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Claremont McKenna College

**A Proposal to Develop and Pilot-Test the Effects of a Culturally Adapted Stigma
Intervention for Latinos**

By
Sandy Ahumada

Submitted to
Dr. Wei-Chin Hwang

In partial fulfillment of the
Degree of Bachelor of Arts

Senior Thesis in Psychology
Fall 2021
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Table of Contents

Acknowledgements..... 4
Agradecimientos 5
Abstract 6
Abstracto 7
Project Narrative..... 8
Specific Aims..... 9
Significance 11
 Stigma 12
 Stigma in Latinos..... 12
Innovation 14
 Public Stigma Interventions..... 14
 Stigma Interventions for Latinos 16
Approach..... 18
 Development of ACCEPTAR Intervention..... 18
 Participants 20
 Measures 21
 Design 25
 Procedure 25
 Data Analysis..... 29
 Expected Results..... 29
 Limitations 31
 Impact and Future Directions 31
Appendix 33
 Appendix A: Screening Questions 33
 Appendix B: Consent Form 34
 Appendix C: Demographics 36
 Appendix D: Attitudes Toward Seeking Psychological Professional Help
 Assessment- Short Form (ATSPPH-SF) 38
 Appendix E: Self-Stigma of Seeking Help Scale-Therapy (SSOSH-T)..... 39
 Appendix F: The Beliefs Toward Mental Illness Scale (BTMI)..... 40
 Appendix G: Mental Health Services Questionnaire (MHSQ) 42

Appendix H: Intention to Seek Counseling Inventory (ISCI) 43
Appendix I: Patient Health Questionnaire-9 (PHQ-9) 44
Appendix J: Vancouver Index of Acculturation (VIA) 46
Appendix K: Debrief Form..... 47
References 48

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Finalmente, esta tesis está dedicada a todas las personas que padecen de enfermedades mentales, pero especialmente a quienes enfrentan barreras al buscar terapia como el estigma. Los veo y quiero hacer del mundo un lugar mejor para ti.

Abstract

The bulk of research examining barriers to mental health services (MHS) for Latinos focuses on financial obstacles such as socioeconomic status and insurance coverage. Unfortunately, less work has been done on cultural barriers such as stigma. The purpose of this proposed study is to develop and pilot-test a culturally adapted contact intervention for Latinos that reduces stigma and increases help-seeking intentions. This study will test the differential efficacy of utilizing psychoeducation with the newly developed interpersonal contact intervention (PIC) as opposed to psychoeducation (P) only. Participants ($n=324$) will fill out pre- (T1), post- (T2), and 1-week follow-up (T3) measurements on stigma and help-seeking intentions. Three individual 2-way ANCOVA analysis will be used to test the effects of intervention type (P vs. PIC) across time (T1, T2, T3) on the dependent variables of a) mental illness stigma, b) therapy stigma, and c) intentions to seek therapy while controlling for language and mental illness (MI) severity. Results will indicate that the PIC intervention will be significantly more effective in reducing both mental illness and therapy stigma as well as increasing likelihood of seeking MHS because such contact can convey normalcy of MI and its treatment. This research will highlight the importance of adapting stigma interventions for the Latino population in order to address cultural barriers to care. Future research should test the efficacy of the intervention in the community at-large with a diverse Latino population, and also examine whether the effects of the intervention will endure across a greater follow-up time period.

Keywords: Latinos, barriers to care, help seeking, mental health stigma, stigma intervention.

Abstracto

La mayor parte de las investigaciones que examinan las barreras a los servicios de salud mental para latinos se centran en obstáculos financieros como el nivel socioeconómico y la cobertura de seguro. Desafortunadamente, se ha trabajado menos en las barreras culturales como el estigma. El propósito de esta propuesta es desarrollar una intervención de contacto culturalmente adaptada para latinos que reduzca el estigma de las enfermedades mentales y la terapia, así como también aumente la probabilidad de buscar atención. Este estudio probará la eficacia diferencial de utilizar la psicoeducación con (PCI) contacto interpersonal en oposición a la psicoeducación (P) únicamente. Los participantes ($n = 324$) completarán mediciones previas (T1), posteriores (T2) y de seguimiento de 1 semana (T3) sobre el estigma de enfermedades mentales y el de la terapia, así como las intenciones de búsqueda de terapia. Se utilizarán tres análisis individuales ANCOVA bidireccionales para probar los efectos del tipo de intervención (P frente a PCI) a lo largo del tiempo (T1, T2, T3) sobre las variables dependientes de a) el estigma de las enfermedades mentales, b) el estigma de la terapia y c) intenciones de búsqueda de ayuda mientras se controla el lenguaje y la severidad de la salud mental. Supongo que la intervención PCI será más eficaz para reducir tanto el estigma contra la enfermedad mental como el estigma de la terapia, así como para aumentar la probabilidad de buscar terapia porque dicho contacto puede transmitir la normalidad de las enfermedades mentales y su tratamiento. Esta investigación destacará la importancia de adaptar las intervenciones de estigma para la población latina con el fin de abordar las barreras culturales a la atención mental. Las investigaciones futuras deberían probar la eficacia de la intervención en la comunidad en general con una población latina diversa, y también examinar si los efectos de la intervención perdurarán durante un período de tiempo de seguimiento mayor.

Palabras clave: latinos, barreras para la atención, búsqueda de ayuda, estigma de salud mental, intervención del estigma.

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Project Narrative

In addition to financial barriers to care, stigma towards mental illness and its professional treatment (e.g., psychotherapy) is thought to be a primary reason why Latinos demonstrate a lower help seeking rate. Therefore, creating interventions that directly reduce stigma in Latino communities is critically important to improving access to care. This project proposes the creation of a culturally adapted contact stigma intervention that will reduce stigma and increase likelihood of seeking psychotherapy.

Specific Aims

Latinos are numerically the fastest-growing group in the United States. In fact, between the years 2010 to 2019, Latinos were responsible for 52% of the entire population growth in the U.S (Noe- Bustamente et al., 2020). Additionally, the Latino population is expected to almost double from 60.5 million to 111.2 million by the year 2060 (U.S. Census Bureau, 2021). With such rates, it is imperative to increase mental health research that focuses on Latino populations.

In addition to population growth, there are a number of reasons why there needs to be a greater emphasis on improving access to mental health services for Latinos. First, they evidence rates of mental illness comparable to that of non-Hispanic Whites (29.7% vs. 43.2%; Alegria et al., 2008). Second, rates of help seeking for Latinos in need are much lower than that of non-Hispanic Whites in need (34% vs. 60%; Alegria et al., 2008). Furthermore, the help seeking rates for those who are less acculturated are much lower than that of the more acculturated, indicating a high need to address cultural and linguistic barriers to care. This highlights the need to develop an intervention that focuses on cultural barriers such as stigma, which is pervasive amongst Latinos. However, few evidenced-based stigma prevention programs have been developed and tailored specifically for Latinos. Therefore, this project seeks to address the gap in this area of research through the following aims:

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Aim 1. Develop a culturally competent stigma intervention using interpersonal contact with a consumer of psychotherapy. Through investigation on previous evidence-based stigma interventions and Latino adaption models, this project proposes the culturally competent contact stigma intervention ACCEPTAR (Addressing and Combating Ethnic-Based Public Stigma through Anecdotes on Recovery), which consists of a Latino therapy consumer sharing their mental health journey.

Aim 2. Measure the efficacy of the newly developed ACCEPTAR intervention. The experiment will do this by assessing Latinos' mental illness stigma, therapy stigma, and intention to seek therapy before (T1), immediately after (T2), and one week after (T3) being presented to either a psychoeducation (P) intervention or psychoeducation plus ACCEPTAR (PIC).

Hypotheses

Primary Hypothesis 1 (H1). I hypothesize that at baseline, participants in the PIC intervention will have similar mental illness stigma, therapy stigma, and intentions of help-seeking rates compared to those in the P only condition.

H1_A: T1 PIC mental illness stigma scores = T1 P mental illness stigma scores

H1_B: T1 PIC therapy stigma scores = T1 P therapy stigma scores

H1_C: T1 PIC help-seeking intentions = T1 P help-seeking intentions

Secondary H1. Furthermore, males, older participants, individuals who took the survey in Spanish, and those with lower acculturation levels, will have higher rates of mental health stigma and treatment stigma as well as low willingness to seek MHS when

compared to their counterparts. Furthermore, consumers of therapy will have higher rates of treatment stigma but lower rates of MI stigma.

Primary Hypothesis 2 (H2). T2 measurements will show a significant decrease in MI and therapy stigma and an increase in intentions to seek help for those in the PIC intervention, but only indicate an insignificant slight change for those in the P only condition.

H2_A: T2 PIC mental illness stigma scores < T2 P mental illness stigma scores

H2_B: T2 PIC mental illness stigma scores < T2 P mental illness stigma scores

H2_C: T2 PIC help-seeking intentions > T2 P help-seeking intentions

Secondary H2. In particular, PIC participants who have higher acculturation and took the intervention in Spanish will have the highest rates of change in stigma due to the culturally adapted component of the intervention.

Hypothesis 3 (H3). Furthermore, post-intervention benefits of the PIC will endure thus showing no significant changes in T3 scores compared to T2 scores. On the other hand, T3 scores for participants in the P only condition will significantly lower compared to T2 scores.

