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Religiosity and attitudes towards professional mental health services: analysing religious coping as a mediator among Mexican origin Latinas/os in the southwest United States

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ABSTRACT

In this study, we examined the relationship between religiosity and attitudes towards professional mental health services. We further examined whether internal religious coping and external religious coping mediated both relationships. Results indicated a significant association with religiosity and negative attitudes towards mental health services, as well as external religious coping and internal religious coping. Results also showed a nonsignificant association with both religious coping and negative attitudes towards mental health services. Finally, external religious coping mediated the relationship between religiosity and negative attitudes towards mental health services for men but not for women.

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Religiosity; attitudes towards mental health services; religious coping; Mexican; mediation

Recent projections estimate that approximately 30% of the population will be Latina/o by the year 2050 (US Census Bureau, 2010). These projections and recent growth have drawn attention to the mental health needs of Latinas/os, which have been consistently marked by the underuse of formal mental health services as compared with non-Latinas/os (e.g., Alegría et al., 2002). To date, research among Latinas/os suggests that this underutilisation is due to a variety of factors, including logistical barriers at the systems and community levels (Nandi et al., 2008). Acculturation and gender have also shown a consistent association with attitudes towards professional mental health services with men and less acculturated individuals endorsing more negative attitudes than women and more acculturated individuals (Albritton, Angley, Gibson, Sipsma, & Kershaw, 2015). In addition, scholars have suggested that negative attitudes towards professional mental health services might play an important role in this underutilisation by Latinas/os. Although the literature on attitudes towards mental health services among Latinas/os may indicate mixed results (e.g., Anglin, Alberti, Link, & Phelan, 2008), a large body of literature suggests that Latinas/os hold relatively negative attitudes towards mental health services when compared to non-Latina/o Whites (Cooper et al., 2003; Nadeem, Lange, & Miranda, 2008; Sleath, West, Tudor, Perreira, King, & Morrissey, 2005). Religiosity, defined as adherence to a set of beliefs, practices, and rituals belonging to an organised system of beliefs (Cervantes & Parham, 2005; Hill & Pargament, 2003; Richards & Bergin, 2000; Tsang & McCullough,

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2003), is one such variable that might be associated with attitudes towards mental health services among Latinas/os. For this paper, we define religiosity occurring in the context of a religious community (Tsang & McCullough, 2003). Among non-Latinas/os, research has generally documented greater scepticism and negative attitudes towards formal mental health services among individual who report higher levels of religiosity, especially men and less acculturated Latinas/os (Koenig, 2001; Moreno & Cardemil, 2013; Sheikh & Furnham, 2000; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). Moreover, in recognition of the fact that over 90% of Latinas/os in the United States report that they are religious and/or spiritually committed (Espinosa, Elizondo, & Miranda, 2003; Pew Research Center, 2008) especially around invidious who are less acculturated and women (Moreno & Cardemil, 2013), a growing body of literature has begun to document associations between religiosity and mental health outcomes in Latinas/os (e.g., Herrera, Lee, Nanyonjo, Laufman, & Torres-Vigil, 2009; Jurkowski, Kurlanska, & Ramos, 2010). However, to date, there has been very little empirical research among Latinas/os investigating the extent to which religiosity might be associated with attitudes towards mental health services among Latinos. In this article, therefore, we examine these relationships in a sample of Latinas/os from the Southwest US In addition, we consider two possible mediators of the relationship between religiosity and attitudes: internal religious coping and external religious coping.

Religiosity and attitudes towards mental health services

Although there has been an increase in research examining the role of religiosity in the attitudes towards mental health services for individuals from racial and ethnic minority backgrounds, only a few studies have focused on Latinas/os. For example, Alvidrez (1999), in a sample of 187 women that included 84 Latinas, found that endorsement of religious or supernatural causes of mental illness was associated with lower rates of mental health service use. Although this study adds insight to the overall literature, it is important to note that aetiological beliefs do not directly measure the construct, religiosity. However, Postolache and colleagues (1997), in a small qualitative study of 41 Latinas/os in New York City, found that those Latinas/os who engaged in religious practices like confession perceived psychotherapy as less helpful than counselling from their priests. Additionally, Moreno and Cardemil (2016) found a similar pattern, whereby highly religious individuals expressed a greater reluctance to use formal mental health services. However, they also identified several contexts in which highly religious Latinas/os endorsed more positive attitudes towards mental health services. In particular, the Latinas/os in the sample were more inclined to seek formal mental health services when they experienced serious mental health problems or encountered problems that they thought were biological in origin. Overall, the limited research on Latinas/os has shown the important role religiosity and the help-seeking behaviours. However, no studies have directly measured the relationships between religiosity and attitudes towards mental health services among this population. Additionally, little is known about the mediators by which religiosity may be associated with attitudes towards formal mental health services.

