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Latina/o/x undocumented college students' perceived barriers and motivations for talking to a campus mental health professional: A focus on communication, culture, and structural barriers

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ABSTRACT

Although undocumented students face numerous stressors that can lead to mental health strain, they often underutilize their campus mental health services. To identify the barriers and motivations for talking to a campus mental health professional (MHP) and to extend the Health Belief Model (HBM), we conducted semi-structured interviews with 24 Latina/o/x undocumented college students. Family communication revealed views that undermined talking to an MHP, but that were deeply rooted in culture and immigration; having to prioritize basic needs; and growing up in an environment where mental health services were unavailable. Our findings reveal important communication, cultural, and structural elements that should be emphasized in the HBM when explicating Latina/o/x undocumented students' beliefs and behaviors about talking to an MHP.

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Health belief model; undocumented immigration; mental health; culture; family communication

U.S. college students' stress and mental health have garnered increasing attention in recent years; however, that attention became more pronounced during the COVID-19 pandemic when new stressors were introduced (Browning et al., 2021; Son et al., 2020). Some students lost employment and internships (Aucejo et al., 2020); experienced delayed graduation (Aucejo et al., 2020); struggled with remote learning (Wang et al., 2020); and suffered from severe financial strain (Browning et al., 2021). Undocumented college students[1] encountered these same stressors as the larger U.S. college student population, but their documentation status poses additional challenges that place them at risk for mental health strain (Alif et al., 2020). Because undocumented students lack authorization to reside in the United States, many fear deportation for themselves or loved ones, feel a lack of belongingness, and experience chronic uncertainty and

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anxiety (Suárez-Orozco & Hernández, 2020). Further, many undocumented students experience severe financial strain because of limited employment opportunities[2] and ineligibility to receive federal aid (e.g., Free Application for Federal Student Aid; Coronavirus Aid, Relief, and Economic Security Act assistance; Enriquez et al., 2021).

Recently, Ngo and Hinojosa (2021) pointed out that the "need for mental health awareness and services for undocumented students has increased due to COVID-19, increased financial challenges, and lack of access to healthcare services during a worldwide pandemic" (p. 63). Thus, talking to a campus mental health professional (MHP; i.e., trained providers such as therapists, counseling or clinical psychologists, clinical social workers, or psychiatrists who work to improve people's mental health), particularly one who is culturally responsive, including being familiar with undocumented students' experiences, might be beneficial for undocumented students. Nevertheless, past research suggests that undocumented students underutilize the free mental health services offered at their college or university (Cha et al., 2019).

A well-established framework that can help explain talking to an MHP is the health belief model (HBM; Champion & Skinner, 2008; Rosenstock, 1974). The framework emphasizes six key constructs: *perceived susceptibility* (i.e., the perceived likelihood of incurring an undesirable experience or condition), *perceived severity* (i.e., the perceived negative consequences of incurring an undesirable experience or condition), *perceived benefits* (i.e., the positive consequences to engaging in a recommended health behavior), and *perceived barriers* (i.e., the external and internal factors that discourage people from engaging in a recommended health behavior), *perceived self-efficacy* (i.e., the belief that they can effectively engage in the recommended health behavior), and *cues to action* (i.e., internal or external factors that prompt people to engage in the recommended health behavior; Champion & Skinner, 2008; Rosenstock, 1974). Although substantial support exists for the HBM, uncovering the relevant communicative, cultural, and structural elements related to undocumented students' mental health-seeking behaviors can extend the HBM and inform campaign and intervention designs.

The HBM considers the perceived benefits and barriers to engaging in a recommended action; however, the HBM was not developed with Latina/o/x[3] undocumented immigrants and mental health in mind. Although the HBM has been used to understand health behaviors among other minoritized communities including Black Americans' perceptions of organ donation (e.g., Williamson et al., 2017) and COVID-19 vaccine hesitancy among Latina/o/x and Black communities (Batement et al., 2021), we extend past applications of the HBM by exploring the psychological, communicative, cultural, and structural elements that discourage or motivate Latina/o/x undocumented students from talking to an MHP. Undocumented students come from different nationalities that all warrant attention, but as a first step, we take a *within-ethnic group* (Umaña-Taylor et al., 2014) approach in this study. Latina/o/x students are heterogeneous, so a within-ethnic-group approach allows us to focus on students who had talked to an MHP and students who had not, as well as students with or without DACA.[4] Overall, the findings can: (1) inform colleges and universities of changes that need to occur to reduce the barriers to talking to an MHP, (2) inform the creation of health-promotion messages rooted in a sample of Latina/o/x undocumented students' experiences, and (3) inform culturally-responsive MHP training.

Talking to a campus mental health professional: Barriers and motivations

Despite being at risk for mental health strain, Cha et al. (2019) found that Latina/o/x and Asian undocumented students underutilized free mental health services at their university for numerous reasons. Some students normalized their mental health strain, felt that their mental health was not an urgent priority compared to basic needs, were uncertain whether they needed to use mental health services, and thought their mental health was not severe enough to warrant mental health services. Moreover, several students questioned the effectiveness of using mental health services because such services could not address the structural problems due to their undocumented status. Other students were afraid that using such services would result in increased mental health strain by forcing them to reflect on stressors related to their undocumented status (i.e., undocumented-related stressors). Lastly, students feared that others would negatively evaluate them, discriminate against them, or discover their status.

Although Cha et al. (2019) is one of the first studies to take a systematic approach to exploring the psychological barriers that prevent undocumented students from using mental health services, they focused only on the psychological barriers rather than also considering how students developed these internal beliefs through communication. They also did not consider experiences that motivate undocumented students to talk to an MHP. Building on their findings, Kam et al. (2020) surveyed undocumented students and found that descriptive norms (i.e., the perception that friends and undocumented students talk to a campus MHP), family injunctive norms (i.e., the perception that their family would approve of them talking to a campus MHP), response efficacy (i.e., perceived effectiveness of talking to a campus MHP), self-efficacy (i.e., the perceived ease in obtaining an appointment with a campus MHP), and communication efficacy (i.e., confidence in one's ability to talk to a campus MHP) were directly or indirectly associated with greater intentions to talk to a campus MHP. Kam et al. revealed the importance of family, peers, and efficacy. Yet, similar to Cha et al. (2019), Kam et al. did not consider how students developed norms and efficacy through communication.