H3_A: T3 PIC mental illness stigma scores < T3 P mental illness stigma scores

H3_B: T3 PIC therapy stigma scores < T3 P therapy stigma scores

H3_C: T3 PIC help-seeking intentions > T3 P help-seeking intentions

Significance

Making up 18% of the population (60.5 million), Latinos are the second largest ethno-racial group and the largest migrant group in the United States (Bustamente et al., 2020). Their high influx of migration will lead their current population to double to 111.2 by 2060 (U.S. Census Bureau, 2021). Therefore, interventions for the Latino population need to be delivered in both English and Spanish, especially since Spanish is spoken to some degree in 72.8% of Latino households (American Community Survey, 2019).

According to the diagnostic interviews of the National Latino and Asian American Study (NLAAS) Latinos have a life time prevalence of any disorder of 29.7% compared to 43.2% of non-Hispanic Whites (Alegria et al., 2008). Similar to Whites, Major Depressive Disorder (MDD) is the most common disorder amongst all Latino subjects at a 15.2% prevalence. Acculturation factors such as place of birth, language, and citizenship status play a role in MI prevalence rates of Latinos. For example, English speaking, U.S.-born Latinos are at higher risk for developing disorders compared to those born in Latin America (37.1% vs. 24.9%) including MDD (18.6% vs. 13.4%; Alegria et al., 2008). Furthermore, Ross and colleagues (2019) found a positive correlation with rates of disorders and acculturation as defined by citizenship status such that U.S. born citizens had the highest rates of mental illness (18%) followed by naturalized citizens (16%), residents (15%), and undocumented individuals (9%). In conclusion, Latinos are a diverse group having different mental health prevalence rates across different factors, but are nevertheless prominent.

Despite having comparable mental illness rates, only 7.3% of the total Hispanic population from the National Survey on Drug Use and Health used formal mental health services (i.e., inpatient, outpatient, and medication) between 2008-2012, which was significantly lower compared to their White counterparts (16.6%; Substance Abuse and Mental Health Services Administration (SAMHSA), 2015). Similarly, a review of 16 epidemiological studies from 1987-2002 consistently found that Latinos underutilize formal MHS (i.e., therapists) and rely more on primary care providers (PCP) compared to Whites (Cabassa et al., 2006), which may impede them from getting appropriate care given that PCP are not trained mental health professionals. Even Latinos who have been diagnosed with a disorder such as depression are less likely to use MHS compared to White adults in need (47% vs. 60%; SAMHSA, 2015).

Moreover, language, place of birth, time spent in the U.S., and ethnic identity may introduce additional barriers affecting access and utilization to mental health care. Spanish-speaking (7.91%) and foreign-born (9.08%) participants from the NLAAS significantly used any MHS less than English-speaking (16.07%) and U.S. Born (14.67%) Latinos (Alegria et al., 2008). While controlling for economic factors such as insurance and income, Keyes and colleagues (2012) assessed sociocultural and individual factors associated with a decrease in MHS utilization of the Latino participants ($N=6,359$) in the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) who have been diagnosed with a psychiatric disorder. Although they all displayed a need, individuals who immigrated to the U.S. within the last ten years had the lowest rates of MHS utilization at only 16.24% compared to 39.63% of U.S. born individuals. In general, mentally ill Latinos who had a strong ethnic identity and preferred a non-English therapist, were less likely to use MHS, even after controlling for severity, time spent in

Commented [SA3]: "The significance of your study should focus on 1. Size of the population, English versus Spanish, rate of mental illness for latinos overall, among different levels of acculturation/language. Helpseeking rates overall and broken down by nativity/language. Barriers to care overall that has been studied, and why we need to study cultural barriers such as stigma."

the U.S., and age of migration. When looking particularly at usage of outpatient services such as psychotherapy, the rate is much lower at only 3.8% (SAMHSA, 2015). Not only are Latinos less likely to use mental health services, but they are also more likely to drop out and do worse in treatment. For example, the rates of usage (i.e., appointments attended) for Spanish speaking Latinos are much lower than their counterparts averaging a total of 22 therapy sessions per year compared to 24 for English speaking Latinos and 26 for Caucasians (Folsom et al., 2007). Accessing informal, limited, or no care may lead Latinos to be ill for longer periods of time (Breslau et al., 2005). This is even more prominent for Spanish speaking Latinos who live with their disorder for an average of 14.6 years compared to 9.4 years for English speaking Latinos (Alegria et al., 2008). In conclusion, when creating programs that address barriers to care, it is indispensable that the material be culturally competent and offered in Spanish in order to address acculturation barriers.

Stigma

Stigma is one of the main barriers to accessing proper mental health care. Goffman (1963) defined stigma as a relationship between stereotype and attribution that is deeply discrediting and thus reduces the person. More recently, scholars separated mental illness stigma into self-stigma (i.e., stigma imposed on the self), public stigma (i.e., stigma imposed by others), and structural stigma (i.e., stigma imposed by a system; Corrigan et al., 2004). Furthermore, Tucker and colleagues (2013) proposed to differentiate between mental illness stigma and therapy stigma given that they influence help-seeking behaviors differently. Public mental illness stigma is defined as stereotyping, prejudice, discrimination, and segregation toward mentally ill individuals. However, mentally ill consumers vs. mental ill non-consumers experience different rates of public stigma, such that therapy goers are more likely to be discriminated and stereotyped (Tucker et al., 2013). Therefore, therapy stigma is defined as stereotypes toward mental illness treatment as well as stereotypes, prejudice, and discrimination toward its consumers (Tucker et al., 2013). Unfortunately, those who are in most need and have more severe mental illnesses also display higher rates of mental illness stigma (Dubreucq et al., 2021). Higher rates of mental illness self-stigma can then lead to higher endorsement of therapy stigma (Conner et al., 2010), lower help-seeking rates (Dubreucq et al., 2021), lower compliance (Shrivastava et al., 2012) and lower attrition (Wade et al., 2011). However, lowering mental illness stigma does not always lead to a reduction in stigma toward treatment thus highlighting the need to simultaneously address both for the greatest potential in changing help-seeking intentions.

Stigma in Latinos

Both mental illness and therapy stigma are consistently identified as a major barrier to MHS and is especially pervasive in the Latino population. In fact, Latinos ($N=1039$) have been found to endorse significantly higher levels of stigma than their White counterparts ($N=2069$) on 10/14 items (Wong et al., 2018). For example, Latinos were more likely to believe that a person with mental illness (PWMI) is a danger to others and will not contribute much to society ($p < 0.001$). This public stigma was

correlated to a decrease in intentions to seek help if they ever did encounter an emotional problem.

In another study of Spanish speaking Latinos ($N=200$), participants who were currently in psychotherapy ($n=128$) endorsed the lowest levels of therapy stigma (4.2%), but low adherence and attrition was still attributed to high rates of therapy stigma (Vega et al., 2010). On the other hands, Latinos who were previously in treatment, but no longer enrolled ($n=72$), were the most likely to *not* seek treatment due to therapy stigma (17.7%). They also were significantly more likely to subscribe to public stigma such as believing that a person with depression is not trust worthy (42.7% vs. 33.3%). This finding may be because these patients may have had a negative therapy experience. They also found that those with higher stigma were significantly less likely ($p<.05$) to tell their friends and family members about their diagnosis, thus preventing them from getting any mental health support from loved ones. Finally, participants who subscribed to self-stigma were less likely to seek treatment for their depression, thus indicating that self-stigma acts as a barrier to care in Spanish speaking Latinos. Similarly, in a sample of depressed low-income, Spanish-speaking Latino immigrants, 83% endorsed at least one mental health or therapy stigma such as fearing disclosing going to therapy for fear of judgement or disapproval (Collado et al., 2019).

Language and acculturation affect the rates of mental illness stigma and therapy stigma distinctly. Wong and colleagues (2017) assessed stigma rates across different ethnicities which included 156 English speaking Latinos and 103 Spanish speaking Latinos from California. Results indicated that Spanish speaking Latinos (39%) were significantly more likely to believe that people with mental illness will never contribute much to society compared to Whites (5%) and English Speaking Latinos (5%; $p<0.0001$; Wong et al., 2017). However, when compared to other racial groups, Spanish speaking participants were the least likely to hide their mental health problems (30%) while English speaking Latino participants were the most likely to conceal their mental health problems (87%; Wong et al., 2017). This may be because English speaking participants endorse higher rates of self-stigma given that they are significantly more likely to feel embarrassed about having a mental health problem compared to Spanish-speaking Latinos (52% vs. 22%; Wong et al., 2017). Similarly, Spanish speaking Latinos also hold the least therapy stigma since 100% of the participants would be willing to go to a professional if they had a serious emotional problem. They additionally are the least affected by public stigma such that 98% would not put off seeking treatment for fear of others knowing. Nevertheless, Spanish speaking Latinos who had faced serious distress were the least likely to recognize that they had mental health issues (18%). On the other hand, English speaking Latinos who experienced serious distress were the most likely to recognize their issues (67%). This discrepancy between willingness and need may be due to a faulty definition of mental health problems that qualify for professional help.

Lack of information has created many culture-specific stigmatized views for Latinos. For example, a stereotype that acts as a barrier and is pervasive with Latinos is the notion that they cannot trust mental health professionals. Because Latinos value privacy and *familismo*, they may be reluctant to share their mental health struggles with anyone outside their family, including mental health professionals. Low willingness to disclose has consistently acted as a barrier to seeking treatment (Rüsch et al., 2011). A

lack of trust may also come from perceived discrimination. Moreover, Latinos are the most likely to define discrimination and prejudice as a barrier compared to all other racial groups (SAMHSA, 2015). This may be because they are unaware of how to find culturally competent therapists, which can lead them to stereotype all therapists as culturally incompetent.