Religiosity and religious coping

In the general population, those who endorse higher levels of religiosity (especially women and less acculturated Latinas/os; Moreno & Cardemil, 2016) may handle their

distress by coping through religious methods (e.g., Herrera et al., 2009; Sanchez, Dillon, Ruffin, & De La Rosa, 2012). Although researchers have highlighted how religiosity and religious coping may have shared practices (e.g., Tsang & McCullough, 2003), it is important to investigate these constructs as individuals who engage in higher levels of religious practices may engage in other coping strategies when under distress. Similarly, individuals may report low levels of religiosity and higher levels of religious coping when in conflict.

Regarding religious coping, scholars in the field have developed a number of different religious coping categories (e.g., Pargament, 1997). Two forms of religious coping that have been well-established in the literature are internal and external religious coping (Boudreaux, Catz, Ryan, Amaral-Melendez, & Brantley, 1995). Internal religious coping includes such activities as prayer and spiritual practices, while external religious coping consists of seeking advice from a religious counsellor or connecting with religiously affiliated support groups (Boudreaux et al., 1995; Moreno & Cardemil, 2013). Although internal and external religious coping may include similar religious behaviours (e.g., praying, reading religious books), internal religious coping is generally conceptualised as consisting of religious practices that are privately conducted, whereas external religious coping entails engaging in religious practices where others are also engaged (e.g., social support groups, pastoral counselling, etc.; Boudreaux et al., 1995). Among Latinas/os, especially those older in age, internal and external religious coping served as important and preferred methods when handling adversity among those that reported higher levels of religious involvement. For example, Moreno and Cardemil (2013), in a qualitative study of 20 Latinas/os in the Northeast, found internal and external religious coping as a consistent theme primarily for individuals who identified as religious. However, very limited research has been conducted in this area among the Latina/o population. The few studies in the field for this population are also qualitative studies that describe and/or explore these constructs. Quantitative studies are needed to investigate differences and statistical significance between these relationships among this population.

Religious coping and attitudes towards mental health services

The overall literature also highlights significant associations between religious coping and attitudes towards mental health services. A large portion of this literature describes how individuals who engage in external religious coping were more inclined to have less positive attitudes towards mental health services (e.g., see Ward, Wiltshire, Detry, & Brown, 2013). For example, Smolak et al. (2013), in a meta-analysis of 43 research studies found that those individuals that engage in religious coping (particularly external religious based services) had more negative attitudes towards professional mental health services predominately for individuals with schizophrenia. Additionally, Wamser, Vandenberg, and Hibberd (2011), in a quantitative sample of 142 undergraduate students, found that religious coping were found to be associated with greater preference for religious help-seeking and held a negative attitude towards professional mental health services. Despite these general findings, gaps remain in the literature when investigating these relationships among Latinas/os. Most of these studies have focused on a college student and/or African American sample, but very little is known about a community sample of Latinas/os. Furthermore, to our knowledge, no research has directly measured the associations between both external and internal religious coping and attitudes

towards mental health services. That is, since none of these studies explicitly used a measure of religious coping, it is unclear the extent to which either external or internal religious coping may be associated with the relationship between religiosity on the attitudes towards professional mental health services.

Current study

The current study therefore investigates the relationship between religiosity and attitudes towards professional mental health services. Since significant data also highlight how among Latinas/os living in the United States, 67% are of Mexican origin or background (US Census Bureau, 2016), this study specifically investigates this relationship among Latinas/os of Mexican origin or background. In addition, to the first relationship between religiosity and attitudes towards professional mental health services, we examined whether external religious coping and/or internal religious coping mediates the relationship between religiosity and attitudes. Based on the extant literature, we had four hypotheses: (1) religiosity will be negatively associated with attitudes towards professional mental health services, such that more religious individuals will endorse more negative attitudes; (2) religiosity will be positively associated with both internal and external religious coping, such that highly religious individuals will report greater use of both internal and external religious coping; (3) external and internal religious coping will both be negatively associated with attitudes towards professional mental health services, such that individuals who report greater use of either form of religious coping will also report more negative attitudes; and (4) both external and internal religious coping will mediate the relationship between religiosity and attitudes towards professional mental health services.