Although Kam et al. (2020) provided support for several important factors, the behavior change theories they drew from were not rooted in undocumented students' lived experiences or communication with family or friends (or mediated communication about mental health). Moreover, they did not offer a comprehensive, nuanced understanding of undocumented students' perceived barriers and motivators for talking to an MHP. By first turning to undocumented students' lived experiences, the present study can provide a deeper understanding of how undocumented students think about mental health strain and talking to an MHP, while also shedding light on communication, cultural, immigration, and structural components that are important to consider in the HBM. Thus, this study extends prior research on undocumented students' utilization of mental health services by drawing from the lived experiences of Latina/o/x undocumented students, focusing on their perceived barriers and motivations for talking to a campus MHP. Hence, the following research question was created.

> RQ: What psychological, communicative, cultural, and structural elements motivate or discourage Latina/o/x undocumented college students from talking to a campus mental health professional?

Methods

After receiving approval from the University's institutional review board (Protocol # 9-20-0438), undocumented students were recruited in November 2020. Participants had to self-identify as Latina/o/x or Hispanic, undocumented, and 18 years or older. The goal was to recruit two samples of Latina/o/x undocumented students: (1) those who had talked to a campus MHP at least once and (2) those who had not talked to a campus MHP.

Recruitment

For recruitment, we contacted 30 undocumented students who had participated in our previous study (Summer 2020). The focus of that study was to learn more about Latina/o/x undocumented students' experiences during the COVID-19 pandemic, but interviewers did not ask about talking to an MHP. For that project, we emailed different California public and private colleges that had Dream or Undocumented Student Services Centers. In addition, we distributed promotional flyers to undocumented student clubs at several California colleges, and we posted the flyers on social media outlets geared toward undocumented immigrants. Lastly, we applied a snowball sampling procedure (Etikan et al., 2016). Among the 30 Latina/o/x undocumented students who had participated, 15 agreed to participate in this study. To meet our target sample size, we emailed our flyer to Latina/o/x students who had shown interest in participating in our COVID-19 study after the study recruitment period had ended. Undocumented research personnel participated in the formation of the study's research questions, recruitment, data collection, data analysis, and writing of the manuscript (see Supplemental Material 1 for a detailed description of recruitment, trust building, and confidentiality procedures).

Participants

For this study, the sample consisted of two subsamples: (a) 14 Latina/o/x undocumented students who had talked to a campus MHP and (b) 10 Latina/o/x undocumented student who had not talked to a campus MHP. Among the 10 who had not talked to a campus MHP, two students had talked to an MHP from the community once in their lifetime (see Table 1 for demographics).

Interview procedures

Two undergraduate research assistants and one graduate research assistant of Latina/o/x descent (two self-identifying cisgender women and one self-identifying cisgender man) conducted the semi-structured interviews in English because all of the students' English-speaking abilities were at the college level. All participants agreed to have their interview audio-recorded. Each student received $50 via Venmo or their choice of an e-gift card.

We developed two interview guides (see Supplemental Material 2): one for students who had talked to a campus MHP and one for students who had not talked to a

Table 1. Participant demographic characteristics.

	Talked to MHP ($n = 14$)	NOT talked to MHP ($n = 10$)
Gender		
Cisgender women	11 (79%)	8 (80%)
Cisgender men	2 (14%)	2 (20%)
Female	1 (7%)	0
Age		
Mean (SD)	23.9 (4.93)	20.9 years (1.3)
Range	min = 19, max = 34	min = 20, max = 24
Nativity		
Mexico	14 (100%)	8 (80%)
Argentina	0	1 (10%)
El Salvador	0	1 (10%)
Time spent in U.S.		
6–10 years	1(7%)	0
11–15 years	1 (7%)	4 (40%)
15 + years	12 (86%)	6 (60%)
DACA status		
Yes	9 (64%)	7(70%)
No	5 (36%)	3 (30%)
Year in college		
First-year	2 (14%)	0
Second-year	3 (21%)	1 (10%)
Third-year	3 (21%)	5 (50%)
Fourth-year	5 (36%)	3 (30%)
Fifth-year	1 (7%)	0
Sixth-year	0	1 (10%)
Type of institution		
Community college	1 (7%)	2 (20%)
Four-year college	10 (71%)	8 (80%)
Graduate school	1 (7%)	0
Work		
Part time	6 (43%)	5 (50%)
Full time	1 (7%)	3 (30%)
Looking for work	5 (36%)	1 (10%)
Not working/ not looking	1 (7%)	1 (10%)
Frequency of talking to MHP		
Mean (SD) within school	4 times (2.74)	
Mean (SD) within community	3.14 times (3.51)	

campus MHP. The HBM informed the interview guides' questions exploring motivators (benefits) and barriers to talking to an MHP, perceived severity (reflections on their mental health strain), perceived self-efficacy (in obtaining an appointment), and cues to action. For both samples, we asked, "Can you describe any concerns you had in talking to a mental health professional through your school? What would motivate you to talk to a mental health professional in the future?".

Data analysis

Research assistants transcribed the audio recordings verbatim, removed personally identifying information, and conducted accuracy checks. To increase the validity of data analysis (Suter, 2009), investigator triangulation was used. Using Tracy's phronetic iterative approach to data analysis (Tracy, 2018, 2019), the first author, second author, and one undocumented Latina/o/x undergraduate student independently read the transcripts (data immersion). Primary-level data analysis involved first inductively analyzing the data by highlighting segments of text and labeling it with descriptive codes.

