Cultural Values Religiosity and Spirituality as Predictors of Professional Psychological

Help-Seeking Behavior of Black Adults in the United States

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ABSTRACT

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Many Black adults in the United States experience significant mental health problems in their lives yet are reticent to seek professional psychological help. This underutilization of mental health services has been documented in several studies and national reports. Various factors have been identified over the years as researchers attempted to understand the discrepancy between the psychological services that Black adults need and what they access. With the continued low level of access, researchers have begun to examine this behavior within the cultural context of the Black community. More particularly research has focused on investigating how cultural values impact health behavior and might influence the mental health behavior of Black adults in the United States.

This study examined a cluster of cultural values to identify how they might be related to professional psychological help-seeking behavior. More specifically, the study investigated whether collectivism/individualism, fatalism, famalism, spirituality and religiosity would predict professional help-seeking behavior for 343 Black adult men and women from the Northeastern and Southeastern United States. Multiple regression analyses and Chi Square tests were used to analyze the data. A logistic regression model including all of the variables just noted was significantly predictive of whether

professional psychological help had been sought. In subsequent univariate analyses controlling for the effects of the other variables in the model, only familism was found to be a unique predictor of professional help-seeking behavior and was negatively related to having sought help.

Similar results were obtained for a linear regression examining whether the predictors together would predict intentions to seek counseling. In the presence of all the predictors, spirituality was a positively significant predictor over and above the effects of the other variables. Demographic variables (education, years in the U.S., having a family member in therapy, and having a mental health professional in the social network) were positive predictors of help-seeking behavior and intentions to seek counseling. Age was negatively related to intentions to seek counseling. The study also examined whether intentions to seek counseling could be used as a proxy to actual behavior as proposed by the theory of Planned Behavior, and this was supported by the results of a logistic regression that showed intentions to be a positively significant predictor of help-seeking behavior. Chi Square tests examining the difference between the help-seeking behavior of Black men and women found no significant difference. The implications for practice, research and training were discussed.

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ACKNOWLEDGEMENTS

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Chapter I

Introduction

American society, like other societies places great value on the healthy individual, and some have even ventured to say that Americans are obsessed with their health (Adelson, 2000; Thomas, 2003). Those who are healthy are usually valued over those who are ill, because they can carry out their social roles in order to maintain and develop the different systems in society (Lieban, 1977). Stewart and Bennett (1991) maintained that in the United States, illness, whether physical or mental is seen as dysfunctional because individuals are measured by their productive ability, and it is presumed that a person has to be healthy to contribute to society. Thomas (2003) concurred when he wrote, "sickness in U.S. society is associated with inferiority and the condition implies that sick persons are not as capable as well ones. Our compassion for the infirm is tempered by a concern that the individual is not pulling his or her weight as a society member" (p.5).

Consequently, society takes it upon itself to provide a variety of services necessary to minimize illness (Thomas, 2003). For example, the mainstream society in the United States has designated professionals, by virtue of their training and education, that the sick might consult when they are unable to address ill-health (i.e., physical and psychological illness) on their own. In spite of this, scholars have observed that people are less likely to seek help for psychological illness, and research continues to investigate why this is so (Corney, 1990; Furr, Westefeld, McConnell & Jenkins, 2001; Westefeld & Furr, 1987), even as recourse to professional services for mental distress is encouraged (USDHHS, 2001).

Professional Psychological Service Use

Nonetheless, the United States has not been known to provide equal health service opportunities for the different racial and ethnic groups of which it is comprised (Airhihenbuwa, 1995; Airhihenbuwa & Liburd, 2006**).** The incidence of mental health problems among minority groups such as Blacks, Hispanics, and Asians, and the underutilization of mental health services among their members have been cited as evidence of the disparity in mental health services to these sectors in the United States (Cooper-Patrick et al. 1999; Neighbors & Howard, 1987; Rosenthal & Wilson, 2008). For instance, these scholars confirm that Blacks consistently underutilize professional mental health services despite high incidence of anxiety and depression in this population. In analyzing this dilemma, some (e.g., Adewuya & Makanjuola, 2008; Hartog & Gow, 2005; Helman, 2000) propose that a major factor is that minority groups often hold different perceptions and beliefs about mental health problems that are at odds with the services that are available. Such health beliefs and perceptions are based on different models of health and would be discussed next.

Perception of Mental Health Problems

In Western society such as the United States, the medical model of health is the prevalent framework for understanding issues related to illness (Helman, 2000; Scrimshaw, 2001). According to this medical understanding, biological processes and external factors (e.g., germs) that are often out of the person's control cause physical illness, thus people are encouraged to seek help from medical doctors in order to return to health. Similarly, society has extended the medical model that is used in the area of physical illness to emotional or mental illness, although there is debate among

practitioners about the appropriateness of the model for psychological health (Elkins, 2009). In addition, people's belief about the causes of emotional distress often conflicted with the strict medical model that is in use.

In studies of lay beliefs and perceptions about mental or emotional illness, researchers have identified beliefs that are consistent with both the Western medical model and the non-Western understanding (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Scrimshaw, 2001). For example, Luk and Bond (1992) assessed lay beliefs about mental illness, and categorized the factors underlying the beliefs as environmental/hereditary that reflects the Western model, and social/personal that represents non-Western thinking. Factors such as work environment, genetic predisposition and working of the brain and nervous system were associated with the environmental/ hereditary category, while religious beliefs, quality of life and other social and psychological elements were designated social/personal.

Other studies reveal that Whites who are from, or are influenced by Western cultures, are more likely to attribute mental illness to environmental/hereditary factors such as chemical imbalances in the brain, and hereditary or genetic factors, that fit the Western medical model of illness (Chen & Mak, 2008; Link et al., 1999; Sheikh & Furnham, 2000). On the other hand, minority groups such as African Americans, and other people of color who follow non-Western culture, put more emphasis on factors that are sociological (e.g., oppression or racism), psychological (e.g., stress, trauma), spiritual (e.g., distance from God), and supernatural (e.g., witchcraft and evil spirits) (Adewuya & Makanjuola, 2008; Airhihenbuwa, 1995; Dain, 1992; Hartog & Gow, 2005; Matthews, Corrigan, Smith, & Aranda, 2006; Schnittker, Freese, & Powell, 2000). These differences

in beliefs about mental health are attributed to culture, because scholars (e.g. Lieban, 1977; Helman, 2000) submit that beliefs are shaped by the culture of a people. The discussion that follows would address this claim.

Culture and Its Influence on Mental Health

The differences in beliefs about emotional or mental illness, even among people who live within the same society indicate the presence of different value systems for making judgments about illness. Social scientists purport that beliefs are shaped by culture, and in order to understand the beliefs and value systems of a people, one needs to look at the culture within which such beliefs are formed (Harris, 1999; Herskovits, 1967; Nuckolls, 1998). Practitioners and sociologists who work with people from different societies further attest to the need to understand the nature of culture, and how it influences people's behavior in response to illness (e.g., Helman, 2000; Scrimshaw, 2001). They claim that such knowledge could prevent clinicians and researchers from viewing behavior and health practices of people from diverse cultural background as maladaptive when these practices digress from the more acceptable norms.

Although there is voluminous literature on culture, agreement on what constitutes culture is almost non-existent. Kroeber and Kluckhohn (1952) identified as many as one hundred and sixty-four definitions of culture, each promoting an idea of what constitutes culture. Herskovits (1967), later identified the following four common dimensions of culture: (a) it can be learned, (b) it allows humans to adapt to their social setting, (c) there is great variation among cultures, and (d) it is manifested in institutions, ways of thinking and behaving. Harris (1999) added that culture is a socially learned way of living in

human society that includes both thought and behavior, which are influenced by societal values.

Likewise, Nuckolls, (1998) theorized that values are an integral and indispensable aspect of culture because they are the driving force behind actions, for both individuals and groups. He acknowledged that although individual values can be a reflection of self-identity, the values of the collective group (i.e., cultural values) are what bind people together (see also Kluckhohn et al., 1951). Stewart and Bennett (1991) posited that cultural values dictate what actions and attitudes members of a culture accept and embrace as good and desirable. They contended that although values are not inherently behaviors, they guide people of a particular culture in deciding what they ought to do. In other words, the values that people hold decide which actions or behaviors are believed to be better than others.

Culture is therefore the framework within which values are formed. The values in turn shape the beliefs that determine behavior. More importantly, although there are individual values, cultural values are the common norms for forming judgment about behavior. And since these cultural values are the frame of reference for behavior, differences in behavior around health could be ascribed to diverse cultural values. Identifying the health related cultural values and understanding how they influence behavior could therefore provide greater perceptiveness into the professional psychological help-seeking behavior among Black men and women in the United States.

Cultural Values

Sociologists and cross-cultural psychologists have identified and described cultural values that are significant for both the dominant and minority groups in the

United States. Stewart and Bennett (1991) identified individualism, autonomy, mastery, self-reliance, competition and personal responsibility among the cultural values held by the dominant White middle-class population of the U.S., and Carter (2001) noted that mainstream White American life is also characterized by future-time orientation, and doing-oriented activity. On the other hand, non-dominant groups such as African Americans endorse values such as collectivism, interdependence, communalism and cooperation that are seen as opposite to the values of the dominant White population in the United States (Andres-Hyman et al., 2006). Familism, filial piety, and fatalism are also important cultural values that are manifested in the daily lives of people of color (Andres-Hyman, Ortiz, Anez, Paris & Davidson, 2006; Airhihenbuwa 1995; Gaines et al., 1991; Kim, Knight & Longmire 2007; Sabogal, Marín, Otero-Sabogal, Marín, & Pérez-Stable, 1987; Schwartz, 2007).

Commenting on the differences between the cultural values of people of color and White people in the United States, Airhihenbuwa and Liburd (2006) explained that segregation facilitated the preservation of indigenous patterns of behavior and made it possible for minority groups to live in an individualistic society, yet hold collectivistic values. They argued that the hostile social situation also forced minorities, and more particularly Blacks to find ways to make sense of the oppression and disadvantages that were part of their daily experiences. Religion became one of the ways of uniting and encouraging this group and today scholars identify spirituality and religiosity as distinguishing marks of Blacks in the United States (Frame & Williams, 1996; Mattis & Jagers, 2001). Hines, and Boyd-Franklin, (1982) even contended that many of the cultural values of Black people stem from their religious and spiritual beliefs. The place of

spirituality and religiosity in the lives of Blacks will therefore be addressed in the subsequent paragraphs.

Religiosity and Spirituality

Scholars claim that religion and spirituality play an important role in the lives of people of color, especially African Americans (Airhihenbuwa & Liburd, 2006; Lincoln, & Mamiya, 1990; Pargament, Poloma, & Tarakeshwar, 2001; Phinney, 1996; Taylor, Chatters, & Jackson, 2007). They attest that the Black church was a crucial element in Black culture, and that religion provided stability, direction and hope for African Americans amidst times of turmoil and oppression. As a result, Blacks developed a spirituality and commitment to their religious beliefs that allowed them to transcend situations that would have otherwise crippled them psychologically (Williams, 2000). Williams affirms that Black churches facilitated the growth and survival of Black communities by providing the frame of reference for life. Members were expected to live according to the values and beliefs espoused by the faith community and were held accountable for their actions. In fact, Farrow (2004) observed that commitment to religious and spiritual beliefs, or religiosity and spirituality assist in ensuring that values are "lived" by insisting on their indispensability in the culture. This is because religion and spirituality promote prosocial attitudes and behaviors, encouraging behaviors such as altruism, sense of community and acts of social justice in the community (Mattis & Jagers, 2001).

Farrow (2004) further attests that religious and spiritual commitment encourages respect for accepted standards of behavior, and implies that individuals who are spiritual or religious might act differently from those who are not, despite belonging to the same

racial group. As a result, the behavior of Blacks would be more meaningful when it is assessed in light of commitment or lack thereof to the religious and spiritual beliefs of the group. More specifically, such knowledge could prevent misunderstanding, and instead provide greater awareness into the help-seeking behavior that researchers have observed among Blacks in the United States. A cursory examination of how spirituality, religiosity and cultural values influence help-seeking behavior will suffice for the present discussion.

Influence of Cultural Values, Spirituality and Religiosity on Behavior

Cultural values influence a range of behaviors. From consumer behavior, to behavior related to health, cultural values play an important role in guiding people regarding what behavior they ought to engage in. For instance, cultural values guide American consumers' behavior in the purchase of cars (Henry, 1976), and buying of homes (Kellett, 1999). Regarding health, Boyle (2003) observed, that cultural values "shape human behavior and determine what individuals will do to maintain their health status, how they will care for themselves and others who become ill and where and from whom they will seek health care" (p. 3210). The author identifies such cultural values as health related cultural values, because of their connection to people's behavior around health issues.

Researchers have identified various health related cultural values that influence the decisions individuals make when they are confronted with ill health. For instance, research has found that the choice to seek or not seek care for diseases such as cancer and HIV has been influenced by values such as fatalism and familism (e.g., Dettenborn, DuHamel, Butts, Thompson, & Jandorf, 2004; Perry, 2007). The investigators concluded

that in some instances, those who are afflicted with the disease chose not to seek help because they believe that the outcome of the illness was outside their control. Others were committed to following the regimen of their treatments, with support from the family. Spirituality and religiosity too, are other health related values that have been identified as major factors that influence seeking help from professionals, whether for physical or mental health problems (Wallston, et al., 1999). George and colleagues (2001) as well as Matthew and companions (2006) concur that belief in a greater power (i.e., God) can act both as a deterrent to treatment as well as a positive force in seeking professional help for health related problems. In the former case, individuals who decide to depend solely on the power of God for the restoration of their health are more likely to not seek professional help, while others might see these services as opportunities provided by God for their care.

With regard to the influence on behavior related to mental health, cross-cultural psychologists have argued for the consideration of health related cultural values in understanding the professional psychological help-seeking behavior of people of color (e.g., Abe-Kim, Gong, & Takeuchi, 2004; Leong & Ponterotto, 2003; Lo & Fung, 1993; Mayers, Leavey, Vallianatou, & Barker, 2007; Mori, 2000; Sue & Zane, 1987). They agree that these cultural values influence professional psychological help-seeking attitudes (Tata & Leong, 1994; Watkins 2000), and contribute to the behavior, and choice of services that individuals seek when they are faced with mental health problems (Greenley, Mechanic, & Cleary, 1987; Kuhl, Jarkon-Horlick, & Morrissey, 1997; Neighbors, & Howard, 1987; Ojeda, & Bergstresser, 2008; Yorgason, Linville, & Zitzman, 2008).

A cluster of health related cultural values that has been culled from previous studies is the focus of current study**.** In particular, research has focused on investigating the relationship among professional psychological help-seeking behavior and collectivism/individualism, (Gloria, Castellanos, Park, & Kim, 2008; Tata & Leong, 1994), familism (Chadda, Agarwal, Singh, & Raheja, 2001; Russell, 2008), fatalism (e.g., Franklin et al., 2007; Furnham, Akande, & Baguma, 1999) as well as religiosity and spirituality (Matlock-Hetzel, 2005; Mayers et al., 2007; Mitchell & Baker, 2000).

However, unlike the wealth of information about psychological help-seeking attitude that is available, limited information is often gathered about psychological help-seeking behavior because of the focus on actual behavior as the only way to collect data. But, theories of human behavior and action suggest that intentions can also represent behavior on the part of the individual who has the particular intentions (Ajzen, 1988; Fishbein & Ajzen, 1975). The measurement of intentions together with actual behavior can therefore provide a wider range of information about help-seeking behavior. Whereas measurement of actual behavior would provide an account of the history of the behavior, assessing intentions would supply information about the likelihood of the behavior.

In addition, although research supports the intention-behavior connection, few studies have actually investigated the relationship, and scholars have called for future investigations that measure both actual behavior and intentions, or the likelihood of the behavior (Kelly & Achter, 1995). This is pertinent given that within the sample targeted for this investigation, there would be participants who might not have sought psychological help because their situation did not warrant it. Nonetheless, their intentions would be indicative of their help-seeking behavior should the occasion deem it necessary

(Webb & Sheeran, 2006). Current literature will therefore be reviewed in depth, in the next chapter, to outline the intention- behavior relationship and examine how it relates to professional psychological help-seeking behavior. Similar examination of the literature regarding the factors identified above ((i.e., collectivism/individualism, familism, fatalism, religiosity & spirituality) will also be undertaken.

Apart from the values of interest, there are consistent findings that gender is an influential factor in professional psychological help-seeking behavior (Greenley et al., 1987; Good, Dell, & Mintz, 1989; O'Neil, 1981). Researchers record that given similar situations, more women than men will seek help for psychological problems (Komiya, Good, & Sherrod, 2000; Kuo, Kwantes, Towson, & Nanson, 2006; Sheu & Sedlacek, 2004). The issues of traditional gender role and gender role conflict have been cited as an acceptable explanation for the difference. Still, the limitations in existing studies that will be discussed demand that further investigations be undertaken to clarify the relationship between professional psychological help-seeking behavior and the variables identified. This study will improve on existing research by extending the investigation to include intentions as a measure of behavior, and expanding the analysis to take into account variables such as spirituality and religiosity that have not previously been included in research that examined the impact of the health related cultural values such as collectivism/individualism and familism on help-seeking behavior. At the same time, it is worth noting that because of variations in scholars' understanding of these factors that will form the basis of the present study, the definitions of these variables as they would appear in the study are presented below.

Definitions of Variables

This study will focus on a cluster of health related cultural values culled from the literature: Individualism/collectivism, familism, fatalism and spirituality and religiosity. For the purpose of this study collectivism-individualism is defined as the degree to which the needs and wishes of the individual are observed over that of the group to which the person belongs (Triandis, 1989). Familism refers to the attitudes and beliefs that emphasize attachment and commitment to the nuclear and extended family network (Rodriguez, 2007). On the other hand, fatalism expresses the belief in one's inability to control his/her life (Neff & Hoppe, 1993). Religiosity, is defined as commitment to religious practices and beliefs, and is expressed through a religious community or organization (Piedmont, 2001), while spirituality refers to personal belief in the transcendent that gives meaning to life, but is not connected with institutional religion (Miller & Thoresen, 2003). In general, both religiosity and spirituality express commitment to religious and spiritual beliefs, but while religiosity is demonstrated through participation in organized religion, spirituality is more like the attribute of an individual and can be experienced outside of organized religion (George, Larson, Keonig, & McCullough, 2000; Miller & Thoresen, 1999). As will be discussed at length in the next chapter, each value contributes uniquely to decisions that are made about professional psychological help, which is formal help for mental problems that a person receives from professionals such as psychologists, counselors, psychiatrists or other mental health professionals. However, the extent to which these health related values contribute to professional psychological help continues to be the subject of research. The following conclusion summarizes the reasons for further research.

Conclusion

In essence, although there are indications that there are cultural values that influence professional help-seeking behavior, inconclusive and sometimes contradictory results from the studies suggest the need for further investigation in this area. The dearth of current literature suggests that not enough has been done to understand the impact of cultural values and spirituality and religiosity on help-seeking behavior. In the few studies that have focused on this issue, cultural values have been studied in isolation of each other, rather than together. There is therefore a need to understand the influence of the identified cultural values in the presence of others, because values occur together naturally. Further, the fact that religiosity and spirituality have not been assessed with cultural values despite the fact that religious and spiritual commitment can influence the behavior of people of color, calls for an expansion of the factors that are examined. Not least of all is the need for the complementary measurement of help-seeking intentions at the same time that actual help-seeking behavior is assessed. These concerns will therefore drive the investigation for the present study.

Purpose of Study

If cultural values orient a person to how problems are viewed and what behavior one ought to choose when experiencing psychological problems, it is reasonable to assume that cultural values might contribute to the difference in the use of mental health services for Blacks. The present study will therefore examine whether health related cultural values are significant predictors of psychological help-seeking behavior for Black adults in the United States. More specifically, the study will examine the contribution that religiosity and spirituality individually and jointly make with the health related cultural values of fatalism, familism, and collectivism/individualism to professional psychological help-seeking behavior. In addition the study will facilitate the examination of intentions as another measurement of behavior, thus allowing for a wider range of data to describe behavior. Overall the purpose of the study will be to add to the literature on the relationship between spirituality and religiosity and cultural values and professional help-seeking behavior.

Chapter 2

Literature Review

Help-Seeking Behavior of Blacks

Overview

Although Americans might be perceived as being fanatical about health, there is evidence to suggest that ill-health related to emotional and mental states is not viewed with the same severity as that of physical ill-health. For instance, although 28% of the adults in the United States experience mental health problems, only 15% sought professional help (U.S. Department of Health and Human Services, 1999). This is reflected even in situations where access to professional help might be easier. Furr and colleagues (2001) studied 1,455 college students from four different colleges and universities, and found that 53% reported experiencing depression, but only 17% had sought help. Although the general underutilization crosses ethnic and racial boundaries, researchers have found that in the United States, there are varying degrees to which different racial and ethnic groups are able to access services to maintain or promote good health. Willingness to take action to restore good health also differs among groups. This is particularly salient in the Black community in the United States, and this chapter will focus on the literature that examines the factors that might contribute to this situation.

The review of literature will begin with an examination of the present situation in the U.S, namely the disparity in psychological services and the underutilization of such services among Blacks. This will be examined in light of the occurrences of emotional and mental health issues among members of this population. The exposition will continue with a review of the literature on lay beliefs and perceptions of emotional and mental

health problems, because research suggests that use of psychological services is generally preceded by, and sometimes contingent upon, the beliefs about the causes of mental illness. The factors that contribute to such beliefs and perceptions are of major interest, and in this study the proposition is made that culture and health related cultural values should be considered in understanding behavior as it regards professional psychological help. The review will then segue to an overview of culture and health related cultural values and their impact on health behavior in general, but more specifically professional psychological help-seeking behavior. This study also proposes that intentions to seek professional psychological help could be used as a measure for help-seeking behavior because of the intention-behavior relationship established in previous studies. The utility of measuring intentions is that it offers the opportunity to gather information about help-seeking from individuals who might not have had cause to seek psychological help. Thus, assessing both actual behavior and intentions would expand the information that would otherwise reveal only help-seeking history. Examination of the literature on the relationship between intentions and behavior will therefore be undertaken.

Significant attention is then given to examining the literature on spirituality, religiosity, and health related cultural values that have been found to influence psychological help-seeking behavior. Each will be reviewed in relation to professional help-seeking behavior. Lastly, gender difference in professional help-seeking behavior will be examined because of consistent findings that delineate a male-female difference in the use of professional help. The review will end with the purpose of the study and the hypotheses that will guide the study. Throughout this work, the terms mental health

problems, emotional problems, psychological problems and mental illness are used interchangeably.

Disparity in Mental Health Services

In general, the available research indicates that ethnic minorities report higher levels of mental illness, and are less likely to have access to and receive specialized quality mental health services (Padgett, Patrick, Burns, & Schlesinger, 1994; Smedley, Stith, & Nelson, 2003; Sussman, Robins, & Earls, 1987; Thurston, & Phares, 2008; USDHHS, 2001). Theriot, Segal, and Cowsert (2003) concur that African-Americans receive less or inadequate outpatient mental health care, noting that the emergency service, and service from primary physicians that they often receive are usually brief, and often considered less desirable than services in other, more specialized settings. The disparity is substantiated by studies with regional and national samples, as well as more localized private samples.

For example, in an analysis of data from the Baltimore Epidemiological Catchment Area (ECA), Cooper-Patrick and colleagues (1999) found that Whites received more specialized mental health services than Blacks. Data were used to assess whether participants had sought psychological help (i.e., talk to a professional about a psychological problem), within the six months prior to the collection of the data. In this study, 590 African Americans, and 1072 Whites participated. The results showed that African Americans were 40% less likely to receive mental health services than Whites. This trend was observed later, in a national survey on mental illness, which documented that most Black Americans, who indicated that they suffered from depression, and other emotional problems, did not seek mental health services (Neighbors et al., 2007).

Raybuck, (1998), likewise reported the underutilization of professional services among Blacks, in a study that assessed professional help-seeking behavior for emotional, as well as alcohol and drug problems among a multiethnic sample. Data from the Black, and White participants, revealed that Blacks were significantly less likely to use professional help, whether for emotional and nervous problems, or for alcohol and drug problems.