Methods

Participants

Participants for this study were 100 individuals (40 males and 60 females) of Mexican descent or of Mexican origin in the Phoenix metropolitan area in the state of Arizona. 77.5% of participants were first generation immigrants from Mexico, while 22.5% were born in the mainland United States. The participants' average age was 33.21 years (SD = 10.67). With regard to religion, 50% identified as "Catholic", 34% identified as "Protestant Christian" (e.g., Evangelical, Pentecostal, etc.), 15% identified as "nonreligious", and 1% identified as "other". 32% also reported not finishing high school, 38% reported finishing high school or GED, and 30% reported having attended some college or obtained a college degree. 50% reported not having health insurance, while 50% reported having insurance coverage.

Procedure

To be considered for inclusion in this study, participants had to (1) be at least 18 years of age; (2) speak English or Spanish; (3) identify as first generation immigrant from Mexico or as an individual of Mexican descent (e.g., Mexican American); and (4) have no cognitive and/or educational deficits that would impede completion of study measures.

Participants in this study were recruited from local stores, churches, barbershops, and through word of mouth. Participants were approached and asked to take part in this research study. After obtaining informed consent, the investigators gave the participants an assessment battery of self-report measures. Participants were given the option to answer the questions with no assistance or have the questions read to them. The measures of interest were translated and back translated from English to Spanish by the first author and a research assistant, as they were not already available in the Spanish language. The authors first translated the measures from English to Spanish separately and met on a weekly basis to discuss the transitions in the area of linguistics, conceptual meaning, and functionality. The first author and a separate research assistant then back translated from Spanish to English and met on a weekly basis to discuss similarities and differences from the original English measures. They were compensated $10 for their participation in the study. The university's Institutional Review Board approved this research study.

Measures

Demographic variables (e.g., gender, age, and education level): Information was collected on the following demographic variables: age, gender, education, marital status, religious orientation, place of birth, and insurance status.

Bidimensional Acculturation Scale for Hispanics (Marín & Gamba, 1996): A 24-item scale developed to examine acculturation scores for two major cultural dimensions: Hispanic/Enculturation ($\alpha = 91$) and non-Hispanic/Acculturation ($\alpha = .98$) domains by including 12 items (per cultural domain) that measure three language-related areas. All language-related areas indicated high correlations with generation status and years in the United States. Sample items include, "How often do you speak English and how well do you speak in Spanish?"

Brief Multidimensional Measure of Religiousness and Spirituality (Fetzer Institute & National Institute on Aging Working Group, 1999): A 54-item scale developed to examine key dimensions of spirituality and religiosity and how they relate to physical and mental health outcomes. For the purpose of this study, the *Religiosity* subscale ($\alpha = .86$) was utilised. This subscale measures involvement with a formal public religious institution: a church, synagogue, temple, mosque, etc. (e.g., "How often do you attend religious services?"). Items for the religiosity subscale were transformed to *z*-scores and summed in order to make a normally distributed summary score for religiosity.

Ways of religious coping (Boudreaux et al., 1995): A 40-item scaled developed to examine internal/private religious coping and external/social religious coping. The subscale of internal/private religious coping ($\alpha = .94$) measured the magnitude and types of internal/private religious behaviours individuals may use to cope (e.g., "I say prayers"). The subscale of external/social religious coping ($\alpha = .95$) measured the magnitude and types of external/social religious behaviours individuals may use to cope (e.g., "I go to a religious counsellor").

Attitudes Towards Seeking Professional Mental Health Services-short (Fischer & Farina, 1995): A 10-item scale that assesses an individual's attitudes towards seeking professional help ($\alpha = .85$). Each item is rated on a four-point, Likert-type scale, ranging from 1 ("disagree") to 4 ("agree"). Higher scores are associated with more positive attitudes towards seeking professional help (e.g., The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts).