Secondary-level data analysis involved organizing codes into higher order themes and deductively analyzing the data with an eye toward constructs from HBM critical to explaining students talking to an MHP or not. Data analysis at this interpretative stage also involved analyzing data for answering research questions and theory development to extend HBM for the context of understanding how Latina/o/x undocumented students are motivated or discouraged from talking to an MHP. Data within groups and then across groups were compared and contrasted for themes (students who already talked to a campus MHP versus students who had not talked to a campus MHP; students with and without DACA) (Tracy, 2019).

The first author developed an initial coding manual (i.e., codebook) that included a list of themes, corresponding conceptualizations, exemplar quotes, and any connections between themes. During each meeting, the first two authors and the student discussed their findings and added new observations and examples to the codebook. When disagreement occurred, coders returned to the interview transcriptions and discussed until they obtained consensus (Suter, 2009). The benefits to having multiple coders are that different perspectives, including the perspective of a Latina/o/x undocumented student, were represented to reduce bias. The coded findings were then reviewed by the other authors who are of Latina/o/x origin and who have expertise in undocumented immigration.

Findings

In this study, we explored the barriers and motivations to talking to a campus MHP (RQ). As a note, the findings did not differ for students with or without DACA; both subsamples included students who had or had not talked to an MHP. Students did not refer to DACA ineligibility as a barrier to talking to an MHP, most likely because mental health services are available to all enrolled students. Students who had talked to an MHP had reached overwhelming stress, and encouraged by others, talked to an MHP, whereas students who had not talked to an MHP stated that they would if they were in a crisis or breaking point. With respect to gender, the sample only consisted of four cisgender men; themes did not differ by gender. Our findings are not meant to generalize to the larger population of undocumented students, but they provide insight into the perceived barriers and motivations that are salient to some Latina/o/x undocumented when considering talking to a campus MHP.

Barriers for talking to a campus MHP

We identified several barriers that represent the HBM's individual beliefs: (a) *concern for self, safety, and family*, (b) *limited perceived response efficacy*, and (c) *procedural concerns*. Based on the students' responses, it appeared that their individual beliefs about mental health were shaped by anti-MHP and pro-MHP verbal and nonverbal messages from family, friends, mass media, and social media; past experiences talking to an MHP (for students who had talked to an MHP); and their family's culture, immigration experience, undocumented status, generation status, and low socio-economic status.

Concern for self, safety, and family

For *concern for self, safety, and family*, many students feared that talking to a campus MHP would make them feel badly (experience increased mental health strain or feel

badly about themselves), would make them feel uncomfortable opening up to a stranger (felt vulnerable), would lead to others' disapproval of them, would limit future career opportunities, or would place them at risk for hospitalization. The following section elaborates on this larger theme.

Confidentiality. Confidentiality concerns ranged from fear that talking to an MHP would end up on their academic record and interfere with internship or employment opportunities; to disclosure of their mental state leading, potentially, to hospitalization; to fear that their parents would find out and disapprove or misinterpret students' need for therapy. Several students expressed concern that talking to an MHP would threaten their chances of obtaining future funding opportunities. Another student reported that their mother would ask the student repeatedly if talking to an MHP at school would go on the student's school record, thus revealing how family communication can contribute to concerns over confidentiality.

Students also expressed fear of disclosing their pent-up emotions and not being able to handle them. Karla stated, "I think there's a lot of fear around being hospitalized and put under involuntary hold or something like that." Similarly, Eduardo shared:

> I sort of needed to be a bit careful with my word choice and what I would say because if I was a little bit too blunt and too obvious and open about what I would say, they could potentially commit me to a hospital or put me on a suicide watch for the next few days.

The fear of being hospitalized discouraged some students from talking to an MHP or made some students cautious when talking to an MHP.

Confidentiality concerns also emerged when students expressed worry over their parents discovering that they talked to an MHP, particularly during the pandemic when students resided at home. For example, Andrea explained:

> You know, here at home it was, like, I have to talk to them [therapists] on the phone. It's not really a safe place because I don't have a room here, so everybody would listen to what I'm talking about. So, then I just didn't meet with anybody.

Students who expressed concern about others discovering them talking to an MHP seemed primarily afraid that their parents would find out and disapprove. Fatima feared that her parents would interpret her talking to an MHP as an indication that they "are doing a terrible job or they are being bad parents when that is definitely not the case." Given Fatima's undocumented status, one might assume that her primary concern for confidentiality would be to keep her and her family safe from detention/deportation, but instead, she was mostly concerned about protecting her family from feeling responsible for her mental health strain. Like Fatima, some students did not talk to their family about talking to an MHP to avoid burdening their family.

Family/cultural views on mental health. Although a couple of students reported that their parents eventually supported them talking to an MHP, nearly all of the students reported that talking to an MHP ran counter to their family and culture's views. Students shared that the family culture in which they were raised did not perceive mental health as a priority or as a legitimate, serious experience, and that talking to an MHP is a waste of money (e.g., "I don't really talk to them [family] about therapists because they are very traditional Mexican where they are like, 'You don't need to see a therapist. It's only for money,'" Juan). Students also mentioned that their family and culture associate

talking to an MHP with "being crazy," which Margarita attributed to telenovelas, representing people with mental health strain as "crazy."

Students hesitated to talk to an MHP because their family thought they should "snap out of it" (Maya), "carry on and pick yourself up" (Rosa), or turn to other sources for support (Mariana). Consistent with this notion, Mia stated:

> I told my mom that I wanted to see a therapist, and she kind of questioned why I would do that. She kind of told me that I was fine, and I didn't need to see a therapist. And I feel like having conversations with her that are similar to that have discouraged me from seeing people because if she thinks I'm fine then in my mind I'm okay.

Similar to Mia, Gabriela's mother downplayed her mental health strain, "I talked to my mom about it, and I started crying, and then she's like, 'Why are you crying? You don't have reason to be crying.' So, I kind of felt bad." Based on their parents' communicative responses, students concluded that their parents and culture would not approve of them talking to an MHP.

