Title

Beyond access: Psychosocial barriers to undocumented students' use of mental health services.

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Abstract: Rationale: Little is known about how undocumented immigrants navigate healthcare utilization issues apart from access. **Objective:** We examine a unique population of undocumented immigrants who have access to healthcare – college students at the University of California – to identify how immigration status hinders mental health service utilization in the absence of barriers related to eligibility and insurance coverage. **Method:** We conducted semistructured interviews between March and July 2017 with 30 undocumented students at a University of California campus. **Results:** We argue that undocumented immigration status informs mental health-related illness cognitions to negatively affect students' ability to assess their own mental health and need for services. Students expressed low perceived need because they normalized mental strain as a natural product of their unstable immigration status. Many viewed treatment as futile because it could not address underlying immigration-related issues. They also anticipated stigmas associated with mental illness as well as their own undocumented status. **Conclusion:** Solutions to address utilization disparities must go beyond eliminating formal barriers to health access and address such psychosocial barriers, as well as the larger political and social context that produces them.

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Introduction

There is a growing interest in the role of immigration status as a social determinant of health. Undocumented status produces stressors that reflect limited material resources, marginalization and isolation, fear of deportation, uncertainty about the future, acculturative stress, discrimination, and stigmatization (Enriquez et al., 2018; Garcini et al., 2016). Regular exposure to chronic and acute stress has been linked to poorer mental health (Marin et al., 2011), suggesting that undocumented immigrants may be at increased risk for poorer mental health. Indeed, undocumented immigrants have higher prevalence of depressive symptoms, poorer self-assessed mental health, and higher rates of major depressive disorders compared to their documented counterparts or the general population (Hatzenbuehler et al., 2017; Venkataramani, et al., 2017).

Despite their highlighted vulnerability for mental health problems, undocumented immigrants are significantly less likely to seek out mental health services (Derr, 2016). Much of the existing work on undocumented immigrants' healthcare under-utilization has focused on structural barriers to access due to a lack of insurance coverage or program ineligibility. In contrast, we focus on psychosocial barriers, specifically, how immigration status affects perceptions of mental health and need for services. Undocumented college students enrolled in the University of California (UC) are an ideal population to study these issues, as they represent a rare group of undocumented immigrants who have access to comprehensive health insurance and mental health services. Therefore, we can readily identify how immigration status emerges as an obstacle to health services in the absence of structural barriers related to eligibility and insurance coverage. In this paper, we take a closer look at how immigration status impacts mental healthcare utilization through 30 in-depth interviews with undocumented UC students.

We argue that immigration status fundamentally informs students' mental health-related illness cognitions, which in turn, operate as psychosocial barriers to their perception of mental health need and service use.

Psychosocial Barriers to Care and Illness Cognitions

The majority of previous work on undocumented immigrants' healthcare utilization has focused on a lack of enabling material resources, particularly lack of health insurance and limited healthcare access and utilization (Luo & Escalante, 2018; Vargas Bustamante et al., 2012). Undocumented immigrants tend to work in jobs without medical benefits, cannot afford medical care, or are either ineligible for government insurance programs (i.e., Medicaid), or, when eligible, choose not to enroll in other public programs (Madden & Qeadan, 2017; Yoshikawa & Kalil, 2011). Many have called for changing features in the delivery structure – for example, expanding access to healthcare – as a way to expand healthcare utilization among undocumented immigrants (Galarneau, 2011; Murphree, 2016).

However, researchers have long contended that healthcare-seeking is not solely facilitated by enabling resources, but also by psychosocial factors that affect one's perception of need and disposition to utilize services (Andersen, 1995; Angel & Thoits, 1987). One important component in shaping psychosocial factors is illness cognition, which refers to cognitive processes that underlie the beliefs individuals hold about illness and help-seeking (Chan & Mak, 2016; Leventhal, Diefenbach, & Leventhal, 1992). They shape one's perceptions of health status, interpretations of symptoms, and help individuals understand and respond to their illness. Illness cognitions can become barriers to care as they mediate the process between health-related states (i.e., symptoms) and help-seeking. For example, individuals with more negative attitudes and beliefs about healthcare services and a low perception of symptom severity are less likely to

access care (Bradley et al., 2002). Despite their key role in mental health perceptions and help-seeking, psychosocial factors, including illness cognitions, have been understudied given the emphasis on undocumented immigrants' limited access to care.