Data analysis

We examined normality, skewness, and kurtosis for our variables of interest. All variables were deemed fit for analyses. Next, we conducted bivariate correlations to investigate the relationships between our variables of interest. To test the indirect effect of religiosity on attitudes towards seeking professional mental health services though external and internal religious coping, we used Preacher and Hayes' (2004, 2008) bootstrap method using a single-step multiple mediator model. For all of the analyses in this study, we constructed 95% confidence intervals, using 5000 bootstrap estimates. An indirect effect is considered significant if 0 does not fall between the calculated confidence intervals. Unstandardised coefficients for the direct and indirect effects are reported in Table 1. All analyses were conducted using IBM SPSS, version 22.

Results

Preliminary analyses

We present means, standard deviations, and correlations among variables of interest in Table 2. Several one-way analyses of variance indicated that religiosity and attitudes towards seeking professional mental health services did not significantly differ by education, religious orientation, marital, and insurance status. However, there were significant differences in reported levels of religiosity by gender (F (1,91) = 5.51, p = .021), with males (M = 47.74, SD = 11.55) reporting higher religiosity scores than females (M = 40.38, SD = 13.37).

Bivariate Pearson correlations (see Table 2) indicated that there was a significant negative association between religiosity and attitudes towards professional mental health (r = -.29, p = .005). In addition, there was a significant positive correlation between religiosity and both internal (r = .68, p < .001) and external religious coping (r = .71, p < .001). Conversely, there was a significant negative association between attitudes towards professional mental health and external religious coping (r = −.25, p = .02), but not internal religious coping (r = −.17, p = .11). Acculturation was negatively associated with religiosity (r = −.32, p = .002), while enculturation was positively associated with attitudes towards seeking professional mental health (r = .22, p = .04). Given the significant associations between gender, acculturation, and enculturation and the variables of interest, as well as the significance of acculturation to our sample, we controlled for these variables in all subsequent analyses.

Table 1. Mediation model of religiosity on attitudes through religious coping (N = 89).

	External religious coping			Internal religious coping		
	B (SE)	*t*	*p*	*B* (SE)	*t*	*p*
Direct effects						
a path	.63 (.07)	8.57	<.001	.83 (.11)	7.90	<.001
b path	−.04 (.08)	−.56	.58	.02 (.05)	.46	.65
c path	−.16 (.05)	−3.10	.003	−.16 (.05)	−3.10	.003
c′ path	−.13 (.07)	−1.87	.06	−.18 (.07)	−2.63	.01
Total indirect effects						
ab path	−.03 (.05)	–	–	.02 (.04)	–	–
Adjusted R^2	.19			.19		
Confidence interval	(LL = −.14, UL = .07)			(LL = −.06, UL = .11)		

Note: Confidence intervals are biased-estimated intervals; controlling for gender, acculturation, and enculturation.

Table 2. Correlations among religious coping, religiosity, enculturation, acculturation, and attitudes ($N = 89$).

Variables	*M* (SD)	1	2	3	4	5	6
1. External coping	14.09 (11.89)	–					
2. Internal coping	34.86 (16.23)	.70***	–				
3. Religiosity	43.65 (13.25)	.71***	.68***	–			
4. Attitudes	26.43 (6.54)	−.25*	−.17	−.29**	–		
5. Enculturation	3.46 (0.54)	.15	.13	.18	.22*	–	
6. Acculturation	2.51 (1.00)	−.23	−.21*	−.32**	−.09	−.54***	–

Note: 11 out of 100 participants had missing items and were removed from this analysis.
*$p < .05$; **$p < .01$; *** $p < .001$.

Hypothesis-driven analyses

Hypothesis one: Religiosity and help-seeking attitudes

Our findings supported our first hypothesis, as religiosity was a significant negative predictor of attitudes towards professional mental health services. Thus, the total effect (*c* path) of religiosity on attitudes towards professional mental health services was significant ($B = -.16$, $t = -3.10$, $p < .003$).

Hypothesis two: Religiosity and religious coping

We examined the relationship between religiosity and our mediators (*a* path). Consistent with our second hypothesis, religiosity was a significant predictor of both external ($B = 63$, $t = 8.57$, $p < .001$) and internal ($B = 83$, $t = 7.90$, $p < .001$) religious coping.

