UNIVERSITY OF CALIFORNIA

Santa Barbara

Al Frente/At the Front: Understanding Latine Parents' Help-Seeking and Access of Mental Health Services for their Children and Adolescents with Mental Health Needs

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Counseling, Clinical, and School Psychology

by

Iliana Flores

Committee in charge:

Professor Andrés J. Consoli, Chair

Associate Professor Miya L. Barnett

Professor Maryam Kia-Keating

December 2023

The dissertation of Iliana Flores is approved.

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Maryam Kia-Keating

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Miya L. Barnett

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Andrés J. Consoli, Committee Chair

December 2023

Al Frente/At the Front: Understanding Latine Parents' Help-Seeking and Access of Mental Health Services for their Children and Adolescents with Mental Health Needs

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by

Iliana Flores

DEDICATION

I dedicate this dissertation as a love letter to my mother, Maria De Lourdes Flores Castañeda. Gracias por enseñarme como luchar como tú lo has hecho toda tu vida. Todo lo que soy hoy te lo debo a ti. Gracias por nunca rendirte y por enseñarme como seguir adelante, ser fuerte, y mantener la frente en alto. Lo hicimos. Lo logramos, mamá. [Thank you for teaching me how to fight like you have done your whole life. Everything I am today I owe to you. Thank you for never giving up and teaching me how to keep going, be strong, and hold my head up. We did it. We did it, mom].

VITA OF ILIANA FLORES
December 2023

EDUCATION

2023 — Ph.D. Candidate, Counseling, Clinical, and School Psychology
University of California, Santa Barbara (APA Accredited)
Dissertation: *Al Frente*/At the Front: Understanding Latine Parents' Help-Seeking and Access to Mental Health Services for their Children and Adolescents with Mental Health Needs

2019 — Master of Arts, Counseling Psychology
University of California, Santa Barbara (APA Accredited)
Thesis: *"Todo se Hace de Corazón:" An Examination of Role and Identity Among Latina Promotoras de Salud*

2017 — Bachelor of Science, Human Services, Mental Health emphasis
Magna cum laude
California State University, Fullerton

2014 — Associate of Arts, Social and Behavioral Emphasis
Magna cum laude
Mount San Antonio Community College

HONORS AND AWARDS

2022 Chicano Studies Institute Dissertation Award, UCSB
2022 Ray E. Hosford Memorial Dissertation Award, UCSB
2022 UC President's Pre-Professoriate Award Nominee, UCSB
2020 Graduate Opportunity Award, UCSB
2019 Hosford Award, UCSB
2016 Academic Research Consortium Award, UCSB
2016 Dean's List, CSUF
2015 Ronald E. McNair Post Baccalaureate Achievement Award, CSUF
2014 Mt. San Antonio College President's List
2013 Mt. San Antonio Honor's Program

RESEARCH EXPERIENCE

09/22 – 06/23 **Bilingual Principal Investigator, Dissertation Study**
University of California, Santa Barbara
Committee Chair: Andrés J. Consoli, Ph.D.
Conducted a UCSB IRB approved qualitative research study that focuses on the factors that facilitate and obstruct access to mental health services among bilingual (English and Spanish) Latine parents of children and adolescents with mental health needs.

Funding sources: Chicano Studies Institute Dissertation Fellowship ($2,500); Ray E. Hosford Memorial Fellowship ($1,000).

09/18 - 03/21 **Bilingual Principal Investigator, Master's Thesis Study**
University of California, Santa Barbara
Faculty Advisors: Andrés J. Consoli, Ph.D. and Miya L. Barnett, Ph.D.
Thesis qualitative study: *"Todo se Hace de Corazón: An Examination of Role and Identity Among Latina Promotoras de Salud*
Conducted individual interviews in Spanish, transcribed, and analyzed the data. Presented findings to participants via a community presentation for feedback and published in the *Journal of Latinx Psychology.*

1/18 – 1/19 **Bilingual Graduate Student Researcher**
University of California, Santa Barbara
Principal Investigator: Miya L. Barnett, Ph.D.
Project*: Lay Health Worker Mobilization to Address Disparities in Parent Training Funding source*: National Institute of Mental Health (K01 MH110608)
Assisted in the translation of an interview protocol and consent form from English to Spanish. Assisted with workshop to introduce participants to study objective. Administered surveys for data collection. Coordinated dates and times with promotoras and conducted interviews in Spanish.

11/17 – 06/18 **Bilingual Graduate Student Researcher**
University of California, Santa Barbara
Supervisor: Andrés J. Consoli, Ph.D.
Project: *Psychology in Latin America: Contributors & Trends.*
Constructed narratives of distinguished psychologists in Latin America recognized by the Interamerican Society of Psychology with the Interamerican Psychologist Award for their contribution to the advancement of psychology in Latin America. Identified scholarly themes addressed by these psychologists.

06/17 – 07/19 **Bilingual Graduate Student Researcher**
University of California, Santa Barbara
Supervisors: Melissa Morgan, Ph.D., and Andrés J. Consoli, Ph.D.
Publication: "I feel like we're going backwards:" Post-presidential election resilience in Latinx community members.
Transcribed focus group and individual interviews in English and Spanish. Conducted data analysis with Spanish team using a Consensual Qualitative Research (CQR) approach. Wrote the research paradigm and data analysis section of the manuscript.

06/16 – 08/16 **Research Assistant, UCSB CCSP Clinical Psychology Lab**
University of California, Santa Barbara
Supervisor: Erika Felix, Ph.D.
Project: *Parenting After Stressful Life Events*

Collaborated with research project that examined the relationship between indirect exposure to mass violence through the media, and parents' mental health and their subsequent parenting behaviors. Developed online survey on Qualtrics, conducted literature searchers, and developed annotated bibliography.

01/16 – 06/16 **Research Assistant, Center for Research on Educational Access, and Leadership (C-REAL)**

California State University, Fullerton
Performed research duties to assist program in developing strategies to address complex challenges of educational access and leadership through practice, policy, and change. Specifically, entered education data and conducted statistical analysis using statistical software. Transcribed and translated English and Spanish qualitative interviews. Developed PowerPoint presentations with research findings for community staff members.

01/16 – 06/16 **Bilingual Program Co-Facilitator and Lead Research Assistant**
California State University, Fullerton
Supervisor: Melanie Horn-Mallers, Ph.D.
Community Project: Resilient Families Program
Co-facilitated with Principal Investigator to develop a curriculum on wellbeing, mental health, stress, resilience, and coping strategies for Latinx bilingual parents and families from low-socioeconomic backgrounds. Taught weekly workshops in the community and worked closely with Latinx parents to identify mental health concerns. Collaborated with parents to identify coping strategies that were congruent with their cultural backgrounds. Translated pre and post program evaluation measures and consent forms in Spanish. Administered forms to parents and collected quantitative data. Conducted bilingual semi-structured interviews with parents to obtain program evaluation qualitative data to help improve overall effectiveness of program.

09/15 – 06/17 **Researcher, Ronald E. McNair Post-Baccalaureate Achievement Program**
California State University, Fullerton
Supervisor: Melanie Horn-Mallers, Ph.D.
Project: *Exploring Mental Health Access and Utilization Among Latina/o/x Undergraduate Students*
Developed measures, including demographics, counseling utilization, and stigma towards mental health service use. Obtained IRB approval. Recruited 100 Latinx undergraduate students across disciplines at the university for participation in research study. Analyzed data and presented findings California State University, Fullerton Annual McNair Research Symposium.

CLINICAL EXPERIENCE

07/22 - 06/23 **Pre-Doctoral Intern, CBT and DBT Track (12-months)**
University of Texas Health Science Center San Antonio
Training Directors: Cindy A. McGeary, Ph.D., and Tabatha Blount, Ph.D.
Attend track-specific seminars that provide an in-depth study of cognitive-behavioral theories and practice. Attend general seminars on topics including psychodynamic theory, trauma evidence-based treatments and suicide risk assessment.
Co-lead a yearlong and weekly DBT group for outpatient community mental health center.

01/23 - 06/23 **Pre-Doctoral Intern, Transitional Care Clinic (TCC), (6-Month Rotation)**
University of Texas Health Science Center San Antonio
Supervisors: Dave Roberts, Ph.D. and Feiyu Li, Ph.D.
Provided short-term psychotherapy bilingual services to individuals transitioning from psychiatric care at a local hospital to a long-term mental health center. Provided evidence-based treatment interventions for trauma (Cognitive Processing Therapy and Prolonged Exposure).
Co-led weekly DBT groups for a total of 18 patients with chronic suicidality, mood, and personality disorders.
Provided peer-supervision to a master's level clinician.
Responsible for facilitating in-person group-intakes of 10-20 groups of patients and assigning clinic cases to staff.

7/22 – 12/22 **Psychology Resident, San Antonio State Hospital (6-Month Rotation)**
Texas Health and Human Services
University of Texas Health Science Center San Antonio
Supervisors: Steven A. Logsdon, Ph.D., and Heather Holder, Psy.D., Forensic Psychologist
Worked collaboratively with an integrative treatment team of psychiatrists, psychologists, social workers, pharmacists, registered nurses, occupational therapists, rehabilitation therapists, and psychiatric nursing assistants, to develop and support patients person-centered treatment plans.
Provided bilingual (English and Spanish) weekly short-term and long-term individual psychotherapy using evidence-based practices (CBT, DBT, trauma-informed) in civil and forensic units to patients diagnosed with chronic and serious mental illnesses (i.e., schizophrenia, borderline personality disorder, anti-social disorder). Met weekly with patients charged as not guilty by reason of insanity (NGRI) or incompetent to stand trial to provide competency restoration sessions to help patients understand court proceedings and pass competency exam evaluations.
Co-facilitated Dialectical Behavioral Therapy (DBT) in-patient group with forensic, licensed psychologist/supervisor and unit social worker for patients with mental health concerns and borderline personality disorder. Additionally, co-facilitated weekly Co-Occurring Psychiatric Substance Abuse Disorder (COPSD) group to patients with serious mental illnesses and substance abuse disorders.

Obtained referrals from psychiatrists and treatment team to conduct psychological testing in English and Spanish for patients to inform individual person-centered treatment plans (e.g., WAIS-IV Weschler Adult Intelligence Scale Fourth Edition; EIWA-III, Spanish Edition), R-BANDS Repeatable Battery for Neuropsychological Status, TONI-4 Test of Nonverbal Intelligence Fourth Edition). Developed written reports for physicians to inform patient treatment planning and discharge plans. Shadowed forensic licensed psychologists conducting Dangerous Risk Assessments or court-ordered Competency Evaluations to inform patient hospital discharge plans.
Conducted Trial Competency Examination Assessments for individual patients and written reports to determine if patients were competent, incompetent, or unrestorable for court hearings.
Conducted Dangerous/Violence Risk Assessments for patients to support hospital discharge planning.

07/22 – **Psychology Resident, Advanced Clinic, Psychiatry Department (Year-Long Rotation)**
University of Texas Health Science Center San Antonio
Psychodynamic and Psychoanalytic Informed Supervisor: Wayne J. Ehrisman, Ph.D.
Provide bilingual (English and Spanish) long-term individual psychotherapy to patients with psychological difficulties including phobias and mood disorders. Provide services drawing predominantly from psychodynamic, cognitive-behavioral, trauma-informed, and multicultural perspectives.

01/21 – 06/21 **Student Clinician and Supervisee**
University of California, Santa Barbara
Spanish Supervisor Consultant: Emily Maynard,
Ph.D.
Assisted weekly Spanish consultation group to aid with bilingual professional development, case conceptualization, DSM-5 diagnosis, and culturally sensitive psychotherapy provision and clinical interventions. Presented patient cases to consultation team to obtain feedback and enhance quality of care.

08/20 – 08/21 **Third Year Externship**
Bilingual Clinical Counselor Trainee, Family Services Agency (FSA)
Santa Barbara, California
Supervisors: Melinda Gudino, LMFT., De Rosenberry, LMFT., Nancy Ranck, LMFT.
Conducted bilingual (English and Spanish) intakes and provided short-term and long-term individual therapy to individuals affected by various forms of trauma including sexual, physical, emotional abuse, domestic violence, and substance abuse issues. Provided psychotherapy to court-mandated individuals. Made appropriate referrals to agency services when necessary (i.e., housing and food assistance).

09/19 – 06/20 **Second Year Externship**
Student Clinician, Counseling and Psychological Services (CAPS)
University of California, Santa Barbara
Supervisors: Ling, Jin, Ph.D., Isabela França Magalhães, Ph.D., Darren Del Castillo, Ph.D., Juan Riker, Ph.D.
Conducted weekly intakes and provided individual brief and long-term therapy to college students diagnosed with a variety of presenting problems including trauma, mood disorders, self-esteem issues, adjustment difficulties, interpersonal violence, first generation college student difficulties, cultural identity, and gender/sexuality challenges; maintained a full case load. Attended weekly individual supervision with an emphasis in integrative care and multicultural counseling. Attended weekly group supervision and training seminars focused on psychological topics (i.e., trauma-informed interventions, somatic therapy, and psychiatric medication). Conducted Disabled Student Program referrals; administered psychological testing for attention deficit disorder and developed report of findings.

09/19 – 02/20 **Assessment Specialist, Child Abuse Listening & Meditation (CALM)**
Santa Barbara, California
Supervisor: Rachel Hopsicker, Ph.D.
Scored and interpreted clinical assessments (i.e., Child Behavior Checklist (CBCL), Youth Self Report (YSR), Adult Self Report (ASR) for a community mental health center and produced integrative reports for clinicians to inform their treatment plans.

09/18 – 06/19 **Spanish Clinician Supervisee, Hosford Counseling Center** University of California, Santa Barbara
Supervisor: Emily Maynard, Ph.D.
Assisted weekly Spanish supervision to aid with professional bilingual (English and Spanish) development, clinical terminology, case conceptualization, and multicultural counseling approaches and interventions.

02/18 – 06/19 **Student Clinician**, **Hosford Counseling Center**
Supervisor: Miya L. Barnett, Ph.D.
University of California, Santa Barbara
Conducted intakes and provided individual long-term therapy to adults with diverse presenting problems including trauma, mood disorders, interpersonal violence, and substance abuse recovery. Administered survey measures to inform treatment planning and outcomes (i.e., Subjective Wellbeing Scale (SWS), Session Rating Scale (SRS), Outcome Questionnaire (OQ-45, PHQ-9). Collaborated with team of graduate students to administer a personality assessment using Rorschach Test and Minnesota Multiphasic Personality Inventory (MMPI). Produced written report provided feedback and recommendations for patient.

09/17 – 11/17 **Graduate Student Assessment Assistant, Dual Language Immersion Program, Canalino Elementary School**
Supervisor: Matthew Quirk, Ph.D.
University of California, Santa Barbara
Conducted 30 hours of Spanish assessments with children Kindergarten – fourth grade for longitudinal study data.

03/17 – 06/17 **Group Leader Intern, College of Health, and Human Development**
California State University, Fullerton
Supervisors: Kristi Kanel, Ph.D., and James Ruby, Ph.D.
Co-facilitated groups for undergraduate students and provided a setting and structure for personal exploration, self-evaluation, and growth, in weekly small and large group format.

01/16 – 06/16 **Program Co-Facilitator, City of Chino Human Services**
Chino, California
Supervisor: Mayra Pratt, M.A.
Program: CHOICES Batterer's Treatment and Anger Management, court mandated treatment program
Developed and facilitated psychoeducational lectures on domestic violence and anger issues for court-mandated male patients. Conducted new client intakes and assessed client progress through in-class observation. Maintained accurate attendance, payment, and case notes for counselors, probation officers, judges, and lawyers.

PEER-REVIEWED PUBLICATIONS

Flores, I., Sharma, H., Franco, V., Valadez, A., Cerezo, A. (2022). Amidst the Chaos: Developing a psychologist identity during ongoing social unrest. *Journal for Social Action in Counseling and Psychology*.

Flores, I., Consoli, A. J., Gonzalez, J. C., Luis Sanchez, E., & Barnett, M. L. (2021). "Todo se hace de corazón:" An examination of role and identity among Latina promotoras de salud. Advance online publication. *Journal of Latinx Psychology.* Advance online publication. https://doi.org/10.1037/lat0000194

Consoli, A. J., **Flores, I**., & Sharma, H. (2018). Psychology in Latin America: Legacies and contributions. *International Psychology Bulletin*, *22*(2), 29-37.

Consoli, A. J., **Flores, I.**, Sharma, H., Sheltzer, J. M., Gallegos, M., & Pérez Acosta, A. M. (2021). Psychology in Latin America: A qualitative study of commonalities and singularities. *Revista Interamericana de Psicología/Interamerican Journal of Psychology*, *55*(3), e1627 1-28. https://doi.org/10.30849/ripijp.v55i3.1627

Consoli, A. J., & **Flores, I**. (2020). The teaching and training of bilingual (EnglishSpanish) mental health professionals in the US. Teaching psychology around the world (Vol. 5, Chap. 35, pp. 441-454). Cambridge Scholars.

Gonzalez, J.C., **Flores, I**., Tremblay, M., & Barnett, M. L. (2022). How lay health workers engage Latino fathers: a qualitative study. *Child and Youth Services Review.*

Klein, C., Luis Sanchez, B. E., Gonzalez, J.C., **Flores, I**., Green Rosas, Y., & Barnett, M. L. (2020). The role of advocacy within community-partnered research with lay health workers in Latinx communities (promotoras de salud). *The Behavior Therapist, 43*(7), 250-253.

Morgan Consoli, M. L., Consoli, A. J., Hufana, A., Sánchez, A., Unzueta, E., **Flores, I**., Vázquez, M. D., Sheltzer, J., & Casas, J. M. (2019). "I feel like we're going backwards:" Post-presidential election resilience in Latinx community members. *Journal for Social Action in Counseling and Psychology*. *10*(2), 16-33.

SELECTED CONFERENCE PRESENTATIONS

Flores, I., Consoli, A. J., Gonzalez, J. C., Luis Sanchez, E., & Barnett, M. L. (2023, May). "Todo se hace de corazón:" An examination of role and identity among Latina promotoras de salud. Poster presented at Research Quality Improvement Day at The University of Texas Health Science Center, San Antonio, San Antonio, Texas.

Consoli, A.J., **Flores, I**., Sharma, H., & Sheltzer, J. M. (2019, July). Unity and diversity: A qualitative analysis of the multiple perspectives on psychology in Latin America. Paper presented at the XXXVII Interamerican Society of Psychology Congress, Havana, Cuba.

Consoli, A. J., & **Flores, I**. (co-chairs) (2018, October). *Bilingual (English-Spanish) professional training and development: Best (and not so) practices*. Symposium presented at the biennial conference of the National Latina/o Psychological Association, San Diego, California.

Consoli, A. J., & **Flores, I**. (2018, October). Facilitando el entrenamiento y el desarrollo de l*s psicólog*s profesionales bilingües (inglés/español): Necesidades y respuestas [Facilitating the training and development of bilingual (English-Spanish) professional psychologists: Needs and answers]. In A. J. Consoli & I. Flores, *Bilingual (English-Spanish) professional training and development: Best (and not so) practices*. Paper presented at the biennial conference of the National Latinx Psychological Association (NLPA), San Diego, California.

Vazquez, M., Sanchez, A., **Flores, I**., Hufana, A., Unzueta, E., Sheltzer, J., Meza, D., Morgan Consoli, M. L., Consoli, A. J., & Casas, J. M. (2018, August). *Resilience in Latina/o/x community post-Trump election: Themes and considerations*. Poster presented at the annual convention of the American Psychological Association, San Francisco, California.

Flores, I., (2017). *Exploring Mental Health Access and Utilization Among Latina/o Undergraduate Students.* CUDCP Diversifying Clinical Psychology Poster Conference. San Diego, CA.

Flores, I., (2016). *Parenting After Stressful Life Events*. Academic Research Consortium Summer Conference, University of California, Santa Barbara, CA.

Flores, I., (2016). *Exploring Mental Health Access and Utilization Among Latina/o Undergraduate Students*. McNair Scholars Poster Conference. California State University, Fullerton, CA.

INVITED PRESENTATIONS AND LECTURES

Flores, I. (2021, October). *Do I Belong Here: Navigating Imposter Syndrome in Grad School.* Invited Virtual Panelist for the California Forum for Diversity in Graduate Education.

Flores, I. (2019, August). *Thriving Not Surviving: Navigating Higher Education as a First-Generation College Student*. Invited Virtual Panelist for McNair Scholars Program, ONDAS, Transfer Student Center, Educational Opportunities Program, Mixer Event. University of California Santa Barbara, CA.

Flores, I. (2019, November). *Latina Feminism*. Guest Lecturer for Chicana/o Studies Law & Civil Rights, an undergraduate course of the University of California, Santa Barbara, CA.

Flores, I. (2019, April). *Qualitative Methodology and Design*. Guest Lecturer for Research Methods, an undergraduate course of the University of California, Santa Barbara, CA.

Flores, I. (2019, February). *Developing a Professional-Self: A Model.* Guest Lecturer for Introduction to Educational and Vocational Guidance, an undergraduate course of the University of California, Santa Barbara, CA.

Flores, I. (2018, December). "*Todo Se Hace de Corazón:" Un Análisis del Rol y la Identidad Entre Las Promotoras de Salud.* Research presenter for a community workshop and research member checks in Spanish with promotoras de salud (lay health care workers). Hope Elementary School District, Santa Barbara, CA.

Flores, I. (2018, January). *Benefits of the UC Undergraduate Research Experience*. University of California Regents Student Guest Speaker. Academic and Student Affairs Committee of the UC Regents. San Francisco, CA.

Flores, I. (2015, February). *Gender Equity/Equality within Family, Dating, Relationships, and Marriage*. International Women's Day Student Group Facilitator. California State University, Fullerton, CA.

Flores, I. (2015, April). *Designing Your Future and College Planning*. Guest Presenter. Titan Day, Westminster High School. California State University, Fullerton, CA.

TEACHING EXPERIENCE

07/22 – 12/23 **Trainer and Psychoeducation Facilitator and Co-Facilitator**
San Antonio State Hospital, Health and Specialty Care System, Texas Health, and Human Services Commission
Supervisor and Training Co-Facilitator: Dr. Steven A. Logsdon, Ph.D., Program Director for Psychology and Acute Service
Train and provide psychoeducation about borderline personality disorder (BPD) to newly hired registered nurses, licensed vocational nurses, and psychiatric nursing assistants. Provide an in-depth overview of BPD and provide hospital staff with training on behavioral principles of positive and negative reinforcement as well as extinction to decrease patient self-injurious behaviors (SIB) on hospital units. Facilitate discussions with hospital staff about how to effectively work with patients with BPD.

09/19 – 12/19 **Teaching Grader, CHST 172: Chicano/a Studies Law & Civil Rights**
Instructor and Supervisor: Frank J. Ochoa, Retired Judge of the Superior Court
University of California, Santa Barbara
Attended weekly lectures on historical and contemporary Law and Civil Rights within Chicano/a populations. Provided weekly office hours to assist students with mastering the course material and to provide support for test preparation. Graded weekly assignments and a midterm and final exam for 75 students as well as assigned their final grades.

03/19 – 6/19 **Teaching Assistant, CCSP 102: Research Methods**
University of California, Santa Barbara
Attended weekly lectures. Taught four sections weekly of 20 students. Held office hours to assist students with course content questions and test preparation. Graded assignments and exams of 80 students as well as assigned their final grades.

01/19 – 03/19 **Teaching Assistant, CCSP 110: Introduction to Education and Vocational Guidance**
University of California, Santa Barbara
Attended weekly lectures. Taught two sections weekly. Held office hours to assist students with course content questions and test preparation. Graded assignments and exams of 40 students as well as assigned their final grades.

01/16 – 05/16 **Teaching Assistant, Crisis Intervention Coach, HUSR 411: Crisis Intervention Theory and Skill Building for Crisis Workers**
California State University, Fullerton
Taught a crisis intervention model to a group of six undergraduate students and provided supervision over the course of 16 weeks.

