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MENTAL HEALTH OF SPANISH-SPEAKING RESIDENTS LIVING IN PORTUGAL AND PREFERENCES REGARDING PSYCHOLOGY SESSIONS

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Dissertação apresentada à Faculdade de Ciências da Saúde da Universidade Europeia, para cumprimento dos requisitos necessários à obtenção do grau de Mestre em Psicologia Clínica e da Saúde realizada sob a orientação científica da Professora Doutora Inês Saraiva Ferreira, Professora Auxiliar da Universidade Europeia e com a coorientação da Professora Doutora María Belén Rando, Professora Auxiliar Convidada do Instituto Superior de Ciências Sociais e Políticas, da Universidade de Lisboa.

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Palavras-chave Imigrantes hispanofalantes, preferências de clientes, aculturação, modalidade terapêutica, ansiedade e depressão, autoavaliação da saúde mental

Resumo

Os imigrantes hispanofalantes em Portugal continuam sub-representados na investigação em saúde mental. Este estudo analisou como a identidade cultural, as preferências por serviços de psicologia e a perceção da saúde mental se relacionam com sintomas de ansiedade e depressão. Um total de 251 adultos respondeu a um questionário online que avaliou dados sociodemográficos, aculturação, preferências terapêuticas e sintomas, através da Escala Hospitalar de Ansiedade e Depressão (HADS). Embora a maioria tivesse elevada proficiência em português e residência prolongada, apenas 3.6% se identificavam mais com a cultura portuguesa. Quase todos preferiam realizar terapia em língua espanhola. Apesar de 63.4% indicarem necessidade atual de apoio psicológico, apenas 15.5% estavam em acompanhamento. As características do psicólogo (idade, género, etnia) foram amplamente consideradas irrelevantes, exceto a preferência frequente por psicólogas; a presença em redes sociais foi considerada pouco importante; e a competência, acessibilidade financeira e flexibilidade de horário foram os critérios mais valorizados.

As análises bivariadas mostraram que sintomas de ansiedade estavam associados a autoperceção negativa da saúde mental, baixo suporte percebido, história anterior de terapia psicológica, necessidade atual, e preferência por género e idioma do psicólogo. Para sintomas depressivos, as variáveis associadas incluíram autoperceção negativa da saúde mental, maior identificação com a cultura de origem, baixo suporte percebido, e preferência por género do psicólogo.

Os modelos de regressão explicaram 39.2% da variância na ansiedade e 31.5% na depressão. A perceção negativa da saúde mental foi o preditor mais forte em ambos. Os resultados reforçam a importância de considerar o bem-estar subjetivo, o alinhamento cultural e as barreiras de acesso na prestação de cuidados psicológicos.

Keywords

Spanish-speaking immigrants, client preferences, acculturation, therapy modality, anxiety and depression, self-rated mental health.

Abstract

Spanish-speaking immigrants in Portugal continue to be underrepresented in mental health research. This study analysed how cultural integration, preferences for psychological services, and perceptions of mental health relate to symptoms of anxiety and depression. A total of 251 adults answered an online questionnaire that assessed sociodemographic data, acculturation, therapy preferences, and symptoms using the Hospital Anxiety and Depression Scale (HADS).

Although the majority were highly proficient in Portuguese and had lived in the country for a long time, only 3.6% identified more with Portuguese culture. Almost all of them favoured therapy in Spanish. Although 63.4% indicated a current need for psychological support, only 15.5% were being followed up. The psychologist's characteristics (age, gender, ethnicity) were considered mainly irrelevant, except for the frequent preference for female psychologists; presence on social networks was considered unimportant; and competence, affordability, and flexible hours were the most valued criteria.

The bivariate analyses showed that anxiety symptoms were associated with negative self-rated mental health, low perceived support, previous history of psychological therapy, current need, and preference for the psychologist's gender and language. For depressive symptoms, the associated variables included negative self-assessment of mental health, greater identification with the culture of origin, low perceived support, and preference for the psychologist's gender.

The regression models explained 39.2 per cent of the variance in anxiety and 31.5 per cent in depression. Negative perception of mental health was the strongest predictor in both. The results reinforce the importance of considering subjective well-being, cultural alignment, and access barriers when providing psychological care.

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1. Introduction

Mental health disorders represent a growing global concern. According to the World Health Organization (2022), one in eight individuals worldwide lives with a mental disorder, with anxiety and depression among the most prevalent. In Europe, the one-year prevalence of mental disorders is estimated at 38%, with roughly 10% of the population presenting symptoms severe enough to require clinical intervention (Barbato et al., 2014).

Portugal faces similar, if not more severe, challenges. The country has one of the highest treatment gaps in the European Union, with a 22% prevalence of mental disorders — well above the EU average — and 34% of individuals with severe symptoms receiving no care (European Observatory on Health Systems and Policies, 2023; Barbato et al., 2014). Structural barriers such as long public waitlists, high private costs, and limited service availability further restrict access, even for high-need groups. (Bernardo et al., 2021)

As the foreign-born population in Portugal surpasses one million, understanding how immigrants engage with psychological services becomes an increasingly urgent public health priority. Among these residents, Spanish-speaking immigrants — primarily from Latin American countries — represent one of the fastest-growing and least studied cohorts. Despite linguistic and cultural proximity to Portuguese society, their engagement with mental health services remains largely undocumented. In 2021, Spanish-speaking immigrants accounted for 4.83% of the immigrant population, ranking as the third-largest group after Brazilians and British nationals (Gabinete de Estratégia e Estudos, 2023).

While the terms *psychologist* and *therapist* are often used interchangeably in general discourse, this study refers specifically to licensed psychologists. Similarly, *Spanish-speaking* designates individuals born in Spanish-speaking countries; terms such as *Hispanic* or *Latino* appear only when quoting U.S.-based sources.

Research on mental health disparities among immigrants consistently identifies underutilization as a multifactorial issue shaped by structural exclusion, cultural incongruence, and emotional risk. However, most of this evidence comes from Anglophone or Northern European contexts, with minimal attention to Iberian settings. Even within broader studies of migrant mental health, Spanish-speaking populations are often treated as culturally monolithic or are excluded entirely. This generalization obscures critical within-group differences in attitudes toward therapy, symptom experience, and help-seeking behaviours.

Spanish-speaking immigrants occupy a unique position: they are simultaneously positioned as "culturally close" due to shared Iberian linguistic roots, and yet face the same systemic and psychosocial barriers as other migrant groups. The assumption that linguistic similarity ensures therapeutic alignment has been challenged by research showing that shared language does not necessarily produce emotional resonance or psychological safety. Preferences for therapist characteristics, session modality, and access conditions are often driven by deeper identity processes, including perceived cultural fit and social belonging. These mechanisms remain underexplored in Portuguese mental health research.

To address this gap, the current study uses an exploratory, cross-sectional design to examine statistical associations between psychological symptoms and multiple independent variables among Spanish-speaking immigrants in Portugal. Variables include cultural identity indicators (e.g., length of stay, language proficiency, perceived support), service preferences (e.g., psychologist characteristics, session modality), and patterns of service utilization. The primary outcomes — presence or absence of anxiety and depression symptoms — are measured using the Hospital Anxiety and Depression Scale (HADS). To examine these associations, the study first conducts bivariate analyses to identify candidate predictors and then applies multiple logistic regression models to assess their relative contribution to the likelihood of experiencing clinically relevant symptoms.

This research contributes to a more granular understanding of immigrant mental health in Portugal and offers an evidence base for developing culturally responsive psychological services. By highlighting the interplay between preference, context, and symptomatology, it informs both policy and practice in ways that challenge one-size-fits-all approaches to care.

2. Literature Review

2.1. Therapist Characteristics and Client Preferences

Client preferences in psychotherapy have been defined inconsistently across the literature (Eigenhuis et al., 2024; Swift et al., 2018). To address this lack of conceptual clarity, Swift et al. (2018) proposed a tripartite model distinguishing between *therapist preferences* (e.g., age, gender, ethnicity), *treatment preferences* (e.g., preferred therapeutic approach), and *activity preferences* (e.g., degree of structure or interaction style). This taxonomy has improved definitional precision in a field long characterized by overlapping constructs.

Empirical studies suggest that aligning treatment with client preferences may improve early engagement. Documented benefits include greater session attendance, stronger therapeutic alliance, and improved perceived fit (Cheng et al., 2023; Swift et al., 2011). Additional gains include increased comfort with emotional disclosure (Landes et al., 2013; Yu et al., 2022) and greater openness to seeking therapy, particularly among male clients (Black & Gringart, 2019). These effects tend to be more pronounced among individuals experiencing anxiety or depression (Eigenhuis et al., 2024; Swift et al., 2018).

Despite these associations, empirical findings remain inconsistent. Some clients report distinct preferences for therapist characteristics, while others are indifferent (Black & Gringart, 2019; Liddon et al., 2018; Seidler et al., 2022). Preferences are shaped by prior therapy experiences, cultural

background, and psychological safety expectations (Cabral & Smith, 2011; Swift et al., 2018). However, their predictive value for treatment outcomes varies across studies and populations (Cheng et al., 2023; Ilagan & Heatherington, 2022).

Such inconsistencies are particularly evident when examining specific therapist attributes. The sections below review empirical findings regarding client preferences for therapist race/ethnicity, gender, age, and language. These domains have received considerable scholarly attention but continue to generate mixed results.

2.1.1. Racial/Ethnic Preferences

Therapist-client racial or ethnic matching has frequently been examined in psychotherapy research. Several studies suggest that clients who share a racial or ethnic identity with their therapist report higher initial trust, comfort, and willingness to engage, particularly when they hold strong in-group identification or have experienced cultural marginalization (Cabral & Smith, 2011; Cheng et al., 2023). However, evidence regarding therapeutic outcomes is mixed. Cheng et al. (2023) found that while observer ratings favoured matched dyads, clients themselves did not consistently report stronger alliances. Swift et al. (2018) similarly note that effects on treatment efficacy remain inconclusive.

Qualitative research adds further complexity. In a study by Chang and Yoon (2011), some clients actively avoided White therapists due to perceived cultural disconnection, while others avoided therapists of their own background, fearing judgment or overfamiliarity. One Black gay participant reported discomfort with Black therapists, associating them with conservative values. A Hispanic participant similarly avoided Hispanic therapists out of concern that their experiences of discrimination might be minimized.

These findings suggest that racial and ethnic preferences often reflect anticipatory judgments about shared values and relational safety, rather than a desire for demographic similarity per se. In this sense, preferences are mediated by both intergroup and intragroup dynamics.

2.1.2. Gender Preferences

The therapist's gender is another salient variable in client preference research, particularly in the context of trauma or emotionally sensitive topics. Seidler et al. (2022) reported that male clients often preferred male therapists due to fears of judgment, while Landes et al. (2013) found that women with trauma histories favoured female therapists for their perceived emotional attunement.

Nonetheless, findings are inconsistent. Several studies report that many clients hold no strong gender preference (Black & Gringart, 2019; Liddon et al., 2018; Seidler et al., 2022; Ilagan & Heatherington, 2022). Others show that women are more likely to prefer female therapists in contexts involving emotional vulnerability (Landes et al., 2013; Lauber & Drevenstedt, 1994). However, Black and Gringart (2019) found that women in their sample preferred male therapists regardless of presenting concern, further complicating generalizations.

In Spanish-speaking contexts, Valdez et al. (2023) highlight *machismo* as a culturally embedded norm that emphasizes masculine authority and emotional restraint. This framework may shape client perceptions of therapist credibility and emotional safety, potentially reinforcing gendered expectations even when they conflict with personal comfort or therapeutic needs.