To explain her parents' views on mental health strain and talking to an MHP, Fatima described how her parents were scared of Fatima's mental health strain because the parents are "very traditional" and did not grow up talking about MHPs. Consistent with Fatima's experience, other students also reported that their parents treated mental health strain as if it does not exist, a sign of laziness or weakness, or an exaggeration, particularly because their parents experienced far more significant stressors. For example, Andrea stated:

> To my parents it's always been, like, "We've had more struggles, and we never had to talk to anybody about it. Why do you need to talk to somebody?" It's just, like, you have to deal with it … it's just, like, "Oh, you're just a weak person, you know, that doesn't really exist. … We've had bigger issues, you know."

Because parents had to work hard to meet their family's basic needs, parents prioritized those needs over mental health needs. For example, Karla shared,

> I think that had to do with them [students' parents] being immigrants from Mexico and being around a different culture where … it was pretty much discouraged to focus on your mental health because you had to provide, and you had to immediately go into the work field. So my mom and my dad were raised into thinking that, and anything going on in your head is just in your head, and you have free control over it.

Furthermore, Mariana mentioned that her father thought she should instead confide in her family or religion rather than a therapist. Similarly, Ana's mother thought mental health strain reflected Ana's relationship with God.

> My mom and my dad are very religious … if you're more closer to God and you know you let yourself, you let God into your lives, and you know, go to church and Catholic youth groups, you'll feel much better … the way my mom saw it, "You're feeling all of these things because you're not close to God."

Given their family and culture's perspectives on mental health and talking to an MHP, students shared that their parents rarely talked about mental health, and in turn, students felt like they could not discuss their mental health strain or discuss talking to an MHP with their family. For students who had approached their family about mental health strain and talking to an MHP, most students reported family responses that discouraged

talking to an MHP, unintentionally conveying messages that promoted individual beliefs of self-stigma (i.e., negative evaluations of oneself; e.g., "feeling weak") and other-stigma (i.e., others' negative evaluations of the student; e.g., "appearing dramatic"). Family members' stigmatizing responses seemed rooted in cultural views, low socio-economic status, generational differences, religion, and immigration.

Self and other stigma → performing "resilience." The verbal and nonverbal messages that students received from family that stigmatized mental health strain and seeking mental health services seemed to be internalized as self-stigma and other stigma. In turn, students tried to avoid such stigma by performing "resilience." Students were afraid of being weak, vulnerable, and being unable to face or manage their emotions if they talked to an MHP (e.g., "It [talking to an MHP] makes you think, 'Oh, is there something wrong with me?' And sometimes … you don't want to face the reality that you actually do need help," Miguel). Several students who had talked to an MHP had questioned whether they should talk to one because they felt they had to remain strong. Students also discussed the notion that undocumented immigrants are supposed to be resilient and hardworking; therefore, talking to an MHP ran counter to "undocumented resilience." For example, Andrea stated:

> We're always supposed to be like more resilient, and … just deal with it yourself and not have to talk to anybody just because you know that this is just another struggle.

Similarly, Ana explained:

> I have never really acknowledged all the trauma and feelings that come with, you know, being undocumented … .sometimes, you know, that immigrant hustle … just working, working, and not taking breaks or not allowing yourself to be vulnerable, and have mental health breaks. That has been kind of like what has been happening with me.

Although undocumented students are resilient, these quotes demonstrate a potential unintended negative consequence of "undocumented resilience" as a catch phrase. Some students might feel pressured to perform internal resilience rather than realizing that talking to an MHP can be a source of resilience. Many students felt weak for talking to an MHP and feared that others, especially family, would negatively evaluate them. In performing "resilience," students reported teaching themselves to hold their feelings in and avoid talking about mental health strain.

Students also reported that based on observing their parents' way of handling mental health strain, a form of nonverbal communication, students made certain inferences about their family's views on mental health, and in turn, developed their own views on mental health, which discouraged the student from talking to an MHP. For example, Margarita stated:

> We haven't seen my mom cry, and she has people like that in her family, and she never cries in front of us … I think that since, well at least from myself, I feel like I should never be vulnerable. I always also think of being tough.

Margarita's quote is consistent with Theiss (2018); children learn how to cope with stress by observing how their parents respond to stress. Indeed, the ways in which parents express or suppress their emotions teach children how to manage their own emotions (Theiss, 2018).

Perceived response efficacy

Students also questioned whether talking to an MHP would address their problems. This lack of confidence in the effectiveness of talking to an MHP stemmed from hearing from family and friends about their negative experiences talking to an MHP, questioning whether the MHP would understand the students' unique lived experiences, knowing that talking to an MHP would not help them become documented, and turning to alternative coping strategies.

Mental health services reputation. Several students revealed how hearing about others' negative experiences talking to an MHP discouraged them from talking to one. When questioning the response efficacy of talking to an MHP, Liana stated:

> My brother, he actually got better, and he said it was really helpful. However, on the other hand, my sister, she didn't really get much help, and she said it wasn't helping her, so she just decided to get out of it … I don't know if it's going to help or it's going to make things worse. Because my sister really went down. I mean, she's still struggling right now. And, well my brother is kind of just, I don't think he actually needs any help. He's always the strong one.

Although Liana briefly acknowledged that her brother seemed to be doing better after talking to an MHP, Liana quickly placed more weight on her sister's negative experience with an MHP. However, Liana did not consider the possibility that her sister might still be struggling because her sister stopped talking to an MHP. Instead, Liana assumed that her brother had always been the strong one in their family, thereby "projecting resilience" onto her brother as an internal trait that he always had that was unrelated to talking to an MHP.

MHP understanding students' experiences. Another factor that contributed to the perceived effectiveness of talking to an MHP is the extent to which students thought the MHP would understand their unique experiences as members of minoritized communities. Students emphasized the importance of talking to someone who is familiar with their lived experiences, and ideally, who shares a common identity (e.g., race, ethnicity, gender, language, immigrant). Students were unlikely to talk about their undocumented-related stressors if they felt their MHP did not understand their experience or have a shared identity. Liana explained:

> They [MHP] wouldn't understand all the pressure that comes from being undocumented … .they don't understand the pressure coming from your parents. Like, my dad, which [*sic*] is always calling me for money because he was deported, and he's in Mexico, and it's all these things that I have to deal with that I don't think they understand.

