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Factors that affect help-seeking: Examining racial differences between Whites, Asians, and African Americans

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Abstract

The purpose of this study was to identify factors that impact intentions to seek mental health services as well as to explore how they may vary based on race. A total of 172 participants were asked to fill out questions that measured variables related to help-seeking. Results indicated that Asians had significantly higher levels of self-stigma, lower levels of benefits of self-disclosure, and lower intentions to seek help than both Whites and African Americans. Multiple regression analyses showed that self-stigma was a significant predictor of intentions for all three groups, while benefits of self-disclosure was only significant for Whites and Asians. The model was found to be most predictive for Asians and least predictive for African Americans.

Keywords: help-seeking, help-seeking intentions, self-stigma, therapy self-disclosure, mental health utilization

Factors that Affect Help-Seeking: Examining Racial Differences Between Whites, Asians, and

African Americans

Prevalence rates of mental health issues are stark as Rosenberg (2013) posits that nearly

25% of adults in the U.S. have a mental illness, and that approximately 50% will meet the

criteria for at least one mental illness in their lifetime. Worldwide prevalence rates are even more

striking, as it has been revealed that 450 million people suffer from some sort of mental illness

(World Health Organization, 2001). However, the picture of the state of mental health grows

dimmer, even—according to Patel (2012), of those 450 million people, only 50% receive the

professional help that they need (as cited in Tinsley, Lease, & Wiersma, 2016).

The importance of mental health treatment is clearly demonstrated through compelling

evidence, which consistently shows the effectiveness of therapy for individuals with mental

health problems. In Smith and Glass' (1977) famed meta-analysis of 375 studies, results

indicated that psychotherapy was indeed effective, and that participants in therapy conditions

were better off than participants in no-treatment conditions. More recent research also comes to

the same conclusion about the efficacy of therapy (Tinsley, Lease, & Wiersma, 2016). Despite

the evidence of the efficacy of psychotherapy, utilization rates are largely disproportionate to

prevalence rates. This indicates not only a need to encourage individuals with mental health

problems towards treatment, but also a need to explain the discrepancy.

Health Belief Model

The Health Belief model is a social psychological theoretical framework meant to explain

and predict people's decision making related to their health (Rosenstock, 1966), such as illness

prevention (Davis, Buchanan, & Green, 2013), illness detection (Millar & Millar, 1995),

treatment/medication adhesion (Tola et al., 2016), and treatment seeking (Castonguay, Filer, &

Pitts, 2016).

The theoretical foundation of the HBM rests on five key components, which are divided

into two constructs. The first construct relates to patients' expectations about treatment of the

illness, while the second relates to the patient's perception of threat of the illness (Rosenstock,

1966). According to the HMB, an individual's perception of threat is related to three

components: perceived severity (one's beliefs about the seriousness of the illness and/or

consequences of the illness), perceived susceptibility (one's beliefs about how at risk they are to

being affected by the illness), and cues to action (some instigator or trigger related to the illness

that motivates the individual to take action) (Rosenstock, 1966). Related to the first construct, an

individual's expectations about treatment include the perceived benefits of treatment and

perceived barriers to treatment seeking (Rosenstock, 1966). The Health Belief model emphasizes

patients' beliefs (whether they be perceptions or expectations) in order to explain the conditions

under which one may be more likely to be motivated to actively make health-related decisions.

Evaluation of the HBM model indicated less predictive value for perceived susceptibility

and perceived severity, while perceived benefits and perceived barriers were shown to be

consistently significant predictors of positive health-related behaviors (Carpenter, 2010).

Perceived Barrier - Access

Access to mental health resources plays a big role in one's likelihood to get professional

help, as lack of access is a serious and prominent structural barrier. Snowden (2012) talks about

lack of insurance coverage for mental health services as a significant barrier to help-seeking. The

concern is that, even when one overcomes any psychological qualms and resolves to seek help,

lack of access (whether it be financial or accessibility related) will not afford one the opportunity

to do so. To that point, Wang, Demler, and Kessler (2002) identify the underinsured as especially vulnerable to untreated mental illness.

