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Explaining Intentions to Seek Mental Health Services among Black Canadians

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Explaining Intentions to Seek Mental Health Services among Black Canadians

By

Renee E. Taylor

A Thesis
Submitted to the Faculty of Graduate Studies
through the Department of Psychology
in Partial Fulfillment of the Requirements for
the Degree of Master of Arts
at the University of Windsor

Windsor, Ontario, Canada

2018

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Explaining Intentions to Seek Mental Health Services among Black Canadians

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DECLARATION OF ORIGINALITY

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ABSTRACT

The aim of this present study was to test the ability of the theory of planned behaviour (TPB) model (Ajzen, 1991) in explaining psychological help-seeking intention in a sample of 387 community-based Black Canadians. This study further examined: a) an expanded TPB psychological help-seeking model that includes self-stigma and public stigma; and b) a culturally-expanded TPB model of psychological help-seeking that includes cultural variables unique to Black Canadians (e.g., cultural mistrust and afrocultural beliefs). The results showed that TPB was not an adequate fitting model for the data. Furthermore, the addition of stigma and culturally-relevant variables did not improve the TPB's ability to explain Black Canadian help-seeking intention. However, a final respecified model was found to be a good fit for the data. An open-ended question was also included to gain a greater understanding of how Black Canadians would improve utilization of mental health services in their community. Participants emphasized making mental health services more available and accessible to Black Canadians; educating Black Canadians more about mental health and mental illness; and reducing the stigma surrounding the use of mental health services. Overall, the findings of this study revealed the important roles of perceived behavioural control, self-stigma, and afrocultural strength beliefs as the antecedents to help-seeking intention. It is hoped that the study's findings might help better inform mental health initiatives that are designed to address the issues of underutilization of psychological services and mental illness stigma among Black Canadians, and to help encourage Black Canadians to access mental health services.

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CHAPTER1

INTRODUCTION

Black Canadians have been reported as the most underserved group in the Canadian health care system (Health Canada, 2000). Specifically, Black Canadians have been found to be underrepresented in voluntary mental health services¹ in Canada (Centre for Addiction and Mental Health [CAMH] Insite News, 2006). While there have been some studies examining psychological help-seeking among African Americans, there are currently no published studies that have examined psychological help-seeking among Black Canadians in Canada. In recent years, mental health services have been made more accessible to Canadians in general; still, underutilization of these services has persisted among Black Canadians (CAMH Insite News, 2006). It has been suggested that the tendency of mental health services underutilization in this population may be due to a lower level of intention to seek help from mental health professionals for this cultural group (Njiwaji, 2012; Schreiber, Stern, & Wilson, 1998; Waldron, 2002).

Several theoretical models have been proposed to better understand intentions to seek psychological help (Ajzen & Fishbein, 1980; Andersen, 1995). The Theory of Planned Behaviour (TPB) model is one framework that has been found to proficiently explain and predict intentions to seek psychological help among various ethnically diverse samples (Compton & Esterberg, 2005; Mo & Mak, 2009; Schomerus, Matschinger, & Angermeyer, 2009). As such, it is expected that the TPB would explain psychological help-seeking intention among Black Canadians as well. Conceptually, the TPB identifies and posits that three critical variables influence a person's intention to

¹ For the purposes of this study the terms "mental health services" and "psychological help-seeking" refer to seeking help from a mental health professional such as a psychologist, counsellor, psychiatrist, therapist, or social worker.

engage in a behaviour: attitudes toward the behaviour, subjective norms, and perceived behavioural control (Ajzen, 1991). The TPB has been found to effectively predict seeking psychiatric help for depression, and psychological help-seeking in men (Schomerus, et al., 2009; Smith, Tran, & Thompson, 2008). However, the TPB does not account for other variables germane to psychological help-seeking. For example, public stigma and self-stigma are thought to be major barriers to psychological help-seeking, particularly among members of the Black community (Campbell & Long, 2014; Campbell & Mowbray, 2016; Conner, et al., 2010; Corrigan, 2004; Gary, 2005). In addition, cultural clinical studies have also found that distinctive, group-specific cultural variables, such as cultural mistrust and afrocultural beliefs, also influence intentions to seek professional psychological help among Black Canadians (Njiwaji, 2012; Waldron, 2002; Whaley, 2001). To date, however, to the author's knowledge there has not been any study that has applied and tested the TPB model in examining psychological help-seeking among Black Canadians. Nor has there been any study that has expanded the TPB to include stigma and specific cultural variables to investigate psychological help-seeking intention among culturally diverse populations.

