Graduate thesis

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Barriers to Access Mental Health Services in a Colombian Village in the Municipality of Icononzo, Tolima

A Qualitative Descriptive Study

Graduate thesis in Clinical Psychology
Supervisor: Lucas Bietti
Co-supervisor: Francisco Lamus Lemus and Katrin Glatz Brubakk
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The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States (Constitution of The World Health Organization, 1946).

Abstract

This graduate thesis in clinical psychology describes barriers to access help from mental health services for people living in a village in the Municipality of Icononzo in the Department of Tolima in Colombia. Data was collected through semi-structured interviews with 12 participants. A thematic analysis led to the identification of nine barriers divided into three main categories: instrumental, intrapersonal and interpersonal barriers. The thesis has been written in collaboration with Rural Health for Peace, a cooperative project between Colombia and Norway, with the goal of improving health services in rural areas of Colombia and make them more available for the people living there.

Resumen

Esta tesis de grado en psicología clínica presenta barreras para acceder a los servicios de salud mental para gente viviendo en una vereda en el Municipio de Icononzo en el Departamento del Tolima, Colombia. Los datos fueron recolectados a través de entrevistas semiestructuradas con 12 participantes. Un análisis temático resultó en la identificación de nueve barreras divididas en tres categorías: barreras instrumentales, intrapersonales e interpersonales. La tesis está escrita en colaboración con Salud Rural para la Paz, un proyecto colaborativo entre Colombia y Noruega con el objetivo de mejorar y hacer los servicios de salud más accesibles en áreas rurales de Colombia.

Sammendrag

Denne hovedoppgaven i psykologi beskriver barrierer som hindrer tilgang til mentale helsetjenester for personer som bor i en bygd i kommunen Icononzo i departementet Tolima i Colombia. Data ble samlet inn gjennom semistrukturerte, individuelle intervjuer med 12 deltakere. En tematisk analyse ble gjennomført og ledet fram til en beskrivelse av ni barrierer som hindrer tilgang til mentale helsetjenester. Disse ble delt inn i tre kategorier: instrumentelle, intrapersonlige og interpersonlige barrierer. Hovedoppgaven har blitt skrevet i samarbeid med Rural Health for Peace, et samarbeidsprosjekt mellom Colombia og Norge, som har som mål å forbedre helsetjenester i rurale områder i Colombia og å gjøre dem mer tilgjengelige for menneskene som bor der.

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List of Abbreviations

FARC-EP	Fuerzas Armadas Revolucionarias de Colombia – Ejército del Pueblo [Revolutionary Armed Forces of Colombia – People's Army]
NCRM	The Norwegian Centre for Rural Medicine
NSD	Norwegian Centre for Research Data
NTNU	The Norwegian University of Science and Technology
PTSD	Post-traumatic stress disorder
QD	Qualitative Description
REK	Regional Committees for Medical and Health Research Ethics
RHfP	Rural Health for Peace
SISBEN	Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales [Identification System of Potential Beneficiaries of Social Programs]
UiT	The Arctic University of Norway
WHO	World Health Organization

Barriers to Access Mental Health Services in a Colombian Village in the Municipality of Icononzo, Tolima

1. Introduction

There is little information about the barriers to access mental health care in Colombia (Campo-Arias et al., 2020). This graduate thesis in clinical psychology seeks to identify and describe the access barriers to mental health services that the population of a Colombian village meet. Colombia has experienced armed conflict for more than 50 years, and a great amount of its population has been affected by it. Several parts of rural Colombia have, throughout the history, experienced the absence of the Colombian state and its institutions, including health services. This has made it easier for armed groups to step in and take control over these areas, and as a result, most of the violence seen during the armed conflict has happened in remote and rural areas (Thomson, 2011). Because of this, a substantial amount of people in rural areas have experienced the war up-close. Tolima, the department in Colombia where the village in this study is located, was one of the epicentres during the conflict. Mental distress and disorders are in general more prevalent among populations that have experienced armed conflict, which is also the case in the specific context of Colombia (Roberts & Browne, 2011; Tamayo-Agudelo & Bell, 2019). Between 2005 and 2008, Doctors Without Borders provided psychological treatment in Tolima, both in urban and rural parts of the department, to people affected by the armed conflict (Sanchez-Padilla et al., 2009). They found more cases of PTSD in the rural compared to the urban population, and the severity of the disorder was also greater in the rural population. This makes the rural population of Tolima a vulnerable group.

In the end of 2016 two of the main actors in the conflict, the Colombian state and the guerrilla group FARC-EP signed a peace agreement. Norway took part as facilitator in the peace process and stands as a guarantor of the peace agreement. The peace agreement states that victims have the right to reparation of the damages that the war imposed on them (Final Agreement to End the Armed Conflict and Build a Stable and Lasting Peace, 2016). This means that people that experience psychosocial, psychological, or psychiatric problems because of the war, by law have the right to get adequate help. To obtain peace and reconciliation after war,

victims need to get reparation, and this includes necessary attention from mental health services. In order for this to happen, people need to be able to access these services.

My thesis is part of the project Rural Health for Peace (RHfP). The project was founded as a cooperation between Universidad de la Sabana (Colombia), Universidad del Tolima (Colombia) and UiT (Norway) in 2018, initiated by The Norwegian Centre for Rural Medicine (NCRM) after they got a request from the Norwegian Ministry of Health. From Norway's side, taking part in this project is a way to support the peace process in Colombia. Through RHfP, a team from the three beforementioned universities aims to follow up the peace process by focusing on the field of health in rural areas. Their goal is to improve the health services in rural parts of Colombia and make them more available for the people who live in these areas. Through my thesis I contribute to the work of RHfP by focusing on mental health services and describing barriers that hinder access to these for people living in rural areas.

The research question of this thesis is "What barriers hinder people in a Colombian village in the Municipality of Icononzo in the Department of Tolima from getting help from mental health services?". The main objective is to identify and describe barriers that hinder people in this village from accessing help from mental health services. The specific objectives are:

- Explore the mental health stigma that may exist in the village.
- Explore what role mental health stigma plays in the help-seeking from mental health services for people that live in the village.

1.1 The Village

The context, and location, of the thesis is a "vereda" (from Spanish: small village) in the Municipality of Icononzo in the Department of Tolima in Colombia, with a population consisting of approximately 120 persons. Hereafter it will be mentioned as *the village*. The population of the municipality Icononzo is 11953. Sixty-nine percent of the population live in rural areas while the rest live in urban areas. The population is relatively homogenous when it comes to ethnicity, and a total of thirty-five persons can be labelled as natives or part of a minority group (Departamento Nacional de Planeación, 2022). When it comes to the gender distribution in the municipality, 52% are men and 48% women.

The average quality of life, socioeconomic status, and capacity to generate income are relatively low among people living in Icononzo, according to the Colombian national system measuring these factors, SISBEN (Departamento Nacional de Planeación, 2021; Departamento Nacional de Planeación, 2022). There are substantial differences between the people living in rural parts of Icononzo when it comes to these three factors, but the average inhabitant scores well below middle. Nine percent of the population of Icononzo is internally displaced because of the armed conflict, and have come to Icononzo after being forced to flee their homes (Departamento Nacional de Planeación, 2022). The rate of intrafamilial violence is also higher in Icononzo compared to the rest of Tolima and Colombia. In Icononzo the rate is 370,3 per 100 000 inhabitants, compared to 161,4 in Tolima and 188,5 in Colombia (Departamento Nacional de Planeación, 2022). The access to education is relatively good in primary and secondary school. Still, compared to the rest of Tolima and the rest of Colombia, the access to education in Icononzo is lower.

Everyone in Colombia shall, in theory, have a health insurance and therefore access to health services. Between 1997 and 2012 the medical insurance coverage in the country increased from 56,9% to 90,8%, while at the same time the access to health services decreased from 79,1% to 75,5% (Ayala-García, 2017). Simply explained, the health system in Colombia consists of contributors to the health insurances and receivers of subsidized health insurances (Prada & Chaves, 2019). The contributors are employees with the ability to pay for the insurance, while the subsidized population consists of persons unable to pay for it. These persons are generally identified in the lower end of the SISBEN system, or they belong to special populations defined as priority by the Government, for example displaced people, indigenous communities, persons demobilized from the conflict, abandoned children, or elderly people in protection centres (Departamento Nacional de Planeación, 2021). Approximately 50% of the population in Colombia is on the contribution side of the health system while the other 50% is on the subsidized side (Ministerio de Salud y Protección Social, 2022). When it comes to health insurance 87,9% of the population in Icononzo get their health insurance from subsidies while 8,2% are contributors to the health insurances. 3,9% of the population is connected to special health care regimes (Departamento Nacional de Planeación, 2022). This speaks to the generally low mean socioeconomic status of the population of Icononzo.

This thesis seeks to identify and describe the barriers that hinder the population of a village in Icononzo from accessing mental health services. Knowledge about their context is important in order to understand why access to mental health services is an issue for them. To obtain information about the barriers specific for this context can contribute to the work of limiting these barriers and make the mental health services more available.

1.2 Barriers to Access Mental Health Services in Rural Colombia

Few studies have looked at access barriers to mental health services in Colombia, and even less in rural areas. One study done in the Colombian coast-city of Santa Marta showed frequent barriers to access help from mental health services (Campo-Arias et al., 2020). Attitudinal barriers were the most prevalent, followed by stigma-discrimination. Instrumental barriers were not significantly present according to the study, which is explained by the researchers as a result of the context: a small city with a well-working public transport service (Campo-Arias et al., 2020). The further away you get from the big cities in Colombia, the further away you get from the health services. If you have been affected by the armed conflict and live in the village of this study, not only do you have a heightened vulnerability to mental health issues, but you also have scarce access to mental health services. The closest hospital, located in Icononzo, only offers primary care. To reach a hospital with mental health specialists you have to travel to Ibagué, around four hours by car from the village.

2. Theoretical Framework

2.1 Social Constructivism

This study is conceptualized in the paradigm of social constructivism, as formulated by Berger and Luckmann (1966). They stated that “knowledge” and “reality” depend on social contexts. Research that wants to find out something about a specific society, in this case the Colombian culture and the rural setting, will therefore have to take the context into account. The first part of the interview was therefore created with the intention of exploring and trying to understand the participants’ concept of mental health and how they relate to it.

2.2 Cultural Sensitivity

When a researcher is going to do research in a culture different from his or her own, there are several ethical and methodological considerations that must be taken into account (Liamputtong, 2008). One of the most important things to consider when doing research in a foreign culture and in a local community is to build trust between the researcher and the members of the community. This can be done through humility, caring and cultural sensitivity (Eide & Allen, 2005). Cultural sensitivity, also called cultural awareness, refers to being familiar with the cultural context of the participants one is to conduct a study on. This is done through knowing key values and stakeholders (Liamputtong, 2008). In other words, one needs to become familiar with the context of the participants. In the case of this study, understanding the socio-cultural context of Colombians living in rural areas, and having insight in the history of Colombia and its long-lasting armed conflict(s), is enhancing the understanding of the issue with access to health services in these areas. Furthermore, understanding the village, its history, the daily lives of the inhabitants and the social structures they form, is essential in answering the research question.

2.3 Access to Mental Health Services

Looking at help-seeking behaviour is one way of examining whether people get the help they need from mental health services. The action of seeking help for a physical or a mental health issue can be described as a planned action centered around a specific problem, and it includes some form of interaction between the person seeking help and a chosen health-care professional (Cornally & Mccarthy, 2011). One of the aims of this study is to describe the barriers that affects this kind of behavior negatively. The concept of access must also be described and discussed before looking at the barriers that may hinder people from getting the help they need. One way to look at access is to see it as a measure of "the degree of fit" between the clients and the health system (Penchansky & Thomas, 1981). To formulate it as a question: Is there correlation between the needs of potential users of the services, and the services that are being offered? Access is a complex concept that needs to be looked at and measured on several dimensions (Gulliford et al., 2002). Gulliford and colleagues (2002) suggested that equity is the most important aspect when measuring access, if the goal is to have egalitarian health systems.

In other words, people should have the same opportunity to get help when they need it. Further, Gulliford and his colleagues do admit that equity might be the most challenging aspect to operationalize and measure.

2.4 Barriers to Access Mental Health Services

Universal access to health services can be defined as the absence of geographical, economic, organizational, sociocultural, or gender barriers (Báscolo et al., 2020; Pan American Health Organization, 2014). Barriers for seeking help from mental health services can therefore be defined as all factors that hinder people from accessing the services offered in relation to mental health issues, at the time when they need help from these services.

