EXAMINING GENERATION, GENDER, AND RACE CENTRALITY AS PREDICTORS OF STIGMA AND HELP-SEEKING ATTITUDES IN AFRICAN AMERICAN ADULTS

by

Sara Jean-Philippe

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Approved by:

_____
Dr. Clare Merlin-Knoblich

_____
Dr. Xiaoxia Newton

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Dr. Lyndon Abrams

_____
Dr. Tabitha Haynes

ABSTRACT

SARA JEAN-PHILIPPE. Examining Generation, Gender, and Race Centrality as Predictors of Stigma and Help-seeking Attitudes in African American Adults. (Under the direction of DR. CLARE MERLIN-KNOBLICH)

Despite being more likely to encounter, endure, and report higher levels of distress, African Americans are less likely to seek and persist with mental health services. Similarly, African Americans are more likely to report negative attitudes toward help-seeking. Of the numerous barriers influencing negative attitudes, mental health stigma is identified as the most significant barrier. The purpose of this study was to examine factors that may influence attitudes towards seeking psychological help in African American adults. More specifically, the study investigated if, and to what extent, a relationship existed between help-seeking attitudes and three subtypes of stigma (public, social, and self). In addition to this, the study also explored the moderating effect of generation, gender and race centrality. A total sample of 190 African American participants were recruited from across the United States and completed an online survey involving self-report questions. An OLS multiple linear regression analysis was utilized. The results indicated that two of the three types of stigma significantly predicted help-seeking attitudes. The relationship between stigma and mental health seeking attitudes was also found to be moderated by gender on two of the three stigma scales. Implications of this study includes broaching conversations about mental health stigma, designing psychoeducational and outreach programs focusing on the destigmatizing of mental health treatment and the increase of mental health literacy as a means of promoting positive help seeking attitudes, and remedying the current practice of offering a single course in multicultural counseling. These results offer an empirical base for further exploration.

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DEDICATION

This dissertation is lovingly dedicated to my parents. I fully believe I am where I am and who I am because of your faith in me. Dad, you taught me how to dream and dream big. Mom, you taught me what hard work look like. Together, you both instilled in me the values of compassion, education, and leadership. All of which has served as my foundation and has brought me this far. Thank you for your endless support, your prayers, and ultimately your unconditional love. You are my courage. You are my strength. You are my reason why. I live to make you two proud. This accomplishment is ours to share! We did it!

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Chapter 1: INTRODUCTIONS

In 2012, activists conceived the Black Lives Matter (BLM) Movement to highlight social injustices and eradicate white supremacy (Nartey, 2021). Year after year since, the movement gained momentum, notoriety, and influence as countless acts of police brutality against African Americans went unpunished (Clayton, 2018). However, following the inhumane death of George Floyd in 2020, the BLM Movement peaked (Nguyen et al., 2021). The United States found itself immersed in protests and riots despite social distancing mandates due to the coronavirus global pandemic simultaneously at large (Njoku et al., 2021). Themes of discrimination, inequity, and trauma reflected in protests in the streets and became the salient point of discussion with news outlets, social media platforms, businesses, academia, religious affiliations and places of worship, as well as in individual communities. Yet, the fight for justice is not new to the African American community (Harris, 2021). The BLM Movement is the most recent social movement within the African American community, but it has emerged from previous attempts like the civil rights movement and the black liberation movement (Clayton, 2018; Harris, 2021).

Historically, calls for justice and accountability through protest have been rooted in limited or denied quality of life opportunities for African Americans (Jones-Eversley et al, 2017; Brink & Harris, 1964). In the present day, the call for justice and accountability has forced the exploration of the prevalence of racism in what is often coined a post-racial society (Petersen-Smith, 2015). With the abolishment of slavery in 1865 and the electing of the first African American president in 2008, some people would argue that the level of racism has declined dramatically in the U. S. (Williams & Williams-Morris, 2019). Nevertheless, acts of discrimination and prejudice towards African Americans takes multiple forms (i.e. overt and covert) and continue to operate across structural, group, and individual domains (Williams &

Williams, 2000; Jones, 2000). As researchers grow in understanding the influence and impact of racism and oppression over the years, the association between racial discrimination and psychological distress within the African American community cannot be ignored.

Racial Discrimination and Mental Health

Dating back centuries, racism is the ideology of racial superiority (Jones, 1972, 1997; Neville & Pieterse, 2009). Racism is formally defined as "the use of power directed against racial group(s) and their members, who are defined as inferior by individuals, institutional members and leaders, and which is reflected in policy and procedures with the intentional and unintentional support and participation of the entire race and dominant culture (Jones & Cater, 1996, p. 3)." Racism can be subtle or disguised in a manner that is not obvious to the general public, known as covert racism, or deliberate or intentional, known as overt racism. Often used interchangeably with terms such as discrimination and prejudicial behaviors, racism spans across three domains: individual, cultural, and institutional (Neville & Pieterse, 2009; Jones 1997; Jones, 1972; Salter et al., 2018).

Individual racism refers to the conscious and unconscious assumptions, beliefs, and behaviors emphasizing racial superiority that are upheld by an individual (Henry & Tator, 2006). Cultural racial discrimination speaks to the tacit network of beliefs and values that supports and validates prejudiced behaviors (Henry & Tator, 2010). Institutional racism is defined as the differential access to resources and opportunities by ways of policies, laws, and systematic practices (Jones, 2000). Collectively and irrespective of which domain is involved, racial discrimination speaks to the unequal power distribution within society based off of phenomenological, ancestral, or cultural differences. This imbalance of equality is then reinforced and maintained through media (Daniels, 2013; Kilgo, 2021; Van Dijk, 1989),

ideology and policies (Kutateladze et al., 2014; Moore & Bell, 2017), as well as cultural norms and daily practices (Oliver, 2001; Thompson & Neville, 1999).

To date, numerous researchers have shown positive associations between perceived experiences of covert or overt racial discrimination and poor mental and physical health with particular ethnic and racial groups (Benner et at., 2018; Brown et al., 2000; Carter et al., 2019; Chou et al., 2012; Hoggard et al., 2015; McKenzie, 2006; Noh et al., 2007; Sawyer et al., 2012; Williams et al., 2019). Additionally, researchers have linked perceived racial discrimination to a wide range of mental health outcomes such as depression, anxiety, posttraumatic stress disorder, suicidal ideation, and substance use (Borrell et al., 2007; Chou et al., 2012; Li et al., 2013; Noh et al, 1999; Sosoo et al., 2020).

Racial Discrimination, Mental Health, and African Americans

Racial discrimination is a common experience for African Americans (Kessler et al., 1999; Sellers & Shelton, 2003). An overwhelming 80% to 98% of African Americans have reported enduring discrimination in the previous year (Caldwell et al., 2008; Gibbons et al., 2004). However, in order to understand the state of mental health among African Americans, it is important to consider how the historical context of racial discrimination links to present day struggles (US DHHS, 1999; 2001). The history of racial discrimination within the African American community is well-documented (Pager & Shepherd, 2008) and has affected the mental health of African Americans in several ways (Williams & Williams-Morris, 2000). First, impaired psychological functioning is linked to the internalization and involuntary acceptance of being in an inferior social position (Williams & Williams-Morris, 2000). Second, the anticipation of prejudice or racial discrimination due to one's identity is known to increase vigilance or hyperawareness for cues of mistreatment (Inzlicht et al., 2009; Kaiser et al., 2006; Sawyer et al.,

2012). In addition to this outcome, having an inferior social positioning is coupled and compounded with acts of racial discrimination, which then impact living conditions and overall well-being (Williams & Williams-Morris, 2000).

Such discrimination can be viewed through two broad categories: macro societal discrimination and everyday discrimination (Mouzon et al., 2017, Esse, 1991). Macro societal discrimination refers to the direct incidents relating to larger systems in society, whereas, everyday discrimination denotes incidents of insults and daily stressors. Referred to as micro-aggressions, daily forms of discrimination are acknowledged to be more stressful than overt acts of racial discrimination due to being subtle and repetitive (Pierce, 1970). An example of an everyday stressor is prominent in behaviors such as being followed around a store or being "stop and frisked" by the police (Gelman et al., 2007).

As racial discrimination continues to reign prevalent in the U. S. (Kim et al., 2017), psychological risk is exacerbated through cumulative exposure to daily discrimination (Kessler et al., 1999). Accordingly, numerous researchers have explored the relationship between racism-related life experiences and psychological distress in African Americans across age groups (Bynum et al., 2007; Pieterse & Carter, 2007; Torres et al., 2010; Williams et al., 2003) and have correlated such experiences with mental health outcomes such as depression, suicide, violence, stress disorders, and maladaptive coping strategies like substance use (Brown et al., 2000; Carter, 2007; Greene et al., 2006; Polanco-Roman & Miranda, 2013). With African American adolescents, experiences with racial discrimination are correlated with externalizing behaviors (Caldwell et al., 2004; Nyborg & Curry, 2003), depression (Simons et al., 2002), and substance use (Gibbons et al., 2004). Similarly, perceived racial discrimination in emerging adulthood is said to contribute to escalations in anxiety symptoms, depressive symptoms, and alcohol use

across the transition to adulthood among Black men and women (Hurd et al., 2014). Notably, Mays et al. (2007) found that the stress associated with perceived discrimination in the workplace correlated with reduced job satisfaction, skill development, quality of relationships with coworkers, and desire to seek out advancement opportunities. As it relates to older adults, experiences with perceived racial discrimination are linked to higher levels of diastolic blood pressure (Lewis et al., 2009), bodily pain (Burgess et al., 2009), psychiatric disorders (Kim et al., 2017), depression (Nadimpalli et al., 2015), mood and anxiety disorders.

Overview of the Problem

Accounting for just 13.4 percent of the U.S. population, African Americans face greater exposure to a multitude of stressors stemming from covert and overt racial discrimination than European Americans in the U.S. (Bryant et al., 2010; Utsey et al., 2008; Nazroo & James, 2003). Yet, only 32% of African Americans with a mental disorder seek and use professional mental health services (Neighbors, 2007). Despite being more likely to encounter, endure, and report higher levels of distress, African Americans are less likely to seek and persist with mental health services in comparison to European Americans (Cooper-Patrick et al., 1999). In addition, Diala and colleagues (2000) found that African Americans were more likely than European Americans to report negative attitudes toward help-seeking. Thus, given the heightened risks for psychological distress, the role of mental health services within the African American community increases in importance.

Barriers to mental health seeking behaviors for African Americans range from access to care, financial and logistical strains (e.g. health insurance, transportation, and time conflicts), cultural attitudes and practices relating to emotional expression, the role of faith and one's relationship with the church, as well as the longstanding history of cultural mistrust (U. S.

Department of Health and Human Services, 2001). In addition to these barriers, the stigma associated with mental illness and treatment greatly influences the decision of African Americans to seek treatment and is one of the most significant barriers preventing such treatment (Conner et al., 2010; Gary, 2005).

Stigma is defined as a "complex construct that includes public, self, and structural components" (Corrigan et al., 2014, p. 37). Viewed as an "attribute that is deeply discrediting" (Goffman 1963, p. 3), stigma can be broken down into two domains: public stigma and internalized stigma. Public stigma refers to the negative attitudes of mental health held by the general population (Corrigan, 2004). Public stigma also embodies the beliefs and attitudes held by those in an individual's social network. The public's perception of mental health, which also serves as the building block for stereotyping and acts of discrimination towards those that identify with mental illness, creates damaging opinions about seeking treatment. Internalized stigma, also coined self-stigma, however, speaks to the endorsement of shame and the anticipation of social rejection stemming from stereotypes about mental illness (Corrigan, 1998; Link, 1987; Link & Phelan, 2001). Unfortunately, stigma relating to mental illness is widely endorsed by the general public (Corrigan, 2000). Consequently, it is these very damaging opinions of mental health that hinders help-seeking attitudes in African Americans.

The growing body of research around African Americans and help-seeking attitudes centers on themes of culturally competent care and effectiveness (Czyz et al., 2013; Moskos et al., 2007), faith and religion, cultural factors and attitudes of help-seeking (Matthews et al., 2006), and fear of stigma (Taylor & Kuo, 2018). Many researchers have also examined the relationship of such through the lens of gender (Wendt & Shafer, 2016, Verismo & Gruella, 2017), parent-child rearing practices (Obideyi & Sangmin, 2021), diagnoses such as depression

and anxiety (Yu et al., 2021; Conner et al., 2010), and treatment setting (Coombs et al., 2022; Lim et al., 2019). However, few researchers have explored within-group differences regarding help-seeking attitudes and stigma across generations, genders, and centrality of race.

Generational Differences

The role and concept of age is essential to behavioral norms and cultural practices. For example, age is conceptualized and celebrated in milestones such as birthdays and retirement. Age is also relevant in attitudes about music, fashion, career and work place attitudes, policies, and politics. And age is related to emotional regulation (Yeung et al., 2011; Carstensen et al., 2000), the decision-making process (Reed et al., 2008), and attitudes towards medical treatment (Aldwin, 1991, 1994; Aldwin et al., 1996; Kliewer et al., 1990; Mills & Wilmoth, 2002; Robb, 2003; Wintre et al., 1988). With the understanding that the time period and environment in which an individual has grown up is capable of shaping attitudes, age is conceptualized for the study through one's identified generation. Generation is defined as an assigned cohort group in which all members are categorized by the year in which they were born (Strauss & Howe, 1992). Using a generational cohort approach, the influence of age on general outlook and behavior can be conceptualized through generational grouping. Groupings are broken down into four categories: Baby Boomers, Generation X, Generation Y/Millennials, and Generation Z. It is logical to presume that generational differences moderate stigma associated with help-seeking and mental health services, however no researchers to date have examined this hypothesis.

Gender Differences

In addition to generational differences, differences in help-seeking attitudes also vary by gender (Sheu & Sedlacek, 2004). Throughout literature, researchers have demonstrated that women generally have more positive attitudes towards mental health services and utilization

compared to men (Fischer & Farina, 1995; Fischer & Turner, I 970; Leong & Zachar, 1999). As it relates to race, this pattern continues to hold true for the African American community, as well (Ward, 2013). Despite this existing research, no previous researchers have examined gender in concert with generation to understand differences among African Americans and their mental health seeking attitudes.

Race Centrality

Racial discrimination is ever present for many African Americans in the U. S. (Hall & Carter, 2006; Landrine & Klonoff, 1996; Sellers & Shelton, 2003; Utsey, 1999). However, the recognition of racial discrimination is dependent on how one understands the meaning of their racial or ethnic identity (Branscombe et al., 1999; Hall & Carter, 2006; Operario & Fiske, 2001; Postmes et al., 1999). Identity centrality is defined as "the importance or psychological attachment that individuals place on their identities" (Settles, 2004, p. 487). Centrality conveys the extent in which an individual personally identifies with their racial group and consequently the extent to which they view themselves as similar to members of this group (Rodgers, 2008).

Centrality of race is significant as it infers how "one acknowledges, perceives and consequently adapts to the social and political experiences [of being] an African American" (Rodger, 2008, p. 112). Due to individual and within group differences among the African American community, the perception of racial discrimination may differ between individuals (Shelton & Sellers, 2000). Thus, racial centrality plays a critical role in determining the relationships between racial discrimination and psychological outcomes (Seller et al., 2006). Hall & Carter, 2006; Lee & Ahn, 2013; Neblett & Roberts, 2013; Sellers & Shelton, 2003). As researchers continue to explore the impact of centrality on psychological outcomes, more

research is needed to assess the relationship between racial identity attitudes and help-seeking attitudes.

Purpose of the Study

Given these gaps in the literature, as well as the imminent need for more research on African Americans' attitudes towards seeking mental health support, the purpose of this study is to examine the relationships among generation, gender, and race centrality as predictors of stigma on mental health seeking attitudes in African Americans adults.