While illness cognitions have primarily been applied in individual-level theories of health behavior, we build on existing work that views illness cognitions as a product of social, cultural, and class characteristics (Angel & Thoits, 1987; Cauce et al., 2002). This socioecological perspective (Bronfenbrenner & Ceci, 1994) argues that the social environment "constrains the perceptual, explanatory, and behavioral options that individuals have at their disposal for understanding and responding to illness" (Angel & Thoits, 1987). For example, shared understandings of mental health norms can shape one's appraisal of whether certain symptoms warrant concern. We contend that the social, economic, and legal processes that make undocumented status consequential in everyday life (e.g. immigrant "illegality") foreground the context in which undocumented college students assess their mental health strain and weigh the decision to seek services.

Immigrant "Illegality" and the Mental Health Context of Undocumented College Students

Theories of immigrant "illegality" highlight how laws create and sustain an undocumented immigrant category and make it consequential for individuals' everyday lives and incorporation opportunities (Menjívar & Kanstroom, 2014). Using this framework, scholars have captured how socio-legal structures produce inequality for undocumented immigrants by restricting everyday activities, shaping decision-making, and limiting upward mobility (Dreby, 2015; Enriquez, 2017; Gonzales, 2016). A wide variety of federal, state, and local laws and policies work together to construct the material barriers associated with illegality by limiting educational access, employment options, social participation, spatial mobility, and threatening

deportation. This structural exclusion produces negative psychosocial consequences as undocumented immigrants develop a sense of stigma, are unable to meet their own and other's expectations around life course transitions, and experience chronic stress (Abrego, 2011; Gonzales, 2016; Gonzales et al., 2013).

Undocumented 1.5 generation youth and young adults (e.g. those who entered the U.S. as children or adolescents) compose a unique group of undocumented immigrants, comprising over 3 million of the 11 million undocumented immigrants in the U.S. (Batalova et al., 2017). They have a distinct experience of immigrant "illegality" due to their migration journeys, acculturation to U.S. norms, access to educational institutions, and the implementation of laws and policies that view them as more deserving of relief (Abrego, 2011; Olivas, 2012). They are also the focus of federal immigration relief, including the Deferred Action for Childhood Arrivals (DACA) Program, a federal program established in 2012 to provide renewable two-year access to work permits and protection from deportation. Receiving DACA abates some of the most negative consequences of illegality, and recipients report improved high school and college completion rates, higher paying jobs with better working conditions, access to financial accounts and driver's licenses, and better psychological well-being (Capps, Fix, & Zong, 2017; Gonzales, Terriquez, & Ruszczyk, 2014; Patler & Laster Pirtle, 2018; Wong & Valdivia, 2014).

Limited existing data suggest that undocumented students may have a higher risk for mental health problems and lower service utilization than other populations. College students in general have elevated levels of mental distress and low treatment levels compared to the general population (Hunt & Eisenberg, 2010). Latino and Asian students, who comprise the majority of undocumented immigrants, are significantly more likely to report mental health problems but less likely to receive services compared to White students (Lipson et al., 2018). Indeed, a 2016

survey of undocumented UC undergraduate students found them to have markedly elevated levels of perceived stress compared to other national samples comparable in age and ethnicity (Enriquez et al., 2018). Notably, 64% of respondents reported feeling that they needed mental health counseling in the past year, but only 39% of respondents sought professional help (Enriquez et al., 2019a).

Several scholars have described the unique stressors and needs for care that are tied to students' immigration status (Gonzales et al., 2013; Enriquez et al. 2018; Getrich et al., 2019). Undocumented students share some of the same concerns as other college students, but are also burdened with additional stressors, such as limited financial resources due to restricted job opportunities, fear of deportation for self and others, uncertainty about the future, and stigmatization. These unique stressors are themselves significantly associated with poorer overall health (Enriquez et al., 2018). Students can be potentially deterred from seeking help due to fear of being reported to authorities when accessing services, discrimination or stigma related to immigration status, and limited finances (Hacker et al., 2015; Sudhinaraset et al., 2017). Further, both documented and undocumented immigrants in the U.S. face increasingly restrictive policies and hostile political rhetoric. Particularly relevant for undocumented college students is President Trump's rescission of the DACA program in September 2017. At the time of this study, the program continued in a limited scope and its future was entangled in the courts. Still, the possibility of its rescission instilled a sense of uncertainty and fear among undocumented young adults who faced the possibility of losing their tenuous grip on opportunities for upward mobility and social inclusion (Artiga & Ubri, 2017; Enriquez, et al., 2019b).