Hypothesis three: Religious coping and help-seeking attitudes

We predicted that the direct effects of both mediators (external and internal religious coping) would be significant (*b* path). Counter to our expectation, we found that neither external ($B = -.04$, $t = -.56$, $p = .41$) nor internal religious coping ($B = .02$, $t = .46$, $p = .45$) was a significant negative predictor of attitudes towards professional mental health services.

Hypothesis four: Indirect effects of religiosity through religious coping

Counter to our fourth hypothesis, religiosity did not exert significant indirect effects on attitudes towards professional mental health services, through external religious coping (ab$B = -.03$, 95% CI: −.14, .07) or internal religious coping (ab$B = .02$, 95% CI: –.06, .11).

Exploratory analyses

Given the significant gender differences found in our initial analyses, we conducted several moderated mediation models (see Tables 3 and 4) using procedures described by Preacher, Rucker, and Hayes (2007) using PROCESS. We investigated these associations by sex to identify support for possible mechanisms that explain the relationship between religiosity and attitudes towards seeking professional psychological help for Latina/os. As the literature has already suggested differences between males and females regarding attitudes towards help-seeking and religiosity, we explored the possibility that the original mediation analyses would work differently for men as compared with women. Using separate models, external and internal religious coping (mediators) were regressed on

Table 3. Mediation model of religiosity on attitudes through external religious coping with sex as a moderator ($N = 89$).

	B	SE	*t*	*p*	Confidence interval
	External religious coping				
Constant	−15.68	9.32	−1.68	.10	(LL = −34.22, UL = 2.86)
Religiosity	.63	.07	8.88	<.001	(LL = .49, UL = .77)
	Attitudes towards professional mental health services				
External coping	−.28	.13	−2.15	.03	(LL = −.54, UL = −.02)
Religiosity	−.09	.11	−.83	.41	(LL = −.31, UL = .13)
Sex	−.99	5.19	−.83	.85	(LL = -11.31, UL = 9.33)
External coping × sex	−.35	.16	2.17	.03	(LL = .03, UL = .67)
a × *b* (males)	−.18	.08	–	–	(LL = −.34, UL = −.03)
a × *b* (females)	.04	.06	–	–	(LL = −.08, UL = .16)

Note: Confidence intervals are biased-estimated intervals, controlling for acculturation and enculturation.

Table 4. Mediation model of religiosity on attitudes through internal religious coping with sex as a moderator ($N = 89$).

	B	SE	*t*	*p*	Confidence interval
	Internal religious coping				
Constant	−1.67	4.35	−.36	.71	(LL = 31.40, UL = 21.69)
Religiosity	.84	.10	8.22	<.001	(LL = .64, UL = 1.04)
	Attitudes towards professional mental health services				
Internal coping	.03	.13	.25	.80	(LL = −.22, UL = .29)
Religiosity	−.29	.13	−2.16	.03	(LL = −.55, UL = −.02)
Sex	−5.29	4.88	−1.08	.28	(LL = −15.01, UL = 4.43)
Internal coping × sex	−.01	.14	−.08	.94	(LL = −.29, UL = .27)
Religiosity × sex	.17	.15	1.11	.27	(LL = −.14, UL = .48)

Note: Confidence intervals are biased-estimated intervals, controlling for acculturation and enculturation.

religiosity (independent variable), then attitudes towards professional mental (dependent variable) was regressed on religiosity, external and internal religious coping, as well as the interaction between external and internal religious coping and sex (moderator) and religiosity and sex(moderator). Significance tests measure the prediction that the conditional indirect effect equals zero (i.e., not significant) at a specific value (male vs. female). Results indicated that the cross-product term between external religious coping and sex was significant ($B = .35$, $t = 2.17$, $p = .03$), indicating that sex was a significant moderator. To understand this finding, we probed the conditional indirect effect of religiosity on professional attitudes towards seeking mental health services through social coping for males and females separately. Bias-corrected bootstrapping confidence intervals indicated that mediation was observed for men ($B = -.18$, 95% CI: −.34, −.03) but not women ($B = .04$, 95% CI: −.08, .16), which supports moderated mediation.

