EXAMINING THE INFLUENCE OF RELIGIOUS ATTITUDES, ACCEPTANCE OF CHANGE, AND CULTURAL MISTRUST ON THE UTILIZATION OF THERAPY FOR AFRICAN AMERICAN MALE COLLEGE STUDENTS UTILIZING THERAPY

by

Jessica Shine

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University

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ABSTRACT

Cultural mistrust and fear of potential racism from people in the medical profession may be contributing to a noted disdain for mental health counseling among African American men. The purpose of this study was designed to gain insight into how attitudes toward religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma impact therapy utilization among African American male college students. The review of literature explored the theoretical frameworks followed by the historical perspective, epigenetics, family structure, masculinity concept and help-seeking behaviors, noting barriers, fear, stigmas, spiritual influence, and economic hardships. Acceptance of change-evolving action is not currently endorsed by male African American college students. This appears to be due to attitudes, cultural competence, mistrust, risks, and misunderstanding of potential benefits to therapy utilization.

The information examined in the literature review provided a foundational framework for understanding the impact of barriers on African American male college students regarding utilization of therapy. Although there have been awareness efforts, prompted by the federal government and the counseling community, the problem of underutilization continues. A quantitative correlational study was conducted to explore if religious help seeking, acceptance of change, cultural mistrust and mental health stigma have a connection to decreased therapy utilization. The study significance focuses on minimizing barriers to therapy utilization while increasing understanding concerning the benefits of its use. The significance of the study is designed to influence health care outcomes and disparities. The methods and procedures used in this research are presented in eight sections: (a) overview, (b) design, (c) research questions, (d) hypotheses, (e) participants, (f) instrument, (g) data collection, and (h) summary.

Keywords: African American male, college, stigma, students, therapy, utilization
Dedication

God has been with me throughout this journey and prepared me through some personal situations for some of the bumps and bruises I needed to be able to endure to ensure I possessed the mental strength to be successful. God not only carried me through this journey, but God also handpicked and placed some amazing people around me to hold me up and guide me along the way. Before this journey began, I had some angels God blessed me with before I knew I existed. To those angels I dedicate my study to you. Those angels were all my grandparents.

Blanche “Momma” and James Jones “Buck”, although you could not finish this journey with me the seeds you planted long ago were not void. Thank you! Thank you, for reaching back and raising up a little girl who loved and cherished you both dearly. Thank you for loving me unconditionally until the day you both passed. I know you are with me each day and I dedicate this success to you both. My other angels are James and Bertha Hill. I am so grateful that God has kept you here to experience this journey firsthand and see your grandchild accomplishing her goals and dreams. I’ve worked so hard to make you all proud and I can never repay either of you for the unconditional love you’ve given me my entire life or for the many things you’ve done for me. I pray my Thank you, love and support are enough. You too, reached back to help raise a little girl that needed each and every one of you.

To my boys Kingsley and DJ, I love you and thank you for your support in being quiet and understanding when I would have to miss important events or couldn’t be disturbed because I was so focused on writing. I recognize that you boys had to sacrifice certain things as well having a mom in school and for that I thank you. Boys, I hope you also know that in life I’ve tried to work hard to make you boys proud and to display what hard work, sacrifice and
dedication looks like. In this world boys you can be absolutely anything if you want it and work hard enough.

Thank you to my loving husband Darrin Shine. Thank you for being supportive no matter where you were needed. If the support meant me having the house completely to myself to work or debrief it was done, if I needed a praying partner, you were there, if the day and a comment from a professor got the best of me you responded with love and support. Thank you for believing your wife can do anything, you never doubted my abilities to get this done and never let me attempt to give up. Thank you for being the amazing husband you are, I’m so grateful for your love and support.

Finally, this study is dedicated to all the African American men who have experienced adverse treatment, needed the help, wanted the help but don’t understand the true value in their mental health in our community. I will never stop working to help you seek help and understand that you are the foundation of our community. You have people fighting for you, we are standing with you, and we care.
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Acceptance of Change Scale (ACS)
Cardiovascular Disease (CVD)
Flourishing Scale (FS)
Group-Based Medical Mistrust Scale (GBMMS)
Posttraumatic Stress Disorder (PTSD)
Statistical Package for the Social Sciences (SPSS)
CHAPTER ONE: INTRODUCTION

Overview

Underutilization of mental health counseling is a noted problem for African American men, per the 2003-2005 effort of the National Institutes of Health, “Real Men: Real Depression” awareness campaign (Hankerson, Suite & Bailey, 2015). Depressed African American men continue to underutilize mental health treatment and have the highest all-cause mortality rates of any racial/ethnic group in the United States (Hankerson, Suite & Bailey, 2015). Suspected causation is linked to suicide and behavior disregarding self, such as risky activities, poor diet and the impact of stress and depression.

An African American male in the United States is born into a society of injustice, devaluation, and mistreatment (Taylor et al., 2019). African Americans have consistently experienced dehumanization, as demonstrated by the US Constitution previously considering slaves three-fifths a person, lynching, Jim Crow Laws, and through alleged recent displays of police brutality against unarmed African American males (Taylor et al., 2019). There is a historical tolerance of the inequities that African American males continue to face (Taylor et al., 2019).

African Americans have been terrorized and murdered since the 1600s, when more than 12 million Africans were kidnapped, chained, and brought to America. The global impact carries forward to the present day, more than a century and a half after slavery's abolition (Schroeder et al., 2015; Heilbron, 2020). This brings up research of epigenetics, the study of leftover DNA markers in the descendants of abused people, amplified over time, as trauma continues or increases.
DNA inheritance of trauma markers may contribute to a sense of hopelessness and diminished value, as African Americans have been suffering at disproportionate rates since slavery. (Bridges, 2010; Taylor, 2019).

Understanding the factors and historical trauma experienced among African Americans may contribute to the mistrust this group holds regarding help-seeking activity, which is also strongly associated with the historical context of other cultural groups. First Nations People in countries like the United States, Canada, South Africa, Australia, and New Zealand battle with widespread mental health issues that can be closely related to histories of deprivation, oppression, and intergenerational trauma. (Bessarab, 2013; Williams et al., 2007).

Research is being conducted on a multinational level to determine the impact of trauma and hunger on current anxiety issues of today’s Irish descendants, due to indentured servitude in the 1800’s and the possible initial trauma of famine from the potato blight of 1845-1852. There is belief that trauma experienced by ancestors relates to stress and anxiety, today (Schiele, Gottschalk & Domschke, 2020). Given the severity of oppression upon African Americans, it can be correlated that stress and anxiety disorders could likely be amplified for African Americans in modern society.

The experiences of historical and generational trauma potentially lead to mistrust and reduced utilization of mental health services. Research the United States, involving the African American community, leads to mistrust of therapists and mental health professionals as an assumed product of historical oppression and current issues of racism and discrimination (USDHHS, 2001). An acknowledged example or recent trauma is the Tuskegee Study of Untreated Syphilis in the Negro Male, an ethically abusive study conducted between 1932 and
1972 by the United States Public Health Service and the Centers for Disease Control and Prevention. The purpose of this study was to observe the natural history of untreated syphilis but there was no direct or suspected correlation or causation between race and Syphilis. (Friemuth, et al., 2001)

Since 1972 and recent understanding of trauma’s impact upon African American men, research concerning mental illness has increased. However, the number of researchers addressing gender and age differences in beliefs, attitudes, and coping has been limited. Previous research has also failed to include within-group diversity as this has proven to have critical consequences understanding prevalence, treatment-seeking behaviors, and a need for gender and age-specific treatment and outreach (Ward et al., 2013).

This study addressed the current research gap regarding why African American males are not seeking treatment by examining African American male college students' beliefs about mental illness and attitudes regarding the seeking of mental health services.

Chapter one emphasizes the necessity for further investigation into the selected topic and a rationale for exploration, which includes developing scientific knowledge on the matter. This chapter also summarizes the background of this study and findings from previously conducted studies on African American males and perceptions regarding mental health service utilization. Chapter one further identifies a well-defined problem statement and a discussion regarding the true purpose of this study. The research questions included in this chapter were developed to help guide the study and the study's significance. Key terms and definitions have been provided along with the chapter concluding with a summary.
Background

Historical trauma continues to have a long-term effect on the African American community, specifically when considering the lengthy and complicated history of slavery, in addition to the continual invalidation of African Americans (Sarche et al., 2011). Research shows that race-based discrimination is detrimental to the mental and physical health of African Americans. Historical trauma is defined as the "cumulative emotional and psychological wounding over a lifespan and across generations, emanating from massive group experiences" (Williams-Washington & Mills, 2018). Blades (2016) titled a magazine article "Trauma from Slavery Can Actually Be Passed Down Through Your Genes: You Can Get PTSD From Your Ancestors" (Blades, 2016).

The result of inherited trauma may include elevated rates of alcoholism, domestic and child abuse, increased mood and trauma-related disorders, and numerous physiological and psychological issues. There is evidence that reveals that African Americans are much more likely to be diagnosed with a schizophrenia-spectrum diagnosis when compared to White individuals, who are more likely than African Americans to receive an affective diagnosis (e.g., bipolar disorder, major depressive disorder) (Strakowski et al., 1996; Schwartz et al., 2019). Minsky and colleagues (2003) conducted a study on the diagnostic patterns in Latino, African American, and European American Psychiatric Patients consisting of a sample size of 19,213 patients (Minsky et al., 2003). The study findings yielded results suggesting that African Americans were more likely to be diagnosed with schizophrenia when compared with both Latino and White individuals (odds ratio, 1.80; 95% confidence interval, 1.62-2.00) (Minsky et al., 2003). Additionally, the misdiagnosis effect is not limited to the United States but has also been shown in African-Caribbean individuals in England (Bhugra & Bhui, 2001; Sharpley et al., 2001) and in
patient samples in Canada, Netherlands, Portugal, and Sweden (Schwartz, 2014). This may be an indication that diagnostics are taken to the most hopeless of cases when African Americans are involved.

Epigenetics has been explained as how the environment "gets under the skin," facilitating or suppressing the expression of genes, which are themselves fixed and immutable (McEwen, 2012). Hampton and colleagues (2010) cited a specific definition as it relates to African American historical trauma, which is "the collective spiritual, psychological, emotional, and cognitive distress perpetuated intergenerationally deriving from multiple denigrating experiences originating with slavery and continuing with pattern forms of racism and discrimination to the present day" (Williams-Washington & Mills, 2018).

Although previous research focusing on Holocaust survivors indicated that later generations of groups with evidence of historical trauma are at a greater risk of developing mental health symptoms, the term is also applied to numerous ethnic groups throughout the world. Included in those groups that share a history of oppression, victimization, or substantial group trauma exposure are African Americans, Armenian refugees, Japanese American survivors of internment camps, and various cultural groups and communities that share a history of oppression, victimization, or massive group trauma exposure (Mohatt et al., 2014).

Because of mistrust of the secular medical community, the correlation between mental health and religiosity is particularly relevant for African Americans, the racial/ethnic group with the highest rates of church attendance among all racial/ethnic groups in the United States (Taylor et al., 2007). Lukachko and colleagues (2015) conducted a study using data retrieved from the National Survey of American Life (NSAL), analyses from the previous data consisting of 6,082 samples were restricted to the subsample of 3,570 African Americans. Data collection occurred
for two years, consisting of mostly women participants (56%), with an African American participant average age of 42 years possessing high school education or less (Lukachko et al., 2015). Research findings provided insight into how various religiosity measures impact mental health services utilization among African Americans (Chatters et al., 1992). The study reflected those African American adults who reported high levels of organizational and subjective religiosity were less likely than those with lower religiosity levels to utilize professional mental health assistance (Lukachko et al., 2015). Compared with other population’s high religiosity, Blacks have been significantly more representative in organized religion than White Americans (Brown 2006; Krause 2003), although perceptions of control have been substantially stronger among whites (Oates 2004) (explain this area of the writing. I don’t understand). To African Americans, religion is a coping mechanism (Oates & Goode, 2013).

The challenge of being African American compounds the issue of male distaste for counseling. Sharpe and Arnold (1998) conducted a quantitative study, based in the U.K., exploring male gender-specific help-seeking behavior. The study consisted of 760 men yielding results demonstrating that men consistently disregarded health symptoms and avoided seeking help (Galdas et al., 2005). Societal masculinity norms contribute to men's under-utilization of health care. Obtaining mental health treatment is viewed by many men, particularly African Americans, as incongruent with traditional gender norms and cultural norms. Stigma is a very real issue (Ward & Besson, 2013).

Men with mental health issues are more likely to abuse substances; engage in risky behavior; and exhibit mostly negative behavior that can affect themselves and those in their communities (Wendt & Shafer, 2015). It was noted in severe cases; untreated mental health problems can have disastrous results for men, who are four times more likely to commit suicide than women (Addis
Men are frequently pressured to follow socially created masculine standards that value emotional silence, self-reliance, autonomy, and dismissal of personal weakness. These beliefs regularly minimize the value of seeking professional service for one's issues (Wendt & Shafer, 2015). Historically, studies suggest that African Americans combat multifaceted systems of prejudiced and unproductive mental health care experiences even though African Americans have lower mental illness rates than other ethnic groups (McGuire & Miranda, 2008).

Hughes & Thomas (1998) noted that African Americans are more apt to report lower measures of psychological well-being when compared to whites on cognitive assessments and higher levels of flourishing when assessing overall life satisfaction and happiness (Keyes, 2007). The term flourishing refers to high measures of mental well-being and the absence of mental illness (Williams, 2018). The prevalence of chronic stressors such as poverty exposure, neighborhood violence, and discrimination among the minority population could lead some minorities to experience increased breakdowns and increased exposure to health issues (Williams, 2018).

One study involved racial and ethnic differences regarding mental health problems and use of mental health care. It included 134,875 adults classified as white, African American, American Indian/Alaskan Native, Asian, Mexican, Central and South American, Puerto Rican, other Hispanic-Latino, or those with multiple races and ethnicities (Harris et al., 2005). Among each group, there was an estimation of a past year probability of the following categories: (1) having one or more mental health symptoms in the past year, (2) having a severe mental illness in the past year, (3) using mental health care, (4) using mental health care conditional on having mental health problems, (5) reporting an unmet need for mental health care, and (6) reporting an unmet need for mental health care conditional on having mental health problems (Harris et al.,
Findings from the study revealed significantly higher rates of mental health problems and higher self-reported unmet need when compared to whites among American Indian/Alaskan Natives and lower rates of mental health problems and mental health care use among African American, Asian, Mexican, Central and South American, and other Hispanic-Latino groups (Harris et al., 2005). Additionally, African Americans, Asians, Mexicans, and Central or South Americans had significantly (P < 0.05) lower rates of at least one mental health symptom and severe mental illness when compared with whites (Harris et al., 2005).

The research indicates that African American mental illness is more severe and persistent due to inadequate access and treatment, when it is revealed. Treatment access barriers continue to impact this population along with the fears and struggles they face in maintaining effective care while active in treatment (Kawaii-Bogue et al., 2017).

**Problem Statement**

Indications are that African American males continue to underutilize therapy. Killen (2012) conducted a study on African American Men's perception of psychotherapy at a Mental Illness & Chemical Dependency Program, targeting factors men considered therapeutic and or helpful. The study yielded results suggesting that, in ideal circumstances, African American men accept assistance solving their issues through psychotherapy and reported benefit from its use (Killen, 2012). The barriers such as fear, stigmas, shame, access, and cultural mistrust continue to impact African American communities and future generations from utilizing the services needed for mental health. The participants of this study were cooperative and had previously established mental health service treatment within their treatment facility; however, it is unknown if the participants were required to participate in counseling sessions as a condition of admittance and continued treatment (Killen, 2012)
The study participants expressed that psychotherapy helped them solve their problems and incorporated psychotherapy as a tool for coping (Killen, 2012) despite the stigma and shame associated with mental health within the African American community (Sanders Thompson et al., 2004). In addition, African American men perceived psychotherapy as an empowering tool to help them deal with their anger, mental health, addictions, and relationship issues (Killen, 2012).

An important consideration when working to understand the unique mental health needs of ethnic groups, particularly African Americans, is recognizing group differences in respect to mental health service accessibility. A commonly reported and significant barrier to accessing mental health services for African Americans is mental illness stigma (Kawai-Bogue et al., 2017).

Research and previous studies suggest that neighborhood stigma also influences help seeking behaviors. Townley and colleagues conducted a study to assess urban and non-urban differences in community participation, sense of community, mental health stigma, and perceptions of the neighborhood environment among persons with serious mental disorder living independently throughout the United States (Townley et al., 2017). The study consisted of 300 participants in 15 states with serious mental illnesses recruited from 21 outpatient mental health service organizations. The study participants conducted a phone survey concerning their community living and participation. Urbanicity was examined at two spatial scales (block group and county), and independent-samples t-tests were used to evaluate urban and non-urban differences in community living and participation variables. The Urbanicity block group reported higher levels of community participation when compared to individuals in non-urban block groups. Sense of community was also higher in urban counties while perceptions of mental health stigma were higher in non-urban counties (Townley et al., 2017). These findings are likely
attributed to the urban setting which allows community members to live in a setting which provides greater access to stores, and services, as well as greater access to resources such as transportation and walkable roads (Townley et al., 2017).

African Americans experiencing perceived stigma associated with their mental illness frequently prevents help-seeking in professional settings or confiding in others about symptomatology (Johnson et al., 2009). Castle et al. (2011) detailed how manhood in African American men is defined. These defining factors include but are not limited to factors such as family, community, media influences, and general societal expectations, each having differing requirements (Castle et al., 2011). These expectations can substantially influence the mental wellbeing of African American men as they try to negotiate and meet these different beliefs (Castle et al., 2011).

An additional factor that influences the health of African Americans is “John Henryism” which is a metaphor for the struggle of African Americans in society. James (1994) indicated that "John Henryism" is a “strong behavioral predisposition to cope actively with psychosocial environmental stressors interacting with low socio-economic status to influence the health of African Americans”. John Henry was a man well-known for his strength and perseverance in his work against a machine (Williams, 1983, as cited in Plowden et al., 2016). John Henry's perseverance in his daily struggles allowed him small success, but he died shortly after succumbing to physical and mental exhaustion caused by stress. John Henryism is a common thread among African American men who persevere through life stressors such as discrimination and systematic barriers that disproportionately impact mental health in the African American community. John Henry's prolonged struggle of coping with life stressors contributed to his
death. Early mortality in African American men is often correlated with fatigue from chronic life stressors in the African American community.

Plowden et al. (2016) indicated that this phenomenon assumes that persons, especially those from lower socioeconomic status, are exposed to unique environmental stressors requiring great coping strength. These individuals will struggle until they are exhausted, making them susceptible to many other conditions often present in the African American community, such as depression and heart disease. In addition to the susceptibility of mental health and physical health conditions, there lies the outcome of death (Plowden et al., 2016).

Studies have shown that stress has an effect on the body (Yaribeygi et al., 2017). Stress to the nervous system may cause structural changes in different parts of the brain (Lupien et al., 2009) and can lead to atrophy of the brain mass, along with structural brain changes causing issues with cognition, including memory, learning and decision making (Yaribeygi et al., 2017).

Li and colleagues (2008) expressed that exposure to stress can cause pathophysiologic alterations in the brain, and these alterations can be exhibited as behavioral, cognitive, and mood disorders (Li et al., 2008). Stress can also impact the function of the immune system by impairing immune functioning, the cardiovascular system from increased heart rate, hypertension, heart attack, or stroke, endocrine system via increased production of the stress hormone Cortisol and gastrointestinal system from appetite suppression, inflammation, pain, and bloating (Yaribeygi et al., 2017).

African American men continue to have the highest mortality rate among all racial/ethnic and gender groups in the United States (National Center for Health Statistics, 2004, 2008, 2009). In 1960, comparative ratios in age-specific mortality increased from birth to age 40, with Black male mortality rates from 40% to 230% higher than White male mortality rates. In
contrast, Blacks have a lower mortality rate of 10%, if they make it to age 85 (Bond & Herman, 2016). In 2013, comparative ratios remained somewhat constant from birth to age 70, with Black male mortality rates about 40% higher than White male mortality rates. The rate was even at age 85 (Bond & Herman, 2016).

The improvement in life expectancy in the first half of the 20th century is mostly attributed to the reduction in infant and childhood mortality and reductions in deaths from severe infectious diseases (Bond & Herman, 2016). Several predictors of mortality among African American men include but are not limited to low socioeconomic status, access to care, quality of care, health behaviors, and social and environmental conditions, all contributing to higher mortality in African American Men (Thorpe et al., 2013).

**Purpose Statement**

The purpose of this quantitative correlational study was to explore how attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma correlated with decreased therapy utilization among African American male college students. An insufficient amount of data is available on African American male college students’ behaviors on therapy utilization and the influence of cultural factors, such as cultural mistrust, help-seeking intentions, and actual help-seeking behaviors (Mesidor & Sly, 2014). This study attempted to understand how factors including cultural mistrust, masculinity and help-seeking behaviors, and stigma contribute to the narratives of African American males, as it relates to mental health and mental health utilization.