Furthermore, paperwork may be anxiety inducing for undocumented individuals (Cardemil et al., 2006; Shattell et al., 2008). In particular, undocumented individuals believed that mental health records can be used against them in legal processes such as immigration trials (Rastogi et al., 2012). Other believed that their undocumented status prohibited from using therapy services. Therefore, the lack of education about confidentiality protocols can keep Latinos from receiving MHS.

The stigma that Latino women and men subscribe to and face may vary due to cultural bound gender roles. For example, women may face additional stigma if they are unable to fulfill their familial role, while males hide their mental illnesses out of fear of losing status or job (Mascayano et al., 2016). Furthermore, Latino males are more likely to have stigma toward both mental illness and therapy than their female counterparts due to *Machismo*, which may lead males to believe that they do not need these services (Corrigan et al., 2017; Vega et al., 2010).

Innovation

Public Stigma Interventions

Stigma interventions have increased in the past years to reduce its destructive effects. However, evidence-based stigma interventions have not been tailored for Latinos, thus raising the need to create a new intervention that addresses the specific needs of this at-risk group.

Corrigan & O'Shaughnessy (2007) identified three approaches to aid in eradicating public stigma of mental disorders and its treatment: protest, education, and contact. Protest consists of demanding accurate portrayal of therapy and its consumers in the media in order to reduce negative stereotypes. Education allows for individuals of the public to learn about mental illness in order to challenge the stereotypes. Finally, contact or interaction with a person with a mental health disorder can also decrease stigma. In fact, Corrigan and colleagues (2001; 2012) found contact to be the most significantly successful in changing stigma toward severe mentally ill individuals. This thesis will exclude protest and only compare education to contact given that it is a personal intervention as opposed to a societal intervention.

In Our Own Voice. One empirically studied stigma program titled In Our Own Voice (IOOV), was created by the National Alliance on Mental Illness (NAMI). This program is a contact stigma intervention that attempts to “open minds, change attitudes, and educate the public about what it means to have a mental illness,” while giving more confidence to the presenter themselves who are two trained consumers suffering from mental illness (Wood and Wahl, 2006). It achieves these goals through a video of consumers speaking on the categories of: “Dark Days,” “Acceptance,” “Treatment,” “Coping Strategies,” and “Success/Hopes/Dreams.” Due to the far reach of NAMI, as of 2012, IOOV was available in 44 states across NAMI locations and has trained more than

8,000 presenters who have presented to more than 300,000 audience members who are either consumers (i.e., mentally ill individuals), care-takers, or non-consumers (Pandya, 2012).

Corrigan and Gelb (2006) explained three components that could account for the success of IOOV: contact, qualification, and content. Throughout the presentation and in a final Q&A, audience members are encouraged to interact with the presenters allowing them to have more direct contact with a person suffering from mental illness. Furthermore, the presenter themselves are qualified to talk about the topic as they have been diagnosed, gone through treatment, and are trained to present their life story. Finally, the content focuses on recovery, which can provide hope and help eradicate stigma.

Wood and Wahl (2006) were the first researchers to empirically study NAMI's IOOV program on 114 undergraduate college students. Participants were either assigned to participate in IOOV or a control constituent which consisted of watching a video on careers in psychology. Results indicated that the 90-minute IOOV significantly decreased stigma as defined by social distancing ($F(1,112) = 32.30, p < .01$), increased knowledge ($F(1,112) = 27.71, p < .01$), and changed attitudes ($F(1,112) = 10.56, p < .01$). However, Corrigan and colleagues (2010) found that a 30-minute rendition of IOOV was even more efficient than the 90-minute intervention with 200 college students ($F(2,181) = 10.61, p < .001$). Furthermore, Corrigan and colleagues (2010) compared both IOOV conditions to an educational presentation regarding stereotypes and their corresponding facts. Results indicated that the education intervention was the least successful in combatting negative stereotypes compared to both IOOV conditions given that they remembered the most negative statements ($F(2,181) = 13.1, p < .001$). Finally, although only 20% of the participants were non-White participants (i.e., Asian (8.2%), Black (8.2%), Hispanic (10.5%)), results indicated a significant difference ($p < .05$) between White and non-White participants, thus outlining the need to culturally adapt contact stigma interventions.

Rusch and colleagues (2008) studied the impact of the IOOV indirect contact video on stigma compared to psychoeducation on 43 abnormal psychology students with a focus on bipolar disorder. The psychoeducation component consisted of a 50-minute presentation by an expert on bipolar disorder. Results indicated that IOOV significantly reduced stigma of bipolar disorder ($F(1, 37) = 41.822, p = .006$), depression ($F(1, 37) = 9.197, p = .004$), and mental illness in general ($F(1, 37) = 7.750, p = .008$), compared to psychoeducation. However, when the IOOV video was presented subsequently to psychoeducation, stigma actually increased. Therefore, indirect-contact was more effective in decreasing stigma if it is done so alone or prior to education. The authors hypothesized that the poor performance of the psychoeducation is that it emphasized biological causes, which has led to an increase in stigmatized views such as an increase in perceived dangerousness (Walker & Read, 2002), as well as perceived incurability (Lam et al., 2005). Therefore, if psychoeducation is used as a comparable condition, it must not solely focus on biological causes and it should be presented after the contact intervention.

Although NAMI's IOOV has many benefits and has shown to cause significant change across stigma and attitudes, it also has many limitations. For one, IOOV is only offered at NAMI local affiliates in 47 states. Although these locations reach many cities, there is a vast majority of individuals who live nowhere near a NAMI location.

Furthermore, individuals who attend the program are most likely consumers of NAMI already, who are a self-selected group that want to learn more about mental health and its treatment. Therefore, the accessibility and reachability of the program is fairly limited. Moreover, many empirically published studies on IOOV were done with a majority White sample and with White presenters (Wood & Wahl, 2006; Rusch et al., 2008), thus failing to conclude the efficacy of IOOV on diverse populations. In addition, the intervention fails to acknowledge the impact of culture on stigma, mental health attitudes, and recovery. Finally, although IOOV is offered in Spanish, no research has been published on the efficacy of the translated version.

Stigma Interventions for Latinos

Few studies have culturally adapted stigma interventions specifically for Latinos, and even less have used contact as an intervention method. For example, Caplan and colleagues (2015) developed a Spanish, religious-based mental health literacy program (*El Buen Consejo*) for Caribbean Latinos through a community-participatory research approach which included clergy members and lay leaders of the church ($n=64$). They culturally adapted the program by including Caribbean-based values (i.e., *respeto, dignidad, confianza, and familismo*). Additionally, religion was used to explain therapy and mental illness (i.e., God and mental health professionals work in tandem to cure mental illness). Alongside *El Buen Consejo*, the video of IOOV was shown to the group. However, Caplan and colleagues did not measure the efficacy of *El Buen Consejo*. Although the IOOV video was deemed “powerful” by the participants, no statistical data was gathered on the effectiveness of the Spanish IOOV video in particular. Furthermore, this intervention only addresses public and not therapy stigma, which may remain a barrier. Finally, about $\frac{3}{4}$ of the participants who aided in the development of this intervention were female and only spoke Spanish. Therefore, some of the elements that were deemed important components of the stigma intervention may only apply to females or less acculturated individuals and cannot be generalized to the Latino population in the U.S.

In another culturally adapted intervention, Cabassa and colleagues (2012) developed a *fotonovela* or photo comic to address depression literacy, attitudes toward depression care and depression stigma in both Spanish and English. In particular, it addressed the three factors of attitudes toward care which included: a) knowledge of symptoms b) understanding how to use services, and c) evaluation of treatment. Although the *fotonovela* is fiction, it depicted the real-life experiences of a depressed Latina seeking treatment. For example, it outlined that depression can be treated, is real, and is common (normalcy). Additionally, the *fotonovela* included the main character receiving guidance and validation from loved ones on seeking treatment for her depression in order to provide examples of how to help a loved one who is suffering with mental illness.

Unger and colleagues (2013) tested the efficacy of the *fotonovela* on 157 Latino participants who were predominately immigrants (84 %) and Spanish speakers (66 %). Compared to an informational pamphlet on depression (education; $t = 1.45, ns$), the *fotonovela* reduced treatment stigma ($t = 2.01, p < .05$) significantly more immediately after the intervention. Additionally, the knowledge gained immediately after reading the *fotonovela* was greater than prior to reading the pamphlet. The authors

concluded that the *fotonovela* is effective because it is a popular Hispanic media that requires low literacy rates and is captivating because it is a dramatic story with attractive characters as well as vivid pictures. Because the *fotonovela* is an example of a fictitious contact intervention, it may not have as strong of an effect as a contact intervention that depicts a real person. Another intervention is that it is depression centered. On other hand, an in-person intervention would allow for multiple consumers with different diagnosis to present.

Approach

Development of ACCEPTAR Intervention.

To fulfill the first aim of the study, I developed the ACCEPTAR intervention which stands for Addressing and Combating Ethnic-Based Public Stigma Through Anecdotes on Recovery or *Acertando y Combatiendo El Estigma Publico a Través de Anécdotas de Recuperación*. *Acceptar* means acceptance in Spanish, which plays a major role in addressing mental health and stigma. ACCEPTAR is an interpersonal contact stigma intervention where a consumer provides education about mental illness and its treatment and also shares their mental health and treatment journey in the hopes of reducing mental illness and therapy stigma, and increasing the likelihood of help-seeking among those who participate in the program. Two steps were used to develop ACCEPTAR. First, previous interventions on stigma and barriers to care for the general population as well as Latinos were reviewed. Next, models for creating culturally competent interventions for Latinos were examined.