Importantly, Ilagan and Heatherington (2022) showed that these preferences often persist even after clients are informed that demographic matching does not predict better outcomes, highlighting the extent to which gender preferences are rooted in psychological and cultural assumptions rather than empirical effectiveness.

2.1.3. Age Preferences

Preferences for therapist age are generally linked to perceptions of life experience, generational understanding, and authority. Kessler et al. (2020) found that younger clients preferred older therapists for life guidance but favoured younger therapists for issues related to youth culture. Other studies suggest that older therapists are viewed as more competent or credible (Eells et al., 1999, as cited in Landes et al., 2013; Jørgensen & Makransky, 2022).

However, therapist age does not consistently rank as a decisive factor in therapist selection. In a large survey, O'Callaghan et al. (2023) found that most clients rated age as relatively unimportant. These findings underscore the contextual nature of age preferences, which may carry weight in first impressions but are not always central to actual engagement or therapeutic fit.

2.1.4. Language Preferences

Language functions not only as a tool for communication but also as a carrier of emotional and cultural meaning in psychotherapy. For immigrant clients, receiving therapy in a non-native language can impede emotional expression, reduce narrative coherence, and compromise the therapeutic alliance (Aguilera & López, 2008; Cho et al., 2014; Derr, 2016; Griner & Smith, 2006; Miteva et al., 2022). Language mismatches are routinely cited as structural barriers to access, alongside economic and legal constraints.

Still, preferences do not always align with native fluency. Verkerk et al. (2024) found that some clients preferred speaking in a second language to maintain emotional distance when addressing trauma, suggesting that language choice may serve regulatory as well as communicative functions.

Despite its centrality, language is seldom considered an independent variable in therapist preference research. It is often framed as an access issue rather than a psychologically meaningful choice. This oversight minimizes the clinical relevance of language alignment, which can influence

emotional accessibility, perceived safety, and cultural attunement. As such, language remains an underexamined but crucial dimension of therapist-client fit.

2.2. Theoretical Frameworks Related to Therapist Characteristics Preferences

Therapist preferences are often framed as practical or identity-based choices, but underlying many of these decisions are deeper psychological mechanisms shaped by perception, comparison, and bias. Several theoretical frameworks help explain how clients form expectations and preferences for specific therapist characteristics, even before therapeutic contact.

One such framework is the Halo Effect (Lachman & Bass, 1985; Nisbett & Wilson, 1977), which describes the tendency to generalize positive or negative impressions from one trait to unrelated domains. In psychotherapy, clients may form initial judgments about competence, empathy, or trustworthiness based on superficial attributes such as age, attractiveness, clothing, demeanour, or political attitudes (Heinze et al., 2023; Yu et al., 2022). These impressionistic evaluations often occur before any substantive interaction and are shaped by personal identity, cultural conditioning, and prior relational experiences (Cabral & Smith, 2011; Derr, 2016). As a result, perceived therapeutic potential may be inferred from visual or symbolic cues rather than actual therapeutic skill (Harris & Busby, 1998; Landes et al., 2013).

While the Halo Effect highlights the role of cognitive shortcuts in preference formation, other models emphasize the influence of social comparison and identity alignment. According to Social Comparison Theory (Festinger, 1954), individuals evaluate themselves in relation to others — through upward, lateral, or downward comparisons — which can shape their reactions to perceived authority, similarity, or safety in therapist-client dynamics.

Upward comparisons involve clients viewing the therapist as superior in knowledge, life experience, or social status. This can foster admiration and trust, especially when the therapist is older

or more credentialed (Jørgensen & Makransky, 2022; Kessler et al., 2020). For example, in Kessler et al.'s (2020) study, young adults preferred older therapists for life guidance. However, this dynamic can also backfire: Chang and Yoon (2011) reported that a young Black male client avoided a similarly aged and successful therapist due to feelings of inadequacy triggered by the therapist´s perceived achievements.

Lateral comparisons may foster preferences for therapists who share salient identity markers such as age, gender, language, or cultural background, based on expectations of shared understanding or reduced social distance. Kessler et al. (2020) also found that younger therapists were favoured for issues perceived as specific to youth culture. Seidler et al. (2022) reported that male clients who preferred male therapists often cited increased emotional comfort and stronger feelings of being understood.

Though less intuitive, downward comparisons may also influence preferences, particularly among clients managing vulnerability or shame. According to Seidler et al. (2022), some male clients preferred female therapists, perceiving them as less judgmental or emotionally intimidating. These dynamics suggest that preference may not reflect attraction to power or similarity alone, but a strategic attempt to regulate perceived emotional risk during disclosure.

A third explanatory lens is False Consensus Bias (Ross et al., 1977) — the tendency to assume others share one's values, beliefs, or worldview. In therapeutic contexts, this may lead clients to project their assumptions onto psychologists based on shared identity cues, such as ethnicity or age. For example, Cabral and Smith (2011) found that older clients often preferred therapists from similar racial or ethnic backgrounds, expecting congruence in values and life experience, particularly among those with prior exposure to discrimination. However, when such assumptions are unmet, they can generate dissonance, disappointment, or distrust. Conversely, unexpected alignment in mismatched dyads may foster surprise and deepen trust.

These frameworks reveal that therapist preferences are not merely about demographic alignment or convenience. They are embedded in broader psychological processes involving impression formation, identity negotiation, emotional safety, and cultural meaning. Understanding these dynamics is essential for both interpreting client choices and designing therapeutic environments that acknowledge, rather than reduce, the complexity of preference formation.

2.3. Modality Preference

Preferences for therapy modality — specifically, in-person versus online formats — have become increasingly relevant with the expansion of telepsychology. Unlike preferences for psychologist characteristics, modality preference concerns the structural setting through which psychological support is delivered. While Swift et al. (2018) do not explicitly categorize modality within their tripartite model of preferences (therapist, treatment, and activity), their definition of *activity preferences* — which encompasses the structure and format of sessions — offers a conceptual anchor for situating modality within the broader preference literature. The absence of modality from many empirical frameworks suggests an underexplored dimension of client decision-making.

Although often viewed through a logistical lens, modality preference is shaped by both practical and psychological variables. Factors such as emotional comfort, perceived relational quality, and past exposure to therapy strongly influence client attitudes toward delivery format. Novella et al. (2022) found that online and in-person sessions generally yield comparable clinical outcomes, yet outcome equivalence does not neutralize the importance of preference. Many clients continue to favour in-person therapy, citing increased trust, rapport, or perceived effectiveness, regardless of access or clinical parity.

In the Portuguese context, this pattern is reflected in a study by Pinho et al. (2025), which found that despite high levels of depressive symptoms among university students, willingness to engage in

internet-based interventions remained low. Participants cited low confidence and limited familiarity with digital therapy, indicating that psychological readiness — not mere accessibility — may drive reluctance. This finding aligns with broader literature suggesting preference is not always reducible to convenience or availability.

Further evidence comes from O'Callaghan et al. (2023), who reported that while 44% of participants preferred online therapy and 33.6% expressed no preference, individuals already engaged in psychological treatment — especially those not receiving pharmacotherapy — were significantly more likely to prefer in-person sessions. Similarly, Ilagan and Heatherington (2022) observed that clients favoured in-person encounters with demographically unmatched psychologists over matched teletherapy sessions, emphasizing that delivery format can outweigh perceived identity alignment. Parsons et al. (2025) also found that clients rated video-based therapy as less satisfactory than in-person treatment for generalized anxiety disorder, suggesting that modality may directly influence subjective treatment evaluations.

However, this pattern does not hold universally. For certain groups, online therapy may serve not as a second-best alternative but as a uniquely enabling modality. While studying Malaysian university students, Wong et al. (2018) reported that 35% of respondents preferred online therapy and actively avoided face-to-face encounters. For these individuals, digital formats mitigated barriers such as stigma, social exposure, or emotional discomfort, expanding access to care in ways traditional therapy could not.

In summary, modality preference encompasses more than logistical convenience. It reflects a confluence of emotional, cultural, and experiential factors that shape perceived fit and therapeutic engagement. Even where clinical effectiveness is consistent across formats, preferences persist, underscoring the importance of treating modality as a psychologically meaningful component of client-centred care.

2.4. Importance Ratings in Therapist Selection

While much of the literature on client preferences has focused on therapist demographics or treatment modality, importance ratings for practical and contextual factors offer an additional lens into decision-making. Variables such as specialization, availability, cost, and digital presence are not consistently addressed within formal preference taxonomies (e.g., Swift et al., 2018), yet they significantly shape real-world access and selection. This section interprets high importance ratings for these factors as reflective of implicit preferences, expanding the scope of preference research beyond therapist attributes to include logistical and reputational dimensions of service delivery.

2.4.1. Area of Expertise or Formation

Specialization — whether by disorder, population, or intervention type — is consistently ranked among the most valued characteristics in psychologist selection. In a Portuguese sample, O'Callaghan et al. (2023) found that 62.7% of respondents rated the area of expertise as important, second only to personal connection. Similarly, Jørgensen and Makransky (2022) reported that participants prioritized specialization just below years of experience when evaluating psychologist profiles. On digital platforms, Feng et al. (2024) noted that practical experience and specific expertise correlated with higher client selection rates, particularly when paired with elevated service fees.

Earlier findings support this emphasis on competence over convenience. Drawing on Eells et al. (1999), Landes et al. (2013) reported that qualifications — such as licensure, specialization, and clinical experience — were consistently prioritized over logistical considerations like session fee or proximity. These findings suggest that psychologists' expertise is perceived not only as a practical advantage but as a core marker of credibility and therapeutic potential.

2.4.2. Availability for Online and In-Person Sessions

While preference for therapy modality (e.g., in-person vs. online) reflects client ideals, availability captures whether psychologists offer services in the desired format. This distinction is critical: a preference may exist for one modality, but limited availability may override that preference in practice.

Although few studies isolate format availability as an independent selection variable, structural barriers to access are well-documented. Research in Portugal (Bernardo et al., 2021; Pinho et al., 2025) and internationally (Parsons et al., 2025; Wong et al., 2018) highlights the importance of flexibility in delivery mode as a determinant of treatment uptake. Therefore, availability for online or in-person sessions likely reflects clients' efforts to reconcile preference with feasibility, especially when constrained by location, mobility, or caregiving responsibilities.

2.4.3. Session Fee

Cost is a widely recognized barrier to psychological treatment. In O'Callaghan et al. (2023), "too expensive" was the second most cited reason for never attending therapy. This echoes earlier work with Hispanic populations in the United States, where cost was a significant deterrent (Aguilera & López, 2008).

Cultural and systemic contexts shape perceptions of pricing. In Portugal, a private session averages €60, equivalent to more than 11 hours of minimum wage labour (Bernardo et al., 2021). Financial barriers are critical in limiting access, along with long public waitlists and insufficient psychologist availability in national health services.

Interestingly, pricing may not always signal inaccessibility. On Chinese digital platforms, Feng et al. (2024) found that higher therapist fees correlated with increased selection, suggesting that cost may function as a proxy for perceived quality or status. Eells et al. (1999), cited in Landes et al. (2013), found

that cost ranked below qualifications and availability but above demographic characteristics, indicating that session fee, while influential, is often weighed in relation to other evaluative criteria.

In this context, high importance ratings for affordability reflect sensitivity to systemic constraints, whereas low ratings may suggest either sufficient financial flexibility or a willingness to prioritize expertise over cost.

2.4.4. Social Media Presence

Although empirical literature has not fully addressed the impact of psychologists' social media presence on client choice, interest in this variable reflects shifting norms around transparency and digital visibility. While related studies have examined profile content (Feng et al., 2024) and homepage design (Jørgensen & Makransky, 2022), these focus on structured professional presentation rather than informal online activity.

