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ORIGINAL PAPER

Barriers to Mental Health Help Seeking at School for Asian– and Latinx–American Adolescents

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Abstract

Adolescents are most likely to receive mental health services in schools compared to other settings; however, few studies have examined barriers to mental health help seeking at school for ethnic minority adolescents. The current mixed-methods study utilized surveys and semi-structured interviews to explore the mental health literacy (MHL), stigma toward mental illness, and perceived barriers toward help seeking at middle or high schools among 55 adolescents (81.8% female; 50.0% Asian–American, 44.6% Latinx–American, 5.4% Asian/Latinx bi-racial; *M* age = 17.13 years, SD = 2.33). Participants' MHL was assessed using case vignettes that depicted adolescents with symptoms of depression or bulimia. Overall, 83.9% of participants correctly recognized depression and 57.1% correctly recognized bulimia from the vignettes. Stigma correlated with perceived helpfulness of the formal service providers ($r = -.37$, $p < .01$). Qualitative analysis of participant interviews revealed important knowledge, attitudinal, and practical barriers that inhibit Asian– and Latinx–American adolescents from seeking help for mental health problems at school. The current work has implications to assist school personnel and mental health providers in understanding and reducing barriers to help seeking for Asian– and Latinx–American adolescents.

Keywords Mental health literacy · Barriers for help seeking · Stigma · Asian–American · Latinx–American

Introduction

Mental health difficulties among adolescents are growing concerns in the United States, with researchers estimating that between 20 and 22% of American youth experience a mental health problem in any given year (Merikangas et al., 2010; Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015). Despite this high prevalence, the majority (74–80%) of youth struggling with mental health challenges does not seek or receive appropriate treatment (Eisenberg, Hunt, Speer, & Zivin, 2011; Kataoka, Zhang, & Wells, 2002). Adolescents who receive formal or professional mental health services are most often treated at school, because school-based mental health services (SBMHS) reduce many practical barriers,

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such as cost and transportation (Farmer, Burns, Phillips, Angold, & Costello, 2003). However, ethnic minority adolescents are less likely to receive SBMHS than their white peers (Barksdale, Azur, & Leaf, 2010).

Researchers have suggested that these racial disparities in service utilization are not due to differences in the prevalence of mental disorders. Rather, they have been attributed to the disproportionate number of barriers faced by culturally and linguistically diverse students, such as lack of knowledge, stigma about mental health, linguistic or cultural differences, and racism (Anyon, Whitaker, Shields, & Franks, 2013; Guo, Kataoka, Bear, & Lau, 2014; Hampton & Sharp, 2014; Rastogi, Massey-Hastings, & Wieling, 2012). However, few studies have empirically examined barriers that prevent help seeking for mental health problems at school among ethnic minority youth, specifically Asian– and Latinx–American adolescents. The current mixed-methods study aimed to fill this gap by quantitatively examining the relationships between Asian– and Latinx–American students' reports of mental health literacy (MHL), mental health stigma, and attitudes toward help seeking, and qualitatively explore their perception of barriers to seeking mental health services. We focus on Asian– and Latinx–American adolescents, because they are the two largest immigrant groups in the USA. (U.S. Census Bureau, 2010). Asian–American youth are the fastest-growing ethnic minority group in the USA, while Latinx–American youth make up the largest group among all immigrant youth (Pew Research Center, 2013; U.S. Census Bureau, 2010).

Attitudes Toward Help Seeking

One critical barrier that can prevent adolescents from seeking help at school is negative attitudes toward help seeking, defined as the resistance of seeking professional services to address a personal crisis (Fischer & Turner, 1970). Research suggests that many youths hold negative attitudes toward mental health providers and services and are hesitant to seek professional help. Instead, they prefer to seek informal help from family and friends. For example, Coles et al. (2016) found that American adolescents most commonly recommended that someone with social anxiety talk to a friend (32%), followed by family (16%). Few youth (1%) recommended seeking help from a psychologist or psychiatrist, possibly due to their negative attitudes toward formal help seeking. It is also important to note that most of the participants in Coles et al.'s (2016) study were whites.

Among ethnic minority youth, cultural norms and expectations can influence attitudes and willingness to seek professional help (Kim, 2007). For example, Asian–American college students are less likely than their peers to seek help, citing cultural norms that de-emphasize mental health problems and heighten stigma toward seeking professional services (Lee et al., 2009). Mendoza, Masuda, and Swartout (2015) also found that Latinx college students who reported high levels of mental health stigma were less likely to endorse positive attitudes about help seeking. However, additional research is needed to investigate ethnic minority adolescents' attitudes toward seeking formal services at school to identify ways to reduce barriers to help seeking in middle and high school settings.