Previously conducted research has examined and concluded that, among African American men, mental health stigma continues to serve as a chief influence that discourages
them from seeking therapy (Murry et al., 2011). This study examined explanations, according to African American male college students within the United States at a minimum age of 18 years.

The participants that contributed to this study either possessed a history of mental health-related services, mental health services with early termination, or had no history of mental health services. For background information, Mereish et al. (2016) conducted a study providing results exhibiting positive connections between everyday discrimination and inadequate self-esteem as contributors to depression in African American men.

African American men also remain unaware of their value and positions they hold within their communities. Wendt and Shafer (2015) believed that their study emphasized the necessity of open dialogue about mental health, help-seeking, and masculinity as a need in these communities. Men have many opportunities to converse with others, such as coworkers, friends, family members, neighbors, and others, within their social proximity, daily. The opportunities to connect allow men to have meaningful influences upon others about their mental health or mental health services. Men's reluctance to seek help remains a severe public health concern (Wendt & Shafer, 2015). It appears those who can truly use help are hesitant because of presumed vulnerability and stigma.

**Significance of the Study**

The study aimed to minimize barriers to therapy utilization while increasing knowledge about the benefits of its use, which influences health care outcomes and disparities. Therapy utilization has overwhelming benefits that improve overall life quality (Connell et al., 2014). Those benefits include, but are not limited to, the ability to develop and maintain healthy relationships, diminishing the prospect of drug addiction, better performance at school or work, improved concentration, enhanced creativity, reduced absenteeism, increased productivity, and
better overall performance. Furthermore, mental health treatment can decrease the risk and need for medical services since research confirms that untreated mental illness contributes to physical problems such as heart disease, ulcers, and suppression of the immune system (Ormel et al., 2008).

Galdas and colleagues (2005) conducted a study in which a review of gender-specific research revealed potential factors influencing help-seeking behavior in men, which supported the belief that males delay help-seeking. Various research studies favor the concepts of “traditional masculinity” and “masculinity beliefs” as significant variables that influence help-seeking behavior and appraisal of men's health risk when they become ill (Galdas et al., 2005). Such theories argue that men are not allowed to be expressive in their illness behavior due to traditional masculinity views, social conformity when a male role does not permit signs of weakness (Möller-Leimkühler, 2002). Overall, the stigma of mental illness and mental health treatment remains a barrier that could be addressed, as this continues to hinder those needing services. Previous efforts to minimize stigma have been employed, with one effort including an educational approach to challenging stigma. This approach addresses inaccurate stereotypes about mental illnesses by replacing them with truthful information.

Educational strategies include public service announcements, books, flyers, movies, videos, web pages, podcasts, virtual reality, and other audiovisual aids, which result in stigma change (Corrigan et al., 2012). Programs within public schools in earlier grades may also be beneficial.

Accessing mental health services through a therapist or counselor poses a barrier. Speaking with a mental health professional is culturally contradictory in the African American
community, given the dependence on kinship networks, religious commitment, and in-group support (SAMHSA, 2014).

Research continues to show a growing need for more mental health promotional strategies that effectively engage men. While researchers have studied the effectiveness of various mental wellness interventions in male-dominated industries and examined suicide prevention, early intervention, and health promotion interventions for males, few studies have concentrated on sex-specific program outcomes (Seaton et al., 2017). This study's conclusions may influence the delivery of mental health services to African American males and promote a better understanding of influences on their decisions regarding accessing and utilizing therapy. Several

African American celebrities are working to change the narrative and stigma surrounding mental health in the African American community. Charlamagne Tha God (real name Lenard McKelvey) is an African American male and co-host of the American syndicated radio show The Breakfast Club and best-selling author of Shook Ones: Anxiety Playing Tricks On Me (Charlamagne Tha God, 2018). He advocates for mental health utilization and often shares his struggles with mental health. He often discusses experiences with anxiety, panic attacks, negative thoughts, and advocates for therapy by expressing how therapy was life-changing in identifying what he was experiencing with anxiety, becoming more empathetic, and a better listener.

Another celebrity advocate for mental health, specifically in the African American community, is Taraji P. Henson. She is a Golden Globe and Academy Award-winning actress that has openly spoken about her struggles with depression since she was very young (Grant, 2019). As a young child, she suffered from experiencing her father's struggles as a Vietnam
veteran with severe mental health issues and attempts of suicide. He failed to seek treatment (Goldman, 2018).

Henson was able to see the benefits of therapy for her father and herself before he passed. After her father married her stepmother, he sought treatment and was diagnosed correctly with bipolar disorder and treated (Goldman, 2018). Henson also expresses that she suffers from anxiety, in addition to depression, and sees her therapist twice a week because it helps her cope (Goldman, 2018). In 2018 she launched the Boris Lawrence Henson Foundation in memory of her late father (Goldman, 2018).

Research Questions

**RQ1:** Does attitude towards religious help-seeking impact the utilization of therapy among African American male college students?

**RQ2:** Does acceptance of change have a statistically significant impact on the utilization of therapy for African American male college students?

**RQ3:** Do the cultural mistrust and the mental health stigma of African American male college students contribute to the willingness or lack of utilization among African American male college students?

Definitions

The following terms associated with the literature and research throughout the dissertation are defined:

*Afrocentric* - centered on or derived from Africa or the Africans, emphasizing or promoting an emphasis on African culture and Africans’ contributions to the development of Western civilization (Merriam-Webster, n.d.)
Cultural Mistrust - belief acquired by African Americans due to past and ongoing mistreatment related to being a member of that ethnic group that Whites cannot be trusted (Terrell et al., 2009).

Help-seeking behaviors - an individual's active effort to ask for help from other people in terms of information, treatment, or advice (Mohammad-Alizadeh Charandabi et al., 2015).

Mental health - includes promotion of well-being, prevention of mental suffering and disorders, the treatment of mental disorders, and management of a disability (Falissard et al., 2017).

Mental health disparity - when mental health care needs of an ethnic group are met to a lesser degree of another ethnic group (Kawaii-Bogue et al., 2017).

Self-stigma - the process in which a person with a mental health diagnosis becomes aware of public stigma, agrees with those stereotypes and internalizes them by applying them to the self (Corrigan et al., 2012).

Stigma - an attribute that is deeply discrediting that reduces someone from a whole and usual person to a tainted, discounted one (Ahmedani, 2011).

Summary

Research demonstrates that African American men continue to be an underrepresented population regarding mental health treatment and utilization compared to other racial groups (Plowden et al., 2016). Even with the extensive literature on mental health services, there is still much-needed research concerning strategies that reduce mental health stigma and how this affects male's mental health and their community (Wendt & Shafer, 2016). The literature examination indicates that, historically, the African American community has been found to underutilize professional mental health services. Religion plays a significant role in their lives. In
the African American community, religion has been considered an essential source of strength, perseverance, and influence for this group in the face of adversity and unnecessary treatment (Nguyen, 2020).

Religion and religious connections are deeply rooted in this African American identity, culture, and community life (Nguyen, 2020). According to the Pew Research Center (2015), 79% of Black Americans identify as Christian, and an additional 3% identify with other non-Christian beliefs. Nguyen and colleagues conducted a study using data from 1,271 African American men from the National Survey of American Life to test whether church-based social support safeguards the negative impacts of discrimination on severe psychological distress (SPD) among three age groups of African American men: early, middle, and late adulthood. The data reflected that the positive relationship between discrimination and severe psychological distress was more pronounced among men in late adulthood, who reported receiving more frequent support from church members than men who reported receiving infrequent support (Nguyen et al., 2017). The clergy and the church are well-positioned to address the African American population's mental health needs for numerous reasons (Nguyen et al., 2017).

Stansbury and colleagues conducted a qualitative study of pastoral care in black churches, indicating that clergy members tend to have a comprehensive view of mental health, spirituality, and physical health (Stansbury et al., 2011). Pastoral counseling cognizant of the comprehensive outlook may be more consistent with the African American community's values and beliefs since the church is viewed as a safe space for discussing mental health concerns (Campbell & Winchester, 2020). This position can help address barriers to service utilization, such as stigma and mistrust of mental health professionals (Hankerson et al., 2018).
Barriers to mental health service utilization by African Americans have been recognized, such as lack of access to care, cultural mistrust, masculine attitudes, stigma, and shame (Kawai-Bogue et al., 2017; Paradies et al., 2015; Wimer & Levant, 2011; Briggs et al., 2014). Mental illness stigma, along with fear and shame related to having mental health issues, could represent significant barriers to seeking formal mental health services among the African American community (Wallace & Constantine, 2005). This study aims to minimize and highlight barriers to therapy utilization while increasing usage and knowledge concerning the benefits of use.
CHAPTER TWO: LITERATURE REVIEW

Overview

The literature review provides critical information demonstrating a substantial gap between the real and perceived barriers to therapy utilization among African American male college students. The review of literature explores the theoretical framework, followed by historical perspective, family structure, masculinity, help-seeking behaviors, stigmas, spiritual influence, economic hardships, cultural competence, cultural mistrust, and mental health access. This chapter concludes with thoughts regarding acceptance of change. The research examined group-based medical mistrust and perception of illness by African American male college students and use of therapy, along with other mental and psychological health services.

Theoretical Framework

Understanding barriers and stigmas associated with therapy utilization among African American male college students requires evaluation of the stigmas and behaviors of the identified group. In 1968 Ronald Andersen, Ph.D., developed the Behavioral Model for Vulnerable Populations which explores predisposing, enabling, and need factors that may predict health behavior and subsequent outcomes among vulnerable populations (Gelberg et al., 2000).

The Gelberg-Andersen Behavioral Model for Vulnerable Populations is a specialized and expanded version of the Andersen Behavioral Model (Andersen, 1968), which initially described relationships in the general population that may help in explaining the influence on health outcomes and health service utilization (Stein et al., 2007). The traditional predisposing domain consists of demographic, health beliefs, and social structural factors such as age, race/ethnicity, and gender. The vulnerable predisposing domain includes additional social structure factors and childhood characteristics such as mental illness, substance abuse, and psychological resources.
caused by environment and DNA inheritance from an oppressed population (Gelberg et al., 2000).

Personal/family and community resources are encompassed within enabling factors. The traditional enabling domain includes factors such as lack of proper insurance, a regular source of care and social support while the vulnerable enabling domain accounts for factors including competing needs, self-help skills, and social service resources (Small, 2010). Both the traditional and vulnerable need domains consist of perceived and evaluated health, but the vulnerable need domain highlights health conditions specific to the vulnerable population such as those experiencing homelessness, mental illness, and disparate health care issues (Bernard, 2011). The model suggests that traditional and vulnerable predisposing, enabling, and need factors are associated with subsequent health outcomes, which may later impact predictive factors (Bernard, 2011).

This theoretical framework provides the structure for examining how influencing and enabling components relate to intentions to seek psychological or mental health services, which within the Behavioral Model for Vulnerable Populations, is categorized as personal perception of need for health care services. The Behavioral Model for Vulnerable Populations has been previously used to explore topics including differences in mental health service utilization among African Americans and Caucasians (Cooper-Patrick et al., 1999). Williams (2014) conducted a study on mental health service use among African American emerging adults to examine factors associated with mental health service utilization.

Being female and having an evaluated need for services were associated with greater odds of service use, which would suggest the need for additional examination of gender differences in service utilization and greater mental health outreach and education among
African American males. One of the findings from the study were that higher educational attainment, including number of years in college (Henderson, 2004), has been associated with greater likelihood of receiving mental health services among African American emerging adults (Cooper-Patrick et.al, 1999).

An additional finding from the study suggests several assumptions to include mental health outreach and a form of psychoeducation being desired, specifically among African American male emerging adults. Study data reflected that men were consistently less likely than women to have used services, regardless of having comparable lifetime assessed needs (42% versus 48%, respectively) (Williams, 2014). Additionally, only 5% of the sample perceived a necessity for service utilization (Williams, 2014). Burns et al. (2010) suggested creative solutions to circumvent the issue with therapy utilization such as incorporating social media outlets, such as Facebook and Twitter, rather than traditional means for improving understanding of mental disorders and their symptomatology with this population, since many in this age range and demographic have access to technology. The Behavioral Model for Vulnerable Populations specifically targets vulnerable populations including African Americans and focuses on the characteristics that may affect their access to and use of healthcare services.

The Theory of Planned Behavior is an established psychological theory used to predict a multitude of behavioral intentions, including those to seek mental health services (Armitage & Connor, 2001). The Theory of Planned Behavior was developed by Ajzen in 1991 and has a deep-rooted theoretical and empirical basis with the inclusion of health beliefs, involving attitudes and knowledge about health and illness and perceived barriers to care in the traditional domain. The Theory and other barriers can be combined to examine any number of variables that
may be associated with mental health service utilization among African American male college students (Collins et al., 2011).

Based on existing research, there is reason to believe the associations between planned behavior constructs may vary depending on race/ethnicity. In previous studies comparing two or more racial/ethnic groups on two different health behaviors, subjective norms influenced the behavioral intentions of African Americans, but not other groups (Blanchard et al., 2009). There is a theory that suggests the significance of norms in explaining African Americans’ behaviors may be due to the importance of social connectedness within the African American culture. Findings also suggest that perceived behavioral control may be a particularly strong determinant of the health behaviors of African Americans (O’neal et al., 2014).

Reasons why African American college students are reluctant to seek help from mental health professionals require further research. Mesidor and Sly (2014) conducted a study in which the Theory of Planned Behavior was used to better understand the effectiveness of the theory predicting mental health seeking intentions among international and African American college students. Although the Behavioral Model for Vulnerable Populations includes health beliefs, it does not include other factors known to be important in predicting behavior, such as perceived behavioral control. The Behavior Model for Vulnerable Populations and Theory of Planned Behavior work together to assess how attitudes, norms, and control predict intentions to engage in the therapy utilization, while intentions directly predict participation of the actual behavior (Collins et al., 2011; Bernard, 2011).

Individuals are more likely to engage in a behavior if they have positive attitudes toward the behavior, believe that the behavior is acceptable and important to others, and feel that they have control over performance of the behavior (Wallston, 2015). When a more vulnerable
population has a perception of control over self-care behaviors this serves as an important factor of performing self-care actions. It may be considered as an important barrier for developing interventions that aim to improve intention concerning service utilization (Williams, 2014). More control equals more participation. A feeling of not having control evokes avoidance.

**Related Literature**

This study conducted addressed how attitudes toward religious help-seeking, acceptance of change, group-based medical mistrust, and mental illness perception impact African American male therapy utilization. A review of the actual and perceived barriers African American males endure are highlighted with an emphasis on historical perspective, family structure, masculinity, and help-seeking behaviors. Also, stigmas, spiritual influence, economic hardships, cultural competence, cultural mistrust, and mental health access, have been examined.

Exploration of African American college student attitudes, benefits and risk of mental health servicing and acceptance of change are explored.

**Historical Perspective**

Historical trauma has shaped and negatively impacted the overall health of the African American community, according to Wilkins et al. (2013). Historical trauma has created lingering psychological and emotional injuries in African American communities. Racism and discrimination have played a role in the impact of health utilization services for African Americans (Paradies et al., 2015). Although time has passed from the days of slavery, the effects are transgenerational, further impeding the helping relationships with professionals of European descent (Gump, 2010). It was not until the mid-1990’s that reviews of discrimination and health were conducted among the African American population which yielded results of disparity (Paradies et al., 2015). African Americans may be disadvantaged with mental health due to
historical, economic, social, political, environmental, and psychological factors (Fralich-Lesarre, 2012). The historical trauma endured by this population seems to have influenced the reluctance of African Americans regarding the seeking and receiving of mental health treatment or fear of receiving inadequate care and misdiagnosis due to discrimination. Many of those that are a part of the African American culture hold onto past hurts and trauma such as the memory of past abuse that occurred with the US Public Health Service Syphilis Study at Tuskegee (Williams et al., 2012). Throughout African American history in the United States, this group has been subjected to traumatic policies and practices (Vil et al., 2019).

The remnants of traumatic practice have been exhibited in three time-spans endured by African Americans in the United States: the slavery generation (1619–1865), legalized segregation and discrimination generation (1865–1965), and the race-neutral generation (1965–present) (Vil et al., 2019). From 1965 to the present, experiences of African Americans continue to exhibit the disproportionate treatment that has continued even with progression.

Before recent history, African American participation in mental health treatment was practically nonexistent. From the start of the American slave trade through the eighteenth century it was a common belief that African Americans were unlikely victims of mental health disorders (Briggs et al., 2014). African Americans have been at a disadvantage in mental health utilization by being subjected to trauma through slavery, oppression, colonialism, racism, and segregation (Poussaint & Alexander, 2000). The African slave trade is the root of historical trauma as it suggested violence, cruelty, and inhumane conditions that occurred over 430 years (DeGruy-Leary, 2005). The absence of a historically well-established case study accounts and reports of the mental health experiences of African Americans has been attributed to both politics and scientific racism. (Jackson, 2002) stated that, as far back as Benjamin Rush, published as father
of American psychiatry, African Americans with mental health illness or diseases were viewed as combatting a condition referred to as negritude, a condition that was comparable to leprosy. The recommended treatment to cure African Americans of this destabilizing mental health condition was for the victim "to become white".

According to Gamble (1997), the theory that African American distrust of the medical system began with the exposure of the brutalities of the Tuskegee experiment is misguided and simplistic. Gamble emphasizes that African American mistrust dates back to the antebellum period when many free African Americans, along with slaves, were utilized as unknowing test subjects for medical experimentation. The practice of utilizing African Americans in unethical medical experiments continued throughout the twentieth century. Briggs and colleagues (2011) believe that this level of distrust of the medical system has prevented many African Americans from reaping the benefits of modern medical advancements and, in part, explains African Americans' resistance to fully participate in or even access the mental health system.

**Epigenetics**

Epigenetics refers to inherited changes in chromatin and gene expression without modifications in the underlying DNA sequence (Dupont et al., 2009). To simply put, the genotype of an organism remains intact while the outer expression (phenotype) is changed (Aroke et al., 2019). Epigenetic mechanisms such as DNA modifications (e.g., CpG methylation), histone modifications (e.g., acetylation), and microRNAs function as translators between genes and the environment. Exposure to stress is considered an environmental influence that shapes epigenetic patterns, while lifetime experiences continue to modify the genome's function throughout the lifecycle (Schiele et al., 2020). Additionally, epigenetic changes are reversible and do not change an individual DNA sequence but can alter how someone’s body
reads a DNA sequence (CDC, 2020). Matosin and colleagues suggest that chronic stress is associated with numerous long-term biological consequences, expressly stress to the endocrine system influencing intermediate phenotypes such as brain structure and function, immune function, and behavior (Matosin et al., 2017).

Although genetic predisposition presents a percentage of the risk, the most significant molecular mechanisms determining those susceptible and resilient to the effects of stress and trauma may be epigenetic (Matosin et al., 2017). Epigenetics refers to the mechanisms that regulate genomic information by dynamically changing the patterns of transcription and translation of genes (Matosin et al., 2017). A longitudinal study conducted by Rutten and colleagues examined the genome-wide profile changes in blood DNA methylation as related to the development of PTSD symptoms over time in two military units (discovery, n = 93, and replication data sets, n = 98) (Rutten et al., 2017). The study revealed that the development of PTSD symptoms progressively in combat soldiers had a significant association with DNA methylation changes (Rutten et al., 2017).

Due to historical events and oppression, African American experiences tend to be more stressful than non-Hispanic Whites, which can be reflected epigenetically and increase the risk that African Americans will experience more debilitating continuous pain (Williams et al., 2016). Akbar (1996, as cited in Halloran, 2018) argued that the social and psychological impacts of enslavement continued across generations and still affects the African American personality in ways such as dysfunctional attitudes, practices, and behaviors from the time of enslavement. The epigenetics field suggests that an offspring may demonstrate the effects of a parent's environmental challenges despite the offspring not facing the same challenges, which is a phenomenon called epigenetic inheritance (Harper, 2005).
Another example of the potential impacts of generational trauma is The Great Irish Famine. For seven years (1845-1852), the Irish population decreased by 20% due to one million people emigrated, and one million died (Kelly, 2019). Most of the Irish were miserably poor, while others suffered from starvation and disease. They left because disease had devastated Ireland's potato crops, leaving millions without food (Powderly, 2019). The potato crop was overtaken with disease and was either destroyed or considered "unfit for the food of man." By early spring of 1846, panic began among the Irish as food supplies disappeared. People were forced to eat anything they could find, including grass, leaves, and the bark of trees (Powderly, 2019). There were also reports that people resulted to eating food that was so rancid and offensive an odor, so foul accompanied consumption that people were compelled to leave the doors and windows of their cabins open. Additionally, illnesses, including fever from eating infected potatoes, began to spread (Powderly, 2019).

Kelly indicated that famine survivors might have passed on experiences of physical and psychological trauma to their children and future generations in a lasting, biological way (Kelly, 2019). Famine unequivocally exacerbated the social and mental condition of the mentally ill in Ireland; it likely increased their rates of presentation to workhouses primarily (Kelly, 2019). Although it also supported the continued increase in the asylum population, it did not accelerate the latter dramatically. For those in gestation during the Famine, there is a moderate amount of evidence that the Great Irish Famine, like the Dutch Winter Hunger, increased the risk of mental disorder (Kelly, 2019).