Pagnotta et al. (2018) offer partial insight: adolescents who perceived their therapists as digitally competent reported stronger therapeutic alliances, suggesting that online fluency may influence perceptions of credibility or cultural attunement. This may be especially relevant in younger or tech-savvy populations for whom digital presence is a proxy for openness, relatability, or professionalism.

Though understudied, social media visibility may be emerging as a reputational factor in therapist selection, shaped by generational norms and client expectations of transparency.

2.4.5. Recommendation by a Trusted Person

Recommendations from trusted contacts have consistently increased client openness to psychological services. In one study, Eells et al. (1999) found that referral sources ranked just below professional qualifications in importance, and ahead of demographic traits such as race, age, or gender (Landes et al., 2013).

Social endorsement may be particularly important among culturally minoritized or underserved populations. Derr (2016) found that U.S. Hispanic clients were more likely to attend therapy when referred by a trusted individual, underscoring the importance of informal networks in shaping help-seeking behaviour. In contexts where stigma or institutional mistrust impedes access, recommendations from friends, family, or community figures may bridge the gap between need and engagement.

2.4.6. Schedule Flexibility

Schedule flexibility refers to whether psychologists can accommodate clients' time constraints, such as offering evening or weekend appointments. Although this factor is highly relevant to treatment initiation and continuity—particularly for working adults or caregivers—it has not been directly studied as an independent selection criterion in the reviewed literature.

Some studies acknowledge related concerns under broader constructs of access or convenience. For instance, O'Callaghan et al. (2023) and Parsons et al. (2025) reference availability and logistical barriers as determinants of service engagement but do not disaggregate flexibility from general accessibility. This conflation may obscure the specific influence of temporal adaptability on psychologist selection.

Despite its empirical neglect, schedule flexibility is decisive in real-world decision-making. Its inclusion in the present study addresses this gap by operationalizing it as a distinct factor within the broader array of client preferences and access-related considerations. As such, it represents an underexplored yet practically significant dimension of psychological service evaluation.

2.5. Acculturation

Acculturation refers to the complex process through which individuals or groups adapt to a new cultural context following sustained intercultural contact. It involves both behavioural adaptations—

such as engaging with members of the host society, adopting new languages, or participating in unfamiliar cultural practices—and psychological transformations, including shifts in identity, values, and belief systems (Sam, 2024). For migrants, this process is often accompanied by significant emotional and cognitive demands, including experiences of culture shock and acculturative stress, marked by anxiety, confusion, disorientation, and withdrawal from the host environment (Schmitz & Schmitz, 2022).

Berry's model of acculturation strategies remains one of the most influential frameworks in this domain. It identifies four possible orientations: integration (maintaining one's heritage culture while adopting aspects of the host culture), assimilation (abandoning the heritage culture in favour of full adoption of the host culture), separation (rejecting the host culture while maintaining heritage culture), and marginalization (rejecting both cultures) (Donà & Berry, 1994). Integration is typically associated with better psychological and social outcomes and is often reported as the most desirable strategy (Schmitz & Schmitz, 2022). However, recent research suggests that individuals may adopt different strategies across contexts — for instance, favouring integration in public spaces while maintaining separation in private domains (Sam, 2024).

Critically, acculturation is not a static outcome but a dynamic, context-sensitive trajectory influenced by multiple personal and environmental variables. Migrants may shift between strategies over time depending on factors such as intercultural sensitivity, cultural intelligence, and duration of residence. Prolonged engagement with the host society is associated with improved language proficiency and psychological adjustment, while low perceived cultural distance can facilitate smoother transitions. Other relevant moderators include sociodemographic variables, language preferences, pre-existing attitudes toward cultural diversity, and access to social support (Schmitz & Schmitz, 2022).

Understanding the variability and context-dependence of acculturation is essential for interpreting the experiences of immigrant populations within psychological services. These processes

may shape not only emotional well-being but also perceptions of therapy, communication styles, and preferences for therapist characteristics or treatment modalities.

2.6. Barriers to Access and Underutilization of Psychological Services

Underutilization of psychological services persists across both general and high-risk populations, including immigrants and university students. Despite elevated global rates of anxiety and depression, engagement with psychological care remains disproportionately low. The World Health Organization (2022) estimates that one in eight individuals worldwide experiences a mental disorder, most commonly anxiety or depression. In Europe, the one-year prevalence of mental disorders reaches 38%, and around 10% of individuals present symptoms severe enough to warrant clinical intervention (Barbato et al., 2014).

Portugal presents one of the highest treatment gaps in the European Union. With a 22% prevalence of mental disorders — well above the EU average of 16.7% (European Observatory on Health Systems and Policies, 2023) — the country reports that 34% of individuals with severe conditions remain untreated (Barbato et al., 2014). Contributing factors include long public waitlists (often exceeding 600 days), financial burden from required copayments and high private service costs, and widespread uncertainty about where or how to seek help. In Portugal, public waitlists can exceed 600 days, and private sessions average €60—equivalent to more than 11 hours of minimum wage labor—making them financially inaccessible for many. Regional disparities further compound these barriers, as psychological services are disproportionately concentrated in urban centers (Bernardo et al., 2021). Even among high-risk groups, such as university students, service uptake remains limited. Pinho et al. (2025) found that only 12% of students with moderate to severe depressive symptoms had accessed counselling. Many were unsure where to seek help, and interest in digital formats was low.

These access barriers are consistent with international patterns. In the United States, Hispanic populations report high psychological distress but low engagement with mental health services (Aguilera & López, 2008; Derr, 2016; Nelson et al., 2020). Rosales and Calvo (2017) reported that nearly 70% of Latino adults experiencing depressive symptoms lacked access to care, compared to 40% of non-Latino Whites. These disparities suggest that economic precarity and institutional mistrust often coincide with cultural and linguistic factors, compounding psychological service underutilization.

Among immigrants, specific vulnerabilities further reduce access. Postmigration stressors — such as language barriers, discrimination, and difficulties adapting to the host society — are linked to elevated risks of depression, anxiety, and post-traumatic stress disorder (Close et al., 2016; Derr, 2016). Female migrants encounter additional gender-specific challenges, including concerns about emotional safety, social roles, and help-seeking navigation (Nyikavaranda et al., 2023). Although Spanish-speaking immigrants in Portugal may appear culturally proximate due to shared Iberian heritage, this apparent similarity does not ensure service accessibility or emotional attunement in therapeutic contexts (Brasil & Cabecinhas, 2018; Real Academia Española y Asociación de Academias de la Lengua Española, n.d.). Migration is frequently associated with economic hardship, social isolation, and reduced access to healthcare (Abubakar et al., 2018), which may outweigh any advantages conferred by cultural or linguistic similarity.

Moreover, language similarity does not guarantee emotional resonance or shared therapeutic expectations. Aguilera and López (2008), Cho et al. (2014), and Griner and Smith (2006) emphasize that linguistic alignment alone does not ensure mutual understanding between client and psychologist. Cultural Match Theory suggests that outcomes improve when psychological services align with clients' cultural backgrounds, identity, and values (Nelson et al., 2020). Anastasia and Bridges (2015) found that among Spanish-speaking clients, stronger ethnic identity and a preference for Spanish were associated

with both greater depression severity and lower service utilization, even after adjusting for immigration-related and clinical variables.

In addition to cultural distance, internal heterogeneity within Spanish-speaking populations adds complexity. In an extensive U.S. study involving over 16,000 participants, Wassertheil-Smoller et al. (2014) found significant differences in depressive symptomatology across subgroups: Puerto Rican participants reported the highest rates, while Mexican-origin individuals reported the lowest. These findings highlight that broad ethnolinguistic labels often obscure relevant within-group variation in both mental health status and help-seeking behaviour.

Barriers to psychological service use are thus multidimensional. They reflect an interplay between structural limitations, cultural incongruence, perceived emotional risk, and the heterogeneity of immigrant experiences. These factors help explain persistent disparities in service engagement and underscore the need to develop culturally responsive, accessible, and targeted mental health systems tailored to the realities of diverse populations.

2.7. Gaps in the Literature on Immigrant Populations in Portugal

Despite a growing body of European research on mental health access and barriers, there remains a conspicuous absence of peer-reviewed psychological studies focusing on Spanish-speaking immigrants residing in Portugal. More broadly, no studies were located investigating this population within European Union countries outside their region of origin, apart from partial data from Spain. This is not merely a matter of underrepresentation within existing research; it signals a lack of research activity targeting this demographic, revealing a substantial empirical blind spot.

Even in Spain, where Spanish-speaking immigrants from Latin America represent a demographically and linguistically aligned group, peer-reviewed studies examining therapist preferences, therapy modality, or prioritization of selection criteria are absent. This is especially notable

given the historical, linguistic, and cultural continuity between Latin America and the Iberian Peninsula (Brasil & Cabecinhas, 2018; Real Academia Española y Asociación de Academias de la Lengua Española, n.d.). The scarcity of targeted research in such a context underscores how even culturally adjacent immigrant groups may be overlooked in empirical work.

In Portugal, this gap is even more pronounced. The number of immigrants in Portugal has more than doubled since 2015 (Pordata, 2023; Luz, 2024), with Spanish-speaking migrants representing one of the largest non-Lusophone cohorts. Nevertheless, psychological literature that explicitly addresses this population remains minimal. Only a handful of peer-reviewed studies (e.g., Alarcão et al., 2023; Santos et al., 2018) have addressed immigrant mental health in Portugal, and none focus on the Spanish-speaking segment or investigate service preferences from the client's perspective.

Academic literature mentioning Spanish-speaking immigrants in a Portuguese psychological context is limited to a master's thesis (i.e., Anastácio, 2012), a doctoral dissertation (i.e., Monteiro, 2009), and a single published article (i.e., Hernando et al., 2013). None of these works examine preferences related to psychologist characteristics, treatment modality, or decision-making factors during therapist selection. Moreover, there is no record of national or regional research initiatives addressing these questions among Spanish-speaking immigrants in Portugal. It also remains unclear whether their expectations and attitudes toward psychological services differ significantly from other immigrant groups.

Comparative research from neighbouring EU countries highlights the relevance of these omissions. For example, Mugambwa et al. (2023) reported that non-EU migrants receiving care through humanitarian clinics in Germany—often without health insurance or housing—showed high levels of untreated mental health conditions, with over 60% citing cost as a principal barrier to care. While contextually specific, these findings illustrate how structural exclusion from statutory healthcare exacerbates psychological vulnerability among marginalized migrant populations.

The consistent neglect of Spanish-speaking immigrants in Portuguese and European mental health literature does not appear to be a minor oversight but rather reflects a broader structural omission. This absence risks homogenizing immigrant mental health under generic categories such as "foreign-born" or "non-EU national," thereby masking critical within-group differences. It also limits the development of culturally responsive psychological services that account for specific communities' unique preferences, constraints, and sociocultural identities.

In response, the present study positions itself as one of the first to investigate preference-related variables—including psychologist characteristics, therapy modality, and selection criteria—among Spanish-speaking immigrants in Portugal. By addressing this gap, the study contributes not only to localized clinical insight but also to a more equitable and differentiated research agenda in cross-cultural psychology.

2.8. Objectives and Hypotheses

2.8.1. Objectives

This study aims to explore mental health, psychological service use, and therapy-related preferences among Spanish-speaking immigrants in Portugal. Also, other objectives are to identify what variables are related to anxiety and depression symptoms, as well as to obtain a model composed of the most relevant variables associated with anxiety symptoms, and a set of variables that better describe/explain depression symptoms, too. In particular, the objectives are the following:

1. To characterize study participants, describe their sociodemographic characteristics, cultural identity, mental health (including anxiety and depression symptoms, perception of mental health, and psychological service usage history), preferences about therapy, and importance of therapist selection criteria.