Even in situations where there is open access to specialized quality care, Blacks have availed themselves of services less frequently than other ethnic groups. For instance, in a sample of 136 students from a community college, Ayalon and Young (2005) reported less frequent use of psychological services among Black students than Whites. The sample represented almost equal number of Blacks and Whites. Based on the analysis of the data collected, the researchers concluded that White college students were more likely than Black college students to use professional psychological service. Similarly, Rosenthal and Wilson (2008) reported differences in use of professional service, among a multiethnic group of college students. Data from 1342 students from 1995 to 2005 were analyzed, and the researchers found that more than 75% of college students with significant levels of psychological distress, who needed help, did not receive help. As was found in other studies, this study also found the utilization of psychological services to be lower among Black students.

Yet, Bowers and associates (Bowers, Simpson, Nijman, & Hall, 2008) reported that the admission rates for Blacks at psychiatric facilities were higher than that of Whites, Asian Americans/Pacific Islanders, Hispanics and American Indians. Even among non-civilians, Blacks' rate of admission to VA medical centers was also higher than that of Whites, Hispanics and Asian Americans (Snowden & Cheung, 1990). In spite

of these contradictions, there is more evidence to surmise that whether in situations where individuals might be expected to carry the financial responsibility for care, or in other situations where they have free access to specialized services, Blacks engage less frequently in professional psychological services, notwithstanding the higher occurrence of mental health problems among their members.

Various reasons have given for the disproportionate use of mental health services among Blacks. Some scholars purport that the lower socioeconomic status and lack of insurance coverage were responsible for this trend (Rosenheck, & Stolar, 1998). Snowden & Cheung (1990) alluded to the possibility that Blacks might experience lower tolerance of psychopathology, and that they might have more faith in the hospital system to treat such problems, when they occur. Still others note bias in diagnosis for mental health problems, especially citing that Blacks are more likely to be labeled with schizophrenia, and be hospitalized than Whites, and Asians (e.g., Jones & Gray, 1986). Regarding diagnosis, Jones and Gray (1986) observed that differences in culture between the mental health professional and patient, might contribute to extreme diagnosis, especially if behavior that is inexplicable to the health professional, and is deemed bizarre, may be legitimately understood in its community context. They note further that Blacks are more likely than any other racial or ethnic group to be mandated by the court, to receive mental health treatment.

Barring the instances where Blacks seem to be over-represented in public mental health facilities, the general tendency not to seek professional care has led the United States Department of Health and Human Services (2001), to call for research to understand, and address the mental health needs of minority populations, and eliminate

the disparity in services that they experience. Hines-Martin (2002) argues that understanding and improving care must be based on a framework that takes into consideration the multiple influences (e.g., cultural values), and their potential affect on health service use. Comas-Diaz, (1992) concedes to the importance of these influences even contending that mental health services are developed with limited incorporation of minority groups' values and beliefs. The author observed that psychological services have been dominated by Western values that are often at odds with values such as interdependence and spirituality that are central in the lives of many minorities. In fact, the emphasis on individualistic orientation and the de-emphasis on the role of the family and spirituality in therapy have been viewed as psychological neglect among some minority clients (Comas-Diaz, 1992). Hines-Martin, (2002), explains that because of this trend, African Americans, who feel oppressed or excluded, might perceive psychological services as undesirable and of little help.

There is need therefore to examine the cultural values that studies show influence help-seeking behavior. But even before individuals decide that they should seek professional help, a significant factor in this decision rests on their health beliefs and perceptions about mental and emotional problems. Research evidence suggests that beliefs about the causes of mental illness vary within cultures among different racial and ethnic groups. Theorists agree that such beliefs about the causes of illness are crucial for providing effective treatment for problems (e.g., Glick, 1977; Scrimshaw, 2001). More importantly, health beliefs and perceptions often determine what kind of help will be sought for the problem; hence professional help-seeking behavior is subsequent to these beliefs and perceptions. The perusal of the literature on health belief that follows will

contribute to shedding more light on the myriad factors that might contribute to professional psychological help-seeking behavior.

Health Beliefs and Perceptions

Lay beliefs and perceptions of emotional or mental health problems vary among different groups in society. While some understand mental health problems based on the medical model of health, others assess the same illness based on the understanding of an interconnection between the spiritual and natural world. The biological understanding or medical model of health promotes the view that impaired biological processes, and external agents such as viruses that can be detected through different medical procedures cause physical illness (Schrimshaw, 2001). Evidence for this has been documented in research studies with different cultural groups, that scholars have categorized as Western and non-Western (e.g., Chen and Mak, 2008; Glick, 1977; Helman, 2000; Lieban, 1977). Researchers assert that in general, social and supernatural understanding and beliefs about health (e.g., stress, oppression) are characteristic of non-Western society, while the biological and environmental beliefs (e.g., genetics, chemical imbalance) are more dominant in Western European cultures (Airhihenbuwa, 1995). A number of studies elucidate this pattern.

In one study, Link et al., (1999) assessed recognition and perception of mental illness among a national representative sample living in non-institutional settings ($n =$ 1,444). Participants completed the Mental Health module of the General Social Survey, which is a survey designed to collect data from Americans about demographics and attitudes about different topics. Vignettes described individuals with illnesses ranging from mild depression to chronic mental illness. Although participants identified multiple

causes of mental illness, there were strong indications that some conditions (e.g., anxiety and drug related problems) were not recognized as mental health problems. The determinants of mental health problems most frequently identified were stressful situations, chemical imbalance in the brain, and genetic factors. The results were reflective of mainstream United States however, since the sample consisted of mainly White Americans.

Biological determinants of mental health problems were identified in a later study in which Schnittker and colleagues (2000) investigated etiological beliefs about such concerns among Black and White Americans. Analyzing a large data set from the 1996 General Social Survey, the researchers identified differences regarding the beliefs, causes and treatment of psychological problems. Although both Blacks and Whites endorsed biological and environmental factors as causes of illness, each group associated different elements with its cause. Whereas Blacks tended to reject the genetic cause of mental illness, they endorsed chemical imbalance as a contributing factor. Similarly, although they rejected the notion that a difficult family upbringing would result in poor mental health, they identified life stress (e.g. racism) in society as significant. Whites selected life stress (e.g., work related stress), but at the same time attributed genetic factors as the cause of mental illness. The researchers argued that African Americans' rejection of genetic factors as the cause of mental illness, might be linked to negative historical experience, where belief in the superior genetic makeup of Whites had resulted in the oppression of African Americans. An earlier study that compared African Americans and Whites beliefs about mental health found that both groups chose emotional problems and alcohol and drug addiction as causes of mental health problems (Raybuck, 1998).

A subsequent study with a sample of African Americans supported the belief in the biological (e.g., addiction) and sociological (e.g., racism, stress) causes of mental illness (Matthews et al., 2006). In addition, participants identified spiritual (e.g., separation from God) and supernatural forces (e.g., spirit possession) as contributing factors to mental illness. Other studies substantiate the religious and supernatural perception of the cause of mental illness (Dain, 1992; Hartog & Gow, 2005; Loewenthal, 1995).

The findings that African Americans attribute mental illness to both Western biological (e.g., chemical imbalance) and non-Western (e.g. supernatural forces) factors are not surprising. Airhihenbuwa & Liburd (2006) explain that because of segregation, minority groups within the U.S. developed enclaves in the society which allowed them to preserve their culture with values and beliefs that are different from mainstream White middle-class Americans. In fact, some theorists believe that culture is one of the most important factors in people's understanding of physical and mental illness, as well as where they turn for treatment for their illness (Airhihenbuwa, 1995; Helman, 2000; Scrimshaw, 2001). Helman (2000) wrote, "Each culture provides its members with ways of becoming "ill", of shaping their suffering into a recognizable illness entity, for explaining its cause, and of getting some treatment for it." (p.180). Not surprisingly, the role that culture plays in human society has been the object of study for many years. The upcoming section will focus on a review of the literature on culture and cultural values to situate the help-seeking behavior within the context of culture. The review will also discuss the relationship among culture, values and behavior.

Culture and Values

The phenomenon of culture has been of interest to anthropologists and other social scientists for many years, but there is very little agreement as to how culture should be defined. After an extensive review of the definition from different disciplines and scholars, Kroeber and Kluckhohn (1952) summarized the common concepts as the following: (a) culture consists of explicit and implicit patterns, (b) it is the result of human behavior, and at the same time it guides behavior that is acquired and transmitted by symbols, (d) it is a distinct achievement of human beings, and includes their embodiment in artifacts, (e) the essential core of culture consists of traditional ideas with corresponding values, and (f) cultural systems can be simultaneously the product of action, and the conditioning elements of further action.

Krueter and collaborators (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003) contend that culture is learned, shared and transmitted from one generation to another. As such it can be seen in the norms, practices, and way of life of members of the group. In addition, culture also determines the values that guide people's behavior (Herskovits, 1967). That is, culture defines the values through which behavior is evaluated and interpreted. For example, because individualism is a dominant value in the United States, the culture defines health as a personal matter over which individuals have control (Izquierdo, 2005). Knowledge of the values of a society, and understanding how they influence the lives of the people of the society could provide the framework for understanding why one behavior would be chosen over another. Such awareness could prevent the tendency to make negative assumptions about behaviors that might be contrary to the expectations of practitioners who work with diverse populations. As

Kluckhohn and associates (1951) explained, values provide the orientation of what one ought to do in a given situation. However, there are different types of values, thus it is necessary to distinguish between them and evaluate how they influence behavior.

Values and Shaping of Behavior

Values are understandably intertwined with human life and contribute to shaping social life within which people's needs are met (Kluckhohn et al., 1951). Kluckhohn and colleagues identified values as the product of social interaction and defines a value as "a conception, explicit or implicit, distinctive of an individual or characteristic of a group, of the desirable which influences the selection from available modes, means and ends of action" (p.395). In other words, a value is the gauge that is used to determine what actions ought to be chosen by an individual or by a group. Ford, Nonis, and Hudson (2005) affirm that values are beliefs that describe preferences and suggest choices between appropriate and inappropriate behavior.

Kluckhohn (1962) endorsed the belief that values carry both the idea of choice, as well as cognitive and affective meaning. He noted that values could be expressed as individual values or cultural values, and made the point that the distinction between the two can be very elusive. In fact, he contended that values are mainly cultural products. Kroeber and Kulkhohn, (1952), promoted the idea earlier and even argued that because values are primarily social and cultural, what is accepted or defined as individual values are merely individual variants of cultural values.

The influence of cultural values on behavior has been documented. Research studies have established that cultural values guide human behavior within the intimacy of the families (Ellis, McCullough, Wallendorf, & Chin, 1985) as well as in public domain

such as the workplace (Ford et al., 2005; Fullerton, Kerch, & Dodge, 1996; Gregory, & Munch, 1997). These studies also demonstrate that, although some cultural values apply more to one group of people than to another, there are within-group differences (Gaines et al., 1997). Further, minority groups within dominant societies have also found ways to preserve their own cultural values (Airhihenbuwa & Liburd, 2006; Goodwin, 1999) that have resulted in behaviors that are more meaningful within the context of their culture. This interconnectedness among culture, values and behavior is summarized below.

Summary

Experts in the field of social science attest that culture is fundamental to the development of human society and that through culture people transmit the mores and values that are important in preserving the unity and function of the society. They contend that it is within the culture, and through common understanding people come to agree on which values should guide their actions or behavior. In other words, culture is a prerequisite for values, and the cultural values that are tailored from the mores and customs in the society are what guide people's behavior and action. In truth, without culture there would be no cultural values, and outside of cultural values behavior would not be understood as representative of a people. Indeed, without the common values, human behavior will be difficult to predict or understand. One cannot address the cultural values of Blacks however, without also addressing religiosity and spirituality, which are characteristics of Blacks in the United States, because according to Hines & Boyd-Franklin (1982), some of the cultural values have been shaped by the religious and spiritual beliefs that are part of the culture of the people.

Cultural Values and American Society

In a review of empirical research studies that focused on cultural values among groups in the United States, Carter, (2001), using Kluckhohn's typology, noted that the value system of the dominant cultural group (i.e., White) was characterized by individual relationships, doing-oriented activity and mastery over nature. Non-dominant groups such as Hispanics were family oriented and valued interdependence in social relations. Beliefs grounded in fatalism were likewise found to distinguish people of color. Similarly, Stewart and Bennett (1991) observed that interdependence and harmony are characteristic of non-Western collectivistic cultures. And while cultural values are a product of one's culture, another related element of culture that has proven to be significant even in the shaping of values has been religious and spiritual beliefs. Herskovitis (1967) reported that in many non-Western cultures, religiosity and spirituality, which express commitment to religious and spiritual beliefs, give meaning to the lives and behavior of the people in the society. Others attest that spiritual and religious beliefs contributed to shaping cultural values, especially for minority groups (Delgado, 2007; Scanzoni, 1971).

Heterogeneity in religious and spiritual beliefs, as well as cultural values is more common today than it was in the past. For instance, although the United States is labeled an individualistic society that was founded on Protestant beliefs, minority enclaves within the larger society have been able to safeguard the cultural values and religious and spiritual beliefs that are different from mainstream American or Western society (Airhihenbuwa, & Liburd, 2006). The practice of segregation that was enacted in the United States for hundreds of years and which persists to certain extent today made it

possible for minority groups, and people of color to uphold different cultural values, although they live in, and are citizens of the United States (Airhihenbuwa, & Liburd, 2006; Goodwin, 1999; Regis, 1988,). Consequently, it is not uncommon to have minority groups living according to cultural values such as collectivism, and familism, within the dominant individualistic American society (Goodwin, 1999, Rodriguez, 2007, Gonzales-Eastep, 2008).

Evaluating behavior simply through the lens of the dominant group will therefore be a disservice to people of minority groups. To this end, Herskovits (1967) proposed that behavior in society is meaningful to the extent that one understands the relationship between cultural values and behavior. Empirical research with different groups has contributed to corroborating this position. For example, social behaviors such as recreational activities and meal planning have been shown to correlate with cultural values such as respect for elders, and family closeness among Blacks and Hispanics (Chamberline, 2003; Ellis et al., 1985; Kellett, 1999). Values such as harmony with others and the environment, collateral and democratic outlook of the world have been found to influence choice and behavior for Whites (Henry, 1976), and behavior grounded in fatalism, has been identified among people of color (Uehara, 2001; Yamashiro & Matsuoka, 1997). Other researchers have found that in addition to fatalism, commitment to their religious and spiritual beliefs (i.e. spirituality and religiosity) also guide the behavior of people who belong to non-Western culture (e.g., Helman, 2000).

Because health care is a social construct that is culturally based (Becker & Gates, 2007), decisions people make to determine how to address health problems are influenced by many of the cultural values of the community and society with which they

identify. In the context of health, these values are identified as health related values, and researchers like Halbert and colleagues (2007) assert that these health related values drive individuals in their decision regarding the type of help they should seek when faced with ill health, and from whom to seek such help. As noted earlier, there seems to be more acceptance and compassion toward physical health problems, and as such many cultural values positively shape the decisions of individuals to professional help for these problems. On the contrary, some of the same values that validate professional help-seeking for physical illness, seem to pose a challenge for those who would like to seek similar help for mental illness. Since the scope of this project limits the range of these health related values that could be addressed, a cluster of these values have been chosen based on the evidence in the literature regarding their salience in the help-seeking behavior for psychological and emotional problems among Blacks living in the U.S.

In the area of mental health, religiosity and spirituality and the cultural values of individualism/collectivism, familism, and fatalism have been found to influence attitudes and behaviors relating to professional psychological help. Empirical studies, which will be discussed below have yielded results indicating that cultural values are predictors of professional psychological help-seeking attitude (e.g., Gloria et al., 2008; Kuo et al., 2006; Omizo, Kim, & Abel, 2008; Wallace & Constantine, 2005) and professional help-seeking behavior (Angermeyer, Matschinger, & Riedel-Heller, 1999; Baker, & Adelman, 1994; Chang & Subramaniam, 2008; Kuhl et al., 1997; Vanheusden et al. 2008). Professional psychological help-seeking behavior continues to be a focus of investigation in the field as researchers undertake empirical studies to identify factors that might contribute to a better understanding of the notable disparity between the occurrence of

mental health problems and the utilization of mental health services among those who experience such problems. This has resulted in a burgeoning of literature addressing professional psychological help-seeking behavior as will be demonstrated in the upcoming review of various studies.

Professional Psychological Help-seeking Behavior

Professional psychological or formal help-seeking includes contacting professionals such as psychologists, counselors, psychiatrists, social workers or any other mental health workers in an inpatient or outpatient setting to address mental health problems (Russell, 2008). Existing data reveal that paradoxically, many persons who have mental health problems, and who are in need of help, are not receiving help (Gong, Gage, & Tacata, 2003; Neighbors, 1988; Williams et al., 2007). In many instances high levels of depression and anxiety have been recorded by people who indicate that they have not sought professional help, but have talked to friends, family and other informal sources about their problems (Gourash, 1978; Pescosolido, 1998). Acknowledging this, Gourash (1978) proposed that people might choose to seek professional help because it offers a type of service that is not generally found informally.

Mayers et al. (2007) corroborated the benefits of professional help in a qualitative study with individuals who were experiencing psychological distress. Participants who sought professional help explained that they "needed to hear somebody else's voice, somebody who was objective, somebody who wasn't necessarily religious, for them to tell me the truth of what I was facing" (p.322.). Another study conducted by Lawrence et al., (2006) reiterated the value of seeking help from professionals who were distanced from the situation. Participants noted that professional help provided the opportunity to

be listened to without "the fear of boring others, becoming a burden or being judged" (p.1382). Further, other studies have shown that non-professional service is inadequate to address some problems, because ultimately, after turning to friends, faith healers and other non-professionals for help, many people eventually seek psychologists, counselors and other mental health professionals to address their mental health problems (e.g., Cabassa & Zayas, 2007; Liang, Goodman, Tummala-Narra, & Weintraub, 2005). From these and other studies, researchers have identified some common characteristics of those who are more apt to seek professional help.

For instance, findings from research studies indicate that demographic variables such as gender, age, ethnicity, and education are predictors of professional psychological help-seeking behavior. Scholars have found that females use services more than males (Leaf & Livingston, 2008); older adults use mental health services at a lower rate than younger adults and college students (Greenley et al., 1987; Vanheusden et al., 2008), and individuals with higher education utilized professional services at a higher rate than those with basic education (Scheffler & Miller, 1991). Utilization based on race and ethnicity has been documented in other studies (Neighbors et al., 2007; Gong et. al., 2003).

Despite existing findings, a major limitation of studies that have examined professional help-seeking behavior is the focus on actual behavior as the only means of measuring help-seeking behavior. In most studies professional help-seeking is generally conceptualized as actual behavior that has taken place, and is usually operationalized as one question that asked whether help was sought or not. However, the one item question with the dichotomous yes or no answer is only able to provide very restricted data about people's behavior, because the forced choice between the two options does not allow for

the variance that could be caught using continuous data. Actually, Pescosolido (1992)

contended that simply focusing on the use or nonuse of professional help does not

adequately portray help-seeking behavior on the part of lay persons. Other scholars (e.g.

Kelly & Achter, 1995; Kung, 2003) suggested that the sole focus on actual behavior to

measure help-seeking, without attention to measuring the likelihood of carrying out the

behavior could be a confound in existing studies about seeking help for mental health

problems. They therefore advocated that future studies that include both a measure of

actual behavior and intentions should be undertaken.

In essence, although data on actual behavior are helpful, additional information

could be obtained by also assessing individuals' intentions to seek professional help, if

hypothetically, they were to experience mental health problems. This will facilitate some

understanding into the behavior of people should they need psychological help, because

as will be reviewed next, existing theories of behavior purport that there is a strong

relationship between intentions and behavior.

The Intention- Behavior Relationship

The measurement of intentions in the study of behavior is grounded in the Theory

of Reasoned Action (TRA, Fishbein & Ajzen 1975) and the theory of Planned Behavior

(TPB, Ajzen, 1988), which is an extension of the former. Armitage and Conner (2001)

point out the centrality of the construct (i.e., intentions) to both the Theory of Reasoned

Action and the Theory of Planned behavior. Both theories purport that if intentions to

engage in a behavior were accurately measured, it would be a precursor of actual

behavior. Fishbein and Ajzen (1975) theorized that intentions are the most immediate and

important predictor of behavior. Fishbein and Azjen (1975), likewise attest that once an

individual has the freedom to choose a particular behavior, the best gauge of actual behavior will be the measure of the individual's intentions to perform the behavior. Intentions are therefore believed to have a high correlation with behavior, except if there is no relationship between the intentions and the behavior being measure. In a latter work Doll and Ajzen (1992) suggested that intentions could provide additional information about actual behavior, such that intentions could be a proxy to the actual behavior. In their study of the predictors in the Theory of Planned Behavior, they found that behavior correlated positively ($r = .61$, $p = .05$) with intentions.

Significant correlations have been identified in other studies. For instance, in a meta-analysis of 422 studies conducted by Sheeran (2002), the impact of intentions on behavior was found to exceed the criterion of a large effect size based on Cohen's (1992) power primer ($d = .80$). Sheeran reported an effect size of $d = 1.47$. In an earlier meta-analysis of 87 separate studies ($n = 11, 566$) that focused on the use of intentions to predict behavior, Sheppard et al. (1988) observed the strong relationship between intentions and behavior. The researchers undertook to test the predictive utility of the Fishbein and Ajzen's model of reasoned action that postulated that intentions are indications of actual behavior. Special attention was given to examining the degree to which research that had used the model might have gone beyond the limits of the model. In their critique of the model, Sheppard and colleagues had observed the constraint of the model, noting that sometimes "(1) the target behavior is not completely under the subjects' volitional control, (2) the situation involves a choice problem not explicitly addressed by Fishbein and Ajzen, and/or (3) subjects' intentions are assessed when it is

impossible for them to have all of the necessary information to form a completely confident intention" (p.325).

Nonetheless, they hypothesized that there was a strong relationship between intentions and behavior. They further expected that intentions that are measured as self-prediction (e.g., how likely a person would perform a behavior), would provide a better prediction of behavior because they believed that when a person expresses such intentions s/he is also aware of other choices that interfere with the intention to act. This is because these intentions are understood as possibilities in the presence of other choices. They argued that self-predictive intentions accommodate attention to the possibility of likely choice of other competing behaviors.

The researchers found support for their hypothesis and reported a positive correlation between behavioral intentions (e.g. I intend to do X), and actual behavior ($r = .53, p = .01$). However, measures of self-predictive intentions had a stronger relationship with behavior ($r = .57, p = .001$). In other words, there was a 99.99% chance that participants would execute the behavior that they indicated they are likely to perform. Moreover, as the likelihood of performing the behavior increased, so too would the actual behavior. The investigators stated that the predictive result provide "strong support for the overall predictive utility of the Fishbein and Ajzen model" (p.336). They noted above all, that the predictive ability of the model holds true even when the model is used to investigate behavior that falls outside of the strict boundary that was originally specified for the model. For example, the intentions were predictive of behavior even when an explicit choice was given together with alternatives. They concluded that intentions' measures worked well in the prediction of behavior.

Other meta-analyses that examined the Theory of Planned Behavior corroborate the existence of a significant relationship between intentions and behavior. In their study, Armitage and Conner (2001) examined 185 independent empirical studies that were accepted for publication. Based on the analysis, the authors acknowledged that behavioral intentions and self-prediction intentions are superior predictor of behavior. In this study the intention-behavior correlation was measured as $r = .47$; the authors noted that the correlation found between intentions and behavior was comparable to other meta-analyses that focused on the intentions-behavior relationship. Randal and Wolff (1994), and Sheeran and Orbell (1998) respectively reported similar findings ($r = .45$; $r = .44$).