Research Questions

The study is guided by the following research question:

1. Is there any relationship between stigma and predicting one's mental health seeking attitudes?
2. Is the relationship between stigma and mental health seeking attitudes moderated by gender?
3. Is the relationship between stigma and mental health seeking attitudes moderated by generation?
4. Is the relationship between stigma and mental health seeking attitudes moderated by race centrality?

Theoretical Framework

In the examination of these research questions, the present study was guided by theory to shape research efforts. The Common Sense Model of Illness (CSM) is a conceptual framework that proposes that once confronted with a health threat or illness, an individual's reaction is primarily dependent on perception and previous experiences. Proposed by Leventhal et al. (1971), CSM emerged from research exploring the impact of fear on motivating health behaviors

and health outcomes. The set of beliefs one develops about an illness translates into decisions made regarding the management of the illness and ultimately influences the progression and outcome of said illness (Leventhal et al., 1971). The beliefs held regarding an illness not only speaks to health seeking attitudes but is considered to be the first step in seeking professional help and service utilization (Hagger & Orbell, 2003; Bishop & Converse, 1986).

Research Design

I used a non-experimental correlational research design in this study to examine the relationship between the set of variables (Balkin & Kleist, 2017). I applied a standard multiple regression to determine the means in which predictor variables were related to the outcome variable of mental health seeking attitudes. The outcome variable was mental health seeking attitudes as measured by Attitudes Toward Seeking Professional Psychological Help Scale-Short Form. The predictor variables were age, gender, race centrality, self-stigma, perceived stigma held by those within their social network, and perceived stigma held by those within the general public.

Assumptions

The factors I assumed to be true for the study were:

- Participants were willing to volunteer for the study.
- The sample was representative of the population.
- Participants were able to read and write in English.
- Participants completed all surveys and scales voluntarily.
- Participants answered all surveys and scales honestly.
- The instruments used were valid and reliable measures.

Delimitations

The factors I could control were:

- Participants were individuals who identified as African American, Black, or Black American, and who were at minimum 18 years of age and over
- Convenience and snowball sampling were used to recruit participants.
- Data were collected through online self-report questionnaires and scales.

Limitations

The factors I could not control were:

- The online recruitment methods excluded individuals who do not own an electronic device with access to the internet or do not frequent those specific websites, associations, or online groups used for study recruitment.
- Social desirability bias was a limitation in which participants respond to survey questions in ways they believe others might view as favorable (Gittelman et al., 2015).
- Because the research design was correlational, no causal inferences were made.

Threats to Internal Validity

Internal validity in quantitative research speaks to the extent in which change is attributed to the independent variable as opposed to unrelated variables (Mertens, 2019; Johnson & Christensen, 2004). In the present study, I perceived two primary threats to the internal validity of the study: instrumentation and social desirability bias. The non-experimental survey research design of this study had several measures in place to seek internal validity. To begin, the instruments chosen for the study were evaluated in previous studies and deemed reliable and valid (Fisher& Farina; 1995; Vogel et al., 2006; Vogel et al.2009). Secondly, given that participation was anonymous, the held assumption is that participants were more likely to

respond truthfully. This inclination is correlated to the reduction of social desirability bias (McMillian, 2008).

Threats to External Validity

In relation to quantitative research, external validity speaks to the extent in which the findings of the study can be generalized to the population (Mertens, 2019). Although I utilized convenience and snowball sampling methods, any self-identified African American that was 18 years or older across the U. S. could respond to the study. Therefore, I expected the study results to be generalizable only to other African Americans with similar demographics and experience.

Operational Definitions

The operational definitions of the study's significant terms and variables were as follows:

African Americans:

Though often used interchangeably, the terms African American, Black, and Black American hold distinct identities. Whereas African American speaks to the race of an individual while acknowledging African heritage and decent, Black and Black American speaks to one's ethnicity. The terms Black or Black Americans expands one's racial identity to include being from parts of the world other than Africa, such as the Caribbean. This concept also extends to people who feel removed from their African heritage and accounts for identifying more with westernized culture and customs. For the purpose of the present study, however, all three cultural and ethnic identities were accepted as salient characteristics of the targeted population. The term African American was utilized to reflect all three identities. In addition, no distinctions or exclusions were made for people that identify as Black or Black Americans, yet also represented multiracial or multiethnic backgrounds. Racial identification is operationalized for this study as

self-reported by participants identification as being Black, Black American, or African American.

Generational Differences in Attitudes

Generational differences in relation to mental health seeking attitudes was operationalized as one's given age cohort. Age cohort as a Baby Boomer, Generation X, Generation Y/Millennials and Generation Z, was broken down into four distinct generations based off an individual's birth year. Though some participants may be unaware of their generation classification or identify with their assigned generation, for the purpose of this study, I utilized participants' age at the time of the study to categorized them according to their generation.

Baby Boomers:

Baby Boomers is a term used to classify those born between the years of 1946 to 1964. With an estimation of 73 million people, this generation is noted as the second largest age group. Baby Boomers were operationalized for this study as a self-report of participants identification as being between the current age of 58 to 76.

Generation X:

Generation X is a term used to classify those born between the years of 1965 to 1980. Due to being centered between the baby boomers and the millennial generation, this generation is also referred to as the middle child. Generation X is operationalized for this study as a self-report of participants identification as being between the age of 42 to 57.

Millennials:

Millennials is a term used to classify people born between the years of 1981 to 1996. Millennials, representing more than one quarter of the nation's population at roughly 83.1

million, is noted as the largest age group. Millennials is operationalized for this study as a self-report of participants identification as being between the ages of 26 to 41.

Generation Z:

Generation Z is a term used to classify those born between the years of 1997 to 2012. Recruitment efforts for the study excluded those under the age of 18. Therefore, Generation Z is operationalized for this study as a self-report of participants identification as being between the age of 18 to 25.

Help-seeking Attitudes:

Help-seeking attitudes is defined as the overall perception a person has regarding the act of seeking services from mental health professionals (Hammer et al., 2018). Such perceptions may be positive, negative, or neutral. Help-seeking attitudes was operationalized for this study by means of participant's scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form.

Race Centrality

Race centrality describes the extent to which race plays a core part of an one's self-concept (Seller et al., 1997). Race centrality was operationalized for this study by means of participant's scores on the Race Centrality Scale of the Multidimensional Inventory of Black Identity inventory (Sellers et al., 1997)

Stigma

For the purposes of this study, stigma is broken down into two subtypes: public stigma, perceived stigmatization by others, and self-stigma.

Public Stigma

Public stigma is defined as the negative perception held by others (Bathje & Pryor, 2011). For the purpose of this study, public stigma is broken down into two subsets: that of the general public and that of one's personal social network. Public stigma was operationalized for this study by means of participant's scores on the Perceptions of Stigmatization by Others for Seeking Help scale and the Stigma Scale for Receiving Psychological Help scale.

Self-Stigma

Self-stigma is the internalization of public stigma (Cooper et al., 2003; Penn et al., 2005). Self-stigma was operationalized for this study by means of participant's scores on the Self-Stigma of Seeking Help Scale.

Summary

As racial and cultural diversity continues to rapidly grow within the U.S., the underutilization of mental health services across racial and ethnic minority groups continues to be a significant concern (Hines et al. 2017; Kim et al. 2017; Wang et al. 2005a, b). Racial discrimination affects the mental health of African Americans in many ways (Williams & Williams-Morris, 2000). Because one's culture factors into one's attitudes towards mental illness and help-seeking attitudes, continued exploration of help-seeking attitudes within the African American community is essential to understanding and combating barriers to mental health treatment utilization. In response to negative mental health outcomes, the role of mental health counseling services within the African American community is critically important. However, given the held stigma and noted barriers to treatment, African Americans report negative help-seeking attitudes, which in turn contributes to low utilization rates (Diala et al. (2000). To explore the prevalence of stigma and how stigma impacts mental health service utilization rates,

I sought to investigate the influence of generation, gender, and race centrality on help-seeking attitudes in the present study.

Organization of Study

The present study is comprised of five chapters. Chapter One provided an overview of the influence of racial discrimination on the mental health of African Americans. Chapter One also presented the purpose of the study and the primary research question. A brief summary regarding operational definitions, assumptions, delimitations, limitations, and threats to validity were also provided. Chapter Two takes a comprehensive approach to the literature, theoretical framework, and variables. Chapter Three outlines the methodology used in the study including the participants, instrumentation, design, procedures, data collection process, and data analysis. Chapter Four reports the study findings through presentation of the data screening, descriptive statistics, and analysis results. To conclude, Chapter Five engages in a discussion of the study findings, limitations, implications, and recommendation for future research.

CHAPTER 2: LITERATURE REVIEW

The purpose of this study was to examine the role of gender, generation, race centrality, and stigma on mental health seeking attitudes in African American adults. The present study was guided by four primary research questions: (a) Is there any relationship between stigma and predicting one's mental health seeking attitudes? (b) Is the relationship between stigma and mental health seeking attitudes moderated by gender? (c) Is the relationship between stigma and mental health seeking attitudes moderated by generation? (d) Is the relationship between stigma and mental health seeking attitudes moderated by race centrality?

The following chapter will build on the previous chapter by taking a comprehensive approach to the literature about the study variables and establish the need for the current study. The literature review begins with a discussion of the theoretical framework, the Common Sense Model of Illness, and the population of interest, African Americans. The next section provides an overview of the predictor variables, gender, generation and race centrality, followed by a review focusing on how the mediating variable, stigma, and its three subtypes, are related to the outcome variable of mental health seeking attitudes. The final section closes the chapter with a summary and conclusions drawn from the review of the literature.

Theoretical Framework

The Common Sense Model of Illness (CSM) is a cognitive-perceptual and behavioral theoretical framework that I utilized to frame this study. CSM seeks to describe and understand an individual's response to illness in relation to the actions they take to address the illness (Leventhal et al., 2016; Leventhal et al., 1980). Actions taken, which is defined as help-seeking behaviors, are then linked to health outcomes including functioning-level, psychological distress, overall well-being, and quality of life (Ringer, 2021; Hagger & Orbell, 2003; Leventhal et al.,

1980). At its core, CSM proposes that personal experiences, emotional states, and abstract sources of information impact the manner in which an individual cope (Dempster et al., 2010). Information regarding a health threat or illness can be derived from cultural background, age cohort, social communication, knowledge of the illness through indirect exposure, external social environment, media, formal education, and authoritative figures (Donovan et al., 2007; Diefenbach & Leventhal, 1996; Ward, 1993). Due to the nature in which perceptions are formulated, illness representations may or may not reflect an accurate medical depiction of the illness (Ward et al., 2013; Ward et al., 2009).

Nonetheless, utilizing the given information at hand, the individual begins the process of formulating their perceptions and making meaning of the illness, a concept referred to as illness representation. Illness representations are broken down and further explained through seven domains: identity, cause, timeline, consequence, cure or controllability, illness coherence, and emotional representation (Leventhal et al., 2016). Identity focuses on the set of beliefs relating to symptoms. Causes speak to the belief regarding the onset or root of the illness. Timeline refers to the severity of the illness in relation to being acute, chronic, or cyclic. Consequence addresses belief concerning long term and short outcomes of the illness. Cue or controllability describes the individual's belief on their ability to manage symptoms on their own versus seeking treatment as well as treatment effectiveness. Illness coherence is the process of determining what the illness means for the individual. And lastly, emotional representation naturally speaks to the emotional impact of the illness. Once constructed, an individual's illness representation speaks to the decision of integrating coping mechanisms and strategies to combat health threats or illness (Petrie, Jago, & Devcich, 2007; Brownlee et al., 2000).

Cannon and colleagues (2022) conducted a meta-analysis on CSM and mental illness outcomes and two domains of illness representation: threat-related representation and protective illness representation. They found that people with threat related representations (comprising of beliefs regarding identity, timeline, consequences, and emotional representation) held a medium-to-large association with worsened mental health symptoms and quality of life. Whereas people with higher protective illness representations (comprised of sense of control and coherence) denoted a medium-to-large relationship with positive outcomes. For example, a patient with depression harboring a threat-related illness representation may believe that symptoms are out of their control and is bound to last despite efforts made (Cannon et al, 2022). This patient is less likely to seek medical attention or treatment. However, if attempts were made to seek treatment, this patient is more likely to terminate treatment prematurely (Cannon et al, 2022). Naturally, this equates to worse symptoms and a poorer quality of life. Conversely, if the patient harbored a protective-illness representation, tuning into their sense of control and actively engaging in problem solving through treatment, expressed symptoms would be milder and their quality of life is predicted to show improvement.

To date, CSM spans studies regarding physical illness and conditions such as osteoarthritis (Kaptein et al., 2010), diabetes (Shiyanbola et al., 2018), cancer (Postolica et al., 2018; Johnson et al., 2017), brain injuries (Snell et al., 2013), and heart conditions (French et al., 2005; Broadbent et al., 2004). Moreover, the body of literature regarding CSM and mental illness, such as depression, ADHD, schizophrenia, and eating disorders, is starting to grow (Ringer, 2021; Scerri et al., 2019; Holliday et al., 2005; Grace et al., 2005). In addition to this research, and due to its emphasis on culture impacting beliefs and attitudes, researchers have also developed a growing body of literature applying CSM to the African American community

(Ward et al., 2013; Ward et al., 2009; Ward & Heidrich, 2009). Given CSM's application to mental health and its adherence to culture, I applied CSM as the theoretical framework in this study.

African American Adults

The population of interest in this study was African American adults. Though mental illness affects people of all races, ethnicities, genders, and ages, some people are more susceptible to it than others (Williams, 2007). Specifically, African Americans finds themselves at a higher risk for mental health illness. This inflated risk is due to a number of factors, including disproportionate representation in incarceration, homelessness, poverty, and violent crimes (Ward, 2009; Snowden 2001). According to SAMHSA's 2018 National Survey on Drug Use and Health, 4.8 million African Americans reported having a mental illness. Of this 4.8 million, 22.4 percent (totaling approximately 1.1 million) of African Americans reported having a serious mental illness over the past year (SAMHSA, 2018). Yet, Dalencour (2017) found that only 1in 3 African Americans who need mental health services receives it.

Despite the great need for help-seeking and treatment, several studies have shown a great disparity and underutilization of mental health services by African Americans (Woodward, 2021; Snowden, 2000; Kessler et al., 1994; Neighbors, 1988; Wallen. 1992). Unfortunately, African Americans experience stigma when seeking mental health services as levels twice as high as people from other ethnic minority groups (Ward & Benson, 2013). Furthermore, African Americans are half as likely to utilize mental health services in comparison to Caucasians (SAMHSA, 2015). In comparison to Caucasians, African Americans are 20% more likely to refrain from disclosing or reporting psychological distress, and they are more likely to go

underdiagnosed or are misdiagnosed when they do seek psychological support (US Department of Health and Human Services, 2001).

Race Centrality

It cannot be assumed that race is a central aspect of every African American person's identity. An identity only becomes central "when it is valued, frequently used, and incorporated into [one's] self-concept" (Ragins, 2008, p. 199). Though race is a social identity that allots the opportunity for individuals to interpret the world and their position in it (Settles, 2004), racial centrality speaks the degree in which such social group membership is significant to one's perception of self (Ashmore et al., 2004). In simple terms, racial centrality is defined as the "importance of race to an individual's self-definition" (Rodger, 2008, p. 133). Baldwin (1984) argued that a component of healthy psychological functioning in African Americans is found with those that strongly identifies with and embrace their racial identity. In fact, studies have shown that individuals whom have poor racial salience reported higher levels of anxiety and depressive symptomatology (Carter, 1991; Pyant & Yanico, 1991). As racial identity has been directly and indirectly linked to psychological functioning and well-being in African Americans (Baldwin, 1984; Cross et al., 1998; White & Parham, 1990), it is important to consider the means in which it aligns with help seeking attitudes, behaviors, and utilization.

