers stated that help seeking and help receiving are "networked and culturally informed processes, and that the intersecting influences of relationships, context, [and] culture" inform help seeking (p. 1561). In their study, one theme in particular emerged that source and style, need, and prior help seeking experience informed what help participants decided to seek.

Mental Health Stigma

Empirical links have been drawn between help seeking and mental health stigma. Studying mental health stigma is important because people will avoid seeking treatment for mental health concerns until their symptoms are debilitating (DeFreitas et al., 2018). Mental health stigma is defined broadly as the "negative stereotyping, biases, and discrimination often

directed at people with mental illness" (Boyd & Deforge, 2014, p. 17), and "the fear of being socially sanctioned or disgraced leading to hiding or preventing certain actions or behaviors, including the misreporting of mental health problems" (Aguirre Velasco et al., 2020, p. 14). Stigma might include embarrassment, denial of mental health related issues and concerns, and/or resistance to seek treatment. Research has suggested that stigma has also been linked to shame associated with help seeking and beliefs that mental illness is linked to weakness of character (DeFreitas et al., 2018; Martinez Tyson et al., 2016).

Stigma has been described as a social process that operates at multiple levels. For this reason, researchers across disciplines, including psychology, sociology, and anthropology, have attempted to develop models to better understand stigma. Because stigma is a vast concept, many researchers have divided stigma into distinct components (Fox et al., 2017). Stigma ranges from big picture, such as cultural or structural stigma, down to individual level stigma.

Schmitz et al. (2020) explored multiple intersecting minoritized identities (Latinx, LGBTQ+) associated with perceived structural sigma and mental health outcomes. Schmitz et al. examined structural stigma as defined by Hatzenbueher and Link (2014). Structural stigma is the "societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing for stigmatized populations" (Hatzenbueher & Link 2014, p. 2). Schmitz et al. (2020) interviewed 41 participants who identified as Latinx and LGBTQ+ between the ages of 18 and 26. Through qualitative analysis, these researchers were able to capture stories about the nuanced ways in which participants interpreted how structural stigma, related to their intersecting marginalized identities, impacted their mental health. Themes related to their Latinx identity specifically included: (a) stigma toward mental health that was pervasive in their families and communities; (b) messages of "rugged individualism" a tenant of

broader U.S. rhetoric—focus should be on independence as dependence is disparaged; (c) the belief that because elders and ancestors had experienced historical trauma, present day mental health concerns are minimalized in comparison; (d) being hyperaware of how one behaves or acts as a representative of a marginalized racial group (i.e. Latinx) requiring significant psychological energy; (e) stigma of not behaving or existing in a manner appropriate for one's perceived gender role—defined both by one's community and the larger U.S. social structures (Schmitz et al, 2020).

DeFreitas et al. conducted a survey study with 122 college students who identified as African American (n=47) and Latino (n=75). These participants were administered the Mental Health Stigma Scale (MHSS) to assess for mental health stigma, specifically perceived and personal stigma. Additionally, Day's Mental Illness Stigma Scale assessed participants' specific stigma beliefs. Results indicated the following: (a) participants who believed they can have a positive relationship with someone with a mental illness and that counselors can effectively treat mental illness were less likely to have personal stigma; (b) if participants believed that the state of having a mental illness was temporary, they were less likely to have stigma beliefs; (c) participants were less likely to have stigma when they believed a mental illness would not impact their relationship with someone (DeFreitas et al., 2018).

Fox et al. (2017) described individual level stigma as the ways in which individuals respond to having or not having a mental illness. These researchers describe the literature as dividing individual level stigma in two major categories: research from the perspective of those doing the stigmatizing—society, and research from the perspective of those who have been stigmatized—people with mental illness or a history of mental illness. Fox et al. (2017) developed the Mental Illness Stigma Framework (MISF) to complement existing stigma

frameworks by integrating existing definitions and conceptualizations of mental health stigma (2017). Utilizing the MISF is helpful because it considers *intersectionality*. *Intersectionality*, as originally coined by Kimberlé Crenshaw, is a term used to describe how systems of oppression overlap to create distinct experiences for people with multiple marginalized social identities (Crenshaw, 1989, 1991). The MISF framework allows for the commonality in experiences across all people with mental illness (PWMI) while also accounting for individual experiences of mental health stigma based on a client's sociocultural identities (Fox et al., 2017).

In their review of stigma literature, Fox et al. (2017) identified three stigma mechanisms that are most associated with PWMI: experienced stigma, anticipated stigma, and internalized stigma. These researchers note that *internalized stigma* and *self-stigma* are used interchangeably in literature; the latter is the language used in the current study. Experienced stigma is discrimination, prejudice, and stereotypes that PWMI have directly experienced from others. Anticipated stigma is how a PWMI expects to be discriminated against in the future. *Self-stigma* is defined as "the extent to which people endure the negative beliefs and feelings associated with the stigmatized identity for the self" (p. 5). *Self-stigma* represents the application of stereotypes, discrimination, and prejudice toward oneself. People with *self-stigma* may blame themselves, believe they are incapable of taking care of themselves, or even see themselves as dangerous. *Self-stigma* has been linked to low self-esteem, depression, and worsening of mental health concerns (2017).

Differences exist among subgroups of people of color, so it is imperative for mental health educators and professionals to understand these differences and how they intersect to exacerbate mental health concerns and relate to help seeking behaviors. Research has necessitated understanding the impact of mental health stigma on historically marginalized

college students as particularly important given almost half of college-aged students exhibit mental health concerns (DeFreitas et al., 2018). As such, formal interventions need to be responsive to the intersectional sociocultural identities of clients in order to address help seeking behavior and mental health stigma as it relates to these populations.

Culturally Responsive Concepts

Unfortunately, the mental health field continues to privilege individual level therapeutic interventions. This approach is inconsistent with research that illustrates that institutionalized and systemic barriers are the root cause of psychosocial inconsistences and difficulties faced by collectivistic minoritized groups, including Latinx clients (Goodman & Gorski, 2015). This incongruence in values occurs despite the fact that in the mental health field, terms such as cultural competence, diversity, multiculturalism, cultural humility, and social justice have been used to underscore the importance of culturally responsive mental health services and practices. Fortunately, there is no shortage of culturally responsive frameworks or professionals willing to utilize those frameworks. However, too often these frameworks are utilized in ways that incidentally replicate the power and privilege structures that they should be dismantling (Goodman & Gorski, 2015). Therefore, culturally responsive concepts must first be explored—including definitions and limitations—then transformative justice models can be integrated with key frameworks, such as critical race theory, that can be applied in mental health contexts.

Cultural Competence

Earlier concepts of cultural competence required that counselors provided services with skills, attitudes, and values that would make them effective and adequate in serving clients who originate from a variety of cultural backgrounds. However, the specific mechanisms for achieving this goal remained amorphous. Literature across mental health disciplines contained

suggestions for cultural competencies. For example, helping professions such as counseling, psychology, and social work have often organized cultural competencies into categories such as the self-awareness, attitudes, skills, and knowledge (Williams, 2006), needed in order to address the needs of culturally diverse clients, groups, and communities (Ratts et al., 2016). Williams stated that cultural competence demands mental health professionals to continue to explore the skills, attitudes, and values that will enable these professionals to provide services to clients from a variety of cultural backgrounds. Williams also argued that the lack of a coherent theoretical framework for cultural competence to inform the work of mental health educators and professionals resulted in challenges to evaluating its effectiveness in practice (2006).

Multiculturalism

Both the American Psychological Association (APA) and the Council of Accreditation for Counseling and Related Educational Programs (CACREP) outline the importance of diversity and multiculturalism. In 2017, the APA published new multicultural guidelines that resulted in a significant growth in research and theory related to multicultural contexts. These guidelines encourage psychologists to explore the importance of understanding and leaning into identity as a core component of psychological practice. Leaning into the development and importance of identity in mental health work contributes to more effective engagement with clients (American Psychological Association, 2017). The 2016 CACREP Standards consider multiculturalism as foundational to the professional counseling identity. The standards require that "social and cultural identity" are incorporated into curriculum, including but not limited to theories and models of multicultural counseling, cultural identity development, and social justice advocacy; impact of power and privilege for counselors and clients; help seeking behaviors of diverse clients, and strategies for identifying and eliminating barriers, prejudices, and processes of

intentional and unintentional oppression and discrimination (CACERP, 2016). The counseling field originally developed Multicultural Counseling Competencies (MCCs) in the 1990s. These competencies helped to shape the American Counseling Association's (ACA) Code of Ethics, the Association for Specialists in Group Work, and Counselors for Social Justice. Since the early development of the MCCs. The MCCs have also been implicated in the development of additional competencies for key marginalized populations such as Lesbian, Gay, Bisexual, and Transgender (LGBT) clients (Ratts et al., 2016). However, Gorski and Parekh argued that "liberal" minded multicultural frameworks prepare educators and counselors to conform to mainstream values and norms instead of transforming and disrupting systems of oppression, including practices, procedures, and policies (2020).

Cultural Humility

The term cultural humility was born from the healthcare field to be used as a framework to educate and train doctors to work with the increasing cultural, racial, and diverse populations in the United States (Tervalon & Murray-García, 1998). Tervalon and Murray-García (1998) distinguished cultural humility from cultural competence. In the medical field, competence was traditionally conceptualized as "an easily demonstrable mastery of a finite body of knowledge, an endpoint evidenced largely by comparative quantitative assessments" (p. 118). Conversely, cultural humility is a process that requires "humility" on the part of the healthcare provider and is defined by a lifelong process of self-reflection and self-critique. Humility is required in communication with patients and in developing and maintaining mutually respectful and dynamic partnerships with community members (Tervalon & Murray-García, 1998).

Since the seminal work of Tervalon and Murray-García, cultural humility has been applied by mental health educators and professionals. Mental health professionals have utilized

cultural humility frameworks as a step beyond cultural competence. Cultural humility enables mental health professionals to acknowledge their limited knowledge and understanding of their clients' cultural backgrounds. The humility that accompanies this understanding allows for life-long self-reflection and detachment from ego and establishes realistic expectations (Hook et al., 2013). However, it is important for frameworks to also interrogate the sociopolitical systems that create injustice and conditions under which trauma is experienced by historically marginalized and minoritized groups (Goodman & Gorski, 2015).

Inclusive Excellence

Although much of the mental health literature has focused on cultural competence and/or multicultural competencies, other disciplines, such as pedagogical studies in higher education, push these concepts further to what they define as "inclusive excellence." What is currently described as inclusive excellence began as diversity and multicultural education. Multicultural education emerged in the United States during the changing social landscape of the 1960s and 1970s when "minority" activist groups fought for inclusion in schools, colleges, and universities. Since that time multicultural education has involved imparting knowledge about key concepts such as immigration, racism, sexism, cultural assimilation, stereotypes, prejudice, and institutional racism. Today, it continues to evolve as population demographics shift. The newer use of "inclusive excellence" remains rooted in the transformation of education as a force for promoting equity and social justice (Railey et al., 2018).

In recent years, higher education has progressed the concept of inclusive excellence. The Association of American Colleges and Universities (AAC&U) created the concept of inclusive excellence to help leaders understand the interplay between diversity and educational quality. The idea is that moving from a framework of cultural competence to a framework of inclusive

excellence better allows for centering the perspectives and experiences of historically marginalized and/or minoritized populations. The inclusive excellence framework addresses the complex dimensions of institutional behavior, culture, and change that have served as barriers to inclusion, and it reinforces the concept that diversity is vital to institutional success (Railey et al., 2018).

Social Justice

Inclusive excellence is ultimately rooted in social justice. In counseling, social justice as a framework includes multicultural competence but also encourages mental health professionals to become social change agents (Singh et al., 2010). Peters and Luke (2021) identified three major professional influences within the counseling literature: the development of the Multicultural Counseling Competencies, the establishment of social justice as the fifth force of the key counseling approaches and the Multicultural and Social Justice Counseling Competencies. Since the introduction of the originally MCCs, there have been numerous critical evolutions (Ratts et al., 2016). In 2014, the American Counseling Association (ACA) endorsed the Multicultural and Social Justice Counseling Competencies (MSJCC). Outcomes of these competencies include counselors seeking understanding regarding their own privileged and marginalized identities, reducing inequity and injustice related to client work, and interrupting injustice on behalf of clients. These competencies establish the role of counselor as a change agent with roles above and beyond the counseling dyad (Goodman & Gorski, 2015; Singh et al., 2010; Singh et al., 2020).

Social justice movements assert the notion that oppression is so deeply rooted and harmful that a fundamental change in social systems is critical (Pyles, 2018). Therefore, social justice activists argue that creating more inclusivity into and access to an already unjust system is

erroneous; arguing that the focus should be on transforming social, economic, and cultural systems, institutions, discourses and practices while also developing one's personal path to liberation from oppression. Key premises that underlie transformative practice are a synergistic relationship between the personal and political; a drive to change the structures and operations of historically oppressive social systems; a need to decolonize critical spaces (e.g., home, work, school); attention to means and process; an understanding that oppression has a negative impact on mind, body, spirit, and interpersonal relations, and an attention to personal and collective practices of inquiry, care and healing that are needed to transform oppression and trauma (Pyles, 2018).

Given these values as articulated by the literature in counseling and counseling-adjacent fields, a major area of concern is how to make mental health services more culturally responsive through evidence-based practices. Moreover, culturally responsive mental health services require dynamic processes that explore the complex relationships between knowledge and skills, individuals and systems, and culture and society (Whaley & Davis, 2007). Therefore, there is a need for on-going and proactive transformative shifts in how culturally responsive practices and services are researched, developed, and enacted. In recent years transformative justice models have been introduced into the world of mental health.

Restorative Justice and Transformative Justice

Restorative justice has been used therapeutically as a method to address harm and has been defined as, "a process to involve, to the extent possible, those who have a stake in a specific offense and to collectively identify the harm, needs, and obligations, in order to heal and put things as right as possible" (Zehr, 2002, p.37). In the U.S., restorative justice has been historically associated with minor crimes involving juvenile justice and school-based conflict

resolution (Cocker, 2006; Kim, 2021; Zehr, 2002). Restorative justice has roots in indigenous contexts and practices based upon restorative and collective forms of justice. However, the restorative justice used in Western settings has taken on various forms (Cocker, 2006).

Transformative justice was originally conceived as a challenge to restorative justice. Dr. Ruth Morris—an early proponent of transformative justice—criticized restorative justice for not addressing issues of oppression, injustices, and social inequities within conflicts (Coker, 2002; Nocella, 2011). As such, transformative justice is committed to dismantling the criminal legal system and other interlinking systems of oppression, such as racism, to create an alternative vision of justice that focuses on reducing harm and—when integrated with mental health work—improving health outcomes (Kim, 2021; Pyles, 2018).

A transformative justice model can be used to address larger socio-political injustices. While liberal and neo liberal approaches to culturally responsive education and practice can provide students and professionals with hopeful competencies, they lack the transformative potential of critical or transformational approaches (Gorski & Parekh, 2020). As such, Peters and Luke (2021) define transformative justice as a facet of social justice. For mental health professionals, transformative justice represents the meeting point between the criminal justice system and mental health. Research has suggested that effective treatment interventions must be designed to work with those who cause harm and those who are victims of harm. As an example, intersectional-minded minoritized communities such as BIPOC, LGBTQIA+, immigrants, women, and disabled people have sought to define violence—particularly domestic and sexual violence—as conceptualized beyond the gender binary or oversimplified definitions of "victim" and "perpetrator" (Bierria et al., 2012; Kim, 2021). With transformative justice as a framework, language shifted from the use of words such as "perpetrator", "abuser", or "offender" to the less

stigmatizing language of "person who caused harm" (Kim, 2021). As such, transformative justice is more about healing than punishment (Pyles, 2018). Because transformative justice allows for an acknowledgement of both individual and systemic factors that contribute to harm, frameworks rooted in transformative justice have been utilized in mental health practice and education, particularly in service of minoritized communities (Gorski & Parekh, 2020).

Culturally Responsive Interventions

Researchers have proposed that adequate support of Latinx students in higher education will require planned intervention (Sáenz, 2020) due to the major concern of racial and ethnic health disparities in the United States (González-Guarda et al., 2016). Research conducted in the psychological, sociological, and medical disciplines has suggested that stress related to exposure to socially undesirable and/or negative occurrences is associated with decreasing physical and mental health. The additive effects of marginalization, stigma, and mental health experienced by members of historically marginalized groups living in the United States has resulted in accelerated health issues. While a clear link between sociocultural discrimination and negative mental health issues remains empirically unclear, the psychological consequences associated with discrimination against historically marginalized and/or minoritized groups, including psychological distress, substance use, low self-esteem, depression, and suicidality have been documented in research (Arbona & Jimenez, 2014; Schmitz, et al., 2020). For example, in the study by Schmitz et al., participants who identified as both Latinx and LGBTQ+ were asked directly to describe how their sociocultural identities impacted their physical and mental health. Participants reported having to contend with structural oppression and mental health stigma in their own communities and families and the larger sociopolitical society. The researchers stated

that their findings highlight how intersecting marginalized social statuses contribute to health, including mental health, inequalities (2020).

Critical Race Theory (CRT)

To better understand why culturally responsive mental health is important, a critical race theory framework can be utilized. Critical race theory centers racial injustice as foundational and explains how racism is intricately ingrained in the institutions and systems in the U.S. (Anguiano et al., 2020). While CRT centers race, it also accounts for other intersectional forms of oppression that are essential for mental health professionals and educators to understand in order to best serve BIPOC clients. As a framework, CRT advocates for examining oppression beyond interpersonal interactions to examine institutional and systemic oppression—policies and policy-making within historical and cultural contexts (Cerezo & McWhirter, 2012).

Historical Development

CRT originated in U.S. law schools in the 1970s as a reaction to the critical legal studies (CLS) movement's examination of systems of law without the acknowledgement of race as a central component of these systems (Crenshaw et al., 1995; Delgado & Stefancic, 1993; Martinez, 2014; Villalpando, 2004). Influenced by civil rights scholarship and feminist thought, CRT leans into the examination of power, race, and racism to address how power imbalances are racialized. CRT challenges the notion of "color blindness" (race neutrality) and "argues that ignoring racial difference maintains and perpetuates the status quo with its deeply institutionalized injustices to racial minorities." In short, CRT works to understand historical and cultural contexts in an effort to eliminate racism as part of a larger goal to eliminate all forms of subordination (Crenshaw et al., 1995; Martinez, 2014).

Overview

Historically, CRT has been characterized by premises/themes/elements. The number of themes may vary by how CRT scholars organize the components. The resounding themes can be described as follows (Hernandez et al., 2013; Martinez, 2014; Solórzano, 1998):

1. Racism is a central, permanent, and "normal" component of U.S. culture that intersects with other forms of subordination. As such, BIPOC have experiential knowledge through lived experiences with systems of racism and oppression.
2. The experiential knowledge of BIPOC as detailed through narrative is central to understanding racial realities within U.S. culture.
3. CRT offers a challenge to the dominant claims of race neutrality, equal opportunity, color blindness, and merit.
4. CRT values taking an interdisciplinary perspective in order to analyze race in both historical and contemporary contexts.
5. CRT makes a commitment to social justice.

A CRT framework has been applied to college settings in previous research. CRT unmasks the minoritized status stressors that exacerbate the standard college stress associated with persistence and well-being (Anguiano et al, 2020; Marquez Kiyama et al., 2015). CRT centers race and racism as central elements of the educational system and helps to explain how racism is embedded in every aspect of colleges and universities in the United States (Anguiano et al, 2020; Marquez Kiyama et al., 2015; Villalpando, 2004). CRT is a theoretical tool that can be used to uncover overt and covert patterns, practices, and policies that endorse racial inequality. Dismantling these systems of oppression can result in the removal of barriers for Latinx students in higher education (Villalpando, 2004).

