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Mental Health Help-Seeking Behavior of Ghanaian American Immigrants

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**MENTAL HEALTH HELP- SEEKING BEHAVIOR OF GHANAIAAN
AMERICAN IMMIGRANTS**

**BY
GIFTY AMPADU**

**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY
IN
CLINICAL PSYCHOLOGY**

UNIVERSITY OF RHODE ISLAND

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DOCTOR OF PHILOPSHY

OF

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ABSTRACT

Research pertaining to mental health treatment disparities and help-seeking behaviors overwhelmingly focuses on differences between racial and ethnic minorities, who are often compared to the majority. There is a critical gap in psychological research on the subject of intra-group differences in help-seeking among ethnic minorities. This study addressed within-group differences regarding help-seeking intention of Ghanaian American immigrants, a subgroup of the Black population. Specifically, the study examined the relationship among demographic variables (e.g., age, education, marital status, and gender), acculturation, religious commitment, attitudes toward help-seeking, and mental help-seeking intentions in Ghanaian American immigrants. The study was also interested in learning more about preferred help-seeking sources among Ghanaians for mental illness (i.e., depressions, schizophrenia, and anxiety) and physical illness.

In a cross-sectional correlational design, a community-based sample of 131 Ghanaian American, 18 years and above, completed surveys to measure acculturation, attitudes toward seeking psychological help, and religious commitment. Help-seeking intentions for depression, schizophrenia, anxiety, and heart attack were measured through vignettes. A one-way repeated measures analysis of variance was conducted to compare help-seeking intentions for specific help sources across problem type (anxiety, depression, schizophrenia and heart attack). Results indicated that Ghanaians significantly preferred to seek help from intimate partners, phone helplines, and mental health professionals for mental health problems. Furthermore, a hierarchical multiple regression analysis was used to examine the relationship between demographic variables, acculturation strategies, attitudes toward help-seeking, and help-seeking intentions. The

findings from this research showed that age, marital status, attitude towards help-seeking, and religious commitment were strongly associated with help-seeking intention. The study provides valuable information that can be used to inform outreach efforts with respect to increasing mental health utilization among Ghanaian American immigrants.

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In all things, I give glory to God. *“But seek ye first the kingdom of God, and his righteousness; and all these things shall be added unto you.”* Matthew 6:23

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CHAPTER 1

INTRODUCTION

Research pertaining to mental health treatment disparities and help-seeking behaviors overwhelmingly focuses on differences between racial and ethnic minorities, who are often compared to the majority. For example, studies often examine health treatment disparities of Blacks in relation to Whites. Although there are shared intra-group similarities among minorities, Jackson et al. (2004) and Neighbors et al. (2007) recommended that intra-group differences also be explored. For example, African American Blacks should be distinguished from Caribbean Blacks, as well as Black immigrants from Africa. Responding to this call, this study was intended to provide information about mental health-seeking intention as it relates to Ghanaian Americans, a particular ethnic group within the Black population in the United States. (U.S). The primary aim of this study was to examine the impact of levels of acculturation, religious commitment, and attitudes toward help-seeking on mental health help-seeking intentions among Ghanaian Americans.

Disparities in treatment outcomes and treatment seeking are pressing issues in the U.S. among individuals who are racial and ethnic minorities. These disparities are evident in both physical and mental health arenas. Studies have suggested that minorities are more likely than Whites to delay or fail to seek mental health treatment (Atdjian & Vega, 2005; Miranda, McGuire, Williams, & Wang, 2008; Satcher, 2001). In addition, minorities in the U.S. tend to underutilize mental health services compared to their White counterparts. Specifically, Blacks, along with other racial minorities, have been identified as a group with a great health disadvantage due to these help-

seeking disparities. Overall, the unmet need for mental health treatment among Blacks in the U.S. is high (Atdjian & Vega, 2005; Backsdale, Azur & Leaf, 2010; Dobalian & Rivers, 2008; Miranda et al., 2008; Neighbors, 1984; Satcher, 2001; Snowden & Cheung, 1990)

To date, research on the underutilization of mental health services among Blacks in America has focused on the Black population as one homogenous entity, while ignoring intra-group differences within the Black population. Within the racial group of African Americans there is great diversity, which should be addressed in the research on mental health disparities in treatment outcomes and treatment seeking (Jackson et al., 2004). The term African American or Black has been historically used in the research context to refer to individuals of African descent or the Black diasporas within the U.S.. Therefore, Afro-Caribbean and native born Blacks are identified under this category of race. According to Anderson's (2015) census report on the Black population in the U.S., 9% of the Black population is foreign born, with most of this subset originating from the Caribbean and Africa. In order to provide outreach services to the Black population, it is important to examine intra-group differences as they relate to help-seeking behaviors regarding mental health needs (Neighbors et al., 2007). The goal of the present study was to enhance the findings provided by previous studies regarding the underutilization of mental health services among Blacks by focusing on the help-seeking intention of Ghanaian Americans.

Research Objectives and Hypotheses

This study examined the relationship between demographic variables, attitudes toward seeking psychological help, acculturation, religious commitment, and

expressed intentions of seeking help from several help sources for four different types of conditions (e.g., anxiety, depression, schizophrenia, and heart attack), which were represented within vignettes. The following demographic variables were examined; age, education, and gender. The following hypotheses were informed by previous literature:

1. Women will be more likely to report an intention to seek help from a mental health professional than men for the mental health related vignettes.
2. Individuals with higher levels of education (some college education and above) will be more likely to report an intention to seek help from a mental health professional for the mental health vignettes.
3. Individuals with higher levels of acculturation and more positive attitudes toward help-seeking will be more likely to report an intention to seek help from a mental health professional for the mental health related vignettes.
4. Religiosity will be inversely related to help-seeking intention from a mental health profession for the mental health related vignettes. The study asserts that these variables (acculturation, religious commitment, and attitudes towards help-seeking) will contribute significant unique variance to the report of an intention to seek help from a mental health professional for the mental health related vignette beyond the set of demographic variables.

CHAPTER 2

REVIEW OF THE LITERATURE

History of Ghanaian Immigration into the U.S.

The history of African presence in the U.S. dates back to the era of slavery when Africans were forcefully brought to the Americas and sold as property. Since the abolishment of slavery, Africans have immigrated to the U.S. for political, social, and economic reasons. Ghanaian immigration into the U.S. follows a similar immigration pattern as many other Africans, who come to the U.S. to seek educational and professional opportunities that are not available to them within their home countries. In a study surveying African immigrants living in the U.S., respondents indicated that they immigrated to the country due to a desire to advance their educational experience, reunite with family members, take advantage of the economic opportunities, and flee political terror (Arthur, 2000).

Once in the U.S., many African immigrants reside in major metropolitan cities, such as New York City, Los Angeles, Houston, Atlanta, Chicago, and Washington, D.C. According to the U.S. population census of 2014, the number of immigrants from Africa was 1,742, 620. Representing a substantial component of this group is the Ghanaian population, which has grown rapidly between the 1990 and 2000. The population of Ghanaian immigrants and their children living in the U.S. has reached nearly 235,000 (Migration Policy Institute, 2015). According to a report from Gambino, Trevelyan, and Fitzwater (2014), the Ghanaian born immigrant population comprises approximately 8% of the foreign born population from Africa. The authors

reported that the Ghanaian population in the U.S. is on a steady increase; therefore, this population should be a population of interest with respect to health disparities research.

Cultural Views of Mental Health

According to Satcher (2010), understanding culture, and particularly the nuances of subgroups within a culture, within the clinical setting is vital:

With a seemingly endless range of subgroups and individual variations, culture is important because it bears upon what *all* people bring to the clinical setting . . . Consumers of mental health services, whose cultures vary both between and within groups, naturally carry this diversity directly to the service setting. (p. 25)

The influence of culture cannot be ignored in mental health service provision and research. Specifically, cultural norms and views are two important factors that influence one's perspective on mental health. According to Kleinman (1987), culture affects not only etiology of mental illness but also responses to mental illness; this finding underscores the notion that the way in which a person understands an illness and makes decisions with regard to seeking help for that illness is greatly influenced by culture. Several empirical studies have examined the influence of culture on the mental health of minority groups within the U.S. (Cachelin et al, 2001; Kim & Omizo, 2003; Satcher, 2001; Zhang & Dixon, 2003). These studies have suggested that ethnic and cultural norms have an impact on those who seek help for mental health treatment. They also determine the extent to which individuals will engage in treatment. In a study investigating factors that have an impact on treatment seeking for eating disorders among European Americans and Mexican Americans women, results indicated that ethnicity was a key determinant of treatment seeking. The findings

indicated that Mexican women were less likely to seek treatment than their White female counterparts (Cachelin, Striegel-Moore, & Regan, 2006). Kim and Omizo (2003) also found an inverse relationship between Asian cultural values and willingness to seek help from a counselor among a sample of Asian Americans.

In the African cultural view, mental health and illness are taboo. There is a great level of stigma attached to mental illness as a result of the “lack of education, fear, religious reasoning, and general prejudice” (Okasha, 2002) within the general culture. Due to the social stigma of mental illness, many with mental illness live in hiding due to fear of ostracism or discrimination (Okasha, 2002). In a qualitative study investigating the beliefs and community response to mental health in Ghana, Quin (2007) concluded that beliefs about mental illness differ in rural and urban areas. In Quin’s study, respondents from urban areas attributed mental illness to natural causes. Furthermore, results suggested that there is a greater understanding of the biomedical cause of mental illness within urban areas in Ghana (Quin, 2007). This greater understanding could be a result of increased educational levels, socioeconomic status, and acculturation within urban settings. In contrast, respondents from rural areas “saw spiritual factors, such as a curse or bad spirits as being more significant in the causation of mental illness” (Quin, 2007, p. 181). Lamensdorf Ofori-Atta and Linden’s (1995) study examining causal beliefs regarding mental illness and treatment preference in Ghana showed that education, income, and acculturation were factors that influenced one's ascribed etiology of mental illness. Results suggested that participants with increased levels of education, income, and acculturation believed in more internal causes of depression as well as dependent personality disorder than

those with lower education, income, and acculturation levels (Lamensdorf Ofori-Atta & Linden 1995).

