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EXPLORING HELP-SEEKING INTENTIONS AMONG BLACK  
AMERICAN CHURCH-GOERS

by

Krystelle Jean-Michel

A dissertation submitted to the Graduate College  
in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy  
Counselor Education and Counseling Psychology  
Western Michigan University  
August 2014

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## EXPLORING HELP-SEEKING INTENTIONS AMONG BLACK AMERICAN CHURCH-GOERS

Krystelle Jean-Michel, Ph.D.

Western Michigan University, 2014

The present study examined the strength of certain help-seeking barriers and predictor variables in predicting the help-seeking intentions of African American churchgoers. Research suggests numerous barriers impede mental health use among African Americans; however, the present study focused on help-seeking attitudes, cultural mistrust, psychological distress, self-stigma, public stigma, and perceived behavioral control (Hines-Martin, Malone, Kim, & Brown-Piper, 2003; Sullivan, Harris, Collado & Chen, 2006). The theory of planned behavior (TPB) served as a theoretical underpinning, guiding the integration of theory-based and culture-specific variables in one model. The present sample included 159 Black American churchgoers and attendees. The study's variables were each hypothesized to predict help-seeking intentions among the sample. A bivariate correlation and multivariate analysis of variance (MANOVA) provided support in constructing and testing three path models. While the path models demonstrated an overall poor fit of the data, findings from the other statistical tests partially supported the proposed hypotheses. Considering the present study is one of few to investigate the help-seeking intentions of Black American churchgoers, further exploration is warranted, and implications for research and practice are extensive.

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“Giving thanks always for all things unto God and the Father in the name of our Lord Jesus Christ” (Ephesians 5:20). “A man’s heart deviseth his way; but the Lord directeth his steps” (Proverbs 16:9).

To my father, who was not afforded this opportunity when he emigrated from Haiti 27 years ago: Thank you for your diligence, dedication, and sacrifices. Thank you for instilling the value of learning and education at an early age. I hope I have made you proud. Mom, thank you for your much needed prayers. To my stepmom, siblings, family, and friends: Thank you all for your encouraging words, laughter, and strength when I needed it most.

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## CHAPTER I

### LITERATURE REVIEW

In 2001, U.S. Surgeon General Dr. David Satcher presented a special report on mental health at the American Psychological Association Convention entitled, “Mental Health: Culture, Race, and Ethnicity” (DHHS, 2001). In his presentation, Surgeon General Satcher reported poor mental health is more prevalent among persons who are underprivileged when compared to people from affluent backgrounds. Moreover, African Americans are more likely to be labeled as a “high risk population” due to the overrepresentation of homelessness, incarceration, substance abuse, and children who are placed in foster care (DHHS, 2001). In the present study, the terms *African American* and *Black American* are used interchangeably to describe descendants of African ancestry residing in the United States. Despite the established need for mental health services, African Americans underutilize psychological services in comparison to their White counterparts (Neighbors, Musick, & Williams, 1998). Underutilization of mental health services among African Americans has spurred researchers to investigate factors that facilitate and hinder the help-seeking process within this population.

Researchers using quantitative and qualitative research methods have identified a range of barriers including socio-cultural, economic, and internal and external difficulties that impede African Americans from seeking psychological services (Sullivan, Harris, Collado & Chen, 2006; Taylor, Hardison, & Chatters, 1996). Hines-Martin, Malone, Kim, and Brown-Piper (2003) reported three broad types of barriers to help-seeking

behaviors among African Americans: (a) individual (e.g. fear, mistrust, attitudes), (b) environmental (e.g. family, peers, community), and (c) institutional (e.g. bureaucratic red tape). Similar barriers have been found by researchers investigating access to and availability of quality mental health treatment including: (a) stigma associated with seeking services (environmental), (b) mistrust of mental health professionals (individual), (c) provider diagnosis and treatment of mental disorders (institutional), and (d) beliefs that life experiences are the cause of depression (individual/environmental) (Diala et al., 2001; Hines-Martin et al., 2003; So, Gilbert, & Romero, 2005; Sullivan et al., 2006; Worthington, 1992). Another factor influencing help-seeking attitudes among African Americans is the use of alternative sources of support (Chiang et al., 2004). Of particular interest is the role of the Black church, which is endorsed as the pillar of the community, attending to African Americans' social, psychological, and religious needs (Adkison-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005).

The bulk of research examining help-seeking of mental health services among the African American population has mainly assessed help-seeking attitudes. However, the literature has identified help-seeking intentions rather than help-seeking attitudes as more closely related to actual help-seeking behavior (Fishbein & Ajzen, 2010; Wicker, 1969). The knowledge base concerning help-seeking has grown exponentially with new theory and research; however, there is a limited amount of theory-driven research. This study conceptualizes help-seeking intentions of Black American churchgoers using the theory of planned behavior (TPB). This theory served as the framework for the present study, providing the model through which the study's research question, hypotheses, and analysis were conducted.

This chapter provides a rationale for investigating the help-seeking intentions of Black American churchgoers when they are confronted with psychological distress. The literature review begins with an overview of the study of help-seeking, followed by a summary of the significance of culture within the mental health sector and its influence on perceptions of mental illness and help-seeking. This segues into a discussion of mental health disparities that highlights the difficulties African Americans encounter in access to quality mental health services. The role of religion in mental health and the importance of the Black church in responding to unmet needs of African Americans are presented next, followed by an overview of TPB. TPB provides a foundation for exploring help-seeking intentions among Black American churchgoers and serves as an organizing perspective for exploring culture specific factors influencing help-seeking behavior among African Americans. Culture specific barriers to help-seeking including stigma, mistrust, counselor preference, and psychological distress are reviewed next, followed by a summary of recent literature on help-seeking intentions. Essentially this review of literature merges conceptual perspectives from TPB with key empirical findings from literature focused on help-seeking among Blacks. TPB serves as a conceptual model helping to organize existing findings into a set of predictions concerning help-seeking intentions. The chapter closes with a summary of needed next steps, including suggestions for how to operationalize core variables and a presentation of specific research questions.

### **Help-Seeking in Mental Health Services**

Investigations of attitudes have been integral in comprehending the help-seeking process. Yet, this construct alone does not completely depict help-seeking behavior. While there are many forms of help-seeking, the present study focuses on seeking

psychological services from mental health professionals. Help-seeking research has been classified into three branches including attitudes, behaviors, and intentions (Uffelman, 2005). Help-seeking attitude studies provide an understanding of how personal and environmental characteristics relate to attitudes toward seeking mental health services (Uffelman, 2005). Research on help-seeking behavior consists of comparison studies that identify social and psychological correlates of help-seeking behavior (Brown, 1978). Help-seeking intentions research generally investigates a person's willingness to seek professional psychological services (Uffelman, 2005). Researchers posit help-seeking intentions better predict actual help-seeking behavior (Fishbein & Ajzen, 2010). However, there is a dearth of literature reflecting the relationship between the two constructs (Wilson, Deane, Ciarrochi, & Rickwood, 2005). Generally, the help-seeking literature focuses on assessing attitudes toward mental health services and professionals.

Fischer and Turner (1970) conducted ground breaking research examining attitudinal differences among people who view seeking professional help as a personal defeat, and those who are open to mental health services when facing personal issues in hopes changes will occur as a result of psychological intervention. Their research outlined four factors correlated to help-seeking attitudes including: (a) an individual's recognition of need for mental health services, (b) threat of being stigmatized, (c) willingness to disclose personal information with a professional, and (d) confidence in mental health providers (Fischer & Turner, 1970). This landmark study led to the development of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), a widely used instrument within the social sciences. After that time,

researchers were galvanized to investigate the help-seeking process, lending a deeper understanding of how and why individuals solicit mental health services.

Given the high need for mental health services in African American communities, researchers have also explored factors that influence help-seeking among Blacks. The National Survey for Black Americans (NSBA) is perhaps the most influential program of research concerning the lives of African Americans. These studies documented the lived experiences of African Americans, focusing on stressors and the strength used to overcome challenges and maintain psychological well-being (Neighbors & Jackson, 1996). The NSBA went beyond typical methods of expanding knowledge about Black Americans, which often include comparison studies conducted on White participants and lack heterogeneity within the Black population (Neighbors & Jackson, 1996). Instead, the NSBA provided a wide range of literature about African Americans by exploring stressors and coping strategies used by Black Americans with an emphasis placed on at risk groups within the Black population.

Several models have been used to examine help-seeking, however, the NSBA used a comprehensive stage model conceptualized from a “stressful episode” (Neighbors, 1991). In this framework, Neighbors (1991) posited as African Americans encounter a personal struggle during their life course, they will experience considerable distress, employ several coping strategies, and eventually return to their regular level of functioning. The NSBA data collection and analysis was rooted in this model, and sought to ascertain the use of professional helping resources among Blacks (Neighbors, 1991). The model outlined the following stages: (a) recognition of a problem, (b) decision to seek help, (c) decision to use professional services, and (d) choice of a specific

professional helper (Neighbors, 1991). NSBA was set apart from other research studies, as it sought to not only capture the process of seeking professional help for Black Americans, but also investigated the interplay of environmental stress, demographic variables, the use of professional services, and other coping strategies used by Black Americans (Neighbors, 1991; Neighbors & Jackson, 1996). In aggregate, factors influencing help-seeking behavior among Blacks are substantial. For example, one determinant that stands out in the help-seeking literature is culture. Culture appears to play a major role in many aspects of mental health among Blacks including their outlook on mental illness, help-seeking utilizations, and sources of helpers (DHHS, 2001).

### **Culture and Mental Health**

Culture consists of the beliefs, behaviors, objects, and other characteristics common to the members of a particular group or society (DHHS, 2001). Culture has an integral role in determining how one seeks help, whom they receive help from, how they define mental illness, and the coping strategies they employ when facing struggles (DHHS, 2001). Culture is believed to have an impact on one's decision to engage in any form of help-seeking, but is rather significant in the mental health setting, as it accounts for various aspects of how clients present including their description of their chief complaints and the symptoms they choose to disclose (DHHS, 2001). Furthermore, an individual's description of their symptoms is greatly influenced by culture, which may reflect the variation of somatic complaints among racial and ethnic minorities, particularly Asians, African Americans, and Latinos (DHHS, 2001; Myers et al., 2002; Snowden, 2001).

Persons who attribute their stressors to physical ailments are more likely to seek medical attention rather than mental health services (Ayalon & Young, 2005). Many African Americans minimize their stressors, as reflected in the NSBA sample. According to the NSBA study, 17% of participants reported not experiencing a serious problem in the past month or within their lifetime they could not handle (Johnson & Crowley, 1996). Although research has not yet concluded disorders are culture specific, there is evidence of differences in the expression of certain syndromes across ethnicities (DHHS, 2001; Myers et al., 2002). Specifically, the expression of depressive symptoms among African Americans most often appears cognitive-affective in nature, with an overrepresentation of anger, hostility, and anxiety in comparison to their Caucasian counterparts (Myers et al., 2002). Moreover, African Americans have a tendency to report more suspiciousness and paranoia in comparison to their Caucasian peers (Myers et al., 2002). Adkison-Bradley, Bradshaw, and Sanders' (2007) conceptual investigation of depressive symptoms among African American women revealed an inability to relax, feelings of worthlessness, being detached from own personal needs, and excessive preoccupation with the completion of tasks (p. 81).

Hines-Martin and associates (2003) presented a qualitative study, which vividly captured the difficulty of defining mental health problems among African Americans. The sample in their study expressed the need to appear "strong," resulting in minimizing their symptoms and deferred the help-seeking process. Delaying treatment often exacerbates symptoms, leading to use of emergency or crisis services when conditions seem unbearable (Bolden & Wicks, 2005). This is likely to be a detriment to African

Americans as emergency and crisis providers are not adequately trained in assessing, diagnosing, and treating mental health disorders (Bolden & Wicks, 2005; DHHS, 2001).

Aside from its influence on how a client presents and defines their symptoms, culture provides certain protective and risk factors, which influence a client's view of mental health and illness (DHHS, 2001). Risk and protective factors of mental health vary across persons and demographic features such as age, gender, and culture (DHHS, 2001). Family members within the Black community often serve as a protective factor, providing advice and comfort, merchandise and services, monetary assistances, child rearing, general help, and assistance during sickness and bereavement (Hatchett & Cochran, 1991). Hatchett and Cochran (1991) conducted a quasi-experimental study, which found over 30% of their sample between the ages of 18 and 34 years relied on family for advice and comfort during difficult times. Despite the many plights of African Americans, which include overrepresentation in homelessness, incarceration, and being victims of violence (DHHS, 2001), coping strategies substantially alter African Americans' response to stressful situations (Broman, 1996). Few researchers have delved into coping styles of racial and ethnic minorities despite the implications for mental health and illness (Broman, 1996; DHHS, 2001). Nevertheless, the examination of African American coping styles has increased over time, outlining cognitive and behavioral coping strategies as effective techniques when facing difficulties (Broman, 1996; Constantine, Donnelly, & Myers, 2002; Utsey, Adams, & Bolden, 2000).

Utsey and associates (2000) presented culture specific coping behaviors exhibited by African Americans in their daily struggles. Using an African-centered theoretical orientation, the researchers outlined four primary coping strategies among African

Americans: (a) cognitive/emotional debriefing (e.g., “Hoped things would get better with time”), (b) spiritual-centered coping (e.g., “Prayed that things would work themselves out”), (c) collective-coping (e.g., “Used a group of family or friends during stressful situations”), and (d) ritual-centered coping (e.g., “Burned incense for strength or guidance in dealing with problem”) (Utsey et al., 2000).

Coping strategies among African American adolescents has also been an area of interest. Constantine and associates (2002) conducted a quasi-experimental study, which found adolescents with increased esteem from others and themselves tend to use spiritual and collective African coping techniques to better manage their struggles. Overall, it is apparent from the results of these studies, the culture of a client greatly influences his or her outlook on mental health and illness; however, a clinician’s cultural background also has a significant impact on his or her experience in providing mental health services (DHHS, 2001).

### **Clinician Bias**

The 2001 Surgeon General’s report acknowledged the importance of a clinician’s culture, values, and biases in the therapeutic process (DHHS, 2001). Differences between the clinician and patient are significantly heightened when racial and ethnic differences are present in the therapeutic context (DHHS, 2001). Considering that mental health services are entrenched in Western culture, the implication of cultural value orientation poses a substantial barrier among ethnic minorities (DHHS, 2001; Leong & Lau, 2001). Moreover, the strong emphasis on verbal communication between the clinician and patient lends much room for miscommunication in the therapeutic setting, leading to misconstruing the patients’ complaints, misdiagnosis, and disagreement over treatment

method, and patient noncompliance (DHHS, 2001). Given that ethnic minorities encompass a burgeoning group within the population, researchers strongly encourage mental health professionals to incorporate culturally sensitive approaches when working with clients (Malgady, Rogler, & Costantino, 1987).

Beyond the therapeutic process, there is also evidence of potential clinical bias in classifying certain disorders to particular groups, most notably African Americans being disproportionately diagnosed with schizophrenia and affective disorders (Neighbors, 1991; Snowden, 2001; Strakowski et al., 1996). According to the 2001 Surgeon General's report, African Americans are nearly twice as likely to be diagnosed as schizophrenic than their non-Hispanic White counterparts (DHHS, 2001). The expression "over-diagnoses" is frequently used to describe findings with respect to African Americans and schizophrenia, while "under-diagnosis" is frequently used to refer to findings on mood disorders within this population (Neighbors, Trierweiler, Ford, & Muroff, 2003). Loring and Powell (1988) used an experimental analogue approach to validate the notion of misdiagnosing paranoid schizophrenia among African Americans in a study featuring psychiatrists presented with case descriptions wherein the patient's race and gender were manipulated. Investigators found cases depicting African American patients were more likely to be diagnosed with paranoid schizophrenia, regardless of the racial/ethnic background of the psychiatrist (Loring & Powell, 1988; Snowden, 2001; Neighbors, 1991).

An increased rate of schizophrenia diagnoses within the African American community is perceived to exacerbate the risks of ineffective treatment interventions (Barnes, 2004). Admission statistics for African Americans diagnosed with schizophrenia

at state psychiatric hospitals illustrate the seriousness of this concern (Barnes, 2004). From 1988 to 1995, the admission rates to state psychiatric hospitals among African Americans increased from 26.8% to 34.8% (Barnes 2004). Even more alarming is the juxtaposition of Black and White patients diagnosed with schizophrenia. Of the 1,825 Whites in psychiatric care, only 50.5% were diagnosed schizophrenic, while 82.8% of 442 Blacks were diagnosed with schizophrenia (Barnes, 2004). Barnes (2004) presented several factors correlating to schizophrenia diagnoses including race, gender, age, education, and prior admission in psychiatric hospital. Moreover, upon controlling for the previously listed factors, race appeared to be the most significant predictor of schizophrenic diagnosis (Barnes, 2008). Findings from the Barnes (2008) study with inpatient residents were congruent with previous research reflecting an over-diagnosis of schizophrenia among African Americans (Neighbors et al., 2003) and underdiagnoses of mood disorders (Trierweiler, Muroff, Jackson, Neighbors, & Munday, 2005). Moreover, clinicians often perceive symptoms of paranoia among ethnic/racial groups to be more severe than is warranted (Whaley, 1997).

Researchers using a survey-based quasi-experimental design found Black patients' symptoms are perceived as more severe than their White peers (Strakowski, et al., 1996). As a matter of fact, Black patients were more likely to be diagnosed with schizophrenia than with psychotic depression particularly when being rated by White providers. Strakowski and associates (1996) also reported Black patients were grossly underdiagnosed for depression, despite the fact 24% of Black patients exhibited depressive symptoms. Research on mental health disparities show African Americans are underdiagnosed with bipolar disorder, depression, and anxiety (DHHS, 2001). Despite

the paucity of information on racial and ethnic disparities of depression, there is evidence clinician bias and misdiagnosis is prevalent (Myers et al., 2002). For example, bias in clinical interpretation of depressive symptoms among African Americans and Whites was presented in a study that found White therapists to rate African American patients more negatively than White patients, even when symptoms displayed were identical (Jenkins-Hall & Sacco, 1991). Non-African American clinicians are less likely than African American clinicians to account for “situational information” such as social conditions and specific life events in diagnosing low-income African Americans (Trierweiler et al., 2005). Non-African American clinicians are also more inclined to diagnose mood disorders to low income patients than their African American counterparts (Trierweiler et al., 2005).

Further research shows clinician bias in diagnosing and treating mental health disorders significantly influences help-seeking among African Americans (Diala et al., 2000). Ethnic minorities perceive prejudice and lack of cultural competency within the health care system more than their White counterparts (Johnson et al., 2004). Members of underrepresented groups, specifically African Americans, Asians, and Hispanics believe they would receive a better quality of care if they belonged to a different race/ethnic group (Johnson et al., 2004). Ethnic minorities further perceived medical practitioners lacked respect and dignity for them based on their racial/ethnic background (Johnson et al., 2004). A committee investigating health care disparities found differences were still present when insurance status, age, and income were taken into account (Nelson, 2002). Nelson (2002) conceptually outlined how bias, stereotyping, prejudice, and provider uncertainty may contribute to racial/ethnic disparities in help-seeking.

Researchers posit the overwhelming ambiguity of diagnosing promotes clinician bias and stereotyping of patients based on racial/ethnic background (DHHS, 2001; Neighbors et al., 2003). Whether clinician bias is conscious or unconscious is debatable (DHHS, 2001). However, given the significance of race in the United States and within educational institutions, ignoring the interplay of race in healthcare settings is unacceptable (Neighbors et al., 2003). While racial/ethnic disparities in help-seeking cannot be wholly attributed to clinician bias, mental health professionals are urged to examine their own cultural identification as well the racial identities of other groups (Dana, 2002). Clinician bias in assessment and diagnosis are obviously present in mental health services. Researchers also document differences in access, availability, utilization rates, quality of care, therapy, and intervention (Dana, 2002).

### **Mental Health Disparities**

To fully comprehend difficulties of the Black American experience with access and availability to mental health services, an overview of their unmet needs is warranted. African Americans continue to face socioeconomic displacement due to past inequities such as slavery, Jim Crow laws, and discriminatory practices within health and educational intuitions (Dana, 2002; DHHS, 2001). Disparities in socioeconomic status (SES) are strongly associated with mental health concerns. A correlation between low SES and high risk for mental illness has been replicated in social science research for the past seven decades (DHHS, 2001; Faris & Dunham 1939; Hudson, 2005). The large population of Black Americans residing in southern states, particularly in impoverished rural communities, has received much needed attention in the mental health sector (DHHS, 2001; Logan, 2007). Logan (2007) reported on the hardships of African

Americans residing in impoverished rural districts in South Carolina. Many in her study were facing low paying jobs, unemployment, and a host of structural and financial barriers to mental health services. Understanding poverty stricken neighborhoods is believed to be central in comprehending racial/ethnic differences in utilization rates of mental health services (Chow, Jaffee, & Snowden, 2003).

The literature concerning unmet mental health needs among African Americans reflects extensive sampling from elderly, college student, substance abuse, and female African American communities. Older African Americans display higher rates of cognitive impairments in comparison to their younger counterparts (DHHS, 2001). Aside from a growing need for medical care among the aging population, their psychiatric needs are also increasing. In particular, the mental health needs of elderly public housing residents are unmet (Black, Rabins, German, McGuire, & Roca, 1997). Black and associates (1997) quantitatively examined a program intervention among a predominantly African American sample, and found those who were in need of mental health services had not received any care in the past 6 months. Such findings suggest elderly African Americans rely on specialists to meet their needs as opposed to informal resources such as family and friends. Researchers have also found African American elders with mental health disorders are disproportionately less likely to receive mental health services compared to their White counterparts (Neighbors, Woodward, Bullard, Ford & Taylor, 2008). Specifically, Neighbors and associates (2008) examined data from a national survey among African Americans aged 55 and older and found underutilization of mental health services for participants diagnosed with one or more psychological disorder.