Stigma Toward Mental Illness

Stigma toward mental illness is a significant barrier that contributes to negative attitudes and low levels of formal help seeking. Stigma is defined as "objectifying and dehumanizing a person known to have or appearing to have a mental disorder" (Mendoza et al., 2015, p. 206). A recent meta-analysis of 144 studies, with over 90,000 participants of all ages, suggests that stigma has a small to moderate negative effect on help-seeking attitudes and behaviors (Clement et al., 2015). Among adolescents, stigma appears to play an especially strong role in determining help-seeking attitudes due to a heightened focus on peer acceptance. For instance, Hart et al. (2014) revealed that nearly 44% of high school students endorsed embarrassment or stigma as a barrier to help seeking, and nearly 40% endorsed social/interpersonal reasons as a barrier. In another study, half of adolescents stated they would hesitate to access mental health care, because they were "too embarrassed by what other kids would say" (Chandra & Minkovitz, 2006).

Unfortunately, stigma can be particularly burdensome for Asian– and Latinx–American adolescents due to specific cultural expectations and stereotypes surrounding mental illness and help seeking. For instance, some Asian–American families emphasize solving problems within the family unit and consider seeking outside help as "losing face" and bringing shame to the family (Lee et al., 2009). Similarly, some Latinx–American communities tend to place a strong emphasis on both personal and familial honor and having a mental health problem can be perceived as a dishonor to one's family (Graf, Blackenship, Sanchez & Carlson, 2007; Hampton & Sharp, 2014).

Compared to their white peers, both Asian and Latinx youth endorse higher levels of stigma and shame surrounding mental health help seeking (Gilbert et al., 2007; Hampton & Sharp, 2014). However, most studies on stigma have utilized quantitative methodologies, which fail to explore the unique perspectives of participants, especially those from ethnic minority backgrounds. Two recent studies did employ qualitative methods to investigate perceptions of mental health stigma with Filipino-American college students (Maramba, 2013) and Latinx–American adults (Uebelacker et al., 2012). However, they did not examine stigma in the context of seeking help from SBMHS.

Mental Health Literacy (MHL)

In addition to attitudes and stigma, another factor related to help seeking is MHL, defined as "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (Jorm et al., 1999, p. 182). Existing research has identified low MHL as a primary reason for the underutilization of mental health services among Asian–American (Collier, Munger, & Moua, 2012) and Latinx–American adults (Coffman & Norton, 2010). The small number of studies examining adolescent MHL has shown an overall lack of knowledge surrounding mental health problems. For example, Olsson and Kennedy (2010) found that less than a third (27.5%) of middle and high school students in the USA (most of whom were whites) correctly identified anxiety, and 42.4% correctly identified depression, as mental health problems. Limited research has specifically examined MHL for eating disorders. One study found even lower recognition of eating disorders compared to other mental health problems among Irish adolescents (O'Connor, McNamara, O'Hara, & McNicholas, 2016).

It is important to study MHL among ethnic minority youth, because MHL is influenced by a variety of cultural factors, such as language, familiarity with and accessibility of mental health services, and cultural norms or expectations regarding appropriate ways to seek help (Altweck et al., 2015; Collier et al., 2012). For instance, Anyon et al. (2013) found that Chinese–American youth were less aware of the mental health services offered at school compared to their black, Latinx, and multiracial peers. As research on SBMHS continues to grow, more studies are needed to examine MHL among ethnic minority adolescents to understand unique challenges they face to effectively address the disparities in help seeking.

Current Study

The current study explored Asian– and Latinx–American adolescents' perceptions of seeking help for mental health concerns at middle or high schools. We utilized both survey and interview data to examine adolescents' MHL, stigma, and attitudes toward help seeking and to explore perceived barriers to help seeking at school. This mixed-methods approach allowed us to capture the unique challenges that Asian– and Latinx–American adolescents face when seeking help for mental health problems at school.

Methods

Participants

Fifty-five ethnic minority adolescents ($n = 10$ males, 18.2%) ranging in age from 11 to 19 years ($M = 17.13$, SD = 2.33) completed the survey. Seven adolescents were in middle school and 48 were in high school or recently graduated from high school (within 1 year). The overall sample comprised of 49.1% Asian ($n = 27$), 45.5% Latinx ($n = 25$), and 5.5% biracial (Asian and Latinx, $n = 3$) adolescents. The majority of the participants ($n = 45$, 86.5%) were second generation, who were born in the USA to first-generation immigrant parents. Ten participants were foreign-born and had been living in the USA for an average of 9.87 years (SD = 5.75). Participant-reported countries of origin included China ($n = 16$, 29.1%), Mexico ($n = 16$, 29.1%), Vietnam ($n = 4$, 7.3%), Philippines ($n = 4$, 7.3%), Taiwan ($n = 2$, 3.6%), El Salvador ($n = 2$, 3.6%), South Korea ($n = 2$, 3.6%), Cambodia ($n = 1$, 1.8%), Central America ($n = 1$, 1.8%), India ($n = 1$, 1.8%), and Peru/Cuba ($n = 1$, 1.8%). Five participants (9.1%) did not report their country of origin but self-identified as Hispanic or Latina. Of the 55 students, 51 completed the interview.

Data Collection Procedure and Measures

The current study utilized a mixed-methods design that included a survey and a semi-structured interview (either in-person or over the phone) during the 2014–2015 academic year. The project was approved by the University's Internal Review Board (IRB). Participants were recruited through fliers posted online and in the community (e.g., stores, restaurants, health clinics) in southern California. Written informed consents were collected from youth over the age of 18. Written parental informed consents and written adolescent assents were collected from participants who were under age 18.