ADDITIONAL PROFESSIONAL EXPERIENCE

10/21 – 01/22 **Program Admissions and Selection Committee Member, Ronald E. McNair Post-baccalaureate, Achievement Program**
University of California, Santa Barbara
Assisted McNair Faculty Director, Program Director, and program staff with reviewing undergraduate applications to the UCSB McNair Program. Collaboratively discussed the strengths and areas of growth of applicants. Assisted in the application review and interview process of prospective applicants. Worked closely with program staff to make conscientious decisions about student acceptances.

10/21 – 05/22 **Advanced Graduate Mentor, Graduate Student Program: Thriving in the Academy Series**
Graduate Division, University of California, Santa Barbara
Mentored incoming and minoritized graduate students in psychology. Provided information about campus resources to students that could facilitate their personal and professional development. Discussed career, and short-term and long-term goals.

10/21 – 05/22 **Graduate Mentor, ACCESS Program**
Psychological and Brain Sciences Student Organizations,
University of California, Santa Barbara
Mentored psychology undergraduate students from diverse racial and ethnic backgrounds. Provided information about campus resources to students that could facilitate their personal and professional development. Discussed career, and short-term and long-term goals.

09/19 – 05/22 **Graduate Research Mentor, Ronald E. McNair Post-Baccalaureate Achievement Program**
University of California, Santa Barbara
Mentored first-generation, low-income, underserved students applying to graduate school programs. Facilitated personal and professional development workshops. Provided administrative support and assisted with McNair summer research program lectures, workshops, and grading. Developed social media outreach content to recruit students.

06/19 – 08/19 **Graduate Mentor, Academic Research Consortium (ARC) Admissions, Outreach and Diversity Initiatives, Graduate Division**
University of California, Santa Barbara
Mentored ARC, UC LEADS and UC/HBCU scholars and provided research support on interdisciplinary projects. Collaborated with Graduate Division staff on weekly personal and professional development workshops. Provided visiting scholars with college campus tours. Collaborated with program staff and directors to coordinate end of year symposium.

06/18 – 07/19 **Co-President, Department of Counseling, Clinical, and School Psychology Associated Student Body**
University of California, Santa Barbara
Served as a student liaison between department faculty and graduate student body. Oversaw clinical, research, diversity, and self-care graduate student committees. Attended monthly faculty meetings to understand program, faculty, and student concerns and provide feedback and suggestions from graduate student perspective. Reviewed a Graduate Student Diversity Report and created a PowerPoint for staff to share findings and discuss possible ways to address student needs and expand diversity training initiatives. Attended weekly meetings with graduate students and program faculty to develop a CCSP Black Lives Matter (BLM) Solidarity Statement.

01/13 – 04/13 **Peer Mentor, Ronald E. McNair Scholars Program**
California State University, Fullerton
Mentored prospective McNair Scholars. Worked closely with students to identify their research interests and shared information about campus resources from a first-generation, underrepresented, and low-income student perspective.

01/13 – 04/13 **Peer Mentor, College of Health, and Human Development**
California State University, Fullerton
Assisted with the program development and implementation of a pilot undergraduate Peer Mentor Program. Collaborated with faculty, staff, undergraduate students, and Department Deans to identify the needs of incoming students and develop a structured mentoring curriculum. Mentored six incoming undergraduate students and solicited feedback to inform program effectiveness.

07/11 – 12/11 **High School Outreach Student Assistant, Student Services**
Mt. San Antonio Community College
Collaborated with Outreach Specialists on college presentations and application workshops for high school seniors and incoming freshman. Assisted freshman with college applications. Provided students with college-wide campus information and resources.

PROFESSIONAL AFFILIATIONS

2019- Present National Latinx Psychological Association

TRAININGS AND CERTIFICATIONS

2023 Completed certification in Motivational Interviewing and Reflective Psychotherapy
Trainer: Dave Roberts, Ph.D.
University of Texas Health, Science Center, San Antonio

2023 Cognitive Processing Therapy (CPT) for Post-Traumatic Stress Disorder Workshop Training; Strong STAR Training Initiative
Sponsor: University of Texas Health, Science Center, San Antonio

2022 Dialectical Behavioral Therapy (DBT) Skills Training: Foundation, Fundamentals, and Essentials Workshop
Sponsor: University of Texas Health Science Center, San Antonio

2022	Prolonged Exposure (PE) for Post-Traumatic Stress Disorder Workshop Training; Strong STAR Training Initiative *Sponsor:* University of Texas Health, Science Center, San Antonio
2022	TIPS State Hospital Training Trained in verbal interventions and self-protection skills to effectively work in psychiatric hospital settings with patients in crisis. San Antonio State Hospital, Texas Health, and Human Services
2022	Certification in Columbia Suicide Severity Rating Scale (C-SSRS) San Antonio State Hospital, Texas Health, and Human Services
2018	Faith Based Academy Training in Mental Health and Spirituality San Diego County, Health and Human Services
2018	Community Based-Suicide Prevention, Santa Barbara Wellness Project Training University of California, Santa Barbara Trainer: Melissa Morgan, Ph.D.
2017	Reviewer for a manuscript for the American Psychologist
2017	Trained in Proposal, Program Design, and Program Evaluation California State University, Fullerton
2017	Trained in Crisis Intervention Counseling and Crisis Coaching California State University, Fullerton Trainer: Kristi Kanel, Ph.D.
2017	Trained in Group Leading Trainer: Kristi Kanel, Ph.D., Jim Ruby, Ph.D., Amy Meredith, Ph.D.
2016	Trained in Case Management California State University, Fullerton
2016	Certification in Spanish for Health and Mental Health Professionals College of Health and Human Development
2016	Completed Certification of 40-hour training with specialization in Domestic Violence Victim Services in compliance with Section 1037.1 of the Evidence Code for the State of California Human Services Department at California State University, Fullerton and YWCA of San Gabriel Valley

ABSTRACT

Al Frente/At the Front: Understanding Latine Parents' Help-Seeking and Access of Mental Health Services for their Children and Adolescents with Mental Health Needs

by

Iliana Flores

Help-seeking is the active process of searching for formal mental health services and an important first step to obtaining mental health care. Help-seeking can be influenced by individual, social, cultural, and structural factors that can help to facilitate or obstruct the process. Using a qualitative design, this study examined the lived experiences of eleven Latine parents who sought and accessed mental health services for their children to identify the factors that made their process easier or harder. A multiple case study approach was used to examine the similarities and differences across participants responses. Using thematic analysis, a total of eight themes were identified across the eleven interviews. Five themes were identified as facilitative and three themes as obstructive.

The facilitative factors in participants' help-seeking and realized access to mental health services included the following: *Support from Social Networks, Being Persistent, Using Spirituality to Cope, Increase in Mental Health Literacy,* and *Positive Treatment Experience. Support from Social Networks* referred to the emotional and practical support that participants received from their family, friends, spiritual leaders, or mental health professionals in their help-seeking of mental health services. *Being Persistent* referred to participants tenacity to find the mental health services they needed for their children. *Using Spirituality to Cope* referred to participants faith and use of prayer to overcome difficult moments in their help-seeking journeys. *Increase in Mental Health Literacy* referred to participants' increased knowledge and

understanding about mental health and mental health services. *Positive Treatment Experience* referred to the favorable outcomes and benefits that participant and their children experienced from using mental health services.

The obstructive factors in participants' help-seeking and realized access included the following: *Limited Mental Health Literacy*, *Interference from Social Networks*, and *Structural Barriers to Treatment. Limited Mental Health Literacy* referred to participants markedly reduced mental health background. *Interference from Social Networks* referred to social networks' dismal views and reactions about participants help-seeking decisions. Finally, *Structural Barriers to Treatment* referred to the multiple challenges participants faced to access mental health services for their children.

This study findings illustrate how individuals' help-seeking can be facilitated or obstructed by diverse factors. Importantly, an understanding of these factors associated with help-seeking is necessary to strengthen the overall process of accessing care for parents of children with mental health concerns. Findings have implications for researchers, clinicians, educators, and policy makers committed to improving racial and ethnic minority populations' access to formal mental health services.

Keywords: Latine mental health, Latine parents, Latine children, help-seeking, realized access, facilitators of care, mental health barriers, racial and ethnic minority populations.

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Al Frente/At the Front: Understanding Latine Parents' Help-Seeking and Access of Mental Health Services for their Children and Adolescents with Mental Health Needs

Chapter I: Study Rationale and Purpose

Rationale for the Study

Latine[1] populations are one of the fastest-growing racial and ethnic groups in the United States (U.S.). As of 2021, nearly 62.6 million Latines comprised 18.9% of the U.S. population (United States Census Bureau, 2022). As a group, they are projected to constitute 111.2 million of the nation's demographic makeup in 2060, or 28% of the total U.S. population. Latine populations are not only one of the largest racial and ethnic groups in the nation, (second largest after white non-Latines), but also one of the youngest (Pew Research Center, 2020). Most young Latines are U.S.-born (93%) and have a median age of 20, indicating that most have not entered adulthood.

In 2019, Latine children under 18 accounted for 18.6 million or 26% of the nation's total child population, an increase from 9% in 1980 (National Research Center on Hispanic Children and Families, 2021). While Latine children primarily reside in the Southwest, statistics show children live across all 50 states in the U.S. A quarter or more of children account for most of the child population in 12 states (National Research Center on Hispanic Children and Families, 2022).

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[1]In this study, the term Latine is used to challenge the gender binary and support the use of inclusive language, gender identities, and expressions that are present in communities.

Latine Population Mental Health Needs

Research shows that Latine populations experience racial and ethnic disparities in mental health across the lifespan, especially in comparison to non-Latine whites (Alegria et al., 2010). Some researchers also suggest that mental health outcomes may also differ by Latine heritage (Mexican, Puerto Rican, Salvadoran, and other Central American), though unclear given relatively few studies to date (Alegria et al., 2008; National Research Center on Hispanic Children and Families, 2022).

National survey data by U.S. government sources reveal a wide range of mental health problems among Latine populations. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2022), mental illness and substance abuse disorders have increased for U.S. Latine populations in the past year. Findings show that 7.7 million, or 18.4% of Latines aged 18 or older had a mental illness. Of Latines aged 18 and older with a mental illness, 1 in 4 or 1.9 million (24.4%) had a serious mental illness (SMI). Additionally, 5.7 million or 13.5% of Latines had a substance abuse disorder. Further, 2.4 million Latines or 5.8% of Latines aged 18 and over had a substance abuse disorder and a mental illness. Together, 10.8 million or 25.7% of Latines had a mental illness, a substance abuse disorder, or both.

Latine Youth Mental Health Needs

A report by the U.S. Department of Health and Human Services, [USDHHS] Office of Minority Health, based on results from the Centers for Disease Control and Prevention 2019 Youth Risk Behavior Surveillance Survey (YRBS), showed that Latine youth were at an increased risk for experiencing serious mental distress. In this report, Latine youth in high school reported higher depressive symptoms, suicide attempts, and suicide ideation than non-Latine white youth. Findings from the YRBSS also showed that suicide ideation among students who

attempted suicide in grades 9-12 was higher for Latine youth than non-Latine white youth. The data revealed that 5.8% of Latine males attempted suicide compared to 4.6% of non-Latine white males. Among Latinas, 10.5% attempted suicide compared to 7.3% non-Latine white females. Latina youth were also twice more likely than Latine males to report suicide ideation and attempt suicide. More recently in 2020, almost 9% of Latine young adults aged 18-25 reported serious thoughts of suicide and were more likely to have planned suicide or attempted suicide compared to Latine adults aged 26-49. Latine youth ages 18-25 also demonstrated an increase in SMI from 4% to 6.4% between 2008-2018 (SAMHSA, 2022).

Latine Mental Health Treatment Underutilization

Despite a prevalence of mental health problems among Latine populations, research data show that treatment services are largely underutilized (Goodwin et al., 2002; Hingwe, 2021; Marin et al., 2006; USDHHS, 2001). In a survey report, SAMSHA (2022) found that 64.9% of Latine individuals over 18 with mental illness (7.7 million) did not receive treatment. Of Latines aged 12 years or older with a substance abuse disorder 93.8% (6.2 million) did not receive treatment. As for Latines with serious mental illness over the age of 18, 51.3% (1.9 million) did not receive treatment. For Latine youth aged 12-17 with major depressive disorder, half of them reported they had not received treatment within the past year.

A study by Kataoka et al. (2002) examined data from three nationally representative samples of U.S. children and found significant patterns of mental health treatment underutilization for youth from racial and ethnic backgrounds. The National Survey of American Families study found that among children 6-7 years old with a mental health problem, 79% had not used services within the past 12 months. Further, Latine children with assessed mental health concerns were less likely to obtain services (88%) compared to non-Latine white children (76%).

In the National Health Interview Survey, Latine (82%) and Black (80%) children with mental health concerns demonstrated higher percentages for the underutilization of mental health services compared to non-Latine white children (72%). Additionally, Latine youth, preschool children, and uninsured individuals had the highest rates of unmet mental health needs compared to non-Latine white children. In these studies, non-Latine white children demonstrated higher levels of service use including psychiatric care and mental health treatment, regardless of insurance, compared to minority youth. Similarly, a study by Alegria et al. (2010) conducted a comprehensive review of pediatric and service use among racial and ethnic minority children. The findings of this study demonstrated minority children (Black and Latine), compared to non-Latine white children, were underserved across different domains, including having access to care, diagnostic assessments, pharmacological treatments, and psychotherapy services.

Latine Populations and Stressors

Research studies have identified numerous stressors that can contribute to the mental distress, suicide ideation, and suicide completion for Latines (American Psychiatric Association, 2017; SAMHSA, 2019; USDHHS, 2001). Latines can be more likely to face certain disproportionate stressors including challenges associated with acculturative stress and immigration (Garcia & Lindgren, 2009; Goldston et al., 2008; USDHHS, 2001). For instance, Latine youth born to immigrant, non-U.S.-born parents may experience difficulties with managing different values, beliefs, and identities between their culture of origin and their host culture which can increase a vulnerability to mental health concerns (Lawton & Gerdes, 2014). Moreover, immigration status can be a significant stressor for documented and undocumented Latine youth (mixed-status households). Studies show that Latines report fears about sudden or unexpected individual or family detainment, separations, or deportations (Rayburn et al., 2021).

Indeed, the interplay of these stressors have been associated with high levels of distress and negative mental health implications for Latine youth, making the examination of help-seeking pathways to mental health care for youth relevant (Ornelas et al., 2020; Salas et al., 2013).

Latines and Help-Seeking Barriers to Mental Health Treatment

Researchers have examined the help-seeking barriers to mental health care services across Latine populations. Studies reveal that some barriers to mental health care can include mental health stigma, concerns about privacy, language discrepancies between individuals and providers, poverty, and lack of health insurance (Garland et al., 2005; Goetz et al., 2023; Himmelstein et al., 2021). For instance, a study by Ransford et al. (2010) outlined the barriers to healthcare among documented and undocumented Latines with a particular focus on Latine immigrants. In their review, common barriers to healthcare included belief barriers and structural barriers.

Ransford et al. (2010) referred to belief barriers as the fears, anxieties, and concerns that prevented Latines from seeking care and approaching the system. In this study, help-seeking for undocumented Latines could provoke heightened anxiety, fears about being asked about their legal status, being deported, not being able to communicate with providers, worries about the cost of treatment, and enduring long waits for services. These belief barriers, according to authors, were believed to diminish treatment utilization for Latines, making some people only approach healthcare services when they were extremely ill. Furthermore, structural barriers referred to obstacles that could collectively affect or dampen a person's ability to seek services. For instance, the absence of language translators, discrimination by class, ethnicity, immigration status, and procedures that required economic eligibility but could not be afforded impeded the use of mental health services among immigrant adults and children with needs.

Background of the Problem

Since most children and adolescents do not seek help independently, parents, guardians, or caregivers can serve as key figures in their access to mental health care (Stiffman et al., 2004). Depending on certain factors including having knowledge of mental health problems or having the financial resources, parents can help their children identify their mental health problems, seek care for them, and ensure the continuity of care (Godoy et al., 2014; Lindsey et al., 2012). However, parents' help-seeking of mental health services can also be dampened by scarcity of resources or markedly limited mental health literacy.

Research studies have shown that parents may inadvertently overlook the mental health problems their children or adolescents may be facing for different reasons (Teagle, 2002; Zahner et al., 1997). Teagle (2002) found parents could be less likely to seek help if they believed their children's behavior was "normal," which was associated with being unfamiliar with mental health concepts. Similarly, Sayal et al. (2010) found that parents who did not seek services for their children believed treatment was either unnecessary or their condition was "not a serious problem" despite their children's pronounced symptomology. Moreover, in cases where parents observed an issue with their children or adolescents' well-being, they reported being unsure of how to deal with the problem or informed of resources that could help (Stiffman et al., 2004).

The help-seeking pathways to services can be important for youths' development. Mental health problems that are left untreated can have challenging implications on individual, social, and occupational levels of functioning (World Health Organization [WHO], 2021). The early detection of mental health problems is critical to treat and prevent serious and persisting mental health outcomes among children and adolescents. Furthermore, as the mental health concerns for youth are shown to steady increase and the number of Latine populations continue to expand in

the U.S., it is essential to examine help-seeking pathways to realized care to understand the factors that may serve to facilitate or obstruct parent populations' access to treatment for their youth.

Help-Seeking

Help-seeking is the active process of searching for mental health resources to address a mental health problem with the intent to resolve it (Rickwood et al., 2005). The help-seeking process has been described as a non-linear route rather than a step-by-step event, or a one-time event (Logan & King, 2001). Help-seeking may generally include help from two main sources such as formal and informal services. Informal services may include social networks such as family, friends, relatives, spiritual leaders, or folk healers (Rickwood et al., 2005). Formal services may include professional, western healthcare services, such as counseling or psychotropic medication (Yeh et al., 2005). Moreover, help-seeking pathways can be influenced by a diversity of factors including individual beliefs and perceptions, social influences, cultural values and norms, and structural factors (Cauce et al., 2002; Kapke & Gerdes, 2016; Pescosolido, 1992; USDHHS, 2001).

Realized Access

Realized access includes using health services to resolve a mental health problem or increase one's well-being (Anderson, 1973). Specifically, studies have identified facilitators of realized access to understand the different elements that can support access to treatment. Furthermore, facilitators of help-seeking are identified as factors that can make seeking, obtaining, or completing mental health treatment more likely or easier (Planey et al., 2019). Moreover, studies have shown that facilitators to care may include individual's self-recognition for needing professional help, a persons' perceived ability that others can help them with their

problems, social support from family and friends, or having the actual resources to obtain care such as health insurance (Kim & Lee, 2022; Randles & Finnegan, 2022; Teo et al., 2022).

DeSa et al. (2022) conducted a systematic review to examine help-seeking and facilitators of realized care among refugee women in high-income countries. Common facilitators were identified across seven studies. These factors included service awareness and availability, social support, and resilience. Service awareness referred to the vigorous promotion of mental health resources in participants resettlement country, making it easier for individuals to know where to find services. The availability of services for mental illness prevention at the primary care level was instrumental for participants to get connected to mental health services and to obtain care long term. Social support from friends, family, and relatives were an additional key factor for immigrant women. Social support helped immigrant women cope with mental health problems and encouraged them to seek services which helped build on their autonomy, self-efficacy, and look for the services. Another factor involved women's resilience which was described as independent and highly self-efficacious. Participants were empowered to take control of their lives despite traumatic experiences and get the help they needed.

There have been significant developments in research studies involving racial and ethnic populations and their respective help-seeking pathways to services (Goetz et al., 2023; Kim & Lee, 2022). However, more research is needed that examines the help-seeking pathways to care among racial and ethnic minority populations. Specifically, more studies are needed that investigate the facilitative factors to care among Latine parents of children with mental health problems or concerns given that majority of studies have solely focused on identifying the barriers to care. Indeed, examining the lived experiences of Latine parents that accessed and realized mental health services for their children is relevant to identify the facilitative factors at

the individual, social, cultural, and structural level. Moreover, identifying the facilitators to realized care among Latine parents can offer suggestions about how individuals may capitalize on different resources to strengthen their help-seeking pathways to care (Caplan & Buyske, 2015).

Research Framework

The current study used the Network Episode Model (NEM) as a conceptual framework to examine parents' help-seeking pathways to care for their youth (Pescosolido et al., 1998). The NEM asserts that help-seeking is embedded within a cultural context, and that pathways to realized access of services can be influenced by many different multi-level factors (Pescosolido & Boyer, 2010). For instance, the NEM recognizes the role of influential factors such as mental health attitudes, knowledge, behaviors related to problem recognition, and perceptions about mental health that can positively or negatively impact help-seeking and realized care of services (Garcia & Saewyc, 2007; Yeh et al., 2004; Snowden, 2003). Drawing from the NEM, this dissertation examined the individual, social, cultural, and structural factors that shaped Latine parents' help-seeking of mental health services for their children, and that facilitated or obstructed their access and utilization of mental health care.

Purpose of the Study

Research shows that mental health problems are prevalent across Latine populations, yet the actual use of mental health services are reportedly underutilized (Alegría et al., 2023). Given that Latine youth populations in the U.S. may be susceptible to experiencing numerous mental health stressors and barriers to care, examining parent' pathways to mental health care requires more attention, specifically among underrepresented and minoritized populations (Buitron et al., 2023).

The purpose of this dissertation study was to examine Latine parents' help-seeking pathways to realized care for their youth to identify the factors that facilitated or obstructed their process. Specifically, this study used a multiple case study to analyze participant cases individually and collectively and to identify themes as informed by Braun and Clarke (2006). This study sought to contribute to the existing literature on facilitators of access and utilization of mental health services among Latine parents, which has been largely concentrated on understanding the barriers to mental health care. Findings from the study have the potential for informing clinical practice and research studies involving Latine parent and youth populations. Additionally, the results of the study can contribute to understanding of which factors can influence help-seeking and realized access to services for underserved populations.

Research Questions

1) What factors facilitated Latine parents' help-seeking and realized access to mental health services for their children/adolescents who experienced mental health problems or needs?
2) What factors obstructed Latine parents' help-seeking and realized access to mental health services for their children/adolescents who experienced mental health problems or needs?

Chapter II: Literature Review

Latine Populations

The Latine population in the U.S. is a diverse group with roots tracing back to Mexico, Puerto Rico, and more than 20 nations across Central and South America (Pew Research Center, 2022). In the U.S., Latine populations continue to expand in size and geographic location. California is the state with the most Latine residents (39.4%), with Los Angeles County being home to the nation's largest Latine populations (4.8 million; Pew Research Center, 2020). Other top states following California are Texas (39.3%), New Mexico (47.7%), Arizona (30.7%), Florida (26.5%), Colorado (21.9%), and New York (19.5%).

A 2020 statistical portrait by the U.S. Census Bureau (2022) revealed percentages of Latines by origin living in the U.S. Latines with a Mexican origin were the largest group (37 million), followed by Puerto Ricans (5.6 million), Salvadorans (2.3 million), Cubans (2.3 million), Dominicans (2 million), Guatemalans (1.4 million), and other South American, Central American or Latine origin (Pew Research Center, 2019). A large subset of the Latine population also includes youth under 18 years of age. In 2019, Latine youth made up 18.6 million or 26% of the total child population in the U.S. overall.

The National Research Center on Hispanic Children and Families (2021) used data from the Integrated Public Use Microdata Series (IPUMS) 2019 American Community Survey to provide a nationwide snapshot of Latine youth percentages by state. The percentages showed that Latine children populations range from 2% in Vermont to 61% in New Mexico. The states with the highest percentage of Latine youth, accounting for approximately half of the state's total child population, are in the Southwest: New Mexico (61%), California (52%), and Texas (50%); Latine youth also exceeded more than 40% of the youth population in Nevada (41%) and

Arizona (45%). Outside of the Southwest, 25% to 40 % of Latine youth account for the child population: Florida (32%), Colorado (32%), New Jersey (28%), Rhode Island (27%), Connecticut (25%), New York (25%), and Illinois (25%).