Determining the unmet health mental needs of African Americans could help improve overall access to quality mental health care (Black et al., 1997).

In examining unmet mental health needs among students, Hyun, Quinn, Madon, and Lustig (2007) found 44% of the international graduate students in their study acknowledged emotional stressors had a considerable impact on their welfare or scholastic performance. In general, these students' needs included help with mental/emotional stressors, acculturation adjustments, trouble with language, and lack of social support (Hyun et al., 2007). Although perceived need and unmet need may have various definitions, stakeholders are urged to prioritize mental health service among students (Zivin et al., 2009). Furthermore, outreach seems to be central in student utilization rates. Students may be more inclined to use services when facing hardships if they are aware of services. With the surge of international students pursuing advance degrees in the United States (Hyun et al., 2007), the need for culturally competent professionals is essential in providing culturally sensitive and appropriate care (Kuo & Kavanagh, 1994).

The need for more appropriate care is also apparent among substance abuse and other vulnerable populations. Wells, Klap, Koike, and Sherbourne (2001) found ethnic minorities were less likely than their White counterparts to receive treatment for substance abuse and possible co-occurring psychological disorders, and noted the gap between African Americans and Whites is also significant in terms of continuity of care. Moreover, mandated referrals by judicial institutions are more prevalent among Blacks in comparison to Whites, particularly in impoverished communities (Chow et al., 2003). Outside of judicial institutions, Blacks are more likely to be referred for mental health

services through social services. And, due to the overrepresentation of African Americans among the homeless and the incarcerated, it is likely many who are severely mentally ill go undiagnosed within these epidemiological samples, or unrepresented among those receiving mental health services (Mojtabai et al., 2009).

A national survey assessing quality of care for depressive and anxiety disorders among a predominantly White sample found Blacks with major depressive disorder, anxiety, and co-morbid disorders to be “high risk” for receiving ineffective treatment (Young, Klap, Sherbourne, & Wells, 2001). Additionally, Blacks receiving subpar treatment predominantly frequented primary care settings where mental health issues were not evaluated (Young et al., 2001). Studies of ethnic differences in utilization rates commonly sample from predominantly White, young, college undergraduates. In this context, students with unmet mental health needs were oblivious to university services afforded to them (Eisenberg, Golberstein, & Gollust, 2007). Student mental health needs included depression, anxiety, eating disorders, self-injury, and suicidal ideation (Zivin et al., 2009). Moreover, students were skeptical of pharmacological and psychological treatment of depression (Eisenberg et al., 2007). African Americans students are particularly distrustful of service providers and the mental health system (Duncan, 2003; Nickerson, Helms, & Terrell, 1994; Terrell & Terrell, 1981), tending to rely on familial support during hardships (Chiang et al., 2004).

Despite the increased need for mental health care among African American women, data on mental disorders for this population are relatively sparse (Brown & Keith, 2003). Researchers summarized data from national studies, finding African American women had the highest rate of schizophrenia, generalized anxiety disorder,

somatic complaints, and phobia when compared to African American males and Whites (Brown & Keith, 2003). African American women are frequently reported survivors of rape, domestic violence, and other violent offenses (Belgrave & Allison, 2006, p. 343). Adkison-Bradley, Bradshaw, and Sanders (2007) conceptually explored emotional experiences and the interplay of depression of African American women through historical and contemporary portrayals. Mays, Caldwell, and Jackson (1996) found unmet mental health needs among a sample of African American woman with adjustment, financial, health, and emotional problems. Incarcerated African American women face the challenge of reintegrating into society as they struggle with access to shelter, employment, educational opportunities, and mental health services. African American women are susceptible to substance use, gang violence, HIV/AIDS, and mental health disorders due to psychosocial factors (Waggoner & Brinson, 2007). A review of the literature reflects a dearth of longitudinal studies extensively examining mental health and illness among African American women.

Thus far, the present chapter has reviewed the interplay of culture within the mental health sector specifically in client and counselor relations. Culture influences an individual's understanding of mental health, mental illness, and use of mental health services (DHHS, 2001). Moreover, cultural bias on the part of clinicians has a significant impact on the assessment, diagnosis, and treatment of mental illness among the greater population (DHHS, 2001). Disparities in diagnosing and treating mental illness greatly influence help-seeking attitudes and behaviors within the African American community. Consequently, the need for quality mental health services continues to grow among

African Americans. A review of availability and access to mental health services among African Americans is presented below.

### **Availability and Access to Mental Health Services**

The overrepresentation of African Americans among high needs groups (DHHS, 2001) suggests availability and access to care is limited. Snowden, Masland, Ma, and Ciemen (2006) conducted interviews with ethnic program specialists to ascertain strategies to effectively minimize the access gap to mental health services among ethnic minorities. African Americans are disproportionately impeded by financial and environmental barriers to quality mental health services (DHHS, 2001; Hines-Martin et al., 2003). Safety net care providers are able to offset some obstacles for underserved populations, as they provide comprehensive care to low-income, uninsured groups by facilitating availability and access to medical care (Rosenbaum & Shin, 2003). Safety net providers are scarce however. Even with great effort, they lack the resources and funding to provide quality care to patrons (Chow et al., 2003).

As for mental health services, community mental health centers (CMHC) appear to be a practical resource for economically disadvantaged individuals, however, accessibility to these services are limited (DHHS, 2001; Hartley, Bird, Lambert, & Coffin, 2002; Lewin & Altman, 2000). Moreover, persons seeking services at CMHCs may not receive treatment due to lack of availability of services or remaining on extended waiting lists for care (Hartley et al., 2002). Impoverished minority neighborhoods are often limited in resources needed to maintain community services, further influencing help-seeking attitudes and behaviors (Chow et al., 2003). Other institutional barriers to mental health care among African Americans include time spent waiting to be accepted

into facilities, limited acceptance, and the imbalance of greater need versus resources (Hines-Martin et al., 2003).

Access and availability are central concerns to quality mental health care within the general population (Logan, 2007), and in the case of Black Americans, lack of access and availability significantly impedes help-seeking. Research links access to and availability of quality mental health services to utilization rates among ethnic minorities (Alvidrez, 1999). African Americans are likely to receive care from primary care professionals and emergency/crisis treatment (Bolden & Wicks, 2005). These venues tend to provide inferior mental health care and limited referrals to mental health professionals, which diminishes mental health treatment outcomes (Bolden & Wicks, 2005). Mental health disorders are likely to go undetected or misdiagnosed due to lack of training on the part of providers (Bolden & Wicks, 2005). Moreover, emergency care does not endorse continuity of care, is limited in treatments, and may not thoroughly evaluate mental health issues (DHHS, 2001; Snowden, Masland, Libby, Wallace, & Fawley, 2008).

Limitations in mental health care is also a concern among ethnic minority youth, as children from minority families had minimal access to services for ADHD treatment, even when lack of insurance and poverty were manipulated in a Bussing, Schoenberg, and Perwien (1998) study. African American children residing in California overwhelmingly used psychiatric emergency departments as an initial point of entry into mental health services (Snowden et al., 2008). Given the limitations in mental health care for African Americans, and African American children in particular, further exploration

of better access to outpatient mental health services in order to minimize emergency and crisis services is warranted (Snowden et al., 2008).

### **Factors Influencing Utilization**

Age, gender, marital status, and race/ethnicity are consistent predictors of mental health service use among African Americans (Roy-Bryne, Joesch, Wang, & Kessler, 2009). African American males in particular have the most use and longest length of stay in crisis/emergency departments (Bolden & Wicks, 2005; Chow et al., 2003). The complexities of mental health service use are also evident outside of the United States, as more Blacks residing in the United Kingdom use crisis services as an entry point of services (Bhui et al., 2003). African Americans postpone seeking medical services, which greatly affects their condition. This is also present in the mental health sector, which reports that Black men present for therapy only when their issues seem unmanageable (Duncan, 2003; Warfield & Marion, 1985).

Interestingly, some studies find the help-seeking behavior of mental health services is greater among African American youngsters than White youngsters (Chow et al., 2003). African American children living in California exhibited greater use of crisis care, and were also more likely to use such services repeatedly (Snowden et al., 2008). Referrals appear to be a factor in help-seeking behavior, as Blacks are less likely to be referred to mental health care by self, family, or friends, and more likely to be referred by social services and the judicial system in comparison to Whites (Chow et al., 2003). In addition to the many unmet needs of minority children with special health care needs, girls are also less likely to be referred for mental health care in comparison to their male counterparts (Ngui & Flores, 2007). The tremendous mental health disparities among

Black adolescents and adults warrants educating parents and children on mental health services in order to minimize the gap between Black and White Americans (Flisher et al., 1997).

Hu, Snowden, Jerrell, and Nguyen (1991) analyzed data for Asian, Black, White, and Hispanic Americans from the management information systems of San Francisco and Santa Clara counties in California. The researchers reported a continuing concern for Blacks who have a low likelihood of using case management and outpatient services in comparison to Whites and other minority groups (Hu et al., 1991). The use of such services promotes continuing care and assistance to patrons by providing ongoing assistance with housing, employment, and accessing community resources (Hu et al., 1991). Racial/ethnic disparities are also ubiquitous in psychiatric institutionalization, as Blacks and Native Americans are disproportionately more likely to be admitted in hospitals than Whites (Snowden & Cheung, 1990).

Mays, Caldwell, and Jackson (1996) found an association between severity of problem and the use of professional mental health services among African American women. In a sample of Black women, researchers found only 15% engaged in help-seeking behavior, 10% sought help from the private sector, and 5% used community mental health centers (CMHC) (Caldwell, 1996). Self-identified religious African American women reported using faith-based resources such as ministers, church associations, or church members when facing personal struggles (Mays et al., 1996). According to the 2001 Surgeon General's report, religious and spirituality beliefs are historically embedded within the African American culture (DHHS, 2001). Despite the centrality of religious and spiritual practices within the African American culture, little is

known about how such beliefs impact help-seeking attitudes and behaviors of African Americans toward mental health services and professionals.

### **Religion and Mental Health**

The terms *religion* and *spirituality* are often used interchangeably, however, the literature reflects a distinction between the two constructs (Zinnbauer et al., 1997; Evans, 2002). Religion is related to “higher levels of authoritarianism, religious orthodoxy, intrinsic religiousness, parental religious attendance, self-righteousness, and church attendance” (Zinnbauer et al., 1997). While spirituality was connected to “mystical experiences, New Age beliefs and practices, higher income, and the experience of being hurt by clergy” (Zinnbauer et al., 1997). Mental health professionals will likely encounter a diverse group of people affiliated with various religious and spiritual practices (Keller, 2000). Professionals must be prepared to address client spiritual and religious concerns in the counseling process as part of being a culturally competent provider (Constantine, Lewis, Conner, & Sanchez, 2000).

Religious and spiritual competency among clinicians appears to be vital in the counseling process, particularly for African Americans, as researchers have found clients with religious and spiritual beliefs are apprehensive in discussing their faith with secular therapists for fear of being misunderstood (Mayers, Leavey, Villianatou, & Barker, 2007). Yet, individuals engaged in counseling rely on their religious and spiritual values as a coping strategy before they enter therapy, and even during the therapeutic process (Mayers et al., 2007). Nearly 84% of Americans report an affiliation to various religious traditions and denominations (Pewforum, 2007). Black Americans are more likely to endorse a formal religious association in comparison to all other major racial and ethnic

groups in the United States (Pewforum, 2007). Researchers have concluded religion and spirituality is interlaced in the lives of African Americans, influencing interpersonal interactions, employment, educational, and political decisions (Belgrave & Allison, 2006). Religious and spiritual beliefs of African Americans promote psychological well-being, and serve as a significant coping strategy (Belgrave & Allison, 2006). Mental health professionals have acknowledged the significance of religion and spirituality in African American communities; yet, little is known about the most effective ways to integrate religious practices into the counseling process to better serve Black clients (Bradley et al., 2005).

Findings from a national study revealed significant differences among Black and White individual's attitudes regarding religious coping, with higher approval ratings among Blacks (Chatters, Taylor, Jackson, & Lincoln, 2008). African Americans and Caribbean Blacks were more likely to acknowledge the use of religious coping when encountering stressful episodes and health related problems in comparison to their non-Hispanic White counterparts (Chatters et al., 2008). Cunningham (1984) found individuals who identify as religiously oriented were found to be less stressed than their non-religiously oriented counterparts; this was particularly significant among elderly Blacks. A qualitative study by Morris (2006) identified several rationales for the use of prayer as a coping mechanism among African American women. More specifically, participants reported that prayer "is a necessary part of life" that consists of praying for oneself, family, others, and praying for peace and direction. Researchers continue to gain awareness of religious coping among persons with mental health issues within the mental health and medical sector.

Coleman (2004) found a significant negative correlation between higher religious well-being and lower depression among a sample of African American heterosexuals with HIV infection. Tepper, Rogers, Coleman, and Maloney (2001) conducted a quasi-experimental study investigating the prevalence of religious coping among individuals with mental illness within a predominantly White sample consisting of Hispanic, Asian, and African Americans. The researchers suggested integrating religious practices within psychological and psychiatric treatment, as they found engaging in religious activities to be associated with decreased symptomology among severely mentally ill individuals (Tepper et al., 2001). Religious coping strategies often include the following activities: prayer, attending religious services, worshipping God, meditation, reading scriptures, and meeting with a spiritual leader (Tepper et al., 2001). Tepper and associates (2001) reported 65% of individuals who were diagnosed with mental illness used religious coping to better manage mental illness especially when symptoms worsened.

Ellison, Boardman, Williams, and Jackson (2001) also found an inverse association between religious services and psychological distress among a predominantly African American sample. In this study, an increase of religious involvement led to a reduction in stressors. The researchers also found more prayer diminished psychological stressors among adults residing in the city of Detroit and neighboring counties (Ellison et al., 2001). Moreover, research shows Blacks report higher levels of religious involvement including attending church services in comparison to their White counterparts (Taylor, Chatters, Jayakody, & Levin, 1996). Lincoln and Mamiya (1990) eloquently stated, “Much of Black culture was forged in the heart of Black religion and the Black church”

(p. 10). Accordingly, religion appears to be a notable resource for mental health in the African American community.

### **The Black Church**

The Black church is documented as one of the most influential and established institutions within the African American community (Chatters et al., 2002). Despite the prominence of religion for Blacks, few researchers have examined the role and function of the Black church with respect to psychological well-being, mental health concerns, or help-seeking. An examination of the Black church as a form of social support for African Americans follows.

Many have sought to define Black religion, classifying it as an abnormal effort to emulate White culture (Lincoln, 1979). However, such trite conceptions prove they know little about religion, and even less about the Black person's expression of faith (Lincoln, 1974; Lincoln & Mamiya, 1990). Lincoln and Mamiya (1990) described the Black church as a foundation in which Black Christian individuals are worshippers within a primarily Black congregation. The Black church has seven historical denominations: the African Methodist Episcopal (AME) Church; the African Methodist Episcopal Zion (AMEZ) Church; the Christian Methodist Episcopal (CME) Church; the National Baptist Convention, USA, Incorporated (NBC); the National Baptist Convention of America, Unincorporated (NBCA); the Progressive National Baptist Convention (PNBC); and the Church of God in Christ (COGIC) (Lincoln & Mamiya, 1990). The Black church continues to provide strength and hope within its communities; striving to meet the educational, social, economic, religious, spiritual, and psychological well-being of Black Americans (Boyd-Franklin, 2010; Cook & Wiley, 2000). Traditionally, the Black church

has served as a safe haven for Blacks during hardships (e.g., slavery, segregation, discrimination, oppression), and continues to have a positive influence within African American communities providing agency and a sense of self-worth and dignity for many (Bradley et al., 2005).

In a conceptual based report, Bradley and associates (2005) acknowledged the significance of the Black church within African American communities, and provided suggestions for counseling professionals in forging a relationship with Black church leaders. In addition, Black clergy have recognized the importance of psychological well-being and have subsequently added mental health and counseling services to their organization (Belgrave & Allison, 2006). McRae, Thompson, and Cooper (1999) used focus groups to examine how the Black church serves as a therapeutic mechanism among a sample of African Americans. These researchers assert the Black church operates as a therapeutic group by offering a constructive environment in which members are able to openly express their thoughts, feelings, and emotions (McRae et al., 1999). Church members are able to congregate and form a cohesive unit through “prayer, music, sermons, fellowship, and meditation” (McRae et al., 1999).

### **The Black Church as a Resource**

The Black church is a well-established organization with African American communities, serving the unmet health and mental health needs of its congregants through community outreach programs (Thomas, Quinn, Billingsley, & Caldwell, 1994). Investigators have found Black churches in the south offer significantly more programs than White churches for adults and children in the areas of marital counseling, alcohol and substance use, sex education, domestic violence, and sexual assault counseling

(Blank, Mahmood, Fox, & Guterbock, 2002). Similarly, Rubin, Billingsley, and Caldwell (1994) surveyed 635 Northern Black churches to examine church based programs that cater to youth within African American communities. They reported Black churches provide numerous services for adolescents including counseling, group discussions, seminars, and workshops (Rubin et al., 1994). Researchers also posit the Black church is an ideal context to provide interventions for depression and suicide prevention, as African Americans are less likely to experience stigma and cultural mistrust, which is often reported when seeking help through other community facilities (Molock, Matlin, Barksdale, Puril, & Lyles, 2008). Neighbors, Musick, and Williams (1998) found Black Americans encountering issues with death, grief, and loss are more likely to seek assistance from clergy, and that they are unlikely to seek help from other professionals when clergy is the first point of contact.

The Black church serves as a social welfare organization meeting the medical, mental health, and social needs of members (Levin, 1984; Taylor, Thornton, & Chatters, 1987). Traditionally, public health and medical professionals have used the Black church as a place to connect with African Americans with limited access to quality care (Thomas et al., 1994). Considering the multitude of barriers to mental health services among Blacks and the prevalence of the Black church within the African American community, it would behoove mental health practitioners to form an alliance with clergy to minimize gaps in the mental health system. Strategies for developing a collaborative relationship are beyond the scope of this study, however, mental health professionals are urged to acknowledge the pivotal role of Black church in providing mental health services and serving as gatekeepers to the mental health service system (Taylor, Ellison, Chatters,

Levin, & Lincoln, 2000). By recognizing the significance of the Black church among African Americans, mental health practitioners will go a long way in minimizing the disconnect, mistrust, and stigma attached to seeking psychological services.

In summary, several variables predict help-seeking behavior among African Americans including age, gender, education, SES, and marital status. There is clear evidence of great need for professional psychological services within the African American community. The literature suggests the Black church serves as a prominent mental health resource among Black Americans. This reflects the positive influence of the church in the lives of Black Americans. However, this may pose as a problem if church leaders are not trained to manage severe emotional and psychological disorders (Taylor et al., 2000). In addition, mental health professionals who miss the spiritual and religious aspects of clients in therapy may be just as problematic (Constantine, Lewis, Conner, & Sanchez, 2000).

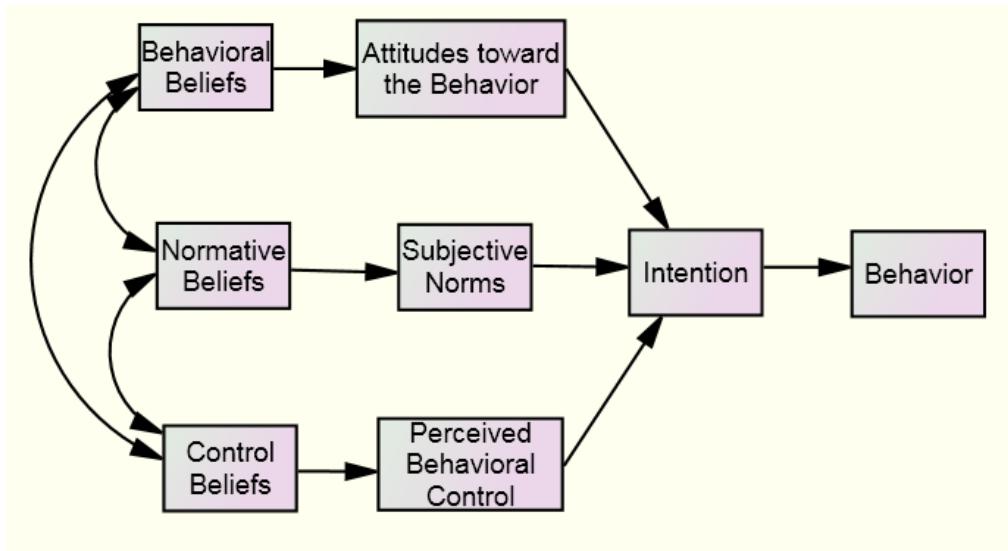
In reconciling these ideas, Bradley and associates (2005) strongly encourage mental health professionals to collaborate with Black church leaders in order to better meet client needs. A review of the help-seeking literature reflects several constructs that are related, including attitudes, culture, race, religion, access and availability care. Past literature has provided a wealth of information but has mainly focused on measuring help-seeking attitudes. The current study draws from the theory of planned behavior to examine predictors of help-seeking intentions among Black American churchgoers. Intentions are believed to be a direct antecedent of behavior (Fishbein & Ajzen, 2010), whereas attitudes operate more indirectly. In this study, help-seeking intention refers to an individual's willingness to engage in seeking mental health services.

### **Theory of Planned Behavior**

For African Americans, there are a number of barriers to developing positive attitudes toward seeking help from mental health professionals. When African Americans do seek help for mental health concerns, they are more likely to encounter the least effective aspects of the health care system (e.g., hospitalization, misdiagnosis, cultural bias, and subpar treatment). There is, however, a long history of gaining help from within the faith community. This help has advantages such as fewer stigmas associated with seeking help, less distrust of the provider, and culture specific interventions that embody religious values. However, this form of help-seeking likely lacks the level of sophisticated mental health knowledge to be wholly effective, particularly for more severe mental health concerns.