In this paper, we identify three psychosocial barriers to mental healthcare: low perceived need for services, perceived futility of treatment, and multiple stigmas related to mental illness as

well as their own undocumented status. While these are common barriers to care-seeking among college students (Eisenberg et al., 2011), we demonstrate that they are fundamentally shaped by students' experiences of "illegality".

Methods

Our data is drawn from the Undocumented Student Equity Project (USEP), specifically interviews with 30 undocumented UC students about their mental health and mental health service utilization. The UC requires all registered students to have medical insurance and provides access to a student health insurance program that offers comprehensive medical, pharmacy, dental, vision, mental health and substance use disorder benefits. As a result, all participants had comprehensive health insurance and access to mental health services, including short-term, on-campus mental health services.

Qualitative interviews were conducted from March to July 2017 on one UC campus. We aimed to interview 30 participants split evenly between the two largest racial/ethnic groups within the undocumented population – Latina/o/x and Asian American Pacific Islanders (AAPI). We use "Latina/o/x" to refer to Latin American origin participants; this captures the range of male (Latino), female (Latina), and gender-neutral (Latinx) racial/ethnic identifiers used. When referring to a specific participant, we use their chosen racial/ethnic identification. In California, 78% of undocumented immigrants are Latina/o/x and 13% are AAPI (Hayes & Hill, 2017). We built in this comparison to assess if there are racial differences given that previous research has identified uniquely racialized experiences of illegality for each group (Enriquez, 2019), as well as racial/ethnic differences in mental health status and mental health service use (Lipson et al., 2018; SAMHSA, 2015). We also aimed for equal numbers of men and women. Our previous

experience and other qualitative studies suggested that this sample size would be sufficient to reach data saturation (Sudhinaraset et al., 2017).

We used purposive sampling to recruit participants according to our race and gender quotas. We sent a recruitment email to prior USEP study participants who consented to be contacted for future research purposes. The same email was sent out through the campus' undocumented student list-serv to recruit new volunteers. Finally, we drew on research personnel's personal networks to fulfill our quotas. Participants were told it was a study of undocumented students' mental health; no selection criteria were established for one's mental health or use of mental health services. Participants were interviewed at a place of their choosing on campus; most elected to be interviewed in private office space available to research personnel. Interviewers used an information sheet to guide the informed consent process and obtained participants' verbal consent to participate in the study; this minimized the risk of a breach of confidentiality associated with written records and preserved a more conversational atmosphere. No participants raised concerns during the consent process. We received approval from the University of California, Irvine's Institutional Review Board (HS# 2015-2463).

Interviews conducted by three trained team members followed a semi-structured interview guide that addressed overall mental health and wellbeing, stress, formal and informal coping strategies, and the impact on their educational experiences. Questions most relevant to our analysis included: 1) Where do you turn when you feel like you need support to deal with your stress or issues related to your undocumented status? 2) Have you felt like you need professional mental health support? What made you feel like you needed it or not? 3) In a recent survey of UC undocumented students, almost half of respondents said they needed mental health

services and didn't get them. Why do you think this is so? What factors, if any, have prevented you from using these resources? Interviews averaged one hour and participants received $20.

We interviewed 30 self-identified undocumented students (Table 1). We interviewed relatively equal numbers of men and women (women=53%) as well as Latina/o/x and AAPI (Latinas/os/xs=53%). Slightly more than three quarters (77%) were DACA recipients. Most had over two years of college experience, with only 23% who were in their first or second year of college. To protect confidentiality, all names are pseudonyms.

Interviews were audio recorded, transcribed, and coded in HyperRESEARCH. We used a "flexible coding" method commonly used to analyze interviews using qualitative data analysis software (Deterding & Waters, 2018). Three research team members conducted index coding to identify large chunks of interview text connected to the broad topics explored in the interview guide. For this paper we focused on one theme – use of professional mental health care services – for which we applied analytic codes for factors preventing use, factors that led them to access services, assessments of the process of seeking services, descriptions of service use, and perceptions of counselor awareness. One primary coder trained two others on applying the codebook and they resolved discrepancies as they arose. Reviewing the codes revealed that the factors fell into two categories identified in the extant literature – material barriers and psychosocial barriers. We conducted a second round of analytic coding to identify all instances and types of barriers within these two categories. We compared these codes across gender, racial/ethnic background, and DACA protection, but did not find group differences in barriers to mental health service use. Given the current empirical emphasis on material barriers to service utilization, we focused our analysis on the less-studied psychosocial barriers. We applied the

theoretical lens of illness cognitions to interpret our results and incorporate theories of "illegality."