Latine youth also account for 10% to 22% in 22 states: Oregon (22%), Washington (22%), Massachusetts (19%), Kansas (19%), Hawaii (19%), Idaho (18%), Utah (18%), Nebraska (18%), Oklahoma (18%), North Carolina (17%), Delaware (16%), Maryland (16%), Georgia (15%), Wyoming (15%), Virginia (14%), Pennsylvania (13%), Arkansas (12%), Wisconsin (12%), Indiana (12%), Iowa (10%), Tennessee (10%), Alaska (10%) and the District of Columbia (17%). Moreover, less than 10% of Latine youth live in 16 states: South Carolina (9%), Minnesota (9%), Michigan (9%), Alabama (8%), Louisiana (7%), Missouri (4%), New Hampshire (7%), Ohio (6%), Kentucky (6%), South Dakota (6%), North Dakota (6%), Montana (6%), Mississippi (4%), Maine (3%), West Virginia (3%), and Vermont (2%).

Latines in the U.S.

Latines are a heterogenous, multi-ethnic, and multi-racial group with a plethora of commonalities and differences. Latines may share some commonalities including languages spoken, cultural values, traditions, beliefs, and religion. Conversely, Latines can differ significantly in terms of their country of origin, migration histories and age of migration, documentation status, skin color, discrimination, and socioeconomic status. Moreover, Latines have a history of oppression due to colonialization, modern-day oppression, and racist political agendas in the U.S. and their countries of origin (National Hispanic and Latino Mental Health Technology Transfer Center Network, 2022).

Latines can vary in the terms they use to describe their identities. The Pew Research Center surveyed U.S. Latine adults in 2018 and 2019 about their views on how they describe

their identity and their preferences for the term "Hispanic" or "Latino." The results showed that individuals had mixed views on describing their identity. In the survey conducted in 2019, 47% of individuals described themselves most often by their place of birth or country of origin, 39% as Hispanic/Latino, and 14% as American. In the survey conducted in 2018 about individuals' preference for the term "Hispanic" or "Latino," 54% of people did not have a preference, 27% preferred Hispanic, and 18% chose American. In the same survey administered in 2019, Latines were asked if they had heard the term "Latinx" a term used to challenge the Latina/o gender binary and promote inclusive language, and if they used it to describe their identity. The findings showed that 20% of Latines had heard of the term Latinx and 76% reported that they had not heard of it. Of those who had heard Latinx, 3% indicated using the term.

Latines and Mental Health Needs

Statistics show that U.S. Latine populations have comparable or higher rates of mental health problems than non-Latine whites (Escobar & Gorey, 2018). Compared to 41% of non-Latine white adults, 46% of Latine adults reported having some symptoms of anxiety or depression between 2019 and 2020 (Silesky et al., 2023). During one of the highest increases in suicide rates between 2010 to 2020, 27% of Latine individuals had twice the increase compared to non-Latine whites. Furthermore, suicide death rates were found to be the second leading cause of death for Latines aged 15-34 in 2019, with suicide rates for Latine men increasing by 5.7% between 2019 and 2020 (Yard et al., 2021).

Studies suggest that differences in mental health disorders can differ within Latine sub-groups. For instance, mental health problems are more significant for U.S.-born Latines than foreign-born Latines, a concept referred to as the immigrant paradox. The immigrant paradox involves the outperformance of immigrant individuals compared to U.S.-born individuals, and

studies speculate this might be due to significant cultural values that buffer the negative impacts of low socioeconomic status on mental health problems among Latines (Escobar & Gorey, 2018). Moreover, social determinants of health and health disparities are often associated with several social and economic disadvantages.

Social Determinants of Health

Social determinants of health refer to the social, economic, and environmental factors influencing health and health outcomes such as life expectancy, health status, and functional limitations. These factors are outlined by Artiga and Hinton (2018) to include economic stability, neighborhood and physical environment, education, food, community and social context, and the health care system. Economic stability refers to employment, income, expenses, debt, medical bills, and support. Neighborhood and the physical environment include housing, transportation, safety, parks, playgrounds, walkability, and zip code/geography. Education factors involve literacy, language, early childhood education, vocational training, and higher education. Food includes hunger and access to healthy options. Community and social context factors refer to support systems, social integration, community engagement, stress, and discrimination. Finally, the health care system includes health coverage, provider linguistic and cultural competency, provider availability, and quality of care.

Social determinants of health among Latine populations show that Latines can face economic and environmental disadvantages. For instance, in 2020, Latines were more likely than white adults to report stress about not having enough food or stable housing, creating stressful living conditions. Between 2019 and 2020, food insecurity and economic hardship were exacerbated by the COVID-19 pandemic among Latines (15.8% to 19.1%) but decreased among non-Latine whites. According to survey data by the Pew Research Center (2019), poverty rates

for Latine populations in the U.S. were 19%. The highest poverty rate percentages among Latine subgroups were of Hondurans (26%), Guatemalans (24%), Puerto Ricans (23%), Dominicans (22%), and Mexicans (20%). Lower poverty rates were of Argentines (9%), Peruvians (11%), and Colombians (11%). Moreover, the median household income for Latines in the U.S. was $49,010, with Hondurans having the lowest income ($41,000) compared to Argentines ($68,000).

Latines often work low-paying and hazardous jobs that are unlikely to offer benefits such as healthcare coverage. In 2023, 18% of all Latines in the U.S. lacked health insurance. Within Latine ethnic groups, Hondurans (35%), Guatemalans (33%), Salvadorans (24%), Venezuelans (24%), and Mexicans (20%) had some of the highest uninsured percentages compared to Puerto Ricans (8%), Panamanians (11%), Dominicans (12%), and Argentines (12%).

The socio-political climate in the U.S. and the anti-Latine rhetoric that political figures have overtly and explicitly demonstrated have also been deemed as psychological violence by some, irrespective of immigration status. Taken together, the collective presence of several factors compounded by other day-to-day and environmental stressors, including pressures from school, work, or intrapersonal relationships, may create untenable environments for some Latines and lead to feelings of depression, anxiety, and other psychological problems (Pew Research Center, 2019).

Youth Mental Health Needs

National data sources reveal that mental health problems are prevalent for children and adolescents living in the U.S. According to the U.S. Centers for Disease Control and Prevention (CDC; 2020), common mental health diagnoses for American children include depression, anxiety, Attention Deficit Hyperactive Disorder (ADHD), and behavior problems. For children

aged 3-17, approximately 1.9 million or 3.2% have been diagnosed with depression, with approximately 4.4 million or 7.1% diagnosed with anxiety. Among children aged 2-17, approximately 6.1 million, or 9.4%, have been diagnosed with ADHD. As for children aged 3-17 years, approximately 4.5 million, or 7.4%, have a diagnosed behavioral problem. Among adolescents, findings showed that 1 in 3 high school students indicated feeling sadness or hopelessness. In 2019, 1 in 6 youth had considered a suicide plan, indicating a 44% increase since 2009.

Reports find that child mental health issues can be comparable to or higher for Latine youth compared to their non-Latine counterparts. A report by the U.S. Census Bureau (2023) revealed that nearly one-third of Latines in 2021 indicated that their mental health was most of the time or always not good. Furthermore, data by the Centers for Disease Control Center (2019) found that among 4,330 Latine individuals that died by suicide and 2.32% were under the age of 19. Among Latine LGBTQ youth, 30% were more likely to attempt suicide than non-Latine LGBTQ youth. Despite data that reveal that Latine youth may experience high levels of mental health problems, studies have consistently showed they also largely underuse mental health treatment.

Pumariega et al. (1998) showed that when Latine youth access mental health care services, they receive half as many sessions on average compared to non-Latine white children. Marrast et al. (2016) found that Latine children with behavioral or psychiatric problems were less likely to receive mental health services for their problems compared to non-Latine white children. Similarly, Schieve et al. (2012) found that Latine and Black children were less likely to have a documented ASD diagnosis than white children, and even less for Latine children with

two foreign-born parents. Liptak et al. (2008) also found that Latine parents of children with ASD reported less satisfaction with healthcare and reduced access to services.

Latine Youth and Social Inequalities

Latine youth can be vulnerable to experiencing stress and emotional or psychological problems given social inequalities. Studies among Latine youth find that psychological vulnerability can be exacerbated by factors beyond an individual's characteristics. Latine youth may experience chronic stress from living in high-stress environments or poverty. Studies show that Latine youth living in communities or neighborhoods with high levels of violence or crime can be predisposed to mental health disorders (Acevedo-Garcia et al., 2013).

Latine youth may experience inequalities related to factors such as immigration. In the U.S., one in four children, or 53% have an undocumented immigrant parent (National Research Center on Hispanic Children and Families, 2020). Among Latine youth eligible for DACA (Deferred Action for Childhood Arrivals) and the DREAM (Development Relief and Education for Minors) Acts, individuals can be susceptible to experiencing prolonged anxiety and stress in the waiting period, the process of renewal, or uncertainty related to political attempts to cancel these processes (National Alliance on Mental Illness, 2023). Eskenazi et al. (2019) found that Latine youth self-reported high symptoms of anxiety and depression which were correlated with the Trump administration's anti-immigrant rhetoric or having an undocumented parent that were migrant seasonal farm workers.

Latine children born to first-generation immigrants report higher mental health rates than their foreign-born parents (again referring to the immigrant paradox with parents born outside of the U.S. showing better mental health outcomes). Studies suggest that these youth, also referred to as second-generation immigrants, may show increased mental health problems which may be

associated with different cultural beliefs or generational trauma. For instance, U.S.-born youth may experience conflict with immigrant parents, given differences in attitudes, beliefs, and values between the parent's country of origin and those specific to the U.S. Youth may face social pressures to assimilate and be "more American," which can create separation from their parents' beliefs and lead to interpersonal conflicts among family members with differing perspectives (National Alliance on Mental Illness, 2023). Generational trauma refers to the experiences that undocumented immigrants can face while immigrating to the U.S., which can be influenced by violence, political persecution, poverty, and other traumatic experiences in their countries of origin that can indirectly impact youth development and require the use of mental health services.

Models to Understand Help-Seeking

Researchers have developed models to understand individuals' help-seeking patterns, such as when, how, and where people decide to seek services for their mental health problems. Help-seeking models have generally included several different steps in realized access to care (e.g., problem recognition, the decision to seek help, service selection, and service utilization). According to Andersen's original behavioral model for usage of health care services (e.g., inpatient care, physician visits) developed in 1968 by Ronald M. Anderson (which since has expanded through its 6th iteration), help-seeking is a linear, step-by-step process. Anderson's behavioral model of help-seeking includes three distinct levels: predisposing, enabling, and need factors (Anderson, 1973).

Predisposing factors refer to an individual's predisposition to use services associated with demographic variables such as race, age, and health beliefs. Enabling factors involve the resources an individual has access to that can facilitate realized access, such as health insurance

or funds. For instance, a person's attempt to seek services may be restricted by enabling factors such as ability to pay for services. Finally, need factors refers to an individual's perceived or influenced need for services depending on personal views regarding the severity of their health. Since Andersen’s original behavior model, help-seeking models have considered the cultural and contextual factors that can influence racial and ethnic minority individuals' help-seeking pathways. For instance, Eiraldi et al. (2002) Help-Seeking Behavior Model (HSB) acknowledges that parents’ problem recognition can be dampened by socioeconomic factors such as poverty or being uninsured, lack of knowledge about the mental disorder, or beliefs and perceptions about the etiology of symptoms and behaviors.

Help-Seeking Pathways to Mental Health Services

For children and adolescents who do obtain services, entrance to treatment is done via several help-seeking pathways (Boydell et al., 2013; Lindsey et al., 2010; Pescosolido, 1992; Pescosolido et al., 1998; Stiffman et al., 2004). Help-seeking pathways to care can include formal mental health and general medicine which are considered essential avenues for identifying mental health problems among youth, particularly of white descent (Edbrooke-Childs & Patalay, 2019; Shanley et al., 2008). Youth may enter treatment through educational systems and referrals from teachers and counselors, or the social justice legal system. Youth may also enter treatment by way of their lay systems which includes family, friends and other significant figures in the child’s life (Ortega et al., 2007; Ungar et al., 2014).

The Role of Parents

Most children and adolescents do not often seek mental health services alone so they may rely on their parents for help (Reardon et al., 2017; Stiffman et al., 2004). Research studies note parental figures as having the ability to influence, advocate, and contribute (or delay) access to

treatment for youth in some situations (Boulter & Rickwood, 2013; Reardon et al., 2017). Specifically, studies that examine the role of parents in their access to mental health services for youth have deemed parents as "primary help-seekers," "key figures," or "gateway providers" (Lopez et al. 2018; Stiffman et al. 2004).

Parents can play a primary role in identifying their child's mental illness given that they may be more likely to be able to recognize youths' needs in times of crisis (Murry et al., 2011; Oldershaw et al., 2018). Parents' help-seeking can be influenced by their child's mental illness profile including the type of problem they have, symptom severity, and their level of functioning and impairment (Merikangas et al., 2011). Help-seeking can also be influenced by a child's age, sex, and gender. For instance, Bussing et al. (2003) found that among boys and girls with equally observed Attention Deficit Hyperactive Disorder (ADHD), parents were more likely to seek services for boys than girls.

The Influence of Individual Factors on Help-Seeking

Mental Health Perceptions

Perceptions about mental illness and mental health treatment are influenced by an individual's specific beliefs, attitudes, and knowledge about mental health (Fripp & Carlson, 2017; Kapke & Gerdes, 2016; Wallen, 1992). Namely, perceptions of mental health and treatment can influence an individual's help-seeking pathways, and use of informal or formal services. Among Latine communities, research studies have found that Latines may hold negative, stigmatized perceptions and attitudes about mental illnesses (Fripp & Carlson, 2017). These negative or stigmatized perceptions may include the belief that people with a mental illness are "crazy/*loco*," dangerous, out of control, or uncurable which can discourage help-seeking (Guarnaccia, 2005). Individuals may also deter from mental health services for fear of

appearing weak or mentally unfit. According to Zvolensky et al. (2023), some Latines may prefer to seek care from health providers for physical and neurological problems and therefore explain their mental health symptoms in physical terms instead of describing emotions.

Parents' perceptions about their child's mental health problems, beliefs about psychological treatment, and their knowledge about medication can significantly inform how they make sense of their child's mental health problems, how they choose to deal with them, and how likely they are to adhere to keeping their children in treatment (Cabassa et al., 2006; Cabassa et al., 2012; Leong & Kalibatseva, 2011; Pumariega & Rothe, 2003; Rodriguez & Smith, 2020). For instance, racial and ethnic minority parents, often those from lower socioeconomic backgrounds, may have higher "distress thresholds" and, therefore, not perceive symptoms as requiring professional help (Cleek et al., 2012). Likewise, some parents may not seek services despite pronounced symptomology due to the perception or belief that their child's mental health concerns do not require or could benefit from mental health service provision.

Mental Health Etiology Explanations

Studies have speculated that an association exists between etiological explanations of mental health problems and service use among racial and ethnic minority parents of children with mental health needs (Gerdes et al., 2014). Research by Yeh et al. (2004) found that Latine and Asian Pacific Islander American parents were less likely to endorse etiologies for their children that were related to physical causes, domestic issues, or personality traits which predicted lower levels of mental health service use for diverse youth compared to non-Latine whites.

Yeh et al. (2005) conducted a similar study the following year to examine different parental beliefs about the causes of their child's problems and the relationship between mental

health service use in a diverse sample. Findings revealed that parents who believed their child's mental health problems were caused by trauma or physical causes were more likely to seek mental health services. For instance, individuals that endorsed their child's mental health problems to physical causes were 1.56 times more likely to seek biopsychosocial mental health services such as counseling and psychotropic medications. Comparatively, parents who believed mental health problems were caused by relational issues, their child's personality, or domestic issues were less likely to be associated with service use.

Mental Health Attributions

Parents' attribution of mental health problems can be related to spiritual, supernatural, interpersonal, or scientific perspectives depending on their cultural background; Pumariega & Rothe, 2003). Latine populations may attribute different mental health concerns to supernatural phenomena out of their control and controlled by fate or destiny (i.e., fatalism; Interian et al., 2010). These phenomena can include mal de ojo (evil eye), nervios (nerves/anxiety), espanto (spooked), miedo (fear), or susto (shock/fright; Barrera & Longoria, 2018; Guarnaccia et al., 2003). Latines who attribute their mental health needs to these phenomena may identify resources, such as folk healers, within their communities to cure or alleviate symptoms (Interian et al., 2010).

Gomez-de-Regil (2014) examined attributions of mental health disorders in Mexican patients who had experienced psychosis (i.e., schizophrenia) and those of their relatives. Participants viewed five distinct categories of etiological attributions for psychotic illnesses. These categories included biology (e.g., disturbance of brain biochemistry, hereditary factors, organic disease external to the brain), personality (e.g., failure in life, lack of willpower, drug/alcohol abuse, too bright, too ambitious), family (e.g., broken home, lack of parental love,

father too severe, overprotective mother), society (e.g., stressful life events, the influence of bad friends, loneliness, troubles in marriage/partnership, and esoteric (e.g., possession by evil spirits, punishment by God, lack of vitamins, unfavorable horoscope, radiation, and environmental pollution). Moreover, participants in this study (patients and their relatives) were more likely to attribute psychosis to society (e.g., stressful life events, the influence of bad friends), followed by esoteric as a minor cause (e.g., possession by evil spirits, punishment by God).

The Influence of Cultural Factors on Help-Seeking

Familismo and Religion

Certain cultural values have been identified as predictors of help-seeking among racial and ethnic minority populations. Studies suggest that cultural values can influence whom parents may seek help from to address their children's mental health concerns. For instance, among Latine populations, cultural values of familismo and religion have been associated with informal help-seeking for mental health concerns. Familismo refers to strong family ties and loyalty, unity, and honor to the nuclear and extended family. According to Villatoro et al. (2014), one-third of Latines who endorsed high behavioral familismo were most likely to use informal or religious services to cope with their mental health (Villatoro et al., 2014). Moreover, religiosity or spirituality refers to a person's set of beliefs regarding the existence of a higher being or power. Religion can include certain practices or expressions depending on the individual and their beliefs. Research by Yeh et al. (2005) showed that Latine parents that interpreted their child's disruptive behavior as an indicator of being out of balance in their religiosity were more likely to seek guidance from spiritual leaders in their communities than healthcare personnel.

Caplan (2019) explored the perceptions of mental illness among sixty-four religious-affiliated participants (e.g., Catholic, Presbyterian, and Methodist) that identified as Dominican

(40%), Puerto Rican (12%), or Other (12%). For participants in this study, mental illness and depression were culturally defined and perceived as a spiritual problem rather than a "sickness." Most participants believed that mental health problems were due to "a lack of faith, not praying, demons, the devil taking over their mind, or the cause of sin." Participants indicated depression could be cured by praying and having faith, with many participants reporting their ability to resolve their depression by way of this method, and 44% of participants agreed and strongly agreed with this belief. Furthermore, participants' non-biomedical interpretation of illness lowered the perceived need to seek mental health services, regardless of illness severity.

Acculturation. A model of acculturation by Berry (2008) defines acculturation (at the individual level) as a process that involves cultural change and adaptation when two groups come into contact. Berry (2008) proposed four acculturation modes: assimilation, integration, separation, and marginalization. Assimilation refers to the process in which an individual adopts a host culture resulting in the loss of their culture of origin/cultural identity. Integration refers to maintaining an individual's own culture while participating in the host or dominant culture. Separation refers to an individual's retaining their country of origin's cultural and traditional values without adopting those of the host culture and maintaining separation. Finally, marginalization is characterized by disengagement between dominant and host cultures. According to researchers, integrated acculturation is associated with favorable psychological outcomes compared to marginalization (Nguyuen et al., 2007).

An individual's level of acculturation has been identified as a factor associated with the help-seeking of mental health care services. For instance, studies examining mental health service use predictors controlling for individuals' acculturation level find that monolingual Spanish speakers with lower levels of acculturation are less likely to seek or use mental health

services. Moreover, acculturation levels have also been associated with informal mental health service use. For instance, Latines with lower levels of acculturation show they may primarily seek help from religious leaders or folk healers to cope with mental health problems or distress. Conversely, Latines with higher levels of acculturation have been associated with higher levels of formal service use for mental health problems.

The Influence of Social Factors on Help-Seeking

A person's social networks can include extended family, kinship networks, neighborhood, and cultural organizations (Pumariega & Rothe, 2003). Studies examining the role of social networks on help-seeking reveal that social networks can positively or negatively influence a person's pathways to mental health care (Martinez et al., 2011; Shanley et al., 2008). For instance, social networks can encourage or discourage individuals decision to seek out mental health services or use formal treatment to address mental health concerns. Interestingly, some researchers suggest individuals may also not seek mental health services given their close attachment to their social networks and the support they receive from them (Dillon et al., 2019). For instance, Cauce et al. (2002) asserted that informal services can reflect individuals' cultural norms, making them less stigmatized avenues for help-seeking.

A study by Boydell et al. (2013) examined pathways to mental health care among youth at high risk for psychosis. According to findings, youths' pathways to mental health care were significantly shaped by three main factors: family content, structure and function, community/school, and the treatment system. Family content referred to the impact of families' knowledge, beliefs, and attitudes about mental illness and mental health treatment on help-seeking. For instance, parents with prior experience with healthcare systems and ongoing use of services obtained medical knowledge and pertinent information that assisted with their help-

seeking for their youth. Additionally, parents' experiences with using mental health services in the past helped them to facilitate their access to care. Furthermore, the size and cohesion of family connections were related to parents' help-seeking for their youth. In other words, the smaller parent’s social network was, the less likely they were to get help from others with problem identification, recognition, or help-seeking initiation and vice versa. In addition, families that regarded their children's mental health problems as typical or 'just a stage' were more likely to be deterred from seeking help for their youth.

The Influence of Structural Factors on Help-Seeking

Parents help-seeking pathways to realized care for their children can be obstructed by structural barriers to care. More specifically, studies show that parents can face both practical and structural barriers to mental health care for their children with psychological needs (Kazdin et al., 1997). Practical barriers among parents have been shown to include a lack of insurance coverage, lack of availability, transportation, childcare, or scheduling conflicts (O'Brien et al., 2016). Practical barriers can also become compounded by low socioeconomic status or a single-parent provider role (Garcia & Weisz, 2002). Structural barriers include poor availability of services or resources, waiting lists, and limited agency hours (Cabassa et al., 2006).

While parents of non-white children endorse similar barriers to mental health services as white parents, the extent of these barriers differs (Planey et al., 2019). Among Latines, barriers to help-seeking can include fear, cultural mistrust of U.S. government institutions, dealing with a lack of non-Spanish-speaking mental healthcare providers, having an undocumented status, or having negative experiences with the mental health care sector (Alegria et al. 2007; Leong & Kalibatseva, 2011). Cook et al. (2018) found that Latines children were more likely to drop out of treatment prematurely when parents reported feeling judged or discriminated against by

mental health professionals. Furthermore, a recent systematic review by Rivera-Figueroa et al. (2022) found that Latine and Black American parents of children with autism spectrum disorder related more negative experiences with healthcare providers compared to non-Latine white families. In addition, parents reported having less access to information about ASD, more inaccurate beliefs about ASD, and higher levels of ADS-related stigma.

Decades of early childhood research show that healthy development is associated with well-being and functioning in several areas of an individual's life, such as school, work, intrapersonal relationships, and social integration (Sawyer et al., 2002). Conversely, mental health problems left untreated in childhood or adolescence have been associated with academic failure, alcohol and drug problems, parent-child conflict, involvement with justice systems, and suicide (Patel et al., 2007; Singer, 2009). Moreover, understanding the help-seeking experiences from the perspective of Latine parents who accessed mental health services for their youth is relevant to close the gap between mental health needs and the underutilization of services. Furthermore, the current study examined Latine parents help-seeking pathways to care for their children to identify the factors that facilitated and obstructed their access to mental health services. Importantly, this study shares guidance for addressing the service gap between children’s mental health needs and low service use. Additionally, this study offers information about how parents' help-seeking pathways can be strengthened to increase access to care (Boulter & Rickwood, 2013; Villatoro et al., 2014).

