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**AFRICAN AMERICAN PSYCHOLOGISTS'
ATTITUDES TOWARD PSYCHOTHERAPY**

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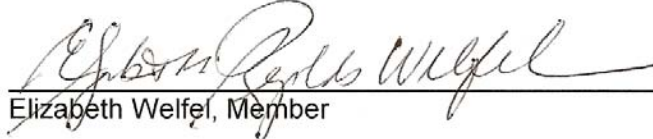
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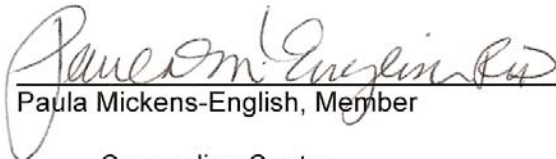
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DEDICATION

This is dedicated to my Lord and Savior, Jesus Christ. “Where would I be, you only know. I’ m glad you see through eyes of love. A hopeless case, an empty place, if not for grace.” Thank you for adopting me into your family despite my shortcomings and now I am forever in debt. “For Christ I live, for Christ I die”.

In addition, this dissertation is dedicated to every Black person throughout the history of The United States who refused to be denied the right to an education. It’s also dedicated to everyone who has fought and died knowing that the right to quality education is a basic human right.

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God's time! Also, thanks to my sister and brothers for all of the encouragement that you gave me over the years. Also, thanks to all of my grandparents, aunts, uncles, and countless cousins who kept asking, "How much longer do you have?" Believe it or not that was encouragement to finish.

Last, but definitely not least, thanks to all of the saints who sent up prayers to Almighty God. You are wonderful indeed. "The prayer of a righteous man is powerful and effective" James 5:16.

**AFRICAN AMERICAN PSYCHOLOGISTS' ATTITUDES TOWARD
PSYCHOTHERAPY**

RAMONE FORD

ABSTRACT

Over the last fifty years, Americans' attitude of psychotherapy has become more accepting. However, in the African American community the attitudes have not been as accepting. Thompson, Bazile, and Akbar (2004) documented that African Americans had utilized alternative resources such as friends, the church and other community resources, in attending to commonly treatable mental health disorders (e.g., depression, anxiety).

The purpose of this dissertation is to discover the attitudes of African American psychologists toward psychotherapy. Jordan, Bogat, and Smith (2001) hypothesized that African American professional psychologists will be the future of conducting research with African Americans, because of their cultural knowledge, communal ties and psychological professionalism. This development could have huge implications in changing the attitudes of the African American community's position towards psychotherapy, depending on these psychologists' own views of psychotherapy for African Americans.

Eighty-nine African American psychologists served as participants. They were asked to respond to scales that measured attitudes of receiving professional psychological help, Africentrism, and psychological stigma. The participants were surveyed electronically using Survey Monkey and email.

Data analyses using correlational analyses and ANOVAs determined that African American psychologists with more positive attitudes towards receiving professional

psychological help and who indicate a strong identification with Africentric values are less likely to associate social stigma with psychological treatment. There were no significant differences with regard to the African American psychologists' gender, educational level, area of work expertise, and years of professional experience and their scores on three measures, the Attitude Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970), Africentrism (Grills & Longshore, 1996), and Social Stigma for Receiving Psychological Help (Komiya, et al., 2000).

This study shed light on foundational aspects of African American psychologists' attitudes. It appeared that many variables, including education and training from the professional psychological community, may have had a positive effect on African American psychologists' attitudes towards help-seeking behavior and psychotherapy when compared to the views of African Americans in the community.

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CHAPTER I

INTRODUCTION

Historical perspective of psychotherapy

Historically, the aim of psychotherapy has been to treat mental disorders and one purpose for treatment has been to provide some relief from emotional and cognitive disturbances. Specifically, psychotherapy's principal goal has been to provide services to those who suffer from mental problems and seek help for them (Astin, 1959). The treatment of mental disorders has been the focus of many professional conventions, think tanks, and conferences around the world. Since the later part of the 19th century, Americans' views of psychotherapy have become more accepting, as psychology has become regarded as a more reputable science (Fuller, 2006; Mayes & Horowitz, 2005). However, understanding and utilization of psychotherapy services is still not as widely accepted by the African American community (Atkinson & Gim, 1989; Snowden & Cheung, 1990; Sue & Sue, 2003). As well, the attitudes and perspectives of African American psychotherapists have not been clearly documented. The following paragraphs will provide a brief history of psychotherapy in the United States and of the African American context for utilization of psychotherapy services. This chapter concludes with sections which provide the purpose of this study, definitions of terms, and the research questions.

Historical Context

During the early 1950s, many colleges and universities began to offer classes and programs in psychology. Many of the early psychology programs were research oriented with the intent of learning more about human behavior and intelligence. These programs also included the study of abnormal behavior and psychopharmacology. The academic study of psychology created greater awareness of mental health, mental illness and its origins (University of Pennsylvania, 2006).

As United States' citizens became more familiar with the field of psychology and more comfortable with improving personal mental health, human and civil rights advocates began to make mental health issues public policy (Frank & Kamlet, 1987). Many insurers provided employees with mental health benefits and, in many American homes, psychotherapy became a more common occurrence.

In 1987, 7.85 million people, or 3.24% of the nation's population, made visits to mental health professionals for psychotherapy. Ten years later, in 1997, 9.69 million or 3.59% of Americans were involved in psychotherapy (Goode, 2002). Currently about one in every three individuals who need mental health therapy receive it (U.S. Department of Health and Human Services, 2001). More Americans appear to be getting involved with therapy overall. In addition, there are more than 70,000 students a year who graduate from colleges with degrees in psychology (Fuller, 2006). According to Sax (2003), more college freshmen come to school and major in psychology than the field of economics, political science, and sociology combined. In addition to doing therapy, the high need for psychologists' expert opinions in our schools, courts, and clinics is a burgeoning dilemma.

Public understanding mental illness, however, has been a slow process (Frank & Kamlet, 1987). In the last century, many of the negative perceptions that Americans held of mental illness, the field of psychology, and psychotherapy were a result of the popularity of Freudian analysis and early mental health hospitals. Freudian psychotherapy was perceived as a long, arduous, expensive treatment modality. The field placed a large amount of emphasis on articulation and those who were treated had to be highly verbal. Also self-disclosure was a major part of successful psychotherapy (Ridley, 1984). Those who could partake of analysis were usually in the upper social class, while only limited help could be garnered for those who were seriously and persistently mentally ill. Affluent individuals often worked through their mental health challenges with this very expensive therapy, while those individuals unable to afford private psychotherapy would go to state run mental hospitals.

The enormous American mental health hospitals of the early 1900s, which housed mentally ill patients for extended time periods, also contributed to Americans' attitudes and beliefs about psychotherapy. Bethlehem Royal Hospital in England (Bedlam, as it was historically known), was the mental health institution that encapsulated the concept of poor treatment of the mentally ill. In the 18th century, people would go there just to see the "lunatics." For the small fee of usually a penny, one could peer into the cells and view the residents. Entry was free on the first Tuesday of the month. Visitors were permitted to bring long sticks and poke the inmates. In 1814, there were 96,000 such visits (Hollingshead, 2004). Treatment was intended to provide services to those who suffered from mental problems and sought help for them (Astin, 1959). Much later, the cruel and inhumane treatment in mental health institutions was denounced.

Over the next fifty plus years, Americans' accepting attitudes and understanding of the mentally ill would greatly increase, occurring as a result of two inextricably linked factors. First, the responsibility of caring for the mentally ill would shift from state and county care to the local and private sector. Secondly, the advancement of medication allowed for those who had previously been considered seriously and persistently mentally ill to remain in their communities (Frank & Kamlet, 1987; Geller, 2006). From the late 1950s to the 1980s, many state and county run mental health institutions aimed at returning long term mental health patients back to the community. This process of deinstitutionalization was designed to not only re-introduce the mentally ill back into their communities, but also to give clients a better quality of life (Frank & Kamlet, 1987; Geller, 2006; Mayes & Horowitz, 2005).

Psychotropic medication advancements began to take place in the 1950s and successful drug treatment for mental illnesses increased dramatically (Frank & Kamlet, 1987; Mayes & Horowitz, 2005). The image of the mentally ill went from individuals who should be hospitalized to individuals who could co-exist in society with the correct medications and supports in place. Psychologists and other mental health care providers helped to empower clients with achievable treatment plans and individual goals. This viewpoint rang true with the public, coinciding with society's increased preoccupation with self-help and wellness (Mayes & Horowitz, 2005).

However, acceptance of psychotherapy, psychotropic interventions, and mental health services is not as prevalent in the African American community. Bernal and Saez-Santiago (2006) stated that psychotherapy is a cultural phenomenon and thus, cultural differences may affect service utilization. An empirical study by Thompson, Bazile &

Akbar (2004), documented that in the African American community a chasm still exists regarding knowledge of the mentally ill. They discovered that many African Americans lacked sufficient knowledge of signs and symptoms of mental illnesses. They also documented that African Americans had utilized alternative resources such as friends, the church and other community resources, in attending to commonly treatable disorders (e.g., depression, anxiety).

The inconsistent usage of mental health services is common in many minority communities (Atkinson & Gim, 1989; Snowden & Cheung, 1990), and for African Americans the reasons are varied. A cursory glance of the African American experience in the United States will help to further contextualize inconsistent utilization of psychotherapeutic services.

The African American Context

Most African Americans had ancestors who came to America from Africa through the transatlantic slave trade. For over two hundred and fifty years, Africans were brought from the continent of Africa and relocated in the United States and Caribbean. Conservative estimates 12 million to upwards of 100 million slaves were displaced from the continent of Africa and brought to the United States during the slave trade (Robinson, 2005). Most of those enslaved suffered unfathomable physical and sexual abuses (Franklin, 2000). They were forced to do work that was physically and mentally draining, with little or no reprieve.

Slavery in the United States legally ended in 1865 with the Emancipation Proclamation. Many of those who had been enslaved had no skills and nowhere to go. Their families had been decimated and their sense of self had been destroyed. As the

former enslaved African Americans began to put their lives back together another issue began to emerge: Jim Crow laws were put into place. These laws were very discriminatory by nature, making discrimination permissible by the government. All African Americans were discriminated against because of the color of their skin (Franklin, 2000).

Since African Americans were not considered full citizens, they were denied many of the privileges that European Americans were allowed, such as adequate health services. When psychotherapy became available in the United States, African Americans were often residing in hostile environments and appalling conditions, yet no psychotherapy services were afforded to them. This trend would continue through the civil rights era. The effects of the institution of slavery and the Jim Crow era had deleterious and long lasting sociological and psychological effects on the majority of those who were involuntarily relocated to America (Akbar, 1996; Cress-Welsing, 1990).

Many of the stereotypes and attitudes that American society has towards African Americans are based on information gathered from the mostly European American research establishments (Mason, 2005). Historically, psychological profiles presented by psychologists that intended to increase understanding of intelligence and human behavior failed to do so with African Americans. There were many instances where, through poorly designed methodologies, African Americans were classified as unintelligent, irresponsible, and lazy (Gould, 1996). The "Tuskegee Study of Untreated Syphilis in the Negro Male" was another example of the misuse of research power. In 1932, the Public Health Service and the Tuskegee Institute began a study to record the natural course of untreated syphilis. The study involved 600 African American men, 399 had syphilis and

201 did not have the disease. Researchers told the men they were being treated for "bad blood," this term described several ailments, including syphilis, anemia, and fatigue (U.S. Department of Health and Human Services, 2007). The men did not receive the proper treatment needed to cure their illness; however, in exchange for taking part in the study, they received free medical exams, free meals, and burial insurance (U.S. Department of Health and Human Services, 2007).

Originally, the project was scheduled to last six months; however the study actually went on for 40 years. The main problem with the study, barring the morally reprehensible behaviors of the researchers, was that the study was conducted without the benefit of patients' informed consent. They were not informed of all of the risks of the study. This study showed the extent to which researchers were willing to go to make advancements in technology, medicine and society. This event also widened the mistrust and racial relations gap that existed between European Americans and African Americans.

The field of psychology and other sciences, in instances such as these, played a critical role in the defamation and destruction of African Americans' self-concepts. There is no wonder that many in the African American community remain leery of the field of psychology. These negative attitudes were not ameliorated when African Americans sought mental health services. In fact, Thompson et al (2004) documented that African Americans were more likely to reference negative attitudes and less likely to use mental health services after professional contact. Nickerson, Helms, and Terrell (1994), suggested that African Americans have a cultural mistrust of European Americans. It should be noted that between 2004 and 2005, the majority of psychologists in this

country were European Americans. There were approximately 3911 European American doctorate degrees in psychology conferred in 2005, compared to 323 degrees conferred to African Americans in the same year (U.S. Department of Education, 2007).