Participants first completed the survey, which assessed stigma and MHL in addition to several demographic variables (e.g., age, gender, grade level, race/ethnicity, country of origin, and number of years living in the USA). The stigma scale was adapted from Skre, Friborg, Breivik, Johnsen, Arnesen, and Wang (2013) to measure stigmatized and prejudiced beliefs about mental illness using a five-point Likert scale. One prior study showed that the scale had an acceptable internal consistency among adolescents ($\alpha = .76$; Skre et al., 2013). Skre and colleagues also found one factor for the scale using exploratory factor analysis and suggested that "[t]he content of the scale had high face validity, since it clearly contained utterances of prejudiced beliefs about mental health issues" (Skre et al., 2013, p. 885). The internal consistency in this study was $\alpha = .69$. Scores were averaged, with higher scores indicating higher levels of stigma.

MHL was assessed using a questionnaire (Jorm et al., 1997) based on two case vignettes depicting a female adolescent with an eating disorder (bulimia; Hart, 2010) and a female adolescent with depression (Jorm, Morgan, & Wright, 2010; Olsson & Kennedy, 2010). Following each vignette, participants were asked to choose what they

considered the vignette character's main problem from a list of potential problems. They could choose more than one answers. Symptom recognition scores for bulimia and depression were dichotomized (Yes/No). Participants also rated whether they believed various formal service providers (e.g., general doctor, psychiatrist, school counselor, psychologist), formal services (therapy, counseling), informal sources of help (e.g., minister, family, close friend) and or other activities (e.g., becoming more physically active, receiving psychotherapy) would be helpful (coded as "1"), harmful or neither (coded as "0") for each of the two vignette characters (Table 1). The mean score was used as the indicators for the perceived helpfulness of formal providers or formal services, with higher scores indicating perceiving more formal providers or services as helpful. We decided to use vignettes featuring female adolescents because eating disorder and depression are more prevalent among female students, and most participants who signed up for our study were females (81.8%).

Following completion of the survey, trained research assistants administered a semi-structured interview in English. Interview questions were developed based on Jorm's MHL framework (e.g., Jorm & Wright, 2007) and on treatment-engagement research for ethnic minority youth (Breland-Noble, Burriss, Poole, & The AAKOMA PROJECT Adult Advisory Board, 2010). Participants were asked to discuss the two vignette characters from the survey; how they would help a friend going through a similar problem; and what barriers prevented adolescents from seeking help for SBMHS at middle or high schools (A full copy of the interview protocol is available upon request).

Data Analyses

Descriptive data from the survey was used to examine participants' MHL, stigma, and perceived helpfulness of the formal providers and services. Interviews were coded using a descriptive thematic analysis procedure (Braun & Clark, 2006), which consisted of two stages. In stage one, we established a coding frame using three a priori categories: (1) *definition and contributing factors of mental health issues*, (2) *helpful strategies or ways of seeking help*, and (3) *barriers preventing help seeking*.

Overall, 20% of the interviews were randomly selected to code for reliability, using a negotiated agreement approach (Campbell, Quincy, Osserman, & Pedersen, 2013). First, four coders independently coded each transcript based on the three a priori categories. Coders added memos to record their observations, thoughts, or questions. Intercoder reliability was calculated on a line-by-line basis using a formula adapted from Campbell et al. (2013; Percent agreement = Number of matched lines/Total number of lines coded). The coders communicated after each transcript to discuss observations and challenges and to clarify the coding rules. Then, each transcript was recoded based on the discussion, and reliability was recalculated. This process continued for the remaining 12 transcripts. After the transcripts were recoded, intercoder reliability was recalculated. The final intercoder reliability was 82% (range 70–94%).

During the second stage, the first three authors focused on one of the three a priori categories (*barriers preventing help seeking*) to generate specific themes relating to barriers toward seeking mental health services. They read each text segment designated as a barrier and assigned code labels to capture the overall idea or meaning of the text segment. For instance, "people are afraid others will judge them" would be labeled *stigma*; "What is a psychiatrist?" would be labeled *lack of knowledge*. The coders discussed discrepancies in labeling to reach a consensus. Code labels were combined into subthemes and then organized into broader themes. For example, finances, lack of time, lack of providers, and lack of access/transportation were subthemes that were placed under the broader theme of *structural barriers*. Finally, the total barriers and unique barriers each participant mentioned during the interview were calculated.

Results

Quantitative Results

Overall, 83.9% of the youth participants correctly identified depression, and 57.1% correctly identified eating disorder (bulimia) from the survey case vignettes. Participants' mean stigma score was low ($M = 1.69$, SD = .53, range 1–7). For attitudes toward help seeking, participants endorsed formal providers, informal sources of help, and different services as helpful at different levels (Table 1). Most participants (87%–92.6%) considered school counselors and psychologists to be helpful, but only about 20% considered social workers to be helpful. Only about half of the participants considered specialty psychotherapy (e.g., cognitive behavior) as helpful. Less than 60% considered antidepressant to be helpful, and 52.8% considered admission to the psychiatric ward as harmful for someone with an eating disorder.