Perceived Barrier – Self-Stigma

Stigma is no stranger to mental health discourse, though it typically revolves around negative beliefs about people with mental illnesses. However, stigma also surrounds the issue of getting professional help, and so serves as a psychological barrier to one's likelihood to do so, as the avoidance of shame is a powerful motivator (Kim & Zane, 2016). Stigmatized fears about labels can foster ideas about how mental health services should be reserved for the severely disturbed. Two forms of stigma have revealed themselves as relevant to a lessened likelihood of getting help: social stigma and self-stigma (Corrigan, 2004). Social stigma typically involves stereotypes that evoke negative beliefs and prejudices about those who inhabit them. Regarding treatment seeking, social stigma can create collective perceptions about those who seek help—painting them as weak, incompetent, or undesirable (Komiya, Good, & Sherrod, 2000). Self-stigma can refer to internalized attitudes and, related to help-seeking, can negatively influence one's self-esteem, self-worth, and self-efficacy, as well as foster the belief that seeking help is unacceptable (Vogel, Wade, & Haake, 2006). Both self-stigma and social stigma were shown to be significantly related to unfavorable attitudes about seeking help (Nam et al., 2013).

Perceived Benefit – Self-Disclosure

Perceived benefits of treatment is a relevant variable to help-seeking, as it relates to one's own beliefs about whether professional help will produce favorable outcomes and effectively reduce distress (Kim & Zane, 2016). Perceived benefits can be examined through the lens of two particular concepts: anticipated self-disclosure utility and treatment credibility. Treatment credibility refers to the extent to which one believes that therapy/counseling is useful or effective

(Zane et al., 2005), while anticipated utility of self-disclosure "refers to the perceived value of the outcome of disclosing to a mental health professional" (Kim & Zane, 2016, p. 313).

Nam et al. (2013) also identified anticipated benefits as one of three (alongside stigma and self-disclosure) variables with the largest effect sizes in their study examining the attitudes about seeking professional help, finding a positive relationship between anticipated self-disclosure utility and attitudes about help-seeking. In examining self-disclosure as an avoidance factor in help-seeking, Vogel and Wester (2003) posit that people weigh both the risks and utilities of revealing private and sensitive information about themselves, and that this process weighs heavily on one's decision to get professional help.

Racial Differences in Help Seeking

Research has repeatedly revealed a pattern of mental health disparities in terms of prevalence rates of disorders, utilization of mental health resources, and quality of treatment care for marginalized groups such as Asians (e.g., Hall & Yee, 2012; Na, Ryder, & Kirmayer, 2016; Sue, Cheng, Saad, & Chu, 2012) and African Americans (Kawaii-Bogue, Williams, & MacNear, 2017; Snowden, 2012; Whitley & Lawson, 2010) as compared to their White counterparts. In trying to understand these patterns of discrepancies between them, it is essential to understand that each group may be faced with individual barriers related to their racial and cultural identity.

Asians

Sue et al. (2012) wrote about Asian Americans being prone to delay care, and how they have the "lowest rates of service utilization and help-seeking behaviors among ethnic minority groups and Whites" (p. 538). Instead, studies show that Asians often prefer to utilize other coping strategies—disengagement being a frequent theme (Ahn, Kim, & Park, 2009; Kim, Zane, & Blozis, 2012; Lei & Pellitteri, 2017). As an as avoidant strategy, disengagement is meant to

focus attention away from the distress, and while it may provide temporary reprieve, it can be detrimental because it only delays tending to the issue at hand.

While disengagement may partially explain the discrepancy in help-seeking, researchers have identified several other cultural-related factors that help us understand the low service utilization of Asians. For example, culture-specific values such as saving face (Zane & Yeh, 2002), maintaining social harmony (Kim, 2007), and emotional self-control (Kim & Lee, 2014) have been shown to foster negative attitudes about professional help-seeking. In fact, strict adherence to these values predicts less likelihood to seek help (Leong & Lau, 2001). Saving face and maintaining social harmony seems to relate to mental illness and help-seeking in Asian communities in that, individuals are concerned with disturbing, or negatively painting, the community of which they are part. Because of the stigma associated with mental illness, Asians may consequently feel an intense pressure to conceal their personal issues (Chang & Subramaniam, 2008). Seeking help would therefore disgrace the group. Similarly, emotional self-control—the ability to regulate and restrain one's feelings—also negatively affects Asians' attitudes about seeking help (Kim & Lee, 2014). Emotional self-control means that one should be personally responsible for one's own emotional reactions, and therefore, should not need outside assistance (Kim, Kendall, & Chang, 2016).