Africentrism

In response to racism, the negation of African American culture for many years, and a litany of negative stereotypes that had developed since the time that African Americans were enslaved, many in the African American community wanted to rediscover pride for their community. Cultural pride and political integrity became a way by which the African American community would redefine itself. Molefi Asante and Maulana Karenga (founder of Kwanzaa) were two individuals who were instrumental in this cultural and political movement. They promoted African American regard for self and all other blacks as syncretic Africans and believed that their worldview should positively reflect traditional African values (Early, 2007).

Asante, the scholar most closely related to Africentrism, defined it as a philosophy and a way of life (Asante, 1989). The values of Africentrism include communalism (i.e., emphasizing the importance of human relationship and interrelatedness of people), collectivism (i.e., placing priority on group goals instead of individual or personal ones based on family and ethnic group norms), unity, cooperation, purpose, self-determination, harmony, authenticity and spirituality (Karenga, 1988; Wallace & Constantine, 2005). Africentrism gained significant legitimacy and notoriety in the United States beginning in the 1960s as a result of the civil rights movement. Its following increased dramatically during the 1980s, when many African Americans felt alienated from the “conservative revolution” of President Ronald Reagan, but were

simultaneously attracted by the conservatives' call for a return to traditional values (Early, 2007).

Wilson (1996) characterized the era of civil rights as a critical time for African Americans, because it helped to shape the psychological nature of the African American people. Many African Americans began to resist any systems that were demeaning to them. Many of the stereotypes and attitudes that American society had towards African Americans were based on the psychological profiles presented by psychologists, through poorly designed research methodologies. In conjunction with lack of accessibility to services, the developments during this era may be partially responsible for inconsistent help-seeking attitudes and behaviors and attitudes towards mental health services by African Americans.

African Americans' Help Seeking Behavior

In light of the apparent positive attitude changes that European Americans have had over the past fifty years towards psychotherapy, there still remains a gap in acceptance of therapy by African Americans (Thompson et al, 2004). The concept of psychotherapy, in the African American community, has taken longer to receive acceptance and is still not fully accepted (Atkinson & Gim, 1989; Snowden & Cheung, 1990; Sue & Sue, 2003). African Americans in the United States (United States Census, 2000) comprise 13% of the population, currently representing the second largest ethnic minority group. Research has shown that African Americans' utilization of therapeutic services is inconsistent. Some research has shown over-utilization of services, while some has shown underutilization of services (Sue, Zane & Young, 1994). The

inconsistent usage of mental health services is common in many minority communities (Atkinson & Gim, 1989; Snowden & Cheung, 1990).

According to the 2001 Surgeon General's Report on Mental Health, the prevalence of mental disorders is believed to be higher among African Americans than among European Americans. It estimated that more than 2.5 million African Americans have bipolar disorder. African Americans with depression are less likely to receive treatment than European Americans (16% compared to 24%). It has been documented that only 26% of African-Americans with diagnosed generalized anxiety disorder received treatment for their disorder compared to 39% of European Americans with a similar diagnosis (U.S. Department of Health and Human Services, 2001).

Negative attitudes towards psychotherapy are not exclusively within the African American population. Other ethnic minority groups also hold negative attitudes towards psychotherapy. As stated previously, Bernal and Saez-Santiago (2006) theorized that psychotherapy is a cultural phenomenon which could affect service utilization. Wallace and Constantine (2005) found that strong adherence to Africentric cultural values affected psychological help seeking attitudes. Thompson, et al (2004) cited cultural mistrust, lack of resources and stigma as important reasons that African Americans do not consistently seek psychological help. Sue et al. (1994) stated that traditional forms of psychotherapy are Eurocentric and may have little cultural value to ethnic minorities.

Considerable interest has been given to African Americans and attitudes toward usage of psychological services (Wallace & Constantine, 2005), yet there is no literature about African American psychologists' attitudes towards psychotherapy. Discovering the attitudes of those who are professionals in the mental health field and their relationship

with psychotherapy could have implications for the African American community's position towards psychotherapy. Yet, are African American psychologists able to navigate some of their most ingrained attitudes and beliefs about psychotherapy to fully enhance and support some basic misconceptions about psychotherapy in the African American community?

Significance of this Dissertation Research

Slavery in the United States provided a legacy of extreme inequality, victimization, and powerlessness for a predominantly southern rural population. Following the Civil War, segregation and Jim Crow laws continued and supported oppression and expectations for verbal and physical abuse and injury from European Americans. Moreover, the depth of individual personal hurt and despair has resulted in transgenerational emotional scars. (Dana, 2002, p. 4)

There has been inconsistent utilization of psychotherapy services by African Americans despite estimation of many psychological and emotional problems. Considerable interest has been given to African Americans and attitudes toward usage of psychological services (Wallace & Constantine, 2005). In the African American community there is an expectation that individuals will seek help from within their community. The expectation is higher than those with emotional and psychological problems will seek assistance from family, friends and community (church). Wallace and Constantine (1995) explained that African Americans, historically, have not sought professional psychological help because it goes against the cultural norms of collectivism (i.e., placing priority on group goals instead individual or personal ones) and

communalism (i.e., emphasizing the importance of human relationship and interrelatedness of people). West (1994) argued that the predicaments of the African American community are inseparable from African American scholars. Many African American professional psychologists have vowed to work within their community to change the cultural attitudes that their community has of psychotherapy and of the field of psychology (Jordan, Bogat & Smith, 2001). This dissertation is one step taken by an African American scholar to make a contribution to understanding cultural attitudes towards psychotherapy for the benefit of the African American community. The following section provides additional context for the attitudes of African American psychologists.

African American Psychologists

Dana (2002) wrote that the education and training of professional psychologists has traditionally been predicated on a European American perspective that is designed to represent European Americans. Jordan et al (2001) hypothesized that African American professional psychologists will be the future of conducting research with African Americans, because of their cultural knowledge, psychological professionalism, and communal ties. Although African Americans are still underrepresented on the undergraduate and graduate level, there appears to be a growing trend (Olson, 1999). African Americans comprise a substantial amount of psychology students, earning 341 doctorate degrees in psychology and 2,294 psychology master's degrees in 2004 (U.S. Department of Education, 2004).

One organization, The Association of Black Psychologists (ABPsi), boasts a membership of over 1500 members. The Association of Black Psychologists was founded

in 1968. The overarching mission of the organization is: “the liberation of the African mind, empowerment of the African character, and enlivenment and illumination of the African Spirit” (Association of Black Psychologists, 2007). One purpose of the organization is to influence and affect social change while focusing on creating community change for all minority groups (Association of Black Psychologists, 2007). Due to the mission and functions of the ABPsi, the members’ help-seeking attitudes are of primary interest for the purposes of answering the research questions of this dissertation. Also, psychology faculty and staff professionals from Historically Black Colleges and Universities and those who are in private practice settings will be utilized. The following paragraphs provide more details about the purposes, terms, research questions and the anticipated limitations of this research.

Purpose of Dissertation Research

There is a gap in the literature on the attitudes of African American professional psychologists as it relates to psychotherapy. This dissertation follows in the same vein as the mission of ABPsi, in that learning more about African American psychologists’ attitudes may illuminate ways to further positively influence the African American community attitudes about psychotherapy. Discovering the attitudes of African American professional psychologists in the field and their relationships with psychotherapy could have huge implications in changing the negative attitudes of the African American community’s position towards psychotherapy. Consequently, if negatively ingrained attitudes based on historical and cultural barriers prevent African American professional psychologists, such as those in ABPsi, from fully supporting and utilizing

psychotherapeutic services for the African American community, then a disservice is being done.

The outcomes of this study may increase awareness among African American psychologists and the general public. It will also identify factors that may hinder African Americans decisions to seek professional psychological assistance. Another goal is to offer theoretical contributions to the body of the multicultural counseling literature.

Definitions of Terms

Administrator. One who manages or is in charge of the organization the business.

Attitude. A psychological state that predisposes a person to act favorably or unfavorably to an event or situation (Al-Rowaie, 2001).

Africentrism/ Africentric Cultural Values. Interacting with the world through values that are consistent with an Africentric worldview, which includes communalism (i.e., emphasizing the importance of human relationships and interrelatedness of people), collectivism (i.e., placing priority on group not personal goals), unity, cooperation, harmony, spirituality, balance, creativity and authenticity (Wallace & Constantine, 2005).

Culture. According to Hoare (1991), this is the belief system, behavior, and tradition that shape our everyday reality.

Cultural Barriers. People and situations that impede the belief system with which a particular group of people is familiar.

Psychologist. Psychologists study the human mind and human behavior. The American Psychological Association defines a psychologist as a person trained and educated to perform psychological research, testing, and therapy. A doctoral degree from an organized, sequential program in a regionally accredited university or professional

school is usually required for independent practice as a psychologist. Masters level psychologists can perform similar duties but are supervised by Ph.D. level psychologists (U.S. Department of Labor, 2007).

Psychotherapy/ Professional Psychological Help. The process in which a licensed or credentialed, trained professional helps a person function more effectively emotionally, cognitively and behaviorally while improving his or her quality of life. This is done by addressing problems in a preventive, developmental, or remedial way.

Stigma. Corrigan (2004) identified two types of stigma: public stigma and self-stigma. Public stigma is the perception held by a group or society that an individual is socially unacceptable. This often leads to negative reactions towards the individual such as, stereotyping, prejudice and discrimination. Self-stigma is the reduction of self-esteem or self-worth caused by the individual self-labeling himself or herself as socially unacceptable.

Work Expertise. An occupation or area of work in which a person has training and can provide specific skill or knowledge.

Research Questions

For the purpose of this study, the research questions will be:

1. Is there a relationship among Attitude Toward Seeking Professional Psychological Help Scale scores (ATSPPHS; Fischer & Turner, 1970), Africentrism Scale scores (AS; Grills & Longshore, 1996) and Social Stigma for Receiving Psychological Help scores (SSRPH; Komiya, et al, 2000) for African American psychologists?

2. Are there significant differences between African American psychologists' ATSPPHS scores, AS scores and SSRPH scores with regards to educational level, work expertise and professional experience?
3. Are there significant gender differences among African American psychologists with regards to ATSPPHS scores, Africentrism scores and SSRPH scores?

Summary

To provide background for this study about African American professional psychologists' attitudes towards psychotherapy, this chapter outlined the historical context and reviewed African Americans' tumultuous tenure in the United States. It offered a review of the literature and some explanations of why African Americans may be more inconsistent in psychotherapeutic service utilization. In addition, term definitions, research questions, and significance of this study were included.

Research related to cultural and historical barriers, inconsistent psychological services utilization, and African American professional psychologists working within their community to eradicate basic misconceptions of psychotherapy was introduced here and is discussed further in the next chapter. Chapter Two reviews the literature that corresponds with the background, purposes, and research focus of this dissertation study. Chapter Two will also discuss minority attitudes towards psychotherapy, age and gender differences and help seeking attitudes.

CHAPTER II

REVIEW OF LITERATURE

Introduction

African Americans and psychotherapy have been studied extensively, with a plethora of research on service utilization, psychological help-seeking attitudes, stigma and the psychotherapeutic process with African American college students (Atkinson & Gim, 1989; Snowden & Cheung, 1990; Sue, Zane & Young, 1994; Sue & Sue, 2003; Thompson, et al, 2004; Wallace & Constantine, 2005). Although numerous studies have focused on African American student attitudes towards psychotherapy, there is not much research about African American psychologists' attitudes towards psychotherapy. The purpose of this literature review is to determine how minorities, specifically African Americans, have historically viewed psychotherapy. This review will take into account cultural and social influences, gender differences, and psychological help seeking attitudes and behaviors.

Minorities' Perceptions of Mental Health and Psychotherapy

In the past, the United States prided itself on having a "melting pot mentality." This mentality emphasized equal opportunities and equal access to services, yet it diminished cultural differences. In 1977 Stanley Sue wrote, "For many years researchers

and practitioners have found that minority-group clients who seek psychotherapeutic services receive discriminatory treatment from White therapists” (p. 616). According to Hoare (1991), clients cannot disassociate themselves from culture. Culture is an integral part of their being. Years of discrimination and cultural denial made it apparent there needed to be a paradigm shift, one that acknowledged cultural differences and encouraged and appealed to minorities.

Cultural influences on psychological services utilization are not unique to the African American community. The following research will document Asians (Japanese, Chinese, and Korean), Latinos, Middle Eastern and African American patterns of behavior and attitudes towards psychotherapy and mental health issues to highlight that lack of awareness and attention to cultural differences is a focus of merit, rather than assuming that lack of utilization and attitudes is inherently an African American deficit.