Therefore, the current study aimed to examine the extent to which the TPB explains psychological help-seeking intention among Black Canadians. This also study tested an expanded TPB model that includes other help-seeking-related variables, including self-stigma and public stigma. Further to that, this study incorporated critical cultural variables specific to Black Canadians into the TPB model. Lastly, the model fit of each model will be tested. The results of this study will provide much-needed understanding of psychological, social, cultural, and structural barriers of help-seeking

for Black Canadians. The results will in turn contribute to the implementation of culturally-responsive mental health interventions for this growing yet severely underserved and under-researched ethnic population in Canada.

Mental Health Service Use among African Americans

Up until now, most of the existing research examining psychological help-seeking within the Black community has been conducted in the United States. This body of research has shown that African Americans use voluntary mental health services less than other ethnic groups. For instance, the Substance Abuse and Mental Health Services Administration (2015) created a chartbook using data from the National Survey on Drug Use and Health (NSDUH) collected from 2008 to 2012 in the U.S. The results of this large-scale survey showed that, among all American adults, African Americans used mental health services less than mixed-race Americans, White Americans, and American Indian or Alaskan Native Americans. When looking at mental health service use among Americans with mental illness (i.e., individuals who met the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV] criteria), African Americans were found to be utilizing mental health services much less than White Americans, mixed-race Americans, and American Indian or Alaskan Native Americans.

Another U.S. study by Broman (2012) found that, when compared to Latin American and White American young adults, African American young adults were least likely to use mental health services among the three groups. Similarly, data from the NSDUH revealed that African American adolescents with major depression received less treatment for major depression from mental health professionals, as compared to their White counterparts (Cummings, & Druss, 2011). Algeria and colleagues (2008)

integrated data collected from the National Latino and Asian American Study (NLAAS), the National Comorbidity Survey Replication (NCS-R), and the National Survey of African American Life (NSAL). They found that ethnicity predicted probabilities of accessing mental health treatment. After controlling for covariates such as socioeconomic status, education, and insurance coverage, it was found that African Americans were least likely to access mental health treatment when compared to White Americans, Latin Americans, and Asian Americans.

Therefore, cumulative research has shown that African Americans with and without mental illness use mental health services significantly less than other ethnic groups in the United States. Current research on psychological help-seeking among Black Canadians is, however, quite sparse. Although there are parallels between African Americans and Black Canadians, it is important to acknowledge that major differences do exist between these two groups as will be expounded in the following section.

Demographics of Black Population in Canada

Unlike in the United States, Canadian immigrants are not required to assimilate or relinquish their culture because of the protection of Canada's official multiculturalism policy (Government of Canada, 2012). Since 1971, the proportion of visible minorities in Canada has been growing (Statistics Canada, 2011). The Employment Equity Act defines 'visible minorities' as "persons, other than Aboriginal persons, who are non-Caucasian in race or non-white in colour." (Statistics Canada, 2011, p.4). In 2011, the three largest visible minority groups, including South Asians, Chinese, and Blacks, accounted for 61.3% of the total visible minority population in Canada (Statistics Canada, 2011).

Many Black Canadians are immigrants from the Caribbean and Africa, while others are the descendants of Black Canadians who have been living in Canada for many generations. In 2001, 45% of Black Canadians were born in Canada (Milan & Tran, 2004). In the same year, among Black Canadians who were over the age of 15, 19% were second generation (individuals who were born in Canada with at least one parent born outside of Canada) and 10% were third generation (individuals who were born in Canada and whose parents were also born in Canada) and beyond. In regions such as Nova Scotia, where there is a long history of Black settlement, 84% of Black Canadians are at least third-generation Canadians. According to the 2001 census, in the 1990's approximately 48% of Black Canadian immigrants were born in Africa and about 47% were born in the Caribbean, or Central and South America (Milan, & Tran, 2004). Still, the experience of Canadian-born Black Canadians is quite different from the experience of foreign-born Black Canadians. Those Black Canadians born and raised in Canada would be more acculturated to Canadian society and may therefore have views about mental health and help-seeking that differ from non-native Black Canadians.

It is also important to consider that there are differences in how Black Canadians ethnically self-identify. Black Canadian immigrants with origins in the Caribbean, or Central and South America often identify their ethnicity as 'Caribbean Canadian' or 'West-Indian Canadian'; whereas, Black Canadians who are decedents of Black slaves who arrived in Eastern Canada in the 1600s, describe themselves as 'African Canadians'. Furthermore, immigrants born in Africa sometimes do not consider themselves 'Black'. Statistics Canada (2011) classifies any person of African decent as 'Black'. For the purposes of this study Canadians of African origins are referred to as Black Canadians.

Despite these generational differences, there are common threads that connect most members of the Black Canadian community. For example, Black Canadians are said to share similar experiences of discrimination because of their race or skin colour (Lindsay, 2007). Research has found that Black individuals who have reported experiencing elevated levels of perceived discrimination also have elevated levels of psychological distress (Pieterse, Todd, Neville, & Carter, 2012). It should also be noted that, according to the Ethnic Diversity Survey, “a large majority of Canadians of African origin feel a strong sense of belonging to Canada” (Lindsay, 2007, p16). At the same time, Canadians of African origin also reported feeling “a strong sense of belonging to their ethnic or cultural group” (Lindsay, 2007, p16).