Among common barriers found to hinder people from seeking help from mental health services are a low perceived need to seek help, a desire to handle the problem on one's own, a perception that the problem is not that severe, financial barriers, and a lack of availability (Andrade et al., 2014). These barriers were found through a study based on the WHO World Mental Health surveys, administered across 24 different countries ranging from low- to high-income. In another study where they looked at low- and middle- income countries, common barriers to seek help were stigma, both personal and the concern of social stigma; cost of services; lack of support from family and friends; transportation; and knowledge barriers, such as lack of knowledge about mental health problems and available mental health services (Sarikhani et al., 2021).

When talking about barriers for seeking help from mental health services it is useful to divide them into categories. A categorization that has been used by several researchers is the one suggested by Clement and colleagues (2012): instrumental barriers, attitudinal barriers and barriers related to stigma-discrimination. Not knowing where to find help, or not being able to pay for the treatment or the transportation to get to the place where the help is found, are both examples of instrumental barriers for seeking help. Preferring to solve the problem oneself or thinking that the problem will resolve itself are both examples of attitudinal barriers. So are thinking that the treatment offered will not work or be effective or fearing that one will be hospitalised against one's will. Stigma and discrimination, or a fear of either of the two, have received increasing attention as barriers to access mental health services. Mental health-related stigma can be defined as the societal and/or internalized disapproval or discrediting of people with mental disorders and people who seeks help for mental health-related issues (Fox et al.,

2018; Goffman, 1963; Sickel et al., 2014). Studies have shown that this kind of stigma is more pronounced in rural than in urban areas (Schroeder et al., 2021).

In my study I have chosen to categorize the identified barriers in a slightly different way. The concept of instrumental barriers has been conserved, while instead of using attitudinal barriers and barriers related to stigma-discrimination, I introduce two other categories: intrapersonal and interpersonal barriers. I argue that these two categories are less steered by theory and more steered by the collected data, which is in line with the chosen methodology. This categorization still has elements from and shares similarities with the one presented by Clement et al. (2012). The barriers presented and described in this thesis seek to reflect the themes identified through the words of the participants. Intrapersonal barriers are connected to personal attitudes and expectations that may affect help-seeking, while interpersonal barriers arise in relation with other people.

This thesis seeks to answer "What barriers hinder people in a Colombian village in the Municipality of Icononzo in the Department of Tolima from getting help from mental health services?". In the next section I explain how I answered the research question.

3. Design and Method

3.1 Research Design

The research questions of this study have been addressed by using Qualitative Description (QD). QD is a methodology that seeks to answer the "what," "who" and "where" of a phenomenon by staying close to the opinions of the participants of the study (Colorafi & Evans, 2016; Kim et al., 2017; Neergaard et al., 2009; Sandelowski, 2000). A study that uses QD seeks to describe the phenomenon in question as close as possible to the reality expressed by the participants. The methodology is flexible when it comes to its commitment to theory and frameworks, and in this study a social constructivist approach has been used. This study seeks to answer the "what", "who" and "where" of access to mental health services in a Colombian village, and QD is therefore considered an appropriate methodology.

3.2 Participants

The participants invited to take part in the study were people aged over 18 years, living in a specific village in Icononzo, Tolima. The participants had to be able and willing to give their informed consent to participate in the study. To ensure rich data about the phenomenon in question the sampling method of maximum variance was used, in combination with convenience. This involved aiming for a varied group of participants when it came to age, gender, occupation, and time lived in the village. In total, 12 participants took part in the study (see table 1). The age range was between 21 to 78, and the gender distribution was 5 men and 7 women. Three of the participants had earlier received help from mental health services. Some of the participants (7) had lived their whole lives in the village, one participant had grown up there, lived in another place and had come back as an adult, while the rest (4) had moved there as adults. Most of the participants were farmers by occupation. Two of the participants owned local shops in the village while another offered motorbike taxi service.

Table 1

Sociodemographic information about the participants

Sex	n=
Female	7
Male	5
Age	
20-29	3
30-39	0
40-49	2
50-59	2
60-69	4
70-79	1
Occupation	
Farmer	7
Store owner	2
Motorcycle taxi driver	1

Other	2
Earlier contact with mental health services	
Yes	3
No	9

Participants were recruited with the support of RHfP, which was the bridge between me and the population of the village. The team of RHfP has been working in the department of Tolima since 2018 and thus has a network of collaborators in villages in the area, including the village that was chosen for this study. I was introduced to a local woman, "Juliana", and she was my main contact within the community. A pseudonym has been used to protect the anonymity of Juliana and the rest of the community. The participants have also been assigned pseudonyms.

I went to the village five times in total, each time for a duration of three to five days. The first two trips to the village were used to get to know the village and the people living there, build trust and expand my network. During the last three stays in the village, I recruited participants and conducted the interviews.

3.3 Interview Guide

To collect data for the study I used in-depth individual semi-structured interviews. The interviews were guided by an interview guide (see appendix III and IV) that sought to investigate the following three a priori topics:

1. Mental health and mental health problems
2. Help-seeking for mental health problems
3. Mental health-stigma

These three topics and their associated questions were considered appropriate to uncover information about barriers to get help from mental health services. The interview guide was developed under guidance by Ángela Acero, a psychiatrist and professor at Universidad de La Sabana, in order to adapt the questions to the rural Colombian context. The assistance from Ángela was also important to overcome possible language constraints. The interviews were held in Spanish, the native language of the participants. The interview guide was written by me in Spanish and later proof-read by Ángela and one of the thesis supervisors, who is also a native Spanish speaker. I am a fluent speaker of Spanish as a second language, but I am not a native

speaker. The interview guide consisted of a mix of open-ended questions and more closed ones, formulated with the help of my supervisors, Ángela, and two theses regarding attitudes to mental health professionals and mental health-related stigma (Arbeláez, 2021; Sanguino, 2021).

Before interviewing the participants, a pilot study was done with one member of the village. This was done to further adapt the interview guide to the context and to make sure that the questions would be understood by the people that were going to take part in the study. It was also done to test the audio recording equipment in the environment where I was going to do the interviews. During this process I became aware that some of the questions had formulations that were too complicated, and these were therefore simplified. Some changes were also made to make the questions less complicated and more understandable. For example, in question 3.1 the symptoms mentioned were changed from "flashbacks and sadness" to "anxiety and sadness". All the changes were small, but they made the interview flow better. The last, but maybe most important thing that I added to the interview was the following sentences: "There are no correct answers to the questions I am going to ask you. The only thing I am interested in is knowing what you think about these things". This was done to let the participants know that I was not looking for specific answers to my questions and to show them that I was interested to hear what they were going to tell me.

3.4 Interview Process

The interviews were conducted in July and August 2022. They were conducted in the homes of the participants or the home of Juliana, depending on convenience and what the participants themselves wanted. Before the interview started the participants were presented with a document that contained information about the study including a consent form (see appendix I and II). The participants were given time to ask me and Juliana questions about the study and they all signed the consent form before starting the interview. One participant had some questions about the audio recorder and the consent form before starting the interview but seemed content regarding the answers he got and consented to take part in the study and be audio recorded. After the participants had signed the consent forms, I started the audio recorder, and the participants were informed about this. All the participants were interviewed by me, and Juliana accompanied me during all the interviews. The audio recorder did not seem to bother any of the participants. The interviews lasted between 30 and 60 minutes. After the interviews I

checked the audio files and wrote down my immediate thoughts and reflections about the interviews.

3.5 Transcription and Storage of Data

The interviews were recorded and later transcribed, partly by the program HappyScribe (n.d.), and partly by me. Afterwards, 27% of the transcriptions were quality-checked by one of the thesis supervisors, who is a native Spanish speaker. The audios were transcribed word for word, including sounds aiding the flow of conversation such as “hmm”, “ehh”, and “mhm”.

During the interviews two recorders were used, in case of technical issues. Since the interviews were done in a village without connection to the internet, the audio files were saved locally in the recorder and in my personal computer. The personal information of the participants was anonymized as the files were saved, by giving the files names that consisted of one letter and one number. The transcribed files did not contain information that could identify the participants, as names and personal information were anonymized in the transcription process.

3.6 Analysis

A thematic analysis was conducted to develop themes from the data collected in the interviews. This was appropriate, as it is a method of analysis which seeks to identify, analyze, and describe themes in qualitative data. The analysis followed the 6-step guide presented by Braun and Clarke (2006): 1) familiarizing oneself with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes, and 6) writing the report. I generated the initial codes and proposed preliminary themes that were then reviewed by my supervisors. After some rounds of refining the themes, the analysis resulted in nine themes.

The second and third step in the thematic analysis was done by using the internet-based program DeDoose (Salmona et al., 2006). DeDoose is a tool used for mixed-method research that enables the user to do manual coding of data in an efficient and structured way.

To identify themes that would answer the research question I used several techniques during the thematic analysis. To choose which techniques to use I consulted the flow-chart presented by Ryan and Bernard in their article, “Selecting among Theme-Identification Techniques”, as a guideline (2003, p. 102). The choice of techniques was based on the type of data material, which was verbatim text with relatively brief descriptions. The scrutiny techniques

I used the most were similarities and differences, and repetitions. To a certain degree I also looked for metaphors and analogies, but because I am not a native Spanish speaker these techniques were of less relevance in the theme development process. Still, there were instances where these techniques contributed to the development of certain themes. The only processing technique I used was cutting and sorting, which is considered to be one of the most versatile techniques to identify themes (Ryan & Bernard, 2003). To describe my theme identifying process, I will use the theme "gossiping" as an example.

The first step in a thematic analysis is to familiarize oneself with the data. This step started during the interviews, continued through the transcription phase and lasted until I started generating codes. Already during step 1) I noticed that the participants mentioned gossiping and a lack of trust between people several times, and that they would rather keep personal things to themselves than sharing them with the neighbors. They were afraid that the information would be spread throughout the village and that "todo el mundo" (in English: the whole world) would know about their private life. This struck me as important in relation to the research question, because not talking with the people around you is counter-productive if you want and need to seek help. When I started step 2) of the thematic analysis "gossip" (in Spanish: chisme) was one of the first codes I made, due to the frequency of the word. In some interviews the word was mentioned several times, and thus, the techniques of looking for similarities and differences, and repetitions, were important in the development of this theme. Example of excerpts that were coded "gossip" are: "I don't think I would talk about it because maybe they would start bullying", "the whole village will know and they will make fun of me", "here, there's a lot of gossip…", "look, the gossiping around here, everyone will know", and "small village, big hell" (in Spanish: "pueblo pequeño, infierno grande". Expression that describes the tendency of gossiping in small communities). Other codes were also made, such as "lack of trust", "lack of confidentiality", "making fun of", "keeping things inside", but in step 3) and 4), through using cutting and sorting, it became clear to me that they were all connected to the same phenomenon. Therefore, in step 5), these things were integrated and became part of the definition and description of the theme "gossiping".

4. Ethical Considerations

The study follows the guidelines given by the Declaration of Helsinki (World Medical Association, 2013) and the Colombian ethical guidelines given in Resolution 8430 (Resolución número 8430, 1993). The Norwegian Center for Research Data (NSD) was consulted since the collection of data included recording and saving of the interviews (Norwegian Center for Research Data, 2022a). NSD gave their approval to conduct the study. No health information was collected, and personal data such as name, was anonymized. Regional Committees for Medical and Health Research Ethics' (REK) guidelines were consulted. This study was not considered to coincide with research that should be followed up by REK, and therefore it did not need their approval (Regional Committees for Medical and Health Research Ethics, 2022). Since the study was conducted in Colombia, local approval was sought and given. This was through presenting the thesis project to the "Subcomisión de Proyección Social de la Facultad de Medicina de la Universidad de La Sabana" (Social Projection Subcommittee of the Faculty of Medicine of La Universidad de La Sabana), which considered the ethical and methodological aspects of the study.

Written consent was provided by all participants (see appendix I and II) (Norwegian Center for Research Data, 2022b). In addition, all participants received oral information about their right to withdraw their consent at any point without any consequences.

Before recruiting participants and conducting the interviews, I met with a local psychologist in Icononzo. I informed her about the study I was going to do and she agreed to be the emergency contact should some of the participants have the need to talk with a mental health professional during or after the interview. The participants were informed about this both verbally and through the information letter they received before taking part in the study.

The name of the village and the participants have been anonymized in order to reduce the risk associated with the participants being identified. This consideration is important especially in cases of domestic violence, which is a topic being handled in my thesis.