In commenting about the relationship between intentions and behavior, Webb and Sheeran (2006) observed that although scholars have established that intention is the key determinant of behavior, most of reviews that examined the phenomenon relied on correlational evidence that does not allow conclusions about the causal impact of intentions on behavior. This is because correlation does not explain whether having the intentions caused the behavior, for it is possible that even with the best of intentions a person might fail to carry out the corresponding action. Webb and Sheeran addressed this issue through their meta-analysis of experimental studies that manipulated intentions and follow up behavior. This seminal work was in an effort to quantify the extent to which changes in intentions resulted in changes in behavior. Given that the Theory of Reasoned Action indicates that the most immediate and important predictor of behavior are intentions, the authors hypothesized that a change in intentions would result in a change in behavior. To this end, the investigators analyzed studies that applied experimental

manipulations that resulted in significant increases in intentions' strength, and examined changes in subsequent behavior.

For this study, Webb and Sheeran (2006) selected 47 intervention studies that assessed changes in both intentions and behavior. They computed the effect size for the differences in intentions between conditions following the intervention, and reported that the effect sizes (d) in individual studies ranged from 0.12 to 2.97. The sample-weighted average effect size obtained from the 47 studies was $d_{+} = .66$, with a 95% confidence interval from .51 to .82. In other words, the true effect size was no less than .51 and no greater than .82. This indicates that, based on Cohen's (1992) criteria, when intentions were manipulated, there was a medium to large corresponding change in intentions. Similar results were found in the analysis of the change in behavior. In separate studies the effect sizes ranged from -.25 to 2.31, but together they averaged out to $d_{+} = .36$ with a 95% interval from .22 to .50. This means that when the manipulation of intentions was successful, there was a small to medium corresponding change in behavior. The investigators further noted that the correlation between the effect size for intentions and the effect size for behavior was .57, suggesting that a similar change in behavior was achieved when there was a change in intentions.

The authors concluded that this finding supported the proposal that changing intentions will engender changes in behavior. More importantly, the study substantiated the claim made in correlational studies that intentions are a reliable predictor of actual behavior. Consequently, in this study, an intentions' scale that is self-predictive in nature will also be utilized in the exploration of help-seeking behavior for mental health concerns. Conceptualization of professional help-seeking behavior proposed for this

study is therefore two-fold, namely, actual professional psychological help that was sought or not sought, and intentions to seek counseling (i.e. hypothetical help-seeking behavior from a mental health professional such as psychologist, counselor or other mental health professional, if one were to experience mental health problems).

Be that as it may, behavior does not happen in a vacuum and identifying and understanding the factors that influence behavior contributes to helping the observer make sense of the choice of one type of behavior over another. Therefore, after focusing on the target behavior that is of interest in this study (i.e., professional psychological help-seeking behavior), the discussion will now turn to the elements that impinge upon the target behavior among Blacks within the American society. The elements that will be discussed have been extracted from the literature about help-seeking behavior. Although the list of factors are far from exhaustive, they have been chosen because of their centrality in the lives of Blacks in the United States and the consequent impact that they have on the behavior of Blacks. The subsequent narrative will begin with an examination and discussion of religiosity and spirituality that researchers have identified as central to the culture of Blacks and which is a framework for their decisions and behavior (Johnson, Elbert-Avila, & Tulsky, 2005).

Religiosity, Spirituality and Professional Psychological Help-Seeking Behavior

Religiosity and spirituality are terms used to describe the degree to which a person is committed to religious or spiritual beliefs, and practices. Some theorists contend that religion and spiritual beliefs have shaped many of the values of racial /ethnic groups within the society (e.g. Herskovits, 1967; Jaynes & Williams, 1989; Mc.Davis, Parker & Parker, 1995; Wittmer, 1995). Further, Farrer (2004) contended that religiosity and

spirituality have the potential to affect the degree to which other values are upheld. For example, commitment to religious belief about the family influences the parent-child relationship, and filial obligations among family members of some ethnic/racial group (Brody, Stoneman, & Flor, 1996; McQuillan, 1999,).

According to Miller and Thoresen, (2003) religiosity and spirituality are multidimensional constructs that overlap, but they can be distinguished one from the other. They contend that religiosity involves engaging in more public behavior such as religious service attendance, and incorporates the beliefs and practices of a particular religion. Worthington et al. (2003) explain that religiosity is manifested in religious commitment, which can be gauged by examining commitment to the values, beliefs, and actions that are characteristic of a particular religion. In contrast, spirituality is not necessarily rooted in organized religion, but involves personal belief in, and involvement with, the transcendent. In addition, spirituality influences a person's worldview, and gives meaning and purpose to life (Murray, Ciarrocchi, & Murray-Swank, 2007; Piedmont, 2001). George et al. (2000) note that both spirituality and religiosity focus on the sacred or the divine, express commitment to beliefs and practices, and have an effect on behavior. According to the authors, the main difference is that spirituality can be experienced apart from organized religion, whereas religiosity necessitates expressions that include behaviors such as church attendance and interaction with the religious community.

Miller and Thoresen, (2003) argue for an understanding of spirituality and religiosity that can be used to characterize all persons with, or without an affiliation to organized religion, because although about 90% of Americans believe in a Higher power,

almost 40% admit having no connection to organized religion (Fuller, 2001).

Nonetheless, Zinnbauer, Pargament and Cole (1999), warn that while participation in organized religion has decreased, people have not become less religious or spiritual. In fact, most Americans claim to be highly religious or spiritual on a personal level, notwithstanding what some scholars have noticed as the lack of distinction between the two (e.g., Jagers & Smith, 1996; Piedmont, 2001). Nevertheless, those who promote the distinctiveness between the two call for the separate measurement of each construct so as to serve both those who are not affiliated with organized religion, but who are deeply spiritual, as well as those for whom involvement with institutional religion is very important (e.g., Abe-Kim et al., 2004; George et al., 2000; Miller & Thoresen, 2003).

Although the discussion about the distinctiveness or similarity of spirituality and religiosity continues, studies show that spirituality and religiosity are integral to the lives of many people. To this end, examination of the impact on mental health and help-seeking behavior has been encouraged (U.S. Surgeon General Report, 1999). Already, an extensive body of literature points to the connection between spirituality and religiosity and mental health (Chamberlain & Hall, 2000; Graham, Furr, Flowers, & Burke, 2001; Pargament, Poloma, & Tarakeshwar, 2001; Plante & Sherman, 2001). While some research studies identify the positive effect of religiosity and spirituality on mental health (e.g., Lent, 2004; Park & Folkman, 1997; Plante & Sherman, 2001), others point out the deleterious impact, as will be noted below.

Religiosity has been purported to predict good health among African Americans, Caucasians, as well as other people of color (Ellison, Musick, & Henderson, 2008; Gall et al., 2005; Musick, 1996; Miller & Thoresen, 2003; Thoresen, 1999). Theorists have

identified the promotion of healthy behaviors, the promotion of social support and coherence as mechanisms through which religiosity is related to health (George et al., 2001). Some explain that membership in a religion could provide encouragement to pursue a healthy lifestyle and avoid behaviors such as alcohol and drug use that could be detrimental to the health of individuals (Musick, Blazer, & Hays, 2000). Others believe that the hope and courage that people get from religious activities such as prayers and devotions encourage them to avoid unhealthy behavior and choose instead, those behaviors that would enhance or maintain a healthy lifestyle (Cochran, Beeghly & Book, 1988; Ellison, 1991). Similarly, denominational membership provides social capital resources (e.g. friends, elders) that can allow individuals to feel more empowered to choose behaviors that would maximize their worth and their growth. These resources can provide real or perceived moral support and emotional support for members (Davis-Molock, Puri, Matlin, & Barksdale, 2006; Mattis & Jagers, 2001). In addition, religiosity and spirituality provide "a sense of coherence and meaning so that people understand their role in the universe, the purpose of life, and develop the courage to endure suffering'' (George et al., 2000, p. 108). In fact the process of making meaning of the circumstances in life has been associated especially with greater spiritual striving, which is believed to be an important dimension of spirituality (Gall et al., 2005; Oman & Thoresen, 2002). A number of studies document the relationship between spirituality and religiosity and mental health.

In a study conducted by Abe-Kim and colleagues (2004), data from the Filipino American Epidemiological Survey (FACES) which utilized structured interviews which did not distinguish the constructs, was used to analyze the influence of religiosity and

spirituality on help-seeking from professionals, as well as clergy, for emotional distress. A total of 2, 285 Filipino Americans, equal male and female participants, who underutilized mental health services, responded to the interview. The researchers hypothesized that participants who were high in religiosity and spirituality would be less likely to seek professional help, and more likely to seek help from clergy. The result was mixed, showing that individuals who had high religiosity were as likely to seek professional help, as help from clergy for emotional distress. The investigators concluded that this was because both clergy and professionals were equally accessible, and that participants could have held the belief that God's intervention could be experienced through others. At the same time, persons who were high in spirituality were less likely to seek help, whether professionals or from clergy. The investigators accepted the lack of distinction between the constructs in the instruments as a limitation of their study. Nonetheless, they noted that there was an inverse relationship between spirituality and levels of distress. It is possible then that the low incidence of distress could have accounted for the lack of help-seeking from those who were high in spirituality. In short, although the predictive value of religiosity and spirituality was found in this study, it still remains a matter to explore in order to extricate the separate contributions of spirituality and religiosity. Separate instruments to measure the construct could be utilized to facilitate this. Abe-Kim and colleagues (2004), actually recommend assessing the constructs independently to discern the influence on help-seeking.

Another study explored the influence of religiosity and spirituality on psychological help-seeking and therapy of persons who acknowledged that spiritual and religious beliefs were important in their lives. In this study, Mayers et al., (2007) targeted

persons who had received, or were receiving therapy for psychological problems.

Subjects included persons who were affiliated with religious denominations and had a

long-standing relationship with their faith communities. Other persons without church

membership, but who described themselves as spiritual were included in the study.

Semi-structured interviews were used to explore the role of the participants' religious and

spiritual beliefs and practices in the process of seeking and receiving psychological (i.e.,

professional) help. The researchers reported that a significant and surprising finding was

that there was a rejection of counseling from within the Church, because subjects were

resistant to having their problems understood simply as a spiritual problem, which in their

view would have done more harm than good. Instead there was openness to seeking help

from professionals outside of the Church.

However, participants also reported a struggle to seek help from professionals, as

they feared that such behavior would indicate a lack of faith in God's healing power.

Although the result suggests that religiosity and spirituality influence professional

psychological help-seeking behavior, it is not known which construct contributed more to

the results. Given that religiosity and spirituality were not distinguished in the interview,

and that the study was qualitative in nature, future studies should measure both constructs

with instrument/s that would better facilitate the identification of religious and spiritual

diversity of the group.

Yet other studies show that individuals who are considered religious are not likely

to seek professional help. Matthew and collaborators (2006) reported a negative

relationship between religiosity, spirituality and professional help-seeking in their study.

As part of an anti-stigma campaign for mental health, the authors conducted a study with

focus groups, and discovered that participants used their religiosity and spirituality to deal with emotional and mental health problems. In some cases, participants who identified as highly religious and spiritual reported that they had not considered professional help, because they were taught to deal with problems themselves, with the help of God.

Additional information about the possible influence of religiosity and spirituality can be gleaned from an examination of the influence of religiosity and spirituality on professional help-seeking attitudes. In one study Matlock-Hetzel (2005) concluded that religiosity, positively predicted professional help-seeking attitude, because, those who scored high on religiosity had a more positive attitude towards seeking professional psychological help. This researcher (i.e., Matlock-Hetzel, 2005) contended that religiosity resulted in faith that allowed these individuals to be open to trying different solutions for problems, because they have confidence that God can use various means (e.g. counseling) to address their problem.

Rogers (2007) obtained similar findings in a study of African American churchgoers, from a southern eastern region of the U.S. In the study, Rogers (2007) explored religiosity and attitudes towards seeking mental health services. Data from a sample of convenience, which included 170 females and 88 males, were analyzed. Among the questions examined were whether there was a relationship between religiosity and confidence in mental health practitioners, and religiosity and interpersonal openness. Religiosity was not significantly related to confidence in mental health practitioners or interpersonal openness, but scores on the attitude scale indicated that participants had a positive attitude towards counseling. Although the researcher hypothesized that high

religiosity scores would be related to negative attitude towards mental health practitioners, the results did not support this. This could have been because most of the churches in the study provided professional services to the members of the congregation through their staff psychologists, and other psychologists who were contracted separately to provide services for the members. On the other hand, the scale used might not have adequately captured the construct, because the items mainly addressed spirituality, which other studies have shown, is related to openness to counselors (e.g., Barker, Pistrang, Shapiro, & Shaw, 1990). But, as will be deliberated in the following summary, it is evident that a relationship exists among spirituality, religiosity and psychological help-seeking behavior.

Summary

The preceding exposition considered studies that showed that religiosity and spirituality are important factors that are related to professional psychological help-seeking behavior. More specifically, some studies show that individuals who endorse religiosity are just as likely to seek help for personal emotional problems because although they believe in God's direction for their lives, this does not preclude God's intervention through indirect means. On the other hand there are those who regard seeking professional psychological help as a testimony of weak faith, and as such are reticent about this avenue of help. Sometimes they even fear being devalued by professionals whom they believe might not respect their faith.

The contrasting results regarding the influence of religiosity and spirituality on professional psychological help-seeking behavior could be due to various factors. In the first place, inappropriate measurement of religiosity and spirituality could have

contributed to the confusing findings. For instance, spirituality and religiosity were generally measured with a unidimensional instrument, and although some theorists argue against the dichotomous appraisal of the construct, (e.g., Hill & Pargament, 2003), the fact remains that there are people who identify as spiritual, but who are not religious. Secondly, there is evidence that seems to indicate that other factors might influence the results. In many studies, religiosity and spirituality have been generally measured in isolation, and rarely have the constructs been measured in the presence of other variables. Neff and Hoppe (1993) noted that spirituality and religiosity work in conjunction with other resources to impact the lives of people of color. There is a need therefore to expand studies with the constructs to include other variables. For example, in studies that have found that religiosity and spirituality precluded professional psychological help-seeking behavior, participants often indicated that they were not in control of their health (Lawrence et al., 2006). This lack of belief in personal control, and the belief that events in one's life are mainly dependent on external forces reflect a fatalistic orientation. Studies identify fatalism, which is the antithesis of personal control or mastery, as one of the cultural values that influence professional psychological help-seeking behavior. This and the other cultural values that are salient to professional psychological help-seeking behavior will be discussed next.

Cultural Values and Help-Seeking Behavior

Fatalism

Theorists and researchers have defined fatalism as a belief in fate and luck or chance as the determinant of what happens in a person's life (Plante & Sherman, 2001), as a lack of mastery or the belief in an external locus of control (Neff & Hope, 1993;

Wade, 1996), or the belief in an inevitable outcome that is beyond human control (Franklin et al., 2008). Despite the variation in conceptualization, fatalism has consistently been found to lead to inaction when individuals are faced with problems (Perry, Davis-Maye, & Onolemhemhen, 2007), or risky behavior (Unger et al., 2002). Pearlin and Schooler (1978) suggested that fatalistic orientation prevents people from addressing problems in life because often, they lack the will to do so. On the other hand, people who have a sense of mastery or control are more likely to take steps to address distressing events, and to improve conditions in their lives (Ross, Mirowsky, & Cockerham, 1983).

Zytkoskee and colleagues (Zytkoskee, Strickland, & Watson, 1971), and Farris and Glen (1976) contended that fatalism is characteristic of people from minority groups, and people of lower socioeconomic status. They argued that through repeated experience, people from minority groups and the lower class learn that despite their efforts to get ahead, powerful others and unpredictable forces control their lives. Madsen (1973) substantiated this claim and added that fatalism results in an attitude of resignation among people who are poor. Others have contended that Blacks subscribe to more fatalistic beliefs than Whites (Galanos, Strauss, & Pieper, 1994; Wade 1996), because their ethnic minority status, and the fact that Blacks have had more limited access to opportunities than people from the dominant racial group, could contribute to fatalism. It is worth noting that as a cultural value, fatalism is not attached to health behaviors per se, but is a general worldview or value orientation that arises within the society as a result of social conditions. As such, it has the potential like other cultural values to influence

behavior. Thus the relationship between fatalism and professional psychological help-seeking behavior will be examined in the subsequent discourse.

Fatalism and Professional Help-Seeking Behavior

Studies examining the relationship between fatalism and professional help-seeking behavior have been extensive, but have focused mainly on physical health (e.g. Perry et al., 2007; Schnoll et al., 2004; Talbert 2007). In fact, a notable characteristic of such studies is the measurement of fatalism with an instrument that was developed specifically to measure health fatalism or religious fatalism, despite the fact that fatalism is a cultural value. Consequently, there is a plethora of research studies that have used various health locus of control scales to examine fatalism and professional help-seeking behavior for terminal illnesses such as cancer (e.g., Dettenborn et al., 2004; Talbert 2007), HIV (e.g., Perry et al., 2007) and other chronic illnesses such as arthritis (Wallston, et al., 1999). In contrast, few studies have focused on the relationship between fatalism and help-seeking behavior as it relates to psychological issues.

In one of these studies, Ayalon & Young, (2005) explored factors that influenced professional help-seeking behavior among 70 Black and 66 White undergraduate students. They hypothesized that Blacks would use psychological services less than Whites, and that they would report higher levels of external control (i.e., fatalism). As expected, Blacks endorsed fatalism more strongly than Whites, but there was no difference between the two in psychiatric and medical use. The researchers also found that belief in external control was linked to belief in God, and concluded that belief in God as the locus of control might preclude attributing mental or emotional distress to psychological factors. They suggested instead, that individuals might attribute spiritual

meaning to their symptoms, and consequently opt for help from clergy instead of from professional counselors. At the same time, given that both groups had easy access to professional care through the psychological services offered on campus, and that there was no difference in psychiatric and medical use, the researchers suggested further studies with this population to identify other variables that might shed light on the difference that was found in the utilization of psychological services on campus.

Another study of a national sample of 241 African Americans identified significant levels of fatalism, although this did not prevent professional psychological service use (Watkins, 2000). Watkins investigated the behavior and beliefs of African American in psychotherapy in this dissertation study, which included a measure of internal as well as external locus of control (i.e., mastery vs. fatalism). The author hypothesized that women who were high on internal motivation with the corresponding low levels of fatalism, would be less likely to seek help, because they would perceive more control over the events in their lives. The results confirmed the hypothesis; women who endorsed high internal locus of control or low fatalism, showed reticence towards professional help. Unlike Perry et al., (2007) and Lawrence and colleagues (2006) who found fatalism to be associated with religiosity, and avoidance of professional help, no such connection was evident in this study, which also assessed religiosity. Perhaps the fact that a fatal illness (i.e. HIV/AIDS) was the subject of Perry and associates' study, would explain the difference regarding the connection between fatalism and religiosity that was found in the study. Individuals with a terminal or fatal illness might come to depend totally on God, rather than professional help when faced with such illness. On the other hand, those who are not so afflicted, and who at the same time have internal

strength, and a sense of personal control might depend more on themselves, and similarly shun professional help.

This suggests that fatalism is not necessarily an offshoot of religiosity and spirituality, and highlights the need for further studies to examine the relationship between fatalism and professional psychological help-seeking behavior together with other cultural values. In addition, if the construct were to represent a cultural value, it would necessitate the use of an instrument that was not developed specifically to measure fatalism as it relates to health. Instead, an instrument that is neutral, and that measures fatalism, as a value orientation will be better suited to do so. This would mean that no reference to a particular condition would be made in an instrument that measures the value of fatalism, even when examining a relationship between said value and a terminal illness such as cancer. More specifically, assessing an individual's lack of personal sense of control (i.e. fatalism or low mastery) might better facilitate the measurement of the cultural value of fatalism.

Neff and Hope (1993) assessed fatalism, which was conceptualized as the individual's perception of his/her ability to control situations in life, and explored the joint effect of fatalism and religiosity in the occurrence of depression among a sample of 1,784 Anglo, African American, and Mexican American adults. Participants completed a survey assessing whether fatalism and religiosity were resources in the face of psychological distress caused by both socioeconomic and sociocultural determinants (e.g., unemployment). Not surprisingly, the result showed that whereas Anglos had the lowest levels of fatalism, African Americans and Mexicans evidenced the highest levels of fatalism. Noteworthy is the fact that the latter groups were the most disadvantaged

economically and educationally, and had higher male unemployment. Given the history

of the US, and the presence of institutional and individual discrimination in society, one

can infer that discrimination is the kind of oppression that could have fostered the lack of

internal mastery or control that was evident among the participants of color. The belief in

external control that is constitutive of fatalism functioned as a barrier to internal control.

Similar to Neff and Hope's study, fatalism in the present study will be assessed as a lack

perceived personal control or mastery.

Like fatalism, researchers have documented identification with, and attachment to

family as significant indicators of whether or not individuals have accessed professional

services for mental health problems. Theorists and researchers have defined this

orientation as familism, noting that a person's connection with his/her family network

can encourage or discourage professional help-seeking behavior. The discussion that

follows will focus on this cultural value to examine why this is so.

Familism

The term familism describes "strong identification with, and attachment to the

nuclear and extended family, along with strong feelings of loyalty, reciprocity, and

solidarity among family members" (Rodriguez, 2007, p.62). In an exploration of the

construct, Roschelle (1997) used the term kinship network to designate the nuclear and

extended family and acknowledged that support and bonding among members of the

kinship group, and reciprocal obligation and concern among members are characteristic

of familism. Others have found family honor and subjugation of self to the family, as

well as interconnectedness and respect among members, as important dimensions of

familism (Gaines et al., 1991; Lugo Stediel & Contreras, 2003; Sabogal et al., 1987).

Recognizing the different elements that are characteristic of familism, Roschelle (1997) postulated that familism would be expressed in the overall commitment to the kinship network, and made the case that members of the network would experience familism in the availability of family support and interconnectedness, and the influence that members exert on each other.

Experts in the field of psychology have underlined the importance of kinship network to diverse groups, and conceded that familism is a value that gives primary importance to the family and the needs of the family, as opposed to individual and personal needs. Since most empirical studies of the construct have been with Hispanics, it was purported that familism was a unique value of the Hispanic populations, but a growing body of literature suggests the importance of familism for other ethnic groups (Gaines, et, 1997; Roschelle, 1997; Schwartz, 2007). Unger and colleagues (2002), in a study of the relationship between cultural values and substance use with a multiracial group of adolescents reported that there was no significant difference in the endorsement of familism among the groups. Gaines et al (1991), Schwartz (2007), and Roschell (1997) also corroborate the existence and importance of the value of familism among Black, Asian, and White adults, noting that family as a source of support characterizes familism and influences help-seeking behavior. Various studies that will be examined below record the influence of familism on psychological help-seeking behavior.

Familism and Professional Psychological Help-Seeking Behavior

Russell (2008) studied the construct among a sample of Black college students and confirmed that inter-connectedness among the family was significantly related to help-seeking attitude and behavior. The researcher found that participants usually

consulted family members about professional help before seeking such help, and were open to professional help if family members encouraged it. In addition, there was a significant and positive relation between family members who had received counseling, and students' openness to receiving professional help. Strong identification with, and attachment to family, as expressed through upholding the wishes of the family over one's own had been found in an earlier study with an African American sample (Castro, 1997). Subsequent research with African Americans and other people of color yielded similar results (e.g., Barksdale, 2008; Gonzalez-Eastep, 2008).

Inter-connectedness among family members was another important factor in professional help-seeking behavior among a sample of Mexican immigrants who were seeking care for depression from an outpatient clinic (Cabassa & Zayas 2007). The sample of 95 immigrants was studied to assess their intentions to seek professional care for depression. Participants read vignettes about persons with major depression, and were asked to indicate whether they would seek professional help if they experience a similar situation. The data from the participants revealed that family connection had a positive impact on professional help-seeking. Participants indicated that they were more likely to seek professional help if family members approved. The investigators noted that the sense of obligation that a person may have towards his/her family members, and the expectations that family members have of each other, would explain the positive impact on decision to seek professional help.

Family support and family connectedness, which are intrinsic to familism, have received attention from other scholars, who found these factors to correlate significantly with help-seeking behavior (e.g., Rundall, 1982; Scharlach et al., 2006). Rundall, (1982)

identified a relationship between family support and help-seeking behavior in a study that examined the role of social network of American elderly in the use professional health care. The research was based on a typology of social network connections that were categorized as engaged, disengaged, abandoned or trapped. Data was obtained from a survey of over 800 households, and participants were included only if there was evidence of high connection or low connection with family or friend social networks. Rundall reported that family network had a greater impact on elderly use of professional health services than other social network, such as friends' network. The data revealed that Americans who were engaged with, and had high connection with their family network were more knowledgeable about the availability of professional services, and used professional health services more regularly.