Acculturation and Mental Health

Major definitions of acculturation. Redfield, Linton, and Herskovits (1936) were among the first who defined the concept of acculturation. They stated acculturation included “Those phenomena, which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture and patterns of either or both groups” (p. 149). Hence broadly speaking, acculturation can be viewed as the change that takes places as two groups of people initiate contact with each other. This definition of acculturation provided by Redfield and colleagues was later reconstructed by the Social Science Research Council (1954) as follows:

Culture change that is initiated by the conjunction of two or more autonomous culture systems. Its dynamics can be seen as the selective adaptation of value systems, the processes of integration and differentiation, the generation of developmental sequences, and the operation of role determinants and personality factors (p. 974).

Based on this definition, the process of acculturation involves both direct and indirect contact between groups. (Berry, 2003; Sam & Berry, 2010).

The theoretical models of acculturation. Within acculturation research, there are two paradigms for conceptualizing the acculturation process, the unidimensional and bidimensional models. These two models of understanding acculturation have informed both theory and the development of measures of acculturation (Berry, Trimble & Olmeda, 1986, Cabassa, 2003; Nguyen, Messé, & Stollak, 1999; Nguyen & von de Eye, 2002; Rumin, 2003; Ryder, Alden, & Paulhus, 2000; Sam & Berry 2010).

The process of acculturation was initially conceptualized as a unidirectional process resulting in assimilation of the nondominant cultures. Within this framework, ethnic minority or nondominant cultures undergo one of two processes of acculturation. The first process involves adapting to the host culture and discarding one's culture of origin, while the second process involves maintaining one's culture of origin and rejecting the host society's culture. This model views maintenance of original cultures and adaptation to one's host culture as irreconcilable. This theory suggested that an individual is either acculturated or not acculturated, or either assimilated into the host culture or separated from the host culture. Individuals are described as either assimilationist or traditionalist (Berry 2003; Berry, Trimble & Olmeda, 1986; Chenug-Blunden & Juang, 2008; Flannery, Reise & Yu, 2001; Trimble, 2003). The unidimensional model stresses assimilation and often equates acculturation with assimilation. Nyguen et al. (1999) indicated that this view of the acculturation process suggests that acculturation is not possible without an individual assimilating to the host culture. The unidirectionality of the unidimensional model ignores the influences of the culture of origin. Acculturation is viewed as the movement on one continuum and in one direction. As an individual moves towards the dominant society, they lose their culture of origin.

Contrary to the unidimensional model of acculturation, the bidimensional model of acculturation is based on an assumption that maintenance of culture of origin and adherence to the host culture are independent of each other. Within this framework, cultural maintenance is explained as the degree to which an individual maintains his or her culture of origin, while adherence refers to the degree of

involvement in the host culture. Understanding acculturation from a bidimensional perspective allows one to assume that individuals can maintain or neglect their home culture while participating and acquiring values, attitudes, and behaviors related to the host culture. (Berry 1997, 2003; Cabassa 2003; Kang 2006; Matsudaira, 2006; Nguyen et al., 1999).

A popular bidimensional paradigm of acculturation is John's Berry's model of acculturation. According to Berry, the process by which one acculturates to a new culture involves strategies that are either attitudinal or behavioral. Berry (1997; 2003) posited that four categories of acculturation are formed because of the intersection between the two independent dimensions of acculturation: receiving-culture (host culture) acquisition and heritage culture (culture of origin) retention.

The four categories or attitudes named by Berry (1997; 2003) are assimilation, separation, integration, and marginalization. Assimilation strategy is represented by a disinterest in maintaining one's cultural identity and a desire to seek daily interaction with one's host culture. In contrast, those who have a separation strategy are more inclined to hold onto their culture of origin, while avoiding interactions with those of the host culture. Those who employ an integrationist strategy are more likely to maintain the beliefs and values of their culture of origin while simultaneously incorporating host culture practices. Finally, a marginalization strategy occurs when there is neither interest in cultural maintenance nor interest in interacting with host cultures.

The bidimensional model of acculturation has been viewed favorably by research aimed at explaining the dynamic process of acculturation. In examining, the

relationship between acculturation and adjustment in a sample of Vietnamese youth across three domains (i.e., interpersonal, personal, and achievement), Nguyen et al., (1999) discovered that the bidimensional model, looked at the maintenance of ethnic culture and involvement in dominant culture, provided more useful information in understanding adjustment in the U.S. than the unidimensional model. Similarly, Flannery, Reise, and Yu (2001) concluded that researchers interested in examining the comprehensive influence of acculturation should rely on the bidimensional model.

Acculturation and wellbeing. Acculturation is an important construct in understanding the wellbeing of immigrants because research suggests that stress associated with acculturation can negatively affect mental health. According to Berry and Ann (1974), the acculturative process can result in psychological stress. When individuals come in contact with a new culture as a result of voluntary immigration, asylum seeking, or refugee status, they are faced with several challenges associated with navigating the adjustment process such as learning a new language, different customs, new norms for social interactions, unfamiliar rules and laws, and undergoing life style changes (Ball, Organista, Organista, & Kurasaki, 2003). Acculturative stress is the conflict that arises from this process. Berry (1997) suggested there is a smooth change in behavior when acculturation produces no problems. However, if problems arise that the individual cannot manage, he or she experiences psychological distress. For example, when an individual feels marginalized during the acculturation process, they could experience significant psychological distress resulting in mental illness such as depression and anxiety

Studies on acculturation strategies and wellbeing have shown that individuals

who adopt the strategy of integration have fewer acculturative problems and better mental health (Berry 1997; Berry 2006; Dona & Ackermann, 20006: Sam & Berry 2010) than those who adopt other acculturation strategies. Sam and Berry (2010) noted that among the four acculturation strategies, an integrationist approach to acculturation is most helpful in adapting to a new culture. Integration can also apply to one's ethnic and national identities during the acculturative process (Phinney, Horenezyk, Liebkind, & Vedder, 2001). Phinney et al.'s (2001) research on the relationship between ethnic identity and national identity and adaptation among adolescent immigrants suggested that adolescents who possess an integrated identity have high levels of psychological adjustment.

Acculturation and Ghanaian immigrants. Presently, there is a dearth of research on the acculturation of Ghanaian immigrants. Only a few studies have investigated the acculturation process of Ghanaian Americans (Knipscheer, De Jong, Kleber, & Lamptey 2000; Knipscheer & Kleber, 2007, Knipscheer & Kleber, 2008). Knipscheer et al. (2000) examined the acculturation process of Ghanaian immigrants living in the Netherlands; their findings suggested that when acculturation was stressful, participants reported a greater number of health symptoms. Additionally, participants' migration experiences and their motives to immigrate to the Netherlands were indicators of health and wellbeing. Participants who immigrated due to political persecution or oppression reported an increased level of acculturative stress due to limited social support upon arrival to the Netherlands.

In examining the acculturation process of Ghanaian Americans, it is important to investigate the multidimensional nature of this process. Zane and Mark (2003)

noted ethnic groups within the U.S. are situated within a multicultural context; therefore, the use of a unidimensional approach would not be sensitive to cultural variation among these individuals. Within the context of the current study, the use of a multidimensional approach assessing acculturation will allow for the identification of intra-group variation among Ghanaian Americans.

Religiosity/Spirituality and Mental Health

Religiosity and spirituality greatly affect an individual's behavior and lifestyle choices. Most importantly, the religiosity or spirituality of an individual is likely to shape decision-making. Both religiosity and spirituality are terms that describe one's connection with the divine and the sacred. Religiosity can be defined as the extent to which an individual subscribes to religious doctrine, practices, and rituals, whereas spirituality is the subjective side of the religious experience (Hill & Pargament, 2003; Pargament, 2001). Religion provides a structure that individuals use to decipher how to behave and relate to the world. Religiosity has an important effect on mental health and coping (Koenig, 2009). In a review of 850 articles published on religion and mental health, researchers concluded that a positive relationship exists between religious involvement and positive mental health (Moreria-Almeida, Neto, & Koenig, 2006).

Moreover, religious attitudes, behavior, and psychological wellbeing are also positively related (Koenig, 1990). The findings of a majority of empirical studies have shown that religious commitment may play a beneficial role in preventing and coping with mental and physical illness, as well as facilitating one's recovery from illness (Matthew et al., 1998). In a meta-analysis of literature on religious coping strategies

and psychological adjustment to stress, results indicated a moderate relationship between seeking support from a clergy and positive outcomes (Ano & Vasconcelles, 2005).

With regard to help-seeking practices, multiple studies have suggested that many religious individuals prefer to use the clergy as a first source of help rather than mental health professionals (Chalfant et al., 1990; Neighbours, Musick & Williams, 1998). A national comorbidity study (Mills 2012) found that 25% of participants contacted clergy more often than psychiatrists for mental health problems. The clergy served as the primary source for mental health treatment and first line of contact for many individuals (Koeing et al., 2012).

Religion and spirituality have an important role in the lives of many Ghanaians. According to Pokimica, Addai and Takyi (2012), religion significantly shapes Ghanaians' perceptions of their living condition (absolute subjective wellbeing), and how they compare their living conditions to that of others (relative subjective wellbeing). Pokimica et al. indicated that outlooks on religion tend to vary among religious groups. Religious groups exhibiting the most positive perceptions of both absolute and relative subjective wellbeing tend to have strong congregational ties and a close knit network (Pokimica et al., 2012). Religious institutions become a resource for dealing with the struggles encountered during their stay abroad for many Ghanaians. This study therefore sought to examine the relationship between religiosity and help-seeking attitudes within this population.

Help-Seeking Attitudes

The theory of reasoned action (Ajzen & Fishbein 1989) and theory of planned

behavior (Ajzen, 1991) describe the way in which an intention to behave a particular way is influenced by one's attitudes towards that behavior. Hence, attitudes are often guided by cultural norms, environmental factors, and personal characteristics. Moreover, research has suggested that levels of help-seeking depend on demographic variables of the individual (Atkinson & Gim, 1989; Cepeda-Benito & Short, 1998; Cochran, Keenan, Schober, & Mays, 2000; Fischer & Cohen, 1972; Milville & Constantine, 2006; Mosley-Howard, 2006; Wallace & Constantine, 2005). One such variable that has an impact on help-seeking is gender. For example, differences appear to exist between males and females regarding psychological help-seeking in that females have more positive help-seeking attitudes in general and are more likely to seek counseling services than males (Fischer & Ferina, 1995; Fischer & Turner, 1970; Gim, Atkinson, & Whiteley, 1990; Gonzalez, Alegria, & Prihoda, 2005; Kelly & Achter, 1995; Leong & Zachar, 1995; Nam et al., 2010).