5. Results

For various reasons, accessing mental health services is difficult for people living in the rural area of Colombia. With my thesis I seek to describe not only the physical and economical

barriers to access mental health care, but also to gain a greater understanding of the social and psychological factors affecting help-seeking.

Through the thematic analysis nine themes were developed. Each of these themes is an answer to the research question "what barriers hinder people in a Colombian village in the Municipality of Icononzo in the Department of Tolima from getting help from mental health services?". In the discussion part the specific objectives of the study will be answered through diving further into some of the identified barriers. The barriers have been divided into three categories:

- Instrumental barriers
    - Lack of local mental health services
    - Limited transportation
    - Lack of money to pay for transportation and treatment
- Intrapersonal barriers
    - Stoicism
    - Male role expectations
- Interpersonal barriers
    - Gossiping
    - Fear of being a burden
    - Fear of rejection
    - Intimate partner violence

All barriers have foundation in the interviews, and support in already existing studies done on barriers to access mental health services (Erdem et al, 2020; Galdas et al, 2005; Jackson et al., 2007; Kantor et al., 2017; Kaukiainen & Kõlves, 2020; Martinez et al., 2020; Mason, 2016; Rice et al, 2018; Salaheddin & Shaheen et al., 2020; Silva et al., 2022). My study adds value to the field because few studies have been done on barriers to access mental health services in rural parts of Colombia, and even fewer of these are based on qualitative data collected directly from members of a rural population, the people who are faced with the barriers.

In the following sections each of the identified barriers will be presented with examples from the interviews and relevant literature. The quotes from the interviews have been translated from Spanish to English by me. Brackets containing formulations by me have been used in the excerpts to elaborate where I found this necessary. The names used to present excerpts from the

interviews are pseudonyms in order to protect the anonymity of the participants. In some of the excerpts, the contributions to the conversation by Juliana and me, have been included. This has been done to show the dynamic of the interview where this is considered relevant, and because some of the excerpts must be seen in its context in order to make sense.

5.1 Instrumental Barriers

Instrumental barriers to access help from mental health services include among other things the lack of knowledge about where to find the necessary help, and financial barriers such as not affording to pay for the treatment or transportation to get to where the services are located (Clement et al., 2012).

5.1.1 Lack of Local Mental Health Services is the first instrumental barrier identified to hinder access to mental health services. Normally, it is necessary to physically meet a mental health professional to get psychological help. Today, there is a growing use of internet-based solutions in therapy, which makes the distance between patients and professionals less relevant, but in the case of the village this is still a problem, since the telephone signal and access to the internet is limited (Departamento Nacional de Planeación, 2022).

In one of the interviews, it became evident that there is a lack of local mental health services and professionals in and around the village, as Darío hypothetically asked: “Well, one asking for help here... from who?” First, there is no psychologist in the village. In Icononzo, the nearest small town, there is a psychologist, but rather than working with clinical therapy, she is involved in various community projects, such as an activity group for children with intellectual disabilities. If you need help from a psychologist you need to travel to Ibagué or another city in the department, Tolima, and this will take you at least four hours by car.

5.1.2 Limited Transportation is another instrumental barrier to access mental health services, and it is closely connected to the lack of local mental health professionals. As a result of the relatively long distance between the mental health services and the homes of the inhabitants in the village, they are dependent on transportation to access the services. For several reasons, it is not always possible to get transportation. As Petro stated: “There is no transportation, no motorcycles, nothing.” Transportation does exist between the village and other

villages and cities in the area. However, the problem is that the transportation is scarce and not always available. Availability of transportation depends on which day and which time of the day it is. There is a local bus passing the village, but it does not pass every day and the days it comes it only passes twice, early in the morning and in the afternoon. The availability of transportation also depends on the weather, since the rain often overflow the roads and make them impassable.

5.1.3 Lack of Money to Pay for Transportation and Treatment was also identified as an instrumental barrier. Mental health professionals can be found at a four-hour distance from the village, but even if the transportation is available another issue is the economic part of traveling and paying for the treatment. In some cases, the health insurance might cover psychotherapy, in others not. And even if the fee for the treatment is covered by the health insurance, the cost of transportation might be a barrier.

Eight of twelve participants mentioned economic problems or a lack of money as a barrier to seek help or a barrier to have a good mental health. “Poverty itself”, José said to me when I asked him what the barriers to have a good mental health for people living in the village were. If you struggle affording more than two meals per day, having the money for transportation and paying for treatment is not even a topic.

> They don’t tell me “Don’t worry, come here and I’ll borrow you some money”, no, they only say “don’t worry”. And that happens! It has happened to me, that’s why I say, “calm down, calm down, what??”. That’s already a problem that the psychology, you... one can’t relax until the debts have been paid.

In the excerpt above, Petro expresses his frustration: if you have debts, your problems will not be solved by going to a psychologist. Living in poverty is a barrier to access help from mental health services, and it is also a driver of mental health issues, such as depression and anxiety (Ridley et al., 2020).

5.2 Intrapersonal Barriers

The second category of barriers to access mental health services is intrapersonal barriers. These barriers are related to attitudes and expectations that people may have towards themselves,

others and life, that might affect their help-seeking behaviour. In this thesis two intrapersonal barriers have been identified: stoicism and male role expectations.

5.2.1 Stoicism was identified as an intrapersonal barrier to seek help from mental health services. In this study I have applied the modern usage of the word. According to this, a person who is stoic accepts things as they are and endures the hardships and pains of life without complaining and in a manner where feelings are not shown (Kaukiainen & Kõlves, 2020). Key components of stoicism are suppression, emotional control and denial (Wagstaff & Rowledge, 1995). People with high levels of stoicism have been found to have negative attitudes toward seeking help, in combination with lower intentions to seek it (Kaukiainen & Kõlves, 2020). A stoic and self-reliant attitude towards life is generally observed to be a more common value among rural residents, than among urban ones, and especially among farmers (Jackson et al., 2006).

Eight out of twelve participants, both men and women, uttered words and sentences that may reflect the existence of stoicism as a barrier to seek help from mental health services. For example, Carlos told us about the death of his mother, and how he handled the grieving process:

> **Carlos:** (…) it was when my mother died.
> **Synne:** Ahh… Difficult.
> **Carlos:** Oh yeah, that was really difficult.
> **Juliana:** Hard, it must have been really hard for you. Difficult.
> **Carlos:** I cried over her for a year.
> **Juliana:** And you what? What did you do with those feelings? Did you carry it alone, kept that pain inside?
> **Carlos:** I carried it alone, I didn't…
> **Juliana:** You didn't go to a psychologist? You didn't talk with a friend? With family?
> **Carlos:** No, no, no, I, I suffered alone.
> **Synne:** Yeah.
> **Carlos:** I mean, what I was thinking, I carried it alone, I kept it inside.

If you *need* help but do not seek it, as a result of thinking you should be able to control your emotions and endure all the hardships and pains in your life, having a stoic attitude might

have become a barrier to seek help from mental health services. Clara said “I’m calm, or, I mean, I’m relaxed, and I let it pass.”. Martín said “(…) When I have such problems, like, when I feel like that, I… I solve it myself.” This can be a good coping skill, depending on the issue at hand, but it can also turn into an attitude that hinders the person from thinking that seeking help is an alternative. If the person finds himself in a situation that is too challenging to solve by himself, it might, at best, delay the help-seeking, and in a worst-case scenario hinder him from seeking it at all.

Stoicism seems to be an important coping mechanism in handling difficult experiences in life. In one of the interviews, Petro told us about how his father was killed right in front of him when he was only nine years old. Through the way he spoke about difficult moments, it became evident that it had been necessary for him to endure and push forward in life. It seemed like this was an attitude he passed on to his children as well:

> To my children I say “well, one has to move forward”. Let’s put it this way, I didn’t have any support, I didn’t have support from anybody, I had to… with my fingernails [expression used when someone has had to make a big effort, often pushed to his limits]. Like we say, oh well, it’s okay, it’s all good, right? No, no more. But the memories… For me, really tough ones, yes, I have those.

Stoicism emerged as a barrier to seek help from mental health services based on the repeated pattern seen across several interviews: the participants elaborated on difficult moments in their lives, and at the same time expressed the necessity to keep things inside, move forward, solve things on one’s own, and let things pass.

5.2.2 Male Role Expectations were identified as another intrapersonal barrier to get help. This barrier shares similarities with stoicism, but through its definition it becomes clear that this barrier affects a specific gender because of the expectations connected to it. While stoicism is more of an attitude towards life, male role expectations is related to the role in the community you live in, and it is therefore to a greater degree socially influenced. The expectations connected to the male role might be coming from the community and thus be external expectations, but a man can also have internalized expectations about how a “proper man” should be.

Male role expectations include being strong, resistant and invulnerable (Rice et al., 2018), characteristics typically associated with masculinity, while features such as softness, emotionality and vulnerability are strongly connected to femininity. To uphold the image of being masculine, a man's behaviour must be in line with the masculine characteristics. Health-promoting behaviour, such as using sunscreen when standing a whole day out in the fields, might stand in contrast to the image of masculinity (Campbell et al., 2006), because as a man you are supposed to be able to stand out there in the sun enduring its damaging rays. Seeking help from mental health services is also a health-promoting behaviour and can thus be perceived as a result of weakness and therefore a threat to one's masculinity. Not only because of its health-promoting feature, but because talking about one's feelings is perceived as more of a feminine quality. Seeking help from mental health services can be connected to a feeling of embarrassment (Rice et al, 2018). Furthermore, this kind of behaviour might lead to an anticipation of being met with judgment, stigma and shame, because one does not live up to the expectations connected to the male role.

Campbell at al. (2006) explores how masculinity affects different aspects of the life of people living in rural areas. One description they were presented with, by a man living in a rural area, was that through living up to the expectations of being strong, silent and tough, he had added layer upon layer inside of himself, and this had made him create a veneer for himself, an image pointing towards something that hinders someone from outwardly showing emotions. The man stated that this did not make him *feel* tough, even though his surroundings might have perceived him as such.

Five out of twelve participants said things that could support that male role expectations are hindering men in the village from seeking help from mental health services. During her interview, Alejandra stated and asked in the same utterance, "I think very few men go to the psychologist, right?". It is a general understanding that seeking help from mental health services is more difficult for men than for women (Erdem et al, 2020; Galdas et al, 2005; Rice et al, 2018). As Clara put it in her interview: "We [women] think about more things, the men, well, they're different.". Here, Clara expresses that she has identified that there is a difference between men and women. She says that women think about more things than men, and it can be assumed that this is based on her experience during conversations: that women talk and verbally share more than what men do. Further, José shared some reflections around how men and women are

different when it comes to expressing and talking about feelings:

> Yes, undoubtedly, undoubtedly. The woman is much better when it comes to that [talking about her and others' feelings]. The woman has like a, like a predisposition, more sensitivity, I would say, and the man is more like an... iron. The man has more of a shield around himself, and sometimes he dismisses those kinds of things, and thinks that those topics are reserved for women, if you understand what I mean?

The man is here presented as tough, and even compared to an *iron.* This metaphor points towards the man as someone durable, robust and stable. Further in the excerpt the man is presented as seemingly reluctant to dive into his feelings. This points toward a difficulty in engaging in and talking about issues related to mental health. The image of the man as someone who must be strong and tough, in opposition to someone who opens up about their feelings and shows vulnerability, seems to hinder men from getting help when they need it. One of the female participants, Paula, expressed concern regarding her husband, who, like a lot of other men, struggles to open up about how he is doing, even to his own family: "My husband too. He's also part of that, my husband. And he represses a lot. So, when he finally lets things out that's, that's terrible...".

Male role expectations emerged as a second intrapersonal barrier to seek help from mental health services. It is a barrier that specifically hinders men from accessing help, and has basis in the expectations connected to the image of the masculine man. Being vulnerable is associated with weakness, and stands in contrast to the concept of masculinity. It might therefore be more difficult for men to seek help from mental health services than for women.

5.3 Interpersonal Barriers

The last category of barriers to access help from mental health services is interpersonal barriers. These barriers must be seen as a result of dynamics which have arisen in the relationships between the person that needs help and the people around him or her, or the community he or she is part of. Rather than being direct barriers to seek help, I suggest that these can be moderating factors that either hinder or slow down the help-seeking process. The interpersonal barriers seem to work in such a way that if a person in need of help from mental health services should disclose information about this to the people around him or her, the

reaction from the family, friends, or the community is something that might interfere in the help-seeking process and in this way pose a barrier to seek further help.