Generational Differences in Help-seeking Attitudes

Age cohorts play an integral role in determining behaviors, including shaping individual health care behaviors and service use (Groden et al., 2017; Mitchell, 1995). Generation is a commonly used term to define a group of individuals born and living at about the same time (Merriam-Webster, 2003). A generation conceptualizes the role of unique historical and social events within a particular era and its influence in shaping lives and perspectives (Alwin &

McCammon, 2007). As each generation ages, it is replaced by a younger generation who often embraces novel and differing attitudes and values (Roberts & Manolis, 2000; Sessa et al., 2007).

Baby Boomers (Older Adults)

Born between the years of 1946 and 1964, members of this generation are now in their late fifties, sixties, and seventies (Kirkman & Fisher, 2021). Coming to age within the late 1960s and early 1970s, baby boomers were exposed to varying views regarding diet, exercise, complementary and alternative medicines, as well as the development of self-care and health consumer movements (Groden et al., 2017). Acknowledged as having a free-spirited characteristic trait, Baby Boomers are viewed as individuals that do not think or react in a customary fashion (Strauss & Howe, 1991). Coined the "therapy generation", baby boomers display greater willingness to seek out help and support for mental health difficulties in comparison to their parents and previous generation (Williamson, 2008). Within their study of help-seeking attitudes and treatment across the lifespan, Mackenzie et al. (2008) found that more than 80% of adults age 55 and up held a positive help-seeking attitudes and more than 70% held positive treatment beliefs. Despite held positive attitudes and having higher need, older adults greatly underutilize mental health services (Hatfield, 1999; Qualls, Segal, Norman, Niederehe & Gallagher-Thompson, 2002; Robb et al., 2002). It is estimated that less than half of older adults with a diagnosable disorder seek treatment or receive care (Gonçalves et al., 2014; Shapiro, 1986). Groden et al. (2017) found that older adults utilize contemporary and alternative medicine to address mental health disorders. Similarly, Mackenzie et al. (2006) implicated that older adults are more likely to seek help from their primary care physician than a professional mental health clinician.

Generation X and Generation Y/Millennials (Middle Aged Adults)

Generation Xers were born between the years of 1965 and 1980. Generation Xers are found to be more independent, self-reliant, accustomed to facing issues on their own, and able to function with increased autonomy in comparison to Baby Boomers (Crowther & Kemp, 2009; Tulgan, 2001). According to an examination of trends in mental health treatment, in comparison with the two preceding generations, Generation Xers shows a decline in treatment utilization (Han et al., 2016).

Born between the years of 1981 and 1996, members of this generation are now between the ages of 26 to early 40s. Due to proximity to the new millennium, Generation Y members are more commonly referred to as Millennials (Kaifi et al., 2012) Compared to the previous generation, Millennials are perceived to be more individualistic, confident, socially active, educated, and technologically literate and savvy (Shaw & Fairhurst, 2008; Skiba & Barton, 2006; Twenge et al., 2010). Millennials experiencing general mental health issues and those presenting with clinical levels of psychological distress are found to utilize mental health services less than other generations experiencing similar problems (Han et al., 2015).

Generation Z (Young Adults)

Born between the years of 1997 and 2012, members of this generation are now between the ages of nine and their mid-twenties. For the purposes of the present study, an emphasizes was placed on young adults, rather than children or adolescents. Young adulthood, marked by 18 to 24 years of age, is often characterized by identity development and initial career-making decisions (Newman & Newman, 2012). With mental health disorders having an onset prior to the age of 24, young adults are at higher risks of developing mental health problems (Kessler et al., 2005). Noted as the most vulnerable cohort, young adults have higher rates of symptoms, conditions, and diagnoses (Beatie et al., 2016; Kessler et al., 2005; Leahy et al., 2010; Reavley et

al., 2012). Alarmingly, apart from a higher prevalence of mental health problems, young adults demonstrate greater reluctance to seek professional mental health care, report having fewer positive attitudes towards help-seeking, and are less likely to seek mental health treatment compared to older adults (Leaf et al., 1987; Rickwood et al., 2007; Swartz et al., 1998). In a large scale study exploring adult help seeking patterns, Andrews et al. (2001) found that help-seeking is least likely to occur between the ages of 16 to 24. Factors affecting attitudes and utilizations are related to concerns regarding confidentiality, prominent coping styles, peers in the role of primary support systems, and self-esteem (Gonzalez et al., 2005).

Generational Cohorts and African Americans

Considerable research has documented the underutilization of mental health services among African American children and adolescents (Cummins & Druss, 2011; Garland et al., 2005; Kataoka et al., 2002; Marrast et al., 2016; Mesidor et al., 2014; Tanielian et al., 2009; Zahner & Daskalakis, 1997). However, very few research studies have explored help-seeking attitudes with respects to specific age cohorts or generations. Alternatively, existing research has been focused on help-seeking attitudes in particular age groups. For example, extensive research is dedicated to exploring help-seeking attitudes among young adulthood, primarily African American college students (Kam et al., 2019; Masuda et al., 2012; So et al., 2005; Wallace & Constantine, 2005). The same can be said regarding helping attitudes in older adults.

Existing research demonstrates that compared to their younger counterparts, African American older adults are less likely seek and utilize mental health services despite having high needs (Mackenzie et al., 2010). Contrary to the held perception of reluctance of older adults and help-seeking, African American older adults are receptive to mental health care (Dupree et al., 2005). However, reluctance to care is noted in obtaining services provided by traditional

professional mental health practitioners (Dupree et al., 2005). In its place, African American older adults prefer and are more liking to consult a family member, friends, or clergy to obtain care (Dupree et al., 2005). The influence of generational attitudes of help-seeking is found in that beliefs and values are passed down within the parent-child relation. According to a study exploring disparities in mental health services and perception of mental health services, Copeland (2006) found that a subset of the African American adolescents surveyed reiterated their parent's beliefs regarding cultural mistrust, reluctance towards emotional disclosures, and the inability of mental health professionals to identify with their concerns.

Gender Differences in Help-seeking Attitudes

Researchers have also examined the role that gender plays in help-seeking attitudes. Women have been consistently found to have more positive help-seeking attitudes compared to men, and women are more likely to utilize counseling services than men (Fischer & Farina, 1995; Fischer & Turner, I 970; Leong & Zachar, 1999). A prominent variance noted in the help-seeking behaviors of men lies within adherence to traditional hegemonic masculinity norms and shared cultural expectation about male behaviors (Addis & Mahalik, 2003; McCusker & Galupo, 2011; Noone & Stephens, 2008; O'Brien et al., 2005; Spence & Helmreich, 1979; Yousaf et al., 2015). These differences in help-seeking attitudes have been replicated across ethnic groups and nationalities; ranging from Caucasians (Leong & Zachar, 1999, Chinese Americans (Tata & Leong, 1994), African Americans (Neighbors & Howard, 1987), Taiwanese (Yeh, 2002), Jordanians (AI-Samadi, 1994), and Kuwaitis (Soliman, 1993). In addition to race, gender differences in help-seeking attitudes have been replicated across age group, also accounting for help-seeking behaviors in adolescents (Garland & Zigler, 1994; Gould, 2002).

African American Women

African American women are more likely to report feelings of sadness, hopelessness, or worthlessness in comparison to Caucasian women (CDC, 2012). According to a national study conducted by the California Black Women's Health Project (2003), 60 percent of African American women experience symptoms of depression. However, a report completed by the National Alliance on Mental Illness (2008) revealed that only 12 percent seek help or utilize treatment. In fact, African American women utilize psychological intervention resources less than other ethnic groups (American Psychiatric Association, 2017; Steven et al., 2018). Attitudes towards seeking mental health treatment and poor utilization rates in African American women are correlated to the perceived obligation of having to present an image of strength, suppress emotions and resist vulnerability or dependence on others, and in addition having multiple roles in caring for others (Gary, 2005; Hines-Martin et al., 2003; Waite & Killian, 2008; 2009; Ward et al., 2013; Warren, 1994; Woods-Giscombe et al., 2016). Despite both genders having low psychological openness and help-seeking propensity, Ward et al. (2013) found that African American women are significantly more open and receptive to seeking professional help compared to the men.

African American Men

Studies investigating barriers to African-American men's health help-seeking are scarce (Powell et al., 2016). The majority of African American men are reluctant to seek mental health treatment when needed (Richardson et al., 2003). Richardson et al. (2003) found that two-thirds of African American men suffering from mental illness chose not seek treatment. Similar attitudes have been found among African American adolescent men (Samuel, 2015). Reluctance regarding treatment stems back to experiences with shame, racial discrimination, cultural mistrust, and social stigma (Madison-Colmore & Moore, 2002; Richardson et al., 2003; Samuel,

2015). African American men and adolescents view utilizing mental health services as a sign of weakness (Lindsey et al., 2006).

Stigma

Given the underutilization of mental health services given poor help-seeking attitudes, it is important to explore the role of stereotypes and stigma. Stereotypes are knowledge structures that are created and learned by members within a social group (Hilton & von Hippel, 1996; Judd & Park, 1993; Krueger, 1996). Considered an efficient means of categorizing information, stereotypes represent a collectively agreed upon set of notions directed at a group of persons (Corrigan & Penn, 2015). Stigma is the term associated with the endorsement of negative stereotypes accompanied by discriminatory behaviors (Corrigan & Penn, 2015). Complex in nature, stigma is a process that is driven by psycho-sociological factors, including individual differences, community factors, cultural structures (Barber et al., 2020; Pescosolido & Martin, 2015; Pescosolido et al., 2008).

As explained by Pescasolido and Martin (2015), stigma requires "(a) distinguishing and labeling differences, (b) associating human differences with negative attributions or stereotypes, (c) separating "us" from "them," and (d) experiencing status loss and discrimination" (p. 91). Stigma is considered to be the most profound social barrier to the utilization of mental health services as it is seemingly widely endorsed by the general public (Clement et al., 2015; Corrigan & Pen, 2015; Krupa et al., 2009; U.S. Department of Health & Human Services, 2001). Concerns regarding stigma are associated with both psychological distress and health outcomes (Quinn & Chaudoir (2009). A number of researchers have explored the relationship between stigma and help-seeking attitudes (Kushner & Sher, 1991; Corrigan & Rüsch, 2002; Corrigan, 2004; Gary, 2005; Schomerus & Angermeyer, 2008; Thornicroft, 2008).

I evaluated three subtypes of stigma in the present study. Stigma can first be broken down into two subtypes: public stigma and self-stigma. Public stigma refers to the perception of being less socially acceptable by the community given the shared belief regarding mental health and on the bases of one's diagnosis (Vogel et al., 2006). Public stigma consists of two additional subtypes: perceived stigma held by people within one's social network and perceived stigma held by people in the general public. The difference found between the two subtypes is found in the delineation is made between the belief held by the general public and that of one's personal and social network of family and friends. This distinction is imperative as it considers the influence of one's social network in attitude formation and decision making. Self-stigma refers to the internalization of the negative views held by others.

Mental Health Stigma and Help-seeking Attitudes

Mental health stigma is defined as the objectification and dehumanization of people with a mental disorder that, in turn, results in the avoidance of seeking therapeutic help (Mendoza et al., 2015). Mental health stigma includes the ideology that people with mental illness need to be feared because they are dangerous (Durand-Zaleski et al., 2012), unpredictable (Stewart et al., 2012), and somehow responsible for their illness (Corrigan & Kleinlein, 2005). Ideologies may go as far as recommending exclusion from the community or having to be directly cared for due to being considered as having child-like perceptions or rebellious and irresponsible (Corrigan & Penn, 2015).

Fundamentally, the fear of being stigmatized is what deters one from contemplating seeking professional help (Clement et al., 2015; Fisher & Turner, 1970). This fear is also correlated to the belief of having to conduct one's self in a particular manner so others are not attributing psychotic traits to one's character (Farina et al., 1968). Similarly, stigma is related to

treatment avoidance due to having to publicly bare the label of someone requiring psychological assistance (Corrigan, 2004). Efforts to conceal the utilization of mental health services can include opting against the use of insurance and paying for services out of pocket (Sibicky & Dovidio, 1986). It is also more common for people to pursue informal methods of help-seeking, such as through their church or primary care physician to minimize potential exposure to social rejection (Phillips, 1963). When endorsed, stigma concerns are linked to disinterest to seeking mental health treatment (Nadeem et al., 2007). Lower endorsements of mental health stigma have been linked to identifying as female (Corrigan & Watson, 2007), identifying as Caucasian (WonPat-Borja et al., 2012), and previous exposure to mental illness (Couture & Penn, 2003).

Self-Stigma and Help-seeking Attitudes

Self-stigma is the internalizing of stigmatizing views (Cooper et al., 2003; Penn et al., 2005). Internalized stigma is used to described the negative thoughts and emotions that one may have about themselves as a consequence of their mental illness (Vass et al., 2017). Corrigan et al. (2009, 2010) proposed that once an individual is conscious of the negative stereotypes related to their mental illness, the devaluing and discriminatory attitudes are adopted and applied to the manners in which they carry and evaluate themselves. As damaging to one's self-concept as self-stigma can be, it also can lead to self-deprecation which in turn compromises the effort taken to gain control over life's circumstances (Markowitz, 1998; Wright et al., 2000). Emotions such as inferiority, shame, fear, embarrassment, guilt, and alienation are central to self-stigma (Goffman, 1963; Link et al, 2004) and are associated with low levels of self-esteem (Cavelti et al., 2012; Vass et al., 2017; Werner et al., 2008), self-efficacy, and overall quality of life (Yen et al., 2009). Self-stigma ultimately hinders the process of treatment and recovery (Schulze & Angermeyer, 2003) and is the strongest contributor to predicting help-seeking attitudes (Beatie et al.. 2016).

Perceived Stigma and Help-seeking Attitudes

Perceived stigma is a significant factor that influences the decision of implementing help-seeking behaviors (Corrigan, 2004; Link et al, 1989). Societal perceptions and attitudes toward mental health help-seeking serves as a catalyst to how an individual in that society relates to, create opportunities for, and provides support to a person with mental illness. Viewed as a form of societal discrimination, perceived or public stigma is the perception regarding a person who seeks psychological treatment as undesirable or social unacceptable (Vogel et al., 2006). Public stigma differs from self-stigma in that is encompasses the negative perception and reaction from others (Bathje & Pryor, 2011). Perceived stigma is negatively associated with help-seeking attitudes and behaviors (Barney et al., 2006; Vogel et al., 2007).

Stigma and African Americans

Stigma is the prominent reason behind African Americans' reluctance to seek mental health services (Bathje & Pryor, 2011; Vogel et al., 2006). Sources of stigma generate from peers, family, employers, and one's community (Buser, 2009; Cooper et al., 2003) The act of receiving care may be viewed by African Americans as degrading and humiliating (Kennedy et al., 2007). Moreover, African Americans have reported low willingness to acknowledge psychological distress, hold strong and high concerns around stigma, and display poor openness to help-seeking (Ward et al., 2013).