Additionally, higher educational levels have also been linked to favorable attitudes towards seeking help from psychological professionals (Leaf, Bruce, Tischer, & Holzer, 1987; Tijhuis, Peters & Foets, 1990). Gonzalez, Alegria, Prihoda, Copeland, and Zeber (2011) attributed these findings to the likelihood of an increased awareness and exposure to mental health treatments among this population.

Research has suggested that ethnic and racial minorities underutilize help-seeking agencies because of their cultural perspective and levels of acculturation. For example, Essandoh's (1992) study on help-seeking attitudes and psychological symptoms of African college students in the U.S. indicated that the level of acculturation was a good predictor of positive attitudes towards help-seeking. Results

showed that students with high levels of acculturation reported more positive attitudes towards seeking professional psychological help than those with lower levels. In a study examining the relationship between psychological distress, acculturation, and helping seeking attitudes among people of African descent, the findings indicated that increases in psychological distress had a negative impact on attitudes towards seeking professional psychological services (Essandoh's, 1992). Furthermore, low levels of acculturation were associated with negative attitudes towards help-seeking (Obasi & Leong, 2009).

Studies have suggested that ethnic minorities often attempt to solve problems by seeking help from informal networks of support, such as friends, family, and preachers or spiritual healers (Abe-Kim, Takeuchi, & Hwang, 2002; Constantine, Wilton, & Caldwell, 2003; Essandoh, 1992; Knipscheer & Kleber, 2001; Utsey, Adams, & Bolden, 2000; Zhang, Snowden, & Sue, 1998). In their study of variations in help-seeking behavior among White and Black college students, Ayalon and Young (2005) discovered that African American college students preferred to seek assistance from religious organizations before relying on professional psychological help. Furthermore, ethnic minorities are more likely to seek professional psychological help only when encountering a severe escalation in symptomology (Zhang et al., 1998). The findings of Essandoh's (1992) study also indicated that participants preferred informal sources of help for psychological distress.

Vignettes as a Measure of Mental Health Seeking Behavior

According to Link, Yang, Phelan, and Collins (2004), vignettes are a "form of stimulus that researchers can ask people to react to" (p. 526). Vignettes are a helpful

means of measuring socially difficulty or sensitive topics, such as mental health.

Vignettes are practical in research for mental health issues because they allow research participants to assume the role of the vignette character, thereby decreasing the potential for a socially desirable response (Hughes & Huby, 2000; Link et al, 2004).

Vignettes have been implemented as a methodological approach for measuring help-seeking in various studies (Anglin et al., 2008; Barney, Griffiths, Jorm, & Christensen, 2005; Bonfield, Collins, Guishard-Pine, & Langdon, 2000; Jorm et al., 2000; Raviv, 2009; Yang, Phelan, & Link, 2008).

In a study examining the relationship between attitudes toward people with depression and action taken when expressing depressive symptoms, Jorm and colleagues (2000) used vignettes to measure the attitudinal responses of the participants. Barney et al. (2005) also used vignettes to examine perceived stigma and the likelihood of seeking help from numerous helping professionals. Participants in Barney et al.'s study were asked to assume the role of the vignette character, while indicating the degree to which they were embarrassed about seeking help and their likelihood of seeking help from five different mental health professionals.

Additionally, in their investigation of help-seeking behavior of foster parents, Bonfield and colleagues (2010) used vignettes to measure mental health literacy, which is "knowledge and beliefs about mental disorder, which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182). For the purposes of this study, help-seeking intention regarding mental health will be measured using a vignette approach.

CHAPTER 3

METHODOLOGY

Research design

This study used quantitative measures to assess the relationship between help-seeking intention and levels of acculturation, attitudes toward seeking help, and religiosity. The independent variables for the study were acculturation, attitude towards seeking help, and religious commitment. The dependent variable, help-seeking intention, was assessed through vignettes. The study used a correlational design. The statistical analyses performed to compare means cross groups included analysis of variance (ANOVA) and hierarchical multiple regression.

Power analysis

A power analysis was employed in order to determine the number of subjects needed to provide significant findings. Without a power analysis, one might use too few or many more subjects than actually needed for the purposes of the study. According to Cohen (1988), in order to generate a large effect size of a study, an experimenter has to set power at 0.80 and alpha at 0.05. Due to the design of this study, Cohen's formula for multiple regression was used to determine sample size for the selected values of alpha, power, and effect size. For the purpose of the study, a calculated sample size of 99 was needed to generate results that have a medium effect size of 0.15.

Sample Characteristics

Study participants were Ghanaians Americans living within the U.S. Table 1 provides information on the demographic characteristics of the participants in the study. Participants were approximately equally divided across gender and marital status. Over

three quarters of the participants reported they spoke English "extremely well," 50% reported having some college education or a bachelor's degree, and 20% reported having earned a graduate or professional degree. The average age of participants in the study was 34.62 ($SD = 12.53$). Seventy- one percent of participations were foreign born immigrants in the U.S.; included 1st generation and 1.5 generation immigrants. Fifty-seven percent of the participants had lived in the U.S. for more than 11 years. These sample characteristics approximate those of the population of Ghanaians Americans living within the U.S.

Table 1

Demographic Characteristics of the Participants

Demographic Characteristic	<i>n</i>	%
Gender		
Male	50	48.5
Female	53	51.5
Marital status		
Single	51	49.5
Married	48	46.6
Divorced/Separated	4	3.9
Educational level		
Elementary School	1	1.0
Some High School	1	1.0
High School/GED	9	8.7
Associates/2-year Degree	18	17.5
Some College	23	22.3
Bachelors/ 4-year Degree	29	28.2
Graduate or Profession	21	20.4
Years in the United States		
Less than 1 year	2	1.9
1-2 years	16	15.5
3-5 years	10	9.7
6-10 years	18	17.5
More than 11 years	57	55.3
Born in the United States		
Yes	2	1.9
No	101	98.1
Generational status		
1st Generation	57	55.3
1.5 Generation	14	13.6
2nd Generation	17	16.5
Other	9	8.7
Confidence in English ability		
A little bit	2	1.9
Moderately	14	13.6
Quite a bit	7	6.8
Extremely well	79	76.7

Note. *N* = 101; 1.5 generation are children and adolescents of 1st generation immigrants who are born in parent's homeland and immigrated with parents.

Procedure

Participant recruitment. Participants were recruited for the study in the New York and New England area through various Ghana American associations and churches that mainly serve Ghanaian Americans. Recruitment letters and study packets were sent out to members of the above-mentioned associations. Ghanaian American students who were attending colleges within these areas were also invited to participate in the study.

The study packet included a cover letter (Appendix A), an informed consent form (Appendix B), demographic data sheet (Appendix C), Inventory of Attitudes Toward Seeking Mental Health Services (Appendix D), the Religious Commitment Inventory -10 (Appendix E), the Measurement of Acculturation Strategies for people of African Descent (Appendix F), and vignettes along with questionnaires (Appendix G). The cover letter explained the purpose and intent of the research and highlighted the importance of the study for the Ghanaian American community. Study participants were also invited to participate in a raffle to win one of three \$25 gift certificates to Amazon.com. Participants indicated their consent to participate in the study by filling out the surveys and returning them through the mail. If participants were interested in the raffle they provided their email addressed on their returned survey.

300 surveys were distributed in total to participants. The researchers mailed 100 surveys initially to study potential study participants. The researcher then packaged research packets with self- addressed stamps to different community-based and faith-based organizations. Some packages were returned back to the researcher through the mail and some were returned to the organizations and collected by the researcher in

person. In all the 131 surveys were returned back to the research resulting in a 44% response rate.

Measures

Independent variables. This study assessed constructs from four domains: demographics, acculturation, attitudes towards help-seeking, and religiosity.

Demographic Data Sheet. Participants were asked to indicate their age, gender, marital status, educational level, time in the U.S., born in the U.S., dominant language, confidence in language ability, language fluency, and generational status (Appendix C)

Help-seeking attitudes. Help-seeking attitude was assessed using the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) (Mackenzie, Knox, Gekoski, & MacAulay, 2004). The IASMHS is a 24-item scale, which measures three constructs in the following subscales: psychological openness, help-seeking propensity, and indifference to stigma (Mackenzie, Knox, Gekoski, & MacAulay, 2004). For the purposes of this study, the eight-item help-seeking propensity scale and the eight-item indifference to stigma scales were utilized to measure help-seeking attitudes. According to Mackenzie and colleagues (2004), help-seeking propensity is defined as the willingness and ability to seek help from a psychological professional. A sample item is, "If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy." Indifference to stigma is explained as the degree to which an individual is concerned about how important people in his or her life might react to the fact that the individual is seeking professional help for a psychological problem (Mackenzie et al., 2004). An example of a subscale item is "Having been mentally ill carries, with it a burden of shame." Response options range

from 0 = *somewhat disagree* to 4 = *agree*. The internal consistency for the full scale was .87 and the two subscales were 0.76 for the help-seeking propensity subscale, and 0.79 for the indifference to stigma subscale (Mackenzie et al., 2004).