Six Constructs of Critical Race Theory

CRT draws from a diverse body of interdisciplinary research from law, sociology, history, feminist and postcolonial studies, economics, political science, and ethnic and cultural studies. Its general goal is to analyze, deconstruct, and transform systems of race, racism, power, and privilege (i.e., oppression) in order to create social change (Abrams & Moio, 2009). Abrams and Moio, scholars in social work, outline six constructs or tenets of Critical Race Theory (2009), which form the basis of the Critical Race Theory measure utilized in the present study.

Endemic Racism

CRT asserts that racism is commonplace and pervasive and occurs at multiple levels (Abrams & Moio, 2009). Unlearning racism requires both normative and transformative approaches. Part of the normative approach requires White people to examine their white identity development and BIPOC to examine the impact of white supremacy on their own identity development. The transformative approach includes institutional reforms, such as changes in practices, policies, procedures, and legislation (Asumah & Nagel, 2014). Put simply, a critical race theory framework requires understanding and dismantling racism at every level. Racism and white supremacy did not end with civil rights legislations in 1964. Racism is ubiquitous and has permeated the fabric of all aspects of U.S. society, including education (Asumah & Nagel, 2014; Railey et al., 2018). As previously stated, navigating PWIs can be a challenging and complicated endeavor for Latinx college students. CRT utilized in college settings must challenge the historical claims of objectivity, meritocracy, color and gender blindness, race and gender neutrality, and equal opportunity. These historical tactics of erasure and denial serve to disguise the underlying self-interest, power, and privilege embedded in U.S. institutions (Martinez, 2014; Solórzano, 1998).

Race as a Social Construction

CRT maintains that race was socially constructed based on limited phenotypic information with no basis in genetic or biological reality (Abrams & Moio, 2009; Bryant et al., 2021). CRT explores whiteness and "color" as social systems with the U.S. that contributed to the development and significance of ethnic identity within a color-conscious society (Asumah & Nagel, 2014). Specifically, race as a construct has been used to assign "whiteness" as the standard or norm while promoting the idea that Black and other minoritized people are inherently genetically inferior. The notion of race as a biological determinant of behavior, intelligence, and other attributes has perpetuated negative stereotypes and furthered the stigmatization of BIPOC. Additionally, these notions have extended into the clinical realm, including mental health settings, creating barriers to positive mental health outcomes (Bryant et al., 2021).

Differential Racialization

Dominant (i.e., White) social discourses and people with access to power can racialize the beliefs, behaviors, and access of BIPOC depending on historic, social, or economic need (Abrams & Moio, 2009). For instance, how people experience oppression is often tied to how they are "othered" based on their sociocultural identities. As Tatum stated, people are often defined as "other" based on their race and/or ethnicity, gender identity or expression, religion, sexuality, socioeconomic status, age, and/or physical or mental ability. Each of these sociocultural identities is tied to a form of oppression: racism, sexism, transphobia, religious oppression (e.g., Islamophobia, anti-Paganism, anti-Semitism), heterosexism, classism, ageism, and ableism (2000). In clinical settings, racial determinism has very real and harmful consequences. Racial determinism can contribute to false diagnostic conclusions, resulting in BIPOC experiencing exacerbated mental health concerns. This outcome highlights the need for

greater examination into how systemic and institutionalized oppression can influence diagnostic practices (Bryant et al., 2021).

Interest Convergence/Materialist Determination

Racism serves to bring material and psychological advantage to the majority race (i.e., White) and progressive change may occur only when the interests of White people converges or aligns with the interests of BIPOC. In the case of oppression (e.g., racism), there are groups with privilege (i.e., access to systemic advantages due to group membership) and groups that have been marginalized and/or minoritized historically and presently (i.e., systemic disadvantage) (Asumah & Nagel, 2014; Tatum, 2000). As evidenced by CRT, there are complex intersections that result in unique advantages and disadvantages for a given individual in societal frameworks. A non-profit organization called Race Forward offered a framework for understanding the dimensions at which racism occurs (Race Forward, 2015) (refer to Figure 2). Race Forward addresses the fallacy that the U.S. is a "post-racial" society. Both empirical and anecdotal knowledge demonstrate that race still plays a defining role in a person's life trajectory, experiences, and outcomes. The shifting U.S. landscape makes it even more urgent the need for open dialogue about racial bias and inequity that are deeply embedded in U.S. history, culture, and institutions. This system of racialization—which normalizes advantage and disadvantage based on skin color and other characteristics—must be clearly understood (2015). In order to adequately support college students who have been historically disadvantaged by racism, college counselors must have an understanding of the complexities of these disadvantages at each dimension. This framework offers a baseline understanding of what Latinx students, and other marginalized populations, may be navigating.

Voices of Color

The dominant group's accounting of history steadily excludes the perspectives of BIPOC. The silencing of the experiences of BIPOC serves to minimize the role of power and oppression across time and place. CRT advocates for inclusion of narratives from BIPOC in order to challenge claims of neutrality, color blindness, and universal truths (Abrams & Moio, 2009). White extant literature is so pervasive it appears "natural." As such a counterstory is defined as a method for BIPOC to tell stories in a manner that challenges the "master narratives" of White privilege (Martinez, 2014; Sablan, 2019). BIPOC may also reproduce structures, systems, and practices of racism. However, by writing from their perspectives the social world no longer appears static, as it becomes built by people with words, stories, and also silences. Therefore, CRT scholars can construct counterstories that are built upon commitments to social justice and elimination of racial oppression (Martinez, 2014).

Anti-essentialism/Intersectionality

Intersectionality has been defined as "studying multiple locations of social inequality simultaneously to more fully understand the interlocking dynamics of disadvantage for marginalized populations" (Schmitz, 2020, p. 164). CRT acknowledges the existence of multiple systems of intersecting oppressions and that a primary focus on one form of oppression can eclipse other forms of oppression. CRT describes the essentialism of one form of oppression (e.g., racism) over other forms of oppression (e.g., sexism, heterosexism, classism) is both a political choice and not strategically sound. A stronger strategy is to build coalitions—coalitions have greater ability to effect social change (Abrams & Moio, 2009).

Utilization of Culturally Responsive Concepts

The application of culturally responsive concepts requires taking a decolonizing standpoint, which can be applied across all aspects of mental health service. To decolonize is to

take a multidisciplinary and political stance rooted in critical social theories, methodologies, and practices, particularly Critical Race Theory (CRT) and transformative justice frameworks. These are two inherently linked concepts that provide a roadmap to liberation. Doing decolonizing work involves identifying and uprooting systems of oppression, de-centering whiteness/Western ways of knowing and doing, and bringing the voices and lived experiences of BIPOC and other marginalized groups to the forefront (Goodman & Gorski, 2015).

Utilization in Education

Research suggests that pervasive and consistent patterns of miseducation, inequity, injustice, and educational malpractice cause harm to BIPOC students throughout the U.S. (Souto-Manning & Winn, 2019). As such, counseling education programs should center critical race theory and transformative justice frameworks in order to train teachers and professors who can "commit to interrupting an unjust status quo" (Souto-Manning & Winn, 2019, p. 309). This commitment arises from the use of critical pedagogy as a conceptual framework. Critical pedagogy outlines two pathways—one is to maintain the status quo and the other is to work toward transformation. The latter involves recognizing that education is inherently politicized around dominant social identities. Notions such as neutrality and objectivism have served the purposes of hiding the true interests of those in power in order to keep hierarchies of power in place (Souto-Manning & Winn, 2019; Souto-Manning & Stillman, 2020). The key is to engage in problem solving and to identify shared commitments that can be utilized to transform teacher educators, who can then transform teacher education (Souto-Manning & Winn, 2019).

Research into the themes of equity and justice suggest that teacher education is best served when these themes are spread throughout teacher education curriculum. Specifically, the expansion of culturally responsive themes beyond diversity or multicultural courses can

strengthen student knowledge (Gorski & Parekh, 2020). This expansion may include "what is taught (or not taught), the perspectives and values centered (and decentered), the bodies that occupy such programs (and those missing), the tools and materials included (and excluded), and the communities engaged (and those dismissed)" (Souto-Manning & Stillman, 2020, p. 1). These are all political choices.

Utilization in Research

The goal of research should be framed around transformative participation. Transformative participation occurs when research findings elicit change from within communities, such as alleviating problems and suffering, including oppression (Goodman & Gorski, 2015). Transformative practices can be hindered when communities are not included in research about and allegedly for those communities. When communities do not have power over the methods or analyses used in researching those communities, then transformative justice is likely restricted or impaired. For example, transformative justice in research cannot occur if the analysis is restricted to "Western concepts and metaphors" (Goodman & Gorski, 2015, p.89). If the research has a linear method in which data is extracted and analyzed—whether it is qualitative or quantitative—transformative justice may not be achieved. For example, research proposals based on previous and current literature are often based on a Western understanding of the community and phenomenon being researched. As such, the research proposal may have a trajectory that is not inclusive from the start. This may result in the community feeling that the results of the research study will not provide the transformative power needed to produce change (Goodman & Gorski, 2015).

Utilization in Practice

Asumah & Nagel suggest that counselors who possess culturally responsive skills can improve the manner in which clients seek out and participate in mental health services, engage in the therapeutic relationship with their mental health professionals, and benefit from and retain treatment outcomes. Because cultures and sociocultural identities are diverse and continuously evolving, striving toward culturally responsive practices and services must also evolve (2014). Developing one's commitment to transformation is a lifelong process that starts with an acknowledgement of culture, diversity, and systems of oppression and a commitment to understanding the role that culture and sociocultural identities play out in systems, including in mental health services (Goodman & Gorski, 2015). Asumah & Nagel (2014) outline the following steps for mental health professionals:

1. First, mental health professionals must understand their own cultures as a basis for understanding others.
2. Second, mental health professionals must cultivate the willingness and ability to acquire knowledge of their clients' cultures. This involves learning about and respecting their clients' worldview, beliefs, values, and attitudes toward their own identities and how these identities inform how they navigate the world, including mental health and help seeking behavior. Therefore, mental health professionals should incorporate culturally appropriate knowledge, understanding, and attitudes into their actions; this should include an understanding of how their identities and the identities of their clients might interact at interpersonal and system levels. This may include communication style, verbal and non-verbal messages, and how their clients are impacted by policies, procedures, services, and legislation.

However, Goodman and Gorski (2015) state that this is just a start. Taking concrete steps, as defined by Asumah & Nagel (2014), to becoming more aware of cultural issues without a critical and transformative lens creates the risk of perpetuating systems of oppression. Goodman and Gorski affirm taking a decolonizing standpoint. They specifically define decolonizing as: "transdisciplinary and political stance grounded in critical social theories and methodologies to understand and expose the continuing legacy of coloniality" (p. 133). Goodman and Gorski suggest practices such as using critical ethnography, critical reflection, and cultural capital to inform clinical practice (2015).

Furthermore, research into supervision and other field supports in counseling suggest the importance of creating systems of support. However, many researchers and professionals argue that these supports are not enough. For instance, opportunities to explore counselor vulnerability and self-healing are not always present. As such, Pyles (2020) stated that "professionals-in training may be learning more about how to be highly boundaried professionals who can function in a neoliberal climate and less about how to be vulnerable collaborators who share the humanity of their clients" (p. 179).

In addition, transformative justice provides a framework for self-healing for mental health professionals. Social issues occur within human constructed systems and contexts. Professionals are simultaneously co-creating and being affected by the systems, institutions, organizations, and communities in which they navigate. Therefore, professionals need some level of care and healing in similar ways to the people they are serving. The journey to self-care for helpers can lead to a level of wholeness that then informs the transformation process for themselves and others (Pyles, 2018).

Community Advisory Board

In order to enact transformative practices and research, the current study utilized an 8-member community advisory board consisting of Latinx males aged 23 – 27. This advisory board provided guidance and feedback on the design of the study, the methodology and measurements, and the recruitment of participants.

Moreover, community-based participatory research (CBPR) is a research practice designed to reduce health disparities. CBPR requires a close relationship between researchers and community members who would benefit from the research (Cramer et al., 2017; Newman et al., 2011). A primary component of CBPR is community engagement. Mlambo et al. (2019) define community engagement as "the process of working collaboratively with groups of people affiliated by geographic proximity, special interest or similar situations, to address issues affecting the well-being of those people" (p. 2). In community-based research, community engagement promotes ethical conduct and ensures that the research is relevant to the community about which research is being conducted (Mlambo et al., 2019). The use of community advisory boards (CABs) is a best practice for including community involvement in health-related research (Cramer et al., 2017; Mlambo et al., 2019; Newman et al., 2011). CABs provide structure in a manner that ensures community feedback is considered during all phases of the research process and that the study is culturally competent for the population of study (Cramer et al., 2017).

Conclusion

Given the richness of literature regarding cultural competencies and frameworks for providing mental health support, the current chapter examined links between mental health stigma (Aguirre Velasco et al., 2020; Cabassa, 2007; Porcari et al., 2017; Rickwood et al., 2005; Zack Iskikawa et al., 2010), masculinity ideologies (Arciniega et al., 2008; Berger et al., 2005; Cole & Ingram, 2020; Davis & Liang, 2015) and the future intention to seek help for mental

health support. In order to add to the extant literature, the current study examined importance of applying critical race theory constructs in mental help supports. Toward that end, the next chapter will outline the research methodology and data analysis procedures.

CHAPTER III

METHODS

The aim of the present study was to gather data about Latinx male college students' help seeking attitudes and behaviors at a large Predominantly White Institution (PWI)/Hispanic-Serving Institution (HSI) in the United States. This chapter presents the research methodology and data analysis procedures to answer the research question and test the corresponding hypotheses. The description of the research methodology includes information about the participants' demographics, data collection procedures, sampling, and measures. The process for data analysis is discussed; although, results will be detailed in Chapter IV.

Research Design

The present study used a quantitative survey design. Survey research has been defined as "the collection of information from a sample of individuals through their responses to questions" (Check & Schutt, 2012, p. 160). Historically, survey data has been collected from large populations. The primary purpose of survey research is to obtain information describing characteristics of a large sample of individuals of interest relatively quickly (Ponto, 2015). A survey design can be a rigorous approach to research supported by scientifically significant strategies such as choosing a sample, distributing the survey, data collection instruments, and engagement with non-responders (Ponto, 2015). Data from the survey can be analyzed statistically in order to draw meaningful conclusions about the research questions.

Community Advisory Board

Prior to establishing the research design for this study, a community advisory board was formed. The primary objective for forming and utilizing the community advisory board for the present study was because the primary researcher did not identity as *Latinx*. Transformative

practices can be hindered when communities are not included in research about and allegedly for those communities (Goodman & Gorski, 2015). As such, each member of the community advisory board identified within the *Latinx* umbrella and identified as male. The current study was informed by the primary researcher's professional work with Latinx male college students. As such, convenience sampling was used to select community advisory board members from the primary researcher's former students. A totally of eight of the primary researcher's former students agreed to serve on the community advisory board.

Meetings with advisory board members were conducted over phone (voice and FaceTime) and Zoom. Members reviewed all aspects of the study, including determining measures that would be best utilized with Latinx male college students. In addition, advisory board members took an early unofficial version of the Qualtrics survey to provide feedback on order of questions, readability, completion time, and technology accessibility—ensuring the survey would be accessible to participants on multiple devices (i.e., cell phones, tablets, and computers). Advisory board members also provided their insights and perspectives regarding implications of the present study and potential steps for future research.

Research Question and Hypotheses

The present study sought to understand the relationship between mental health stigma, masculinity ideologies, and need for culturally relevant mental health support services. To achieve this purpose, the following research question was examined:

> *To what extent does mental health stigma, masculinity ideologies, and culturally relevant support services predict the intention of Latinx male college students to seek mental health support?*

The variables were measured in the following ways:

- Mental health symptoms as measured by the Mental Health Inventory-5 (MHI-5).
- Mental health stigma as measured by two variables. Self-stigma was measured by the 10-Item Self-Stigma of Seeking Help Scale (SSOSH) and attitudes toward help seeking was measured by the 10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF).
- Masculinity ideologies as measured by three variables. Restrictive emotionality was measured by the 9-item Gender Role Conflict Scale-Restrictive Emotionality (GRCS-RE) subscale. Machismo and Caballerismo as measured by the two subscales of the 20-item Machismo and Caballerismo Scale.
- Need for culturally relevant support services as measured by the 19-item Critical Race Theory Measurement (CRTM).
- Intention to seek mental health support as measured by the 22-item General Help Seeking Questionnaire-Original Version (GHSQ).

The following hypotheses were tested as part of this study.

1. Mental health symptoms (measured by the MHI-5) will negatively predict the intention to seek mental health support (measured by the GHSQ). Lower mental health scores will be associated with higher intent to seek mental health support.
2. Self-stigma (measured by the SSOSH) will negatively predict the intention to seek mental health support (measured by the GHSQ). Higher scores on the SSOSH indicate a greater concern that seeking help for mental health support will negatively affect one's self-regard, satisfaction with oneself, self-confidence, and overall worth as a person.
3. Attitudes toward mental health support (measured by the ATSPPH-SF) will positively predict the intention to seek help for mental health support (measured by the GHSQ).

Higher scores on the ATSPPH-SF indicate more positive attitudes toward seeking professional help for mental health support.

4. Restrictive Emotionality (measured by the GRCS) will negatively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the GRCS indicate higher levels of gender role conflict with respect to men engaging in help seeking behaviors such as relying on others, asking for help, admitting to a problem, and willingness to express emotions.
5. Machismo (measured by the Machismo subscale) will negatively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the Machismo subscale indicate more aggression, sexism, chauvinism, and hypermasculinity.
6. Caballerismo (measured by the Caballerismo subscale) will positively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the Caballerismo subscale indicate more nurturing, family centered, and chivalrous attitudes.
7. Need for culturally relevant support services (measured by the CRTM) will positively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the Critical Race Theory Measurement (CRTM) indicate less agreement with critical race theory constructs and culturally relevant mental health supports.

Measures

Demographic Questionnaire

The researcher collected standard demographic information, including race/ethnicity, gender identity, age, generation in the United States, and university classification (including year and status at the university—full-time or part-time). Participants were asked to self-report these demographic variables. Demographic information was collected to describe the sample of the study but was not used in the data analysis. Refer to Appendix A.

Mental Health Inventory-5 (MHI-5)

Participants were asked to complete the Mental Health Inventory 5-item survey (MHI-5) developed by Berwick et al. (1991). The MHI-5 was developed from the Mental Health Inventory (MHI) created by Veit and Ware (1983). The original MHI was a 38-item instrument used to assess psychological well-being and distress among the general population (Rivera-Riquelme et al., 2019; Veit & Ware, 1983). The MHI-5 included the 5-items from the original item pool that best reproduced the total score based on the MHI (Rivera-Riquelme et al., 2019). The MHI-5 is comprised of five questions, each with six possible responses, with items 3 and 5 being reverse scored (Yamazaki et al., 2005). In alignment with previous research, the total score was transformed into a variable ranging from 0 (poor mental health) to 100 (good mental health) (Theunissen et al., 2011; Thorsen et al., 2013). Five categories were identified based on the study by Thorsen et al. (2013), and the researcher of the current study assigned the following descriptors to those categories: Excellent, Very Good, Good, Fair, and Poor (Likert, 1932). The MHI-5 provided information regarding participants who may be in need of mental health support, but who have not sought help. The MHI-5 has been tested for both reliability and validity. Internal consistency tests showed high reliability coefficients (.88) and contrast validity was comparable to the General Health Questionnaire (GHQ-12) across various socio-

demographic and economic characteristics for the MHI-5 (McCabe at al., 1996). Refer to Appendix B.

Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF)

The 10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF) was developed by Fischer and Farina (1995). This short form was developed from the 29-item Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale (Fischer & Turner, 1970), the most widely used contemporary assessment of help seeking attitudes (Picco et al., 2016). The short form is a modified inventory that consists of 10 items rated on a 5-point Likert type scale ranging from 1 (disagree) to 4 (agree) with five of the ten items revered scored. High scores reflect a more positive attitudes toward seeking help for mental health support. A total score ranging from 10 – 25 points was considered to reflect more negative attitudes toward mental health support, whereas scores ranging from 26 – 40 reflected more positive attitudes toward mental health support (Fischer & Farina, 1995).

Sample items included, *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*, and *There is something admirable in the attitude of a person who is willing to cope with their conflicts and fears without resorting to professional help*. The latter is an example of an item that was reverse scored. The ATSPPH has been examined for adequate psychometric properties in both Western and Eastern settings (Fischer & Farina, 1995; Mackenzie et al., 2004; Picco et al., 2016). Similarly, the ATSPPH-SF used in the current study has documented psychometric support (Picco et al., 2016). The revised scale strongly correlated with the longer scale (.87), suggesting the two scales are measuring the same construct (Fischer & Farina, 1995; Vogel et al., 2006). The revised short-form scale correlated with a previous study that used professional help seeking as the problem

explored ($r = .39$, $p < 0.001$), and the one-month test–retest (.80) and internal consistency (.84) reliabilities were also adequate (Fischer & Farina, 1995). In the Vogel et al. study, the internal consistency of the measure was .82 (2006). Refer to Appendix C.

Self-Stigma of Seeking Help Scale (SSOSH)

Vogel and colleagues developed this assessment to measure the self-stigma associated with seeking help for mental health support (Porcari et al., 2017; Vogel et al., 2006). Items are rated on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree) with five of the ten items revered scored; higher scores indicate a greater level of mental health stigma.

Sample items included, *I would feel worse about myself if I could not solve my own problems*, and *I would feel okay about myself if I made the choice to seek professional help*, with the latter item being reverse scored. Through a series of five studies, Vogel et al. (2006) found that The Self-Stigma of Seeking Help Scale was correlated with the 29-item Attitudes Toward Seeking Professional Psychological Help (ATSPPH) Scale (.63) and the 17-item Intentions to Seek Counseling Inventory (ISCI) (.38) and distinguished those who had sought psychological services from those who did not across a two-month period.

Vogel et al. (2006) stated that "most studies examining the factors influencing help seeking decisions have used cross-sectional designs and assessed the relationship of a measure with current attitudes, current intentions, or past behavior. Although this is an important step, the true measure of the validity of a self-stigma scale is its ability to predict future help seeking behavior" (p.333). Because the current study utilized intention to seek help as the criterion variable, this assessment was selected with this research aim in mind. Vogel et al. (2006) found that reliability and validity of the SSOSH scale was adequate for research purposes—the scale

exhibited strong internal consistency reliability and good two-month test-retest reliability. In addition, confirmatory factor analyses indicated that a unidimensional factor model provided a good fit for the data utilized in their study (Vogel et al., 2006). Refer to Appendix D.

Gender Role Conflict Scale (GRCS)

In order to assess this variable, the participants were administered the 9-item Gender Role Conflict Scale-Restrictive Emotionality subscale and the 20-item Machismo and Caballerismo Scale. The Gender Role Conflict Scale-Restrictive Emotionality subscale enabled the researcher to collect data related to masculinity and help seeking behavior linked to emotional concerns. The Machismo and Caballerismo scale enabled the researcher to collect data related to Latinx masculinity ideologies specifically.

The specific subscale of the GRCS was obtained from the adapted version by Blazina et al. (2005). These researchers adapted the language of the scale to be more user-friendly for adolescents. For example, one of the items used in the current study was: *When I am personally involved with others, I do not express my strong feelings*. Blazina et al. (2005) substituted *sexually involved* in the original scale for *personally involved* in the scale utilized in the current study. These researchers argued that although male adolescents may be sexually active, retaining the original wording could produce a higher number of missing items and/or socially desirable responses. The researchers also stated that this change in wording was more consistent with the original theme of the Restrictive Emotionality subscale. In their study, Blazina et al. (2005) found that the Restricted Emotionality subscale was the most consistent factor correlated with their measure of psychological distress (Conners-Wells' Adolescent Self-Report Scale-CASS). The two-week test-retest reliability coefficients were assessed for the Restrictive Emotionality scale (r = .87). (Blazina et al., 2005).

The 9-item Gender Role Conflict Scale-Restrictive Emotionality subscale enabled the researcher to examine the role of gender role conflict (GRC) in help seeking attitudes (Berger et al., 2005; Davis & Liang, 2015). This subscale was adapted from the original GRCS, which was created by O'Neil et al. (1986). The GRCS consists of 37 statements that participants rate on a Likert-type scale from 1 (*strongly agree*) to 6 (*strongly disagree*). The four factors assessed by the scale are: Success, Power, and Competition (SPC); Restrictive Emotionality (RE); Restrictive Affectionate Behavior Between Men (RABBM); and Conflict Between Work and Family Relationships (CBWFR). Subscale scores can be obtained by averaging the items; scores range from 1 to 6; higher scores indicate higher levels of gender role conflict. (Berger et al., 2005). Good validity and reliability have been widely reported for this often used scale (Blazina et al., 2005). Refer to Appendix E.

Machismo and Caballerismo Scale

The 20-item Machismo and Caballerismo Scale is a shortened version of a longer scale that was created by Arciniega et al. (2008). These researchers describe, in detail, their process for shortening the scale to 20 items, while still ensuring the existence of two factors: *Machismo* and *Caballerismo*:

> For a simpler, shorter measure, the best 10 items for each factor with empirical characteristics were retained. Items were selected with the two criteria of (a) highest loading items on each factor and (b) greater loading than |.30| on only one factor. The resulting 20 items were subjected to an identical exploratory principal axis factor analysis. The eigenvalues for the first 5 factors extracted were 4.3, 3.1, 0.77, 0.61, and 0.54, again clearly supporting the presence of two factors, as expected (Arciniega et al., 2008, p. 23).

Factor 1 was called *Traditional Machismo* because it fit with the definition of previous literature—hypermasculinity and power. Factor 2 was identified as *Caballerismo* because it fit the definition of previous literature—emotional connectedness, honor, nurturance (Arciniega et al., 2008). The Traditional *Machismo* subscale contained items regarding culturally reinforced expected male and female roles in Latinx cultures (e.g., *a man should be in control of his wife*; *the bills should be in the man's name*; *it is important for women to be beautiful*). The *Caballerismo* subscale contained questions regarding men's responsibilities to their family and society in general (e.g., *men should be willing to fight to defend their family*; *men should be affectionate with their children*; *men must display good manners in public*) (Arciniega et al., 2008; Gonzalez-Guarda et al., 2016). Ten of the items correspond to *machismo* (Items 1, 3, 6, 8, 9, 11, 13, 14, 16, 18), and ten of the items correspond to *caballerismo* (Items 2, 4, 5, 7, 10, 12, 15, 17, 19, 20) (Arciniega et al., 2008).

The internal consistency for *Traditional Machismo* was .85; the internal consistency for *Caballerismo* was .80. The shortened scales correlated highly with the scales derived from the original factor analysis, *Traditional Machismo* (r = .94) and *Caballerismo* (r = .93), and they also correlated highly with the expert ratings of *Traditional Machismo* (r = .83) and *Caballerismo* (r = .79), thereby supporting the construct validity of the shortened scale. Refer to Appendix F.

Critical Race Theory Measurement (CRTM)

In order to assess this variable, the researcher used the Critical Race Theory Measurement (CRTM) developed by Campbell (2014). The CRTM consists of a 19-item scale measuring the six aspects of Critical Race Theory. The measurement uses a 6-point Likert scale (1 = strongly disagree to 6 = strongly agree). In the previous study, participants who scored

lower on this scale had a higher understanding of CRT, while participants who scored higher on this scale have a lower understanding of CRT. Seven items (items: 5, 10, 12, 13, 14, 15, and 16) were reversed scored for reliability purposes (Campbell, 2014). Campbell (2014) did not report on means from their study, so the scoring was kept the same in the present study.

Campbell, the scholar who developed the CRTM, conducted a pilot study at a public historically black university (HBCU) in the Southeast to evaluate the inter-rater reliability and internal consistency reliability of the measurement. Faculty from departments that study critical race theory were used to evaluate the inter-rater reliability of the instrument. These departments included Women's and Gender Studies, Social Work, Counseling Psychology, and Black Studies. Internal consistency reliability was evaluated using matric correlations of each of the six constructs of CRT: endemic racism, social construction of race, differential racialization, convergence/determinism, racial narratives, and intersectionality. In addition, face validity and construct validity were used to evaluate the validity of the CRTM. Faculty members with expertise and knowledge of critical race theory assessed each item and provided feedback as needed to ensure each item measured the intended construct (Campbell, 2014). Refer to Appendix G.

General Help Seeking Questionnaire-Original Version (GHSQ)

In order to assess the dependent (criterion) variable, the researcher used a modified version of the General Help seeking Questionnaire-Original Version (GHSQ). The GHSQ was originally developed by Deane et al. (2001) to assess formal help seeking intentions for non-suicidal and suicidal problems. On the original version, participants were asked to rate the likelihood they would seek help from a variety of sources for three types of problems: personal-emotional, anxiety-depression, and suicidal thoughts. For each problem, respondents were asked

to rate the likelihood they would receive help on a Likert-type scale as follows: 1 = extremely unlikely to 7 = extremely likely. Higher scores indicated higher intentions to seek help (Deane et al., 2001; Deane et al., 2002).

The GHSQ has been shown to have adequate reliability and validly and provides a flexible measure of help seeking intention that can be applied to a range of contexts. Wilson, et al. (2005) analyzed the two scales as follows: suicidal problems (Cronbach's alpha = .83; test-retest reliability assessed over a three-week period = .88); personal-emotional problems (Cronbach's alpha = .70; test-retest reliability assessed over a three-week period = .86). Reliability was also best if all response items were included. Several studies have used a single response item, which created problems with reliability. As such, the current study used all response items. In addition, it is important to note the threat to construct validity given the lack of a comprehensive definition of help seeking intention. Convergent and divergent validity were supported by positive correlations found between participants' intention to seek counseling and the perceived quality of previous experience with a mental health professional, and by a negative correlation between the participants' intentions to seek counseling and their self-reported barriers to seeking professional mental health help (Wilson et al., 2005). Refer to Appendix H.

Procedures

Recruitment for the present study occurred from July 13, 2022 through September 12, 2022 via electronic mail (email). Participants for the present study were undergraduate students attending a large southwest public university. Participants were recruited using several student centers on campus as follows: Thrive Center (supports first-generation students, immigrant students, TRIO—SSS participants, and transfer students), Guerrero Center (support services for Latinx/Latine students), and Hispanic Serving Institution Initiatives (HSI) as well as select

courses, including UNIV 101 (introduction to the general education experience), PSY 150A1 (the structure of mind and behavior), SERP 525 (counseling theory), and SERP 585 (career and vocational planning). Email announcements included who was eligible to participate in addition to information about the purpose of the study, encouragement to share the study with others, and incentives for students who chose to participate. The incentives offered were the chance to win 1 of 5 $50 Amazon gift cards. The email announcements also provided students with an online link to the Qualtrics study. Permission to conduct this study was granted through an application to the Institutional Review Board (IRB); therefore, once students navigated to the Qualtrics page, they were able to read the Informed Consent information which detailed the purpose of the study, provided information about their rights as participants, and their option to join the lottery to win an Amazon gift card. Participants were instructed that by clicking the "I Agree" button at the bottom of the Informed Consent page, they were giving their consent to participate in the study.

Once participants agreed to consent, they were directed to the official survey. The questionnaires that formed the official survey for the study were presented in the following order: the 7-item Demographic Questionnaire, the 5-item Mental Health Inventory-5 (MHI-5), the 10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF), the 10-Item Self-Stigma of Seeking Help Scale (SSOSH), the 9-item Gender Role Conflict Scale-Restrictive Emotionality subscale, the 20-item Machismo and Caballerismo Scale, the 19-item Critical Race Theory Measurement (CRTM), and the 22-item General Help seeking Questionnaire-Original Version (GHSQ). The order of the assessments enabled participants to think first internally then more broadly.

Upon completion of the survey, participants' responses were kept securely on Qualtrics; only the researcher had access to the results. Accessing the completed data required the

researcher to log into Qualtrics using their official university login and password; the university utilizes Duo Mobile to ensure appropriate security measures are utilized. Once participants submitted their responses, they were taken to a debriefing page, which reiterated the purpose and implications of the study and explained the lottery process.

Once the data collection time period had elapsed, the data were downloaded as a password-protected Excel file and then imported into SPSS for data cleaning. Data cleaning consisted of assigning meaningful variable names to the study variables, reverse coding certain items on the various instruments that required it, measuring the reliability of each construct by calculating Cronbach's alpha and forming the constructs by combining the items on each instrument by summing the responses. Once this was completed, frequencies and percentages were generated for the categorical demographic variables, and means and standard deviations were generated for each variable measured at the interval level of measurement.

Sample

The participants for this study were a convenience sample of 87 undergraduate college students who self-identified as *Latinx* and *male*. Latinx is used as a pan-ethnic term in the current study, but participants were asked to identify their preferred term (See Appendix A). Participants who did not identify as *Latinx* or *male* were excluded from the study. Participants were recruited from a large Hispanic-Serving Institution (HSI) in the U.S. Southwest region. The most frequent age range of the participants was 18 – 22, 79 (90.8%). Latinx is used as a pan-ethnic term in the current study, and thus participants were asked to identify their preferred racial and ethnic term (See Appendix A). Participants could select more than one category. The participants identified with the terms Chicano/Chicana (71; 81.6%); Hispanic (41; 47.1%); Latino/Latina (43; 49.4 %); Xicano/Xicana (24; 27.6%); Latine (6; 6.9%), and Latinx (6; 6.9%). In addition, 28 (32.2%)

participants identified with their Country of Origin, which was predominantly Mexican or Mexico. Regarding generational status in the United States, 60 (69.0%) were first-generation, 21 (24.1%) were second-generation, and 6 (6.9%) were third-generation. Regarding class standing, 20 (23.0%) were freshman, 22 (25.3%) were sophomores, 19 (21.8%) were juniors, and 26 (29.9%) were seniors. Regarding enrollment, 80 (92/0%) were enrolled full-time and seven (8.0%) were enrolled part-time.

Data Analysis

SPSS data analysis software was used to analyze the primary research. Preliminary analyses were performed to obtain descriptive statistics for all demographic variables and scales. The present study utilized a correlational research design using multiple regression analysis. Multiple regression is an analytic method commonly applied in behavioral sciences because it can be used to examine the individual and collective contributions of one or more predictor variables to the variation of a dependent or criterion variable (Efroymson, 1960; Kelley & Bolin, 2013; Wampold & Freund, 1987). In traditional multiple regression, the contributions of all predictor variables are considered simultaneously. However, it can be beneficial to examine sets of predictors in a predetermined order that is conceptually driven (Kelley & Bolin, 2013). As such, a sub-strategy of multiple regression is hierarchical linear models (HLM), whereby predictor variables are added using a predetermined order based on a rationale established by the researcher (Kelley & Bolin, 2013; Wampold & Freund, 1987).

Before conducing the hierarchical regression analysis, the researcher examined the relationships between the predictor variables: mental health symptoms, stigma toward help seeking for mental health support, masculinity ideologies (*restrictive emotionality*, *machismo,* and *caballerismo*), and importance of applying culturally relevant support services (using critical

race theory) in mental help supports. The researcher's aim was to examine the bi-variate relationships among the predictor variables to help understand the results of the hierarchical regression (Allen, 2017). In addition, bivariate correlations can unveil multicollinearity—correlations among predictor variables, which can have adverse effects on the accuracy of regression computations (Pedhazur, 1997).

In hierarchical regression, richer steps—those with new predictors—are compared to the simpler steps with fewer predictor variable (Kelley & Bolin, 2013). The current study sought to understand the impact of several predictor variables: mental health symptoms, stigma toward help seeking for mental health support (*attitudes* and *self-stigma*), masculinity ideologies (*restrictive emotionality*, *machismo,* and *caballerismo*), and importance of applying culturally relevant support services (using critical race theory) in mental help supports. As such, the current study used hierarchical regression (Kelley & Bolin, 2013; Wampold & Freund, 1987).

In the present study, the criterion variable in the regression analysis was intention to seek help for mental health support as measured by the 22-item General Help seeking Questionnaire-Original Version (GHSQ). In an effort to explain the degree to which the predictor variables predicted intention to seek help for mental health support, a series of four regression steps were completed as follows:

Step 1: Mental Health Symptoms

In Step 1, the following predictor variable was entered: (a) mental health symptoms as measured by the Mental Health Inventory-5 (MHI-5). In hierarchical regression models, there are often predictor variables that the researcher would like to control for (control variables) before assessing predictor variables of primary importance (Kelley & Bolin, 2013). Mental health symptoms served as a control variable.

Step 2: Mental Health Stigma

In Step 2, the following two mental health stigma predictor variables were entered: (b) self-stigma and (c) attitudes toward help seeking. Self-stigma was measured by the 10-Item Self-Stigma of Seeking Help Scale (SSOSH) and attitudes toward help seeking was measured by the 10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF). Research has identified links between the ability to screen for mental health symptoms and treatment and intervention outcomes (Aguirre Velasco et al., 2020; Deane et al., 2002; Rivera-Riguelme et al., 2019; Theunissen et al., 2011). In addition, attitudes toward help seeking for mental health support and stigma toward help seeking for mental health support are inextricable linked (Aguirre Velasco et al., 2020; Cabassa, 2007; Davis et al., 2015; Picco et al., 2016; Porcari et al., 2017; Zack Ishikawa, 2010).

Step 3: Masculinity Ideologies

In Step 3, the following three predictor variables related to masculinity ideologies were entered: (d) *restrictive emotionality*, (e) *machismo*, and (f) *caballerismo*. Restrictive emotionality was measured by the 9-item Gender Role Conflict Scale-Restrictive Emotionality subscale. Machismo and Caballerismo were measured by the two subscales of the 20-item Machismo and Caballerismo Scale. Research has identified the links between mental health beliefs, masculinity, and the intention to seek help for mental health support (Arciniega et al., 2008; Berger et al., 2005; Cole & Ingram, 2020; Davis & Liang, 2015).

Step 4: Critical Race Theory

In Step 4, the following predictor variable was entered: (g) importance of applying culturally relevant support services (using critical race theory) in mental help supports as measured by the 19-item Critical Race Theory Measurement (CRTM). The last step in a

hierarchical regression analysis typically includes variables that the researcher is most interested in exploring. The predictor variable—importance of applying critical race theory constructs in mental help supports —is unique to the present study. Comparing Step 4 to the subsequent steps provided the researcher with information about how much variance this particular predictor variable accounted for beyond the variables added in previous steps.

Conclusion

Chapter III provided a description of the research design and assessments that were used to examine the relationship between the predictor variables—mental health symptoms, stigma toward help seeking for mental health support (*attitudes* and *self-stigma*), masculinity ideologies (*restrictive emotionality*, *machismo,* and *caballerismo*), and importance of applying culturally relevant support services (using critical race theory) in mental help supports—and the criterion variable—intention of young adult Latinx male college students to seek help for mental health support. This section included a description of the independent and dependent variables and the rationale for the chosen assessments. Chapter IV will present the results of the data collection for the current study.