Asian Attitudes

The Asian population in the United States has steadily increased since World War II. Approximately 270,000 people emigrated from Asian countries in 1995, which is 37.2% of all immigrants (U.S. Immigration and Naturalization Service, 1996). Approximately 64% of all international students in the United States in 1994-1995 were from south, middle and eastern Asian countries (US Department of Education, 1996). Many times the life circumstances of this population provided a number of stressors. They experienced relocation, separation from family, financial concerns and difficulties with language. Due to the higher levels of stress, they may be more at risk to suffer from psychological disorders than non-immigrant Americans (Masuda, Suzumura, Beauchamp, Howells & Clay, 2005).

Kinzie and Leung (1993) suggested that approximately 50 percent of Indochinese in California needed treatment for psychological disorders due to their life histories as refugees. Yet, Asian people in particular, have been underrepresented in psychological treatment facilities, which provide western-style psychological treatment. Asians and Asian Americans/Pacific Islanders are less likely than European Americans to use mental health services. Several authors (Atkinson & Gim, 1989; Snowden & Cheung, 1990) described a low rate of utilization of mental health services among the Asian population including Chinese, Japanese, and Filipino in the United States. This tendency may reflect the attitudes toward the utilization of such services formed in their home countries.

The stigma of mental illness often barricades individuals from job and educational opportunities. One recent study by Zhang and Dixon (2003) found that cultural barriers such as proneness to shame, concern for face, and adherence to traditional Asian values contribute to the very low rates of utilization of mental health services by Asian populations. Buhain's study and a study by Snowden and Cheung (1990) have both suggested that in Asian countries such as China, Korea, and Japan, mental illness traditionally has brought shame upon the entire family and raised concerns about the appropriateness of those who have such mental condition for such social institutions as marriage.

Filipino Americans tend to believe that only a person whose behavior dangerously deviates from societal norms requires psychological treatment (Zhang and Dixon, 2003). Although western people in general may attribute causes of psychological disorder to such factors as social and psychological factors, Asian people may attribute causes of mental disorders to factors less susceptible to personal influence. One accepted Chinese

view of psychological disorder is that it is a sign of the wrath of the Gods or of one's ancestors (Gaw, 1993).

Based on research with Asian populations, it appears that psychotherapy is not a widely accepted means of treatment for those who suffer from a mental illness (Snowden & Cheng, 1990). The literature suggests that the seriousness of psychological disorders has not been appropriately addressed and the magnitude of some of the disorders may be minimized. The literature also denoted that mental illness is deemed taboo by many Asian societies and there may not be ample resources allocated towards treatment. Nevertheless, there appears to be some promise within Asian communities; at predominantly American universities Asians are seeking help more and getting their psychological needs met (Atkinson & Gim, 1989; Zhang and Dixon, 2003).

Latino/a Attitudes

In 2002, the number of Latinos and Latinas living in the United States was estimated at approximately 37.9 million, comprising 13.5% of the entire population (U.S. Census Bureau, 2002). Latinos and Latinas are currently the largest ethnic minority group living in the United States. According to the Census Bureau (2002), the Latino population in the United States is diverse and heterogeneous. Of those in America, 63.3% were Mexican Americans, 9.5% were Puerto Ricans, 3.4% were Cubans, and 23.8% were from some other Hispanic/Latin American country. Though very diverse culturally, all of the various Latino ethnic groups in the United States share certain similarities, among which are, poverty, acculturative stress, and discrimination, and relatively low educational and economic status (Bernal & Saez-Santiago, 2006).

The western world Latinos, also called “la raza,” which means “the race” or “the people,” is comprised of Mexicans, Puerto Ricans, Cubans, Central Americans (Belize, Costa Rica Honduras, Nicaragua, Guatemala, Honduras, and Panama), South Americans (Chile, Argentina Bolivia, and Brazil), and Spanish speaking people in the Caribbean (Robinson, 2005). There is a multitude of diversity among this group, and identifying a client’s racial and ethnic group is essential. Phinney (1990) stated that racial and ethnic identity comprises the perceptions, knowledge, and ownership of the cultural traditions and beliefs of one’s ethnic group relative to the dominant culture. This is important because racial and ethnic diversity is an important facet of psychological health (Gloria & Rodriguez, 2000).

Research has found that Latinos and Latinas were resistant to therapy because of a lack of racially/ethnically similar, culturally sensitive, and bi-lingual therapists (Bernal & Saez-Santiago, 2006). Research has also shown that stigma can be a big deterrent for Latino/a Americans seeking professional psychological help (Leal, 2005). The following research review further investigates salient issues to the Latino community.

In a study of Latino/a psychological adjustment to college life, Gloria and Rodriguez, (2000) determined that there were cultural factors that affected adjustment. Issues such as social support and family were cultural factors that were very important to the participants in the study. Many of the college students saw attending college as a separation from their primary social support. In many cases this was seen as rebellion and disrespectful of the family (Gloria & Rodriguez, 2000).

Frequently, college students struggled with cultural incongruence. For these Latino/a students, the successful adjustment to college life was contingent on support

from family and friends. In an attempt to assist students with the adjustment period, college counseling centers intervened. Many of the Latino/a students initially were resistant to these initiatives, because they attached stigma to professional psychological counseling (Gloria & Rodriguez, 2000; Leal, 2005). This study helped to eventually identify specific cultural variables that were necessary to meet the psychosocial needs of the students (Gloria & Rodriguez, 2000).

Constantine, Wilton, and Caldwell (2003) studied the role of social support in moderating the relationship between psychological distress and willingness to seek psychological help using African American and Latino/a participants. This study took place on a predominantly European American campus in the Northeastern part of the United States. The results revealed that those Latinos with high levels of psychological distress were more willing to seek mental health psychotherapy than those with lower levels of distress. The study acknowledged that the social support (family and faculty mentors) was very important for both Latino/a and African Americans. The results obtained by Constantine et al (2003) suggested that Latino students who were satisfied with their close relationships often used those relationships to help reduce lower levels of psychological distress. They tended to not utilize university counseling services to the same degree as their European American colleagues.

Based on research with the Latino populations, it appeared that psychotherapy is not the most accepted means of treatment for those who suffer from a mental illness. Researchers have identified specific future recommendations for working with the Latino population. Latinos want culturally competent and sensitive therapists who are aware of their specific issues (Bernal & Saez-Santiago, 2006). Latinos also tend to rely on family

members and to give deference to the elderly people in the race (Robinson, 2005). Researchers should not erroneously pathologize them for a strong focus on family assistance instead of psychotherapy for psychological distress (Constantine et al., 2003). These issues are important to this racial/ethnic minority group, just as they are to all of the other racial and ethnic minority groups.

Middle Eastern Attitudes

Middle Easterners refer to a group of individuals who originate from Middle East countries including Iran, Turkey, Iraq, Kuwait, Lebanon, and Syria. Many Middle Easterners are called Arabs, who are a Semitic group whose commonalities are their language and cultural attributes. Currently, there are about three million Middle Easterners in the United States who immigrated in four distinctive phases (Nassar-McMillan & Hakim-Larson, 2003). The first phase of immigration occurred when workers from Yemen, Syria and Lebanon came to the factories of Detroit to work. The second phase was post World War II and workers primarily from Egypt and Iraq came to the United States. The third phase occurred around 1966 when Palestinians entered in large numbers. Finally, since the occurrence of the Gulf War a high number (25,000) of Iraqis settled into the Detroit area and other places (Nassar-McMillan & Hakim-Larson, 2003). Immigration has continued since their 2003 publication.

It was not until very recently, post September 11, 2001, that the Arab community and Arab Americans received much attention. The majority of the attention, however, has been negative in nature. A plethora of psychological research with Arab Americans has been done in light of these events and a great deal of psychology and counseling research is appearing every day, as the following paragraph demonstrates.

In a study with Arab Americans by Nassar-McMillan and Hakim-Larson (2003), the authors identified some barriers that were common among Arabs with regard to psychotherapy. One barrier mentioned was cultural mistrust issues. Cultural mistrust appears to be a significant issue among Arab Americans and a barrier to engaging in therapy (Shahmirzadi, 1983; Nassar-McMillan & Hakim-Larson, 2003).

A focus group conducted by Nassar-McMillan and Hakim-Larson (2003) revealed particular difficulties related to establishing rapport. First, Arabs adhere to traditional values, usually seeking advice or direction from an authoritative figure within their community. If the therapist is not Middle Eastern, establishing rapport could become an issue. Secondly, it could be problematic if a client has a family-related problem that requires them to disclose pertinent information about their family. Traditionally, Arabs do not go outside of their family and talk about their family members. This could be seen as bringing shame on their family (Shahmirzadi, 1983). Therefore, within the counseling context, the counselor needs to consider bringing family members into the session to help expedite the counseling relationship (Poyrazli, 2003).

African Americans Perceptions of Psychotherapy

Historically, African Americans have held less than favorable attitudes toward psychotherapy (Ridley, 1984; Sue & Sue, 2003; Thompson et al, 2004), finding psychological and emotional consultation and relief among family, friends and within the church (Thompson et al., 2004; Wallace & Constantine, 2005). However, research has not demonstrated a totally unfavorable attitude towards psychotherapy by African Americans. African Americans have been identified as a group that inconsistently uses mental health services (Sue & Sue, 2003). Thompson et al (2004) documented the over

usage of inpatient services by African Americans. In many situations, African Americans are referred through the legal system and are diagnosed with paranoid schizophrenia at an epidemic rate (Whaley, 2004).

Atkinson, Morten, and Sue (1998) documented under usage in outpatient settings. Two variables which specifically contributed to under usage of psychotherapeutic services were cultural mistrust and therapist characteristics. African Americans, in particular, feared that European American therapists could not understand their viewpoints (Atkinson et al., 1998; Thompson et al., 2004). They also feared that they would be misdiagnosed. Also, African American men were concerned about the race of the therapist, expressing a strong desire to have an African American therapist to whom they could relate (Thompson et al., 2004)

In many instances, African Americans have utilized prayer as a means to cope with everything from slavery to present day life challenges, including mental health issues (El-Khoury, Dutton, Goodman, Engel, Belamaric, & Murphy, 2004; Thompson et al, 2004). This culturally relevant remedy in the African American community is especially evident with older African Americans whose utilization of prayer is paramount in survival of life challenges. Many of the participants in the Thompson et al (2004) study disclosed that relationship concerns were often perceived as problems that could be addressed by a minister or with assistance from family members.

The failure to gain appreciable mental health services may have negative implications for the African American community. El-Khoury et al. (2004) stated in contrast to the relatively low use of formal health system, research suggests that African Americans report a relatively high usage of clergy or the church as a resource for many

problems, including mental health. Although the church has been a very reputable commodity for the African American community, in some instances professional psychological help would have been preferable. However, there are many barriers that prevent African Americans from utilizing these professional psychological services.

Many studies (e.g., So, Gilbert & Romero, 2004; Thompson et al, 2004; Wallace & Constantine, 2005) have identified several barriers that African Americans may have that prevent them from seeking professional psychological help. Thompson et al (2004) conducted twenty-four mixed-sex focus groups ranging in size from three to twelve members and found that cultural barriers, stigma, financial barriers, and lack of knowledge of the availability of services affected psychological treatment seeking by African Americans. The following paragraphs will explore each variable and utilize additional research for support.

Cultural Barriers and Africentrism

Hoare (1991) remarked that a person's reality is shaped by the culture in which it is embedded. Cultural barriers are attitudes and norms that are a part of a person's socialization that may prevent a person from doing something not considered culturally acceptable by that person's cultural group affiliation. According to the literature, African American cultural attitudes and beliefs are only understood within the context of an Africentric worldview.

The concept of Africentrism or an Africentric worldview is very important to the well being of the African American community. The values of Africentrism include key components also associated with Kwanza, an African American holiday celebrated around the time of Christmas. The values are communalism, collectivism, unity,

cooperation, purpose, self-determination, harmony, authenticity and spirituality (Karenga, 1988; Wallace & Constantine, 2005). Many of these values are in stark contrast to traditional European American culture, which is more individualistic, competitive, rigid, and self-assertive (Sue & Sue, 2003).

In a psychotherapeutic setting, problems may arise if the therapist does not understand the dynamics of the clients' worldview. Sue, Zane, and Young (1994) remarked that not knowing the culture of the client with whom the therapist is working with could be detrimental to the client. Traditional psychotherapy has an expectation that psychologically minded clients are willing to disclose personal information and willing to trust the therapist. In many instances this includes the relationship that the client has between himself/herself and their families, friends and community.