2. To assess whether sociodemographic factors, cultural identity, mental health, preferences about therapy, and the importance of different therapy selection criteria are associated with anxiety symptoms and depression symptoms (as measured by the HADS), respectively.
3. To obtain a model with the variables most strongly related to the presence of anxiety symptoms and depression symptoms, respectively.

2.8.2. Hypotheses

H1. Participants who report a sense of cultural identity aligned more with either both cultures or Portuguese culture are expected to be associated with less anxiety and/or depression symptoms.

H2. Participants who report a higher perception of support received are expected to be less associated with anxiety and/or depression symptoms.

H3. Bicultural identity will be the most frequent cultural identity response.

H4. It is anticipated that the rate of past attendance of psychology sessions will be relatively low, with most participants never having attended sessions, and a substantial proportion reporting an unmet need.

H5. Among those who hold preferences, older, female psychologists, and Spanish as the language of therapy are likely to be preferred.

H6. Most participants are expected to prioritize therapist specialization, cost, and recommendation by a trusted person in their selection process.

3. Methodology

3.1. Participants

A total of 255 individuals participated in the study. To be included, participants had to meet three criteria: (1) be at least 18 years old; (2) have been born in a Spanish-speaking country; and (3) have provided informed consent before beginning the questionnaire. Recruitment relied on a combination of convenience and snowball sampling.

The final sample was obtained after excluding 4 participants, 3 who did not agree to the informed consent forms, and 1 who was younger than 18 years old, thus leaving us with a total of 251, all presented in Table 1, below. The final sample comprises 198 women (78.9%) and 53 men (21.1%). Ages ranged from 19 to 68 years, with an average age of 38.05 years (SD = 10.48). The largest age group was 26 to 35 years (43.8%), followed by 36 to 45 years (30.3%).

Educational attainment was relatively high: more than three-quarters of the participants (77.3%) held at least a bachelor’s degree, including 23.1% holding a master's degree and 1.2% holding a PhD, while the other 22.7% reported education up to the secondary level.

Regarding civil status, most respondents (59.4%) were married or living with a partner, while 30.6% were single and 10.0% were divorced. In terms of the professional situation, the majority (80.9%) were working, including worker-students (6.4%), individuals employed by others (57.4%), and self-employed individuals (17.1%). Unemployed individuals represented 19.1% of the sample, which includes retirees (2.8%) and full-time students (2.0%).

As for nationality, three countries stood out: Venezuela (40.2%), Colombia (27.5%), and Argentina (12.4%). The remaining 19.9% (n = 50) included individuals from Bolivia (0.4%), Chile (3.6%), Cuba (0.4%), Ecuador (1.6%), Mexico (3.2%), Nicaragua (0.4%), Peru (4.0%), Puerto Rico (0.4%), Spain

(4.4%), Uruguay (0.4%), and the Other (1.2%) option; unfortunately, the number of participants was too low to allow for statistical analysis between nationalities to establish heterogeneity.

Regarding geographical distribution, most participants resided in the Lisbon Metropolitan Area (Grande Lisboa, 58.2%). Others lived in the Norte (13.9%), Centro (12.7%), Região Autónoma da Madeira (7.2%), Algarve (4.8%), Oeste e Vale do Tejo (2.4%), and Alentejo (0.8%) regions. The predominance of participants from urban areas, especially Lisbon, is noteworthy.

These demographic tendencies—such as the high proportion of women, the overrepresentation of participants with university degrees, and the urban bias—are likely linked to the online recruitment method and the nature of the digital platforms used. Social media distribution may have particularly reached those who are digitally literate, socially connected, and live in metropolitan areas.

Table 1

Participants' sociodemographic characteristics (N = 251).

Variable	*N*	%
Gender		
Woman	198	78.9
Man	53	21.1
Age		
19 to 25	13	5.2
26 to 35	110	43.8
36 to 45	76	30.3
45+	52	20.7
Education		
Up to secondary	57	22.7

Bachelor’s	133	53.0
Master’s	58	23.1
PhD	3	1.2
Civil status		
Single	77	30.7
Married or cohabiting	149	59.4
Divorced	25	10.0
Professional status		
Student	5	2.0
Self-employed	43	17.1
Employed by others	144	57.4
Worker-student	16	6.4
Unemployed, not studying, not retired	36	14.3
Retired	7	2.8
Nationality		
Argentinian	31	12.4
Colombian	69	27.5
Venezuelan	101	40.2
Other	50	19.9
Region		
Norte	35	13.9
Algarve	12	4.8
Centro	32	12.7
Grande Lisboa	146	58.2

Alentejo	2	0.8
Oeste e Vale do Tejo	6	2.4
Região Autónoma da Madeira	18	7.2

3.2. Instrument

The questionnaire was composed of seven sections, each designed to assess a specific construct relevant to the research objectives:

3.2.1. Factors Associated with Living in Portugal and Cultural Identity

The first section assessed the length of stay in Portugal; language fluency in Portuguese; perceived emotional, bureaucratic, or general support received in Portugal; and cultural identity. Participants were asked: how long they had lived in Portugal, choosing from "Less than a year," "Between 1 and 3 years," or "More than 3 years"; their level of Portuguese language proficiency, with response options ranging from "None" to "Full fluency"; whether they had received the emotional, bureaucratic, or general support they needed, responding on a scale from "None" to "Complete support"; and which culture they identified the most with, between their own birth culture, Portuguese culture, or both similarly.

3.2.2. Perception of Own Mental Health and Service Utilization History and Need

The second section focused on previous engagement with psychology sessions, current perception of the need for psychology sessions, and perception of current mental health. Participants were asked: whether they had previously attended psychology sessions, with the possible answers being "No, never had any", "Yes, for less than 6 months", "Yes, for 6 to 12 months", and "Yes, for more than a

year"; whether they had previously attended psychology sessions, with the possible answers being "Yes, and I am attending sessions", "Yes, but I am not attending sessions for reasons beyond my control", "Yes, but I do not want them at the moment", and "I do not need them at the moment"; and lastly, they were asked their perception of their mental health from "Excellent" to "Awful".

3.2.3. Therapy Modality Preference

The third section asked participants whether they would prefer to attend therapy online or in person if they needed psychology sessions. The response options were "In-person-only", "Preferably in-person", "Preferably online", "Online only", "No preference", and "I would not attend psychology sessions in any modality".

3.2.4. Therapist Characteristics Preferences

The fourth section explored participants' preferences regarding a therapist's age, gender, language, and skin colour or race or ethnicity. Participants were asked: regarding a therapist's age whether they had no preference, or preferred a therapist of around the same age as themselves, or older, or younger; regarding a therapist's gender whether they had no preference, or a preference for the therapist being a woman, or a man; regarding a therapist's language whether they had no preference, or preferred Spanish, or preferred Portuguese, or preferred a different language.

3.2.5. Selection Criteria Importance Ratings

The fifth section focused on the criteria considered important when choosing a psychologist by asking participants to rate different factors using a four-point Likert scale ranging from "Not at all important" to "Quite important". The factors assessed included the psychologist's field of expertise or background, availability for in-person or online sessions, scheduling flexibility, session fee, the

professional being recommended by the participant's social circle, and the professional's presence on social media.

3.2.6. Anxiety and Depression Symptoms

The sixth section assessed participants’ levels of anxiety and depression using the Spanish version of the Hospital Anxiety and Depression Scale (HADS), a brief 14-item instrument originally developed by Zigmond and Snaith (1983) to detect emotional distress in hospital settings. Each item is scored on a 4-point Likert scale (0–3), with seven items measuring anxiety and seven measuring depression, yielding subscale scores ranging from 0 to 21. The version used in this study corresponds to the Peruvian adaptation validated by Vilela-Estrada et al. (2025), which demonstrated a bifactor structure with one general factor (emotional distress) and two orthogonal specific factors (anxiety and depression). This version showed strong psychometric properties in a cancer patient population, including high internal consistency (α = .90 for the general factor; α = .84 for both subscales), measurement invariance across gender and education levels, and moderate to strong convergent validity with the Beck Depression Inventory-II and the Beck Anxiety Inventory.

3.2.7. Sociodemographic Data

The final section collected sociodemographic information to characterize the sample. Participants provided their age, gender (male or female), nationality (with a list of Spanish-speaking countries and an “Other” option), civil status (single, married, divorced, or widowed), highest level of education attained (ranging from none to PhD), and current professional status (student, freelance worker, employed, worker-student, unemployed, or retired), and their district of residence, selecting from the 18 districts of mainland Portugal and the autonomous regions of Madeira and the Azores.

3.3. Procedure

The Ethics Committee of Universidade Europeia approved this study. In line with the principles outlined in the Declaration of Helsinki, the ethical codes of the American Psychological Association and the Ordem dos Psicólogos Portugueses, and the General Data Protection Regulation (EU 2016/679), participation was entirely voluntary, and data were anonymized and processed in accordance with European data protection standards.

The study was conducted between January and May 2025 using an anonymous, self-administered online questionnaire hosted on Microsoft Forms. Recruitment followed non-probabilistic methods, combining convenience and snowball sampling strategies. The survey was distributed through Facebook and WhatsApp groups of Spanish-speaking communities in Portugal, and participants were encouraged to disseminate the link through their own networks.

Before accessing the questionnaire, all participants were required to read and accept an informed consent form detailing the study's purpose, participation conditions, inclusion criteria, handling of personal data, identities of the responsible researchers, and contact information in case of questions or interest in receiving results. All items in the questionnaire were mandatory to ensure completeness of the data. No financial or material compensation was offered for participation.

The questionnaire was developed after a review of the literature. It consists of three parts: the informed consent form, a set of direct questions using Likert-scale response formats, and the Hospital Anxiety and Depression Scale (HADS).

3.4. Statistical Analysis

Descriptive analyses, bivariate analyses, and multiple logistic regression (MLoR) analyses were conducted using SPSS v.29.

For the descriptive analysis, the percentage distribution of each original variable included in the questionnaire is presented. The descriptive results are organized into three main topics, in line with the thematic areas covered by the questionnaire: Characteristics related to Residence in Portugal; Mental Health; and Professional Characteristics and Preferences for Psychological Support.

Regarding the bivariate analyses, these were performed separately for each dimension of the HADS scale—that is, for general anxiety symptoms and general depression symptoms. These analyses served two purposes: on one hand, to identify variables related to anxiety and depression symptomatology, respectively; on the other, as a preliminary step for applying MLoR. Although not mandatory, bivariate analysis through the Chi-Square Independence Test or Fisher's Exact Test can be used as a preliminary covariate selection method for MLoR. In such cases, all variables that show a statistically significant association with the dependent variable to be included in the MLoR are selected, or, if not statistically significant, those with a p-value less than .25. This selection criterion is based on the rationale that variables may behave differently when analysed together rather than separately, and that p-values below .25 may yield significant results in multivariate analysis (Hosmer & Lemeshow, 2000).

The variables "level of anxiety symptoms" and "level of depression symptoms," originally ordinal with four severity levels (1 = Normal, 2 = Mild, 3 = Moderate, 4 = Severe), were recoded into two categories: "no symptoms" (level "normal") and "with symptoms" (remaining severity levels). These new dichotomous variables (hereafter referred to as "anxiety symptoms" and "depression symptoms," respectively) were used in the bivariate analyses and subsequently considered as dependent variables in the respective MLoR analyses.

The bivariate analyses involved crossing the "anxiety symptoms" and "depression symptoms" variables with other variables in the study, applying the corresponding hypothesis test (Chi-Square Independence Test or Fisher's Exact Test). For this purpose, some original variables were transformed,

grouping categories where possible to avoid low absolute frequencies, as near-empty cells in cross-tabulations can dominate the solution—an undesirable outcome (Tabachnick & Fidell, 2013). These transformed variables were also used in subsequent MLoR analyses. Table 2 presents the variables used in the bivariate analyses and their recoding.