CHAPTER IV

RESULTS

The purpose of this study was to explore the intent of Latinx male college students to seek mental health support on a college campus. To achieve this purpose, the following research question was examined:

> *To what extent does mental health stigma, masculinity ideologies, and culturally relevant support services predict the intention of Latinx male college students to seek mental health support?*

The following hypotheses were tested by conducting hierarchical regression with SPSS software:

1. Mental health (measured by the MHI-5) will positively predict the intention to seek mental health support (measured by the 22-item General Help Seeking Questionnaire or GHSQ).
2. Self-stigma (measured by the SSOSH) will negatively predict the intention to seek mental health support (measured by the GHSQ).
3. Attitudes toward mental health support (measured by the ATSPPH-SF) will positively predict the intention to seek help for mental health support (measured by the GHSQ).
4. Restrictive Emotionality (measured by the GRCS-RE) will negatively predict the intention to seek help for mental health support (measured by the GHSQ).
5. Machismo (measured by the *machismo* subscale) will negatively predict the intention to seek help for mental health support (measured by the GHSQ).
6. Caballerismo (measured by the *caballerismo* subscale) will positively predict the intention to seek help for mental health support (measured by the GHSQ).

7. The need for culturally relevant support services (measured by the Critical Race Theory Measurement) will positively predict the intention to seek help for mental health support (measured by the GHSQ).

In this chapter, the results of the study are presented, including frequencies and percentages for categorical variables and means and standard deviations for continuous variables. The testing of parametric assumptions for the statistical analysis is presented along with the results of the hierarchical regression model for each of the research hypotheses. Finally, this chapter concludes with a discussion of the results.

Description of the Sample

The participants for this study were a convenience sample of undergraduate college students who self-identified as Latinx and male ($N = 87$). All of participants identified as Latinx and male and were enrolled at a large Hispanic-Serving Institution (HSI) in the U.S. Southwest region. Latinx is used as a pan-ethnic term in the current study, and thus participants were asked to identify their preferred racial and ethnic term (See Appendix A). Participants could select more than one category. The participants identified with the terms Chicano/Chicana (71; 81.6%); Hispanic (41; 47.1%); Latino/Latina (43; 49.4 %); Xicano/Xicana (24; 27.6%); Latine (6; 6.9%), and Latinx (6; 6.9%). In addition, 28 (32.2%) participants identified with their Country of Origin, which was predominantly Mexican or Mexico. Table 1 depicts this information.

Table 1. *Participant Preferred Terminology*

Terminology	*F*	*%*
Chicano/Chicana	71	81.6
Latino/Latina	43	49.4
Hispanic	41	47.1
Xicano/Xicana	24	27.6
Latine	6	6.9
Latinx	6	6.9
Country of Origin (Write-In)	28	32.2

Mexican/Mexico	25	28.7
Peruvian	1	1.1

The most frequent age range of the participants was 18 – 22, 79 (90.8%). Regarding generational status in the United States, 60 (69.0%) were first-generation, 21 (24.1%) were second-generation, and 6 (6.9%) were third-generation. Regarding class standing, 20 (23.0%) were freshman, 22 (25.3%) were sophomores, 19 (21.8%) were juniors, and 26 (29.9%) were seniors. Regarding enrollment, 80 (92/0%) were enrolled full-time and seven (8.0%) were enrolled part-time. Table 2 depicts this information.

Table 2. *Demographics of Sample*

Demographic	*f*	*%*
Age		
18-22	79	90.8
23-29	7	8.0
30+	1	1.1
Generational status		
First generational	60	69.0
Second generational	21	24.1
Third generational	6	6.9
Class standing		
Freshman	20	23.0
Sophomore	22	25.3
Junior	19	21.8
Senior	26	29.9
Enrollment		
Full-time	80	92.0
Part-time	7	8.0

Descriptive Statistics of Study Measure

The reliability of each construct was measured by calculating Cronbach's alphas (α). A generally accepted rule is that α of 0.6-0.7 indicates an acceptable level of reliability, and 0.8 or greater is considered a good level (Šerbetar & Sedlar, 2016). Reliability statistics for all of measures used in the study were either acceptable or good reliability ranging from 0.727 to 0.919 (Table 3). Additionally, Tables 4 through 10 provide reliability measures for each separate item that comprise the construct.

Table 3. *Reliability of Study Measures*

Measure	#Items	Cronbach's Alpha
Mental health	5	.790
Stigma of Seeking Help Scale (SSOSH)	10	.759
Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF)	10	.811
Gender Role Conflict Scale-Restrictive Emotionality	9	.919
Machismo Scale	10	.850
Caballerismo Scale	10	.768
Critical Race Theory Measurement (CRTM)	19	.727
General Help seeking Questionnaire (GHSQ)	22	.897
Intent to Seek Help (Suicidal)	11	.894
Intent to Seek Help (Personal)	11	.711

Table 4. *Mental Health Inventory-5*

Item	Reliability
Been a nervous person?	.802
Felt calm and peaceful?	.752
Been a happy person?	.750
Felt so down in the dumps that nothing could cheer you up?	.736
Felt downhearted and blue?	.730

Table 5. *Attitudes Toward Seeking Professional Psychological Help-Short Form*

Item	Reliability

Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	.778
There is something admirable in the attitude of a person who is willing to cope with their conflicts and fears without resorting to professional help.	.776
If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	.757
A person with an emotional problem is not likely to solve it alone; they are likely to solve it with professional help.	.756
I might want to have psychological counseling in the future.	.752
Personal and emotional troubles, like many things, tend to work out by themselves.	.745
I would want to get psychological help if I were worried or upset for a long period of time.	.737
A person should work out their own problems; getting psychological counseling would be a last resort.	.737
The idea of talking about problems with a counselor strikes me as a poor way to get rid of emotional conflicts.	.727
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.	.725

Table 6. *Self-Stigma of Seeking Help Scale*

Item	Reliability
My self-esteem would increase if I talked to a therapist.	.824
My view of myself would not change just because I made the choice to see a therapist.	.811
I would feel inadequate if I went to a therapist for psychological help.	.801
My self-confidence would NOT be threatened if I sought professional help.	.798
My self-confidence would remain the same if I sought help for a problem I could not solve.	.797
I would feel worse about myself if I could not solve my own problems.	.796
I would feel okay about myself if I made the choice to seek professional help.	.789
Seeking psychological help would make me feel less intelligent.	.780
If I went to a therapist, I would be less satisfied with myself.	.770
It would make me feel inferior to ask a therapist for help.	.769

Table 7. *Gender Role Conflict Scale-Restrictive Emotionality*

Item	Reliability

Strong emotions are difficult for me to understand.	.922
I often have trouble finding words that describe how I am feeling.	.917
I have difficulty telling others I care about them.	.910
Expressing feelings makes me feel open to attack by other people.	.910
When I am personally involved with others, I do not express my strong feelings.	.908
It's hard for me to talk about my feelings with others.	.906
I do not like to show my emotions to other people.	.906
It's hard for me to express my emotional needs to others.	.904
Telling others about my strong feelings is difficult to me.	.901

Table 8. *Machismo Subscale*

Item	Reliability
It is necessary to fight when challenged.	.851
The birth of a male child is more important than a female child.	.842
It would be shameful for a man to cry in front of his children.	.840
It is important not to be the weakest man in a group.	.838
Men are superior to women.	.833
A man should be in control of his wife.	.832
It is important for women to be beautiful.	.831
In a family, a father's wish is law.	.830
Real men never let down their guard.	.830
The bills (electric, phone, etc.) should be in the man's name.	.828

Table 9. *Caballerismo Subscale*

Item	Reliability
Men should be affectionate with their children.	.767
A real man does not brag about sex.	.764
Men hold their mothers in high regard.	.757
Men must exhibit fairness in all situations.	.753
The family is more important than the individual.	.751
Men want their children to have better lives than themselves.	.748
Men should respect their elders.	.746
A woman is expected to be loyal to her husband.	.743
Men should be willing to fight to defend their family.	.728
Men must display good manners in public.	.727

Table 10. *Critical Race Theory Measurement (CRTM)*

Item	Reliability
A mental health professional should often modify or change interventions to capture better and understand experiences of marginalized clients.	.762
"Otherness" results in a group's decision/power to separate or distance themselves from the dominant group.	.744
Race is significant in determining who will become successful and who will not.	.740
A mental health professional should allow the client time to digress on their concerns, while the mental health professional takes the role of the listener.	.736
It is more effective for a mental health professional to focus and identify the most oppressive personal identity (e.g., race, ethnicity, sexuality, class, gender), in order to determine the best intervention.	.729
When interacting with new people, the first thing I notice is one's race/ethnicity.	.728
Race exists as a social construct.	.721
A major component of any intervention should be providing a space for the client to voice their personal story.	.714
It is important for people to think of themselves as American & not Latinx-American, African American, Asian American etc.	.712
Race/ethnicity is the most effective way to categorize people.	.712
Race biologically determines one's personalities and abilities.	.709
Discussing issues of race causes unnecessary conflict and anger.	.708
It is time consuming to address clients social locations (e.g., race, ethnicity, sexuality, class, gender, etc.); therefore, it is more effective to focus on one.	.707
Regardless of race/ethnicity, people who work hard have an equal chance of becoming wealthy and successful.	.689
Race/ethnicity determines the type of services and opportunities people receive in the U.S.	.697
Racial incidents are rare and isolated in the U.S.	.692
History continues to exclude narratives and perspectives from racial/ethnic minoritized people.	.692
Racial/ethnic minoritized people should try to fit into the dominant cultural & adapt the values of the U.S.	.691
Racial/ethnic minoritized people do not have the same opportunities as White people in the U.S.	.687

The reliability of the study measures is based on how well the individual items relate to the overall mean score. The mean score was calculated by summing the individual items for each study measure. This process was completed for the 5-item Mental Health Inventory-5 (MHI-5),

the 10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF), the 10-Item Self-Stigma of Seeking Help Scale (SSOSH), the 9-item Gender Role Conflict Scale-Restrictive Emotionality subscale, the 20-item Machismo and Caballerismo Scale, the 19-item Critical Race Theory Measurement (CRTM), the 22-item General Help seeking Questionnaire-Original Version (GHSQ), and the 7-item Demographic Questionnaire. The minimum, maximum, mean (*M*), and standard deviations (*SD*) are provided in Table 11.

The only study measure that required a transformation in the total scores was the MHI-5, which is comprised of five questions with six possible responses (Yamazaki et al., 2005). The summed total score ranged from 11 to 30 ($M = 20.82$, $SD = 4.52$). Consistent with previous research, the total score was transformed into a variable ranging from 0 (poor mental health) to 100 (good mental health) (Theunissen et al., 2011; Thorsen et al., 2013). The transformed score ranged from 24 to 100 with a mean of $M = 63.26$ ($SD = 18.06$). Based on previous research, a mean score of 63.26 is considered "fair," with the scores under 60 characterized as "poor" (Theunissen et al., 2011; Thorsen et al., 2013). Overall, the average mental health score of participants in the present study was only slightly above the lowest rating of poor based on the following criteria:

- Excellent: 91 – 100
- Very Good: 81 – 90
- Good: 71 – 80
- Fair: 61 – 70
- Poor: < 60

Table 11 provides the means and standard deviation for the predictor variables.

Table 11. *Descriptive Statistics of Study Measures*

	Minimum	Maximum	*M*	*SD*
Mental Health*	11.00	30.00	20.82	4.52
Stigma1_ATSPPHSF	11.00	39.00	24.78	5.53

Stigma2_SSOSH	11.00	40.00	25.85	6.37
Gender Roles	9.00	54.00	35.25	11.23
Machismo	10.00	56.00	29.83	10.64
Caballerismo	40.00	70.00	56.94	7.86
Culturally Relevant Support	36.00	83.00	56.94	10.37
Intention Seek Help	33.00	140.00	67.21	16.77

*After transformation to a 0-100 scale, mental health ranged from 24 to 100 with a mean of M = 63.26 (SD = 18.06).

The means and standard deviation for the criterion or outcome variable of the GHSQ (intention to seek help for personal and suicidal reasons) is listed in Tables 12 and 13. On the GHSQ, participants were asked to rate the likelihood they would seek help from a variety of sources for two types of problems: (1) personal-emotional and (2) suicidal ideation. Consistent with previous research, the two types of problems were combined into a total score on the GHSQ in this study (Deane et al., 2001; Deane et al., 2002; Wilson et al., 2005). In addition, it is useful to report similarities and differences in the descriptive statistics of the two types of problems.

For each problem, respondents were asked to rate the likelihood they would receive help on a Likert-type scale as follows: (1) extremely unlikely, (3) unlikely, (5) likely, and (7) extremely likely. Across the two problems, only two individual items had a mean above 5.0 or "likely" to seek support from this source. The two items were intent to seek help for suicidal ideation from an "intimate partner" (M = 5.97, SE = .13) or "friend" (M = 5.26, SE = .21). All of the rest of the items across both scales was below a score of "likely" and approaching "extremely unlikely" in many cases. Scores approaching "extremely unlikely" were most evident for seeking support for problems with personal and emotional problems from an intimate partner (M = 2.30, SE = .17) and from a mental health professional (M = 2.20, SE = .19). In fact, for a personal-emotional problem, the highest mean or greatest intent was through someone else not listed (M = 4.31, SE = .57) (Table 13). Participants in the present study were most likely to seek help from

someone not listed on the GHSQ for personal and emotional problems (Table 14 contains a list of other sources of support). One of the most common write-in responses was "counselor," suggesting that participants differed a "mental health professional" from a counselor, even though a counselor was listed within the category of mental health professional.

Table 12. *Intent to Seek Help (Dependent Variable: Suicidal Ideation)*

	M	*SE*
• Intimate partner (e.g., girlfriend, boyfriend, spouse, significant other)	5.97	.13
• Friend (not related to you)	5.26	.21
• Mental health professional (e.g., counselor, psychiatrist, psychologist, counselor, social worker)	4.70	.21
• Parent	4.69	.19
• I would seek help from another not listed above (please list in the space provided (e.g., work colleague. If no, leave blank): _____	4.60	.23
• Phone helpline (e.g., Lifeline)	4.37	.25
• Other relative/Family member	4.21	.23
• Doctor/General practitioner	3.77	.20
• I would not seek help from anyone	3.72	.21
• Religious leader (e.g., Minister, Priest, Rabbi, Imam, Chaplain)	3.30	.22

Table 13. *Intent to Seek Help (Dependent Variable: Personal-Emotional Problem)*

	M	*SE*
• I would seek help from another not listed above (please list in the space provided (e.g., work colleague. If no, leave blank): _____	4.31	.57
• I would not seek help from anyone	3.82	.48
• Doctor/General practitioner	3.71	.22
• Friend (not related to you)	3.35	.23
• Other relative/Family member	3.24	.21
• Religious leader (e.g., Minister, Priest, Rabbi, Imam, Chaplain)	3.09	.23
• Parent	2.88	.19
• Phone helpline (e.g., Lifeline)	2.32	.21

• Intimate partner (e.g., girlfriend, boyfriend, spouse, significant other)	2.30	.17
• Mental health professional (e.g., counselor, psychiatrist, psychologist, counselor, social worker)	2.20	.19

Table 14. *Intent to Seek Help-Another Source Not Listed*

Source (written in)	Intent to Seek Help (Dependent Variable: Suicidal Ideation) Raw Score	Intent to Seek Help (Dependent Variable: Personal-Emotional Problem) Raw Score
Mentor	7	7
Counselor	7	6
ASSIST Coach	7	2
School Services	5	4
Strangers	4	5
Coworker	3	5
Mejor amigo (*best friend*)	3	3

GHSQ scoring: 1 = extremely unlikely, 3 = unlikely, 5 = likely, and 7 = extremely likely.

Bivariate Correlations

Bivariate correlations were examined between the study variables. The Pearson correlation was used to determine the strength and direction of a linear relationship between two continuous variables. More specifically, the Pearson correlation generated a coefficient to measure the strength and direction of the linear relationship between the study variables. The value ranged from -1 for a perfect negative linear relationship to +1 for a perfect positive linear relationship. A value of 0 (zero) indicated no statistically significant relationship between two variables (Field, 2018). Table 15 below provides these correlations. There was a significant positive correlation between attitudes toward mental health support (measured by the ATSPPH-SF) and intention to seek help ($r = .260$, $p = .016$). There were no other significant correlations ($p > .05$).

Table 15. *Pearson Correlations*

	1	2	3	4	5	6	7	8

Intention Seek Help (1)	*r*	1						
Mental Health (2)	*r*	.145	1					
	p	.183						
Stigma1_ATSPPHSF (3)	*r*	.260*	-.059	1				
	p	.016	.585					
Stigma2_SSOSH (4)	*r*	-.124	-.168	-.479	1			
	p	.256	.120	.000				
Gender Roles (5)	*r*	-.166	-.381	-.196	.436	1		
	p	.127	.000	.068	.000			
Machismo (6)	*r*	.015	-.064	-.420	.319	-.008	1	
	p	.791	.555	.000	.003	.941		
Caballerismo (7)	*r*	.020	.217	-.207	.112	-.047	.393	1
	p	.996	.044	.055	.303	.668	.000	
Culturally Relevant Support (8)	*r*	.036	-.007	-.266	.204	.022	.514	.249
	p	.740	.949	.013	.058	.843	.000	.020

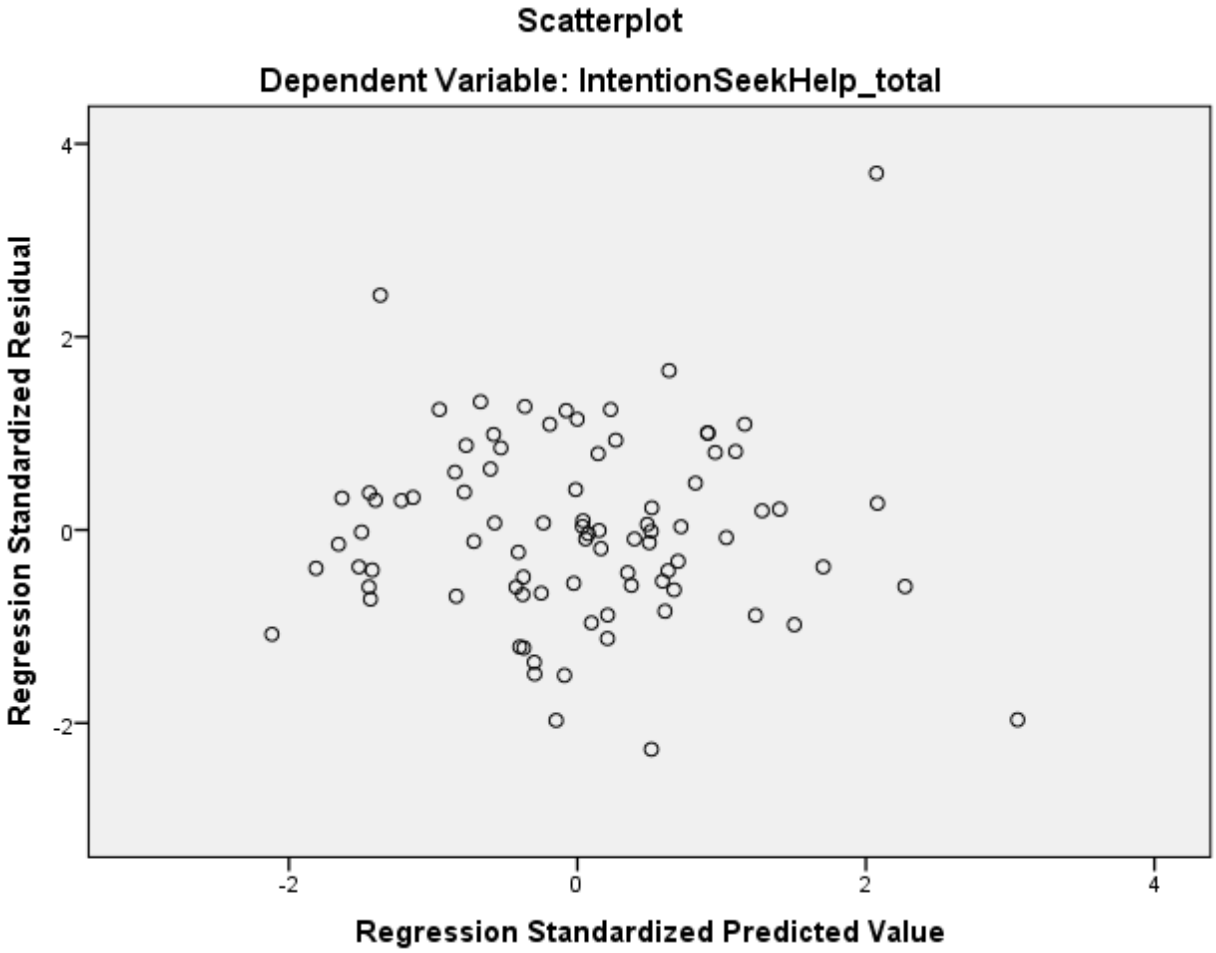
Testing of Parametric Assumptions

Prior to conducting hierarchical multiple regression, parametric assumptions were tested (Field, 2018). These assumptions included linearity, homoscedasticity, independence of residuals, multicollinearity, outliers, and normality of regression residuals.