In contrast, those who were disengaged or abandoned, and had low connection with their social networks were less knowledgeable about the availability of professional services, and made less use of the services of which they were aware. More specifically, elderly adults who were connected with their family were twice as likely to access professional mental health services as persons who were disengaged from their families. Although more elderly reported having a greater connection and were more engaged with friend networks than their family network, it was connection with the family network that was significantly related to the use of professional health care. This influence of the family network could be understood in light of Gourash's (1978) explanation of the mechanism through which social networks operate to influence professional help-seeking. Gourash contends that social networks act both as screening for professional agents and transmit attitudes, values and norms about professional help-seeking.

It is worth noting that most of the participants were elderly, thus, the use of professional service may have been contingent upon the aid which family members provided. For example, family members might have supplied the finances, as well as other material support, such as transport, to and from the places of health services. Studies that include another sample of adults (e.g. college students), who might not be necessarily dependent on their family in a concrete way, could contribute additional information about the relationship between familism and help-seeking behavior. Nonetheless, the results of the study cited lend support to previous findings that indicate a relationship between familism and professional help-seeking.

While a connection between familism and help-seeking behavior seems possible, scholars continue to explore why individuals who endorse this value with its characteristic support, would still seek professional help. Pillay and Roa (2002) posit that persons who perceive support within their family network and who seek professional help might do so because they do not want to burden family members. At the same time, there might be persons for whom family support is available, but who might not experience the support. Kaniasty, and Norris, (2000) addressed the dilemma in their explanation of cultural differences in social support. They contend that individuals who identify with individualistic world-view might not receive help despite the availability of support from family because they would perceive asking for help as a sign of weakness. People from collectivistic cultures might experience a similar lack of support because the level of interdependence that is characteristic of collectivistic culture might lead them to expect help to be given voluntarily, without having to ask for it.

A conspicuous shortcoming in the psychological literature is the minimal attention that has been given specifically to understanding the relationship between familism and professional psychological help-seeking behavior. If attachment to family network is as important to all people, especially people of color, as scholars have suggested, it seems imperative to expand on the limited studies that have addressed this value in relation to professional psychological help-seeking. Additionally, an important issue in the study of familism is the measurement of the construct. Roschell (1997) contend that because familism is a value, attitudinal measures, which are presumed to reflect values, should be used to assess how emotionally committed individuals are to their family network. He further argues for a measurement that is not restricted to family support, but which captures different elements of the construct, since there are more dimensions to familism than support. In most cases however, such a measure was not utilized. Instead more focus has been given to assessing individual factors such as family support, family connectedness, and family togetherness as separate entities rather than as multidimensional factors that make up the construct. In addition, factors such as family honor, family loyalty, subjugation of self to the family and family solidarity, all of which are dimensions of familism have not been reflected in the measurement of the construct. The use of an instrument that incorporates the different aspects of the construct, and which provides an indication of overall commitment to familism is therefore warranted to understand the true nature of familism in its relationship to professional psychological help-seeking.

As with familism, the propensity to hold the group's need over individual need, is also a feature of collectivism, which scholars identify as an important cultural value of

people of color. Among minority groups especially, collectivism generally characterizes the society and communities within which behavior is carried out. At the same time, the value of individualism espoused by the dominant group in American society, within which minority groups find themselves might also impact collectivists. No empirical studies have examined how collectivism/individualism affect actual professional psychological help-seeking behavior. However, intimations of this can be gleaned from an examination of the construct in relation to attitudes towards seeking professional psychological help. The following section will examine this cultural value as another possible factor that might explain the underutilization of mental health services among Blacks.

Collectivism/ Individualism

Tirandis and colleagues (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988) explain that the main manifestation of collectivistic cultures is that individuals' goals become subsumed by the goals of the group to which they belong (e.g., family), to such an extent, that the person might be more concerned about working for the goal of the in-group than his/her own personal goals. Interdependence and harmony are fundamental elements in such cultures. At the same time, collectivists tend to be uncooperative with members of the out-group, and are generally distrustful of them. In contrast, in individualistic cultures, the individual has less concern for the in-group, which is generally, made up of like-minded persons (e.g., political groups, sports groups, literary clubs), and is encouraged to be self reliant, independent and creative. Competition is espoused, and there is a lack of emphasis on relational harmony in order to prevent over-conformity that could be construed as a lack of individuality (Cheung, 2000).

In early studies, individualism/collectivism was measured as a single construct, that was either present or absent. However, recognizing the complexity of the construct, Triandis (1989) proposed a different model that included different types of individualism, and collectivism. Triandis & Gelfand, (1998) suggested that both individualism and collectivism can coexist at the same time, and that a person can subscribe to both individualistic and collectivistic values. They describe this multidimensional construct as horizontal and vertical collectivism, and horizontal and vertical individualism. Horizontal individualism places value on the uniqueness and independence of persons, and supports equality rather than social hierarchy. On the other hand, independence, self-reliance, and the social status that one acquires through competition are inherent in vertical individualism (Gushue & Constantine, 2003). With horizontal collectivism, common goals and interdependence are valued, and group consensus is the method of arriving at a decision. Similarly, vertical collectivism stresses interdependence, but unlike horizontal collectivism, this model allows individual decisions, and accepts personal authority and inequality, if they are for the common good.

Some researchers have identified collectivism as a salient cultural value for non-dominant groups that are predominately people of color (Schwartz, 2003), and individualism has been described as one of the most important cultural value of mainstream White European Americans (Singelis & Sharkey 1995). Nevertheless, empirical evidence indicates, that in some circumstances (e.g., self-knowledge, valuing personal uniqueness), Blacks, who are generally categorized as collectivistic, are as individualistic as Whites (Oyserman, Coon, & Kemmelmeier, 2002). Support for the coexistence of collectivism/individualism is found among those who argue, that culture is

a dynamic process, and that attitudes towards others, and oneself evolve over time, in response to social change (Matsumoto, Kudoh, & Takeuchi, 1996). In fact, research conducted with homogenous ethnic groups, have identified the presence of both individualism and collectivism among members of the group (Gaines et al, 1997; Gushue & Constantine, 2003). And studies related to psychological help-seeking have found that collectivism/individualism influences attitudes related to professional psychological help. The pertinent studies will be reviewed in the following segment.

Collectivism/Individualism and Professional Psychological Help

In the area of psychological research, no study has examined the relationship between collectivism/individualism and professional psychological help-seeking behavior specifically. Instead, most of the attention has focused on the relationship with attitudes towards seeking psychological help. For instance, Hom (1998) examined individualism/ collectivism and attitudes towards seeking professional help among a sample of 323 Asian American students. More specifically, the investigator explored the influence of individualism-collectivism and acculturation, on counselor preference and attitudes toward seeking counseling, among the participants. A significant relationship between vertical individualism and attitude towards seeking professional help was found. Students who evidenced vertical individualism had a less positive attitude towards seeking professional help. Addtionally, vertical individualism was found to be more characteristic of men than women. In contrast, those who were horizontally individualusitic had a more positve attitude towards professional help-seeking.

Similarly, students who were identified as vertically collectivistic had a less positive attiutude towards counseling, but the more horizontally collective students were,

the more positive their overall attitudes toward counseling. The study identified a negative relationship between attitude towards professional help and the vertical dimensions of the construct. It appeared that individuals who valued status difference and achievement orientation that are associated with the vertical dimensions of collectivism and individualism found it more difficult to seek professional help. This might have been because they percieved professional help as a threat to their own status, and that of their social group.

Subsequent studies contributing to the literature on individualism/collectivism, and help-seeking attitudes also focused on Asians. Yoo (1997), assessed individualism-collectivism, attribution to mental health, and the relationship to attitudes towards seeking professional help among 95 Korean students in Korea, and 88 American students enrolled in two Universities in the Midwest, and Western U.S. The sample comprised male and female, but no information was given regarding the American students' race. The findings indicated a significant difference between the Korean and American students, on the individualism /collectivism dimensions. American students were higher on the horizontal dimension on both individualism and collectivism, than the Korean students, and had a more positive attitude towards seeking professional help. They also evidenced low ratings on vertical individualism and vertical collectivism. Yoo attributed the difference to the nature of American culture, which is believed to be individualistic, but horizontal, while Korean culture is believed to be collectivistic. The researcher surmised that because American students value equality, and put less emphasis on status than their Korean counterparts, they would be less intimidated by professional counseling and thus be more open to seeking and receiving psychological help. This idea is consistent with

the conceptualization of the construct of horizontal individualism and collectivism because both dimensions are characterized by equality. Hence, the American students might not view seeking professional help negatively because they might be less inclined to perceive such help as a negation or abdication of their status or authority. After all, the American society is built on the premise that all are created equal. The finding is also in keeping with Triandis's (1995) observation that individualistic societies tend to be more horizontal whereas collectivistic societies are shaped by vertical relationships.

These findings reflect that of an earlier study, in which Tata and Leong (1994) investigated whether individualism/collectivism would predict attitude towards seeking psychological help among 219 Chinese American students. Considering that most of the information on the construct had been developed from the work of Triandis and his colleagues, the researchers measured the construct with the existing instrument that these scholars developed, and which consisted of three subscales that measured the three major factors that were identified as elements of the construct (i.e. self-reliance, distance form the ingroup, low concern for the ingroup).The analyzed data revealed a significant and inverse relationship between high individualism and attitudes, with respondents who subscribed to self-reliance with competition showing a negative attitude towards seeking professional help. Self-reliance or independence is characteristic of vertical individualism, which is concerned with power and competition. What is more, self-reliant persons place more emphasis on being self-sufficient, thus it is likely that such persons would have a more negative attitude towards seeking help, as they would prefer to address their problems on their own.

The results also indicated that women had a more positive attitude towards seeking professional help. Although this was a seminal study focusing on collectivism/ individualism, the finding regarding the gender difference in attitudes appeared to be consistent with earlier studies that found women to have a more positive attitude towards professional help-seeking (e.g., Cook et al., 1984; Fischer, & Turner, 1970). Overall, it appears that current research has established that there is a relationship between collectivism/individualism and psychological help-seeking behavior. The relationship is summarized below.

Summary

In general, there is substantial evidence to indicate that there is a significant relationship between collectivism/individualism and attitude towards seeking professional psychological help. In particular, there appears to be a negative correlation between the vertical dimensions of collectivism and individualism and professional help-seeking attitude. In contrast, the horizontal dimensions of individualism and collectivism seem to be related to a positive attitude. This might be because equality, which is an element of the horizontal dimensions, neutralizes and de-emphasizes the struggle for authority and power which some might associate with counseling. This is unlike the inequality of the vertical dimension and its accommodation of authority and difference in status, which might be threatened, in the therapeutic relationship. The result is the corresponding negative attitudes that it accommodates.

However, while this might be true of attitudes, an unequivocal statement cannot be made regarding actual behavior, or even intentions to seek help because of the gap that exists in the literature concerning the impact of the constructs on help-seeking behavior.

This begs for caution therefore, despite the fact that the Theory of Planned Behavior (Ajzen, 1988) suggests that a positive attitude is likely to lead to the behavior for which the attitude is expressed. Whether horizontal and vertical individualism/collectivism would have the same impact on help-seeking behavior as was generally found for help-seeking attitudes remains to be examined. It is with this in mind that this study undertakes to explore the relationship between the horizontal and vertical individualism/collectivism and help-seeking behavior.

The present study will also redress the tendency of previous studies that examined the relationship between collectivism/individualism, and professional help-seeking behavior to focus almost exclusively on Asian American samples. Similar patterns can be found in the research on familism that focuses mainly on Hispanics, and spirituality with its emphasis on African Americans. This is curious, given that these values are identified as salient to people of color in general. In addition, the isolation of the constructs calls for expanding the study of cultural values from the examination of one cultural value to include other salient cultural values that have been found to influence help-seeking behavior. In this way, the effect of the combination of the values could be observe while simultaneously gathering information about the unique contribution that each value makes to help-seeking behavior.

At the same time, one cannot ignore the fact that there are gender differences in help-seeking behavior. Gender differences have been found in attitudes and intentions towards seeking professional psychological help as well as in actual behavior. An examination of the literature captures this trend among members of the Black community (e.g., Neighbors et al., 2007; Williams et al., 2007).

Gender Differences and Help-Seeking Behavior

Biological theory of gender difference has been used to understand the contrast in behavior in the study of men and women in a variety of settings. The theory purports that the reproductive fitness of women predisposes them to be caretakers and nurturers who value closeness and solidarity, whereas men's role in the lives of their offspring depends more on their ability to provide resources and security. Men are therefore viewed as providers who must utilize their power and status in ensuring their offspring's survival (Ickes, 1993). But according to O'Neil (1981) when male roles result in negative consequences such as restrictive emotionality, this is known as gender role conflict. Good and associates (1989) affirm that men are socialized to seek power and control and to avoid showing emotion, whereas women are expected to show interpersonal openness and to give free reign to their emotions. Ickes (1993) summarized the gender role dynamic as the social orientation that emphasizes closeness and solidarity as basic characteristics of women. In contrast traditional masculine gender role supports power and status.

Empirical literature reflects these general characteristics especially in the area of professional psychological help-seeking. Good and colleagues (1989) recorded that one-third of men seek professional counseling compared to double that figure for women. The ratio of men to women seeking help for a problem that they experience shows a stark difference, with one in three women seeking help, compared to the one in seven men who will seek help if they are experiencing emotional or psychological distress. Some theorists have attributed this discrepancy to traditional gender roles (Good et al., 1989; O'Neil, 1981; O'Neil, Helms, Gable, David, & Wrightsman, 1986). O'Neil (1981)

explained that gender difference in help-seeking is based on the erroneous assumption that interpersonal communication that emphasizes emotions, feelings and intuition should be avoided because it is considered feminine. Other assumptions are that men who seek help that requires emotional expressiveness fear being considered immature, weak, dependent, and therefore feminine. In addition, the power differential that is evident in the therapeutic alliance might be unacceptable to the traditional male who has been socialized to value power and control.

Good et al., (1989) tested this premise in their study of 401 undergraduate male students. The researchers investigated the relationship among factors (e.g., power and competition) related to traditional male sex role (e.g., power/competition), and attitude towards seeking professional help, likelihood of seeking help and past help-seeking behavior. The results indicated that there was a significant relationship between factors associated with traditional male role and help-seeking attitude and behavior. In particular students who had concerns about expressing emotions had a more negative attitude towards seeking help, and had sought help less often for psychological problems. Men's restrictive emotionality was related to decreased likelihood of seeking help. On the other hand, belief that men's need for power might prevent them from seeking psychological help was not supported by the study. While the results were supported by theory, caution in generalizing the results is still warranted because of the sample population. The investigators noted that 91.5% of the participants were White males with a mean age of 19.3 years.

In contrast to men, research evidence indicates that women report a more positive attitude, as well as higher intentions to seek psychological help; they tend to utilize

psychological services more frequently than men. In the study of 219 Black college students Braksdale (2008) examined factors (perceived community and perceived peers) that influence mental health help-seeking behavior with this population. ANCOVAs and multiple regression analyses were implemented to explore and understand the relationship between study variables. The investigator reported that women have a more positive attitude towards seeking professional psychological help, and had higher intentions to seeking professional help than men. The results are consistent with previous literature that found that in general, females had a more positive attitude towards seeking help than men (Good et al., 1989; Greenley & Cleary, 1987).

Krogh (2007) presents complementary evidence of the male-female difference in an investigation of intentions towards psychological counseling for alcohol and depression among 264 participants. The investigator explored the factors that would predict intentions towards seeking professional psychological help. Gender differences were found among the factors relating to intentions to seek help. More specifically, women had greater intentions to seek help than men. Women also evidenced a more positive attitude towards seeking professional psychological help. This was also documented in a study of 400 ethnically diverse students at a university in Canada (Kuo et al., 2006). The study was meant to explore the social factors that might determine the students' attitude towards seeking professional psychological help. The authors reported that there was a significant relationship between the gender of the student and their attitude towards seeking help, with male-female difference recorded at $[F(1, 391) = 13.62, p < .01]$. In this study, women had a more positive attitude towards seeking professional psychological help than men. Other studies with similar populations reported

corresponding results (Duncan, 2003; Komiya, et al., 2000; Lee, 2002; Lopez, Melendez, Sauer, Berger, & Wyssmann, 1998; Morgan, Ness, & Robinson, 2003; Sheu & Sedlacek, 2004; Tsan & Day, 2007).

Finally, yet another study of African American adults corroborates the gender difference in help-seeking behavior. In this study Duncan and Johnson (2007) worked with 315 Black college students (119 males; 196 females) to examine attitude towards counseling and counselor preference. Simultaneous multiple regression analysis identified gender as a significant predictor of attitude towards counseling. In particular women were more likely to have a positive attitude towards counseling than their male counterparts. However since gender was grouped together with other variables to explain the variance, and only account for 11% of the variance in attitude towards counseling, more research is needed to identify and separate the difference that might be present.

After considering the role of gender in psychological help-seeking, the following section will conclude the review of the literature that examined the relationship between the variables of interests and professional psychological help-seeking behavior.

Conclusion

Studies suggest that the health related cultural values of collectivism, fatalism, and familism, in addition to religiosity and spirituality might constitute factors that would impact professional psychological help-seeking behavior. Presently, there is a gap in the literature that addresses the combined impact of dominant cultural values on help-seeking behavior. Additionally, given that studies have shown that commitment to spiritual and religious beliefs, or spirituality and religiosity, influence behavior, there is need for further exploration of the relationship between cultural values and spirituality and

religiosity, and professional help-seeking behavior, with a sample that has experienced continued disparity in the quality and use of mental health services within the American society. The present study will therefore attempt to contribute to filling the gap, by examining whether cultural values (i.e., collectivism/individualism, familism, fatalism) and spirituality and religiosity would be predictive of professional psychological help-seeking behavior among Black adults in the United States. In addition, the investigation will also focus on identifying the difference in professional psychological help-seeking behavior between Black men and women.

Problem Statement

Current data indicate that a significant percentage of the Black population suffers from depression and anxiety. Yet, Black adults are among those who do not exploit the services that society provides for individuals who suffer with mental or emotional problems. And in cases where they do seek help, Blacks are overrepresented in facilities where care is not of the high quality that is available to the dominant social group. Researchers have postulated different reasons for this reality. Some studies have looked at barriers to mental health for Blacks and have identified factors such as stigma, counselor/client fit, socioeconomic status, and preference for informal help, among others, as contributing to the reasons why Blacks do not to seek professional help. And although some studies have established a correlation between these factors and professional help-seeking, they do not account for all of the contributing factors that might influence help-seeking behavior for Blacks. This means that other considerations must be examined. Some posit that cultural values, in addition to spirituality and religiosity might constitute other factors that would explain why Blacks do not use professional psychological help at the same rate as other racial groups (e.g., Whites).

Cultural values are an important consideration in psychological help-seeking behavior because every culture has values that guide individuals in choosing what they should do in a given situation. In a society that is as multicultural as the United States there are values that characterize the dominant White middle-class American and other values that are reflective of the non-dominant groups, that are mainly people of color. Whereas values like horizontal individualism of the dominant group seem to facilitate professional psychological help-seeking behavior, values such as familism, as well as

spirituality and religiosity, that characterize people of color, often do not support professional help for addressing mental health problems.

However, these variables have not received much attention in studies that have examined factors that might contribute to the scant use of professional mental health services. In addition, when cultural values that are related to health have been examined, studies have focused predominately on one value, in isolation of other important values. But, according to theorists on human behavior, it is rare that only one factor would influence a person at a time. Rather it is usually a combination of elements that affect human behavior. In addition, the conflicting and inconclusive results about most of the cultural values identified indicate further need for research in this area. Other drawbacks have been that many studies utilized semi-structured interviews that restricted the use of instruments with proven psychometric properties to measure the constructs. There is need therefore for studies that would assess identified cultural values together with spirituality and religiosity, among people who endorse these values, and who have been known to underutilize professional services for mental health problems.

The present study will therefore undertake the exploration of a cluster of health related cultural values and professional psychological help-seeking behavior among a sample of Black female and male adults. It is this researcher's hope that this study will add to the literature on these health related cultural values and help-seeking behavior by providing information about the relationship between professional psychological help-seeking of Blacks in the U.S. and cultural values, which studies have found to influence such behavior.

Overall, the purpose of the study is to investigate whether horizontal and vertical collectivism/individualism, familism, fatalism and religiosity and spirituality together will predict professional psychological help-seeking behavior for Black adults. The study will also expand on the restricted measurement of behavior by facilitating the simultaneous assessment of intentions to seek psychological help. To this end, the study will provide the opportunity to reexamine the intentions-behavior relationship that is fundamental to the Theory of Planned Behavior. Not least of all is the interest in the gender differences in help-seeking behavior. The present study will therefore examine whether there is a difference between the help-seeking behavior of Black adult men and women. In sum, it is hoped that this study will contribute to the literature on help-seeking behavior of Black adults, which in turn could help to change the conditions that make it difficult for this group to seek professional help for mental health problems.

Hypotheses

This study will test the following hypotheses:

Hypothesis 1: Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism and Spirituality and Religiosity together will be significantly predictive of professional psychological help-seeking for Black adults, such that a positive relationship will be found with not having sought help, but there will be a negative relationship with having sought help.

Hypothesis 2: Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism and Spirituality and Religiosity together will be significantly predictive of intentions to seek professional psychological help for Black adults, such that an inverse relationship will be found between higher levels of spirituality, religiosity, familism, fatalism, and vertical and horizontal collectivism/individualism and intentions to seek professional psychological help.

Hypothesis 3: Intentions to seek professional psychological help will be significantly predictive of professional psychological help-seeking behavior for Blacks, such that a positive relationship will be found between intention to seek help and having sought help, but a negative relationship will be found with not having sought help.

Hypothesis 4: Black women's professional psychological help-seeking behavior will be significantly different from Black men's professional psychological help-seeking behavior, such that more women than men would report that they have sought psychological help.

Chapter III

Method

Overview

The present study was designed to investigate whether spirituality/religiosity and the cultural values of vertical and horizontal collectivism/individualism, familism, and fatalism would predict professional psychological help-seeking for Black men and women in the United States. The predictor variables were chosen from the literature because of indications that they exert significant influence on professional psychological help-seeking behavior. The criterion variable is of interest because scholars seem to agree that in the United States, people of African descent often choose not to seek professional help in spite of the mental health problems that they experience. In addition to measuring actual behavior, intentions to seek help was also measured to assess the likelihood of seeking help for individuals who are currently not in need of mental health services, but who might need such services in the future. The current study therefore examined cultural values, spirituality and religiosity and their impact on both intentions and professional help-seeking behavior of Blacks in the United States.

Sample Size:

The sample size was based on an estimation of Cohen's presumed medium effect size (.15) and desired power (.80) of the independent variables for multiple regression (Cohen, 1992). The estimated minimum sample size was also determined by a priori statistical calculation according to Soper (2009). The power analysis utilized alpha level of .05, predictors and demographic categories, anticipated medium effect size (.15) and desired statistical power of .80. Based on the calculations, a minimum of 146 adults was

needed for the study, but at least 292 participants were required to compare two groups (help-seeking behavior of men and women). A sample size of 394 was obtained for the study.

Procedure

Prior to the collection of data, IRB approval was obtained from Teachers College, Columbia University to recruit participants both online and through the more traditional method. Participants for the online study were subsequently recruited through email invitations that were sent to list-serves of various Black organizations in the community and on different college campuses, as well as through snowball sampling. The invitation asked participants to participate in an online study about cultural values, religiosity, spirituality, and seeking help for emotional problems. They were told that there was little or no risk in participating in the study, and that they have the option of withdrawing at any point during the completion of the instruments. Participants were also apprised of the chance to be entered in a raffle of three prizes (i.e., three $100 Visa gift cards). They were then directed to the link for the study and were required to sign the consent form before they could complete the instruments. At the end of the survey, online participants were directed to submit the data, which then connected them to a separate link to submit their information to participate in the raffle.