Chapter III: Methods

Research Design

A qualitative design was utilized to examine the experiences of Latine parents in their access to mental health care services for their children and adolescents with mental health needs. Qualitative research is used to explore individual experiences, understand understudied constructs, and describe phenomena (Vishnevsky & Beanlands, 2004). Notably, a qualitative design allows researchers to delve into and understand the worldview of others (Ponterotto, 2013). Moreover, within this qualitative design, a multiple case study approach was implemented (Stake, 1995, Yin 2006).

Multiple case studies are vital for providing descriptive information about a phenomenon within real-life contexts and from the views of Latine parents in this study (Bobblin et al. 2013). This multiple case study approach used a cross-analysis of the cases to understand similarities and differences among participant responses. A multiple case study approach helps preserve a holistic understanding of cases within their diversity rather than generalizing beyond them (Stake, 1995). Stake (1995) describes two types of case studies, intrinsic and instrumental. Intrinsic case studies focus on exploring a singular case of specific interest. Conversely, instrumental case studies focus on studying several cases to provide insights into a phenomenon, and the cases themselves are of secondary interest. The observation of a few cases at once, wherein they are jointly studied, is identified as a multiple case study or collective study.

Given the aims of this study, a thorough examination of multiple cases was chosen to facilitate a collective understanding of the experiences of Latine parents' help-seeking of realized access to mental health care services for their children in need. Furthermore, utilizing an instrumental case study approach allowed for a close examination of parent's contexts and

diverse approaches to accessing mental health services, as well as an exploration of a myriad of factors that encouraged and thwarted parents' help-seeking pathways to realized care for their youth with mental health needs (Pescosolido, 1998).

Research Paradigm

This study was informed by social constructivism and critical ideology paradigms. Social constructivists assert that individuals' subjective and contextualized experiences shape multiple realities and that meaning is co-constructed between researcher and participants (Creswell & Poth, 2016). Relatedly, constructivists underline the importance of acknowledging participants as the experts of their own lives (Morrow, 2005). Critical ideology values subjectivity and acknowledges how power relations permeate individuals' realities. In practice, critical ideology includes individuals gaining critical consciousness of oppressive systems and identifying ways to dismantle them (Ponterotto, 2010). Critical ideology is committed to ending oppression and promoting social justice to improve society (Creswell & Poth, 2016; Ponterotto, 2006).

Application of Research Paradigm

In this study, participants were invited to share the factors that helped facilitate and obstruct their access to mental health services. Considering the social constructivist and critical ideology paradigms, it was necessary to acknowledge parents' diverse views and the different elements that supported their help-seeking process to raise awareness about mental health and service use and to make a step towards helping to demystify access to mental health treatment within Latine parent populations. Namely, these facilitative elements among Latine parents who sought and accessed services for their children with needs were intended to facilitate change at the individual and social level by raising awareness on the topic (Vera & Speight, 2003).

The Network Episode Model

The NEM was used to examine the multiple factors that could serve to facilitate or obstruct the help-seeking pathways to mental health care services for Latine parents. The NEM shifts the focus from solely highlighting a single individual's characteristics or predisposing factors (i.e., age, sex, gender, education) to also acknowledge the influence of social networks (e.g., social processes, social groups, or communities) on the process of seeking help (Johnson et al. 2010; Perry & Pescosolido, 2015; Pescosolido et al. 1998; Becker et al. 1977).

Social networks are categorized as the formal system (e.g., specialty mental health care and general medical care), the lay system (e.g., friends and family), the folk system (e.g., religious advisors and alternative healers), and the human social service system (e.g., clergy, police, and teachers; Pescosolido et al. 1998). In this study, the NEM was used as a framework to examine the influence of various factors on participants' help-seeking experiences. Specifically, this study examined the influence individual, cultural, social, and structural barriers on participants access to realized mental health services (Beatie et al. 2020; Pescosolido et al. 1998).

Sampling Method

Purposeful sampling was used to identify a group of participants that would be able to provide insight and in-depth information about their help-seeking experiences and their decision-making process, in addition to information about the facilitative or obstructive factors that they encountered in their pathways to care. Namely, a criterion sampling technique helped to narrow the sample to include cases of Latine-identified individuals that identified as parents (i.e., primary caregivers, legal guardians) of at least one child or adolescent with mental health problems or concerns. Participants' children must have had completed at least one counseling session with a mental health professional in an outpatient clinic within the past five years. The

established time parameter was used to help participants maximize their recollections about their help-seeking experiences at the time of their interviews.

The participant exclusion criteria included children with severe neurodevelopmental or mental disorders, including autism spectrum, schizophrenia spectrum, or other psychotic disorders. Additionally, participants' children could not be court-mandated to mental health services. The rationale for this exclusion criterion was to focus on Latine parents that self-initiated the help-seeking process to understand their decision-making processes.

Participants

Participants were 11 Latine individuals residing in Los Angeles County, California; their ages ranged between 26 and 56. Ten participants identified as Latina/o and one as Hispanic. Majority of participants were born in Mexico (64%), two in California (18%), one in Guatemala (9%), and one in Peru (9%). All the participants identified as a parent of a child whom they sought mental health services for within the past five years. Five participants (45%) indicated their civil status was single, two separated (18%), two married (18%), and two in a relationship (18%). Ten participants were female (91%), and one was male (9%). Of these participants, two individuals (one male and one female) identified as parents of a male child and interviewed as a couple. Six (55%) of the 11 participants were interviewed in Spanish and five (45%) in English. One participant completed the interview, received the incentive, and then asked to withdraw from the study; the researcher deleted their interview, and their data were not included in this study.

Participants varied in their annual family income. Six (55%) participants reported an income lower or between $20,000- $29,000, one (9%) between $30,000- $39,000, three (27%) between $40,000-$49,000, and one (9%) between $50,000 or more. Participants also reported a

wide range of highest levels of education, with one individual finishing grade school (9%), four completing middle school (36%), two completing four-year university (18%), one completing some university with degree (9%), one earning a vocational degree (9%), and two (18%) completing a master's degree. Six participants (55%) identified as Catholic, two as Christian (18%), one as Adventist (9%), and one indicated no religious or spiritual affiliation (9%). Participants reported that their religious or spiritual practices were Very Influential (36%), Somewhat Influential (36%), Influential (18%), or None (9%). Participants were compensated with an electronic $25 gift card incentive for their participation in the study. See Table 1 for participant demographics and additional information.

Table 1.

Participant Demographics and Information

Participant	Age	Ethnicity	Place of Birth	Language	Civil Status	Socioeconomic Status	Highest Level of Education	Past Use of Formal Services	Religious/ Spiritual Affiliation	Religious Influence
P.1	49	Latina/ Mexicana	Mexico	Spanish	Single	< 20k or less	Grade School	Therapy (after child)	Christian	Very Influential
P.2	38	Latina/ Mexicana	Mexico	Spanish	Separated	< 20k or less	Grade School	No	None	None
P.3	56	Latina/ Chicana	U.S.	English	Married	> 50k or more	Master's Degree	Therapy (before child)	Spiritual	Influential
P.4	47	Latina/ Hispana/ Peruana	Peru	Spanish	Single	30-39k	Occupational, Technical, or Vocational School	Parenting Class	Adventist	Very Influential
P.5	44	Latina/ Mexicana	Mexico	Spanish	Single	< 20k or less	Grade School	No	Catholic	Somewhat Influential
P.6	40	Hispanic	U.S.	English	Single	< 20k or less	Bachelor's Degree	No	Christian/ Catholic	Influential
P.7	26	Latina/ Guatemalan	Guatemala	Spanish	Single	< 20k or less	Grade School	No	Christian	Very Influential
P.8	37	Latina/ Mexicana	Mexico	English	Separated	40k-49k	Bachelor's Degree	Therapy (before child)	Catholic	Somewhat Influential
P.9	54	Latina/ Mexicana	Mexico	Spanish	Married	< 20k or less	Grade School	No	Catholic	Somewhat Influential
P.10	31	Latino/ Mexicano	Mexico	English	Domestic Relationship	40-49k	Master's Degree	No	Catholic	Very Influential
P.11	30	Latina/ Mexicana	Mexico	English	Domestic Relationship	40-49k	Some University with Degree	No	Catholic	Somewhat Influential

Participants' Children Demographics

With respect to sex, the participants' children for whom they obtained mental health services were six girls and five boys. At the time of the study, children were between the ages of two and 17. On average, participants' children attended at least five sessions with a mental health professional. Participants' children received a wide range of mental health services including counseling or individual therapy, psychotropic medications, and other therapies (i.e., speech therapy to treat anxiety concerns, group therapy, play therapy, family therapy), psychological evaluations, and in-patient residential treatment. Participants' children's mental health problems

or concerns included mood disorders (i.e., anxiety, depression), behavior problems (i.e., attention deficit hyperactivity disorder, oppositional defiant disorders), bullying, gender dysphoria, and suicidal ideation. See Table 2 for additional child/adolescent demographics and information.

Table 2.

Participant Child and Adolescent Information

Participant	Child/ Adolescent Sex/Age	Participant Reason for Help-Seeking Mental Health Services	Type of Mental Health Service Use	Inpatient Hospitalization/ Length of Stay	Coverage	Average Number of Sessions with a Helping Professional
P.1	Female 8	Bullied and learning problems at school	Individual counseling, Medication	No	Insurance/out of pocket	36 sessions
P.2	Female 16	Depression, anxiety, self-harm	School counseling, Individual therapy	Yes, two weeks	Medical	10 sessions
P.3	Female 14	Questioning gender identity	Individual counseling/group, Residential program, Medication	Yes, multiple times, weeks, or months	Insurance/out of pocket	8 sessions
P.4	Male 15	Bullied, irritability, hitting other children	School counseling, Individual therapy, Family therapy	No	Medical	16 sessions
P.5	Female 13	Anxiety, depression, self-harm, bullying	Individual therapy, Medication	No	No Cost Services	3 years
P.6	Female 16	Behavioral problems in school, problems paying attention	Individual therapy	No	Medical	20 sessions
P.7	Male 4	Speech and behavioral problems	Psychological assessment, Speech therapy	No	Insurance/out of pocket	6 sessions
P.8	Male 7	Anxiety, separation anxiety	Play therapy	No	Private insurance/out of pocket	18 sessions
P.9	Female 17	Depression, isolation, anger problems, self-harm	Individual counseling	Yes, 72-hour hold	Medical	1 session
P.10	Male 2.5	Anxiety, speech concerns	*Speech therapy	No	Medical	6 sessions
P.11	Male 2.5	Anxiety, speech concerns	Speech therapy	No	Medical	6 sessions

Note: *speech therapy services were obtained to address anxiety concerns.

Procedures

Recruitment

The researcher obtained approval from the University of California, Santa Barbara's Institutional Review Board (IRB) for the current study (IRB study # 13-22-001). Upon approval, participants were recruited through recruitment flyers on social media (i.e., Facebook, Instagram,

and Twitter). Recruitment flyers were posted on different social media platforms with information about the study, such as the IRB approval number, project details, participant eligibility, incentive amount, and the research team's contact information. Flyers were shared specifically within Latine parenting and mental health groups on Instagram and Facebook (@Latineparenting; @Latinepsychology).

Participant recruitment was also completed through psychology-related listservs (National Latinx Psychological Association) and educational institutions in Southern California (University of California, Santa Barbara, California State University Fullerton, and the University of Southern California). The researcher contacted local community members, non-profits, and community mental health agencies that serve Latine populations in Los Angeles and Santa Barbara Counties (Santa Barbara Promotora Network, Family Services Agency of Santa Barbara, City of Chino Human Services) to support the recruitment of eligible participants.

Phone Screen

The researcher contacted the individuals that expressed interest in participating in the study by phone or email. Prospective participants were invited to complete a 10–15-minute phone screen to determine their eligibility for the study. The phone screens were conducted in individuals' language of preference (English or Spanish; See appendix A). Individuals not meeting the study's eligibility were thanked for their interest and time. Individuals were also informed that the preliminary information collected from them (e.g., name, age, race/ethnicity) would be destroyed immediately. Moreover, individuals that met the study criteria were asked to provide verbal consent to conduct a semi-structured interview by videoconference or phone. Participant interviews were scheduled at their preferred date and time by the researcher.

Ethical Considerations

Consent Process

Following the demographic questionnaire, the researcher reviewed the consent form with participants over the phone or via Zoom to inform them about the purpose of the research study. The consent forms stated the names and contact information of the principal investigator and supervisor, the purpose of the research study, the benefits and level of involvement, potential risks, and limits to confidentiality, including the mention of imminent risk or danger to self, others, elders, and suspected, or known child abuse. The researcher emphasized to participants that information they shared that did not fall outside of the limits of confidentiality would remain confidential and be removed or anonymized, including information that they disclosed about themselves or their child that would help to identify them as individuals (Standard 4.02, Discussing Limits of Confidentiality, APA, 2017). Participants were informed about their right to withdraw from the study at any time or their right not to answer any of the interview questions that they did not want to without facing the consequence or compromising their $25 electronic gift card incentive (Standard 8.02, Informed Consent to Research, APA, 2017).

Participants who consented to participate in the interview were electronically emailed a copy of the consent form and asked to sign and return it to the researcher for record-keeping purposes. Participants were asked a second time to provide verbal consent to be interviewed and recorded by video, audio, or phone audio. All participants consented to video and audio or phone audio. Participants were informed that recording the interview would facilitate the researcher's analysis of their responses. Participants were informed that all their information would remain in the researcher's password-protected laptop and cloud-based storage provided by the university

known as Box. The researcher emphasized that all participant forms and materials (i.e., signed consent forms, video, and audio recordings) would be destroyed upon study publication.

Mental Health Resources

Participants were emailed a list of mental health resources at the end of the interview. Given the sensitive and personal nature of the mental health content discussed during interviews, this resource was provided to support participants (APA: "Principle A: Beneficence and Nonmaleficence"). The list of mental health resources included a list of national mental health crisis hotlines, as well as a list of strategies identified by the researchers that participants could use to cope with complicated feelings after their interview (e.g., calling a friend or family member, going for a walk, breathing exercises; See Appendix D for a complete list).

Measures

Demographic questionnaire

Before beginning the interview, the researcher verbally asked participants basic demographic questions (see Appendix A) to gather general information from individuals. Participants were asked to provide information about their race/ethnicity, age, sex/gender, sexual orientation, generation status in the U.S., level of education, income level, number of children in the household, previous experiences with seeking mental health care services for themselves or other family members (see appendix B).

Semi-Structured Interview Protocol

Semi-structured interviews were conducted with participants to understand the facilitative and obstructive factors in participants' help-seeking experiences (Ponterotto, 2006). The interview protocol questions were formulated and based on the NEM. They included questions about the underlying facilitative or obstructive factors in three overarching domains: parents'

decision to seek mental health services, the actual process of seeking mental health services for their children, and the influence of their social networks on their overall experiences with accessing care. Given that NEM acknowledges the potential role of cultural values in access to mental health services, the interview protocol in this study included questions about the role of religion on parents' help-seeking pathways (see Appendix C).

Data Analysis

All interviews were recorded and transcribed verbatim by the researcher and remained in the original language in which they were conducted (English or Spanish). Each interview was recognized as a case per a multiple-case study approach. The cases were each read by the researcher to become familiarized with the data. Each case was analyzed individually and collectively to capture similarities and differences and identify data patterns and themes.

Thematic analysis

The data was analyzed using Braun and Clarke's (2006) thematic analysis to answer the study's research questions. After each transcript was re-read several times, initial codes were generated using the participant's words. These codes were organized into overarching categories to identify the themes and patterns in participants' responses. The themes were defined, written up, and reviewed regularly. Each theme includes individual participant quotes to provide rich descriptions (Maguire & Delahunt, 2017).

Trustworthiness

Lincoln and Guba (1985) propose specific criteria for evaluating a qualitative research's trustworthiness, which includes credibility, dependability, conformability, transferability, and authenticity. Credibility refers to the participants in the study and if they are identified and represented accurately in the research study. Dependability refers to whether the data is

consistent and, in some form, repeatable. To achieve dependability, researchers may include an external auditor to confirm the accuracy of the findings (Lincoln & Guba, 1985). Conformability is the congruence between two or more independent people about the data's accuracy, meaning, or relevance. Transferability refers to the degree that data can be applied or transferred to other settings and groups (different from generalization in quantitative design). Finally, authenticity in qualitative design refers to how researchers fairly and faithfully describe and include the wide range of participant realities (Lincoln & Guba, 1985).

While researchers suggest that two or more of these trustworthiness criteria be included in qualitative studies (Creswell & Poth, 2016), others argue that it does not have to require a specific criterion and should consist of fewer rigid "guidelines" (Hammersley, 2007; Stige et al. 2002). Notwithstanding, researchers assert that qualitative research should establish some form of rigor since achieving all forms of trustworthiness and authenticity may not be feasible (Lietz & Zayas, 2010). According to Morrow (2005), qualitative research within a field that has been largely postpositivist can be evaluated on the premise of including a research positionality and researcher reflexivity statement which were included in the study.

The Research Team

The team was constituted by the researcher and a faculty member who guided the work of the researcher and served as an auditor, all the while chairing the dissertation committee. To help establish the study's credibility, the researcher met regularly with the faculty member to check in about the study's development. Research meetings with the faculty member were important to facilitate an exchange of perspectives and ensure the accuracy of the findings.

Reflexivity

The researcher is a Mexican American, second-generation female in a counseling psychology doctoral program. She has personal and professional relationships with Latines who have similarly faced difficulties accessing healthcare services or have delayed seeking treatment due to mental health barriers. Given the researcher's insider status in this area, open discussions with the auditor of this project helped ensure the accuracy of the findings and interpretations. An insider status also allowed the researcher to relate to participants' cultural backgrounds and build rapport.

This dissertation study was developed with and chaired by a faculty member; accordingly, it is important to declare his positionality as well. He identifies as a Latine male immigrant from Argentina, formerly undocumented, who, as a faculty member in counseling psychology, has researched matters concerning access and utilization of mental health services by Latines.

Chapter IV: Results

Participants in this study demonstrated a high level of interest for sharing about their help-seeking experiences through long and engaging discussions during their respective interviews. Notably, majority of participants expressed their desire to share about their personal experiences related to seeking and accessing mental health services for their children to help raise awareness on the topic for other parents with similar demographic backgrounds in their communities.

The facilitative and obstructive factors that influenced participants' pathways to treatment are reflected in the following themes that emerged from the data analysis. The facilitative factors in help-seeking and realized access to care include five themes: *Support from Social Networks, Being Persistent, Using Spirituality to Cope, Increase in Mental Health Literacy,* and *Positive Treatment Experience.* Furthermore, the obstructive factors in help-seeking and realized access to care include three themes: *Limited Mental Health Literacy, Interference from Social Networks,* and *Structural Barriers to Treatment.* Descriptions for each theme are provided, followed by illustrative quotes from participants in both English and Spanish.

Facilitative Factors

Support from Social Networks

Social networks (family, friends, community members, spiritual leaders, and helping professionals) played a significant role in participants seeking help and realized care for their children. Participants highlighted their social group's support with becoming more aware of their children’s mental health problems and their help with identifying how they could address these concerns. Participant (P.[2]) 11 discussed her family's role in raising their concerns about her son's

[2] P. is abbreviated for Participant followed by their corresponding number.

mental health problems. She underlined her family's suggestion to her to seek mental health services for her son's separation anxiety. She stated:

> My sisters and both of his grandmas just telling me like, 'Oh, you know what? It would help him out a lot [mental health services']. They would see what he would go through his separation anxiety, and I'd think, 'Yeah, that's the right decision.'

P.10 also discussed the concerns his family expressed to him about his child's speech delay, followed by their suggestion to look for mental health services to address the problem. He shared: "Her aunt would say, 'Oh, you should get services,' so you kind of have to do it." Furthermore, participants emphasized the help they received from their social networks about who or where they could look for help, particularly when they were unsure about where to start. P.5 shared her sisters' suggestion to turn to school personnel to ask others for help given her suspicion that her daughter was not doing well. She mentioned: "Me dijo mi hermana, '¿Oye, qué tiene? Pienso que ella no está bien. Búscale ayuda en la escuela, que le den, no sé, pero ella necesita ayuda.'" [My sister told me, 'Hey, what does she have? I think she is not okay. Find her help at school, they need to give her, I don't know, but she needs help'].

Participants highlighted turning to their social networks for guidance about how to deal with their children's symptoms. P.4 emphasized going to speak with the director of a community center to ask for help and sharing about her daughters' problems. She discussed her interaction with him and his help with finding resources, including making the first appointment for her daughter. She stated:

> Yo fui a hablar con él. Mire, tengo problema con mi hija, está en la adolescencia y pues (…) 'Oh, no, no, no, no te preocupes, me dijo. Ahí vamos.' Me dijo, 'Alguien te va a ayudar'. Y luego él mismo me sacó la cita.' [I went to talk to him. Look, I have a

problem with my daughter, she is in adolescence and well (…) 'Oh, no, no, no, don't worry he told me, we'll go there.' He told me, 'Someone is going to help you.' And then he made the appointment for me himself].

Similarly, P.7 underscored asking her family and friend networks for their advice and input about what she should do to help her daughter. She shared: "I would ask for advice and input. 'What would you do?' Especially my friends that have kids already." Furthermore, among some participants, individuals underscored asking their social networks about specialized services for their children and receiving helpful recommendations. For instance, P.3 highlighted learning about her daughters' gender affirming services from her pastor, a queer Black woman. She stated: "She gave me some resources to some mental health practitioners that may be able to help."

In conjunction with receiving help to find services in their communities, participants underscored the emotional support they received from people in their social networks. Namely, participants highlighted feeling motivated by others to seek help. For instance, P.4 traced her motivation to seek services back to when she learned more about mental health resources from people in her social network. She underscored learning from others that she was not the only one with problems and that there were services she could look for to help her and her child. She mentioned: "Me dijeron que no solamente yo soy la que tiene el problema y que hay muchos recursos y que hay lugares donde se va, y hay muchos beneficios, y que tienes que buscar, y que le va ayudar." [They told me that I am not the only one with the problem and that there are many resources and that there are places where many benefits will go, and that you have to look for it, and that it will help you]. Moreover, she underscored becoming motivated by her social networks

by learning from them about the potential positive therapy outcomes she and her child could experience. She shared:

> Para que los dos tengan paz y estén tranquilos y puedas aprender técnicas para que tu hijo esté mejor. Para que sean felices (…) para que no te vayas a enfermar, porque eso te enferma (…) esas cosas en verdad te motivan también. [So that they both have peace and can be calm and you can learn techniques so that your child is better. So that they are happy (...) so that you don't get sick because those things make you sick (...) those things really motivate you too].

P.7 underscored her social networks role in motivating her to move forward with her plans to seek care for her daughter and exploring her available treatment options. She shared: “They made a difference just by motivating me to reach out to the school and figure out what's going on, even though I was going to do it.”

In addition to being motivated by their social networks, participants highlighted the emotional support and encouragement they received from others, especially when they had trouble with finding resources. For instance, P.3 underscored her pastor’s encouragement to keep looking for the services she needed for her daughter which she exclaimed helped her carry on with her search. She mentioned: “She said don't allow them to pathologize her. Just because they don't understand where she's coming from. So that made me feel like, okay, my gut is right. I'm going to continue looking. I'm going to continue.” Importantly, participants emphasized relying on their family members for emotional support when they faced challenges to accessing care. For instance, P.6 stated feeling emotionally supported and comforted by her family when she was unable to find mental health resources for her son. She stated:

> Ahí estaba mi familia y tenía ese apoyo emocional. A veces uno se puede sentir como muy estresado, agobiado, desesperado, hasta triste por no encontrar algún recurso que necesita. Entonces, me he sentido muy confortada con mi familia, que ha sido de mucho apoyo. [My family was there, and I had that emotional support. Sometimes one can feel very stressed, overwhelmed, desperate, even sad for not finding some resource that they need. So, I have felt very comforted by my family, which have been of a lot of support].