T tests showed no significant differences between Latinx– and Asian–American participants in terms of correct recognition of bulimia or depression, stigma, or perceived helpfulness of formal services or providers. Correlational analyses showed that stigma correlated with perceived helpfulness of the formal service providers ($r = -.37$, $p < .01$).

Qualitative Results

We explored the perceived barriers for SBMHS. Three general types of barriers—*knowledge barriers*, *attitudinal*

Table 1 Participant attitudes toward formal and informal providers, services, and activities for the bulimia and depression vignettes

Eating disorder vignette				
Providers/services	Helpful (%)	Harmful (%)	Neither (%)	I don't know (%)
Formal providers				
School counselor	92.6	.0	5.6	1.9
Psychologist	87.0	1.9	5.6	3.7
Psychiatrist	72.2	1.9	11.1	14.8
General doctor	66.7	1.9	24.1	7.4
Pharmacist	20.4	3.7	51.9	24.1
Social worker	20.8	18.9	45.3	15.1
Informal sources of help				
Close friend	83.3	1.9	11.1	3.7
Self-help support group	83.3	1.9	11.1	3.7
Family	77.8	3.7	9.3	9.3
Minister	22.6	7.5	50.9	18.9
Therapy services				
Counseling	90.7	0	9.3	0
Relaxation therapy	74.1	5.6	11.1	9.3
Cognitive behavior therapy	46.3	7.4	24.1	22.2
Psychotherapy	38.9	16.7	20.4	24.1
Other activities				
Getting information about problem eating and available services	75.9	5.6	13	5.6
Using a self-help book	24.5	17	41.5	17
Admission to the psychiatric ward	9.4	52.8	30.2	7.5
Trying to deal with the problem on her own	7.4	68.5	20.4	3.7
Depression vignette				
Formal providers				
School counselor	92.6	0	5.6	1.9
Psychologist	92.6	0	1.9	5.6
Psychiatrist	72.2	3.7	11.1	13
General doctor	51.9	0	37	11.1
Social worker	22.2	11.1	38.9	27.8
Informal sources of help	Helpful (%)	Harmful (%)	Neither (%)	I don't know (%)
Close friend	88.9	0	7.4	3.7
Telephone hotline	50.9	7.5	22.6	18.9
Teacher	38.9	5.6	31.5	24.1
Therapy services				
Therapy with a specialized professional	81.5	3.7	5.6	9.3
Specialized mental health service	51.9	9.3	18.5	20.4
Other activities				
Getting relaxation training	87	0	3.7	9.3
Joining a support group	85.2	1.9	11.1	1.9
Becoming more physically active	83.3	0	7.4	9.3
Practicing meditation	77.8	1.9	11.1	9.3
Getting up early each morning and getting out into the sunlight	64.8	1.9	20.4	13
Taking antidepressants	59.3	13	7.4	20.4
Reading a self-help book	44.4	5.6	33.3	16.7

Participants were asked to indicate whether each provider and service would be helpful, harmful, or neither for the character in each vignette. "N endorsed" indicates the number of participants who endorsed that each answer choice would be helpful for the vignette character

barriers, and *practical barriers*—emerged, with ten specific barriers (see Table 2). Additionally, each participant mentioned an average of 5.9 (SD = 2.31) distinct barriers at least once during the interview (e.g., stigma, confidentiality). *T* test analyses showed that Latinx– and Asian–American youth did not vary significantly in the number of barriers identified during the interviews. Each of the three types of barriers is described below. We also used pseudo names in this paper to protect confidentiality of the participants.