Putting the above ideas together highlights the potential complexity of the relationship between help-seeking attitudes and help-seeking behaviors. Although there has been a long standing correlation between help-seeking attitudes and behaviors, scholars in the field of social psychology have increasingly emphasized the indirect relationship between attitudes and behaviors, highlighting the importance of understanding intentions as a critical intermediate variable. Research on help seeking intentions is sparse, however, particularly for African Americans. Moreover, given the many environmental and demographic variables that influence help-seeking, it seems helpful to use a theory to conceptualize the complexity of the help-seeking process. Applying the theory of planned behavior to help-seeking intentions among African Americans is useful in expanding what is currently known about help-seeking behavior within this population.

Icek Ajzen introduced the theory of planned behavior (TPB) as an extension of the theory of reasoned action. TPB includes an additional factor called perceived behavioral control, which works in the model to predict intention and behavior of a designated action (Ajzen, 1991; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 2010). Figure 1 depicts TPB and its associated factors.



*Figure 1.* Theory of planned behavior (Ajzen, 2006).

According to TPB, human behavior is directed by three overarching concepts: (a) behavioral beliefs, (b) normative beliefs, and (c) control beliefs (Fishbein & Ajzen, 2010). Behavioral beliefs involve perceptions an individual maintains about likely outcomes and an evaluation of the consequences of executing the action (Ajzen, 1991). These beliefs elicit either positive or negative attitudes toward the designated behavior; essentially, behavioral beliefs translate to attitudes toward the behavior in the model. The individual's belief that performing a behavior will lead to a desired outcome shapes his or her attitude toward the behavior. This concept within the theory does not focus on attitudes toward objects, persons, or institutions, however. Its sole focus is attitudes

toward a particular behavior (Ajzen & Fishbein, 1980). Attitude has received significant concentration with respect to its relationship with behavior in the mental health sector (Ajzen, 1991).

Normative beliefs stem from perceived expectations of others and represent subjective norms in the model. Essentially, a subjective norm is perceived peer pressure an individual internalizes from persons around them. Individuals attempting a certain behavior are likely to take into account (a) beliefs that people around them maintain about the action, (b) expert's perception of the behavior, and (c) their own level of motivation to comply with people around them.

Control beliefs entail perceived factors that enable or hinder the performance of a particular action. Perceived behavioral control is often likened to Bandura's self-efficacy concept, and is the newly added variable that forms TPB (Fishbein & Ajzen, 2010). Perceived behavioral control is derived from control beliefs, and involves an individual's belief in his or her ability to execute the intended behavior. In the development of TRA, it was assumed people have volitional control over the behavior of interest. Since the introduction of perceived behavioral control in TPB, performance of an action is believed to be influenced by environmental factors that facilitate or hinder one's ability to complete an action (Ajzen, 2006).

Researchers posit that attitudes, subjective norms, and perceived behavioral control direct one's intentions and behaviors (Fishbein & Ajzen, 2010). Generally, if the attitude and subjective norms are positive, the perceived behavioral control will be increased and the individual's intention to fulfill the behavior will also increase (Ajzen, 2006). The stronger an individual's intention to perform an act, the greater the likelihood

that the behavior will be performed (Fishbein & Ajzen, 2010). While TPB does not encompass external variables that influence help-seeking behavior, the authors acknowledged the significance of contextual factors that have an impact on an individual's belief about a behavior (Fishbein & Ajzen, 2010). The integration of external variables seems particularly meaningful in the present study because the existing literature suggests a number of factors such as cultural mistrust, stigma, counselor preference, and psychological distress have a considerable, if not damning, influence on help-seeking behavior among Black Americans. It seems only necessary to investigate culture-specific factors and other demographic features in the help-seeking behavior of Black Americans. The following sections discuss common barriers to help-seeking identified in the literature with an emphasis on stigma, cultural mistrust, counselor preference, and psychological distress.

### **Help-Seeking Barriers**

Although the Black American experience has been plagued with oppression and degradation, it is also marked by resiliency and adaptability which has allowed many to triumph over adversities (DHHS, 2001). Black Americans have exhibited upward mobility in social, educational, and economical achievements; however, when considered collectively, African Americans are relatively financially poor (DHHS, 2001; Snowden, 2001). Between 2004 and 2005 poverty rates among African Americans remained relatively unchanged at 25%; however, there was a decrease in poverty among European Americans from 8.7% to 8.3% in 2005 (U.S. Census Bureau, 2005). In 2009, approximately 18% of Black families were living below the federal poverty line in comparison to 7% of White families (Statistical Abstract of the United States, 2009).

While census data reflects a decline in poverty within predominantly African American neighborhoods, African American homeowners face 35% more home depreciation in comparison to their White peers (Belgrave & Allison, 2006). Limited economic resources translates to minimal financial cushion to bear the brunt of social, legal, or health-related hardships that are often associated with mental illness (DHHS, 2001).

Researchers have identified numerous barriers in help-seeking among African Americans, most notably structural or institutional obstacles (Hines-Martin et al., 2003). Poverty stricken populations often do not have insurance coverage or have limited insurance needed for specialty care including mental health services (Wu et al., 2003). While poverty may limit access to specialty care, impoverished individuals are not at a complete disadvantage because they may qualify for Medicaid, which is the single largest funding source for mental health care in America (Snowden, 2001). Another factor that is particularly salient in help-seeking behavior among African Americans is stigma associated with mental illness and seeking professional psychological services (DHHS, 2001). Stigma is believed to be the most significant stumbling block in help-seeking behavior (Mann & Himelein, 2004), particularly among Black Americans (DHHS, 2001).

Alvidrez, Snowden, and Kaiser (2008) used qualitative research methods to conduct interviews with 34 Black volunteers receiving mental health services. Interviewees (62%) expressed that they avoided mental health treatment despite being in need because they were afraid of being mocked and judged by others (Alvidrez et al., 2008). To the contrary, Ward and Heidrich (2009) conducted a survey-based quasi-experimental research study, which found 83% of African American women endorsed being comfortable talking with health care professionals. In this sample, these researchers

found 60% of African Americans women reported they would not be embarrassed if their friends were aware of them seeking help (Ward & Heidrich, 2009). In reconciling such polar findings, the present study hopes to distinguish the association between stigma and help-seeking intentions by examining the impact of stigma. Corrigan (2004) conceptually outlined a distinction between two types of stigma, public and self-stigma as it relates to mental health, which will be reviewed. This will be the first study to examine the magnitude of both public and self-stigma in help-seeking intentions among Black Americans.

### **Public Stigma**

Corrigan (2004) defined public stigma as unfavorable cognitions, feelings, and attitudes maintained by the general public about persons with mental illness. Public stigma may be manifested through stereotypes, prejudice, and discrimination, which prove to be harmful to individuals with mental disorders (Corrigan, 2004). Persons with mental illness are likely to be discriminated against in various arenas including employment, housing, health care, education, and the judicial system (Corrigan, 2004). Participants sampled in Australia endorsed fewer stigmas about receiving help for depression from general practitioners (Barney, Griffiths, Jorm, & Christensen, 2006), which resonates with the overrepresentation of Blacks who seek help from primary care settings often receiving poor quality mental health care. In a data-based quantitative study, Vogel, Wade, and Hackler (2007) found that perceptions of public stigma influence the experience of self-stigma, which has an impact on help-seeking attitudes and subsequently affects help-seeking intentions. Similarly, Bathje and Pryor (2011) measured components of public stigma (i.e., stigma awareness and endorsement of public

stigma) finding a strong relationship to self-stigma which was associated with help-seeking behavior. Researchers have also found high levels of perceived public stigma and discrimination among Europeans diagnosed with bipolar disorder and depression (Brohan, Gauci, Sartorius, & Thornicroft, 2010).

### **Self-Stigma**

Individuals with mental illness may internalize stigma associated with disorders, experiencing significant reduction in self-worth, confidence, and efficacy (Corrigan, 2004). Researchers suggest helping individuals with mental illness build their self-esteem because many people experience discriminatory and oppressive practices as personal failures (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Persons with mental illness are likely to internalize stigma along three broad levels including stereotype, prejudice, and discrimination (Corrigan, 2004). Individuals with severe mental illness do not commonly find success in employment and independent living, which greatly influences self-efficacy (Corrigan, 2004). Individuals with high levels of self-stigma will likely endorse thoughts such as: “I would not feel good about myself if I went to a counselor for mental health services.”

Hobson’s thesis (2008) noted a significant association between self-stigma and help-seeking attitudes and intentions within the college student population. Researchers reported that self-stigma is significantly related to unfavorable attitudes and intentions to help-seeking for depression from helpers: general practitioners, counselors, psychologists, psychiatrists, and complementary practitioners (Barney et al., 2006). Researchers found that self-stigma is a primary factor in the decision making process of seeking help (Vogel, Wade, & Haake, 2006). Self-stigma associated with seeking

professional services appears to be the most predictive variable of help-seeking behavior when compared to public stigma associated with mental health services, disclosure of personal information to psychological professionals, and help-seeking attitudes toward mental health services (Vogel et al., 2006). The potential pervasive impact of self-stigma is reflected in research indicating 22% of participants with bipolar disorder and depression acknowledged moderate to significant levels of self-stigma across 13 European countries (Brohan et al., 2010). Corrigan (2004), who has greatly contributed to literature in the area of stigma and mental health care, also acknowledged limitations in previous research suggesting that more clarification is needed to determine how much public versus self-stigma influences help-seeking behaviors within African Americans.

### **Cultural Mistrust**

Cultural mistrust is a significant barrier in the use of mental health services within the African American community. Terrell and Terrell (1981) have extensively studied cultural mistrust and developed the most widely used instrument measuring the construct, referred to as the Cultural Mistrust Inventory (CMI). Cultural mistrust entails a general distrust of Whites maintained by Blacks, which is most evident across four major sectors: (a) education and training, (b) employment and work, (c) interpersonal interactions, and (d) politics and law (Terrell & Terrell, 1981). Using the CMI, researchers have also identified cultural mistrust as one of the most reliable and powerful predictors of help-seeking among African Americans college students (Nickerson, Helms, & Terrell, 1994).

Despite great effort to minimize help-seeking disparities among mental health professionals, centuries of racism and discriminatory practices in science, research, and medicine continue to haunt those victimized by “helpers.” Researchers coined the term

*healthy cultural skepticism* to explain the African American cultural reaction to years of racial discrimination and subjugation (Whaley, 2001). Clinical trial studies such as the Tuskegee syphilis experiment have led to a general mistrust of European Americans within African American communities (Zekeri & Habtemariam, 2006). Fear and distrust of the medical community are identified as primary barriers to participation in clinical trial studies among African American subjects (Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999). In addition, race has been significantly associated with higher levels of distrust. Investigators found 46% of African American participants were likely to believe that physicians would expose them to unwarranted harm, compared to 35% of White respondents (Corbie-Smith, Thomas, & St. George, 2002). Investigators also reported 79% of African American participants believed they would be used as guinea pigs without their full consent, in comparison to 52% of their White counterparts (Corbie-Smith et al., 2002).

Distrust is also ubiquitous in the mental health sector and significantly contributes to diminished help-seeking attitudes and behaviors (Duncan, 2003, Terrell & Terrell, 1984; Whaley, 2001). The interplay of cultural mistrust in the counseling process has been well documented. African Americans reported higher levels of mistrust of Caucasian counselors, and endorsed overall negative attitudes toward seeking help from agencies primarily staffed by European American counselors (Nickerson et al., 1994; Watkins, Terrell, Miller, & Terrell, 1989). African Americans often have lower expectations of European American therapists, and feel therapy will not cure their ailments (Terrell & Terrell, 1981). Investigators found Blacks with significant levels of mistrust believed White counselors were less equipped to help them with struggles

around general anxiety, bashfulness, romantic issues, and feelings of inadequacy (Watkins et al., 1989). Moreover, Blacks who enter counseling are likely to attend fewer sessions or prematurely terminate services when seen by White counselors (Terrell & Terrell, 1984).

Despite its significance, cultural mistrust has received little attention as a psychological construct in the Black American experience (Whaley, 2001). Whaley (2001) found severely mentally ill Black patients with high levels of mistrust exhibit a preference for clinicians of similar race/ethnic background. Interestingly, Black patients reported being more comfortable with African American clinicians but perceived White clinicians to be better trained (Whaley, 2001). Thompson, Worthington, and Atkinson (1994) reported Blacks with low cultural mistrust matched with Black counselors were more likely to disclose intimate details in counseling, while those with high levels of mistrust were not comfortable with self-disclosing to Black or White counselors at a predominantly White university counseling center. Further exploration of cultural mistrust is warranted in order to assist mental health professionals in exhibiting culturally sensitive diagnoses and treatment of African Americans (Whaley, 2001).

More generally, there is a dearth of literature on specificity of traits that Black Americans seek in mental health providers. In spite of the role of religion, spirituality, and the Black church in African American communities, even less is known about characteristics Black American churchgoers look for in the counseling process. Plunkett (2009) significantly contributed to the knowledge base, as he found Black American churchgoers preferred counselors with similar religious values as themselves. Additional

information about counselor preference as it relates to client's racial identity and counselor's racial background is reviewed below.

### **Counselor Preference**

A review of the literature reflects an association between self-identified ethnic minorities and their preference for a counselor based on several demographics including race, gender, education, age, values, and personality (Atkinson, Furlong, & Poston, 1986; Helms & Carter, 1991; Jackson & Kirschner, 1973, Parham & Helms, 1981). Due to the significant relationship between cultural mistrust, African American ethnicity, and help-seeking attitudes and behaviors, it comes as no surprise African Americans report a preference for counselors who are similar to their racial/ethnic background (Jackson & Kirschner, 1973). Interestingly, Jackson and Kirschner (1973) found self-identified African American and Black students significantly endorsed a preference for counselors of African descent in comparison to self-reported Negro students. While the racial categories have changed since the publication of Jackson and Kirschner's (1973) study, their findings suggest within group differences associated with variations in racial identity among participants. Parham and Helms (1981) also found evidence to support the notion an individual's racial identity attitude influences counselor preference, as Black college students who were unaware of their race or racial implications favored White counselors. Black students who had some awareness of their race and those who fully embraced characteristics of their race while excluding values and behaviors of the dominant culture (i.e., pre-encounter and immersion/emersion stage) endorsed a preference for Black counselors.

Black students who ascribe to values and behaviors of their group as well as the dominant group also report that the race of a counselor is insignificant, while those who exclude values and behaviors of the dominant group display a strong preference for Black counselors (Morten & Atkinson, 1983). Researchers found Black students were more willing to seek psychological services from a university counseling center regardless of their presenting concerns if they were assured of a Black counselor (Thompson & Cimbolic, 1978). Atkinson and associates (1986) suggested counselor preference based on racial/ethnic background is significant. However, Black clients also prefer individuals who are experienced and competent. Belaire and Young (2000) reported competency and sensitivity to client's spiritual needs were highly regarded among participants with higher levels of spirituality. Although literature of counselor preference among Black American churchgoers is scarce, based on the limited findings we can infer that this group will embrace a counselor who values and integrates their religious connections within the counseling process (Plunkett, 2009). Counselor race and racial identity of clients are likely to affect help-seeking attitudes and behaviors through expression of preference for certain counselors.

### **Psychological Distress**

Psychological distress appears to be associated to help-seeking as well. For example, researchers found Black and Latino students who reported increased levels of psychological distress displayed more positive help-seeking intentions (Constantine, Wilton, & Caldwell, 2003). Psychological distress is generally an antecedent to seeking mental health services (Vogel & Wei, 2005). Research suggests individuals are more likely to seek mental health services when psychological distress increases and when

attitudes toward seeking psychological services are positive (Cramer, 1999).

Interestingly, Obasi and Leong (2009) found psychological distress was a significant predictor of help-seeking attitudes; however, the constructs were negatively correlated, meaning that as persons of African descent became more distressed, their attitudes toward professional psychological services were less favorable. While it may be difficult to reconcile such polar findings, a relationship between psychological distress and help-seeking is substantiated, warranting further investigation.

African Americans often use alternative sources when experiencing psychological distress, particularly help-seeking from clergy (Neighbors, Musick, & Williams, 1998). Data from the innovative NSBA provides specific information about variations in the association between problem severity, help-seeking attitudes, and behaviors (Neighbors, 1991). Findings from NSBA shows 32% of African Americans suffering from high levels of distress sought help from ministers (Neighbors, 1991). While help-seeking from clergy may be helpful to those in distress, minimal empirical evidence exists on the efficacy of services provided by ministers and church leaders within the Black church. To date, investigations of psychological distress and help-seeking among Black American churchgoers is sparse. The present study provides a richer understanding of help-seeking intentions of Black American churchgoers when experiencing increased stressors.

In summary, cultural mistrust and stigma (avoidance factors) are associated with variables that perpetuate underutilization of mental health services in African American communities, while counselor preference and psychological distress (approach) serve as predictive variables related to engaging in help-seeking behavior. Vogel, Wester, and Larson (2007) posited avoidance and approach factors provide a deeper understanding of

a person's attitude, intention, and behavior toward seeking professional psychological services. Help-seeking intention is an under-studied sector within mental health. However, research shows that it is a better predictor of help-seeking behaviors than attitudes. Researchers have investigated help-seeking intentions, as well as other predictors of mental health behaviors, within the theory of reasoned action (Harewood, 2010) and the theory of planned behavior (Clansy, 1998) framework. The TPB framework in particular helps to illuminate the potential role of help-seeking intentions separate from help-seeking attitudes.

### **Help-Seeking Intentions**

As noted previously, help-seeking is usually examined in three areas: attitudes, intentions, and behaviors. This study sought to expand the help-seeking intentions literature in particular. The reason for investigating intentions is twofold: (a) intentions are the most immediate determinant and the strongest predictor of behaviors such as help-seeking (Ajzen, 2006), and (2) intentions serve as a useful theoretical framework based on empirically supported research lending to causal inferences of the present study's outcomes. The theory of reasoned action (TRA) and the theory of planned behavior (TPB) have been applied to various constructs in predicting intentions to perform a behavior including volunteering (Okun & Sloane, 2006), blood and organ donation (Baughn, Rodrigue, & Cornell, 2006; Reid & Wood, 2007), and exercising (Budden & Sagarin, 2007). TPB has also served as a significant underpinning in predicting intentions to seek mental health services (Bayer & Peay, 1997; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Yet, the concept of help-seeking intentions remains understudied, particularly among the African American population.

## **Help-Seeking Intentions Studies Focused on African Americans**

Existing research has generally used the Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975) to examine help-seeking intentions in terms of intent to seek professional psychological help from primary care physicians and mental health professionals. Much of the research using TRA and TPB has encompassed attitudes, subjective norms, and perceived behavioral control variables as predictors of intentions. However, researchers also suggest predicting intentions can be improved by incorporating significant variables that are not included in the theory (Fishbein & Ajzen, 2010). As such, there is a strong case for merging variables from TPB and what is known about help-seeking among African Americans. In reviewing the help-seeking intentions literature, there were two dissertations focused on African Americans that closely resembled the present study. These studies are reviewed in depth because they examined culture specific variables not included in the TPB model to explain help-seeking intentions among Blacks (Clansy, 1998; Harewood, 2009).

Clansy's dissertation (1998) expanded the help-seeking literature by using TPB as a conceptual framework to examine differences between Black Americans who attended churches with mental health ministries and Black Americans who attended churches without a mental health component. Using a quasi-experimental between subjects design, the investigator sought to assess the differences between the two groups in terms of their attitudes, subjective norms, perceived behavioral control, self-efficacy, and intentions to seek professional mental health services. Clansy's (1998) sample consisted of 352 African American participants; 242 of the participants were members of African American churches that offered mental health services, and 110 of the participants

attended churches without a mental health component. The author discovered individuals who attended churches with a mental health ministry had more positive attitudes toward seeking help, believed that significant referents would be supportive of their help-seeking behavior, and exhibited greater intentions to seek mental health services.

Harewood's (2009) dissertation used TRA as a theoretical foundation, along with path analysis, to explore the relationship between help-seeking attitudes, social norms, cultural mistrust, and self-stigma in aggregate to predict help-seeking intentions of Black college students. The researcher found self-stigma did not directly predict help-seeking intentions, which is a contrast to previous research (Hines-Martin et al., 2003); however, there was a correlation between self-stigma and help-seeking intentions. These unexpected findings may be due to numerous reasons, including the instruments used to measure the variables. Therefore, further exploration of self-stigma and help-seeking intentions is warranted. Another important finding from Harewood's (2009) study indicated the social norms variable in TRA, specifically, referents in the Black community concerning seeking mental health services, significantly influence how Black college students perceive themselves with respect to seeking mental health services. This finding further validates the idea that stigma associated with seeking psychological services is a cultural specific variable in help-seeking among African Americans (DHHS, 2001). Harewood (2009) concluded subjective norms may be a stronger predictor of self-stigma than social norms because Black students are more concerned with the perceptions of important individuals in their lives rather than the Black community at large.

Harewood's (2009) sample consisted of 113 self-reported Black or African American students, which reflects a relatively small sample size and may present

significant issues with the quality of the study findings. Harewood (2009) used a convenient sampling method, which does not always capture a true depiction of the population. While there are many advantages in using web-based studies and recruitment methods, little is known about the psychometric implications of transferring traditional paper-pencil surveys into web-based instruments (Granello & Wheaton, 2004). Despite its limitations, Harewood's (2009) study furthers the understanding of TRA, and suggests a need to consider using a different model that better predicts help-seeking intentions among Black Americans.

In summary, Clansy's (1998) and Harewood's (2009) findings build upon the literature of help-seeking intentions among African Americans. These studies were selected because they support the value of using a theory based model such as TRA and TPB. Moreover, these studies examined the relationship between help-seeking attitudes, subjective norms, perceived behavioral control, and help-seeking intentions among African American college students and those residing in the community, which provides a rationale for the present study. Harewood's (2009) study supports findings that stigma is a cultural variable that significantly influences help-seeking utilization among African Americans. The present study aims to identify other contextual variables that influence help-seeking intentions among Black Americans, specifically attitudes, cultural mistrust, self-stigma, and public stigma.