Religiosity. Religiosity was assessed with the Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2003), which is a brief 10-item measure developed to assess the extent to which an individual adheres to his or her religious values, beliefs, and practices and uses them in daily living. RCI-10 is rated on a five-point Likert scale ranging from 1 = *not at all true of me* to 5 = *totally true of me*. The total score is obtained by summing all ratings across the 10 items. Scores may range from 10 to 50, with a higher score indicative of greater religious commitment. An example of one of the items participants responded to within this scale is, "Religion is especially important to me because it answers many questions about the meaning of life." RCI provides two subscales that measure intrapersonal religious commitment (six items) and interpersonal religious commitment (four items). The coefficient alphas were 0.93 for the full scale, 0.92 for intrapersonal religious commitment subscale, and 0.87 for interpersonal religious commitment subscale. A Pearson correlation coefficient for intercorrelations between the two subscales indicated that they are highly correlated, $r(154) = 0.72$. (Worthington et al., 2003)

Acculturation. Acculturation was measured using the Measurement of Acculturation Strategies for People of African Descent (MASPAD), an instrument developed to measure the acculturation strategies of those who are of African descent (Obasi, 2004). It is the first multidimensional acculturation instrument developed for individuals of African descent. The MASPAD assesses four acculturation strategies

(traditionalist, integrationist, assimilationist, and marginalist) along the dimensions of behavior and belief. The MASPAD is a 45-item scale that accesses beliefs and behaviors associated with two macro-dimensions: “relative preference for maintaining the heritage of one’s ethnocultural group” and “relative preference for having contact with and participating in the society of a different ethnocultural group” (Obasi, 2004, p. 2). Two examples of items within the scale are, “I express different cultural values in order to fit in” and “I take a great deal of pride in being a person of African ancestry (African, African American, Black Cuban, Black Brazilian, Trinidadian, Jamaican, etc.).” Each item is rated on a 6-point Likert scale, ranging from 1 = *strongly disagree* to 6 = *strongly agree*. The MASPAD was designed to obtain independent scores for the bidimensional assessment (traditionalist and assimilationist) and four independent scores for the multidimensional assessment (traditionalist beliefs, traditionalist behavior, assimilationist beliefs, and assimilationist behavior). For the purpose of the study, the bidimensional assessment was used for its strong psychometric properties. Obasi (2004) reported the reliability coefficient of the bidimensional scales as follows: The traditionalist subscale was $\alpha = 0.87$, and the assimilationist subscale was $\alpha = 0.81$. High scores on traditionalist subscale items reflect a preference for maintaining the heritage, behaviors, and beliefs of one’s own ethnocultural group, and high scores on assimilationist subscales reflect a preference for having contact with and participating in the society of a group with different ethnocultural behaviors and beliefs.

Dependent variable: help-seeking intentions. The study sought to understand the association between independent variables and the dependent variable, help-seeking intentions. The study employed the General Help-Seeking Questionnaire (Wilson, Dean,

Ciarrochi & Rickwood, 2005) to measure help-seeking intentions. The GHSQ uses a matrix response format in which, after reading a problem vignette, the respondent is asked to rate his or her help-seeking intentions on a 7-point scale ranging from 1 = *extremely unlikely* to 7 = *extremely likely* for each of eight targeted help sources (e.g., intimate partner, friend, parent, other relative / family member, mental health professional, phone helpline, doctor/general practitioner, and minister or religious leader). Higher scores indicate higher intentions to seek help. The respondent had the option to respond, “I would not seek help from anyone” as well as the option of filling in a blank, listing someone who was not among the eight listed help sources.

Using a sample of 218 high school students, the GHSQ was found to have satisfactory reliability (Cronbach’s alpha = 0.85; test-retest reliability assessed over a three-week period = 0.92). Convergent validity was supported by a positive correlation found between students’ intentions to seek counseling and the perceived quality of their prior mental health experiences. Divergent validity was supported by a negative correlation between the students’ intentions to seek counseling and their self-reported barriers to seeking professional psychological help. Finally, predictive and construct validity was supported by a significant correlation between help-seeking intentions and reports of actually seeking help from the corresponding source in the following 3 weeks (Wilson et al., 2005).

The GHSQ format was explicitly designed so that specific problem-types or helping source could be modified to meet sample characteristics and study requirements. In this study, four short vignettes were used to present specific problem types. Three of the vignettes (anxiety, depression and schizophrenia) were adopted directly from

Cheslock (2005) who determined these three vignettes had very high inter-rater reliability ($r = .95$). A fourth vignette, adapted from the GHSQ, concerning symptoms of a heart attack was used to examine any potential differences between help-seeking intentions for the three mental disorders and a physical disorder.

Data Analysis Procedures

Data cleaning. A missing values analysis was conducted in SPSS 20. Of the 131 completed surveys that were returned, 21% (28) of the surveys were deleted due to incompleteness of survey and high rates of missing items from the key independent and dependent variables. The 101 remaining cases were examined for accuracy of data, means, standard deviations, missing values, and distribution and assumptions of univariate and multivariate analyses.

Missing item analysis. In the remaining 101 cases, further missing item analysis was conducted. A mean substitution method was employed to replace items that were missing. This allowed for the analysis of descriptive statistics of independent variables. A mean substitution was employed for cases where no more than two items within a scale were missing, with the exception of the MASPAD scale, where four missing items was the cut off (out of the 45 items).

Statistical analyses. Data analysis procedures included computing descriptive statistics on demographic data, bivariate correlational analyses on the demographic variables and the measures used in the study, as well as performing an ANOVA and hierarchical regression analyses to determine help-seeking intentions for specific help sources across problem type (anxiety, depression, schizophrenia, and heart attack) and to determine the most significant predictors of help-seeking intention.

CHAPTER 4

RESULTS

Descriptive Statistics

A descriptive analysis was performed on the measures and demographic variables. Table 2 provides the means, standard deviation, skewness, and kurtosis reported for each variable. An assessment of the normality of the independent variables suggested that the assimilationist and intrapersonal religious commitment variables (RC1-10 Intrapersonal) were skewed and kurtotic. The assimilationist variable was log transformed. The intrapersonal religious commitment variable was reflected and then log transformed as well. The mean scores of the religious commitment scales were relatively high. The mean score on the RCI10-Intrapersonal, measuring intrapersonal commitment, was 24.76, with 30 as the highest score on the scale. For the RCI10-Interpersonal scale, measuring interpersonal religious commitment, the mean score was 16.25, with 20 as the highest score on the scale.

With regard to attitudes towards psychological help-seeking, average scores of the two subscales help-seeking propensity ($m = 23.19$; $SD = 5.622$) and indifference to stigma ($m = 19.68$; $SD = 6.138$) indicated moderately positive attitudes towards psychological help-seeking. While overall attitudes appear to be favorable toward psychological help-seeking, it is important to note that the average score of indifference to stigma was comparably low, considering the highest score on the scale is a 32. With regard to the two measures of acculturation, the mean score on the traditionalist subscale was 94.96, which indicates a moderate endorsement of traditionalist beliefs and behaviors. With regard to the assimilationist subscale, the mean score was 74.13, which

suggests low-to-moderate levels of assimilationist beliefs and behaviors in the sample relative to the total score on both scales.

Table 2

Descriptive Statistics of the Independent Variables

	<i>M</i>	<i>SD</i>	<i>N</i>	Range	Skewness (after changes)	Kurtosis (after changes)
Age	34.62	12.53	97	18, 71	.903	-.057
RCI10- Intrapersonal*	24.76	4.44	103	6, 30	-.453	-.604
RCI10- Interpersonal	16.25	3.36	103	4, 20	-1.013	.726
Help-seeking Propensity	23.19	5.62	103	6, 32	-.810	.287
Indifference to Stigma	19.68	6.14	102	3, 32	-.248	.372
Traditionalist	94.96	13.65	103	59, 129	-.328	.195
Assimilationist **	74.13	12.24	103	53, 130	.659	1.460

Note: *Reflected and Log transformation; **Log Transformation

Bivariate Correlations of Independent and Demographic Variables

A correlation analysis was performed to assess the collinearity of demographic and independent variables. Table 3 presents the correlation matrix for demographic variables, as well as the independent variables, and dependent variables used in the hierarchical multiple regression. An inspection of the correlation matrix indicates that there were significant correlations between some independent variables. Results suggested that marital status positively correlated with years in the U.S. ($r = 0.498, p < .01$), and age was positively correlated with marital status ($r = 0.651, p < .01$), years in the U.S. ($r = 0.492, p < .01$), and help-seeking propensity ($r = 0.313, p < .01$). In

contrast, age was negatively correlated with interpersonal religious commitment ($r = -0.227, p < .05$), and educational status was negatively correlated with assimilationist acculturation patterns ($r = -0.288, p < .05$). Results also indicated generational status was negatively correlated with intrapersonal religious commitment. Furthermore, intrapersonal religious commitment was negatively correlated with interpersonal religious commitment ($r = -0.685, p < .01$) and traditionalist acculturation patterns ($r = -0.239, p < .05$). Interpersonal religious commitment was also positively correlated with traditionalist acculturation patterns ($r = 0.265, p < .01$). Help-seeking propensity was significantly correlated with assimilationist acculturation patterns ($r = 0.264, p < .01$). Indifference to stigma was significantly correlated with traditionalist ($r = -0.309, p < .01$) and assimilationist ($r = -0.228, p < .05$) patterns of acculturation. Traditionalist acculturation and assimilationist acculturation were also significantly correlated ($r = 0.205, p < .05$). With respect to multicollinearity of predictor variables, there was a high correlation between the two subscales of religious commitment, which indicates that religious commitment could be measured by either of the two variables.

Table 3
Pearson's Correlation Matrix of the IVs, Demographic Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Gender	----	-.171	-.062	-.154	.087	-.137	.112	-.029	.143	-.007	.083	.010	.008
2. Age		----	.654**	-.054	.492**	.129	-.058	.058	-.227*	.313**	-.007	-.065	.064
3. Marital Status			----	.072	.498**	.134	.071	-.010	-.082	.155	.048	-.071	-.028
4. Educational status				----	.092	-.047	-.014	-.068	-.025	.023	.175	-.066	-.288*
5. Years in the US					----	-.048	.023	.014	.058	-.012	.002	-.053	-.025
6. Birth in US						----	-.131	.090	-.115	.068	-.038	-.106	-.030
7. Generation Status							----	.251*	-.146	-.162	.041	.029	-.037
8..RCI10 IntrapersonalRLog10								----	-.685**	-.154	-.089	-.239*	-.061
9..RCI10 Interpersonal									----	-.115	-.070	.265**	.180
10. Help-seeking Propensity										----	.126	-.065	.264**
11. Indifference to Stigma											----	-.309**	-.228*
12. Traditionalist												----	.205*
13. AssimilationalsitLog10													----

*significant at the .05 level (two-tailed) **Significant at the .01 level (two-tailed)

Descriptive statistics of intention to seek help from each help source (i.e., intimate partner, friend, parents, other relatives, mental health professional, phone helpline, doctor, minister or religious leader, no help) for each of the problem type vignettes (anxiety, depression, schizophrenia, heart attack) was obtained and presented in Table 4 - 7). An exploration of the results suggested that intention to seek help from an intimate partner was endorsed higher than the other sources for each problem type.