Results

Normalizing Strain: Low Perceived Need for Services

One important illness cognition is the recognition and labeling of illness, which then enables help-seeking (Angel & Thoits, 1987). People develop a perceived need for services based on how they view their own health status, whether and how they experience symptoms or pain, and whether they judge their problems to be of sufficient importance and magnitude to seek help (Andersen, 1995; Bradley et al., 2002). All participants readily acknowledged that they experienced high levels of stress and mental strain, yet they did not usually seek services. Often, this was because they normalized their stressors and mental health strain, lowering their perceived need for services.

When asked about their sources of stress, participants identified multiple stressors related to their immigration status. All discussed fears of the future, which centered on their potential inability to obtain formal employment and pursue a career after graduation. Despite receiving state and institutional aid that covered tuition and fees, many reported financial strain, struggling to cover additional educational costs like books, food, and housing. Although many felt insulated from deportation threats to themselves, they worried about the safety of parents and other family members. These immigration-related concerns also fed general stress about their academic performance (Enriquez et al., 2018).

Despite these unique circumstances and high levels of perceived stress, students' chronic exposure to stressors made their mental health strain seem normal, rather than indicative of poor

mental health. Many felt like Sebastian, a Mexican/Latinx student, and Charlie, a Taiwanese recent graduate:

> *Sebastian*: "It was just normal to feel like that. I've always felt like that my entire life you know. *Interviewer: And when you say feel like that, what do you mean specifically?* I think a lot of uncertainty. … You never know if just literally one day out of nowhere, they can take away DACA. One day out of nowhere, my dad might be at the wrong place at the wrong time. Or my mom or someone else I know or one of my friends. So just kind of living with that in the back of your head, it doesn't go away. Although you can make yourself feel good for like a certain amount of time. At the end of the day, those thoughts are still in your head."

> *Charlie*: "I think a lot of people in that situation [of being undocumented] … they're not quite sure if they actually need help or they might be just in typical stress. It's been with me throughout college; I treat it as normal. I'm pretty stressed out all day."

The chronic nature of their stress blurred their perceived need for help because it was so pervasive in their daily lives.

Mental health strain was further normalized in light of other material stressors they believed were more legitimate and urgent problems. For example, Karina, a Mexican student, observed: "I just feel like it's not something, it's not like something you see. It's not a tangible problem or something you can point out. Like, 'Oh, I'm low on money or my car's not working.' It's not a real problem. … At least in my family, money problems, that's a real problem." Instead, she felt that seeking mental health services, "had to be a last resort kind of thing. I wouldn't have gone just casually because I feel stressed or something." Like many participants, she concluded

that her mental health problems were not as pressing as material barriers raised by her immigration status.

The normalization of mental health strain was further compounded by students' prominent use of avoidance as a coping strategy. For example, Heisy, a Hispanic student, explained, "I just lie to myself like, 'Nah, it's not gonna affect me too much.' … And in the back of my head, I know what's going on. But I'm trying to not let it bother me even though it is affecting me." Similarly, Isaac, a Filipino student, told himself, "I can do this by myself. I'll just pull through myself. I don't really need help. I'll contain it all." He admitted, "[I] internalize it until I explode [laughs]. Which is not good, not good." Seeking to avoid thinking about immigration status related barriers, students pushed these thoughts to the side, which lowered their perceived need for services.

Furthermore, many students viewed mental health services as only for individuals with severe symptoms, pushing them to further normalize and dismiss their own strain as insufficiently serious. Alondra, a Mexican student, stated, "Sometimes I feel like [undocumented status is] not valid enough, or it's not a valid enough reason to actually go and seek help. Because I have friends ... they have clinical disorders and stuff and I see them and I'm like well, I don't have it as bad as them so I don't need to go." Ellen, a Chinese student, shared, "I don't have any serious mental health issues. But I mean, I worry a lot about my family. But I don't really think that counts as mental health issues or anything. I guess to me, mental health means having some sort of serious problem that needs to be diagnosed by a mental health practitioner and I don't think mine really qualifies that extensively." Many participants similarly invalidated their mental health strain as insufficiently severe to merit their use of mental health services.

When participants did experience severe mental health strain, they often framed it as

temporary and thus an insufficient reason to seek services. Angie, a Mexican student, highlighted this trend:

> I feel like when I need to see someone, it's like at the moment and I'm having my breakdown at the moment but then it just takes me to do—it just takes me a day or two to get over it and it's just kind of like, I don't need it anymore. After I feel fine. … But there's times when it hits me and I'm like ahhh, I wish I would have someone, I wish I would be able to tell someone. … But once I move on from it, it's just kind of like it doesn't exist again until, yeah. So I just kind of let go of it.