Linearity and Homoscedasticity

The assumption of linearity refers to a relationship between the predictor and criterion variables that can be described mathematically and represented visually as a straight line. In addition, homoscedasticity is the assumption that the residuals at each level of the predictor variable(s) have similar variances. In the present study, assumptions of linearity and homoscedasticity were assessed by a plot of standardized residuals against the predicted values. The plot showed no apparent pattern, and the data points were approximately randomly spread indicating no violation of these assumptions (Field, 2018).

Figure 1. *Scatter Plot of Standardized Predicted Versus Regression Residuals*

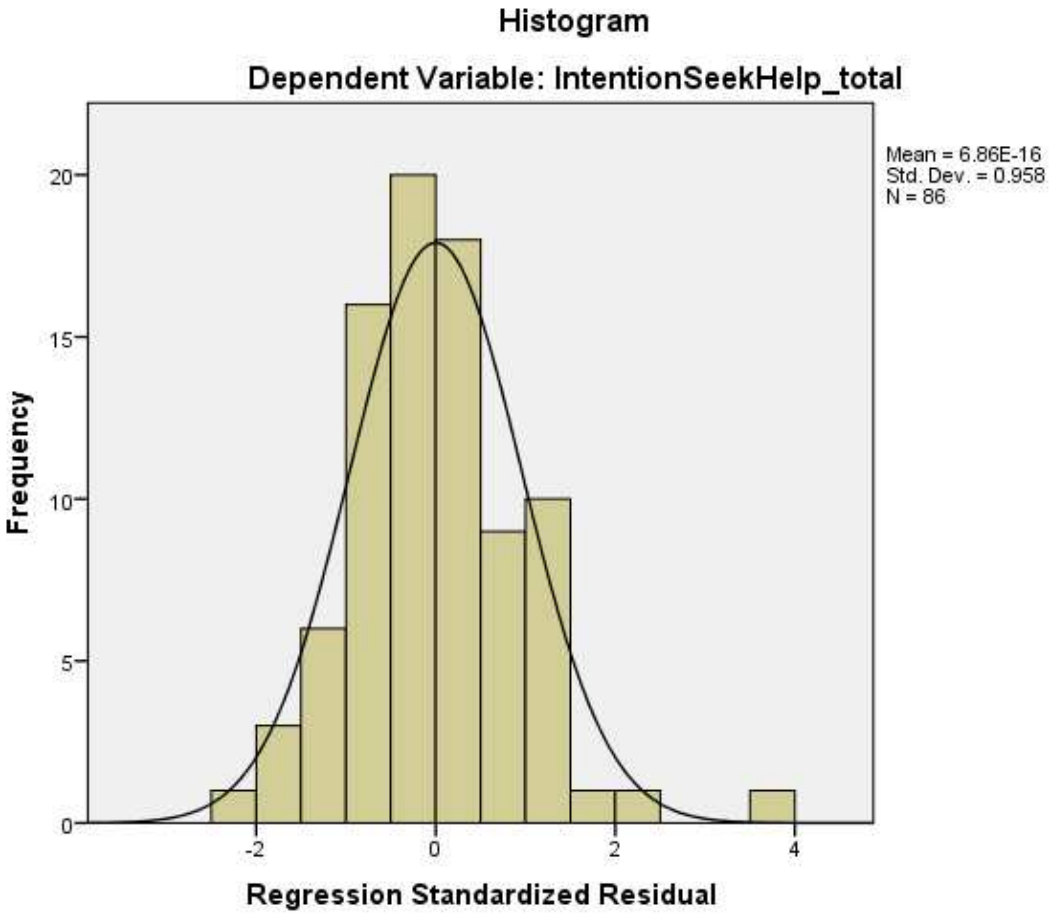


Independence and Normality of the Residuals

Independence of residuals refers to the assumption that predictors are independent from one another and observed with little error (Field, 2018). Independence of residuals was assessed by a Durbin-Watson statistic of 1.838. The independent of residuals as in an acceptable range from 1.5 to 2.5 (Field, 2018). In addition, multicollinearity refers to a situation where two or more variables are closely and linearly related (Field, 2018). In the present study, there was no evidence of multicollinearity, as assessed by variance inflation factors (VIFs) of less than 10. There were no standardized residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. Furthermore, estimates of parameters

can be affected by non-normal distributions (e.g., distributions with outliers) (Field, 2018). In the present study, the assumption of normality was met, as assessed reflected in the histogram of regression residuals (Figure 2).

Figure 2. *Histogram of Regression Residuals*



Results of Hierarchical Regression

Hierarchical regression was conducted with SPSS in order to address the following research question:

> *To what extent does mental health stigma, masculinity ideologies, and culturally relevant support services predict the intention of Latinx male college students to seek mental health support?*

As part of the hierarchical regression, the predictor variables were entered separately into steps into the SPSS regression procedure. The first step consisted of the mental health symptoms variable. The second step consisted of the two mental health stigma predictor variables: (b) self-stigma and (c) attitudes toward help-seeking. The third step consisted of three predictor variables related to masculinity ideologies, entered as follows: gender role, machismo, and caballerismo. The fourth step consisted of the importance of applying the culturally relevant support services (using critical race theory) variable. Lastly, the dependent variable of intention to seek help was entered. The model summary is below in Table 16. The corresponding R^2, standard errors, R^2 change, and significance of the change are shown.

Table 16. *Model Summary*

Step	*r*	R^2	Adjusted R^2	*SE*	Change Statistics					Durbin-Watson
					R^2 Change	*F* Change	df1	df2	*p*-value *F*-Change	
1	.145[a]	.021	.009	16.69155	.021	1.806	1	84	.183	
2	.308[b]	.095	.062	16.24520	.074	3.340	2	82	.040	
3	.365[c]	.133	.067	16.19467	.039	1.171	3	79	.326	
4	.369[d]	.136	.059	16.26973	.003	.273	1	78	.603	1.818

a. Predictors: (Constant), Mental Health
b. Predictors: (Constant), Mental Health, ATSPPHSF, SSOSH
c. Predictors: (Constant), Mental Health, ATSPPHSF, SSOSH, Caballerismo, Gender Roles, Machismo
d. Predictors: (Constant), Mental Health, ATSPPHSF, SSOSH, Caballerismo, Gender Roles, Machismo, Culturally Relevant Support
e. Dependent Variable: Intention to Seek Help

H1: Mental Health Symptoms and Intention to Seek Mental Health Support

The results of this study failed to support the first hypothesis that mental health scores (MHI-5) would predict the intention to seek mental health support (GHSQ). In step 1 of the regression analysis, mental health explained only 2.1% of the variance in the intention to seek

help $F(1, 84) = 1.806$, $p = .183$. This indicated that MHI-5 as a measure of mental health was not a significant predictor of GHSQ and the intention to seek help, ($B = .537$, $p = .183$). This finding aligns with the non-significant bivariate correlations between the GHSQ and MHI-5, indicating a non-statistically significant relationship between mental health and intention to seek mental health support. Overall, the mean of the MHI-5 ($M = 63.26$), and GHSQ ($M = 67.21$) suggested the sample consisted of participants with low mental health scores who did not intend to seek support if they experienced personal and emotional problems or suicidal ideation.

In the present study, the transformed mean for mental health symptoms was 63.26 ($SD = 18.06$; $N = 87$). This mean is lower than the transformed means reported in previous studies that also utilized the MHI-5. McCabe et al. (1996), who surveyed patients from two general doctors' offices aged 16-64 years, found that the overall mean on the MHI-5 for male respondents was 76 ($SD = 18$ SD; $N = 781$) and 72 ($SD = 18$; $N = 246$) for the 16-24 age group (across male and female participants). Hoeymans et al. (2004), who collected data from the Second Dutch National Survey of General Practice in the Netherlands, found that the overall mean on the MHI-5 for male respondents was 83 ($SD = 15$; N not provided) and 80 (SD = 6; N not provided) for the 18-24 age group (across male and female participants). Yamazaki et al. (2015), using a stratified-random sample of 4,500 people in Japan 16 years old or older, found that the overall mean on the MHI-5 for male respondents was 73.31 ($SD = 18.63$; $N = 1,573$). Hartley (2011), using a sample of college students from two U.S. Midwestern universities, found an overall mean of 73.15 (across all gender and racial groups). The mean of the MHI in the present study was below all of these comparison studies.

H2 and H3: Self-stigma and Attitudes Toward Mental Health Support

The results of the present study supported the hypothesis that mental health stigma negatively predicted intent to seek help, $F(2, 82) = 3.340$, $p = .040$. In step 2 of the hierarchical regression, the mental health stigma predictor variables of (b) self-stigma and (c) attitudes toward help seeking explained 7.4% of the variance in the intention to seek help ($R^2 = .074$). However, there were differences in the regression coefficients. For H2, the regression coefficient for the variable of self-stigma (as measured by the SSOSH) was not statistically significant ($B = .121$, $p = .708$). In contrast, the regression coefficient for the attitudes toward mental health support (measured by the ATSPPH-SF) was statistically significant ($B = .880$, $p = .019$). Thus, the second hypothesis was not supported, but the third hypothesis was supported. This fits with the bivariate correlations: self-stigma ($r = -.124$) did not have a statistically significant relationship with intention to seek help, while attitudes toward help seeking did have a statistically significant relationship ($r = .260$). In summary, positive attitudes toward help seeking was associated with a higher intent to seek support, while self-stigma was not associated with a change in help seeking.

Table 5 contains the reliability score for each item on the ATSPPH-SF. The item—M*y self-esteem would increase if I talked to a therapist*—had the highest correlation with the total score, indicating that this item best predicted intention to seek help among the sample in the present study (Table 5). Table 6 contains the reliability score for each item on the SSOSH. The item—*Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me*—had the highest correlation with the total score. Given that the regression coefficient for the variable of self-stigma was not statistically significant, this item did not predict intention to seek help.

In the present study, the mean of the score for attitudes toward help seeking was 24.78 (*SD* = 5.53; *N* = 87). This mean is higher than the means reported in previous studies that also utilized the ATSPPH-SF. Karaffa & Hancock (2019), using a sample of veterinary medical students enrolled in accredited programs in the U.S., found a mean of 19.55 (*SD* = 5.88 SD; *N* = 542) among their sample. Davis et al. (2015), using a convenience sample that consisted of Latinx men in California who ranged from 18 to 81 years of age, found a mean of 16.83 (*SD* = 5.77; *N* = 202). Berger et al. (2005), using a sample of men of all races who lived in Florida between the ages of 18 to 88 years, found a mea of 18.51 (*SD* = 6.52; *N* = 149).

In the present study, the mean of the score for self-stigma was 25.85 (*SD* = 6.37; *N* = 87). This mean is comparable to the means reported in previous studies that also utilized the SSOSH. Karaffa & Hancock (2019), using a sample of veterinary medical students enrolled in accredited programs in the U.S., found a mean of 24.98 (*SD* = 7.83; *N* = 542). Vogel et al. 2013, using previously unpublished archival data from a sample of undergraduate students, found a mean of 27.13 (*SD* = 6.64; *N* not provided) for the U.S. portion of their cross-cultural sample. Vogel et al. (2006), using a sample of U.S. college students across three studies, found the following means: 27.2 (*SD* = 7.2; *N* = 240), 27.3 (*SD* = 7.0; *N* = 227), and 27.3 (*SD* = 6.6; *N* = 271). Cole & Ingram (2020), using a sample of college men at a large Midwestern U.S. university, found a mean of 27.28 (*SD* = 6.88; *N* = 291).

H4, H5, and H6: Masculinity Ideologies

Masculinity was measured by the 9-item Gender Role Conflict Scale-Restrictive Emotionality subscale and the two subscales of the 20-item Machismo and Caballerismo Scale. In step 3 of the regression model, the predictor variables were gender role, machismo, and caballerismo. The total amount of variance explained by steps 1, 2, and 3 was 2.6% of the total

variance in predicting intention to seek help. However, the individual variance accounted for by step 3 alone was not significant, $F(3, 79) = 1.171$, $p = .326$. Thus, hypotheses 4, 5, and 6 were not supported. This is consistent with the non-significant bivariate correlations between gender role, machismo, and caballerismo and intention to seek help in the present study. Furthermore, the predictor variables themselves did not have a statistically significant bivariate correlation with one another. Gender role was not related to machismo ($r = -.008$) nor caballerismo ($r = -.047$). Furthermore, machismo and caballerismo were not related ($r = .393$).

Table 7 contains the reliability score for each item on the GRCS-RE. The item—*Strong emotions are difficult for me to understand*—had the highest correlation with the total score. Given that the regression coefficient for the variable of gender role conflict was not statistically significant, this item did not predict intention to seek help among the sample in the present study. Table 8 contains the reliability score for each item on the Machismo subscale. The item—*It is necessary to fight when challenged*—had the highest correlation with the total score. Given that the regression coefficient for machismo was not statistically significant, this item did not predict intention to seek help. Table 9 contains the reliability score for each item on the Caballerismo subscale. The item—*Men should be affectionate with their children*—had the highest correlation with the total score. Given that the regression coefficient for caballerismo was not statistically significant, this item did not predict intention to seek help.

In the present study, the mean for gender role conflict (GRCS-RE) was 35.25 ($SD = 11.23$; $N = 87$). This is comparable to the study by Davis et al. (2015), which found a mean of 32.72 ($SD = 11.29$; $N = 162$). Davis et al. (2015) used a sample of Latinx men (mostly Mexican) who ranged from 18 to 81 years of age. On the other hand, the mean in the present study was higher than the mean in the Berger et al. (2005) study. Using a sample of men of all races

between 18 to 88 years old, Berger et al. (2005) found a mean of 2.94 (*SD* = 1.02; *N* = 145). Berger et al. (2005) did not sum the scores on the Likert scale for each participant. Therefore, the mean in the present study had to be converted for comparison. The converted mean was 3.92, which is higher than the mean reported by the Berger study (Berger et al., 2005).

In the present study, the mean for machismo was 29.93 (*SD* = 10.64; *N* = 87). This mean is lower than the mean reported by Davis et al. (2015), which found a mean of 34.06 (*SD* = 11.54; *N* = 162). The mean in the present study is also slightly lower than the mean in the study by Arciniega et al. (2008). Arciniega et al. (2008) used a sample of an educationally and socioeconomically diverse group of men who self-identified as having Mexican heritage. For the participants under the age of 30, these researchers found a mean of 3.43 (*SD* = 1.15; *N* = 249). Arciniega et al. (2008) did not sum the scores on the Likert scale for each participant. Therefore, the mean in the present study had to be converted for comparison. The converted mean was 2.99, which is slightly lower than the mean reported by the Arciniega study (Arciniega et al., 2008).

In the present study, the mean for caballerismo was 57.95 (*SD* = 7.86; *N* = 87). This is comparable to the study by Davis et al. (2015), which found a mean of 60.09 (*SD* = 6.64; *N* = 162). The mean in the present study is lower than the mean in the study by Arciniega et al. (2008). For the participants under the age of 30, these researchers found a mean of 6.00 (*SD* = 0.64; *N* = 249). Arciniega et al. (2008) did not sum the scores on the Likert scale for each participant. Therefore, the mean in the present study had to be converted for comparison. The converted mean was 5.80, which is lower than the mean reported by the Arciniega study (Arciniega et al., 2008).

H7: Culturally Relevant Support Services and Intention to Seek Help for Mental Health Support

Culturally relevant support services was measured by the 19-item Critical Race Theory Measurement (CRTM). In step 4 of the regression model, the need for culturally relevant support services variable was entered. All four steps of the regression steps accounted for a total variance of 12.4% in the intention to seek help, but the culturally relevant support services variable only accounted for 0.3% of the variance. As such, step 4 alone did not have a significant R2 change beyond the previous steps, $F(1, 78) = 0.247$, $p = .620$. Thus, the seventh hypothesis was not supported. This is consistent with the fact that the bivariate correlation between culturally relevant support services and intention to seek help was not statistically significant in the present study ($r = .036$). Table 10 contains the reliability score for each item on the CRTM. The item—*A mental health professional should often modify or change interventions to capture better and understand experiences of marginalized clients*—had the highest correlation with the total score. Given that the regression coefficient for the variable culturally relevant support services was not statistically significant, this item did not predict intention to seek help.

Regression Coefficients

Table 17 provides the regression coefficients of the predictors entered in each step. In summary, out of the seven predictors, only attitudes toward mental health support (measured by the ATSPPH-SF) was a significant predictor of intention to seek help ($B = 0.880$, $p = .019$). For every one unit increase in ATSPPH-SF measure, the intention to seek help increased on average by 0.880. No other predictors were significant ($p > .05$).

Table 17. *Regression Coefficients**

Model							Collinearity Statistics	
		B	*SE*	*β*	*T*	*p*	Tolerance	VIF
1	(Constant)	56.051	8.496		6.597	.000		
	Mental Health	.537	.400	.145	1.344	.183	1.000	1.000
2	(Constant)	29.150	18.905		1.542	.127		

	Mental Health	.631	.401	.171	1.577	.119	.943	1.061
	ATSPPHSF	.880	.366	.292	2.403	.019	.748	1.337
	SSOSH	.121	.323	.046	.375	.708	.728	1.374
3	(Constant)	25.559	24.232		1.055	.295		
	Mental Health	.742	.457	.201	1.626	.108	.721	1.387
	ATSPPHSF	1.089	.390	.361	2.794	.007	.656	1.524
	SSOSH	.082	.352	.031	.233	.816	.609	1.641
	Gender Roles	-.070	.189	-.047	-.369	.713	.680	1.470
	Machismo	.366	.212	.228	1.725	.088	.631	1.585
	Caballerismo	-.199	.263	-.091	-.754	.453	.750	1.332
4	(Constant)	21.625	25.483		.849	.399		
	Mental Health	.747	.459	.202	1.627	.108	.721	1.387
	ATSPPHSF	1.102	.392	.366	2.809	.006	.654	1.530
	SSOSH	.079	.354	.030	.225	.823	.609	1.641
	Gender Roles	-.070	.190	-.047	-.368	.714	.680	1.470
	Machismo	.326	.227	.203	1.437	.155	.558	1.793
	Caballerismo	-.216	.267	-.099	-.810	.420	.739	1.353
	Culturally Relevant Support	.102	.196	.063	.522	.603	.753	1.328

* Dependent Variable: Intention to Seek Help

Summary

The present study sought to understand the relationship between mental health symptoms, mental health stigma, masculinity ideologies, and the need for culturally relevant mental health support services. To achieve this purpose, the following research question was examined:

> *To what extent does mental health stigma, masculine ideologies, and culturally relevant support services predict the intention of Latinx male college students to seek mental health support?*

Results of the hierarchical regression conducted with SPSS revealed that attitudes toward mental health support (measured by the ATSPPH-SF) was a significant predictor of intention to seek help ($B = .880$, $p = .019$). Increasing ATSPPH-SF measures result in a significant mean increase in intention to seek help. No other predictors were significant ($p > .05$). Table 18 below

provides a summary of the hypotheses tested as well as the decision to support or not support each hypothesis.