The common thread between culture-specific barriers, like saving face and maintaining social harmony, seems to be the emphasis on interpersonal dynamics. With much of Asian culture having a collectivist emphasis, it makes sense that stigma and shame would serve as a particularly prominent major deterrent to help-seeking (Sue et al., 2012). In one interesting study, Kim and Lee (2014) even found that internalization of the model-minority myth was a significant predictor in participants' negative attitudes about help-seeking, suggesting a concern

with maintaining a positive image and conforming to societal expectations. These concerns align with other research, which shows that Asians emphasize the need to avoid shame (Kim, 2007).

African Americans

Wang, Berglund, and Kessler (2000) stress that untreated mental illness is an especially prevalent problem in the Unites States among African Americans. Interestingly, studies show that religion and spirituality play a significant role in why African Americans don't seek professional help. Neely (2017) sought to explore the role of spirituality in the help-seeking behaviors of African Americans and found that, though a majority of her participants reported turning to prayer, gospel, or scripture during hardship, they also agreed that, if their churches provided mental health services (e.g., counseling, educational workshops), they would utilize them. While these alternative coping strategies are not inherently bad, they are still being used as substitutes for *professional* help. Using these strategies exclusively may obstruct an individual's decision to seek help for a serious problem for which a mental health professional would be most appropriate. In fact, in one study, participants reported that even though they believed mental health care providers would likely be helpful, their preferred sources for help were family, church, and schools (Murry, Heflinger, Suiter, & Brody, 2011).

As with Asians, studies also continue to explore what culturally related variables are relevant for African Americans in denying professional help. In one study specifically on African American men, Powell, Adams, Cole-Lewis, Agyemang, and Upton (2016) sought to explore race and masculinity-related influences in their help-seeking behaviors. Powell et al. (2016) found that reactance to threats of masculinity can diminish help-seeking, and that this response is stronger when experienced in tandem with everyday race-related stressors. The study concludes that, in order to address these disparities, emphasis must be put on timely help-seeking as well as

being cognizant of how their intersectional identities put them at risk for experiences that decrease their motivation to get help (Powel et al., 2016). Research shows that African Americans show a concern about stigma towards those with mental health problems, and that this serves as a significant barrier to their help-seeking (Murry, Heflinger, Suiter, & Brody, 2011). Related to stigma, family dynamics within African American communities can also be a barrier, as family can promote negative attitudes about mental illness and actively discourage others from seeking help (Whitley & Lawson, 2010).

Current Study

In order to conceptualize the relationship between intention-impacting variables and race, an adapted model is depicted in Figure 1. This expanded version of the Health Belief Model is inspired by Kim and Zane (2016), who conducted a study attempting to explain the underutilization of mental health services by Asian American college students relative to White American college students. This study builds on Kim and Zane (2016) by including African Americans, and by focusing solely on specific perceived barrier and perceived benefit variables.

The current study aims to examine relationships between benefits of self-disclosure, barriers of self-stigma, access, and intentions to seek help, as well as explore and compare the roles of perceived barriers and perceived benefits in help-seeking intentions among Whites, Asians, and African Americans. The hypotheses for this study were that Asians and African Americans would report significantly lower intentions to seek help, and significantly higher perceptions of barriers to their intentions to seek help than Whites. I also hypothesized that all three key study variables would be significant predictors of intentions to seek help, especially for Asians and African Americans.