Like Angie, many participants recounted "breakdowns" when their mental health strain rose to a point that it could no longer be normalized. When these passed, they returned to their prior strategy of normalizing strain. Given this tactic, participants reasoned that they would seek mental health services when their symptoms became so severe that they were no longer temporary. Cristina, a Mexican student, shared that her stress usually didn't "last more than like two weeks." She reasoned that she would likely seek professional help if it was longer than that and she "ever felt really, really sad. … If it was just too much."

Futility of Mental Health Services to Address Immigration Issues

A person's attitude about health services can influence their perception of treatment effectiveness and the likelihood of service utilization (Andersen, 1995). Immigration status uniquely contributed to perceptions of effectiveness because it creates structural barriers that can only be solved with a change in legal status. Thus, participants anticipated futility in using mental health services because it would not address the underlying source of their stress and could potentially exacerbate their mental health strain.

Leaving the real problem unaddressed. Approximately a quarter of participants chose not to access care because they felt that speaking with a counselor would not resolve underlying immigration-related issues that were the sources of stress. Ellen, a Chinese student, recalled attending a school workshop where a counselor encouraged students to focus on self-care. She observed matter-of-factly, "I don't think that's gonna help my problems. (Laughs) Like taking a really nice bath isn't gonna make my problems go away. … Doing yoga and meditating isn't going to impeach Trump (Laughs). That's how I see it. I appreciate what they're doing but it's not gonna help me." Although such techniques may have been helpful for coping, Ellen dismissed them as ineffective because they would not address the laws and policies producing her mental health strain.

Perceived ineffectiveness stemmed from students' low perceived control over immigration policies. Some, like Ellen, tried to exercise some sense of control by participating in activism to demand policy change. Others acknowledged that their futures lay in the hands of policymakers and bureaucrats. Epitomizing this, Angie, a Mexican student, highlighted the structural nature of her unique stressors: "Because whatever is going on in society, there's very little control that I can have over it." The legally-bounded nature of her problems prevented her from seeing the utility of "reach[ing] out for help when I do feel like I'm down."

Some students who had previously seen a counselor and decided to discontinue care echoed this sentiment. When students reached a tipping point and sought services, they were looking for tangible answers and solutions. Megen, a Hispanic/Mexican student, reflected on how her first session went: "I was looking for a solution to all my problems but it wasn't that way. It was just more like talking about your feelings and stuff like that than actually having a solution." This created a mismatch between students' expectations and what mental health

professionals actually provide. When misperceptions persisted, they often left counseling before seeing benefits, further reifying perceptions that it would be a futile source of support.

Creating additional strain. A few participants worried that discussing immigration-related issues could increase mental health strain, rather than resolve it. Doing so would be in direct opposition to students' frequent use of avoidance as a common coping strategy to try to ignore immigration-related stressors outside of their control. Paola, a Hispanic student, shared how she coped with the barriers she faced as an undocumented student:

> I think for me, it's mostly about just rejecting that part of my life. And pretending it's not there. Not wanting to be there so that I pretend like it's not real. … I almost want to say it's like a survival mechanism. We have so much limited time and energy. And it's also, going there, I feel like it can make you sad, you know? … I think for me, I haven't fully accepted that part of my life. Because like if I— I almost— I guess I used to think if I accept it, I can't have these other things. I can't be successful or whatever.

While Paola had recently made a second attempt at seeing a counselor, she voiced how her desire to disengage from thinking about her immigration status deterred her, and likely other students, from seeking help.

Participants who considered accessing services understood that it would require them to actively think through and process immigration-related stressors. Tania, a Mexican student, reasoned that her mental health strain would worsen if she were to talk about it:

> It literally feels like when you take one step and two steps back. That's what it feels like. You take one step in a sense that you're going to feel better or you're going to get these resources, you're going to get the help you need, you're going to get all

> this. But at the same time, it's like two steps back because you're just reminded, one, I don't have a status, and two, now I have to encounter all these situations and all these questions and answer things.

Thus, students did not seek help out of fear that the counseling process itself would produce additional, potentially debilitating, mental health strain.