To further demonstrate this phenomenon, Perroud and colleagues (2014) conducted a study examining 25 women exposed to the Tutsi genocide in Rwanda during pregnancy and their children in comparison with 25 non-exposed Rwandan control mothers and their offspring; the
study results observed higher rates of PTSD and depression symptoms in mothers exposed to the genocide as well as in their children (Perroud et al., 2014).

Sullivan (2013) examined how people of color could biologically inherit the damaging effects of racism. The article focused on how the harmful physiological impact of white privilege can extend across generations. Social environments occupied by ancestors can shape a person today, and this occurrence is a physiological inheritance (Sullivan, 2013). The field of epigenetics can provide a breadth of knowledge to philosophers and researchers in understanding the transgenerational biological influence of social constraints such as inequality (Sullivan, 2013).

**African American Family Structure**

Empirical evidence has shown that the African American family’s expectations about mental health treatment are influenced by their experience with past treatment. Past experiences include the clinical outcomes of treatment and the quality of the relationship with the treatment provider, along with the autonomy granted in treatment (Thompson et al., 2012). When mental health professionals develop helping relationships it is imperative to explore the complex areas of African American family life to provide holistic counseling. Racist socialization is the idealization of the nuclear family structure in U.S. society, which includes a mother, a father, and their young children residing in a home, and also the gender roles played by each person. The idea of the nuclear family and accompanying traditional gender roles in the United States which are promoted through media, policies, and practices have resulted in many African Americans idealizing this model despite their inability to obtain it, thus causing anxiety, depression and hopelessness.
Many African Americans, particularly those who are economically vulnerable, live-in extended families, including grandparents, aunts, uncles, cousins. They may not subscribe to traditional gender roles, although these roles have helped many African American families endure economic challenges, manage demands of parenting, and maintain good mental health (Vil et al., 2019).

Brown and colleagues conducted research investigating the association between stress overload and coping with DNA patterns in African Americans. Psychosocial stress exposure and high effort coping strategies have been identified as risk factors that may explain the high prevalence of high blood pressure among African Americans (Brown et al., 2019). In addition, one biological agent through which stress and coping may affect the risk of hypertension is epigenetic modifications in blood pressure-related genes (Brown et al., 2019).

Social stressors such as discrimination, low socioeconomic status, impoverished neighborhoods, and familial stress have previously been associated with methylation patterns (Needham et al., 2015). In addition, Brown and colleagues noted that early evidence suggests that stress management activities such as yoga and psychotherapy can affect DNA (Brown et al., 2019).

The slave trade’s traumatic historical impact on the African American family included slaves not being able to wed or have children that would be legally recognized as family. Mothers, fathers, and children would be separated and sold away from each other continuing to disrupt family stability and structure (Boyd-Franklin, 2013). Although the trauma endured has generationally impacted this group, the strength of bonds and importance of maintaining family and community cohesion provides tight kinship networks of emotional and economic support.
The traditional source of help and support historically from kinships extends out to, not only family members, but also close friends, pastors and or members of their church family. The significance and high regard of these networks of support causes a hesitation to seek therapy out of fear of being labeled “crazy” by their family and friends. In addition to fear of labeling from their network of support it is important to note that African American families are not often self-reporting for mental health services but yet mandated for treatment by schools, courts, hospitals, social welfare agencies under threat and pressure which further contributes to a resistance to seek or utilize therapy (Boyd-Franklin, 2013).

**Masculinity and Help-Seeking Behaviors**

Traditional rules of men account for men being less likely than women to seek help for psychological problems, career concerns and medical problems (Wimer & Levant, 2011). Males underutilize therapy due to a more unfavorable attitude regarding medical and professional help than women. Research has suggested that men have self-stigma (Vogel et al., 2011). Among male college students, the endorsement of the use of violence, demonstration of dominance, and self-reliance was associated with higher scores on the Global Severity Index of the Brief Symptom Inventory (Ramaeker & Petrie, 2019). According to Aymer (2010), African American men are hesitant to seek clinical services due to the increase of personal vulnerability. Due to these negative experiences and stereotypes, men generally avoid entering therapy and building therapeutic relationships by being stoic, or by acting out to avoid or to sabotage the emotional bond. Men that seek medical and psychological help less frequently than women report less favorable attitudes toward seeking psychological services which predict help-seeking behaviors (Gonzalez et al., 2011).
Research has indicated that a higher level of conformity to masculine norms and endorsement of traditional masculinity ideology are associated with avoidance of help-seeking for mental and physical health problems among men (Wimer & Levant, 2011).

**Stigma**

A stigma is “an attribute that is deeply discrediting” that reduces someone “from a whole and usual person to a tainted, discounted one” (Ahmedani, 2011). Stigma has been noted as a major obstacle of mental health service use among African Americans (Masuda, Anderson & Edmonds, 2012). McCusker and Galupo (2011) suggested that the stigma associated with mental illness hinders men from seeking mental health services. Social stigmas and prejudices towards seeking psychological treatments have been found to have a negative influence on African American college students help-seeking behaviors (Cadaret & Speight, 2018). Social stigma can create barriers for persons with a mental or behavioral disorder (Ahmedani, 2011). Stigmas impact the traditional male gender roles of African American males which have shown an influence on their social networks, which reduces the likelihood of recommendations to seek psychological help when needed (Cadaret & Speight, 2018). Mental health stigma is a set of negative attitudes toward people with a psychological disorder, such as that they are unpredictable or hopeless in recovery (Masuda & Latzman, 2011). The public stigma associated with psychological help-seeking “refers to the belief that a person who seeks mental health service is perceived by the general public as flawed and socially undesirable, however, self-stigma refers to an individual's negative perceptions about herself or himself for seeking psychological help” (Cheng et al., 2013).

**Fear of Mental Health**
Previous findings indicate that fear contributes to the shaping of people experiences who utilize mental health services (Sweeney et al., 2015). Fear and mental health have been associated and maintained that fear drives the present mental health system (Sloan, 2003). The relationships between black communities and mental health services are laden with fear (Keating & Robertson, 2004). Keating and Robertson (2004) expressed that members of the black community receive mental health services they do not want and express mistrust and fear services. The staff members of mental health facilities in these communities are said to express suspiciousness of Blacks, fear Blacks specifically young Black men, fear criticism from the group, and ignorance in responses to their issues (Keating & Robertson, 2004). The position of fear among the Black community is driven by prejudice, confusion, misunderstandings, and occasional racism (Sweeney et al., 2015). Additionally, in relation to mental illness, there is evidence that the stigma associated with mental illness produces fear of being labeled (Kent & Keohane, 2001). The fear of mental illness leads to a fear of rejection and ostracism by others, and consequently, will contribute to those with mental illnesses making extensive efforts to hide this from others (Angermeyer et al., 2004; Sweeney et al., 2015).

The fear of mental health labeling for the African American population also extends to the workforce in which structural racism currently exist (McCluney et al., 2018). This population, when, compared by race, reflect that Whites make up the majority of the labor force (78 percent) and Blacks and Asians composed of an additional 13 percent and 6 percent, separately when compared to 328.2 million in the U.S. population (Bureau of Labor Statistics [BLS], 2019).

An interview review by Dew and colleagues explored the issue of patients’ willingness to disclose mental health problems to General Practitioners through interviews (Dew et al., 2007).
The interview findings suggested that fear was a significant barrier to participants disclosure. Individuals with mental health issues were afraid that disclosure would include a process of confronting themselves and required to come to terms with parts of their personality that had threatening feelings (Dew et al., 2007). Participants feared the “unknown” and the loss of control that might accompany disclosure (Dew et al., 2007).

A study conducted by Dew (2014) explored deeper impacts of fear by examining the perceptions of workers towards mental disorders in the workplace. The study consisted of a sample of 2219 working adults who either completed a telephone questionnaire administered by professional interviewers or a web-based survey. Dew (2014) found that negative attitudes could become a significant deterrent to help seeking in the workplace often, taking the form of fear. Previous articles have suggested that among the general public, there is fear and stigma that mental illness is associated with violence (Dewa, 2014). The study results suggested that employees with mental health disorders contained a significant proportion of participants that did not seek support due to barriers (Dewa, 2014). One barrier mentioned is fear of negative consequences (Dew, 2014). Additionally, study results suggested that males and those who were members of noticeable minorities were less likely to have positive attitudes towards mental illness (Dewa, 2014). This finding is consistent with literature suggesting that in terms of the relationships between demographic factors and mental illness disclosure preference, results from multilevel modeling showed gender to be the only factor associated with disclosure preferences (Pahwa et al., 2017). A suggestion noted to minimize and or eliminate this barrier to disclosure in the workplace is for leadership to make disclosure safe, therefore decreasing stigma and the burden of mental disorders in the workplace (Dewa, 2014).

**Spiritual Influence**
African Americans rely heavily upon spiritual influences in times of trouble and through life challenges (Avent & Cashwell, 2015). Literature has positively linked religious and spiritual participation in the African American culture that has shown an increase in self-esteem, life satisfaction, social support and decreased self-destructive behaviors (Bell-Tolliver & Wilkerson, 2011). The Black Church in the African American community is an independent institution with roots planted in history that dates back to 1787 after the Free African Society was established, where the attending congregants were Black and identified as Christians (Hardy, 2014). Black churches are considered to be trusted institutions in the African American community and when coupled with various interventions has shown success in health promotion and implementation when collaborating with the church (Hankerson & Weissman, 2012).

Leadership in Black churches is often led by a pastor, reverend or bishop who holds magnetic leadership qualities. This type of leadership style helps to motivate the congregation and community through the use of authority that is viewed to be derived from a higher power (Hays, 2015). African American men may feel more comfortable seeking counseling from clergy and other faith-based leaders. Pastors, Bishops, or other clergy leaders are considered trusted gatekeepers (Hankerson et al., 2015). Evidence suggests that although African American men feel more comfortable seeking mental health services from other faith-based leaders, professional psychological services can also be beneficial for this group (Aymer, 2010). African Americans who seek clergy first for a serious problem are less likely to subsequently visit a mental health professional (Hays, 2015).

**Economic Hardships**

Economic hardships are prevalent in African American communities. In the African American community, the impoverished population seeking therapy can pose a financial burden.
Also, a lack of health insurance is another reason why African Americans may choose not to seek mental health treatment (Conner et al., 2010). African Americans are not able to fully utilize mental health services or have the same improvements in health as their white counterparts, due to the racial disparity being largest at the highest levels of SES (Williams et al., 2010). Africans Americans are almost three times as likely to live in poverty, experience unemployment levels that are almost twice as high, earn 42% less in median household income and have substantially higher rates of incarceration than non-Hispanic Whites (Mouzon et al., 2016).

Due to higher prioritized obligations, such as use of money for food, shelter, and other health obligations, there is a limit to the ability to pay for mental health services (Santiago et al., 2012).

Renwick (2015) states that poverty is a prime predictor for lacking basic human essentials including adequate clean water, nutrition, health care, education, clothing, and shelter. African Americans are the poorest ethnic group in the USA. African Americans have had the lowest median household income in the USA for the past 50 years: in 2014, measured at $35,398, compared to $53,657 for all races, and $74,297 for Asians (Renwick, 2015). The quality of housing affects health, and African Americans live in some of the country’s lowest quality housing. Segregated housing is correlated with a significant increase in cardiovascular disease, and African Americans live in the most segregated conditions (Kershaw et al., 2015). African Americans live in the poorest neighborhoods with the highest rates of homicide. Persons who live in poor neighborhoods are also much less likely to gain the benefits of exercise because of safety concerns outside of the home.

Cultural Mistrust
Whaley (2011) stated that cultural mistrust or healthy cultural paranoia is considered by many Black researchers and scholars as an important mental health variable in the lives of African Americans. Furthermore, a clinicians’ ability to distinguish between cultural and clinical dimensions of paranoid symptoms in African American patients may be a key factor in preventing psychiatric misdiagnosis. The rates of racial disparities of psychotic disorder diagnosis, specifically Schizophrenia, have been reported across time and mental health professions (Swartz & Blankenship, 2014). African Americans are almost five times more likely to be diagnosed with Schizophrenia compared with Whites when admitted to state psychiatric hospitals (Barnes, 2003). Additionally, Eack and colleagues (2012) reported that a significant factor that was significant concerning increased Schizophrenia diagnoses was clinician-perceived honesty being lower for African American clients after mental health interviews. To the contrary, increased distrust and a more inadequate clinical relationship were reported by African American clients (Eack et al., 2012).

Mistrust has been identified as one of the barriers to the utilization of mental health services among racial and ethnic minority populations. Terrell et al. (2009), defined cultural mistrust as “the belief acquired by African Americans, due to past and ongoing mistreatment related to being a member of that ethnic group, that Whites cannot be trusted”. The issues of trust for African American males are rooted in historical and social contexts. Crime data and negative mass media portrayals, embellished images of black urban youth culture, including fashion and hairstyles, place public focus upon the most incendiary elements of hip-hop culture, such as gangster rap. This foster stereotypes of Black males as criminal and uncivilized, making it difficult for the “anonymous Black male” to prove his common decency (Scott et al., 2011).

*Tuskegee Syphilis Study*
The Tuskegee syphilis study can be considered as one of the most infamous medical experiments in American history among African American males due to its intentional deception. In 1932, the U.S. Public Health Service (USPHS) initiated an experiment in Macon County, Alabama with the Tuskegee Institute. The purpose of the experiment was to document the natural history of syphilis in an effort of validating treatment programs for Blacks. This study was called the “Tuskegee Study of Untreated Syphilis in the Negro Male.” (CDC, 2020). The study consisted of 600 mostly poor African American men, 400 African American men with untreated or late syphilis and approximately 200 men without syphilis as the control participants (Paul & Brookes, 2015). The study had a short-term design but turned into a long-term commitment that lasted for 40 years from 1932-1972. More than 300 study participants were not notified about their disease or offered treatment such as metal therapy and penicillin which was available during this time (Brandt, 1978; Paul & Brookes, 2015).

Alsan and Wanamaker (2017) found evidence suggesting that the suffering associated with this experiment extended beyond the tragic test subjects. They found that the public exposure of the study's existence led to a deep mistrust of the medical community among Black males, who later avoided hospital and physician interactions. In the years following disclosure of the study's tactics, findings reflected considerably lower utilization of both outpatient and inpatient medical care by older Black men in close cultural proximity to the study's subjects (Alsan & Wannamaker, 2017).

Health care utilization reduction contributed to a significant increase in the probability of mortality before the age of 75. The researchers also document heightened medical mistrust (Alsan & Wannamaker, 2017).

Slave Medical Experimentation
African Americans fears about medical mistrust and exploitation among those in the medical professional date back to the Antebellum period. Slaves were often deliberately used in medical experimentation and surgical procedures in the South (Savitt, 1982). Fisher (1968) indicated that white medical doctors and researchers often used slave bodies for dissection and experimentation. For medical and experimentation purposes Blacks were considered easy targets due to their positions as voiceless slaves who were unable to vocalize their wishes in decision making (Savitt, 1982). While poor white participants were also used for experimentation purposes, blacks were used more often (Savitt, 1982).

Two experiments used in the Antebellum period among white southerners were carried out in Georgia and Alabama (Gamble, 1997). In the first experiment, a Georgia physician name Thomas Hamilton wanted to develop a medication for heat stroke to decrease the effects of overheating while outside. The experiment consisted of a series of brutal experiments on a slave named Fed to test his solutions (Gamble, 1997). The slave was loaned to Hamilton as repayment for a debt owed by the slave owner. Hamilton forced Fed to sit naked on a stool placed in a pit that had been heated to a high temperature with only the slave’s head above ground for over a period of 2 to 3 weeks (Gamble, 1997). During this period, Fed received multiple remedies to test the effectiveness for study purposes, but the study was paused when Fed fainted and had to be revived for the experiment to continue (Poussaint & Alexander, 2001).

The second experiment, Dr. J. Marion Sims who was considered to be the Father of Modern Gynecology used three Alabama slave women to develop an operation to repair vesicovaginal fistulas and conducted his experiments over the course of four years between 1845 and 1849 (Gamble, 1997; Wall, 2006). Wall (2006) defined vesicovaginal fistula as a catastrophic complication of childbirth in which a hole develops between a woman's bladder and
her vagina, leading to constant, unremitting, and uncontrollable urinary incontinence among 19th century American women (Wall, 2006). The first patient, Lucy, endured the operation without anesthetics (Gamble, 1997). Another young woman, named Anarcha who had specific difficulties with combination vesicovaginal and rectovaginal fistula, suffered 30 operations before Sims was able to close the holes in her bladder and rectum (Wall, 2006). The wellbeing of these slaves was not a concern nor priority.

**Mental Health Access**

Because of such history and reluctance to seek help before an emergency exists, mental health disparities continue as a national problem, with overrepresentation in emergency and inpatient services (Snowden et al., 2009). The disparities of mental health access for African Americans can be traced to system-level mental health treatment. Some disparities in mental health among African Americans can be firmly established in inequalities such as access to adequate providers, insurance coverage and clinical discrimination among mental health professionals in the clinical setting (McGuire & Miranda, 2008). Minority clients are less likely than whites to receive adequate care for anxiety and depression after entering care (Wang et al., 2000).

These treatments promote inadequate opportunities for welcoming outpatient care (Snowden, 2012). A study reported that treated African Americans had lower odds of receiving evidence-based treatments than treated White Americans indicating that African Americans receive a lower quality of care than treated White Americans (Snowden, 2012). Lack of transportation and geographic accessibility (Alegria et al., 2012) may also present an obstacle for African Americans seeking mental health treatment. A study showed that increasing access to
mental health providers and living proximal to the clinics are linked to the continuity of psychotherapy visits (Alegria et al., 2012).

Historically, African Americans tend to have an inability and reluctance to trust both the mental healthcare system and the mental health providers which ultimately contributes as a barrier to African Americans seeking mental health treatment (Allen et al., 2010). Literature suggests that African Americans are often hesitant to seek services from a mental health provider who does not have a similar ethnic, racial, and cultural background. (Murry et al., 2011)

**African American College Student Attitudes**

A study conducted by Conner and colleagues (2010), examined the impact of perceived stigma and self-stigma on treatment-seeking attitudes among older African Americans and Caucasian Americans with depression. They found stigma associated with having a mental illness had a negative influence on attitudes and intentions toward seeking mental health services, especially among African Americans. The result of the study indicated that self-stigma mediated the relationship between race and attitudes toward seeking mental health treatment. African American college students have been found to be as distressed as students from other ethnic backgrounds, but the students are less likely to use psychological and or counseling services from professional mental health sources when compared to other races (Cheng et al., 2013).

Gender plays a substantial role in the expression of presenting problems among African American students exposed to racism in U.S. college environments (Whaley & Dubose, 2018). Although African American students are native-born citizens of the U.S., they are still a minority group because of the nature of their culture which is shaped by their ongoing troubled relationships with the dominant European American culture (Whaley & Dubose, 2018).
Cultural Competence

When working to understand the cultural barriers in therapy utilization among African Americans, Horst et al. (2012) conducted a study that had a cultural influence of particular clients in therapy. In the study, clients had interviews analyzed from clients that were in domestic violence relationships who were currently in therapy. Their results found that clients' beliefs were that a therapist of the same racial background would be more understanding and have more shared life experience. This finding could suggest race to indirectly influence the client's preference because it serves as a mediator for shared understandings. These clients also believed sharing the same race would result in a more comfortable interaction between client and therapist. The findings from the majority of the clients also yielded the results of clients reporting that shared culture, a culturally competent therapist, and the quality of the therapist were the most significant criteria and these qualities led to more effective treatment (Horst, 2012). Less than 50% of African American men that are affected by mental illnesses or mental defects seek treatment due to holding Afrocentric cultural values (Ward & Mengesha, 2013). Studies conducted by Thompson, Bazile, and Akbar examined the roles of African American men's values and belief systems on their psychological help-seeking behaviors yielded results of cultural barriers (Williamson, 2014). African American male belief system barriers involved the perception of being weak and pride diminishment, if therapy was sought (Ward & Mengesha, 2013).

Underutilized Mental Health Services Risk Factors

According to the U.S. National Institute of Mental Health, in 2017 only 42.6% of adults in the U.S. suffering from psychiatric illness received psychiatric care in the past year (National Institute of Mental Health, 2019). In recent years African Americans have been found to view
seeking mental health services in a positive light but yet the positive beliefs do not translate to actually obtaining mental health treatment. A study conducted on racial differences in beliefs about how the natural course of mental illness relates to perceptions of treatment effectiveness, found that African Americans were more likely than Caucasians to believe that mental health specialists could aid people with psychological illnesses. The study indicated that African Americans were more apt to believe that mental health problems could improve on their own (Anglin et al., 2008). African American belief that mental health problems will improve on their own proves to be problematic, because it prevents the use of mental health services as a source to cope. Regarding mental health use, symptoms of disorders that go untreated could lead to one of the greatest risks such as suicidal ideation, attempts and death. According to Drapeau and McIntosh (2018) 80% of the suicides in the African American community consisted of African American men. Research reports that men with comorbid depression and alcohol use disorder have a very high long-term suicide risk (16.2%). Individuals with untreated mental illness are at elevated suicide risk (Nordentoft, 2011). It is imperative to consider how African Americans process and deal with levels of individual trauma on top of new mass traumas such as COVID-19 that presents a new set of anxieties such as uncertainty, isolation, financial hardships, health concerns or deaths which intensifies the difficulty for individuals to responsibly manage their mental health (Sher, 2020).