Previous Stigma Interventions. Unfortunately, few studies have examined contact interventions specifically on Latinos even though it is the most successful intervention in reducing stigma for the general population (Thornicroft et al., 2016). Wong and colleagues (2018) conducted a meta-analysis review of contact stigma interventions and compared their efficacy across participant race. When analyzing results for Latinos across all contact stigma studies ($N = 1039$), they found that contact interventions significantly reduced stigma and even had greater improvements than Whites on beliefs about dangerousness ($\beta = 0.14$; $SE = 0.04$), social distance ($\beta = -0.12$; $SE = 0.02$), and socialization ($\beta = -0.09$; $SE = 0.02$). Furthermore, Latinos reported significantly greater increases in intentions to seek treatment ($\beta = -0.09$; $SE = 0.02$) compared to Whites. Because of the efficacy of contact on Latinos, the ACCEPTAR stigma intervention allows participants to interact with PWMI who has attended therapy.

THE ACCEPTAR intervention contains two aspects of contact intervention (i.e., normalcy and hope), which have been found to help improve stigma intervention effectiveness (Corrigan et al., 2016). Normalcy is used to convey similarities between the consumer (presenter) and non-consumer (audience member), which helps foster emotional closeness and normalizes shared experiences between participants and the PWMI presenter. Similar to the IOOV intervention, this is accomplished by the presenter sharing their current position (i.e., student, full-time employee, etc.), hopes, and dreams. Presenters will directly speak about ways in which therapy aided their healing journey to tackle stereotypes of incurability and promote hope. Finally, presenters will share their hopes for the audience in this shared responsibility to tackling stereotypes and discrimination, which is another evidence-based method of combating stigma (Corrigan et al., 2012).

Ensuring Cultural Effectiveness. In addition to normalcy and hope, previous research on curating interventions specifically for Latinos guided the creation of ACCEPTAR. Recent meta-analyses indicated that culturally adapted mental health interventions tend to be more efficacious than unadapted interventions when assessing culturally-diverse individuals (Hall, et al., 2016; Smith & Trimble, 2016). Although few

to no research has compared a culturally adaptive stigma intervention to a non-adapted intervention, Latinos suffer from cultural-bound mental illness and stigmatized beliefs making it necessary to ensure the cultural competence of ACCEPTAR. To do so, Bernal and colleagues (1995) model for culturally adapting clinical interventions was applied during the development of ACCEPTAR. In particular, they recommend 8 components to culturally adapting clinical interventions for Latinos including a) language, b) persons, c) metaphors and idioms, d) content, e) concepts, f) goals, g) methods and h) context. Table 1 describes examples of how each component was integrated into ACCEPTAR while also taking into consideration the cultural stigmas previously stated.

Table 1
Culturally Adapting Stigma Intervention for Latinos

	Description	Example
1. Language	Content is presented in preferred language	Presentation in Spanish
2. Persons	Presenter has similar characteristics to audience	Latino presenter
3. Metaphors and Idioms	Cultural language	Use of <i>dichos</i>
4. Content	Content based on cultural values and traditions	Cultural coping mechanisms (I.e., religion and family)
5. Concepts	Defining concepts through cultural comparisons	Describing therapy through confession and <i>desahogo</i>
6. Goals	Outcomes based on cultural needs and priorities	Goal based on familism and collectivism (I.e., supporting one another)
7. Methods	Intervention methods based on cultural tradition.	Cultural reframing (I.e., externalizing rather than internalizing diagnosis)
8. Context	Consider social context	Demographics considered in analysis

Note. Based on Bernal et al. (1995).

Structure. The ACCEPTAR intervention consists of a Bilingual Latino consumer of therapy relaying their mental health and treatment journey via a series of videos to ensure its widespread accessibility. In particular, they will answer a series of 6 questions (Table 2) which were adapted from the sections of IOOV (I.e., “Dark Days” and “Treatment”), but also include additional questions regarding barriers, culture, and stigma.

For the purpose of the proposed experiment, there will be only one presenter who will answer two questions at a time in three 5-minute segments to ensure attentiveness. They will answer a total of 6 questions over the span of 3, 5-minute videos. In the first 5-minute video, they will answer questions 1 and 2 describing their mental health issues and darkest moments. In the second video, they will answer questions 3 and 4 regarding barriers and stigma. In the final video, they will answer questions 5 and 6, which focus on their therapy experience.

Table 2
Guided Questions for intervention

-
1. What types of mental health issues do you struggle with and at what point did you realize you needed help?
 2. What was one of the darkest moments in your mental health journey?
 3. What barriers did you face in getting help and how did you overcome them? What role did your culture play in these barriers?
 4. How did stigma impact your mental health journey and how did you overcome it?
 5. What was it like getting help?
 6. What about therapy was the most helpful?
-

Participants.

Research participants that will take part of the interventions will include 324 Latino adults (162 females, 162 males), between the ages of 18-65 years old ($M=42$, $SD=5$). Majority of respondents will identify as ethnically Mexican (61%), followed by Puerto Rican (10%), Cuban (4%), or Salvadoran (4%). Additionally, the majority will identify as single race Latino (95%), and that 5% will identify as being two or more races (i.e., White and Latino, Black and Latino, Asian and Latino, etc.). Participants will be predominately U.S. born citizens (68%). Finally, about half will take the Spanish survey while the remaining will take the survey in English. Those who do not identify as Latino and are currently residing outside of the U.S. will be excluded from the study. Finally, a majority of participants will reside in LA County given that in-person recruitment will take place in this area.

Recruitment. To recruit a diverse Latino sample across the U.S, the study will be carried in an online survey platform that is mobile friendly. An English and Spanish flyer with a QR code linking to survey will be created and disseminated both online and in person. The flyer and link will be posted on Latino social media groups such as LinkedIn's [Latino Professionals for America group](#) with over 30k members and general participant recruiting groups such as Reddit's [r/samplesize](#) group with over 100k members. In addition, the flyer will be sent to leaders, organizations, and institutions within the Latino community (i.e., schools, churches, Latin American consulates) for dissemination. To establish a relationship and trust with these communities, the research team will personally hand out flyers and announce the research opportunity at events in Los Angeles County including parent-teacher meetings, after religious ceremonies, etc. When recruiting, there will be an emphasis on benefits such as pay. In order to ensure the

Commented [WH4]: Patient about what you would expect your numbers to break out these various ways. For example, consistent to the census numbers for the Los Angeles area, we expect that...

Commented [ASSR4]: If I am not collecting information on their location, is it still worth mentioning here?

completion of the survey and avoid technical difficulties, the research team will also be hosting several survey sessions across LA County with laptops at school computer labs, outside religious buildings, etc. Recruitment will happen over a 1-month period.

Measures

All measures that will be used in the study as well as when they will be used can be found on table 3. Most proposed measures have Spanish translations that have been validated by previous researchers. Measures that have not been translated will be translated and back translated by two bilingual clinicians as is the gold standard for translation when working with Latinos (Marín & Marín, 1991). The back-translated and original English versions will then be checked for similarities.

Commented [WH6]: Statement on when measures will be given and what time points.

Table 3
Materials

Measure	T1	T2	T3	Spanish Translation
Screening questions	X			Translated and back-translated by bilingual clinicians
Informed Consent Form	X		X	Translated and back-translated by bilingual clinicians
Demographics	X			Translated and back-translated by bilingual clinicians
ATSPPH-SF (Fischer & Farina, 1995)	X	X	X	Torres et al., 2020
SSOSH-T (Owen et al., 2013).	X	X	X	Larrahondo et al., 2021
BTMI (Hirai & Clum, 2000)	X	X	X	Hirai et al., 2021
MHSQ	X	X	X	Translated and back-translated by bilingual clinicians
ISCI (Cash et al., 1975)	X	X	X	(Kuo et al., 2015).
VIA (Ryder et al, 2000)	X			Translated and back-translated by bilingual clinicians
PHQ-9 (Kroenke et al., 2001)	X	X	X	Torres et al., 2020
Debrief Person		X	X	Translated and back-translated by bilingual clinicians

Note. ATSPPH-SF: Attitudes Toward Seeking Psychological Professional Help Assessment- Short Form, Self-Stigma of Seeking Help Scale, SSOSH-T: Self-Stigma of Seeking Help Scale, BTMI: Beliefs Toward Mental Illness MHSQ: Mental Health Services Questionnaire, ISCI: Intention to Seek Counseling Inventory, VIA: Vancouver Index of Acculturation, PHQ-9: Patient Health Questionnaire- 9

Screening Questions. For the purpose of the present study, all participants must identify as Latina/o/x or Hispanic and live in the United States given that therapy access varies across countries and may therefore not be effective in other Latin American countries. Therefore, participants will first answer screening questions regarding their identification as Latina/o/x or Hispanic, and residence in the U.S. (Appendix A).

Demographics. Demographic information will be collected on age, gender, race, ethnic background, years in the U.S., place of birth, educational level, and insurance status.