Table 4

Descriptive Statistics of Help Source for Anxiety Vignette

Help source	<i>M</i>	<i>SD</i>	<i>N</i>
Intimate Partner	5.91	1.54	102
Mental Health Professional	5.03	2.01	99
Doctor	4.87	1.97	102
Minister or Religious leader	4.41	2.10	103
Parents	4.11	2.19	101
Friend	4.11	2.01	101
Other Relative	3.88	1.86	100
Phone helpline	2.56	1.90	100
No Help	2.15	1.70	97

Table 5

Descriptive Statistics of Help Source for Depression Vignette

Help source	<i>M</i>	<i>SD</i>	<i>N</i>
Intimate Partner	5.65	1.86	102
Mental Health Professional	5.31	2.01	101
Doctor	5.25	1.89	103
Minister or Religious leader	5.25	2.01	102
Parents	5.12	1.96	99
Friend	4.33	1.91	101
Other Relative	3.81	1.82	100
Phone helpline	3.32	2.21	100
No Help	2.09	1.86	97

Table 6

Descriptive Statistics of Help Source for Schizophrenia Vignette

Help source	<i>M</i>	<i>SD</i>	<i>N</i>
Intimate Partner	5.69	1.97	101
Mental Health Professional	5.36	1.98	103
Doctor	5.36	2.24	102
Minister or Religious leader	5.28	2.15	102
Parents	5.13	2.01	99
Friend	4.09	2.17	100
Other Relative	4.07	2.24	101
Phone helpline	3.74	2.20	100
No Help	2.31	2.05	97

Table 7

Descriptive Statistics of Help Source for Heart Attack Vignette

Help source	<i>M</i>	<i>SD</i>	<i>N</i>
Doctor	6.41	1.33	103
Intimate Partner	5.76	1.76	102
Parents	5.48	1.89	99
Minister or Religious leader	4.58	2.09	102
Friend	4.48	2.05	101
Mental Health Professional	4.43	2.29	101
Other Relative	4.25	1.95	100
Phone helpline	3.42	2.24	100
No Help	2.05	1.72	97

Analysis of Variance

A one-way repeated measures analysis of variance (ANOVA) was conducted to compare help-seeking intentions for specific help sources across problem type (anxiety, depression, schizophrenia, and heart attack). This analysis examined the impact of problem type and help source on help-seeking intention. Mauchly's test of sphericity was used to assess the assumption of sphericity. For variables that violated sphericity a Greenhouse- Geisser correction was applied. The results of the repeated measures ANOVA suggested there was a significant effect of help source on problem type for the following help sources: intimate partner, phone helpline, doctor, and mental health professional. Table 8 shows the results of the ANOVA test.

Pairwise comparison of the significant ANOVA results was performed using a Bonferroni adjustment. For help-seeking intention from an intimate partner, results

suggest there was no difference in means with respect to all four problem types. For help-seeking intention from a phone helpline, there was a significant difference between depression and anxiety, schizophrenia and anxiety, and heart attack and anxiety. Results suggested that help-seeking intention via a phone helpline was significantly higher for depression, schizophrenia, and heart attack than for anxiety.

With regard to help-seeking intention from a doctor, there was a statistically significant difference between depression and anxiety, schizophrenia and anxiety, heart attack and anxiety, heart attack and depression, and heart attack and schizophrenia. Help-seeking intention from a doctor for a heart attack was significantly higher than for depression, schizophrenia, and anxiety.

For help seeing intention from a mental health professional, there was a significant difference between depression and anxiety and depression and heart attack. There was also a significant difference between schizophrenia and anxiety, and schizophrenia and heart attack, suggesting that help-seeking intention from a mental health professional was higher for schizophrenia than anxiety and heart attack. See Table 9 for the post hoc comparisons.

Table 8

Results of the Repeated Measure Analysis of Variance of Help-Seeking Intention With Various Help Sources

Mauchly's Test of Sphericity					Test of Within-Subjects Effects					
					Greenhouse-Geisser					
Variable	χ^2	<i>df</i>	<i>P</i>	ε	Square Sum	<i>df</i>	Mean Squares	<i>F</i>	<i>p</i>	Eta
Intimate partner	19.814	5	.001	.879	16.559	2.638	6.277	3.456	.02*	.033
Friend	27.424	5	.000	.858	11.017	2.575	4.279	1.664	.182	.016
Parents	13.663	5	.018	.919	12.212	2.758	4.428	2.043	.114	.020
Other relative	15.580	5	.008	.920	12.087	2.759	4.381	2.073	.109	.021
Phone helpline	16.641	5	.005	.904	74.960	2.713	27.627	10.235	.000*	.094
Doctor	20.826	5	.001	.876	207.658	2.627	79.050	28.814	.000*	.220
Minister or religious leader	30.809	5	.000	.865	34.654	2.595	13.354	6.227	.001	.058
No help	18.772	5	.002	.879	3.719	2.636	1.411	.703	.534	.007
Mental health professional	10.378	5	.065	.939	166.067	3	55.356	17.786	.000*	.15

Table 9

Pairwise Comparisons of Significant ANOVA Results

Help seeking source	Post Hoc Analysis Results
Intimate partner	Nonsignificant
Phone helpline	Depression>Anxiety Schizophrenia>Anxiety Heart attack>Anxiety
Doctor	Depression>Anxiety Schizophrenia>Anxiety Heart attack>Anxiety Heart attack>Depression Heart attack>Schizophrenia
Mental health professional	Depression>Anxiety Depression> Heart attack Schizophrenia>Anxiety Schizophrenia> Heart attack

Bivariate Correlations of Independent and Dependent Variable

Table 10 presents information on the correlations performed between predictor variables and dependent variables. Results suggested that age was positively correlated with help-seeking intention from a mental health professional for anxiety ($r = 0.284, p < .05$). Additionally, interpersonal religious commitment was significantly, negatively correlated with help-seeking intention from a mental health professional for schizophrenia ($r = -0.246, p < .05$). Help-seeking propensity was positively correlated to help-seeking intention from a mental health professional for anxiety ($r = 0.461, p < .01$), depression ($r = 0.435, p < .01$), schizophrenia ($r = 0.259, p < .01$). Assimilationist acculturation patterns was positively correlated with help-seeking intention from a mental health professional for depression ($r = 0.257, p < .01$).

Table 10

Pearson's Correlation Matrix of the DV, IVs, Demographic Variables

	1	2	3
1. Anxiety -Mental health professional	---	.503**	.258*
2. Depression-Mental health professional	.503**	---	.286*
3. Schizophrenia-mental health professional	.258*	.286*	---
4. Gender	-.087	-.065	-.182
5. Age	.284*	-.011	.178
6. Marital Status	.031	-.187	.097
7. Educational status	-.058	.007	-.121
8. RCI10 Intrapersonal RLog10	-.026	.034	.062
9. RCI10 Interpersonal	-.166	-.148	-.246*
10. Help-seeking propensity	.461**	.435**	.259**
11. Indifference to stigma	.018	.159	.152
12. Traditionalist	.056	-.084	-.084
13. Assimilationist log10	.155	.257**	.144

Note. DV = dependent variable, IVs = independent variables

* significant at the .05 level (two-tailed) **significant at the .01 level (two-tailed)

Hierarchical Multiple Regression

The results of an examination of the correlations (Table 10) and collinearity statistics (i.e., tolerance and VIF), which were all in the acceptable range, suggested that the assumption of multicollinearity was met. The residual and scatter plots indicated the assumption of normality and independence of error terms, linearity, and homoscedasticity were all met. In this analysis, the transformation of two independent variables, intrapersonal religious commitment and assimilationist, were utilized.

Impact of demographic variables on helping seeking intention for anxiety, depression, and schizophrenia. A hierarchical multiple regression with stepwise specifications was performed with demographic variables to determine which demographic variables had the strongest relationship with help-seeking intention from a

mental health professional for three problem types (anxiety, depression, schizophrenia). In terms of help-seeking intention for anxiety from a mental health professional, results suggest that age ($\beta = 0.47, p < .01$) and marital status ($\beta = 0.29, p < .05$) were significant predictors, $F(2, 93) = 6.76, p < .01$, of help-seeking intention for anxiety from a mental health professional. These two demographic variables explained 13% of the variance in help-seeking intention for anxiety ($R^2 = 0.13$). In terms of help-seeking intention for depression from a mental health professional, results suggest that marital status ($\beta = -0.86, p < .05$) was a significant demographic predictor, $F(1, 94) = 4.64, p < .05$, of one's intention to seek help from a mental health professional for depression. Marital status explained 5% of the variance in help-seeking intention for depression ($R^2 = 0.05$). In predicting help-seeking intention for schizophrenia, no demographic variables were found to be significant predictors of help-seeking intention from a mental health professional. Table 11 and 12 show the results of the hierarchical regressions.

Impact of religiosity, acculturation, and attitudes towards seeking psychological help on helping seeking intention for anxiety, depression, and schizophrenia.

A second hierarchical multiple regression with stepwise specification was performed to analyze the predictive power of religiosity, acculturation, and attitudes towards seeking psychological help on help-seeking intention over and above the variance accounted for by demographic variables. To test for the impact of attitudes towards seeking psychological help on help-seeking intention for anxiety, depression, and schizophrenia, a two-step hierarchical multiple regression analysis was performed separately for each dependent variable (Table 11). In the first step of the analysis demographic variables

were entered. At step 2, a set of six additional independent variables were entered: help-seeking propensity and indifference to stigma, traditionalist and assimilationist subscales, and intrapersonal and interpersonal religious commitment subscales. Results of the analysis suggested that for help-seeking intention for anxiety from a mental health professional, help-seeking propensity was the only independent variable included in the equation. The final model with help-seeking propensity ($\beta = 0.39, p < .01$), which included age ($\beta = 0.32, p < .05$) and marital status ($\beta = -0.25, p < .05$) was significant, $F(3, 91) = 10.52, p < .01$.