Further, participants underscored the validation they received from their social networks regarding their decision to pursue mental health services to address their children's concerns. P.9 highlighted her family's perception aligning with hers about the need to seek services for her son. She shared: "Validated (…) Like it's not just us reacting or making a big deal out of this. I think people are seeing it. So, there must be something there." Similarly, P.11 underscored her family's recognition about her son's problem giving her the push to take the first step and look for help. She stated:

> It kind of pushed me more to want to make that phone call and take the first steps because I was like, 'Okay, it's not just me that's making things up. He is having trouble with different things like separation anxiety.'

Being Persistent

Participants emphasized being insistent in finding the help they needed to resolve their children's mental health problems. For instance, P.5 encouraged parents to seek help for any problem they detected their children had rather than ignoring them. She stated:

> Entonces yo sin gravedad recomiendo mucho, mucho a los papás que ayudemos también a nuestros hijos con cualquier problemita uno puede detectar. Hay que tomarlo en cuenta y hay que resolverlo, porque si hay, si hay solución a todo. Ponerles atención más que

nada a los hijos. Porque si no hay vienen como una cadenita de problemas y a eso se van con los amiguitos a querer llenar ese vacío que uno mismo crea en los hijos. [So I seriously recommend to parents that we also help our children with any little problem one may detect. It must be taken into account, and it must be resolved, because there is a solution to everything. Pay attention more than anything to the children. Because if we don't, then comes a chain of problems and that's when they go with their friends to want to fill that void that we ourselves create in children].

Participants highlighted not giving up in searching for mental health treatment. P.10 shared his process of searching for mental health services for his son. He underscored calling several providers, following up with them, and refusing to take 'no' for an answer. He stated: "If they don't call you back, call them back again. Always push for more services. And don't take a no as an answer." Moreover, P.7 highlighted being direct with mental health care providers about the treatment she needed for her daughter with ADHD. She stated:

> Be very direct. Be very direct with your providing physician and don't hold back. Speak out. Be very direct and tell them, this is what's going on. This is what I need. And be consistent and don't let them tell you otherwise.

Furthermore, participants highlighted not giving up on finding providers that they themselves, and their children, felt comfortable working with. P.11 shared her own personal experience with needing to bond with therapists. She shared:

> So, make sure it's somebody that you feel comfortable talking to, that your child feels comfortable talking to (…) I know with my experience, you kind of have to have a bond with your therapist. Go for it and (…) and don't give up trying to find somebody.

Participants emphasized not giving up on doing what is right for their children, regardless of the circumstances. P.6 emphasized including herself in her child's treatment plan and asking providers how she could support her son outside of therapy sessions. Although she was met with certain reactions, she encouraged people to not give up in becoming involved. She shared:

> Tenemos que incluirnos a nosotros mismos [en el plan de tratamiento de nuestros hijos] también. Yo haría preguntas. Tal vez había algunos [proveedores] que se enojaban, se molestaban, porque ahí estaba yo preguntando ¿cómo lo ayudo? qué más podemos hacer? ¿Dónde más puedo ir? Nunca debemos darnos por vencidos (…) Por ellos [los niños], estamos dispuestos a hacer lo que sea para estar al frente de ellos. [We need to include ourselves [in our child's treatment plan] as well. I would ask questions. Perhaps there were some [providers] that would get mad, they would get annoyed, because there I was asking how do I help him? What else can we do? Where else can I go? We should never give up (…) For them [the children], we are willing to do whatever it is to be to the front of them].

Finally, participants acknowledged their fears towards seeking and utilizing mental health services. However, participants underscored confronting their situation anyway. P.4 exclaimed not letting the fear of looking for services carry people away from doing it. She mentioned: "No tengan miedo. Como humanos, si los vamos a tener esos miedos. Está bien tener miedos. Pero también no dejarse llevar por los miedos y dejarse llevar por lo que dicen, sino que hay que enfrentar la situación." [Don't be afraid. As humans, we are going to have those fears. It's okay to have fears. But also, do not let yourself be carried away by the fears and let yourself be carried by what they say, rather you have to face the situation]. Moreover, P.4 discussed her initial fears about seeking mental health services for her son. Nevertheless, she expressed seeking the help

she needed despite her fears and now being the person to help him the most. She shared: "I think to myself, 'before I had so much fear to use services (…) now I'm the one helping him the most'"].

Using Spirituality to Cope

Participants shared their reliance on their faith and spirituality to find mental health services for their children. Namely, participants emphasized having faith that they would, in time, find the services they pursued. Participants highlighted praying to God about finding the adequate resources for their children during their help-seeking. For instance, P.6 shared her prayer to God and stated: "Pidiéndole de encontrar los recursos necesarios y adecuados para mi niño." [Asking to find the necessary and adequate resources for my son]. Similarly, P.2 expressed asking god for help with finding mental health treatment in addition to getting close with her church community during this time. She mentioned: "Pedirle a Dios y también, en ese tiempo me acerqué más a la iglesia ¿Pues si, quién mas lo puede ayudar a uno? Solo Dios." [Ask God and also at that time I got closer to the church. Well yes, who else can help you? Only God]. Moreover, participants emphasized praying during moments of worry and concern about not being able to find or receive the help for their children. P.9 expressed praying that her son would be eligible to receive services. She shared:

> I really did pray. I'm like, oh, God, please, I just pray. We were like in so much need and needed those services. I would just pray. I pray like he does get it, or he does qualify, or he is eligible.

Moreover, P.2 expressed praying a lot to find mental health services. She underlined praying to God with all of her heart and finding it to be helpful. She shared: "Más que todo ha sido la oración. Pedirle mucho, mucho a Dios de todo corazón." [More than anything it has been

prayer. Asking God, a lot, a lot, with all of my heart]. Furthermore, participants echoed having faith that they would receive the help they needed and believing that their situations would improve for their children. P.1 shared her faith as a leading source in helping her find the services for her daughter and trusting that she would be well. She shared: "La fe a mí me ha ayudado. (…) a buscarle ayuda (…) tener esa fe de que ella va a estar bien." [Faith has helped me (…) to seek help for her (…) to have that faith that she will be fine.]. Importantly, participants underscored not losing faith during their process of seeking help, despite how difficult it could be to find mental health services. P.6 shared not losing faith that services were out there somewhere, and searching for them as if they were gold nuggets. She shared:

> Nunca perder la fe (...) Y ha sido lo más importante, tener la fe de que si hay recursos no más hay que buscarlas, buscarlas hasta encontrar, son como pepitas de oro. Tienes que buscar por donde quiera y hasta el fondo hasta encontrarlas. [Never lose faith (...) And the most important thing has been to have the faith that if there are resources, you just have to look for them, look for them until you find them, they are like nuggets of gold. You have to search everywhere and all the way to the bottom until you find them].

P.9 also mentioned having faith about her situation. She shared: "Having faith that things are going to work out. This is temporary. We're going to figure this out. We had a lot of faith."

Indeed, participants asserted their spirituality helped them get through challenging moments in their help-seeking. For instance, P.3 shared her ability to continue 'staying in the fight' and looking for services because of her spiritual guide. She explained:

> My spiritual guide, if you will, was very much present for that because there were times where we were really struggling (…) we do have kind of like ancestral work that we do, a

> religious practice, and just trying to commune with our ancestors and our spirit guides and asking for that guidance I think was instrumental in staying in the fight.

Increase in Mental Health Literacy

Participants discussed the impact that increasing their mental health literacy had on their understanding about mental health and mental health services. P.4 shared learning more mental health concepts at the workshops offered in her community. She stated: "Escuché las clases de salud mental y eso mismo me ayudó ir a buscar ayuda porque yo no sabía que había ayuda para eso." [I listened to mental health classes and that helped me go get help because I didn't know there was help for that]. Furthermore, she discussed the impact of learning about different treatment resources. She shared: "Me impactó que había tantos recursos, tantas terapias disponibles, tantos beneficios, tantos recursos, tantos lugares, tantos programas de diferente tipo, para el papá, para la mamá, para el hijo. Terapias diferentes, tipos de terapias diferentes, tipos de terapia depende de la ansiedad o lo que sea. Eso me encantó." [It struck me that there were so many resources, so many therapies available, so many benefits, so many places, so many programs of different types, for the father, for the mother, for the son. Different therapies, different types of therapies, types of therapy depending on the anxiety or whatever. I loved that].

Participants emphasized the changes their increased mental health literacy had on their attitudes and beliefs about using mental health services. Specifically, participants acknowledged former beliefs that changed for them over the course of their children receiving therapy. For instance, P.1 underscored believing in a myth that people who used mental health services were 'crazy.' She shared:

> Yo pensaba que la salud mental era parar los que estaban locos, y después yo aprendí que la salud mental es muy importante para nosotros (…) porque ese es un mito que tenemos

antes de conocer sobre la salud mental. Tenemos el mito de que es para locos. [I thought that mental health was to stop those who were crazy, and later I learned that mental health is very important to us (…) because that is a myth that we had before we knew about mental health. We have the myth that it is for crazy people].

Importantly, she explained changing her opinion after learning more about mental health and mental health services. P.1 acknowledged the differences for her between knowing about mental health services from what she heard from others and gaining a formal understanding from going through the process. She shared:

> Hay una gran, gran diferencia en el saber de qué se trata la salud mental por lo que dicen y aprender lo que es (…) Porque yo antes tenía una opinión, ahora tengo una opinión diferente sobre la salud mental por todo lo que he aprendido. [There is a big, big difference in knowing what mental health is about from what others say and learning what it is (…) Because I used to have an opinion, now I have a different opinion about mental health because of everything I've learned].

Moreover, participants discussed their views about mental health treatment being important to support an individual's wellbeing. For instance, P.2 discussed her views about the importance of using mental health services to prevent mental health complications in the future. She provided her personal thoughts on reasons to seek mental health services and stated: "Se necesita buscar ayuda para que no pase otras cosas más graves. Es muy importante en la vida de cada persona, ya sean jóvenes o adultos." [You need to seek help so that other more serious things do not happen. It is very important in the life of every person, whether they are young or old].

P.2 explained keeping her daughter in mental health treatment to monitor her depression and suicide ideation. She shared keeping her daughter in treatment to provide her with the support she needed. She stated:

> Mantenerla en terapia porque nadie me la va a quitar, ni la depresión ni nada de eso (…) ella tenía pensamientos suicidas y yo dije no, a mí nadie me va a arrebatar a mi hija, ni el suicidio me la va a rebatar. [Keep her in therapy because nobody is going to take her away from me, not depression or anything like that (…) she had suicidal thoughts and I said no, nobody is going to take my daughter away from me, nor is suicide going to take her away from me].

In addition to participants increased understanding about mental health and mental health services, individuals highlighted their heightened knowledge for how to navigate the help-seeking process. Consequently, participants discussed feeling equipped to help their friends and families in their own pathways to care. For instance, P.11 recognized feeling lost in the beginning of her help-seeking efforts. She discussed feeling like she did not have enough information on the topic before, but now being in a position to guide others through the process. She shared:

> I'm more aware, more informed. So, if any of my friends or family members ever go through it, I know what advice to give them or where to go, what to do to help them (…) help others and guide them, because when we were new to this, we were totally lost, but we found our way (…).

Similarly, P.1 expressed sharing information about mental health, mental health services, and help-seeking with others to help them through their own journeys. Importantly, she emphasized helping others to help them avoid going through some of the challenges she went

through herself with her daughter. She shared: “Les doy la ayuda que yo he sabido y que conozco. Yo se las doy porque no quiero que estén igual que uno al rato.” [I give them the help that I have known and that I know. I give them to them because I don't want them to be the same as one after a while].

Positive Treatment Experience

Participants underscored the positive changes they observed mental health service use had in the lives of their children and on individuals themselves. Namely, participants associated their children’s service use with improvements to their mental health. P.2 discussed her daughter’s thoughts of suicide change after using therapy. She emphasized seeing her daughter become more relaxed. She mentioned: “Los pensamientos suicidas con las terapias cambió, todo cambió. Y ya la miro más relajada, más relajada.” [Her thoughts of suicide with the therapies changed, everything changed. Now I see her more relaxed, more relaxed]. Similarly, P.4 shared the changes she observed. She stated: “Hubo muy buenos resultados positivos. Yo miré su cambio en ella (…) su cambio de mal a bien.” [There were good positive results. I saw the change in her (…) her change from bad to good].

P.6. underscored the positive changes she noticed therapy had on her son, as well as on the other children in her household receiving mental health care services. She discussed the children’s enhanced ability to communicate with their parents and express their feelings with adults. Additionally, she highlighted therapy helping to cultivate their self-worth. She shared her observations and stated:

> Se expresan, ellos dicen lo que sienten, y es más fácil comunicar con ellos. Y pues su egoísmo no es tan alto, pero están anivelado a forma de que nadie les puede decir que no sirven, sino que saben el valor de sí mismo. [They express themselves, they say what they

feel, and it is easier to communicate with them. And well, their egoism is not that high, but they are leveled in such a way that no one can tell them that they are useless, but rather they know their self-worth].

Participants highlighted the positive changes they believed therapy created in their parent-child relationships. For instance, P.5 attributed the increased connection that developed between her and her daughter, to her participation in therapy. She described the quality of her relationship with her daughter as being stronger post-treatment. She shared:

> Yo doy testimonio de que las terapias ayudan mucho. Ella y yo nos unimos más. Hubo más unión, hubo más confianza, más amor, más conexión, más que unión, una conexión entre ella y yo. Eso es lo que recuperamos porque no teníamos esa conexión, cada quien vivíamos por su lado. [I testify that the therapies help a lot. She and I got closer. There was more union, there was more trust, more love, more connection, more than union, a connection between her and me. That is what we recovered because we did not have that connection, each of us lived in separate ways].

P. 2 expressed her daughter's positive therapy outcomes changing her life. She stated:

> La verdad cambió mi vida. Ya no estaba yo nerviosa (…) me impactó bastante porque yo empecé a tenerle confianza a ella (…) Entonces también fue eso que me impactó bastante favorablemente, porque la verdad recuperé su confianza, la recuperé como hija, la recuperé en todos los aspectos. [The truth is it changed my life. I was no longer nervous (...) it impacted me a lot because I began to trust her (...) So it was also that that impacted me quite favorably, because the truth is that I recovered her trust, I recovered her as a daughter, I recovered her in all aspects].

Moreover, participants highlighted feeling a sense of ease knowing their children were receiving the professional help they needed and were being cared for by professional providers. P.4 mentioned feeling good about the therapist that was assigned to her daughter. She stated: "Me sentía bien porque si se miraba que se preocupaban y me gustaba el terapista que le tocó (…) que le ayudaran, que me sentía bien." [I felt good because they did look like they cared and I liked the therapist that he got (…) by helping him, I felt good]. Additionally, P.10 viewed the time therapists spent working with his son as positive. He stated: "Therapists spend quality time with him, so that's the positive."

Participants underlined the support they received from therapists and psychiatrists to help support their children's mental health and wellbeing. Specifically, participants noted the tips and strategies they learned from their providers. P.6 highlighted the resources she got from therapists to help practice the skills he was learning in session. She explained: "Nos dejaban objetos como algunos juegos para que jugase con él, a practicar con él." [They left us objects like some games so that I could play with him, to practice with him]. Furthermore, participants underscored the advice they obtained from helping professionals that influenced them to make changes in their parenting to support their children's mental health. For instance, P.6 highlighted the advice she received from her son's psychiatrist which she related helped her become more patient with him, especially when he became emotionally dysregulated. She shared:

> Me daban ciertos puntos de como enseñarle más, cómo ponerle más atención y tener esa paciencia para él. Porque no era de que estar regañando a cada rato que no gritarle, me decían, sino que hay que hablarles y con más calma. [They gave me certain tips on how to teach him more, how to pay more attention to him and have that patience for him.

Because it was not necessary to be scolding all the time that not to yell at them, they told me, but that you have to talk to them and with more calmness].

Similarly, P.8 discussed her son's psychiatrist helping her become more aware about his own stress and emotional suffering. She shared:

> Me dijo mira, tú te frustras, tú te enojas, tú te molestas, pero imagínate, él cómo se siente…él tiene un problema y tiene mucho estrés. Yo sé que su estrés te está afectando a ti, pero él también está sufriendo con esto. [He told me, look, you get frustrated, you get angry, you get upset, but imagine how he feels…he has a problem and is under a lot of stress. I know that his stress is affecting you, but he is also suffering with this].

Consequently, P.8 expressed learning to be more patient with her son when he became emotionally distressed. She outlined the changes she made within herself and stated: "No ser tan negativa, decidir no mirarlo malo. Como cuando él se desesperaba, trataba de ser un poquito más paciente y decir, 'Él también, él también está sufriendo.' Eso me ayudó mucho a mí." [No longer be so negative, decide not to look it at in a bad way. Like when he got desperate, he tried to be a little more patient and say, 'He too, he is suffering too.' That helped me a lot].

Obstructive Factors

Limited Mental Health Literacy

Participants underscored the impact their decreased mental health literacy had on their help-seeking efforts. Participants highlighted their difficulties with understanding the mental health problems or concerns their children showed. P.5 shared her challenges with understanding her daughter's mental health needs given her unfamiliarity on the topic. She stated: "Yo realmente la verdad no sabía yo cómo reaccionaban los niños o los adolescentes. Porque pues era mi primera hija. No, yo no tenía conocimiento de cómo reaccionan hacia ante un problema así."

[I really didn't know how children or adolescents reacted? Because it was my first daughter. No, I had no knowledge of how they react to a problem like this]. Additionally, P.8 shared having a hard time with conceptualizing her daughter's mental health symptoms which included low energy, irritability, and suicidal ideation. She shared the questions she made to herself at the time and stated: "¿Qué está pasando? ¿Por qué? No entiendo que lo que está pasando en su mente." [What is happening? Why? I don't understand what is going on in her mind].

Participants highlighted feelings of confusion as they tried to make sense of the situations they were facing with their children. P.1 underscored feeling confused after she learned her daughter was hospitalized for being at imminent risk and danger to herself. She expressed her challenges with being able to comprehend the situation and blaming herself for her daughter's mental health problems. She stated:

> Conforme veía a mi hija yo decía pues, o ¿está mal o estoy mal? Yo no sé, ya no sabía (…) Me puse enojada conmigo misma porque yo me sentí como que si yo no era buena mamá. ¿Y entonces dije estoy haciendo las cosas mal, porque ella está reaccionando así? [As I saw my daughter, I said well, is she wrong or am I wrong? I don't know, I didn't know anymore (…) I got angry with myself because I felt like I wasn't a good mom. And then I said I'm doing things wrong, why is she reacting like this?].

Participants underscored the emotional impact of not having enough information to understand their children's mental health problems. P.2 described experiencing several emotions towards her situation, including feeling sadness. She stated: "Me sentí triste por la situación. No me esperaba que eso me tenía que pasar a mí. Fueron muchas emociones." [I felt sad about the situation. I did not expect that this would have to happen to me. There were many emotions]. Moreover, P.2 recalled becoming emotional in the initial stages of realizing her child's

symptoms and wondering why it was happening to her. She mentioned: "Triste. Enojada. Preocupada por ella. ¿Por qué está pasando esto? ¿Y por qué a mí? ¿Por qué me va a pasar a mí eso? Entonces fueron muchos nuestros sentimientos.” [Sad. Angry. Worried about her. Why is this happening? And why me? Why is that going to happen to me? A lot of feelings].

Participants highlighted the challenges with accessing help for their children when they were not sure where to go and look for mental health services. P.6 shared her difficulties with finding care for her son for the first time. She stated: “Pues, para mí fue un poquito difícil porque ser principiante y tratar de buscar información donde no sabía de dónde agarrarlo.” [Well, for me it was a little difficult because of being a beginner and trying to look for information where I didn't know where to get it]. P.2 shared learning about mental health resources which she did not know about before. She shared: “Antes yo no sabía la verdad. En realidad, soy sincera, yo no sabía que existía eso de la gente que se dedicaban a la salud mental. Y si pues, sí hay.” [Before I didn't know, that’s the truth. I'm honest, I didn't know that people who dedicated themselves to mental health existed. And well there is”]. Furthermore, P.1 exclaimed the need for others to inform people about mental health services. She shared: “Necesitamos alguien que nos guíe y que nos diga que existen estos servicios y que aquello. Porque le digo, en mi caso a mí nadie me dijo. Yo tuve que estar investigando.” [We need someone to guide us and tell us that these services exist and this and that. Because I tell you, in my case nobody told me. I had to be investigating].

Participants reflected on their childhood experiences and wondered how having an increased mental health literacy could have helped them in their lives. P.1 underscored unpleasant feelings when thinking about the possibility of having ADHD as a child but not having a formal understanding about mental health related concepts, thus not being able to

confirm. She mentioned: “Se siente feo. Creo que también tuve ese problema cuando era niña, pero yo no sabía que yo tenía ese problema de ADHD y todo eso, porque nadie nos explica.” [It feels ugly. For example, I say I think that I also had that problem when I was a little girl, but I also didn't know that I had that problem of ADHD and all of that, because no one explains it to us.]

P.4 underscored wishing her parents had knowledge about mental health and mental health services. She wondered how her parents’ own access to mental health information and mental health resources could have made a difference in her life. She shared: “Si mis padres hubieran tenido esta información, no habría pasado por esto. Me hubiera gustado que mi mamá y mi papá supieran sobre psicología y estos recursos, pero no tenían esta información.” [If my parents would've had this information, I wouldn’t have passed through that. I would have liked for my mom and my dad to know about psychology and these resources, but they didn't have this information].

Interference of Social Networks

Participants underscored the range of comments they received from their family and friend networks about seeking and utilizing mental health services to address their children’s problems. Participants highlighted their social networks beliefs about therapy being unhelpful. P.5 underscored her Latine family’s comments to her about therapy not being able to help her or her son. She stated: “Mi familia, especialmente nosotros que somos Latinos, te lo digo por experiencia, ‘Ah, que para que vas para allá, no te van a ayudar.’” [My family, especially us who are Latinos, I tell you from experience, 'Ah, why are you going there, they are not going to help you’]. Moreover, participants highlighted their social networks perspectives about mental health services being ineffective and threatening to families. P.1 summarized the statements she heard

from others about utilizing therapy, including the possibility that her daughter could be taken away by therapists. She discussed the things she heard about therapy from her social networks:

> Decían que no servían, que las terapistas a veces hacían que se quitaran a los niños (…) en lugar de ayudar, a veces quitaban. A los niños y esto y aquello. Y como yo no sabía de cómo estaba todo eso, pues yo decía, ¿pero por qué me la van a quitar si yo lo que quiero es ayudarla? [They said they didn't work, that the therapists sometimes would get children taken away (…) instead of helping, sometimes they would take them away and this and that. And because I didn't know much about any of that, I would say, but why are they going to take my child away from me if all I want to do is help her?].

Participants emphasized their social networks minimizing their children's symptoms, in addition to the need for services. P.1 shared her social networks beliefs about her daughter not needing therapy. She discussed the advice from her social networks to 'cure her' instead by praying to God and physically disciplining her. She mentioned:

> Me dijeron 'ay el no tiene nada, no tiene nada.' ¿Qué más? Como te dije que yo soy Cristiana (…), [me decían a mi] 'cree en Dios y ora y ya, no necesitan eso (…) terapia. Eso no ayuda en nada (…) 'pégale y hazle así y se va a curar.' [They told me 'oh he has nothing,' he doesn't have anything. What more? Like I told you that I am Christian (…) [they would say to me] 'believe in God and pray and there, they don't need that (…) therapy. That doesn't help at all. Hit and do it like this and he will be cured'].