According to Wallace and Constantine (2005), disclosing personal information that might compromise the integrity of family and friends, and trusting those who are not African Americans goes against traditional Africentric cultural norms which indicate that harmony for the community is preferred. They stated:

In order to preserve the well-being and balance of themselves, family members and even close friends, some African Americans may not disclose their problems to important others to preserve harmony or to not burden them with their concerns. In interactions with mental health service providers, in particular, some African Americans might hesitate to disclose negative information out of concern that they will misrepresent the integrity of their larger ethnic community. (Wallace & Constantine, 2005, p. 372)

Wallace and Constantine (2005) investigated the relationship among Africentric cultural values (adherence to African worldview stressing communalism, unity and spirituality), psychological help-seeking attitudes, perceived counseling stigma, and self-concealment (withholding personal information perceived as negative or upsetting) in a sample of 251 African American college students. They used the Africentrism Scale, the Attitude Toward Seeking Professional Psychological Help – Short Version Scale, the Social Stigma for Receiving Help scale, and the Self Concealment Scale.

The study hypothesized that Africentric cultural values would be (a) negatively associated with favorable attitudes about seeking professional psychological help and (b) positively predictive of both perceived stigma about counseling and self-concealment. The results of the analyses revealed that African American women reported significantly higher ATSPPHS-S scores than did the men. They also found that both African American men and women, who held higher degrees of Africentrism also, had higher scores on perceived stigma and self-concealment measures.

Africentrism and stigma have proven to be important aspects of the African American community (Karenga, 1988; Wallace & Constantine, 2005). Without any knowledge of cultural norm, a psychologist or other mental health worker might simply determine that the client is non-compliant or very high in self-concealment. Therefore, psychologists and other mental health workers need to ensure that they are properly trained in multicultural issues as they relate to the intervention and treatment techniques specific to African Americans.

Stigma

Stigma appears to be a huge concern for African Americans with regard to barriers that prevent them from seeking psychological help. Corrigan (2004) documented two types of stigma that prevent individuals from seeking professional psychological help: public stigma and self-stigma. Public stigma is a perception held by a group or society that a person is socially unacceptable. Self-stigma relates to the individual's perception that their self-concept, self-esteem or self-worth is compromised for seeking treatment. Vogel, Wade and Haake (2006) developed a scale that measures self-stigma associated with seeking psychological help and found this to be a major factor in an individual's decision not to engage in therapy.

Thompson, Bazile, and Akbar (2004) developed twenty-four mixed-sex focus groups to study public and self-stigma in African Americans. The participants were mental health consumers, relatives of the mental health consumers, and individuals who had no previous psychotherapeutic experience. Two hundred and one participants participated in the focus groups. The participants lamented that stigma was a significant barrier to seeking treatment. The participants in the study felt that seeking these services was meant for use by "crazy people" (public stigma) and that there would be a diminished pride and weakness (self-stigma) in seeking services. This was especially true with the men who participated in the focus groups. They felt that the negative things that they may experience were a part of life and that they were tolerable. They suggested that African Americans could cope with any adversity, given their history.

Wallace and Constantine (2005) investigated the relationship among Africentric cultural values (i.e., the extent to which an individual adheres to a worldview

emphasizing communalism, unity, harmony, and spirituality), favorable psychological help-seeking attitudes, perceived counseling stigma, and self-concealment (i.e. tendency to withhold personal, sensitive information that is perceived as negative or upsetting). They found that high levels of Africentric culture were predictive of greater levels of stigma.

Financial Barriers

Another variable, according to research, that has had a negative affect on psychological treatment seeking attitudes among African Americans was finances. With regards to financial barriers, African Americans cited this as one of the foremost deterrents to seeking mental health treatment (Thompson et al., 2004). As noted in Chapter 1, psychotherapy has been perceived as exclusively for those who suffered from mental problems and sought help for them (Astin, 1959). It was also perceived for those of affluence. The United States Census Bureau (2000) documented mean European Americans' household income (\$59,696) was about \$20,000 more than the mean household income of African Americans (\$39,877). The participants in the Thompson et al. (2004) study suggested that most of the participants did not have mental health insurance coverage and that the hourly fees charged were excessive. Considering the average household incomes, there is a good possibility that the African Americans considered psychotherapy a luxury more than a necessity.

Limited Knowledge

A final barrier for African Americans regarding seeking psychological help was a limited knowledge of the capacity of psychotherapy. In spite of having average educations, the African Americans in the Thompson et al (2004) study claimed that they

had a limited knowledge of what concerns that psychotherapy could effectively address and had limited knowledge of the signs and symptoms of mental illness. The participants noted a particular inability to discern when a situation or condition had reached a stage that required professional intervention.

Although the study's participants usage of emergency rooms to address mental health needs was common to avoid stigma, in many instances the lack of knowledge of psychotherapy resulted in inaccurate service utilization. Often the participants failed to utilize the proper mental health specialist and attempted to get their mental health needs met through other professionals. Murstein and Fontaine (1993) found that among mental health professionals most likely to be consulted, "most people prefer to consult physicians (non-psychiatrists), rather than mental health professionals for emotional problems" (p. 841), followed by a psychologist, then a psychiatrist or a clergy person. Their findings from a previous report (as cited in Murstein & Fontaine, 1993) also yielded some interesting results: 60% of clients received their mental health services solely from a non-psychiatric physician.

Although Murstein and Fontaine's (1993) findings show that the general public's knowledge of mental health professionals is improving, the study revealed a continued lack of knowledge of the duties and goals of mental health professionals. It also showed that the general public is not able to distinguish between the duties of the professionals. For example, Murstein and Fontaine found that the role of psychologists still was vague to the participants when compared to other mental health professionals such as, marriage and family therapist.

Trude and Stoddard (2003) collected a survey from primary care physicians and conducted an analysis to study difficulties that primary care physicians experience when trying to obtain mental health services for their patients. They found that 54 percent of primary care physicians, regardless of race, reported difficulties in both obtaining hospitalizations and referrals for outpatient mental health services. Many of the problems occurred as a result of lack of knowledge. They concluded, “primary care is an important entry point for mental health services, yet inadequate referral systems between medical and mental health services may be hampering access” (Trude & Stoddard, 2003, p. 442).

Even though American society is more tolerant of racial and ethnic differences, some situations, such as access to adequate health care and misconceptions of mental health services, continue to prevail. Years of systematic denial, discrimination and unequal treatment of minority groups appear to have had a detrimental affect on minority attitudes toward mental health service utilization in our society. The need for a change in the help-seeking attitudes and behaviors is clear. The following paragraph will explain differences in men and women with respect to help-seeking attitudes and it will explain the process of help-seeking attitudes and behaviors.

Gender Differences in Mental Health Perceptions

There is a wealth of literature that is related to men and women’s perceptions of mental health and psychotherapy. Most of the published research explores barriers that affect men more than women. Traditionally, men in the United States are socialized and reared to be strong and self-reliant. Komiya, Good and Sherrod (2000) have suggested that gender and gender roles play a part in help-seeking behavior. Robertson (2001) stated that traditional counseling requires men to set aside much of their masculine

socialization simply to get through the door and ask for help. Furthermore, many of the men believed that vulnerability and emotions were signs of femininity. For this reason, men tended to avoid psychotherapy.

Levant (1990) reported four gender-role characteristics that contributed to men's avoidance of therapy. First, men have difficulty admitting that a problem exists; second, they have difficulty asking for help, and third, they have trouble distinguishing between the various emotional states. Finally, they may be socialized to fear intimacy. Levant's research epitomizes what many of the barriers are for men with regards to psychotherapy.

On the other hand the research showed that women, traditionally, are more likely to utilize mental health services than men, without regard to age or sexual orientation (Sheu & Sedlacek, 2002). One estimate in the literature stated that one in three women would seek professional mental health services in their lifetimes, while only one in seven men will do so (Collier, 1982).

African American women have historically been lumped in with African American men with regards to psychological help seeking attitudes and behaviors (Sheu & Sedlacek, 2002; Snowden & Cheung, 1990). These findings are intergroup findings and are a result of comparing racial differences among African Americans and European Americans with regard to psychological help-seeking attitudes, yet African American women have a depression rate twice that of European-American women (Brown, 1990).

According to Warren (1994), African American women are at a greater risk than others because they live in a majority-dominated society that frequently devalues their gender, culture, and race. In addition, they find themselves at the lower spectrum of the American political and economic continuum. Finally they are involved in multiple roles

as they attempt to survive economically and advance themselves and their families through mainstream society. All of these factors intensify the amount of stress within their lives which can erode their self-esteem, self concept, social support systems, and physical and mental health.

African American women, as many African American men, have a tendency to rely on social and community supports other than mental health services. There is a strong reliance on the support of family, and the religious community during periods of emotional and psychological distress (Leary, 2007). Leary (2007) wrote that African American women seek mental health care less than European American women; and, when they do seek it, they do so later in life and at a later stage of their illness. African American women have limited access to health care compared to European Americans (Wallace and Constantine, 2005). Many times this is due to socioeconomic factors (Wallace & Constantine, 2005).

However, Wallace and Constantine (2005) conducted intra-group research on Africentric cultural values, psychological help-seeking attitudes and self-concealment among African American college students and found that African American women are more likely to receive services than African American men. They also reported more positive attitudes towards seeking professional psychological help scores than African American men, based on the Attitudes Toward Seeking Professional Psychological Help Scale (Wallace & Constantine, 2005). This may be in part to initiatives such as The California Black Women's Health Project. This program was designed to address the disparities in African American women's mental health in the state of California.

Theories of Help-Seeking

Vogel, Wester, Larson and Wade (2006b) developed a theoretical model to help explain a person's decision to seek professional help. They created an information-processing model that addresses how individuals interpret their environment and their ability to respond to that environment. The model is presented as a step-model, yet individuals may not experience the steps in a specific order. In fact, many times individuals will make a decision based on a habitual pattern not on an evaluation of information (Vogel et al., 2006b). The information-processing model is composed of four steps: (1) encode and interpret internal and external cues, (2) generate and evaluate behavioral options, (3) decide on a response and enact it, and last (4) respond to personal and peer evaluations of the selected behavior.

In the *Encoding and Interpreting stage*, the individual focuses on relevant stimuli and interprets it based on personalized schema (previous knowledge about similar situation). According to Vogel et al. (2006b), a major factor in encoding and interpreting process is the significance that an individual places on symptom and what it means. Thompson et al (2004) assert that one issue that keeps African Americans from consistently using mental health services is that African Americans have limited knowledge of signs and symptoms. The participants noted a particular inability to discern when a situation or condition had reached a stage that required professional intervention.

The second stage, the *Generating stage*, is where individuals generate behavioral options. This stage is dependent on the way that the individual previously interpreted the stimuli and their current goals (the process of establishing a possible solution to address one's internal and external demands (Vogel et al., 2006b). According to Vogel et al

(2006b), individuals may not generate seeking psychological help as a viable option. Thompson et al (2004) denote that African Americans may struggle with this option and thus do not consider it as one of their behavioral options. Ironically, they consider the emergency room at a greater rate. Although the study participants' usage of emergency rooms to get mental health needs met was common to avoid stigma, in many instances the lack of knowledge of psychotherapy resulted in inaccurate service utilization.

In the third stage, the *Decision Making stage*, individuals determine which response they will utilize based on the costs and benefits. This stage is often influenced by the way that a person is socialized. It is influenced by cultural, racial and gender norms. These values can influence with whom a person feels comfortable disclosing psychological and emotional distress.

Wallace and Constantine (2005) posited that African Americans may not disclose their problems to important others to preserve harmony or to not burden them with their concerns and with regards to mental health service providers some African Americans hesitate to disclose negative information out of concern that they will misrepresent the integrity of their larger ethnic group.

The final stage is the *Evaluation of Behavior stage*. This is the stage where the individual assesses his or her behavior based on the outcome of the situation. This is a critical stage because, "those who do not seek professional help may perceive (accurately or not) that earlier attempts were successful or successful enough to not warrant additional action at that time" (p. 403). In other words, if no harm or minimal negative effects came as a result of them not addressing psychological and emotional distress then this behavior may be reinforced. Understanding this could have huge implications for

African Americans, especially if psychological distress is reduced by talking to non-professional (pastors, emergency room attendants, friends, etc.). Considering the history of seeking professional psychological service, it appears that this may be a contributing factor to the underutilization of mental health service by African Americans. Mental health workers who work with this population need to be keenly aware of the historical context in which African Americans view mental health services.

Help-seeking Attitudes

A common frustration among psychologists and other mental health practitioners is knowing that there are a lot of people who are reluctant to seek professional psychological help though they desperately need it (Vogel, Wade, & Haake, 2006a; Vogel, et al., 2006b). Severe underutilization of psychotherapy by the public is found on the local and national level (Komiya et al., 2000). One goal of psychologists and other mental health practitioners is to identify and then eliminate barriers that affect individuals' psychological help seeking attitudes.