Method

Participants

Participants in this study were gathered in two phases in order to expand the sample and gather data from a more diverse pool of participants. In total, data were collected from 172 participants, the majority of which (70.3%) reported being in college. Of those who provided their gender identification, 50 identified as male, 98 as female, and 6 as transgender. Ages ranged from 16 to 71 with a median score of 21. Data for age were skewed, as the majority of the sample (92.2%) was between 16 and 40 years old. The ethnic/racial self-identifications of the participants were as follows: 69 identified Caucasian, 36 as Asian, 28 as African American, 8 as Hispanic/Latinx, and 18 identified as Bi/Multiracial.

For analyses on racial differences, only data for Whites, Asians, and African Americans were included. The decision to exclude the data from Hispanic/Latinx participants was due to small sample size. Furthermore, data from Bi/Multiracial participants were excluded because experiences of Bi/Multiracial people are uniquely influenced by the intersections of their specific racial identities. These nuances would not be accurately captured or represented if analyses were made by grouping them all together. Table 1 shows a break down of demographics by racial group. There were no racial differences across demographics, with the exception of age, $F(2, 130) = 4.49$, $p = .01$, $\eta^2 = .07$. LSD post hoc analyses indicated that the African American sample was older than both the White sample, $p = .02$, and the Asian sample, $p = .004$.

Measures

Participants completed four scales to measure perceived benefit of self-disclosure, perceived barrier of self-stigma, intentions to seek help, and perceived access to mental health resources (see Appendix).

Perceived Benefit of Self-Disclosure

In order to assess perceived benefits specifically in regards to disclosing sensitive information to a counselor, items were adapted from the anticipated utility subscale of the Disclosure Expectation Scale (Vogel & Wester, 2003). Participants are asked to use the following response scale: 1 = *not at all,* 2 = *slightly*, 3 = *somewhat*, 4 = *moderately*, 5 = *very*, where lower scores indicated low perception of benefits and higher scores indicated high perception of benefits. Kim and Zane (2016) modified these items to use more encompassing language, changing *counselor* to *therapist/counselor/mental health professional.* These changes are reflected in the items of this survey. Sample items include: *Would you feel better if you disclosed feelings of sadness or anxiety to a therapist/counselor/mental health professional* and *How helpful would it be to self-disclose a personal problem to a therapist/counselor/mental health professional?* Cronbach's alpha for this scale was .89.

Perceived Barrier of Self-Stigma

Items adapted from the Self-Stigma for Seeking Help Scale (Vogel, Wade, & Haake, 2006) were meant to measure participants' internalized, stigmatized attitudes related to seeking help. Participants were asked to rate their responses on a 5-point Likert scale from 1 (*do not agree at all)* to 5 (*definitely agree*), with higher scores indicating higher self-stigma. Terminology in the current survey was modified by changing *therapist* to *therapist/counselor/mental health professional,* in order to be broader. Certain items in this scale required recoding. Sample items include: *I would feel inadequate if I went to a therapist/counselor/mental health professional for psychological help* and *I would feel worse about myself If I could not solve my own problems.* Cronbach's alpha for this scale was .88.

Perceived Access

Participants' perceived access to mental health resources was assessed by asking two questions. Participants were asked to answer either *Yes*, *No*, or *I Don't Know* to the following questions: *Do you have access to free mental health counseling services at your college institution?* and, *Do you have insurance that would cover mental health services (such as therapy, medication, etc.*? However, since the online version of the survey also included non-students, participants were first asked if they were in college. If yes, participants were instructed to answer both questions. Skip logic was incorporated so that participants who reported not being in college were allowed to skip the college access question and instead allowed to only answer the insurance access question. Because the question is about *perceived* access rather than *actual* access, the variables were recoded so that *Yes* responses represented perceived access and *No* and *I Don't Know* represented *no* perceived access.