P.9 shared her hesitation to tell her family about seeking mental health services given her anticipation that her child's symptoms would be minimized. She explained: "I was a little hesitant telling my family because for them it's like it's just a phase and they'll be fine later you know. That's it. Because for them, it's just they'll catch up, they'll be fine." Furthermore, P.6 also

noted her social networks' regard for therapy services as unnecessary for her child. She delineated the reasons her social networks believed her son did not need mental health services despite her own belief that he could use the help. She shared: "Me decían que no, que no lo necesitaba, que era un niño muy inteligente y le decía yo, yo sé que sí lo es pero yo siento que hay algo más que le falta." [They told me no, that he didn't need it, that he was a very intelligent child and I told him, I know he is, but I feel that there is something else that he lacks].

Participants expressed their hesitations to share with their networks about their children's use of mental health services. P.1 discussed her reasons for not telling her family about her son's use of therapy initially. She stated:

> I didn't want to tell them because they're very opinionated about everything [laughs]. So it's kind of like I didn't really want to talk to them about it. As we made progress in therapy, and I saw that it helped him a little bit I was more open to telling them (…) without their opinion influencing me anymore.

Participants also underscored their concerns to share with their social networks about using mental health services to avoid being met with judgement. P.2 underlined her experiences of being judged poorly by her social network because of the problems her son had. She stated: "Te juzgan mal. O dicen ¿por qué le está pasando eso a él, por qué te está pasando?" [They misjudge you. Or do they say why is this happening to him, why is it happening to you?]. Moreover, participants emphasized hesitation to share about using mental health services for their children because they could become discouraged. P.4 discussed her social networks beliefs about therapy not working if they did not observe fast changes in her son. She shared: "Te desaniman. ¿ven que no se están curando rápido? Entonces, hay, no hay un cambio de conducta."

[They discourage you. Do you see that they are not healing fast? So, there is, there is no change in behavior].

Structural Barriers to Treatment

Participants discussed their difficulties with finding mental health resources for their children in their communities. Participants emphasized contacting mental health centers and not having their calls answered or not hearing back from clinics altogether. P.6 discussed her experiences with calling several mental health clinics to inquire about services for her son. She shared: "Muchas veces simplemente no me contestaban, hay veces me ponían en línea y ya no me volvían a llamar, me decían le devolvemos la llamada como en una hora y me quedaba allá esperando." [Many times, they simply did not answer me, there were times that they put me on hold and then they wouldn't call me back. They would tell me that they were going to return my call in an hour, and I would be left waiting].

Participants underscored long delays in finding services for their children. P.2 expressed feeling worried about not obtaining services for her daughter in a timely manner given her most recent hospitalization. She expressed: "Era preocupante para mí, porque yo quería que fuera rápido, porque ella necesitaba." [It was worrisome for me, because I wanted it to be fast, because she needed it]. Moreover, participants expressed feeling helpless about finding the mental health treatment for their children. P.9 highlighted looking for treatment her son was eligible for and not being able to find it. She explained:

> It sucked. I really needed those services for my son. I felt helpless. I wish I could do more. And obviously I didn't just sit there. I did my best research, but there's only so much I could do. I'm not a professional. I don't know. I didn't know what I was doing.

Participants also highlighted feeling hopeless about their children receiving the help they needed given their difficulties with securing services. For instance, P.3 shared her fear of losing her daughter to suicide because she could not find the services she needed. She shared:

> After a while, you kind of start to feel a little hopeless, like this is just not going to get better (…) It was very draining. It was very scary because we didn't know if she was going to live through this [begins to cry]. It was really scary because even though we're trying to access services and they're available to us, supposedly, we're still having this difficulty, and it just felt like we were really battling to keep her alive.

Moreover, participants underscored their challenges with securing providers for their children. For instance, P.7 emphasized not hearing back from her daughter's therapist after two of her visits. She expressed:

> I had her see this therapist that was not calling me back and she saw him twice. He was supposed to call me back for a follow-up. Never heard from him again. What kind of a service is that? It's inconsistent.

Given the challenges participants faced in their own process of finding mental health services for their children, individuals discussed wanting to share their stories to help other parents in their own help-seeking. P.4 emphasized her intention with participating in the study. She shared: "Participe en este estudio porque pienso que a más de a una persona le puede ayudar, y de lo que se trata es correr la voz. El estudio que ustedes están haciendo eso también va a ayudar a otros papás." [I participated in this study because I think that it can help more than one person, and what it is about is spreading the word. The study that you are doing is also going to help other parents].

Participants voiced what they wish would have been different about their help-seeking experiences. Specifically, participants expressed a desire for the referral process to be quicker to obtain help. P.9 stated: "I wish the process of sending the referral and getting services (…) I wish it was much faster. I mean, it's already a big step to go ahead and seek services and then for them to have you wait?"

In addition to a faster referral process, participants expressed wanting transparency from providers about how long they would have to wait for their children to receive treatment, or if mental health centers would be able to provide the services in the first place. P.6 expressed: "Pues que las respuestas sean más rápidas y contundentes. Que si no van a poder dar los servicios, pues que lo digan de una sola vez, no estar ahí que 'Oh, hay luego les informamos.'" [Well for responses to be faster. That if they are not going to be able to provide the services, well, they should say it at once, not be there saying 'Oh, we will inform you later'].

Similarly, P.9 expressed her preference for wanting to be kept informed by providers about her status on the waitlist for services, especially since it was her first time going through the help-seeking process for her son. She highlighted: "A heads up (…) when you are going through the whole process with your child for the first time, you're pretty much on your own. So, it would be nice to have some sort of heads up or something." P.10 expressed a preference for providers and clinics that were on top of service delivery. He stated: "Having a better provider, someone who is on top of it, a clinic that is more organized, a place they're going to get things done."

Chapter V: Discussion

The findings of this study provide insight into understanding the experiences of Latine parents seeking mental health services for their children with problems or concerns. Namely, this study sheds light on the factors that helped to facilitate or that obstructed participants' help-seeking pathways. Specifically, identifying the facilitative factors to care is important to understand and strengthen the access to services among parents from marginalized backgrounds (Cauce, 2011). Further, examining factors associated with parental help-seeking is relevant to research and clinical efforts focused on reducing the mental health disparities gap among underserved children and adolescent populations. The themes are discussed in the context of their relevance and contribution to current literature.

Facilitative factors

Support of Social Networks

Research studies have shown that social networks can be strong predictors of an individual's help-seeking of services for a wide range of problems including mental health problems, intimate partner violence, and eating disorders (Ali et al. 2017; Heerde & Hemphill, 2018). Congruent with the NEM framework, social networks in this study had a highly influential role in participants help-seeking experiences and access to realized services for their children (Pescosolido, 1991). The influential informal networks in this study included participants' family, friends, spiritual leaders, and community leaders. Further, participant's children entered treatment via different pathways including the lay system (self-referral from parents influenced by their informal networks), the medical system (primary care providers) or the hospital system (emergency hospitalizations). Importantly, social networks facilitated participants help-seeking and access to realized services by providing individuals with

significant practical and emotional support conceding with research that shows social networks can involve multiple characteristics that serve different functions (Pescosolido, 2011, Arce et al. 2020).

In this study, participants' social networks offered individuals help and support throughout their help-seeking stages. These stages have generally been referred to by existing models in the help-seeking literature as 1) problem recognition 2) the decision to act to seek help and 3) the selection of a help source (Cauce et al. 1992; Rickwood & Thomas, 2012). Indeed, participants experienced challenges associated with the first stage related to problem recognition which included not being able to comprehend their children's symptoms. More so, participants were confused by symptoms shown by their children pre-treatment, or wondered why these problems were happening to them which is consistent with research that shows racial and ethnic parents (more likely than non-Latine white parents) tend to be mis-informed about mental health problems and therefore can experience increased challenges with problem recognition (Caplan, 2019; Teagle, 2002).

Although participants faced challenges initially with problem recognition, social networks helped individuals become more aware of their children's symptoms by labeling the problem or raising their own concerns about the situation with parents. Said differently, social networks in this study helped participants recognize their children's subjective needs, a factor which has been deemed as an important antecedent to help-seeking behavior (Heerde & Hemphill, 2018). Importantly, participants also turned to their social networks for advice about how they could approach the situation or address their children's concerns. This finding aligns with research studies that show *familismo* can be a central value among Latine populations wherein it can be important to seek the family's advice for important decisions (Volpert-Esmond

et al., 2023). Furthermore, studies show Latine populations can heavily rely on the support of their social networks, particularly during times of crisis or stressful events. Coincidingly, Mildred et al. (1998) showed that Puerto Rican adults with mental health needs were four times more likely to recognize their mental health problems and receive formal mental health services if they reported having discussions with their family or friend networks about their problems compared to individuals that did not discuss their concerns with their informal system. Furthermore, majority of participants' informal networks in this study suggested the use of formal services which is a finding that diverts from studies that reveal Latine populations can place a heavier influence on the use of informal sources for help with psychological problems.

Social networks helped participants decide to seek services for their children which corresponds to the second stage of help-seeking (decision to seek for help). Social networks facilitated participants help-seeking trajectories by sharing relevant information about mental health and mental health treatment which was particularly important given that majority of parents were among the first in their immediate families to seek formal mental health services, thus unfamiliar with possible outcomes of service use. For instance, social networks shared their knowledge about mental health and mental health treatment resources with participants. Social networks regarded mental health treatment as an important source of support that participants needed to consider highly, coupled with sharing about the possible treatment outcomes they could expect, such as increased mental well-being for their children and an enhanced peace and happiness in their parent-child relationships.

Participants were encouraged by the discussions they had with their social networks and were motivated to seek help as they learned more about possible treatment outcomes and the potential impact that service utilization could make in their lives and the lives of their children.

While studies have indicated that social networks can encourage an individual's help-seeking, this study helps to expand on the ways in which social groups may facilitate parent's pathways to care by helping to demystify mental health service utilization by sharing about favorable treatment outcomes. Furthermore, this study's finding underscores not only the influence that social networks can have in raising awareness about mental health and mental health services for individuals with mental health problems, but their role in facilitating the decision to seek services by sharing their own favorable views, beliefs, and perspectives about mental health treatment with participants.

The third stage of help-seeking involves choosing a helping source and actively looking for mental health services. For participants in this study, participants were often unfamiliar with who or where they could seek help from for their children's mental health problems. Congruent with these findings, studies show Latines can be limited in their help-seeking of services given an unfamiliarity with where or who to seek help from despite an openness and willingness to utilize services. However, social networks emboldened individuals in this study to ask other people such as educators or school personnel for guidance about where parents could go to seek help if they were not familiar with resources themselves, and sometimes they made referrals to mental health services if they had prior experiences with service use. Similar to other studies, social networks have been identified as important for transmitting important knowledge about mental health, providing referrals for disorders, and influencing help-seeking behaviors, especially if an individual has previous experience with the mental health sector. Relatedly, studies examining the characteristics of social networks have identified *content* as "channels of transfer" from social networks which can include information, knowledge, or non-material resources. Indeed, social networks in this study shared and transferred their knowledge about

mental health and mental health resources to participants which were facilitative and supportive to their help-seeking.

In this study, social networks were reliable sources of emotional support for participants. Social networks encouraged participants to seek mental health services for their children and validated the importance of individuals taking the initiative to find the help. Participants in this study could become discouraged from the scarcity of available mental health resources for their children. However, social networks reassured participants that they were making the correct decision by pursuing treatment. Earlier research studies have shown that social networks can serve different functions, including the provision of emotional support and appraisal which were reflected in this study findings (Ko et al., 2013; Pearlin & Aneshensel, 1986). Additionally, the support from social networks have been found to be comforting and supportive in helping individuals move forward in their pathways to care (Bagwell et al., 1998; Thoits, 1986; McFarlane at al., 1995).

Being Persistent

A key finding from this study are the recommendations identified by participants themselves about what helped them individually on their help-seeking pathways to realized care. That is, participants reiterated to others the importance of 'not giving up' in their search for mental health services. Namely, participants in this study urged others to maintain a high level of endurance in their help-seeking by calling different providers and frequently following up with them to inquire about the availability of services or about their waitlist status. The finding of *being persistent* which reiterates the sentiment of 'not giving up' and being insistent in the search for mental health services is a finding that aligns with research studies focusing on Latine populations' resilience in overcoming hardships. For example, studies have shown Latine

immigrant parents demonstrate high levels of parental investment in their children's futures in areas of health and education despite barriers associated with language, level of education, employment, and differing cultural norms (Cardoso et al., 2018).

Participants reiterated to others to not give up on finding and receive mental health services from professionals they believed best met the needs of their family. Participants highly recommended others to find providers they felt comfortable working with and encouraged finding alternative resources if they believed their needs were not being met. Participants suggestion to other parents about finding providers that they felt comfortable working with coincides with research studies that show certain Latine value orientations can be important for psychotherapy, particularly in the initial stages of treatment. For instance, studies have emphasized the importance of therapist interpersonal skills that are consistent with Latine culture which include personalismo (formal friendliness), confianza (trust), and cariño (warmth and affection) to support patient outcomes, treatment engagement, and retention (Gallardo, 2012; Santiago-Rivera et al. 2002; Warda, 2000).

Participants acknowledged being afraid or apprehensive about seeking mental health care for their children given the mis-information they had learned from others about service utilization which is consistent with findings from other studies (Contractor et al. 2012; Umpierre et al. 2014). In this current study, participants were warned by individuals in their social groups that their decision to seek mental health services could have threatening outcomes such as having their children taken away by therapists. Similarly, research by Umpierre et al., (2015) found that parents reported similar fears of potential harmful results from seeking mental health care for their children. However, as parents entered care and formed personal relationships with service providers, they indicated their fears about possible negative outcomes diminished.

Intertwined with the message of 'not giving up' was the message of 'not being afraid' which needs to be appreciated in the context of historically unfair and unjust practices and conditions that have harmed Latine populations in healthcare. For example, the CDC (2022) outlined historical policies and practices that have had notable implications for mental and physical service use among Latine populations. Specifically, the mistrust of healthcare systems and medical providers by some Latines can be traced back to the sterilization of Latine women without their consent, or the discrimination of immigration policies such as the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 which caused many individuals to avoid interaction with public officials. Despite these historical and modern challenges to accessing healthcare services across Latine populations, participants in this study resisted fear-based barriers to establish mental health care for their children and be, as one participant mentioned, "*at the front*" of their mental health needs.

Using Spirituality to Cope

Participants in this study relied on their religion and spiritual resources to help them remain optimistic and hopeful about finding mental health services, especially since the search for treatment was often an emotionally troubling experience for these individuals. Specifically, one of the main strategies these participants voiced was that of frequent prayer. For participants in this study, praying helped them connect with a transcendent being (i.e., God) and share their worries and concerns. For instance, participants use of prayer often involved asking God to grant them the help they needed to find mental health services, in turn helping to provide a sense of trust and hopefulness that God would provide the services in due time.

The finding above is aligned with other research studies that show Latine populations may turn to their faith to cope with stressful situations or psychological distress (Campesino &

Schwartz, 2006; Caplan, 2019; Planey et al. 2019). Arce et al., (2020) found that undocumented parents used their faith to remain hopeful about their future and for the protection of other undocumented members in their families in face of restrictive immigration policies and the fear of possible deportation, detainment, or separation from their family members. Additionally, undocumented parents were found to rely on their faith-based organizations and deemed them as important sources of resilience and support. Relatedly, some participants in the present study sought advice from church leaders (pastors) or turned to their church communities for emotional support or help with finding mental health resources.

Participants' use of their faith in this study may have likely served as a protective factor against their feelings of hopelessness and helplessness about not being able to find mental health services which coincides with research studies that assert religion and faith are believed to play a salient role in maintaining mental health and coping with mental illness (Diaz et al. 2011; McField & Belliard, 2009; Sternthal et al. 2010). As one participant mentioned, her spiritual guide were instrumental for her to metaphorically 'stay in the fight' and find adequate treatment for her daughter for whom she was worried she would lose to suicide given her history of multiple attempts.

A key finding from this study showed that participants significantly relied on their faith and spirituality to remain hopeful about finding formal mental health care services for their children, contrary to studies that show that Latines may solely rely on religious practices or the support from religious leaders to deal with or resolve psychological distress (Interian et al., 2010). While some studies have shown that those with higher levels of religiosity were less likely to report confidence in the efficacy of professional services or perceive the need for psychotherapy, participants in this study viewed treatment access as essential to their children's

wellbeing (Moreno & Cardemil, 2013). Furthermore, majority of the participants that self-identified as religious or spiritual reported mostly favorable views about using mental health treatment which differs from work that has predominantly shown associations between religiosity and negative attitudes towards help-seeking (Chandler, 2018; Miller & Eells, 1998; Moreno & Cardemil, 2013).

Increased Mental Health Literacy

Before obtaining formal care for their children, some participants discussed their beliefs that only ‘crazy people’ utilized mental health services, a finding that has been commonly referred to as a barrier to mental health care in the help-seeking literature (Clement et al. 2015). While parents themselves were not the ones directly receiving treatment, rather it was their children, individuals gained a formal understanding about mental health and mental health treatment throughout the process which helped to influence their perspectives on the topic.

Consistent with the findings of this study, research studies have shown receiving mental health treatment can help to challenge stigmatized views about mental health among some underserved clinical populations. Collado et al., (2019) conducted a study examining correlates and predictors of mental health stigma among Spanish-speaking Latines that met criteria for major depressive disorder. The study’s findings showed Latines experienced a reduction in mental health stigma after receiving psychotherapy that was not targeted on reducing mental health stigma. Similarly, participants in this study increased their understanding about mental health and mental health services which helped to reinforce caregivers’ outlook on the utility of using treatment resources to support their child's well-being. Participants voiced perceiving therapy services as a preventative resource and essential to support their children’s wellbeing.

Positive Treatment Experience

Participants discussed positive changes occurring in their child's wellbeing, as well as on parents themselves, and attributed them to mental health service utilization. Specifically, participants noticed a decrease in their children's mental health distress. For instance, one participant evidenced a reduction in her daughter's suicidal thinking which she associated as a positive treatment outcome. Relatedly, this finding aligns with research studies that show different forms of therapy and psychotropic medication can be effective in reducing psychological symptoms and distress among racial and ethnic minority populations. While participants in this study were not asked exclusively about the specific treatment approaches their children received, research studies have revealed the efficacy for several different theoretical orientations. For instance, research by Lee and Lange (2023) found that among a sample of 1,861 Latine children with posttraumatic stress disorder (PTSD) who received trauma-focused cognitive behavioral therapy (TF-CBT) at 25 outpatient clinics showed significantly greater improvements than children who did not receive the treatment. Correspondingly, the authors reiterated TF-CBT as one possible frontline treatment for children with PTSD.

In this study, several participants in this study noted the positive benefits they derived themselves from discussing their concerns with providers, including learning and actively building on their parenting skills, techniques, and strategies to help facilitate their children's wellbeing. For instance, one participant revealed building on her patience for her son after her provider suggested to her that he was also suffering mentally and emotionally. Indeed, positive treatment experience have been recognized as facilitators of help-seeking in clinical populations and this study helps to expand on what those experiences could entail, including increased skillset among parents and involvement in their children's treatment plans.

Obstructive Factors

Limited Mental Health Literacy

In the current study participants underscored their limited knowledge about mental health and mental health care prior to seeking and accessing services for their children. Specifically, participants discussed limitations in their ability to relate to their children's mental health needs, comprehend their concerns, or know about what steps they could take to address their problems. Relatedly, studies show that differences in mental health disorders can be higher for U.S.-born youth (or more highly acculturated immigrants) than foreign-born immigrants (often less acculturated; Sun et al., 2016). In this study, 82% of parent participants were foreign-born and highlighted discrepancies between their subjective experiences with mental health problems and their U.S.-born children's mental health problems which is consistent with research associated with the immigrant paradox (e.g., better health and psychosocial outcomes for new immigrants who may be more strongly connected to their culture; So et al., 2023). Furthermore, two (18%) of the participants born in the U.S. utilized mental health services themselves in the past or knew a close family member that used services. Additionally, U.S.-born parents in this study highlighted learning about mental health and mental health services in their higher education courses. Specifically, U.S.-born parent participants underlined having more information about mental health symptoms and treatment options (i.e., counseling) which aided their help-seeking endeavors compared to foreign born parent participants with lower levels of formal education attainment and overall mental health literacy exposure.

Studies show that less familiarity about mental health concepts can be associated with reduced problem recognition and subsequently, the use of mental health services (Caplan, 2019). A study involving parents of children with ADHD found that common reasons for not seeking

help included not knowing where to seek help as a leading item (Bussing et al., 2003). Moreover, a key finding in this study is the impact of having a limited mental health literacy among participants. Participants felt confused, angry, sad, and wondered if they were personally responsible or the ones to blame for their children's mental health problems which coincides with Gordillo et al., (2020) which showed that Latine mothers were more likely than non-Latine mothers to report guilt or self-blame for their child's ASD and wondered if they played a role in the etiology of their child's disorder (e.g., via delivery complications).

Inference from Social Networks

The comments social networks made to participants about their decision to pursue and access mental health treatment for their children often obstructed individuals process of help-seeking. Participants expressed interest to their social networks about pursuing mental health services to address their children's symptoms. However, social networks could regard the utilization of mental health services as ineffective forms of help, a finding that coincides with other studies.

As participants vocalized their observations about their children's symptoms to others, social networks occasionally perceived or minimized children's symptoms as transient, therefore not requiring professional attention which aligns with findings from other studies. Furthermore, participants consideration to seek services could be affected by the negative opinions or views of their social networks which coincides with studies that show perceived characteristics of social networks can inhibit service use if associated social norms do not encourage or reinforce help-seeking behaviors.

In this study, participants were hesitant to share at times about their help-seeking plans with their social networks given their anticipation that they would be negatively criticized or

judged about their decision to pursue treatment. This finding aligns with Beatie et al., (2020) which found that the help-seeking process is complex and that the opinions or beliefs held by personal/social and treatment networks can influence an individuals' decisions to seek services. Specifically, Beatie et al., (2020) participants reported that when certain members in their social network made stigmatizing comments after they disclosed their mental health problems and did not show compassion (i.e., public stigma), they were more likely to doubt the utility of mental health services in helping them to get better and felt alone or embarrassed. On the contrary, individuals who received support from their social networks reported being more likely to seek treatment, accept their need for mental health services, and reported higher treatment satisfaction. Individuals who were supported by their social networks in receiving mental health care also reported that they felt less alone and benefited more from therapy services overall.

A key finding from this study is participants decision to pursue mental health services for their children independently without discussing their decision with others, or disclosing about their children's participation in treatment after services were established. For instance, to manage interpersonal conflict and divert from people's opposing views and beliefs about therapy, participants were intentional about whom in their social groups they shared with about their decision to seek care. In some cases, participants chose to share their decision to seek and pursue mental health care with members that affirmed their decision.

Structural Barriers to Treatment

Participants faced multiple barriers in their pursuit of accessing mental health care. Participants underscored difficulties in finding providers, finding accessible services (e.g., clinics within proximity to their home and after-work clinic hours), being placed on long waitlists, not receiving follow up calls from mental health centers, or being ineligible to receive services due

to being undocumented which is consistent with studies that show Latine caregivers can report greater barriers to mental health services compared to non-Latine whites (Vàzquez et al. 2022). Specifically, participants emphasized the psychological impact (i.e., preoccupation, stress, hopelessness) that navigating structural barriers had on their own emotional wellbeing. This finding helps to provide another layer of understanding for the challenges parents can experience in their search for mental health services. as well as possible insight into factors that may contribute to the underutilization of mental health services among the general population, particularly among underserved groups.

Research studies have shown that the public mental health system has been described as disorganized and inefficient in providing services to children which can be a major deterrent from seeking care among parents (Contractor et al. 2012; Regier et al. 1993; U.S. Department of Health and Human Services, 1999). Moreover, mental health professionals are encouraged to become involved in matters involving public policy to advocate for changes at the structural level, including increased funding that can help to address the shortage of mental health professionals and services available across diverse communities.