Discussion

The purpose of this study was to examine the relationship between religiosity and attitudes towards professional mental health services among Latinas/os of Mexican origin in the southwest United States. We further investigated whether internal religious coping and external religious coping mediated this relationship. Results indicated that levels of religiosity were significantly associated with attitudes towards professional mental health services. Specifically, results noted a negative relationship between

religiosity and attitudes towards seeking professional mental health services. In general, these findings are consistent with previous work in this area (e.g., Miller & Eells, 1998). Most of these studies, however, have focused primarily on non-Latino populations and typically with a sample of college students. Our study supports and extends these findings by highlighting how religiosity is significantly associated with attitudes towards help-seeking services Latinas/os. These findings also highlight another predictor of the under-utilisation of formal help-seeking services among Latinas/os in the United States.

Our results also suggest a significant positive relationship for religiosity and both internal and external religious coping. These findings are consistent with the literature (e.g., see Herrera et al., 2009; Moreno & Cardemil, 2013; Sanchez et al., 2012). That is, Latinas/os who report higher levels of religiosity significantly engage in both external and internal religious coping when in distress. Contrary to our hypothesis, our results found that neither forms of religious coping were significantly associated with attitudes towards seeking professional mental health services. Similarly, our results suggest that neither internal nor external religious coping met criteria as a mediator for the relationship between religiosity and attitudes towards seeking professional psychological help. This is a great contribution to the literature as these findings highlight how neither external nor internal religious coping is significantly related to attitudes towards professional mental health services. Although religiosity is significantly and negatively related to attitudes towards professional mental health services, it is not through these coping strategies that we see this relationship among a Latina/o sample. Further research is needed to continue to investigate other possible mediators that explain the significant and negative relationship between religiosity and attitudes towards professional mental health services.

Interestingly, however, our exploratory moderation analyses revealed support for a mediation relationship among religiosity, coping, and attitudes for the men in our sample only. Specifically, we found that for the men, external religious coping (and not internal religious coping) mediated the relationship between religiosity and attitudes towards professional mental health services. These data suggest that the social environment that is part of some forms of religious activities might be associated with men's attitudes towards psychological services. It is plausible that men may be more influenced than women by the attitudes of religious leaders or church members; however, it is also possible that men may be more likely to seek out the company of those with shared beliefs and attitudes. Future research is needed to disentangle these possibilities. This finding is of interest since the help-seeking literature identifies men, especially men from ethnic minority populations, as being less likely than women to seek out mental health services (Addis & Mahalik, 2003; Hodgetts & Chamberlain, 2002; Tudiver & Talbot, 1999).

Limitations and strengths

There are several limitations to this study worth noting. First, the sample was very homogenous in terms of religious affiliation (e.g., Roman Catholic and Protestant Christian backgrounds). Future research should investigate these questions with Latinas/os from different religious affiliations. Second, this Latino sample consisted of individuals of Mexican origin in a state from the Southwest, limiting our understanding of this topic with different Latino nationalities in other geographic regions. Specifically, future research on this topic should seek to include Latinas/os across different regions of the United States.

Third, the focus of the study was on organised religiosity, and so we did not explore spiritual practices outside of traditional religious approaches. It would be interesting for future research to examine how engagement with spirituality (e.g., traditional indigenous spirituality) and religious practices might also be related to coping with adversity and help-seeking attitudes.

Despite these limitations, this study has several notable strengths. First, although there is a growing body of literature that examines the relationship between religiosity, religious coping, as well as attitudes towards mental health services, this is one of the few studies that have been conducted with a Latino sample. Finally, this study extends the religious coping literature by making a clear distinction between internal and external religious coping and its relations to the help-seeking process.

Given that over 90% of Latinas/os self-identify as religious, clinicians who work with Latinas/os may do well to collaborate with religious organisations and leaders to disseminate educational mental health programmes relevant to Latinas/os in the United States and reduce negative attitudes towards mental health services and psychopathology. Additionally, clinicians who work with Latinas/os would do well to address a client's level of religious involvement to further enhance cultural sensitivity. Furthermore, since it is plausible that some Latinas/os, especially Latino men, may be more likely to seek out the company of those with shared beliefs and attitudes, clinicians who work with this population would do well to acquire additional knowledge about the life experiences, beliefs, and values of these religious individuals. This knowledge and sensitivity could play an important role in developing and supporting a strong therapeutic relationship with these clients. It could also help reduce some of the negative attitudes towards mental health services that affect the Latino help-seeking underutilisation.

Disclosure statement

No potential conflict of interest was reported by the authors.

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