5.3.1 Gossiping was identified as an interpersonal barrier to seek help. This kind of behaviour involves the sharing of information about a person who is not present (Dores Cruz et al., 2021; Foster, 2004; Tan et al., 2022). The information being shared is often described as reputational information and is believed to be an important way to promote cooperation among existing and future in-group members (Tan et al., 2022), play a role in partner selection (Dores Cruz et al., 2021), and constitute an effective and low-cost form of punishment against free riders in the community (Wu et al., 2016).

Through gossiping the members of a community can share information about fellow members. If someone behaves as a free rider, and acts in ways that fall outside of existing norms, this might be perceived as a threat to the community. To counteract this kind of behaviour is therefore desirable, and gossiping is a means to do this due to its efficiency in spreading information about *who* the person is and *what* he or she is doing. Gossiping might, in an evolutionary perspective, be useful and even essential in the development of our societies, but when it comes to mental health and illness, and seeking help from mental health services, rather than having a useful function it might create barriers.

Almost all participants, 9 out of 12, mentioned that they would rather keep quiet about their personal issues, because they feared that the information would be spread throughout the whole village. Patricia said that “Yes, because if one for example goes to the neighbour [and shares something], that “Fuh! Fuh! Fuh!”. There seems to be an expectation in the village that the information you share with your neighbour will not be held in confidentiality, but rather be spread in all directions.

Early in the interview process it became evident that the phenomenon of gossiping is engrained in the community, the following quote by Patricia being a good example of this: “(...) Because you know, love, that “small village, big hell”, ha-ha-ha”. She said this in a matter-of-fact kind of way. The Colombian saying “pueblo pequeño, infierno grande” (in English: “small village, big hell”) pretty much sums up the phenomenon of gossiping in small communities. Gossiping is a part of the daily life in the village, and it is reasonable to think that this is part of the reason why several of the participants mentioned lack of trust as an issue. At least when it

comes to trusting fellow inhabitants with personal information. Gossiping might therefore pose a barrier to be open about mental health problems.

As mentioned above, the interpersonal barriers might not necessarily be direct barriers to seek help from mental health services, but rather something that moderates the help-seeking behaviour. If you do not know where the information you share with the people around you end up, this might discourage you from opening up about the things you struggle with. As José exclaimed when I asked why he would rather keep things for himself: “Look, the gossip here, everyone knows!”.

Some participants mentioned that people would make fun of them if they told them about their mental health problems. If you fear that the people around you will laugh and make jokes about your vulnerabilities, this can lead you to prefer to keep things inside instead of talking about how you are doing. José continued after I asked him whether he would tell the people around him about it, if he had any mental health issues:

> Impossible, impossible, because then, to begin with, they don’t answer you and nothing is solved, and they will break you down in the blink of an eye because the whole village will know, and they will bully you for whatever is happening to you.

Not only does gossiping seem to be a barrier to open up about your problems to friends, family and neighbours, but Paula also said that: “If the person was from here, from the community, I would never have gone [to the psychologist]”. There is a lack of trust inside the community that seems to affect the willingness to seek help from in-members, even if he or she was a mental health professional.

Gossiping was identified as an interpersonal barrier to access help from mental health services, based on a substantial part of the interviews. Seventy-five percent of the participants mentioned that they would rather keep things to themselves, because of the fear of gossiping. Gossiping seems to influence the trust between people in the village, and might affect help-seeking indirectly because people fear that they will be made fun of and talked about behind their back.

5.3.2 Fear of Being a Burden is another interpersonal barrier. A burden is

something that is heavy to carry, maybe even a bit heavier than what the carrier can handle. Figuratively speaking a burden is something that might be hard for us to accept and something that weighs us down. A fear of being a burden can therefore be framed as a fear of being "too much" for the people around you, and a perception that if you bring all of you to the table, this will be difficult for people to handle. There might be an anticipation that the receivers will start worrying or become sad and experience negative emotions as a result of you disclosing information about your mental health issues. Several studies on barriers to access help from mental health services have identified fear of being a burden as a barrier (Martinez et al., 2020; Salaheddin & Mason, 2016).

This barrier was based on the answers of 3 of the 12 participants. These participants expressed that they would rather keep things to themselves because they feared that disclosing would be burdensome to the ones that they shared it with. This can be seen in an excerpt from the interview with Laura and Rosa. They were interviewed together because they expressed that this would make them feel more comfortable in the interview setting.

> **Synne:** So, you think a lot about how she feels?
> **Laura:** Yes, of course.
> **Rosa:** Yes, definitely!
> **Laura:** Because it can affect her as well.
> **Rosa:** Worry. That, yes, she will become sad, or, well, she will feel worse than the one [who discloses], so it's worse.

The following excerpt is interesting, because it seems like Rosa thinks it would be better to talk with a psychologist than her mother or other loved ones: "Well, I would prefer a psychologist. Because if you start sharing how you're feeling and what is happening to you, let's say to your mom, it's like... it's worse. Because she'll start worrying.".

Fear of being a burden emerged as a barrier in a small amount of the interviews. Twenty-five percent of the participants mentioned that they preferred keeping things to themselves because they did not want to bother or burden their loved ones. This is seemingly not excluding the opportunity of them wanting to talk with a mental health professional, but it is still considered a barrier because it indirectly might influence the behaviour of seeking this help.

5.3.3 Fear of Rejection is similar to fear of being a burden in the way that it is an anticipation of a negative reaction from the receiver of the disclosed personal information. Rejection is a way of showing that something is not accepted and can be a very powerful and efficient tool in social relations to say that something is not okay. The person that is experiencing rejection is not being met by the other party in what he or she is experiencing, and this can result in negative emotions and a decreased willingness to open up about his or her issues. If you are being rejected when you disclose sensitive information about yourself, the message that is being conveyed by the receiver is that sharing this kind of information is something that is not accepted. Drawn further, to have mental health issues is not something that is looked upon as accepted. Rejection as a barrier to seek help from mental health services has been seen in correlation with stigma and shame (Kantor et al., 2017). Choosing not to disclose might be a way to protect oneself from the pain and shame one might experience as a result of being rejected.

In the interviews 9 of the 12 participants mentioned things that could support that fear of rejection is a barrier to seek help from mental health services for people in the village. One of the things that the participants mentioned was that they did not want to disclose personal information to other people because there was a lack of trust between them:

> **Synne:** When you experience any of these emotions or sensations, can you talk with other people about it?
> **Andrea:** Well, I would like to.
> **Synne:** Yes, so you want to do it, but...
> **Andrea:** Yes, I want to do it, but one doesn't have, like, the trust.

Other participants had an expectation that people would not care if they disclosed topics related to their mental health. Laura said,

> And sometimes, well, like we said, if something happened, I would tell my mom because she will pay me attention, or my sister. But with other people, no, because they don't care. Like "blah... why are you telling me this?".

Laura expresses that she would rather talk with her sister or her mom about sensitive topics, because she expects that she will be met by indifference or even irritation if she discloses to other members of the village. Petro expressed similar expectations toward disclosing personal information: “Because, like, like, what’s my friend trying to say? That he doesn’t give a shit about how I’m doing?” Being met in this way by someone you are trying to disclose important information about yourself to, is a rejection. Laura continued talking about the indifference she expects being met with, and in the following excerpt we can see that a consequence of this is to avoid disclosing:

> Or she doesn’t care. Let’s say that I’m sad, and I tell her, let’s say she’s not my sister, she’s another person, like, normal. I tell her about my sadness, and she doesn’t care. Like she doesn't pay me attention and because of that I don’t vent with her.

Laura expressed that she can talk with her family, and that they will not reject her, but José had a different experience with this: “But [telling it] to the family would be terrible, because instead of helping they’d condemn me.”

Fear of rejection shares some similarities with fear of being a burden, in the way that it is a negative expectation connected to how people will react should you disclose information about you struggling with mental health issues. The person being rejected might experience shame; therefore, it might seem like a better option not to share personal information or disclose.

5.3.4 Intimate Partner Violence is not only damaging to the mental health of the people experiencing it, but it can also be a barrier to seek help from mental health services. Intimate partner violence, also called domestic violence, can be defined as physical violence, stalking, psychological aggression and sexual violence exercised by a partner or ex-partner (Buchanan & Jakuboski, 2022). Even though intimate partner violence can be experienced across different ages, socioeconomic statuses, gender, heterosexual and homosexual relationships, there are factors that may increase the probability of its occurrence, such as low income, and on the abuser's side depression, personality disorders, low academic achievement, delinquency in adolescence, heavy alcohol use, and experiencing or witnessing violence as a child (Buchanan & Jakuboski, 2022). On a community level poverty and the reaction of the community to intimate

partner violence are factors that might affect its prevalence (Buchanan & Jakuboski, 2022). In Icononzo, the rates of intrafamilial violence are higher than the rest of the department, Tolima (TerriData, 2022), which makes it a relevant barrier to examine.

There are different reasons as to why being in a violent relationship can function as a barrier to seek help from mental health services. Qualitative studies have identified several barriers to seek help from health professionals and disclosing information about intimate partner violence, including fear of repercussions, being blamed, being labelled "mentally ill", losing access to children, bringing shame upon oneself or the family, or being ostracized from the community (Shaheen et al., 2020; Silva et al., 2022).

Intimate partner violence as a barrier to access help from mental health services was identified in two of the interviews, and I had to consider whether this was enough to defend its existence. Even though the data comes from only two of the interviews, I argue that the importance and impact of this barrier become clear through the excerpts presented.

> **Patricia:** So, one goes back to the moment, it's like "isss!", forget about it all, if you understand what I mean? Like, to say something, I've been thinking, like "I'm going to sell this house, this home, and leave!". Hm? It's not all roses. And sometimes people physically abuse you, and mentally too, and one hour or two later...
> **Juliana:** They want to pretend that everything is normal.
> **Patricia:** Normal! As if nothing happened. Right?
> **Juliana:** I told Synne that, what happens in this country is that...
> **Patricia:** Yes, it's...
> **Juliana:** But he [her husband] has never touched me, never...
> **Patricia:** Uff, my husband has hit me... [crying].

During the interview with Patricia, her husband came back home. Some minutes earlier she disclosed to us that her husband had hit her. When we came to the part of the interview where I asked about barriers to have a good mental health and to seek help from mental health services, she mentioned the word "fear" and pointed with her head in the direction of the room where her husband was. The following excerpt gives support to the notion that intimate partner violence is a barrier to seek help:

Synne: And in your community, what are the barriers to have a good mental health or emotional well-being? What are the barriers?
Juliana: Why do you think that the people here in the village, from [name of the village], don't seek out, let's say, look for help?
Patricia: Because of fear.
Synne: Fear of what?
Juliana: Because of fear of what, do you think?
Patricia: Because... Because then... From... [talking with a low voice to avoid that her husband listens].

As Patricia briefly mentioned in the first excerpt, you can experience both physical and mental abuse from your partner. Alejandra reflected upon the different forms violence from an intimate partner can take:

Alejandra: I think that it's still, well, not like it was, but they are still (…) well, maybe they don't hit them anymore, but they do treat them [wives], like, badly.
Juliana: Like, other types of abuse.
Alejandra: Like other types, yes.
Juliana: Like... we've been talking about psychological and emotional abuse.
Alejandra: It's not only to hit her.
Juliana: (…) and economical abuse.
Alejandra: Exactly, economical.

Further, she elaborated on her experience of being economically independent from a young age, and how this had given her the freedom to divorce from her husband. She emphasised that this was not necessarily the case for most women living in the village and other rural areas. For her, it had been possible to say "no" to stay in a relationship with a husband she characterized as "rude". As she put it: "I prefer a husband that - that doesn't give me that much luxury, but that treats me well and isn't rude. I think that my husband was very rude."

Seeking help and disclosing information about experiences connected to violence from an intimate partner is often avoided because of fear. The importance of this barrier is highlighted through the high rate of intrafamilial violence in Icononzo.

6. Discussion

In my thesis I have attempted to answer the research question “What barriers hinder people in a Colombian village in the Municipality of Icononzo in the Department of Tolima from getting help from mental health services?”. The main objective was to identify and describe the barriers that hinder people in a Colombian village from accessing mental health services. The specific objectives of the study were to 1) explore the mental health stigma in the village, and 2) what role it plays in people’s help-seeking.