Table 18. *Results of Hypothesis Testing*

Hypothesis	Decision
1. Mental health (measured by the MHI-5) will predict the intention to seek mental health support (measured by the GHSQ). Lower mental health scores will be associated with higher intent to seek mental health support.	Not supported
2. Self-stigma (measured by the SSOSH) will negatively predict the intention to seek mental health support (measured by the GHSQ). Higher scores on the SSOSH indicate a greater concern that seeking help for mental health support will negatively affect one's self-regard, satisfaction with oneself, self-confidence, and overall worth as a person.	Not supported
3. Attitudes toward mental health support (measured by the ATSPPH-SF) will positively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the ATSPPH-SF indicate more positive attitudes toward seeking professional help for mental health support.	Supported
4. Restrictive Emotionality (measured by the GRC) will negatively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the GRC indicate higher levels of gender role conflict with respect to men engaging in help-seeking behaviors such as relying on others, asking for help, admitting to a problem, and willingness to express emotions.	Not supported
5. Machismo (measured by the *machismo* subscale) will negatively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the machismo subscale indicate more aggressive, sexist, chauvinistic, and hyper masculine ideologies.	Not supported
6. Caballerismo (measured by the *caballerismo* subscale) will positively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the caballerismo subscale indicate more nurturing, family-centered, and chivalrous attitudes.	Not supported
7. The need for culturally relevant support services will positively predict the intention to seek help for mental health support (measured by the GHSQ). Higher scores on the Critical Race Theory Measurement (CRTM) indicate more agreement with critical race theory constructs and culturally relevant mental health supports.	Not supported

What follows in Chapter V is a discussion of how the results of this study are interpreted in the context of the theoretical framework. Any limitations of the results of the study will be provided. Additionally, recommendations for future research will be discussed.

CHAPTER V

DISCUSSION

The present study explored how sociocultural identities, specifically race/ethnicity, related to help seeking for mental health among Latinx male college students. Research has suggested that it is important for mental health professionals to understand mental health stigma as it relates to people of color (Defreitas et al., 2018). Due to historical mistrust of mental health services and therapy, issues such as the capabilities and cultural competencies of mental health professionals and treatability of mental health concerns are increasingly important for BIPOC (Defreitas et al., 2018). Unfortunately, the current sociopolitical climate in the U.S. has included resistance to Latinx immigration and increased animosity and racism, exacerbating already existing mental health concerns in these communities (Hwang & Goto, 2009).

The rationale for this study was to further test the claim that mental health fields, including psychology, counseling, and social work, must increase their focus on diversity, multiculturalism, and social justice. The present study used a quantitative survey design, whereby information was collected from a sample of undergraduate college students (Check & Schutt, 2012). Results of the hierarchical regression revealed that attitudes toward mental health support (as measured by the Attitudes Toward Seeking Professional Psychological Help-Short Form or ATSPPH-SF) had predictive power for the intent to seek help among Latinx male college students ($B = .880$, $p = .019$). Specifically, higher scores on the ATSPPH-SF were associated with greater intent to seek help for emotional problems and suicidal ideation. No other variables in the full regression model had predictive power for the intent to seek help ($p > .05$). Given these findings, Chapter V is a discussion of these results with a focus on implications and recommendations for future research.

Interpretation of Findings

The discussion and interpretation of findings from the present study is based on the following research question and corresponding hypothesis statements:

RQ: To what extent does mental health stigma, masculinity ideologies, and culturally relevant support services predict the intention of Latinx male college students to seek mental health support?

H1: Mental Health Symptoms and Intention to Seek Mental Health Support

Hypothesis one tested whether mental health (measured by the Mental Health Inventory-5 or MHI-5) negatively predicted the intent to seek mental health support (as measured by the General Help Seeking Questionnaire or GHSQ). Lower scores on the MHI-5 indicated poorer mental health and thus were hypothesized to be associated with higher intent to seek help as measured by the GHSQ. In the present study, this hypothesis was not supported. Results indicated that participants with lower mental health scores were not more likely to seek help (Theunissen et al., 2011; Thorsen et al., 2013). This is concerning because the average mental health score of participants in the present study was only slightly above the lowest rating of "poor" based on the MHI-5. Put simply, the majority of participants in the present study would have benefited from mental health supports.

An important direction for future research is to better understand the reasons that Latinx men with low mental health scores do not intend to seek mental health support. The mental health scores in the present study were lower than what has been reported in previous research (Rivera-Riquelme et al., 2019; Theunissen et al., 2011; Thorsen et al., 2013; Yamazaki et al., 2005). One possible explanation is that mental health symptoms as measured by the MHI-5 have increased during and since the COVID-19 pandemic (Frankenthal et al., 2022; Janah et al., 2020;

Racine et al., 2021). COVID-19 may have contributed to the high rate of symptoms in the present study. While an explanation of the high rate of mental health symptoms is beyond the scope of the presents study, the findings of the present study suggests other factors may have prevented this sample from seeking help for mental health concerns.

H2: Self-stigma and Intention to Seek Mental Health Support

Hypothesis two tested whether self-stigma (as measured by the 10-Item Self-Stigma of Seeking Help Scale or SSOSH) negatively predicted the intent to seek mental health support (as measured by the GHSQ). Higher scores on the SSOSH indicated greater concern that seeking help would negatively impact one's satisfaction, confidence, and overall worth as a person and thus be negatively associated with the intent to seek help as measured by the GHSQ (Porcari et al., 2017; Vogel et al., 2006). In the present study, this hypothesis was not supported. The findings of the present study revealed that self-stigma (SSOSH) was not a significant predictor of participants' intent to seek help for mental health support (GHSQ). This finding is surprising because other scholars have reported different results. For instance, Vogel et al. (2006) conducted a study in which 583 college students were surveyed about the role of self-stigma in their intention to seek therapy. Because the present study used a more homogenous sample—Latinx men from the southwest U.S.—the sample selection could in part explain the lack of relationship between self-stigma and intention to seek help.

For men specifically, seeking formal mental health services may be considered weak and counter to masculine socialization (Davis & Liang, 2015). It would thus make sense that participants who responded affirmatively to SSOSH items such as "I would feel inadequate if I went to a therapist for psychological help" would be less likely to seek help. While not supported in the present study, previous research using the SSOSH has found self-stigma to be a key factor

in the decision to seek mental health support (Vogel et al., 2010; Vogel et al., 2013). Both the means and standard deviations on the SSOSH in the present study are comparable with previous research (Karaffa & Hancock, 2019; Vogel et al., 2006; Vogel et al. 2013). More information is needed to understand why the SSOSH was not a statistically significant predictor of intent to seek help for emotional problems and suicidal ideation in the present study. Moving forward, researchers need to further explore the stigma of seeking mental health support among Latinx men as a sign of personal weakness (Picco et al., 2016; Subramaniam et al., 2017).

H3: Attitudes Toward Mental Health Support and Intention to Seek Mental Health Support

Hypothesis three tested whether attitudes toward mental health support (as measured by the 10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form or ATSPPH-SF) positively predicted the intent to seek help for mental health support (as measured by the GHSQ). Higher attitudes toward mental health support (as measured by the ATSPPH-SF) indicated more positive attitudes toward help seeking and thus positively associated with the intent to seek mental health support (as measured by the GHSQ). This hypothesis was supported. Put simply, a more positive attitude toward help seeking was associated with a greater intent to seek help among Latinx male college students in the present study.

The results of this study thus add evidence of the relationship between attitudes toward mental health support and help seeking among Latinx male students (Chen et al., 2016; Elhai et al., 2008; Komiya et al., 2000; Thomas et al, 2012). For instance, Thomas et al. (2012) conducted a study in which students in an undergraduate psychology course were surveyed about their attitudes and intentions to seek help for general psychological distress (i.e., stress, anxiety, or depression). These researchers found that participants who scored higher on the ATSPPH-SF

were more likely to express intentions to seek help (as measured using the General Help Seeking Questionnaire-vignette version or GHSQ-V). In another study, Chen et al. (2016) surveyed 212 undergraduate college students about their help seeking intentions. These researchers used the ATSPPH-SF to assess personal and perceived campus attitudes toward help seeking. In this study, participants with more positive attitudes toward seeking help for mental health support had higher help seeking intentions. As such, the findings from the present study add to the body of evidence that improving attitudes toward help seeking may be an important strategy for counseling centers and mental health professionals to improve the use of mental health services on college campuses.

Summary of Mental Health Stigma

A summary of step two of the regression model, the variables associated with hypothesis two (10-Item Self-Stigma of Seeking Help Scale or SSOSH) and hypothesis three (10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form or ATSPPH-SF) were entered together. However, only the ATSPPH-SF had predictive power for the criterion variable of intent to seek help. While both of the variables assessed mental health stigma, they also varied in important ways (Cole & Ingram, 2020; Corrigan et al., 2012; Day et al., 2007; DeFreitas et al., 2018; Fox et al., 2017; Griffiths et al., 2008; King et al., 2007; Wei et al., 2008).

The ATSPPH-SF assessed more general attitudes about seeking psychological help. Sample items included—*Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me*; *A person with an emotional problem is not likely to solve it alone; they are likely to solve it with professional help*, and *If I believed I was having a mental breakdown, my first inclination would be to get professional attention*. (Fischer & Farina, 1995; Mackenzie et al., 2004; Picco et al., 2016). In contrast, the SSOSH assessed participants'

feelings about themselves in relation to seeking psychological help. Sample items included—*My self-esteem would increase if I talked to a therapist*, *My view of myself would not change just because I made the choice to see a therapist*, and *I would feel inadequate if I went to a therapist for psychological help* (Porcari et al., 2017; Vogel et al., 2006).

The ATSPPH-SF and SSOSH were used in the present study because of their previous use with college students (Chen et al., 2016; Cole & Ingram, 2020; Davis et al., 2015; Elhai et al., 2008; Karaffa & Hancock, 2019; Vogel et al., 2006). Studies by Vogel et al. (2006), Vogel et al. (2010), Karaffa & Hancock (2019), and Brenner et al. (2021) used both the ATSPPH-SF and SSOSH scales. Using a sample of college students, Vogel et al. (2006) found a negative association between the ATSPPH-SF and SSOSH across three studies (*correlations: -.63, -.60, and -.53*). Using a sample of college students, Vogel et al. (2010) also found a negative association between the ATSPPH-SF and SSOSH (*bootstrapping correlation: -.72*). Using a sample of veterinary medicine students, Karaffa and Hancock (2021) found a negative association between the ATSPPH-SF and SSOSH (*-.69*) (2019). These researchers also found means of 24.98 (SSOSH) and 19.55 (ATSPPH-SF) across the two scales. Using a sample of community adults, Brenner et al. found that the ATSPPH-SF, when combined with the Help Seeking Attitudes Scale, was negatively associated with the SSOSH (*-.60*) (Karaffa & Hancock, 2021).

In comparison to previous studies, the present study found a much smaller negative association between the ATSPPH-SF and SSOSH (*-.479*). For the ATSPPH-SF, the mean in the present study (24.78) was much higher than the mean in the Karaffa and Hancock (2019) study (19.55) as well as the Berger et al. (2005) study (18.51). Higher scores on the ATSPPH-SF reflected more positive attitudes toward seeking help for mental health concerns. For the

SSOSH, the mean in the present study (25.85) was comparable to the mean in the Karaffa and Hancock (2019) study (24.98) as well as the Vogel et al. (2013) study (27.13). These results suggest the participants in the present study had more positive attitudes toward mental health (ATSPPH-SF) and comparable levels of self-stigma (SSOSH) compared with previous research.

The results of the present study support the need for more research on the role of mental health stigma as a barrier to help seeking, especially among Latinx men (Boyd & Deforge, 2014; DeFreitas et al., 2018; Fox et al., 2017; Griffiths et al., 2008; Vogel et al., 2006; Vogel et al., 2010). There is evidence that even when controlling for presenting mental health concerns, Latinx men are less likely than Latinx women to utilize mental health services from a mental health professional or primary care physician (Cabassa, 2007; Peifer et al., 2000; Zack Ishikawa et al., 2010). This may be due to a lack of emotional competence, negative beliefs and attitudes toward mental health support services, and the stigma of seeking help for mental health concerns (Rickwood et al., 2005). Importantly, stigma has been found to be one of most common barriers to help seeking barriers for men (Aguirre Velasco et al., 2020).

H4: Restrictive Emotionality and Intention to Seek Help for Mental Health Support

Hypothesis four tested whether restrictive emotionality (as measured by the Gender Role Conflict Scale-Restrictive Emotionality Subscale or GRCS-RE) negatively predicted the intent to seek help for mental health support (as measured by the GHSQ). Higher scores on the gender role conflict scale among men has been associated with not seeking help for mental health concerns (Berger et al., 2005; Blazina et al., 2005; Davis & Liang, 2015). In the present study, this hypothesis was not supported. In other words, gender role conflict-restrictive emotionality as a measure of masculinity was not a predictor of help seeking within the sample in the present study. A potential explanation for the lack of relationship in the present study is the homogeneity

of the sample used—90.8% of the participants in the current study were between the ages of 18-22; only one participant identified in the 30+ age category. In contrast to the present study, previous literature—with more heterogeneous samples—revealed various relationships between gender role conflict and help seeking intentions (Berger et al., 2005; Blazina et al., 2005; Cole & Ingram, 2020; Davis & Liang, 2015). Specifically, Berger et al. (2005) examined help seeking attitudes in adult men. Like the present study, Berger et al. also used the GRCS-RE and the ATSPPH-SF scales in their study. Another similarity to the present study is Berger et al. did not find a significant relationship between gender role conflict-restrictive emotionality (GRCS-E) and attitudes toward seeking psychological help (ATSPPH-SF) (Berger et al., 2005).

However, there are key differences between the Berger et al. (2005) study and the present study. First, the Berger study used all subscales of the GRCS, but found that only the restrictive affectionate behavior between men subscale (GRCS-RABBM) was significantly correlated with their measure of help seeking—ATSPPH-SF. This is in comparison to the present study, which only used the restrictive emotionality subscale of the gender role conflict scale (GRCS-RE). Another difference is that unlike the present study, Berger and colleagues used the scores on the ATSPPH-SF as their dependent variable. In contrast, the ATSPPH-SF was a predictor variable in the present study. Another difference is that Berger et al. found that older men adhered less to traditional masculinity as measured by the GRCS and had more positive attitudes toward formal help seeking than younger men (2005). The sample in the present study consisted of primarily traditional age college students (18-22) with a higher mean than the mean in the Berger et al. (2005) study. The average GRCS-RE items in the Berger et al. (2005) study was 2.94 (SD = 1.02; N = 145) compared to a mean of 3.92 in the present study. More research is needed to explore the GRCS among traditional age college students (18-22).

H5: Machismo and Intention to Seek Help for Mental Health Support and H6: Caballerismo and Intention to Seek Help for Mental Health Support

Hypothesis five and hypothesis six tested whether machismo and caballerismo predicted intent to seek help. More specifically, hypothesis five tested whether machismo (as measured by the Machismo subscale) negatively predicted the intent to seek help for mental health support (as measured by the GHSQ). Higher scores on the Machismo subscale indicated more aggressive, sexist, chauvinistic, and hypermasculinity traits, which were hypothesized to be negatively correlate with intent to seek help (Archiniega et al., 2008). Hypothesis five was closely connected with hypothesis six testing whether caballerismo (as measured by the Caballerismo subscale) positively predicted the intent to seek help for mental health support (as measured by the GHSQ). Higher scores on the Caballerismo subscale indicated more nurturing, family centered, and chivalrous attitudes that were hypothesized to be positively correlated with help seeking (Archiniega et al., 2008). In the present study, neither hypotheses five and six were supported, indicating that neither machismo nor caballerismo predicted intent to seek help for emotional problems or suicidal ideation.

This finding is interesting because most participants in the present study identified with Mexican specific terms such has Chicano, Xicano, and Mexican. Hegemonic masculinity in Latinx populations, particularly Mexican culture, has been described as machismo or caballerismo. *Machismo* has been defined as hyper-masculine, sexist, and chauvinistic attitudes and behaviors of Latinx men. *Caballerismo* originated from the Spanish words for horse (*caballo*) and horseman (*caballero*) and is defined by a code of masculine chivalry (Archiniega et al., 2008). Research has drawn links to machismo and caballerismo to negative cognitive-emotional problems (e.g., depression, anger, anxiety, hostility), and gender role conflict (Davis

& Liang, 2015; Nuñez et al., 2016). Using the same variables as the present study, Davis and Liang (2015) examined the relationships between the masculinity ideologies and attitudes toward seeking mental health support. Similar to the present study, these researchers did not find a link between traditional masculinity (all subscales of the GRCS, including the restrictive emotionality subscale) and psychological help seeking attitudes (ATSPPH-SF) (Davis & Liang, 2015). The lack of a relationship between traditional masculinity and attitudes toward help seeking may help to explain the lack of a relationship between masculinity and intent to seek help as measured by the GHSQ.

In contrast, other studies have found a relationship between traditional masculinity as measured by machismo and caballerismo with help seeking (Berger et al., 2005; Levant et al., 2003; Pederson & Vogel, 2007). A potential explanation for the lack of relationship in the present study may have been due to the age and acculturation of the sample—primarily between the ages 18-22. In addition, acculturation patterns may differ across different geographic areas. For instance, only nine of the participants surveyed by Berger et al. (2005) identified as *Hispanic*, and this sample lived in Florida. In contrast, all 87 participants in the present study identified within the Latinx umbrella and lived in the southwest U.S. It is possible that the participants in the present study differed from participants in studies conducted in other parts of the country, which may explain the lack of a relationship between masculinity and help seeking. With that said, more research is needed to better understand the relationship (or lack thereof) between traditional masculinity and intent to seek help among Latinx male college students.

Summary: Masculinity Ideologies

The variables associated with H4, H5, and H6 related to masculinity and were entered together in the regression model. The results indicated that none of these variables had predictive

power for intent to seek help in the present study. However, this may have been due to variation in how masculinity has been defined and measured. Levant and Richmond (2007) defined masculinity ideologies as "an individual's internalization of cultural belief systems and attitudes toward masculinity and men's roles, which informs expectations for boys and men to conform to certain socially sanctioned masculine behaviors and to avoid certain proscribed behaviors" (p. 131). Using this definition as a framework, the present study used ideologies associated with Latinx populations, namely machismo and caballerismo (Archiniega et al., 2008). While these ideologies have been used in previous research by Berger et al. (2005), it is possible that other measures may be a better predictor of negative attitudes toward formal help seeking. Thus, although previous research supported the rationale for including gender role conflict-restrictive emotionality, machismo and caballerismo in the present study, it is possible that other indicators of traditional masculinity ideology may be more appropriate for Latinx men (Archiniega et al., 2008; Davis & Liang, 2015).

Previous research has demonstrated men who score high on measures of traditional masculinity tend to have more negative views toward help seeking behaviors for mental health concerns (Davis & Liang, 2015). Furthermore, Davis and Liang found that Latinx men search for help first within their social networks (informal sources) before seeking help from formal sources (Davis & Liang, 2015). This phenomenon is supported by Cabassa (2007). Cabassa (2007) also suggested that Latinx men search for help first within their social networks (i.e., informal sources; 70%) before seeking help from formal sources. Social networks may influence how Latinx men cope with distress and can facilitate pathways that lead to the use of formal sources of help, or they could delay and/or discourage the use of formal sources. The results of the present study align with Davis and Liang (2015) and Cabassa (2007), as the participants were

most likely to seek help for suicidal ideation from an intimate partner, a friend, and a parent before seeking help from any formal source. For a personal or emotional concern, the sample was most likely to seek help from a source not listed. These sources—which participants wrote in—included the following: co-worker, mejor amigo (best friend), strangers, coach, school services, and mentor. Future research should continue to explore the role of informal supports regarding help seeking among Latinx male college students.