Intent to Seek Help

To measure participants' intentions to seek help from a mental health professional, participants were asked questions adapted from the Intent to Seek Help Scale (Hammer & Vogel, 2013). Items were rated on a 5-point Likert scale from 1 (*not very likely*) to 5 (*very likely*) where higher scores indicated a higher likelihood of intent to seek help. The items were modified in three significant ways for the current study. First, the original items asked how likely it would be that someone would seek help *in the next 3 months*. This was changed to *if I felt I needed to*. This modification was made so as not to limit participants' responses in terms of time. Next, in line with Kim and Zane (2016), terminology was changed from *psychologist* to *therapist/counselor/mental health professional* in order to be more encompassing. Lastly, the items all followed the same template: *I would _____ to seek help from a therapist/counselor/mental health professional if I felt I needed to.* Participants were asked

whether they would *want* to seek help, *try to* seek help, *plan* to seek help, *intend,* and so on. These terms were italicized in the current survey in order to bring the participants' attention to them, and to highlight the subtle differences in what each item was asking them. A reliability analysis yielded an alpha of .95.

Procedure

The current study consisted of two forms of data collection: initially, an in-person paper survey completed by participants during the Psychology department's data collection day; and later, an online version of the survey was distributed through various online platforms. Independent-samples *t* tests and chi-square tests of independence comparisons revealed that, with the exception of intentions, there were no significant differences in any of the key study variables or demographics between the paper and online groups. Intention to seek help was rated higher among those who completed the survey on paper ($M = 23.20$, $SD = 6.73$) than those who completed the survey online ($M = 19.79$, $SD = 7.80$), $t(138.67) = 2.86$, $p = .005$. Additionally, there was more variance in the online survey group than in the paper survey group.

In both phases, participants were first asked to read an informed consent form. The form indicated that (1) the study focused on help-seeking intentions, (2) participants were not required to participate in the study, and (3) should they choose to participate, they reserved the right to withdraw at any point without penalty. The form also specified what their participation would entail—that they would be asked to fill out a survey with a series of questions about a variety of variables related to help-seeking. Additionally, the form described the steps that I, as the researcher, planned to take to ensure the confidentiality of their answers.

In the paper version of the survey, once a participant signed the form volunteering their participation, it was placed in a designated folder. The participant was then handed a packet that

contained the survey and a page for demographic information about the participant. Specifically in the paper version of the survey, steps were taken to counterbalance, in order to address possible order effects. Four versions of the paper survey measures existed, with the scales in different orders. The versions (1, 2, 3, 4) were noted next to the ID number in the top right hand corner of the survey, in order to ensure ease of data entry. The different versions of the survey were mixed up before being handed to participants. Finally, once the participant completed the packet, I put it in a separate folder and handed them a debriefing form. The form briefed the participant of the nature of the study, its aims, as well as a short description of the expectations for results. The form also included contact information, should they have any concerns, want to ask any follow-up questions or ask for the results of the study.

In the online version, participants were asked to check a box, acknowledging that they understood the information laid out in the informed consent form and consented to participating in the survey. Once the participant did this, they were allowed to proceed to the rest of the survey. The scales in the paper survey were transcribed into an online format using Survey Monkey. The first phase of data collection consisted of only college students. However, in order to access a wider and more diverse pool of participants, the online version of the survey was opened to participants who were not in school. Minor changes were made to the demographics information page in order to accommodate this. Changes include: asking whether or not the participant was in college as well as asking participants their highest level of education completed. Once participants taking the online version completed the survey and demographics page, they were redirected to a debriefing form page similar to the one participants saw in the paper version.

Results

Correlations Among Study Variables

Zero-order correlations (Pearson and point biserial) were run to examine the correlations among intentions to seek help, perceived barrier of self-stigma, perceived benefit of self-disclosure, and the two access variables. Several of the key study variables predicted intentions to seek help at a statistically significant level. Intentions to seek help was positively correlated with benefits of self-disclosure and access via insurance, and negatively correlated with self-stigma. Additionally, there were significant correlations among these predictors: self-stigma was negatively related to benefits of self-disclosure and access via insurance, and benefits of self-disclosure was positively related to access via insurance (see Table 2).