6.1 The Absence of Mental Health Services

This study identifies and describes barriers between people living in a village in Colombia and mental health services. It is assumed that limiting the effect of these barriers would lead to better access to mental health services for the inhabitants of the village. The first barriers presented in this study are instrumental barriers to access help from mental health services. According to the participants of the study, there is a lack of local mental health services, the transportation is limited, and a substantial part of the population lack money to pay for both transportation and treatment. Overcoming these instrumental barriers would imply either bringing the mental health services closer to where people are living, or improving the economic situation of people, so that they can access the services despite the physical distance and the costs associated with it.

Help from mental health services is perceived by several of the participants as too costly compared to their purchasing capacity. The economic situation of the people living in the village is hindering them from accessing mental health services. Studies show a clear correlation between poverty and mental illnesses such as depression and anxiety (Ridley et al., 2020). Based on this and statistics regarding socioeconomic status in the current context (Departamento Nacional de Planeación, 2022), it can be assumed that the average inhabitant has a heightened risk of having mental disorders, at the same time as having limited access to mental health services. As the situation is today there seems to be an absence of a health professional that can attend the psychological needs of the population of the village. This raises questions regarding how the health system is structured and what can be done to make it fit better with the social, physical, and economic structures and constraints that forms the context of the village.

Statistics showing that the medical insurance coverage in Colombia increased, at the same time as the access to health services decreased (Ayala-García, 2017), is a good example of how complex the issue of access is. When other significant barriers are still present, such as distance and a lack of transportation, a better health insurance will probably not make much of a difference for people in the village or other similar contexts. The importance of health insurance coverage should not be undermined, but if the health care system is not adapted to rural contexts, the access people living in these areas have to the services cannot be called more than theoretical. This is why projects such as Rural Health for Peace are important, because they seek to uncover the reality of health care access from the perspectives of the people that are faced with the barriers.

6.2 Mental Health-Related Stigma

Even though the instrumental barriers to access mental health services might be the greatest hinders, mental health-related stigma also seems to influence the population of the village in this study, when it comes to seeking help. This kind of stigma seems to be more pronounced in rural than in urban areas (Schroeder et al., 2021; Stewart et al., 2015; Thornicroft, 2008), and affects help-seeking for mental health problems negatively (Clement et al., 2015; Ferris-Day et al., 2021; Otálora et al., 2021). In smaller communities, such as the one in the village of this study, it is more difficult to remain anonymous than in towns and cities. This might be a driver of the heightened stigma seen in rural areas, since people fear that information about their mental health and them seeking help from mental health services will be known to the whole community (Thornicroft, 2008). The existence of mental health-related stigma in the village can be seen through the identified barriers in this study, and especially the interpersonal barriers gossiping, fear of being a burden, and fear of rejection. One could therefore say that the stigma related to mental health is an overarching barrier to access mental health services, and that the interpersonal barriers are all different expressions of this kind of stigma. The participants mentioned that they would rather keep things to themselves than sharing it with neighbours and friends. The explanations they gave were among others that they feared people would make fun of them, spread their personal information behind their backs, be indifferent to them, talk badly of them, be upset, or worry. To fully understand how mental health-related stigma affects the

people living in the village and their access to mental health services, further research in this context is needed.

6.3 Rural Men and Rural Women Meet Different Access Barriers

Three of twelve participants had sought help from mental health professionals, and all of them were women. The women I interviewed were generally more open to talk about their feelings and experiences, while the men had more concise answers and a low degree of elaboration when it came to feelings and reflections around what they would do if they experienced any mental health issues. Since this is a qualitative study with relatively few participants, I cannot draw any significant conclusion from these observations, but it is in accordance with what we already know about men meeting greater barriers when they need to access help from mental health services. Mental health-related stigma is more pronounced among rural men than both urban men and women, and rural women (Schroeder et al., 2021). In this study several barriers point towards the notion that men have a harder time when it comes to seeking help and reaching out to the people around them. Male role expectations and stoicism are barriers that are similar in the way that they contain expectations about how one should be and behave. They are also similar because both hold highly the value of being strong and stable during challenging moments and limit the display of feelings. The exploration of these two barriers together is helpful in gaining a greater understanding about why rural men have more difficulties seeking help from mental health services.

Stoicism was present in the narratives of both female and male participants, but the men more explicitly said that they had suffered alone and kept things for themselves during difficult times. Some of the women also mentioned that the men around them seemed to have more difficulties when it came to seeking help and opening up about how they were doing. Three out of five of the males that were interviewed mentioned their wives as important conversation partners, also when they needed to talk about difficult topics. It might be that they feel more comfortable talking with women about sensitive topics, than with other men, because it is more important to uphold the image of the “proper man” among peers (Rice et al, 2018).

6.4 Methodological Considerations

6.4.1 Internal Validity is the extent to which a study manages to say something about what it is meant to say something about, in relation to its research question (Harper et al., 2011). It is important that the results are credible and anchored in the empirical findings of the study. In order to increase the internal validity of this study various measures have been taken. In the development of the study and the interview guide I consulted both Norwegian and Colombian professionals (including two psychologists, one psychiatrist, and one physician). They assisted me in the development of the interview guide. The thought was that the interview guide would create the conditions for the participants to give me information that would help me answer my research question. Also, they helped me adapt my study to the rural Colombian context. Both the Norwegian psychologist and the Colombian psychologist had experience working with vulnerable populations, which was also a strength in the development of my study. In addition, I did a pilot interview with Juliana, who is familiar with the specific context of the village. I was immersed almost one year in the Colombian culture before doing the interviews, and while staying in the village I lived with Juliana and her husband. This gave me greater insight in the local culture and was also a way of enhancing my cultural sensitivity. Being able to conduct the interviews in the participants' own language without using a translator, was a strength because it gave me direct access to the data collected. I could also add prompts and ask more in depth about the things that I found relevant for the research question and the study. Being able to fluently communicate in Spanish increased my chances of building rapport with the participants, which might have been more challenging if I had used a translator.

6.4.2 External Validity in qualitative research says something about the contribution of a study, and looks at the extent to which the results are applicable outside of the context where the study has been done, also called transferability or generalizability (Harper et al., 2011). Rather than statistical generalizability, a measure of external validity in quantitative research, qualitative studies might contribute with analytical and theoretical generalizability (Harper et al., 2011). One of the things that influences the transferability of a qualitative study, is the sample size. The results of my thesis are based on interviews with twelve participants. This is

a relatively small sample size, and one should therefore be careful to draw lines to other contexts (Harper et al., 2011). Still, the sampling method was maximum variance in combination with convenience, and the variation in both age, gender, occupation and time lived in the village was relatively broad. The results from this study are also in line with results from previous studies done in similar contexts. As a result, one might be able to say something about other villages of the same size in Colombia based on the conclusions drawn in my study.

6.4.3 Researcher Reflexivity. Another important aspect of the methodological quality of a study is the role of the researcher. Researcher reflexivity shows that the investigator acknowledges that he or she has biases, assumptions, and beliefs and that these can influence the research (Creswell & Miller, 2000). One way to increase the validity of a qualitative study is then for the investigator to self-disclose the biases, assumption, and beliefs that he or she thinks may affect the research. In this thesis I have conducted interviews with participants with a different background than mine. In the design and development of the study, and during the analysis and the interpretation of the data, I have sought taking a critical and reflexive attitude to my assumptions and beliefs. Through designing my study in cooperation with local professionals and a member of the community where I did my fieldwork, I was constantly made aware of the differences between the context I came from and the context where I was to conduct the study. I was in contact with several local mental health professionals during the development of my study, and this gave me important insight into the differences and similarities between the role of a Colombian and a Norwegian psychologist, and how the mental health services are structured in Colombia compared to Norway. Lastly, I want to stress the importance of having Colombian friends and being included in local communities, which has increased my cultural knowledge and reflection around my own background and culture.

I believe that all the aspects mentioned above contributed to increase researcher reflexivity. Still, it is impossible to avoid all the influence that my background, ethnicity, education, personality and experiences may have had on the research process. Even though I have been immersed in the Colombian culture for one year, I will always have my Norwegian background that shapes the lens with which I see the world.

6.5 The Strengths and Limitations of Having a Gatekeeper

One aspect of the study that I consider both a strength and a possible limitation is the role of Juliana. She introduced me to the village and helped me in recruiting the participants and conducting the interviews. Without her support in the process, I would probably not have been able to go through with the study in such a short amount of time.

Juliana functioned as a gatekeeper between me and the community. She introduced me to the village, made sure that I learnt about the life there, and got to know different people. This was an advantage and a necessity for me and my study. At the same time, this meant that the people I met was based on who Juliana knew and maybe the people closest to her. It should be mentioned that through her role in the community as the unofficial "local nurse" she knows most of the people living in the village, and therefore has broad social connections. This might also, to a certain degree, have reduced the risk of her introducing me to only a small segment of the population, since she is in contact with a substantial part of the community through her occupation.

Juliana was present during all the interviews. To have someone local with me during the interviews was a prerequisite from the ethical committee at Universidad de La Sabana, since I am not a native Spanish speaker. The interviews were conducted in Spanish by me, a fluent, but not a native speaker. When doing a study in a different language than one's own, there is a risk that some information gets lost or misinterpreted. This potential risk was mitigated by conducting the interviews with the assistance of Juliana, and it made sure that the participants were presented with the questions in a way that they understood. Juliana formulated the questions in a different way if the participants did not understand them, and she also helped me if I struggled with understanding the participants. Before conducting the interviews, Juliana and I went through the interview guide to make sure that we both understood the questions in the same way. This, of course, did not guarantee that the participants understood and responded to the questions in the exact manner that was intended, but it was an attempt to get closer to a common understanding.

Juliana's role during the interviews functioned well. Since the participants already knew her, her taking part in the interviews might have contributed to creating a safe space. On the other hand, it might be that some of the participants felt that they had to answer the questions in a

specific way, or moderate or change their answers when Juliana was there, since she is a member of the community. It is difficult to fully understand in which way her presence affected the participants and their answers, but I would argue that the positive sides of having her with me outweighed the possible negative ones.

6.6 "Rural Year" for Newly Graduated Psychologists

Today, approximately half of all the medical students in Colombia must undertake obligatory service in a rural area after finishing their education, the so-called *año rural* (in English: *rural year*). This involves working for one year as a general practitioner in a small hospital offering primary health care in places such as Icononzo, the municipality that the village is connected to. A similar system is in place for dental and nursing students. The newly graduated health professionals are assigned positions in municipalities throughout the whole country, a strategy from the government's side for retainment of health personnel in rural areas of Colombia. It is challenging to make health personnel stay in rural areas for more than one year, which means that the number of specialists and physicians with experience is scarce in these areas. This puts limitations on what kind of health services can be offered to the rural population. Should a patient need health care beyond primary level, he or she needs to travel to the nearest city, where they offer specialized health services. The students get paid during their rural year and get their medical license when they have finished the service. This system is similar to the internship Norwegian medical students must pass in order to work as general practitioners or start a specialization. Originally, this was a way to make sure that the rural areas of Norway, "the districts", were covered when it came to primary health care. As in Colombia, an issue in the rural areas of Norway was to get hold of enough health personnel that wanted to work there.

One way to bring mental health services closer to the rural population of Colombia is to expand the obligatory service to include psychology students. In addition to sending newly graduated medical students to rural areas, psychology students could also be integrated in this system and contribute to the health care services offered in rural areas. Since the road has already been built for other health professions, it is not an entirely new concept, and it should therefore be feasible to implement as long as there is a political will to invest more in mental health services and make them more accessible.

One thing that I noticed during my time in the village and during the interviews was that people were relatively open with me. Before conducting the interviews, I had an expectation that I would be met with more reservation and scepticism, based on the topics I was going to present the participants with. The degree of openness depended on the person, some of the participants were more reserved than others, but in general I was surprised by how willingly they shared their thoughts and feelings. As the interviews passed it became more and more clear that gossiping played an important role in the community, and that this was something that hindered people from being entirely open with each other. One participant mentioned that she would not visit a psychologist if it was someone from the village, and another participant mentioned having negative experiences with being attended by a mental health professional that she had mutual acquaintances with. Based on these observations it seems like at least some of the participants would be more comfortable being attended by a mental health professional from outside of the community than by an in-member, independently of his or her education. Having psychology students coming from other parts of the country to Icononzo, would solve the problem of meeting someone from the community at the psychologist's office, and it might counter-act the negative effects gossiping has on the access to mental health services.

Employing newly graduated psychologists in the municipalities has the potential to make mental health services more accessible for people in the village, since it is a solution that addresses at least four of the barriers identified in this study: all the instrumental barriers and gossiping. The first instrumental barrier was a lack of local mental health services. This barrier would be drastically limited if one or two newly graduated psychologists worked in Icononzo, only a half- an- hour drive from the village. Because of the reduction in distance between The Village and the place where the mental health services are offered, the effect of the other two instrumental barriers would also be limited.