According to a study conducted by Forde et al. (2020) it was found that Black Americans who had stress, due to lifelong discrimination, were at a higher risk for developing hypertension. Discrimination has also been found to lead to the development of hypertension through unhealthy behaviors, such as unhealthy eating or inactive lifestyles, which could serve as a coping strategy, due to the stress of discrimination (Jackson et al., 2010). Jackson and colleagues
also found that when individuals are persistently encountering chronic daily stressors, including poverty, crime and inadequate housing, they will participate in unhealthy behaviors in addition to those previously mentioned, such as smoking, alcohol use and abuse and drug use. These unhealthy coping behaviors show a direct contribution to physical health morbidities and early mortality (Barden, 2004).

The direct effect of stressful living combined with unhealthy behaviors create great physical health disparities that are unfavorable to African Americans. There are also significant costs of untreated mental illness. They include financial, public health and social costs. According to the Agency for Healthcare Research and Quality, patients hospitalized with serious mental illness are much more likely to be readmitted in the next 30 days if they do not receive follow-up treatment (Heslin & Weiss, 2015). Individuals not utilizing mental health services often co-occur with substance abuse, therefore increasing the risk of death from overdose.

In 2017 there were 70,237 drug overdose deaths in the United States (Hedegaard et al., 2018).

Untreated mental illness may cause severe emotional, behavioral, and social consequence. Mental illness causes disruptions in the lives of those with the disorder and those surrounding the individual within their community. There is supporting data that links legal issues such as imprisonment to untreated mental illness. Mental illness within the African American community indicates one leading factor. A study conducted on 250 African American ex-offenders examined the relationship between socio-behavioral factors and mental health. Mental health issues are three times higher among prisoners than the general population. African Americans represent the largest incarcerated racial group (35%), despite comprising 13% of the general population (Carson, 2016; U.S. Census Bureau, 2015). Higher rates of mental health problems among the incarcerated population could be due to the use of prisons as an alternative
for mental health treatment facilities. This rationale is troublesome and indicates a vicious cycle developing because those with mental health issues are not being treated for their illness and often leave the facilities and commit additional crimes, hence returning to prison (Mahaffey et al., 2018).

Homelessness is also a risk factor for untreated mental illness. Chronic mental health illness is one of the leading causes of homelessness in the United States (Martin, 2015). Approximately twenty-five percent of the homeless population in the United States suffers from a form of severe mental illness (USDH, 2012, as cited in Martin, 2015). Mental illness greatly disrupts a person’s ability to function in day-to-day living, affecting their ability to relate to others and conduct essential duties of daily living such as personal hygiene, life management and attending work or school.

In a study conducted by Kessler and Frank (1997) it was found that mental disorders can significantly impede a person's ability to work by increasing nonattendance and reducing on-the-job productivity (Kessler & Frank 1997). Previous studies have examined the impact of past homelessness on victimization among individuals with severe mental illness also found that homelessness was one of the most significant risk factors (White et al., 2006). Homeless individuals with severe mental illness, are more likely than the general population to be crime victims (Kohm, 2006,). Evidence further proves that individuals who are not homeless with severe mental illness are also more likely to be victims than perpetrators of violence (Choe et al., 2008).

Among those that are homeless with mental health disparities there is a high prevalence of comorbidity between substance use disorders. African Americans are an over-represented group among that population and, as a direct result of the mental illness symptoms, some begin
self-medicating through use of street drugs, causing a further hinderance in gaining stability in all areas of their life. Although some drugs may temporarily reduce symptoms of a mental illness, the drugs can also worsen symptoms.

According to Post and Kalivas (2013) evidence suggested that periods of cocaine use may worsen the symptoms of bipolar disorder and contribute to progression of the illness. Untreated mental illness can also inhibit individuals from forming and maintaining meaningful and stable relationships due to the symptoms of their untreated disorder often, pushing others away that served as a support system, further leading to homelessness (Martin, 2015). The symptoms of mental illness cause significant challenges and hardships when attempting to relate to others through communicating. For example, those that struggle with symptoms of depression, anxiety, and other symptoms may avoid social contact altogether to prevent embarrassment, hurt or shame.

**Benefits of Utilizing Mental Health Services**

A mental health disorder could be developed by anyone, although African Americans are more likely to experience more severe forms of mental health illnesses due to underrecognized and undertreated needs. According to the Health and Human Services Office of Minority Health, Black adults in the U.S. are more likely than White adults to report persistent symptoms of emotional suffering, such as sadness and hopelessness. The National Alliance on Mental Illness (NAMI), (n.d) reported that Black adults living below the poverty line are more than twice as likely to report severe psychological suffering than those with greater financial security.

Despite the awareness of mental health services as an evident need, only one in three Black adults who need mental health care receive it. Previous research findings on the
effectiveness of mental health services with African American men is limited due to this population not consenting to research participation because of cultural mistrust.

One noted benefit of seeking treatment in the early stages of the mental illness is the controlling the severity of episodes, along with associated costs such as absenteeism and impaired productivity (Goldberg & Steury, 2001). Research also suggests interventions that are culturally congruent prove to be effective when treating African Americans (Longshore & Grills, 2000). Therapeutic interventions have been noted to have successful outcomes such as Cognitive–Behavioral Therapy (Kelly & Parsons, 2008).

CBT focuses on altering disturbing thought patterns. It has shown equal effectiveness in reducing anxiety among African American men as well as Caucasian children (U.S. Department of Health and Human Services, 2001). A study compared CBT intervention and 12-Step facilitation for a group of mostly African American men, 80 percent of the group who were homeless, yielding results that CBT achieved better abstinence outcomes, except among those who considered themselves very religious (Maude-Griffin et al., 1998). Therapy utilization can support individuals in overcoming and facing pain from past traumas, develop adaptive coping strategies, identify goals, and improve overall communication.

The British Medical Journal provided a study conducted which found that even mild mental health problems can often lead to a lower life expectancy (Russ et al., 2012). A mentally healthy lifestyle can prevent the onset of additional mental health illnesses or the worsening of mental health illnesses as well as heart disease, diabetes, obesity, and other chronic health problems (Russ et al., 2012). Ultimately, utilization of mental health treatment by mental health professionals can signify an improvement in overall quality of life functioning (Fleury et al., 2010).
African American Religious Coping

In the African American community, the significance of the church to the culture is more than a place of worship but serves a vital role in providing resources and support for the African American community since the time of slavery (Holt et al., 2017). Traditionally, African Americans have had inadequate access to formal mental health services when compared to Whites therefore preferring religious counseling (Taylor, et al., 2000). African Americans have significant levels of religious involvement, with religion also playing a vital role in coping styles that influence health (Holt et al., 2017). Religious coping has been defined as the use of cognitive or behavioral practices that begin in one's religion or spirituality to confront stressful life events (Tix & Frazier, 1998).

Taylor and colleagues (2020) conducted a study investigating the use of religious coping among African Americans and Black Caribbean with psychiatric disorders using data from the National Survey of American Life to examine three indicators of religious coping: Utilizing prayer and other spiritual activities for mental health problems, Importance of prayer during stressful moments and Looking to God for strength (Taylor et al., 2020).

Prayer was noted as one of the most frequent methods used for religious coping and remained an essential feature of religious life and a common practice even for those who do not frequently attend religious services. For example, Brown and colleagues (2013) explained that 6 out of 10 Americans who never attend religious services revealed that prayer is vital during stressful times and seek God for strength when facing difficulties (Brown et al., 2013).

Research results on the role of religious practices concerning mental health and psychiatric disorders indicate that prayer and related practices may be helpful in ways such as
depression recovery and (Bonelli & Koenig, 2013), including recovery from depression and controlling anxiety symptoms (Ellison et al., 2014).

The use of religious coping has been continually acknowledged as a traditional method of confronting stressful events among African Americans (Hill et al., 1995). Watlington & Murphy (2006) conducted a study examining the relationship between religious participation, spirituality, religious coping and social support and symptoms of posttraumatic stress and depression in 65 African American women who were victims of domestic violence who reported both high levels of spirituality and religious involvement (Watlington & Murphy, 2006). Additionally, the women also reported less symptoms of posttraumatic stress and depression (Watlington & Murphy, 2006). Furthermore, the results of the study suggested that the women who reported being more spiritual reported greater use of religious coping strategies (Watlington & Murphy, 2006).

Lindsey and colleagues stated that among African Americans, religious coping may be such an effective approach to problem solving psychological distress that this group may choose to forgo formal mental health services and use religious coping instead (Lindsey et al., 2006). Ayalon & Young (2005) also suggested that because of the religious influence, African Americans are more likely to use religious services and less likely to use psychological services to alleviate distress.

**Acceptance of Change**

Researchers, therapists, and mental health professionals often speculate why African American males do not utilize mental health services as a means to solve their mental health issues. In recent years, text publications have been created to help reduce the mental health stigma among African Americans. Titles including: “The Unapologetic Guide to Black Mental Health: Navigate an Unequal System”, “Learn Tools for Emotional Wellness”, and “Get the
Help you Deserve Community Mental Health Engagement with Racially Diverse Populations”.

In addition to some of the publications mentioned, there are also overwhelming amounts of podcasts and vlogs, along with social media influencers who are working to help end the sigma on mental health utilization and normalize its usage among the African American community.

Killen (2012) conducted a study on African American men’s perception of psychotherapy at a Mental Illness & Chemical Dependency Program at the African American Family Services agency (AAFS) in Minneapolis. The study targeted factors men considered therapeutic and or helpful. The study used a qualitative design, using eight volunteer participants of African American men to explore their perception of psychotherapy (Killen, 2012). The study results suggested that in ideal circumstances, African American men are accepting of assistance solving their issues through psychotherapy and reported benefit from its use (Killen, 2012). Killen (2012) reported that the study participants reported feelings of empowerment by their therapist when equipped with the skills and knowledge gained from therapy for their personal growth and progression. A condition noted by participants in the study that could prove to benefit the outcome of therapy, is that therapist must learn to address racial issues in therapy that the client is battling and how these internalized issues affect them in coping and succeeding in life (Muran, 2007). Other circumstances reported by study participants was the therapist being up-front, sincere, authentic and understanding of African American culture through experiences, open to learning the cultural specifics of language usage, and being careful not to use too many technical therapeutic terms (Killen, 2012). If the goal is to improve service utilization for African American males and minimize the stigma through acceptance of change, the focus of efforts should target education, normalizing treatment and creating more alliances through social media, along with spiritual and religious sectors within the African American community.
Summary

This review of literature explores the disparities African Americans males face in both access to and utilization of mental health services. The historical perspective illustrates various ways African Americans have historical traumas that present difficulties in trusting, accessing, and utilizing mental health services. The historical context also explained systemic racism, discrimination and exclusion experienced by this community, which continues to promote mistrust among African Americans to engage with mental health professionals. The historical context was appropriately followed by the influence of epigenetics on African Americans with research exhibiting that people of color could biologically inherit damaging effects of racism and these effects have a harmful physiological impact and can extend across generations.

In addition to racism and discrimination, those in the black community hold a position of fear relative to mental health which is driven by prejudices, confusion, and misunderstandings (Sweeney et al., 2015). Evidence also reflects that the stigma associated with mental illness diagnoses creates fear of being labeled (Kent & Keohane, 2001). Research proves that African American men are less likely to seek help for mental health needs, which produce negative consequences to include late detection of chronic diseases, illnesses, and critical health counseling (Powell et al., 2016). Common barriers such as stigma, spiritual influences, economic hardships, lack of cultural awareness therapy utilization it is imperative that healthcare professionals consider the factors that contribute to healthcare disparities and distrust among African Americans. To improve mental health service utilization and minimizing stigma, there must be an acceptance of change among African American males and increase in mental health access. Mental health professionals will need to invest in increased cultural competence and
foster relationships with influential community and religious leaders within the African American community.
CHAPTER THREE: METHODS

Overview

In order to explore how religious attitudes toward help seeking, acceptance of change, group medical mistrust, and perception of mental illness impact the utilization of therapy among African American male college students, a quantitative research design was completed. This chapter utilizes a quantitative correlational study to explore how these factors impact therapy utilization among African American male college students. Research indicates that African American men are hesitant to seek clinical services due to the exposure of personal vulnerability (Scharff et al., 2010). There have been various studies conducted on help seeking behaviors and barriers to therapy use, which were also employed as a part of this research design. For example, Essau, (2005) conducted a school-based study of 12- to 17-year-old German adolescents which reflected that only 18.2% of those with diagnosable anxiety disorders, and 23% of those with depressive disorders had ever utilized mental health services. Additionally, Bains (2014) completed a meta-synthesis on African American adolescents and mental health care and found that there was a persistent negative view of those who pursued mental healthcare services. The purpose of the study was to understand the experiences of African American adolescents dealing with mental health conditions and what contributed to the hinderance of their mental health servicing access (Bains, 2014). Bains (2014) identified four themes: uncertainty and soul searching, strength of the inner circle, shame and reluctance, and belief in the system. African American males’ daily experiences of poor living conditions, such as insufficient housing, elevated crime rates, overcrowding, noise pollution, lack of community recreational activities, and safety concerns, are widespread in these areas (Amutah et al., 2016). These issues influence the overall health and
well-being of health outcomes and inequalities among this group (Amutah et al., 2016). Lastly, chapter three provides details regarding the research design, participants to be studied, data collection procedures and data analysis utilized within this study.

**Research Design**

Survey research enables the researcher to study needs and challenges through the use of self-reporting instruments. Ponto (2015) stated that survey research allows for a variety of methods for participant recruitment, data collection, and methods of instrumentation. Survey research has recently developed into a rigorous approach to research. Survey research can use quantitative research strategies, qualitative research strategies, or both strategies (i.e., mixed methods) (Ponto, 2015). Surveys are often used to investigate and explain human behavior and commonly used in social and psychological research (Singleton & Straits, 2009).

This research focused on the relationship of various factors to better identify the barriers African American male college students face regarding psychotherapy and utilization of mental health services. More specifically, this study used self-reporting instruments that measured attitudes toward religious help seeking, acceptance of change, group based medical mistrust, perception of mental illness and obstacles to alcohol, drug, and mental health service utilization. This method enabled African American male college students to remain anonymous. The goal of this study was to identify if attitudes towards religious help seeking, acceptance of change, group based medical mistrust and perception of mental illness had a correlation to decreased therapy utilization for African American male college students.

It is necessary when choosing a research methodology that the methodology relates to the purpose of the study which determines the success and overall quality of research (Walker, 1997). The best suited approach for this study was a quantitative correlational and survey
approach. Apuke (2017) proposed that this approach seeks to research measures and analyze variables to acquire results. This approach involves the use and analysis of numerical data using specific statistical methods to answer questions such as who, how much, what, where, when, how many, and how (Apuke, 2017). This approach additionally describes the methods of explaining an issue or phenomenon through data collection in numerical form. Quantitative methods can be categorized into survey research, correlational research, experimental research, and causal-comparative research (Apuke, 2017).

**Research Questions**

The purpose of this quantitative study was to gain an increased understanding and explore the barriers that contribute to African American male college students’ lack of help seeking behaviors regarding mental health services. The three research questions used to guide this study were selected to examine perceptions of African American male college students as it relates to mental health service utilization. The intentions of the study were to increase awareness among mental health professionals in relation to approaches that may be implemented to increase service utilization among African American male college students. This study addressed these questions:

**RQ1:** What impact does religious attitudes towards help seeking have on the utilization of therapy for African American male college students?

**RQ2:** Does acceptance of change have a statistically significant impact on the utilization of therapy for African American male college students?

**RQ3:** Does group medical mistrust and the perception of mental illness of African American male college students contribute to the willingness or lack of utilization among African American male college students?
Null Hypotheses

Through the use of survey research, the expectations for the study were as follow:

\( H_01: \) Attitudes towards religious help seeking does not have an impact on the utilization of therapy for African American male college students.

\( H_02: \) Acceptance of change does not have a statistically significant impact on the utilization of therapy for African American male college students.

\( H_03: \) Group based medical mistrust of African American male college students does not contribute to the willingness or lack of utilization among African American male college students.

\( H_04: \) Perception of mental illness does not impact therapy utilization among African American male college students.

Participants and Setting

In this study the participants were African American male college students. Participants were required to be at least 18 years of age and currently attending a postsecondary institution that had been identified as an educational establishment. Participants were offered the opportunity to enter a raffle to win one of five $25 gift cards. If the participant wanted to be included in the drawing, the participant would click on the link within the survey that redirected the participant to a secondary survey located within google docs to provide their email to be entered into the drawing which ensured participant anonymity was not affected. A randomization tool was used to select raffle winners, participants were contacted via email, and upon confirmation were sent a $25 virtual gift card. This study included the use of online surveys to collect data from participants. Regmi et al. (2017) highlighted that data collection through online surveys have the possibility to collect large amounts of data efficiently (i.e., with less
error due to the lack of transferring written data on to a computer), economically (as it requires low human resource efforts while collecting or managing data) and within reasonably short time spans. These surveys provided convenience in numerous ways, for example, participants could respond at a time of convenience or take time in responding, so the participant did not feel rushed. Online surveys have also been found to be useful when collecting data from hard-to-reach populations. The online survey approach helped to access hard to reach populations by sending an invite through a social media form or other media outlet (Regmi et al., 2017). When selecting participants for research it is imperative for the participants to have the experience that the researcher is seeking and be able to give an account of their experience (Heppner et al., 2016).

**Advertisement and Recruitment**

Social media has been identified as a favorable instrument for delivering health interventions and facilitating study recruitment. The participants of this study were recruited online using various professional organization list serves and data sets (i.e., Facebook and Instagram). Another resource for locating possible participants for the sample group were individuals that were directly known through the use of personal contacts from the colleges and universities that the researcher had been employed by, along with community connections which provided a potential sample group for use. Using Facebook and or Instagram for health-related research is in a progressing stage (Kapp et al., 2013). Ramo and colleagues conducted a study on internet recruitment comparing three methods: craigslist advertisements, internet advertisements through social networking sites, and e-mail invitations (Ramo et al., 2010). The study findings reflected that when used through social networking sites advertisement produced increased percentage of consent validity, meeting eligibility criteria, content-specific data, and
completion of surveys by participants when compared to other methods (Ramo et al., 2010). Facebook and Instagram was used in this study to attempt to capture participants, although Instagram has been shown to attract users in the age range of 13-18 years of age. According to the Pew Research Center (2018), 95% of teens have access to smartphones and or devices, and 45% of the teens state that their online constantly. Among adolescents, 13–17-year-olds prefer YouTube and Instagram as the most popular social media platforms, with 85% and 72%, using them (Thomas et al., 2020).

The study acquired a sufficient number of participants through the use of social networks. Therefore, individuals interested in contributing to research were directed to the next step required for participation, including the opportunity to join immediately by agreeing to the consent. The email address of the researcher was provided to all participants upon acceptance into the study.

**Inclusion and Exclusion Criteria**

Participants preliminary screening was for their willingness to participate in study. Inclusion criteria required the participant to be at least 18 years of age, African American male, currently attending college, and demonstrate the ability to understand and agree to an informed consent form. Exclusion criteria consisted of (a) under the age of 18, (b) inactive college enrollment, (c) female gender and (d) not identified as African American race.

**Instrumentation**

Participants were screened based on inclusion and exclusion criteria.

**Consent for treatment**

Applicants that met the inclusion criteria completed an assessment package to include the following: an informed consent form that detailed the risks and benefits of participation, the
limits of confidentiality, participation incentives, and a demographic information form. If participants met the inclusion criteria, they were given an opportunity to complete the online survey or have the option to decline participation in the survey by exiting the survey.

**Demographics Questionnaire**

The demographic questionnaire assisted in ensuring that participants met the inclusion criteria as well as enabling the researcher to collect descriptive data regarding the population that was being surveyed. Abdelal and colleagues (n.d.) expressed that researchers collect demographic information in research surveys for the purpose of collecting data to answer research questions. These questions contain content that include demographic information for the purposes of analyzation to determine whether identity is causing an individual to exhibit a particular behavior or if there is a variable causing an individual to assume a certain identity (Abdelal et al., n.d.). It should be noted that researchers also collect demographic information for the purpose of describing their samples. The researcher used questions such as the following to collect the demographic data:

- Are you an African American male, currently enrolled in college?
- Are you 18 years of age or older?
- Do you live in the United States?