### **Other Help-Seeking Intentions Studies**

Along with Clansy (1998) and Harewood's (2009) contributions to the help-seeking intentions literature as it relates to African Americans, there are other empirical studies that examine help-seeking intentions from a TRA or TPB perspective. The bulk of

the samples used in these studies were outside of the United States; however, the findings support the use of TPB. These studies are modeled based on the theory of reasoned action and theory of planned behavior, and also incorporate contextual variables such as prior mental health services use, psychological distress, treatment fearfulness, and stigma.

A quantitative survey-based study investigating factors related to intentions to seek mental health services from a TRA context, found attitude toward the behavior to be more significant than normative beliefs of important persons in predicting intentions (Bayer & Peay, 1997). The study also found attitude toward a behavior and subjective norms to be significantly related within a sample of 142 patients at a community-based general practice office approximately 13 kilometers from the center of Adelaide, Australia (Bayer & Peay, 1997). Moreover, an individual's attitude toward mental health services was found to be significantly more related to help-seeking intentions than social influence (Bayer & Peay, 1997). In the context of this study, social influence was assessed using the normative beliefs and subjective norm component of the theory of reasoned action.

There is also research investigating the relationship between demographic variables and avoidance factors in help-seeking intentions. Deane and Todd (1996) empirically assessed attitudes and intentions to seek mental health services when experiencing personal issues or suicidal thoughts among 107 college students with the respective ethnicities: (86%) European New Zealanders, 6% Maori, and 8% classified as "other." The researchers found participants with prior counseling experience with a psychologist or counselor reported a stronger likelihood to seek help when experiencing personal-emotional problems and suicidal thoughts (Deane & Todd, 1996). Deane,

Skogstad, and Williams (1999) conducted a quasi-experimental study examining attitudes, ethnicity, and quality of prior therapy among 111 European/Pakeha (commonly refers to Caucasian citizens of New Zealand) prisoners. Investigators found help-seeking intentions to be greater among inmates experiencing personal-emotional problems in comparison to persons endorsing suicidal ideation (Deane et al., 1999). Attitudes toward mental health services were measured with Fisher and Turner's (1970) ATPPHS and found to be a significant predictor of intentions. However, psychological distress and treatment fearfulness were not significant predictors of intentions (Deane et al., 1999).

Wilson, Deane, Ciarrochi, and Rickwood (2005) assessed help-seeking intentions using the General Help-Seeking Questionnaire (GHSQ) within a TPB framework among New South Wales high school students in Australia. The GHSQ was developed to assess help-seeking intentions from various sources for different problems. In a sample of 218 students, the researchers found subjects were more willing to seek help from friends and family rather than formal help when experiencing personal-emotional and suicidal problems. Based on the TPB subjective norms construct, students exhibited greater intentions to seek help from significant referents in their lives including parents (55%) and non-parent family members (26%) (Wilson et al., 2005).

The link between stigma and help-seeking behavior has also been supported in help-seeking intentions literature. Barney, Griffith, Jorm, and Christensen (2005) conducted an investigation among 1,312 adults randomly sampled from the Australian community, examining help-seeking intentions and stigma associated with depression. Self-stigma and perceived stigma was negatively related to help-seeking intention from professional sources (i.e., general practitioners, counselors, psychologists, psychiatrists,

and complementary practitioners) when experiencing depression. Moreover, Barney and associates (2005) found self-stigma to fluctuate depending on the source of help. Participants reported greater embarrassment about seeking help from mental health professionals, particularly psychiatrists for depression. Participants also reported seeking professional psychological services put them at risk to being stigmatized by the general public (Barney et al., 2005).

In another study exploring the link between stigma and help-seeking behavior, Vogel et al., (2006) used the Self-Stigma of Seeking Help (SSOSH) scale to examine self-stigma among 583 college students. Participants were identified as European American (86%), African American (4%), Latino/Latina American (3%), Asian American (3%), multiracial (2%), and international (2%). Individuals who reported increased levels of self-stigma associated with seeking mental health services exhibited less intention to seek assistance for personal and psychological distress. These findings support previous research indicating self-stigma functions as an avoidance factor in an individual's decision to seek care.

Finally, Vogel and associates (2007) used surveys to investigate public stigma and help-seeking intentions to seek counseling among the following college students ( $N = 680$ ): European American (90%), Asian Americans (4%) African American (2%), Hispanic (2%), international (1%), and other (1%). Structural equation modeling (SEM) showed public stigma associated with mental illness predicted self-stigma related to seeking counseling, which subsequently predicted attitudes toward seeking help, and finally, help-seeking intention for mental health services when experiencing psychological and personal issues (Vogel et al., 2007).

## Purpose of Study

The purpose of this study was to address the underuse of professional psychological services among African Americans despite the need for mental health services. Building on the existing literature described above, the present study explored the help-seeking intentions of Black American churchgoers by predicting factors that may impede or influence help-seeking behavior. This study provides mental health professionals with more insight on how to better serve African American clients. Moreover, academic training programs may gain insight on equipping counselors with the tools needed to address multicultural and diversity issues, as well as religious matters when working with clients. The present study contributes to the body of literature suggesting the beliefs and practices of the African American religious experience should be incorporated into the counseling process (Adkison-Bradley et al., 2005). Moreover, this study provides an understanding of the influence of the Black church within the African American community, and its influence on help-seeking attitudes toward mental health services among congregants. It provides mental health professionals with important information concerning working collectively with longstanding resources present in the Black community to better serve African Americans holistically.

The theory of planned behavior served as a practical tool for conceptualizing this dissertation. The present project used TPB as a framework to organize variables thought to predict intentions of Black American churchgoers to seek mental health services. Previously identified cultural specific predictors of help-seeking attitudes and intentions, psychological distress, cultural mistrust and stigma were conceptualized in terms of their relationships to behavioral beliefs, normative beliefs, and control beliefs. The model was

further adapted to include demographic variables, as well as the previously listed cultural specific variables. Cultural mistrust (avoidance factor) was thought likely to predict an individual's attitude toward seeking help, and attitudes would then predict intentions to seek mental health services. Fishbein and Ajzen (2010) theorized that subjective norms might influence behavior indirectly by their effects on intentions. Stigmatizing beliefs (avoidance factor) send messages that may be interpreted and internalized to avoid seeking mental health services. Public and self-stigma was thought likely to influence an individual's intentions to seek mental health services. External factors such as access and availability to mental health services was thought likely to assist or hinder one's ability to perform a behavior. Moreover, if an individual perceives that they lack the ability to access services in times of distress they are less likely to engage in help-seeking behavior. Perceived behavioral control predicts intentions, subsequently, predicting performance of a behavior.

TPB suggests attitudes toward a behavior, subjective norms, and perceived behavioral control in combination, directly influence intentions, which in turn influence behavior. In the present study, the predictor variables are attitudes toward seeking professional psychological help, cultural mistrust, psychological distress, public stigma, self-stigma, and perceived behavioral control. The criterion variable is intention to seek professional mental health services.

### **Research Question and Hypotheses**

Drawing from the conceptual framework of TPB, the major research question and hypotheses for the present study were as follows: Do attitudes toward seeking professional psychological services, psychological distress, cultural mistrust, public

stigma, self-stigma, and perceived behavioral control predict help-seeking intentions?

H1: Help-seeking attitudes will be the most significant predictor of intentions among

Black American churchgoers H2: Psychological distress will predict help-seeking

attitudes, which in turn will predict help-seeking intentions. H3: Cultural mistrust will

predict help-seeking attitudes, which in turn will predict help-seeking intentions. H4:

Cultural mistrust will predict perceived behavioral control, which in turn will predict

help-seeking intentions. H5: Public stigma will predict self-stigma, which subsequently

predicts help-seeking intentions. H6: Self-stigma will be a significant predictor of

intentions to seek help.

## **Summary**

The previously discussed research reflects a relationship between help-seeking attitudes, intentions, and behaviors, and supports the need for further exploration of each variable within a theory of planned behavior context. There were some limitations in providing a rationale for examining the variables in TPB and contextual variables that are applicable to help-seeking among African Americans because few studies have merged these constructs to fit within the TPB framework. Findings show help-seeking attitudes influence social norms to stigma, which predicts help-seeking intentions; however, the magnitude of these associations is unknown. The need for a theory-based investigation like path analysis such as the one used in the present study is needed to examine these variables rather than a simple regression model. As the current literature stands, researchers are unable to make extensive generalizations about the American population, much less a minority subgroup such as Black American churchgoers. Most of the studies expanding the TRA and TPB literature have been conducted outside of the United States,

while investigations conducted in the United States consist of limited sample sizes that are homogenous in nature and have methodological errors that minimize generalizations to the population at large. A significant amount of literature around both TRA and TPB were found in non-peer reviewed scholarly works such as dissertations.

Non-peer reviewed studies facilitate scholarly communication; however, they have not been subjected to the same rigors as peer reviewed articles. For example, Clansy (1998) and Harewood (2009) have used TRA and TPB as vehicles to investigate help-seeking intentions and behaviors across different racial/ethnic groups. These researchers exhaustively combed through the literature, informing, synthesizing, and teaching about relevant constructs as they relate to the population of interest. These projects were critical in expanding the help-seeking intentions literature, providing future direction in the field of study and serving as an impetus for this dissertation.

Given the remaining need for research concerning underutilization of mental health services among African Americans, the present study drew from the theory of planned behavior to examine the strength of certain help-seeking barriers and predictor variables in predicting the help-seeking intentions of African American churchgoers. The research participants, instrumentation, recruitment and data collection procedures, design, and statistical analyses used to examine the research question and hypotheses of this study are outlined next in Chapter II, Methodology.

## CHAPTER II

### METHODOLOGY

The purpose of this study was to address the underutilization of mental health services among African Americans. More specifically, the present study explored the relationship of several major concepts associated with help seeking intentions including psychological distress, cultural mistrust, self-stigma, public stigma, attitudes toward mental health services, and perceived behavioral control. This chapter outlines the participants, instrumentation, recruitment and data collection procedures, design, and statistical analyses used to examine the research question and hypotheses of this study.

#### **Participants**

Participants for this study consisted of 159 African American church members and attendees of Black churches. Recruitment and data collection occurred at five traditionally Black Christian churches in a large mid-western city. Ninety-two participants were female (60%) and 63 were male (40%). Participant ages ranged from 18 years to 75 years with a mean age of 44 years ( $SD = 14.7$ ). The average age of female and male respondents was 45 ( $SD = 14.24$ ) and 44 ( $SD = 15.47$ ) years old, respectively. One hundred fifty-one respondents self-identified as African American, 5 respondents self identified as Haitian, one respondent self identified as Jamaican, one respondent self identified as bi-racial/multi-racial, and one respondent did not specify their racial or ethnic background.

Thirteen percent of the sample earned less than \$10,000 annually. Fifty-five percent of the sample earned between \$10,000 and \$45,000 annually, while 2% earned more than \$150,000 annually. A full range of the income earnings for the present sample is listed in Table 1. Less than 1% identified their highest level of education as grade/elementary school, 11% reported highest level of education at high school, 40% reported having some college education, 25% reported being college graduates, 23% identified their highest level of education as graduate or professional school, and 1% reported having vocation or technical education. Forty percent of participants identified as married and single, equally, while, 15% identified as divorced and 4% identified as widowed.

Participants for this study identified as members or attendees of traditionally Black churches with the denominational distribution as follows: Methodist (3%), Church of God in Christ (22%), Baptist (60%), United Church of Christ (1%), Non-denominational (12%), and other (1%). One percent of participants did not specify their denomination. Seventy-two percent of respondents were involved in a church ministry such as the choir, hospitality, youth, or men and women's ministry. Twenty-seven percent of the sample attended church one to three times per month, 29% attended church four to six times per month, 33% attended church seven to nine times per month, and 10% attends church over nine times per month.

Forty percent of the sample reported they had previously sought counseling services from a licensed professional counselor, psychologist, psychiatrist, or social worker for personal or emotional concerns. Fifty-nine percent of the participants had never sought counseling services from a licensed professional counselor, psychologist,

psychiatrist, or social worker for personal or emotional concerns. Interestingly, there was a perfect split between the number of female participants who sought mental health services ( $n = 47$ ) and those who have not sought counseling services ( $n = 47$ ).

Finally, 10% of the respondents reported serving in the armed forces. All frequencies and percentages of participant demographic characteristics are listed in Table 1.

Table 1

*Demographic Characteristics of Participants (N = 159)*

Variable	f	%
<b>Gender</b>		
Male	63	39.62
Female	92	57.86
Missing	4	2.52
<b>Marital Status</b>		
Married	64	40.25
Divorced	23	14.47
Widowed	6	3.77
Single	64	40.25
Missing	2	1.26
<b>Ethnicity</b>		
African American	151	94.97
Haitian	5	3.14
Jamaican	1	0.63
Multi-racial	1	0.63
Other	1	0.63
Missing	0	0.00
<b>Annual Income</b>		
Under \$10,000	21	13.21
\$10,000-\$25,000	35	22.01
\$26,000-\$45,000	48	30.19
\$46,000-\$65,000	19	11.95
\$66,000-\$85,000	17	10.69
\$86,000-\$105,000	5	3.14
\$106,000 or more	7	4.40
Missing	7	4.40
<b>Education</b>		
Grade School/Elementary School	1	0.63
High School	17	10.69
Some College	63	39.62

Table 1—Continued

<b>Variable</b>	<i>f</i>	%
<b>Education</b>		
College Graduate	40	25.16
Graduate or Professional School	36	22.64
Other	2	1.26
Missing	0	0.00
<b>Religious Affiliation</b>		
Methodist (AME, AME Zion, CME)	4	2.52
Church Of God in Christ (COGIC)	35	22.01
Baptist	96	60.38
United Church of Christ (UCC)	2	1.26
Non-Denominational	19	11.95
Other	2	1.26
Missing	1	0.63
<b>Involvement in Church Ministries</b>		
Yes	114	71.70
No	44	27.67
Missing	1	0.63
<b>Church Service</b>		
1-3 times per month	42	26.42
4-6 times per month	46	28.93
7-9 times per month	53	33.33
Other	16	10.06
Missing	2	1.26
<b>Prior Mental Health Service Experience</b>		
Yes	64	40.25
No	93	58.49
Missing	2	1.26
<b>Armed Forces Experience</b>		
Yes	16	10.06
No	142	89.31
Missing	1	0.63

## **Instrumentation**

Participants completed a packet of eight measures, in addition to a brief demographic questionnaire. The packet included the following measures: The Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHS-SF), Cultural Mistrust Inventory (CMI), Self-Stigma of Seeking Help Scale (SSOSH), Stigma Scale for Receiving Psychological Help (SSRPH), Hopkins Symptom Checklist-21

(HSCL-21), Intentions to Seek Counseling Inventory (ISCI), General Help-Seeking Questionnaire (GHSQ), and Perceived Behavioral Control (PBC). Research shows the order in which survey items are presented can greatly influence participant responses (Johnson, O'Rourke, & Severns, 1998). The sequence in which the questionnaires were presented to participants was counterbalanced to minimize order effect. For this study, the placement of the help seeking attitudes and intentions scales were deemed most important. These measures were presented first to decrease the likelihood that measures of barriers to help seeking would influence responses. Participants randomly received one of two research packets: (a) ATTPHS-SF followed by CMI, SSOSH, SSRPH, HSCL-21, ISCI, GHSQ, and PBC or (b) ISCI followed by CMI, SSOSH, SSRPH, HSCL-21, ATTPHS-SF, GHSQ, and PBC.

### **Demographic Questionnaire**

The researcher designed the demographic questionnaire. Items included sex, age, marital status, race/ethnicity, annual income, level of education, religious affiliation, church attendance including ministry affiliation, and veteran status. Participants were also asked about their previous experience with mental health services. Responses obtained from the demographic questionnaire were used to describe the sample and to explore variation in results across participants. A copy of the demographic questionnaire is included in Appendix A for viewing.

### **Attitudes Toward Seeking Psychological Services**

The Attitudes Toward Seeking Professional Psychological Help Scale—Short Form (ATSPPHS-SF; Fischer & Farina, 1995) was used to measure help-seeking attitudes. The ATSPPHS-SF is a 10-item shortened version of the original Fischer and

Turner (1970) Attitudes Toward Seeking Professional Psychological Help Scale.

Participants used a 4-point Likert-scale from 0 (disagree) to 3 (agree), to respond to such items: "If I believed I was having a mental breakdown, my first inclination would be to get professional attention," and "The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts." Five of the items are reversed coded. Responses to the negative statements are reverse-coded, and all responses are summed for total scores. Total scores range from 0 to 30, with higher scores indicating more favorable treatment attitudes.

The ATSPPHS-SF is a short form of the original. It is easier to administer and more inconspicuous in assessing attitudes toward help-seeking (Fischer & Farina, 1995). Unlike the original version of the scale, the ATSPPHS-SF includes one help-seeking factor yielding a single score to represent the participant's attitude. Fischer and Farina (1995) developed the abbreviated instrument by subjecting 14 original items from Fischer and Turner's (1970) original scale to a factor analysis, which yielded a two-factor solution. One of the factors contained 10 items, which were retained for the short form. These items were representative of the constructs in the original instrument resulting in a uni-dimensional measure of help-seeking. Besides being easier to administer than the original, the ATSPPHS-SF was selected because the items were revised to reflect contemporary language and usage in comparison to the original inventory, which was constructed more than 3 decades ago.

Fischer and Farina (1995) reported initial reliability and validity estimates for the short version of the scale. Based on a sample of college students, the short form yielded internal consistency (.84) comparable to the original scale (.83-.84) (Fischer & Turner,

1970). A test-retest reliability coefficient of .80 was obtained within a one-month interval. Reliability of this instrument was also supported by Constantine (2002) with a Cronbach's alpha of .83 among a sample of ethnic minority students who were clients in therapy. There was also a strong correlation between scores from the ATSPPHS-SF and the original scale (.87). Fischer and Farina (1995) reported the shorter version of the scale was equivalent to the original version of the scale. The association between the original scale and the shortened version demonstrates evidence of construct validity. The ATSPPH-SF was negatively related to stigma in a study using the Perceptions of Stigmatization by Others for Seeking Help (PSOSH; Vogel, Wade, & Ascheman, 2009). Validity was also supported by the significant difference between the ATSPPH-SF scores of participants who had sought prior help for emotional and personal issues and those who had not sought help (Fischer & Farina, 1995). Internal consistency for the present sample was .74.

### **Cultural Mistrust**

The Cultural Mistrust Inventory (CMI) was used to assess Black's mistrust of Whites and White-related organizations (Terrell & Terrell, 1981). The CMI is a 48-item scale that measures Black's distrust of Whites across 4 domains: (a) educational and training setting, (b) political and legal systems, (c) work and business relations, and (d) interpersonal and social interactions. Items are rated on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). Examples of CMI items include: "Whites are usually fair to all people regardless of race" and "A Black person can usually trust his or her White co-workers." Higher scores indicate a greater tendency toward mistrust of Whites. A total score is gathered through the summation of the scores on each item.

The CMI (Terrell & Terrell, 1981) was selected because of its consistent validity and reliability within research studies among African Americans. Terrell and Terrell (1981) reported an internal consistency coefficient alpha for the CMI at .85 among African Americans in clinical samples, and .89 in nonclinical samples. A two-week test-retest reliability coefficient of .86 for the CMI scores has also been reported among samples of Black college students (Terrell & Terrell, 1981). Moreover, CMI scores predicted premature termination of treatment in a sample of African Americans seeking counseling services (Terrell & Terrell, 1981). Whaley (2002) reported Cronbach's alpha for the total scale at .85, and subsequently findings for the following subscales: education and training setting (.63), political and legal system (.63), work and business relations (.71), and interpersonal and social interactions (.43) among African American psychiatric patients. CMI was shown to have good convergent validity as it was found to be correlated to the Fenigstein Paranoia Scale when used among a non-clinical population (Whaley, 2002). Whaley (2002) reported weak correlations between CMI and instruments assessing self-esteem and social desirability as evidence of discriminant validity. Internal consistency for the present sample was .91.

### **Stigma**

Stigma is believed to be a significant barrier in recognizing mental health issues, in seeking psychological services, and in successfully completing treatment (DHHS, 2001). Stigma associated with seeking mental health services was measured using two separate instruments: one measuring self-stigma and the other measuring public stigma. Corrigan (2004) suggested stigma might be damaging to a person's sense of self-worth, and limits social opportunities. The relationship between stigma and help-seeking has been

empirically supported; however further clarification of how much public and self-stigma impact help-seeking behavior among ethnic minorities is warranted (Corrigan, 2004).

Self-stigma associated with seeking psychological services was measured using the Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006). This instrument measures the internal reactions an individual experiences with respect to seeking psychological services based on the social rejection of mental health services. SSOSH contains 10 items, five of which are reverse-coded. The scale is rated on a 5-point Likert type scale ranging from 1 (strongly disagree) to 5 (strongly agree) with elevated scores reflecting increased self-stigma. Sample items on the SSOSH include: "I would feel inadequate if I went to a therapist for psychological help" and "My view of myself would not change just because I made a choice to see a therapist" (reverse coded). Higher scores on the inventory indicate heightened self-stigmatizing beliefs with respect to seeking psychological services. Moreover, seeking psychological services would be viewed as a great threat to an individual's self-worth (Pederson & Vogel, 2007). Scores are summed to obtain a total with a possible range from 10 to 50.

SSOSH is a uni-dimensional tool with internal consistencies ranging between .86 and .92 (Vogel et al., 2006). It should be noted, however, these findings were among predominantly White college students (Pederson & Vogel, 2007; Vogel, Shechtman, Wade, 2010; Vogel, Wade, & Hackler, 2007). Two-week test-retest reliability was reported at .72 in a predominantly White college student sample (Vogel et al., 2006). Vogel and associates (2006) further demonstrated evidence of validity through correlations with attitudes toward seeking professional help ( $r = -.53$  to  $-.63$ ), intentions to seeking psychological services ( $r = -.32$  to  $-.38$ ), and measures of public stigma ( $r =$

.46 to .48). Correlations between the SSOSH and public stigma using a measure called the Stigma Scale for Receiving Psychological Help were .48 and .46. This is to be expected as individuals are likely to internalize negative stigmatizing beliefs stemming from social rejection of seeking psychological services. Moreover, Corrigan (2004) suggested that public and self-stigma are interrelated in help-seeking behavior. Vogel and associates (2006) reported evidence supporting adequate construct validity of the SSOSH scale, as it was demonstrated to be positively correlated to anticipated risks, public stigma, and the tendency to conceal personal information. Further support of construct validity was reported as this instrument was shown to be negatively related with anticipated benefits and the tendency to disclose distressing emotions. The SSOSH scale was able to discriminate between participants who had previously sought mental health services and those who had not for both men and women (Vogel et al., 2006). Internal consistency for the present sample was .74.