Self-Stigma of Seeking Help Scale- Therapy (SSOSH-T). The SSOH-T (Appendix E) was adapted from the SSOH in order to assess stigma specifically associated with seeking treatment (Owen et al., 2013). In the present study, the measure will be used to assess the dependent variable of therapy stigma at pre-, post-, and follow-up. It is an 11-item questionnaire that is separated into two parts. Part one asks general

questions about therapy such as “Going to therapy is a sign of personal weakness.” Part 2 asks about participants about their decision to go to therapy such as “My decision to go to therapy has made me feel inadequate.” These questions are measured on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The total score ranges from 5-50 with higher scores indicating higher levels of stigma. The SSOSH-T has a Cronbach alpha of .89, indicating good reliability. Because not all participants in the present study have previously sought treatment, the questions were adapted for individuals who have not gone to therapy (i.e., “Going to therapy would make me feel inadequate”). The SSOSH-T has not been validated in Spanish. However, the Spanish version of the SSOSH, which the SSOSH-T was adapted from, has a Cronbach’s alpha of .80 in a Colombian sample (Larrahondo et al., 2021).

The Beliefs Toward Mental Illness Scale (BTMI). In the present study, the BTMI will be used as the primary assessment for dependent variable of mental illness stigma at pre-, post-, and follow-up. The BTMI (Appendix F) is a 21-item scale that measures both public and personal stigma on four factors: dangerousness, social dysfunction, incurability, and embarrassment (Hirai & Clum, 2000). It includes 4 statements assessing dangerousness (i.e., “A mentally ill person is more likely to harm others than a normal person.”), 7 statements regarding social dysfunction (i.e., “I would not trust the work of a mentally ill person assigned to my work team.”), 6 statements about incurability (i.e., “I do not believe that psychological disorders are ever completely cured.”), and 4 statements on embarrassment (i.e., “I would be embarrassed if a person in my family became mentally ill.”). They are rated on a 6-point Likert scale ranging from 0 (*completely disagree*) to 5 (*completely agree*). The overall scale showed an alpha coefficient of .91. The subscales had alpha coefficients of .75 for dangerousness, .84 for social dysfunction, and .82 for incurability (Hirai & Clum, 2000). Hirai and colleagues (2021) were the first to translate and validate a Spanish scale of the BTMI also known as the Spanish-BTMI (S-BMTI). The S-BTMI showed comparable alpha coefficients to the English version: Dangerousness/*Peligrosidad*: .85; Social Dysfunction/*Disfunción Social*: 0.89; Incurability/*Incurabilidad*: 0.87; Embarrassment/*Vergüenza*: 0.82. Additionally, the BTMI showed good-excellent test-retest reliability (.87-.90).

Attitudes Toward Seeking Psychological Professional Help Assessment-Short Form (ATSPPH-SF). The ATSPPH-SF will be a secondary measure to get more insight on participant’s attitudes toward therapy at T1, T2 and T3 (Fischer & Farina, 1995; Appendix D). Participants rate 10 statements on a 0-3 Likert scale with 0 being “Disagree” and 3 being “Agree.” It includes statements such as “Personal and emotional troubles, like many things, tend to work out by themselves,” and “I would want to get psychological help if I were worried or upset for a long period of time.” Questions 2, 4, 8, and 9 were reverse coded and all points were added for a score range of 0-30. Higher scores indicated more positive attitudes toward seeking professional mental health help. A recent study (Torres et al., 2020) was the first to assess the reliability of the ATSPPH-SF on 437 Latino adults in both Spanish and English. Both Spanish and English forms had a Cronbach’s alpha of .70. Although the test showed an acceptable reliability, Torres and colleagues (2020) found that item 7, “A person with an emotional problem is not

likely to solve it alone; they are likely to solve it with professional help,” had low reliability, and was therefore taken out in the Openness to Seeking Treatment questionnaire created by Torres and colleagues (2020). Furthermore, the ATSPPH-SF had a Cronbach’s alpha of .78 with a Mexican-American college sample (Miville & Constantine, 2006) and .81 with Latina undergraduate students (Gloria et al., 2010). Some changes were made in accordance to recent recommendations. For example, “his or her” and “he or she” was changed to “their” and “they” to encompass all gender expressions in accordance to the most recent APA guidelines (2019). In addition, “psychologist” was changed to mental health therapist to directly assess therapy stigma and education.

Mental Health Services Questionnaire (MHSQ). Next, participants will answer questions regarding MHS, which was developed for the present study (Appendix G). First, participants’ perceived need will be assessed by inquiring if they ever *felt* the need to seek professional help for their emotions, nerves, mental health, or substance use. Then, participants will answer if they have seen a professional in the last 12-months for. Next, they will indicate who they had received their mental health treatment from a list of services from mental health specialists (i.e., psychiatrist, psychologists, etc.) and non-mental health specialists (i.e., primary care providers, religious leaders, etc.). In addition, participants will rate on a 5-point Likert scale how likely they are to use therapy within the coming month with higher scores indicating greater chances of utilization.

The Intention to Seek Counseling Inventory (ISCI). The ISCI be used to measure for the dependent variable of intention for help seeking given that it assesses participant’s willingness to seek *therapy* for specific issues (Appendix H). It asks participants the likelihood of seeking counseling on a 4-point Likert scale for 17 issues regarding interpersonal problems, drug/alcohol problems, and academic/work problems (Cash et al., 1975). Responses vary from 1 (*very unlikely*) to 4 (*very*) making the score range 17-68 with higher scores indicating higher intentions of seeking help. However, because the proposed study has a focus on MDD, it will only use the interpersonal problems subscale. Examples of items in the interpersonal problems subscale include depression, loneliness, and difficulty with friends. When tested on 723 university students, the ISCI had an excellent- acceptable reliability for intentions to seeking help for all three of its subscales including interpersonal problems (0.90), drug/alcohol problems (0.86), and academic problems (Cepeda-Benito & Short, 1998). In Spanish, the overall inventory had excellent internal consistency ($\alpha=0.94$) when tested on Latin American immigrants residing in Canada (Kuo et al., 2015).

Patient Health Questionnaire-9 (PHQ-9). The PHQ-9 (Appendix I) is widely used self-assessment scale for Major Depressive Disorder (MDD) in accordance to the DSM-IV (Kroenke et al., 2001). In the proposed study, it will be used to measure the participants’ depression severity given that the presenter will have a diagnosis of depression. It assesses the frequency of 9 symptoms over the last two weeks on a four-point Likert scale ranging from 0-3 where 0 is *never* and 3 is *most days*. The symptoms include a depressed mood, feelings of guilt or worthlessness, and suicidal ideation. In

English, it has a cutoff score of 10 with scores of 10–14 points indicating moderate severity, 15–19 points indicating moderately severity, and 20–27 points indicating severe depression. A 10-point cutoff has a sensitivity reliability of 0.88 and specificity reliability of 0.88 (Kroenke et al., 2001). Muñoz-Navarro and colleagues (2017) assessed the reliability of the Spanish PHQ-9 (Appendix H) on 178 Spaniard participants from a variety of primary care providers across Spain. With a 10-point cutoff, the Spanish PHQ-9 had a sensitivity reliability of 0.95, a specificity reliability of 0.67 and overall reliability of 0.89. The English PHQ-9 has an internal consistency of 0.80 when assessed on Latinos in the U.S. ($n=974$; Huang et al. 2006).

Vancouver Index of Acculturation (VIA). The VIA (Appendix J) is a bi-dimensional assessment that assess both acquisition of host cultural norms (acculturation) and preservation of heritage cultural norms through 20 items (Ryder et al, 2000). It is rated on a 1 (*strongly disagree*) to 9 (*strongly agree*) Likert scale where 10 items are about the host (American U.S. culture) and 10 items about their own heritage. Participants are first asked to identify their heritage. Then, participants rate items such as “I often participate in my heritage cultural traditions,” and “I believe in mainstream American values.” The original scale uses “North American” to define the host culture, but was changed to “American” in the present study as the U.S. is the host culture for all participants. Furthermore, when referring to a person, “North American” was changed to White American. The original scale, which was tested on individuals of Chinese descent had an internal consistency of .75 for the mainstream subscale and .79 for the heritage subscale. In a study of 142 Christian Hispanics, the VIA heritage scale had Cronbach’s alpha of .88 for the heritage subscale and .90 for the mainstream scale. (Santos & Kalibatseva, 2019).

Design

For the primary design, a 3 x 2 between-subjects factorial design will be used with the independent variables of time (pre-, post-, or follow-up) and intervention (P or PIC). The primary dependent variables measured at T1, T2, and T3 will be mental health stigma using the SSOH-T, therapy stigma using the BTMI scale and help-seeking intention using the ISCI. Additionally, I will control for the depression severity using the PHQ-9 and survey language (English or Spanish).

Procedure

ACCEPTAR Manual. First, the principal investigator will create the training manual in English. ACCEPTAR’s training manual will be adapted from IOOV’s 75-page training manual. The manual will start off with general information on the purpose and philosophy of ACCEPTAR, benefits of becoming a trained presenter, and objectives of the training. Subsequently, the manual will list general rules and tips on sharing one’s stories such as the use of “I” statements and not sharing information that is still triggering to the presenter. Then, the manual will include 6 separate sections dedicated to each of the 6 ACCEPTAR questions (table 2) outlining a) the purpose of the question b) structure, c) target messages and d) follow-up questions and e) tips on integrating culture. Once finalized in English, it will be reviewed by several clinicians who specialize on stigma

interventions. Subsequently, it will be translated into English by one clinician and back-translated into Spanish by another clinician.

ACEPTAR Presenter Recruitment. Next, a bilingual Latino consumer of therapy will be recruited via online advertising 12 weeks prior to the initial data recruitment date in accordance to IOOV training (NAMI, 2013). Screening requirements will be adapted from IOOV's. The presenter must be: a) a Latino adult (18+) residing in the U.S. who has lived with significant mental health issues and has attended therapy as a part their recovery journey, b) able and willing to describe how therapy contributed to their mental health recovery, c) prepared to share their mental health journey clearly and without fear, d) disposed to making their name, image, and personal story public to a variety of Latinos across the U.S. including potential acquaintances. For the proposed study, a consumer diagnosed with MDD will be chosen given that it is the most common mental illness amongst Latinos (Alegria et al., 2008).