Attitudes Towards Mental Health Help-seeking

Help-seeking describes the process in which considerations regarding available options, both formal and informal, are taken into account compared to a problem at hand (Tipping & Segall, 1995). Multidimensional in nature, attitudes regarding help-seeking encompass numerous personality, interpersonal, and social components (Fischer & Turner, 1970). Proposed by Fischer

and Turner (1970) the decision to accept and seek professional help is a direct reflection of (a) one's perceptions regarding the need for professional psychotherapeutic treatment; (b) the level of support from immediate community (friends and family) and stigma associated with help-seeking; (c) ability and willingness to disclose feelings and experiences; and (d) the depth of interpersonal difficulty and confidence of practitioners' skills. Whether negative, neutral, or positive, personal beliefs and attitudes regarding mental health is predictive of help-seeking attitudes and service utilization (Voorhees et al., 2005). Whereas positive attitudes regarding professional psychological services are predictive of increased likelihood of service utilization (Nam et al., 2013; Elhai et al., 2008; Kessler et al., 2001; Bayer & Peay, 1997), negative attitudes have similarly shown a lower propensity to seek help and correlates with underutilization of services (Segal et al., 2005).

African American Attitudes Towards Mental Health Seeking

Research on African Americans' attitudes towards help-seeking are mixed. On one hand, researchers have found African Americans to hold positive attitudes towards mental health treatment (Gonzalez et al., 2005). For example, Diala and colleagues (2000) found that African Americans displayed more positive attitudes towards seeking care than Caucasians. Alternatively, Campbell and Mowbray (2016) found that African Americans viewed help-seeking for any life problems as being stigmatizing and consequently turn to alternative method of coping. Diala and colleagues (2000) also found that negative attitudes were stronger for African Americans who showed a need and received mental health services. These negative attitudes towards mental health services received holds great implications regarding African Americans being less likely to use and persist with using services. To further this point, in their study exploring the perceptions of psychotherapy and psychotherapists, Thompson and

colleagues (2004) found that African Americans perceive providers as unhelpful, insensitive, and at times harmful. Chang and Yoon (2011) found that African Americans would rather stay silent out of fear of being judged and misunderstood than to open up and share their way of life.

Notably, there appears to be a shift in African Americans' perceptions and preferences towards mental health services if service providers mirror their own ethnic background (Diala et al., 2000; Nickerson et al., 1994; Sue et al., 1993; Thompson & Alexander, 2006; Wintersteen, 2005). Research on the role of race within the therapeutic dyads is unclear, as some research correlates race to positively influencing the therapeutic alliance because of increased rapport within the dyad due to shared ethnic experiences, culture specific knowledge and perspective, and overall quality of care (Farsimadan et al, 2007; Maki, 1999; Meyer & Zane, 2013). Other research, however, highlighted that though race does have an impact on treatment outcome, racial similarities in the counseling dyad are not deemed statistically different in their impact (Johnson & Caldwell, 2011; Cabral & Smith, 2011; Thompson & Alexander, 2006). It ought to be noted, however, that African Americans mental health clinicians make up only three percent of the psychological profession and workforce (APA, 2017). Of this three percent, 71% are female and 29% are male. These statistics reflect approximately 2,600 African American practitioners serving as viable options for a community that makes up 13.4% of the U.S. population (46.8 million people).

Barriers Towards Seeking Mental Health Services

The disparities among different racial and ethnic populations accessing professional mental health services are a pressing public health concern (Roberts et al., 2011). Understanding and improving access to care and culturally compatible service requires addressing barriers to care (True, 2015; Wang et al, 2005). Barriers are defined as any internal or external factors that

decrease the likelihood of help-seeking behaviors (Calloway et al., 2012). Barriers spans three domains: the means in which services are provided and organized (systematic and institutional), delivery modality (provider-based), and individual disposition (consumer based) (Diala et al., 2000). As it relates to community mental health services and utilization rates (Stefl & Prosperi, 1985), the most common barriers to help-seeking behaviors are categorized in four distinct features: (a) availability, (b) accessibility, (c) acceptability, and (d) affordability.

Availability refers to the awareness of existing service options and their locations. With this barrier comes a need for more public education and community outreach highlighting the range in services and programs offered within minority communities (Snowden, 2001). Accessibility focuses on the ease of getting to services, including the option of having another companion accompany and attend appointments with a client. Acceptability touches on themes of stigma and cultural attitudes regarding service utilization. Finally, affordability emphasizes the cost of services and the feasibility off taking time off from work (Stefl & Prosperi, 1985). Financially, African Americans have some of the lowest incomes in the U.S., as well as impeded access to employment-based health insurance, which serves as the backbone of the health care system in the country (Diala et al., 2000; Holden & Xanthos, 2009; Muntaner, 1999; Snowden & Thomas, 2000). As a result, mental health services are viewed as a luxury, as opposed to a necessity, due to perceptions regarding cost and fees associated to service (Thompson et al., 2004).

In addition to the four general barriers to service utilization, African Americans also find themselves having to combat culturally distinctive barriers to mental health services (US Department of Health and Human Services, 2001). These barriers includes cultural mistrust, lack of culturally competent care, and role of language. I explain them more fully next.

Cultural Mistrust

African Americans' history with the medical model is one that is riddled with transgenerational emotional scars (Dana, 2002). Coined as historical hostility (Vontress & Epp, 1997), African Americans are said to harbor a consciousness "that shares both the current frustrations and the memory of the sufferings the group has endured over time" (p. 173). Accordingly, the history of African Americans and their relationship with health field must be explored and considered to understand the present-day perspective held by the community.

As slaves, reliance on custom remedies were essential for African Americans, as access to physicians and nurses was not available (Leininger & McFarland, 2002). Once freed and post slavery, access to medical treatment was limited to free medical care at teaching hospitals due to poverty and financial instability (Howell & McLaughlin, 1992). This limitation gave way to enduring inadequate and unnecessary procedures for the purpose of demonstration (Savitt, 1982). Incidents such as the Tuskegee Experiment (Green et al., 1997), the purchasing of African slaves to perfect gynecological procedures (Wall, 2006), the story of Henrietta Lacks (Skloot, 2017), the maternal mortality rates of Black women (Joseph et al., 2021), and Black patients going undertreated for pain due perceived higher tolerance (Meghani et al., 2012) has continued on to perpetuate reluctance negative attitudes and lowered help-seeking attitudes amongst African Americans. In current times, level of distrust and hesitancy were also noted in help-seeking attitudes regarding COVID-19 vaccines (Batelaan, 2022; Khubchandani et al., 2021).

The relationship with African Americans and the mental health field is equally as horrendous as the relationship between African Americans and the medical field. African Americans' relationship with the mental health field is marked by confinement in psychiatric hospitals as a means of intimidating, punishing, and controlling African Americans who would

not remain docile (Kanani, 2011; Snowden & Cheung, 1990). Leis et al. (2011) found African Americans had a greater reluctance to seek professional mental health services due to the fear of being prescribed psychotropic medication as the primary mode of treatment prior to a comprehensive understanding of who they were as clients.

The pervasive link between health, psychiatry, and social order illustrates African Americans' negative attitudes towards help-seeking (Kanani, 2011). As a culture, the African American community continues to express a degree of distrust with the medical model and the Caucasian providers that fill majority of the roles (Nickerson, Helms & Terrell, 1994). Medical distrust has been linked to willingness to participate in research (Shavers et al., 2001), help-seeking behaviors and consent to treatment (Jacobs et al., 2006), and medication management and adherence (Lewis et al., 2010). Due to the degree of cultural distrust, African Americans require great sensitivity in approach within the therapeutic relationship and the process of counseling (Vontress & Epp, 1997).

Culturally Competent Care

Cultural sensitivity in counseling symbolizes the recognition of cultural differences and similarities. As the therapeutic process is not a culture free activity, it is important to acknowledge the means in which it influences the therapeutic alliance (Griffith, 1977). Culturally competent care begins with understanding that an individual's identity and sense of self are a byproduct of race and culture and must be of consideration when attempting to provide quality care (Dana, 2002). Fuertes et al. (2006), whose study explored the importance of multicultural competencies within the clinical dyad, also defined culturally competent care as one's awareness regarding the need for trainings to ensure effectiveness in relationship building and communication when working with diverse clientele. Additional components of integrating a

multicultural framework into one's practice is noted in the (a) clinician's awareness of cultural comfort and (b) clinician's ability to assess cultural comfort through reflection of thoughts and feelings when engaging in discussion about culture (Owen et al., 2017). Though some scholars assert that adhering to the principles of universal humanness would account for respect, differences and cultural sensitivity and naturally balance out the role of culture (Farsimadan et al., 2007), others would note that culturally congruent care is essential to addressing the role of culture as it increases understanding and empathy (Reddy, 2019). Few theories emphasize adapting to the sensitive needs of multicultural clients and their life experience (Boyd-Franklin, 2006). Though race may or may not be the driving force of a client's reasoning for seeking services, the capacity in which a clinician is aware of racial undertones, is able to navigate discussions around the topics, and is adequately trained to provide culturally sensitive appropriate care does reflect quality of care.

Language

Alongside the notion of culturally competent care comes the influence of language. Language is an essential component to the therapeutic alliance as it serves as the primary vehicle in which clinicians proceed to gather information, conduct assessments, integrate interventions, and glen subjective experiences, emotions, and perspectives (Leanza et al., 2014; Faubert & Locke, 2005). Linguistic barriers contribute to health disparities, as they are correlated with rapport, treatment satisfaction, alienation, diagnosing practices, medical errors, adherence to medication, premature terminations rates, and treatment recommendations (Brisset et al., 2014; Divi et al., 2007; Jacobs et al., 2006).

Researchers estimate that approximately 80% of African Americans speaks African American Vernacular English (AAVE; Graham et al., 2020; Johnson, 1998). AAVE is the fusing

of West African languages with an English Vocabulary (Pollock & Meredith, 2001; Baugh, 1999). Developed by African slaves and their descendants, AAVE served as a method of communicating in the absence of education and formal training (Day-Vines et al., 2009). The use of AAVE is generally perceived in society to be representative of lower-class status and is looked upon as a reflection of education and wealth (Cargile et al., 2006). Similarly, in counseling, some people have considered African American clients to be lacking and unsuited for treatment due to their perceive cognitive aptitude based on the use of AAVE (Sue & Sue, 2012; Sue & Sue, 1977). As Caucasians makes up 80.9% of mental health professionals, attention given to language is crucial to communication and trust as counselors may unintentionally perpetuate and reinforce linguistic bias (Sadavoy et al., 2004; Chen-Hayes et al., 1999).

Summary

A number of barriers stand in the way of African Americans seeking mental health services, yet, the primary issue for African American seeking mental health intervention is stigma **(**Haynes et al., 2017). An investigation into the role of stigma holds great implications for exploring help-seeking attitudes and the utilization of professional mental health services (Watson and Hunter, 2015). Information on help-seeking attitudes, especially amongst African Americans, can aid the development of psychoeducational efforts, early diagnosis, and management of health conditions (Van der Hoeven & Greerff, 2012). Currently, many African Americans harbor negative perceptions about seeking mental services due to concerns such as the fear of being ridiculed, prevalence of racial discrimination, and numerous barriers to treatment (Harris et al., 2020). The proposed study will help examine if generation, gender, and race centrality are related to such attitudes among African American adults.

CHAPTER 3: METHODS

The purpose of the present dissertation study was to investigate how generation, gender, race centrality, and stigma might predict attitudes towards seeking mental health services among adult African Americans. My dissertation study was guided by the following four research questions: (a) Is there any relationship between stigma and predicting one's mental health seeking attitudes? (b) Is the relationship between stigma and mental health seeking attitudes moderated by gender? (c) Is the relationship between stigma and mental health seeking attitudes moderated by generation? (d) Is the relationship between stigma and mental health seeking attitudes moderated by race centrality? In each research question, stigma was measured in three ways: self-stigma, perceived stigma held by those within their social network, and perceived stigma held by those within the general public.

In this chapter, I describe the study methods in five sections. Whereas the first section is dedicated to providing a description of the research design, the remaining sections describe participants, data collection procedures, and instrumentation. The fifth and final section concludes the chapter with an overview of data analysis procedures.

Research Design

In this study, I utilized a non-experimental correlational research design to examine the relationship between the response and explanatory variables (Balkin & Kleist, 2017). Specifically, I employed the use of an Ordinary Least Regression (OLR) multiple regression to examine the relationships among attitudes towards seeking mental health services, stigma, generation and gender of a sample of African American adults. The response variable in the present study was mental health seeking attitudes as measured by Attitudes Toward Seeking Professional Psychological Help Scale-Short Form. The predictor variables were generation,

gender, race centrality, self-stigma, perceived stigma held by those within social network, and perceived stigma held by those within the general public.

Study Participants

Participants in the present study included a purposive sample of African American adults. Inclusion criteria for the study were: (a) participants who self-identify as African American, Black, or Black American, and (b) those that identify as 18 years or older at the time of data collection. Exclusion criteria included participants under the age of 18 and people who do not identify as Black, Black American, or African American. The inclusion criteria were stated at the beginning of the recruitment email, which allowed participants to verify if they qualified to participate in this study.

Given the intended population of research interests and the sensitive nature of the study topic, I employed a purposive sample strategy. A purposive sampling strategy is optimal for discovering and gaining insights on a certain occurrence amongst participants who share similar characteristics. Purposive sampling strategy affords the opportunity for study participants to be grouped according to a set of preselected conditions based on the research questions (Lopez & Whitehead, 2013). In addition to being purposeful, I also used the snowball sampling technique. With this recruitment method, I invited participants initially recruited to share the call for participation with other potential participants and help recruit other people who met the inclusion criteria and were eligible for the study. According to a G*power analysis, a minimum of 110 respondents were necessary to achieve a sufficient level of power to detect effects ($f2 = .10$, alpha = .05, power = .95, and number of predictors = 6). Thus, I sought to obtain 110 participants for this study.

Data Collection Procedures

I began with obtaining approval from the Institutional Review Board (IRB) at the University of North Carolina at Charlotte prior to recruiting study participants and collecting data. Upon approval, I created a database of known associates and acquaintances that met the inclusion criteria. I then emailed the recruitment flier and survey link to associates. Recruitment of participants also included utilizing Facebook and Instagram social media platforms. Recruitment efforts, by means of posting on researcher's personal social media handles, spanned a total of three weeks. Recruitment posts included an explanation of the purpose of the study, eligibility for participation, and researcher's contact information. A direct link was also provided for interested participants to click and access the informed consent and questionnaire.

Qualtrics was the online platform utilized in obtaining informed consents and completion of the questionnaire. The informed consent outlined the study purpose, participation criteria, confidentiality statement, and risks and benefits of participating in the study. The informed consent form also explained that participation in the study was voluntary and responses were confidential and anonymous. Participants were also informed that they could retract their consent at any time during the study without explanation or penalty. Participants were able to electronically indicate, by selecting an agreement box, that they read and understood the informed consent. After indicating consent, participants were able to continue onto the online survey.

The online questionnaire included six components: a demographic questionnaire, Self-Stigma of Seeking Help Scale (SSOSH), Perceptions of Stigmatization by Others for Seeking Help (PSOSH), Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF), Stigma Scale for Receiving Psychological Help (SSRPH), and the Centrality scale portion of the Multidimensional Inventory of Black Identity (MIBI). The entire

questionnaire included a total of 49 items. The estimated time to complete the online survey was 7 to 10 minutes. I did not collect any personally identifying data. All demographic items, aside from age and gender, were optional to complete. The data collected from Qualtrics was then exported to Statistical Package for the Social Sciences (SPSS) for subsequent statistical analysis.

Instrumentation

The online questionnaire was adapted from five existing instruments, in addition to demographic information items. Next, I will review these instruments in detail.

Stigma Scale for Receiving Psychological Help

As it relates to mental health and illness, public stigma encompasses the perception of being less socially acceptable on the basis of one's diagnosis (Vogel et al., 2006). Mental health stigma is often associated with impaired functioning, severe psychiatric symptoms, and poor engagement with treatment (Livingston & Boyd, 2010; Yanos et al., 2012). In response to the stigma of mental health, those people who require mental health services have a greater tendency of avoidance as a means of bypassing the consequences of stigma (Corrigan, 2004). Consequently, in exploring stigma in conjunction with attitudes regarding seeking mental health treatment, it is essential is gage the degree of public stigma that an individual harbors.