Maya made a similar point, "I felt he [MHP] didn't understand because he didn't look like me. I think it was him and another lady, and she was also a white female … I felt I was getting what I needed, but not to the deeper level." Students emphasized the importance of having an MHP who understood their experiences, which they often determined based on the MHP's identity. Mia noted that this perceived lack of understanding might discourage students from talking about their undocumented-related stressors, and in turn, make the therapy session feel ineffective.

Alternative coping strategies. Lastly, some students relied on other strategies such as managing their stress alone, trying not to talk about it, ignoring it, or seeking distractions that they perceived were more effective than talking to an MHP. Nicole stated:

> It's maybe not the healthiest thing, but I do kind of isolate myself just because I don't want to think about it or I don't want to pay much attention to it … .but I have noticed that if I do that it'll build up and then I'll kind of just become very overwhelmed.

Students also relied on friends, particularly undocumented friends. Several students also noted the benefits of Instagram and other social media outlets in normalizing and validating their mental health strain. They mentioned posts that provide uplifting and encouraging comments that would alleviate their distress. Daniela mentioned listening to podcasts on mental health to manage her stress. Students also went to mindfulness events, yoga, listened to music, and developed hobbies. Students who talked to an MHP also engaged in these coping strategies.

Procedural concerns

In addition to questioning the effectiveness of talking to an MHP, students reported procedural concerns. Several stated that they had intended to schedule an appointment, but they lacked knowledge of scheduling, appointment availability, what talking to an MHP might be like, what to say to an MHP, financial costs, and feared exhausting their allotted sessions. Indeed, Ana stated,

> I kind of came into the room just not knowing what to say. I don't know if other folks experienced the same thing of, you know, your first therapy session. You don't know how it's going to go, like, what do you say? What do you hold back?

Because of the limited knowledge that students had about talking to an MHP, some students did not know how to start the conversation, what to expect during the session, and how much to disclose or withhold; these concerns are indicative of *low disclosure efficacy*.

Several students also emphasized the anxiety around talking to an MHP. Maya shared:

> I was definitely really, really nervous, and I think it added more to it since you just walk into the room with someone you don't even know, or you know, you don't identify with. And you're expected to just tell them this whole life story and have them try to help you solve it. So, yeah, it's pretty scary, and I think it added a lot more stress.

Further, students expressed discomfort over having to possibly talk to different MHPs in subsequent visits. The emphasis on "stranger" corresponds to the desire that other students had for the MHP to understand their experiences, and ideally, have a shared identity. Being unfamiliar with what to expect from an MHP session resulted in anxiety and nervousness.

Students also reported low *self-efficacy* or confidence in being able to schedule and keep an appointment with an MHP. Low self-efficacy is not unique to undocumented students. Indeed, mental health services on college campuses have a reputation for being understaffed and requiring long wait times to schedule a session (Cha et al., 2020). Thus, it is not surprising that some undocumented students, similar to undergraduate students more broadly, anticipated having to wait a long time to obtain an initial or subsequent appointment. Students were also unaware of their health insurance coverage and financial responsibility. They did not know what services (e.g., the number of sessions) were available to them at no cost.

Lastly, students mentioned that they intended to schedule an appointment, but their busy schedule made it difficult to find time to make an appointment, talk to an MHP, or think about their mental health needs. Mayra noted,

> since I work and go to school and I have no time at all not even to rest, I was always running and everything. So that was one of the challenges that I had about getting an appointment, other than making it.

Fatima shared, "I never gave myself time to really feel my stress. You know, allow it to affect me. I would always, like, 'No, it's okay, get over it. And I'd have to get over it because I had work.'" Overall, concerns about availability, talking to the same MHP, affording an MHP, and their busy schedule contributed to perceived self-efficacy, the ease and ability to obtain an appointment.

Motivations for talking to an MHP

Among students who had talked to an MHP, reported motivators included: (a) *overwhelming stress,* and at that time, many received (b) *encouragement from others*, prompting them to talk to an MHP (i.e., cues to action). Other benefits included (c) *providing a sense of relief* and (d) *offering effective coping strategies*. Students who had not talked to an MHP also mentioned overwhelming stress as a motivation for talking to an MHP.

Overwhelming stress

For students who had talked to an MHP, they often referred to their numerous stressors that overwhelmed them to the point of needing to talk to someone, and similarly, students who had not talked to an MHP mentioned possibly talking to one in the future if they felt unable to control their mental health strain (e.g., "I feel like it would have to be me failing at life completely. Getting to the point where I don't want to get out of bed," Carlos). Here, Carlos thought of talking to an MHP as occurring only in crises when he felt overwhelmed, not for general mental health maintenance. Thus, perceived severity, in the form of overwhelming stress, seemed to function as a cue to action. Some students felt overwhelmed to the point where they needed to talk to someone; otherwise, they felt that nothing would improve. Eduardo noted,

> I guess what really pushed me to do it [talk to an MHP] was the fact that, I just woke up one day and I felt I really need to get help because if not, nothing was going to change, and I was going to keep on feeling like this … .I don't want to feel like this anymore, like, maybe I should just give it a try once and see how it works out.

Students reported being at their breaking point where they needed someone to confide in, particularly someone who was not a family member (e.g., "I think it was just one of those things. I felt kind of like I needed to talk to someone besides just someone close to me," Sophia).

Encouragement from others

Although some students realized that they needed to talk to an MHP, they voiced that encouragement from others, primarily friends, not only normalized and validated students' feelings but also signaled the cue to actually go talk to an MHP.