Limitations

This study included several limitations that should be considered in the context of the findings. Participants in this study were self-selected. It is important to consider the role of participant selection bias, with those with stronger opinions about mental health given prior experience with using mental health treatment choosing to participate in this study. Additionally, social desirability could have also influenced participants in this study to overemphasize or underemphasize certain factors related to their help-seeking experiences. Moreover, member checks were not conducted in this study. Member checks is a technique used to enhance the

credibility of the study's findings by following up with participants and asking them about the accuracy of the researcher's interpretation of their responses (Hirose & Creswell, 2023).

Participants in this study belonged to different demographic backgrounds including age, ethnicity, immigration status (only when self-reported by participants), languages spoken, and educational level. Additionally, participants varied in the type of mental health problem their children had and for which they sought formal help for. Even though participants all resided in Southern California, in the greater Los Angeles County, it is important to acknowledge the potential influence of certain demographic variables specific to participants and their individual help-seeking experiences (i.e., education level, socio-economic status, privately insured vs no insurance).

This study involved asking participants about the influence of their cultural background on their help-seeking experiences with a specific interest in understanding the potential role and influence of religious/spiritual views or beliefs as one of the domains (i.e., *What things from your cultural background did you rely on to help you through any challenges you faced with your child and their mental health problems (e.g., faith/spirituality).* Furthermore, majority of participants asked the researcher to clarify and provide examples of factors that could be related to one's cultural background. It is possible that the researchers' example of faith/spirituality as a cultural factor could have prompted participants to respond in a certain way and led them to discuss or emphasize the role of faith/spirituality in their help-seeking process. Despite these limitations, the findings of this study converge with the existing literature on help-seeking among racial and ethnic minority populations which is encouraging because it points to important information that can help further understand Latine individuals' pathways to care and the facilitators to care (Gallardo, 2012).

Implications

The findings of this study offer multiple considerations and suggestions for how policy makers and practitioners can improve caregiver's access and utilization of mental health services for their children with mental health needs. In particular, the data of this study provides specific ideas and recommendations for how to systematically increase facilitators of care for individuals seeking mental health services, as well as suggestions for how to decrease barriers to help-seeking and service use among underserved populations.

Capitalizing on Facilitative Factors

Social networks played a key role in participants help-seeking experiences. Social networks supported participants' help-seeking process by encouraging them or motivating them to take the first step and reach out to others for help. The influential role that social networks can have on individuals' help-seeking experiences suggest the importance of facilitating conversations about mental health in social group settings to address potential stigma or misconceptions about mental health. For instance, healthcare professionals may consider facilitating workshops at health fairs which are known to attract large groups of diverse populations. To engage participants in discussions about their views and attitudes about mental health, facilitators may consider the use of testimonios (testimonies) to facilitate conversations about mental health. Members may also share how they overcame barriers to services to help to spread the word about the things they did to help them realize care for themselves, their children, or family members.

Participants in this study acknowledged the need to be persistent in their search for mental health services, especially in light of multiple barriers to accessing care. Participants also discussed 'not be afraid' to seek services. Because several factors can prevent people from

accessing care, such as fear of facing potential legal repercussions among undocumented Latine individuals, it seems relevant that mental health outreach interventions can include patient rights information in their clinic spaces. In this way, parents can make informed decisions about accessing care and not be deterred by any misinformation. These brochures may also be shared in geographic areas that are known to be occupied by documented and undocumented Latine populations to increase awareness among these groups.

Research studies show that Latine families are more likely to report problems with dissatisfaction with the care they receive, or the quality of patient-provider communication is poorer than the general population (Dehlendorf et al. 2017; Morales et al. 1999; Ngui & Flores, 2006). The demand participants placed on being persistent and ‘not give up’ to find mental health services or providers that they felt comfortable working with, in addition to actively involving themselves in their children’s treatment shows the importance of increasing parent activation among underserved groups. A study involving a randomized clinical trial conducted in a Spanish-language clinic with 172 Latines included a four-week group psychoeducational intervention known as MePrEPA (*metas, preguntar, escuchar, preguntar para aclarar* [goals, questioning, listening, questioning to clarify]) to increase parent activation among Latine parents (Thomas et al. 2017). The construct of parent activation was defined as, “self-efficacy in self-management of chronic disease, knowing when and where to go for help, and getting one’s needs met in a health care visit” (Thomas et al. 2017, p. 1068). Notably, participants in this study identified as a parent or primary caregiver raising a child with mental health needs or whom they had sought mental health services for within the past 22 months. According to the results of the study, parents that were taught activation skills in the psychoeducation intervention group compared to individuals in the parent-support group indicated increased parental activation.

Specifically, parents demonstrated increased involvement during their child's visit with professional providers, as well as in the area of their children's education. Accordingly, a qualitative study among Latine adults indicated that individuals with higher levels of activation reported viewing their participation in their visits as valuable and were confident to ask clinicians questions (Maranda et al. 2014).

Given the important role that religious or spiritual beliefs and practices can have among many Latine individuals, such as being a source for coping with psychological distress or other stressors, mental health professionals have the potential of reaching people with mental health needs in faith-based communities and increase help-seeking behaviors. For instance, studies have shown clergy can play an influential role in the perceptions of the etiology of mental health problems and treatments. Further, studies reveal that clergy can serve as gatekeepers and can encourage or dissuade professional help-seeking (Hays & Payne, 2020). Conversely, mental health professionals encouraged to continue developing partnerships with spiritual leaders such as pastors or clergy who are often regarded as trusted authority figures by members of congregations and sought out for advice or support to provide mental health literacy trainings to support their role in helping others with mental health problems, including having the option of making referrals to formal mental health counseling services when necessary (Caplan, 2019). For instance, a study by Bledsoe et al. (2013) examined the demands placed on clergy by parishioners. The results indicated that clergy often provided crisis interventions for difficult situations which could lead to high levels of clergy stress. Interestingly, pastors reported positive attitudes about referring to mental health professionals with a higher preference for counseling centers compared to other community centers. Indeed, collaboration and partnerships between

mental health providers and clergy members can be an effective way to promote the well-being of religious and spiritual communities, as well as encourage professional help-seeking.

As technology evolves and social media continues to have a large presence in the U.S nation and globally, national mental health organizations are encouraged to continue producing content that can assist with demystifying mental health concepts and debunking mental health myths for the general population. For instance, social media videos known commonly as "Instagram Reels" or "Tik Toks" can be used a tool to provide psychoeducation about mental health concepts to a wide range of populations (McCashin & Murphy, 2023). Psychoeducation videos can include links to credible national mental health websites to help consumers access mental health information directly. Moreover, mental health organizations can consider creating content that uses language that is shown to be effective in reducing stigma. For instance, a study piloted a program to help reduce stigma associated with seeking mental health services for mental illness and substance abuse disorders (Volkow et al., 2021). The findings showed that language could reduce public stigma and therefore increase the likelihood that a person would consider seeking mental health services. With this strategy in mind, mental health outreach invested in increasing help-seeking behavior among parents. For instance, outreach may target English and Spanish-speaking parents of children that may be exhibiting behavioral concerns by using non-stigmatizing language such as "*Do you know a parent with a child that is having difficulties with his comportamiento* [behavior]*?"* rather than "*Is your child having difficulties with his comportamiento*?"

In this study, Latine parents shared positive experiences with working with mental health providers that they felt comfortable working with, discussing their concerns, and that provided tips and strategies for how parents could support their children. Given the emphasis that some

Latine populations may place on provider characteristics that align with certain cultural traditions or values, clinical training programs are encouraged to continue integrating guidance on how to provide culturally sensitive services with racial and ethnic minorities to increase engagement for individuals, parents, families, and children. Indeed, the training for early mental health professionals with an emphasis on delivering culturally relevant and sensitive services is already being accomplished by several institutions in the U.S. which are focused on the training and development of bilingual (English and Spanish) professionals (Consoli & Flores, 2020).

Eliminating Obstructive Factors

Participants in this study experienced multiple challenges in being able to understand their children's mental health needs or knowing where they could go to seek services. Given the strong association research studies have shown between mental health literacy and help-seeking behaviors, the dissemination of mental health information is critical to underserved communities. Consequently, the findings of this study suggest mental health centers can consider funded partnerships with promotoras de salud (i.e., lay healthcare workers), who are identified as trusted members of Latine communities to facilitate workshops and disseminate information about mental health and treatment resources to underserved populations (Flores et al. 2021). Indeed, promotoras involvement in increasing mental health literacy among minoritized populations have shown positive outcomes and can potentially strengthen the pathways to realized care for parents.

In line with increasing mental health literacy among underserved populations, the study's findings can serve to raise awareness for Latine parents about the process of seeking services for their children with mental health needs and the potential benefits and outcomes of realized care. Specifically, researchers and practitioners are encouraged to consider building partnerships and

collaborate with public and social platforms such as television networks (Univision, Telemundo) or radio stations (La Raza 97.9 KLAX, Los Angeles) to raise awareness in diverse communities, including Los Angeles County and beyond, about mental health literacy, treatment resources, and possible outcomes (e.g., increased well-being, reduced psychological distress and symptoms).

In this study, social networks were facilitators of parents help-seeking and access to care, but they could also be obstructive to their process. Given the influential role of family members, friends, and other people in parents' lives, mental health professionals are encouraged to assess caregiver's social networks' perspectives on parents' decision to seek care for their children. Assessing whether parents are supported or not by their social networks can offer mental health professionals the opportunity to offer extra support and guidance about how they can manage public stigma or avoid becoming discouraged by other people's negative views or beliefs about treatment with the goal of retaining parents, children, and families in mental health services. For instance, providing parents with psychoeducation about the different forms of stigma with an emphasis on public or social stigma can render positive outcomes. Pérez-Flores and Cabassa (2021) conducted a systematic review of the effectiveness of mental health literacy and stigma interventions for Latine adults in the U.S. The findings of this review supported the role of interventions in improving knowledge of mental health disorders, with mixed results on reducing mental health stigma toward mental health problems and mental health treatments.

Given that Latine populations can be more likely to seek care from primary care clinics (Cabassa, 2006) continued funding allocated to increase in-house psychologists may have promising outcomes. In this way, individuals experiencing increased psychological distress, symptoms, or that are managing a chronic mental health condition can be advised by trusted

primary physicians to meet with a mental health provider during their visit or at follow-up (Wakida et al. 2018). Further suggestions include making services more readily accessible to populations by reducing practical barriers to care, such as making services available at convenient hours for patients, offering low-cost resources to families when possible, and increasing the number of staff employed in clinics to receive or return phone calls to individuals that call to inquire about services or obtain more information (Pereira & Barros, 2019).

The shortage of mental health providers and mental health services in the U.S is a major national health priority. More even, it is of utmost relevance to increase bilingual (Spanish and English) training in mental health service delivery and primary care for helping professionals to improve access to quality and equitable mental health services (Consoli & Flores, 2020). In the U.S., the Spanish language is the most common non-English language spoken in homes (62%) which is 12 times greater than four of the other most common languages (U.S. Census Bureau, 2022). Furthermore, only 5% of psychologists in the U.S. (or 5,000 people) can provide services in Spanish (APA, 2018). Undoubtedly, the shortage of providers that can deliver services in Spanish indicates the importance of training, preparing, and equipping the next generation of helping professionals to provide quality services to diverse populations.

Future Directions

Future research studies can conduct focus groups with Latine caregivers with diverse intersecting identities (i.e., gender, age, education level, income, religious/spiritual background) to examine influential demographic factors involved in help-seeking pathways (e.g., generational status and language). More so, researchers could conduct longitudinal studies to examine the facilitative and obstructive factors involved in caregivers' pathways to care over time to investigate which elements could be more salient or influential at different stages of help-seeking

(e.g., social networks' perspectives during caregiver initial stages of seeking care vs when treatment services are established).

While research on help-seeking and utilization is essential to better understand how to improve care for families, it is also important for research to examine the predictors of treatment adherence and continuity of care for Latine caregivers. On the one hand, researchers can examine from the perspective of Latine caregivers and consumers broadly the subjective facilitators and barriers to receiving quality mental health treatment. On the other hand, studies could interview agency providers to examine their own beliefs and views for what supports or limits treatment engagement in their mental health centers. Finally, help-seeking among Latine parents of children with mental health needs can be studied in different geographical regions within the U.S, as well as internationally, to examine differences or similarities in their access to healthcare.

Future studies may also consider conducting community participatory research to develop community member and participant led help-seeking frameworks from the perspectives of those with lived experiences as well as those who have not received services (Eigenhuis et al., 2021). In doing so, researchers can have the opportunity to learn more about the facilitative factors in addition to the ones that can obstruct help-seeking. Importantly, a community workshop that can include individuals with lived experiences related to accessing care can work together to collectively address an important topic which can have promising outcomes such as the development of program interventions designed to increase mental health literacy among underserved communities. Moreover, future studies involving help-seeking among Latine populations are encouraged to further identify the facilitators to care from a strengths-based perspective given that most studies have generally focused on identifying the barriers to health and mental health care (Bussing et al., 2003; Escobar et al., 2021; Fripp & Carlson, 2017).

Indeed, more research attention need to be devoted for understanding how underserved populations overcome challenges in pathways to help-seeking with a special focus on identifying the factors that help to make their process of seeking and accessing mental health services easier.

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Appendices

Appendix A

Screening Questionnaire

Hello, (good morning/afternoon/evening). May I speak to _________? My name is Iliana Flores, and I am calling about the study that you are interested in. The purpose of this brief phone call is to determine your eligibility for this study. This study focuses on learning about parents' experiences who have sought mental health services for their child/adolescent. I would like to ask you a few questions to determine if you can participate in the study. These questions are related to your background in general and your experiences with seeking mental health services for your child. I am only asking these questions to see if you are eligible; there are no right or wrong answers. We may be on the phone for 15-20 minutes. Do you have time right now? If not, when can I call you? Next call: ___________.

Do I have your permission/verbal consent to ask you questions?

[If yes, proceed. If not, do not continue with the interview.]

Please answer the following questions as honestly/candidly as possible.

1. In which language would you prefer to have this interview (Spanish/English)?
2. What is your first and last name?
    a. How would you like to be addressed? Some people prefer Mr. /Miss / Mrs., by name, or they have another preference. Do you have a preference? ______________.
3. Are you over the age of 18?
    a. How old are you?
    [If the participant is under the age of 18, thank them for their time and inform them that we are interested in interviewing participants over the age of 18].
4. Do you self-identify as Latina/o/x, Hispanic, or of Spanish origin?
    a. How do you identify?
    [If they do not identify as Hispanic, Latine, or of Spanish origin, thank them for their time and inform them that we are interested in interviewing participants that identify as Hispanic, Latine, or of Spanish origin].

5. Are you a single or married parent (e.g., caregiver, or legal guardian) of at least one child/adolescent under 18 who you have accessed mental health services for within the past two years)?
    a. [If they identify as a single or married parent (e.g., caregiver, legal guardian) but the child is over the age of 18, they did not personally seek or access mental health services for this child/adolescent, or it has been more than two years, thank them for their time and inform them that we are interested in interviewing participants that have a child who is under the age of 18 AND who they have sought and accessed mental health services for within the past two years].
6. Were the services your child/adolescent accessed required by law?

    [If the child/adolescent is required by law to attend mental health treatment (e.g., court-mandated, on probation, or diversion program), please thank them for time and inform them that we are interested in interviewing participants whose children/adolescents are not legally required to attend counseling].
7. Where is your child receiving counseling services?
    a. What is the name of this clinic? Where is it located?

       [Please excuse yourself for 2-3 minutes to verify on the internet that the clinic the child/adolescent is receiving mental health services from is not an inpatient community mental health clinic (e.g., psychiatric hospital), or county mental health services];

       [If the participant shares that their child has never been in at least one counseling session or they are receiving services from an inpatient or county mental health services after verifying this, please thank them for their interest and inform them that we are interested in participants who have sought and accessed at least one counseling session for their child/adolescent from an outpatient clinic].
8. Could you briefly tell me about the reason you felt the need to look for help for your child? What was your child saying or doing (briefly tell me what brought your child to treatment)?
    a. [If the participant mentions any symptoms of schizophrenia spectrum or other psychotic disorders, autism spectrum disorder, please thank them for their

participation and inform them that we are interested in interviewing children/adolescents with different mental health needs than the ones mentioned].

Eligibility:

**If the participant is not eligible: Thank you for your interest in this study. The study is about people who __________ (fill in the blank with what makes participant non-eligible). I want to thank you for your interest and your time today. Just in case you are interested, here is a list of resources in the community you could consider.

**If the participant is eligible: Thank you very much for answering the questions candidly. Based on your responses, you are eligible to participate in the study, which consists of one interview. Let's set that up.

1. In which language would you prefer to be interviewed (Spanish/English)?
2. How would you prefer to be interviewed? Here are some of our options:
    a. We can do a phone interview, a video interview, or an in-person interview.
        i. If video, do you have internet access? Do you need assistance accessing a video conferencing service? If so, please let me know, and I will provide more information about how to do this.
3. Is this the best telephone number to reach you? If not, what is it? ___________.
4. Do you have an email address that I can use to communicate with you if need be? Email address: _____________.
5. What days and times work best for you to have this interview?
    a. [Ask about days of the week that work best for participant: ____________]
    b. [Ask about times that work best for participant between 8am-8pm: ___________].
    c. [Ask about preferred in-person location to have the interview, if not by phone or video call (e.g., UCSB private research office): ___________].
    d. [Ask if the participant has the transportation means to the said location. If so, what is their form of transportation: ___________].
6. A $25 gift card incentive will be provided to you at the end of our interview. The gift card will be provided to you either in person or over email.
7. Do you have any questions for me?
   Questions asked by participant: _______________.

Appendix B

Demographic Questionnaire

1. In which language would you prefer to answer these questions about your background (Spanish/English)?
2. Where were you born?
    a. Where were your parents born?
    b. Where were your grandparents born (their parents)?
3. What is your educational background (how far did you go in school)?
    a. __ No formal schooling
    b. __ Grade school (1-12)
    c. __ High school graduate
    d. ___ General Equivalency Diploma (GED or equivalent)
    e. ___ Some college, no degree
    f. ___ Occupational, technical, or vocational program
    g. ___ Associate degree
    h. ___ Bachelor's degree
    i. ___ Master's degree
    j. ___ Professional Doctorate Degree (e.g., law, medicine)
    k. ___ Academic Doctorate Degree (e.g., graduate study)
4. What is your family income? ___________.
    a. How many people are supported by that income? ____________.

       ___ 20,000 or below

       ___ 21,000 – 29,000

       ___ 30,000 – 39,000

       ___ 40,000 – 49,000

       ___ 50,000 or above
5. What is your religious affiliation, if any?
    a. How influential would you say are your religious beliefs in your day-to-day life?
        i. Very influential ______
        ii. Influential ______

iii. Somewhat influential _____

iv. Not influential ______

v. Not sure ______

6. Please take a moment to think about how many times you have looked for mental health services for your child/adolescent with mental health problems and needs and the times you were able to access these services (e.g., your child had at least one counseling session).
    a. ____ Number of times you sought mental health services and accessed them for each child.
    b. ___ For which child/adolescent? (Please indicate their age or ages)
7. Please tell me all the formal services you have obtained in the past for your child/adolescent (e.g., counseling, medication)

    ____

8. How do you pay for your child's counseling or other services?
    a. Do you have private insurance, Medi-Cal? Does the clinic use a sliding scale or provide services at little to no cost?

Appendix C

Interview Protocol

Latine Parents' Help-Seeking and Access of Mental Health Services for their Children and Adolescents

Thank you very much for agreeing to participate in this study. My Name is Iliana Flores, and I am a counseling psychology doctoral student at the University of California, Santa Barbara. We will talk for about 45 minutes to an hour. I will be asking you some questions regarding your experiences as a parent who has previously accessed mental health services for their child or adolescent. The purpose of this interview is to discuss the process of how you came to decide to seek mental health services for your child, your thoughts about the process of seeking these services and using the services. I would also like for you to know that there are no right or wrong answers to any of these questions. I am interested in learning about your experiences.

We'll begin with your decision and experience to seek mental health services for your child, including what you or others noticed about your child needing help and when you accessed mental health services for your child.

Your Decision to Seek Services

1. Walk me through your decision to seek services for your child, and let's start from the very beginning.
    a. What problem did you, or others around you, notice regarding the way your child was feeling or how they were acting that made you want to seek mental health services?
    b. What was it like for you when you first noticed this problem?
    c. What did you think, believe, or tell yourself that was happening to your child?

Your Process of Seeking Services

2. Thank you so much for sharing with me about your decision to seek services for your child. Now I would like to learn more about your experience with accessing mental health services for your child and what that process was like for you. Please, walk me

through the process you went through. Let's start with where you decided to access mental health services from for your child.

   a. What made you decide to seek services from the clinic your child has received services from?
   b. What kind of services did they receive?
   c. What was this experience in accessing services for your child like for you?

3. How much time passed (days, months, years) from the moment you realized you wanted to seek mental health services for your child to the time you accessed these services for your child?
4. What things made it hard for you to seek mental health services for your child?
   a. What got in the way for you (what made it difficult or challenging) to seek out these mental health services?
   b. What things do you remember from this process of seeking mental health services for your child that you did not like? How come? What do you wish had been different about your process of accessing mental health services for your child?
5. What things made it easier for you to access mental health services for your child?
   a. What things helped you, especially when you faced any of the challenges that you mentioned previously?
6. What things from your cultural background do you think slowed down your process of seeking mental health services for your child?
7. What things from your cultural background do you think helped the process of accessing services move forward for your child?
8. What things from your cultural background did you rely on to help you through any challenges you faced with your child and their mental health problems (e.g., faith/spirituality)?

The Influence of Your Social Network in your Help-Seeking

Thank you for answering all these questions about your experiences with seeking mental health services for your child and the overall process. Now I would like to ask you about the role or influence that other people had on your help-seeking process and experiences.

To begin, did you discuss your decision to seek mental health services for your child/adolescent, if at all, with others?

   a. Who were these people?
   b. Did you hesitate to tell certain people about your decision to seek mental health services? How about after you accessed these mental health services for your child?

9. What were some helpful things that people said or reactions they had that encouraged you to seek out mental health services for your child or that kept you motivated to schedule that first appointment for your child?
   a. How did the helpful things these people said make a difference for you in the process of seeking mental health services for your child?
10. What were some unhelpful things or reactions that people said or did to you that made you doubt your decision to seek services or make the first appointment?
   a. Please share with me what you did to overcome these unhelpful or discouraging things or reactions that you received from others as you were considering or in the process of seeking mental health services for your child?
11. How did seeking out mental health services for your child/adolescent impact you, if at all?

The Personal Impact of Help-Seeking

Thank you so much for sharing more about the role or influence that other people had on your help-seeking experiences. In this last part of the interview, I would like to learn more about your views, beliefs, and perspectives on mental health, as well as any suggestions you might have for other parents who are seeking mental health services for their children.

12. What are your thoughts on mental health problems?
   a. Where and from who do you remember learning about mental health problems?
   b. Have those changed since your child (adolescent) accessed mental health services?
13. In your opinion, what suggestions or recommendations do you have for parents seeking mental services for their children/adolescents with mental health problems or needs?

a. What are some things you have learned about seeking mental health services that you wish you knew before accessing services for your child?

We have reached the end of the interview questions now. But before we end the interview and I stop the recording, is there anything about this topic that I did not ask you that you would feel comfortable to discuss or share with me?

End of Interview

Thank you very much once again for sharing your personal experiences and those of your family with me today. I really appreciate you making time to meet with me today. As a thank you for your participation in this study, I will provide you with a $25 gift card.

[Hand the gift card to participant if in person].
[Verify participant email address and email gift card if meeting with participant over the phone or video. Confirm email address provided at phone screen: ___________].