Researchers have identified various factors associated with the reluctance of people to seek professional psychological help such as the desire to avoid emotionally painful feelings (Komiya et al., 2000) and the desire to avoid public and self-stigma (Corrigan, 2004). For African Americans and other people of color, there are the additional factors of cultural and financial barriers that make them reluctant to seek professional psychological help (Thompson et al., 2004), cultural mistrust (Nassar-McMillan & Hakim-Larson, 2003), and a fear of casting shame on their family (Buhain, 2006; Shahmirzadi, 2003; Thompson et al., 2004). Men have also been found to have a

fear of intimacy (Levant, 1990) and seek professional psychological services at a lower rate than women (Sheu & Sedlacek, 2002).

Some researchers believe that along with severity of life stressors, a person's social network had some bearing on one's decision to seek professional psychological help. Vogel, Wade, Wester, Larson and Hackler's (2007) studied how participants' social networks affected their decisions to seek professional psychological help. Vogel et al (2007) study revealed that a person's social network highly determined if the person would seek professional psychological help. Ninety five percent of the participants knew someone who had sought professional psychological help. Also, the participants who sought professional psychological help had more positive attitudes towards seeking help.

In a study by Dearing, Maddux and Tangney (2005), 262 clinical and counseling psychology graduate students participated to determine what factors affected their personal psychological help-seeking attitudes. Their findings indicated that issues of confidentiality, cost, and time were some concerns. Also the researchers found that the perceptions and views of faculty toward students seeking therapy was a significant determinant in whether the clinical and counseling psychology graduate students sought help for psychological issues.

Help-Seeking Among Professionals

Most of the research conducted in the area of help-seeking attitudes and behaviors has been done with the college student population (Atkinson & Gim, 1989; Komiya, Good, & Sherrod, 2000; Dominicus, Gilbert, & Romero, 2005). A lot of what may be gleaned from this population (underutilization of psychological services when a person is in psychological distress) may also inform our understanding of help-seeking attitudes

and behaviors in general. Knowing that the general population underutilizes mental health services can be beneficial because it can create an open dialogue to pinpoint issues such as barriers that reduce service usage. However, issues that are related to the general population's under usage (fearing emotionally painful feelings, stigma, and cultural mistrust) probably has some effect but these may not be as salient when it comes to underutilization of professional psychological help among the helping professionals (Schoener, 1999).

Psychologists and other mental health workers, much like the rest of the general population, experience depression, burnout and other psychologically distressing situations (Mahoney, 1997; Norcross, 2000). Often psychological distress negatively affects work performance (Siebert & Siebert, 2007). However, professionals, like the general population, fail to regularly seek professional psychological help. The following research addresses psychologists and self-care, yet the studies do not reveal much about their attitudes toward seeking professional psychological therapy, specifically as it relates to African American psychologists.

Barnett, Baker, Elman and Schoener's (2007) article on self-care addressed issues that are salient to psychologists and mental health professionals. Their work outlines the necessity for psychologists to maintain proper self-care so that no harm can be done to the clients, or the profession. Barnett, Baker, Elman and Schoener stated that as a result of distressed experiences not being properly addressed over time, psychologist may experience burnout. Burnout may lead to ineffectiveness with clients and failure to report to colleagues. The article provides insight and preventive strategies for the individual psychologist to address self-care issues.

The authors stated that it is essential that psychologists see themselves as vulnerable to the effects of personal and professional stressors. Psychologists need to be aware of, and be able to effectively identify and assess, risk. After identifying the situation, it is essential that psychologists be aware of and avoid the use of negative coping strategies such as: self-medicating, seeking emotional support from clients, and engaging in minimization or denial (Barnett, Baker, Elman & Schoener, 2007). Psychologists should strike a balance between personal and private lives and identify positive outlets, as well as seek professional help when needed.

Mahoney (1997) completed a study with 155 psychotherapy practitioners. He was interested in self-care patterns and attitudes toward personal therapy. The study used an anonymous questionnaire that focused on the practitioners' personal problems, self-care patterns and attitudes toward personal therapy. Mahoney stated that 90% of the practitioners reported that they had experienced personal therapy. The study revealed that the practitioners also engaged in meditation, prayer and physical activities as self-care behaviors. They identified emotional exhaustion and fatigue as the most frequently reported personal problems. The practitioners also acknowledged cost and accessibility were major concerns. They rated their overall personal therapeutic experience as satisfying.

Gilroy, Carroll, and Murra's (2002) study with counseling psychologists revealed how they cope and deal with depression. The study was conducted with a random sample of 1000 psychologists from the Counseling Psychology division of the American Psychiatric Association. They discovered that Depression (Dysthymia) was the most frequently acknowledged disorder. The participants experienced lessened energy and

ability to concentrate. They also discovered that the counseling psychologists experienced an increased sense of isolation from their colleagues Gilroy.

Siebert and Siebert's (2007) study with professional social workers used a racially mixed sample; the study raised some concerns, because unlike the general population the professional, social workers' training emphasizes the importance of intervention for psychologically distressing issues. The study documented that having more years of practice experience did not influence the help-seeking attitudes and behaviors of the professionals, yet having a clinical license improved the likelihood of professionals seeking help. The study also documented that experiencing depressive symptoms was the only kind of psychological distress that significantly increased the likelihood of seeking professional psychological help.

The results of Siebert and Siebert's study should be generalized with caution because the participants in this study were all members of the North Carolina chapter of the National Association of Social Workers. Psychologists, who are mental health practitioners and a part of the helping professional field, also are trained to identify and intervene whenever a person is suffering from psychological distress.

Although there is a small amount of research on psychologists and mental health workers related to self-care, not much is known about their attitudes toward seeking professional psychological therapy. The current study proposes to study help-seeking attitudes of African American professional psychologists. This study is critical given the nature of the existing attitudes that prevail across a large portion of the African American community as documented by professional psychological help-seeking behaviors. Those who are a part of the community have, in many instances, been inundated with cultural

dimensions of the community. Yet, as psychologists, they also have training from the professional psychological community and are trained to identify psychologically distressing situations. In order to bridge the gap in psychotherapeutic attitudes usage and eventually service usage, the African American psychologist will be instrumental. This study may shed light on foundational aspects of African American psychologists' attitudes.

Summary

In this chapter, literature pertaining to the study of minority group attitudes towards psychotherapy was reviewed. Information was discussed related to cultural barriers, viewpoints and behaviors towards seeking professional psychological help. Studies determining professional psychological interventions depending on culture were reviewed. Research related to cultural and historical barriers, inconsistent psychological services utilization, and African American professional psychologists working within their community to eradicate basic misconceptions of psychotherapy was examined. Other related topics, such as a theoretical model of help-seeking behavior were examined and specifically help-seeking behavior for the helping professional was discussed. Relevance for the topic to be explored in this study was noted through the review. The next chapter will describe the methodology, including a description of the instruments, the participants, the data collection procedures, including details of SurveyMonkey and the process of analyzing the data will be discussed.

CHAPTER III

METHODOLOGY

Introduction

This chapter provides information regarding the ethical considerations, as well as a description and rationale for the identification of the sample selection. Also, descriptions of both the instruments and data analyses are reviewed. Validity and reliability measures are discussed with regards to the instruments. The three research questions are restated, along with the analyses selected to test each question.

Ethical Considerations

Institutional Review Board

This research study's description, including purpose of the study, interview questions, the online survey process, confidentiality assurance, possible risks and benefits, consent forms and any other pertinent information were presented to Cleveland State University's Institutional Review Board (IRB) prior to collection of data. The IRB correspondence is included in Appendix A.

Implied Consent

Research participants read the invitational email and chose whether or not to select the link to partake in the study. The first page of the survey included a project

description along with the consent form. Survey responses were collected and monitored by the website survey service, SurveyMonkey.

Risks and Benefits

There were no known or anticipated physical or emotional risks associated with participation in this study. The researcher's telephone and email contacts and The Cleveland State University IRB's telephone number were included in the consent form, in case the participants had any questions about associated risks.

The primary benefit of this study was to increase awareness among African American professional psychologists with regards to potential barriers that may affect their seeking professional psychological help for personal problems. A secondary benefit was to explore how their personal help-seeking behavior may influence their professional judgment. A final benefit was to ensure that professionals would be encouraged to do more research in this area of study.

Sampling

To ensure a representative sampling of African American professional psychologists, African American psychologists from the Association of Black Psychologists, members from the psychology departments at several historically Black colleges and universities, and African American psychologists who practiced in private settings served as the participants in this study. These three settings were chosen in order to maximize the available amount of African American psychologists.

A letter (Appendix B) describing the study was sent to potential participants. It was sent out via email to 519 potential participants (321 from the Association of Black Psychologists Listserv, 170 from 19 historically Black colleges and universities, and 28

in private practice). A second form (Appendix C) was administered to 89 of the potential participants. These potential participants received the second form as a result of nine of the original email participants claiming that they had additional potential participants to whom they could forward the email. Subsequently the second form was forwarded to each of the nine participants who then forwarded it to their contacts. SurveyMonkey does not allow for the original form (Appendix B) to be forwarded to others, due to compatibility issues, therefore the second form (Appendix C) with a new link had to be sent to these potential participants.

Potential participants were asked to participate voluntarily in this anonymous study examining general attitudes and perceptions about mental health and cultural issues, by completing a questionnaire packet consisting of (a) a brief demographic questionnaire (Appendix D), (b) the Africentric Scale (AS; Grills & Longshore, 1996) included here as Appendix E, (c) the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) included here as Appendix F, and the Stigma Scale for Receiving Psychological Help (SSRPH; Komiya, Good, & Sherrod, 2000) in Appendix G.

For the purposes of this study, 100 survey responses were defined as a methodologically sound sample size. After obtaining 105 surveys from African American psychologists, the survey was closed to additional potential participants. Closing the survey occurred in early January 2008, after two additional reminder emails had been sent out to the Association of Black Psychologists professional listserv and the other potential participants. Overall, fifteen surveys had to be omitted. Five surveys were removed because they were not received from African Americans. Four participants were

removed because they had less than a master's degree. Finally, six participants were removed due to incomplete surveys. All surveys were completed and maintained through SurveyMonkey, an external website that saved the collected data and assured confidentiality.

Participants

From the 519 usable email contacts, 105 individuals responded to the survey. Of those who responded, 89 participants were included in this dissertation research, providing a response rate of 20%. The participants were 89 African American professional psychologists. The gender composition of the sample was 65 (70.2%) females and 24 (29.8%) males. The educational level reported by the participants was doctoral degree ($n = 78$; 87.6%), followed by master's degree ($n = 11$; 12.4%), while bachelor's degree composed ($n = 2$; 1.9%). Most of the sample ($n = 63$; 70.8%) held a mental health license. There were 54 (60.7%) who were psychotherapists, 21 (23.6%) were researchers, and 14 (15.7%) who were administrators.

The participant with the least amount of experience had only one year of experience. The participant with the most amount of experience had 45 years of experience. The participants yielded an average of 17 years of experience. In their current capacities, 81.7 percent of the participants have referred others to psychotherapy. Also, 96.2% of the participants had, in their professional careers, referred others to psychotherapy. The survey results were saved to the SurveyMonkey database, accessible with a personal password. The results were downloaded into an Excel Spreadsheet file format. All personal information about the participants was omitted. The participants' IP Addresses were used to ensure that there were no duplicate surveys collected.

Instrumentation

The following section describes the demographic questionnaire and the three assessment instruments that participants were asked to complete online.

Demographics

A brief demographic questionnaire, designed for the purposes of this dissertation, was administered to participants. Items included questions about their age, gender, race/ethnicity, professional experience, educational level and level of expertise. Items were recorded as self-reported yes/no and fill-in responses. The demographics questionnaire is included in this dissertation (Appendix D).

Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS)

The ATSPPHS (Fischer & Turner, 1970) was initially developed with a college student sample (Fischer & Turner, 1970). The ATSPPHS is a 29-item, 4-point Likert-type (0 = Disagree, 1 = Partly Disagree, 2 = Partly Agree, 3 = Agree) questionnaire for assessing general attitudes toward seeking therapeutic help for psychological problems. Eighteen items (1, 3, 4, 6, 8, 9, 10, 13, 14, 15, 17, 19, 20, 21, 22, 24, 26, & 29) are reverse scored. Higher scores are associated with more positive psychological help-seeking attitudes. This scale has been most widely used with people of color (Dominicus, Gilbert & Romero, 2005).

The ATSPPHS was chosen for its reliability and validity. Fischer and Turner (1970) reported an internal consistency coefficient of (.86). The ATPPHS was found to have good test-retest reliability of .84 over a 2 month time period (Dominicus et al., 2005). The scale has four subscales that measure: Factor 1 – recognition of need for

psychological help; Factor 2 – Stigma tolerance; Factor 3 – Interpersonal openness, and Factor 4 – Confidence in mental health practitioner. Fischer and Turner (1970) stated that the instrument sufficiently distinguished mental health facility users from non users.