For the more traditional paper/pencil survey, the investigator contacted individuals from her social network who were in positions of leadership in Black communities in the Northeastern and Southeastern United States to request their support and collaboration for the study. More specifically, the investigator requested and received help in securing participants for the study from pastors of Black churches, leaders of

Black organizations in colleges, Black community groups, and friends and family members with major connections in their work places and social groups. In the process, the invitation to participate was given through announcements made at churches, colleges, and social functions such as dinners, barbeques, and cultural festivities where members of the Black community were present. The investigator also canvassed business places including shopping centers, and beauty parlors to recruit participants. Random encounters in Black communities and snowballing were also helpful in the recruitment process.

Groups and individuals were asked to participate in the paper/pencil study or online study. The description of the study was as above. Participants then received the survey packet, which contained the invitation, the consent form, which they were asked to sign, and the instruments for the study. They were asked to complete and return the survey package, except for the page with the information about the link for the raffle. Participants were invited to submit their names for the raffle at their convenience. In both instances, participants completed the Demographic Questionnaire, and the Individualism/Collectivism Scale, the Fatalism/Mastery Scale, the Spiritual Involvement and Belief Scale, the Familism Scale, the Intentions to Seek Counseling Inventory, and the Religious Commitment Inventory scales, which were counterbalanced for order effect.

Participation in the paper pencil survey was higher than the online survey. After five months online, there were 82 entries for the online survey. Of these, 31 (38%) were not included in the preliminary analysis because although the participants completed the demographic questionnaire, at least two of five instruments were not attempted. On the

other hand, within three months of the distribution of 625 packets for the paper pencil survey, 344 (55%) were returned. The data set from one packet was excluded because the participant did not meet the inclusion criteria (identified as White). The final data set for the preliminary analysis included the combined data from the online and the paper pencil surveys ($n = 394$). The initial decision to combine the online and paper pencil data in the preliminary analysis was informed by research evidence that concluded that there is no significant difference between data that is collected on line and data that is collected through the more traditional paper/ pencil (Gosling, Vazire, Sirvastava & John, 2004; Meyerson & Tryon, 2003). However, the online sample was excluded because of differences that were observed between the two groups of participants, as will be noted in Chapter IV.

Participants

A total of 394 Black adults from the Northeastern and Southeastern United States completed the study. Of these, 51 participants comprised the online sample that was excluded. Overall this sample consisted of mainly female participants (66.7%). Most indicated that they were born in the United States (52.9%) or Grenada (29.0%), had completed an Associate degree (45.1%), did not graduate high school (21.6%) or completed a bachelor's degree (17.6%). Of these 49.0% identified as middle class and 35 % as working class. The average age of participants from this group was 30.78 years (SD = 9.30 years), and the average number of years in the United States was 21.12 (SD = 10.25). Participants who had sought help (52.9%) slightly outnumbered those who had not sought help (47.1%), and most did not have a family member in therapy (70.6%), but have a mental health professional in their social network (66.7%). The majority of

participants in this group identified as African American (47.1%) or Caribbean American (37.3%).

Demographic and descriptive data for the sample that was included in the analyses (*n* = 343, see Table 1) indicate that most of the participants were female (68.5%). The most common country of birth was the United States (50.7%), followed by Jamaica (14.0%), Grenada (10.8%), and Trinidad & Tobago (9.3%). The levels of education included high school graduate (32.7%), bachelor's degree (29.7%), associate's degree (15.2%), and master's degree (15.2%). Two (.6%) persons indicated that they had attained a doctorate. In terms of SES, most of the participants considered themselves either working class (48.7%) or middle class (42.6%). Ethnically, African American was the most common group (40.8%), followed by West Indian (28.9%), and Caribbean American (28.0%). Most of the participants (79.0%) did not have a member of their family who was in therapy, and most did not have a social network member who was a mental health professional (73.5%). The average age of the participants was 33.14 years old (*SD* = 10.39 years), and the average number of years in the United States was 25.46 (*SD* = 11.04). The majority of the participants (85.1%) reported not having sought help from a mental health professional. Table 1 contains additional descriptive statistics for the demographic and background characteristics of the participants.

Instruments

Participants completed a package of six instruments, in addition to a demographic questionnaire. The package included the following instruments which were counterbalanced: The Individualism-Collectivism scale, Familism scale,

Fatalism/Mastery scale, the Religious Commitment Inventory, the Spiritual Involvement and Belief scale, and the Intentions to Seek Counseling Inventory.

Demographic questionnaire

A demographic questionnaire was designed to gather information about gender, age, ethnicity, place of birth, years in the U.S., socioeconomic status, education and whether participants had a mental health professional in their social network or had someone from their social circle in therapy. The factors included were significantly related to psychological help-seeking behavior among participants in previous studies.

Professional Help-seeking Behavior:

Professional help-seeking behavior was measured with a single question requiring a dichotomous answer, and the Intentions to Seek Counseling Inventory. Following previous studies (Arorash, 2003; Constantine & Gainor, 2004; Franklin et al., 2007; Miville & Constantine, 2006; Russell, 2008; Vogel, Wade, Wester, Larson, & Hackler, 2007; Yorgason, et al., 2008)**,** professional help-seeking behavior was assessed by a question requiring a "yes" or "no" answer. The question, which was included in the demographic questionnaire asked, "Have you ever sought professional psychological services (e.g. from a psychiatrist, psychologist, counselor, social worker or other mental health professional)? The Intentions to Seek Counseling Inventory was used to gather more continuous data on professional help-seeking behavior.

Intentions to Seek Professional Psychological Help

Intentions to seek professional psychological help were measured by the Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975). The ISCI is a 17-item measure, and was validated with a sample of college students. The

instrument requires respondents to rate on a scale from 1 (*very unlikely*) to 6 (*very likely*), how likely they would be to seek counseling, if hypothetically, they were experiencing problems such as general anxiety, relationship difficulties, depression, worries, and academic and drug problems. The questionnaire is scored by summing the responses to the items. Scores can range from 17 to 102 with higher score indicating greater likelihood of seeking counseling.

The instrument has evidenced adequate reliability and validity with diverse populations. Cash et al., (1975) reported that the ISCI was able to detect preferences in college students' intentions to seek counseling from counselors who were presented as more or less attractive. In a study with a racially diverse group of undergraduate students that included 4% Blacks, Cepeda-Benitio and Short's (1998) analysis of the data estimated Cronbach's alpha of .89. Kelly and Achter's (1995) study with a multiracial sample of 256 undergraduate college students including thirteen Blacks yielded an alpha of .84 for the 17 items. They reported a positive relationship between the ISCI and positive attitude towards psychotherapy, and found that correlations with perceived significance of a current problem was significant ($r = .36$). Cronbach's alphas of .88 and .89 have been reported with other college samples with 5% or less Black participants (Hermosisima, 2005; Vogel & Wei; 2005). The current study yielded Cronbach's alpha of .93.

Collectivism/Individualism

The Individualism-Collectivism scale (INDCOL, Hui; 1988; Triandis, 1994) is a 32-item scale that was developed to measure the vertical and horizontal dimensions of individualism and collectivism. The scale comprises four subscales, each of which

consists of eight items that are measured on a 9-point Likert-type scale, ranging from 1= strongly agree, to 9 = strongly disagree. The Vertical Collectivism subscale measures the extent to which individuals value the groups to which they belong (e.g., family), and respect the decisions of these groups. It is made up of items such as, "I usually sacrifice my own interest for the benefit of my group. Horizontal Collectivism (H-C) expresses both interdependence and equality. The Horizontal Collectivism subscale measures the extent to which individuals accept both interdependence and equality among members of the group to which they belong. The 8-item subscale includes items such as "I feel good when I cooperate with others." The Horizontal Individualism (H-I) subscale measures the extent to which an individual is autonomous, yet recognizes the equal status of others. The items in the subscale include "When I succeed, it is usually because of my own ability. The Vertical Individualism (V-I) subscale measures the sense of independence of the individual, and the recognition of inequality of status among persons. Self-reliance and competition are characteristic of this aspect of individualism, as expressed by items such as, "I enjoy working in situations involving competition with others" (Singelis, Triandis, Bhawuk, & Gelfand, 1995). In the current study, scores were computed and standardized to correct for the reference effect following the direction of the author of the scale (personal correspondence from Triandis, see APPENDIX H).

Validity and reliability for the scale have been moderate. In the study of Asian and White undergraduate students from three universities ($N = 316$), Singelis et al., (1995) reported Cronbach's alpha of .67 for Horizontal Individualism, .74 for Vertical Individualism, and .74 and .68 for Horizontal and Vertical collectivism respectively. The scale demonstrates adequate convergent and discriminant validity, when compared to

instruments such as the Self Construal Scale (SCS, Singelis, 1994), and the Sinha
individualism and collectivism scales (Sinha & Verma, 1994). The researchers reported
positive correlation ($r = .45$, $p < .01$) between the Horizontal Individualism scale, and
Independence subscale of the Self Construal Scale, and a negative correlation with the
Interdependence subscale ($r = -.25$, $p < .01$). The Horizontal Collectivism subscale was
positively correlated with the Interdependence subscale of the SCS ($r = .43$, $p < .01$), and
negatively correlated with the Independence subscale of the SCS ($r = -.26$, $p < .01$).
Triandis and Gelfand (1998) reported good convergent and divergent validity in their
study with a Korean sample, and a multiethnic group of American students.

Gushue and Constantine (2003) reported equivalent alphas in their study of 123
African American College students. For this study the scale produced alphas of .77, .61,
.68, .64 for HI, VI, HC, and VC, respectively. Another study by Hunter (2007), with a
sample of African American, and Caribbean American adults produced similar results.
The alphas were computed based on the total score of the overall sample. Horizontal
Individualism yielded an alpha of .84, Vertical Individualism .74, Vertical Collectivism
.67 and Horizontal individualism, .67. The researchers also reported separate reliability
for the African American subgroup as .87, .70, .69, and .68 for the HI, VI, HC, and VC
subscales and .78, .77, .64, .66 for the West Indian sample. For the current study alphas
for Vertical Individualism, Horizontal Individualism, Vertical Collectivism and
Horizontal Collectivism were recorded at .72, .76, .72, and .72 respectively.

The validity of the instrument has been supported with Gushue and Constantine
(2003) reporting a significant positive relationship between horizontal individualism and
the I-position of the four Self-Differentiation constructs that were measured by the

Differentiation of Self scale (DSI, Skowron & Friedlander, 1998) (*r* = *.41, p* < .01), whereas horizontal collectivism was significantly negatively related to emotional reactivity (*r* = -.18, *p* < .05) and fusion with others (*r* = -.30, *p* < .01). Hunter (2007) reported that Horizontal Collectivism was positively and significantly related to Collective Self Esteem Scale-Ethnic Specific (*r* = .23, *p* < .01) and Vertical Individualism positively and significantly related to the Index of Racism Related Stress- Brief Version scale (*r* =. 15, *p* <. 05), for a sample of Caribbean Americans.

Spirituality and Religiosity

        The Spiritual Involvement and Belief Scale and the *Religious Commitment Inventory* will be used to measure Spirituality and Religiosity. *Spiritual Involvement and Beliefs Scale* (SIBS, Hatch, Burg, Naberhaus, & Hellmich, 1998) is a 26-item instrument that measures spiritual involvement and activity, as well as beliefs. It was developed with a sample of 83 participants between the ages of 21-84 years, 50 of whom were patients in a family practice, and 33 of whom were family practice professionals. No information about the racial composition of the sample used in the development of the scale was included.

        The SIBS assesses aspects of spirituality (e.g. meditation), not covered by other instruments such as *The Spiritual Well-Being Scale* (SWBS, Paloutzian, & Ellison, 1982), which, although most commonly used to measure spirituality, has been criticized for its psychometric limitations (Ledbetter, 1991). The instrument is scored on a modified Likert-type format. Items are worded positively and negatively, and include, "I can find meaning in times of hardship," and "I solve my problems without using spiritual resources." A total spirituality score is obtained by adding the reverse scores of the

negative items with the scores from the other items. Higher scores indicate greater spiritual involvement and beliefs.

Hatch et al., (1998) reported high internal consistency (Cronbach's alpha = .92), and strong test-retest reliability (r = .92) for the instrument. Elam's (2000) study with a multiracial undergraduate college sample 18-22 years yielded an alpha of .85. This is supported by Conner's (2003) study with 104 Black adults (18 years and over). Result from the analysis of the data yielded an alpha of .85. Gauthier (2001) reported a Cronbach's alpha of .92 for the scale, in the study of a sample of White, Black, Asian, and Hispanic adults 21-65 years old. Construct validity was established with the Spiritual Well Being Scale with Hatch and colleagues reporting a high correlation between the two scales (r = .80). Elam (2000) reported that the scale had significant and positive correlation with the Satisfaction with Life Scale (SWLS, Diener, Emmons, Larson, & Griffins, 1985) (r = .39; p = .01) and the SIU Religiosity Scale (Dollinger, cited in Elam, 2000) (r = .69; p < .01). In the present study, Cronbach's alpha of .90 was obtained.

The Religious Commitment Inventory (RCI-10, Worthington, et al., 1998) was developed to measure a person's commitment to his or her religious values, beliefs, and practices. The RCI-10, a shortened form of the 17-item version instrument (i.e., RCI–17; McCullough, Worthington, Maxie, & Rachal, 1997) that was developed for use in research, counseling and health psychology measures religious commitment from an ecumenical perspective. The instrument is measured on a Likert-type scale with 1= *not at all true of me*, to 5 = *totally true of me*, and includes items such as, "My religious beliefs lie behind my whole approach to life" and "I enjoy spending time with others of my religious affiliation."

Validity studies were conducted with four samples of university undergraduates, and college students, adults and counselors. Participants were Caucasians, African American, Asian and Hispanics. Alpha coefficient for the full scale was reported as .93. Three-week test-retest reliability was .87. In a religious sample of undergraduate students, Cronbach's alpha was .88, and 5-month test-retest reliability was .84. Among a community sample of adults, Cronbach's alpha was .96 for the full scale. The present study yielded a similar Cronbach's alpha of .95.

Construct validity was measured against Single Item Measures of Religiosity (i.e., Participation in organized religion, Frequency of religious activities), and Rokeach religiosity from the Rokeach's Value Survey (Rokeach, 1967), which categorizes individuals as religious and non-religious, based on the values that they endorse. The researchers reported that the RCI was significantly correlated with Participation in organized religion ($r = .70$, $p < .01$) and Frequency of religious activities ($r = .72$, $p < .003$). The scale was also significantly correlated with Rokeach's religiosity realm ($r = .54$, $p < .01$).

Discriminant validity, as measured by Pearson correlation coefficients was calculated with scores on the Vision of Everyday Morality Scale (VEMS, Shelton & McAdams, 1990). Morality was not significantly related to religious commitment as measured by the full-scale RCI–10 ($r = .09$, $p = .26$). Criterion validity was calculated with frequency of attendance at religious activities. There was a significant relationship with the full scale ($r = .70$, $p < .01$). African Americans scored higher on the full-scale measure than did Asian Americans, and Caucasians, who did not differ.

Fatalism

The *Fatalism/Mastery* scale was developed by Pearlin and Schooler (1978) to assess the degree to which people ascribed external control to factors that protect people from being psychologically harmed by problematic events in life. This scale consists of seven items that are scored on a 4-point Likert- type scales. Five items are positively worded, and two are negatively worded, including, "I have little control over the things that happen to me," and "I can do just about anything I really set my mind to". The scale was originally developed with a sample of 2,300 adults 18-65 years old, from an urban area in Chicago. It was subsequently used in a longitudinal study with a large sample of Black youths ranging from 14 to 47 years old (Mizelle, 1999) and yielded Cronbach's alpha of .78. Johnson (2003) reported an alpha of .78 in a study with Black undergraduate male students.

In a study with a large diverse sample, Neff & Hoppe (1993) reported internal consistency reliabilities were .70 for Anglo-Americans, .76 for African- Americans, and .80 for Mexican-Americans. Roberts et al., (2000) reported an alpha of .71 with a sample of Hispanic, African Americans, Europeans and others adolescents, in an ethnically and socio-demographically diverse section of Houston. Cronbach's alpha for the current study was .74.

Familism

Lugo Steidel and Contreras (2003) developed the 18-item Familism Scale to assess attitudes associated with support within the family, family interconnectedness, and subjugation of self to the family. The validation sample included mainly persons of Puerto Rican and Dominican descent, who were 18 years and older. The scale is scored

on a 10-point Likert-type scale ranging from 1=*strongly disagree* to 10 =*strongly agree,* and includes items such as, "A person should be a good person for the sake of his or her family," "A person should cherish the time spent with his or her relatives," and "a person should help his or her elderly parents in times of need, for example, helping financially or sharing a house." The developers of the scale reported a total score to measure the construct of familism. Scores are calculated by summing the value of each item. Higher scores indicate greater adherence to familism.

Lugo Steidel and Contreras reported Cronbach's alphas of .83 for the full scale. Measures of reliability have been relatively consistent in studies that used the scale. Schwartz (2007) reported reliability coefficient of .82 with a multiethnic sample of 318 Hispanic, White and non-Hispanic Black young adult students. In a study of Latino high school seniors, Esparza and Sanchez (2008) reported alpha of .83. In the present study reliability coefficient of .88 was obtained.

Validity was demonstrated with measures of acculturation, from the Acculturation Rating Scale for Mexican Americans–II (ARSMA-II, Cuellar, Arnold, &Maldonado, 1995). Lugo Steidel and Contreras (2003) reported a significant negative correlation between the linear acculturation and overall familism score (r = -.26, $p < .01$). A significant negative correlation between familism and scores on the Anglo Orientation Scale was also found (r = -.23, $p < .05$). Schwartz (2007) assessed the convergent validity of the scale with the Individualism/Collectivism scale, and the Self Construal Scale, and reported correlation (r = .61) between vertical collectivism and the familism scale.

Hypotheses

The preceding instruments and the demographic questionnaire provided the data that were utilized to test the four hypotheses upon which the current study is based.

Hypothesis 1: Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism and Spirituality and Religiosity together will be significantly predictive of professional psychological help-seeking for Black adults, such that a positive relationship will be found with not having sought help, but there will be a negative relationship with having sought help.

Hypothesis 2: Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism and Spirituality and Religiosity together will be significantly predictive of intentions to seek professional psychological help for Black adults, such that an inverse relationship will be found between higher levels of spirituality, religiosity, familism, fatalism, and vertical collectivism and individualism and intentions to seek professional psychological help.

Hypothesis 3: Intentions to seek professional psychological help will be significantly predictive of professional psychological help-seeking behavior for Blacks, such that a positive relationship will be found between intentions to seek help and having sought help, but a negative relationship will be found with not having sought help.

Hypothesis 4: Black women's professional psychological help-seeking behavior will be significantly different from Black men's professional psychological help-seeking behavior, such that more women than men would report that they have sought psychological help.

Given the dichotomous nature of the dependent variable in Hypothesis 1 and

Hypothesis 3, logistic regressions constituted the main analyses for those hypotheses.

Field (2005) contested that a logistic regression is in principle a multiple regression

except that the outcome variable is a categorical dichotomous variable. He noted that

predictors can be continuous, categorical or a combination of the two. Similarly, Morgan

and colleagues (2003) posit that logistic regression is useful " to identify a "good" set of

independent variables (a model) that helps predict or explain group membership on the

dependent variable" (p. 995). More specifically, the researchers highlight that in addition

to predicting the likelihood that an event would happen, logistic regression also identifies

the variables that would be useful for fulfilling the prediction. Additionally, Le Blanc and

Fitzgerald (2000) observed that although other types of analyses such as discriminant

analysis and log linear modeling can be used with dichotomous variables, logistic

regression provides a more flexible model that is easier to understand. They explained

that the Wald statistic (χ^2) is most commonly used for testing whether the model being

tested is statistically different from the model without any predictors. Field (2005) also

recommended using the R-statistic (Nagelkerke R^2), which is an indication of the partial

correlation between the predictor variables and the outcome variable.

A multiple regression was used to test Hypothesis 2. Field (2005) recommends

multiple regressions in cases where the outcome variable can take any numerical value

for a set of predictor variables. On the other hand, Chi-Square was used in the analysis

for Hypotheses 4 to accommodate the categorical nature of the outcome variable.

According to Field (2005) Chi-Square is most useful for testing the difference between

groups when a categorical variable is used to generate data. He contends that examining

the difference in means, which is obtained through ANOVA would be inappropriate with categorical variables, which do not yield means. Instead a Chi-Square may be utilized to assess the difference in frequencies across categories. The results of the forgoing analyses are presented in the following chapter.

Chapter IV

Results

Introduction/Overview

The current study investigated whether Vertical and Horizontal Collectivism/ Individualism, Familism, Fatalism and Spirituality and Religiosity predicted professional psychological help-seeking behavior for Black adults. In addition, this study also examined the difference between the help-seeking behavior of Black men and Black women in the United States. Four hypotheses formed the basis of the investigation, which utilized a series of Multiple Regression, Logistic Regression, Chi Square and Analysis of Variance to examine the data. The current chapter presents the results of the analyses that were performed. Initially, the results from preliminary analyses are presented, including descriptive statistics for the sample demographic characteristics and the predictor variables. The results for each hypothesis are then presented. The chapter ends with a summary of the key findings from this study.

Preliminary Analyses

All analyses were performed using SPSS version 15.0. A preliminary check was conducted to determine whether the data from participants who completed the survey online (n = 51) should be combined with the data from those who did not ($n = 343$). Statisticians recommend that before combining data sets from different groups, analyses should be performed to determine the comparability of the groups (Minnesota Department of Education, 2010). If differences are observed, they recommend further analyses to identify the items that contribute to the differences, and to eliminate those items until a common set of items remain for the groups.

The results of the analysis to test for differences indicated that those participants who completed the survey online had higher Intentions to Seek Counseling scores ($M =$ 53.96, $SD =$ 25.65) than those who did not complete the survey online ($M =$ 45.87, $SD =$ 20.92), t (392) = 2.50, $p =$ .013. In addition, those who completed the survey online had higher Horizontal Individualism scores ($M =$ 4.74, $SD =$ 2.37) than those who did not complete the survey online ($M =$ 3.25, $SD =$ 2.98), t (392) = 3.41, $p =$ .001, and lower Spirituality scores ($M =$ 59.33, $SD =$ 16.11) than those who did not complete the survey online ($M =$ 94.11, $SD =$ 15.16), t (392) = -15.16, $p <$ .001. The two groups also differed in terms of having sought professional help, $\chi 2$ (1) = 40.53, $p <$ .001, with online survey respondents being much more likely (52.9%) to have sought professional help than the other respondents (14.9%). Based on the above differences, item analyses were warranted. However, the analyses that were necessary to identify common items for the two groups were beyond the scope of the current study. Consequently, the 51 participants who completed the survey online were excluded from all subsequent analyses insofar as they appeared to represent a different population from those who completed the paper/pencil survey.

Of the 343 participants included in the main analyses for this study, 277 (80.8%) had no missing data. A total of 12.8% of the participants was missing one value, 3.5% had two missing values, 1.7% was missing three values, .9% was missing four values, and .3% was missing five values. No participant was missing more than two values for any scale. There was a total of 103 missing data points out of 41,503 values, missing at random, for a missing data rate of .2%. To accommodate analyses with missing data, pairwise deletion of missing values was used for the inferential statistical tests. Scores for

predictor variables were computed as the mean of the available data for the scale for each participant.

Descriptive statistics for the nine predictors examined in this study are shown in Table 2. The scores for five of the variables were computed as item sums, while those for the Individualism/Collectivism scale were computed using the individually standardized method recommended by Triandis (2009). Skewness and kurtosis were examined for the variables and were generally within the acceptable range of 1- and 1 (see Table 2). Attempts to improve the distribution of the scales with skewness greater than 1, using common data transformation (i.e. square root, log) recommended by Field (2005) did not yield significant improvement and thus the original scales were used. Cronbach's alpha reliability coefficients were also computed for the nine scales, and all values were greater than the conventional cutoff of .70 for adequate reliability. Reliability coefficients ranged from .72 (for the Horizontal Collectivism, Vertical Collectivism, and Vertical Individualism scales) to .95 (for the Religiosity scale).