Racial Differences

One-way ANOVAs revealed racial differences for self-stigma, $F(2, 126) = 3.43$, $p = .04$, $\eta^2 = .05$, benefits of self-disclosure, $F(2, 127) = 4.66$, $p = .01$, $\eta^2 = .07$, and intentions to seek help, $F(2, 127) = 5.49$, $p = .005$, $\eta^2 = .08$ (see Table 3 for cell means). LSD post hoc analyses revealed that Asians reported significantly lower intentions to seek help and significantly lower perceived benefits than both Whites and African Americans. Results of the LSD post hoc also indicated that Asians reported significantly higher self-stigma scores than Whites. Additionally, the difference between Asians and African Americans approached significance ($p = .054$), suggesting Asians have higher self-stigma scores. In all cases, differences in scores between African Americans and Whites were not shown to be statistically significant.

Chi-square Test of Independence analyses were conducted to examine perceptions of access between Whites, Asians, and African Americans (see Table 3 for percentages). Results for both access through a college institution, $\chi^2 (1, N = 100) = 3.90$, $p = .14$, $\phi^2 = .04$, and access through insurance, $\chi^2 (1, N = 133) = 4.47$, $p = .11$, $\phi^2 = .03$, were not statistically significant.

Although statistically non-significant, it should be noted that there was a considerably low perception of college access for African Americans, compared to Whites and Asians. However when looking at combined percentages overall (perceptions of access *either* through college *or* through insurance) the numbers were slightly more even between Whites (84.1%), Asians (66.7%), and African Americans (78.6%).

Regression Analyses

Multiple regression is a statistical tool that allows for the analysis of how multiple independent predictor variables relate to a single outcome variable. One merit of multiple regression is that it shows the total variability accounted for by all the predictor variables (R^2; Adams & Lawrence, 2015). Relative to the specific key variables of the present study, intentions to seek help is the outcome variable, while self-stigma, perceived benefit of self-disclosure, and perceived access are the predictor variables. For regression purposes, both access variables (college and insurance) were combined into one variable, so that one either had a perception of access (either through college or insurance) or had a perception of no access at all.

Multiple regression analyses were run first for the whole sample, and revealed that the predictors accounted for 55% of the variation in intentions, $F(3, 146) = 59.91$, $p < .001$. Analyses were then run separately based on racial group. The model was shown to be most predictive for Asians ($R^2 = .61$), $F(3, 32) = 16.56$, $p < .001$, and least predictive for African Americans ($R^2 = .44$), $F(3, 23) = 6.04$, $p = .003$. The model accounted for 52% of the variance in intentions among Whites, $F(3, 62) = 22.15$, $p < .001$.

Another benefit of multiple regression is that one can examine the unique impact of each individual predictor on the outcome variable (Adams & Lawrence, 2015). In linear regression, the slope of the line is represented by b, although β is typically reported because it is a

standardized measure of slope. Additionally, one can calculate the semi-partial correlation squared (sr^2), which shows the unique proportion of variance accounted for by each predictor variable.

Results revealed that self-stigma significantly predicted intent to seek help for the full sample ($p < .001$), as well as for the subgroups of Whites, ($p = .001$), Asians, ($p = .006$), and African Americans ($p = .04$). Benefits of self-disclosure also significantly predicted intentions in the full sample ($p < .001$). However, when looking at racial subgroups, benefits was only statistically significant for Whites ($p < .001$) and Asians ($p < .001$). Access was not a significant predictor in any of the models. With the exception of the lower predictive value of benefits of self-disclosure among African Americans, the unique impact of these variables was similar across all the groups (see Table 4).

Discussion

The present study hypothesized that Asians and African Americans would report significantly lower intentions to seek help, and significantly higher perceptions of barriers to their intentions to seek help than Whites, and that all three key study variables would be significant predictors of intentions to seek help, especially for Asians and African Americans. Results indicated that the hypotheses were somewhat supported.