**Attitudes Toward Religious Help-Seeking Scale**

The Attitudes toward Religious Help-Seeking Scale (Hardy, 2015) is a 12-item scale developed to measure African American Christians’ attitudes toward religious and non-religious help-seeking for serious personal or mental health issues. The scale is scored on a 4-point Likert-type style scale ranging from strongly disagree (1) to strongly agree (4) with a higher overall score indicating a stronger preference for religious help-seeking from one's pastor (Hardy,
The ATRHSS is a three-section instrument; Part I of the survey focuses on the reliability and validity of Religious Help-Seeking, Part II of the survey examines the responders' preferred source of help during a crisis and Part III of the survey gathers demographic data related to age, gender, prevalence and type of religious activity, and denominational affiliation (Hardy, 2015). Hardy (2015) administered the ATRHSS twice with the first sample including 116 African American members identifying as Christian over 18 years of age and the second sample consisted of 616 people from Sunday services at eight churches in a predominantly African American county in Maryland (Hardy, 2015).

Results exhibited from the two factor analyses revealed the scale has two factors: Significance of Faith and Pastoral Disapproval (Hardy, 2015). Cronbach's alpha coefficient for the ATRHSS was obtained after each administration of the survey to determine the internal reliability producing a Cronbach's alpha coefficient of 0.72, after the first administration, thus indicating good internal reliability for the measure (Hardy, 2015). The instrument was also subjected to a principal components analysis (PCA) and used in a replication study to retest the scale (Hardy, 2015). The reliability of the scale decreased after the second administration, producing a Cronbach's alpha coefficient of .59 on the 15-item measure, likely due to variance across the samples but the reliability of the measure was considered acceptable after revisions were made (Hardy, 2015).

The development of the ATRHSS replaces the need for multiple measures which was necessary previously to capture the relationship between African Americans, religion, and help-seeking behaviors (Hardy, 2015). As previously noted, higher scores on the ATRHSS indicated a stronger preference for religious help-seeking (Hardy, 2015). This information provides knowledge that can promote the collaboration of relationships between
mental health professionals and African American clergy members (Hardy, 2015). The ATRHSS used in intake with African American clients could help a mental health professional demonstrate culture awareness and provide an opportunity for discussion regarding religious standards that may impact the helping relationship (Hardy, 2015).

**Acceptance of Change Scale**

The Acceptance of Change Scale (ACS) is a self-report measure that evaluates the tendency of clients to accept or move toward change. The dimensions of the measure are Positive Reaction to Change, Change Seeking, Cognitive Flexibility, Predisposition to Change, and Support for Change. The ACS uses a 5-point Likert-type scale (1 = not at all, 2 = a little, 3 = somewhat, 4 = much, 5 = a great deal) that consists of 20 items (e.g., “When I am faced with a change, I can see things from multiple perspectives,” “I normally seek different ways to do the same things in my daily routine,” “I am able to give new meanings to the things that I have been doing for a long time,” “It's easy for me to change my mind when I realize that I am wrong”) (Di Fabio & Gori, 2016).

Di Fabio et al. (2016) conducted a study on The Challenge of Fostering Healthy Organizations: An Empirical Study on the Role of Workplace Relational Civility in Acceptance of Change and Well-Being. The aim of this study was to examine the relationship between workplace relational civility and both acceptance of change along with the well-being beyond the effect of personality traits (Di Fabio et al., 2016). Results yielded from the hierarchical regression analyses revealed that workplace relational civility explained a fraction of incremental variance beyond personality traits relative to acceptance of change, life satisfaction, and meaning in life (Di Fabio et al., 2016). The study utilized The Acceptance of Change Scale with the aim of evaluating the tendency of the participants to accept or move
toward change (Di Fabio et al., 2016). The Cronbach’s alpha coefficients for the five dimensions were $\alpha = 0.83$ for Predisposition to change; $\alpha = 0.79$ for Support for change; $\alpha = 0.80$ for Change seeking; $\alpha = 0.75$ for Positive reaction to change, $\alpha = 0.72$ for Cognitive flexibility, and $\alpha = 0.88$ for the overall scale (Di Fabio et al., 2016). The research results emphasized the positive relationship between workplace interpersonal relationships, acceptance of change, thus suggesting new opportunities for research and intervention for the purposes of confronting the challenge of developing healthy establishments (Di Fabio et al., 2016).

**Group Based Medical Mistrust Survey**

The Group Based Medical Mistrust Survey uses a 12-item scale that measures suspicion of mainstream health care systems and health care professionals and the treatment provided to individuals of the respondent's ethnic or racial group (Thompson et al., 2004). The survey includes statements such as “People of my ethnic group cannot trust doctors and health care workers”, and “People of my ethnic group should not confide in doctors and health care workers because it will be used against them” (Thompson et al., 2004). This inventory uses a Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree) and the score range was 12 to 60 using reverse scoring (Thompson et al., 2004). The survey development was based on descriptive literature on medical mistrust and health care utilization among medically underserved ethnic groups that report a lack of confidence in medical techniques, as well as beliefs that members of certain ethnic groups do not receive accurate or adequate medical information or care when compared to other groups (Baldwin, 1996).

Thompson and colleagues modified two items from the Cultural Mistrust Inventory (CMI) (Terrell, & Terrell, 1981) for inclusion in the GBMMS. These additional items measure general suspicion and one’s belief that African Americans should be suspicious about the
information they provide to Whites because it could be used against them with an alteration in
the GBMMS as follows: “People of my ethnic group should not confide in doctors and health
care workers because it will be used against them” and “People of my ethnic group should be
suspicious of information from doctors and health care workers (Thompson et al., 2004). The
suspicions reflected are often the expressed feelings of those in the African American
community therefore further contributing to mistrust of healthcare professionals (Thompson et
al., 2004).

Thompson and colleagues study investigated the psychometric properties of the Group-
Based Medical Mistrust Scale (GBMMS), and its connection with cancer screening attitudes and
practices among African American and Latina women. The study consisted of 164
participants including measures of sociodemographic, cancer screening pros and cons,
acculturation, breast cancer screening practices and doctor recommendation of breast
screenings (Thompson et al., 2004). The inventory revealed three factors examined as subscales:
(1) suspicion, (2) group disparities in health care, and (3) lack of support from health care
providers (Thompson et al., 2004). Convergent validity of the GBMMS was maintained by its
negative connection with perceived benefits of cancer screening and acculturation and positive
association with perceived disadvantages of cancer screening (Thompson et al., 2004).
Additionally, results further revealed that women with no previously reported mammogram or a
long-term lapse in mammography participation (>5 years) had significantly higher total GBMMS
scores (P < 0.04) when compared to women in support of mammography guidelines or
unsupportive within the past 5 years (Thompson et al., 2004).

Perception of Mental Illness Scale
The Mental Health Stigma Scale (Yasuhara et al., 2019) currently known by Dr. Yasuhara as the Perception of Mental Illness Scale measures several dimensions of mental illness stigma, including perceived dangerousness, self-care, social distance, treatment amenability and predicted police behavior. An initial 28 items were developed to assess 5 subscales, (dangerousness, performance of daily activities, social distance, treatability, and predicted police behavior) (Yasuhara et al., 2019). Questions on the scale consist of questions asking, “are individuals with mental illness likely to do something harmful to themselves or others” and asking “how close in distance and relationship are you comfortable getting close to a person with mental illness”) (Yasuhara et al., 2019). Psychometric assessment of the data was completed using undergraduate students as the study sample. Exploratory factor analysis revealed a final 24 items across three factors (Yasuhara et al., 2019). Internal consistency, concurrent validity, and convergent validity were reported for the items. Internal Consistency: The final scale has acceptable reliability (alpha = .92). The Cronbach's alpha coefficients for the factors range from .86-.92 (Yasuhara et al., 2019).

Yasuhara and colleagues’ purpose of the study was to measure various areas of mental illness stigma, to include perceived dangerousness, self-care, social distance, treatment responsiveness and predicted police behavior. The study consisted of 641 undergraduate students from several American universities reaching from areas from the south to the northeast (Yasuhara et al., 2019). The study participants completed the scale yielding results indicating that measured stigma had an acceptable three-factor solution consisting of self-care, dangerousness, and police behavior (Yasuhara et al., 2019). The self-care and dangerousness factors were found to have simultaneous validity with corresponding scales of the present measures (Yasuhara et al., 2019).
Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale

The Obstacles to Alcohol, Drug and Mental Health Service Utilization scale evaluates four clusters of obstacles: Self-reliance, privacy, quality of care, and communication and or trust (Oetzel et al., 2006). The obstacle of self-reliance focuses on a patients’ desire to address the ADM problem on their own and includes two items (Oetzel et al., 2006). Privacy obstacle emphasizes the wish for information to remain confidential and includes two items (Oetzel et al., 2006). The quality of care includes concerns about the quality of care provided in the area and consists of five items (Oetzel et al., 2006). Communication and or trust obstacle comprises questions about the communication and or trust between patients and ADM health providers and includes three items (Oetzel et al., 2006). ADM health service utilization scale consist of 16 items listed in response to general questions such as: “Did you experience any concerns or difficulties when you went to the X for the care of your emotional (or drug/ alcohol) problem(s) this past year?” The 16 items are measured on a dichotomous scale (Oetzel et al., 2006).

Oetzel and colleagues (2006) conducted a study on rural American Indians’ perspectives of obstacles in the mental health treatment process in three treatment sectors. This study aimed to identify obstacles associated with alcohol, drug, and mental (ADM) health care utilization for residents on three reservations in the United States (Oetzel et al., 2006). The participants of the study disclosed that they had sought treatment for ADM problems in the past year and identified obstacles they faced during this process (Oetzel et al., 2006). Four obstacles were identified: (a) self-reliance, (b) privacy issues, (c) quality of care, and (d) communication/trust (Oetzel et al., 2006). Oetzel and colleagues stated that 71% of the study participants reported at least one of these obstacles during treatment, and 61% of the participants faced two or more obstacles. The study reported no differences in the type or number of obstacles by treatment sector (Oetzel et
al., 2006). Privacy and communication/trust obstacles were more likely to occur in emotional treatment compared to alcohol/drug treatment (Oetzel et al., 2006). Improvement of cultural competence of health care providers, quality of care, and communication/trust obstacles have been noted as efforts that will improve self-reliance based on the results of the study (Oetzel et al., 2006).

**Procedures**

The Attitudes Toward Religious Help-Seeking, Acceptance of Change Scale, Group Based Medical Mistrust Scale, Perception of Mental Illness and Obstacles to Alcohol, Drug and Mental (ADM) Health Service Utilization Scale were all retrieved from the open domain. The scales were combined in the above order along with demographic questions to create one survey that was accessed by participants using Survey Monkey. The survey link was provided to study participants via social media after receiving IRB approval from Liberty University. Participants had the ability to access the survey at their convenience from any mobile device that had internet capabilities. The beginning of the survey included the informed consent letter which included the participants role, purpose of the study, time required to complete the survey, explanation of participant selection, risks and benefits of study participation and confidentiality of the study. Following the informed consent, the participants had the option to acknowledge that they read the informed consent and agreed to participate in the study, or they could select the option to exit the survey. At the conclusion of one month, all collected data was exported out of Survey Monkey database, coded, and imported into SPSS for data analysis.

**Data Analysis**

All participants received the same set of questions which made the data nonexperimental. The researcher exported the data from Survey Monkey and imported the coded
data into the SPSS data set file for cleaning. The data that was uploaded into SPSS was inclusive of all variables and these were represented using proper formatting. There were four independent variables for this study which were attitudes toward religious help seeking acceptance of change, group medical mistrust, and perception of mental illness. All independent variables were ordinal level variables. Additionally, the study had one dichotomous dependent variable which is therapy utilization.

A quantitative correlational design was used for data analyzation purposes. This design was used to assess the relationship between African American male college students’ attitudes toward religious help seeking, acceptance of change, group based medical mistrust, perception of mental illness, and therapy utilization. The researcher retrieved participants’ characteristics using survey questions that request demographic information such as ethnicity, gender, age, educational enrollment status, religious affiliation, and mental health services related information. The researcher used descriptive and inferential statistics to present and interpret numerical data obtained from the African American male participants to evaluate whether there were significant relationships between the independent and dependent variables. Frequency tables and descriptive statistics summarized study variables, and each research question was analyzed using appropriate statistical tools (Simpson, 2015).

**Descriptive Statistics**

Descriptive research is a method that includes observing behavior to describe attributes, objectively and systematically (Descriptive Research vs Correlational Research, 2018). Descriptive statistics aim to describe the midpoint of a spread of scores, commonly referred to as the measure of central tendency, and the spread of scores known as the dispersion or variance (Descriptive statistics, n.d.). Descriptive statistics provide researchers with useful
strategies for summarizing data and provide a description of the sample but cannot provide information for causal analysis (Fisher & Marshall, 2009). Descriptive statistics were used in this study to show a summary of the participants that were involved. The main objective of descriptive research is to create a view of the current circumstances while correlational research helps in comparing two or more entities or variables (Fisher & Marshall, 2009).

**Binomial Logistic Regression**

Binomial logistic regression which is also referred to as logistic regression predicts the probability that an observation falls into one of two categories of a dichotomous dependent variable based on one or more independent variables that can be either continuous or categorical. Logistic regression is used to obtain odds ratio in the presence of more than one explanatory variable. The process is similar to multiple linear regression, with the exception that the response variable is binomial. The result of this process is the impact of each variable on the odds ratio of the observed event of relevance. The core benefit is to avoid confounding effects by analyzing the association of all variables together (Sperandei, 2014).

Binomial logistic regression has seven assumptions that must be met in order to be conducted. Assumptions for binomial logistic regression include the following: (1) the dependent variable should be measured on a dichotomous scale, (2) there should be one or more independent variables, which can be either continuous or categorical (ordinal level independent variables can be used; however they must be treated as continuous or nominal level variables), (3) there should be independence of observations, (4) there should be a minimum of 15 cases per independent variable, (5) there needs to be a linear relationship between any continuous independent variables and the logit transformation of the dependent variable, (6) data must not show multicollinearity, and (7) there should be no significant outliers high leverage.
points or highly influential points (Laerd Statistics, 2017). The Box Tidwell is specifically used for binomial logistic regressions and was ran in this study to check linearity of the impact of religious attitude towards help seeking, acceptance of change, group based medical mistrust on therapy utilization among African American male college students.

Research question one aimed to find the relationship between the impact of attitudes towards religious help seeking among African American male college students and therapy utilization. To measure this relationship, the statistical test used to determine this relationship was binomial logistic regression.

Research question two aimed to learn if acceptance of change had a statistically significant impact on the utilization of therapy for African American male college students. To measure this, the statistical test used to determine this relationship was a binomial logistic regression. Research question three aimed to discover whether group based medical mistrust and the perception of mental illness of African American male college students contributed to the willingness or lack of utilization of therapy. To measure this, the statistical test used was a binomial logistic regression.

**Box Tidwell**

The Box Tidwell was used to check for linearity while using binomial logistic regression. The Box Tidwell is a method that is recommended to evaluate whether a continuous independent variable is linearly related to the logit of the dependent variable (Laerd Statistics, 2017). The Box-Tidwell procedure was developed for linear regression but is also applicable to logistic regression models (Laerd Statistics, 2017).
Cronbach Alpha

The Cronbach alpha is a common measure of internal consistency, a measure of reliability. This test is used to determine how much the items on a scale are measuring the same underlying dimension. Cronbach alpha is generally used when you have multiple Likert questions in a survey/questionnaire that form a scale or subscale, and the researcher desires to determine if the scale is reliable. This test is also frequently used in conjunction with a data reduction technique such as principal components analysis (PCA) or factor analysis (Laerd Statistics, 2017). Cronbach alpha was used within each scale and research question to check for internal consistency.

Internal and External Validity Aspects

Patino and Ferreira (2018) stated that research validity of a study is indicative of how accurately a method measures what it is anticipated to measure. Internal validity also reflects that a given study makes it possible to eliminate alternative explanations for a finding. The validity of a research study includes two domains: internal and external validity. Patino and Ferreira (2018) defined internal validity as a way to measure if research was conducted properly and the confidence that a cause-and-effect relationship cannot be interpreted by other factors.

The internal validity of a study can be threatened by many factors, including errors in measurement or in the selection of participants in the study, while recruiting participants it is important to acknowledge the potential for personal and perceived bias (Patino & Ferreira, 2018). During the study, the researcher must be aware of their own values and beliefs while selecting participants and conducting the research (Patino & Ferreira, 2018). External validity refers to the degree to which the conclusions in your study would hold for other
individuals in other places and at other times (Patino & Ferreira, 2018). One threat to external validity would be the demographics of the study participants. The researcher captured demographic characteristics that were representative of African American male college students on a broader scale including age, enrollment status, and as a way to ensure that the study results could be generalized and replicated.

**Summary**

The aim of this quantitative correlational design was to measure the relationship between African American male college students’ attitudes toward religious help seeking, acceptance of change, group based medical mistrust, perception of mental illness, and therapy utilization. Previous literature has indicated that African American men are reluctant to seek mental health treatment and usually have a negative attitude toward mental health. A quantitative correlational method was chosen for this study because it was most appropriate for the research questions raised, which were aimed at increasing understanding and exploring the barriers that contribute to African American male college students’ experiences utilizing mental health services.
CHAPTER FOUR: FINDINGS

Overview

In this chapter, the findings and statistical analysis are presented. As expressed in Chapters 2 and 3, Previous research findings on the effectiveness of mental health services with African American men are limited due to African American men not consenting to research participation because of cultural mistrust. The rise in mental illnesses among the African American community constitutes a critical in-depth understanding of the needs and wants of this population surrounding their mental health (NAMI, n.d.). The study was designed to explore how attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma correlate with decreased therapy utilization among African American male college students. In this chapter the researcher presents a review of the data analyses (e.g., descriptive statistics, testing of assumptions) as well as results from the binomial logistic regression. Lastly, the chapter concludes with a summary of the results.

Research Questions

The study investigated the following research questions:

RQ1: What impact does religious attitudes towards help seeking have on the utilization of therapy for African American male college students?

RQ2: Does acceptance of change have a statistically significant impact on the utilization of therapy for African American male college students?
RQ3: Does group medical mistrust and the perception of mental illness of African American male college students contribute to the willingness or lack of utilization among African American male college students?

Null Hypotheses

Through the use of survey research, the expectations for the study were as follow:

\( H_0^1: \) Attitudes towards religious help seeking does not have an impact on the utilization of therapy for African American male college students.

\( H_0^2: \) Acceptance of change does not have a statistically significant impact on the utilization of therapy for African American male college students.

\( H_0^3: \) Group based medical mistrust of African American male college students does not contribute to the willingness or lack of utilization among African American male college students.

\( H_0^4: \) Perception of mental illness does not impact therapy utilization among African American male college students.

Participants

For this study, a total of 82 participants completed the research study by completing an online survey. A screening survey was utilized to identify the qualified study participants for the study (see Appendix A). All qualified participants were African American males, 18 years of age or older who currently attended a college. The screening survey consisted of the following five questions: (a) Are you an African American male, currently enrolled in college? (b) Are you 18 years of age or older? (c) Do you live in the United States? (d) Have you ever utilized mental
health services? and (e) Has your commitment to your religious or spiritual beliefs encouraged mental health service utilization outside of your religious or spiritual community? Participants who did not meet qualifications were thanked for their willingness to participate and exited from the survey. All survey data was then downloaded from SurveyMonkey and into an Excel spreadsheet for a detailed review and inspection of the data for missing data and outliers. Outliers were assessed using a box plot and frequency charts. Data was then coded for successive analysis using SPSS.

Descriptive Statistics

Descriptive statistics were used in the study to examine demographic variables. In the descriptive statistics, measurements for central tendency and varied data values for demographic variables such as (a) frequencies, (b) mean, (c) standard deviation, and (d) ranges were assessed. The study consisted of 84 participants. Two participants were removed because of the raw data containing values that needed to be recoded and recalculated for the Mental Health Stigma scale. The final dataset consisted of response data for 82 participants. Participants were recruited through the use of social media.

When examining the summary of demographic data results for the study participants, specifically when examining gender, males consisted of 100.0% of the study participants. The same held true for current enrollment in college, 18 years of age or older, and living in the United States for the study participants. Most of the study participants (70.7%) have utilized mental health services. When examining the commitment to religious or spiritual beliefs encouraging mental health service utilization outside their religious or spiritual community 78% of the study participants answered yes.
The four independent variables in this study were scores on the Attitude Toward Religious Help-Seeking (ATRHHS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma scale (MHSS). The dependent variable for this study was the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM). A summary of the descriptive statistics for each instrument is shown in Figure 1 through Figure 4. The ATRHHS measured the attitude toward religious help-seeking Figure 1 ($M=36.94$, $SD=3.831$). The ACS measured the tendency of clients to accept or move toward change Figure 2 ($M= 60.44$, $SD=8.392$). The GBMMS measured the feelings about healthcare system Figure 3 ($M= 33.76$, $SD=6.11$). The MHSS measured mental health stigma Figure 4 ($M=74.39$, $SD=15.108$). The study consisted of one dependent variable Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM).