Correlations were then computed among the predictor and control variables and are shown in Table 3. The highest correlations were between Religiosity and Spirituality ($r = .60$, $p < .001$), between Vertical Individualism and Vertical Collectivism ($r = -.51$, $p < .001$), and between Vertical Individualism and Horizontal Collectivism ($r = -.51$, $p < .001$).

Data Analysis for Hypotheses

Hypothesis 1

The first hypothesis of this study was: Vertical and Horizontal Collectivism/ Individualism, Familism, Fatalism and Spirituality and Religiosity together will be

significantly predictive of professional psychological help-seeking for Black adults, such that a positive relationship will be found with not having sought help, but there will be a negative relationship with having sought help. Given that only conditional effects can be extrapolated when a variable is analyzed in the presence of others, preliminary univariate analyses were conducted to observe the direct effect of each predictor variable on professional psychological help-seeking (See Table 4). A block entry logistic regression analysis was then conducted to look at each of the predictors when controlling for others, since this was the main interest underlying the hypothesis. In this analysis the demographic control variables of gender, age, country of birth, socioeconomic status, education, ethnicity, years in the U.S, having a family member in therapy, and having a social network member who was a mental health professional were entered as a single block (See Table 5), followed by Religiosity, Spirituality, Fatalism/Mastery, Familism, Vertical Collectivism, Horizontal Collectivism, Vertical Individualism, and Horizontal Individualism in the second block (Table 6). Whether or not the individual has sought professional psychological help was the outcome variable.

The coding of country of birth was modified based on the observed frequencies in Table 1. Specifically, separate groups were included for those born in the United States, born in Grenada, and born in Jamaica, with all other individuals included in the "other country" group. The outcome variable was coded as 0 = psychological help not sought, 1 = psychological help sought. For the categorical covariates, country of birth was coded as 0 = United States (the reference category), 1 = Grenada, 2 = Jamaica, and 3 = other, while ethnicity was coded as 0 = African American (the reference category), 1 = Caribbean American, 2 = West Indian, 3 = other. The variable years in the United States was

calculated and entered as the ratio between years in the United States and age. Having a member of their family who was in therapy was coded as 0 = no and 1 = yes. Having a social network member who was a mental health professional was coded as 0 = no and 1 = yes.

Table 5 shows the results from Block 1 of this analysis. In Block 1, the demographic and background control variables were statistically significant as predictors of whether or not the participant had sought psychological help, χ^2 (14) = 60.73, p < .001; Nagelkerke R^2 = .29; -2 log likelihood = 227.68; Percentage correctly classified = 86.3%. There were three statistically significant control variables. First, years in the United States was predictive of having sought professional psychological help, Exp (B) = 2.82, p = .002. This indicated that participants who were born in, or had spent most of their lives in the United States were more likely to have sought professional psychological help. Second, age was predictive of having sought help, Exp (B) = 1.04, p = .009. This suggested that older participants were more likely to have sought help for mental health problems. In addition, having a family member in therapy was statistically significant, Exp (B) = 2.73, p = .018. This indicated that participants who had a family member in therapy were more likely to have sought professional psychological help.

The results of Block 2 of the analysis are presented in Table 6. Although the addition of the predictors reduced the –2LL by 13.61, the improvement was non-significant (p = .833). Nonetheless, the overall model was statistically significant as predictors of whether or not the participant had sought psychological help, Model χ^2 (22) = 74.34, p < .001; Nagelkerke R^2 = .34; -2 log likelihood = 214.07; Percentage correctly classified = 88.3%. Only one predictor variable was individually statistically significant

while controlling for the variables in Block 1. Scores on the Familism scale were statistically significant, Exp (B) = .97, *p* = .005, indicating that participants with higher scores on the Familism scale were less likely to have sought professional psychological help. Hochberg and Benjamini's (2005) False Discovery Rate post hoc analysis was subsequently conducted to control for Type I error and to confirm the significance observed. The results confirmed that only Familism was a significant predictor of help-seeking behavior.

The three statistically significant demographic control variables in Block 1 were again significant in Block 2. First, the variable, years in the United States was predictive of having sought professional psychological help, Exp (B) = 5.99, *p* = .005, indicating that professional psychological help was more likely to have been sought by participants who were born in, or had spent most of their life in the United States. Again, older participants were more likely to have sought help since age was a significant predictor in the analysis Exp (B) = 1.04, *p* = .027. Finally, having a family member who was in therapy was statistically significant, Exp (B) = 3.04, *p* = .013, suggesting that participants with a family member in therapy were more likely to have sought professional psychological help. Since the overall the model was significant, the hypothesis that cultural values and spirituality/religiosity together will significantly predict having sought help was confirmed.

Hypothesis 2

The second hypothesis was: Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism and Spirituality and Religiosity together will be significantly predictive of intentions to seek professional psychological help for Black Adults, such

that an inverse relationship will be found between spirituality, religiosity, familism, fatalism, and vertical collectivism and individualism and intentions to seek professional psychological help. To test this hypothesis, a block entry multiple regression was utilized. The demographic control variables of gender, age, socioeconomic status, education, years in the U.S, ethnicity, country of birth, having a family member in therapy, and having a social network member who was a mental health professional were entered together in Block 1 (See Table 7), followed by Religiosity, Spirituality, Fatalism/Mastery, Familism, Vertical Collectivism, Horizontal Collectivism, Vertical Individualism, and Horizontal Individualism which were entered as a single block in Block 2 (See Table 8). The outcome variable was Intentions to seek professional psychological help.

Categorical variables were recoded for the analysis; gender was coded as $0 =$ male, $1 =$ female. Country of birth was coded as three dummy variables (coded as $0 =$ no, $1 =$ yes) representing those born in Grenada, born in Jamaica, or born in the "other" country group, with those born in the United States as the reference category. Ethnicity was coded with three dummy variables (coded as 0 no, $1 =$ yes) for Caribbean American, West Indian, and other, with African American as the reference category. Having a member of their family who was in therapy was coded as $0 =$ no and $1 =$ yes. Having a social network member who was a mental health professional was coded as $0 =$ no and $1 =$ yes.

Table 7shows the results from Block 1 of this analysis. In Block 1, the demographic control variables as a group were statistically significant, $R^2 = .10$, $F(17, 325) = 2.19$, $p = .005$. Individually, three control variables were statistically significant. First, age was negatively related to Intentions to Seek Counseling scores ($\beta = -.14$, $p =$

.012), indicating that participants who were older had lower intentions to seek counseling. Second, having a mental health professional in the social network was predictive of Intentions to Seek Counseling scores ($\beta = .19$, $p < .001$), indicating that participants with a mental health professional in their social network had stronger intentions to seek counseling. Having a Bachelor's degree was also predictive of intentions to seek help ($\beta = .13$, $p < .042$), and suggested that compared to participants who had only graduated high school, those who had higher education, specifically a bachelor's degree had higher intentions to seek counseling.

When the predictor variables were entered in Block 2 of the model (See Table 8), the change in R^2 was not statistically significant, Step 2 R^2 change = .04, $F(8, 317) =$ 1.86, $p = .066$, although the overall regression model was still statistically significant, R^2 = .14, $F(25, 317) = 2.12$, $p = .002$. Despite the lack of statistical significance for the addition of the predictor variables as a group, the Spirituality scale was statistically significant on an individual basis, $\beta = .18$, $p = .025$. The positive regression coefficient indicated that participants with higher Spirituality scores tended to have higher intentions to seek counseling. Although the variables together significantly predicted intentions to seek counseling, a linear rather than the expected inverse relationship was found between the predictor variable (i.e. spirituality) and the intentions scores. The second hypothesis was therefore partially supported.

Hypothesis 3

The third hypothesis was: Intentions to seek professional psychological help will be significantly predictive of professional psychological help-seeking for Blacks, such that a positive relationship will be found between levels of intentions to seek help and

participants who have sought help, but a negative relationship will be found with those who have not sought help. To examine this hypothesis, a logistic regression analysis was performed with Intentions to Seek Counseling scores as the predictor variable, and whether or not the individual has sought professional help as the outcome variable (coded as 0 = no, 1 = yes). Table 9 shows the results from this logistic regression analysis. Overall, the model was statistically significant, $\chi^2(1) = 6.53$, $p = .011$; Nagelkerke $R^2 = .03$; -2 log likelihood = 281.88; Percentage correctly classified = 85.1. The results showed that Intentions to Seek Counseling scores were predictive of whether or not the participant has sought professional help (Wald = 6.48, Exp $(B) = 1.02$, $p = .011$); participants with higher Intentions to Seek Counseling Scores were more likely to have sought professional help. Therefore, the third hypothesis of this study was supported.

Hypothesis 4

The fourth hypothesis of this study was: Black adult women's professional psychological help-seeking behavior will be significantly different from Black adult men's professional psychological help-seeking behavior, such that more women than men would report that they have sought psychological help. A chi-square test was performed to examine the relationship between gender (coded as 0 = male, 1 = female) and having sought professional help (coded as 0 = no, 1 = yes). Field (2005) recommends using Chi-Square rather than ANOVA to examine the difference between groups when one of the variables is categorical. The groups in this chi-square test were mutually exclusive and the expected frequency of all cells was greater than 5, indicating that the assumptions of the test were met.

Table 10 shows that 12.0% of males had sought professional help, compared to 16.2% of females. However, the chi-square test indicated that this difference was not statistically significant, $\chi^2(1) = 1.00$, $p = .318$. The odds of seeking help for males were .14 (13 / 95), while for females the odds of seeking help were .19 (38 / 197). The odds ratio was therefore 1.36, indicating that for female participants, the odds of seeking professional help is 1.36 times the odds of that for male participants. However, as noted above, this effect was not statistically significant, indicating that the fourth hypothesis of this study was not supported.

Summary of Findings

There were four hypotheses in this study. The first hypothesis of this study was: Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism and Spirituality and Religiosity together will be significantly predictive of professional psychological help-seeking for Black adults, such that a positive relationship will be found with not having sought help, but there will be a negative relationship with having sought help. Results of the analysis indicated that participants who were born and lived their entire lives in the United States, and those who had lived most of their lives in the United States were more likely to have sought professional psychological help. Participants' age, and having a family member who was in therapy were also statistically significant. Among the main variables of interest, participants with higher scores on the Familism scale were less likely to have sought professional psychological help, indicating that the first hypothesis of this study was partially supported.

The second hypothesis was: Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism and Spirituality and Religiosity together will be significantly

predictive of intentions to seek professional psychological help for Black Adults, such that an inverse relationship will be found between spirituality, religiosity, familism, fatalism, and vertical collectivism and individualism, and intentions to seek professional psychological help. Participants who had higher education such as a bachelor's degree had more intentions to seek professional help than those with a high school education, and participants with a mental health professional in their social network had stronger intentions to seek counseling. On the other hand, participants who were older had lower intentions of seeking professional psychological help.

Among the main predictors, scores from the spirituality scale were significantly related to Intentions to Seek Counseling scores. More specifically, participants with higher Spirituality scores tended to have higher intentions to seek counseling. This result indicated that the second hypothesis of this study, though partially supported was contrary to the hypothesized direction of the relationship between the predictors and intentions to seek counseling.

The third hypothesis was: Intentions to seek professional psychological help will be significantly predictive of professional psychological help-seeking for Blacks, such that a positive relationship will be found between intentions to seek help and having sought help. The results from the logistic regression analysis indicated that Intentions to Seek Counseling scores were predictive of whether or not the participant has sought professional help, and the third hypothesis of this study was supported.

Lastly, the fourth and final hypothesis of this study was: Black adult women's professional psychological help-seeking behavior will be significantly different from Black adult men's professional psychological help-seeking behavior, such that more

women than men would report that they have sought psychological help. Although the odds of seeking professional help were higher for females than for males, this difference was not statistically significant. Therefore, the fourth hypothesis of this study was not supported.

Table 1

*Participant Demographic and Background Characteristics (*N = *343)*

Variable	Frequency	Percentage
Gender		
Male	108	31.5
Female	235	68.5
Country of Birth		
Antigua	3	.9
Barbados	5	1.5
Grenada	37	10.8
Jamaica	48	14.0
Trinidad & Tobago	32	9.3
St. Lucia	1	.3
St. Vincent	3	.9
Haiti	8	2.3
United States	174	50.7
Other Country	32	9.3
Education		
Elementary	7	2.0
Junior high	1	.3
Some high school	15	4.4
High school graduate	112	32.7
Associate's degree	52	15.2
Bachelor's degree	102	29.7
Master's degree	52	15.2
PHD/doctorate	2	.6
SES		
Working class	167	48.7
Middle class	146	42.6
Upper middle class	27	7.9
Upper class	1	.3
No response	2	.6

Table Continues

Variable	Frequency	Percentage
Ethnic group		
African American	140	40.8
Caribbean American	96	28.0
West Indian	99	28.9
Other	8	2.3
Participant sought help from a mental health professional		
No	292	85.1
Yes	51	14.9
Family member in therapy		
No	271	79.0
Yes	72	21.0
Social network member mental health professional		
None	252	73.5
Family member	32	9.3
Friend	49	14.3
Spouse	2	.6
Partner	2	.6
Sibling	6	1.7

	M	*SD*
Age	33.14	10.39
Years in the United States	25.46	11.04

Table 2

*Descriptive Statistics for Predictor Variables (*N *= 343)*

Variable	Items	Min.	Max.	*M*	*SD*	Skew	K
Intentions to Seek Counseling	17	17.00	97.00	45.87	20.92	.34	-.90
Individualism/ Collectivism							
Horizontal Collectivism	8	-7.32	6.96	1.26	2.75	-.57	.25
Vertical Collectivism	8	-8.38	8.90	1.28	2.64	-.54	.48
Horizontal Individualism	8	-8.82	9.49	3.25	2.98	-.88	1.34
Vertical Individualism	8	-12.26	7.52	-5.81	3.60	1.20	2.04
Spirituality	26	38.00	129.00	94.11	15.16	-.35	.24
Religiosity	10	10.00	50.00	32.34	11.94	-.29	-1.03
Fatalism/Mastery	7	7.00	25.00	13.55	3.34	.10	-.01
Familism	18	18.00	180.00	122.93	22.21	-.48	1.07

Table 3

Correlations of Study Variables N (343)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Gender	1.0																		
2. Age	.09	1.0																	
3. Country	-.06	.17**	1.0																
4. Education	-.01	.12*	.04	1.0															
5. SES	-.09	.05	.13*	.38**	1.0														
6. Ethnicity	.07	.05	.44**	-.01	-.08	1.0													
7. Years in the U.S.	-.04	-.21*	.49**	.07	.19**	-.55**	1.0												
8. Sought Help	.05	.10	.18**	.10	.10	-.18**	.26**	1.0											
9. SN Professional	.10	-.04	.06	.16**	.07	-.04	.06	.21**	1.0										
10. SN Member	.06	-.03	.10	.01	.08	-.08	.08	.13*	.24**	1.0									
11. HC	.11*	.13*	-.05	-.02	-.03	.03	-.07	.12*	.05	-.02	1.0								
12. VC	-.01	.11	.15**	-.04	-.04	.08	-.24**	-.08	-.09	-.04	.08	1.0							
13. H I	.21**	.11*	.20**	.10	-.04	-.10	.28**	.08	.07	-.01	-.39**	-.35**	1.0						
14. VI	-.25**	-.08	-.02	-.02	.09	-.01	-.01	-.10	-.03	.05	-.51**	-.51**	-.28**	1.0					
15. Spirituality	.22**	-.20**	-.16**	.14**	.04	.12*	-.18**	.01	-.05	-.05	.12**	.18**	.01	-.30**	1.0				
16. Religiosity	.07	.24**	-.16**	.09	.05	.14**	-.21**	-.02	-.02	-.02	.12	.20**	-.13*	-.14***	.60**	1.0			
17. Fatalism/ Mastery	-.12**	-.03	-.03	.14*	.02	.14*	-.11*	-.05	-.09	.04	-.05	.01	-.19**	.18**	-.17**	.23**	1.0		

Table Continues

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
18. Familism	-.04	.03	.12*	-.10	-.02	.04	-.10	-.17**	.01	-.03	.10	.29**	-.09	-.22**	.23**	.22**	-.17**	1.0	
19. Intentions	.03	-.10	-.03	.05	.05	.03	-.06	.14**	.06	.16**	.06	-.03	-.04	.01	.13*	.07	.07	.05	1.0

*$p < .05$. **$p < .01$.

Note: SES = Socioeconomic status, SN Professional = Mental Health Professional in Social Network, SN Member = Social Network Member in Therapy, HC = Horizontal Collectivism, VC = Vertical Collectivism, HI = Horizontal Collectivism, VI = Vertical Collectivism

Table 4

Results of Correlation and Univariate Logistic Regression Analysis for Variables Predicting Professional Psychological Help-Seeking Behavior

Variable	r	p	Exp(B)
Horizontal Collectivism	.12*	.029	1.142
Vertical Collectivism	-.08	.131	.919
Horizontal Individualism	.08	.130	1.088
Vertical Individualism	-.10	.065	.913
Spirituality	.01	.880	1.002
Religiosity	-.02	.689	.995
Fatalism/Mastery	-.05	.358	.959
Familism	-.17**	.003	.980

*p < .05. **p < .01.

Table 5

*Results of Block 1 of the Logistic Regression Analysis for Variables Predicting Professional Psychological Help-Seeking Behavior (*N = 343*)*

							95% CI for B	
Effect	B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
Gender (female)	-.61	.40	2.30	1	.129	.54	.24	1.19
Ethnicity (reference group = African American)			.01	3	.906			
Education (reference category = High School Graduate)			2.95	3	.399			
Age	.04	.01	6.83	1	.009	1.04	1.01	1.08
SES (reference category = Working Class)			.02	3	.989			
Years in the United States	4.80	1.57	9.32	1	.002	2.82	5.58	7.09
Country (reference category = United States)			2.19	3	.533			
Family member in therapy (yes)	1.01	.42	5.62	1	.018	2.73	1.19	6.29
Social network member mental health professional (yes)	.71	.39	3.20	1	.073	2.04	.93	4.46
Constant	-7.77	1.77	19.19	1	.001	.01		

Notes. Overall model χ^2 (14) = 60.73, p < .001; Nagelkerke R^2 = .29; -2 log likelihood = 227.68; Percentage correctly classified = 86.3%.

Table 6

*Results of Block 2 of the Logistic Regression Analysis for Variables Predicting Professional Psychological Help-Seeking Behavior (*N = 343*)*

Effect	B	S.E.	Wald	df	Sig.	Exp(B)	95% CI for B	
							Lower	Upper
Gender (female)	-.33	.45	.53	1	.464	.72	.29	1.75
Ethnicity (reference group = African American)			.02	3	.882			
Education (reference category = High School Graduate)			2.93	3	.403			
Age	.04	.02	4.86	1	.027	1.04	1.01	1.08
SES (reference category = Working Class)			.02	2	.988			
Years in the United States	4.55	1.61	8.02	1	.005	5.99	4.06	2.08
Country (reference category = United States)			1.82	3	.611			
Family member in therapy (yes)	1.11	.44	6.23	1	.013	3.04	1.27	7.27
Social network member mental health professional (yes)	.60	.41	2.14	1	.143	1.82	.81	4.07
Religiosity	-.01	.02	.01	1	.942	.99	.95	1.04
Spirituality	-.04	.02	.04	1	.825	.99	.96	1.03
Fatalism	-.02	.06	.13	1	.713	.97	.86	1.10
Familism	-.03	.01	7.40	1	.005	.97	.95	.99
Vertical Collectivism	-.13	.84	.05	1	.818	.82	.15	4.28
Horizontal Collectivism	-.09	.85	.01	1	.916	.91	.17	4.87
Vertical Individualism	-.29	.83	.12	1	.725	.74	.14	3.81
Horizontal Individualism	-.209	.845	.061	1	.805	.812	.155	4.255

Table Continues

| Effect | B | S.E. | Wald | df | Sig. | Exp(B) | 95% CI for B | |
							Lower	Upper
Constant	-4.525	2.686	2.837	1	.092	.011		

Notes. Overall model $\chi^2 (22) = 74.34$, $p < .001$; Nagelkerke $R^2 = .34$; -2 log likelihood = 214.07; Percentage correctly classified = 88.3%.

Table 7

Results of Block 1 of the Linear Regression Analysis for Variables Predicting Intentions to Seek Counseling (N = 343)

Effect	B	SE_B	β	t	p	95% CI for B	
						Lower	Upper
Constant	53.93	7.86		6.85	.000	38.46	69.41
Gender (female)	1.76	2.43	.04	.72	.469	-3.03	6.56
Ethnicity (reference category = African American)							
Caribbean American	3.03	3.05	.06	.99	.322	-2.97	9.04
West Indian	1.56	3.56	.03	.43	.668	-5.44	8.56
Other	-11.05	8.25	-.08	-1.33	.185	-27.30	5.18
Education (reference category = High School Graduate							
Bachelor's	6.01	2.94	.13	2.04	.042	.21	11.81
Associate	-.17	3.53	-.00	-.05	.960	-7.13	6.78
Other	3.30	3.27	.06	1.01	.314	-3.14	9.75
Age	-.28	.11	-.14	-2.51	.012	-.50	-.06
SES (reference category = Working Class)							
Middle Class	1.44	2.46	.03	.58	.560	-3.41	6.29
Upper Middle Class	3.23	4.42	.04	.73	.465	-5.46	11.93
Other	32.46	22.22	.08	1.46	.145	-11.26	76.18
Years in the United States	-8.31	6.41	-.10	-1.30	.196	-20.94	4.31
Country (reference category = United States)							
Grenada	-6.22	4.45	-.09	-1.40	.163	-14.99	2.54
Jamaica	2.50	4.47	.04	.56	.576	-6.30	11.31
Other	.06	3.93	.01	.02	.987	-7.68	7.81
Family member in therapy (yes)	-.30	3.01	-.006	-.100	.920	-6.213	5.61
Social network member mental health professional (yes)	9.33	2.75	.19	3.39	.001	3.91	14.74

Notes. Overall model R^2 = .10, F (17, 325) = 2.19, p = .005

Table 8

Results of Block 2 of the Linear Regression Analysis for Variables Predicting Intentions to Seek Counseling (N = 342)

Effect	B	SE_B	β	t	p	Lower	Upper
						95% CI for B	
Constant	17.83	14.63		1.22	.224	-10.96	46.63
Gender (female)	1.37	2.61	.030	.52	.601	-3.77	6.51
Ethnicity (reference category = African American)							
Caribbean American	2.97	3.06	.064	.97	.332	-3.05	8.99
West Indian	.68	3.58	.015	.19	.848	-6.36	7.73
Other	-11.56	8.31	-.084	-1.39	.165	-27.92	4.79
Education (reference category = High School Graduate							
Bachelor's	6.30	2.93	.138	2.15	.032	.53	12.07
Associate	.32	3.54	.006	.09	.927	-6.65	7.30
Other	2.38	3.32	.048	.72	.474	-4.16	8.93
Age	-.29	.11	-.146	-2.59	.010	-.51	-.07
SES (reference category = Working Class)							
Middle Class	1.10	2.48	.026	.45	.657	-3.78	5.98
Upper Middle Class	3.10	4.45	.040	.70	.487	-5.66	11.86
Other	30.19	22.23	.078	1.36	.175	-13.55	73.94
Years in the United States	-6.15	6.56	-.077	-.94	.349	-19.05	6.75
Country (reference category = United States)							
Grenada	-6.57	4.49	-.098	-1.47	.144	-15.41	2.25
Jamaica	1.64	4.53	.027	.36	.717	-7.27	10.55
Other	.85	3.95	.018	.22	.828	-6.92	8.64
Family member therapy(yes)	-.59	3.04	-.012	-.20	.845	-6.57	5.38
Social network member mental health professional (yes)	9.60	2.73	.20	3.51	.001	4.22	14.99

Table Continues

Effect	B	SE_B	β	t	p	95% CI for B	
						Lower	Upper
Religiosity	-.11	.13	-.06	-.85	.396	-.39	.15
Spirituality	.25	.11	.18	2.25	.025	.03	.48
Fatalism	.64	.35	.10	1.82	.070	-.05	1.34
Familism	.06	.05	.07	1.22	.225	-.04	.17
Vertical Collectivism	-9.27	5.09	-1.16	-1.82	.069	-19.29	.74
Horizontal Collectivism	-8.62	5.13	-1.13	-1.68	.094	-18.73	1.48
Vertical Individualism	-8.62	5.07	-1.48	-1.70	.090	-18.60	1.36
Horizontal Individualism	-9.02	5.09	-1.28	-1.77	.077	-19.03	.99

Notes. Overall model R^2 = .14, $F (25, 317)$ = 2.12, p = .002; Block 2 R^2 change = .04, $F (8, 317)$ = 1.86, p = .066.