6.7 Limitations of the Study

The limitations of this study should be noted. The list of barriers presented in this thesis is not exhaustive. The results are based on what I have interpreted from the interviews done with inhabitants of The Village. I might have blind spots, and the questions asked in the interviews might not have been formulated in a way so that the participants were able to identify and describe all the barriers they meet. This study is not able to comment on the effect size or the

prevalence of the access barriers identified, which makes it difficult to judge which barriers are the most relevant for people in the village. It is also necessary to examine whether the results of this study are transferable to similar contexts, such as other villages in Colombia, or rural areas in other countries. Some of the barriers affect certain segments of the population more than other, such as intimate partner violence and male role expectations. To improve the access to mental health services it is important to research who are more affected by which barriers.

Violence Against Women

Intimate partner violence is in this study identified and described as a barrier to seek help from mental health services, based on the narratives of two of the participants, both females. It is often men who exercise physical violence on their intimate partners, and it is therefore easy to draw lines between male role expectations and violence. Violence is never good, but trying to understand the reasons behind the use of violence can be useful in order to do something about it and limit its consequences. Intimate partner violence is a sensitive topic, and trust between the interviewer and the interviewee is a requirement for the interviewee to be more opened. I believe that a longer stay in the village could have brought forward more information about this barrier to access help from mental health services. More knowledge about the relationship between male role expectations and intimate partner violence might give implications for ways to fight intimate partner violence and at the same time limiting the effect of barriers to access mental health services.

7. Conclusion

The inhabitants of a village in the Municipality of Icononzo in the Department of Tolima in Colombia are met with several barriers to access mental health services. This qualitative descriptive study has identified and described nine access barriers divided into three categories: 1) instrumental barriers: a lack of local mental health services, limited transportation, and a lack of money to pay for transportation and treatment; 2) intrapersonal barriers: stoicism and male role expectations; and 3) interpersonal barriers: gossiping, fear of being a burden, fear of rejection, and intimate partner violence. Based on the interpersonal barriers to access mental health services, mental health-related stigma seems to play a role in the community. People rather keep quiet about how they are doing if they experience difficult moments, than sharing it,

because they fear being rejected, being gossiped about, or being a burden to the people around them. Men seem to meet even greater barriers should they have the need to seek help from mental health services, because of the role expectations tied to their gender. Domestic violence was also identified as a barrier, and this is particularly alarming because of the relatively high rate of intrafamilial violence in Icononzo and the far-reaching consequences this can have in itself and as a hinder to seek help.

Implications and Future Directions

Each of the barriers identified in this study give implications for future work to improve access to mental health services. The results of this study imply that one way to improve access to mental health services would be to reduce mental health-related stigma in the community. Overcoming instrumental barriers is also necessary in order to increase the access. That is why I suggest implementing an obligatory service in rural areas for psychology students, similar to the one that Colombian medical students must carry out. This would bring mental health services closer to the inhabitants of villages such as the one in Icononzo, and it would also give the psychology students valuable experience in the field.

8. Other

8.1 Conflict of Interests

I declare no competing interests in this study.

8.2 Funding

I did not receive any funding for the work with the thesis.

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Appendices

Appendix I: Informed consent (English, translated version)

Appendix II: Informed consent (Spanish, original version)

Appendix III: Interview guide (English, translated version)

Appendix IV: Interview guide (Spanish, original version)

Appendix I: Informed consent (English, translated version)

Information Letter to the Participant

Barriers to access help from mental health services in the rural area of The Village, Municipal of Icononzo, Tolima, Colombia

Psychology student, Synne Eilertsen
E-mail address: synne.eilertsen@gmail.com /WhatsApp: +4795972040

You have been invited to participate in a study about mental health and barriers to seek help in rural areas of Colombia, **because you are** an adult (18 years or more) who lives in The Village.

The aim of this study is to describe barriers to seek help from mental health services. The study has a special focus in the meaning of mental health and mental health-related stigma, and the effects it has on help-seeking. To improve the access to the mental health services it is important to gain information about what the barriers are.

The study involves your participation in an interview conducted by the investigator of the study, Synne Eilertsen. Juliana, who lives in The Village, will assist Synne during the interview to make sure that everything is clear in the communication between you and the investigator. The interview has several questions about mental health, mental health problems and barriers to access help from mental health services. You will not be asked to talk about difficult personal experiences (traumatic events related or non-related to the armed conflict in Colombia).

The study takes place in The Village, **date**: between the 18th of July and the 5th of August 2022, and lasts for about an hour.

The results of this investigation will be used in the graduate thesis of a Norwegian psychology student. The thesis is part of Rural Health for Peace, a project with a goal of improving the health

services and making them more accessible for people in rural areas of Colombia. If you are interested, the investigator can send you the results of the investigation. The graduate thesis and the results of the study **will be accessible for everyone** who wants to read it.

According to the 8430 Resolution of 1993 of the Health Ministry of Colombia, **this project has a risk greater than minimum**. This refers more to the situation of the population of victims of the armed conflict in Colombia who live in rural areas of Tolima, than the intervention of this study in itself.

It is not expected that the interview can revictimize the participant, but it should still be mentioned that touching upon topics related to mental health has the potential to trigger reactions and feelings that can affect the participant. If you experience any negative emotions or sensations during or after the interview the investigator is there to listen to you. And if you have the need to talk to anyone about it, she will help you in finding someone to talk to. You can also contact any of the following persons:

- Synne Eilertsen
- Francisco Lamus Lemus
- Local mental health profesional: Dary Segura, cel.: 311 5106258

We take all measures to make sure that your answers are confidential. To make you anonymous in the study the audio and later, the transcription of your interview, will be marked with a letter and a number instead of your name. This will make sure that nobody can identify that the information has been given by you, except for the investigator and her supervisor. In the results of the study, it will not be possible to identify the people that have been interviewed in the study.

We also guarantee your confidentiality through limiting the number of persons who will have access to your data. The persons that will have access to the data collected through the interview are:

- Synne Eilertsen (will have access to the audio, the transcription of the interview and the consent form)

- Supervisor and Associate Professor Lucas M. Bietti from NTNU (will have access to the transcription of the interview and the consent form)
- Co-supervisor and Professor Francisco Lamus Lemus from la Universidad de La Sabana and co-supervisor and Assistant Professor and Psychologist Katrin Glatz Brubakk from NTNU (will have access to the transcription of the interview)

Your rights

Participation in the project is voluntary. If you choose to participate, you can withdraw your consent at any time without giving a reason. All information about you will then be made anonymous. There will be no negative consequences for you if you choose not to participate or later decide to withdraw. To do so, reach out to one of the following:

- Synne Eilertsen – email: synne.eilertsen@gmail.com /WhatsApp: +4795972040
- Francisco Lamus Lemus (co-supervisor) – email: francisco.lamus@unisabana.edu.co/ 3162232546
- The Department of Psychology (NTNU) via Lucas Bietti (supervisor) – email: lucas.bietti@.ntnu.no

So long as you can be identified in the collected data, you have the right to:

- Access the personal data that is being processed about you
- Request that your personal data is deleted
- Request that incorrect personal data about you is corrected/rectified, and
- Receive a copy of your personal data

If you have any question at any moment during the investigation, please reach out to Synne or Francisco.

This study has been revised and approved by:

- Universidad de La Sabana
- NTNU (The Norwegian University of Science and Technology)
- REK (Regional Committees for Medical and Health Research Ethics)
- NSD (Norwegian Centre for Research Data)

There will be no financial remuneration for your participation in this study.

If you would like to participate in the study, please sign at the end of the sheet and let Synne know.

If you would like to receive a summary of the study findings, please contact Synne.

Yours sincerely,

Student

Consent form

Proyect:

Barriers to access help from mental health services in the rural area of The Village, Municipal of Icononzo, Tolima, Colombia

Investigators:

Synne Eilertsen, Francisco Lamus Lemus, Lucas M. Bietti and Katrin Glatz Brubakk

To be filled out by the participant

Please answer each of the following questions:

Do you feel that you have been given sufficient information about the investigation to decide whether to participate or not?

YES NO

Have you had the opportunity to ask questions about the investigation?

YES NO

Do you understand that your participation is voluntary and that you have the right to withdraw your participation at any moment, without giving explanations and without any consequences?

YES NO

Are you willing and able to participate in the investigation?

YES NO

Are you aware that the interview will be audio recorded?

YES NO

Do you permit that the investigators use some of your contributions without revealing your identity in presentations and publications?

YES NO

Name of the participant: _____

Age: _____

Occupation: _____

Phone number: _____

Date: _____

Signature of the participant:

Appendix II: Consentimiento Informado (Spanish, original version)

Carta de Información al Participante

Barreras de acceso a los servicios de salud mental para personas en el área rural de La Vereda, Municipio de Icononzo, Tolima, Colombia

Estudiante de psicología, Synne Eilertsen
Correo electrónico: synne.eilertsen@gmail.com /WhatsApp: +4795972040

Usted está siendo invitado a participar en un estudio sobre salud mental y barreras para buscar ayuda en áreas rurales en Colombia. **Porque usted** es adulto (tiene 18 años o más) y vive en La Vereda, Icononzo.

El propósito del estudio es describir barreras para buscar ayuda de los servicios de salud mental. El estudio tiene un enfoque específico en el significado de la salud mental y el estigma de la salud mental, y su efecto en la búsqueda de ayuda. Para poder mejorar el acceso a los servicios de salud mental es importante obtener información sobre lo que esté impidiéndole.

El estudio implicará su participación en una entrevista realizada por la investigadora del estudio, Synne Eilertsen. Juliana, que vive en La Vereda, asistirá a Synne durante la entrevista si hay algo que no sea claro en la comunicación entre el entrevistado y la entrevistadora. La entrevista tiene varias preguntas sobre salud mental, problemas de salud mental y barreras para el acceso de los servicios de salud mental. La entrevista no pedirá narrar hechos personales difíciles (situaciones traumáticas relacionadas o no con el conflicto armado en Colombia).

El estudio tendrá lugar en La Vereda, **fecha**: entre el 18 de julio y el 5 de agosto 2022 y tardará aproximadamente una hora.

Los resultados de esta investigación serán usados para la tesis de grado de una estudiante noruega. La tesis forma parte del proyecto Salud Rural para la Paz, que tiene el objetivo de

mejorar y hacer los servicios de salud más accesibles para la gente en áreas rurales en Colombia. Si usted está interesado, la investigadora le podrá enviar los resultados de la investigación. La tesis de grado y los resultados del estudio **serán accesibles a todos** los que quieran leerla.

Según la Resolución 8430 de 1993 del Ministerio de Salud, **el proyecto tiene un riesgo mayor que el mínimo**. Esto se refiere más a la situación de la población víctima de violencia en las áreas rurales en el Tolima, que a la intervención durante la entrevista.

No se anticipa que la entrevista puede revictimizar al entrevistado, sin embargo, al tocar temas de salud mental existe la posibilidad de desencadenar reacciones o sentimientos que puedan afectar. Si experimenta malestar emocional durante o después de la entrevista la investigadora está para escucharle. Si siente que necesita o quiere hablar con alguien al respecto, ella te apoya en encontrar con quien pueda contactar. También puede comunicarse con uno de los siguientes contactos:

- Synne Eilertsen
- Francisco Lamus Lemus
- Profesional local de salud mental: Dary Segura, cel: 311 5106258

Tomaremos todas las medidas para asegurar la confidencialidad de sus respuestas. Para hacerle anónimo en el estudio la grabación y luego la transcripción de su entrevista serán marcados no con su nombre sino con una letra y un número. Esto hará que nadie pueda reconocer que la información que dará a través de la entrevista viene de usted, excepto de la estudiante y su tutor, Lucas. En los resultados no será posible identificar las personas entrevistadas en el estudio.