Figure 1

Histogram for Attitudes Toward Religious Help-Seeking
Note. A frequency summary is shown for African American male college students Attitudes Toward Religious Help Seeking.

**Figure 2**

*Histogram for Acceptance of Change Scale*

Note. A frequency summary is shown for African American male college students Acceptance of Change.
Figure 3

*Histogram for Group Based Medical Mistrust*

*Note.* A frequency summary is shown for African American male college students Group Based Medical Mistrust.
Figure 4

*Histogram for Mental Health Stigma*

![Histogram for Mental Health Stigma](image)

*Note.* A frequency summary is shown for African American male college students Mental Health Stigma.

**Results**

A Box-Tidwell test was ran to test for linearity between the predictors and logit. Data screening checked for errors to ensure the data was clean and prepared before further statistical analyses was conducted.

**Assumption Tests**

When completing the binomial logistic regression for analysis, seven assumptions needed to be met. The first assumption required that the predictor variable be dichotomous (Laerd
Statistics, 2017). The dependent variable was the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) which consisted of 12 yes or no questions.

The next assumption was the independent variables are either continuous or categorical. The continuous independent variables are the four scales that were created cumulatively from Likert-scale questions (ATRHSS: 4-point, ACS: 4-point, GBMMS: 5-point, and MHSS: 7-point): Attitudes Toward Religious Help-Seeking Scale (ATRHSS: questions 7 to 21), Acceptance of Change Scale (ACS: questions 43 to 62), Group Based Medical Mistrust Scale (GBMMS: questions 63 to 74), and Mental Health Stigma Scale (MHSS: questions 75 to 98) (Laerd Statistics, 2017).

Assumption three required that there should be independence of observations and the dependent variable should have mutually exclusive and exhaustive categories. No subject influenced another subject response which leads one to believe independence of observations and the dependent variables (1=yes and 2=no) are mutually exclusive and exhaustive categories (Laerd Statistics, 2017).

The fourth assumption recommends a large sample size of at least 15 participants (Laerd Statistics, 2017). The sample size for this study was 82, which was sufficient for this analysis.

The fifth assumption requires a linear relationship between the continuous independent variables and the logit transformation of the dependent variable. The Box-Tidwell test was used and revealed a linear relationship (Laerd Statistics, 2017).

Assumption six requires no multicollinearity. To ensure the data met this assumption, the inspection of correlation coefficients and Tolerance/Variance Inflation Factor values (VIF) were
calculated. The VIF identifies correlation between independent variables and the strength of that correlation (Laerd Statistics, 2017). To meet this assumption, the VIF value should remain between .2 and 10. In our case, all variables demonstrated that there were no statistically significant correlations between the three independent variables as the VIF value was between .2 and 10. A review of the data in Table 1 reveals that all VIF values were less than 10. The general rule of thumb is that values greater than .2 indicate a lack of multicollinearity among the variables (Laerd Statistics, 2017). Based on the VIF and tolerance values presented, the assumption regarding the lack of multicollinearity was met for the data collected in this study (Laerd Statistics, 2017).

**Table 1**

*Collinearity Statistics*

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% C.I.for EXP(B)</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attitudes Toward Religious Help-Seeking Scale by LN_ATRHSS</strong></td>
<td>-.307</td>
<td>.986</td>
<td>.097</td>
<td>1</td>
<td>.756</td>
<td>.736</td>
<td>.106</td>
<td>5.084</td>
<td></td>
</tr>
<tr>
<td><strong>Acceptance of Change Scale by LN_ACS</strong></td>
<td>-.197</td>
<td>.313</td>
<td>.395</td>
<td>1</td>
<td>.529</td>
<td>.821</td>
<td>.445</td>
<td>1.517</td>
<td></td>
</tr>
<tr>
<td>Variable</td>
<td>Coefficient</td>
<td>Standard Error</td>
<td>t-value</td>
<td>p-value</td>
<td></td>
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</tr>
<tr>
<td>Group Based Medical Mistrust Scale by LN_GBMMS</td>
<td>-.496</td>
<td>.444</td>
<td>1</td>
<td>.264</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>LN_MHSS by Mental Health Stigma Scale</td>
<td>-.058</td>
<td>.159</td>
<td>.132</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Group Based Medical Mistrust Scale, Mental Health Stigma Scale.

The seventh assumption for logistic regression analysis is that there be no significant outliers. Prior to the logistic regression being completed this assumption was tested using SPSS. The predictor variables were included when testing the assumption and no outliers were found.

**Statistical Analysis**

Question 1 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You thought the problem was not serious enough, or it would get better by itself?” A binomial logistic regression analysis was ran which indicated that all interactions were not significant, the binomial logistic regression was then re-ran without these interactions' terms and all are above 0.05 which means the scales (Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) do not impact question one as shown in table 2. The variables, Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) have the following p-values (.102, .287, .550 and .700) as listed in Table 2.
The Chi-square is 7.007 with a significance of 0.536 which is not less than 0.05 meaning the data fits the model well as indicated in Table 3.

**Table 2**

*Results of a Logistic Regression of ATRHSS, ACS, GBMMS and MHS on ADM Question 1*

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes Toward</td>
<td>.108</td>
<td>.066</td>
<td>2.674</td>
<td>1</td>
<td>.102</td>
<td>1.114</td>
<td>.979</td>
<td>1.268</td>
</tr>
<tr>
<td>Religious Help-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeking Scale</td>
<td></td>
<td></td>
<td></td>
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<td>.909</td>
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<td>.018</td>
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a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Group Based Medical Mistrust Scale, Mental Health Stigma Scale.
Table 3

Model Fitting Results

Hosmer and Lemeshow Test

<table>
<thead>
<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<td>.536</td>
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</tbody>
</table>

Note. Model fits well

Question 2 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You wanted to solve the problem on your own?” A binomial logistic regression analysis was ran which indicated that all interactions were not significant, the binomial logistic regression was then re-ran without these interactions' terms and all are above 0.05 which means the scales (Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) do not impact question two as shown in table 4. The variables, Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) have the following p=values (.056, .864, .995 and .584) as listed in Table 4. The Chi-square is 6.647 with a significance of 0.575 which is not less than 0.05 meaning the data fits the model well as indicated in Table 5.

Table 4

Results of a Logistic Regression of ATRHSS, ACS, GBMMS and MHS on ADM Question 2
### Variables in the Equation

<table>
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<tr>
<th>Step</th>
<th>Attitudes</th>
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<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% C.I. for EXP(B)</th>
</tr>
</thead>
<tbody>
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<td>1a</td>
<td>Toward Religious Help-Seeking Scale</td>
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<td>3.649</td>
<td>1</td>
<td>.056</td>
<td>1.132</td>
<td>.997</td>
</tr>
<tr>
<td></td>
<td>Acceptance of Change Scale</td>
<td>-.005</td>
<td>.030</td>
<td>.029</td>
<td>1</td>
<td>.864</td>
<td>.995</td>
<td>.938</td>
</tr>
<tr>
<td></td>
<td>Group Based Medical Mistrust Scale</td>
<td>.000</td>
<td>.045</td>
<td>.000</td>
<td>1</td>
<td>.995</td>
<td>1.000</td>
<td>.916</td>
</tr>
<tr>
<td></td>
<td>Mental Health Stigma Scale</td>
<td>.009</td>
<td>.017</td>
<td>.301</td>
<td>1</td>
<td>.584</td>
<td>1.009</td>
<td>.976</td>
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<tr>
<td></td>
<td>Constant</td>
<td>-5.597</td>
<td>3.327</td>
<td>2.831</td>
<td>1</td>
<td>.092</td>
<td>.004</td>
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</table>
a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Group Based Medical Mistrust Scale, Mental Health Stigma Scale.

Table 5

Model Fitting Results

<table>
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<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6.647</td>
<td>8</td>
<td>.575</td>
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</tbody>
</table>

Note. Model fits well

Question 3 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You feared a lack of privacy, or that staff would talk to other people about your emotional problems?” A binomial logistic regression analysis was ran which indicated that one scale, Group Based Medical Mistrust Scale (GBMMS) cannot be removed from the model. Which means there is collinearity between the dependent variable, ADM Q#3 and the independent variable, scale Group Based Medical Mistrust Scale (GBMMS). The participants response to this question is understandable especially since the question asks about lack of privacy. The binomial regression was re-ran with the Box-Tidwell test using only three of the scales Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), and Mental Health Stigma Scale (MHS). Results reflected that the interactions are not significant, and all are above 0.05 which means the scales (Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), and Mental Health Stigma Scale (MHS) do not impact question three as shown in table 6. The variables have the following p=values (Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change
Scale (ACS), and Mental Health Stigma Scale (MHS). Based on the p-value (.530) being above 0.05, which means the binomial logistic regression analysis showed that only the ACS scale has no impact on ADM Q#3, You feared a lack of privacy, or that staff would talk to other people about your emotional problems. The Chi-square is 15.511 with a significance of 0.050 which is not less than 0.05 meaning the data fits the model well as indicated in Table 7.

**Table 6**

*Results of a Logistic Regression of ATRHSS, ACS, and MHS on ADM Question 3*

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% C.I.for EXP(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Attitudes Toward</td>
<td>.142</td>
<td>.066</td>
<td>4.573</td>
<td>1</td>
<td>.032</td>
<td>1.152</td>
<td>1.012</td>
</tr>
<tr>
<td>Religious Help-</td>
<td>.142</td>
<td>.066</td>
<td>4.573</td>
<td>1</td>
<td>.032</td>
<td>1.152</td>
<td>1.012</td>
</tr>
<tr>
<td>Seeking Scale</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptance of</td>
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<td>.029</td>
<td>.395</td>
<td>1</td>
<td>.530</td>
<td>1.018</td>
<td>.962</td>
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<tr>
<td>Change Scale</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Stigma Scale</td>
<td>.048</td>
<td>.018</td>
<td>7.400</td>
<td>1</td>
<td>.007</td>
<td>1.049</td>
<td>1.014</td>
</tr>
<tr>
<td>Constant</td>
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<td>3.556</td>
<td>8.031</td>
<td>1</td>
<td>.005</td>
<td>.000</td>
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</tr>
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</table>

a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Mental Health Stigma Scale.

**Table 7**

*Model Fitting Results*

*Hosmer and Lemeshow Test*
Note. Model fits well

Question 4 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You were concerned about what others might think?” A binomial logistic regression analysis was ran which indicated that once again one scale, Group Based Medical Mistrust Scale (GBMMS*LN_GBMMS) cannot be removed from the model. Which means there is collinearity between the dependent variable, ADM Q#4 and the independent variable, scale Group Based Medical Mistrust Scale (GBMMS). Since the ATRHSS, ACS and MHSS interactions are not significant, the binomial regression analysis was re-ran without their interaction terms. The variables have the following p=values for the Acceptance of Change Scale (ACS), and Mental Health Stigma Scale (MHS) of (.473 and .512) as indicated in table 8, with the p=values being above 0.05, this means the binominal logistic regression analysis showed the scales ACS and MHSS do not impact ADM Q#4, You were concerned about what others might think. The Chi-square is 5.950 with a significance of 0.653 which is not less than 0.05 meaning the data fits the model well as indicated in table 9.

Table 8

Results of a Logistic Regression of ATRHSS, ACS, and MHS on ADM Question 4

| Variables in the Equation |
|---------------------------|-------------------|----------------|----------------|-------------------|-------------------|
| B | S.E. | Wald | df | Sig. | Exp(B) | Lower | Upper |

<table>
<thead>
<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
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</thead>
<tbody>
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<td>.050</td>
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<tr>
<td>Step</td>
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<td>Acceptance of Change Scale</td>
<td>Mental Health Stigma Scale</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------</td>
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<td>---------------------------</td>
</tr>
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</table>

a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Mental Health Stigma Scale.

---

**Table 9**

*Model Fitting Results*

**Hosmer and Lemeshow Test**

<table>
<thead>
<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
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</thead>
<tbody>
<tr>
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<td>5.950</td>
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<td>.653</td>
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</table>

*Note.* Model fits well
Question 5 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You preferred to go somewhere else for care?” A binomial logistic regression analysis was ran which indicated that all interactions were not significant, the binomial logistic regression was then re-ran without these interactions' terms and all were above 0.05 which means the scales (Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) do not impact question do not impact question five, “You preferred to go somewhere else for care” as shown in table 10. The variables, Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) have the following p=values (.064, .434, .637 and .448), as listed in table 10. The Chi-square is 4.434 with a significance of 0.816 which is not less than 0.05 meaning the data fits the model well as indicated in table 11.

Table 10

Results of a Logistic Regression of ATRHSS, ACS, MHS and GBMMS on ADM Question 5

<table>
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<td>Step 1</td>
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<tr>
<td></td>
<td>Acceptance of Change Scale</td>
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<tr>
<td>Variable</td>
<td>Coefficient</td>
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<td>-----------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Mental Health Stigma Scale</td>
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<td>Group Based Medical Mistrust Scale</td>
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<td>Constant</td>
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</table>

a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Mental Health Stigma Scale, Group Based Medical Mistrust Scale.

**Table 11**

*Model Fitting Results*

**Hosmer and Lemeshow Test**

<table>
<thead>
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<th>Step</th>
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<th>df</th>
<th>Sig.</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>4.434</td>
<td>8</td>
<td>.816</td>
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</table>

*Note.* Model fits well

Question 6 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You thought treatment there probably would not help.” A binomial logistic regression analysis was ran which indicated that all interactions were not significant, the binomial logistic regression was then re-ran without these interactions' terms and all were above 0.05 which means the scales (Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) do not impact question six, “You thought treatment there probably would not help?” as shown in table 12. The variables, Attitudes
Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) have the following p-values (.064, .434, .637 and .448), as listed in table 12. The Chi-square is 10.993 with a significance of 0.202 which is not less than 0.05 meaning the data fits the model well as indicated in table 13.

**Table 12**

*Results of a Logistic Regression of ATRHSS, ACS, MHS and GBMMS on ADM Question 6*

<table>
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<th>Variables in the Equation</th>
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<th>Sig.</th>
<th>Exp(B)</th>
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</tr>
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<td>.906</td>
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</tr>
<tr>
<td>Seeking Scale</td>
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</tr>
<tr>
<td>Acceptance of</td>
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<td>1</td>
<td>.814</td>
<td>1.007</td>
<td>.952</td>
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<tr>
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<td>.415</td>
<td>1.013</td>
<td>.982</td>
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<tr>
<td>Group Based</td>
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<td>1.635</td>
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<td>.201</td>
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<td>1.699</td>
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a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Mental Health Stigma Scale, Group Based Medical Mistrust Scale.

---

**Table 13**

*Model Fitting Results*

<table>
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<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
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</thead>
<tbody>
<tr>
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<td>10.993</td>
<td>8</td>
<td>.202</td>
</tr>
</tbody>
</table>

*Note.* Model fits well

Question 7 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “The quality of medical care is poor at that/those facilities”. A binomial logistic regression analysis was ran which indicated that all interactions were not significant, the binomial logistic regression was then re-ran without these interactions' terms and three scales were above 0.05 which means the scales Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) do not impact question do not impact question seven, “The quality of medical care is poor at that/those facilities” as shown in table 14. The variables, Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHS) have the following p=values (.586, .889, and .603), as listed in table 14. The Chi-square is 8.433 with a significance of 0.392 which is not less than 0.05 meaning the data fits the model well as indicated in table 15.
Table 14

Results of a Logistic Regression of ATRHSS, ACS, MHS and GBMMS on ADM Question 7

Variables in the Equation

<table>
<thead>
<tr>
<th>Step</th>
<th>Attitudes Toward Religious Help-Seeking Scale</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% C.I. for EXP(B)</th>
</tr>
</thead>
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<td></td>
<td>.131</td>
<td>.064</td>
<td>4.247</td>
<td>1</td>
<td>.039</td>
<td>1.140</td>
<td>1.006 - 1.291</td>
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<tr>
<td>1a</td>
<td>Acceptance of Change Scale</td>
<td>.017</td>
<td>.029</td>
<td>.325</td>
<td>1</td>
<td>.568</td>
<td>1.017</td>
<td>.960 - 1.076</td>
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<tr>
<td></td>
<td>Mental Health Stigma Scale</td>
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<td>.016</td>
<td>.270</td>
<td>1</td>
<td>.603</td>
<td>1.008</td>
<td>.977 - 1.041</td>
</tr>
<tr>
<td></td>
<td>Group Based Medical Scale</td>
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<td>.042</td>
<td>.019</td>
<td>1</td>
<td>.889</td>
<td>1.006</td>
<td>.926 - 1.092</td>
</tr>
</tbody>
</table>
a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Mental Health Stigma Scale, Group Based Medical Mistrust Scale.

Table 15

Model Fitting Results

Hosmer and Lemeshow Test

<table>
<thead>
<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8.433</td>
<td>8</td>
<td>.392</td>
</tr>
</tbody>
</table>

Note. Model fits well

Question 8 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You went to those facilities in the past, but it did not help”. A binomial logistic regression analysis was ran which indicated that all interactions were not significant, the binomial logistic regression was then re-ran without these interactions' terms and three scales were above 0.05 which means the scales Acceptance of Change Scale (ACS), Mental Health Stigma Scale (MHS) and Group Based Medical Mistrust Scale (GBMMS) do not impact question do not impact question eight, “You went to those facilities in the past, but it did not help” as shown in table 16. The variables, Acceptance of Change Scale (ACS), Mental Health Stigma Scale (MHS), and Group Based Medical Mistrust Scale (GBMMS) have the following
p=values (.055, .187, and .178), as listed in table 16. The Chi-square is 8.014 with a significance of 0.432 which is not less than 0.05 meaning the data fits the model well as indicated in table 17.

Table 16

*Results of a Logistic Regression of ATRHSS, ACS, MHS and GBMMS on ADM Question 8*

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>95% C.I.for EXP(B)</th>
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<td>Attitudes Toward Religious Help-Seeking Scale</td>
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<tr>
<td>Acceptance of Change Scale</td>
<td>.064</td>
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<tr>
<td>Mental Health Stigma Scale</td>
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</table>

a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Mental Health Stigma Scale, Group Based Medical Mistrust Scale.
Table 17

Model Fitting Results

Hosmer and Lemeshow Test

<table>
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<tr>
<th>Step</th>
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<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
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<td>8.014</td>
<td>8</td>
<td>.432</td>
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</tbody>
</table>

Note. Model fits well

Question 9 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “The kind of care you needed was not available”. A binomial logistic regression analysis was ran which indicated that one scale, Group Based Medical Mistrust Scale GBMMS was removed from the model and the binomial logistic regression with Box-Tidwell test was re-ran with only three of the scales Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), and Mental Health Stigma Scale (MHS).

Results reflected that the interactions were not significant, and scales Acceptance of Change Scale (ACS), and Mental Health Stigma Scale (MHS) are above 0.05 which means the scales Acceptance of Change Scale (ACS), and Mental Health Stigma Scale (MHS) do not impact question nine as shown in table 18. The variables have the following p=values (Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), and Mental Health Stigma Scale (MHSS). Based on the p=value (.580 and .254) being above 0.05, which means the binomial logistic regression analysis showed that both the ACS and MHSS scale had no impact on ADM Q#9, The kind of care you needed was not available. The Chi-square is 8.868 with a significance of 0.354 which is not less than 0.05 meaning the data fits the model well as indicated in table 19.
Table 18

Results of a Logistic Regression of ATRHSS, ACS, and MHS on ADM Question 9

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>95% C.I.for EXP(B)</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1^a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes Toward Religious Help-Seeking Scale</td>
<td>.200</td>
<td>.069</td>
<td>8.269</td>
<td>1</td>
<td>.004</td>
<td>1.221</td>
<td>1.066</td>
<td>1.399</td>
<td></td>
</tr>
<tr>
<td>Acceptance of Change Scale</td>
<td>.016</td>
<td>.028</td>
<td>.307</td>
<td>1</td>
<td>.580</td>
<td>1.016</td>
<td>.961</td>
<td>1.074</td>
<td></td>
</tr>
<tr>
<td>Mental Health Stigma Scale</td>
<td>.018</td>
<td>.016</td>
<td>1.303</td>
<td>1</td>
<td>.254</td>
<td>1.019</td>
<td>.987</td>
<td>1.051</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>-9.574</td>
<td>3.449</td>
<td>7.707</td>
<td>1</td>
<td>.006</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Mental Health Stigma Scale.

Table 19

Model Fitting Results

Hosmer and Lemeshow Test

<table>
<thead>
<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8.868</td>
<td>8</td>
<td>.354</td>
</tr>
</tbody>
</table>

Note. Model fits well
Question 10 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You did not trust the staff”. A binomial logistic regression analysis was ran which indicated that one scale, Mental Health Stigma Scale needed to be removed from the model and the binomial logistic regression with Box-Tidwell test was re-ran with only three of the scales, Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), and Group Based Medical Mistrust Scale (GBMMS). Results reflected that the interactions were not significant, and therefore the binomial logistic regression analysis was re-ran without these interaction terms. The two scales, Acceptance of Change Scale (ACS) and Group Based Medical Mistrust Scale (GBMMS) are above 0.05 which means the scales Acceptance of Change Scale (ACS), and Group Based Medical Mistrust Scale (GBMMS) do not impact question ten as shown in table 20. The variables have the following p=values (Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS), and Group Based Medical Mistrust Scale (GBMMS). Based on the p=value (.729 and .337) being above 0.05, which means the binomial logistic regression analysis showed that both the ACS and GBMMS scale had no impact on ADM Q#10, “You did not trust the staff”. The Chi-square is 5.456 with a significance of 0.708 which is not less than 0.05 meaning the data fits the model well as indicated in Table 21.