Stigma Scale for Receiving Psychological Help (SSRPH)

Permission was received from the scale's developers, Dr. Glenn Good and Dr. Noboru Komiya. Emails granting permission can be found in Appendices (H and I). The SSRPH (Komiya et al., 2000) is a five-item, 4-point Likert-type scale used to assess individuals' awareness of social stigma associated with receiving psychological services. Scores can range from 0 to 15. Higher scores indicate a greater perceived stigma connected to receiving psychological treatment. Komiya, Good and Sherrod (2000) found a coefficient alpha of .72 for the SSRPH. In a study by Wallace and Constantine (2005), a Cronbach alpha of .67 was obtained for the SSRPH.

Africentrism Scale (AS)

A request for permission to use the Africentric Scale was sent to its creator, Cheryl Grills. Her permission was granted (Appendix J). The Africentric Scale (AS; Grills & Longshore, 1996) is a 15-item, 4-point Likert-type scale (1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree). The AS measures the extent to which an individual adheres to an Africentric worldview. Asante (1988) defined Africentrism as a philosophy and a way of life. The core principles of Africentrism include communalism, collectivism, purpose, unity, cooperation, harmony, authenticity and spirituality (Karenga, 1988; Wallace & Constantine, 2005). Higher scores on the AS correspond to greater degrees of Africentrism. In four validation studies, the alpha coefficients ranged

from .62 to .82, with an average of .74 for the total Africentrism Scale (Grills & Longshore, 1996).

Africentric values are conceptually related to aspects of ethnic identity, which are widely viewed as important to a healthy sense of self (Grills & Longshore). Among these values are commitment to ethnic identity, group pride and involvement in group traditions and activities. With regards to validity, the AS related positively to aspects of ethnic identity achievement, ethnic behavior and group affirmation (Grills & Longshore). Wallace and Constantine (2005) acquired a Cronbach alpha of .76 in their study.

Research Questions

For the purpose of this study, the research questions were:

1. Is there a relationship among Attitude Toward Seeking Professional Psychological Help Scale scores (ATSPPHS; Fischer & Turner, 1970), Africentrism Scale scores (AS; Grills & Longshore, 1996) and Social Stigma for Receiving Psychological Help scores (SSRPH; Komiya, et al, 2000) for African American psychologists?
2. Are there significant differences between African American psychologists ATSPPHS scores, AS scores and SSRPH scores with regards to educational level, work expertise and professional experience?
3. Are there significant gender differences among African American psychologists with regards to ATSPPHS scores, Africentrism scores and SSRPH scores?

Table 1 outlines the measures utilized to address each research question and the analyses used to determine the results.

Table 1.

Research Questions, Measurements, and Analyses

Research Questions	Measurements	Analyses
Is there a relationship between Africentrism, help-seeking attitudes and social stigma?	AS, ATSPPHS and SSRPH	Correlation
Are there differences between psychologists with regards to type of degree, educational level, area of expertise and professional experience?	Demographic Questionnaire	One-Way ANOVA
Are there gender differences with regards to Africentrism, help-seeking attitudes and social stigma?	Demographic Questionnaire, AS, ATSPPHS and SSRPH	One-Way ANOVA

Summary

This chapter contained a description of the methodology that was be utilized in this study, including instrumentation, participants, data collection and analyses. The following chapter contains the results for each hypothesis.

CHAPTER IV

RESULTS

Introduction

The purpose of this chapter is to present the participants' demographics and the results from the statistical analyses. The chapter will address each research question, the results of the findings and the corresponding tables. Testing was conducted to determine if there was a relationship between professional psychological help-seeking attitudes, Africentrism and social stigma.

Participant Demographic Characteristics

The participant demographics are contained in Table 2.

Table 2.

Number and Percent of Participants by Demographic Variable

Characteristic	Level	Frequency	Percent
Gender	Male	24	27.0
	Female	65	73.0
Highest Degree	Doctorate	78	87.6
	Masters	11	12.4

Characteristic	Level	Frequency	Percent
License	Yes	63	70.8
	No	26	29.2
Work	Psychotherapy	54	60.7
Concentration	Research	21	23.6
	Administration	14	15.7

(*n* = 89)

In summary, the participants were comprised of 65% females. Additionally, 87.6% of the participants' highest earned degrees were doctorate degrees, while 12.4% of the participants highest earned degrees earned were master's degrees. More than half of the participants (63%) in the study had a mental health provider license while the others did not have a license. Finally, when the participants were asked to describe the type of work that they did, 54% stated psychotherapy, while 21% stated research, and the other 14% endorsed administration.

Statistical Analysis

The statistical analyses utilized to address each of the three research questions are outlined in Figure 1 in Chapter 3. In summary, a correlation analysis was employed to test research question 1, the relationship between attitudes toward seeking professional psychological help, Africentrism, and social stigma as related to receiving mental health services. An ANOVA was used to determine the results for research question 2, regarding whether a significant difference exists among the psychologists' Attitudes

Toward Seeking Professional Psychological Help scale, Africentrism score and Social Stigma scores with regards to educational level, work expertise and professional experience. Finally, for research question 3, an ANOVA was conducted to determine if there was a significant difference among the psychologists' Attitudes Toward Seeking Professional Psychological Help scores, Africentrism scores and Social Stigma scores based upon gender. An alpha level of .05 was used for all statistical tests. The following section presents the results for each research question.

Research Questions

Research Question 1

Is there a relationship among Attitude Toward Seeking Professional Psychological Help Scale scores (ATSPPHS; Fischer & Turner, 1970), Africentrism Scale scores (AS; Grills & Longshore, 1996) and Social Stigma for Receiving Psychological Help scores (SSRPH; Komiya, et al, 2000) for African American psychologists?

For the first research question, correlation analysis (see Table 3) indicated significant inverse relationships between the SSRPHS and the ATTSPPHS ($r = -.43$), and for the SSRPHS and the AS ($r = -.27$).

Table 3

Correlation Table Showing Relationship Between Attitude Toward Seeking Professional Psychological Help Scores, Africentrism Scores and Social Stigma Scores

Instrument	ATSPPHS	AS	SSRPH
ATSPPHS	1.0	.17	-.43**
AS	.172	1.0	-.27**
SSRPH	-.43**	-.27**	1.0

(N = 89) ** $p < 0.01$ (2-tailed)

The results indicate a moderate, inverse relationship between the ATSPPHS and the SSRPH ($r = -.43$). The findings suggest that those individuals with more positive attitudes towards receiving professional psychological help were less likely to associate social stigma with psychological treatment. Perceptions of social stigma account for approximately 18.5 percent of the variation in attitudes toward seeking professional help. Also a moderate, inverse relationship was indicated between the AS and the SSRPH ($r = -.27$). The findings suggest that those individuals who indicated a strong identification with Africentric values were less likely to associate social stigma with psychological treatment. This suggests that Africentric beliefs accounts for less than 8 percent of the variation on social stigma.

Research Question 2

Are there significant differences between African American psychologists ATSPPHS scores, AS scores and SSRPH scores with regards to educational level, work expertise and professional experience?

The second research question sought to discover if there were significant differences between the Attitudes Toward Seeking Professional Psychological Help Scale Scores, Africentrism Scores and Social Stigma for Receiving Psychological Help Scores with regards to educational level, area of expertise and professional experience of the psychologists.

One-Way ANOVAs by Educational Level, Area of Work Expertise, and Years of Professional Experience to were computed to determine any significant differences between Attitude Toward Seeking Professional Psychological Help Scale scores, Africentrism scores and Social Stigma for Receiving Psychological Help scores. The results indicated that there were no significant differences between educational level on

the Attitudes Toward Seeking Professional Psychological Help Scale Scores $F(1, 87) = 0.36, p = 0.55$, Africentrism Scores $F(1, 87) = 0.44, p = 0.51$ and Social Stigma for Receiving Psychological Help Scores $F(1, 87) = 0.74, p = 0.79$.

Additionally, results indicated no significant differences between work expertise by the Attitudes Toward Seeking Professional Psychological Help Scale scores $F(2, 86) = 3.89, p = 0.24$, Africentrism scores $F(2, 86) = 1.72, p = 0.18$ and Social Stigma for Receiving Psychological Help scores $F(2, 86) = 2.44, p = 0.09$. There appeared to be a trend with regard to area of expertise. Psychologists whose area of expertise as administrators had more positive attitudes toward seeking professional psychological help ($M = 98.36, SD = 11.07$), than those whose area of expertise was psychotherapy ($M = 95.61, SD = 8.66$), or those with expertise in research ($M = 94.14, SD = 11.62$).

Finally, results indicated no significant differences between professional experience by the Attitudes Toward Seeking Professional Psychological Help Scale scores $F(2, 86) = 0.65, p = 0.53$, Africentrism scores $F(2, 86) = 1.31, p = 0.28$ and Social Stigma for Receiving Psychological Help scores $F(2, 86) = 0.11, p = 0.90$. On average, the findings indicated variation in educational and vocational backgrounds and did not suggest differences in attitudes toward psychological assistance or Africentrism.

Research Question 3

Are there significant gender differences among African American psychologists with regards to ATSPPHS scores, Africentrism scores and SSRPH scores?

The third research question asked whether there are gender differences with regards to Attitudes Toward Seeking Professional Psychological Help Scale Scores, Africentrism Scores and Social Stigma for Receiving Psychological Help Scores.

A One-Way Analysis of Variance was conducted to explore the impact of gender on Attitudes Toward Seeking Professional Psychological Help Scale Scores, Africentrism Scores and Social Stigma for Receiving Psychological Help Scores. The results show no significant differences regarding gender on Attitudes Toward Seeking Professional Psychological Help Scale scores $F(1, 87) = 0.39, p = 0.53$, Africentrism scores $F(1, 87) = 1.65, p = .20$ and Social Stigma for Receiving Psychological Help scores $F(1, 87) = 0.41, p = 0.52$. On average, the findings indicated attitudes toward psychological assistance and Africentrism were not impacted by gender.

Summary and Conclusion

Chapter four presented the demographic information of the participants along with statistical analyses. Significance was found for the first research question. Further interpretation of the research questions is discussed in Chapter V.

CHAPTER V

SUMMARY, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

Chapter 5 provides a summary of findings and serves as a context for the discussion of the results. It includes limitations of the study and possible future research of this topic area.

Summary of Findings

This study sought to determine the relationship of African American psychologists' attitudes toward seeking professional psychological help, Africentrism, and the perception of social stigma when receiving psychological help. This was explored among a sample of African American psychologists and mental health providers.

Research Question 1

Is there a relationship among Attitude Toward Seeking Professional Psychological Help Scale scores (ATSPPHS; Fischer & Turner, 1970), Africentrism Scale scores (AS; Grills & Longshore, 1996) and Social Stigma for Receiving Psychological Help scores (SSRPH; Komiya, et al, 2000) for African American psychologists?

There was a significant relationship among the scores on the Attitudes Toward Seeking Professional Psychological Help Scale, the Africentrism Scale and the Social Stigma for Receiving Help Scales. This suggests that of those who participated in the

study, the psychologists with more positive attitudes towards receiving professional psychological help and who indicated a strong identification with Africentric values were less likely to associate social stigma with psychological treatment. This finding is consistent with what Komiya, Good, and Sherrod (2000) found. They reported that college students with more positive attitudes towards receiving professional psychological help were less likely to associate social stigma with receiving psychological treatment. It is not surprising that those psychologists who have professional training in helping those with psychological and emotional distress, would have more positive attitudes towards receiving professional psychological help and attach less stigma to receiving psychological treatment.

In contrast, Wallace and Constantine (2005) found that African American college students who had a strong identification with Africentric values had more negative perceptions to receiving professional psychological treatment. Perhaps, the professional psychological training that the African American psychologists received negated any previously held negative perceptions of receiving professional psychological treatment. Also, many of the psychologists in this study were in private practice and it would be in their best interest to have a positive perception of the profession.

In general, the African American psychologists in this study may have more positive attitudes toward psychotherapy because of additional education and training; however, it is possible that their attitudes were positive before they had any additional education or training. This segment of the African American community may have held some positive, pre-existing attitudes before they enrolled in a psychology program. The reviewed research showed that African Americans' use of psychological services was

inconsistent; some African Americans underutilized psychological services, but others regularly utilized professional psychological help. It is possible that this segment of the population has had some prior experience and has confidence in the benefits of psychotherapy.

Research Question 2

Are there significant differences between African American psychologists ATSPPHS scores, AS scores and SSRPH scores with regards to educational level, work expertise and professional experience?