Table 9

Results of Logistic Regression Analysis for Intentions to Seek Counseling Predicting Professional Psychological Help-Seeking Behavior (N = 343)

							95% CI for B	
Effect	B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
Intentions to Seek Counseling	.02	.01	6.48	1	.011	1.02	1.00	1.03
Constant	-2.64	.40	43.12	1	.000	.07		

Note. χ^2 (1) = 6.53, *p* = .011; Nagelkerke R^2 = .03; -2 log likelihood = 281.88; Percentage correctly classified = 85.1%

Table 10

*Results of Chi-Square Analysis Examining the Difference Between Professional Psychological Help-Seeking Behavior of Black Men and Black Women (*N = 343)

	Help-seeking		
Gender	No	Yes	Total
Male	95 (88.0%)	13 (12.0%)	108 (100.0%)
Female	197 (83.8%)	38 (16.2%)	235 (100.0%)
Total	292 (85.1%)	51 (14.9%)	343 (100.0%)

Note. $\chi^2(1) = 1.00$, *p* = .318.

Chapter V

Discussion

The underutilization of mental health services among Black adults in the United States has been documented in national surveys as well as many research studies (Neighbors etc al., 2007, USDHHS, 2001; Williams et al., 2007). This reticence to use professional services has been striking especially in light of the high incidence of mental health problems that are reported by Black adults, and researchers have attempted to identify factors that are related to help-seeking behavior of Blacks in order to address the problem (e.g. Corney, 1990; Schrieber, Stern, & Wilson, 2000; Westefeld, McConnell & Jenkins, 2001). Some studies have identified factors such as age, education, socioeconomic status, and social network among those factors that might contribute to the underutilization of professional mental health services (Gourash, 1978; Miller, 1991; Scheffler & Vanheusden et al., 2008). More recent studies are beginning to examine the role that cultural values play in accessing services, for although there is growing recognition of the importance of cultural values as determinants of behavior related to health, research that examines the relationship between health related cultural values and professional psychological help-seeking behavior is limited at best and provides results that are inconsistent for the most part.

This study was an effort to expand research that examines whether cultural values, spirituality and religiosity are related to the help-seeking behavior of Black men and women in the United States. The current chapter will focus on discussing the results of the analyzed data from a sample of 343 Black men and women who were recruited from organizations and personal contact in cities in the Northeastern and Southeastern

United States. In particular, the findings of each hypothesis that formed the basis of the study will be addressed in light of previous research in this area. The discussion will then segue into an examination of the implications that the current study holds for future work. More specifically, the conversation will center on how the findings from the study can inform clinical practice, future research and training of psychologists in counseling programs. As indicated above, discussion will begin with the first hypothesis.

Hypothesis I:

It was hypothesized that Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism, Spirituality and Religiosity together would significantly predict professional psychological help-seeking for Black adults, such that a positive relationship would be found with not having sought help, but there would be a negative relationship with having sought help. The logistic regression that was utilized to test the hypothesis yielded results that indicated that the variables together were significant predictors of not having sought help. In this analysis, the best predictor of help-seeking was familism, which was significant on its own after controlling for other predictors and demographic variables. This indicated that in the presence of the other cultural values, familism exerted the greatest influence on whether or not help was sought by the individuals who experienced mental health problems. As such, individuals who identified strongly with this value were less likely to have sought help for mental health problems. This result was not surprising and was consistent with other studies that examined the relationship between familism and professional psychological help-seeking behavior (e.g. Barksdale 2008, Cauce et al., 2002; Garcia 2007).

To understand this result, it is helpful to look at the construct of familism which includes family support, inter-connectedness, family honor, family loyalty and subjugation of self to the family (Lugo Steidel & Contreras, 2003; Roschell, 1997). There is extensive literature that underscores these aspects of familism and demonstrates how they function to influence the lives of individual members in a family. For instance Unger et al. (2002) observed that individuals high in familism were more likely to perceive themselves as being extremely grounded within their family. Such individuals first look within the family for any type of support that they might need to cope with their struggles. With regard to mental health problems, individuals are more likely to discuss their problems with other family members who would be perceived as having the individual's best interest at heart. Boyd-Franklin (1987) contended that within the Black family, members generally turn to parents, grandparents and other extended family members to cope with stress and anxiety in their lives.

In the case of Blacks in the United States, the literature further highlights how familism functions in the process of seeking help for mental health problems. Some researchers and theorists purport that because many Black families share the cultural belief that people who seek mental health services are crazy, individuals might avoid professional services to safeguard the honor of the family (Baptiste et al., 2002; Boyd-Franklin, 1989). This is especially pertinent if family members believe that mental health problems are transmitted genetically. Further, when one considers the stereotype about the dysfunction of Black families, it is possible that a person might refrain from seeking professional help in order to protect their family from being further stigmatized. Similarly, in the effort to uphold the wishes of the family over one's own, individuals

tend not to seek help outside of their family network (Castro, 1997; Gonzalez-Eastep, 2008). This may arise especially when family members are concerned about having the family's problems aired to strangers. As Boyd- Franklin (1987), and Cabassa and Zayas (2007), noted, family members often depend on the approval of the family before seeking help; therefore they would avoid professional help if the family disapproves.

Other studies have substantiated the claim that familism is an important factor that interfaces with help-seeking. The value is especially salient when help-seeking is influenced by past experiences with professionals in the mental health field. This is pertinent for Black adults, especially with the general agreement that members of minority populations are more likely to have had negative experiences with mental health professionals and mental health institutions than individuals from the dominant culture (Williams et al, 2007). A sense of loyalty to the family could therefore preclude further contact with the professional world, if family members have had a history of negative experiences with mental health services. In such cases, loyalty to the family would be a major factor that would contribute to avoiding professional help.

The fact that the other variables were not significant was not expected. For instance other studies have found that religiosity and spirituality are predictors of having sought professional psychological help (Abe-Kim et al., 2004; Fowler, & Hill, 2004; Mayers et al., 2007). Most notably, researchers have found that Blacks who are high in religiosity tend not to seek help for mental health problems, and if they do, they are most likely to access help from their pastors or other religious clergy (Matthews et al., 2006). Notwithstanding this finding, another study by Matlock-Hetzel, (2005) showed that Blacks who identify as religious, and who are exposed to counseling within their

religious environment are open to seeking professional psychological help. Thus, in cases where counseling was part of the ministry of the Black Church, members were more likely to seek help for mental health problems. Perhaps the fact that no significance was found for these variables in this study could be due to a lack of exposure to counseling among this particular sample of Black adults. On the other hand as has been explained, members might be seeking informal help from the clergy.

Similarly, Individualism/Collectivism and fatalism were expected to be significant predictors of help-seeking. At the same time, it is possible that familism was more reflective of the collectivistic dimension with which this particular sample of Black adults identified. Schwartz, Montgomery, and Briones, (2006) contend that on a broad level, familism and other similar cultural constructs may reflect a collectivist value system that involves behaviors based on interdependence and subjugating of self for the benefit of the group. Nonetheless, since few studies have investigated these constructs and their relationship with help-seeking behavior of Black adults further research is required to better understand this relationship. Another important consideration is that there were many variables that were correlated, and although there was no evidence of multicollinearity, the relationship among the variables might have been strong enough to preclude any one variable, except familism, from being significant in the presence of the other variables.

Regarding the demographic control predictors, the results indicate that having a family member in therapy, an increase in age, and years in the United. States (having been born or spent most of one's life in the U. S.) were significant predictors of having sought help. First, participants with a family member in therapy were more likely to have

sought help. Although familism itself was significantly related to not having sought help, it is understandable that having a family member in therapy was positively related to having sought help. This suggests that family members who have had experience with mental health services are more inclined to offer the support that would allow other members to benefit from such services. Consequently, participants with a family member in therapy are more likely to be those who had sought help themselves. Pescosolido's (2006) premise that the social network (e.g. family) creates the push to action elucidates this finding. Applied here, this means that when family members have positive experiences in therapy they are more likely to encourage and support other family members to seek the services. They might also be better able to identify mental health problems that need professional help, and have the knowledge to guide their family members to the appropriate resources.

Years in the U.S. is another significant demographic in predicting whether or not help had been sought. The variable "years in the US" was calculated as the ratio between the number of years lived in the United States and the age of the participants. The result indicates that Black adults who are native born (i.e. African Americans), and immigrants who have lived most of their lives in the United States are more likely to have sought help for mental health problems. This is an interesting finding given that about 57% of the participants identified as Caribbean (i.e., non-U.S.) Blacks. One explanation for the results is that people who identify as African American might have higher rates of mental health problems than non-U.S. born Blacks. In fact, Miranda and colleagues (2005) found that in a study of Black women, those who were born in the U.S. and identified ethnically

as African American were more likely to suffer from depression that Black women from the Caribbean.

Perhaps U.S. born Black adults are exposed to more stressors, and lack some of the resources that might be protective against these stressors. More importantly, they might have a keener awareness of experiences of oppression that are related to higher incidence of mental health problems that warrant professional help. Some researchers agree that Blacks in the U.S have to contend with stressors such as racism and other forms of social injustice that might precipitate problems such as depression (Airhihenbuwa, & Liburd, 2006; Baptiste, & Hardy, 1997). Murphy and Mahalingam (2004) concur and assert that Blacks are the most disparaged group in the U.S. However, they contend that Blacks from the Caribbean might experience social injustices differently; they come from countries where Blacks are in the majority, hold the positions of power, and discrimination based on race is largely absent. Similarly the researchers assert that the transnational experience of immigrant Blacks from the Caribbean acts as another protective factor against the racism and injustices that Black adults face in the United States.

Nonetheless, despite the fact that "years in the U.S." was controlled for in the current analysis, the result that psychological help was sought more often by individuals born in the U.S. was consistent with other studies that have had similar results (e.g. Furnham, & Andrew, 1996). Nadeem and colleagues (2008) also found that U.S. born Black adults were more likely to have sought professional psychological help than non-U.S. born Blacks. They explained the difference on the premise that non-U.S. born Blacks had less exposure and familiarity with the system that regulates mental health

services. The lack of familiarity with mental health system might therefore constrain individuals to use resources such as family to cope with problems. This might explain too the significant negative relationship between familism and help-seeking behavior. Perhaps further research with a sample of non-U.S. born Black adults would be able to elucidate further the current finding.

With regard to age, other studies support the finding that age is a predictor of help-seeking behavior. For example, Cooper-Patrick et al. (1999) found that participants who were less than 65 years old, but more than 30 years old were more likely to have sought help than younger adults. The authors observed that mental health distress increased with age in the population that was observed over a period of time. This seems to indicate that individuals might have more difficulty dealing with stressors, as they grow older. Perhaps too, older persons might be more aware of the benefits of mental health services and might have more knowledge and resources to access these services. In addition, they might feel less able to deal with problems on their own, and concede that some problems are beyond the scope of the help that they might be able to receive informally. The result is also consistent with other studies that found older adults were more likely to seek help than younger adults (Hathaway, 2005; Oliver, Pearson, Coe, & Gunnell, 2005).

Hypothesis 2

Hypothesis 2 posited that Vertical and Horizontal Collectivism/Individualism, Familism, Fatalism and Spirituality and Religiosity together would predict intentions to seek counseling, such that an inverse relationship will be found with intentions to seek help. To test this hypothesis, a multiple linear regression was utilized and the results

suggested that the predictor variables were predictive of intentions to seek help. The results further indicated that among the main predictors of interest, spirituality was the best predictor of intentions to seek help. Essentially, after controlling for demographics (i.e., ethnicity, years in the U.S., age, country of birth, etc), and in the presence of other predictors, higher levels of spirituality were positively correlated with intentions to seek counseling. The results deviated from the expected relationship that was hypothesized based on evidence in the literature from past studies. This result was unexpected because some studies have shown that individuals who identified as highly spiritual were less open to seeking help (e.g., Abe-Kim et al., 2004; Schrieber, Stern, & Wilson, 2000). A more recent study by Nadeem and colleagues (2008) corroborate the finding that Black adults use their belief in God rather than professional psychological services to cope with mental health problems. In fact, other research found that professional psychological help was viewed as a lack of trust in God, and therefore people who identify with strong spirituality were opposed to seeking help for their problems (Matthew et al., 2006; Mayers, 2007).

However this finding is consistent with the conceptualization of spirituality, which involves finding and making meaning in life (Hill & Pargament, 2003). Similarly, it is consistent with the idea of spirituality as an urge toward wholeness, fueled by the experience of human incompleteness (Moberg, 1990). In addition the results might signal a shift in the understanding of spirituality that allows individuals who identify as spiritual to embrace professional help as a way of making meaning in their lives. Another possible explanation is that the construct possible taps into modern life, such that people who are engaged in making meaning of their lives are more open to resources such as counseling

that would allow them to do so (Gall et al., 2005). In the same vein, some researchers observe that the onset of secularism and disillusionment with religion might contribute to the growing interest in spirituality (George et al., 2000), and it is safe to say that counseling is a natural part of the landscape of a secular society. It is noteworthy also that although religiosity can be expressed as identification with religious institution, it does not preclude a person from a different expression of this defining aspect of the self. What seems clear however is the paucity of research that has examined the relationship between spirituality together with other cultural values, and professional psychological help-seeking behavior of Black adults in the United States. This lack of research seems to contradict the general belief in the salience of religion and spirituality in African American culture and life. It means therefore that more research focusing on spirituality is needed.

What is surprising though is that religiosity was not a significant predictor of intentions to seek help. This is especially striking given the direct relationship between formal religiosity and greater cohesive African American family relationships that theorists and researchers have proposed (Brody et al., 1996; George et al., 2000). Connected to this, an inverse relationship between religiosity and intentions to seek help was expected because of the central role that religious commitment and involvement play as coping strategy and support mechanism for Blacks in the United States (Krause & Tran, 1989; Musick, Blazer, & Hays, 2000; Rogers 2007). One explanation for the findings could be that the significant correlation between spirituality and religiosity resulted in spirituality subsuming the power in the analysis. The lack of significance

might also reflect the decline in the religious attendance and adherence to denominational religion among Americans that Hill and colleagues (2005) have noted.

In addition, Boyd-Franklin (2010) contended that individuals might access membership in church not because of religious or spiritual belief but because the church is a refuge from a world where they encounter many hostilities. The author noted further that the church is often experienced as an extended family, and a place for social interaction and support. Moreover, the fact that the concept of spirituality facilitates a broader understanding of relationship with a higher power allows more people to identify as spiritual rather than religious. Such expansiveness of the concept makes it easier to understand the result. Additionally, this result seems to support previous call for the distinction between religiosity and spirituality in research (e.g. Miller, &Thoresen, 1999).

As with actual behavior, the lack of significance among the other variables is a curious finding, given the strong endorsement of these values among the participants. Nonetheless, perhaps the findings are reflective of the need to consider mediating factors that might influence help-seeking. On the other hand, there is a scarcity of literature regarding the relationship between collectivism/individualism and fatalism and actual professional psychological behavior. Where there have been studies, most have focused on attitudes rather than behavior. The paucity of literature in this area is another indication that further research is needed.

It is interesting to note that demographic predictors are also significant. The results of the analysis show that demographics such as age, having a mental health professional in their social network, and education are all significantly related to intentions to seeking counseling. These findings are substantiated by previous research

studies that show demographic variables to predict help-seeking behavior (Cooper –

Patrick et al., 1999; Jagdeo, Cox, Stein, & Sareen, 2009). In the first place, age is a

significant demographic in predicting intentions. The results indicate that older adults

have fewer intentions of seeking help for mental health problems. However, this finding

is not supported by converging evidence from a number of studies that have found that

older individuals are more likely to seek help than younger persons (Cooper –Patrick et

al., 1999; Greenley, Mechanic, & Cleary, 1987; Portes, Kyle, & Eaton, 1992). What

seems curious about this finding is the fact that although an increase in age is negatively

related to intentions to seek counseling in this hypothesis, it is positively correlated with

having sought help in Hypothesis 1.

Taken together with the positive correlation between high levels of spirituality

and intentions to seek help, the result seems contradictory. This is particularly salient in

light of the fact that older Black adults endorse higher spirituality than younger Black

adults (Boyd-Franklin, 2010). However the results are within the realm of possibility

when one considers that a major expression of Black spirituality is prayer, and that older

Black adults believe in the power of prayer for healing and relief from all forms of

distress, both physical or psychological. Again, as Boyd-Franklin (2010) points out, it is a

common practice among older Black adults to have prayer partners who support each

other with prayers in times of distress and trauma. Many older adults also observe the

practice of writing their prayer intentions in the church's book of intercession so the

entire church can pray for their intentions. Given the role of prayer in their lives, it is

possible that older Black adults might be more likely to use their personal relationship

with God for healing, rather than depending on the relationship with a mental health

professional. The result of Hypothesis 1 that older adults are more likely to have sought

help for mental health problems therefore begs the question whether the help-seeking

behavior of older Black adults was involuntary. The result warrants future research to

clarify whether help-seeking is voluntary behavior on the part of older Black adults or

whether behavior is mandated and is related to an emergency.

Another possible explanation for the result could be that among this sample,

participants might have felt that their years of experience have prepared them to cope

with the challenges that life presents. Further, older adults might believe that some

problems are intrinsic to the aging process and would be hesitant to seek help to address

them. For example, Laidlow and colleagues (2003) assert that for older adults, depression

is like the common cold and is not seen as something for which one should seek help.

Blacks also tend to believe that a person should only seek help for severe mental health

problems such as schizophrenia, and psychosis (de Toledo Piza Peluso, & Blay, 2004).

On the other hand, lack of knowledge of the mental health system and the benefits of

counseling might contribute to fewer intentions to seek professional help. In addition,

past negative experiences with mental health professionals might also be linked to a lack

of openness to seeking counseling for further problems.

Yet, having a mental health professional in one's social network predicted higher

intentions to seek help. A possible explanation might be found in the cultural value of

family orientation that is part of the Black community. Body-Franklin (1989) explained

that although the professional might not necessarily be a blood relative, the broad

expression and experience of family in the Black community would facilitate inclusion

into the network. For instance, members of the church community (e.g. pastors, pastor's

wife) have served as extended family to members of the Black community. In fact, Boyd-Franklin (2010) recommended that psychologists establish relationship and collaboration with Black churches so that a relationship would already be in place when members of the Black community need the services.

In addition, it is possible that having a mental health professional in a person's social network serves to demystify and de-stigmatize mental health services. Such network members might be able to provide the kind of guidance and directions that will facilitate easier access and identification of persons from whom one can receive mental health services. In some cases, the social network members might be the ones who recommend that counseling should be sought. These members might include counselors in school, churches and other places where the individuals have developed a trusting relationship. Consequently, they are more likely to follow the recommendations that are made. Not least of all, having a social network member as a professional might make counseling more palatable and less foreign and removed from the individual's experience. As such it is likely that knowing someone on that level could engender trust in the profession.

Previous studies also validate the finding that individuals who know and have a personal relationship with professionals in the mental health field, fully embrace seeking help for mental health problems should the need arise (e.g. Pescosolido, Wright, Alegría, & Vera, 1998). Professionals within the social network can help individuals to identify symptoms related to mental health problems and provide them with information about resources that they might access. An increase in the number of mental health professionals of color who would work with this population would be one way to

cultivate professionals in the social network. In addition, professionals from the mainstream dominant culture who provide services for members of the Black community should strive to be more integrated into the Black community. Through personal contact and outreach that includes information about the system that regulates mental health services and personnel who provide such services, members of the Black community would have more opportunities to familiarize themselves with the field of mental health.

It is not surprising then, that education was positively related to intentions to seek counseling. More specifically, when compared to those who had only completed high school, individuals with a Bachelor's degree evidenced greater intentions to seek help. According to Portes, Kyle and Eaton, (1992), more educated individuals will have easier access to information about mental health services. This is corroborated by Cooper – Patrick et al., (1999) who proposed that higher education exposes people to more information about counseling, and might facilitate more openness to seeking help in the event that the person might need such help. Other studies have confirmed this finding (e.g., Jagdeo, Cox, Stein, & Sareen, 2009).

Hypothesis 3

This hypothesis posited that intentions to seek counseling would be significantly predictive of having sought help, such that higher intentions would be related to having sought help. The result of the logistic regression that was utilized to test this hypothesis supported the hypothesis and showed that there was a positive linear relationship between intentions to seek help and actual behavior, that is, having sought help. The finding is supported by the theory of Planned Behavior and Reasoned Action, which posit that intentions are a good and reliable measure of behavior. Unfortunately, there are limited

studies that have examined the intentions-behavior relationship related to professional psychological help-seeking behavior. However, the finding is consistent with the results of two studies that have examined and confirmed the intentions-behavior relationship (Burdon, 1999; Turchik, 2010). Further, the Theory of Planned Behavior provides the best explanation for this finding. According to the theory, intentions act as a central factor in undertaking a given behavior, and are able to capture the motivational factors that influence a behavior (Ajzen, 1991). Ajzen proposes that intentions indicate the amount of personal investment people are willing to devote to performing the behavior. In the current study however, it is unclear whether intentions were necessary for seeking help in the past or whether intentions were the result of having sought help in the past. Albeit in need for further research given the small effect size (*Exp (B)* − 1.02) and the small simple correlation (*r* = .14) between intentions and behavior, the finding from the current study is encouraging and promising. At least, it points to the opportunity to nurture the good intentions of individuals so that when the occasion arise, there will be a natural transition towards seeking the help that they require.

Hypothesis 4

It was hypothesized that there would be a significant relationship between gender and help-seeking behavior. Contrary to the study's expectation, no significant difference was found between the help-seeking of Black adult male and female participants. The result was surprising and inconsistent with most of the literature that indicate a greater willingness on the part of female adults to seek help for mental health problems (Boyd-Franklin, 1989; Braksdale, 2008; Good et al., 1989; Komiya et al., 2000; Krogh, 2007; Rickwood & Braithwaite, 1994; Tsan & Day, 2007).

Still, the lack of significant difference between the help-seeking behavior of Black adult men and women has special implications for this group. Perhaps the intersection of race with gender within this sample is more important than the salience of gender on its own. This seems to suggest that for this sample, experience based on membership in the Black racial minority group has more influence on behavior than the experience based on gender. This is highly possible given the established fact that Blacks experience institutionalized as well as individualized racism in many areas of life in the United States. Pertinent to the mental health service system, Miranda, Lawson and Escobar (2002) contend that racism within the system of care is one of the reasons that ethnic minorities do not access care.

Cook, McGuire and Miranda (2007) provided support for this position. The researchers examined the mental health care received by different ethnic groups from 2000-2004, and found persistent worsened care for Black Americans during this period. In addition Miranda and colleagues (2008) found that discrimination by providers of mental health services, as well as disparities of mental health professionals who are minorities within the work force contributed to the resistance to use mental health services among people of color. The authors underscored the minimal representation of minorities in professional roles in the mental health care system as a possible contributing factor for the underutilization of mental health services among members of the Black community. According to Miranda et al. (2002), Black adults, whether male or female would be more reluctant to trust the institutions that provide services if most of the providers are members of the dominant group that perpetuate oppression of people of

color. This might explain why there was no difference in mental health services use for Black men and Black women in this sample.

Similarly, the impact of the intersection of cultural identity with gender might have been greater than the difference in help-seeking behavior based on gender on its own. In general, it is accepted that seeking professional counseling is more in keeping with the cultural values of the dominant White society than it is for people of color. In keeping with this, research with Blacks provides evidence that they consistently underutilize mental health services. Moreover, within group differences in the use of mental health services have been observed among Blacks even when they do seek professional help. Research studies show that non- U.S. born Blacks are less likely to seek professional help than those born in the U.S. (Cook et al., 2007; Neighbors et al., 2007). Since the majority of the participants were non-U.S. (i.e., Caribbean) Black adults, it is possible that the result could have been more of a reflection of cultural identity of the sample than of the difference or lack thereof of the helping seeking behavior of the Black men and women who participated in the study.