Multiple Dimensions of Stigma

Stigma denotes attitudes and beliefs towards individuals or groups who are perceived as different, leading to discrimination, devaluation, exclusion, and lowered social status (Link & Phelan, 2001; Weiss, Ramakrishna, & Somma, 2006). Mental health-related stigma is a commonly-understood barrier to mental health care among college students (Eisenberg, Downs, Golberstein, & Zivin, 2009), undocumented immigrants (Garcini et al., 2016), and within immigrant families (Spencer, Chen, Gee, Fabian, & Takeuchi, 2010; Vega et al., 2007). Participants spoke about the role of mental health stigma when asked why they did not seek mental health treatment. However, additional forms of stigma arose from their immigration status, creating a unique barrier that further deterred their help-seeking.

Mental health-related stigma. Nearly all participants expressed mental health-related stigma that reduced their likelihood of using services. Calvin, a Korean American student, and Alondra, a Mexican student, highlighted this issue:

> *Calvin*: "I would say there's still some sort of social stigma with mental health issues. I know there's one especially for API students. Asian American culture, the minute you have some sort of social issues, it's a sign of weakness."

> *Alondra*: "In terms of mental health, I feel like there's a big stigma in Hispanic culture with going to seek help."

Although some students sought to assign this stigma to their specific racial/ethnic group, both Latina/o/x and AAPI students voiced the presence of stigmatizing attitudes toward mental health services within their families and communities. This reflects previous scholarship on racial/ethnic minorities' high levels of stigma around mental health and related help-seeking (Clement et al., 2015; Golberstein, Eisenberg, & Gollust, 2009; Wu et al., 2017).

Part of the stigma students described was related to their fear that using mental health services would lead to a clinical diagnosis. Isaac, a Filipino student explained, "Part of the reason why is because of an attached stigma of, 'Oh, I'm going to see the counselor.' … There's this whole conception of once you start seeing a professional mental health counselor, it's kind of like thinking you have a mental disorder." Students felt that getting help for mental health issues would become a self-fulfilling prophecy; it would lead to a clinical diagnosis, creating additional strain and stigma on top of those related to their immigration status.

Immigration status-related issues compounded the dissuasive effects of mental health stigma on help seeking. Markus, a Filipino student, explained how the normalization of stress intersected with stigma: "I used to think that oh man, being sad is normal, just suck it up, right. And going to counseling means you're giving up, you're being a little bitch, you're weak as fuck." Similarly, Eliaseo, a Mexican student, believed that stigma could create additional strain for those who already felt excluded by their immigration status: "Just bringing up your mental health has always been like, it's already stigmatized. It still is. But I would say for people who struggle being undocumented and in an academic setting, the big reason why we don't seek those services is because we already don't feel like we belong here."

Immigration status-related stigma, Concern about disclosure and confidentiality is a common illness cognition barrier for the general population (Clement, 2014), but this was further

complicated for undocumented immigrants who risk social stigma and deportation threats when revealing their status to others. Alondra, a Mexican student, explained that she felt that she could not indiscriminately reach out to anyone, "because not only are you endangering your status but I just feel like it's harder to reach out also because people are very ashamed to talk about it." As a result, most participants had only ever shared their status with people they knew well and trusted. Sung, a South Korean recent graduate, explained,

> Just coming out and saying that you're undocumented is a big thing. There's some friends who I consider that I'm close to that I haven't told I'm undocumented. So going to a counselor who you've never known and you've never talked to and just telling them you're undocumented, I think is a big trust you have to build. … I think I would never outright go and tell them.

Most undocumented young adults elect to disclose their status for very precise purposes, such as accessing information about educational resources or advocating for changes to immigration policy (Enriquez & Saguy, 2016; Patler, 2018). As with any decision to reveal their status, participants wrestled with the idea of disclosing to a mental health professional as they weighed the potential risks and benefits of this choice. Many anticipated that the risk of immigration status-related stigma was high given that mental health services may not have counselors that share students' backgrounds.

Although disclosure of one's immigration status was not required to receive care, it was often a critical factor driving students' need for services. Not wanting or being unable to reveal these issues early on could thus delay or disrupt the delivery of effective services. Mauricio, a Latinx student, reflected on how reluctance to reveal one's immigration status or speak about its

connection to their mental health strain might prevent service providers from seeing students' need:

> If people have to go through these screening processes and the therapist doesn't really know how big of an issue it [undocumented status] actually is and the student … can't communicate exactly what they feel at that point, maybe because … you're meeting somebody for the first time. … And [then] the therapist doesn't really think they need help, then the student is not going to get that help.

Along this line, students, particularly those who feel they are seeking services for issues presumably unrelated to their immigration status, may elect not to share their immigration status. This could leave an important underlying stressor unacknowledged and unaddressed.