Recruitment of the presenter will span over a 2-week period. A flyer will be created outlining a description of ACCEPTER and the proposed study, the role of presenter, and presenter requirements. The flyer will be disseminated on Latino and therapy social media groups such as Reddit's [r/therapy](#) with over 91k members.

Those interested will have an initial interview with the primary investigator to confirm adherence of the previously stated screening requirements as well as assess language, vulnerability, and story-telling abilities. After a two-week period, the research team will choose one female and one male primary consumer based on their success of the interview and similarities to reduce confounding variables. They will resemble each other in age, occupational field, diagnosis, and story. Ideally, the consumers will exemplify resilience, charisma, relatability, and self-awareness. Back-up presenters will be kept on file.

Creating ACEPTAR Content. Then, the presenter will receive the training manual as well one verbal training session from the primary investigator that will go over the entire manual and allow for questions. Next, the presenter will create an English script that answers all questions on table 2 and follows all the training's guideline. Once written and reviewed in English, the script will be reviewed by the research team for adherence to the training manual. After it is finalized, the script will be translated and back-translated by the previously mentioned clinicians.

Finally, the script will be filmed into 3 separate 5-minute videos. In particular, the first 5-minute video will answer questions 1 and 2 (table 2) regarding the presenter's overview of mental health issues and realization of needing professional help. In the second 5-minute video, the presenter will answer questions 3 and 4 regarding the barriers they faced to receiving help and the impact that stigma has played in their treatment. Finally, the third 5-minute video will answer questions 5 and 6 regarding their experience in receiving therapy and the most helpful aspect of therapy.

Psychoeducation Condition. To experimentally assess the efficacy of the newly developed ACEPTAR contact intervention, it will be tested against a non-culturally adapted psychoeducation condition. The experiment will use three educational brochures

from the National Institute of Mental Health (NIMH) that are readily available in both English and Spanish, but has not been curated specifically to Latinos. The three brochures were chosen to relay information on the same topics that would be relayed in an ACCEPTAR intervention excluding culturally based information. The first brochure is titled “My Mental Health: Do I Need Help?” which includes a review of general mental health symptoms, self-care tips, and professional health options along with a link of mental health resources. This brochure educates reader on a broad range of symptoms and formal MHS. The second brochure is titled “Taking Control of Your Mental Health: Tips for Talking with Your Health Care Provider” which includes 5 tips on starting a conversation with a PCP regarding mental health. It outlines a potential way of seeking help that is not only common amongst Latinos, but for the general population as well. The final brochure is meant to provide education about the presenter's specific diagnosis. NIMH has over 20 brochures on a variety of diagnosis ranging from Depression to Schizophrenia. Its wide array of options ensures the replicability of this proposed studies across different diagnoses. For this study, participants will be presented with the depression brochure, but sections titled “Brain Stimulation Therapy” and “Medication” will be excluded since the study focuses on therapy as treatment. Fair use of all NIMH materials was ensured.

Study Procedure. First, participants will be asked for language preference (Spanish or English), if they identify as Latina/o/x or Hispanic, and if they live in the U.S. (Appendix A). If participants do not identify as Latino or reside outside of the United States, they will be taken to the debrief page (Appendix K).

Participants then continue the survey in their preferred language. Secondly, they will be presented with a consent form which outlines the study's purpose, risks, benefits, length, voluntary participation, ability to withdraw and the principle researcher's contact information (Appendix B). If participants agree to voluntarily participate in the study and meet the age criteria, they will proceed to take the survey.

The survey initially asks about demographics including gender identity in order to randomly assign equal amounts of genders to either the control (P) or experimental group (PIC). Immediately after the demographics and before the interventions, respondents will answer T1 measures (I.e., ATSPPH-SF, SSOSH-T, MHSQ, ISCI, BTMI, VIA, PHQ-9).

Subsequently, half of the participants will be randomly assigned to either the ACETAR intervention plus educational pamphlets while the other half will only be presented with the educational pamphlets. Those in the experimental group will be randomly assigned to watch either the male or female participant. Immediately after they will be presented with the three NIMH brochures. Those in the control condition will only be presented with the three NIMH brochures.

After the interventions, participants will immediately proceed to answer T2 measures (I.e., ATSPPH-SF, SSOSH-T, MHSQ, ISCI, BTMI, PHQ-9). Finally, participants will be presented with a debrief form which explains the what, why, and how of the study (Appendix K). In addition, it will include mental health resources specifically for Latinos, Spanish speakers, and undocumented individuals as well as the contact information of the principle investigator once more. Participants will then be

asked to input their email for compensation and follow-up purposes. To maintain the data anonymous, email contacts will be kept separate from the collected data.

One week later, participants will be emailed a second survey which includes T3 measures (I.e., ATSPPH-SF, SSOSH-T, MHSQ, ISCI, BTMI, PHQ-9).

Once finalized, they will be presented to the debrief form once more (Appendix K).

Data Analysis

SPSS will be used to analyze all variables. First, descriptive statistics of the sample will be calculated to assess demographics. Next, because previous studies show contradictory results as to what constitutes a barrier to care for Latinos, cross sectional analysis will be calculated for baseline scores of therapy and public stigma to assess which sociodemographic were more likely to subscribe to stigmatized views using t-tests (H1). Then, correlations amongst variables will be calculated to verify ANCOVA assumptions.

As the primary level of analysis, three individual 2-way analysis of covariance (ANCOVA) will be used to determine the efficacy of the intervention by analyzing effects of intervention time point (T1, T2, T3) and intervention condition (PIC or P) on the dependent variables of mental illness stigma, therapy stigma, help seeking intention, while controlling for the factors of depression symptoms and survey language (H2, H3). As secondary analysis, three individual hierarchal regression analyses will be conducted to determine the effect size of time point, intervention, gender, intervention language, depression symptoms, and acculturation on MI stigma, therapy stigma, and help-seeking intentions.

Expected Results

H1: T-tests of T1 scores will indicate that participants in the PIC and P conditions will have comparable mental illness stigma (figure 1), therapy stigma (figure 1), and intentions of help-seeking (figure 2).

Secondary H1: Results from the hierarchal regression analyses of T1 scores will indicate that males, older participants, individuals who took the survey in Spanish, those who meet the MDD cutoff, and those with lower acculturation levels, will have higher rates of mental health stigma and treatment stigma as well as low willingness to seek MHS when compared to their counterparts.

H2: ANCOVA tests will show a significant decrease in MI (figure 1) and therapy stigma (figure 1) and an increase in intentions to seek help (figure 2) for those in the PIC condition, but only indicate an insignificant slight change for those in the P only condition between T1 and T2.

Secondary H2. Hierarchal regression analyses of T1 vs. T2 scores will indicate that PIC participants who have higher acculturation and took the intervention in Spanish will have the highest rates of change in stigma due to the culturally adapted component of the intervention.

Hypothesis 3 (H3). Finally, ANCOVA tests will show no significant changes in T3 scores compared to T2 scores for the PIC intervention. On the other hand, T3 scores for participants in the P only condition will significantly lower compared to T2 scores (figure 1 and 2).

Figure 1
Contact & Education vs. Education on Mental Illness and Therapy Stigma

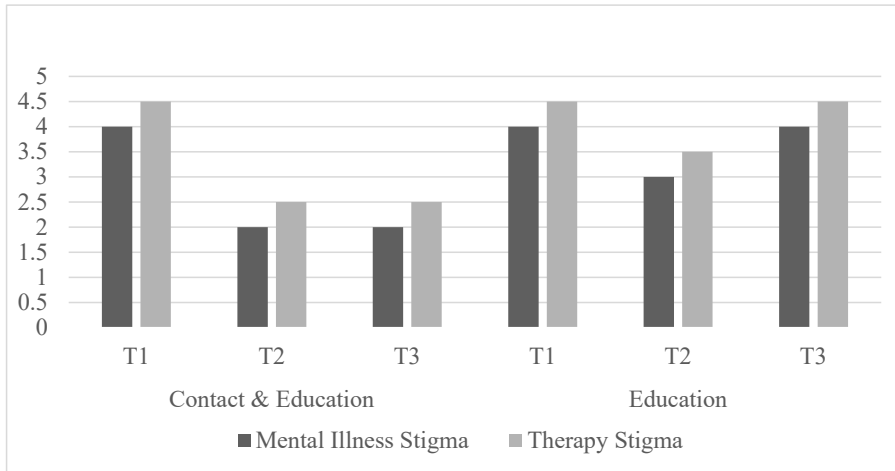
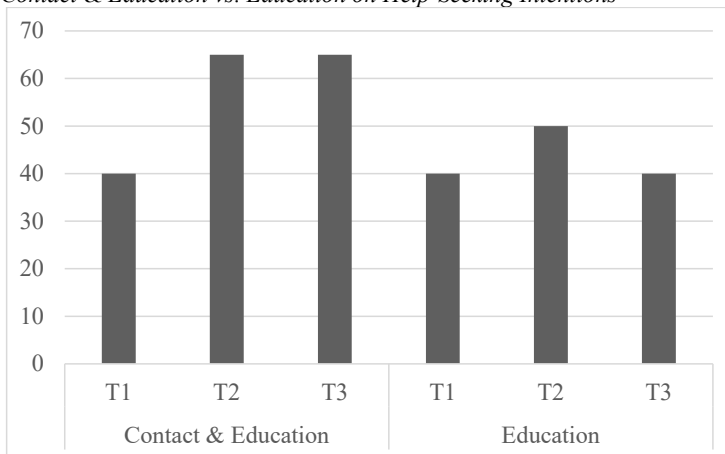


Figure 2
Contact & Education vs. Education on Help-Seeking Intentions



Limitations

While the proposed study aims to address many of the previous literature gaps, there may still be some limitations. First, given that there is a one-week follow up for T3 measures, there may be a large fallout rate that will decrease the overall participants that we can assess. For this reason, we have doubled the required participants to have 0.80 power. Nevertheless, fallout rate can exceed 50%.