También aseguramos su confidencialidad a través de limitar el número de personas que tengan acceso a sus datos. Las personas que vayan a tener acceso a los datos recolectados a través de las entrevistas serán:

- Synne Eilertsen (tendrá acceso a la grabación y la transcripción de su entrevista, y su formulario de consentimiento)
- Tutor Profesor Asociado Lucas M. Bietti de NTNU (tendrá acceso a la transcripción de la entrevista y su formulario de consentimiento)

- Co-tutor Profesor Francisco Lamus Lemus de la Universidad de La Sabana y co-tutora Profesora Asistente y Psicóloga Katrin Glatz Brubakk de NTNU (tendrán acceso a la transcripción de la entrevista)

Sus derechos

Su participación en esta investigación es estrictamente voluntaria: usted podrá retirarse del proyecto sin ninguna penalidad. Para hacerlo por favor comuníquese con:

- Synne Eilertsen – correo electrónico: synne.eilertsen@gmail.com /WhatsApp: +4795972040
- Francisco Lamus Lemus (co-tutor) – correo electrónico: francisco.lamus@unisabana.edu.co/ 3162232546
- El Departamento de Psicología (NTNU) vía Lucas Bietti (tutor) – correo electrónico: lucas.bietti@.ntnu.no

Siempre que pueda ser identificado en los datos recopilados, tiene derecho a:

- Acceder a los datos personales que serán procesados sobre usted. Esto significa que, si quiere, la investigadora puede darle acceso a la transcripción de su entrevista.
- Solicitar que sus datos personales sean borrados
- Solicitar que datos personales incorrectos sobre usted sean corregidos/rectificados, y
- Recibir una copia de sus datos personales

Si tiene alguna pregunta o preocupación en cualquier momento de la investigación por favor comuníquese a Synne o Francisco.

El plan para este estudio ha sido revisado por:

- ✔ Universidad de La Sabana
- ✔ Universidad Noruega de Ciencia y Tecnología
- ✔ REK (Comités regionales de ética de la investigación médica y sanitaria en Noruega)
- ✔ NSD (Centro Noruego de Datos de Investigación)

No habrá remuneración económica por su participación.

Si quiere participar en el estudio por favor firme al final de la hoja y avísale a Synne.
Si quiere recibir un resumen de los hallazgos del estudio por favor comuníquese con Synne.

Saludos cordiales,

Estudiante

Hoja Consentimiento Informado

Proyecto:
Barreras de acceso a los servicios de salud mental para personas en el área rural de La Vereda, Municipio de Icononzo, Tolima, Colombia

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Investigadores:
Synne Eilertsen, Francisco Lamus Lemus, Lucas M. Bietti y Katrin Glatz Brubakk

---

Para ser completado por el participante
Por favor responda cada una de las siguientes preguntas:

¿Siente que se le ha dado la información suficiente acerca de la investigación para poder tomar la decisión de participar o no?

SI NO

¿Ha tenido la oportunidad para hacer preguntas sobre la investigación?

SI NO

¿Entiende que su participación es voluntaria, y que es libre de retirarse cuando quiera, sin dar explicaciones y sin ninguna penalidad?

SI NO

¿Está usted dispuesto a participar en la investigación?

SI NO

¿Está usted consciente de que las actividades serán grabadas?

SI NO

¿Permitirá usted que las investigadoras utilicen algunas de sus contribuciones sin revelar su identidad en presentaciones o publicaciones?

SI NO

Nombre del participante: _____

Edad:_____

Ocupación:_____

Teléfono: _____

Fecha: _____

Firma del participante:

_____

Appendix III: Interview guide (English, translated version)

Interview guide

Estimated time: 30-60 minutes

Content

- Introduction
- Mental health and mental health problems
- Seeking help for mental health problems
- Mental health-related stigma

Introduction

"Thank you for taking part in my study. My name is Synne and I am a psychology student from Norway. I am doing my master's thesis here in Colombia and Guatimból. I want to find out what you think about mental health in general and seeking help from professionals for mental health problems. I will ask you different questions to explore this topic. The interview will last for around 30-60 minutes. Before starting the interview, I will give you this form that you have to read and sign to participate in this study. It explains the purpose of the study and your rights as a participant. This study is completely voluntary to take part in. You can at any moment withdraw from the study, and this will have no consequences for you. If you withdraw from the study, I will erase all the data you have given me. The information that I get from you during the interview will be anonymized, which means that people that read the study will not be able to identify you. I will record the interview to be able to transcribe it and analyse the data. After I have transcribed the data, I will erase the recording of the interview. The transcribed interview will be saved by my tutor, Lucas Bietti, in a crypted folder, and after three years this will also be erased. You have the right to get insight in and correct the data you give me, at any moment."

"In this interview I will ask you questions about mental health, emotions, help for mental health problems and barriers to access this help. One way to define mental health is the following, which is the definition used by WHO, the World Health Organization:

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community.

In other words, we can say that mental health is a sensation of emotional well-being that makes us able to meet the challenges that our daily life contains. Now I will start the interview, and I just want to add one important thing: there are no correct answers to the questions I am going to ask you. The only thing I am interested in is knowing what you think about these things."

Topic 1 – Mental health and mental health problems

1.1: "If I mention mental health, what does this mean to you?"

1.2: "Do you think differently about mental and physical health?", "Can you explain to me in which way?"

"People can experience a range of different physical and psychological sensations. I will mention some of these to you and afterwards ask you some questions. These are sensations that all people can experience, and most people have experienced at least one of the following things:"

Sadness	Crying, says he/she is sad/feels down.
Isolation	Less sociable than before, spends more time alone, becomes quieter.
Irritability and anger	Shows signs of being annoyed, bothered or angry, and more than usual.
Anxiety	Over worrying. Catastrophe-thinking – "things will go badly".
Difficulties sleeping	Difficulties falling asleep or frequently waking up during the night.
Flashbacks	People that have been through traumatic events can experience so-called flashbacks: short glimpses where they, unwillingly, remember the most scary and threatening parts of the traumatic event.

Tension/nervousness	Both a physical and a psychological sensation of being alert. The muscles can be tense, and the person have a feeling of being more attentive to possible danger or changes in the environment than usual.
Concentration problems	Difficulty concentrating. Hard directing and keeping the focus on one thing.
Low self-esteem and self-confidence	Feelings of worthlessness, inferiority, not being good enough, not believing in oneself.
Palpitations	Physical sensation often felt when one is anxious, nervous or stressed. As if the heart is racing faster and pounding harder than when it is at rest.
Feelings of guilt	Feeling that one has done something wrong.
Fatigue	Tiredness that does not go away after sleeping, resting, eating. A feeling of never getting fully rested.

1.3: "Have you seen or heard about friends, family, or neighbors that have experienced any of these things?"

1.4: "What did you do when you found out that the person or persons felt like that?"

1.5: "What do you think is the reason that some people experience these kinds of emotions, feelings, and physical sensations?"

1.6: "In your community, what are barriers that hinder people from having a good mental health or emotional well-being?"

1.7: "We have different ways of speaking about how we are feeling, about emotional well-being and emotional discomfort, and about mental health. Do you use other words or expressions to talk about these things than those I have used?"

Topic 2 – Seeking help for mental health problems

2.1: “When you experience any of the emotions or sensations that have been mentioned here, can you talk with the people around you about how you feel?” (If “no”: “Why do you think it is like this?”)

2.2: “Some days one can feel sad and down, but often it passes, and the next day is better. But if you experienced having this “bad day” - feeling for a longer period of time, what would you do?”

2.3: “If you sought help because of experiencing any of these emotions or sensations, would you tell your friends? Your family?”

2.4: “Have you ever gotten any psychological help from professionals?”, “How did you experience this?”

2.5: “Are there anyone in your community offering help for these kinds of issues?”

2.6: “If you could choose who would help you with these things, who would it be? A psychologist? A psychiatrist? Someone in your family? A friend? A priest? Or someone else?”

2.7: “If someone told you that there was a place in the village where one could seek help for mental health issues, would you seek help from it?”

2.8: “If you wanted to seek help, but didn’t do it, what was it that stopped you from doing so?”

Topic 3 – Mental health-related stigma

Category 1: shame

3.1: “If you struggled with some of the things I mentioned earlier, like anxiety or sadness, how would you tell the people around you about it?”

3.2: “Would you feel that you had to hide it from people?”

Category 2: discrimination

3.3: “If you struggled with any of these things, do you think telling people around you about it would change the way they treated you?”

3.4: “How would struggling with some of the sensations we talked about earlier affect your daily life?”

3.5: “Could it get any consequences for you (job, relationships, caring for your kids)? In what way?”

Category 3: social judgment

3.6: "What do you think that people in the village would think about you as a person if you experienced for example sadness, flashbacks, fatigue or anxiety? Your family? Friends?"

3.7: "Let's say you have a family member, a neighbor, or a friend, that suddenly starts acting differently. Maybe he or she withdraws himself or herself from social gatherings, becomes more isolated. Maybe they talk in a different way, more negative and critical. Maybe they tell you that they are sad. What feels natural for you to do in a situation like this?"

3.8: "What would you think about a person that experienced these things?" "Does your answer depend on who it was? Family? Friends? A neighbor?"

"I will now present to you two different persons in different situations, and afterwards I will read you some claims about these persons that I want you to take a stand towards:

José is a bachelor of 40 years old, and people often say that he is "crazy", someone has even mentioned the word "schizophrenia". Sometimes he hears voices and changes his behavior. He often drinks beer in the local "tienda" in the village and sometimes he seems very anxious and nervous – he says he is afraid that someone is coming to hurt him or even kill him. He lives alone in his "finca" and owns cows and grows "plátanos"."

1. I would feel sorry for José. (yes/a little bit/no)
2. I would think that José was dangerous. (yes/a little bit/no)
3. José would scare me. (yes/a little bit/no)
4. I would think that it was José's fault that he found himself in the current situation. (yes/partly/no)
5. I think it would be better for the community if they put José in a psychiatric hospital. (yes/maybe/no)
6. I would be angry at José. (yes/a little bit/no)
7. What is the possibility that I would help José? (not possible/small possibility/possible)
8. I would try to keep a distance from José. (yes/maybe/no)

9. I think José should be obliged to get medical treatment, even if he did not want it himself. (yes/maybe/no)

"Maria is 28 years old. She finds it hard to relate to others, she has a difficult time trusting people, and sometimes she thinks that the whole world is against her. During the last years she has had three crises that lasted for approximately one month. During these episodes she started believing that the people in the village talked badly about her, followed her and tried to hurt her. In addition to this, one night she started insulting her mother and threaten her that she was going to kill her, because she thought that she was also part of the conspiracy against her."

1. Would you accept Maria as your neighbor? (yes/maybe/no)
2. If you had a company, would you contract her? (yes/maybe/no)
3. Would you accept Maria as a friend? (yes/maybe/no)
4. Would you accept her, or a person like her, as a romantic partner? (yes/maybe/no)
5. If you had children, would you accept that a person like Maria took care of them? (yes/maybe/no)

Outro:

"Thank you for participating in this project. I really appreciate you taking the time to talk with me and share your thoughts and experiences. Are there any things that you would like to add before we end the interview? I am listening."

Appendix IV: Guía de entrevista (Spanish, original version)

Guía de entrevista

Tiempo estimado: 30-60 minutos

Contenido:

- Introducción
- La salud mental y problemas de la salud mental
- Búsqueda de ayuda por problemas de la salud mental
- El estigma frente a la salud mental

Introducción

"Gracias por formar parte de mi estudio. Mi nombre es Synne y soy una estudiante de psicología de Noruega. Estoy haciendo mi tesis de grado acá en Colombia. Quiero saber cómo piensa usted sobre la salud mental en general y la búsqueda de ayuda profesional por problemas de salud mental. En la entrevista voy a hacerle preguntas sobre este tema. La entrevista dura aproximadamente 60 minutos. Antes de que empecemos le daré un formulario que necesita leer y firmar para poder participar en el estudio. Este formulario explica el objetivo del estudio y sus derechos como participante y entrevistado. Toda su información personal será anonimizada para que nadie le pueda identificar. Es completamente voluntario participar en este estudio y puede en cualquier momento retirar su consentimiento. Si quiere retirarse de la entrevista antes de su finalización esto no tendrá ninguna consecuencia para usted y borraré toda la información que me haya dado. Grabaré la entrevista para poder escucharla y transcribirla después de que terminemos. Después de transcribir la entrevista borraré la grabación. Usted tiene el derecho de ver y corregir sus datos en cualquier momento."

En esta entrevista le voy a hacer preguntas sobre salud mental, emociones, ayuda para problemas de la salud mental y barreras para acceder ayuda por esos problemas. Una definición de salud mental es la siguiente, y es la definición de OMS, la Organización Mundial de la Salud:

La salud mental es un estado de bienestar en el que la persona realiza sus capacidades y es capaz de hacer frente al estrés normal de la vida, de trabajar de forma productiva y de contribuir a su comunidad.