In some cases, students feared that unaware counselors might make negative comments about undocumented immigrants. Angie, a Mexican student, explained, "They might have assumptions or they might have opinions about it that I might not want to hear." Tania, a Mexican student, explained her hesitance to speak to a counselor because she would, "have to encounter all these situations and all these questions and answer things. You know? And having to be asked, why don't you just fix it? Or just questions like that." These concerns epitomize how students perceived service structures as being unprepared to serve them.

In most cases, students' expressed concern that counselors would not understand immigration-related issues and would react inappropriately to this topic, a subtler form of stigma. Mauricio, a Latinx student, remembered speaking with a counselor who was not sufficiently aware of undocumented students' issues: "Something that I did not like about it is that the therapist was not really informed on undocumented status issues. So a lot of it was, like, me explaining what issues undocumented individuals face and then her just, like, pitying me." While

the counselor may have strove to express empathy, Mauricio interpreted this as a stigmatizing interaction. Tasia, an Indonesian student, and Hye-Young, a Korean student, shared similar concerns:

> *Tasia*: "I felt like maybe they would think I was exaggerating my problems. That was kind of why I was hesitant to go back. *Interviewer: What aspects did you think they might feel you were exaggerating?* Maybe just issues of money or my family life. Maybe they thought, 'Oh, I don't know why she's so overwhelmed by all this stuff.' That's why I didn't go back."

> *Hye-Young*: "A counselor is supposed to keep a poker face and keep it internal whatever the client says or patient says. But most of the times, many people kind of overreact to whatever we're talking about. So then that kind of becomes an issue for the [undocumented] students to reveal or talk about their particular issue."

Although they had opposite perceptions of under- versus over- reaction, both sentiments led to reluctance to visit mental health professionals due to the potentially stigmatizing responses to their undocumented status. Further, such stigmatizing interactions could reproduce mental health strain.

Perceptions of the cultural competence of mental health service providers directly impacted students' willingness to seek services, indicating that the service structure needs to hire counselors that share students' backgrounds. Several students wholeheartedly believed that a personal connection to the undocumented immigrant experience was critical to understanding their concerns and reducing potential stigma. Tania, a Mexican student, frankly stated, "If you're not living it, if you're not experiencing it, if you're not going through the mental state, I'm sorry but you're just not going to understand." This contributed to students' willingness to seek

services from a counselor known to have this connection. Sandra, a Hispanic student, shared her positive experience: “I was told beforehand that [the counselor] would be [aware of undocumented student issues] because she was undocumented herself at one point in her life. So she understood our worries. And that's why she was there, to alleviate the stress we were all feeling as undocumented students.” Calvin, a Korean American student who had not yet utilized mental health services, shared that his service use depended on his ability to find a counselor who was aware of undocumented immigrants’ experiences: “I don't want to meet with just a random counselor. I want to meet with someone who's an ally. … Because my stresses aren't just regular stress. It's on top of … [being] undocumented, and how that plays out.” Such perceptions can influence willingness to access services and may impact the effectiveness of therapy.

Finally, mental health stigma compounded the dissuasive effects of immigration status-related stigma on help-seeking. A few students worried that talking to professionals who did not understand the complex sources of their mental health strain might lead to a stigmatizing mental health diagnosis. Hye-Young, a Korean student, worried that counselors might not distinguish between diagnosable illness and the anxieties that stemmed from immigration policies and anti-immigrant political environments: “It's kind of like oh, I'm undocumented, I can't sleep and I'm in constant fear. ‘Okay, I think you have anxiety, let me send you over to a psychiatrist so they can prescribe you with something.’ It's normal that we're going to have anxiety because the Trump administration tactic is to implement fear. But they're kind of making this a mental issue.” This was not to say that diagnoses should never happen; in fact, some participants had benefited from being diagnosed and treated for specific psychiatric illnesses. Rather, some feared that a lack of understanding would lead to improper diagnosis and treatment.