Table 2 Themes and subthemes related to barriers for help seeking at school

Themes and subthemes	sample quotes
I. Knowledge barriers	
Lack of knowledge about mental disorders (50%)	"I never really was exposed to depression. I never really knew what it [was], how it affected people, so never thought that's what I had."
Lack of knowledge about treatments, providers or where to seek help (47.7%)	"I didn't know that we had psychologists at school."
Lack of problem recognition (36.4%)	"If someone in an Asian family has a mental illness, they usually don't like recognize it as a mental illness."
II. Attitudinal barriers	
Stigma (86.4%)	"I think there is definitely a stigma […] most people associate school counselors or psychologists with people that are crazy." "Cultural constraints, because [in the] Hispanic tradition it's very weird that you go to a therapist. What's wrong with you if you're going to a therapist?" "Mental illnesses and stuff, it's not spoken about a lot […] It's taboo basically […] I think it's just kind of avoided, not really talked about, it's in the shadows."
Negative perceptions (72.3%)	"I had a friend who was suffering from depression and she wanted to go talk to someone [at school], but she felt the school counselors didn't care about her problems […] She said that they were only there to help you schedule classes" "Just they are scared and they don't like or want to talk about it to strangers" "It made me not want to look for help, 'cause it didn't seem like it [therapy] was helpful [for my friend]"
Perceived lack of support (59.5%)	"The school psychologists are not real psychologist." "You don't feel like there's someone out there like there's a support system, or like there's anyone that can help you with what you're dealing with." "They've talked to their family and they're just like, "Just brush it off. You're fine." They didn't really try to help." "I can't really talk to my friends about a lot of these issues because they just don't understand."
Desire for independence (51.1%)	"I feel like a lot of kids feel like […] that they can just fix it on their own" "Usually it was their parents wanting them to go [to counseling], and if they didn't want to go […] they wouldn't really open up and try to get better"
III. Practical barriers	
Concerns about confidentiality (61.7%)	"They're afraid that like, word will get out and rumors will spread and people will not, not be friends with them anymore." "They don't want people in school or in their social circle or people that know them to know what they've been doing" "In [the Chinese American community], I don't know, it's usually like if someone hears that you have a mental disorder, like eventually like the whole neighborhood knows about it. And then they'll talk about it, it's like, oh that person is not well […] So people don't really want others to know about it"
Structural barriers (55.3%)	"[Students] put so much emphasis on school that you don't really have time or you don't want to make time to see someone [for mental health concerns]" "Counselors are really busy […] So there was just never like a time to actually sit down and talk about how she felt" "Maybe they feel like they don't have the resources at school to help them with their problem"
Symptoms of certain mental disorder (51.1%)	"[Individuals with depression are] just not motivated in any way to seek help, because they kind of just feel like it's the end of the road in a way" "It could be like their fear again, especially if they have like a social anxiety of some sort. Like fear of approaching another person [to ask for help]" "The symptoms that come with the disorders may not be helpful, because it'll make them not want to look for help"

Percentages indicate the percent of participants who mentioned each theme/subtheme at least once during the interview

Knowledge Barriers

The most common type of barrier is lack of knowledge or low MHL. It includes: (a) *lack of knowledge about mental disorders*, (b) *lack of knowledge about treatments, providers, or where to seek help,* and (c) *lack of problem recognition.* Participants reported that adolescents are often unable to recognize mental health problems or differentiate between typical stress and more severe symptoms that are indicative of mental illness. Approximately half of the sample (47.7%) also reported feeling uninformed about the various mental health professionals and services available to help them at school. Several youths commented that they did not know that their school had a school psychologist. They also did not know that the school counselors offered mental health services (e.g., "I've never had to go to a school counselor except for like scheduling, but I'm not so entirely sure what they can do."), or that mental health services were offered free of charge to students at school.

The lack of knowledge about mental health issues was mainly due to a lack of discourse/discussion about these topics. Several participants mentioned that these topics are "not something that's normal to talk about" among some Latinx and Asian families and communities. For example, Sofia think that mental illnesses is "not as noticeable" among Latinos because "it's not spoken about a lot" and that it is "basically taboo". This lack of discussion in the cultural communities coupled with a lack of prior experiences contributed to the low MHL or the lack of knowledge about mental illness, which inhibited problem recognition and professional help seeking for adolescents.

Attitudinal Barriers

Even after a youth recognizes that she/he has a mental health problem and knows where and how to seek help, attitudinal barriers can prevent them from seeking help for SBMHS. Attitudinal barriers included: (a) *stigma,* (b) *negative perceptions,* (c) *perceived lack of support,* and (d) *the desire for independence.* First, the majority of participants (86.4%) described a heightened level of mental health *stigma* at school. For example, one student explained that "most people associate school counselors or psychologists with people that are crazy". Youths also described the mental health stigma in their respective cultural communities, viewing mental illness as "taboo" and something that is "in the shadows". They worried about being judged or ostracized by their families or communities for seeking treatment. For instance, Camila explained that in the "Hispanic tradition, it's weird that you go to a therapist". She added that people would wonder if something is "wrong" with you. Similarly, Jade described how Asian families often considered it "weak" to ask for help. Stigma or fear of judgment and shame leads youth to deny or hide their problems, and not seek professional help.

In addition to stigma, youths (72.3%) also reported many *negative perceptions* of providers and of the help seeking process based on their personal experiences, peers' experiences or general misperceptions. They felt that seeking help is an intimidating and uncomfortable process, possibly due to their young age, lack of familiarity with providers, and discomfort with self-disclosure. Some participants also had negative perceptions about school-based mental health providers (SBMHP). They felt that SBMHP would not be helpful, because they lacked training and expertise compared to providers outside of school (e.g., in hospital or outpatient clinics). For example, a few youths did not view school psychologists as "actual psychologists" or view school counselors as "real counselors". They also perceived school counselors to be "more focused on academics" and not focused on supporting students' mental health. For instance, Amy remarked that the school psychologists at her high school were "undertrained". She felt that they only saw "one side of the story" and viewed problems "as kind of like a manual. Just do this and you will be fine". Another aspect of this negative perception in adults and providers is the age difference. Mariana provided her perspective:

> [T]he therapy person, therapist, probably in their mid-thirties, and they wouldn't understand what a twelve-year-old will be going through.