> They [friends] told me that it was okay to feel the way that I was feeling, that there was days that I was going … to have ups and downs, and it was totally valid to feel like that. But what

> wasn't okay was that I was, I would just ignore these feelings and bottle them up and push them away. That I needed to speak to someone about it. Or, in the long run it was going to affect me. (Eduardo)

Friends also tried to de-stigmatize talking to an MHP (e.g., "she said you take on too much in your life … .There's nothing wrong with talking to someone about your feelings. Everybody needs that at one point in their life," Mariana).

In an attempt to normalize and de-stigmatize talking to an MHP, some friends shared their positive experience with their MHP:

> She [friend] told me she started going to a counselor because she has certain issues as well … "You're taking on a lot in your life, and it's sometimes good to talk to someone … .because it's good to talk to a professional and tell them how you feel because they'll help you be able to express and give you new ways to cope." (Mariana)

Several students reported how their friends emphasized the importance of being able to talk to a professional, not a family member. Reasons to talk to an MHP included their expertise, needing a neutral party to confide in, and to avoid disapproval from family.

Providing a sense of relief

As a motivation and perceived benefit, students discussed how talking to an MHP gave them a sense of relief, as if a weight had been lifted off their shoulders, especially after trying to manage the mental health strain alone and keeping their emotions contained. Although some students initially thought about canceling their appointments, they were glad they kept their appointment. The sense of relief came from catharsis, the MHP normalizing the stressor, and helped students develop a better understanding of their stressors. Rosa, for example, "realized the impact of talking to someone and letting it out instead of keeping it in." Liana shared:

> He made me realize that everything was tied to my [undocumented] status, and so I always have to live in fear, and you know, my status isn't – it's not decided by me but it's decided by the people above me. … He helped me realize that I should look into it, if that makes sense, find a community.

Other students discussed how gaining a sense of relief created space for applying the MHP's advice and coping strategies. Veronica stated:

> I was laughing even though I was crying. And when I would leave I would feel a little weight lifted off my shoulders. I was able to reflect and also be able to apply them [coping strategies]. So it gave me a sense of hope of, oh, I can apply even though they're not hard milestones. I think I can do this, can achieve it.

After experiencing catharsis, Veronica was able to apply the coping strategies that the MHP provided outside of the therapy session. Overall, students emphasized how relieved they felt from having someone actively listen to them.

A couple of students also stated that their MHP normalized their mental health strain by letting them know they are not alone. The MHP helped them realize that others experience stressors and feel similar mental health strain. For example, Eduardo shared,

> I definitely felt a load had been taken off my shoulders. I felt better that I wasn't the only one who was being like this. There was definitely other people in my situation, and it just felt alleviating to know that I'm not alone in situations like these.

Thus, gaining a sense of relief could be a motivation for talking to an MHP.

Offering effective coping strategies

In addition to feeling a sense of relief, students reported that their MHP offered them "good advice," informed them of campus resources and services (e.g., food banks and food vouchers), and provided emotion-focused and problem-focused coping strategies. For example, Andrea discussed how the MHP introduced her to a resource:

> Me being undocumented, he did mention grants that undocumented services had, and so it was really helpful because I didn't really know about this … I never went to the food bank until my second year when I did speak to [MHP] and that was really helpful … it wasn't a solution to financial aid issues, but it was something that was really helpful to me and just being more food secure.

Students also mentioned different calming exercises. Another MHP (for Camila) provided advice to help Camila connect with family and friends back home and make new friends in college.

Similarly, Andrea felt that her MHP helped her transition to a new university:

> I kind of stopped going home every weekend because I knew that, you know, if I was going to make friends here or just meet people, then I had to actually try and get involved rather than, you know, just being in my room doing homework … the advice really helped.

Eduardo noted relationship benefits from talking to an MHP:

> my experiences have been helpful to me because they've [MHP] helped me open up more with my parents. They've helped, definitely it helped me get close with my parents, and they taught me that feeling vulnerable isn't a bad thing. It's a good thing because it shows that you're able to trust people.

Although MHPs could not offer solutions that would eliminate one of the primary causes of stress (i.e., their undocumented status), students felt that the resources, coping strategies, safe environment, and active listening were helpful.

Discussion

By conducting in-depth semi-structured interviews, we obtained insights into undocumented students' perceived barriers and motivations to talking to an MHP about general strain and undocumented strain specifically. Our findings provide a starting point for understanding why some Latina/o/x undocumented students might or might not talk to an MHP; extends past behavior change and disclosure theories by focusing on communication, culture, and structural barriers; and identifies key factors that can be addressed in culturally-responsive therapy trainings, campaigns, and interventions.

Extending the HBM by considering Latina/o/x undocumented students' experiences

The HBM suggests that six important factors predict engaging in a recommended health behavior: perceived susceptibility, severity, barriers, benefits, self-efficacy, and cue to action (Rosenstock, 1974). The model's origin is in public health, and most of the variables in the model are individual beliefs, with little emphasis on communication and little reflection of the structural determinants that may motivate or discourage talking to campus MHPs. Thus, we place communication as a focal point in the HBM by revealing: (1) the socialization process that is related to individual beliefs across a lifespan, paying particular attention to the content of the messages about mental health, (2) the transactional nature of communication about mental health that is related to mental health help-seeking behaviors, and (3) how structural determinants such as culture, immigration, and socioeconomic status are not merely demographics to control for but instead are experiences that warrant great consideration.

First, one of this study's main contributions is in providing a nuanced representation of interpersonal communication in the form of verbal and nonverbal messages that are related to beliefs about mental health strain and talking to an MHP. Past quantitative HBM research (e.g., Asare & Sharma, 2014; Yang, 2015; Yoo et al., 2013) often measures the extent to which people have talked to someone about the recommended health behavior in general or the extent to which someone was encouraging or discouraging of the recommended health behavior. Our findings revealed specific types of verbal and nonverbal messages that some Latina/o/x parents engaged in, whether intentionally or unintentionally, consciously or unconsciously, that students felt shaped their views on mental health and talking to an MHP. Our findings also identified structural and individual factors that might explain why some Latina/o/x undocumented students have certain views on mental health and talking to an MHP, thereby providing a greater range of relevant determinants that MHP trainings and communication campaigns should consider.