In the second research question, which posits whether the psychologists' educational level, area of work expertise, and years of professional experience demonstrated any significant differences between Attitude Toward Seeking Professional Psychological Help Scale Scores, Africentrism Scores and Social Stigma for Receiving Psychological Help Scores, there were no significant differences in the scores.

In terms of educational level of the psychologists, there were no significant differences in the scores of the ATSPPHS, AS, and SSRPH scales between those with a master's degree and those with a doctorate degree. It was hypothesized that higher educational levels would increase positive attitudes toward professional psychological help and reduce the stigma that may be associated with receiving psychological help. In fact, those holding master's degrees ($M = 97.36$, $SD = 9.46$) had higher mean scores than those holding doctorate degrees ($M = 95.46$, $SD = 9.90$).

It may be that the level of education is actually comparable between those with a doctorate degree and those with a master's degree, due to the salience of continuing education in the field. It is essential for those in the fields of psychology, and other

mental health professions, to maintain a certain level of competence and licensure. This competence allows them to provide quality services to clients. There are many opportunities as psychologists, whether doctorate level or master's level, to increase knowledge in specific areas of the field. It is also possible that clinical experiences contributed more to positive attitudes than education.

There were no significant differences in work expertise with regards to scores on the Attitudes Toward Seeking Professional Psychological Help Scale Scores, Africentrism Scores and Social Stigma for Receiving Psychological Help Scores. It is interesting to note that psychologists whose area of expertise was as an administrator had more positive attitudes toward seeking professional psychological help ($M = 98.36$, $SD = 11.07$), than those whose area of expertise was psychotherapy ($M = 95.61$, $SD = 8.66$), or those with expertise in research ($M = 94.14$, $SD = 11.62$). This may be due to the fact that administrators usually are in charge of departments or organizations that service those with mental and emotional disturbances. Many times they have had experience in direct-service related jobs or in private practices. Consequently, this may provide a more global view of larger systems that could also enhance their attitudes toward those seeking professional psychological help, since they may have more information about final outcomes.

Finally, with regard to years of experience there were no significant differences in the participants' scores on the Attitude Toward Seeking Professional Psychological Help Scale, Africentrism Scale and Social Stigma for Receiving Psychological Help Scale. However, there appeared to be a trend: as years of experience increased, stigma toward receiving psychological help decreased.

Research Question 3

Are there significant gender differences among African American psychologists with regards to ATSPPHS scores, Africentrism scores and SSRPH scores?

Although there were no significant differences between males and females with regards to Attitude Toward Seeking Professional Psychological Help Scale Scores, Africentrism Scores and Social Stigma for Receiving Psychological Help Scores, the data revealed that females scored higher on the ATSPPHS and SSRPH (see Table 4).

Table 4
Means and Standard Deviations Across Gender by Attitudes Toward Seeking Professional Psychological Help Scale Scores, Africentrism Scores and Social Stigma for Receiving Psychological Help Scores

Scale	<i>N</i>	<i>M</i>	<i>SD</i>
ATSPPHS			
Males	24	94.63	9.03
Females	65	96.09	10.09
AS			
Males	24	52.17	5.41
Females	65	50.69	4.57
SSRPH			
Males	24	9.08	2.04
Females	65	9.38	1.93

These findings support what Wallace and Constantine (2005) found regarding women having more positive attitudes toward seeking professional psychological help

than men and also that men scored higher on the Africentrism scale than women. The lack of a significant difference between the scores of men and women on the ATSPPHS may be attributable to the equal training that they received to become psychologists and the additional training that is always available, through continuing education courses, for those in the field of psychology.

However, the results of this dissertation research found that women reported more stigma associated with receiving psychological help. The results did not support the findings of Komiya, Good and Sherrod (2000). They reported that women, there was an association between less stigma and receiving psychological help. The results of this dissertation research, although not significant, may be the result of the small number of male participants in the study. It may also be the result of the education and training received by the participants.

In summary, it appears that the psychologists in this study had positive attitudes towards seeking professional psychological help and fewer stigmas about receiving psychological help regardless of educational level, work concentration or work experience. It also appears that men and women were comparable in their positive attitudes toward seeking professional psychological help and holding fewer stigmas about receiving psychological help. This could be considered a first step in helping to establish what makes professional African American psychologists' attitudes different from the African American community in general.

Limitations

The limitations of this dissertation research are divided into three categories: participants' traits, the online data collection format and the survey response procedures.

Many of the participants were members of the Association of Black Psychologists and faculty of Historically Black Colleges and Universities (HBCUs). The purpose of the Association of Black Psychologists is to help other African Americans maintain good psychological health. Historically, the mission of HBCUs has been predicated on assisting African American students to achieve the highest level of education in a culturally accommodating environment. It is possible that those who were association members and HBCU faculty and staff had stronger Africentric cultural views than those who were not members, especially considering their mission.

Another limitation is the need for social desirability among professionals. Siebert and Siebert (2007) indicated that professionals have an idealized image of themselves as professional caregivers. This idealized image is threatened when the professionals experience psychological and emotional issues. This may coincide with the fact that the participants may have discerned the true purpose of the research. Subsequently, they may have provided responses that were deemed appropriate, socially acceptable, or consistent with the focus of the study. A Social Desirability measure was not included in this dissertation's data collection.

Online data collections may make traditional mail surveys obsolete in the future. The usage of computer and internet links to participants appears to be more cost effective and more efficient. Kraut, Olson, Banaji, Bruckman, Cohen and Couper (2004) asserted that online data collection has revolutionized the field, in terms of attaining larger volumes of participants and expanding research limits. Yet, an online data collection procedure does not appear to be without its problems. Often, it does not take into consideration the ever changing advancements that the Internet encompasses. Online data

collection procedures also fail to incorporate individuals that are not computer savvy or email vigilant.

Consequently, one limitation of this research was that the online data collection did not allow access to those members who did not have email addresses or who were not on the professional organization listserv. Also, a large percentage of internet users frequently change their e-mail addresses or have many different email accounts. Some initial contacts made with participants identified for the study may have been thwarted, because of these conditions. As well, data collections conducted online have produced lower response rates, limiting this research by the unknown, unique characteristics of those who did respond.

Another limitation of this research, in terms of online data collection, was lack of familiarity. Some potential participants may have been skeptical of opening emailed surveys from those with whom they were not familiar. The online survey link may have mistakenly been filtered as SPAM or converted into a junk mail file. This could have drastically decreased the amount of sample participants and made these findings less generalizable.

This study may also have been limited by the timelines associated with this research. The participants were expected to complete the survey in a timely manner and be vigilant in responding to email. According to research, participants may respond in a lackadaisical or haphazard manner ignoring timelines and deadlines (Kraut et al., 2004). The participants might have looked at the invitation at an inconvenient time and forgotten to participate in the study later. This, along with the fact that it is impossible to determine if someone received and opened the invitation, makes sample selection and response rate

management difficult. A hard copy of the surveys mailed to the participants may have increased response rate.

Finally, an area to consider may have been the misinterpretation of instructions. The absence of a live investigator to clarify and explain proper procedures and terminology to the participants could have been problematic. Kraut et al. (2004) considered the absence of a proper debriefing being a concern with online surveys. They further suggested that participants could skip details making the study not as effective as one with an investigator present for verbal debriefing. Also, the fact that the terminology of the Attitude Toward Seeking Professional Psychological Help Scale may have been considered confusing or outdated. For example the instrument used the term psychiatrist instead of therapist or psychologist. Also, the instrument used the term “mental hospital.” This may have denoted what many considered the older hospitals as opposed to a hospital which had a section specifically for mental health consumers.

There also were instrumentation limitations. The assessments used were identified through the review of relevant literature. However, not all of the instruments were specifically designed to assess professional psychologists. Each assessment was used in previous research, but no reliability and validity analyses were available from a sample of all psychologists.

Future Research

This study sought to discover the attitudes that African American psychologists had towards psychotherapy. This dissertation research was based on a sample size of 89 participants. To increase the validity of the results, future research would need to be designed to include a larger sample. Future research should include all doctorate level

psychologists as well as diverse racial groups, diverse ethnic groups and regional locations to help improve generalizability.

Being able to identify those in the African American community with negative attitudes is also essential. Future research should explore, through qualitative techniques and focus groups, any counseling-related approaches and avoidance factors related to intended or actual psychological help-seeking behavior. It is hoped that additional resources and education could help those in the African American community shed negative attitudes toward professional psychological help. The more people understand about professional psychological help, the greater the possibility of decreasing the rate of those who suffer from emotional and psychological distress.

The results of the present study could be taken to the next level by adding a category for age to the demographics page. The present dissertation study was unable to discern any relationship with age. It was hypothesized that a younger generation might have a more positive attitude toward psychotherapy than older generations, considering the accessibility that younger generations have to psychotherapy. Twenty years ago, psychotherapy was less visible and there were less psychologists available. Currently, psychotherapy is more of the norm. This may have occurred as a result of things such as television shows, online counseling and public advertising. Adding an age category would help to highlight any age-related questions.

Finally, future research should seek to compare and understand any differences in attitude toward receiving psychological help that may exist between the general college population and psychology majors on the undergraduate and graduate level. Identifying factors may help to uncover reasons that student go on to become psychologist. In fact,

there may have been previous experiences with a loved one or personal experiences that give them positive attitudes towards therapy. Yet, on the other hand, there may also be negative experiences that automatically decrease attitudes toward psychotherapy.

Implications

In 2006, 314 African American students had doctorate degrees conferred on them by universities around the United States. There were also over 2,400 psychology master's degrees conferred on African Americans students by universities around the United States (U.S. Department of Education, 2006). Although this comprises less than 10% of doctorate and masters degrees, it is a substantial amount for the African American community, since it shows a trend of growth and positive implications for entering the field of psychology and mental health care. Colleges and universities will have to continue to develop culturally sensitive classes and programs that accommodate the needs of African American students and clients.

Changing the attitudes of potential African American clients is paramount in getting the community to accept proper mental health care. In order to increase positive attitudes toward psychotherapy, proper education of the benefits of receiving quality psychotherapy and the dissolution of barriers is necessary. Komiya, Good and Sherrod (2000) stated that the fear of experiencing painful emotions is one reason that people do not seek psychological services. A major barrier in the African American community is that a lot of emotional pain may exist which has not been dealt with adequately. The effects of slavery, Jim Crow law and on-going racism, and discrimination may make the task of educating the community about psychotherapy that much more daunting. Dealing with this type of pain may be unimaginable, but it could be at the root of high rates of

depression, schizophrenia, joblessness, relationship problems and excessive rates of incarceration in the African American community.

Another barrier is that existing stereotypes about psychotherapy are still entrenched in the African American community's experience. Many African Americans feel threatened with disclosing personal information about themselves and others. Values, such as communalism, collectivism, unity, and cooperation, are pertinent to African Americans (Karenga, 1988; Wallace & Constantine, 2005). This is where the educator's role could be taken to another level. Educators could take on the task of helping students to understand the psychological effects history and the implications for usage of psychological services. This would probably be most effective in a college setting. By educating African American students about ethical guidelines, patient confidentiality and entities such as the Institutional Review Board some of the apprehension and mistrust may be alleviated. Further education would also give African American students the knowledge that there have been changes to prevent the past wrong doings from ever happening again.

Conclusion

In order to be effective in providing clients with comprehensive services, it is paramount that everyone involved in the therapeutic process be on the same page. It is essential for any psychologist who is in a direct service role to maintain a positive outlook toward the benefits of psychotherapy. The purpose of this study was to understand how African American psychologist felt towards psychotherapy.

Overall, many of the participants in this study were very interested in the results of the study. Over twenty participants requested receiving the results by email. The

results may have been of interest to them, because of their dedication to the profession and to helping those with emotional and psychological disorders, specifically in the African American community. This sample was very proactive in assisting others with the psychotherapeutic process. They appeared to have a genuine belief that psychotherapy works. Eighty-four percent of the psychologists in this study currently refer others for professional psychological help. Ninety-five percent have referred others before in their professional career. This shows their high level of participation, engagement and belief in the psychotherapeutic process.

This study has shed light on foundational aspects of African American psychologists' attitudes. It appears that several variables, including education and training from the professional psychological community, may have had a positive effect on the African American psychologists' attitudes towards help-seeking behavior and psychotherapy. In addition, American culture may be much more accepting of psychotherapy due to the influx of pop culture's portrayals. Today, television shows like "Dr. Phil," "Intervention," and "Celebrity Rehab" have allowed the average individual to view a representation of the psychotherapeutic process. This familiarity can offer individuals a level of confidence in the process. It also allows individuals to see psychotherapy as a viable option when dealing with psychological or emotional problems.