Help-seeking propensity was the most significant independent predictor of help-seeking intention over and above the variance accounted for by age and marital status. The addition of help-seeking propensity to the model explained 13% of the variance in help-seeking intention for anxiety. $R^2_{\text{change}} = 0.13, F(1, 91) = 16.29, p > .01$. For help-seeking intention for depression, help-seeking propensity was the only independent predictor to be included with the demographic variable, marital status, in the model. The final model with help-seeking propensity ($\beta = 0.46, p < .01$), and marital status ($\beta = -.30, p < .01$), was significant. $F(2, 92) = 16.69, p < .01$. The addition of help-seeking propensity to the model explained 21% of the variance in help-seeking intention for depression, $R^2_{\text{change}} = .21, F(1, 92) = 26.22, p > .01$. Help-seeking propensity was the most significant predictor in predicting help-seeking intention for schizophrenia; stepwise regression analysis included help-seeking propensity and interpersonal religious commitment. The final model with these two variables was significant, $F(2, 91) = 5.72, p < .01$. Help-seeking propensity, $\beta = 0.24, p < .05$, and interpersonal religious commitment, $\beta = -0.21, p < .05$, accounted for 11% of variance in help-seeking intention from a mental

health professional for schizophrenia, $R^2 = 0.11$. Help-seeking propensity was the most significant predictor accounting for 7% of variance in help-seeking intention.

Table 11

Summary Statistics of Hierarchical Multiple Regression with Stepwise Specification for Predicting Help-Seeking Intention With all Predictor Variables

Dependent	Step	Variable	<i>B</i>	<i>SE</i>	β	<i>t</i>	<i>R</i>	<i>R</i> ²	ΔR^2
Anxiety -Mental health professional									
	Step 1						.27	.08**	.08
		Age	.05	.02	.27	2.74**			
	Step 2						.35	.13*	.05
		Age	.08	.02	.47	3.62**			
		Marital Status	-1.29	.56	-.30	-2.29*			
	Step 3						.51	.26**	.13
		Age	.07	.02	.32	2.26*			
		Marital Status	-1.12	.52	-.25	-2.11*			
		Help-seeking Propensity	.152	.04	.39	4.04**			
Depression -Mental health professional									
	Step 1						.24	.06*	.06
		Marital Status	-.96	.40	-.24	-2.37*			
	Step 2						.52	.27**	.21
		Marital Status	-1.22	.36	-.30	-3.37**			
		Help-seeking Propensity	.17	.03	.46	5.12**			
Schizophrenia -Mental health profession									
	Step 1						.26	.07*	.07
		Help-seeking Propensity	.09	.04	.26	2.59			
	Step 2						.33	.112*	.04
		Help-seeking Propensity	.09	.04	.24	2.39			
		RCI-10 Interpersonal	-.12	.06	-.21	-2.11			

Note. *B* = Unstandardized beta coefficients; β = standardized beta coefficients; *SE*= standard error; *R* = Regression coefficient; *R*² = *R* squared; ΔR^2 = *R* squared change.

Table 12

Summary Statistics of Hierarchical Multiple Regression with Stepwise Specification for Predicting Help-Seeking Intention With all Demographic Variables

Dependent	Variable	<i>B</i>	<i>SE</i>	β	<i>t</i>	<i>R</i>	<i>R</i> ²	ΔR^2
Anxiety -Mental health professional	Step 1					.28	.08**	.08
	Age	.05	.02	.28	2.87**			
	Step 2					.37	.13*	.05
	Age	.08	.02	.47	3.67**			
	Marital Status	-1.26	.57	-.29	-2.23*			
Depression -Mental health professional	Step 1					.22	.05*	.05
	Marital Status	-.88	.40	-.22	-2.15*			
Schizophrenia -Mental health profession	Step 1							
No Variables Included								

Note. *B* = Unstandardized beta coefficients; β = standardized beta coefficients; *SE*= standard error; *R* = Regression coefficient; *R*²= R squared; ΔR^2 = R squared change.

CHAPTER 5

DISCUSSION

Research indicates that minorities are more likely to delay seeking help or fail to seek help for mental health issues (Atdjian & Vega, 2005; Dobalian & Rivers, 2008; Miranda et al., 2008; Neighbors, 1984; Satcher, 2001; Snowden & Cheung, 1990). Additionally, studies of mental health disparities have largely focused on comparing ethnic minorities to ethnic majorities, thereby ignoring the impact of within-group difference on mental health treatment disparities. There is a critical gap in psychological research on the subject of intra-group differences in help-seeking among ethnic minorities. In their study on racial and ethnic influence on mental health, Jackson and colleagues (2004) concluded that intra-group differences should be addressed in health disparities research in order to inform outreach programs. The purpose of this study was to extend the literature on mental health help-seeking intentions of Ghanaian Americans, a subgroup of the Black population in the U.S. Specifically, the study examined variables associated with intentions to seek help from a mental health professional for mental health related conditions (e.g., anxiety, depression, and schizophrenia).

The study's sample is similar the demographics of the Ghanaian American population in the U.S. According to the Migration Policy Institute (2015), the median age of Ghanaian immigrants in the U.S. is 40, which is comparable to the mean age of the sample within this study, which was 34.62. The report also suggested that approximately 65% of this population identifies as first generation. Results from this study indicate that 68.9% of the sample within the study was of first generation status.

According to the *Foreign-Born Population From Africa: 2008-2012*, by Gambino et al. (2014), 8% of Ghanaian-born immigrants generally had less than a high school education, while 56.4% had high school education or some college education, and 34.9% had a bachelor's degree or higher. These demographics are also comparable to results of the educational status in this study's sample. Based on these key demographic variables, it is evident that the sample of Ghanaians used within the study is representative of the population of the Ghanaians living in the U.S..

An initial examination of the results on help-seeking suggests that with respect to intention to seek help for four problem type vignettes, there were noted differences. When comparing various help sources participants reported they would seek help from for depression, anxiety, schizophrenia, and heart attack, results revealed there was higher intention to seek help from doctors, and mental health professionals than other sources, such as ministers or religious leaders, parents, friends, or other relatives. Intentions to seek help from a doctor were, understandably, higher when the indicated problem was a heart attack, whereas intention to seek help from a phone line was higher for depression and schizophrenia. Similarly, intention to seek help from mental health professionals was higher for schizophrenia and depression. These results suggest that, when the problem was psychological in nature, help-seeking intention from a psychological professional was higher versus problems that were thought to be physical in nature, such as a heart attack or anxiety. These results suggest a moderate level of mental health literacy among the sample.

Jorm and colleagues (1997) discussed mental health literacy as the knowledge and beliefs that one possesses about mental disorders, which helps the individual

recognize, manage, or prevent mental illness. Research on mental health literacy suggests that mental health illiteracy has implications to help-seeking behavior, such as unfavorable attitudes towards mental health professionals and interventions, stigma toward mental health illness, and perceptions regarding the ability to of professionals to assist those who need help (Jorm 1997, 2000; Jorm et al. 2006). Moreover, lack of mental health literacy may pose problems regarding communication between practitioners and clients. Overall, mental health literacy may promote the recognition of poor wellbeing in oneself and others, aid in timely help-seeking, and help to lower attitudes of stigma associated with mental health (Dadrich, 2009; Stein & Soraya, 2007). Although the sample appeared to have a moderate levels of mental health literacy with respect to illnesses that were representative of physical (heart attack) problems, and mental health (schizophrenia and depression) problems, anxiety was not viewed as a mental health problem that would require psychological help. These results could be explained by the fact that symptoms of anxiety often take somatic forms or that culturally Ghanaians do not view anxiety as mental illness.

Venter and Gany (2010) argued that mental health is poorly differentiated in African immigrants. Examining health problems of West African immigrants, which included a Ghanaian population, Venter and Gany (2010) indicated that mental health issues were among the top three health problems reported by participants to their primary medical doctor. These results indicate that African immigrants often report mental health issues to their primary medical doctors. Further investigation into the nature of mental health issues reported by African immigrants to their primary medical doctors is warranted. An implication of this study's results, which compared problem

type and help source, is that mental health programs targeting African immigrants should engage the population in understanding depression and anxiety as mental illnesses. Within this population, the symptoms of anxiety, which often manifest themselves physically, might be more likely interpreted as physical problems in comparison to depression or trauma. Additionally, a dialogue with cultural stakeholders about manifestations of the depression and anxiety in Ghanaians is also warranted in order to determine if there are some cultural differences in the expression of these two illnesses. For examples, it is important to understand how depression and anxiety are expressed among Ghanaians with a focus on terminology used to express symptomology and the nature of the symptoms expressed.

Study Hypothesis

This study was interested in understanding intentions to seek psychological help for anxiety, depression, and schizophrenia. Intention to seek psychological help was assessed through asking participants in the study to indicate their intention to engage in help-seeking for three types of mental health problem through responding to a vignette on each. Previous research suggests that demographic variables, such as gender, age, education status, and marital status have an impact on help-seeking intention. Specifically, research has shown that females, youth, and individuals with higher levels of education are more likely to seek psychological help (Fischer & Ferina, 1995; Fischer & Turner, 1970; Gim, Atkinson, & Whiteley, 1990; Gonzalez, Alegria, & Prihoda, 2005; Gonzalez, Alegria, Prihoda, Copeland, & Zeber, 2011; Kelly & Achter, 1995, Leaf, Bruce, Tischer, & Holzer 1987; Leong & Zachar, 1995, Nam et al, 2010; Tijhuis, Peters, & Foest, 1990) .

Based on the findings of previous research, this study hypothesized that being female and having a high level of education, which was operationalized as college and beyond, would be significantly associated with intention to seek formal psychological help. The results of this study did not support this hypothesis, in that being female and having a higher level of education was not associated with help-seeking intention. These findings were similar to results from Knipscheer and Kleber's (2008) study on help-seeking behavior, which focused on Ghanaian Immigrants living in the Netherlands. Knipscheer and Kleber's (2008) study revealed males and those with a lower education were more likely to utilize mental health care in the Netherlands. These authors did not indicate the conditions for which participants sought help. However, when ethnic and racial minorities seek help, they often seek help during the later more acute stages of their illness. Additionally, due to late detection of mental illness in minorities, there is an overrepresentation of minorities within emergency room settings (Snowden, 2003). Within the current study, an explanation for the lack of association between educational level and intention of seeking help from a mental health professional could be a restriction of range in the education variable, due to the fact that 89.3% of those in the sample possessed an associate degree or higher.