H7: Culturally Relevant Support Services and Intention to Seek Help for Mental Health Support

Hypothesis seven tested whether views on culturally relevant support services (as measured by the Critical Race Theory Measurement or CRTM) positively predicted the intent to seek help for mental health support (as measured by the GHSQ). Higher scores on the Critical Race Theory Measurement indicated less agreement with critical race theory constructs and culturally relevant mental health supports and thus were expected to positively predict help seeking (Campbell, 2014). Specifically, participants with higher agreement with CRT (lower scores on the CRTM) were expected to be more discerning and apprehensive about seeking help—especially from formal sources—leading to lower help seeking scores (combined sum on the GHSQ). Hypothesis seven was not supported in the present study. As such, it is important to note that the mean on the CRTM scale fell on the lower end of the CRTM scale ($M = 56.94$; lowest possible score = 19; highest possible score = 114; midpoint = 66.5), suggesting participants had more agreement with critical race theory constructs and culturally relevant mental health supports (Campbell, 2014). As such, a potential explanation for the findings in the present study is that participants may seek out informal sources of help that better reflect their sociocultural identities and perspectives. More research is needed to explore the importance of

culturally-responsive treatment interventions that utilize critical race theory concepts for Latinx male college students' help seeking behaviors.

In the present study, there was no significant relationship between viewpoints on Critical Race Theory (CRT) concepts and intent to seek help. However, there is a need for more research to confirm this finding. As such, future research should continue to use CRT as an underlying framework for culturally responsive mental health support. CRT centers racial injustice to explain how racism is intricately ingrained in the institutions and systems in the United States (Anguiano et al., 2020; Crenshaw et al., 1995; Delgado & Stefancic, 1993; Martinez, 2014; Villalpando, 2004). Viewing race and racism as central elements of the educational system, CRT focuses on how racism is embedded in every aspect of colleges and universities (Anguiano et al., 2020; Marquez Kiyama et al., 2015; Villalpando, 2004). CRT unmasks the minoritized status stressors that exacerbate the standard college stress associated with persistence and well-being (Anguiano et al., 2020; Marquez Kiyama et al., 2015).

CRT is important research framework to account for intersectional forms of oppression. Terminology such as *twice disadvantaged*, *twice penalized*, and *double jeopardy* have been used to describe the discrimination faced by people with multiple marginalized identities. For example, women and racially minoritized groups with mental health symptoms and disabilities often experience multiple forms of discrimination in society (Alston & Bell, 1996; Ferraro & Farmer, 1996; O'Hara, 2004). CRT advocates for examining oppression beyond interpersonal interactions to examine institutional and systemic oppression policies and policymaking within historical and cultural contexts (Cerezo & McWhirter, 2012). CRT also highlights that racial determinism can contribute to false diagnostic conclusions, resulting in BIPOC experiencing exacerbated mental health concerns. This outcome indicated the need for greater examination

into how systemic and institutionalized oppression can influence diagnostic practices (Bryant et al., 2021).

The CRT scale used in the present study was the Critical Race Theory Measurement (CRTM) developed by Campbell (2014). Each of the six constructs of CRT were included in the scale as follows: endemic racism, social construction of race, differential racialization, convergence/determinism, racial narratives, and intersectionality. The CRTM scale was initially created for mental health professionals to complete. The scale was intended to provide a roadmap for these practitioners to evaluate their ability to appropriately serve BIPOC clients. However, other than the research conducted by Campbell, the CRTM scale has not been utilized in previous research. Therefore, the instrument has not been validated for use with specific populations, including Latinx male college students (Campbell, 2014). An explanation for the absence of a relationship in the present study may include participant biases above and beyond the instrumentation concerns. The self-reporting on this measure could have been affected by individual participant characteristics including, ability to understand CRT terminology, language ability, social expectations and other measurement biases. Despite assurances of anonymity, participants may have answered questions based on how they believed they should feel about issues related to race and racism.

Implications

Implications for Universities

The results of the present study have implications for mental health professionals and administrators at universities. Mental health and wellness are growing concerns for Latinx students in college, and mental health professionals need to be prepared to address these concerns (Hope et al., 2018). As such, mental health professionals and administrations on college

campuses may use these findings to understand the help seeking behaviors of Latinx male college students at their universities. In the present study, attitudes toward mental health was found to be a significant predictor of help seeking intention among the sample of Latinx male college students. As such, college mental health professionals and administrators may endeavor to create marketing materials, workshops, and sessions that address and improve attitudes toward mental health and help seeking for mental health concerns. As part of educational campaigns, it is important to highlight the fact that adolescents and young adults present the highest prevalence of mental health concerns compared to other age groups, yet they are also the least likely to seek help (Aguirre Velasco et al., 2020; Wilson et al., 2005). As a result, the results of this study add evidence that mental health professionals and administrations need to make mental health support services more welcoming to Latinx male college students.

One strategy for making mental health services more welcoming is to pay attention to preferred language. In the present study, one example of a write-in response was "counselor," suggesting that participants differentiated a "mental health professional" from a "counselor" even though a counselor was listed within the category of mental health professional. Participants may associate the word "counselor" with the concept of a high school counselor who supports course scheduling, achievement strategies, and post-secondary preparation, in addition to mental health concerns such as emotion management (American School Counselor Association, 2022). This multifaceted and collaborative role may facilitate better rapport with Latinx male college students, who may have a stigmatized view of professional mental health and "therapy" (American School Counselor Association, 2022). As such, it may be particularly important for mental health services to be integrated within other more academic services provided by the university. This may assist university counseling centers in building rapport with

Latinx male college students outside of their primary clinical roles of providing mental health counseling (Fox et al., 2020; Kivlighan et al., 2021).

In addition, universities should explore help seeking in the context of peer relationships (i.e., informal sources), Peer mentoring is a strategy used to support marginalized and minoritized student populations at institutions of higher education (Collier, 2017; Lev et al., 2010; Plaskett et al., 2018). Peer mentors offer information, guidance, advice, and emotional support (Collier, 2017), which can improve mental health outcomes for college students. Peer mentors are typically paid student employees who have gained experience on campus—they meet regularly with mentees and assist them with navigating the institution, building community, connecting to campus and community resources, and developing psychosocial skills (Collier, 2017; Davidson & Foster-Johnson, 2001; Lev et al., 2010). University investment in peer mentor programs could be a method for closing the gap between informal and formal help sources.

Implications for Understanding Patterns in Help Seeking

Help seeking for mental health concerns has received attention in research, policy and practice (Rickwood & Thomas, 2012). However, progress has been hindered by an inability to develop a standard operational definition of help seeking behavior. Researchers have found complex empirical links between the intention to seek help and the actual behavior of seeking help (Wilson et al., 2005). While studies have established the relationship between prior help seeking behavior and intentions, there is limited research on future help seeking behaviors and intentions (Wilson et al., 2005). The present study sought to add to address that gap in the literature. The present study examined the likelihood of help seeking behavior to occur in the future by using the 22-item General Help seeking Questionnaire-original version (GHSQ) (Wilson et al., 2005).

One decision that may have impacted the results of the present study was the use of a total score on the GHSQ, which is how the scale is typically used (Deane et al., 2001; Deane et al., 2002; Wilson et al., 2005). A benefit of the total score of the GHSQ is a single scale — an average of all help source options for emotional and suicidal problems — contributed to strong reliability (Cronbach's alpha = .85, test-retest reliability assessed over a three-week period =.92). However, by combining the two subscales of emotional problems and suicidal ideation, it was not possible to distinguish between the two problem types: suicidal problems (Cronbach's alpha = .83, test-retest reliability assessed over a three-week period = .88) and personal-emotional problems (Cronbach's alpha = .70, test-retest reliability assessed over a three-week period = .86) (Wilson et al., 2005). While the use of a total score is recommended by previous researchers, it reduced the ability to distinguish differences across types of problems as well as sources of help seeking such as formal and informal (Deane at al., 2001; Wilson, et al., 2005).

Prior research has consistently demonstrated that Latinx men search for help first within their social networks before seeking help from formal sources (Cabassa, 2007; Davis & Liang, 2015). This finding is also true of the present study. These sources have included family members, friends, and significant others. Social networks may influence how Latinx men cope with mental health problems and can facilitate or hinder pathways that could lead to formal mental health professionals. Additional research is needed in order to understand the specific influences of social networks on pathways to formal help seeking (Cabassa, 2007).

Implications for Understanding Mental Health Stigma

Previous literature has highlighted the impact of mental health stigma on help seeking behaviors. Specifically, mental health stigma has resulted in negative stereotyping, biases, and discrimination often directed at people with mental illness. This has contributed to people

avoiding seeking help and not reporting mental health problems (Aguirre Velasco et al., 2020; Boyd & Deforge, 2014). It is thus important to understand how universities can counter mental health stigma on college campuses in order to combat embarrassment, denial of mental health-related issues and concerns, and resistance to seeking treatment. If stigma is not addressed, students may not reach out to available mental health support services. In addition, stigma has been linked to shame associated with help seeking and beliefs that mental illness is linked to weakness of character (DeFreitas et al., 2018; Martinez Tyson et al., 2016).

Implications for Terminology

Latinx people in the U.S. are markedly heterogeneous, representing 23 countries and speaking more than 12 languages and dialects (Ruiz & Steffen, 2011). This diversity in populations is represented in the diversity of terms used to describe the people from Latin America. The language and terminology to describe individuals who trace their heritage to Latin America has changed over time. The U.S. Census Bureau uses the terminology *Hispanic or Latino* (Jones et al., 2021). A Pew Report published in 2020 suggested that the term *Hispanic* is still the preferred term overall with fewer participants preferring *Latinx* (Noe-Bustamante et al., 2020). In the present study, participants could select more than one category. Of the 87 participants, 71 identified with Chicano/Chicana; 41 identified with Hispanic; 43 identified with Latino/Latina; 28 identified with Country of Origin, of which all but one participant identified with Mexican or Mexico; 24 identified with Xicano/Xicana; 6 identified with Latine, and 6 identified with Latinx. An explanation for these results is likely due to demographics being overwhelmingly Mexican in the southwest U.S. Identity selection and terminology would likely be different in different parts of the country. In addition, the survey was distributed by the

Latinx-serving cultural center on campus, which is heavily tied to Chicano-studies on campus and largely frequented by Mexican heritage students.

This dissertation used Latinx as a pan-ethnic term, while recognizing this is not a monolithic group. The term *Latinx* has been most widely used in academic communities to challenge the limitations of binary gendered constructs. The intent of the term *Latinx* is to build unity and affirm all members of these populations, and to call attention to the historical and present imperialism, marginalization and violence associated with the gender binary (Cardemil et al., 2019; Noe-Bustamante et al., 2020). Because this dissertation was produced in an academic English-speaking setting and because Latinx was used as an identifier when recruiting participants, the term Latinx was used. However, the results of the study suggested that other terminology should also be used to reflect the voices and perspectives of such a heterogeneous population. Recent publications by Borrell and Echeverria (2022) and Dame-Griff (2021) explored the use of the term Latinx in public health research and other academic settings. These publications stated that given the inherent intention of the term Latinx to provide inclusivity and to offer a voice and visibility to those who have been oppressed and marginalized because of norms and expectations associated with gender identification, the term *Latinx* should be used with groups who identify with, like and/or accept the term. Dame-Griff stated the following regarding the use of Latinx by institutions of higher education:

> Latinx as it is used by institutions and organizations centers the term's perceived utility as a signal or marker of "inclusivity," rather than as a term originally developed as part of self-naming practices of members of the Latina/o/x community whose non-binary identities are hyper-marginalized, most demonstrably by binary terminology (Dame-Griff, 2021).

This approach of aligning identification with groups may lead to the term Latinx becoming a welcomed addition to identification of the Hispanic or Latino populations, rather than a replacement for ethnic identification (Borrell & Echeverria, 2022), which has clear implications for researchers working with these populations.

Implications for Using a CRT Framework

The present study demonstrated a continued need to examine the utilization of CRT in education, research, and practice. Each field in the mental health profession—counseling, psychology and social work—has developed cultural competencies into categories such as the self-awareness, attitudes, skills, and knowledge (Williams, 2006) needed in order to address the needs of culturally diverse clients, groups, and communities (Ratts et al., 2016). Critical race theory can help support the rationale for culturally responsive mental health. Additional research into CRT could produce research findings that elicit change from within communities, such as alleviating problems and suffering, including oppression (Goodman & Gorski, 2015). Goodman and Gorski suggested practices such as using critical ethnography, critical reflection, and cultural capital to inform clinical practice (2015). Despite the findings in the present study, CRT may provide educators, researchers, and practitioners with a transformative tool for examining and developing methodologies and approaches to historical and contemporary issues in order to better serve minoritized clients and students.

Limitations of the Study

There are limitations to the present study. First, the survey design collected information from a sample of individuals through their responses to structured questions (Check & Schutt, 2012). Survey design is a rigorous approach to research supported by scientifically significant strategies such as choosing a sample, distributing the survey, data collection instruments, and

engagement with non-responders. (Ponto, 2015). However, the survey used in this study did not include open ended questions that would have enabled participants to elaborate on their responses. The primary purpose of survey research is to obtain information by describing the characteristics of a large sample of individuals of interest relatively quickly (Ponto, 2015). However, a limitation of the present study was that it did not allow participants to explain—in their own words—why they answered questions in a particular manner.

A second limitation is that the present study used a small sample size, thereby limiting the generalizability of findings (Check & Schutt, 2012). The findings in this study are limited to the present sample of Latinx male college students, who predominately identified as Mexican. Results may vary for Latinx male college students from other parts of the country. The setting provided a limitation as data was only collected from one geographical location. Generalizability is thus limited to the participants of this study who live in a specific region of the U.S. In addition, the study participants were Latinx students who self-identified as male. This means the findings of the present study cannot be applied to students from other racial and ethnic identities nor from gender identities other than male. Gender not only limited the sample size, but it may have affected the small sample size. Previous research has suggested that women were more likely than men to participate in online surveys (Curtin et al., 2000; Moore & Tarnai, 2002; Singer et al., 2000) and White people are more likely than non-White people to participate in online surveys (Curtin et al., 2000; Voight et al., 2003).

The length of the survey was another limitation. The present study did not use a progress bar but required completion of 102 items. These items took advisory board members an average of fourteen minutes and twenty seconds to complete—the fastest time was ten minutes and thirty seconds, and the slowest time was twenty minutes. As such, survey design may have contributed

to the smaller sample size (Saleh & Bista, 2017). Relevance of the topic to potential participants, survey length, and wording of the questions (including question difficulty) can all affect response rate. Through the examination of 25,080 web surveys, Liu and Wronski (2017) found a negative relationship between completion rate and survey length and question difficulty. These researchers also found that surveys without progress bars had higher completion rates than surveys with progress bars (Liu & Wronski, 2017). Additional studies have found that surveys that can be completed in less than thirteen minutes have the best response rate (Asiu et al., 1998; Handwreck et al., 2000). The length of the survey may have contributed to a smaller sample size.

Lastly, the recruitment method may have been a limitation. Participants were recruited during the summer of 2022. Specifically, email announcements requesting participation were sent to students' email accounts during a small two-month window. Some participants failed to respond to emails, rendering online participant engagement unreliable. Such limitation could result in the unreliability of the study findings, explaining some of the discrepancy between the study findings and the previous literature findings.

Recommendations for Future Research

More research is needed to further understand the relationships between mental health symptoms, mental health stigma, masculinity ideologies, and culturally relevant support services as predictors of the intention of Latinx male college students to seek mental health support. Specifically, continued research should examine the specific impact of racism on mental health and academics in a college setting (Anguiano et al, 2020; Marquez Kiyama et al., 2015). With this in mind, future studies should be conducted using a larger and more diverse sample to uncover the unique characteristics of people within Latinx populations. In hindsight, it may have been advantageous to recruit participants across many universities in the U.S. This tactic may

have produced not only a larger number of participants, but a more heterogeneous sample even within the identities of Latinx and male. A larger sample may have made it possible to explore nuance in participants' beliefs about study variables such as masculinity.

Exploring Masculinities

There is a need for more studies to examine the relationship between masculinity ideologies and help seeking for mental health support services among BIPOC college students. Masculinity is a complex and elusive concept that is culturally constructed (Arciniega et al., 2008; Berger et al., 2005; Cole & Ingram, 2020; Davis et al., 2015; Levant & Richmond, 2007). On college campuses, it is important to consider how conceptions of masculinity impact help seeking behaviors. An executive summary conducted by the American College Health Association suggested that most men on college campuses reported depressive symptoms in the previous 12 months (ACHA, 2019). In this study, 78% of men surveyed felt overwhelmed, 61% experienced sadness, 58% reported loneliness, 48% reported hopelessness, 37% experienced decreased functioning due to depression, and 1% considered suicide. Despite self-reporting these symptoms, only 11% of the participants reported receiving treatment for depression within the past 12 months. Another study highlighted that self-stigma was associated with seeking help, albeit with differences between men and women, and participants who had previously sought help and those who had not (Vogel et al., 2006). Masculinity can influence the following: relying on others, asking for help, admitting to a problem, and willingness to express emotions (Berger et al., 2005; Blazina et al., 2005; Davis & Liang, 2015). Future research could help uncover this disparity in help seeking behavior and the mitigating effects of gender identity and previous help seeking behavior (ACHA, 2018; Vogel et al., 2006).

Exploring Culturally Responsive Practices

Previous research has indicated that culturally relevant support could significantly predict mental health help seeking among college men (Cole & Ingram, 2019). This is because institutionalized and systemic barriers are the root cause of psychosocial inconsistences and difficulties faced by collectivistic minoritized groups, including Latinx people (Goodman & Gorski, 2015). Attitudes toward mental health support as well as prediction of help seeking behavior can be affected by many intersectional sociocultural realities, including language, immigration, ethnicity, culture, identity, phenotype, and sexuality (Martinez, 2014; Villalpando, 2004). Dismantling oppressive systems can result in removing barriers for Latinx students in higher education (Villalpando, 2004). Previous research has suggested that understanding the need for more culturally relevant support services could significantly predict help seeking behavior among clients with minoritized identities (Acevedo et al., 2007; Anguiana et al, 2020; Goodman & Gorski, 2015). However, the current study revealed that culturally relevant support services did not predict help seeking among the sample of Latinx male college students.

Future research should focus on how culture and acculturation influence attitudes toward mental health support among Latinx college students. Culture, including racial identity, is an ever-evolving concept. Because cultures and sociocultural identities are diverse and continuously evolving, striving toward culturally responsive practices and services must also evolve (Asumah & Nagel, 2014). In particular, *acculturation* is the process of internalizing values, beliefs, and traditions of the larger society; it has been described as a powerful force in the development of identity for BIPOC, particularly immigrants. Research has indicated that Latinx people who have been exposed to the values, beliefs, and standards of the larger White/Western U.S. culture, may become increasingly Westernized (Wing Sue et al., 2019). Acculturation is multifactorial. Immigration patterns effect acculturation and those patterns differ by country of origin (Alvarez

et al., 2004; Hayes-Bautista & Chapa, 1987; Page 2013). Perhaps shifting the lens of future research to the underlying cultural and acculturation factors affecting attitudes toward mental health support could uncover the reasons for the significance of that construct in the present study.