Table 2

Variables considered in the bivariate analyses for anxiety symptoms and depression symptoms.

Variable	***New Answer Scale***
Age	1= 19 to 25; 2= 26 to 35; 3= 36 to 45; 4= 45+
Gender	(not transformed) 0= Man; 1= Woman
Education	1=High School; 2= Bachelor's; 3=Master's/PhD
Time living in Portugal (years)	(not transformed) 1= Less than 1; 2= 1 to 3; 3= 3+
Portuguese language proficiency	1= None/Low; 0= High/Full fluency
Support received	1= None/Low; 2= Moderate; 3=High/Complete
Cultural identity	1= Mainly culture of origin; 0= Mainly Portuguese culture/Both cultures
Past attendance at sessions	1= Yes; 0= No
Current need for sessions	1= Yes; 0= No
Perception of own mental health	1= Awful/Bad; 2= Neither good nor bad; 3= Good/Excellent
Modality preference	1= No preference; 2= In-person (just or preference); 3= Online (just or preference)
Age preference	1= No preference; 2= Same age; 3= Different age
Gender preference	1= Yes; 0= No

Language preference	1= Yes; 0= No
In-person availability (importance)	1= Completely/Quite; 0= Slightly/Not at all
Online availability (importance)	1= Completely/Quite; 0= Slightly/Not at all
Scheduling flexibility (importance)	1= Not at all/Slightly; 2= Quite; 3= Completely
Session fee (importance)	1= Not at all/Slightly; 2= Quite; 3= Completely
Therapist recommended (importance)	1= Completely/Quite; 0= Slightly/Not at all
Therapist's social media visibility	1= Completely/Quite; 0= Slightly/Not at all

The MLoR technique has been widely used, especially in the field of epidemiology. Its purpose is to model relationships between variables by estimating the value of a dichotomous dependent variable ("presence" vs. "absence") from multiple independent variables or covariates. While it is not possible to infer causality between the latter and the response variable, the technique can be used to model the functional relationship between variables (Hosmer, Lemeshow, & Sturdivant, 2013; Marôco, 2021).

MLoR offers several advantages: it allows for the use of independent variables of any nature (quantitative or qualitative), provided qualitative variables are transformed into dummy variables; it does not require a linear relationship between the independent and dependent variables; it does not require covariate normality; and it is less sensitive to outliers. These advantages give robustness to the method (Marôco, 2021).

When applied, MLoR yields a parsimonious model composed of the smallest number of variables that best describe the relationship between the dependent variable and the predictors. For each independent variable in the model, the technique indicates its influence on the probability of the event occurring, represented by the "presence" category of the dependent variable compared to the "absence" category (Hosmer & Lemeshow, 2000).

In this study, the events modeled were the presence of general anxiety symptoms and the presence of general depression symptoms. The goal was to assess the influence of each independent variable on the likelihood of presenting vs. not presenting symptoms. It is important to note that both the bivariate and MLoR analyses were conducted separately for anxiety and depression symptoms, both dichotomized as previously described.

In regression analysis, qualitative independent variables must be transformed into dummy variables (coded as 0 and 1) before being included. This transformation creates as many dummy variables as there are original categories, such that only one dummy variable per individual is coded as 1, corresponding to their original response. One of the dummy variables must be excluded from the analysis to avoid multicollinearity (high correlation between dummy variables), which is undesirable in regression. The excluded dummy variable then serves as the reference for interpreting results (Marôco, 2021).

In MLoR, SPSS can automatically create dummy variables, indicating which category (first or last) will be the reference by excluding the corresponding dummy variable from the analysis. Tables 3 and 4 present the independent variables used in the respective MLoR analyses, following bivariate analysis and the application of the p-value < .25 selection criterion. As all variables were qualitative, only the reference dummy variable is presented in these tables. The dummy variables were entered using the "Indicator" contrast, as recommended for this variable type (Hosmer & Lemeshow, 2000, 2013).

Table 3

Independent variables considered in the MLoR analysis for anxiety symptoms.

Variable	***Dummy Variable Reference***
Age	4= 45+
Gender	0= Man

Education	1= High School
Time living in Portugal (years)	3= 3+
Received support	3= High/Complete
Cultural identity	0= Mainly Portuguese culture/Both cultures
Past attendance of sessions	0= No
Current need for sessions	0= No
Perception of own mental health	3= Good/Excellent
Modality preference	0= No
Gender preference	0= No
Language preference	0= No
In-person availability (importance)	0= Not at all/Slightly
Online availability (importance)	0= Not at all/Slightly
Therapist Recommended (importance)	0= Not at all/Slightly

Table 4

Independent variables considered in the MLoR analysis for depression symptoms.

Variable	***Dummy Variable Reference***
Education	1= High School
Portuguese language proficiency	0= High/Full fluency
Received support	3= High/Complete
Cultural identity	0= Mainly Portuguese culture/Both cultures
Current need for sessions	0= No
Perception of own mental health	3= Good/Excellent

Modality preference	0= No
Gender preference	0= No
Language preference	0= No
Session fee (importance)	1= Not at all/Slightly

The Forward LR method was used to select independent variables to be included or excluded from the model, until the final model was obtained for both general anxiety symptoms and general depression symptoms.

MLoR results are interpreted using the concept of odds (probability ratio), i.e., the probability of the event occurring vs. not occurring, and the concept of odds ratio (OR), or the ratio of odds based on a given independent variable. If the independent variable is qualitative (dummy), the OR represents the odds of the event occurring vs. not occurring when the variable takes value 1, compared to when it takes value 0. If the independent variable is quantitative, the OR represents the odds of the event occurring vs. not occurring when the variable increases by one unit, compared to when it remains constant (Marôco, 2021). In this study, the event refers to the presence of symptoms.

It is also worth noting that an OR greater than 1 corresponds to a positive regression coefficient ($\beta > 0$), indicating a positive or direct relationship between variables. This means increased odds of the event occurring when the independent variable equals 1 (qualitative) or increases by one unit (quantitative) compared to when it equals 0 or remains constant, respectively. An OR less than 1 corresponds to a negative regression coefficient ($\beta < 0$), reflecting a negative or inverse relationship, i.e., decreased odds of the event occurring when the variable equals 1 or increases by one unit, compared to when it equals 0 or remains constant. An OR equal to 1 corresponds to a regression coefficient of 0 ($\beta = 0$), indicating no relationship between variables—i.e., equal odds when the independent variable equals

1 or increases by one unit, compared to when it equals 0 or remains constant, respectively. In other words, the independent variable has no effect on the dependent variable.

4. Results

4.1. Descriptive Statistics Results

4.1.1. Factors Associated with Living in Portugal and Cultural Identity

The data from the first section of the instrument are organised in Table 5, which establishes that participants demonstrated a profile of partial identity aligning with Portuguese society, shaped by both linguistic adaptation and persistent identity aligned with their native culture. The majority had been residing in Portugal for over a year, with nearly half reporting a stay between one and three years and over 40% living in the country for more than three years, which suggests a largely settled population.

Despite the length of residence, most respondents (57.8%) continued to identify primarily with their culture of origin. Only a small fraction (3.6%) identified more with Portuguese culture, while 38.6% expressed dual identity. This tendency toward cultural retention contrasts with the high levels of Portuguese language proficiency reported. Over 60% of the sample described their language skills as high or fluent, with very few indicating low or no ability to communicate in Portuguese.

Perceptions of support also varied. While a majority (61.0%) reported at least a medium level of emotional, instrumental, or social support in Portugal, a significant minority experienced either low (20.3%) or no support (18.7%) at all. This disparity emerged despite the group’s high language proficiency and long-term residence.

Table 5

Factors associated with living in Portugal and cultural identity (N = 251).

Variable	*N*	%
Time living in Portugal		
Less than a year	23	9.2
Between 1 and 3 years	123	49.0
More than 3 years	105	41.8
Cultural identity		
Mostly with birth culture	145	57.8
Similarly with both	97	38.6
Mostly with Portuguese culture	9	3.6
Portuguese language proficiency		
None	1	0.4
Low	15	5.9
Medium	78	31.1
High	90	35.9
Full fluency	67	26.7
Received support		
None	47	18.7
Low	51	20.3
Medium	102	40.6
High	40	16.0
Complete support	11	4.4

4.1.2. Perception of Own Mental Health, Anxiety and Depression Symptoms, and Service Utilization History and Need

Table 6 is composed of the data from sections 2 and 6 of the instrument. Its data shows that most participants rated their mental health positively, with over half (57.0%) describing it as either "good" or "excellent." Nonetheless, one in ten (10.8%) reported their mental health as “bad” or “awful,” and nearly a third (32.3%) assessed it as “medium,” indicating that for almost half of the sample, well-being was either moderate or compromised.

Symptom screening using the Hospital Anxiety and Depression Scale (HADS), which aggregates responses across multiple items into overall anxiety and depression scores, showed that psychological distress was relatively common. While the majority fell within the normal range, anxiety symptoms were more prevalent, with over 44% of participants scoring above the normal threshold, compared to only 30% for depression symptoms. These results reflect a general trend of lack of symptom presence, with anxiety being the most common.

The distribution of past engagement with psychological services offers further insight. A total of 36.7% of participants had never attended therapy. This proportion coincidentally mirrors the percentage of those who stated they currently do not need it, an overlap that may suggest some individuals have consistently viewed therapy as unnecessary. In contrast, the remainder of the sample reported having accessed therapy at some point, with most of them having attended either for less than 6 months or for more than 12 months.

Furthermore, in terms of current need for therapy, just over 63% of participants affirmed a perceived need, out of which only 15.5% were currently attending sessions, with 38.2% being unable to attend, and 9.6% expressing no intention to seek treatment; revealing a marked disparity between the number of individuals recognizing a need and those currently engaged in treatment.

Table 6

Perception of own mental health, anxiety and depression symptoms, and service utilization history and need (N = 251).

Variable	*N*	%
Perception of own mental health		
Excellent	17	6.8
Good	126	50.2
Medium	81	32.3
Bad	24	9.6
Awful	3	1.2
HADS anxiety		
No symptoms	139	55.4
Mild	63	25.1
Moderate	39	15.5
Severe	10	4.0
HADS depression		
No symptoms	175	69.7
Mild	48	19.1
Moderate	23	9.2
Severe	5	2.0
Past attendance of sessions		
Never had any	92	36.7
Yes, less than 6 months	79	31.5

Yes, 6 to 12 months	34	13.5
Yes, more than a year	46	18.3
Current need for sessions		
Yes, attending sessions	39	15.5
Yes, not attending sessions	96	38.2
Yes, do not want sessions	24	9.6
Do not need sessions	92	36.7

4.1.3. Preferences for Therapy Modality and Therapist Characteristics

Table 7 comprises data collected from sections 3 and 4 of the instrument, and displays that although a majority expressed some openness to in-person and online formats, there was a clear tilt toward in-person settings. Nearly 37% preferred in-person sessions, of which only 5.6% exclusively wanted in-person sessions; on the other hand, only 18.7% favoured online formats, of which only 4.0% exclusively wanted online sessions. However, the most frequent response—selected by over 40%—was "no preference," suggesting that modality may be a secondary consideration for many, conditional on other factors. Only a small minority (2.4%) reported being unwilling to attend therapy in any format.

Regarding the therapist's characteristics, preferences were strongest about language. A combined 98.8% of participants preferred speaking in Spanish or were comfortable with both Spanish and Portuguese, while only 1.2% preferred Portuguese alone. A clear majority (64.5%) preferred Spanish, highlighting the central role of native language in therapeutic communication for this sample.