Table 20
Results of a Logistic Regression of ATRHSS, ACS, and GBMMS on ADM Question 10

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>95% C.I.for EXP(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>S.E.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Step</td>
<td>Attitudes Toward Religious Help-Seeking Scale</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Acceptance of Change Scale</td>
</tr>
<tr>
<td></td>
<td>Group Based Medical Mistrust Scale</td>
</tr>
<tr>
<td></td>
<td>Constant</td>
</tr>
</tbody>
</table>

a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Group Based Medical Mistrust Scale.

**Table 21**

*Model Fitting Results*

<table>
<thead>
<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5.456</td>
<td>8</td>
<td>.708</td>
</tr>
</tbody>
</table>

*Note. Model fits well*

Question 11 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You were worried about racial prejudice or discrimination”. A binomial logistic regression analysis was ran which indicated that one scale, Acceptance of Change Scale (ACS) needed to be removed from the model and the binomial logistic regression with Box-Tidwell test was re-ran with three of the scales, Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale.
Results reflected that the interactions terms for Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHSS) were not significant, and therefore the binomial logistic regression analysis was re-ran without these interaction terms. The two scales, Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHSS) are above 0.05 which means the scales Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHSS) do not impact question eleven as shown in table 22. The variables for the Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma Scale (MHSS) have the following p-values (.295 and .293). Based on the p-values (.295 and .293) being above 0.05, which means the binomial logistic regression analysis showed that the two scales, GBMMS and MHSS do not impact ADM Q#11, You were worried about racial prejudice or discrimination. The Chi-square is 7.923 with a significance of 0.441 which is not less than 0.05 meaning the data fits the model well as indicated in table 23.

**Table 22**

*Results of a Logistic Regression of ATRHSS, GBMMS and MHS on ADM Question 11*

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>95% C.I. for EXP(B)</th>
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<tbody>
<tr>
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<td>B</td>
</tr>
<tr>
<td><strong>Step</strong></td>
<td></td>
</tr>
<tr>
<td>1&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Attitudes Toward</td>
<td>.133</td>
</tr>
<tr>
<td>Religious Help-Seeking Scale</td>
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</tr>
</tbody>
</table>
Table 23

Model Fitting Results

Hosmer and Lemeshow Test

<table>
<thead>
<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7.923</td>
<td>8</td>
<td>.441</td>
</tr>
</tbody>
</table>

Note. Model fits well.

Question 12 of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM) asked “You and the staff had problems understanding one another”. A binomial logistic regression analysis was ran which indicated that one scale, Group Based Medical Mistrust Scale (GBMMS) needed to be removed from the model and the binomial logistic regression with Box-Tidwell test was re-ran with three of the scales, Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS) and Mental Health Stigma Scale (MHSS). Results reflected that the interactions terms for Attitudes Toward Religious Help-Seeking Scale (ATRHSS), Acceptance of Change Scale (ACS) and Mental Health Stigma Scale...
(MHSS) were not significant, and therefore the binomial logistic regression analysis was re-ran without these interaction terms. The two scales, Acceptance of Change Scale (ACS) and Mental Health Stigma Scale (MHSS) are above 0.05 which means the scales Acceptance of Change Scale (ACS) and Mental Health Stigma Scale (MHSS) do not impact question twelve as shown in table 24. The variables for the Acceptance of Change Scale (ACS) and Mental Health Stigma Scale (MHSS) have the following p-values (.442 and .073). Based on the p-values (.442 and .073) being above 0.05, which means the binomial logistic regression analysis showed that the two scales, ACS and MHSS do not impact ADM Q#12, You and the staff had problems understanding one another. The Chi-square is 3.545 with a significance of 0.896 which is not less than 0.05 meaning the data fits the model well as indicated in table 25.

Table 24

Results of a Logistic Regression of ATRHSS, GBMMS and MHS on ADM Question 12

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% C.I.for EXP(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1a Attitudes Toward Religious Help-Seeking</td>
<td>.145</td>
<td>.065</td>
<td>4.96</td>
<td>1</td>
<td>.026</td>
<td>1.156</td>
<td>1.018 to 1.314</td>
</tr>
<tr>
<td>Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptance of Change Scale</td>
<td>.022</td>
<td>.028</td>
<td>.59</td>
<td>1</td>
<td>.442</td>
<td>1.022</td>
<td>.967 to 1.080</td>
</tr>
<tr>
<td>Mental Health Stigma Scale</td>
<td>.030</td>
<td>.016</td>
<td>3.21</td>
<td>1</td>
<td>.073</td>
<td>1.030</td>
<td>.997 to 1.064</td>
</tr>
<tr>
<td>Constant</td>
<td>-9.144</td>
<td>3.420</td>
<td>7.149</td>
<td>1</td>
<td>.008</td>
<td>.000</td>
<td></td>
</tr>
</tbody>
</table>

a. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Mental Health Stigma Scale.
Table 25

*Model Fitting Results*

<table>
<thead>
<tr>
<th>Step</th>
<th>Chi-square</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.545</td>
<td>8</td>
<td>.896</td>
</tr>
</tbody>
</table>

*Note.* Model fits well

**Hypotheses**

The summary of the hypothesis testing using the logistic regression analyses were as follows:

**H₀₁:** The null hypothesis “Attitudes toward religious help-seeking does not have an impact on the utilization of therapy for African American male college students” was found not to have a statistical significance after running the binomial logistic regression as reflected in Table 26 (p=.741). The null hypothesis was accepted.

**H₀₂/H₀₁:** The null hypothesis “Acceptance of change does not have a statistically significant impact on the utilization of therapy for African American male college students” was found not to have a statistical significance after running the binomial logistic regression as reflected in Table 26 (p=.543). The null hypothesis was accepted.

**H₀₃:** The null hypothesis “Group based medical mistrust of African American male college students does not contribute to the willingness or lack of utilization among African American male college students” was found not to have a statistical significance after running the binomial logistic regression as reflected in Table 26 (p=.258). The null hypothesis was accepted.
**H₀4:** The null hypothesis “Perception of mental illness does not impact therapy utilization among African American male college students” was found not to have a statistical significance after running the binomial logistic regression as reflected in Table 26 ($p=.709$). The null hypothesis was accepted.

**Table 26**

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% C.I.for EXP(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1ᵃ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitudes Toward Religious Help-Seeking Scale</td>
<td>1.506</td>
<td>4.564</td>
<td>.109</td>
<td>1</td>
<td>.741</td>
<td>4.509</td>
<td>.001   34599.206</td>
</tr>
<tr>
<td>Acceptance of Change Scale</td>
<td>.963</td>
<td>1.585</td>
<td>.370</td>
<td>1</td>
<td>.543</td>
<td>2.621</td>
<td>.117   58.507</td>
</tr>
<tr>
<td>Group Based Medical Mistrust Scale</td>
<td>2.255</td>
<td>1.992</td>
<td>1.282</td>
<td>1</td>
<td>.258</td>
<td>9.536</td>
<td>.192   472.717</td>
</tr>
<tr>
<td>Mental Health Stigma Scale</td>
<td>.317</td>
<td>.847</td>
<td>.140</td>
<td>1</td>
<td>.709</td>
<td>1.373</td>
<td>.261   7.225</td>
</tr>
<tr>
<td>Attitudes Toward Religious Help-Seeking Scale by LN_ATRHSS</td>
<td>-.307</td>
<td>.986</td>
<td>.097</td>
<td>1</td>
<td>.756</td>
<td>.736</td>
<td>.106   5.084</td>
</tr>
<tr>
<td>Acceptance of Change Scale by LN_ACS</td>
<td>-.197</td>
<td>.313</td>
<td>.395</td>
<td>1</td>
<td>.529</td>
<td>.821</td>
<td>.445   1.517</td>
</tr>
<tr>
<td>Group Based Medical Mistrust Scale by LN_GBMMS</td>
<td>-.496</td>
<td>.444</td>
<td>1.246</td>
<td>1</td>
<td>.264</td>
<td>.609</td>
<td>.255   1.455</td>
</tr>
<tr>
<td>LN_MHSS by Mental Health Stigma Scale</td>
<td>-.058</td>
<td>.159</td>
<td>.132</td>
<td>1</td>
<td>.717</td>
<td>.944</td>
<td>.691   1.289</td>
</tr>
<tr>
<td>Constant</td>
<td>-46.801</td>
<td>44.658</td>
<td>1.098</td>
<td>1</td>
<td>.295</td>
<td>.000</td>
<td></td>
</tr>
</tbody>
</table>

ᵃ. Variable(s) entered on step 1: Attitudes Toward Religious Help-Seeking Scale, Acceptance of Change Scale, Group Based Medical Mistrust Scale, Mental Health Stigma Scale, Attitudes Toward Religious Help-Seeking Scale * LN_ATRHSS, Acceptance of Change Scale * LN_ACS, Group Based Medical Mistrust Scale * LN_GBMMS, LN_MHSS * Mental Health Stigma Scale.
Summary

An insufficient amount of data is available on African American male college students' behaviors on therapy utilization and the influence of cultural factors, such as cultural mistrust, help-seeking intentions, and actual help-seeking behaviors (Mesidor & Sly, 2014). The data from this study was used to explore how attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma correlated with decreased therapy utilization among African American male college students. In Chapter 4, an overview of the data collection process was discussed. Data was analyzed from survey responses of 82 African American male college students which were used to answer survey questions on SurveyMonkey.com. Any inconsistencies within the recruitment process and statistical assumptions were examined in this chapter. Results from the binomial logistic regression analysis showed that the independent variables Attitude Toward Religious Help-Seeking (ATRHHS), Acceptance of Change Scale (ACS), Group Based Medical Mistrust Scale (GBMMS) and Mental Health Stigma scale (MHSS) measure were not significant predictors of the Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale (ADM). Therefore, the null hypothesis was accepted. The interpretation of the findings, recommendations for future research, and implications are discussed in Chapter 5.
CHAPTER FIVE: CONCLUSIONS

Overview

This study assessed the analytical relationships between African American male college students’ attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma correlation with decreased therapy utilization for mental illness. Findings from a binomial logistic regression analysis revealed that attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma were not statistically significant predictors of African American male college students' utilization of therapy for mental illness. In this chapter, the discussion section will review the hypotheses and the study results. This chapter also provides limitations, conclusions, and recommendations for further research.

Discussion

The purpose of this study was to provide insight on how attitudes toward religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma impact therapy utilization among African American male college students. According to Keys et al. (2012), there is an increase in mental illness among college students and often a comorbidity pattern with substance abuse (Keyes et al., 2012). Specifically, African American college students encounter various stressors when compared with other races, despite their shared college experience (Greer & Chwalisz, 2007). Notably, African American college students may encounter injustices that increase their vulnerability to mental health disorders such as racism, a cultural tension, and lack of educational and social support (Dzokoto et al.; Swail, 2003). As mentioned in previous chapters, mental health in the African American community is often stigmatized (Dzokoto et al.,
The National Alliance conducted a nationwide survey consisting of 765 college students on Mental Illness (NAMI) suggested that 40% of students with mental health disorders did not access mental health services when needed, with stigma being the most significant barrier to access (National Alliance on Mental Illness, 2012). These perceived stigmatizations can increase African American college students’ vulnerability and discourage them from seeking mental health services (Cheng et al., 2013). These factors likely explain why many African American students self-report a mental health diagnosis such as depression; however, they fail to utilize mental health services (Soet & Sevig, 2006; Watkins et al., 2012).

This study was designed to examine how attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma correlate with decreased therapy utilization among African American male college students. While there is existing research surrounding this topic, much of the data are outdated as recent research has not been available due to a lack of desire of researchers to conduct studies on African American men as well as participation from African American men.

The results of this research study were collected using a survey targeted towards African American male college students and their Influence of Religious Attitudes, Acceptance of Change, and Cultural Mistrust on the Utilization of Therapy. The survey allowed African American male college students an opportunity to respond to questions of a private nature as they related to their mental health in an anonymous setting. The research study's findings may minimize barriers to therapy utilization while increasing knowledge about the benefits of its use, which influences health care outcomes and disparities among males in the African American community.
The following research questions were addressed:

**RQ1:** Does attitude towards religious help-seeking impact the utilization of therapy among African American male college students?

**RQ2:** Does acceptance of change have a statistically significant impact on the utilization of therapy for African American male college students?

**RQ3:** Do the cultural mistrust and the mental health stigma of African American male college students contribute to the willingness or lack of utilization among African American male college students?

**Implications**

The results from the research study revealed that attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma were not statistically significant predictors of therapy utilization among African American male college students. Although the study did not exhibit a statistically significant difference with attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma on decreased therapy utilization for mental illness, there is known stigma associated with mental illness in the African American community (Baoku, 2018).

The study results imply that African Americans still have much work to mental health help-seeking. Suggested implications are to promote culturally competent practice, to ensure that therapies and intervention strategies effectively increase emotional recovery for African American males (Bauer et al., 2020). Previous research studies have demonstrated the influence that religion, family, and ethnicity have on the resilience among African American males, which
can contribute to their decreased use of therapy services (Bauer et al., 2020). A strategy for improvement requires government officials and researchers to address systemic injustices such as racism, discrimination, employment, housing, and health that impact mental health among African American males (Williams, 2014). Addressing these issues will provide the opportunity for mental health service providers to create outreach mental health programs that encourage and support African American students and explore help-seeking intentions (Mesidor & Sly, 2014). Additionally, researchers should consider partnerships with religious groups, community and healthcare organizations, schools, community figures and implementing psychoeducational training programs (Estacio et al., 2017).

The purpose of this research study was to gain insight into the current barriers surrounding therapy utilization among African American male college students and assess if the black community had become more progressive in the discussion surrounding mental health and therapy, specifically African American male college students. Although this research study provided a questionnaire in an online, anonymous setting to answer questions, this process still promoted more opportunities for African American males to begin having more conversations about mental health in formal and informal settings.

Limitations

Price and Murnan (2004) stated, “a study limitation or instrument are defined as the systematic bias that the researcher did not or could not control and which could inappropriately impact the results”. The purpose of presenting limitations of a study is to provide meaningful information to the reader; When conducting a study, a researcher has an obligation to be honest when presenting the limitations presented in a study. Ultimately, study limitations indicate flaws
within a research study that may affect outcomes and assumptions of the research (Ross & Bibler Zaidi, 2019).

This study consisted of several limitations. The methodology used in the study was quantitative. Rasinger (2013) stated that this research method attempts to examine the answers to the research questions starting with how many, how much, and to what extent (Rasinger, 2013). Additionally, the quantitative research method can be restrictive as it focuses strongly on measuring variables that exist in society (Rasinger, 2013). The issue with this method is that the influence of the variables and social world are only represented numerically. Payne and Payne (2004, p. 180 as cited in McNeil, 2008) detailed that, “Quantitative methods seek consistencies in human lives, by separating the social world into experimental components called variables which are represented numerically as frequencies or rates (McNeil, 2008). Qualitative research methods require more depth of content by analyzing the subjective significance of issues, events, or practices by collecting non-standardized data and analyzing texts and images rather than numbers and statistics (Macur, 2013).

Secondly, the study included limited demographic factors and did not include other demographic factors such as socioeconomic factors. Socioeconomic factors such as income, educational level, job, and marital status have been noted in prior research studies to show the impact demographic factors could have as predictors to treatment help-seeking for care (Villatoro et al., 2017). Specified SES factors such as income and education have been observed as correlating with positive attitudes towards treatment, problem acknowledgment, and repeated help-seeking (Villatoro et al., 2017). Additional factors specific to this study also include the option for the participants to identify their religious group and college major as this may also serve as a predictor towards help seeking. For example, students that may have been enrolled in a
psychology program may be more inclined to participate in therapy when compared to a student that may be an economics major.

Thirdly, the online survey used for data collection was anonymous, and although this was a convenient and effective method for data collection, there were limitations of study participants. Online surveys have grown in popularity recently for research studies, perhaps because of their ease and cost efficiency as a means for data collection (Andrade, 2020). Andrade (2020) notes that “online surveys frequently experience two serious methodological limitations: the population to which they are distributed cannot be described, and respondents with biases may select themselves into the sample. Additionally, due to the nature of the study being online, the researcher could not determine if the study participants completed the survey multiple times or if the participants indeed met the screening requirements.

Finally, the small sample size could further limit the generalizability of the results (Faber & Fonseca, 2014). One hundred sixty-four study participants responded to the survey; however, only 82 participants could be included in the study. Samples in the study should not be either too big or too small since both have limitations that can compromise the conclusions drawn from the studies (Faber & Fonseca, 2014). A sample too small may prevent the findings from being extrapolated, while too large a sample may increase the detection of differences, highlighting statistical differences that are not significant (Faber & Fonseca, 2014). The researcher utilized a G*Power calculator to determine the minimum sample size needed accurately. The inadequate response of potential participants decreased the statistical power of the study. According to Kang (2021), the larger the sample size, the more likely it will accurately represent the population the study is examining (Kang, 2021). Sampling bias and high variability in study findings can be a drawback in using this method for recruitment (Kang, 2021). For instance, although the
participation of the study was online and anonymous, the smaller number of male participants in this study may have been due to the study being open for 30 days.

**Recommendations for Future Research**

This section of the study presents recommendations for further research regarding therapy utilization among African American male college students. This continued research is needed due to the scarcity of literature related to the topic to obtain more insight into the barriers of mental health therapy utilization among African American males. It is well known that African Americans especially emerging adults are a perilous group because of combined influences of disproportionate mental illness problems experienced (Williams, 2014). When compared with older adults, three-fourths of all lifetime cases of mental illness begin by age 24; emerging adults of any race or ethnicity are at increased risk for the onset of severe mental illness (Jackson et al., 2004). As noted by Williams (2014), few studies have pursued the examination of specific rates of mental illness among African American emerging adults; in particular, complex interactions between age and race have been noted (Jackson et al., 2004). Jackson and colleagues (2004) provided findings from the Epidemiologic Catchment Area Study demonstrating that African American emerging adults had higher 12-month rates of major depression when compared with other racial-ethnic and age groups (Jackson et al., 2004).

Untreated mental illness often leads to severe personal and societal consequences (Stolzenburg et al., 2018).

Also, I recommend that future researchers consider conducting a mixed-method approach for data collection. A mixed-method approach allows a more comprehensive and collaborative data utilization than separate quantitative and qualitative data collection and analysis (Guetterman et al., 2015). Mixed methods also allow the participants’ experiences to be shared
and ensure that study findings are grounded in participants’ experiences (Guetterman et al., 2015). They were explicitly addressing those study findings regarding therapy utilization among African American males. The qualitative component of the mixed methods could use open-ended interview questions concerning personal experiences, stigmas, influences, and other barriers to help-seeking to gain greater insight among this population. Responses to these open-ended questions could aid in understanding the needs of African American males and help produce more opportunities of therapy options that will serve them best, primarily since mistrust among African Americans and medical professionals still exists. Furthermore, mixed-method studies add breadth to research by strengthening the rigor and enhancing the analysis and research findings (Guetterman et al., 2015).

Additionally, I recommend future researchers conduct additional studies, using Asian and Hispanic populations as research on this topic is limited. In 2015, the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), the National Institute of Mental Health (NIMH), National Institutes of Health (NIH), and RTI International collected data reflecting the highest estimates of past year mental health service use were for adults reporting two or more races (17.1 percent), Native adults (15.6 percent), followed by black (8.6 percent), Hispanic (7.3 percent), and Asian (4.9 percent) adults (SAMHSA, 2015).

Lastly, an increase in sample size to generalize the results to a larger group of African American men would benefit the research drastically. It is necessary to express that this study is not representative of every African American male college student, and only represents a sample amongst this population and suggests what some may find beneficial in gaining insight on increasing therapy utilization.
Summary

The quantitative, correlational study examined the influence of attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma on the utilization of therapy among male African American college students. Study findings indicated that attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma were not significant predictors of therapy utilization among African American male college students. As previously mentioned, several factors, including cultural and healthcare mistrust and disparities, inhibit African Americans and other minorities from taking advantage of mental health services (Fripp & Carlson, 2017). According to NAMI (2004), African Americans usually do not participate in mental health treatment for reasons that may include but are not limited to distrust, stigma, misdiagnosis, lack of knowledge about mental illness, and feeling misunderstood culturally. In the future, a mixed-methods approach should be considered to understand better the attitudes that African Americans possess associated with mental health (Fripp & Carlson, 2017). The qualitative component would provide the opportunity to explore the unique relationship that those attitudes share with stigma and thinking patterns towards mental health service utilization (Fripp & Carlson, 2017).