En otras palabras, podemos decir que la salud mental es un sentido de bienestar emocional que nos permite hacer lo que la vida cotidiana exige de nosotros. Ya voy a empezar con la entrevista, pero es importante decir que no hay respuestas correctas. Yo solo estoy interesada en saber qué piensa usted.

Tema 1 – La salud mental y problemas de la salud mental

1.1: "Si yo digo salud mental, ¿qué significa esto para usted?"

1.2: "¿Piensa diferente cuando piensa sobre la salud mental que cuando piensa en la salud física?" "¿Me puede explicar de qué manera?"

"Como humanos podemos experimentar muchas sensaciones mentales y físicas. Voy a mencionar algunas de estas sensaciones y después hacerle preguntas sobre el tema. Estas sensaciones pueden ser experimentadas por todos, y todos han experimentado al menos una de ellas en sus vidas":

Tristeza (más que usualmente)	La persona llora más que usualmente, dice que él/ella se siente triste/deprimido/a.
Aislamiento	Menos sociable que antes, pasa más tiempo solo/a, se vuelve más quieto/a.
Agresión e irritabilidad	Actúa más agresivo/a y parece más irritable que normal.
Angustia	Preocupación excesiva, pensamiento catastrófico – "las cosas irán mal".
Problemas con el sueño	Dificultades para dormir, se despierta frecuentemente en la noche.
Reviviscencias/revivir algo ocurrido antes (flashbacks)	Una persona que haya experimentado un evento traumático puede experimentarlo de nuevo a través de reviviscencias. Flashbacks

	son vistazos cortos donde uno, sin querer, recuerda las partes más miedosas y amenazantes del evento traumático.
Tensión/nerviosismo	Tanto una sensación física como mental. Los músculos pueden estar tensos y la persona tiene un sentido de estar más atenta a peligro o cambios en el ambiente.
Problemas con la concentración	Dificultades para concentrarse. Difícil enfocarse en una cosa y mantener la atención en esta cosa.
Baja autoestima y confianza en uno mismo	Sentimientos de inferioridad, inutilidad, no ser suficientemente bueno, no creer en uno mismo.
Palpitaciones	Se siente como que el corazón está corriendo más rápido y golpeando más fuerte.
Sentimientos de culpa	Se siente como que uno haya hecho algo mal.
Fatiga	Cansancio que no desaparece después de dormir, descansar y comer. Un sentimiento de nunca estar completamente descansado.

1.3: "¿Ha visto o escuchado algo sobre algunas de estas cosas en otras personas – familia, amigos, vecinos?"

1.4: "¿Qué hizo cuando se enteró de que esa persona o esas personas se sentían así?"

1.5: "¿Cuál es la razón, cree usted, por la cual las personas experimentan estos sentimientos, pensamientos o reacciones?"

1.6: "En su comunidad, ¿cuáles son las barreras para las personas que viven acá para tener una buena salud mental o bienestar emocional?"

1.7: "Tenemos formas diferentes de hablar sobre cómo nos sentimos,

sobre malestar y bienestar emocional, y sobre salud mental, ¿usted usa otras palabras o expresiones que las que yo haya usado hasta ahora? ¿Cuáles?"

Tema 2 – Búsqueda de ayuda por problemas de la salud mental

2.1: "Cuándo siente algunas de estas emociones o sensaciones, ¿puede hablar con otros sobre cómo se siente?" (Si "no": "¿Por qué cree que es así?")

2.2: "Algunos días uno puede sentirse triste y deprimido, pero usualmente pasa y el día siguiente uno se siente mejor. Si experimentaría tener este "día malo" por más tiempo, más días que uno, ¿qué haría?"

2.3: "¿Si buscara ayuda por algunas sensaciones o emociones, se lo contaría esto a su familia, sus amigos?"

2.4: ¿Ha recibido alguna vez ayuda psicológica de profesionales?" "¿Cómo fue/estuvo esa experiencia para usted?"

2.5: ¿Hay alguien en su comunidad que ofrezca ayuda para estos asuntos?

2.6: "Si usted pudiera elegir quién podría ayudarle con esas cosas, ¿quién sería? ¿Un psicólogo? ¿Un psiquiatra? ¿Alguien de tu familia? ¿Un amigo? ¿Un sacerdote? ¿Otra persona?"

2.7: "¿Si alguien le hubiera dicho que había un lugar en la vereda donde podía recibir ayuda por problemas que tuviera conectados a las sensaciones o emociones mencionadas, ¿hubiera ido a ese lugar?"

2.8: "Si quería buscar ayuda, pero no lo hizo - ¿Cuál cree que fue la razón por la que no lo haya hecho? ¿Qué le impidió hacerlo?"

Tema 3 - El estigma frente a la salud mental

Categoría 1: vergüenza

3.1: "Si usted lucharía con algunas de las cosas que mencioné anteriormente, como reviviscencias o tristeza, ¿cómo se lo contaría a su familia, sus amigos y otras personas en su vida?"

3.2: "¿Siente que necesita esconder esto de la gente que le rodea?"

Categoría 2: discriminación

3.3: "Si le molestaría algunas de las sensaciones o emociones anteriormente mencionadas, ¿cree que contárselo a la gente cambiaría la forma en que le trataran?"

3.4: "¿Cómo afectaría su vida diaria si experimentara algunas de esas cosas?"

3.5: "¿Cree que podría tener consecuencias para usted (trabajo, relaciones, familia) experimentar alguna de esas cosas? ¿De qué manera?"

Categoría 3: juicio social

3.6: "¿Si usted experimentaría por ejemplo tristeza, fatiga, ansiedad o reviviscencias, qué cree que hubieran pensado su familia, sus amigos y/o sus vecinos?"

3.7: "Digamos que tiene un amigo que de repente comienza a actuar de una manera diferente. Tal vez él o ella se retire de las reuniones sociales, se vuelva más aislado. Tal vez hable de otra manera, más negativa y crítica. Tal vez le diga que esté triste. ¿Qué le parece natural hacer en una situación como esta?"

3.8: "Qué pensaría usted sobre una persona que experimenta esas cosas mencionadas?" "Su respuesta depende de quién hubiera sido? ¿Familia? ¿Amigos? ¿Un conocido?"

"Le voy a presentar a dos personajes imaginarios en situaciones diferentes y luego le voy a preguntar si pueda tomar una posición sobre varias acusaciones[7]:

José es un soltero con 40 años y la gente a menudo dice que es "loco", alguien incluso ha mencionado la palabra "esquizofrenia". A veces escucha voces y cambia su comportamiento. A menudo toma cerveza en la tienda en la vereda y a veces parece muy ansioso y nervioso – él dice que tiene miedo de que alguien venga a hacerle daño o incluso matarle. Él vive solo en su finca, tiene vacas y siembra plátanos."

"Con respeto a José, cuénteme qué pensaría o sentiría de estas declaraciones:"

1. Sentiría pena por José. (sí/un poco/no)
2. Pensaría que José es peligroso. (sí/un poco/no)
3. Me asustaría de José. (sí/un poco/no)

4. Pensaría que es culpa de José que se encuentre en su situación actual. (sí/parcialmente/no)
5. Creo que sería mejor para la comunidad de José que lo recluyeran en un hospital psiquiátrico. (sí/quizás/no)
6. Me sentiría enfadado con José. (sí/un poco/no)
7. Cuál es la posibilidad de que ayudaras a José. (no posible/posibilidad pequeña/posible)
8. Trataría de estar separado de José. (sí/quizás/no)
9. Creo que José debe ser obligado a ponerse en tratamiento médico incluso si él no quiere. (sí/quizás/no)

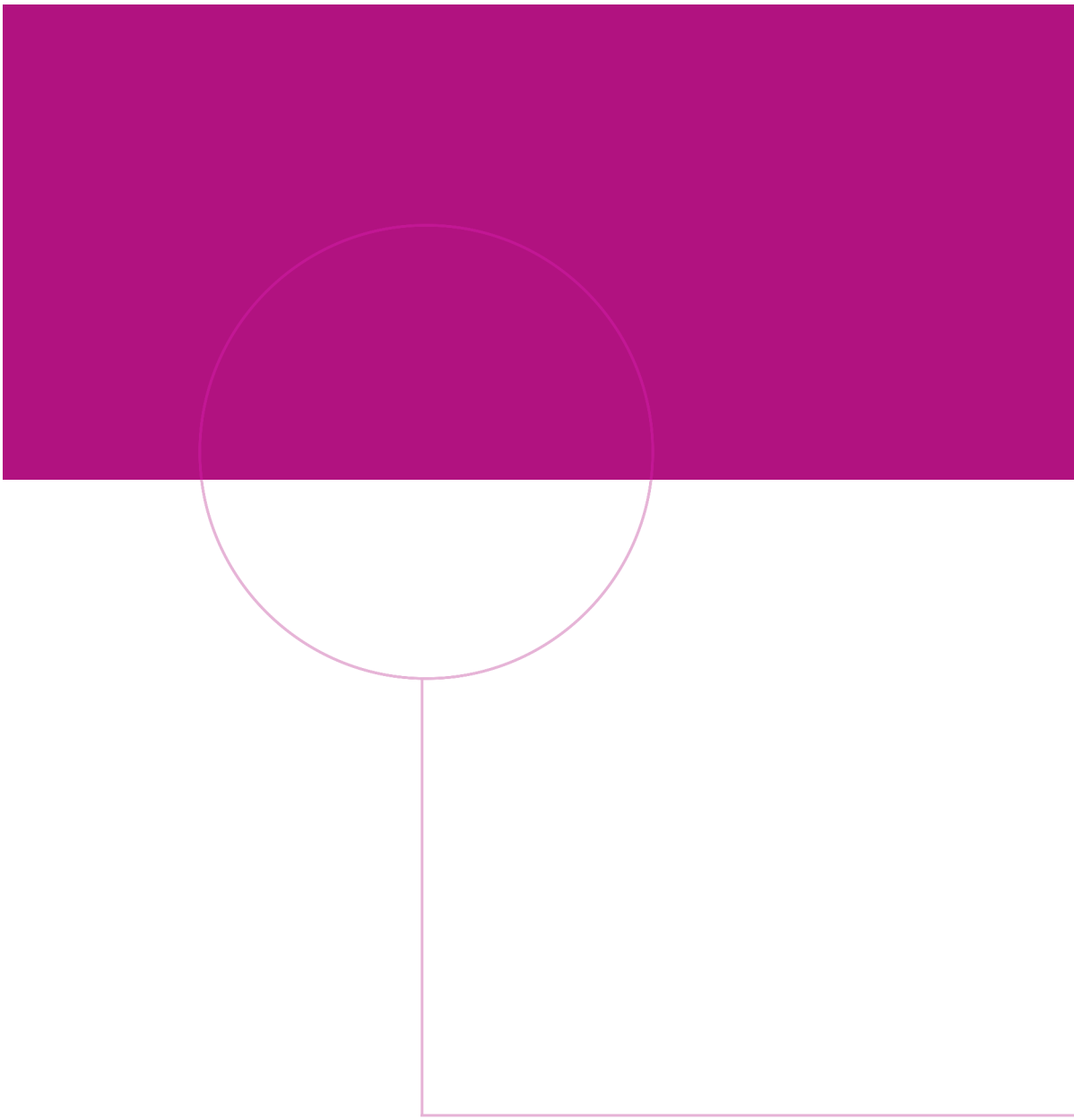
"María tiene 28 años. Le cuesta relacionarse con los demás, es recelosa, desconfía de la gente y, a veces, cree que todo el mundo está en su contra. En los dos últimos años tuvo tres crisis que duraron aproximadamente un mes. Durante estos momentos llegó a creer que las personas que iban en la vereda hablaban mal de ella, le seguían o conspiraban para hacerle daño. Incluso una noche, empezó a insultar a su madre y a amenazar con matarla, porque según dijo estaba conspirando en su contra igual que las demás personas."

"Con respeto a María, cuénteme qué pensaría o sentiría de estas opciones:"

1. ¿Aceptaría a María como vecina? (sí/quizás/no)
2. Si le preguntaría por trabajo, ¿la contrataría? (sí/quizás/no)
3. ¿La aceptaría como amiga? (sí/quizás/no)
4. ¿Aceptaría como pareja a María o a una persona como María? (sí/quizás/no)
5. Si tuviera hijos, ¿aceptaría que cuidara de ellos una persona como María? (sí/quizás/no)

Despedida:

"Gracias por participar en el estudio. Estoy muy agradecida por su colaboración y por tomar este tiempo para hablar conmigo. Antes de terminar la entrevista, ¿hay algo que quisiera añadir?, le escucho."



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