Yet, the finding is consistent with other studies. For instance, Leaf and Bruce (1987) did not find a significant gender difference within the sample collected from an epidemiological study, when varied sources of mental health services were examined. They noted that gender difference only became an issue when specific types of services were examined. They further contended that the gender related difference might become less significant since services are now more accessible, and a more positive attitude abound toward mental health services. This might provide another explanation for the lack of significance in the current study. Perhaps too, the smaller number of men made it

difficult to compare the data from the group of men to that of the large percentage of women. Not least of all, the results of the study could have been skewed because of the limitations that were inherent in the development and execution of the study. The following sections will address these limitations, as well as the implications of the study for practice, training and research.

Limitations of the Study

Despite the findings that contribute to the understanding of the relationship between the cluster of health related cultural values, spirituality, and religiosity with professional psychological help-seeking behavior, there are several limitations to the current study. Consequently, care must be taken in considering the results that have been set forth. First, the current study used a correlational design. Given that the study was designed to look at the relationship between the cultural values, spirituality, religiosity and professional help-seeking behavior, the analyses utilized provided data from which only conclusions about how the predictor variables were related to professional help-seeking could be made. This means that no causal relationship was established and as such, unequivocal conclusions as to whether or not these predictors are indispensable for professional psychological help-seeking cannot be made. This is particularly salient for the positive intention-behavior relationship that was obtained. As such it is not unequivocally established that it was the high intentions that were measured in the present that resulted in the help-seeking behavior in the past. At best, it can only be said that there is a positive relationship between intentions and behavior. In light of this it appears that the Theory of Planned Behavior might not be suitable for understanding the relationship between present intentions and behavior that has occurred in the past.

Furthermore although multiple regressions were utilized to look at specific variables while controlling for others, the effect sizes that resulted could have provided data that were misleading. For even when a relationship was found, the effect size of the variables that were related to help-seeking was so small that the strength of the relationship between the variable and professional help-seeking could not be unequivocally established. Perhaps a more homogenous sample (e.g., non-U.S. Blacks) might provide data with minimum deviation from mean scores that would allow more reliable interpretation of the relationship between the predictor and outcome variables. Future research might also consider the use of different instruments that might be more suitable for measuring the constructs among this population. In this vein, clearer results might be obtained by using an instrument that distinguishes between professionals and paraprofessionals to measure help-seeking behavior. The absence of such an instrument, and the fact that the criterion variable "having sought help" was not clarified could have provided misleading data. Participants could have failed to distinguish between help received from their pastors and services that they received from psychologists or social workers. The correlation among some of the variables could have also influenced the results of the study. Excluding variables that are highly correlated might have provided a more parsimonious model that would have been a more reliable fit for the data.

Additionally, the use of survey reports presents another compromise to the internal validity of the study. This presents a limitation specifically because individuals are generally prone to present a more favorable view of themselves than is otherwise the case. Consequently, responses on the survey might not have been a true representation of the values that the participants hold. For instance, studies have shown that the familism

scale is prone to social desirable report and thus, the endorsement of factors such as

interconnectedness may be due more to social desirability than with harmony and

connection among family members (Holtgrave, 2004). Including a measure of social

desirability might therefore provide a solution to the problem.

There are also limitations related to the external validity of the current study. The

first concerns the sampling procedure for the study. Although participants were solicited

from the Northeastern and Southeastern United States, the locations were chosen because

of some form of connection that the investigator had with the Black population in that

area. As a result, Black adults in other parts of the country did not have the same

opportunity to participate in the study. Consequently those who participated might

represent a restricted sample, and as such the results of the study can only be generalized

with caution. This means that conclusions drawn from the study might preclude

application to the mental health behavior of Black adults in other parts of United States

who did not participate in the study. Future research should therefore attempt to utilize a

more random sample if generalizations are to be made. Nonetheless, there is something to

be gleaned from the results that were obtained from the study. In light of this, the

following section shall address the implications for practice, research and training.

Implications for practice

The current study provides information that can inform clinical practice with

Black adults in the United States. In particular, the results from the study provide support

for the salience of the cultural values of familism and spirituality among Black adults.

With regard to familism Utsey et al., (2007) affirm that familial bond is an integral aspect

of the worldview of Blacks in the United States**.** Moreover, there is sufficient empirical

evidence linking familism to behaviors in general, and health behavior in particular. It therefore behooves mental health professionals to consider familism as an important element in the development of appropriate interventions for Black adults who are seeking help for mental health problems. First, there might be a need for a shift in paradigm when working with Black adults. For instance it is often commonplace within the Western understanding of self-actualization to focus on the individual as the most important person of interest in the dyadic relationship with the therapist. What this result suggests however is that it might be profitable to include the family from which the individual comes. In fact, this seems to be reflected in the result that indicated a relationship between having a family member in therapy and help-seeking behavior. When one considers that individuals often look for the approval of the family in order to seek help, paying attention to family dynamic, and addressing family values and beliefs with respect during therapy might pave the way for providing services for other members in the future.

More attention should therefore be given to promoting family therapy, although not at the exclusion of individual therapy. Bearing this in mind, it would be important to be attentive to the promotion or advertising of mental health services within the Black community. If the family is as important as studies have found, it seems prudent to think that focusing on emphasizing mainly the individual benefits of counseling might not be very productive. Rather, the family will need to be sold the idea about counseling. This could be done through outreach and education to community organizations and church assemblies where families may be gathered. This might also be the place where older adults might be found, and since the results suggests that older adults are less likely to

seek help, the opportunity might be ripe to provide information that might be able to address this finding. Educating individuals and families about mental health problems, and presenting counseling as a form of collaboration and support might help to provide an incentive for increased utilization of mental health services.

Committing resources for outreach to the Black community is also informed by the fact that having a mental health professional in the social network is predictive of intentions. This suggests that psychologists and other mental health professionals need to be more visible in the Black community. One of the ways through which this could be achieved would be outreach to the community. A genuine interest in the welfare of the Black community would be a requirement for such work however, for even with outreach, a lack of trust could be sustained if professionals are aloof and not genuinely present when they interact with members of the Community.

Outreach to the Black community can be accomplished in various ways. For instance, in the Northeast, mental health professionals can have outreach activities during orientation in schools such as Medger Evers College and other educational institutions with a predominantly Black student population. Being a presence at, and providing information about mental health, and mental health services during predominantly Black festivities (e.g. West Indian Carnival in major cities such as Brooklyn, Miami, Washington, D.C., Atlanta, etc) could be another way of reaching the community. In addition, working with cultural groups to create ways to communicate the message about mental health might also prove useful. Using cultural productions such as plays could be an effective way to communicate information about mental health issues to both individuals with higher education, and those who have not had the opportunity of a

college education. In essence, cultural presentation could supplement and provide new ways of disseminating valuable information to the Black community. In fact, committing time and resources for outreach to cultural and educational organizations might be the way to maximize and bring to fruition the intentions- behavior relationship that was brought to light in the current study. It is not enough to focus on nurturing good intentions; rather it would be more fruitful to ensure that the good intentions that have been identified actual become the behavior that is needed.

Regarding spirituality in particular, the results indicate that Black adults who value spirituality are open to seeking counseling should they require such services. However, the fact that spirituality, and not religiosity was the significant predictor of help-seeking seems to call for a reevaluation of the common belief that for many Blacks, spirituality and religiosity are interchangeable. Therefore, more attention needs to be given to assessing nontraditional expressions of the belief in the sacred that Black adults might endorse. This would be consistent with the position of theorists and researchers who urge mental health professionals to address spirituality when counseling members of the Black community (Boyd-Franklin, 2010). While there have been advances in this area, a more concerted effort needs to be made in that regard. Studies show that although Black adults would like their therapists to address spiritual issues, they are hesitant to bring it up in therapy. It would be a great service to Black individuals therefore if attention to spirituality is a natural component of their treatment, because according to Edelma, and Mandle (2006), Blacks are the most religious and spiritual people in the world.

Mental health professionals might also want to focus on collaboration with spiritual personnel who work with Black adults. Studies have shown that individuals who trust their pastors are more likely to seek help when such help is promoted within their church community. In fact, Wells, Miranda and colleagues (2004) recommend community intervention that includes faith-organizations to promote awareness of mental health issues within the Black community. This should not be to the exclusion of other types of collaboration since spirituality is not necessarily connected with formal church organization. Therefore, it might be important to address spirituality during outreach to community or academic organizations that are part of the life of the Black community.

Implications for Research

Further research is needed to extend and perhaps replicate this study to further elucidate and support the relationship between cultural values, spirituality religiosity and help-seeking behavior. First, given that the constructs of familism and spirituality encompass various dimensions, future researchers might want to examine these values to identify the dimensions that are salient to professional psychological help-seeking. This might mean focusing on fewer variables and using a different method of analysis (such as Path Analysis or Structural Equation Modeling) that will accommodate observation of the underlying construct of the variables and the relationship with the outcome, namely help-seeking behavior. The use of analyses that examine the different factors that comprise the variable (e.g. familism) while simultaneously examining the direct effect of the variable would help to clarify the relationship between these variables and help-seeking behavior.

Moreover, providing a measure of help-seeking that incorporates a list of informal and formal personnel from whom one might seek help, or have sought help could extend

the results of the study. In addition, it might be useful to look at mediators that might influence professional psychological help-seeking behavior. For example, a measure of beliefs about mental health or of experiences of racism and oppression might be useful when investigating the relationship between cultural values and professional psychological help-seeking behavior. Future research might also want to consider extending the research through the use of qualitative studies. Providing Black adults the opportunity to give voice to their experience, in addition to using psychometrically sound instruments could provide a store of rich information that would illuminate the help-seeking behaviors of Black adults in the United States. In sum, there is no doubt that if there is to be unequivocal support for the importance of attending to cultural values, spirituality and religiosity in the mental health services that are provided for members of the Black community, future research will be needed.

Implications for Training

The current study supports the significance of cultural values, spirituality and religiosity in predicting professional psychological help-seeking behavior of Black adults in the United States. The study provides data that can be used to inform and develop counseling programs that prepare mental health professionals, particularly psychologists, to work with members of the Black community. At the most basic, the results of the study suggest the need for counseling programs to incorporate the study of Black cultural values in multicultural courses. In addition to ensuring that trainees are culturally competent, focus needs to be placed on helping trainees to negotiate how they can go beyond awareness, knowledge, and skills to incorporate meaningful interactions with individuals, groups and organizations within the Black community. Developing programs

or projects that necessitate interactions that go beyond a strictly clinical role that involves providing services in an office is necessary. Such programs might prove to be among the most significant contributors to nurturing a greater openness to mental health services among members of the Black community. This is especially pertinent in light of the positive relationship that exists between having a mental health professional in the social network and intentions to seek counseling.

Finally, perhaps more effort can be made to encourage trainees to complete externships and other practical requirements in Black communities or agencies that serve predominantly members of the Black community. This might be another way of establishing meaningful and more personal contact and interaction with individuals in the Black community. This is certainly within the portfolio of the mental health community, for the data from national surveys for one, provide strong enough evidence to warrant programs to prepare competent professionals to provide services to this population.

Conclusion

This study makes a unique contribution to the field with its focus on investigating the relationship between a cluster of health related values together with spirituality and religiosity, and professional psychological help-seeking behavior of Black adults in the United States. The study investigated whether the health related cultural values of collectivism/individualism, fatalism, together with spirituality and religiosity could be used to predict the help-seeking behavior of Black adults in the United States. The results underscored the significant relationship between these values and help-seeking, and especially highlighted the importance of familism and spirituality in the process of seeking help for mental heath problems. In addition, another unique contribution of the

study was in identifying the distinctiveness of spirituality versus religiosity in the relationship with the psychological help-seeking behavior of Black adults. Further, the study also establishes the relationship between intentions to seek help and actual behavior that is specific to mental health help-seeking behavior for Black adults in the study. Nonetheless, there is room for continued examination of these relationships that would contribute to supporting the extant literature that addresses the relationship between health related cultural values and professional psychological help-seeking behavior. It is this investigator's hope therefore, that future research will continue to respond to the clarion call to identify the factors that contribution to the underutilization of mental health services for Black adults. It is only when this is known that meaningful interventions could be utilized to reverse this trend.

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APPENDIX A

RECRUITMENT LETTER

Dear potential participant:

My name is Cecilia Rougier and I am a doctoral candidate in the Counseling Psychology program at Teachers College, Columbia University. I am currently recruiting participants for an online study about cultural values, religiosity, spirituality, and seeking help for emotional problems. The data collected could help researchers, educators, and practitioners in the field of psychology, better understand the relationship between cultural values and decision to seek help for emotional problems. The survey should take approximately 25-30 minutes to complete. Your participation is completely voluntary and confidential, and you would have a chance to win one of three $100 Visa Gift Cards. Please consider the study if you meet the following criteria:

- You are 18 years or older
- You were born in the U.S. or
- You have lived in the US for at least five years.
- You identify as Black
- You speak and understand English

If you meet the above eligibility criteria and are interested in participating, you may complete the following paper/pencil version of the survey. If you prefer you may opt to complete the survey online using the following link:

https://www.surveymonkey.com/s.aspx?sm=nUNlamRI_2blf9t0Km_2bQXRXQ_3d_3d
 If you have questions you may use my contact address below to reach me. Please share this information with anyone you know who might be interested in participating. Thank you in advance for your participation.

Sincerely,

Cecilia Rougier
Doctoral Candidate, Counseling Psychology
Department of Counseling and Clinical Psychology
Teachers College, Columbia University
CAR2116@columbia.edu

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

Please complete the following:

1. Please check _____ Male _____Female

2. Age: _____

3. Country of birth _____

4. Highest level of education completed:
_____Elementary _____Junior High _____High school non-Graduate
_____High school Graduate _____ Associate Degree _____Bachelor's
_____Master's

5. Socioeconomic Status:
_____Working Class _____Middle Class _____ Upper Middle Class
_____Upper Class

6. What is your ethnic group?
____ African American _____ Caribbean American, _____ West Indian
_____ Other (Please specify) _____

7. How many yeas have you lived in the U.S.? _____ Years

8. Have you ever sought help for emotional or mental health problems from a
professional person (e.g., as psychologist, counselor, psychiatrist, social worker)?
_____ Yes _____ No

9. Is there anyone in your social network (e.g. family member, friend, spouse, partner,
significant other, sibling) who is a mental health professional?
------------------ Yes ---------------------- No

10. Is there anyone in your social circle who is in therapy? If yes:
_____Family member, _____friend, _____ spouse, _____partner, _____sibling

APPENDIX C

INDCOL

This questionnaire is anonymous, and there are no right or wrong answers.
 We want to know if you strongly agree or disagree with some statements. If you strongly agree select 9; if you strongly disagree, select l; if you are unsure or think that the question does not apply to you, select 5.

In short, use this key:

Strongly   Strongly
Disagree   1 2 3 4 5 6 7 8 9   Agree

1. My happiness depends very much on the happiness of those around me
1   2   3   4   5   6   7   8   9
2. Winning is everything
1   2   3   4   5   6   7   8   9
3. I usually sacrifice my self-interest for the benefit of my group
1   2   3   4   5   6   7   8   9
4. It annoys me when other people perform better than I do
1   2   3   4   5   6   7   8   9
5. It is important for me to maintain harmony within my group
1   2   3   4   5   6   7   8   9
6. It is important to me that I do my job better than others
1   2   3   4   5   6   7   8   9
7. I like sharing little things with my neighbors
1   2   3   4   5   6   7   8   9
8. I enjoy working in situations involving competition
1   2   3   4   5   6   7   8   9
9. The well-being of my co-workers is important to me
1   2   3   4   5   6   7   8   9
10. I often do "my own thing"
1   2   3   4   5   6   7   8   9
11. If a relative were in financial difficulty, I would help within my means
1   2   3   4   5   6   7   8   9
12. Competition is the law of nature
1   2   3   4   5   6   7   8   9
13. If a co-worker gets a prize I would feel proud
1   2   3   4   5   6   7   8   9
14. Being a unique individual is important to me
1   2   3   4   5   6   7   8   9
15. To me, pleasure is spending time with others
1   2   3   4   5   6   7   8   9
16. When another person does better than I do, I get tense and aroused
1   2   3   4   5   6   7   8   9

17. Children should be taught to place duty before pleasure
1   2   3   4   5   6   7   8   9
18. Without competition it is not possible to have a good society
1   2   3   4   5   6   7   8   9
19. I feel good when I cooperate with others
1   2   3   4   5   6   7   8   9
20. Some people emphasize winning; I am not one of them
1   2   3   4   5   6   7   8   9
21. It is important to me that I respect decisions made by my groups
1   2   3   4   5   6   7   8   9
22. I rather depend on myself than on others
1   2   3   4   5   6   7   8   9
23. Family members should stick together, no matter what sacrifices are required
1   2   3   4   5   6   7   8   9
24. I rely on myself most of the time; I rarely rely on others
1   2   3   4   5   6   7   8   9
25. Parents and children must stay together, as much as possible
1   2   3   4   5   6   7   8   9
26. My personal identity independent from others is very important to me
1   2   3   4   5   6   7   8   9
27. It is my duty to take care of my family, even when I have to sacrifice what I want
1   2   3   4   5   6   7   8   9
28. My personal identity is very important to me
1   2   3   4   5   6   7   8   9
29. I am a unique person, separate from others
1   2   3   4   5   6   7   8   9
30. I respect the majority's wishes in groups of which I am a member
1   2   3   4   5   6   7   8   9
31. I enjoy being unique and different from others
1   2   3   4   5   6   7   8   9
32. It is important to consult close friends and get their ideas before making a decision
1   2   3   4   5   6   7   8   9

APPENDIX D

Fatalism/Mastery Scale

Indicate how strongly you agree or disagree with the following statements:

1 I have little control over the things that happen to me

Strongly Agree   Agree   Disagree   Strongly Disagree

2 There is really no way I can solve some of the problems I have

Strongly Agree   Agree   Disagree   Strongly Disagree

3 There is little I can do to change many of the important things in my life

Strongly Agree   Agree   Disagree   Strongly Disagree

4 I often feel helpless in dealing with the problems of life

Strongly Agree   Agree   Disagree   Strongly Disagree

5 Sometimes I feel that I'm being pushed around in life

Strongly Agree   Agree   Disagree   Strongly Disagree

6 What happens to me in the future mostly depends on me

Strongly Agree   Agree   Disagree   Strongly Disagree

7 I can do just about anything I really set my mind to

Strongly Agree   Agree   Disagree   Strongly Disagree

APPENDIX E

Spiritual Involvement and Belief Scale

Indicate how strongly you agree or disagree with the following statements:
1. In the future, science will be able to explain everything.
 Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
 2. I can find meaning in times of hardship.
 Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
3. A person can be fulfilled without pursuing an active spiritual life.
 Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
4. I am thankful for all that has happened to me.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
5. Spiritual activities have not helped me become closer to other people.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
 6. Some experiences can be understood only through one's spiritual beliefs.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
7. A spiritual force influences the events in my life.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
 8. My life has a purpose.
 Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
9. Prayers do not really change what happens.
 Strongly Agree   Agree   Neutral   .Disagree   Strongly Disagree
10. Participating in spiritual activities helps me forgive other people.
    Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
11. My spiritual beliefs continue to evolve.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
 12. I believe there is a power greater than myself.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
13. I probably will not reexamine my spiritual beliefs.
 Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
14. My spiritual life fulfills me in ways that material possessions do not.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
 15. Spiritual activities have not helped me develop my identity.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
16. Meditation does not help me feel more in touch with my inner spirit.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
 17. I have a personal relationship with a power greater than myself.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
 18. I have felt pressured to accept spiritual beliefs that I do not agree with.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree
 19. Spiritual activities help me draw closer to a power greater than myself.
Strongly Agree   Agree   Neutral   Disagree   Strongly Disagree

Please indicate how often you do the following:

20. When I wrong someone, I make an effort to apologize.

Always Usually Sometimes   Rarely Never

21. When I am ashamed of something I have done, I tell

Always Usually Sometimes   Rarely Never

22. I solve my problems without using spiritual resources.

Always Usually Sometimes   Rarely Never

23. I examine my actions to see if they reflect my values.

Always Usually Sometimes   Rarely Never

24. During the last WEEK, I prayed. . . **(check one)**

   -- 10 or more times.

   -- 7-9 times.

   -- 1-3 times.

   -- 4-6 times.

   -- 0 times.

25. During the last WEEK, I meditated... **(check one)**

   -- 10 or more times.

   -- 7-9 times.

   -- 4-6 times

   -- 1-3 times.

   -- 0 times.

26. Last MONTH, I participated in spiritual activities with at least one other person... **(check one)**

   -- more than 15 times.

   -- 11-15 times.

   -- 6-10 times.

   -- 1-5 times.

   --- 0 times.

APPENDIX F
Religious Commitment Inventory

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

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

1. I often read books and magazines about my faith   1 2 3 4 5

2. I make financial contributions to my religious organization   1 2 3 4 5

3. I spend time trying to grow in understanding of my faith   1 2 3 4 5

4. Religion is especially important to me because it answers

many questions about the meaning of life.   1 2 3 4 5

5. My religious beliefs lie behind my whole approach to life.   1 2 3 4 5

6. I enjoy spending time with others of my religious affiliation.   1 2 3 4 5

7. Religious beliefs influence all my dealings in life.   1 2 3 4 5

8. It is important to me to spend periods of time in private

religious thought and reflection.   1 2 3 4 5

9. I enjoy working in the activities of my religious affiliation.   1 2 3 4 5

10. I keep well informed about my local religious group and

have some influence in its decisions.   1 2 3 4 5

APPENDIX G

Intentions to Seek Counseling Inventory

For each of the problems listed below, please rate how likely you would be to seek help from a counselor at the university counseling center or other mental health professional <u>if you were experiencing the problem</u>:

I would be likely to seek professional counseling services for:

1. Choosing a major

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

2. Weight control

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

3. Relationship difficulties

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

4. Self-confidence problems

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

5. Over-use of alcohol

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

6. Personal worries

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

I would be likely to seek professional counseling services for:

7. Difficulty in sleeping

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

8. Concerns about sexuality

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

9. Procrastination with schoolwork

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

10. Difficulty concentrating

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

11. Depression

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

12. Fear of failure

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

13. Improvement of self-understanding

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

I would be likely to seek professional counseling services for:

14. Relaxation training

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

15. Test anxiety

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

16. Loneliness

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

17. Drug problems

1	2	3	4	5	6
Very Unlikely	Moderately Unlikely	Slightly Unlikely	Slightly Likely	Moderately Likely	Very Likely

APPENDIX H

ICMEASUREMENT

There are many ways to measure individualism and collectivism, and none of them is totally satisfactory. Thus, it is necessary to use more than one method.

The 32 items in the Appendix of Triandis (*American Psychologist*, 1996)(also known as INDCOL) provide 4 scores. Eight items correspond to each of four constructs: Vertical Individualism, Horizontal Individualism, Vertical Collectivism, and Horizontal Collectivism.

However, one must correct for the reference effect. For example, if you ask a person who is 5 feet 10, from a culture where the average height is 6 feet, if he is short or tall, the chances are that the answer will be: "short." But if you ask a person who is 5 feet 10 from a culture where the average height is 5 feet if he is short or tall, the answer will be "tall." The real difference between the cultures is one foot. But the perceived difference will be smaller than one foot. Thus, where you have real cultural differences they may not show up.

The way to correct for that is to standardize within participant. That is, you compute the mean and standard deviation of the 32 scores, and convert each score given by the participant by subtracting this mean and dividing by this standard deviation. Now the participant's scores will be between –3 and + 3 and they will tell you whether one of the 4 attributes is emphasized or de-emphasized by the participant in relation to the other 3 attributes. If you are not interested in the Vertical and Horizontal scores, you just compute the Individualism scores on the basis of the 16 individualist items, and the Collectivism scores on the basis of the 16-collectivist items.