*Public stigma toward receiving psychological services* refers to the perception that an individual who seeks psychological help is flawed and socially unacceptable. Perceived public stigma was measured with the Stigma Scale for Receiving Psychological Help (SSRPH; Komiya, Good, & Sherrod, 2000). The SSRPH was developed to measure how stigmatizing it is for individuals to receive psychological help (Komiya et al., 2000). The SSRPH is a 5-item measure with a 4-point Likert scale 0 (strongly disagree) to 3 (strongly agree). A sample item is “Seeing a professional for emotional or interpersonal problems carries social stigma.” Elevated scores indicate a greater perception of stigma associated with seeking psychological services.

The internal consistency for the SSRPH has ranged from .73 to .76 (Komiya et al., 2000; Vogel et al., 2006) on mostly White college student samples. The consistency of this instrument over time is undetermined, as test-retest reliability information has not been reported. The SSRPH's negative correlation with the ATSPH-SF ( $r = -.40$ , Fischer & Farina, 1995; Komiya et al., 2000) provides some evidence of construct validity among White college student samples. The negative correlation is desirable as higher scores on the SSRPH indicate a higher degree of perceived stigma while higher scores on the ATSPH-SF indicate a lesser degree of perceived stigma associated with seeking psychological services (Komiya et al., 2000). Internal consistency for the present sample was .76.

### **Psychological Distress**

Psychological distress was measured with the Hopkins Symptom Checklist-21 (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988). This inventory is an abbreviated form of the Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). The HSCL-21 is a self-report inventory with 21 items that assess general, somatic, and performance distress respondents have encountered in the prior week. Responses are rated on a 4-point Likert scale from 1 (not at all) to 4 (extremely). This instrument contains 3 subscales of 7 items each: (a) general feeling of distress ("feeling blue"), (b) somatic distress ("pains in your lower back), and (c) performance difficulties ("difficulty speaking when you are excited"). The total score used in the present study, indicates a respondent's level of general psychological distress; higher scores equate to higher distress.

The authors reported high internal consistency of the total scale at .90, with split-half reliability at .91 on a sample of 203 New Zealand students (Green et al., 1988). Internal consistency estimates for the three subscales for this New Zealand sample were also high: general feeling of distress (.86; split-half .89), somatic distress (.75; split-half .80), and performance difficulty (.85; split-half .88) (Green et al., 1988). More recently, the three subscales have been demonstrated to have adequate internal consistency on a sample of predominantly white undergraduate students: general feelings of distress (.84), somatic distress (.80) and performance difficulty (.79) (Vogel & Wei, 2005). Although the previously mentioned reliability information was obtained on predominantly young, White college students, the HSCL-21 was reported to have equivalent validity across diverse groups including European American, African American, and Latino college students (Cepeda-Benito & Gleaves, 2000). Researchers tested the factor structure of the instrument with samples of 514 European American, 154 African American, and 229 Latino college students using confirmatory factor analysis with tests of invariance across groups (Cepeda-Benito & Gleaves, 2000). Cepeda-Benito and Gleaves (2000) posit that a 3 factor model with Performance, General, and Somatic factors adequately fits among all racial/ethnic groups examined. Christopher and Skillman (2009) further reported an alpha coefficient of .86 among a sample of African American and Asian American students.

The HSCL-21 has been reported to be helpful in detecting changes in psychotherapy outcome and to be related to other therapy outcome measures, providing further evidence of instrument validity (Deane, Leathern, & Spicer, 1992). Deane and associates (1992) further confirmed construct validity in noting statistically significant elevations of distress among a clinical sample versus a nonclinical sample of clients

presenting for outpatient psychotherapy. This instrument was also demonstrated to be valid in detecting symptoms of distress as scores on the HSCL-21 were reduced over the course of psychotherapy (Deane et al., 1992). Internal consistency for the present sample was .90.

### **Help-Seeking Intentions**

Help-seeking intentions were measured with two separate instruments. The Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975) has been widely used to assess one's willingness to seek help for a myriad of issues. The 17-item instrument includes a list of problems that may be presented in counseling. Participants are asked to rate how likely they would seek professional psychological help for that problem. Some of the issues presented include relationship difficulties, depression, personal concerns, and drug-related problems. The instrument includes three subscales: Interpersonal Problems (10 items), Academic Problems (4 items), and Drug/Alcohol Problems (2 items). Items are answered on a 4-point Likert scale ranging from 1 (very unlikely) to 4 (very likely). Scores are summed to reflect intentions to seek counseling among the three subscales or in aggregate to obtain an overall score on willingness to seek out services when needed (Cepeda-Benito & Short, 1998). Total scores ranging from 17 to 42 indicate the participant is less likely to seek services, while scores ranging from 43 to 68 indicate the participant is more likely to seek services.

Cash et al. (1975) reported an alpha of .84 for the scale among a sample of White college students. Cepeda-Benito and Short (1998) also reported good internal consistency with a Cronbach's alpha of .89 among a sample of predominantly White college students. The ISCI appears to have adequate internal consistency for each subscale Interpersonal

Problems (.90), Academic Problems (.71), and Drug/ Alcohol Problems (.86) as well (Cash et al., 1975). There is minimal information on the validity of the ISCI; however, Kelly and Achter (1995) found the ISCI to be positively correlated with the Attitudes toward Seeking Professional Psychological Help Scale and the Self-Concealment Scale. Internal consistency for the present sample was .92.

Help-seeking intentions were also measured in the present study using the General Help-Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005). The GHSQ has been used in prior help-seeking research, and was developed to formally assess help-seeking intentions for a range of problems and from several helping sources (Wilson et al., 2005; Rickwood et al., 2005). Specifically, respondents are asked to rate the likelihood that they would seek help for different problem types (e.g., suicidal thoughts or depression) from a range of potential helpers (e.g., minister, family, or counselor). Participants are prompted to respond to two specific questions: "If you were having a personal-emotional problem, how likely is it that you would seek help from the following people?" "If you were having suicidal thoughts, how likely is it that you would seek help from the following people?" Respondents are asked to rate their intentions to seek help from ten helping sources on a 7-point Likert scale ranging from 1 (extremely unlikely) to 7 (extremely likely). Higher scores equal higher help-seeking intentions (Wilson et al., 2005). Notably, the GHSQ yields two separate scores for intentions to seek help. One of the scores is for personal and emotional issues. The other score is for intentions to seek help when experiencing suicidal thoughts.

The GHSQ was selected because it is sufficiently sensitive to distinguish help-seeking intentions for different problems and help sources. The GHSQ has been reported

to have good internal consistency (Cronbach's alpha = .85) and test-retest reliability (assessed over three week period = .92) on a sample of Australian high school students (Wilson et al., 2005). Wilson and associates (2005) further reported a Cronbach's alpha of .83 for the Suicidal Problems subscale and .70 for the Personal-emotional Problems subscale. Validity was supported with GHSQ intentions correlating positively with both prior and prospective help-seeking behavior (Wilson et al., 2005). Convergent and divergent validity were supported with positive correlations found between high school students' intentions to seek counseling and their perception of prior use of mental health services, and by a negative correlation between the students' intentions to seek counseling and their self-reported barriers to seeking professional psychological help (Wilson et al 2005). Internal consistency for the present sample for GHSQ for personal and emotional problems was .75. Internal consistency for the present sample for GHSQ for suicidal thoughts was .91.

### **Perceived Behavioral Control**

Perceived behavioral control (PBC) was assessed with 4 items obtained from previous research in accordance with theory of planned behavior guidelines. There is no existing instrument to measure this component of TPB. This theory assumes the magnitude of each control belief ( $c_i$ ) is weighted by the perceived power ( $p_i$ ) of the control factor, and the products are aggregated, as demonstrated in the following equation: PBC  $\alpha \sum c_i p_i$ .

In the context of the present study, PBC assesses an individual's ability to perform a behavior associated with seeking mental health services. Participants are asked to rate their ability to perform the following acts: (a) find a therapist to contact for

counseling, (b) choose a professional counselor, (c) schedule an appointment, and (d) attend an initial meeting with the counselor. Respondents were asked to rate each item on a 7-point Likert type scale that ranged from 1 (strongly agree) to 7 (strongly disagree). The items were summed to obtain a total perceived behavioral control score ranging from 4 to 28. These items were obtained from a previous study conducted by Greene (1999). Internal consistency for the present sample was .94.

### **Recruitment and Data Collection Procedures**

The researcher was granted permission to collect data for this study from the Human Subjects Institutional Review Board (HSIRB) at Western Michigan University. A purposive sampling method was used to recruit participants. This method of sampling is employed when a researcher needs to examine a cultural domain with knowledgeable experts within (Tongco, 2007). The researcher identified 10 predominantly Black Christian churches within a large mid-western city via the Internet. The researcher had personally visited three of the 10 churches in the past, and was familiar with the other churches through community wide events. Pastors and church representatives were contacted via email or telephone for a meeting to discuss this project. Of the 10 pastors and church representatives contacted, five churches agreed to meet with the researcher. The researcher met with all five pastors to discuss the purpose of the study and the logistics of recruitment throughout the course of eight months. During the meeting, the pastors were given a recruitment letter to request their permission to present this study to their congregation. Pastors were asked to provide a written statement via email granting the researcher consent to speak to church members and attendees. The researcher and pastors agreed to make a general announcement of the study after church service and

Bible study, at which point volunteers would have an opportunity to approach the researcher to learn more about the study.

The researcher generally attended two Bible studies held on Wednesday evenings and two church services held on Sunday mornings after the initial announcement was made. After each Bible study and worship service, the pastor introduced the researcher and provided an opportunity for a brief explanation of the study. Interested volunteers were asked to meet the researcher in a designated room on the church premises to learn more about the study at the conclusion of worship service and or Bible study. At this time, participants were further informed that the research questionnaires would focus on their thoughts, perceptions, and attitudes concerning counseling services. They were told it would take approximately 30 to 40 minutes to complete the entire survey packet without monetary compensation. The researcher explained there was minimal risk in participation; however, participants were informed that they could become aware of problems troubling them while completing the questionnaires. They were strongly encouraged to discuss their concerns with family, friends, and other sources of support. The researcher provided all participants with a contact number for a local crisis hotline. They were also informed on their right to refuse to participate or quit the study without penalty or prejudice. Participants were then invited to complete a survey packet consisting of several questionnaires.

Participants who were interested in completing the survey at church were provided a quiet room on the church premises. Participants were invited to ask any questions or concerns they had about the study. They received a white envelope containing an informed consent, a questionnaire packet, and debriefing statement. The

researcher informed all participants that their informed consent and questionnaire would be kept separately and would not be linked to one another. They were instructed to thoroughly read and sign the informed consent before completing the study. The researcher retrieved signed consents and participants were then provided time to complete the questionnaire.

Some participants requested to complete the survey at home and return it to the researcher at the following church service or Bible study. These participants provided the researcher with their contact information for follow-up. They were informed the researcher would contact them via email or telephone to make arrangements to retrieve the packet if not collected by the following week. The researcher made two separate attempts to contact the participants once per week and twice total. After, two attempts were made the researcher did not contact participants; however, respondents were able to contact the researcher directly if they were interested in returning the survey packet. The researcher expressed gratitude upon receipt of completed packets and informed participants to keep the debriefing statement.

### **Research Design**

The present survey-based study used the theory of planned behavior as a theoretical framework. A path analysis was selected to answer the following research question: Do attitudes toward professional psychological services, psychological distress, cultural mistrust, public stigma, self-stigma, and perceived behavioral control predict help-seeking intentions? The rationale for the use of path analysis was twofold: (1) it allowed for the examination of direct and indirect effects among the variables and (2) it permitted the researcher to test if the model appropriately fit with the data. This advanced

and complex statistical technique was determined to be the most parsimonious in exploring the help-seeking intentions of African Americans. This groundbreaking study is the first to feature theoretically based and culturally relevant variables in one model to predict help-seeking intentions of Black American churchgoers. In addition, to testing the TPB, this study also used two separate instruments to measure one's intention to seek mental health services. This provides a deeper understanding of African American's willingness to seek help and their preference for source of help when facing a personal or emotional issue (Wilson et al., 2005).

### **Data Analysis**

Analyses were conducted using PASW Statistics 18, formerly known as SPSS, and IBM Amos 19 statistical software. The researcher computed means, standard deviations, Pearson *r* correlations, MANOVA, and path analysis for the variables in this study. The significance level was set at .05 for all statistical tests. Basic descriptive statistics were used to describe characteristics of the sample and measures used in this study. Bivariate correlations coefficients were also used to summarize observed relationships among study variables.

A path analysis was conducted to calculate the magnitude of the direct and indirect effect of the variables. The analysis began with a diagram illustrating the hypothesized relationships among study variables. Considering that path analysis is an expansion of multiple regression the assumptions of regression were assessed before conducting the path analysis. The Pearson *r* correlation was also computed to determine the strength of the relationship among the variables used in this study. The following question and hypotheses were examined:

Research Question: Do attitudes toward seeking professional psychological services, psychological distress, cultural mistrust, self-stigma, public stigma, and perceived behavioral control predict help-seeking intentions?

H1: Help-seeking attitudes will be the most significant predictor of intentions among Black American churchgoers.

H2: Psychological distress will predict help-seeking attitudes, which in turn will predict help-seeking intentions.

H3: Cultural mistrust will predict help-seeking attitudes, which in turn will predict help-seeking intentions.

H4: Cultural mistrust will predict perceived behavioral control, which in turn will predict help-seeking intentions.

H5: Public stigma will predict self-stigma, which in turn will predict help-seeking intentions.

H6: Self-stigma will be a significant predictor of help-seeking intentions.

## **Summary**

This chapter outlined the participants, instrumentation, recruitment and data collection procedures, design, and statistical analyses used to examine the research question and hypotheses of this study. Several instruments measuring help-seeking attitudes, help-seeking attitudes, psychological distress, cultural mistrust, perceived behavioral control, public stigma, and self-stigma were used to obtain data from 159 Black American churchgoers at five predominately African American churches in a mid-western city. Data were analyzed using Pearson  $r$  correlations, MANOVA, and path analysis. Results are presented next in Chapter III, Results.

## CHAPTER III

### RESULTS

The present chapter is comprised of several sections. First, preliminary analyses are reported. Then, descriptive statistics are provided for each variable in the general sample. The results of a multivariate analysis of variance (MANOVA) conducted to determine group differences among the study's variables, particularly, across gender and prior use of mental health services, attitudes toward seeking professional psychological help, and help-seeking intentions are presented next, followed by results from a bivariate correlation analysis performed to ascertain the individual relationships among the variables. Results from a path analysis model are then reported to answer the main research question and hypotheses. This chapter ends with the presentation of a simplified post-hoc model incorporating a substitute instrument to measure help-seeking intentions.

#### **Preliminary Analysis**

Prior to conducting main analyses, the data were screened for accuracy, missing data, outliers, and normality of distribution using PASW 19. A total of 159 participants completed and returned the questionnaire packets. Ten cases were dropped from the analysis due to missing values across several variables leaving a total of 149 participants for the main analysis. The researcher used graphical (histograms) and statistical (skewness and kurtosis) observations to determine univariate normality among the variables. Given that path analysis is an extension of regression, the data were examined for normality, linearity, and homoscedasticity using graphical tools. Particularly, residual

plots were observed to ensure homoscedasticity and linearity assumptions were not violated. There were no problematic variables in the dataset.

### **Descriptive Findings**

This section provides a detailed description for the final sample ( $N = 149$ ), organized in three major subsections in accordance with the performed analysis. Initially, the sample is described by reporting the mean and standard deviation for each variable. Given that Black American churchgoers are an under-studied subgroup, the descriptive statistics information about their help-seeking attitudes, help-seeking barriers and predictors of intentions, and intentions to seek help will greatly contribute to the help-seeking literature. This subsection features results from bivariate correlations demonstrating the relationships between help-seeking attitudes and intention variables, and the help-seeking barriers and predictor variables: cultural mistrust, psychological distress, self-stigma, public stigma, and perceived behavioral control. Based on past help-seeking attitudes and intentions literature, differences between gender and prior mental health experience are posited. The present study uses a multivariate analysis of variance (MANOVA) to capture these differences across help-seeking attitudes and intentions. Statistical significance tests are set at .05.

### **Means and Standard Deviations for Help-Seeking Barriers and Intentions**

Means and standard deviations are presented for the following variables: attitudes toward seeking professional psychological help, cultural mistrust, psychological distress, self-stigma, public stigma, perceived behavioral control, and intentions to seek help. Means, standard deviations, correlation coefficients ( $r$ ), and coefficient of determination ( $r^2$ ) are listed in Table 2.

Table 2

*Pearson Correlation Matrix and Coefficient of Determination*

<b>Variables</b>	1	2	3	4	5	6	7	8	9
1.ATSPPH	1								
2.GHSQ <sub>1</sub>	.36** (.130)	1							
3.GHSQ <sub>2</sub>	.35** (.122)	.61** (.372)	1						
4.ISCI	.34** (.115)	.38** (.144)	.30** (.090)	1					
5.PBC	.37** (.136)	.32** (.102)	.24** (.057)	.22** (.048)	1				
6.SSRPH	-.18* (.032)	-.08 (.006)	-.08 (.006)	-.02 (.000)	-.08 (.006)	1			
7.SSOSH	-.43** (.184)	-.32** (.102)	-.22** (.048)	-.17* (.028)	-.49** (.240)	.18* (.032)	1		
8.HSCL21	.02 (.000)	-.21* (.044)	-.13 (.016)	.14 (.019)	-.16 (.025)	.05 (.002)	.15 (.022)	1	
9.CMI	-.14 (.019)	-.18* (.032)	-.19* (.036)	-.14 (.019)	-.18* (.032)	.18* (.032)	.15 (.022)	.14 (.019)	1
Mean	17.97	43.50	47.35	38.40	21.85	10.38	21.90	32.82	179.16
SD	5.44	10.89	13.57	11.89	5.74	3.09	5.73	9.35	31.23

*Note.* ATSPPH = Attitudes toward Seeking Professional Psychological Help; GHSQ<sub>1</sub> = General Help Seeking Questionnaire (personal & emotional issues); GHSQ<sub>2</sub> = General Help Seeking Questionnaire (suicidal ideation); ISCI = Intentions to Seek Counseling Inventory; PBC = Perceived Behavioral Control; SSRPH = Social Stigma for Seeking Psychological; SSOSH = Self-Stigma of Seeking Help; HSCL21 = Hopkins Symptom Checklist-21; CMI = Cultural Mistrust Inventory. Coefficient of Determination for variables is listed in parentheses.

\*\**p* < .01; \**p* < .05

Attitudes toward seeking professional psychological help were assessed using the ATSPPHS-SF (Fischer & Farina, 1995). Total scores range from 0 to 30, with higher scores indicating more favorable treatment attitudes. The mean score for ATSPPHS-SF for this sample is 17.97 (*SD* = 5.44; item level mean = 1.79 with 2 representing the partly agree response between 0 = disagree and 3 = agree). Basic descriptive statistics from the present study were similar to Fischer and Farina's (1995) first study in the development

of ATSPPHS-SF ( $M = 17.45$ ;  $SD = 5.97$ ). The present sample appears to have positive attitudes toward seeking help from mental health professionals.

The Cultural Mistrust Inventory (CMI) was used to assess Black's mistrust of Whites and White-related institutions across four domains: (a) education and training, (b) business and work, (c) interpersonal relations, and (d) politics and law (Terrell & Terrell, 1981). Total scores on this measure range from 48 to 336. Higher scores indicate elevated levels of cultural mistrust. The mean score for the present sample is 179.16 ( $SD = 31.23$ ; item level mean = 3.73 with 4 representing the neutral response between 1 = strongly disagree and 7 = strongly agree). The means for the present sample across the four subscales featured in CMI are as follows: education and training 22.97 ( $SD = 6.68$ ); business and work 53.67 ( $SD = 9.13$ ); interpersonal relations 51.52 ( $SD = 9.98$ ); and politics and law ( $M = 42.87$ ;  $SD = 7.91$ ). Terrell and Terrell reported a mean of 118.61 with a standard deviation of 11.84 among a sample of 172 African American first and second year college students. The authors reported the following means and standard deviations for the CMI subscales: education and training ( $M = 28.23$ ;  $SD = 3.23$ ); business and work ( $M = 42.41$ ;  $SD = 5.74$ ); interpersonal relations ( $M = 43.91$ ;  $SD = 5.18$ ); and politics and law ( $M = 39.53$ ;  $SD = 4.92$ ). Overall, the present sample appears to be relatively neutral with respect to whether or not Whites can be trusted.

The Hopkins Symptom Checklist-21 (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988) was used to measure emotional and psychological distress. The total score obtained in the present study indicates a respondent's level of general psychological distress. Higher scores signify high levels of stress. The mean score for the present sample is 32.82 ( $SD = 9.35$ ; item level mean = 1.56 with 2 representing a little distress

between 1 = not at all and 4 = extremely). The present sample exhibits little psychological distress, which was similar to a group of outpatient psychology clients in New Zealand ( $M = 38.17$ ;  $SD = 11.20$ ) after engaging in psychotherapy (Deane, Leathem, Spicer, 1992).