The Stigma Scale for Receiving Psychological Help (SSRPH) assesses an individual's perceptions of how stigmatizing it is to receive psychological treatment (Komiya et al., 2000 a,b). The SSRPH was originally developed by Komiya et al. (2000) utilizing a sample of 311 undergraduate college students enrolled within an introductory psychology class. Sixty percent of the sample's population were female and ranged across racial groups (Caucasians, African Americans, Hispanic Americans, Asian American, and Multiracial Americans). The SSRPH consists of five items rated on a 4-point Likert scale (0= strongly disagree to 3= strongly agree).

A sample item is, "People will see a person in a less favorable way if they come to know that he/she has seen a psychologist." Responses to the items are combined for a total score. Higher scores indicate greater perception of stigma associated with receiving psychological treatment.

Perceptions of Stigmatization by Others for Seeking Help

In an attempt to conceptualize the role of stigma in help-seeking attitudes, Vogel et al. (2009) recognized the importance of distinguishing the prevalence of stigma between the general public and one's social network of family and friends. This distinction is critical to help-seeking attitudes and behaviors in that if one's social network is deemed supportive, the person would be more likely to seek services as those within the social network are least likely to react (Vogel et al., 2009). Likewise, the same can be predicted conversely (Vogel et al., 2009). Thus, it was deemed essential to gage the degree of stigma perceived within one's social network.

To measure the influence of public stigma noted within one's social network of family and friends on help-seeking attitudes, I employed the use of the Perceptions of Stigmatization by Other for Seeking Help scale (PSOSH; Vogel et al., 2009). The PSOSH consist of five items rated on a 5-point Likert scale (1 = not at all to 5 = a great deal). Participants are first instructed to consider a having an emotional or personal issue in which a solution is not easily attained without assistance. With said problem in mind, participants are then asked to rate the reactions of others in social network if the decision was made to pursue counseling services to address the problem. A sample item includes "think of you in a less favorable way" and "see you as seriously disturbed." Responses to the items are combined for a total score or averaged together for a composite score. Higher scores are associated with greater perceptions of stigmatization by social network for seeking mental health or counseling services (Vogel et al., 2009). The scale

has a Cronbach's alpha value that ranges from .84 to .91. Internal consistency estimates have ranged from .78 to .93.

To gage the social influence of stigmatization, the scale was initially developed utilizing five samples of college students. Sample One, utilized for scale development, contained of total of 985 college student with the racial composition of 89% European Americans, 3% African Americans, 3% Asian Americans, 2% Latino/Latina Americans, 2% multiracial Americans, and 1% international students. With sample Two ($N = 842$), the researchers conducted a confirmatory factor analysis. The racial composition of sample two ranged from European Americans (51%), Asian Americans (14%), African Americans (10%), Latino/Latina Americans (8%), multiracial Americans (8%), Native Americans (1%), and international students (8%). Researchers assessed the concurrent validity of the scale in sample Three ($N = 506$). The sample consisted of 92% European Americans, 4% Asian Americans, 2% Latino/a Americans, 1% African Americans, >1% multiracial Americans, and >1% international students. Sample Four ($N = 144$) was used to examine the test-retest reliability and validity. The racial composition of the sample consisted of 88% European Americans, 5% Asian Americans, 3% African Americans, 1% Latino/Latina Americans, 2% multiracial Americans, and 1% international students. Sample Five ($N = 130$) had a similar racial composition as the previous sample, however demographic information was not explicitly reported. Since the instrument was published, it has since been used to explore stigma in regards to gender (Baxter et al., 2016; Shepherd & Rickard, 2012), age (Ashworth, 202; Conner et al., 2010; Préville et al., 2015), and across racial and ethnic minorities (Arora et al., 2016).

Self-Stigma of Seeking Help Scale

The internalization of the stereotypes and discrimination associated with public stigma is referred to as self-stigma (Corrigan, 2004; Eisenberg et al., 2009; Vogel et al., 2006). Self-stigma is damaging as it results in the reduction of self-esteem, self-worth, and self-efficacy due to feelings inferior or inadequate (Corrigan, 2004). Similar to public stigma, self-stigma leads to delays or avoidance in seeking mental health treatment. Developed by Vogel, Wade, and Haake (2006), the Self-Stigma of Seeking Help (SSOSH) scale is a 10-item instrument used to assess a general sense of worth in association with seeking psychotherapy or counseling services. Comparable to the PSOSH, the SSOSH was normed on a college population through a series of five studies. Study One, utilized to develop content domains of the scale, consisted of 583 college students. Of whom the racial grouping of the sample population ranges from Caucasians, Asian American, multiracial Americans, and international students. African Americans made up 4% of the study one's sample. Study Two, comprising of the confirmatory factor analysis, consisted of 470 college students. African Americans made up 2% of the study two's sample. Study Three serving as the test-retest and cross validation consisted a sample of 546 college students. The racial grouping of the sample population ranges from Caucasians, Asian American, multiracial Americans. African Americans made up 3% of the study three's sample. Study Four serving as further cross validation consisted a sample of 271 college students. The racial grouping of the sample population ranges from Caucasians, Asian American, multiracial Americans. African Americans made up 2% of the study four's sample. Finally, Study Five concluded the scale validation by examining the predictive validity. The sample population consisted a total of 655 is college students. The racial grouping of the sample population ranges from Caucasians, Asian American, multiracial Americans. African Americans made up 2% of the study five's sample.

By use of a 5-point Likert scale (1= strongly disagree to 5= strongly agree), participants are asked to respond to prompts such as "I would feel inadequate if I went to a therapist for psychological help," and "It would make me feel inferior to ask a therapist for help." Composite scores are calculated by first reserve coding five items. Reserve coding details the process of re-coding responses in the opposite direction, thus, a high score would be transformed into the corresponding low score. Total scores fall between the range of 10 and 50. Scores falling at or below 30 are associated with a lower self-stigma, whereas, scores of 31 or above indicate an increased presence of self-stigma. Higher scores on the SSOH are correlated with having greater help-seeking stigma. Accordingly, higher scores may symbolize someone harboring a negative stigma towards seeking mental health or counseling services. The scale has a demonstrated a 2-month test-retest reliability of .72 and internal consistency of 0.92 (Vogel et al., 2006).

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

The association between treatment attitudes and treatment use is one that cannot be ignored (Elhai et al., 2008). The Inventory of Attitude Toward Seeking Professional Psychological Help Shorten Form (ATSPPH-SF) is a 10-item questionnaire used to measure one's belief regarding mental health treatment. Adapted from the original version, the goal of the ATSPPH-SF was to provide an easier and a less obtrusive approach to assessing attitudes towards help-seeking (Fisher, & Farina, 1995). Aligned with the previous three instruments, researchers developed the ATSPPH-SF through a college student sample (N= 300). The racial grouping of the sample population ranges from Caucasians, Asian American, Native Americans, and Hispanics. The percentage of African Americans within the study's sample was not explicitly noted. of the study's sample. In addition to this, also with intentions of investigating reliability and validity, a second study was conducted extending the population to incorporate a

sample of healthcare users (Elhai et al., 2008). The racial grouping of the sample population primarily consisted of Caucasians. Only five participants of Hispanic ethnicity were included, and African Americans made up only 1.5% of the study five's samples, accounting for six participants.

The scale has a one-month test-retest reliability of .80 and an internal consistency of 0.84 (Fisher, & Farina, 1995).The 10-items questionnaire are rated on a 4-point Likert scale (0= disagree to 3= agree). Respondents are prompted to indicate the extent to which they agree or disagree with the items. A sample item includes "The idea of talking about my problems with a psychologist strikes me as a poor way to get rid of emotional conflicts." Parallel to the SSOH, five items of the ATSPPH-SF are reverse scored. Once computed, total scores ranges from 0 to 30. Higher scores are associated with not only a more positive attitude toward seeking professional help, but also a decreased stigma regarding treatment.

Race Centrality Scale

The Multidimensional Inventory of Black Identity (MIBI) was created as a means of "providing a conceptual framework for understanding both the significance of race in the self-concepts of African Americans and the qualitative meaning they attribute to being members of that racial category" (Sellers et al., 1997, p. 19). The MIBI measures four dimensions of Black identity: salience, centrality, regard, and ideology. Given this study's interest in exploring the relationship between the centrality of race and attitudes towards help seeking, only the centrality dimension of this instrument was used. Similar to the previous scales, the MIBI was validated using two samples of 474 African American college students; one group whom attended a predominantly White institution, while the second group attended a predominantly African American university. Utilizing a 7-point Likert scale, the centrality scale is comprised of eight

items measuring the degree to which being African American is central to self-definition. A sample item includes "Being Black is an important reflection of who I am." Three of the items on the scale are reverse coded. Higher scores on the centrality scales correlate with individuals who identify strongly with their racial group. Lower centrality of race scores correspond to people with decreased identification with racial identity, who are more likely to downplay membership in their racial identity (Roberts et al., 2008). The scale has a demonstrated an internal consistency of 0.70 to 0.79.

Demographic Questions

For the purpose of the study, I created the self-report demographic questionnaire, which includes a total of 11 items. The questionnaire includes both multiple-choice items and open-ended short answer items. Items address participants' age, gender identity, education level, employment status, household income, religion, state of residency, and previous psychological treatment history. Of the 11 items, age and gender were forced responses. Although participants will not be asked to self-identify their generation, I utilized the data collected regarding age to classify them into generations for the analysis. Those self-identified as falling between 18 to 25 represented Generation Z. Those self-identified as falling between 26-41 represented Millennials. Those self-identified as falling between 42 and 57 represented Generation X. Finally, those falling in between the age of 58 and 76 represented the Baby Boomer generation. The demographic questionnaire takes approximately one to two minutes to complete.

Data Analysis Plan

Utilizing Statistical Package for Social Sciences (SPSS) Version 18.0 software, the data was transferred over from Qualtrics. The data was then screened to check for data quality and address any data related issues such as missing data, outlying cases, and data entry errors. In

addition to data cleaning, I assessed key assumptions underlying OLS regression, including normality, homoscedasticity, linearity, and collinearity. The analytic approach included descriptive statistical analysis followed by OLS regression.

Statistical Analysis

I used descriptive statistics to describe the participants in the study. Descriptors included information about participants' age, gender, religious affiliation, education level, employment status, household income, and previous counseling experience. I organized descriptive analysis utilizing frequencies and percentages for categorical variables and means, standard deviations, and central tendency measures for continuous variables.

OLS Multiple Regression Analysis

A regression is a "statistical technique for finding the best-fitting straight line for a set of data" and is commonly used for predictions (Gravetter & Wallnau, 2007, p.551). OLS regression was used in this study because it is ideal for answering my research questions, as the questions center on the relationship between multiple predictor variables and one continuous outcome variable (Hahs-Vaughn, 2017). The significance of each predictor variable is indicated by a t-test and associated p-value for that predictor. Partial eta squared was used to estimate the amount of unique variance each predictor variable contributed to explaining the response variable variance.

The current study has three predictor variables, the three subtypes of stigma, and three possible moderators: gender, generation, and race centrality. Composite scores for each measure (attitudes towards help-seeking, three stigma subtypes, and race centrality) were calculated and categorical variables (gender and generation) were dummy coded into new variables for analysis. I first conducted a bivariate correlation analysis to gauge the relationship between the predictor variables (gender, generation, three types of stigma, and race centrality) and the outcome

variable (attitudes towards psychological help-seeking). This was then followed by running a regression model utilizing the outcome variable and the predictor variables (three types of stigma). As a means of assessing the relationship between the three types of stigma and the possible moderators, interaction terms were created. Interaction terms consist of multiplying the independent variables with the moderator variables (Bedeian & Mossholder, 1994). There was a total of nine interaction terms; gender x perceived stigmatization of others in one's social network, gender x self-stigma, gender x public stigma, generation x perceived stigmatization of others in one's social network, generation x self-stigma, generation x public stigma, race centrality composite score x perceived stigmatization of others in one's social network, race centrality composite x self-stigma, and race centrality composite score x public stigma. Once created, I was able to run three additional regressions models to specifically explore the relationship between the attitudes towards psychological help-seeking, three types of stigma, and the three possible moderators.

Summary

This current chapter described the methodology, including participants, data collection procedures, and instrumentation. Additionally, I described the research design, research questions, and data analysis to explain the process by which I examined the predictor variables examined for their predictive relationship to the dependent variable, help-seeking attitudes among African American adults.

Chapter 4: RESULTS

The purpose of this study was to examine the role of gender, generation, race centrality, and stigma on mental health seeking attitudes in African American adults. In this study, I aimed to answer the following research questions: (a) Is there any relationship between stigma and predicting one's mental health seeking attitudes? (b) Is the relationship between stigma and mental health seeking attitudes moderated by gender? (c) Is the relationship between stigma and mental health seeking attitudes moderated by generation? (d) Is the relationship between stigma and mental health seeking attitudes moderated by race centrality? In the following chapter, I present the results of this dissertation research study. First, I provide a description of the participants. Then, I outline instrument reliability, the process for screening the data, bivariate correlations, and results from the data analyses. The final section of the chapter concludes with a summary.

Descriptive Statistics

In this study, I utilized convenience and snowballing sampling to recruit participants that self-identified as African American, Black, or Black American and were at least 18 years of age or older at the time of data collection. Participants followed an electronic link to the online platform, Qualtrics, for study consent and completion of the questionnaire. Due the nature of purposive and snowball sampling, I cannot account for the number of participants that received the invitation to participate in the study or response rate. However, I can report that within the time allotted for data collection a total of 230 participants responded, and a total of 190 participants finished the questionnaire. All participants self-identified as African American, provided consent, and were deemed eligible to be included in this study.

Participants completed an 11-item demographic questionnaire that included questions regarding age, gender, region, religion, level of education, employment status, and household income. As all participants self-identified as African Americans, I did not collect race/ethnicity demographic information. Of the demographic information collected, age and gender were the only two identifiers that required a forced response. All other demographic questions were optional. Thus, the question of age and gender were grouped at the start of the survey, following the consent to participate, whereas, the remaining demographic information were collected at the completion of the questionnaires. In Table 1, I present frequencies and percentages of the demographic variables.

Table 1
Categorical Demographics of Participants

Variable	Frequency	Percent
Gender		
Female	155	67.4%
Male	68	29.6%
Other	7	3%
Generation		
18-25	15	6.6%
26-41	151	66.8%
42-57	46	20.4%
58-76	14	6.2%
Region		
West	13	7%
Midwest	10	5%
Northeast	17	9%
Southeast	141	74%
Religion		
Christian/Catholic	122	64.2%

Other	7	3.7%
Agnostic	3	1.6%
Prefer not to say	58	30.5%
Education		
High/Trade Sch. Degree	27	14.2%
Bachelor's Degree	63	33.2%
Graduate Degree	98	51.6%
Prefer not to say	2	1%
Employment		
Student	8	4.2%
Employed	169	88.9%
Unemployed	8	4.2%
Retired	4	2.1%
Prefer not to say	1	1%
Household Income		
Below 100k	107	56.3%
Above 100k	70	36.8%
Prefer not to say	13	6.8%

As shown in Table 1, a total of 155 (67.5%) participants identified as female, 68 (29.6%) as male, and 7 (3%) identified as other or preferred not to disclosed their gender identity. Participants were asked to identify their age range, which correlated with the four generations studied within this study. The age ranges were grouped based on a particular generation. A total of 15 (6.6%) participants identified as being between the ages of 18 and 25, thus representing Generation Z. A total of 151 (66.8%) participants identified as being between the ages of 26 and 41, thus representing Generation Y/Millennials. A total of 46 (20.4%) participants identified as being between the ages of 42 and 57, thus representing Generation X. Representing the final age

cohort, Baby Boomers, a total of 14 (6.2%) participants identified as being between the ages of 58 and 76.