In contrast, preferences for therapist age, gender, or ethnicity were relatively limited, with most participants reporting no preference in age, gender, or ethnicity. Over two-thirds of participants (67.3%) reported no gender preference, with the portion holding a preference being composed of almost

entirely a preference for female therapists (29.9%); 94% reported no preference regarding the therapist's skin tone, race, or ethnicity; lastly, 58.2% expressed no preference regarding age, though a notable minority did prefer either an older therapist (21.9%) or one of approximately the same age (19.5%), with preference for a younger therapist being nearly non-existent at 0.4%.

Table 7

Preferences for therapy modality and therapist characteristics (N = 251).

Variable	*N*	%
Modality preference		
In-person only	14	5.6
Prefer in-person	79	31.5
Prefer online	37	14.7
Online only	10	4.0
No preference	105	41.8
Would not attend sessions in any modality	6	2.4
Age preference		
None	146	58.2
Approximately the same age	49	19.5
Older therapist	55	21.9
Younger therapist	1	0.4
Gender preference		
None	169	67.3
Female therapist	75	29.9
Male therapist	7	2.8

Language preference		
Spanish or Portuguese	86	34.3
Prefer Spanish	162	64.5
Prefer Portuguese	3	1.2
Skin tone, race, or ethnic preference		
None	236	94.0
Prefer same	13	5.2
Prefer different	2	0.8

4.1.4. Importance Ratings for Therapist Selection Criteria

Data from section 5 of the instrument is presented in Table 8, in which we can see that participants assigned the highest importance ratings to two factors: the therapist's area of expertise and session fee. A combined 96% rated the field of expertise as either "quite" or "completely" important, and 94.8% did the same for session fee. This prioritization suggests that competence and affordability are central to therapist selection for this sample, regardless of other contextual or interpersonal variables.

Schedule flexibility also emerged as a critical factor, with 85.7% rating it as "quite" or "completely" important. Availability for online and in-person sessions received moderate importance, with roughly half the sample assigning "quite" or "completely" importance levels (49.8% and 47.5%, respectively). These findings suggest that structural fit, including scheduling compatibility and delivery format, plays a significant role in shaping perceived accessibility and suitability of care.

Recommendations by trusted contacts were also valued: 66.1% rated this as “quite” or “completely” important. This highlights the influence of informal social networks in guiding help-seeking behaviour, particularly in culturally or linguistically distinct populations.

By contrast, therapists’ social media presence received the lowest importance ratings, with only 25.5% assigning it as “quite” or “completely” important. Over 74% rated it as “not” or “slightly” important. While digital visibility may still influence initial impressions or perceived approachability, it carries little weight in direct therapist selection for this sample.

In sum, participants prioritized therapist competence, financial accessibility, and logistical compatibility over digital presence or visual/demographic traits. The prominence of social recommendation also reinforces the social embeddedness of therapeutic decision-making within this sample. Despite the strategies used to collect the sample, the greater level of importance granted to recommendations by social circles compared to therapists' social media presence suggests that participants forming part of social media groups and communities are more associated with social aspects than social media.

Table 8

Importance ratings for therapist selection criteria (N = 251).

Variable	*N*	%
Expertise field or professional formation		
Not important	2	0.8
Slightly important	8	3.2
Quite important	114	45.4
Completely important	127	50.6
In-person availability		

Not important	33	13.1
Slightly important	99	39.4
Quite important	89	35.5
Completely important	30	12.0
Online availability		
Not important	30	12.0
Slightly important	96	38.2
Quite important	90	35.9
Completely important	35	13.9
Schedule flexibility		
Not important	4	1.6
Slightly important	32	12.7
Quite important	147	58.6
Completely important	68	27.1
Session fee		
Not important	1	0.4
Slightly important	12	4.8
Quite important	131	52.2
Completely important	107	42.6
Therapist recommended by social contacts		
Not important	14	5.6
Slightly important	71	28.3
Quite important	118	47.0
Completely important	48	19.1

Therapist's social media visibility		
Not important	56	22.3
Slightly important	131	52.2
Quite important	43	17.1
Completely important	21	8.4

4.2. Bivariate Analysis

Most variables have been chosen for recodification to be statistically adequate for Chi-Square Independence Test and Fisher's Exact Test, and cross-tabulated in bivariate analysis for the recodified binary versions of the HADS Anxiety and HADS Depression variables (defining either presence or absence of symptoms), to be used for Multiple Logistic Regression. The statistics are summarised in Table 9 below. The following variables did not present enough variability to be statistically usable: preference for a therapist's skin tone, race, or ethnicity (94% holding no preference); and field of expertise or formation (96% rating it either quite or completely important).

4.2.1. Bivariate Analysis for Anxiety Symptoms

There was no significant association between participants' age and the presence of anxiety symptoms ($\chi^2(3, N = 251) = 5.577$, $p = .134$), nor with gender (Fisher's exact test, $N = 251$, $p = .088$) nor education level ($\chi^2(2, N = 251) = 4.010$, $p = .135$).

Time spent living in Portugal, cultural identity, and Portuguese language proficiency showed no significant association with anxiety symptoms within this sample's participants ($\chi^2(2, N = 251) = 5.283$, $p = .071$; Fisher's exact test, $N = 251$, $p = .123$; $\chi^2(1, N = 251) = 1.132$, $p = .287$, respectively). Perception of received support, on the other hand, was significantly associated with anxiety symptoms in this sample

(χ^2(2, N = 251) = 6.167, p = .046): among participants without anxiety symptoms, 35.3% perceived having received little or no support, 38.8% perceived having received moderate support, and 25.9% perceived having received high or full support; in comparison to participants with anxiety symptoms, of which 43.8% perceive having received none or little support, 42.9% perceive having received moderate support, and only 13.4% perceive having received high or full support.

All variables related to mental health perception and psychological service usage were significantly associated with anxiety symptoms within the context of this sample's participants. Starting with participants' perception of their own mental health (χ^2(2, N = 251) = 59.095, p < .001), results show that among those without anxiety symptoms, 2.2% rated their mental health as bad or awful, 20.1% rated it as neither good nor bad, and 77.7% rated it as either good or excellent; conversely, the participants with anxiety symptoms reported worse overall ratings, with 21.4% reporting bad or awful, 47.3% reporting neither good nor bad, and 31.3% reporting either good or excellent.

As for past attendance of psychology sessions, Fisher's exact test (N = 251, p < .001) revealed that 51.1% of participants without anxiety symptoms have previously attended psychology sessions, compared to 78.6% of those with anxiety symptoms. Lastly, regarding the current need for psychology sessions, Fisher's exact test (N = 251, p < .001) revealed that while 44.6% of participants without anxiety symptoms indicated a need for sessions, participants with anxiety symptoms were almost twice as likely (86.6%) to report the same need.

Other than the preference for the therapist's age (χ^2 (2, N = 251) = 1.363, p = .506), and preference for the therapist's skin tone, race, or ethnicity (excluded for not presenting enough variability), all the other preferences have a statistically significant association with the presence of anxiety symptoms. Preference for therapy modality (χ^2 (2, N = 251) = 7.143, p = .028) was associated with symptom presence: 45.1% of participants with no anxiety symptoms either preferred or exclusively wanted in-person sessions, and 15.0% preferred or exclusively wanted online sessions; whereas only

29.5% of participants with anxiety symptoms expressed a preference or exclusive desire for in-person sessions, and 24.1% either preferred or exclusively wanted online sessions, differences that establish a clear difference between participants with and without anxiety symptoms.

Fisher's exact test also showed significant associations between anxiety and preferences for the therapist's gender ($N = 251$, $p < .001$) and language ($N = 251$, $p < .001$). Among those without anxiety symptoms, 26.6% expressed a gender preference, and 56.1% had a language preference; these figures were higher among participants with symptoms (40.2% and 77.7%, respectively).

There was no statistically significant association between anxiety symptoms and availability for online sessions (Fisher's exact test, $N = 251$, $p = .205$); schedule flexibility ($\chi^2(2, N = 251) = 2.504$, $p = .286$); session fee ($\chi^2(2, N = 251) = 1.513$, $p = .469$); and therapist's visibility in social media (Fisher's exact test, $N = 251$, $p = .885$). Furthermore, the field of expertise or formation was excluded due to not presenting enough variability.

However, availability of in-person sessions was linked to anxiety symptoms (Fisher's exact test, N = 251, $p = .011$): a bigger proportion of participants with no anxiety symptoms (54.7%) considered in-person availability quite or completely important, compared to 38.4% in the group with anxiety symptoms.

Lastly, therapist recommendation by social circle was significantly associated with anxiety ($\chi^2(2, N = 251) = 6.053$, $p = .048$). Although most of both groups rated this as important, participants with anxiety symptoms were almost twice as likely to rate it as "completely important" (24.5%) than their counterparts without symptoms (12.5%).

4.2.2. Bivariate Analysis for Depression Symptoms

No significant associations were observed between symptoms of depression and age ($\chi^2(3, N = 251) = 2.918, p = .404$), gender (Fisher's exact test, $N = 251$, $p = .866$), nor education level ($\chi^2(2, N = 251) = 5.093, p = .078$).

No significant association was found between depression symptoms and time living in Portugal ($\chi^2(2, N = 251) = 2.183, p = .336$), and Portuguese language proficiency (Fisher's exact test, $N = 251$, $p = .205$).

Cultural identity was significantly associated with depression symptoms (Fisher's exact test, $N = 251$, $p = .027$). Among participants without depression symptoms, 53.1% identified primarily with their culture of origin, compared to 68.4% in the group with symptoms.

Depression was also linked to perceived support received ($\chi^2(2, N = 251) = 16.312, p < .001$): 31.4% of participants without symptoms reported receiving little to no support, 43.4% for moderate support, and 25.1% for high or full support; in contrast, 55.6% of participants with symptoms reported receiving little to no support, 34.2% for moderate support, and only 9.2% reported receiving high or full support.

Unlike anxiety, past attendance of psychology sessions did not show a significant relationship with depressive symptoms (Fisher's exact test, $N = 251$, $p = .319$). Participants' self-rated mental health was associated with depression ($\chi^2(2, N = 251) = 56.113, p < .001$). Among those without symptoms, 3.4% considered their mental health as either bad or awful, 25.7% as neither good nor bad, and 70.9% as either good or excellent; while those that present symptoms have 27.6% whom consider their mental health as either bad or awful, 47.4% as neither good nor bad, and 25.0% as either good or excellent.

Current perceived need for psychological support and depression were also significantly associated (Fisher's exact test, $N = 251$, $p < .001$): fewer participants without symptoms indicated a need for sessions (54.9%), compared to 82.9% in the group with symptoms.

Most preferences were not significantly associated with depression symptoms: therapy modality (χ^2(2, N = 251) = 3.173, p = .205) therapist's age (χ^2(2, N = 251) = 2.394, p = .302); with therapist's skin tone, race, or ethnicity having been excluded due to a lack of variability.

Depressive symptoms were significantly associated with preferences for both therapist's gender (Fisher's exact test, N = 251, p = .009) and language (Fisher's exact test, N = 251, p = .044): within the sample's participants, a preference for therapist gender was less common among those without symptoms (27.4%) than those with (44.7%). Similarly, 61.7% of participants without depressive symptoms had a language preference, compared to 75.0% in the symptomatic group.

No significant associations were found between depression and availability of in-person (Fisher's exact test, N = 251, p = .891) or online (Fisher's exact test, N = 251, p = .412) sessions; schedule flexibility (χ^2(2, N = 251) = 1.625, p = .444); session fee (χ^2(2, N = 251) = 5.719, p = .057); therapist recommendation by social circle (χ^2(2, N = 251) = 2.476, p = .290); or therapist's visibility in social media (Fisher's exact test, N = 251, p = .433). Lastly, the field of expertise or formation was excluded due to not presenting enough variability.