Internalized stigma associated with seeking mental health services was measured using the Self-Stigma of Seeking Help Scale (SSOSH; Vogel, Wade, & Haake, 2006). Total scores on this instrument are summed up to obtain scores ranging from 10 to 50. Scores ranging between 10 to 22 indicates low stigma, 23 to 32 indicates medium stigma, and 33 to 50 indicates high stigma. The mean score for this sample was 21.90 ( $SD = 5.73$ ). The present sample exhibits low internal stigma attached to seeking mental health services. The authors reported a mean of 27.10 ( $SD = 7.70$ ) among a sample of 583 college students. Researchers have also noted public stigma as a major component in the decision making process of help seeking (Corrigan, 1998; Vogel et al., 2006).

Public stigma is the perception that an individual seeking psychological help is flawed or undesirable. This construct was measured using the Stigma Scale for Receiving Psychological Help (SSRPH; Komiya, Good, & Sherrod, 2000). Total scores on this instrument can range from 0 to 15. The present sample's mean was 10.38 ( $SD = 3.08$ ; item level mean = 2.07 with 2 representing disagree between 1 = strongly disagree and 4 = strongly agree) compared to the original scale ( $M = 5.79$ ;  $SD = 3.06$ ) among a sample of 311 undergraduate college students. The present sample endorses some awareness to the stigmatizing perception of the general population.

Perceived behavioral control (PBC) assesses an individual's belief in their ability to execute an action germane to seeking mental health services. Items from the PBC

variable were obtained from prior research (Greene, 1999). To date, there is no formal instrument used to measure PBC. Total scores on this instrument range from 4 to 28, with higher scores indicating higher levels of behavioral control. The mean score on the present sample was 21.85 ( $SD = 5.74$ ; item level mean = 5.46 with 5 representing the somewhat likely response between 1 = strongly unlikely and 7 = strongly likely). The present sample exhibits positive beliefs in their ability to seek psychological services from a mental health professional. Given that this scale was revised for this study means from the present sample could not be compared to empirically supported studies.

Help-seeking intentions were measured with three different instruments. First, the Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975) assessed an individual's motivation to seek mental health services. This brief inventory was normed on college students and it captured typical issues students bring to counseling. Items in this instrument are summed, and higher scores indicate greater willingness to seek help. The present sample had a mean score of 38.40 ( $SD = 11.89$ ; item level mean = 2.25 with 2 representing unlikely between 1 = very unlikely and 4 = very likely); compared to the authors ( $M = 45.86$ ;  $SD = 16.45$ ), the present sample are unlikely to seek help based on the ISCI.

The General Help-Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005) was also used to assess help-seeking intentions. The GHSQ has been widely used in help-seeking research and was developed to measure help-seeking intentions for a range of problems from various helpers. The GHSQ provides the strength of an individual's intentions to seek help and their preference for source of help. The items are summed up to provide two separate scores, one for personal and emotional

issues ( $GHSQ_1$ ) and the other for suicidal thoughts ( $GHSQ_2$ ). Higher scores indicate greater willingness to seek psychological services. The mean score for the present sample for intentions to seek help for emotional and personal problems was 43.50 ( $SD = 10.89$ ; item level mean = 4.35 with 4 representing the neutral response between 1 = extremely unlikely and 7 = extremely likely). The present sample appears neutral in their willingness to seek help for personal concerns. The mean score for the present sample for intentions to seek help for suicidal thoughts was 47.35 ( $SD = 13.57$ ; item level mean = 4.73 with 5 representing the likely response between 1 = extremely unlikely and 7 = extremely likely). The present sample is likely to seek help for suicidal thoughts. In contrast, Deane, Skogstad, and Williams (1999) reported participants were more likely to seek help for emotional and personal problems ( $M = 5.23$ ;  $SD = 2.53$ ) than suicidal thoughts ( $M = 4.45$ ;  $SD = 3.10$ ). The aforementioned Pearson correlation coefficients were calculated to explore the relationships among variables featured in the model and will be briefly discussed.

### **Relationships Among Study Variables**

The present study examined help-seeking intentions by exploring the relationships between theory-based and culturally relevant variables that affect one's intentions to seek help. As previously discussed, help-seeking attitudes serves as a direct predictor of intentions, while public stigma, self-stigma, psychological distress, cultural mistrust, and perceived behavioral control (PBC) serve as barriers and predictors to one's intentions to seek help. The present study explored these relationships with bivariate correlations ( $r$ ). Coefficients of determination ( $r^2$ ) are also reported to provide the proportion of the variance of one variable that is predictable from another variable. Help-seeking barriers

and predictor variables are presented below in the following order: (a) public stigma, (b) self-stigma, (c) psychological distress, (d) cultural mistrust, and (e) PBC.

There was a significant negative correlation between public stigma (SSRPH) and attitudes toward seeking professional psychological help (ATSPPH) ( $r = -.18, n = 149, p = .029; r^2 = .032$ ). This indicates a small association between public stigma and ATSPPH. As levels of public stigma awareness increase, attitudes toward seeking professional psychological help decreases. Moreover, 3.2% of the variability in public stigma was accounted for by attitudes toward seeking help. Public stigma and intentions were not significantly related using GHSQ1, GHSQ2, or ISCI ( $r = -.08, n = 143, p = .335, r^2 = .006; r = -.08, n = 137, p = .373, r^2 = .006; r = -.02, n = 149, p = .810, r^2 = .000$  respectively). Less than 1% of the variability in public stigma was accounted for by help-seeking intentions for personal concerns or suicidal ideation across all variables.

Self-stigma was significantly related to both help-seeking attitudes and intentions. Self-stigma (SSOSH) was negatively correlated to ATSPPH ( $r = -.43, n = 149, p = .000; r^2 = .184$ ). This is indicative of a medium relationship between self-stigma and ATSPPH. Furthermore, 18.4% of the variance in self-stigma was accounted for by attitudes toward seeking help. GHSQ1, GHSQ2, and ISCI were negatively related to SSOSH ( $r = -.32, n = 143, p = .000, r^2 = .102; r = -.22, n = 137, p = .010, r^2 = .048; r = -.17, n = 149, p = .036, r^2 = .030$  respectively). Results indicate a small to medium relationship between self-stigma using all measures of help-seeking intentions. As levels of internalized stigma increase, one's attitudes and willingness to seek mental health services decreases. Approximately 10.2% of the variance in self-stigma was accounted for by help-seeking intentions for personal concerns. Approximately 4.8% of the

variability in self-stigma was accounted for by help-seeking intentions for suicidal ideation. Three percent of the variance in self-stigma was accounted for by intentions to seek help using the ISCI instrument.

Psychological distress (HSCL-21) was not significantly related to attitudes ( $r = .02, n = 149, p = .852, r^2 = .000$ ) or intentions to seek help for suicidal thoughts ( $r = -.13, n = 137, p = .135, r^2 = .016$ ). Less than .5% of the variance in psychological distress was accounted for by attitudes. Approximately 1.6% of the variability in psychological distress was accounted for by help-seeking intentions for suicidal ideation. Psychological distress was predictive of intentions to seek help for personal and emotional stressors ( $r = -.21, n = 143, p = .010, r^2 = .044$ ). Results indicate a small association. As one's personal and emotional stressors increases, their intentions to seek help decreases. Approximately 4.4% of the variance in psychological distress was accounted for by help-seeking intentions for personal and emotional concerns.

Cultural mistrust (CMI) was not significantly related to ATSPPH ( $r = -.14, n = 149, p = .097, r^2 = .020$ ). CMI was not significantly related to intentions using the ISCI ( $r = -.14, n = 149, p = .093, r^2 = .020$ ). Two percent of the variability in cultural mistrust was accounted for by help-seeking attitudes and intentions using the ISCI instrument. CMI was significantly related to intentions to seek help for both personal issues and suicidal thoughts ( $r = -.18, n = 143, p = .030, r^2 = .032; r = -.19, n = 137, p = .030, r^2 = .040$ , respectively). This indicates a small association. As mistrust of whites is reduced, the likelihood of seeking mental health services will increase. Approximately 3.2% of the variance in cultural mistrust was accounted for by help-seeking intentions for personal

and emotional concerns. Four percent of the variability in cultural mistrust was accounted for by help-seeking intentions for suicidal thoughts.

Perceived behavioral control (PBC) was positively related to ATSPPH ( $r = .37, n = 149, p = .000, r^2 = .140$ ). A medium relationship indicates that one's attitudes toward seeking professional psychological help are related to the belief they can adequately seek help when necessary. Fourteen percent of the variability in perceived behavioral control was accounted for by attitudes toward help-seeking. PBC was also significantly related to help-seeking intentions using all instruments: GHSQ<sub>1</sub> ( $r = .32, n = 143, p = .000, r^2 = .102$ ); GHSQ<sub>2</sub> ( $r = .24, n = 143, p = .005, r^2 = .060$ ); and ISCI ( $r = .22, n = 149, p = .007, r^2 = .050$ ). This indicates a small to medium association between PBC and help-seeking intentions. Approximately 10.2% of the variability in perceived behavioral control was accounted for by help-seeking intentions for personal concerns. Six percent of the variance in perceived behavioral control was accounted for by help-seeking intentions for suicidal ideation. Five percent of the variance in perceived behavioral control was accounted for by help-seeking intentions using the ISCI measure.

### **Group Differences for Help-Seeking Attitudes and Intentions**

A multivariate analysis of variance (MANOVA) was computed to test for differences between groups. Variables of interest include: gender and prior mental health experience across attitudes toward seeking professional psychological help and help-seeking intentions. Prior counseling and mental health are used interchangeably. First, the overall  $F$  test significance is reported for the model. Provided the MANOVA is statistically significant, follow-up of univariate results are reported for both dependent

variables. Then, differences between means and standard deviations for men and women and past mental health experience are listed in Tables 3 and 4.

A MANOVA was conducted to determine whether gender had an effect on attitudes toward seeking professional psychological help (ATSPPH) and help-seeking intentions. Results from the MANOVA model were not significant, Pillai's  $\lambda = .033$ ,  $F(4, 132) = 1.14$ ,  $p = .341$ . The present findings contradict previous research highlighting group differences in attitudes toward seeking professional psychological help (ATSPPH) and intentions between men and women (Deane et al., 1999; Fischer & Farina, 1995; Fischer & Turner, 1970). Given that gender had no significant effect on ATSPPH or intentions, univariate findings are not reported. Descriptive findings are listed in Table 3.

Table 3

*Descriptive Statistics for ATSPPH, ISCI, GHSQ<sub>1</sub>, and GHSQ<sub>2</sub> by Gender*

Variable	Gender	M	SD	N
ATSPPH	Male	17.56	4.81	56
	Female	18.26	5.84	81
	Total	17.97	5.44	137
ISCI	Male	36.63	11.30	56
	Female	40.22	12.31	81
	Total	38.75	12.00	137
GHSQ <sub>1</sub>	Male	42.41	10.73	56
	Female	44.13	10.96	81
	Total	43.42	10.86	137
GHSQ <sub>2</sub>	Male	47.72	11.68	56
	Female	47.10	14.80	81
	Total	47.35	13.57	137

*Note.* ATSPPH = Attitudes toward Seeking Professional Psychological Help; ISCI = Intentions to Seek Counseling Inventory; GHSQ<sub>1</sub> = General Help Seeking Questionnaire (personal & emotional issues); GHSQ<sub>2</sub> = General Help Seeking Questionnaire (suicidal ideation).

A MANOVA was also conducted to determine whether prior mental health experience had an effect on ATSPPH and help-seeking intentions. Similar to previous research, prior mental health experience had a significant effect on ATSPPH and help-seeking intentions in the present sample (Deane et al., 1999). Results from the MANOVA model were significant, Pillai's  $\lambda = .170$ ,  $F(4, 130) = 6.64$ ,  $p = .000$ . Given that prior mental health experience was determined to have a significant effect on ATSPPH and help-seeking intentions, univariate statistics were explored across the dependent variables. Findings indicate prior mental health experience has a significant effect of ATSPPH,  $F(1, 133) = 22.52$ ,  $p < .001$ . Prior mental health experience has a significant effect on help-seeking intentions when measured with the ISCI,  $F(1, 133) = 5.08$ ,  $p = .026$ . Prior mental health experience does not have a significant effect on help-seeking intentions when measured with the GHSQ<sub>1</sub>,  $F(1, 133) = 3.13$ ,  $p = .079$ . Similarly, prior mental health experience does not have a significant effect on help-seeking intentions when measured with the GHSQ<sub>2</sub>,  $F(1, 133) = .221$ ,  $p = .639$ . Given the unexpected findings of GHSQ<sub>1</sub> and GHSQ<sub>2</sub>, basic descriptive statistics are reported in Table 4.

Table 4

*Descriptive Statistics for ATSPPH, ISCI, GHSQ<sub>1</sub>, and GHSQ<sub>2</sub> by Prior Mental Health Experience*

Variable	Prior Mental Health Service	M	SD	N
ATSPPH	Yes	20.48*	4.17	57
	No	16.34	5.52	78
	Total	18.09	5.38	135
ISCI	Yes	41.43*	9.98	57
	No	36.81	12.89	78
	Total	38.76	11.93	135

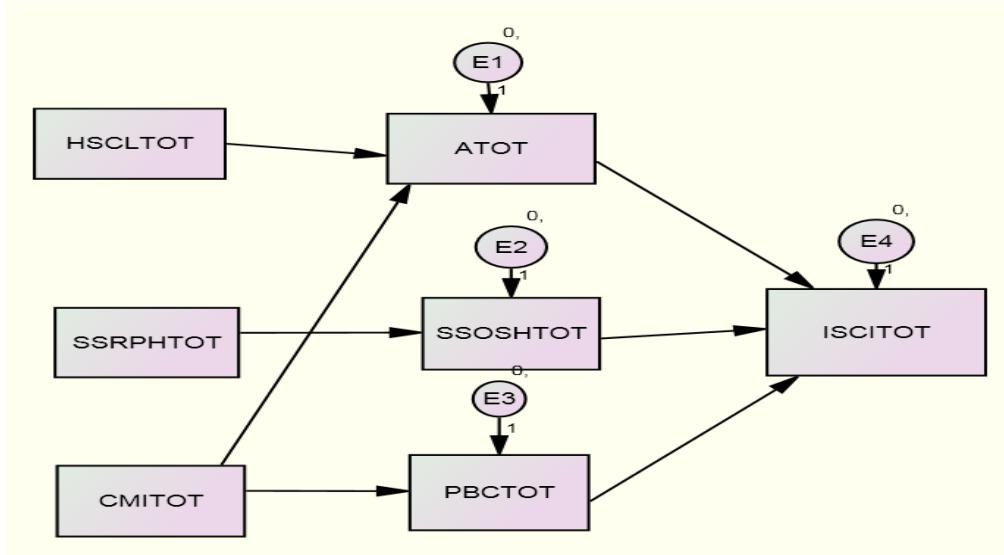
Table 4—Continued

<b>Variable</b>	<b>Prior Mental Health Service</b>	<b>M</b>	<b>SD</b>	<b>N</b>
GHSQ <sub>1</sub>	Yes	45.53	9.47	57
	No	42.21	11.57	78
	Total	43.61	10.83	135
GHSQ <sub>2</sub>	Yes	48.01	12.37	57
	No	46.90	14.34	78
	Total	47.37	13.50	135

*Note.* ATSPPH = Attitudes toward Seeking Professional Psychological Help; ISCI = Intentions to Seek Counseling Inventory; GHSQ<sub>1</sub> = General Help Seeking Questionnaire (personal & emotional issues); GHSQ<sub>2</sub> = General Help Seeking Questionnaire (suicidal ideation).

### Tests of Hypotheses

In order to address the research question and hypotheses concerning help-seeking intentions among Black American churchgoers, a total of three models were constructed using AMOS 19 statistical software. These complex models included a host of culturally relevant and theoretically supported variables based on review of the literature, and were proposed as the a priori model to be tested. The following variables were of particular interest: (a) attitudes toward seeking professional psychological help, (b) psychological distress, (c) cultural mistrust, (d) public stigma, (e) self-stigma, (f) perceived behavioral control, and (g) intentions to seek help. The first model examined the relationships among exogenous variables: (a) psychological distress, (b) public stigma, and (c) cultural mistrust; and endogenous variables: (a) attitudes toward seeking professional psychological help, (b) self-stigma, (c) perceived behavioral control, and (d) intention to seek help. The model is presented in Figure 2.



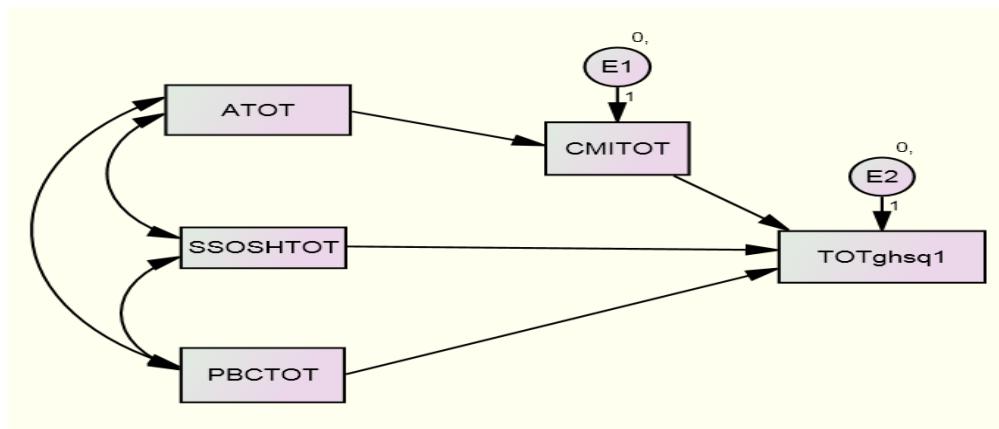
*Figure 2. Model 1: Direct path to help-seeking intentions.*

HSCLTOT = psychological distress; SSRPHTOT = public stigma; CMI = cultural mistrust; ATOT = attitudes toward seeking professional psychological help; SSOSHTOT = self-stigma; PBCTOT = perceived behavioral control; ISCITOT = intentions to seek help.

The second and third models are post hoc examinations of the relationships among study variables based on findings from the bivariate correlations. The post-hoc examinations consist of two trimmed path models featuring the best associated theoretical and culturally relevant variables listed in the correlation matrix. Based on the correlation results, variables with only one statistically significant correlation were not included in the post hoc model; thus, public stigma and psychological distress were dropped from the second and third models. Of note, the second and third models assess intentions to seek help using two different instruments. The original model measures help-seeking intentions using the Intentions to Seek Counseling Inventory (ISCI) while, the second and third models feature the General Help-Seeking Questionnaire for personal and emotional problems (GHSQ<sub>1</sub>) and suicidal thoughts (GHSQ<sub>2</sub>) to measure help-seeking intentions, respectively.

GHSQ<sub>1</sub> and GHSQ<sub>2</sub> were the most significantly associated variables among each other and were strongly related to other variables for the present sample. A post-hoc examination was determined to be the most parsimonious plan of action, as it allowed the researcher to make adjustments to the second and third model. As noted above, these models retained variables that were related to help-seeking intentions (i.e., help-seeking attitudes, self-stigma, and perceived behavioral control) and a culturally relevant variable (i.e., cultural mistrust).

The second model examined the relationships among exogenous variables: (a) attitudes toward professional psychological help, (b) self-stigma, and (c) perceived behavioral control; and endogenous variables: (a) cultural mistrust and (b) intention to seek help for personal and emotional issues. The model is presented in Figure 3.

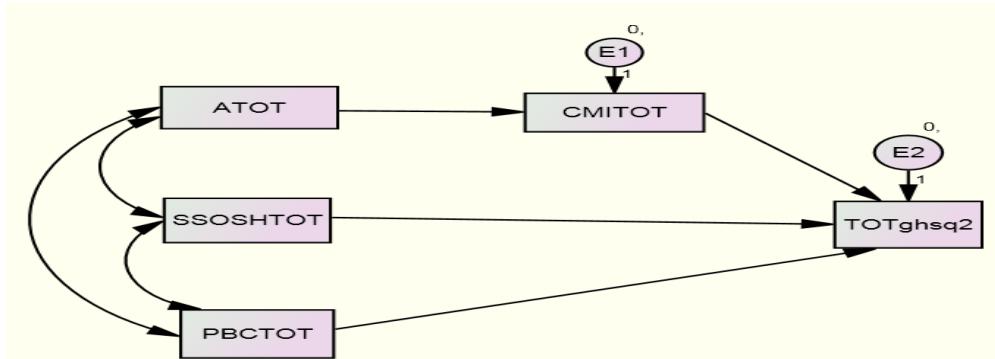


*Figure 3. Model 2: Post-hoc examination featuring help-seeking intentions for personal issues.*

ATOT = attitudes toward seeking professional psychological help; SSOSHTOT = self-stigma; PBCTOT = perceived behavioral control; CMITOT = cultural Mistrust; TOTGHSQ<sub>1</sub> = intentions to seek help for personal issue.

The third model examined the relationship among exogenous variables: (a) attitudes toward professional psychological help, (b) self-stigma, and (c) perceived

behavioral control; and endogenous variables: (a) cultural mistrust and (b) intention to seek help for suicidal ideation. The model is presented in Figure 4.