In addition, hearing about peers' and family members' negative experiences about seeking help deterred youth from seeking help from SBMHP and mental health services in general. Several students relayed messages of counseling or therapy as "not helpful" or that it was "a waste of time". Additionally, they reported that they do not feel welcomed, or that the SBMHP cared about their problems and "truly listen" to their concerns. Overall, adolescents appeared to have negative perceptions and lack confidence in SBMHP's ability to help students with mental health difficulties.

A third attitudinal barrier is a *perceived lack of support*. Over half of the participants in the study indicated that even if youths their age do seek mental health services, their families would not support their help seeking. Youths did not think that their parents would understand. Due to the lack of support, they felt that mental issues are often dismissed. Elisa provided an example of her friends who had depression and had tried to talk to their families. The families responded by saying, "Just brush it off. You're fine". Youths recognized that families may not be informed about mental health and may try to help but "in the wrong way," which were neither helpful nor effective. Camila observed that in Latinx families, if someone faces a mental health challenge, they would "pray" or "go to church" and

they think that will fix the problem. Spiritual support is important; however, some mental disorders require professional interventions.

The fourth attitudinal barrier is adolescents' desire for *independence*. Many participants indicated that teenagers often want to handle problems on their own, without relying on their families or friends. Developmentally, they want to feel "more adult". Luna, who experienced extreme dieting reflected:

> I didn't wanna tell anyone 'cause I didn't think I had a problem, and I could fix it on my own. So, I feel like a lot of kids feel like that…That they can just fix it on their own.

Participants further explained that this desire for independence may come from "pride" or "stubbornness". They felt that everyone goes through similar problems and that they should be able to handle them without professional help. Another aspect of this desire for independence and subsequent resistance toward seeking professional services was the fear of coercion from their parents. Participants described their friends, who were forced by their parents to go to therapy against their will. Youths perceived this as a restriction of their freedom and sense of control over the situation. Of course, sometimes this coercion may provide adolescents with the help that they need, but the coercion may be counterproductive.

Practical Barriers

A final type of barrier that emerged involves key practical barriers that can make help seeking difficult—or impossible— for adolescents, even after they have decided to seek help for a mental health problem. Practical barriers most commonly mentioned included (a) *concerns about confidentiality*, (b) *structural barriers* (e.g., time and cost), and (c) *symptoms of certain mental disorders* (e.g., anxiety and depression) that can inhibit help seeking.

Confidentiality was a recurring concern mentioned by most of the participants (61.7%) due to a perceived lack of privacy at school and a belief that others, namely peers, teacher/staff, and parents, could find out about their problem if they sought help at school. Because of the close proximity to peers and teachers at school (e.g., a peer may see you going to the counselor's office, or hear what you and the counselor are talking about in the hallway), and the potential lack of confidentiality (e.g., teachers may be talking about student private information in the office without paying too much attention that others nearby may also hear the information), adolescents worried about negative social repercussions, such as rumors, bullying, and social judgment. One youth expressed her fear:

> [I]f I had an eating disorder and I was wanting to go to a [school] counselor about it, but I wouldn't really 'cause there's so many people that might talk about it [at school]…I think once a rumor starts, it's kind of gets bigger and bigger.

Youths had increased concerns about confidentiality due to the prevalence of gossip within their cultural communities, which tend to be more collectivistic in nature with less focus on privacy. For example, Vera said that in the Chinese community, "if someone hears that you have a mental disorder, eventually like the whole neighborhood knows about it. And then they'll talk about it". Adolescents felt that the risk of others in their close-knit ethnic community finding out about their mental health problems outweighed the potential benefits of seeking help.

Another aspect of this confidentiality issue is the lack of trust in adults and providers. When asked about the barriers for teenagers to seek help from counselors or psychologists at school, Dara responded, "I feel like they don't trust adults". She explained that this lack of trust may have resulted from negative experiences, such as her friends who had a difficult time trusting "adult guys" due to traumatic experiences in her life. She further stated that it may come from family practices that reinforce distrusting outsiders.

Other practical barriers included a lack of time to seek help due to lower mental health priority in the midst of busy academic and extracurricular schedules. Mai explained it in this way:

> [O]ther barriers would be like the way society is set up, like the fact that mandatory schooling and every class giving at least two hours of homework, and if you have seven classes that is like your whole day… the struggle to also do extra-curricular activities and also trying to be social, by then your week is gone, and you have little to no time to yourself, let alone to seek out help… I know a lot of people in my school that would have probably been helped if they would have just seen the counselor. Or even myself, if I was told to go see the counselor on multiple occasions, but there just would be no time for it, even amongst school, because it's just like: class, eat, class, eat, do homework, class; day after day.

Jaslene echoed this challenge and said that many of her peers often "put academic before health".

Youth also described schools as "understaffed" and noted that school counselors were too busy with other job functions, such as scheduling classes, to deal with students' mental health needs. Yancy recounted a story of her best friend who had depression but was not able to get help in a timely manner. She explained that the school

counselors at her school are "extremely busy", especially around college application time, and that they were "always packed".