Table 9

Chi-Square Independence Test and Fisher's Exact Test bivariate analysis (N = 251).

Variable	***Test Used***	**Anxiety** χ^2 / p	**Depression** χ^2 / p
Age	Chi-square	5.577 / .134	2.918 / .404
Gender	Fisher's exact	— / .088	— / .866
Education level	Chi-square	4.010 / .135	5.093 / .078
Time in Portugal	Chi-square	5.283 / .071	2.183 / .336
Cultural identity	Fisher's exact	— / .123	— / .027*
Language proficiency	Chi-square	1.132 / .287	— / .205

Support received	Chi-square	6.167 / .046*	16.312 / <.001*
Mental health perception	Chi-square	59.095 / <.001*	56.113 / <.001*
Past attendance	Fisher's exact	— / <.001*	— / .319
Current need	Fisher's exact	— / <.001*	— / <.001*
Therapy modality	Chi-square	7.143 / .028*	3.173 / .205
Therapist's age	Chi-square	1.363 / .506	2.394 / .302
Therapist's gender	Fisher's exact	— / <.001*	— / .009*
Therapist's language	Fisher's exact	— / <.001*	— / .044*
Availability in-person	Fisher's exact	— / .011*	— / .891
Availability online	Fisher's exact	— / .205	— / .412
Schedule flexibility	Chi-square	2.504 / .286	1.625 / .444
Session fee	Chi-square	1.513 / .469	5.719 / .057
Recommendation by socials	Chi-square	6.053 / .048*	2.476 / .290
Social media visibility	Fisher's exact	— / .885	— / .433

Note. * = significance at .05

4.3. Multiple Logistic Regression Results

4.3.1. Multiple Logistic Regression Analysis for Anxiety Symptoms

Among the results of the analysis, two indicators are used to assess the model's fit to the data. The Cox & Snell pseudo R^2 ranges between 0 and a value below 1 — even in the case of a perfect model

— while the Nagelkerke pseudo R^2 ranges from 0 to 1. Therefore, interpretation typically focuses on the Nagelkerke R^2 as a better indicator of model quality.

To evaluate the overall significance of the model, the Omnibus Test is used. If the null hypothesis — that all parameters (regression coefficients) are equal to zero — is rejected, it can be concluded that at least one independent variable has explanatory power regarding the dependent variable.

Subsequently, the Wald test is applied to assess the statistical significance of each parameter individually. This test determines which regression coefficients differ significantly from zero and, therefore, which variables contribute to explaining the outcome in the dependent variable.

As previously mentioned, the functional relationship between each independent variable and the dependent variable is interpreted through the corresponding odds ratio values.

Finally, model reliability — namely, its predictive or discriminative ability — is evaluated using the Hosmer & Lemeshow goodness-of-fit test. If the null hypothesis, stating that the model fits the data, is not rejected, one may conclude that the model performs well. Another indicator of reliability is the ROC curve, the area under which corresponds to the probability of the model correctly classifying cases as true positives (i.e., the model classifies a participant as presenting general anxiety symptoms, and the participant in fact presents symptoms) and true negatives (i.e., the model classifies a participant as not presenting symptoms, and the participant indeed does not).

In the present study, the Omnibus Test yielded a significant result ($\chi^2(4) = 85.106$; $p < .001$). Regarding model fit, the Nagelkerke pseudo R^2 was .392. Thus, the model explains approximately 40% of the variability in the “general anxiety symptoms” variable.

The final model included the following dummy variables: “past attendance of psychology sessions: yes”; “current need for psychology sessions: yes”; “perception of one’s own mental health: awful/bad”; and “perception of own mental health: neither good nor bad”. Table 10 presents these

variables alongside their corresponding regression coefficients (β), standard errors (S.E.), Wald statistics, degrees of freedom (d.f.), p-values (Sig.), odds ratios (e^{β}), and 95% confidence intervals.

Table 10

Multiple logistic regression model for anxiety symptoms.

	β	*S.E.*	*Wald*	*d.f.*	*Sig.*	e^{β}	*95% C.I.*	
							Lower	*Upper*
Sessions in the past: Yes	0.931	0.347	7.194	1	<.001	2.537	1.285	5.008
Current need: Yes	1.170	0.365	10.255	1	<.001	3.221	1.574	6.589
P. Mental Health (PMH)			29.251	2	<.001			
PMH: Awful/bad	2.546	0.663	14.731	1	<.001	12.762	3.477	46.843
PMH: Neither good nor bad	1.540	0.336	21.076	1	<.001	4.665	2.417	9.004
Constant	-2383	0.384	38.537	1	<.001	0.092		

According to the respective odds ratio (e^{β}) in the table above, it is possible to conclude that all regressors have a positive relationship with the variable general symptoms of anxiety. More specifically:

- The odds of having anxiety symptoms for someone who had psychology sessions in the past are 2.54 times greater than the odds for a similar individual (with concerning the other covariates in the model) who did not have psychology sessions in the past. So, participants who had sessions in the past have greater chance of showing anxiety symptoms.
- The odds of showing anxiety symptoms for a participant who currently needs psychology sessions are 3.22 times greater than the odds for a similar person

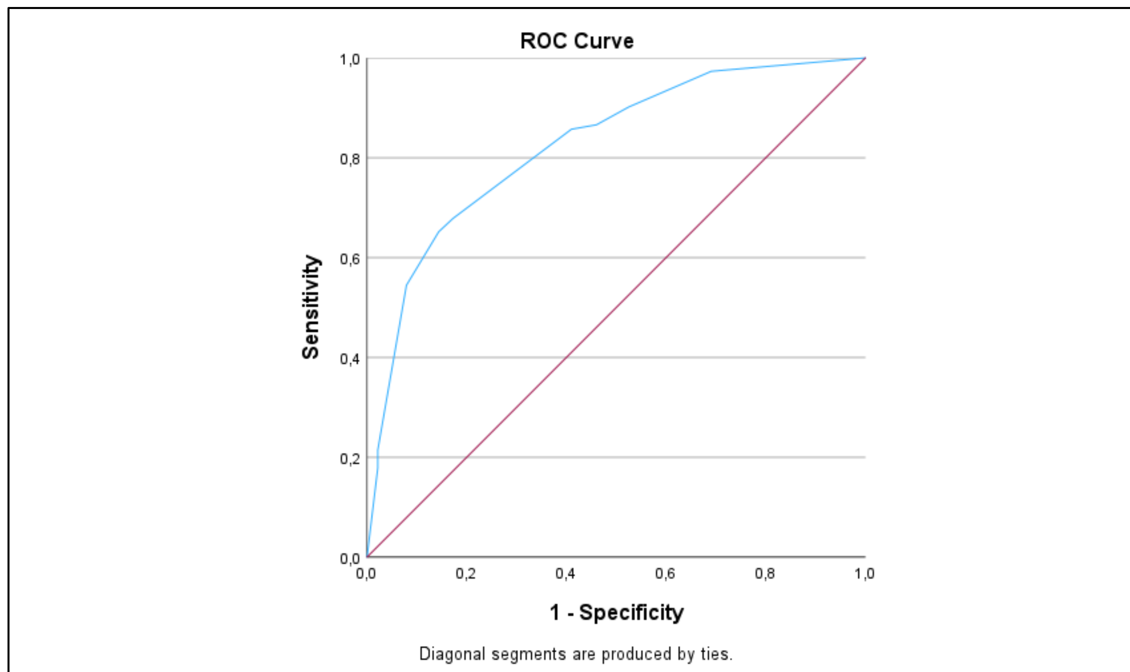
(concerning the other covariates in the model) who does not currently need psychology sessions at present, that is, the possibility of showing anxiety symptoms is greater for people who currently need sessions.

- The odds of having anxiety symptoms for individuals who consider their mental health as awful/bad are 12.76 times greater than the odds for similar participants (concerning the other covariates in the model) who consider their mental health as good/excellent.
- Finally, the odds of showing anxiety symptoms for someone who considers their own mental health as neither good nor bad are 4.67 times greater than the odds for a similar individual (concerning the other covariates in the model) who considers their own mental health as good/excellent.

Regarding model reliability, the Hosmer & Lemeshow test indicated good discriminative capacity ($\chi^2(5) = 2.449$; $p = .784$). More specifically, the ROC curve yielded an AUC of .825, which reflects good discriminant ability (Marôco, 2021).

Figure 1

ROC Curve - Discriminant capability of the anxiety symptoms model.



4.3.2. Multiple Logistic Regression Analysis for Depression Symptoms

Regarding depression symptoms, the model yielded a statistically significant Omnibus Test ($\chi^2(3) = 615.591$; $p < .001$). In terms of model fit, the Nagelkerke pseudo R^2 was .315, indicating that the model explains approximately one-third of the variability in the "general depression symptoms" variable.

The final model included the following dummy variables: "perception of own mental health: awful/bad"; "perception of own mental health: neither good nor bad"; and "preference for therapist's gender: yes". Table 11 presents these variables along with their respective regression coefficients (β), standard errors (S.E.), Wald statistics, degrees of freedom (d.f.), p-values (Sig.), odds ratios (e^{β}), and 95% confidence intervals.

Table 11

Multiple logistic regression model for depression symptoms.

	β	*S.E.*	*Wald*	*d.f.*	*Sig.*	e^{β}	*95% C.I.*	
							Lower	*Upper*
P. Mental Health (PMH)			43.214	2	<.001			
PMH: Awful/bad	3.146	0.536	34.441	1	<.001	23.239	8.127	66.450
PMH: Neither good nor bad	1.688	0.346	23.807	1	<.001	5.406	2.745	10.648
P. Therapist's gender: Yes	0.850	0.333	6.508	1	.011	2.339	1.218	4.493
Constant	-2.221	0.297	56.072	1	<.001	0.108		

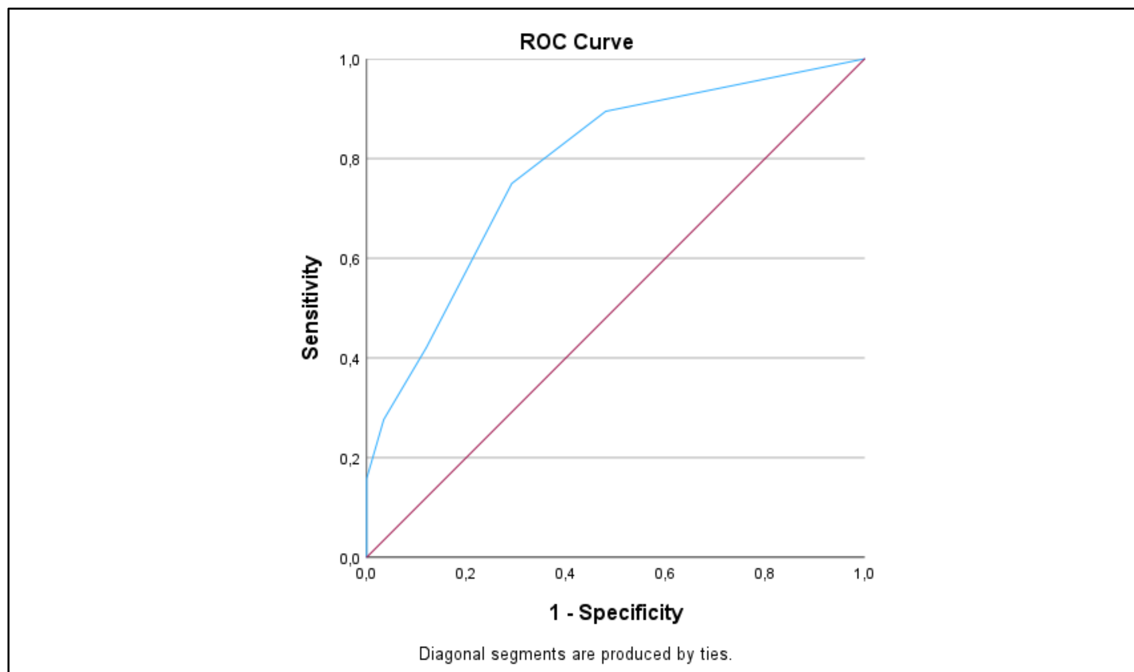
Considering the respective odds ratio (e^{β}) in the table above, it is possible to observe a positive relationship between the regressors and the variable general symptoms of depression. Particularly:

- The odds of having depression symptoms for an individual who considers their own mental health as awful/bad is 23.24 times greater than the odds for a similar participant (concerning the other covariates in the model) who considers their own mental health as good/excellent, that is, the possibility of showing depression symptoms is greater for a person with an awful/bad perception of own mental health.
- The odds of showing depression symptoms for someone who considers their own mental health as neither good nor bad is 5.41 times greater than the odds for a similar individual (concerning the other covariates in the model) who considers their own mental health as good/excellent.
- The odds of having depression symptoms for a person who has preferences for the therapist's gender is 2.34 times greater than the odds for a similar individual in the sample (concerning the other covariates in the model) who does not have a preference about the gender of the therapist.