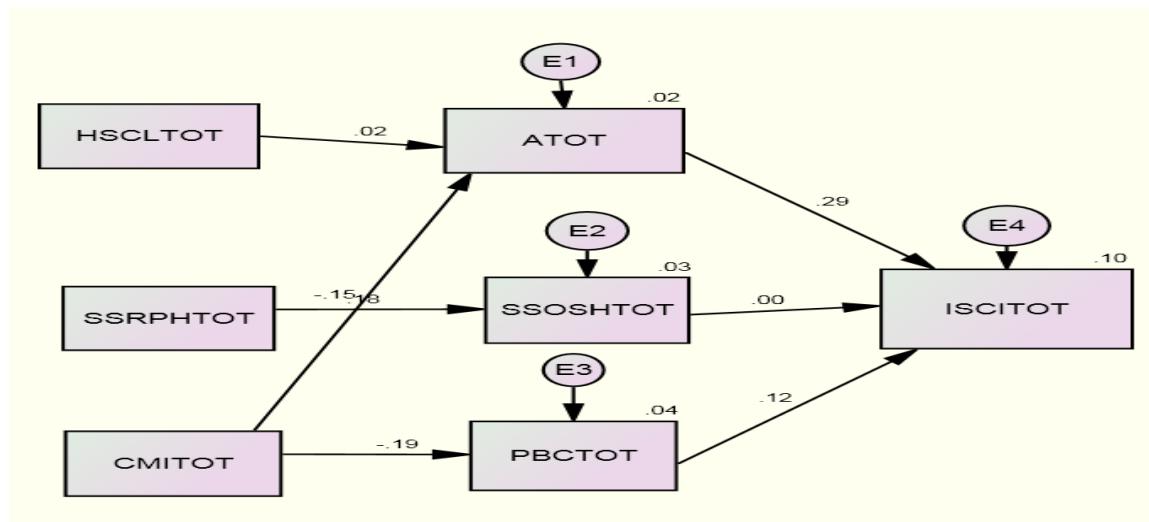
*Figure 4.* Model 3: A post-hoc examination featuring help-seeking intentions for suicidal ideation.

ATOT = attitudes toward seeking professional psychological help; SSOSHTOT = self-stigma; PBCTOT = perceived behavioral control; CMITOT = cultural Mistrust; TOTGHSQ<sub>2</sub> = intentions to seek help for suicidal ideation.

Similar to prior research goodness-of fit tests were used to minimize the probability of committing a Type I error. The present study used three indices to determine adequate fit of each model: comparative fit index (CFI), Tucker-Lewis Index (TLI), and root-mean-square error of approximation (RMSEA). Values on the CFI and TLI range between 0 and 1, with higher numbers indicating a better fit. Per Hu and Bentler's (1999) recommendations CFI and TLI values above .95 indicate a superior fit to the data. Hu and Benteler (1999) suggest a value near .05 for RMSEA is needed to yield an adequate fit of the data. Results exceeding these values are considered a misfit of the data.

Model 1 addresses the research question and hypotheses. The model suggests African American churchgoers' intentions to seek help would be predicted by mediating variables such as their attitudes toward professional psychological help (ATSPPH), their internal perception of seeking help (self-stigma), and the belief that they are able to seek

help (perceived behavioral control). Their level of emotional and personal distress, their level of mistrust toward Whites and White-related institutions, and their perception of how society will view them for seeking help (public stigma) were also hypothesized to be mediating variables. The model was determined to be a poor fit to the data ( $CFI = .185$ ;  $TLI = -.629$ ;  $RMSEA = .201$ ). As evidenced by previous research recommendations, Hu and Bentler (1999) suggested that a good model fit exist if  $CFI$  and  $TLI$  are at .95 or above. Also the  $RMSEA$  falls above the suggested .05. A review of the correlation coefficients provides important statistically significant relationships among these variables and demonstrates the significant predictors of help-seeking intentions. Findings from the path analysis indicate the pattern of relationships described by the model is not a good summary of how the variables affect each other. Figure 5 provides the model and variable estimates.



*Figure 5. Model 1: Results of direct path model featuring standardized estimates.*  
 HSCLTOT = psychological distress; SSRPHTOT = public stigma; CMI = cultural mistrust; ATOT = attitudes toward seeking professional psychological help; SSOSHTOT = self-stigma; PBCTOT = perceived behavioral control; ISCITOT = intention to seek help.

### Summary of Hypotheses for Model 1

Hypothesis 1 stated ATSPPH would be the most significant predictor of intentions to seek help ( $p \leq .001$ ). The researcher rejected the null for hypothesis 1. Hypothesis 2 stated psychological distress would predict help-seeking attitudes, which in turn would predict help-seeking intentions ( $p \geq .05$ ). The researcher failed to reject the null for hypothesis 2. Hypothesis 3 stated cultural mistrust would predict ATSPPH, which in turn would predict intention to seek help ( $p \geq .05$ ). The researcher failed to reject the null for hypothesis 3. Hypothesis 4 stated that cultural mistrust would predict perceived behavioral control (PBC), which would predict intention to seek help ( $p \geq .05$ ). The researcher failed to reject the null for hypothesis 4. Hypothesis 5 stated public stigma would predict self-stigma, which in turn would predict intentions to seek help ( $p \geq .05$ ). The researcher failed to reject the null hypothesis. Hypothesis 6 stated self-stigma would be a significant predictor of intentions to seek help. The researcher failed to reject the null hypothesis 6 ( $p \geq .05$ ); however this hypothesis was partially supported.

Table 5 lists the standardized path coefficient estimates. The following coefficients are statistically significant: SSOSHTOT – SSRPHTOT (.184,  $p = .022$ ); PBCTOT – CMITOT (-.189,  $p = .017$ ); ISCITOT – ATOT (.629,  $p < .001$ ).

Table 5

#### *Regression Estimates in Model 1*

		Estimate	S.E.	C.R.	<i>p</i>
SSOSHTOT	←	SSRPHTOT	.184	.151	2.297
ATOT	←	HSCLTOT	.023	.046	.293
PBCTOT	←	CMITOT	-.189	.015	-2.397
ATOT	←	CMITOT	-.152	.014	-1.917

Table 5—Continued

			Estimate	S.E.	C.R.	p
ISCITOT	←	SSOSHTOT	.000	.153	.002	.998
ISCITOT	←	ATOT	.291	.163	3.846	< .001
ISCITOT	←	PBCTOT	.120	.150	1.587	.113

Note. SSOSHTOT = Self-stigma, SSRPHTOT = Public stigma, ATOT = Attitudes toward seeking professional psychological help, HSCLTOT = Psychological distress, PBCTOT = Perceived behavioral control, CMI = Cultural Mistrust, ISCITOT = Intention to seek help. Statistically significant path coefficients are listed in bold print.

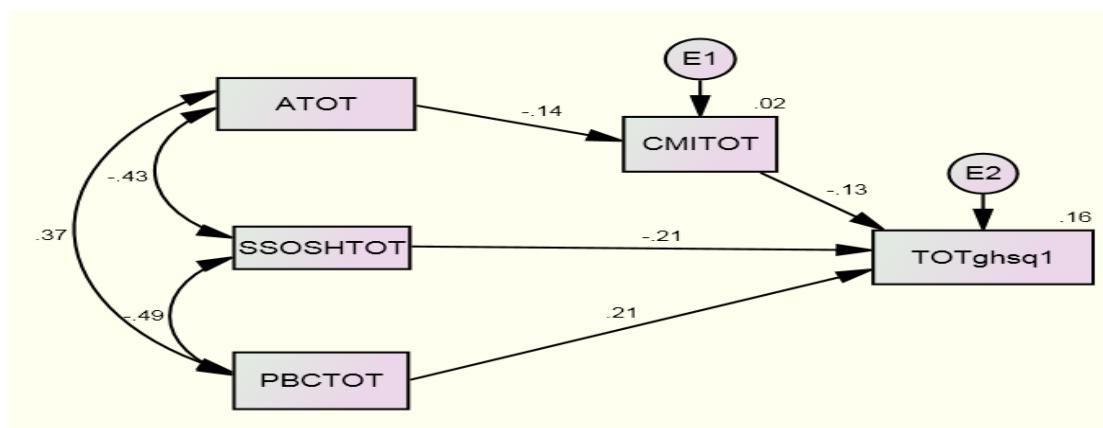
The post-hoc examination models were trimmed in accordance with path analysis literature. Grimm and Yarnold (1995) noted simplified path models are designed by removing variables with relationships that are small and insignificant (p. 81). Based on the correlation matrix, public stigma and psychological distress were removed from the alternative model because they were relatively unrelated to other variables for the present sample. Cultural mistrust and self-stigma remained in the model, serving as cultural determinants of help-seeking among African Americans. Help-seeking attitudes and perceived behavioral control remained in the alternative model because they were theoretically supported in assessing help-seeking intentions based on the theory of planned behavior, and they demonstrated statistically significant correlations with intentions.

The post-hoc models featured several changes including the addition of the General Help-Seeking Questionnaire for personal and emotional issues ( $GHSQ_1$ ) and for suicidal ideation ( $GHSQ_2$ ). The  $GHSQ_1$  and  $GHSQ_2$  replaced the Intentions to Seek Counseling Inventory (ISCI) and included less mediating variables toward help-seeking intentions, yielding two post-hoc models, one for each of the new intention variables ( $GHSQ_1$  and  $GHSQ_2$ ). Cultural mistrust was included as an exogenous variable instead of

an endogenous variable. The original model integrated various theory and culturally based variables to predict help-seeking intentions, the post-hoc models have been trimmed based on finding from the bivariate correlations.

Although the second and third models have been simplified, these models conceptualize cultural variables, particularly cultural mistrust, as adding complexity to how the theoretical model operates for this sample. These simplified models propose African American churchgoers' intentions to seek help for personal and emotional issues would be mediated by level of mistrust of Whites and White-related institutions and attitudes toward seek professional psychological help. Level of internalized stigma and the belief that an individual is capable of seeking help also serve as predictor variables in this model.

Model 2, featuring intentions to seek help for personal and emotional issues, (CFI = .921; TLI = -.604; RMSEA = .134) was determined to be a poor fit of the data. As previously stated, the CFI and TLI should fall above .95 and the RMSEA should be at .05 or less to be considered an adequate model. Figure 6 features the model.



**Figure 6.** Model 2: Results of alternative model featuring standardized estimates.  
ATOT = Attitudes toward seeking professional psychological help, SSOSHTOT = Self-stigma, PBCTOT = Perceived behavioral control, CMITOT = Cultural Mistrust, GHSQ<sub>1</sub> = Intention to seek help for personal and emotional issues.

Table 6 lists the standardized path coefficient estimates. The following coefficients are statistically significant: SSOSHTOT – GHSQ<sub>1</sub>TOT (-.207,  $p = .015$ ) and PBCTOT – GHSQ<sub>1</sub>TOT (.211,  $p = .018$ ). As expected greater intentions to seek help for personal problems was negatively related to internalized stigma toward mental illness and seeking help for emotional or psychological issues (Barney et al., 2006). Also the greater perception individuals maintained about their ability to successfully seek mental health services the greater the intention to seek help for personal and emotional problems. The path from ATOT to CMI to GHSQ<sub>1</sub>TOT is not significant.

Table 6

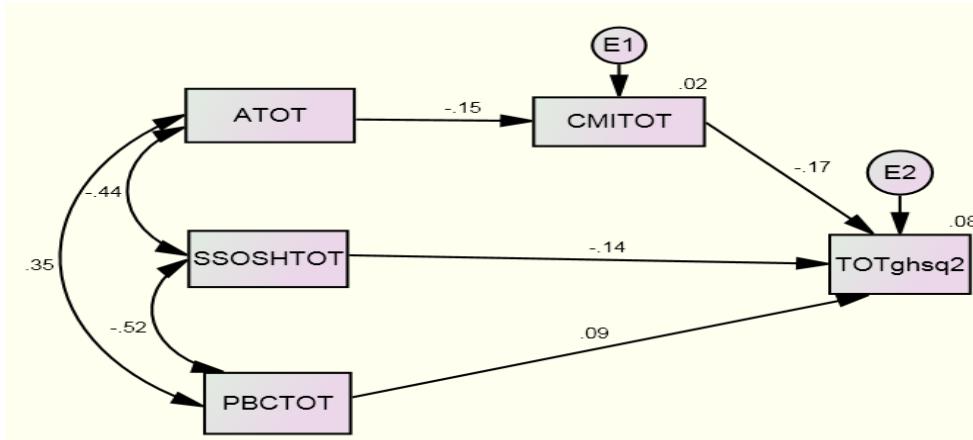
*Regression Estimates in Model 2*

			Estimate	S.E.	C.R.	<i>p</i>
CMITOT	←	ATOT	-.137	.467	-1.677	.094
GHSQ <sub>1</sub> TOT	←	CMITOT	-.129	.027	-1.659	.097
GHSQ <sub>1</sub> TOT	←	SSOSHTOT	-.207	.168	-2.424	<b>.015</b>
GHSQ <sub>1</sub> TOT	←	PBCTOT	.211	.168	2.360	<b>.018</b>

*Note.* CMITOT = cultural mistrust, ATOT = attitudes toward seeking professional psychological help, PBCTOT = perceived behavioral control, GHSQ<sub>1</sub> = intentions to seek help for personal issue. Statistically significant path coefficients are listed in bold print.

Model 3, featuring intentions to seek help for suicidal thoughts, examined whether African American churchgoers' intentions to seek help for suicidal thoughts would be predicted by level of mistrust of Whites and White-related institutions, attitudes toward seeking professional psychological help, level of internalized stigma, and the belief that an individual is capable of seeking help. This model was considered a poor fit as evidenced by statistical test results (CFI = .863; TLI = -.317; RMSEA = .173). The

CFI and TLI fall well below the recommended .95 and the RMSEA is above .05. Figure 7 features the model.



**Figure 7. Model 3: Results of alternative model featuring standardized estimates.**  
 ATOT = attitudes toward seeking professional psychological help, SSOSHTOT = self-stigma, PBCTOT = perceived behavioral control, CMITOT = cultural Mistrust, TOTGHSQ<sub>2</sub> = intentions to seek help for suicidal thoughts.

Table 7 lists the standardized path coefficient estimates. The following coefficients are statistically significant: GHSQ<sub>2</sub> – CMITOT (-.171,  $p = .034$ ). The path from ATOT to CMI to GHSQ<sub>1</sub>TOT is not significant. The present sample results contrast with previous research, which states that lower levels of mistrust of Whites and White-related institutions are associated with more positive attitudes toward seeking professional psychological help (Duncan, 2003; Nickerson, Helms, & Terrell) and a greater intention to seek help for suicidal thoughts.

Table 7

*Regression Estimates in Model 3*

		Estimate	S.E.	C.R.	<i>p</i>
CMITOT	← ATOT	-.150	.453	-1.893	<b>.058</b>
GHSQ <sub>2</sub> TOT	← PBCTOT	.094	.216	1.004	.315
GHSQ <sub>2</sub> TOT	← SSOSHTOT	-.142	.221	-1.510	.131

Table 7—Continued

		<b>Estimate</b>	<b>S.E.</b>	<b>C.R.</b>	<b>p</b>
GHSQ <sub>2</sub> TOT	← CMITOT	-.171	.035	-2.118	<b>.034</b>

*Note.* CMITOT = cultural mistrust, ATOT = attitudes toward seeking professional psychological help, PBCTOT = perceived behavioral control, GHSQ2TOT = intentions to seek help for suicidal thoughts. Statistically significant path coefficients are listed in bold print.

## CHAPTER IV

### DISCUSSION

The purpose of this study was to explore help-seeking intentions among Black American churchgoers through the examination of the following variables: attitudes toward seeking professional psychological help, cultural mistrust, psychological distress, self-stigma, public stigma, and perceived behavioral control. The present chapter begins by connecting major findings and ideas from this study to the Surgeon General's (DHHS, 2001) report discussed in the literature review. Then, the study hypotheses are summarized and findings are reported within the context of previous help-seeking attitudes and intentions literature and research. The chapter concludes with a discussion of implications of the findings, limitations of the study, and recommendations for future research.

#### **Connections to the 2001 Surgeon General's Report**

The 2001 Surgeon General's (DHHS, 2001) report on mental health and ethnic minorities served as a springboard for the present study. The report documented that African Americans are disproportionately affected by poor mental health and face substantial barriers to quality mental health services. Several barriers particularly germane to the present study include limited access and availability to quality mental health services and its link to underutilization of psychological treatment (Alvidrez, 1999). Attitudes toward mental illness, stigma attached to seeking help for mental illness, mistrust of health care providers, and lack of racial and ethnic similarities between

providers and clients have all been highlighted as significant barriers to help-seeking behaviors among African Americans (DHHS, 2001; Hines-Martin et al., 2003; Snowden, et al., 2008; Terrell & Terrell, 1984). The Surgeon General's (DHHS, 2001) report notably highlighted the significance of culture in mental health, including how an individual defines mental illness, how one acknowledges and reports distress, whether one seeks help for distressing issues, who one seeks help from, and coping strategies employed during stressful situations. The link between culture and help-seeking attitudes has been extensively documented. The present study sought to extend understanding of the role of culture in help seeking behaviors by integrating culture-specific variables into an established theory of help-seeking.

A central means by which culture was incorporated into this study was through the sample. Recognizing the integral role the church plays in African American communities, participants were recruited through local congregations. As expected, the present sample was highly involved in religious service attendance and engaging in other religious activities (e.g., Chatters et al., 1999). More than half of the present sample reported attending church services at least four to nine times per month. Many were involved in church ministries (72%), serving as members in the choir, on the church hospitality committee, and or in youth, men's, and women's ministries. Most participants (60%) in the present study self-identified as Baptist. Participants in the present sample were also relatively educated, with at least 88% having some college education. Interestingly, many of the participants (42%) had prior experience with counseling services. As expected, more female participants sought prior mental health services.

This sample differed somewhat from expectations based on the Surgeon General's (DHHS, 2001) report and other literature. Overall, the present sample seemed less influenced by the barriers discussed in this study. For example, they appeared to be well adjusted and minimally distressed. However, it is unclear which factors contribute to their well-being, as this was beyond the scope of the present study. Participants were aware of perceived public stigma attached to mental illness and help-seeking; however, they exhibited low levels of internalized stigma. Theoretically, awareness of public stigma is believed to lead to increased levels of self-stigma (Vogel, Bitman, Hammer, & Wade, 2013). Participants were relatively neutral in their trust level of Whites and White-related institutions. Moreover, participants in the present study strongly believed they were capable of seeking mental health services if necessary.

Although the proposed path models yielded a poor fit with the observed data, findings from other analyses suggest important relationships among study variables. Considering the paucity of literature on help seeking intentions and the dearth of research associated with African American churchgoers, this study provides a wealth of information. The present study found a statistically significant relationship between help-seeking intentions and attitudes among African American churchgoers. As expected, attitudes toward seeking professional help were also related to perceived behavioral control, and help-seeking intentions. These findings support parts of the theory of planned behavior model.

Although stigma has been extensively investigated in the help-seeking literature, little is known about the differences between self and public stigma. As expected, self-stigma was related to help-seeking attitudes and intention; however, public stigma was

only related to help-seeking attitudes. Although prior mental health experience was not included in the present study's model there were statistically significant differences in help-seeking attitudes and intentions based on whether or not participants had prior counseling experience.

### **Review of the Study's Hypotheses**

A review of the study hypotheses follows. For each hypothesis, discussion of path model findings is followed by discussion of notable aspects of bivariate correlation coefficients.

#### **Hypothesis 1: Help-seeking attitudes will be the most significant predictor of intentions among Black American churchgoers.**

Hypothesis 1 predicted attitudes toward seeking professional psychological help (ATSPPH) would be the most significant predictor of intentions; this hypothesis was supported. Research suggests help-seeking attitudes are the most reliable predictor of one's intentions to seek mental health services (Cepeda-Bento & Short, 1998; Vegel & Wester, 2003). The ATSPPH-SF scale used in this study significantly predicted help-seeking intentions for personal and emotional issues and suicidal thoughts. The ATSPPH measure significantly predicted help-seeking intentions across two measures (i.e., ISCI, GHSQ<sub>1</sub>, and GHSQ<sub>2</sub>). There is a dearth of literature on the relationship between help-seeking attitudes and intentions; however, research is available to support the current study's findings. Carlton and Deane (2000) found help-seeking attitudes predicted intentions to seek help for personal problems and suicidal ideation among a sample of 221 high school student in New Zealand. Deane and Todd (1996) found females and participants with more favorable attitudes toward seeking help showed greater

willingness to seek help for personal and emotional issues. In developing the original ATSPPH scale, Fischer and Turner (1970) found strong differences were present between genders, as females tended to endorse more positive attitudes toward seeking psychological help. Fischer and Farina (1995) corroborated the original findings, as their study found females appeared to have more positive attitudes than males. In a sample of 315 Black undergraduate college students, Duncan and Johnson (2007) found females had more positive attitudes toward psychological help. In contrast to previous research, gender did not have a significant effect on attitudes toward seeking help in the present sample. This could be attributed to a myriad of factors including prior mental health service experience, their church connection, and religious behaviors such as prayer.

Consistent with previous research, prior use of mental health services had a significant effect on help-seeking attitudes (Deane, Skogstad, & Williams, 1999). Deane and associates (1999) found participants with positive prior help-seeking experiences had more favorable attitudes and higher help-seeking intentions in comparison to participants with neutral or negative prior help-seeking experiences. Participants who sought mental health services in the past strongly endorsed positive help-seeking attitudes. The present sample had an equal number of women who endorsed prior counseling experience as those who had not previously sought mental health services. The number of women with prior counseling experience was more than double of the male participants.

In the second model, the path from help-seeking attitudes to cultural mistrust to help-seeking intentions for personal and emotional issues was not significant. Standardized path coefficients along the help-seeking attitudes path were not statistically significant. A review of the third model showed the path from help-seeking attitudes to

cultural mistrust to help-seeking intentions for suicidal thoughts was not significant. In contrast, researchers found participants endorsed greater intentions to seek help for suicidal thoughts than for personal and emotional issues. Deane, Skogstad, and Williams (1996) found male prisoners had lower intentions to seek help for suicidal thoughts in a sample of 111 New Zealand male prisoners.

The confirmation of this hypothesis supports the use of Ajzen's (1999) theory of planned behavior (TPB) to better understand help-seeking decisions. As previously stated, TPB posits attitudes are a direct determinant of intentions. In the future, accounting for social desirability might be helpful, as participants from the present study may have responded in a manner they deemed would be favorable to the researcher. More research is needed to examine the various coping mechanisms used within the African American population.