Discussion

The growing interest in immigration status in health research has focused largely on the lack of access to instrumental benefits, such as insurance coverage. Our paper suggests that there are additional barriers that arise from psychosocial features inherent in the social categorization of being undocumented. Specifically, we examined how immigration status shaped the illness cognitions of mental health need and service utilization among undocumented college students. Despite expressing high mental strain and having access to care, the students in our sample were reluctant to seek mental health care services. We identified three illness cognitions: low perceived need for services, perceived futility of treatment, and the stigma associated with mental illness as well as undocumented status; all three were fundamentally informed by their immigration status and disrupted help-seeking. Students normalized their elevated mental strain to be a natural byproduct of their immigration status and did not view their problems as legitimate reasons to seek care. They also did not believe that mental health services could address their immigration status, which was the underlying source of stress, and in some instances, believed it could exacerbate their strain. Finally, students feared that service use would engender stigmatizing experiences related to their mental health and their immigration status. Our findings contribute to the limited literature on psychosocial barriers to undocumented immigrants help-seeking. Prior research suggests that when undocumented immigrants' are eligible for healthcare services, they self-exclude out of fear of being reported to immigration officials by healthcare providers (Hacker et al., 2011; Sudhinaraset et al., 2017). The three barriers we identified represent additional psychosocial barriers. Notably, we found no explicit mention of deportation fear; it is likely that the social location of our sample – as 1.5 generation undocumented students in California – informed their illness cognitions. Previous research has established that 1.5 generation young adults primarily understand illegality as a stigma,

compared to first generation immigrants to develop a legal consciousness grounded in fear (Abrego, 2011). This helps explain why our sample focused on stigma, rather than fear of deportation. Additionally, many participants held legal protections (i.e. DACA) and they all occupied symbolically protected spaces (i.e. college campuses) in one of the most positive state contexts (i.e. California), which further insulated them from deportation threats. Future work should examine the extent to which individual, local, and state factors influence the emergence of specific illness cognitions.

The type of illness cognitions discussed by our participants were not entirely unique from the general population or among college students (Hunt & Eisenberg, 2010). Other work has found that college students are similarly deterred from seeking help due to a lack of time, low perceived need for help, being unaware of service coverage, stigma around receiving services, skepticism about treatment effectiveness, and privacy concerns (Eisenberg et al., 2011; Nam et al., 2013). However, undocumented students' illness cognitions emerged in unique forms as the sources of their illness cognitions and the processes by which they arose were directly informed by their immigration status.

Limitations

Our study had some limitations. First, participants participated on a voluntary basis, which could have led to selection bias. However, we used multiple recruitment strategies and drew people from diverse networks and with varied experiences. Second, there is always a risk of social desirability bias as participants may have replied in a manner that they felt interviewers would view favorably. Yet, candid responses about their mental health diagnoses, negative encounters with counselors, and negative self-mediation coping strategies suggest this was not the case. Third, as a qualitative study we had a small sample size. However, it was comparable to

other qualitative papers recently published on similar topics (Sudhinaraset et al, 2017). We also reached data saturation, where similar themes were repeated by participants.

Conclusion

Solutions to health disparities by immigration status must go beyond eliminating formal barriers to eligibility and address the sources of these illness cognitions. We are not suggesting that participants are responsible for their own under-utilization or that they must find ways to independently overcome these barriers. Rather, it is important for counselors, other healthcare providers, administrators, researchers, and policymakers to consider how the service structure (re)produces these psychosocial barriers, and how to lower them and/or help undocumented students navigate them. This is particularly important given that some of the barriers, such as immigration-related stigma, were directly tied to the service structure and its ability to provide culturally competent care. For example, participants preferred counselors who had knowledge of immigration issues, understood the chronic uncertainty and various barriers they faced, and the ways immigration status affected their access to resources. This suggests a need for targeted hiring of culturally competent counselors, and training on ever-changing immigration policies and issues, possibly through continuing professional education. Indeed, studies have recommended more provider training to meet healthcare needs of undocumented immigrants, in part due to discrimination faced by undocumented immigrants when seeking help (Hacker et al., 2015). Other research has recommended that counselors actively advocate for justice and speak up for immigrants and refugees (Chung et al. 2008). With the recent rescission of DACA, the barriers we identify will likely only grow, underscoring the need for healthcare professionals to engage with the larger political and social context that shapes the mental health status of undocumented immigrants. Group mental health spaces, such as peer-led healing circles or

support groups facilitated by professional mental health care providers, may also prove beneficial to undocumented students' mental health and may help relieve some of the psychosocial barriers to seeking formal services. Creation of such spaces should be conducted in consultation with the campus' undocumented student population to ensure they are appropriate and helpful.

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Table 1

Summary of basic demographic characteristics of interview respondents (n=30). Characteristic	n	%
Gender		
Female	16	53%
Male	14	47%
Ethnicity		
Latina/o/x	16	53%
Asian American Pacific Islander	14	47%
Year in school		
First year	2	7%
Sophomore	5	17%
Junior	13	43%
Senior	8	27%
Graduate/professional student	1	3%
Recently graduated, not in school	1	3%
Mean Age	21.6	
Immigration status		
DACA protection	23	77%
No legal status	6	20%
Other form of liminally legal status	1	3%