Another limitation of the experiment is that it will only assess the efficacy of ACCEPTAR with a depressed consumer. Because depression is the most common mental illness, participants may be more empathetic toward the presenter compared to a presenter with a different diagnosis. For instance, ACCEPTAR may not be as effective at reducing the stigma if the presenter has schizophrenia, which is a much more stigmatized mental illness. To address this limitation, future research should replicate this study with a wide variety of presenters. Because contact interventions are most effective when done face to face (Corrigan et al., 2012), the virtual aspect of ACCEPTAR may also limit its effects. Therefore, future research can compare the effects of a virtual programming vs. an in person programming.

As with any research on Latino populations, we run a risk of generalizing given the diversity of the Latino community. Future research could take into consideration country of origin given that previous research has found varying mental illness, therapy usage, and stigma rates across different Latino ethnicities (Alegria et al., 2008; Keyes et al., 2011). Other factors that were not tested in the present study which can be addressed in future studies include religion, *familismo*, and education level.

Impact and Future Directions

Results from the present study will indicate that the culturally adaptive stigma intervention, ACCEPTAR, will significantly decrease endorsed MI and treatment stigma when compared to the psychoeducational intervention. In particular, because those with lower acculturation levels will show higher rates of stigma at baseline, they will have the highest rate of growth due to the culturally adaptive component of the intervention. The results of the study will highlight the importance of culturally adapting stigma interventions in order to address barriers to care for Latinos. In conclusion, there is hope in closing the treatment gap for Latinos in need if they are given the appropriate attention and content. The future efficacy of the program can encourage institutions to incorporate stigma interventions into their programming to combat prejudice, stereotypes, and discrimination toward treatment and mentally ill individuals.

Stigma not only does it keep Latinos from accessing MHS, but it can also make the services less effective (i.e., more likely to miss appointments; Vega et al., 2010). For example, if they believe others will stereotype them for attending therapy, they will avoid treatment given their collectivistic nature. Therefore, it is imperative to address public stigma of the Latino community as a whole. If ACCEPTAR is successful in erasing stigma, it can increase help-seeking intentions, attrition, adherence, and compliance. As more Latinos seek help and manage to successfully complete therapy, it can lead to lower prevalence rates in the long run.

If it demonstrates efficiency in the proposed study, the intervention may be carried out in trusted locations within Latino communities such as religious sites and schools thanks to ACCEPTAR's replicability. The program can also be led by honorable individuals at these sites such as community health workers, religious leaders, or traditional healers who are consumers of therapy. In conclusion, future studies can test ACCEPTAR synchronously and in the community with numerous diverse presenters and audiences.

Appendix

Appendix A: Screening Questions

The present study is for those who identify as Latina/o/x or Hispanic and are currently residing in the United States

El presente estudio es para quienes se identifican como latina/o/x o hispana y actualmente residen en los Estados Unidos

Do you identify as Latina/o/x or Hispanic?

¿Se identifica como Latina/o/x o hispana/o/x?

Yes/ Si

No/ No

Do you currently live in the United States?

¿Vives actualmente en los Estados Unidos?

Yes/ Si

No/ No

What is your preferred language?

¿Cuál es su idioma preferido?

English/ Ingles

Spanish/ Español

Appendix B: Consent Form

IRB Protocol Number

Informed Consent Form

You are being invited to participate in a research study, which the Claremont McKenna College Institutional Review Board (IRB) has reviewed and approved for conduct by the investigators named here. This form is designed to provide you - as a human subject - with information about this study. You are entitled to a copy of this form. If you have any questions or complaints about the informed consent process of this research study or your rights as a subject, please contact the IRB at the Claremont McKenna College Office of Institutional Research at (909) 607-8395 or IRB@cmc.edu. Also see www.cmc.edu/IRB for more information on research involving human subjects.

Study's Title

Developing and Pilot-Testing the Effects of a Culturally Adapted Stigma Intervention for Latinos

Principle Investigator

Sandy Ahumada
Sahumada21@cmc.edu

Purpose of Study

You are being invited to participate in a research study conducted by a student at Claremont McKenna College. We hope to understand Latinos' attitudes toward mental health treatment before and after being presented with content related to mental health.

Participation in this study will take approximately 30 minutes of your time, and you will receive 0.5 credits toward your Psychology participation requirement, if you are enrolled in a lower-level psychology course at Claremont McKenna College. If you are not enrolled in a psychology course at Claremont McKenna College, you will be compensated \$25.

Participant requirements

Participants must be adults ages 18 or above, identify as Latina/o/x or (I.e., Mexican/Mexican-American, Puerto Rican, Cuban, etc.) and must be residing in the United States

Risks

The present study will ask questions about the participants' own mental health and mentions mental illness, which may be triggering to some. Additionally, the content will include content about mental illness/health.

Anticipated Benefits

Participants will be provided with mental health resources at the end of the survey despite level of completion, which you can also find [HERE](#).

Confidentiality

Your responses to this survey will remain completely anonymous. No information that is obtained during this study can be personally connected to you.

Voluntary Participation

Your participation in this study is voluntary. Your decision of whether or not to participate will not affect your compensation. You are free to withdraw your consent and discontinue participation at any time without penalty.

If you have any questions, please feel free to contact the study's faculty supervisor, Dr. Wei-Chin Hwang (Wei-Chin.Hwang@claremontmckenna.edu) or the study's primary student researcher, Sandy Ahumada (sahumada21@cmc.edu; 323-496-3589).

Consent

I voluntarily agree to partake in this study. I am over 18-years old, identify as Latina/o/x or Hispanic, reside in the U.S. and am consenting to voluntarily participate in this research study having read the information provided above. I understand that I may withdraw from the study at any time without penalty.

Yes

No

Appendix C: Demographics

How do you describe your gender identity?

- Female
- Male
- Non-binary
- Other

What is your age?

With which ethnic/racial groups do you identify? (Select all that apply)

- Asian, Pacific Islander, or Desi
- Black or African American
- Hispanic or Latina/o/x
- Indigenous or Native American
- Middle Eastern or North African
- White
- Mixed Race
- Other

Which of the following best describes your ethnic background? (Select all that Apply)

- I do not identify as Latino/a/x or Hispanic
- Mexican/ Mexican American/ Chicana/a/x
- Puerto Rican
- Cuban
- Salvadoran
- Dominican
- Colombian
- Guatemalan
- Honduran
- Ecuadorian
- Peruvian
- Venezuelan
- Nicaraguan
- Brazilian
- Argentine
- Panamanian
- Chilean
- Costa Rican
- Chilean
- Bolivian
- Uruguayan
- Paraguayan
- Other: _____

Which of the following best describes your generational status?

- First generation: I was born abroad
- Second generation: My parents were born abroad
- Third Generation: My grandparents were born abroad
- Fourth Generation: My great-grandparents were born abroad
- Other

At what age did you immigrate to the United States?

- Age: _____
- I was born in the U.S.

Do you currently have health insurance (i.e., Medicare, Medicaid, employer provided insurance, etc.)?

- Yes
- No

What is your highest level of education?

- Middle School
- High School Diploma or GED
- Some college, but no degree
- Associates degree
- Bachelor degree
- Master's Degree
- Doctoral Degree
- Other

**Appendix D: Attitudes Toward Seeking Psychological Professional Help
Assessment- Short Form (ATSPPH-SF)**

Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

0 = Disagree 1 = Partly disagree 2 = Partly agree 3 = Agree

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

Appendix E: Self-Stigma of Seeking Help Scale-Therapy (SSOSH-T)

1 (strongly disagree) to 5 (strongly agree)

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

Appendix F: The Beliefs Toward Mental Illness Scale (BTMI)

0 (*completely disagree*) to 5 (*completely agree*)

1. A mentally ill person is more likely to harm others than a normal person.
2. Mental disorders would require a much longer period of time to be cured than would other general diseases.
3. It may be a good idea to stay away from people who have psychological disorders because their behavior is dangerous.
4. The term “psychological disorder” makes me feel embarrassed.
5. A person with a psychological disorder should have a job with minor responsibilities.
6. Mentally ill people are more likely to be criminals than non-mentally ill people.
7. Psychological disorders are recurrent.
8. I am afraid of what my boss, friends and others would think if I were diagnosed as having a psychological disorder.
9. Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life.
10. People who have once received psychological treatment are likely to need further treatment in the future.
11. It might be difficult for mentally ill people to follow social rules such as being punctual or keeping promises.
12. I would be embarrassed if people knew that I dated a person who once received psychological treatment
13. I am afraid of people who are suffering from psychological disorders because they may harm me.
14. A person with a psychological disorder is less likely to function well as a parent.
15. I would be embarrassed if a person in my family became mentally ill
16. I do not believe that psychological disorders are ever completely cured
17. Mentally ill people are unlikely to be able to live by themselves because they are unable to assume responsibilities.
18. Most people would not knowingly be friends with a mentally ill person
19. The behavior of people who have psychological disorders is unpredictable
20. Psychological disorders are unlikely to be cured regardless of treatment
21. I would not trust the work of a mentally ill person assigned to my work team

Escala de posturas respecto a los desórdenes mentales

Utilizando esta escala, por favor indique su nivel de acuerdo o desacuerdo con las siguientes afirmaciones escogiendo el número que más se acerca a su postura.