Notably, when considering the content of Latina/o/x parents' messages about mental health strain and talking to an MHP, their responses were consistent with the work of Thompson and Duerringer (2020) that focused on "crying wolf" or the belief that a family member is exaggerating their health symptoms. They identified four primary contestations: "You are not being rational; You are not trying; Your symptoms do not make sense; and You are not being you" (p. 291). Undocumented students discussed how their parents used similar contestations; however, the present study extends Thompson and colleagues' work by shedding light on the structural reasons why some families might accuse someone of "crying wolf." HBM focuses on individual beliefs, but our study emphasizes the importance of moving beyond the individual level to consider interpersonal, cultural, structural, and other central components.

Structural determinants: Making culture, immigration, socioeconomic status, religion, generational differences, and the environment more central to the HBM. Although the HBM (Rosenstock, 1974) posits that demographics shape individual beliefs regarding a health condition or a recommended health behavior, demographics in the form of structural determinants can be made more central to the HBM in communication scholarship. Our findings emphasize the importance of considering culture, immigration, socioeconomic status, religion, generational differences, and the environment as all of these

experiences might explicate why some Latina/o/x undocumented students and their families have certain beliefs about mental health and talking to an MHP. For example, Latina/o/x undocumented parents' low socioeconomic status, a focus on survival, and having to meet their basic needs provided little opportunities for acknowledging mental health strain. Moreover, generational and environmental differences existed such that students described how their parents were raised in a time and in a place (e.g., rural town) when mental health was not a common term. Efforts to de-stigmatize mental health strain or talking to an MHP had not been pervasive.

Our findings do not merely indicate that some families view mental health strain as "being dramatic," but they provide a deeper understanding of why some Latina/o/x undocumented families might develop that view – because of culture, immigration, low socioeconomic status, generational differences, religion, limited access to mental health services and stigmatization. Our findings extend the HBM by emphasizing the centrality of culture, immigration, socioeconomic status, religion, generational differences, and the environment in shaping communication and individual beliefs about mental health strain and talking to an MHP. Such factors can be grouped under the HBM's perceived barriers, but identifying the particular barriers and what they look like for some Latina/o/x undocumented students is crucial to developing effective campaigns and interventions that resonate with students and their families.

A transactional communication perspective on mental health help seeking. Another way in which our study extends the HBM is by emphasizing the dynamic transactional communication environment that families and other socialization agents create that has significant implications for people's health behaviors. According to several students who had told their parents about their mental health strain, they initially directly disclosed to them as a way to activate support from their parents. The students, however, reported primarily receiving dismissive responses from their parents, which made students feel like they could not talk about their mental health strain with their parents. Students reported that they were unlikely to seek mental-health support in the future from their parents because they feared rejection or did not want to burden their parents. They also were more likely to avoid talking to their parents about mental health strain or accessing mental health services. The dynamic transactional communication environment is consistent with sensitive interaction systems theory (SIST; Barbee & Cunningham, 1995). SIST discussed the direct and indirect verbal and nonverbal strategies that people use to activate support, as well as the helpful or unhelpful ways in which the interaction partner might respond. SIST argued that fear of rejection, concern over burdening the other person, and self-presentation concerns are likely to discourage people from seeking support, which some of the students in our study reported.

Moving beyond self-efficacy in the HBM. In addition, we elaborated upon three types of efficacy. Although the HBM identifies self-efficacy as a predictor of engaging in a recommended health behavior, our study revealed that some Latina/o/x undocumented students considered response efficacy, disclosure efficacy, and self-efficacy when considering talking to an MHP. Students questioned whether talking to an MHP would help (i.e., limited perceived response efficacy). Students also reported not knowing what to expect when talking to an MHP and did not know what information they should disclose or withhold and how to describe their mental health strain (i.e., limited disclosure efficacy). Lastly, students doubted their ability to obtain an appointment with an MHP and had difficulty

finding time to talk to an MHP. All of these efficacy components seemed related to communication with various socialization agents, perceptions of family and cultural views on mental health, the reputation of mental health services, the fact that MHPs could not change their undocumented status, having family question MHP response efficacy, and assuming that MHPs would not understand their experiences as undocumented students. Extending efficacy to three types and offering explanations for such views on efficacy offers a comprehensive representation of efficacy beyond what is in the HBM.

Garnering MHP support through disclosure. Another finding worth noting is the distinction between talking to an MHP about general stressors (e.g., feeling overwhelmed by school) from undocumented-related stressors (e.g., having a parent who is deported). This distinction is crucial and consistent with Kam et al. (2020) who separated the two types of communication when predicting talking to an MHP. Our findings provide further support for keeping the two types of communication separate because some students were more inclined to talk to an MHP about their general stressors compared to their undocumented-related stressors. When considering why students might discuss their undocumented-related stressors, the Disclosure Decision-Making Model (Greene et al., 2012) can be of great utility; it identifies, for example, stigma, prognosis, and disclosure efficacy as important predictors of disclosure.

Nevertheless, our study can further inform the disclosure literature by highlighting the importance of additional factors that might be relevant to some Latina/o/x undocumented students. For example, perceiving that the MHP would understand students' lived experiences as undocumented immigrants, which students often determined based on a shared identity (e.g., being an immigrant or a child of immigrant parents, being Latina/o/x, speaking Spanish) was an important factor that they reported affected their decision to talk to an MHP, and even more so when it came to discussing their undocumented status. Furthermore, students might not disclose their undocumented-related stressors to an MHP because of their family and cultural views on discussing their mental health strain and undocumented strain with nonfamily members. Thus, our findings move the HBM past a focus on individual-level beliefs, and instead, reveals how undocumented students' motivations for engaging in a recommended health behavior is strongly rooted in relationships and communication with others – a strong cultural orientation to others.