The hypotheses concerning relevant variables to help-seeking were supported in that self-stigma and benefits of self-disclosure were both found to be significant predictors of intentions to seek help. Though not for African Americans, perceived benefits of self-disclosure was indeed a significant barrier for Asians. Research by Taylor, Welch, Kim, and Sherman (2007) helps contextualize these results by positing that when Asians seek social support, they often do so in a more implicit way, by not disclosing their specific problems, which actually may be preferable

and beneficial to them. If Asians prefer to not disclose personal problems even to their close,

valued, social groups, then this could explain why they would have less intent to seek

professional help, which relies on such disclosure. Additionally, the results of the present study

coincide with Masuda and Boone (2011), which found that Asians have greater self-

concealment, which is "a person's tendency to conceal personal information that is distressing or

negatively evaluated" (p. 270), as high self-concealment would imply lesser likelihood to self-

disclose. Results of this study indicated that stigma was a prominent barrier for all groups. These

findings are supported by other research that shows stigma to be a powerful demotivator for

seeking help for both Asians (Sue et al., 2012) and African Americans (Kawaii-Bogue, Williams,

& MacNear, 2017). Related to the prominence of stigma as a barrier particularly for Asians, the

present study found that Asians reported higher levels of self-stigma than both groups. These

findings are corroborated by Masuda and Boone (2011) and Kim and Zane (2016), which both

found that, when compared to European/White Americans, Asians also reported greater stigma

related to help-seeking. Again, this can be explained by cultural dynamics that dictate that Asians

should not engage in behaviors that would reflect poorly upon the group, such as getting

professional help for mental health issues.

The hypothesis that benefits of self-disclosure would be a significant predictor of intent

to seek help was supported for Asians and Whites, but not for African Americans. This finding

does not seem to fit with previous research. I would speculate that if studies demonstrate that

stigma about mental health and help-seeking is prominent for African American communities,

then this would, in turn, influence their decisions not to self-disclose. Even more interestingly,

access was not a significant predictor of help-seeking intentions for any of the groups, as it was

expected to be. This does not fit with research that shows that there are significant discrepancies

in access to mental health care, especially for African Americans (Snowden, 2012). While it is

possible that this sample simply does have more access to mental health resources, it is also

possible that individuals' perceptions of access can be conceptualized differently. That is to say,

perhaps there is a slight, but important, distinction to be made between available and accessible.

For example, mental health services at a college institution may be technically made available to

individuals, but may not be accessible for reasons such as transportation or scheduling.

       There were a couple of limitations in the study, including the fact that the African

American sample was significantly older than the rest of the sample. This introduces a possible

confound to the study. Additionally, there was shown to be a difference in modalities for

intentions, in that intention to seek help was rated higher among those who completed the survey

on paper than those who completed the survey online. Analyses showed that it wasn't because

more of one racial group took one type of survey over another. So, a possible explanation is that

people may be less honest on surveys presented online, especially when answering potentially

sensitive questions. It should also be acknowledged that there were different ratios of gender in

the Asian, White, and African American samples. The Asian sample was more closely split

between male and female, while the White and African American samples were both

predominantly female. While the analyses revealed that the difference was not statistically

significant, it is still important to note that gender can indeed play a role in mental health

utilization (Juvrud & Rennels, 2017) as well as attitudes towards seeking help (Nam et al., 2010).

       While underutilization continues to be a problem for Asian and African American

communities, these results present various implications and practical applications to address this

issue. One such application is that, since it is evident that discrepancies are prominent, especially

among members of marginalized groups, results of studies like this should provide initiative for

taking action in the promotion of utilizing mental health services. In addition to reaching out to these communities, efforts should be made to highlight the importance of seeking professional help. This could be done by addressing beliefs about help-seeking, which would include enhancing individuals' perceptions about the benefits of treatment, and also destigmatizing treatment seeking for mental health problems. Another implication that is important to address here, but that goes beyond the results of this particular study, is that mental health programs, services, and providers should be incentivized to provide more culturally sensitive care, keeping in mind what barriers are important to a person of color's hesitance to reach out for help. Practitioners should be aware of the ways that one's race and/or culture can inform attitudes and decisions about help-seeking. Overall, this research is useful for mental health professionals who wish to increase utilization rates for underserved populations.