Appendix D

List of Resources for Participants

Here is also a list of resources that I am offering to all participants. Discussing some topics, like mental health problems, can bring up some uncomfortable or difficult feelings for some people. I would like to provide a list of places you can call if you want to speak more about how you feel with a professional. However, after our interview, I also like to tell participants that it can be helpful to think about an activity that you already know of or do that often helps you feel better. For instance, for some people, it is praying. For others, it is calling a friend or a family member to share how they are feeling to deal with difficult feelings. And for others, it may be going for a walk, exercising, and so on. I encourage you to take a few minutes to do something like this if you find yourself experiencing difficult feelings.

RESOURCES

The resources provided below are ways to get help and speak to a trained mental health professional:

- SAMHSA Behavioral Health English and Spanish Language Resources: https://www.samhsa.gov/sites/default/files/spanish-language-resources-obhe-10202020.pdf
  - Substance Abuse and Mental Health Services Administration Behavioral Health Treatment Services Locator: **https://findtreatment.samhsa.gov/**
- National Alliance on Mental Illness of California: (916) 567-0163
- Crisis Text Line – Text NAMI to 741-741 to receive free, 24/7 crisis support via text message from a trained counselor
- National Suicide Prevention Lifeline of California - (800) 273- TALK (8255) or www.suicidepreventionlifeline.org
- The National Institute of Mental Health Information Resource Center: **1-866-615-6464**
  - National Domestic Violence Hotline– Call 800-799-SAFE (7233)
  - National Sexual Assault Hotline – Call 800-656-HOPE (4673)
    - Crisis chat support is available at **https://hotline.rainn.org/online**. Free help, 24/7.

Other Suggestions for Dealing with Difficult Emotions:

- Do something that relaxes you such as:
  - Deep breathing
    - What is deep breathing?: https://www.therapistaid.com/worksheets/deep-breathing-worksheet.pdf
  - Meditation
    - https://www.uclahealth.org/marc/mindful-meditations
  - Stretching exercises/elongation
  - Going for a walk
  - Having a warm drink such as herbal tea (no caffeine/alcohol)
  - Yoga
  - A massage
  - Listening to music
  - Reading
  - A hot bath or shower
  - Talk with your family and friends

Apéndice A

Cuestionario Telefónico

Hola, (Buenos días/tardes/noches). ¿Me permite hablar con _______?

1) ¿En qué idioma prefería tener esta breve llamada (español/inglés)?

Mi nombre es Iliana Flores, y estoy llamando sobre el estudio en el que usted está interesado. El propósito de esta breve llamada telefónica es para determinar su elegibilidad para este estudio. Este estudio se enfoca en aprender acerca de las experiencias de los padres que han buscado servicios de salud mental para su hijo/a o adolescente. Me gustaría hacerle algunas preguntas para determinar si puede participar en el estudio. Estas preguntas son sobre usted en general y sus experiencias en la búsqueda de servicios de salud mental para su hijo/a o adolescente. Sólo hago estas preguntas para ver si usted es elegible; no hay respuestas correctas o incorrectas. Podemos estar al teléfono durante 10-15 minutos.

¿Tiene tiempo ahora mismo? Si no es así, ¿cuándo puedo llamarle? Siguiente llamada: _____________.

¿Tengo su permiso/consentimiento verbal para hacerle estas preguntas?

[*En caso de si, proceda. Si no, no continúe con la entrevista.]*

Por favor, responda a las siguientes preguntas con la mayor honestidad / franqueza posible.

2) ¿Cuál es su nombre y apellido?
   a) ¿Cómo le gustaría que le llamara? Algunas personas prefieren Señor / Señora / Señorita por su primer nombre, o tienen otra preferencia. ¿Tiene alguna preferencia usted, cual es? ___________.
3) ¿Es mayor de 18 años?
   a) ¿Cuántos años tiene? _________.
   [*Si el participante tiene menos de 18 años, agradezca su tiempo e infórmele de que estamos interesados en entrevistar a los participantes mayores de 18 años*].

4. ¿Se identifica como Latina/o/x/e, Hispano, ¿o de origen español?

   a. ¿Cómo se identifica? _______.

   [*Si no se identifica como Hispano, Latine o de origen español, agradezca su tiempo e infórmele que estamos interesados en entrevistar a los participantes que se identifican como Hispana/o/x, Latino/a/x o de origen español*].

5. ¿Es usted un padre o madre soltera/o (por ejemplo, cuidador o tutor legal) y tiene un niño/a o adolescente menor de 18 años por el cual le ha accedido los servicios de salud mental en los últimos dos años?

   a. Si

      [*Si han accedido los servicios de salud mental para sus jóvenes menores de 18 años Y sus jóvenes han tenido al menos una sesión con un profesional de la salud mental proceda a preguntar sobre su estado civil*.]

   b. No (dale las gracias por su participación; ve la letra c).

      [*Si los participantes tienen menores de 18 años, pero no han accedido a servicios de salud mental para sus jóvenes en los últimos dos años, Y el niño no ha tenido por lo menos una sesión con un profesional de salud mental, agradéceles su interés en este estudio e informarles que este estudio está interesado en entrevistar a los participantes que han accedido a servicios para su juventud y que el joven ha recibido por lo menos una sesión*].

6. ¿Cuántas sesiones ha tenido su niño/a o adolescente con un profesional de la salud mental?

      Sesiones totales: _______________

   a. No

      [*En caso negativo, agradezca al participante por su tiempo e interés e infórmele que estamos interesados en entrevistar a los participantes que han accedido a servicios para su juventud Y que el joven ha recibido al menos una sesión con un profesional de salud mental*].

7. ¿Cuál es el nombre y cuantos años tiene su hijo/a o adolescente que le buscó servicios?].

   a. Nombre o el apodo del niño/a o adolescente: ______________

   b. Edad del niño/a o adolescente: __________________

8. ¿Alguna vez usted u otros miembros de su familia inmediata han accedido y utilizado los servicios de salud mental?
   a. No: _____
   b. Si: ______
      i. En caso de si, ¿quién accedió y utilizó estos servicios?
         1. ¿Cuándo se accedió estos servicios?
         2. ¿Qué tipo de servicios se recibieron?
      ii. ¿Se accedió y utilizó estos servicios antes, durante o después de que su hijo/adolescente recibiera servicios de salud mental?
         1. Antes de que mi hijo/adolescente recibiera servicios de salud mental: __________
         2. Durante el tiempo que mi hijo/adolescente recibió servicios de salud mental: ________
         3. Después de que mi hijo/adolescente recibiera servicios de salud mental: ___________
9. ¿Cuál es su estado civil?
   a. Soltera/o
   b. Casada/o
   c. Separada/o
   d. Divorciada/o
   e. Viuda/o
   f. Otro:
10. ¿Sabe si su pareja está interesada/o en participar en esta entrevista?
   a. [*En caso de si, infórmele que la persona se ponga en contacto con la investigadora para expresar su interés*]. *Informe al participante que es una opción que las parejas entrevisten juntas. Sin embargo, los participantes también pueden optar por entrevistar por separado.*
      i. *¿El participante quiere entrevistar en pareja o individualmente?* ____________
      ii. *[Si el participante desea entrevistarse como pareja, por favor infórmeles que ambos individuos tendrán que estar presentes en el momento de la*

entrevista seme-estructurada si se cumple la elegibilidad. Continúe determinando la elegibilidad].

b. [*En caso de que el participante no esté seguro/a, por favor comunique que se sientan libres de compartir con su pareja que todas las personas interesadas en el estudio que cumplan los requisitos están invitadas a participar y que se sientan libres de comunicarse con la investigadora para más información*].

c. [*En caso de que el participante diga no, proceda de forma normal*].

11. ¿Los servicios a los que accedió su hijo/a o adolescente fueron requeridos por la ley?

[*Si el niño/a o adolescente es requerido por la ley para asistir a tratamiento de salud mental (por ejemplo, por mandato de la corte, en probatoria, o programa de diversión), por favor agradézcales por su tiempo e infórmele que estamos interesados en entrevistar a participantes al cual le niño/a o adolescente no están legalmente obligados a asistir en la consejería*].

12. ¿Dónde está recibiendo su hijo/a o adolescente servicios de consejería?

a. ¿Cómo se llama esta clínica? ¿Dónde se encuentra?

[*Verifique en Internet que la clínica de la que el niño/a o adolescente está recibiendo servicios de salud mental no es una clínica de salud mental comunitaria para pacientes hospitalizados (por ejemplo, un hospital psiquiátrico), o servicios de salud mental del condado*];

[*Si el participante comparte que su hijo/a o adolescente nunca ha estado en al menos una sesión de consejería o está recibiendo servicios de un paciente interno o de servicios de salud mental del condado después de verificarlo, por favor, agradezca su interés e infórmele que estamos interesados en los participantes que han buscado y han accedido al menos a una sesión de consejería para su hijo/a o adolescente desde una clínica ambulatoria*].

13. ¿Podría contarme brevemente sobre la razón por la que sintió la necesidad de buscar ayuda para su hijo/a? ¿Qué estaba diciendo o haciendo su hijo/a o adolescente (dígame brevemente qué llevó a su hijo/a o adolescente a buscar consejería)?

[*Si el participante menciona cualquier síntoma de espectro de esquizofrenia u otros trastornos psicóticos, trastorno del espectro autista, por favor agradezca su interés en*

participar e infórmese que estamos interesados en entrevistar a niño/as o adolescentes con diferentes necesidades de salud mental que las mencionadas].

Elegibilidad:

**Si el participante no es elegible: Gracias por su interés en este estudio. El estudio trata de personas que (rellene el espacio en blanco con lo que hace que el participante no sea elegible). Quiero darle las gracias por su interés y su tiempo de hoy. Sólo en caso de que usted esté interesado, aquí está una lista de recursos en la comunidad que usted podría considerar.

**Si el participante es elegible: Muchas gracias por responder a las preguntas con franqueza. En función de sus respuestas, usted es elegible para participar en el estudio, que consiste de una entrevista. Vamos a configurar eso.

1) ¿En qué idioma preferiría ser entrevistada/o (español/inglés)?
2) ¿Cómo prefería ser entrevistada/o? Estas son algunas de nuestras opciones:
    a. Podemos hacer una entrevista en persona, por video. Otra opción es hacerla por teléfono ________.
    b. Si es video, ¿tiene acceso a Internet? ¿Necesita ayuda para acceder a un servicio de videoconferencia? Si es así, por favor hágamelo saber, y le daré más información sobre cómo hacerlo.
3) ¿Es este el mejor número de teléfono para comunicarse con usted? Si no, ¿qué es? ______________.
4) ¿Tiene una dirección de correo electrónico que pueda usar para comunicarme con usted si es necesario?
   Dirección de correo electrónico: ____________.
5) ¿Qué días y horas funcionan mejor para que tenga esta entrevista?
    a. [Pregunte sobre los días de la semana que funcionan mejor para el participante: _________].
    b. [Pregunte sobre los horarios que funcionan mejor para el participante entre las 8 a.m. y las 8 p.m.: _________].
    c. [Pregunte sobre la ubicación preferida en persona para tener la entrevista en persona, si no es por video llamada o teléfono (por ejemplo, oficina de investigación privada de UCSB): ___________].

d. Pregunte si el participante tiene los medios de transporte a dicho lugar. Si es así, cuál es su forma de transporte: _______].

6) Se le proporcionará un incentivo de tarjeta de regalo de $25 (a usted y a su pareja si deciden entrevistar juntos) al final de nuestra entrevista. La tarjeta de regalo se le proporcionará en persona o por correo electrónico.

7) ¿Tiene alguna pregunta para mí?

   a. Preguntas formuladas por el participante: ________.

Apéndice B

Cuestionario Demográfico

Si los participantes están entrevistando como pareja, pedir a cada persona que complete un cuestionario demográfico.

1) ¿En qué idioma preferiría responder a estas preguntas demográficas (español/inglés)?
2) ¿Dónde nació usted?
   a. ¿Dónde nacieron su padre y su madre?
   b. ¿Dónde nacieron sus abuelos/as (los padres/madres de los suyos)?
3) ¿Cuál es su formación académica (hasta dónde llegó en la escuela)?
   a. Ninguna escolaridad formal
   b. Grado escolar (1-12)
   c. Graduado de secundaria
   d. Diploma General de Equivalencia (GED o equivalente)
   e. Alguna universidad, ningún título
   f. Programa profesional, técnico o vocacional
   g. Grado asociado
   h. Licenciatura
   i. Máster
   j. Doctorado
4) ¿Cuál es el ingreso familiar anual?
   a. ¿Cuántas personas son sostenidas por este ingreso? ________.
      ___ 20,000 o menos
      ___ 21,000 – 29,000
      ___ 30,000 – 39,000
      ___ 40,000 – 49,000
      ___ 50,000 o mas
5) ¿Cuál es su afiliación religiosa, si tiene alguna? __________.
   a. ¿Qué influyente diría que son sus creencias religiosas en su vida al día, día?
      i. Muy influyente
      ii. Influyente
      iii. Algo influyente

iv. No es influyente

v. No está seguro

6) Por favor tome un momento para pensar en cuántas veces ha buscado servicios de salud mental para su niño/a o adolescente con problemas y necesidades de salud mental y las veces en que pudo acceder a estos servicios.

   a. ¿Para qué hijo/a? (Indique su edad o edades) _______________.

   b. Número de veces que usted buscó servicios de salud mental y accedió a estos servicios para su hijo/a (e.g., llamó, fue a la oficina) ________.

   c. ¿Cuál hijo/a fue el primero por el cual le buscó servicios? __________.

   d. ¿Cuántas veces pensó en buscar servicios de salud mental antes de hacerlo? ___________.

7) Por favor, dígame todos los servicios que ha buscado y obtenido en el pasado para su hijo/a (por ejemplo, consejería, medicamentos): ___________.

8) ¿Cómo paga por la consejería u otros servicios de su hijo/a o adolescente?

   a. ¿Es reducido el costo de los servicios?

   b. ¿Tiene seguranza?: _________

Muchas gracias por contestar estas preguntas. Pasamos a la entrevista.

Apéndice C

Título: Al Frente: Entendiendo La Búsqueda de Ayuda de los Padres/Madres Latines de Servicios de Salud Mental para sus Niños/as o Adolescentes con Necesidades de Salud Mental.

Protocolo de la Entrevista

Muchas gracias por aceptar participar en este estudio. Mi nombre es Iliana Flores, y soy una estudiante de doctorado en psicología de consejería en la Universidad de California, Santa Bárbara. Hablaremos de 45 minutos a una hora. Le haré algunas preguntas con respecto a sus experiencias como padre/madre que ha accedido previamente a servicios de salud mental para su hijo/a. El propósito de esta entrevista es dialogar sobre cómo usted decidió buscar servicios de salud mental para su niño/a o adolescente, sus opiniones sobre el proceso de buscar estos servicios, y el uso de los servicios. También me gustaría que supiera que no hay respuestas correctas o incorrectas a ninguna de estas preguntas. Estoy simplemente interesada en conocer sus experiencias y reflexiones.

Comenzaremos con su decisión y experiencia de buscar servicios de salud mental para su hijo/a, incluyendo lo que usted u otros notaron acerca de su hijo/a relacionado a necesitar ayuda, y cuando usted accedió los servicios para su hijo/a.

Su Decisión de Buscar Servicios

1. Cuénteme sobre su decisión de buscar servicios para su hijo/a, empezando desde el principio.
   a. ¿Qué problema notó usted, u otras personas a su alrededor, con respecto a la manera en que su hijo/a se sentía o cómo actuaba que le hacían a Ud/Uds querer buscar servicios de salud mental para él/ella?
   b. ¿Cómo fue para usted cuando notó por primera vez este problema? ¿Qué sintió?, ¿que pensó?
   c. ¿Qué pensaba, creyó o se dijo a sí misma/o que le estaba pasando a su hijo/a?
      i. ¿Qué otras preguntas se hizo?

Su Proceso de Búsqueda de Servicios

2. Muchas gracias por compartir conmigo acerca de su decisión de buscar servicios para su hijo/a. Ahora me gustaría aprender más sobre su experiencia con el acceso a los servicios

de salud mental para su hijo/a y cómo fue ese proceso para usted. Por favor, guíeme a través del proceso por el que pasó. Comencemos con dónde decidió acceder a los servicios para su hijo/a.

   a. ¿Qué le hizo decidir buscar servicios de la clínica en la que su hijo/a ha recibido servicios?
   b. ¿Qué tipo de servicios recibió su hijo/a?
   c. ¿Cómo fue esta experiencia con el acceso a los servicios para su hijo/a para usted?

3. ¿Cuánto tiempo pasó (días, meses, años) desde el momento en que se dio cuenta de que quería buscar servicios para su hijo/a hasta el momento en que accedió a estos servicios para su hijo/a?
4. Usted compartió que usted o alguien en su familia inmediata ha recibido servicios de salud mental en un momento antes, durante o después de haber buscado servicios para su hijo/adolescente. ¿Puede decirme el papel que esto jugó en la búsqueda y el acceso a los servicios para su hijo/adolescente, si es que lo hizo?
5. ¿Qué cosas le dificultaron la búsqueda de servicios para su hijo/a?
   a. ¿Qué se le puso en el camino (lo que hizo que fuera difícil o desafiante) al buscar estos servicios?
   b. ¿Qué cosas recuerda de este proceso de buscar servicios para su hijo/a que no le gustaron?
   c. ¿Me puede explicar la razón?
   d. ¿Qué desea que haya sido diferente acerca de su proceso de acceso a los servicios para su hijo/a?
6. ¿Qué cosas le ayudaron al buscar y obtener los servicios para su hijo/a?
   a. ¿Qué cosas le ayudaron, especialmente cuando enfrentaba alguno de los desafíos que mencionó anteriormente?
7. ¿Qué cosas culturales en su vida (pensamientos, creencias) cree que le hizo más lento su proceso de búsqueda de servicios para su hijo/a?
8. ¿Qué cosas culturales cree que le ayudaron en el proceso de búsqueda de servicios para su hijo/a?
9. ¿Qué cosas culturales le ayudaron a enfrentar los desafíos que encontró (por ejemplo, fe / espiritualidad)?

La Influencia de su Red Social en la Búsqueda de Ayuda

Gracias por responder a todas estas preguntas acerca de sus experiencias en la búsqueda de servicios de salud mental para su hijo/a y el proceso general. Ahora me gustaría preguntarle mas específicamente sobre el papel o la influencia que otras personas tuvieron en su proceso de búsqueda de ayuda y las experiencias que tuvo.

Para comenzar, ¿conversó usted con otros (es decir, con su familia o amistades o colegas) sobre su decisión de buscar servicios para su hijo/a?

a. Si, no lo hizo, ¿cuál fue la razón que decidió no hacerlo?
b. Si lo hizo, ¿a quién le contó o le dijo?
c. ¿En algún momento dudó en decirle a ciertas personas acerca de su decisión de buscar estos servicios para su hijo/a? ¿Y qué tal después de haber accedido a estos servicios?

10. ¿Cuáles fueron algunas cosas o reacciones que la gente le dijo que hicieron el proceso más difícil o le hizo dudar de su decisión de buscar servicios o hacer la primera cita?
11. ¿Cuáles fueron algunas cosas útiles que la gente le dijo o reacciones que la gente tuvo que le animaron a buscar servicios para su hijo/a o que le mantuvieron motivada/o para hacer la primera cita para su hijo/a?
    a. ¿De qué manera las cosas útiles que estas personas dijeron hicieron una diferencia para usted en buscar servicios para su hijo/a?
12. ¿Cómo le impactó a usted buscar servicios de salud mental para su hijo/a?
    a. ¿De qué manera le impactó?

El Impacto Personal de la Búsqueda de Ayuda

Muchas gracias por compartir más información sobre el papel o la influencia que otras personas tuvieron en sus experiencias de búsqueda de ayuda. En esta última parte de la entrevista, me gustaría aprender más acerca de sus opiniones, creencias y perspectivas sobre la salud mental, así como cualquier sugerencia que pueda tener para otros padres que están buscando servicios de salud mental para su hijo/a.

13. ¿Qué piensa usted como padre/madre sobre la salud mental en general?

    a. ¿Cómo han cambiado sus pensamientos como padre/madre sobre la salud mental desde que su hijo/a recibió servicios?

14. ¿Qué sugerencias o recomendaciones tiene para los padres que buscan servicios de salud mental para sus hijo/a?
    a. ¿Cuáles son algunas de las cosas que aprendió usted sobre la búsqueda de servicios que hubiera deseado saber mucho antes de hacerlo?

Hemos llegado al final de las preguntas de la entrevista, pero antes de terminar y detener la grabación, ¿hay algo sobre este tema que no le he preguntado que le gustaría compartir conmigo o algo que no le pregunté y que debería haberlo hecho?

Fin de la Entrevista

Muchas gracias una vez más por compartir conmigo sus experiencias personales y las de su familia. Realmente le agradezco que se haya tomado tiempo para reunirse conmigo. Como agradecimiento por su participación en este estudio, le daré una tarjeta de compras por $25. [Entregar la tarjeta o verificar la dirección de correo electrónico del participante y enviar la tarjeta de compras. Confirmar la dirección de correo electrónico proporcionada en la pantalla del teléfono: __________].

Apéndice D

Listado de Recursos para los Participantes

[Como le mencioné anteriormente, dialogar sobre algunos de estos temas, como son los problemas de salud mental, pueden traer algunos sentimientos incómodos, difíciles o embarazosos para algunas personas. Le animo a llamar a cualquiera de los números proporcionados en el folleto de recursos si desea hablar más sobre cómo se siente con un profesional. Al final de cada entrevista, también me gusta decir a los participantes que puede ser útil pensar en una actividad que ya conoce o que hace que a menudo y que le ayuda a sentirse mejor. Por ejemplo, para algunas personas, orar puede ayudar a que se sientan mejor. Para otros, es llamar a un amigo/a o a un miembro de la familia para compartir cómo se sienten y para obtener apoyo para lidiar con sentimientos difíciles. Para otras personas, puede ser ir a caminar, hacer ejercicio, etc. Le animo a que le dedique unos minutos a hacer algo que le ayude. También he proporcionado algunas sugerencias de cómo hacer frente a algunos sentimientos difíciles en el folleto de la lista de recursos. Por favor, dígame si tiene alguna pregunta.

RECURSOS

Los recursos que se proporcionan a continuación son formas de obtener ayuda y hablar con un profesional de la salud mental:

- Recursos en inglés y español de SAMHSA Behavioral Health: https://www.samhsa.gov/sites/default/files/spanish-language-resources-obhe-10202020.pdf
- Localizador de Servicios de Tratamiento de Salud Mental de SAMHSA: https://findtreatment.samhsa.gov/
- National Alliance on Mental Illness de California: (916) 567-0163
- Línea por Texto durante una Crisis: envíe un mensaje de texto con NAMI al 741-741 para recibir apoyo gratuito de crisis las 24 horas del día, los 7 días de la semana, a través de un mensaje de texto de un consejero capacitado

- Línea Nacional para la Prevención del Suicidio: (800) 273- TALK (8255) o https://suicidepreventionlifeline.org/help-yourself/en-espanol/
- El Instituto Nacional de la Salud Mental Centro de Recursos de Información: 1-866-615-6464
- La Línea Nacional sobre Violencia Doméstica: Llame - 800-799-SAFE (7233) o visite https://espanol.thehotline.org
- La Línea de Ayuda Nacional Online de Asalto Sexual: Llame – 800-656-HOPE (4673)

    - El apoyo por chat durante una crisis está disponible en https://hotline.rainn.org/online. Ayuda gratis, 24/7.

Sugerencias para Lidiar con Emociones Difíciles:

- Haga algo que lo/a relaje como:
    - Respirar profundamente
        - ¿Qué es la respiración profunda?: https://www.therapistaid.com/worksheets/deep-breathing-worksheet-spanish.pdf
    - Meditación
        - https://www.uclahealth.org/marc/mindful-meditations
    - Hacer ejercicios de estiramiento/elongación
    - Salir a caminar
    - Tomar una bebida caliente como té de hierbas (sin cafeína/alcohol)
    - Yoga
    - Masajes
    - Escuchar música
    - Leer
    - Darse baños de tina o una ducha
    - Conversar con su familia y amigos