Regarding model reliability, the Hosmer & Lemeshow test indicated acceptable discriminative capacity ($\chi^2(3) = 5.256$; $p = .154$). More specifically, the ROC curve yielded an AUC of .785, which is interpreted as acceptable and approaching good discriminative performance (Marôco, 2021).

Figure 2

ROC Curve - Discriminant capability of the depression symptoms model.



5. Discussion

This study explored how therapy-related preferences, mental health indicators, and acculturation variables intersect with symptoms of anxiety and depression among Spanish-speaking immigrants in Portugal. Aligned with its objectives, the research aimed to (1) characterize the sample in terms of sociodemographic, psychological, and preference-related variables, (2) examine associations

between these variables and anxiety and depression symptoms, and (3) identify the most relevant predictors of symptom presence using logistic regression models. Drawing from a sample of 251 participants, and using descriptive statistics, bivariate testing, and multiple logistic regression, the findings offer preliminary insights into psychological vulnerability and service engagement within this underexamined population.

Despite most participants reporting high Portuguese language proficiency and extended residence duration, identification with Portuguese culture, and perception of received support remained mixed. This dissociation aligns with acculturation literature suggesting that behavioral adaptation does not necessarily lead to psychological or cultural integration (Sam, 2024; Schmitz & Schmitz, 2022), and the combination of factors is reminiscent of past literature associating immigrant status with social isolation (Abubakar et al., 2018). Only 3.6% of participants identified more with Portuguese culture, while nearly 58% aligned more strongly with their culture of origin. H1 was not supported, as alignment with Portuguese culture or a bicultural identity was not associated with lower levels of anxiety or depression symptoms. Furthermore, H3 was contradicted: bicultural identity was not the most common response; identification with the culture of origin was clearly dominant.

This finding has implications for therapeutic rapport and communication, especially given this sample's preference for Spanish in therapy, which confirms prior findings on the affective and relational importance of receiving care in one’s native language (Aguilera & López, 2008; Griner & Smith, 2006; Cho et al., 2014).

It should be noted, however, that the sample's characterization as seemingly functionally adapted but culturally anchored to their countries of origin, with underrepresentation of strong Portuguese cultural identity and mixed experiences of support, might be partially explained by the specific recruitment strategy, which relied heavily on exclusively Spanish-speaking online communities and likely attracted participants who maintained stronger ties to their culture of origin.

Aligned with the national context of Portuguese services and the immigrant status of this sample, service access remains a major concern. While 63.3% of participants reported a perceived current need for therapy, only 15.5% were attending sessions. This confirms H4, which anticipated a relatively low rate of past therapy attendance and a substantial proportion reporting unmet need. The treatment gap is consistent with earlier findings among immigrant and Hispanic populations regarding barriers and underutilization (Aguilera & López, 2008; Derr, 2016; Nelson et al., 2020; Rosales & Calvo, 2017), suggesting that common structural barriers — cost, wait times, and limited availability of culturally or linguistically competent professionals — are likely present in this population as well (Bernardo et al., 2021).

However, despite these limitations, 89.3% of participants rated their mental health as medium or higher, and a majority reported no anxiety (55.4%) or depression (69.7%) symptoms. The discrepancy with earlier studies may reflect real differences in distress levels or varying help-seeking thresholds, consistent with findings by Kujanpää et al. (2017).

Preferences for therapy modality showed that most participants reported no preference, diverging from O'Callaghan et al. (2023), where clear preferences — often favoring online therapy — were found. Among those with preferences, in-person therapy was preferred, consistent with Ilagan & Heatherington (2022) and Parsons et al. (2025), while conflicting with O'Callaghan et al. (2023). The fact that nearly half of the sample rated both in-person and online availability as only moderately important supports the interpretation of general flexibility in this sample.

Regarding therapist characteristics, most participants reported no preference for age, gender, or ethnicity, which aligns with findings by O'Callaghan et al. (2023), Black & Gringart (2019), and Liddon et al. (2018). Among those who expressed preferences, the majority preferred older and female therapists and Spanish as the language of therapy, supporting H5. These findings are especially relevant considering the sample's female predominance (nearly 80%), and align with literature showing greater

comfort with female therapists in emotionally vulnerable contexts (Landes et al., 2013; Lauber & Drevenstedt, 1994; Seidler et al., 2022), as well as gendered cultural norms within Latin American cultures (Valdez et al., 2023).

Language preference was a dominant theme. Only 1.2% preferred Portuguese for therapy, whereas 64.5% preferred Spanish and 34.3% accepted both. Given that most participants reported no ethnic preference, language appears to substitute for ethnic similarity, reinforcing its affective and relational significance (Aguilera & López, 2008; Griner & Smith, 2006; Miteva et al., 2022). Language preference was even more pronounced among those with anxiety symptoms, highlighting its role in emotional safety.

Therapist selection criteria were prioritized in the following order: therapist competence, price, and schedule flexibility, followed by recommendation by trusted persons, and then availability for online and in-person sessions. Social media presence was least valued. These priorities confirm H6, which predicted specialization, cost, and personal recommendation would be most valued. These findings support the primacy of clinical expertise (Feng et al., 2024; Jørgensen & Makransky, 2022; O'Callaghan et al., 2023), affordability (Feng et al., 2024), and the role of informal networks (Derr, 2016). The low relevance of social media may reflect generational or cultural factors (Pagnotta et al., 2018).

Bivariate analyses clarified additional psychological dimensions. Anxiety symptoms were associated with perceived low support, negative self-rated mental health, current perceived need for therapy, and past therapy attendance. They also correlated with stronger preferences for therapist gender, language, and a preference for online therapy, suggesting that relational safety and accessibility are heightened concerns among symptomatic individuals. These findings support H2, which predicted that higher perceived support would be associated with fewer symptoms. These patterns mirror prior findings on postmigration stressors and perceived exclusion (Close et al., 2016; Derr, 2016; Wong et al., 2018).

Depression symptoms showed some overlap but had distinct associations. They were significantly related to stronger identification with the culture of origin and lower perceived support, again supporting H2. However, they were not associated with therapy history or modality preference. Preferences for therapist gender and language remained relevant, but practical considerations such as session fee or availability showed no significant associations, hinting at a more internally oriented symptom profile.

These results suggest that service-related preferences may be, at least partly, state-dependent. Psychological symptoms — not fixed traits — appear to shape how individuals evaluate therapy options and engage with care. This reinforces the value of screening for distress, not just to guide diagnosis, but to anticipate and accommodate relational expectations and logistical needs.

Logistic regression models added depth to these findings. The anxiety model explained 39.2% of variance (AUC = .825) and showed that poor self-perceived mental health, perceived need, past therapy attendance, and language preference were key predictors. These findings validate the use of subjective health measures in immigrant mental health screening (Ahmad et al., 2014) and reflect help-seeking trends described by Kujanpää et al. (2017). Gendered and cultural factors may compound these vulnerabilities, especially given structural barriers faced by female migrants (Nyikavaranda et al., 2023).

The depression model explained 31.5% of variance (AUC = .785), with poor self-perceived mental health again the strongest predictor. A preference for therapist gender also emerged as significant. These findings are congruent with Beck's cognitive theory of depression (1967) and metacognitive perspectives (Papageorgiou & Wells, 2003), where self-evaluation and perceived relational safety drive symptom expression. The preference for female psychologists may reflect culturally grounded expectations of emotional attunement and comfort (Landes et al., 2013; Ilagan & Heatherington, 2022), particularly in female-majority samples and machismo-impacted contexts (Valdez et al., 2023).

Together, these models suggest that vulnerability to anxiety and depression arises through overlapping yet distinct pathways: anxiety is more associated with external engagement factors and help-seeking history, while depression is more inward-facing, linked to affective states and anticipated therapeutic dynamics. Preferences emerge not merely as rational choices, but as emotionally grounded responses shaped by symptomatology and sociocultural scripts.

5.1. Limitations

This study presents several limitations. First, the sample was obtained entirely through non-probabilistic methods — convenience and snowball sampling — limiting generalizability. Participants were self-selected, digitally literate, and predominantly female, which may introduce sampling bias and overrepresent specific perspectives.

Second, data collection occurred over a short time frame and relied on a single cross-sectional design. This restricts causal interpretation and does not allow for temporal assessment of changes in mental health or service preferences.

Third, some variables had to be recoded or reduced to be analyzable, which may have obscured more nuanced differences, particularly regarding nationality subgroups, length of therapy, or levels of identification.

Fourth, despite strong internal reliability of the HADS, it remains a screening tool. The presence of symptoms defined here does not equate to a clinical diagnosis.

Lastly, cultural diversity within Spanish-speaking countries was not explored in depth due to limited subgroup sizes. This limits the ability to account for national and regional variations that may shape preferences and acculturation patterns.

5.2. Future Research

Future studies should adopt more diverse and representative sampling strategies to capture a broader range of experiences, including underrepresented nationalities, gender identities, and socioeconomic statuses.

Longitudinal designs are recommended to better understand the evolution of service preferences and mental health trajectories over time.

Inclusion of qualitative methods — such as in-depth interviews — could illuminate the subjective meanings behind language preferences, perceived barriers, and therapeutic expectations.

Future research should also compare the preferences and experiences of Spanish-speaking immigrants with those of other immigrant groups and native Portuguese residents to identify unique and shared determinants of service engagement.

Lastly, intervention studies targeting perceived need, language accessibility, and cultural identity alignment could evaluate whether matching based on preference improves clinical outcomes or treatment retention.

6. Conclusion

This work expands the limited research on psychological service preferences among Spanish-speaking immigrants in Portugal. It attempted to identify patterns of perceived need, access, and attitudinal factors shaping this population's engagement with psychological services. While descriptive and regression models revealed relevant trends, findings were constrained by methodological limitations and by the need to recode variables for statistical analysis.

Nonetheless, clear patterns emerged linking subjective mental health, language preference, cultural identity, and help-seeking behaviour with symptom severity. These insights underscore the need for more inclusive, culturally attuned, and linguistically competent services in Portugal. They also

point to the continued relevance of client preferences — not only as a practical consideration, but as a critical component of therapeutic accessibility and emotional safety.

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