This study also presents potential for future studies to build on, by collecting data from other racially marginalized groups, and by also testing the predictive value of other essential barriers to help-seeking. Future studies could address social stigma, perceptions of treatment/practitioner credibility, or perception of symptom severity, for example. Furthermore, an important distinction may be made between intentions and actual help-seeking behaviors. This may be important for future researchers to consider. A final suggestion for future research is made in regards to a potential criticism of the current study—that is, the emphasis on cultural explanations for the help-seeking intentions of Asians and African Americans. Causadias, Vitriol, and Atkin (2018) study the cultural (mis)attribution bias, a "tendency to overemphasize the role of culture in the behavior of racial/ethnic minorities, and to underemphasize it in the behavior of Whites" (p. 243). The researchers explain that this can be problematic because 1) it implies that the experiences of Whites are more varied, and the standard/norm to which other

experiences must be compared, and 2) that racial/ethnic minorities and their experiences are

homogenized, and reduced to their culture, which deprives them of their autonomy and

individuality. They also point out that studies on cultural influence on Whites are limited.

Therefore, my suggestions mirror those made by Causadias et al., which would include to not

only conduct studies on cultural influences on Whites, but to also examine within-group

differences (such as comparing Southeast Asians to East Asians).

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Tables

Table 1

Demographics

		Total (N = 172)[a]	Whites (n = 69)	Asians (n = 36)	African-Americans (n = 28)
Gender[b]	Male	29.1%	27.5%	47.2%	25%
	Female	57.0%	66.7%	50%	75%
	Transgender	3.5%	5.8%	2.8%	--
Age[c]		Mdn = 21.0, Range = 55	Mdn = 21, Range = 53	M = 22.61, SD = 3.18	M = 29.93, SD = 13.53
In College		70.3%	78.3%	63.9%	82.1%
Data Collection	Paper	34.9%	36.2%	30.6%	57.1%
	Online	65.1%	63.8%	69.4%	42.9%

Notes. [a]The total includes participants who did not fall into White, Asian, or African American categories

[b]Percentages for gender do not add up to 100 because some participants chose note to report their gender

[c]Age was statistically significant different across racial groups

Table 2

Zero-order Correlations Among Key Study Variables

	1	2	3	4	5
1. Intentions	1.0				
2. Self-stigma	-.61***	1.0			
3. Benefits of Self-Disclosure	.66***	-.48***	1.0		
4. Access (College)	.06	-.14	.09	1.0	
5. Access (Insurance)	.24**	-.18*	.18*	.15	1.0

*p < .05, **p < .01, ***p < .001

Table 3

Cell Means for ANOVAs and Chi-square Analyses

	Whites		Asians		African Americans	
	M	*SD*	*M*	*SD*	*M*	*SD*
Intentions[a]	21.86	6.97	17.92	8.28	23.75	7.13
Self-Stigma[b]	21.92	8.89	26.67	10.24	22.15	7.94
Benefits of Self-Disclosure[c]	14.44	3.75	12.19	4.74	14.93	3.80
Access (College)	70.4%		78.3%		42.9%	
Access (Insurance)	68.1%		47.2%		64.3%	

Note. [a]The difference between Asians and Whites was statistically significant, $p = .01$, as was the difference between Asians and African Americans, $p = .01$.

[b]The difference between Asians and Whites was statistically significant, $p = .01$, as was the difference between Asians and African Americans, $p = .054$

[c]The difference between Asians and Whites was statistically significant, $p = .01$, as was the difference between Asians and African Americans, $p = .01$

Table 4

Regression Results for Intentions to Seek Help

	Total ($N = 150$)[a]	Whites ($n = 69$)	Asians ($n = 36$)	African-Americans ($n = 28$)
R^2	.55	.52	.61	.44
Self Stigma	$\beta = -.38***, sr^2 = .11$	$\beta = -.33**, sr^2 = .09$	$\beta = -.38**, sr^2 = .10$	$\beta = -.43*, sr^2 = .12$
Benefits	$\beta = .46***, sr^2 = .16$	$\beta = .51***, sr^2 = .22$	$\beta = .55***, sr^2 = .23$	$\beta = .28, sr^2 = .06$
Access	$\beta = .07, sr^2 = .005$	$\beta = .08, sr^2 = .01$	$\beta = -.08, sr^2 = .005$	$\beta = .13, sr^2 = .01$

*$p < .05$, **$p < .01$, ***$p < .001$

Figures

Figure 1

Adapted Conceptual Model of Help-seeking Intentions