In order to bridge the gap the African American community has with regards to attitudes toward psychotherapy and service usage, the African American psychologist will be instrumental. They have the unique position of being both an "insider" and "outsider" (Jordan, Bogat & Smith, 2001). Jordan, Bogat and Smith suggested that the

African American psychologist must first focus on the community's needs (high incarceration rates, single parent homes, teen pregnancy) and then involve the community in forums to address these needs. Feedback from the community is essential. Hopefully, psychologists will be able to build positive, culturally relevant collaborations in the community and will establish essential lifelong partnerships with important community entities such as the church, community centers and political leaders.

Finally, focusing on the next generation of African American psychologists is essential to expanding the positive attitudes of psychotherapy. This would make it possible to promote further learning within the person, organization, and the African American community over time.

The current generation needs to ensure that they contribute to training of students so that the next generation will have the skills and expertise required to conduct culturally relevant research and interventions in the African American community.

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APPENDICES

APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL




Cleveland State University

College of Graduate Studies and Research
Office of Sponsored Programs and Research
Institutional Review Board (IRB)

Memorandum

To: Sarah Toman
CASAL
RT 1357

From: Daniel P. O'Donnell 
Consultant for Compliance,
Institutional Review Board
Office of Sponsored Programs & Research

Date: 27 September 2007
Re: Results of IRB Review of your project number: 28004-TOM-HS
Co-Investigator: Ramone Ford
Entitled: African American psychologists' attitudes towards psychotherapy

The IRB has reviewed and approved your application for the above named project, under the category noted below. Approval for use of human subjects in this research is for one year from the approval date listed below. If your study extends beyond this approval period, please contact this office to initiate an annual review of the project. **This approval expires on 9/23/2008**

By accepting this decision, you agree to notify the IRB of: (1) any additions to or changes in procedures for your study that modify the subjects' risk in any way; and (2) any events that affect that safety or well-being of subjects.

Thank you for your efforts to maintain compliance with the federal regulations for the protection of human subjects.

Approval Category:

Date: 9/24/2007

- Exempt Status: Project is exempt from further review under 45 CFR 46.101
- Expedited Review: Project approved, Expedited Category (b) (2)
- Regular IRB Approval

cc: Project file

Mailing Address: 2121 Euclid Avenue, KB 1150 • Cleveland, Ohio 44115-2214
Campus Location: Keith Building, Room 1150 • 1621 Euclid Avenue • Cleveland, Ohio
(216) 687-3630 • Fax (216) 687-9382

APPENDIX B

FIRST INFORMED CONSENT FORM

To: [Email]

From: ramonem55@alltel.net

Subject: In search of African American psychologists

Body:

Informed Consent

Dear Dr.

My name is Ramone Ford. I am a doctoral candidate in the counseling psychology program at Cleveland State University. I am interested in studying African American psychologists' attitudes towards psychotherapy. At this point, I am very desperate for participants. If you know someone who is willing to fill out the survey please feel free to give me their email address.

Discovering the attitudes of African American professional psychologists in the field and their relationships with psychotherapy could have huge implications in affecting attitudes that the African American community has towards psychotherapy. Professional psychologists from the Association of Black Psychologists, independent licensed psychologists, and members of the department of psychology at Historically Black Colleges and Universities will serve as the participants in this study.

You are reading the invitational email and may choose to participate in the study by selecting or not selecting the link. If you choose to participate you will be given a demographic sheet along with three questionnaires that ask about your attitudes and how you feel about different situations. The questionnaires take about twenty minutes to complete. All surveys will be completed and maintained through Survey Monkey, an external website that will save the collected data and assure confidentiality. Survey Monkey is powerful online survey software designed to quickly and easily allow anyone to create professional surveys for use on the World Wide Web. The survey responses will be saved within Survey Monkey's database and can only be accessed by the researcher through a user name and password.

Benefits

The outcomes of this study will increase awareness among African American psychologists and the general public. It will also identify factors that may hinder one's decision toward seeking professional psychological assistance. Another benefit is that it adds theoretical contributions to the body of the multicultural counseling literature.

Risks

There are no known or anticipated physical or emotional risks associated with participation in this study.

"I understand that by selecting the following link:

<https://www.surveymonkey.com/s.aspx>

I am consenting to participation in this research. I understand that my participation in this study is completely voluntary and at any time I may choose to stop participation. If I have any questions I will contact Cleveland State University's Institutional Review Board at (216) 687-3630."

Thank you for your participation. If you would like results of the study please contact me or my advisor.

Ramone Ford, M.A.
Ph.D. Candidate
Cleveland State University
(216) 534-3822

Sarah Toman, Ph.D.
Dissertation Advisor
Cleveland State University
(216) 687-4615

If you choose not to participate select the following link:

<https://www.surveymonkey.com/optout.aspx>

APPENDIX C

SECOND INFORMED CONSENT FORM

Hi my name is Ramone Ford. I am currently a PhD. candidate at Cleveland State University. I am doing research on the attitudes of African American psychologists towards psychotherapy. Dr. NAME suggested that you may be interested in assisting me by completing three surveys. In total they take 10-15 minutes to complete. I am very close to obtaining the number of participants needed and would very graciously appreciate you taking the time to complete the surveys. I am sending the online link to the surveys:

https://www.surveymonkey.com/s.aspx?sm=u4LSfQVPTAE6_2bWDpilIF9g_3d_3d

By clicking on the above link you agree to participate in this study. Thank you for helping me to move forward towards my goal of finishing my dissertation. If you have questions would you please give me a call at 216-534-3822 or my dissertation advisor, Sarah Toman at 216-687-4615.

Thank you,

Ramone Ford

Cleveland State University

APPENDIX D

DEMOGRAPHIC INFORMATION FORM

The following questions are about mental health. Your participation is greatly appreciated Please answer the following questions. Answer each question as clearly as possible. All responses will be kept strictly confidential.

Demographic Information

1. Gender Male___ Female___
2. Ethnicity American Indian/Native American___ African American/Black___
Asian American/Pacific Islander___ Hispanic/Latino___
Multiracial___ European American___ Other___
3. Highest educational degree: Less than a bachelor degree___ Bachelor's Degree___
Master's degree___ Doctorate degree___ MD ___
Other Professional degree/Explain_____
4. What area of concentration is your degree? Counseling___ Psychology___
Education___ Medical___
Other/Explain_____
5. Are you a licensed mental health provider? Yes___ No___
6. If yes, what is your license title? _____
7. In your professional work what area of concentration do you spend most of your time?
Psychotherapy/Counseling___ Research___ Administration___
Other/Explain_____
8. How long have you worked in the field?
9. Which of the following effectively describes your profession?
Psychologist___ Counselor___ Mental health therapist___ Social Worker___
Case Manager___ Other/Explain_____
10. In your professional capacity do you refer others for mental health therapy/counseling?
Yes___ No___
11. In your personal life have you ever referred others for mental health therapy/counseling?
Yes___ No___

APPENDIX E

AFRICENTRISM SCALE

Please read each statement below and indicate whether you: Strongly Disagree (SD) =1, Disagree (D) = 2, Agree (A) = 2 or Strongly Agree (SA) = 1 by circling the appropriate number. Please express your opinion in rating the statements; there are no "right" or "wrong" answers.

	SD	D	A	SA
1. African Americans should make their community better than it was when they found it.	1	2	2	4
2. The problems of other African Americans are their problems not mine.	1	2	3	4
3. The unity of the African race is very important to me.	1	2	2	4
4. I am more concerned with my own goals than with helping other people reach theirs.	1	2	2	4
5. I have very little faith in African American people.	1	2	2	4
6. I owe something to African Americans who suffered before me.	1	2	2	4
7. African Americans need to stop worrying so much about the world around them and take care of their own needs.	1	2	2	4
8. I am doing a lot to improve my neighborhood.	1	2	2	4
9. The success I have had is mainly because of me, not anyone else.	1	2	2	4
10. I have more confidence in White professionals, like doctors and teachers, than in African American professionals.	1	2	2	4
11. African Americans should build and maintain their own communities.	1	2	2	4
12. I must do all I can to restore African American to their position of respect in the world.	1	2	2	4
12. I make it a point to shop at African American business and use African American-owned services.	1	2	2	4
14. It hurts me when I see another African American person discriminated against.	1	2	2	4
15. It is important that African American people decide for themselves what to be called and what their needs are.	1	2	2	4

APPENDIX F

ATTITUDE TOWARD SEEKING PROFESSIONAL

PSYCHOLOGICAL HELP SCALE

Please read each statement below and indicate whether you Disagree (D) = 0, Partly Disagree (PD) = 1, Partly Agree (PA) = 2 or Agree (A) = 3 by circling the appropriate number. Please express your opinion in rating the statements; there are no "right" or "wrong" answers.

	D	PD	PA	A
1. Although there are clinics for people with mental troubles, I would not have much faith in them.	0	1	2	3
2. If a good friend asked my advice about a mental problem, I might recommend that he/she see a psychiatrist.	0	1	2	3
3. I would feel uneasy going to a psychiatrist because of what some people would think.	0	1	2	3
4. A person with a strong character can get over mental conflicts by him or herself, and would have little need of a psychiatrist.	0	1	2	3
5. There are times when I have felt completely lost, and would have.	0	1	2	3
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	0	1	2	3
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	0	1	2	3
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.	0	1	2	3
9. Emotional difficulties, like many things, tend to work out by themselves.	0	1	2	3
10. There are certain problems which should not be discussed outside of one's family	0	1	2	3
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.	0	1	2	3
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3

13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	0	1	2	3
14. Having been a psychiatric patient is a blot on a person's life	0	1	2	3
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.	0	1	2	3
16. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.	0	1	2	3
17. I resent a person- personally trained or not- who wants to know about my personal difficulties.	0	1	2	3
18. I would want to get psychological help if I were worried or upset for a long period of time.	0	1	2	3
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	0	1	2	3
20. Having been mentally ill carries with it a burden of shame.	0	1	2	3
21. There are experiences in my life that I would not discuss with anyone	0	1	2	3
22. It is probably best not to know everything about one's self	0	1	2	3
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3
24. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	0	1	2	3
25. I might want to have psychological counseling in the future.	0	1	2	3
26. A person should work out his or her own problems; getting psychological counseling would be a last resort.	0	1	2	3
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."	0	1	2	3
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.	0	1	2	3
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and, clergymen.	0	1	2	3

APPENDIX G

STIGMA SCALE FOR RECEIVING PSYCHOLOGICAL HELP

Stigma Scale for Receiving Psychological Help

Please read each statement below and indicate whether you Strongly Disagree (SD) = 0, Disagree (D) = 1, Agree (A) = 2 or Strongly Agree (SA) = 2 by circling the appropriate number. Please express your opinion in rating the statements; there are no "right" or "wrong" answers.

	SD	D	A	SA
1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.	0	1	2	2
2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.	0	1	2	2
2. People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.	0	1	2	2
4. It is advisable for a person to hide from people that he or she has seen a psychologist.	0	1	2	2
5. People tend to like less those who are receiving professional psychological help.	0	1	2	2

APPENDIX H

PERMISSION FROM DR. GOOD AND DR. NOBORU TO USE SSRPH

From: "Good, Glenn E." <GoodG@missouri.edu>

Date: 2007/07/24 Tue PM 10:42:13 EDT

To: <ramonem55@windstream.net>

CC: "???(noboru)" <noboru@osaka-ue.ac.jp>

Ramone:

I have attached the scale and you may use it. I have also cc'd Dr. Noboru Komiya, the primary author.

-Glenn

Glenn E. Good, Ph.D.

(573) 882-3084

GoodG@missouri.edu

Confidentiality Notice: Email is not a secure form of communication;
confidentiality cannot be guaranteed.

From:???(noboru) <noboru@osaka-ue.ac.jp>

Date: 2007/07/25 Wed AM 05:31:26 EDT

To:Ramonem55@windstream.net>

CC:<GoodG@missouri.edu>

Subject:Feel free to use the scale.

Ramone,

I wish you good luck with dissertation, from a far place on the globe!

Noboru Komiya, PhD
Associate Professor
Osaka Economics University
Osaka, Japan.

APPENDIX I

PERMISSION FROM DR. GRILLS TO USE THE AS

To:<ramonem55@windstream.net>

From:"Grills, Dr. Cheryl" <cgrills@lmu.edu>

Date:2007/07/11 Wed PM 03:54:56 EDT

Subject:RE: Ramone Ford's Africentric Scale Usage

Hello Ramone:

Please consider this as your formal approval to use our scale. I look forward to hearing the results of your study.

Take care.

Cheryl

Dr. Cheryl Grills
Professor and Chair
Loyola Marymount University
Psychology Dept.
1 LMU Drive
Los Angeles, CA 90045
1-310-338-3016