In conclusion, further research can address the areas that were not examined in this research, which may help to increase treatment participation and improve mental health overall among the African American community.
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Appendix A: Demographic Questionnaire

1. Are you an African American male, currently enrolled in college?
   - Yes (1)
   - No (2)

2. Are you 18 years of age or older?
   - Yes (1)
   - No (2)

3. Do you live in the United States?
   - Yes (1)
   - No (2)

4. Have you ever utilized mental health services?
   - Yes (1)
   - No (2)

5. Has your commitment to your religious or spiritual beliefs encouraged mental health service utilization outside of your religious or spiritual community?
   - Yes (1)
   - No (2)
Appendix B: Attitudes Toward Religious Help-Seeking Scale

(Hardy, 2015)

Attitudes Toward Religious Help-Seeking Scale (ATRHS)

Developed by & Property of Dr. Kimberly Hardy

While some instruments may be developed for a discrete research study, others could have significant utility as a tool for researchers and practitioners if they are found to be both culturally and psychometrically reliable measures. The persistence of religion as a central component of daily life for many African Americans provides a rich opportunity for researchers to develop tools that can be used broadly by clinicians and clergy. Research expendability and cultural neutrality cannot be the hallmarks of measurement instrument design. If the goal of research is to gain awareness of existing viewpoints and desired outcomes among a particular population, it is important to tailor that tool to collect the views and outcomes to the population under study.

This scale was developed specifically to gain insight into the attitudes of African American Christians toward seeking help during times of significant personal distress. Existing measures attempting to capture similar attitudes and perceptions of faith community members tend to lack precision because of the language used, the components being measured, and the lack of cultural context. This measure has successfully overcome these methodological challenges by focusing on the specific historical, social, and cultural context of the Black Church.

The scale has undergone rigorous psychometric validation (Hardy, 2015) and is considered a reliable measure in its current form. As with any validated instrument, any alterations to the measure may impact the validity of the outcomes so researchers are encouraged to make no modifications. Any modifications must be identified and addressed in any written publications and/or conference presentations to ensure that the instrument is not perceived as invalid.

CODING & SCORING

The only section of the instrument that has a code book for scoring is Section One: Religious Help-Seeking. Individual item scores ranged from 1 (Strongly Disagree) to 4 (Strongly Agree) with higher scores indicating more favorable attitudes toward religious help-seeking. The total score for Section One ranges from a low of 15 (negative attitude) and a high of 60 (positive attitude). Several items on the instrument are worded intentionally to avoid acquiescent response bias by requiring reverse scoring. Those items are identified on the Researcher copy of the instrument. For those items, the score received should be as listed below:

1 → 4  2 → 3  3 → 2  4 → 1

In Section Two: Professional Preference, the decision to omit specific definitions and responsibilities associated with the professional options was intentional. In addition to identifying the person to whom one would turn for help in a time of need generally, discovering the default construction of each profession, as associated with their title alone, was an added goal. Those stereotyped activities commonly associated with social workers (welfare distribution, taking children from homes, etc.) were intentionally left off as those activities are not likely to be associated with any other helping profession. Psychology and psychiatry were grouped together in this section as it was believed that their distinctiveness from each other would be immaterial for the respondent.

Section Three: Demographics concludes with an invitation to have the respondent elaborate on any aspect of the instrument’s content. Researchers are cautioned against removing this as it has yielded rich qualitative information in past administrations.
### Section One: Religious Help-Seeking

Please indicate your level of agreement or disagreement with each of the statements below.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My pastor would be the first person I reached out to for help with a serious personal problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not use pastoral counseling because I do not trust that my issues would remain confidential.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have considered pastoral counseling for a serious personal problem before.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not use pastoral counseling because I do not think he/she is trained to handle certain issues.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not use pastoral counseling if I could be guaranteed that my information would remain confidential.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not feel comfortable if my pastoral counselor was significantly younger than me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would prefer pastoral counseling for a serious personal problem rather than a therapist.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some issues are too personal to discuss in pastoral counseling.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not use pastoral counseling because the pastor is so close to God that I would feel judged/condemned.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not feel comfortable if my pastoral counselor was significantly older than me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A primary reason I would use pastoral counseling is because my pastor is African-American.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would use pastoral counseling if it were anonymous (like a crisis hotline).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A primary reason I would use pastoral counseling is because the pastor would understand how my faith/religion impacts my issues.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not use pastoral counseling because he/she might think I don't trust God to handle my problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would not use pastoral counseling because he/she may think I'm weak.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section Two: Professional Preference

<table>
<thead>
<tr>
<th>Problem/Issue</th>
<th>LGCC</th>
<th>PGPA</th>
<th>PGCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief of behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual/homosexuality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotionally abusive relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contemplating abortion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After losing a abortion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General marital difficulties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contemplating divorce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After getting divorced</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extensive illness of a child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contemplating sickness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issues related to mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contemplating infertility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After illness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section Three: Demographics

All information you provide will be anonymous and confidential. Please complete all sections.

**Gender**
- Male
- Female

**Age range**
- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65 years old or older

**Highest level of school completed**
- Less than high school
- 4 years of high school
- 2 years of college/associate’s degree
- 4 years of college/bachelor’s degree
- Master’s degree
- Doctoral degree

**How many years have you been a member of your church?**

**How often do you attend weekly worship services?**
- Once each week
- 2 times per month
- 3 or more times per month

**Do you attend Bible study?**
- Yes
- No

**If you do not attend Bible study, how often does that happen?**
- Once each week
- Twice each week
- 3 or more times each month

**What is your church’s denomination?**
- Baptist
- Southern Baptist
- Catholic
- Lutheran
- Methodist
- Presbyterian
- Other

**Church affiliation**
- Member of Church of the Brethren (COB)
- Member of Church of Jesus Christ of Latter-Day Saints (Mormon)
- African Methodist Episcopal (AME)
- African Methodist Episcopal Zion (AMEZ)
- African Methodist Episcopal Zion (AMEZ)
- African Methodist Episcopal Zion (AMEZ)

Please feel free to share any additional thoughts on the back of this sheet. Thank you for your time!
Appendix C: Acceptance of Change Scale

(Di Fabio & Gori, 2016).

1. I am always looking for changes in my everyday life
2. I normally seek different ways to do the same things in my daily
3. I am looking for changes in my life, even when things are going well
4. Although I do not see the benefits, I cannot wait to change
5. If necessary, it is not difficult for me to change my mind
6. My opinions may have changed
7. It’s easy for me to change my mind when I realize that I am wrong
8. When I’ve made an important decision, I can change it if it involves an advantage
9. I easily identify alternative paths
10. Thinking about new plans is easy for me
11. When I am faced with a change, I can see things from multiple perspectives
12. I am able to take all the opportunities that occur to me
13 I can find the positives in changes that are apparently negative
14. I am able to tolerate even the negative aspects of change
15. I am able to give new meanings to the things that I have been
16. I am aware of mutations that involve the change
17. I can compare myself with other people important to me when
18. I trust the people close to me when faced with change
19. When I compare myself with others, I am better able to cope with
20. I can handle the changes in relationships with others
Appendix D: Group Based Medical Mistrust Scale

(Thompson et al., 2004)

**Instructions:** Below is a list of statements dealing with your general feelings about the healthcare system. Read each item carefully and circle whether you strongly agree, agree, feel neutral, disagree, or strongly disagree with each statement.

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctors and healthcare workers sometimes hide information from patients who belong to my ethnic group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Doctors have the best interests of people of my ethnic group in mind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. People of my ethnic group should not confide in doctors and healthcare workers because it will be used against them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. People of my ethnic group should be suspicious of information from doctors and healthcare workers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. People of my ethnic group cannot trust doctors and healthcare workers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. People of my ethnic group should be suspicious of modern medicine.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Doctors and healthcare workers treat people of my ethnic group like “guinea pigs”.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. People of my ethnic group receive the same medical care from doctors and healthcare workers as people from other groups.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Doctors and healthcare workers do not take the medical complaints of people of my ethnic group seriously.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. People of my ethnic group are treated the same as people of other groups by doctors and healthcare workers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. In most hospitals, people of different ethnic groups receive the same kind of care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I have personally been treated poorly or unfairly by doctors or</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
healthcare workers because of my ethnicity.
Appendix E: Mental Health Stigma Scale

(Yasuhara et al., 2019)

<table>
<thead>
<tr>
<th>Perception of Mental Illness Scale</th>
<th>Extremely Unlikely</th>
<th>Extremely Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

1. If someone has a history of mental health issues, how likely do you feel they are to take care of themselves (grooming, paying bills, etc.)?  

2. If someone has a history of mental health issues, how likely are you to move next door to them?  

3. If someone has a history of mental health issues, how likely do you feel they are able to understand their mental health situation?  

4. If someone has a history of mental health issues, how likely do you feel a police officer would need to draw their weapon?  

5. If someone has a history of mental health issues, how likely do you feel they could raise a family?  

6. If someone has a history of mental health issues, how likely do you feel they are to maintain a job?  

7. If someone has a history of mental health issues, how likely do you feel they are to return to a normal and productive lifestyle?  

8. If someone has a history of mental health issues, how likely do you feel that they could watch after/babysit a child?  

9. If someone has a history of mental health issues, how likely do you feel they are to easily lose control of their temper/have violent outbursts?  

10. If someone has a history of mental health issues, how likely are you to socialize with that person during the day?  

11. If someone has a history of mental health issues, how likely do you feel a police officer would need to tackle the person to the ground?  

12. If someone has a history of mental health issues, how likely do you feel a police officer would need to use other forceful means to subdue the individual (pepper spray, taser, etc.)?  

13. If someone has a history of mental health issues, how likely do you feel they would be able to solve everyday problems?
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>If someone has a history of mental health issues, how likely are you to have them marry into your family?</td>
</tr>
<tr>
<td>15.</td>
<td>If someone has a history of mental health issues, how likely do you feel they are to understand the legal system?</td>
</tr>
<tr>
<td>16.</td>
<td>If someone has a history of mental health issues, how likely do you feel they are to do something violent or harmful to someone else?</td>
</tr>
<tr>
<td>17.</td>
<td>If someone has a history of mental health issues, how likely do you feel they are to understand a personal legal situation if found in one?</td>
</tr>
<tr>
<td>18.</td>
<td>If someone has a history of mental health issues, how likely do you feel they are to make responsible decisions for themselves (finances, employment, etc.)?</td>
</tr>
<tr>
<td>19.</td>
<td>If someone has a history of mental health issues, how likely do you feel a police officer would need to use physical force on them?</td>
</tr>
<tr>
<td>20.</td>
<td>If someone has a history of mental health issues, how likely do you feel they are to do something unpredictable and dangerous?</td>
</tr>
<tr>
<td>21.</td>
<td>If someone has a history of mental health issues, how likely do you feel they are to relapse back into a hospital?</td>
</tr>
<tr>
<td>22.</td>
<td>If someone has a history of mental health issues, how likely do you feel they are to be able to have a good marriage?</td>
</tr>
<tr>
<td>23.</td>
<td>If someone has a history of mental health issues, how likely are you to be in support of the construction for a group home for people like them in your neighborhood?</td>
</tr>
</tbody>
</table>
Appendix F: Obstacles to Alcohol, Drug, and Mental (ADM) Health Service Utilization Scale
(Oetzel et al., 2006)

Self-reliance
8. You thought the problem was not serious enough, or it would get better by itself.
9. You wanted to solve the problem on your own.

Privacy
3. You feared a lack of privacy, or that staff would talk to other people about your emotional problems.
4. You were concerned about what others might think.

Institutional Quality Obstacles
10. You preferred to go somewhere else for care.
11. You thought treatment there probably would not help.
12. The quality of medical care is poor at that/those facilities.
13. You went to those facilities in the past, but it did not help.
15. The kind of care you needed was not available.

Communication/Trust Obstacles
2. You did not trust the staff.
5. You were worried about racial prejudice or discrimination.
16. You and the staff had problems understanding one another.
Appendix G: Consent

Title of the Project: Examining the Influence of Religious Attitudes, Acceptance of Change, and Cultural Mistrust on the Utilization of Therapy for African American Male College Students Utilizing Therapy.
Principal Investigator: Jessica Shine, doctoral candidate, Liberty University

<table>
<thead>
<tr>
<th>Invitation to be Part of a Research Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are invited to participate in a research study. To participate, you must be 18 years old or older, currently living in the United States, an African American male, currently attending a postsecondary institution that has been identified as an educational establishment, possess a history of mental health-related service utilization, history of mental health service utilization with early termination, or no history of mental health services at all and demonstrate the ability to understand and sign an informed consent form. Taking part in this research project is voluntary.</td>
</tr>
</tbody>
</table>

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

<table>
<thead>
<tr>
<th>What is the study about and why is it being done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of the study is to explore how attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma correlate with decreased therapy utilization among African American male college students.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What will happen if you take part in this study?</th>
</tr>
</thead>
</table>
| If you agree to be in this study, I will ask you to do the following things:  
  1. Access the anonymous online survey through Survey Monkey, read and answer the survey questions. The survey will take approximately 30 minutes to complete. |

<table>
<thead>
<tr>
<th>How could you or others benefit from this study?</th>
</tr>
</thead>
</table>
| Participants should not expect to receive a direct benefit from taking part in this study.  
Benefits to society include increased public knowledge and awareness regarding how attitudes toward religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma impact therapy utilization among African American male college students. |

<table>
<thead>
<tr>
<th>What risks might you experience from being in this study?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.</td>
</tr>
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<tr>
<th>How will personal information be protected?</th>
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<tr>
<td>The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.</td>
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</table>
- Participant responses will be anonymous.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.

<table>
<thead>
<tr>
<th>How will you be compensated for being part of the study?</th>
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<tr>
<td>Participants may be compensated for participating in this study. Participants will be offered the opportunity to enter a raffle to win one of five $25 electronic gift cards. Email addresses will be requested for compensation purposes; however, they will be collected via a separate survey to maintain your anonymity.</td>
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<tr>
<th>Is study participation voluntary?</th>
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<tbody>
<tr>
<td>Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey without affecting those relationships.</td>
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<tr>
<th>What should you do if you decide to withdraw from the study?</th>
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<tbody>
<tr>
<td>If you choose to withdraw from the study, please exit the survey prior to submission and close your internet browser. Your responses will not be recorded or included in the study.</td>
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</table>

<table>
<thead>
<tr>
<th>Whom do you contact if you have questions or concerns about the study?</th>
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</thead>
<tbody>
<tr>
<td>The researcher conducting this study is Jessica Shine. You may ask any questions you have now. If you have questions later, you are encouraged to contact her at. You may also contact the researcher’s faculty sponsor, Dr. Gary Probst at</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Whom do you contact if you have questions about your rights as a research participant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at <a href="mailto:irb@liberty.edu">irb@liberty.edu</a>.</td>
</tr>
</tbody>
</table>

_Disclaimer:_ The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

<table>
<thead>
<tr>
<th>Your Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.</td>
</tr>
</tbody>
</table>
Consent

Title of the Project: Examining the Influence of Religious Attitudes, Acceptance of Change, and Cultural Mistrust on the Utilization of Therapy for African American Male College Students Utilizing Therapy.
Principal Investigator: Jessica Shine, doctoral candidate, Liberty University

Invitation to be Part of a Research Study
You are invited to participate in a research study. To participate, you must be 18 years old or older, currently living in the United States, an African American male, currently attending a postsecondary institution that has been identified as an educational establishment, possess a history of mental health-related service utilization, history of mental health service utilization with early termination, or no history of mental health services at all and demonstrate the ability to understand and sign an informed consent form. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?
The purpose of the study is to explore how attitudes towards religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma correlate with decreased therapy utilization among African American male college students.

What will happen if you take part in this study?
If you agree to be in this study, I will ask you to do the following things:
1. Access the anonymous online survey through Survey Monkey, read and answer the survey questions. The survey will take approximately 30 minutes to complete.

How could you or others benefit from this study?
Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include increased public knowledge and awareness regarding how attitudes toward religious help-seeking, acceptance of change, cultural mistrust, and mental health stigma impact therapy utilization among African American male college students.

What risks might you experience from being in this study?
The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.
Appendix H: Social Media Post

ATTENTION FACEBOOK/INSTAGRAM FRIENDS: I am conducting research as part of the requirements for a Doctor of Education degree at Liberty University. The purpose of my research is to better understand how attitudes towards religious help seeking, acceptance of change, and how cultural mistrust impacts therapy utilization among African American male college students. If willing, you will be asked to complete an anonymous online survey, which should take about 30 minutes. If you would like to participate and meet the criteria below, please click the link provided at the end of this post. A consent document will be provided as the first page of the survey. Please review this page, and if you agree to participate, click the “proceed to survey” button at the end. Because this study is anonymous, you do not need to sign the consent form unless you choose to do so. To participate in the study, you must be an African American male located in the United States, 18 years of age or older, a current college student, and possess a history of mental health-related service utilization, a history of mental health service utilization with early termination, or no history of mental health service utilization at all. To take the survey, click here:

https://www.surveymonkey.com/r/CW9MDB9  After completing the survey, participants will be offered the opportunity to enter a raffle to win one of five $25 virtual gift cards.
Appendix I: Recruitment Follow Up

Dear:

As a graduate student in the School of Behavioral Sciences, Doctor of Education Community Care & Counseling program at Liberty University, I am conducting research as part of the requirements for a Doctoral degree. A recruitment flyer was posted on my social media page inviting you to participate in a research study. This follow-up post is to remind you to please complete the survey if you would like to participate and have not already done so. The deadline for participation is September 18, 2021.

If you choose to participate, you will be asked to complete an anonymous online survey, which should take approximately 30 minutes to complete. Your participation will be completely anonymous, and no personal, identifying information will be collected. To participate, click this LINK to complete the survey. A consent document is provided as the first page you will see after clicking on the survey link. The informed consent document contains additional information about my research. Please click on the survey link at the end of the informed consent document to indicate that you have read it and would like to take part in the survey. If you choose to participate, you will have the option to be entered in a raffle to win one of five $25 gift cards.

Sincerely,

Jessica Shine
Doctoral Candidate
Appendix J: Permission to Use Attitudes Toward Religious Help-Seeking Scale

Attitudes Toward Religious Help-Seeking Scale (ATRHSS) Permissions

Appendix K: Permission to Use Acceptance of Change Scale

Removed for Copyright
Appendix L: Permission to Use Group-Based Medical Mistrust Scale

Removed for Copyright
Appendix M: Permission to Use Perception of Mental Illness Scale

Perception of Mental Illness Scale

Shine, Jessica Miranda
Fri 2/5/2021 8:18 AM
To: Yasuhara, Kento

Thank you tremendously Dr. Yasuhara!

Mrs. Jessica M. Shine
From: Yasuhara, Kento
Sent: Friday, February 5, 2021 8:16 AM
To: Shine, Jessica Miranda
Subject: [External] RE: Mental Health Stigma Scale

[ EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content. ]

Hi Jessica,

Attached is the stigma measure, it is the final measure with the 3 factor solution (as you’ve seen in the article, the 3 factor solution seems to be the best fit, which means the measure is now 24 questions instead of 28). The question loading is at the end of the scale.

The original measure was given through Qualtrics, with each question having a sliding scale to rate their thoughts on each question on a scale from 0-7 (Extremely Unlikely to Extremely Likely) – see screenshot for what the original looked like. I’ve also placed the citation at the end.

Good luck!

Best,

-Dr. Yasuhara


From: Shine, Jessica Miranda
Sent: Wednesday, February 3, 2021 10:22 AM
To: Yasuhara, Kento
Subject: Mental Health Stigma Scale
Good morning Dr. Yasuhara, my name is Jessica Shine, and I am currently a doctoral student at Liberty University working on my dissertation. I am enrolled in the Community and Care Counseling program with an emphasis in Traumatology. I am writing you for the purpose of requesting permission to use your Mental Health Stigma Scale in my research study. I believe your scale could be beneficial in identifying barriers to therapy utilization among African American male college students. My dissertation topic is, The Impact of Perceived Success and Acceptance of Change on African American Male College Students Utilizing Therapy. My research is being supervised by my professor and chair Dr. Probst. If permission is granted would you provide me with copies of the test questionnaire, instructions for administering the test, and scoring procedures. Please note that I will only use the Mental Health Stigma Scale for my research study and will not sell or use it for any other purposes. Thank you for your time and consideration.

Sincerely,

Mrs. Jessica M. Shine

CONFIDENTIALITY NOTICE :: This email message and any documents, files, or previous e-mail messages attached to it is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.

YK
Yasuhara, Kento
Fri 2/5/2021 8:16 AM
To: Shine, Jessica Miranda
Final Stigma Scale 3 factor.docx
18 KB
[ EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content. ]

Hi Jessica,

Attached is the stigma measure, it is the final measure with the 3 factor solution (as you’ve seen in the article, the 3 factor solution seems to be the best fit, which means the measure is now 24 questions instead of 28). The question loading is at the end of the scale.

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Good luck!

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Sincerely,

Mrs. Jessica M. Shine
Appendix N: Permission to Use Obstacles to Alcohol, Drug, and Mental Health Service Utilization Scale

Removed for Copyright