Participants self-reported being located all across the United States, mostly in the Southeast (74%, *n* = 141), followed by the Northeast (9%, *n* = 17), then the West (7%, *n* = 13), the Midwest (5%, *n* =10), and Other (2%, *n* = 3). A majority of the participants identified their religious affiliation as Christianity/Catholic (64.2%, *n* = 122), followed by prefer not to say (30.5%, *n* = 58), Other (3.7%), and Agnostic (1.6%, *n* = 3). In relation to education, a total of 27 (14.2%) participants identified as having a high school degree and/or continued on to trade school, 63 (33.2%) participants identified themselves as having a bachelor's degree, 98 (51.6%) identified themselves as having a graduate degree, and 2 (1%) participants opted not to disclose. Regarding work and employment status, most of the participants identified as being employed (88.9%, *n* = 169), followed by unemployed (4.2%, *n* = 8), students (4.2%, *n* = 8), retired (2.1%, *n* = 4), and preferred not to say (1%, *n* = 1). Household yearly income ranged between below 100,000 (56.3%, *n* = 107), above 100,000 (36.8%, *n* = 70, and prefer not to say (6.8%, *n* = 13).

In addition to collecting basic demographic information, I also collected previous experiences with counseling, counseling type, and length of counseling. A total of 143 (75.3%) participants indicated having some experience with counseling. Of the 143, 131 (91.6%) of participants elected to pursue counseling with full autonomy. The type of counseling ranged from individual counseling (82.5%, *n* = 118), family and parenting counseling (7%, *n* = 10), and couples counseling (10.5%, *n* = 15). Most participants reported participating in their counseling 6 months or less (26.6%, *n* = 38). Other participants reports attending counseling for 6 months to a year (22.4%, *n* = 32), 1- 3 years (20.9%, *n* = 30), and more than 3 years (17.5%, *n* = 25). I

provide frequencies and percentages of participant's counseling experience are provided in Table 2.

Table 2
Previous Counseling Experience

Variable	Frequency	Percentage
Previous Counseling Ex.		
Yes	143	75.3%
No	47	24.7%
Mandated		
Yes	12	8.4%
No	131	91.6%
Counseling Type		
Individual	118	82.5%
Family/Parenting	10	7.0%
Couples	15	10.5%
Counseling Length		
Up to 6 months	38	26.6%
6 months to 1yr.	32	22.4%
1yr. to 3yrs	30	20.9%
3 plus yrs.	25	17.5%

Instrument Reliability

I determined reliability for the five quantitative instruments utilized in this study by calculating Cronbach's alpha of internal consistency for each instrument. In Table 3, the alpha coefficients, number of items, means, and standard deviations are shown. The outcome variable, attitudes towards help-seeking, was measured utilizing the Attitudes of Towards Seeking Psychological Help Shorten Form (ATSPH-SF). The Cronbach's alpha for ATSPH-SF had a reliability of .74. The predictor variable of stigma was measured utilizing three surveys:

Perceptions of Stigmatization by Others for Seeking Help (PSOSH), Self-Stigma of Seeking Help Scale (SSSHS), and Stigma Scale for Receiving Psychological Help (SSRPH). The PSOSH had a Cronbach's alpha reliability of .85. The SSSHS had a Cronbach's alpha reliability of .77. The SSRPH had a Cronbach's alpha reliability of .77. Lastly, the final predictor variable, centrality of race, was measured utilizing the Race Centrality Scale (RCS) of the Multidimensional Inventory of Black Identity (MIBI). The Cronbach's alpha for RCS had a reliability of .78. All of these reliability coefficients were all within the optimal range for demonstrating evidence of internal consistency in the measurements.

Table 3
Cronbach's alpha, number of items, means, and standard deviation

Instrument	Items	Cronbach's	M	SD
ATSPHS	10	.74	32.97	4.7
PSOSHS	5	.85	7.72	3.6
SSSHS	10	.77	19.23	5.57
SSRPH	5	.77	9.98	2.81
RCS	8	.78	43.28	8.14

Data Screening

Prior to running any data analysis, I screened the data for any missing values, entry errors, and outliers. I also examined assumptions for multiple regression analysis, including normality, linearity, multicollinearity, and homogeneity of variance. The variation inflation factors (VIFs) for the predictor variables were 1.03 for gender, 1.04 for age, 1.24 for PSOSH, 1.447 for the SSSHS, 1.393 for the SSRPH, and 1.096 for the RCS. All were below the value of 10.0, suggesting multicollinearity was not problematic. In addition, the assumption of normality was met as the normal probability plot (P-P) of standardized residuals showed that points were completely in line.

Bivariate Correlations

I conducted Pearson product coefficients to determine if correlations existed between the predictor variables (three subtypes of stigma), potential moderators (gender, generation, race centrality), and the outcome variable (attitudes towards psychological help-seeking). Table 4 displays the correlations among the predictor and outcome variables, which included four statistically significant relationships.

Table 4
Pearson Correlations Among Outcome and Predictors Variables

	ATSPHS	PSOSHS	SSSHS	SSRPH	RCS	Age	Gender
ATSPHS	1	-.333**	-.420**	-.172*	.162	-.142*	.130
PSOSHS		1	.404**	.317**	1.060	.039	-.121
SSSHS			1	.453**	-.100	.106	-.111
SSRPH				1	.162*	.146*	-.141
RCS					1	.128	-.074
Gen/BMA						1	.010
Gender/Female							1

Note: *Indicates significant correlation at $p < .05$ level (2-tailed).
**Indicates significant correlation at $p < .001$ level (2-tailed).

I found a statistically significant negative relationship between attitudes towards seeking psychological help and all three subtypes of stigma. As shown in Table 4, the correlations between attitudes and perceived stigma by others was -.333, suggesting that respondents who reported more positive attitudes towards counseling tend to have lower perceived stigma associated one's social network. The correlations between attitudes and self-stigma was -.420, suggesting that respondents who reported more positive attitudes towards counseling tend to

have lower self-stigma. Likewise, the correlation coefficient between attitudes and perceived stigma by the general public was -.172, suggesting that respondents who reported more positive attitudes towards counseling tend to have lower perceived stigma associated with receiving psychological help. Additionally, with a correlation coefficient -.142, the data also revealed a negative statistically significant relationship between the ATSPS and generation, suggesting higher values on the ATSPS were less associated with the younger generations.

A positive statistically significant relationship was also noted amongst all three stigma instruments between each other. This relationship suggests that higher values in one subtype of stigma, ranging from self-stigma, perceived stigma within one's social network, and perceived stigma from the general public, is associated with higher values in the other two subtypes. Furthermore, there was a statistically significant positive relationship between the perceived stigma from the general public and race centrality (.162, $p = .026$), indicating respondents who reported greater perception of stigma associated with receiving psychological treatment tended to identify more strongly with their racial group. Similarly, perceived stigma from the general public was positively associated with generation. This means older survey respondents tended to report higher stigma associated with receiving psychological treatment than younger respondents. Gender was not statistically significant with any of the variables.

OLS Multiple Regression

Utilizing Statistical Package for Social Sciences (SPSS) Version 18.0 software, I performed a hierarchical ordinary least square (OLS) regression model to predict attitudes towards psychological help-seeking based on generation, gender, stigma (all three subtypes), and race centrality. The regression answered the following research question: (a) Is there any relationship between stigma and predicting one's mental health seeking attitudes? (b) Is the

relationship between stigma and mental health seeking attitudes moderated by gender? (c) Is the relationship between stigma and mental health seeking attitudes moderated by generation? and (d) Is the relationship between stigma and mental health seeking attitudes moderated by race centrality?

Due to the response rates between generations, and as a means of adjusting the generational cohort totals for data analysis, the generation cohorts were collapsed from four groups into two groups: below middle aged (BMA) and above middle aged (AMA). Below middle age reflected the responses from Millennials and Generation Z generation, ranging between the ages of 18 to 41 and totaling 166 participants. Above middle age reflected the responses from Generation X and Baby Boomers generation, ranging between the ages of 42 to 76 and totaling to 60 participants. Gender was also dummy coded for the analysis.

The first research question I sought to answer was: Is there any relationship between stigma and predicting one's mental health seeking attitudes? The results revealed that the model was a significant predictor of attitudes towards seeking psychological help ($R^2 = .470$, $F(3, 186) = 17.548$, $p < .001$), with an adjusted R^2 of .208. According to the R^2, approximately 47% of the variance in attitudes towards psychological help seeking was explained by stigma. Two of the three subtypes of stigma, perceived stigmatization of others within one's social network ($B = -.264$, $p = .004$) and self-stigma ($B = -.295$, $p < .001$), contributed significantly to the prediction of attitudes towards seeking psychological help. Perceived stigmatization from the general public ($B = .029$, $p = .825$) did not to have a statistically significant contribution to the prediction of attitudes towards seeking psychological help. The unstandardized regression coefficients (B), standard error, standard regression coefficients (β), t-values, and p-values are in Table 5.

Table 5
Multiple Regression Analyses Measuring the Relationship Between Stigma and Outcome Variables

Variables	*B*	*Std. Error*	β	*t-value*	*p-value*
PSOSHS	*-.264*	*.091*	*-.207*	*-2.883*	*.004**
SSSHS	*-.295*	*.064*	*-.354*	*-4.630*	*<.001***
SSRPHS	*.029*	*.129*	*.016*	*.221*	*.825*

Note: *Indicates significant correlation at $p < .05$ level (2-tailed).
** Indicates significant correlation at $p < .001$ level (2-tailed).

The second research question sought to explore if the relationship between stigma and mental health seeking attitudes was moderated by gender. In order to answer this question, I created an interaction variable to test the relationship between gender and the three stigma measures. This was done by means of multiplying gender with the three respective composite scores for the three subtypes of stigma. Gender was dummy coded for the analysis. Gender was found to be statistically significant with two of the three stigma subtypes: perceived stigma held within one's social network ($B = -.649$, $p = .001$) and perceived stigma associated in receiving psychological help ($B = .730$, $p = .011$). Gender was not a statistically significant moderator for self-stigma ($B = .015$, $p = .908$).

The third research question sought to explore if the relationship between stigma and mental health seeking attitudes was moderated by generation. This question was also answered by creating an interaction term by means of multiplying generation with the three composite scores for the three subtypes of stigma. Generation was collapsed into two subgroups, BMA and AMA, and was dummy coded for the analysis. Generation was not found to be a statistically significant moderator with any of the subtypes of stigma: perceived stigmatization by other's in

one's social network (B = .128, p = .527), self-stigma (B = .119, p = .399), or perceived stigmatization from the general public (B = -.351, p = .265), and help-seeking attitudes.

Lastly, the final research question sought to explore if the relationship between stigma and mental health seeking attitudes was moderated by race centrality. Similar to the previous two regression models, this question was answered by multiplying the race centrality composite scores with the three composite scores for the three subtypes of stigma. Race centrality was not found to be a statistically significant moderator between any of the subtypes of stigma: perceived stigmatization by other's in one's social network (B = -.021, p = .082), self-stigma (B = -.002, p = .817), or perceived stigmatization from the general public (B = -.021, p = .121), and help-seeking attitudes. Table 6 displays the unstandardized regression coefficients (B), standard error, standard regression coefficients (β), t-values, and p-values.

Table 6
Moderation Results

Variables	*B*	*Std. Error*	β	*t-value*	*p-value*
*Gender*PSOSHS*	*-.649*	*.198*	*-.648*	*-3.277*	*.001***
*Gender*SSSHS*	*.015*	*.127*	*.031*	*.116*	*.908*
*Gender*SSRPHS*	*.730*	*.284*	*.801*	*2.572*	*.011**
*BMA*PSOSHS*	*.128*	*.202*	*.130*	*.635*	*.527*
*BMA*SSSHS*	*.119*	*.141*	*.259*	*.845*	*.399*
*BMA*SSRPHS*	*-.351*	*.314*	*-.394*	*-1.118*	*.265*
*RCS*PSOSHS*	*-.021*	*.014*	*-.685*	*-1.747*	*.082*
*RCS*SSSHS*	*-.002*	*.007*	*-.099*	*-.232*	*.817*
*RCS*SSRPHS*	*-.021*	*.014*	*-.685*	*-1.557*	*.121*

Note: *Indicates significant correlation at p < .05 level (2-tailed).

** Indicates significant correlation at $p < .001$ level (2-tailed).

Chapter Summary

The purpose of this study was to examine factors that may influence attitudes towards seeking psychological help in African American adults. In the study, I specifically investigated if, and to what extent, a relationship existed between attitudes, generation, gender, three subtypes of stigma, and race centrality. The instruments utilized were found to have adequate reliability for making inferences about participants. The results were presented in the chapter through descriptive statistics, instrument reliability, bivariate correlations, and multiple linear regressions. The multiple linear regression revealed that two of the three types of stigma significantly predict of help-seeking attitudes. The R^2 indicates that 47% of the variability in attitudes was predicted by the predictor variables. The relationship between stigma and mental health seeking attitudes was found to be moderated by gender on two of the three stigma scales. The relationship between stigma and mental health seeking attitudes was not moderated by generation or race centrality.

Chapter 5: DISCUSSION

In this research study, I examined the relationship between one outcome variable, attitudes towards seeking psychological help, three predictor variables, the three subtypes of stigma, and three possible moderating variables: gender, generation, and race centrality. This study aimed to answer the following research questions: (a) Is there any relationship between stigma and predicting one's mental health seeking attitudes? (b) Is the relationship between stigma and mental health seeking attitudes moderated by gender? (c) Is the relationship between stigma and mental health seeking attitudes moderated by generation? (d) Is the relationship between stigma and mental health seeking attitudes moderated by race centrality? The results of the data analyses were reported in the previous chapter. In this chapter, I present a summary of the results, a discussion of the results, implications of the findings, contributions of the study, limitations of the study, recommendations for future research, and concluding remarks

Summary of Results

I utilized an OLS linear regression to examine the relationship between stigma and attitudes towards seeking psychological help. The results of the OLS linear regression indicated that two of the stigma subtypes (perceived stigmatization of others and self-stigma) explained a statistically significant portion of participants' variance in attitudes towards seeking psychological help ($F (3, 186) = 17.548$, $p < .001$), $R^2 = .470$, adjusted $R^2 = .208$). The analysis showed that this group of predictor variables accounted for 47% of the variance in attitudes towards seeking psychological help. Additionally, I explored if generation, gender, and race centrality moderated the relationship between stigma and attitudes towards seeking psychological help. Of the three variables, I found that gender was a statistically significant

moderator between attitudes towards seeking psychological help as it relates to perceived stigma by others in one's social network and perceived stigma by the general public.

Discussion of the Results

Demographic Data

The total sample with usable data for this study included 190 participants. They were mostly female (67.4 %), between the ages of 26 and 41 (66.8%), located in the Southeast (74%), held some form of religious affiliation (64.2%), obtained a graduate degree (51.6%), were employed (88.9%), had an annual household income of $100,000 or less (56.3%), and reported having previous counseling experiences (75.3%). As it relates to gender distribution, median age, location, household income, and religious affiliation the study's sample mostly fall between the national estimates for the African American community. However, a discrepancy was particularly noted with educational attainment. Whereas 51.6% of the study participants held a graduate degree, at a national level, only 7.8 percent of African Americans have attained a graduate degree (Nichols & Schak, 2017). Additionally, the participants in this study unexpectedly had a high percentage of previous counseling experience (75.3%) in comparison to the national percentage (25%) of African Americans whom seek treatment for mental health issues. With consideration of education and previous experience with counseling, the study's sample captured the attitudes of a small subset of the African American community.