Finally, students who experience depression or anxiety may be inhibited by their own symptoms, such as lack of motivation or intense anxiety, to seek professional help on their own. Melanie said:

> I guess depression could be the barrier, because for general schoolwork if their grades start to decline, it's because they're being hindered by it for not being able to keep working on whatever they're doing, so I guess seeking out help would be the same way. Your own emotions or mental state are stopping you from seeking help.

These mental disorders often put people in a "rut". Participants felt that some individuals who have been living with depression may have a difficult time addressing their basic needs, such as getting out of bed or putting socks on in the morning. Especially for those who have been living with depression for a long time, they may have grown used to it and do not know anything different. Those with anxiety may fear approaching other people or unknown professionals for help.

Discussions

The current study provides insights into Asian– and Latinx–American adolescents' MHL, stigma, attitudes toward help seeking, and perceptions of the barriers to seeking help for mental health problems at school. We combined these two groups in our analysis, because as immigrant youth they may face similar challenges to seeking school-based mental health services as discussed above. Survey data revealed that participants had relatively high MHL, with 83% correctly identifying depression and 57% correctly identifying an eating disorder from the vignettes. These percentages were higher than those reported in previous studies (e.g., 33–51% for depression (Burns & Rapee, 2006; Byrne, Swords, & Nixon, 2015) and 18–25% for eating disorders (Mond et el., 2008, 2010), which may be due to the multiple-response format used in our study. Although many students (about 90%) perceived school counselors or psychologists and counseling as potentially helpful for the vignette characters, a closer look at the data suggests more hesitation or uncertainty toward specialty services (e.g., cognitive behavior therapy), antidepressants, and admission to psychiatric ward (e.g., 52.8% considered being admitted to a psychiatric ward as harmful for those suffering from eating disorders).

It is important to note that the symptom recognition and perceived helpfulness of providers and services in the survey only measured certain aspects of MHL. Qualitative interviews provided a more in-depth understanding of Asian and Latinx–American adolescents' MHL. For example, contrary to the survey results, 89.4% of participants mentioned in the interview that low MHL is a barrier for help seeking at school. This is consistent with previous work, which found that Canadian high school students identified the lack of knowledge of where to seek help and lack of problem recognition as two of the most common barriers for accessing SBMHS (Bowers, Manion, Papadopoulos, & Gauvreau, 2013). We found that low MHL is associated with a lack of experience and lack of discourse about mental health problems and services at school and within the students' cultural communities. This likely contributes to uncertainty regarding both the identification of mental health problems and where and how to seek help.

Closely related to this lack of discourse about mental illness is the high level of stigma toward mental illness in the participants' communities. Although most youths reported on the survey that they themselves had low stigma toward mental illness, during the interviews, they described mental health stigma at school and in their communities that prevented youth their age from seeking professional help. A strikingly high percentage (86.4%) of Latinx– and Asian–American adolescents in our sample identified stigma as a barrier for help seeking, as compared to 44% of high school students in a previous study (Hart et al., 2014). This may suggest that stigma is a more salient barrier for ethnic minority students compared with the general student population. This is consistent with the growing body of research among adults documenting the strong stigma toward mental illness in some Latinx (e.g., Graf et al., 2007; Hampton & Sharp, 2014) and Asian (e.g., Gilbert et al., 2007; Lee et al., 2009) communities.

Related to high stigma, concerns about confidentiality and the lack of privacy at school were also reported as barriers, which are exacerbated by adolescents' strong desire to present themselves in a more positive light in front of peers. These findings are consistent with prior qualitative work (e.g.,Hart et al., 2014; Rickwood, Cavanagh, Curtis, & Sakrouge, 2004) showing stigma and concerns about confidentiality as two of the most significant barriers for help seeking at school. Extending existing findings, our study found that Asian– and Latinx–American youth also fear rumors in their ethnic community relating to their mental illness. This indicates the need to provide mental health education to promote awareness and knowledge about mental health challenges among Asian and Latinx youth. Related to stigma, some students also perceived the help-seeking process as intimidating and uncomfortable, particularly at school, possibly due to the lack of understanding or misunderstanding of the therapy process (e.g., disclosure during therapy). Additionally, more culturally appropriate resources and tools, as well as training

of providers are needed in order to improve and increase culturally sensitive practices.

Although SBMHS help to reduce some barriers to help seeking at school (e.g., school-based services are usually free and parents do not need to provide additional transportation for services) our results revealed important attitudinal and practical barriers that inhibit adolescents from seeking help at school. For example, some students perceived SBMHP as being underqualified, lacking time to help students, or serving a limited role (e.g., only addressing academic concerns). These perceptions are in line with prior work on parent-reported barriers for SBMHS (Ohan, Seward, Stallman, Bayliss, & Sanders, 2015). System-level efforts are needed to increase providers' visibility and availability and to decrease negative perceptions of SBMHP.