Interestingly, findings from this study suggested that within this sample, age and marital status were associated with help-seeking intention for psychological help. Specifically, when the psychological problem was anxiety, age and marital status was strongly associated with help-seeking intention. For anxiety, an increase in age positively influenced psychological help-seeking intention and being married was related to a decrease in intention to seek help for psychological help. The results are

comparable to findings showing older age to be associated with favorable intention to seek help (Mackenzie, Gekoski, & Knox, 2008; Mackenzie, Pagura, & Sareen, 2010). In comparing responses from the U.S. national Comorbidity Survey and the Ontario Health Survey about help-seeking for mental illness, researchers discovered negative attitude towards help-seeking were more prevalent in young adults (Jagdeo, Cox, Stein, & Sarren, 2009).

Marital status was also significantly associated with help-seeking intention when the problem was depression. Married participants had less of an intention to seek help from a psychological professional for depression. These results could be attributed to the protective factors associated with being married. Research suggests that being married is associated with improved psychological wellbeing (Mooknerjee, 1995; Kim & McKenry, 2002; Reneflot & Mamelund, 2011). No demographic variables were significantly related to psychological help-seeking intention for schizophrenia.

The study also hypothesized that higher level of acculturation, which was identified as assimilationist beliefs and behavior, and positive attitudes towards help-seeking for psychological help would contribute unique variance to help-seeking intention over and above that which was accounted for by demographic variables. Help-seeking propensity, a measure of attitudes towards seeking psychological help, was strongly associated with seeking help from a psychological professional for depression, anxiety, and schizophrenia. Previous studies have indicated that positive attitudes towards help seeking contributed to help-seeking behaviors (Ajzen & Fishbein 1989; Fisher & Ferina 1995; Gim, Atkinson & Whiteley; 1990, Gonazlez,

Algeria, & Prihoda, 2005; Kelly & Achter, 1995; Leong & Zachar, 1995, Nam et al, 2010). A study on intention to seek psychological help in a college population in Turkey (Seyfi, Poudel, Yasuoka, Otsuka, & Jimba, 2013) further confirmed that positive attitudes towards seeking psychological help was associated with high intentions to seek psychological help. The confirmation of these findings within this study imply that outreach programs targeting mental health help seeking behaviors of Ghanaian American should focus on increasing positive attitudes towards help seeking.

Contrary to expected results, neither the traditionalist nor the assimilationist acculturation strategies were significantly associated with intention to seek psychological help. An examination of descriptive statistics of the measures of acculturation strategies of this sample indicated that the sample exhibited a moderate level of both traditionalistic and assimilationist acculturation strategies. The scale description of the MASPAD suggests that high scores on the traditionalist subscale items reflect a preference for maintaining the behavior and beliefs of one's own culture, whereas high scores on assimilationist subscales reflect a preference for having contact with and participating in the society of a cultural group with differing behaviors and beliefs than one's own heritage. Because the scores of this sample indicated moderate levels on each scale, it may be inferred that the sample adhered to a bicultural and/or integrated strategy of acculturation. Schwartz and Unger (2010) explained biculturalism as the ability for one to maintain one's cultural heritage as well as adapt to the culture of the host country. Additionally, biculturalism can apply to first and second-generation immigrants. Biculturalism is also described as the most

adaptive approach to acculturation because it provides the capacity to use coping skills from both one's culture of origin and one's host culture. The bicultural nature of the sample could be explained by the fact that 55.3% of the sample had been living within the U.S. for 11 years or more. Additionally, the sample was recruited from regions in which Ghanaian immigrants often live in ethnic enclaves and who are thereby able to maintain a strong cultural heritage.

Finally, as hypothesized, religious commitment as measured by the interpersonal religious commitment scale was significantly associated with psychological help-seeking intention. In this study, individuals with low scores on the interpersonal religious commitment scale were more likely to seek help from a psychological professional when the problem was schizophrenia. As previously indicated in research, religious commitment informs how individuals cope with mental illness (Matthew et al, 1998). The inverse relationship between religious commitment and help-seeking intention observed within this study supports previous findings on the impact of religiousness on psychological help-seeking. This research suggests that seeking religious support in times of psychological distress is associated with less intention to seek help from a psychological professional. Additionally, the sample in this study was fairly religious (RCI10- Intrapersonal, $M = 24.76$; $SD = 4.43$; RCI10- Interpersonal, $M = 16.25$, $SD = 3.36$) and could rely on religious clergy as a source of help for schizophrenia. An examination of the mean for help seeking for schizophrenia from a minister or religious leader measured via the vignette suggested a high intention to seek help from this source ($M = 5.28$, $SD = 2.15$). Moreover, research has indicated that in religious samples, the clergy serves as the first source of help for

mental health treatment (Koeing, King, & Carson, 2012). Furthermore, those who seek out help from clergy are often less likely to seek professional mental health services (Farrell & Gobert 2008; Leavey & King 2007; Weaver, Flannelly, Larson, Stapleton, & Koenig, 2007). These results suggest that the clergy are likely to be key stakeholders in outreach efforts about mental health and illness.

Implication of the study

The study's findings make an important contribution to research on psychological help seeking. Specifically, the study provided valuable information, which will inform outreach with respect to increasing mental health utilization among Ghanaian American immigrants. The study's findings suggest that in addition to acculturation strategies, demographic variables, and cultural norms, help-seeking propensity, which is a measure of attitudes towards seeking psychological help and a person's level of commitment to religious activities, should be taken into consideration when designing or tailoring interventions for this population. Additionally, treatment providers working with Ghanaian American immigrants could assess levels of help-seeking propensity and religious commitment, as these could have an effect on engagement of clients in treatment as well. Moreover, because the population appears to be fairly religious, the clergy may be used as a referral source and perhaps be trained regarding when to refer congregants suffering with mental illness to mental health professionals. Clergy may also be trained to identify appropriate mental health professionals who can support congregants. Outreach efforts in this community can focus on assessing and educating clergy about mental health literacy.

Additionally, because previous research and the current study's findings

suggest that Ghanaian immigrant often communicate their mental health issues to their primary medical doctors, efforts to educate primary medical doctors who service these communities is advised. Outreach efforts could be made in an attempt to educate primary medical doctors about the manifestation of some mental illness in Ghanaian communities, specifically those illnesses that take the form of somatization. Additionally, primary medical doctors can be trained to assess and refer their Ghanaian patients with mental health symptoms to mental health professionals.

Limitations to the Study

Although the present study contributes to existing literature on mental health seeking of minorities within the U.S., results of the study should be interpreted with caution. A possible limitation to this study was the length of research packet. The lengthiness of the research packet could have deterred potential participants from returning research measures to the researcher, hence, affecting the potential number of participants for the study. Additionally, the lengthiness of the packet could also have affected motivation and ability to understand the assessment questions. Social desirability is also a threat within this study. The use of self-report instruments increases the chances of participants answering in a socially desirable manner. Finally, the study employed subscales to measure the independent variables rather than considering the full scales, and this may have also had an impact on the findings of the study. The use of subscales can complicate the issue of multicollinearity, which affects the results of the analysis.

Future Directions

Further studies could replicate the current study with a wider population to

compare whether results are similar. Because the study mainly examined help-seeking intention, future studies could utilize measures that actually capture help-seeking behavior rather than intention. Given the interesting results of the study, a study looking at the interaction effect of demographic variable on the measured variables could provide further insight into help seeking intention among this population. Future studies could examine actual behavior related to help-seeking for mental health regarding the various help sources utilized in this study for the same mental health issues. Future research could also examine the mental health literacy of clergy in the Ghanaian community, as well as explore the attitudes of the clergy as they relate to mental illness.

APPENDICES

Appendix A: Cover Letter

Dear Participants,

I am a Ghanaian American student at the University of Rhode Island and currently pursuing my doctoral degree in Clinical Psychology. I am conducting research for my dissertation to study mental health help-seeking behavior of Ghanaian American immigrants. The results of the study will be used to further our understanding of acculturation, attitudes toward mental health, religious commitment and help-seeking behavior of Ghanaian immigrants living in the U.S..

To participate in this study, please fill out all the enclosed questionnaires and return them by _____, in the pre-paid stamped envelope. By returning this research packet, you are indicating that you are consenting to participating in this study.

Your participation will be confidential and anonymous. I will not know who you are unless you wanted the results of the study. I will be the only person reading the responses. If you chose to participate please answer as many questions as you feel comfortable answering. Your responses to these questionnaires are very meaningful to the study.

Additionally, if you would like to be entered into a drawing for a chance to win one of three gift certificates for \$25 dollars for Amazon.com please fill out the attached form indicating your e-mail address and you will be contact if you are the winner for the drawing.

If you have any questions please do not hesitate to contact me. Once again thank you for your participation and your time. I can be contacted at University of Rhode Island, Department of Psychology, and Kingston, RI 02881.

Sincerely

Gifty Ampadu, M.A
Doctoral Student, Clinical Psychology
University of Rhode Island
gifty_ampadu@my.uri.edu
401-277-5302.

Appendix B: Informed Consent for Anonymous Research

Title of Project: The Mental Help-Seeking behavior of Ghanaian American Immigrants

Dear Participant:

You have been invited to take part in the research project described below. If you have any questions, please feel free to call Dr. Paul Florin, 401-277-5302, or Gifty Ampadu, M.A, the people mainly responsible for this study.

The purpose of this study is to learn about mental health seeking behavior of Ghanaians living in the U.S. of America. Responses to these items will be collected through paper and pen/pencil. None of the information will identify you by name and no one can know if you participated in this study. All records will be kept under lock and key and any information saved on a computer will be encrypted. Scientific reports will be based on group data and will not identify you or any individual as taking part in this project.

YOU MUST BE AT LEAST 18 YEARS OLD to be in this research project.

If you decide to take part in this study, your participation will involve filling out some paper questionnaires pertaining to acculturation, religious commitment, and attitudes toward seeking mental health services along with basic demographic questions.

The possible risks or discomforts of the study are minimal, although you may feel some embarrassment answering questions.

Although there are no direct benefits of the study, your answers will help increase the knowledge regarding help-seeking behavior of Ghanaian immigrants as it pertains to psychological services.