Alternatives to engaging in the recommended health behavior. As a potential behavior, we introduce performing "resilience," which is intended to portray strength. This finding is particularly noteworthy because activists and allies have continuously crafted the narrative of the "perfect DREAMer" or "undocumented resilience" to gain support from communities and political leaders. The "perfect DREAMer" is depicted as an undocumented student who has accomplished academic success, is driven, and hardworking (Lauby, 2016). Related, undocumented students are often described as resilient, which Latina/o/x students in our study seemed to equate with "being strong" and coping alone. Such unrealistic standards, particularly when considering the structural barriers that undocumented students face, place a substantial burden on undocumented students and can further alienate them (Mondragón, 2020). Even though it is necessary to portray the success of undocumented immigrants, it is critical to emphasize that seeking help is not a sign of weakness.

Overwhelming stress as a perceived threat and a cue to action. When considering what prompts action (e.g., talking to an MHP), a major cue to action was overwhelming

stress, a form of perceived severity, such that many Latina/o/x undocumented students reported talking to an MHP when they had reached a breaking point. Students who had not talked to an MHP reported that they would talk to an MHP if they were in a crisis, could no longer control their emotions, or had suicidal thoughts. Although the HBM identifies perceived severity as an individual belief that directly predicts actions, our findings reveal how overwhelming stress, as a form of perceived severity, might be a cue to action and a source of motivation.

Practical contributions

In addition to the many theoretical contributions of this study's findings, numerous practical contributions can be identified. For example, culturally-responsive trainings for MHPs can include our findings, so MHPs can have a better understanding of some Latina/o/x undocumented students' motivations and barriers for talking to an MHP about their general stress and their undocumented-related stress. Of course, our findings are not meant to generalize to all undocumented students, but they offer a starting point for understanding some undocumented students' experiences. What is also important to acknowledge is our students' strong other orientation and the central role that family and structural determinants play in shaping how students in our sample think about mental health strain and talking to an MHP. When considering their family and culture's perspectives, trainings, campaigns, and interventions should communicate empathy, understanding, and respect for their family's experiences and viewpoints, while also addressing misperceptions of mental health strain and talking to an MHP. Another noteworthy contribution that this study makes is in identifying the benefits to talking to an MHP, a major component of the HBM, that should be emphasized in campaigns and interventions. Past research (e.g., Kam et al., 2020) has assumed that talking to an MHP is beneficial; however, limited research has asked undocumented students to report their positive experiences with an MHP. Lastly, although our findings are preliminary, they can inform the design of culturally-grounded mental health messaging that breaks down the barriers to talking to an MHP. Our findings reveal certain concerns, misperceptions, and misconceptions that need to be addressed such as stigma and performing "resilience," and increasing the three types of efficacy, while also acknowledging the possibility that others might disapprove or that they might have to talk to more than one MHP to find the right match.

Limitations and future research

Several limitations exist. First, the focus on a Latina/o/x sample (majority of Mexican origin) prevents us from shedding light on the experiences of undocumented students from other nationalities, cultural backgrounds, and races. Enriquez (2017) found that Asian undocumented students felt that their university's resources for undocumented students were not meant for them, whereas Latina/o/x undocumented students felt that people assumed they are undocumented because of their racial features and nationality. Thus, these distinct perceptions of discrimination might result in different views on talking to an MHP for Asian and Latina/o/x students; this idea can be explored in the future. Second, undocumented students' stressors, mental health, and access to mental

health services likely also vary by regionality, which the present study did not consider. For example, California has the largest undocumented immigrant population compared to all other states (Pew Research Center, 2019), and the Universities of California all have an Undocumented Student Services or DREAM Centers that refer students to mental health services. Third, students who volunteered to participate might have had more positive views toward talking to an MHP than students who did not volunteer to participate. Although we attempted to recruit students who had or had not talked to an MHP, we do not claim that their experiences reflect the larger undocumented student population.

In this study, we advance understanding about the mental health-seeking process among a sample of Latina/o/x undocumented students on a theoretical and practical level. Theoretically, our findings inform the Health Belief Model by pointing to several key elements in need of attention for understanding why or why not some Latina/o/x undocumented students talk to an MHP. We also highlight key elements that reflect the family histories, cultural, and structural environments that our sample of Latina/o/x undocumented students felt shaped their mental health-seeking attitudes. Being informed by the lived experiences of Latina/o/x undocumented students lends credibility to the validity of the HBM. Designing messages that respond to these realities are likely to resonate with some Latina/o/x undocumented students.

Notes

1. Undocumented immigrants refer to people who reside in a country without authorization (Internal Revenue Service, August 27, 2017). There are approximately 450,000 undocumented college students in the U.S. (New American Economy, 2021).
2. Undocumented immigrants, including undocumented college students, do not have a social security number or work permit unless they have Deferred Action for Childhood Arrivals; however, many undocumented college students are not DACA eligible (New American Economy, 2021).
3. Hispanic, Latino, Latina/o, Latin@, Latinx, and other ethnic identifiers have all faced legitimate criticism, and there is no agreement on which ethnic identifier should be used (De Onís, 2017). Hispanic is a term that was assigned to Latinas/os/xs by the U.S. government, and some feel the term's inclusion of people from Spain, "privileges the colonizer" (Hernández et al., 2019, p. 9). Latina/o and Latin@ have been used to be gender inclusive, while maintaining Spanish-language gender distinctions ("a" or "o"). Nevertheless, Latina/o and Latin@ are gender binary. Latinx was developed to be more inclusive of LGBTQ+ and non-gender conforming communities. One concern, however, is that the term is an academic elitist identifier that marginalizes a large population in the United States and in Latin America.
4. The Deferred Action for Childhood Arrivals (DACA) program was established in 2012 as an executive order signed by former U.S. President Barack Obama. The program allows undocumented youth temporary relief from deportation as long as they meet certain eligibility requirements and renew their DACA status every two years. DACA recipients can obtain a social security number and a work permit (Gonzales et al., 2018).

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