Several factors may have influence demographic makeup of the study sample. First, the primary recruitment strategy for the current study, convenience sampling, relied heavy on my own personal network. Though the recruitment snowballed outside of my personal social network, the level of cultural mistrust associated with partaking in research studies (Shavers et al., 2001) may speak to the reluctance or lack of personal buy-in from those outsides of my

personal social network. Given my own role as a doctoral student and professional counselor, it is possible that my network of acquaintances contains a higher number of people with graduate degrees and who are open to counseling than the overall population of African Americans in the U.S. As such, the high sample of graduate level participants can speak to the understanding of fulfilling requirements related to obtaining a higher degree, the research process, and having to obtain a high response rate. In addition, participants with previous counseling experience may have been more drawn to and inclined to complete this study given its focus on attitudes towards help-seeking

Research Question One

The primary research question of the present study was centered on investigating the relationship between stigma and predicting one's mental health seeking attitudes. Stigma was explored through the lens of public stigma, accounting for both perceived stigmatization from one's social network as well as the general public, and self-stigma. The bivariate correlation indicated a significant negative relationship with all three subtypes of stigma and help-seeking attitudes. These correlation results signify that positive help-seeking attitudes increases as the degree of stigma across all three subtypes decreases. This is in alignment with previous research as the presence of mental health stigma is commonly associated with negative help-seeking attitudes (Clement et al., 2005; Leong & Zachar, 1999; Vogel, Wester, Wei, & Boysen, 2005). In addition, when I examined the relationship between stigma and attitudes towards help-seeking among participants, I found two subtypes of stigma that were statistically significant predictors: perceived stigmatization by others in one's social network and self-stigma. Next, I review each of these predictors and how these findings compare to previous research on the variables.

An individual's social network plays an integral role in determining help-seeking attitudes and behaviors (Vogel et al., 2009) The perception of stigmatization by others among one's social network is differentiated from the general public due to the direct interaction and level of engagement with one's social group. Given the collectivist culture within the African American community, it is natural that the opinions of people who make up one's social network holds greater weight than that of the general public. This notion is supported by Lindsey and colleagues' (2010) whom found in their study with black male adolescent that the likelihood of service utilization was improved base off the support and opinion of family and friends.

How others see us naturally influences how we see ourselves (Cooley, 1992; Meads, 1925). In this study, I found that self-stigma, the internalization of stigma held by both the general public and that of our social network, had a significant negative correlation and was deemed a significant predictor of help-seeking attitudes. In translation, a higher degree of self-stigma indicates a lower degree of positive help-seeking attitudes. These results align with previous research as self-stigma has consistently been found to serve as a key deterrent towards help-seeking attitudes and decreases the likelihood that an individual would engage in help-seeking behaviors (Cadaret & Speight, 2018; Clement et al., 2015; Corrigan, 2004; Ward & Collins, 2010; Watkins et al., 2010).

The relationship between public stigma and help seeking attitudes has been well documented in previous research, as well (Bathje & Pryor, 2011; Vogel et al., 2006; Vogel et al., 2007a; Vogel et al, .2007b; Wu et al., 2017). Embedded in the concept of public stigma is the perception of judgment in being viewed and labeled as socially undesirable (Corrigan, 2004). The significant correlation between public stigma and help-seeking attitudes aligns with existing literature (Bynum et al., 2008; Caldwell et al., 2002; Shea & Yeh, 2008; Vogel et al., 2006).

However, despite the correlation, perceived stigmatization from the general public (B = .029, p = .825) I did not find a statistically significant contribution to the prediction of attitudes towards seeking psychological help in this study. This result may have occurred due to the participants' high levels of education and previous counseling experience, which were both higher than expected among a sample of African American adults. Previous exposure to graduate education and counseling may decrease the effect of stigma on one's attitudes.

Research Question Two

The second research question built upon the primary research question by examining the relationship between stigma and predicting one's mental health seeking attitudes utilizing gender as a moderator. Women are generally found to endorse more positive attitudes towards help-seeking (Aroara et al., 2016; Cheng et al., 2018; Nam et al., 2010; Topkaya, 2014). However, in the current study, gender did not have a significant relationship with either predictor variable, including the three subtype of stigma, generation, and race centrality, or the outcome variable, help-seeking attitudes. However, in regards to moderating the relationship between stigma and help-seeking attitudes, results indicated that gender was a significant moderator between perceived stigma in others and perceived stigma from the general public with attitudes towards receiving psychological help. Gender was not a significant predictor of help-seeking attitudes in relation to self-stigma. No previous studies have explored the moderating effect of gender on all three subtypes of stigma. These results indicate that the variables may have complicated relationships in that gender may impact some forms of stigma, but not all forms of stigma, in relation to help-seeking attitudes.

In comparison to the male participants, the female participants in the study reported greater stigmatization by other's in one's social network. A possible explanation for these results

can be rooted in the cultural phenomenon known as Strong Black Women (SBW). The role and responsibility of being SBW is evident through acts such serving as a caretaker, resisting vulnerability, controlling emotions, and prioritizing independence (Abrams et al., 2014; Beauboeuf-Lafontant, 2007, 2009; Nelson et al., 2016; Woods-Giscombé, 2010). Coupled with the fact that within the African American, community mental health is negatively viewed, as well as having to fulfill the persona of being SBW, African Americans may internalize less support from their social network and opt to endure any battle with mental health independently. However, considering that majority of the study's sample has had some form of previous counseling experience, it is important to note that negative help-seeking attitudes may not fully account for help-seeking behaviors and utilization (Diala et al., 2000).

In comparison to the female participants, the male participants in the study reported less stigma in one's social network, yet, perceived greater stigma from the general public. Though previous researchers have found public stigma to be significantly associated with help-seeking attitudes in males (Vogel et al., 2007), no previous researchers have identified the discrepancy between perceived stigma from one's social network and the general public that I found in this study. One reason that males perceived stigma from one's social network and the general public were significant predictors in this study may be explained through the premise of the African American community's belief and practice of keeping private matters and adversities within the family structure (Constantine et al., 2003; Thompson et al., 2004). As a result of this cultural belief and barrier, African Americans are more apt to sustain and endure rather than seek professional help (Thompson et al., 2004). Thus, the results of the current study may be explained by the practice of receiving internal support from one's social network while simultaneously adhering societal norms that supports masculine norms.

Research Question Three

The third research question built upon the primary research question by exploring the relationship between stigma and predicting one's mental health seeking attitudes utilizing generation as a moderator. Given that this study excluded participants under the age of 18, participants in this study were between the ages of 18 and 76. I did not obtain a sample with equal numbers of participants in all four generations; Generation Z accounted for 6.6% of the sample, Generation Y accounted for 66.8% of the sample, Generation X accounted for 20.4% of the sample, and Baby Boomers accounted for 6.2% of the sample population. Due to the unequal spread in response rates, and for the purpose data analysis, I collapsed the four generation groups into two groups, dummy coded them, and defined one as below middle age (BMA) and one as above middle age (AMA). Even with these change, BMA accounted for 73.8% of the sample population, whereas, AMA accounted for only 26.2% of this study's sample. Generation was found to have a significant correlation with help-seeking attitudes and perceived stigmatization from the general public, however, generation show no significance as a moderator.

In comparison to AMA participants, BMA participants scored lower (.142) on the ATSPH scale. In other words, older African American participants reported more positive attitudes towards help-seeking than younger African American participants in the study. These results aligned with Mackenzie et al.'s (2019) study, which utilized age as moderator between stigma and help-seeking attitudes and found that older adults had statistically more positive attitudes towards seeking help than younger adults. It is important to note that their study explored stigma through the lens of public stigma and self-stigma, thus, perceived stigmatization by other's in one's social network was not accounted for. It is also important to note that the

racial breakdown for Mackenzie et al's study was not provided to account for the specific percentage of African Americans in the study's sample.

The correlation results I found among generation also align with previous research exploring help-seeking attitudes and treatment across the lifespan. Mackenzie et al. (2004; 2006; 2008) found older adults hold both positive help-seeking attitudes and positive treatment beliefs. This result may emerge because younger adults endorse higher self-reliance and rely on personal social networks and alternative means of help-seeking rather than receiving psychological help. Though previous research highlights older adults as having a more positive outlook towards psychological help-seeking, older adults disproportionately underutilize mental health services (Hatfield, 1999; Mackenzie et al., 2004; Qualls et al, 2002; Robb et al., 2002). No previous research study has explored attitudes towards help-seeking across generations within the African American community, therefore the non-significant results of this study are the first of its kind. Given the disproportionate variance of the generation within the sample, further research will be needed to confirm if it is or is not a moderator.

Research Question Four

The final research question of the present study built upon the primary research question by exploring the relationship between stigma and predicting one's mental health seeking attitudes utilizing race centrality as a moderator. Racial centrality is regarded as the degree to which African Americans define themselves in terms of race and the meaning attached to one's self concept by belonging to a racial group (Sellers et al., 1998). The majority of previous studies about race centrality and African Americans have primarily explored the construct through its impact on academic success or psychological distress and racial discrimination. Additionally, though other researchers have examined the relationship between ethnicity and help-seeking

attitudes, the emphasis on centrality of race is absent (Conner et al. 2009; Masuda et al. 2009; Narendorf et al. 2018; Ward et al. 2013). No previous studies were found to have explored race centrality, the three subtypes of stigma, and help-seeking attitudes.

In the current study, I found race centrality to have a statistically significant correlation to perceived stigmatization from the general public. This correlation indicates that individuals who strongly identified with the African American culture and community tended to also express greater anticipation of social rejection or judgement from the general public as it relates to help-seeking attitudes. Quinn et al. (2014) explored the impact of stigma and concealed stigmatized identities and also found that negative beliefs related to one's identity had a greater effect on attitudes based on the extent that an identity has a greater magnitude within the self. Similarly, Sellers et al. (2003) found that higher levels of racial centrality served as a risk factor for public stigma and racial discrimination. Thus, previous research suggests that individuals with an increased centrality of race are more likely to be aware and sensitive to race-related topics and situations (Operario & Fiske 2001; Sellers & Shelton, 2003). Race centrality, however, was not found to be a significant moderator between any of the three stigma subtypes and help-seeking attitudes in the present study. The literature has shown individuals who strongly identifies with their race are more likely to report lower levels of psychological distress (Sellers et al., 2003). Neblett and colleauges (2004) proposed this to be because high race central individuals have more varied and effective coping skills simply due to increased experiences of having to cope with racial stressors. In situations in which high race centrality African Americans found themselves utilizing mental health services, an increase preference for a counselor of the same race was found (Goode-Cross, 2011; Goode-Cross & Grim, 2014). Given these varied results and

lack of research on race centrality and help-seeking attitudes in general, more research is needed to fully understand the relationship between the constructs.

Contributions of the Study

Investigating the influence of mental health stigma by subtypes helps us better describe and understand attitude formation and one's response to illness through help-seeking behaviors. Researchers have previously found that public stigma is significantly associated with help-seeking attitudes in African Americans (Barksdale et al., 2009; Masuda et al., 2012). However, previous studies have not explored the relationship between the two domains of public stigma (that of the general public and that of one's social network) alongside generation, gender, and race centrality with help-seeking attitudes in African Americans. This study adds to the literature by illuminating how stigma acts as an impediment for attitudes towards receiving psychological help. In particular, this study also sheds light on the influence of stigma on African American men, as results indicated that men reported less stigma in one's social network, yet, perceived greater stigma from the general public.

Additionally, this study expands the literature regarding help-seeking attitudes across the lifespan to include a primary focus on African Americans. More specifically, the study findings adds to the discussion on attitudes toward help-seeking by older African American in comparison to younger African American adults. Understanding the role that generation plays along with stigma assist in deepening our understanding of help-seeking attitudes. Most significantly, the results of this study provide a starting point for investigating the impact of generation and race centrality on help-seeking attitudes, as no previous researchers have examined these factors on help-seeking attitudes in African American adults.

Implications for Counseling

Stigma is a known deterrent for help-seeking attitudes and greatly influences opinions regarding mental health treatment and service utilization (Clement et al., 2015; Fisher & Turner, 1970). Due to low mental health literacy, stigma also serves as the foundation for beliefs and expectations related to counseling and working alongside service providers. However, understanding the relationship of stigma alongside generation, gender, and centrality of race can potentially guide effective preventive actions and interventions via counseling education programs, service providers, and advocacy efforts.

The results of this study have important implications for the field of counseling and practicing counselors. Stigma is clearly an influencing factor on help-seeking attitudes among African American participants, and counselors can respond to this influence in their work. One way to do so on a macro level is to develop outreach programs that address and improve help-seeking attitudes and mental health service utilization by destigmatizing mental health treatment. Outreach programs can help promote positive help-seeking attitudes and behaviors through psychoeducation about the prevalence of mental illness in the African American community, addressing stereotypes and held biases about treatment, and developing relationships with the African American community through culture specific community programming (Briggs et al., 2014). Outreach programs can also align themselves with varying religious organizations, community leaders, Black-owned businesses, and African American service providers for additional impact (Briggs et al., 2014).

On a micro level, counselors and mental health service providers should consider broaching dialogues related to mental health stigma in the African American community with current clients. With the goal of understanding the interrelated linear relationship between all three subtypes of stigma, stigma-based discussions should be sure to assess social stigma, self-

stigma, and public stigma, as opposed to merely focusing on self-stigma or public stigma. Given the result in the current study that social stigma was a significant predictor of attitudes, these dialogues with clients could potentially be shared with their family and friends and influence their attitudes in an expansive way.

Implications for Counselor Educators

In addition to counselors, study findings also have implications for counselor educators. According to Vereen et al. (2012), counselor education programs and curricula may benefit the counseling community by means of providing insight into the worldview of people most often alienated by the counseling profession. Counselor educators and supervisors have the responsibility to support and encourage the development of critical thinking skills and the develop competency skills. Utilizing the Multicultural and Social Justice Counseling Competencies (MSJCC) is an effective starting point for training students to grow culturally competent as it relates to working with diverse populations (Ratts et al., 2016). Though providing counseling services for the African American community is generally approached through courses such as Multicultural Counseling and Techniques, much more can be done to improve the training and development of future counselors.

First, the current practice of offering a single course in multicultural counseling may not be an adequate enough to prepare future counselors to practice outside of their own race. Multicultural and social justice themes, as well as the deconstruction of culturally biased counseling theories and intervention, should be incorporated throughout the courses and the entirety of the program. Second, within the standard Multicultural Counseling and Techniques course, counselor educators need to assist students' understanding regarding the range and complexities between racial and ethnic identities aside from the traditionally homogenous

approach taken to teach this topic. Course topics ought to further extend to the stigma of mental health associated within the African American community, as well as the intersectionality of stigma, as noted in this study through the inclusion of generation, gender, and centrality of race, which are often not differentiated or discussed. Thus, the range, impact, and skills needed to combat the influence of stigma cannot be overlooked.

Third, counselor educators and supervisors must continue to work alongside their students and supervisees to acknowledge, reflect, and confront their own biases and assumptions. As it is essential for students to learn and recognize the cultural views and values of marginalized populations, it is equally critical for them to reflect over their own worldview and how the culture and experiences of clients tie into their worldview. Counselor educators can approach this through class discussions, reflections, immersion projects, guest lectures, role plays, and experiential activities.