Your part in this study is anonymous. That means that your answers to all questions are private. No one else can know if you participated in this study and no one else can find out what your answers were. Scientific reports will be based on group data and will not identify you or any individual as being in this project.

The decision to participate in this research project is up to you. You do not have to participate and you can refuse to answer any question.

Participation in this study is not expected to be harmful or injurious to you. However, if this study causes you any injury, you should write or call Dr. Paul Florin and Gifty Ampadu, M.A at the University of Rhode Island at 401-277-5302.

If you have other concerns about this study or if you have questions about your rights as a research participant, you may contact the University of Rhode Island's Vice President for Research, 70 Lower College Road, Suite 2, URI, Kingston, RI, (401) 874-4328.

You are at least 18 years old. You have read the consent form and your questions have

been answered to your satisfaction. Your filling out the survey implies your consent to participate in this study.

Thank you,
Paul Florin, Ph.D.
Professor
Department of Psychology
University of Rhode Island

Gifty Ampadu, M.A.
Doctoral Student
Department of Psychology
University of Rhode Island

Appendix C: Demographic Sheet

Please answer this questionnaire by checking the response that describes you the most. Or please fill in the blank.

1. Gender: () Male () Female
2. Age: _____
3. Are you:
 - (1) Single (4) Widowed
 - (2) Married
 - (3) Divorced/ Separated
4. What is the highest education you have attained?
 - (1) Elementary School
 - (2) Some High School
 - (3) High School / GED
 - (4) Associates or Two-year Degree
 - (5) Some College
 - (6) Bachelors Degree or 4-year Degree
 - (7) Graduate or Professional Degree
5. How many years have you lived in the U.S.?
 - (1) Less than 1 year
 - (2) 1-2 years
 - (3) 3-5 years
 - (4) 6-10 years
 - (5) More than 11 years
6. Were you born in the U.S.? () Yes () No
7. What is your generation?
 - (1) 1st generation: I was born and educated primarily in Ghana. I live currently in America as a resident or international college/graduate student
 - (2) 1.5 generation: I was born in Ghana. When I was 12 years or older, immigrate to America and was educated primarily in the U.S.
 - (3) 2nd generation: My parents are the first generation of immigrants to the U.S..
 - (4) 3rd generation: My parents are the second generation of immigrants to the U.S..
 - (5) Other
8. In which language do you speak most often? _____

9. How confident are you in your English language ability? (Please check one):
_____ (1) —Not at all	_____ (4) —Quite a bit
_____ (2) —A little bit	_____ (5) —Extremely well
_____ (3) —Moderately	

Appendix D: Inventory of Attitudes Towards Seeking Mental Health Service

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns*, *emotional problems*, *mental troubles*, and *personal difficulties*.

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

	Disagree					Agree				
Help Seeking Propensity Subscale										
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.	0	1	2	3	4					
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.	0	1	2	3	4					
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3	4					
10. If I were to experience psychological problems, I could get professional help if I wanted to.	0	1	2	3	4					
13. It would be relatively easy for me to find the time to see a professional for psychological problems.	0	1	2	3	4					
15. I would want to get professional help if I were worried or upset for a long period of time.	0	1	2	3	4					
19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3	4					
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	0	1	2	3	4					

Indifference to Stigma Subscale

3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.	0	1	2	3	4
6. Having been mentally ill carries with it a burden of shame.	0	1	2	3	4
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.	0	1	2	3	4
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.	0	1	2	3	4
17. Having been diagnosed with a mental disorder is a blot on a person's life.	0	1	2	3	4
20. I would feel uneasy going to a professional because of what some people would think.	0	1	2	3	4
23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."	0	1	2	3	4
24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.	0	1	2	3	4

Appendix E: Multidimensional Acculturation Scale for People of African Descent

(MASPAD)

Identify the response that best reflects your agreement/disagreement to each item

1= Strongly Disagree

2= Disagree

3=Slightly Disagree

4=Slightly Agree

5= Agree

6= Strongly Agree

1. I take a great deal of pride in being a person of African ancestry (African, African American, Black Cuban, Black Brazilian, Trinidadian, Jamaican, etc.)

2. If I have children, I will give them an African naming ceremony.

3. I do not feel connected to my African heritage.

4. If I have children, I will raise them to be American first and a person of African ancestry second.

5. I was raised to maintain cultural practices that are consistent with people of African descent.

6. I have difficulty accepting ideas held by the Black community.

7. I tend to generate friendships with people from different racial and cultural backgrounds.

8. I was socialized to treat my elders with respect.

9. Everyone has an equal opportunity to be financially successful in this country.

10. I am comfortable putting on the mask in order to fit in.

11. Despite facing potential discrimination, it is important for me to maintain my cultural beliefs.

12. I have in ways that are consistent with people of African ancestry even if other cultural groups do not accept it.

13. The way that I behave in public (work, school, etc.) is different than how I behave at home.

14. I consider myself to be a spiritual person.
15. I do not take things from the Earth without giving back to it.
16. I consider myself to be a religious (Christian, Catholic, Muslim, etc.) person.
17. It is vital for me to be actively involved in the Black community.
18. The word, "communalistic" describes how I interact with other people.
19. I prefer to be around people that are not Black.
20. I participate in many social events where few Blacks are in attendance.
21. I actively support Black owned businesses.
22. People should modify many of their values to fit those of their surroundings.
23. I express different cultural values in order to fit in.
24. I was socialized to support Black owned businesses.
25. My beliefs are largely shaped by my religion (Christianity, Catholicism, Islam, etc.)
26. Most of my closest friends and past romantic partners are from a variety of different cultural groups.
27. I prefer entertainment (movies, music, plays, etc.) that highlights Black talent.
28. I buy products that are made by people of African ancestry.
29. I do not purchase products from Black owned businesses.
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30. I believe festivals maintain spiritual and physical balance in my community.
31. I perform various rituals for my departed ancestors.
32. I see no problem assimilating into other cultural values in order to be financially successful.
33. People of African descent should know about their rich history that began with the birth of humanity
34. I am actively involved in an African spiritual system.
35. Verbal agreements do no mean as much to be as written contracts do.
36. I do not own products that were made by people of African descent.
37. I use words from an African language when participating in by spiritual practices.
38. People in America should only speak English.
39. I will probably marry someone that is not Black.
40. Members of my culture should have an appreciation for African art and music.

- 41. My individual success is more important than the overall success of the Black community.
- 42. I expose myself to various forms of media (television, magazines, newspapers, internet, etc.) in order to keep up with current events that impact my community.
- 43. Blacks should not obtain reparations for being descendents of enslaved Africans since we are all reaping the benefits of slavery today.
- 44. I choose not to speak out against the injustices that impact people of African descent.
- 45. In embracing my culture, I can also recognize the dignity and humanity of other cultural groups.

Appendix F: Religious Commitment Inventory- 10

Instructions: Read each of the following statements. Use the scale to the right, CIRCLE the response that best describes how true each statement is for you.

Not at all	Somewhat	Moderately	Mostly	Totally
True of me	True of me	True of me	True of me	True of me
1	2	3	4	5

Intrapersonal Religious Commitment Subscale

1. I often read books and magazines about my faith	1	2	3	4	5
3. I spend time trying to grow in understanding of my faith	1	2	3	4	5
4. Religion is especially important to me because it answers many questions about the meaning of life.	1	2	3	4	5
5. My religious beliefs lie behind my whole approach to life.	1	2	3	4	5
7. Religious beliefs influence all my dealings in life.	1	2	3	4	5
8. It is important to me to spend periods of time in private religious thought and reflection.	1	2	3	4	5

Interpersonal Religious Commitment Subscale

2. I make financial contributions to my religious organization	1	2	3	4	5
6. I enjoy spending time with others of my religious affiliation.	1	2	3	4	5
9. I enjoy working in the activities of my religious affiliation.	1	2	3	4	5
10. I keep well informed about my local religious group and have some influence in its decisions.	1	2	3	4	5

Appendix G: General Help-Seeking Questionnaire-Vignette Version (GHSQ-V)

Please read the following vignettes and answer accompany question.

Question 1

John is 32 years old, married and works full-time. For the past 6 months, he complains that he has a difficult time relaxing and enjoying his hobbies. John constantly worries about not being able to provide for his family, completing projects at work in a timely manner, being able to please his parents, and paying bills. He avoids going out with friends and meeting new people.

If you were feeling like John, how likely is it that you would seek help from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7
j. I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no,	1	2	3	4	5	6	7

leave
blank) _____

Question 2

John is 32 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making any decisions. Even day-to-day tasks seem too much for him. John feels he will never be happy again and believes his family would be better off without him. John has been so desperate, he has been thinking of ways to end his life.

If you were feeling like John, how likely is it that you would seek help from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7
j. I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave	1	2	3	4	5	6	7

blank) _____

Question 3

John is 32 years old, and has not worked for years. He wears the same clothing in all types of weather and has left his hair grow long and untidy. He is always alone, and is often seen sitting in the park talking to himself. At times, he stands and moves his hands as if communicating with someone in nearby trees. He hardly ever drinks alcohol. He speaks carefully using uncommon and sometimes made-up words. He is polite but avoids talking with other people. At times, he accuses salesclerks of giving information about him to other people. John has asked his landlord to put extra locks on his door and to remove the television set from his room. He says spies are trying to keep him under observation because he has secret information about international computer systems, which control people through television transmitters. John's apartment is becoming increasingly dirty and filled with glass objects. John says he is using these "to receive messages from outer space."

If you were feeling like John, how likely is it that you would seek help from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)	1	2	3	4	5	6	7
b. Friend (not related to you)	1	2	3	4	5	6	7
c. Parent	1	2	3	4	5	6	7
d. Other relative/family member	1	2	3	4	5	6	7
e. Mental health professional (e.g. psychologist, social worker, counsellor)	1	2	3	4	5	6	7
f. Phone helpline (e.g. Lifeline)	1	2	3	4	5	6	7
g. Doctor/GP	1	2	3	4	5	6	7
h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	1	2	3	4	5	6	7
i. I would not seek help from anyone	1	2	3	4	5	6	7

j. I would seek help from another not listed above (please
list in the space provided, (e.g., work colleague. If no,
leave blank)_____

1 2 3 4 5 6 7

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