Finally, Asian and Latinx students in our sample valued family, peer, and community support. Unfortunately, over half (59.5%) of the students explained that lacking social support was a major barrier to help seeking. Therefore, in addition to reducing stigma, strategies to develop stronger support systems around ethnic minority youth mental health should also be explored. Social support, particularly parental support, has been found to protect youth against mental health challenges (Stice, Ragan, & Randall, 2004). Creating support systems at home and school is especially important for youth who are currently experiencing a mental health challenge, as peer support tends to erode over time when adolescents experience mental health difficulties (Stice et al., 2004). While adolescents reported wanting support from adults, they also want independence and do not want to be coerced into seeking help. Over half of the youth (51.1%) in our study described desiring independence as a barrier to seeking help. It is important to establish a balance between providing support while giving youth some autonomy in accessing SBMHS. Future research is needed to help us understand what types of support youth need most in navigating decisions around mental health help seeking, particularly for those of Asian and Latinx backgrounds.

Limitations and Future Directions

Although this mixed-methods study allowed for a more in-depth understanding of the barriers to accessing SBMHS, several limitations warrant discussion to inform future research. The current sample was obtained through convenience sampling in California, and most of the participants (or their parents) were from China and Mexico. The Asian– and Latinx–American communities are quite diverse, and our sample is not representative of these communities. Future studies should use larger samples and recruit different subgroups of Asian– and Latinx–American youth. In the current study, we combined middle and high school students together for data analysis (instead of separating them). Moreover, we had only seven middle school students in our sample. We recognize that youth in middle school may differ from those in high school in their understanding of mental illness and help seeking. Future studies could examine middle and high school students separately to specifically understand their unique perspectives.

Additionally, the majority of our sample was female (81.8%), which prevents generalizability to adolescent males. Instead, our findings provided an in-depth understanding of barriers to seeking mental health services at school from the perspective of female students. Research has shown that mood-related disorders (Steel et al., 2014) and eating disorders (American Psychiatric Association, 2013) tend to be more common among females. However, there is growing evidence showing that certain eating disorders (e.g., bulimia nervosa; Smink, van Hoeken, & Hoek, 2012) are becoming more common in males. More research is needed to explore the unique challenges and barriers faced by adolescent males. Similarly, the two case vignettes utilized in the current study featured adolescent females. Future studies should use counter-balancing and assign vignettes featuring adolescents of both genders and recruit more ethnic minority adolescent males. Furthermore, we did not include school psychologist or school social worker in the quantitative survey although we asked about them specifically in the interview. Future studies should include school psychologist and school social worker in the survey to examine students' perception about these providers.

Implications

Our results highlight the need to engage ethnic minority youth in SBMHS. First, SBMHP should understand the unique needs of ethnic minority students and recognize the impact of culture on the help-seeking process. Because students are especially concerned about stigma in their cultural communities and at school, school-wide and community-specific stigma reduction efforts are needed. Since low MHL relates to stigma, SBMHP should implement evidence-based MHL curricula during the school day (e.g., health class) to promote MHL and reduce stigma among all students. This Tier I prevention is likely to benefit both ethnic minority students and their peers. The curricula may need to be tailored to address the unique barriers that ethnic minority students often experience when seeking SBMHS. Considering the cultural stigma and the importance of home-school partnership, SBMHP also need to build partnerships with community organizations, local mental health clinics, and local universities, to conduct outreach workshops to immigrant parents and community members to reduce stigma and normalize

mental health struggles (Wang, Do, Frese, & Zheng, 2019). During these outreach presentations, SBMHP may want to involve Asian– and Latinx–Americans who have experienced a mental illness to talk about how they sought help and recovered from their illness. When mental illness is no longer a tabooed topic, community members will be more comfortable talking about mental health, which will increase awareness and the likelihood of adults encouraging youth to seek professional help when needed. To further encourage parents and adolescents to prioritize youth mental health, SBMHP should emphasize that when students' mental health needs are not met, it is likely to have detrimental impact on their academic success (Arora & Algios, in press).

Adolescents in our study also described a lack of knowledge and awareness surrounding SBMHS at their school. Their immigrant parents are probably unfamiliar with SBMHS, because they did not attend school in the US. School staff should introduce and advertise SBMHS during school-wide events (e.g., new student orientations, parent–teacher conferences) to increase the visibility and awareness of these services. School personnel should also ensure that students are aware of providers' roles (e.g., helping students with academic, as well as social emotional and behavioral concerns) and of policies surrounding confidentiality.

Seemingly minute factors, such as the location of the school counselor or school psychologist's office, can also impact students' perception of privacy, confidentiality, and willingness to seek help (Rickwood et al., 2004). Providers should also make themselves available to all students. For example, school districts could implement Tier I prevention efforts, such as student wellness days, where school psychologists or counselors visit various classrooms to conduct health-related activities with students (e.g., breathing or relaxation exercises). Schools also need to ensure sufficient resources and staff for SBMHS and consider creating walk-in hours at the counseling center so that students can receive immediate help as needed. Moreover, to change youths' negative perceptions toward SBMHP and increase their confidence toward these providers, it is also important for SBMHP to increase their competency to earn students' trust. Understanding the specific barriers that ethnic minority youth faced in seeking SBMHS allows schools and providers to better target these barriers and better address the mental health needs of all students and their families.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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