In addition, future research should consider investigating cultural competency among mental health professionals for counseling BIPOC in colleges. The CRTM was developed for mental health professionals. Focusing on mental health professionals and the services they provide to diverse clients, instead of focuses on potential clients, as in the present study, could result in better mental health outcomes for clients across various demographics. Using the CRTM, future research should explore the link between acculturation and endemic racism (CRT) in Latinx populations. Despite increasing multicultural competencies and awareness, racism remains a significant problem in the U.S. (Abrams & Moio, 2009; Bryant et al., 2021; Crisp et al., 2015; Gorski & Parekh, 2020; Ruiz & Steffen, 2011; Wing Sue et al., 2019). Racism produces additional stress that can negatively affect mental health outcomes for BIPOC; as the perceptions and experiences of racism increases, mental health problems increase and academic performance can be negatively affected in college students (Anguiano et al, 2020; Arbona & Jimenez, 2014; Crisp et al., 2015; Marquez Kiyama et al., 2015; Ruiz & Steffen, 2011; Schmitz, et al., 2020). Future research could use a CRT framework to examine the link between experiences with racism and mental health symptoms and help seeking behavior.

Expanding Sociocultural Identities and Demographics

Latinx populations are not homogeneous. Future research should explore the subgroups. Torres summarized three over-arching issues that contribute to the heterogeneity of the Latinx population: distinct immigration patterns, varying sub-group experiences in the U.S., and

research findings that vary by sub-group (2004). Some across group inferences have been made, and research has summarized Latinx immigration patterns as being economic or political in motivation. Yet, varying laws, norms, and sociopolitical responses to Latinx sub-groups further impact the migration patterns and treatment of these groups. As such, the 'one-size-fits-all' approached utilized in much of the research may be ineffective (Torres, 2004).

The present study utilized a sample that was primarily between the ages of 18-22. Future research could be expanded across all age groups. Previous research exploring age and help seeking behavior has been inconsistent. Picco et al. (2016) found that a younger age (18–34 years) was significantly associated with increased openness to seek professional psychological help. Other studies have shown that older adults display negative attitudes to help seeking (Currin et al., 1998; Estes, 1995; Hatfield, 1999; Picco et al., 2016; Segal et al., 2005). Meanwhile, other studies have shown older adults' attitudes toward seeking help were more positive (Robb et al., 2003). Given these inconsistencies in research findings, more research is needed on the effects of age and willingness to seek psychological help and attitudes toward help seeking.

Future research may also be expanded to included participants of all gender identities. For the current study, participants were excluded if they identified with a gender identity other than male. These excluded identities—as written by participants—included: female, gender fluid, gender nonconforming, trans male, transgender, and non-binary. Future research could uncover gender differences on college campuses, as research has shown that gender identity is related to attitudes toward help seeking and help seeking behavior (Cabassa, 2007; Davis & Liang, 2015; Griffiths et al., 2008; Schmitz et al., 2020).

In addition to gender, other sociocultural differences to explore could include socioeconomic status, education level, immigration status/citizenship, and sexuality. Previous research suggested links between socioeconomic status, education level and attitudes toward mental health (Goldman, 2014; Gloria et al., 2005; Picco et al., 2016; Teruya & Bazargan-Hejazi, 2013; Torres, 2004; Zack Ishikawa et al., 2010). Picco et al. (2016) stated that higher socioeconomic status (Figueroa et al., 1984) and higher education level (Sheikh and Furnham, 2000; Al-Krenawi et al., 2004; Goh and Ang, 2007) have been consistently associated with more positive attitudes toward seeking professional psychological help (ATSPPH). Previous research was consistent with the Picco et al. study in which lower education was associated with less openness to and value in seeking professional help for a psychological concern (Picco et al., 2016). More diverse studies could be conducted to examine comparisons across racial and ethnic groups (Cole & Ingram, 2020; Tatum, 2000; Torres, 2004; Turcios-Cotto & Milan, 2013; Wester, 2008) and sexual identities (Berger et al., 2005; Schmitz, 2020; Tatum, 2000; Wester, 2008).

Within family differences could be explored, including generational differences (Crisp et al., 2015; Page, 2013). Personal and cultural values, acculturation, and generation in the United States have a complex multidirectional relationship (Hirai & Clum, 2000; Mackenzie et al., 2004; Teruya & Bazargan-Hejazi, 2013; Torres, 2004). In their work to adapt the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), Mackenzie et al. (2004) stated that attitudes may differ between older and younger age cohorts based on generational variability in the acceptability and availability of mental health services. Examining generational differences within families regarding help seeking attitudes and behavior could contribute to insights into the complexities of these relationships in addition to outside societal forces.

Using Transformative Practices to Inform Instrumentation

The present study utilized an advisory board consisting of Latinx male college students and recent college graduates. Future research could improve the transformative practices used to examine and utilize instruments to measure the criterion and predictor variables examined in the present study. Previous research clearly supported the use of the included instruments (Arciniega et al., 2008; Berger et al., 2005; Berwick et al., 1991; Blazina et al., 2005; Campbell, 2014; Davis & Liang, 2015; Fischer & Farina, 1995; Fischer & Turner, 1970; Porcari et al., 2017; Veit & Ware, 1983; Vogel et al., 2006); however, there are many instruments that can be used to measure mental health stigma, masculinity ideologies, culturally responsive practices, and help seeking behavior. Chapter II mentions transformative practices—including the communities that research is conducted about and for in research (Goodman & Gorski, 2015). The current study utilized an 8-member advisory board consisting of Latinx males aged 23 – 27. This advisory board provided guidance and feedback on the design of the study, the methodology and instruments used, and the recruitment of participants. However, only one member of the advisory board identified as Mexican and lived in the southwest U.S. In conjunction with the demographic considerations discussed in this section, future research might better draw from the demographics specifically being researched to offer input and collaboration.

Additional Research Designs

Future research might consider qualitative designs to explore the constructs examined in the present study. Qualitative research is the process of collecting and analyzing non-numerical data in order to understand people's experiences, beliefs, attitudes, behaviors, and interactions (Pope & Mays, 1995; Pathak et al., 2013). Qualitative data can add a new dimension to research studies by enabling participants to describe their experiences through narrative (Clandinin,

2007). A qualitative research design would enable participants to describe their identities, attitudes and stigma toward helping seeking in their own words and potentially name what they would need regarding culturally responsive mental health support. Qualitative data could help mental health professionals gain insight about specific individuals in specific settings by using a narrative approach in which participants could describe their thoughts and feelings (Clandinin, 2007; Clandinin et al., 2018).

Conclusion

The purpose of this study was to explore the relationship between mental health symptoms, mental health stigma, masculinity ideologies, and the need for culturally relevant support services as predictors of the intention of Latinx male college students to seek mental health support**.** The results indicated that attitudes toward mental health support was a significant predictor of intention to seek mental health support services. Results indicated that higher ATSPPH-SF scores related to higher intent to seek help measured by the GHSQ. In other words, the findings revealed that seeking help for mental health support services depended on the attitudes to seek mental health help among the sample.

The findings partially supported previous literature by establishing that attitudes toward mental health support is a significant predictor of help seeking behavior. However, the findings also failed to support the hypotheses regarding the impact of masculinity ideology and culturally relevant support services on predicting help seeking behavior among Latinx male college students. Future research should be conducted to understand the influence of masculinity and culturally relevant support on the intention to seek help for mental health support services among Latinx male college students.

Appendix A

Demographic Questionnaire, 7-Items

Participants in the study will provide the following demographic information.

1. Race/Ethnicity
    - Latino(a)/Latinx/Hispanic
        - Specify nationality
    - If non- Latino(a)/Latinx/Hispanic
        - Asian/Pacific Islander
        - Black/African American
        - Middle Eastern/North African
        - Multiracial/Two or More Races
        - Native American/Indigenous
        - White (non-Hispanic/Latinx)
        - Other
2. Regarding your race/ethnic identity, which term(s) do you most identify with (select all that apply):
    - Chicano/Chicana
    - Hispanic
    - Latinx
    - Latine
    - Latino/Latina
    -
    - Xicano/Xicana
    - With Country of Origin (e.g., Mexican, Bolivian, Cuban): _____ (write in)
3. Gender Identity (*select one*)
    - Male, Female, Transgender, Agender, Gender non-conforming, Other
4. Age
    - 15 – 17
    - 18 – 22
    - 23 – 29
    - 30+
5. Classification/Year
    - First-year, Second-year, Third-year, Fourth-year+, Graduate Student
6. University Status
    - Part-time, Full-time
7. Generational Status in the U.S.
    - First-generation, Second-generation, Third-generation, Fourth-generation or more

Appendix B

Mental Health Inventory-5 items
(Berwick et al., 1991)

Instructions: How much time during the last four weeks has each of the following questions applied to you?

	All of the time 1	Most of the time 2	A good bit of the time 3	Some of the time 4	A little of the time 5	None of the time 6
1. Been a nervous person?						
2. Felt so down in the dumps that nothing could cheer you up?						
3. Felt calm and peaceful?						
4. Felt downhearted and blue?						
5. Been a happy person?						

*Items 3 and 5 were reverse scored

Scoring:

Response Category	Scores on questions 1, 2, 4	Score on questions 3, 5
1. All of the time	1	6
2. Most of the time	2	5
3. A good bit of the time	3	4
4. Some of the time	4	3
5. A little of the time	5	2
6. None of the time	6	1

The scores from the MHI-5 is computed by adding the scores for each question item and them transforming the raw scores to a 0-100 point scale. Total score on MHI-5 = 100((score a + score b + score c + score d + score e)-5)/25

MHI-5 Categories:

- Excellent: 91 – 100
- Very Good: 81 – 90
- Good: 71 – 80
- Fair: 61 – 70
- Poor: < 60

Appendix C

10-Item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF) (Fischer & Farina, 1995)

Instructions: Read each statement carefully and indicate your degree of agreement using the scale provided.

	Disagree			Agree
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	1	2	3	4
2. The idea of talking about problems with a counselor strikes me as a poor way to get rid of emotional conflicts*.	1	2	3	4
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.	1	2	3	4
4. There is something admirable in the attitude of a person who is willing to cope with their conflicts and fears without resorting to professional help*.	1	2	3	4
5. I would want to get psychological help if I were worried or upset for a long period of time.	1	2	3	4
6. I might want to have psychological counseling in the future.	1	2	3	4
7. A person with an emotional problem is not likely to solve it alone; they are likely to solve it with professional help.	1	2	3	4
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me*.	1	2	3	4
9. A person should work out their own problems; getting psychological counseling would be a last resort*.	1	2	3	4
10. Personal and emotional troubles, like many things, tend to work out by themselves*.	1	2	3	4

*Items 2, 4, 8, 9, and 10 were reverse scored

Scores are summed together, with higher scores indicating more positive attitudes toward seeking professional help.

For the current study, modifications were made to the ATSPPH-SF as follows.

- Items 4, 7 and 9: Gender neutral pronouns *them* and *they* were used.

Appendix D

10-Item Self-Stigma of Seeking Help Scale (SSOSH)
(Vogel et al., 2006)

Instructions: Read each statement carefully and indicate your degree of agreement using the scale provided.

	Strongly Disagree				Strongly Agree
1. I would feel inadequate if I went to a therapist for psychological help.	1	2	3	4	5
2. My self-confidence would NOT be threatened if I sought professional help*.	1	2	3	4	5
3. Seeking psychological help would make me feel less intelligent.	1	2	3	4	5
4. My self-esteem would increase if I talked to a therapist.	1	2	3	4	5
5. My view of myself would not change just because I made the choice to see a therapist.	1	2	3	4	5
6. It would make me feel inferior to ask a therapist for help.	1	2	3	4	5
7. I would feel okay about myself if I made the choice to seek professional help*.	1	2	3	4	5
8. If I went to a therapist, I would be less satisfied with myself.	1	2	3	4	5
9. My self-confidence would remain the same if I sought help for a problem I could not solve*.	1	2	3	4	5
10. I would feel worse about myself if I could not solve my own problems.	1	2	3	4	5

*Items 2, 4, 5, 7, 9, were reverse scored

Scores were summed together, with higher scores indicating a greater concern that seeking help for mental health support would negatively affect one's self-regard, satisfaction with oneself, self-confidence, and overall worth as a person (Vogel et al., 2006).

Appendix E

Gender Role Confusion Scale-Restrictive Emotionality Subscale, 9-Items
(Blazina et al., 2005; O'Neil et al., 1986)

Instructions: Please identify the level to which you agree or disagree with each of the following statements.

	Strongly Disagree 1	Disagree 2	Slightly Disagree 3	Slightly Agree 4	Agree 5	Strongly Agree 6
1. I have difficulty telling others I care about them.						
2. Strong emotions are difficult for me to understand.						
3. Expressing feelings makes me feel open to attack by other people.						
4. It's hard for me to talk about my feelings with others.						
5. It's hard for me to express my emotional needs to others.						
6. When I am personally involved with others, I do not express my strong feelings.						
7. I often have trouble finding words that describe how I am feeling.						
8. I do not like to show my emotions to other people.						
9. Telling others about my strong feelings is difficult to me.						

Scores were summed together, with higher scores indicating higher levels of gender role conflict (Berger et al., 2005).

Appendix F

Machismo and Caballerismo Scale, 20-Items
(Arciniega et al., 2008)

Instructions: Please identify the level to which you agree or disagree with each of the following statements.

	Strongly Disagree						Strongly Agree
1. Men are superior to women.	1	2	3	4	5	6	7
2. Men want their children to have better lives than themselves.	1	2	3	4	5	6	7
3. In a family, a father's wish is law.	1	2	3	4	5	6	7
4. A real man does not brag about sex.	1	2	3	4	5	6	7
5. Men should respect their elders.	1	2	3	4	5	6	7
6. The birth of a male child is more important than a female child.	1	2	3	4	5	6	7
7. Men hold their mothers in high regard.	1	2	3	4	5	6	7
8. It is important not to be the weakest man in a group.	1	2	3	4	5	6	7
9. Real men never let down their guard.	1	2	3	4	5	6	7
10. The family is more important than the individual.	1	2	3	4	5	6	7
11. It would be shameful for a man to cry in front of his children.	1	2	3	4	5	6	7
12. Men should be willing to fight to defend their family.	1	2	3	4	5	6	7
13. A man should be in control of his wife.	1	2	3	4	5	6	7
14. It is necessary to fight when challenged.	1	2	3	4	5	6	7
15. Men must exhibit fairness in all situations.	1	2	3	4	5	6	7

16. It is important for women to be beautiful.	1	2	3	4	5	6	7
17. A woman is expected to be loyal to her husband.	1	2	3	4	5	6	7
18. The bills (electric, phone, etc.) should be in the man's name.	1	2	3	4	5	6	7
19. Men must display good manners in public.	1	2	3	4	5	6	7
20. Men should be affectionate with their children.	1	2	3	4	5	6	7

Machismo Items: 1, 3, 6, 8, 9, 11, 13, 14, 16, 18
Caballerismo Items: 2, 4, 5, 7, 10, 12, 15, 17, 19, 20

Appendix G

Critical Race Theory Measurement (CRTM)-19 items
(Campbell, 2014)

Instructions: The following is a set of questions that were given to mental health professionals in a previous study. These questions relate to social issues in the United States (U.S.). Using the 6-point scale, please give your honest rating about the degree to which you personally agree or disagree with each statement from the perspective of a potential client receiving help from a mental health professional who will complete the same measure. Please be as open and honest as you can; there are no right or wrong answers.

	Strongly disagree 1	2	3	4	5	Strongly Agree 6
1. Racial/ethnic minoritized people should try to fit into the dominant cultural & adapt the values of the U.S.						
2. It is important for people to think of themselves as American & not Latinx-American, African American, Asian American etc.						
3. Discussing issues of race causes unnecessary conflict and anger.						
4. Racial incidents are rare and isolated in the U.S.						
5. Race exists as a social construct.						
6. Race biologically determines one's personalities and abilities.						
7. Race/ethnicity is the most effective way to categorize people.						
8. When interacting with new people, the first thing I notice is one's race/ethnicity.						
9. "Otherness" results in a group's decision/power to separate or distance themselves from the dominant group.						
10. Race is significant in determining who will become successful and who will not.						

11. Regardless of race/ethnicity, people who work hard have an equal chance of becoming wealthy and successful.						
12. Racial/ethnic minoritized people do not have the same opportunities as White people in the U.S.						
13. Race/ethnicity determines the type of services and opportunities people receive in the U.S.						
14. A major component of any intervention should be providing a space for the client to voice their personal story.						
15. History continues to exclude narratives and perspectives from racial/ethnic minoritized people.						
16. A mental health professional should allow the client time to digress on their concerns, while the mental health professional takes the role of the listener.						
17. A mental health professional should often modify or change interventions to capture better and understand experiences of marginalized clients.						
18. It is time consuming to address clients social locations (e.g., race, ethnicity, sexuality, class, gender, etc.); therefore, it is more effective to focus on one.						
19. It is more effective for a mental health professional to focus and identify the most oppressive personal identity (e.g., race, ethnicity, sexuality, class, gender), in order to determine the best intervention.						

*Items 5, 10, 12, 13, 14, 15, and 16 were reverse scored

For the current study, modifications were made to the CRTM as follows.

- Items 1, 12, 15: The word *minorities* was changed to *minoritized people* to reflect more current social justice informed language (Benitez, 2010; Sotto-Santiago, 2019; Stewart, 2013).
- Items 8 and 11: The word *people* was used in place of the word *individual* due to the collectivist preferences of Latinx populations (Chang et al., 2020; Del Pilar, 2009; Hwang & Goto, 2009; Turner & Llamas, 2017).
- Item 2: *Mexican* was changed to *Latinx* to include the many populations that identify under this umbrella classification. *Latinx-American* was placed first in the list of identities considering the demographics of the present study.
- Item 16: *I often allow the client time to digress on their concerns, while I take the role of the listener* was changed to *A mental health professional should allow the client time to digress on their concerns, while the mental health professional takes the role of the listener*.
- Item 17: *I often modify or change interventions to capture better & understand experiences of marginalized clients* was changed to *A mental health professional should often modify or change interventions to capture better and understand experiences of marginalized clients*.
- Item 19: *It is more effective for women of domestic voice to focus & identify the most oppressive personal identity (race, class, gender), in order to determine the best intervention* was changed to *It is more effective for a mental health professional to focus and identify the most oppressive personal identity (e.g., race, ethnicity, sexuality, class, gender), in order to determine the best intervention*.

Appendix H

General Help-Seeking Questionnaire-Original Version (GHSQ), 22-items (Deane et al., 2001)

1. If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?

Please indicate your response by circling the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, spouse, significant other)	1	2	3	4	5	6	7
b. Friend (not related to you)							
c. Parent							
d. Other relative/Family member							
e. Mental health professional (e.g., counselor, psychiatrist, psychologist, counselor, social worker)							
f. Phone helpline (e.g., Lifeline)							
g. Doctor/General practitioner							
h. Religious leader (e.g., Minister, Priest, Rabbi, Imam, Chaplain)							
i. I would not seek help from anyone							
j. I would seek help from another not listed above (please list in the space provided (e.g., work colleague. If no, leave blank): _____							

2. If you were experiencing suicidal thoughts, how likely is it that you would seek help from the following people?

Please indicate your response by circling the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, spouse, significant other)	1	2	3	4	5	6	7
b. Friend (not related to you)							
c. Parent							
d. Other relative/Family member							
e. Mental health professional (e.g., counselor, psychiatrist, psychologist, counselor, social worker)							
f. Phone helpline (e.g., Lifeline)							
g. Doctor/General practitioner							
h. Religious leader (e.g., Minister, Priest, Rabbi, Imam, Chaplain)							
i. I would not seek help from anyone							

j. I would seek help from another not listed above (please list in the space provided (e.g., work colleague. If no, leave blank): _____							

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