0 = totalmente en desacuerdo, 1 = mayormente en desacuerdo, 2 = un poco en desacuerdo, 3 = un poco de acuerdo, 4 = mayormente de acuerdo, 5 = totalmente de acuerdo

1. Una persona con trastornos mentales tiene más posibilidades que una persona normal de hacerle daño a otras personas.
2. Los trastornos mentales requieren más tiempo para curarse que otras enfermedades.
3. Puede que sea una buena idea alejarse de personas que padecen de trastornos psicológicos porque su comportamiento es peligroso.
4. El término “trastorno psicológico” me hace sentir avergonzado.
5. Una persona que tiene un trastorno psicológico debe tener un trabajo con pocas responsabilidades.
6. Los enfermos mentales tienen más posibilidades de ser criminales que los que no son enfermos mentales.
7. Los trastornos psicológicos son recurrentes.
8. Tengo miedo de lo que mi jefe, amigos u otras personas podrían pensar si soy diagnosticado con un trastorno psicológico.
9. Personas diagnosticadas con una enfermedad mental, padecerán de sus síntomas toda su vida.
10. Es probable que personas que hayan recibido tratamiento psicológico necesiten más tratamiento en el futuro.
11. Puede ser que sea más difícil para enfermos mentales seguir reglas sociales como ser puntuales y cumplir promesas.
12. Me daría vergüenza si la gente supiera que he salido con una persona que recibió tratamiento psicológico.
13. Las personas que padecen de trastornos psicológicos me dan miedo porque podrían hacerme daño.
14. Es poco probable que una persona que tiene un trastorno psicológico funcione bien como padre.
15. Me daría vergüenza si a un miembro de mi familia le diera una enfermedad mental.
16. No creo que los trastornos psicológicos se curen completamente.
17. No es probable que los enfermos mentales vivan solos porque no pueden asumir responsabilidades.
18. La mayoría de la gente no sería amigo a sabiendas de un enfermo mental.
19. El comportamiento de personas con desórdenes psicológicos es impredecible.
20. No es probable que los desórdenes psicológicos se curen independientemente del tratamiento.
21. Desconfiaría del trabajo de un enfermo mental que haya sido asignado a mi equipo de trabajo.

Peligrosidad: 1, 3, 6, & 13

Disfunción Social: 5, 11, 14, 17, 18, 19 & 21

Incurabilidad: 2, 7, 9, 10, 16, & 20

Vergüenza: 4, 8, 12, & 15

Appendix G: Mental Health Services Questionnaire (MHSQ)

Perceived need

Was there ever a time during **the past 12 months** when you *felt* that you might need to see a professional because of problems with your emotions, nerves, mental health, or substance use?

- Yes
- No

Usage

Was there ever a time during **the past 12 months** where you *sought* services for your emotions, nerves, mental health, or substance use from a professional (i.e., therapist, psychiatrist, etc.)

- Yes
- No

Previous Preference

From whom have you sought mental health services from in the past? (Select all that apply)

- Therapist (i.e., Psychologist, Counselor, etc.)
- Psychiatrist
- Social Worker
- Primary Doctor/ General Physician
- Spiritual or Religious Advisor
- Traditional Healers, curandera/o/xs
- Other _____
- I have never sought mental health services

Intention

How likely are you to visit a psychotherapist for mental health problems **in the next month**?

- 1= highly unlikely to 5= highly likely

Future preference

In the future if you were having problems with your emotions, nerves, mental health, or substance uses, which one of the following professionals would you be willing to seek help from?

- Therapist (i.e., Psychologist, Counselor, etc.)
- Psychiatrist
- Social Worker
- Primary Doctor/ General Physician
- Spiritual or Religious Advisor
- Traditional Healers, curandera/o/xs
- Other _____
- I would not be willing to seek mental health services

Appendix H: Intention to Seek Counseling Inventory (ISCI)

1. Weight control
2. Excessive alcohol use
3. Relationship difficulty
4. Concerns with sexuality
5. Depression
6. Conflict with parents
7. Speech anxiety
8. Difficulties dating
9. Choosing major
10. Difficulty sleeping
11. Drug problems
12. Feelings of inferiority
13. Test anxiety
14. Difficulty with friends
16. Self-understanding
17. Loneliness

Appendix I: Patient Health Questionnaire-9 (PHQ-9)

**PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

PHQ9P

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE - 9 72883								
(US Spanish version of the PHQ)								
Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias por cualquiera de las siguientes dificultades?	No del todo	Varios días	Más de la mitad de los días	Casi todos los días				
1. Poco interés o placer en hacer cosas	0	1	2	3				
2. Sintiendo decaído(a), deprimido(a), o sin esperanzas	0	1	2	3				
3. Dificultad en caer o permanecer dormido(a), o dormir demasiado	0	1	2	3				
4. Sintiendo cansado o teniendo poca energía	0	1	2	3				
5. Pobre de apetito o comer en exceso	0	1	2	3				
6. Sintiendo mal con usted mismo(a) – o que usted es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3				
7. Dificultad en concentrarse en cosas, tales como leer el periódico o ver televisión	0	1	2	3				
8. ¿Moviéndose o hablando tan lento, que otras personas podrían notarlo? O lo contrario – muy inquieto(a) o agitado(a) que usted ha estado moviéndose mucho más de lo normal	0	1	2	3				
9. Pensamientos de que usted estaría mejor muerto(a) o de alguna manera lastimándose a usted mismo(a)	0	1	2	3				
SCORING FOR USE BY STUDY PERSONNEL ONLY _____ + _____ + _____ + _____ =Total Score: _____								
<p>Si usted marcó <u>cualquiera</u> de los problemas, ¿qué tan <u>difícil</u> han afectado estos problemas en hacer su trabajo, encargarse de tareas del hogar, o llevarse bien con otras personas?</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 25%;"> Para nada difícil <input type="checkbox"/> </td> <td style="text-align: center; width: 25%;"> Un poco difícil <input type="checkbox"/> </td> <td style="text-align: center; width: 25%;"> Muy difícil <input type="checkbox"/> </td> <td style="text-align: center; width: 25%;"> Extremadamente difícil <input type="checkbox"/> </td> </tr> </table>					Para nada difícil <input type="checkbox"/>	Un poco difícil <input type="checkbox"/>	Muy difícil <input type="checkbox"/>	Extremadamente difícil <input type="checkbox"/>
Para nada difícil <input type="checkbox"/>	Un poco difícil <input type="checkbox"/>	Muy difícil <input type="checkbox"/>	Extremadamente difícil <input type="checkbox"/>					

Appendix J: Vancouver Index of Acculturation (VIA)

Please select one of the numbers to indicate your degree of agreement or disagreement. Many of these questions will refer to your heritage culture, meaning the original culture of your family (other than U.S. American). It may be the culture of your birth, the culture in which you have been raised, or any culture in your family background. If there are several, pick the one that has influenced you most (e.g. Cuban, Mexican, Salvadoran). If you do not feel that you have been influenced by any other culture, please name a culture that influenced previous generations of your family.

Your heritage culture (other than U.S. American) is: _____

1. I often participate in my heritage cultural traditions.
2. I often participate in mainstream American cultural traditions.
3. I would be willing to marry a person from my heritage culture.
4. I would be willing to marry a white American person.
5. I enjoy social activities with people from the same heritage culture as myself.
6. I enjoy social activities with typical American people.
7. I am comfortable interacting with people of the same heritage culture as myself.
8. I am comfortable interacting with typical American people.
9. I enjoy entertainment (e.g. movies, music) from my heritage culture.
10. I enjoy American entertainment (e.g. movies, music).
11. I often behave in ways that are typical of my heritage culture.
12. I often behave in ways that are typically American.
13. It is important for me to maintain or develop the practices of my heritage culture.
14. It is important for me to maintain or develop American cultural practices.
15. I believe in the values of my heritage culture.
16. I believe in mainstream American values.
17. I enjoy the jokes and humor of my heritage culture.
18. I enjoy white American jokes and humor.
19. I am interested in having friends from my heritage culture.
20. I am interested in having white American friends.

Appendix K: Debrief Form

Thank you for your participation in this study.

If you are in need of mental health services and are a student at the Claremont Colleges, [click here](#).

If you are in need of mental health services and are not a 5c student, [click here](#).

Stigma towards mental illness and its professional treatment (e.g., psychotherapy) is thought to be a primary reason why Latinos demonstrate a lower help seeking rate compared to the general population. Therefore, we created a culturally competent contact stigma intervention that aims to reduce stigma and increase likelihood of seeking psychotherapy specifically for Latinos.

The purpose of this study was to assess the efficacy of this newly created stigma intervention. We did this by manipulating which intervention each participant received (psychoeducation intervention vs. psychoeducation plus interpersonal contact intervention).

If you have any further questions, please feel free to reach out to the principal researcher at sahumada21@cmc.edu or the study's faculty supervisor, Dr. Wei-Chin Hwang (Wei-Chin.Hwang@claremontmckenna.edu).

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