Lastly, counselor educators can place an emphasis on the recruitment of African American counseling students, especially males. Researchers have found that African American clients have a greater preference for same race therapeutic dyads (Diala et al., 2000; Nickerson et al., 1994; Sue et al., 1993; Thompson & Alexander, 2006; Wintersteen, 2005). As the field is largely comprised of Caucasian counselors, increasing the percentage of African Americans counselors and counselor educators will increase representation and service providers options. Such increased representation could, in turn, increase the frequency with which African American clients seek counseling and potentially decrease negative attitudes towards help-seeking. Moreover, it is essential that counselor educators also focus on better training counseling students on working within same-race dyads (Goode-Cross & Grim, 2016).

Limitations of the Study

Like all research studies, this dissertation study was not without its limitations. Several limitations were embedded in this study design, including that of recruitment, response rate, and generalizability. First, I limited study participation to African Americans who were 18 years of age or over. Thus, the attitudes and perspectives of those under the age of 18 were not captured. Additionally, online modalities, Facebook, and Instagram, were the primary sources for recruitment. By nature of the of sampling method, I cannot account for who saw the recruitment postings and decided to participant and the means in which this method contributed to the diversity of the sample population. I also cannot account for people who do not frequent these particular social media sites. Therefore, results cannot be generalizable to African Americans who are under the age of 18 or those who had limited access to the social media platforms utilized.

The study sample also consisted mostly of female participants, resulting in the absence of the attitudes held by many African American males. The same can be said regarding capturing attitudes across generations, as Millennials made up a majority of the sample population, and participants from Generation Y, Baby Boomers, and Generation Z may not have been sufficiently represented. As previously noted, graduate degree attainment and previous counseling experience appear overrepresented in the sample's population. Supplementary, the demographic breakdown of the present study lacks the attitudes and perspective of varying populations including those identify as non-binary or transgendered, of differing sexual orientation, and diverse religious affiliations. Given these limitations, the generalizability of the sample's result is impacted.

As it relates to data analysis, the sample size and missing data also serve as a limitation. Although 230 participants complete part of the study questionnaire, only 190 responses were

complete and usable in the data analysis. The participants' attention and motivation to complete the questionnaire could have impacted their desire to complete the entirety of this survey. There is no way of knowing if the missing data, had it been present, would have changed the study results, thus serving as a limitation.

Furthermore, the measurements and methods utilized in this study may also serve as a limitation. Though the measurements were chosen to capture specific attitudes and experiences of the sample's population, the measurements themselves, Stigma Scale for Receiving Psychological Help (SSRPH; Komiya et al., 2000), Self-Stigma Scale of Seeking Help Scale (SSOSH; Vogel et al., 2006), Perceptions of Stigmatization by Other for Seeking Help scale (PSOSH; Vogel et al., 2009), and the Inventory of Attitude Toward Seeking Professional Psychological Help Shorten Form (ATSPPH-SF; Elhai et al., 2008) were all normed on a sample of predominantly Caucasian, female, and college-age population.

Lastly, due to the self-report method of the measures utilizes, though completely anonymously, response bias and social desirability could have potentially influenced the means in which respondents answered the scaled items (Krosnick, 1999). Social desirability and response bias in survey research speaks to the likelihood that participants respond to survey questions in a manner they believe could be viewed as positive by others (Walzenbach, 2019). Socially desirable responding is noted to mostly likely occur in responses to socially sensitive topics, questions, and direct messages (self-reports) (King & Bruner, 2000; Van de Mortel, 2008). As this study sought responses exploring attitudes and centrality of race, participants could have found themselves faking good as a means to adhering to perceived socially acceptable values.

Recommendations for Future Research

One of the most referenced factors considered to influence the help-seeking process is one's help-seeking attitudes (Hammer et al., 2018). Thus, it is essential to develop a more nuanced understanding of what predicts help-seeking attitudes. Despite the limitations of this study, its results serves as a meaningful contribution to the literature that can be built upon to further support and enhance continued research on the topic. For starters, this study provided a quantitative perspective regarding attitudes towards help-seeking attitudes within African American adults. Future research can consider taking a qualitative or a mixed-methods approach towards understanding the depths of stigma within the African American community and its relationship with help-seeking attitudes. This approach could potentially yield data on how stigma has manifested over time and the various means it is still reinforced amongst the African American community.

In addition, researchers may also consider exploring attitudes towards psychological help-seeking behaviors through racial or ethnic demographic information. Understanding that the African American community is not monolithic, this approach would provide the opportunity to capture attitudes between groups. This focus could also be coupled with exploring the types and degree of stigma within the African American community as it relates to geographical location. Though collected and reported in this study, geographical information was not factored into attitude formation and help-seeking behaviors. This expansion can provide insight to the messages be told, felt, and experienced within the African American community during the sociopolitical era. Likewise, a majority of the sample population in this study held previous counseling experience, therefore it could be beneficial to conduct further research on African Americans with previous counseling experiences. Such research could explore the degree of stigma within different stages of help-seeking behaviors and its impact on help-seeking attitudes.

Researchers can also explore the influence of self-referral counseling versus mandated counseling.

In addition to higher rates of previous counseling experiences, this study also had a higher degree of graduate level of education. Future studies can explore the relationship between stigma and attitudes towards counseling, utilizing level of education as a moderator. As support from one's social network was deemed significant towards predicting positive help-seeking attitudes, future researchers can help expand upon the subtypes of one's social network and gage which holds a greater influence. Lastly, the non-significant findings between constructs in this study also provides potential areas for expansion. Given the poor generational distribution of this study, future studies can replicate the current study on a smaller geographical subscale as a means of strategically marketing and capturing the intended age groups. With a smaller geographical subscale, recruitment effort can also be tailored to align with effective strategies, such as by using one-on-one interactions, tangible incentives, recruitment through religious institutions and community organization, which are shown in previous studies to effectively induce willingness among African Americans in research studies (Avent & Cashwell, 2015; Lohse & Arcury, 2016; Satia et al., 2005)

Concluding Remarks

Historical trauma is described as the psychological and emotional injuries that happen throughout a life span and across generations due to traumatic events that have been directed at one cultural group (Burkett, 2017; Mohatt et al., 2014; Sotero, 2006). For African Americans, these historically traumatic events encompasses the enslavement of ancestors, segregation, and sustained institutionalized racism, and discrimination (Burkett, 2017). The stress of historical trauma creates a burden on African American's spiritual, physical, and mental health (Waldron,

2019). Despite the great need for service utilization in light of such trauma, African Americans are greatly underrepresented in treatment spaces (Woodward, 2021; Snowden, 2000; Kessler et al., 1994; Neighbors, 1988; Wallen. 1992). Prior to changing these dynamics, one must first identify understand the barriers that influence help-seeking attitudes held by African Americans. In this study, I aimed to address this critical gap in the research by exploring African American adults' attitudes towards help-seeking by generation, gender, three subtypes of stigma, and race centrality.

The results indicated a statistically significant relationship between attitudes towards psychological help-seeking, perceived stigmatization by others, self-stigma, and generation. Gender was also found to have a moderating effect between two subtypes of stigma and help-seeking attitudes. The results of this study provide a starting point for investigating the impact of generation and race centrality on help-seeking attitudes, as no previous researchers have examined these factors on help-seeking attitudes in African American adults. These results offer an empirical base for further exploration. Future researchers can build upon the results to continue to explore the impact of racial discrimination, the degree of stigma, and the importance of one's social network on both help-seeking attitudes and behaviors.

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Appendix A: Recruitment for Research Study

College of Education
9201 University City Boulevard, Charlotte, NC 28223-0001

Email Recruitment Letter
Examining Generation and Gender as Predictors of Stigma and Help-seeking Attitudes in African American Adults

Hello,

My name is Sara Jean-Philippe and I am a third year doctoral student in the Counselor Education and Supervision Program at University of North Carolina at Charlotte. I am working alongside Dr. Clare Merlin-Knoblich to conduct a study to explore the relationship between stigma and attitudes regarding going to therapy. The purpose of this study is to examine the relationships among generation, gender, race centrality, and stigma on mental health seeking attitudes in African Americans adults. Participants will complete a survey that should take approximately 7-10 minutes.
We are seeking participants who self-identify as:

- African American, Black, or Black American, and
- as 18 years or older at the time of data collection.

If you or someone you know meets the criteria for participation, study information, and consent form can be found here < https://uncc.qualtrics.com/jfe/form/SV_dbQXfPZs2mP4VyS >

Thank you for considering participating in this study. Questions can be directed to the study investigators using the contact information below.

Sara Jean-Philippe, LCMHC
Doctoral Student | Counselor Education and Supervision
University of North Carolina at Charlotte
sjeanphi@uncc.edu

Clare Merlin-Knoblich, Ph.D., NCC
Associate Professor, Director of Masters in Counseling
Director of Post Masters Certificate in School Counseling
UNC Charlotte ● Cato College of Education ● Department of Counseling
9201 University City Boulevard ● Charlotte, NC 28223 ● cmerlin1@uncc.edu

UNCC IRB Approval Number: 22-1189

Appendix B: Informed Consent for Study

College of Education
9201 University City Boulevard, Charlotte, NC 28223-0001

Consent to be Part of a Research Study

Title of the Project: Examining Generation, Gender, and Race Centrality as Predictors of Stigma and Help-seeking Attitudes in African American Adults

Principal Investigator: Sara Jean-Philippe, LCMHC

Co-investigator & Faculty Advisor: Clare Merlin-Knoblich, Ph.D.

You are invited to participate in a research study. Participation in this research study is voluntary. The information provided is to help you decide whether or not to participate. If you have any questions, please ask. Please read this form and ask any questions you may have before you decide whether to participate in this research study.

Why are we doing this study?

As racial and cultural diversity continues to rapidly grow within the U.S., the underutilization of mental health services across racial and ethnic minority groups continues to be a significant concern. More specifically, African Americans finds themselves at a higher risk for mental health illness. Yet, despite the great need for help-seeking and treatment, several studies have shown a great disparity and underutilization of mental health services by African Americans. With the understanding that one's culture factors into one's attitudes towards mental illness and help-seeking attitudes, continued exploration of help-seeking attitudes within the African American community is essential to understanding and combating barriers to mental health treatment utilization. However, given the held stigma and noted barriers to treatment, African Americans report negative help-seeking attitudes, which in turn contributes to low utilization rates. As a means of exploring the prevalence of stigma and the means in which it continues to impact utilization rates, this study seeks to investigate the influence of generation, gender, and race centrality on help-seeking attitudes. Given these gaps in the literature, as well as the imminent need for more research on African Americans' attitudes towards seeking mental health support, the purpose of this study is to examine the relationships among generation, gender, race centrality, and stigma on mental health seeking attitudes in African Americans adults.

Important Information You Need to Know

- Participation is voluntary. You may choose not to take part in the survey. You may start participating in the survey and change your mind and stop participation at any time.
- Participants will be ask to complete a survey that will take approximately 7-10 minutes.
- All response will remain anonymous

Why are you being asked to be in this research study?
You are being asked to be in this study because you self-identify as

- African American, Black, or Black American, and
- as 18 years or older at the time of data collection.

What will happen if I take part in this study?
If you choose to participate in this study, you will be asked to complete a survey which will take you approximately 7-10 minutes. Collectively, the survey will consist of 49 Likert scale questions.

The online questionnaire will include six components: a demographic questionnaire (11 questions), Self-Stigma of Seeking Help Scale (SSOSH), Perceptions of Stigmatization by Others for Seeking Help (PSOSH), Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF), Stigma Scale for Receiving Psychological Help (SSRPH) and The Multidimensional Inventory of Black Identity Race Centrality Scale (MIBI-Race Centrality).

What benefits might I experience?
Though there are no direct benefits to individual participants, indirectly sharing knowledge will benefit the counseling field due to increased understanding of the constructs.

What risks might I experience?
There are minimal to no risks associated with the current study. The probability of harm or discomfort is not greater than those encountered in daily life. Risks are mitigated by the anonymity of the survey.

How will my information be protected?
Data collection from survey will be collected anonymously. To further protect your privacy, the study/survey will not illicit any information that could identify you (such as your name). Data will be stored within a password protected University secured drive. Other people may need to see the information we collect about you. Including people who work for UNC Charlotte and other agencies as required by law or allowed by federal regulations.

How will my information be used after the study is over?
After this study is complete, the data could be used for future research studies or distributed to another investigator for future research studies without additional informed consent.

What are my rights if I take part in this study?
It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer.

Who can answer my questions about this study and my rights as a participant?
For questions about this research, you may contact Sara Jean-Phillipe sjeanphi@uncc.edu or Dr. Clare Merlin-Knoblich claremerlin@uncc.edu

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Office of Research Protections and Integrity at 704-687-7248 or uncc-irb@uncc.edu.

Consent to Participate

If you have read this informed consent form, understand the information contained in this informed consent form, and agree to participate in this study, click on the "Next" button located at the bottom of the first page of the online survey. If you do not wish to participate, click the 'x' in the top corner of your browser to exit.

Appendix C: Demographic Questionnaire

- Age Range
  - 18-22
  - 22-41
  - 42-57
  - 58 and older
- Gender
  - Male
  - Female
  - Non-Binary
- What is the highest degree or level of education you have completed?
  - Some high school
  - High school
  - Bachelor's degree
  - Master's degree
  - Ph.D. or higher
  - Trade School
  - Prefer not to say
- State of Residency
  - (Drop down response)
- What is your current employment status?
  - Employed full time
  - Employed part time
  - Seeking opportunities
  - Student
  - Retired
  - Prefer not to say
- What is your household income?
  - Below 10k
  - 10K-50K
  - 50k-100k
  - 100k-150k
  - Over 150k
- If applicable, please specify your religion

- Have you had any previous experiences with counseling?
  - No (skip to survey)
  - If Yes,
    - Was previous counseling experience mandated?
    - Please describe the type of counseling
      - Individual
      - Family/Parenting
      - Couples
      - Partial hospitalization
    - Length of time of counseling experience

Appendix D: Perception of Stigmatization by Other Seeking Help Scale

Perception of Stigmatization by Other Seeking Help Scale

(Vogel et al, 2009)

Imagine you had an emotional or personal issue that you could not solve on your own. If you sought out counseling services for this issue, to what degree do you believe that the people you interact with would _____

Not at all	A little	Some	A lot	A great deal
1	2	3	4	5

_____React negative to you

_____Think bad things of you

_____See you as seriously disturbed

_____Think of you in a less favorable way

_____Think you posed a risk to others

Appendix E: Stigma Scale for Receiving Psychological Help (SSRPH)

Stigma Scale for Receiving Psychological Help (SSRPH)

Items

1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.

2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.

3. People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.

4. It is advisable for a person to hide from people that he/she has seen a psychologist.

5. People tend to like less those who are receiving professional psychological help.

Note . Each question is rated from 0 (strongly disagree) to 3 (strongly agree), with higher scores indicating greater perception of stigma associated with receiving psychological treatment.

Appendix F: Self-Stigma of Seeking Help Scale

Self-Stigma of Seeking Help Scale

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

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

Items 2, 4, 5, 7, and 9 are reverse scored.

Appendix G: Attitudes Toward Seeking Professional Help Scale

Attitudes Toward Seeking Professional Help Scale

Instructions

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

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

_____ 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

_____ 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

_____ 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

_____ 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

_____ 5. I would want to get psychological help if I were worried or upset for a long period of time.

_____ 6. I might want to have psychological counseling in the future.

_____ 7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

_____ 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

_____ 9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

_____ 10. Personal and emotional troubles, like many things, tend to work out by themselves.

Scoring

Reverse score items 2, 4, 8, 9, and 10, then add up the ratings to get a sum. Higher scores indicate more positive attitudes towards seeking professional help. Calculate a mean for males, for females, and for each of the ethnic groups to examine group differences. Discuss any observed similarities and/or differences between the groups with the class.