**Hypothesis 2: Psychological distress will predict help-seeking attitudes, which in turn will predict intentions to seek help.**

Hypothesis 2 stated psychological distress would predict one's help-seeking attitudes, which would predict help-seeking intentions; this hypothesis was not supported. In the present study, psychological distress was not associated with help-seeking attitudes. Psychological distress was negatively associated with intentions to seek help for personal issues, and was not significantly related to intentions to seek help for suicidal thoughts. Psychological distress served as exogenous variable in model 1, and was not included in the post-hoc examination given its lack of association among other study variables. The path from psychological distress to help-seeking attitudes to help-seeking intentions was not significant. The psychological distress path coefficient to help-seeking

attitudes was also not statistically significant; however, the path coefficient from help-seeking attitudes to intentions to seek help was significant. Deane and Todd (1996) reported only a small proportion of individuals who face distress seek help. Psychological distress and help-seeking attitudes in their study were reported as possible avoidance factors to mental health treatment.

Although findings from this study did not support the hypothesis, similar findings were reported by Wilson (2010) among a sample of Australian students. Wilson (2010) found higher levels of distress were associated to weaker intentions to seek help, a phenomenon referred to as help-avoidance. The researcher hypothesized help-avoidance is associated with increased levels of psychological distress among persons aged 15 to 25 years. The present findings support the need for deeper exploration of help-avoidance among the African American population.

**Hypothesis 3: Cultural mistrust will predict help-seeking attitudes, which in turn will predict help-seeking intentions.**

Hypothesis 3 stated cultural mistrust would predict attitudes toward professional psychological help, which in turn predicted help-seeking intentions; this hypothesis was not supported. A meta-analysis conducted by Whaley (2001) indicates cultural mistrust is significantly evident in African Americans psychosocial functioning, and cultural mistrust serves as a factor in the underutilization of mental health services among Blacks. In the present study, cultural mistrust was not significantly related to help-seeking attitudes; however, there was a significant negative correlation between cultural mistrust and intentions to seek help for personal issues and suicidal thoughts.

In model 1, the path from cultural mistrust to help-seeking attitudes to help-seeking intentions was not significant. Standardized path coefficients from cultural mistrust to attitudes were not statistically significant. The present conflict in findings is unclear, as Whaley (2001) reported cultural mistrust among African Americans predict more negative attitudes toward White clinicians in a sample ( $N = 154$ ) of African Americans with severe mental illness (Whaley, 2001). Duncan (2003) also reported a negative correlation between ATSPPH and CMI among a sample ( $N = 131$ ) of Black male college students. Nickerson, Helms, and Terrell (1994) found cultural mistrust to be the most reliable and powerful predictor of help-seeking attitudes among a sample ( $N = 105$ ) of Black college students. Notably, the present sample is minimally distressed and is neutral with respect to their mistrust of Whites and White-operated institutions. Hypothesis 3 is based on the relationship between cultural mistrust and help-seeking attitudes, which has been demonstrated to predict help-seeking intentions in prior research.

Few studies have examined the relationship between help-seeking attitudes and cultural mistrust among African American churchgoers, and even fewer have investigated the role of intentions on utilization among this population. Such contradicting findings illuminate the need for future research expansion. Although the present study did not capture the significance of cultural mistrust in the executed path analysis models, based on past literature and research cultural mistrust remains an important variable in the help-seeking process within this population. To date there are no peer-reviewed articles examining the relationship between cultural mistrust and help-seeking intentions, further exploration is, therefore, warranted.

**Hypothesis 4: Cultural mistrust will predict perceived behavioral control (PBC), which in turn will predict help-seeking intentions.**

Hypothesis 4 stated cultural mistrust would predict perceived behavioral control, which in turn would predict help-seeking intentions; this hypothesis was partially supported. Cultural mistrust and PBC had a significant negative association. As expected, PBC was significantly associated with help-seeking intentions (Ajzen, 1991). Mo and Mak (2009) found PBC to be the least related variable to intentions in a study that tested the Theory of Planned Behavior. In reconciling these inconsistent findings the researchers noted the influence of Chinese cultural might have played a role in the study outcome (Mo & Mak, 2009) in the aforementioned study.

In model 1, cultural mistrust serves as an exogenous variable. The path from cultural mistrust to PBC to help-seeking intentions was not significant. Model 1 featured a path from cultural mistrust to help-seeking attitudes to help-seeking intentions, which was not significant. In models 2 and 3, cultural mistrust is an endogenous variable mediating the relationship between help-seeking attitudes and intentions to seek help for personal concerns and suicidal thoughts. A review these models shows cultural mistrust does not serve well as a mediator among help-seeking attitudes, PBC, and intentions to seek help. While these models could not support this hypothesis, the role of cultural mistrust was definitely worth exploring within the context of help-seeking intentions among African Americans.

To date there are no peer-reviewed studies, only a dissertation, that have explored these variables within the framework of theory of planned behavior (Harewood, 2009). The lack of supporting evidence found in this study does not mean cultural mistrust is not a significant factor in one's intentions to seek help. In fact, the present study

demonstrates cultural mistrust is negatively associated with help-seeking intentions. In other words, higher levels of mistrust toward Whites and White-related institutions reduce a person's desire to seek help for interpersonal issues. Another point for consideration is mistrust of receiving mental health services within a secular system. Stegeman (2008) noted distrust of non-religious based counseling as one of four reasons why people choose to seek counseling services from clergy. Moreover, persons with religious ties fear secular counselors will not understand their problems or will disregard their values (Stegeman, 2008). It is possible that reported attitudes toward help-seeking for the present sample were influenced by concerns about engaging in counseling with secular mental health professionals.

**Hypothesis 5: Public stigma will predict self-stigma, which will predict help-seeking intentions.**

Hypothesis 5 stated public stigma would predict self-stigma, which would predict help-seeking intentions; this hypothesis was partially supported. The stigma of mental illness and seeking help from providers is well documented in the help-seeking literature; however, further exploration is needed in the distinction between self and public stigma (Corrigan, 2004). In the current study, self and public stigma were significantly related. Public stigma was not significantly related to help-seeking intentions (i.e., GHSQ<sub>1</sub>, GHSQ<sub>2</sub>, and ISCI). Self-stigma had a significant negative relationship with help-seeking intentions (i.e., GHSQ<sub>1</sub>, GHSQ<sub>2</sub>, and ISCI).

Vogel, Wade, and Hackler (2007) explored the relationship between self and public stigma, help-seeking attitudes, and intentions to seek mental health services. They found public stigma associated with mental illness predicted self-stigma associated with

seeking counseling, which in turn, predicted attitudes toward seeking help, and, finally, predicted help-seeking intentions for interpersonal issues (Vogel et al., 2007). Other researchers have found increased public and self-stigma minimizes the likelihood of seeking help from professional sources, as well as informal sources of help; in other words, stigma negatively predicts help-seeking (Barney, Griffiths, Jorm, & Christensen, 2006). The present study supports findings from prior research showing self-stigma to be independently related to help-seeking, whereas public stigma was not (Eisenberg et al., 2009). Although stigma has been identified as a significant barrier to help-seeking, more research is needed to distinguish the impact of public versus self-stigma on help-seeking, particularly among African Americans (Corrigan, 2004).

In model 1, the path from public stigma to self-stigma to help-seeking intentions was not significant. Standardized path coefficients for public stigma to self-stigma were statistically significant; however, the path coefficients from self-stigma to help-seeking intentions were not significant. Notably, self-stigma was a significant predictor of intentions to seek help for personal and emotional issues in the second model; however, self-stigma was not a significant predictor of intentions to seek help for suicidal ideation. Despite the discrepancies in findings the relationship between self and public stigma, and help-seeking intentions should not be dismissed. Findings from the present study suggest further exploration of the interplay between self and public stigma is needed. Future research could go a long way in providing practical interventions designed to minimize stigma and encourage people to enter counseling (Vogel et al., 2007).

**Hypothesis 6: Self-stigma will be a significant predictor of intentions to seek help.**

Hypothesis 6 stated self-stigma would significantly predict intentions to seek help; this hypothesis was supported in one of the three path analysis models. In model 1, self-stigma served as a mediating variable between public stigma and help-seeking intentions. Standardized path coefficients from self-stigma to intentions were not significant using the Intentions to Seek Counseling Inventory (ISCI). In the second model, self-stigma was a significant predictor of intentions to seek help for personal and emotional issues. Standardized path coefficients were statistically significant. In the third model, self-stigma was not a significant predictor of intentions to seek help for suicidal thoughts. This hypothesis was based on previous findings in the help-seeking literature. Self-stigma was the most significant predictor of help-seeking attitudes and intentions to seek help for personal and emotional issues. Similarly, researchers found self-stigma to be an important predictor of help-seeking attitudes and intentions and is said to be a more proximal predictor than public stigma (Vogel et al., 2007).

In aggregate, self-stigma was found to be a significant predictor of intentions in one of the hypothesized models, and self-stigma had a significant negative association to help-seeking intentions across all measures used in the present study. These findings support previous research stating increased self-stigma diminishes one's willingness to seek help (Vogel, Shechtman, & Wade, 2010). The present findings and supporting evidence suggest more research is needed on efficacious interventions to minimize stigma of mental illness and help-seeking for interpersonal concerns and suicidal ideation.

### **Implications for Clinical Practice**

The following implications for clinical practice integrate findings from the present study with ideas from the 2001 Surgeon General's (DHHS, 2001) report. Improvement of access and availability of treatment has been exhaustively noted in the help-seeking literature; however, the average clinician may not have the power to bring about systemic change in managed care and public health systems. The current study challenges mental health professionals to work within their own communities to promote good mental health, which could go a long way in the prevention of mental illness. This can be accomplished through hosting presentations, workshops, consultative services, and treatment programs at local churches, schools, and businesses within African American communities. A discussion concerning stigma and cultural mistrust would be helpful in changing attitudes toward seeking professional mental health services within the black community. Before this can take place, clinicians must actively seek more knowledge to understand the role of culture in mental health (DHHS, 2001). The present study provides mental health professionals with some insight on the many obstacles encountered by Black Americans within the mental health sector.

It would behoove clinicians to be familiar with the many barriers, coping strategies, and resources used within the African American community. Given the level of influence church leaders possess within the Black community, establishing an open line of communication with clergy on behalf of mental health professionals has the potential to significantly diminish barriers to seeking mental health services (Adkison-BRADLEY et al., 2005). Moreover, mental health professionals may strive to develop connections with church leaders and affiliates who could serve as an initial contact or

gatekeeper to psychological services. This strategy could be helpful in improving utilization of psychological services among African Americans.

A conceptual article by Brach and Fraser (2000) suggests cultural competency could greatly diminish the health disparities gap among racial and ethnic groups. The present study advises clinicians to strive to expand their training in their work with all ethnic groups. In the event that an African American client should seek treatment for an issue, clinicians should provide quality services with cultural awareness and sensitivity being paramount. Findings from the current study suggest that to appropriately respond to the African American clients, clinicians should have an understanding of how cultural mistrust, stigma, help-seeking attitudes, and spirituality serve as protective or risk factors for mental illness among racial and ethnic minorities.

### **Implications for Future Research**

This section provides implications for future research in the area of help-seeking and African Americans. One of the objectives of this study was to examine the utility of the theory of planned behavior to better understand help-seeking intentions of Black churchgoers. Over the years, several groundbreaking studies have highlighted significant mental health disparities among racial and ethnic groups in the United States. Studies collectively reflect differences between groups in the decision making process of seeking help for mental health problems. The help-seeking literature has made progress in facilitating a discussion about the role of culture in the help-seeking process; however, few studies have taken on the cumbersome task of incorporating both theoretical and cultural determinants into a help-seeking model. The present study considered some of

the cultural and theoretical factors supported by prior research to explore predictors of help-seeking intentions among African American churchgoers using the TPB.

The main research question and most hypotheses were not supported by the models used in this study. While TPB has demonstrated efficaciousness in predicting intentions for a host of health related behaviors, its effectiveness across mental health related categories varies (Godin & Kok, 1996). The TPB model does not account for the cultural factors that significantly impact racial groups in help-seeking behavior, which is a major limitation. Moreover, in an effort to create a parsimonious model to explain help-seeking intentions of African Americans, the present study did not include other barriers to help-seeking such as treatment fearfulness (Deane & Chamberlain, 1994), self-concealments (Masuda, Anderson, & Edmonds, 2012), and prior help-seeking (Deane et al., 1999). In reconciling the poorly fitted models featured in this study, the researcher concludes a culturally based model similar to TPB would have gone a long way in understanding help-seeking intentions of Black American churchgoers.

Stigma and help-seeking attitudes received a notable mention as two culturally determined factors in mental health service use in the 2001 Surgeon General's report (DHHS, 2001). The current study found help-seeking attitudes and self-stigma to be significant predictors of one's willingness to seek mental health services. Lastly, public stigma was found to significantly predict self-stigma in this study. The areas of self and public stigma have been documented as central factors to underutilization of mental health services (Vogel et al., 2010); yet, little is known about the interplay between self and public stigma and the help-seeking process. Future research should incorporate both forms of stigma in a model to examine its relationship to help-seeking behaviors along

with other mediating variables (Vogel et al., 2007). Moreover, further clarification is needed on which form of stigma is the most significant predictor of help-seeking among ethnic minorities (Corrigan, 2004).

### **Contributions and Limitations of Study**

Given the dearth of knowledge on help-seeking intentions of Black American churchgoers, the present study fills a much-needed gap in the literature. This study provides a useful starting place to address the complex relationship among attitudes toward seeking professional psychological help, cultural mistrust, psychological distress, self-stigma, public stigma, perceived behavioral control, and intentions to seek help. The contributions of this study highlight more research is needed to fully understand help-seeking within a cultural context. Most importantly, this study demonstrates the importance of conducting research that intentionally focuses on the overwhelming unmet mental health needs of Blacks. Prior to conducting this dissertation, the researcher read various studies that examined the current mental health state of African Americans from a deficit perspective; however, the present sample reflects a well-adjusted group. More research is needed to better understand coping strategies and strengths possessed by this population.

Much to the researcher's dismay, methodological and procedural limitations are inherent in all studies. Several issues with external validity are present in this study, particularly, sampling methods used to examine help-seeking intentions of African Americans. The use of purposive sampling allowed for a deeper understanding of an under-researched group within the African American population. However, researcher's bias in recruitment and selection of participants can pose a problem in defending the

sample's representativeness. The present sample was restricted to Black American churchgoers involved in ministries within traditional Black Christian church denominations. Consequently, Black Americans attending more racially integrated churches or those residing in other regions of the country did not have an equal opportunity to participate in this study. These drawbacks limit the researcher's confidence in generalizing results across the greater African American population. There were unique variations among the present sample worth highlighting: age, level education, income, relationship status, religious affiliation and attendance, and help-seeking attitudes toward mental health services, which in turn have an impact on intentions to seek mental health services when facing psychological distress. These characteristics among the sample help us better understand help-seeking within the African American population.

The present study featured two separate instruments to measure intentions to seek help. Although both instruments had previously demonstrated adequate reliability and validity, these findings were not demonstrated on a sample similar to the present study. The Intentions to Seek Counseling Inventory (ISCI) may not have been an appropriate instrument for this sample, as this measure is widely used to assess one's willingness to seek help for typical college student problems. The General Help-Seeking Questionnaire is used to assess intentions to seek help for a variety of problems from various help sources, not just mental health providers. Considering the dearth of research and literature on help-seeking intentions among the African American population, the GHSQ is an appropriate method for measuring help-seeking intentions and supports the specification of different problem-types and different help sources (Wilson et al., 2005). While it was

beyond the scope of this study to ascertain who the present sample would be willing to seek help from for concerns related to personal problems and suicidal ideation, future studies should assess whether GHSQ is psychometrically appropriate among ethnic minority groups. A more nuanced examination of the specific ways Black American churchgoers and the broader African American population seek help would further our understanding and ability to support positive mental health in this population.

Given the level of influence church leaders have among congregants and the researcher's connection to local churches, social desirability bias is a potential limitation in this study. Participants were asked to respond to personal questions about their church attendance and affiliation, level of psychological distress, previous help-seeking behavior, and intended use of mental health services. Participants may have felt pressured to respond to items in a socially acceptable manner especially in a church setting. Moreover, self-report instruments are susceptible to purposeful or inadvertent misrepresentations on behalf of the participant (Heppner et al., 2008). Assuring anonymity and confidentiality of participants on behalf of the researcher is integral in best practice research methods (Crow & Wiles, 2008). While the researcher could not guarantee total anonymity, participant responses were kept confidential and personal identifying characteristics were not collected. In reviewing previous research the present sample seemed to respond to the measures in a typical manner.

The present study was loosely based on the theory of planned behavior. Findings gained from the analysis should be interpreted with caution because of the additional variables added to the TPB model. Considering what is known about help-seeking among African Americans, adding culture-specific variables such as cultural mistrust, stigma,

and other demographic information has robustly contributed to the literature. Although these variables were not demonstrated to fit well into TPB, researchers assert that culture plays a pivotal role in understanding the help-seeking process among African Americans (DHHS, 2001). Further expansion to a better culturally sensitive model is warranted for TPB. TPB assumes people have beliefs about factors that facilitate or impede them from executing a behavior (Fishbein & Ajzen, 2010). However, TPB does not take into account the numerous individual, environmental, and institutional barriers that may influence an individual's intention to seek help. The use of TPB model also highlights further clarification is warranted for how African Americans define mental health concerns, how they go about seeking help for their problems, and preferred treatment providers (Neighbors, 1985).

Neighbors (1985) used a "stressful episode" model to examine the use of medical and mental health services for serious personal and emotional problems among a sample of Black Americans. Results indicated only 9% of the respondents sought professional help from a community mental health center, psychiatrist, or psychologist, even when their problem was so severe it brought them to a point of a nervous breakdown (Neighbors, 1985). These findings along with results from the present study suggest help-seeking behavior is not always a planned action, particularly, among African Americans. Researchers suggest the process of help-seeking is largely driven by cultural and contextual factors that determine how an individual identifies a problem, decides to seek help, and selects a treatment provider (Cauce et al., 2002). Application of Neighbors' (1985) stressful episode model in future research examining the breadth of variables

included in the present study may provide important information concerning varied help seeking behaviors in African Americans.

The primary methods of analyses used in the present study were path analysis and multivariate statistical methods. Moreover, variables used within the path model were based on correlational data. At its core path analysis assesses whether the relationships between variables in the data set reflect the causal hypotheses in the model (Lleras, 2005). While correlational research design is helpful in explaining how one phenomenon is related to another (Heppner et al., 2008, p. 245). Consequently, results gathered from the analysis must be interpreted with caution as causal inference cannot be made.

### **Closing Remarks**

In conclusion, the present chapter reviewed and explained findings from the study. While most hypotheses could not be supported, the findings featured in this study contribute to filling major gaps in the help-seeking literature. The present study took our understanding of the mental health utilization one step further with the inclusion of help-seeking intentions; particularly, the addition of TPB provided a theoretical underpinning to better understand the help-seeking process. Given that help-seeking intentions have been heavily investigated outside of the United States, particularly in Australia (Bayer & Peay, 1997; Deane & Todd, 1996; Wilson et al., 2005), little is known about how help-seeking intentions fit into the decision making process to seek mental health services among Americans much less African Americans. This study highlighted the overwhelming need of further examination of help-seeking intentions, which provides a deeper understanding of utilization among African Americans.

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Appendix A  
Demographic Questionnaire

**Demographic Data Questionnaire**

**Please complete each of the following items. Thank you for your participation.**

1. Gender:                    Male                    Female

2. Age \_\_\_\_\_

3. Marital Status:            Married              Divorced              Widowed              Single

4. Please circle racial/ethnic background

1. Black or African American
  2. Other (e.g. Haitian, Jamaican, Bi-racial, multi-racial)
- 

5. Approximate Annual Income

1. Under \$10,000
  2. \$10,000-\$25,000
  3. 26,000-\$45,000
  4. \$46,000-65,000
  5. \$66,000-85,000
  6. 86,000-105,000
  7. 106,000 or more
  8. Other \_\_\_\_\_
- 

6. Highest level of education

1. Grade School/Elementary School
  2. High School
  3. Some College
  4. College Graduate
  5. Graduate or Professional School
  6. Other \_\_\_\_\_
- 

7. Please indicate religious affiliation that best describes you.

1. Methodist (AME, AME Zion, CME)
  2. Church Of God In Christ (COGIC)
  3. Baptist
  4. United Church of Christ (UCC)
  5. Non-Denominational
  6. Other \_\_\_\_\_
-

8. Are you involved in any ministries in the church if so please specify?

1. Yes \_\_\_\_\_
2. No

9. How often do you attend church service, bible study, auxiliary meetings, and other church events?

1. 1-3 times per month
2. 4-6 times per month
3. 7-9 times per month
4. Please specify \_\_\_\_\_

10. Have you ever sought counseling services from a licensed professional counselor, psychologist, psychiatrist, or social worker for personal or emotional concerns?

1. Yes
2. No

11. Have you served in the United States armed forces, if so please specify branch of service?

1. Yes \_\_\_\_\_
2. No

**Appendix B**  
**Human Subjects Institutional Review Board Approval**

# WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: June 19, 2012

To: Mary Z Anderson, Principal Investigator  
Krystelle Jean-Michael, Student Investigator for Dissertation  
From: Amy Naugle, Ph.D., Chair *Amy Naugle*  
Re: HSIRB Project Number 12-06-03

This letter will serve as confirmation that your research project titled "Exploring Help-Seeking Intentions Among black-American Church Goers" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., *you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study."*) Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

**Reapproval of the project is required if it extends beyond the termination date stated below.**

The Board wishes you success in the pursuit of your research goals.

Approval Termination: June 19, 2013

# WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: February 6, 2013

To: Mary Z. Anderson, Principal Investigator  
Krystelle Jean-Michael, Student Investigator for Dissertation  
From: Amy Naugle, Ph.D., Chair *Amy Naugle*  
Re: HSIRB Project Number 12-06-03

This letter will serve as confirmation that the change to your research project titled "Exploring Help-Seeking Intentions Among black-American Church Goers" requested in your memo received February 5, 2013 (to add statistical consultants Haolai (Lincoln) Jiang and Marianne Di Pierro) has been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: June 19, 2013