In sum, Black Canadians and African Americans differ greatly in terms of migratory history and cultural identity. Therefore, it cannot be assumed that Black Canadians and African Americans have the same experiences with and views of psychological help-seeking.

Mental Health Service Use of Black Canadians

Black Canadians also differ from African Americans in that Canada and the United States have very different health care systems (MacKenzie, 1999). For example, unlike the United States, Canada has a universal health insurance plan that Canadians financially contribute to and are meant to have equal access to healthcare services. However, mental health services provided by non-physicians outside of hospitals are not covered by Canada’s universal health insurance plan, while most American public and private health insurance plans cover said services (MacKenzie, 1999). Mojtabai and Olfson (2006) conducted a study comparing mental health service use between Canadians

and Americans for the treatment of depression. They found that Canadians were more likely than Americans to seek psychological help from a general practitioner or family doctor. Of the respondents who sought help from a family doctor or general practitioner, Canadians were more likely to subsequently seek services from a psychologist or psychiatrist, than their American counterparts. Mojtabai and Olfson (2006) also found that in both countries being an ethnic minority was associated with reduced likelihood of seeking psychological help.

However, so far research on ethnic differences in mental health service use in Canada is quite sparse. Based on the 2003 Canadian Community Health Survey (CCHS-1.1) data, Tiwari and Wang (2008) found that White Canadians used mental health services more than Chinese Canadians, South Asian Canadians, and South East Asian Canadians. As far as the author is aware, however, no study has compared mental health service use of Black Canadians with other ethnic groups in Canada. However, CAMH (2006) has found that Black Canadians are typically underrepresented in voluntary mental health services overall. That is, even though there have been efforts to make mental health services more accessible to Canada's culturally diverse population (e.g., Ochocka et al., 2010), underutilization of these services has persisted among Black Canadians. What remains unclear is why ethnic group disparities in the utilization of psychological services continues to exist in Canada.

Accessibility of Mental Health Services

A model that has been widely used to understand how and why people use healthcare services is Andersen's Behavioural Model (Andersen, 1968). The original model was developed in the 1960's and has undergone three phases of revisions since

then (Andersen, 1995). The most recent model proposes that there are four main factors that influence a person's likelihood of using healthcare services: Environment, Population Characteristics, Health Behaviour, and Outcomes (Andersen, 1995). The Environment component emphasizes the importance of health policy's influence on the healthcare system. The Population Characteristics include predisposing characteristics (e.g., age, gender, socioeconomic status, attitudes, values and knowledge about health and health services), enabling/impeding factors (e.g., income, health insurance, travel, and service waiting time), and perceived need for healthcare services. Health Behaviour involves personal health practices and use of health services. Outcomes refers to the combination of a person's perceived and evaluated health status and satisfaction as the consumer. This model includes feedback loops showing that the outcome variables then influence predisposing factors, perceived need for services, and health behaviour. One study used Andersen's (1995) Behavioural Model to examine variables correlated with seeking mental health services among adults in the U.S. (Dhingra, Zack, Strine, Pearson, & Balluz, 2010). It was found that the variables most associated with using mental health services were predisposing characteristics, enabling/impeding factors, and perceived need.

Several aspects of Andersen's model apply to how and why people in the Black community do not use mental health services. For example, according to the United States Department of Health and Human Services (2001) for African Americans "lack of health insurance is a barrier to seeking mental health care" (p.63). It has been suggested that the options available to African Americans when seeking treatment for mental illness are more limited than for White Americans because of their low rates of insurance

coverage (Snowden, 2001; Thompson, Bazile, & Akbar, 2004). However, the passage of legislation like the Mental Health Parity and Addiction Equity Act, and the Affordable Care Act have enabled many uninsured and under insured American to have greater access to mental health services (Barry & Huskamp, 2011; Garfield, Zuvekas, Lave & Donohue, 2011). Furthermore, the Substance Abuse and Mental Health Services Administration (2015) found that the proportion of African Americans who reported that cost or insurance was the reason for not using mental health services was in fact less than their White American counterparts. Likewise, Cummings and Druss (2011) found that socioeconomic status and health insurance only accounted for a small portion of variance when predicting the use of mental health treatment utilization. Thus, it was concluded that other factors are predominantly driving ethnic differences in mental health service use.

Andersen's Behavioural model also touches on the concept of "mental health literacy," which can be defined as knowledge about mental health and mental health services (Jorm, 2000). It has been found that difficulty recognizing symptoms of depression and a lack of information about mental health services prevented depressed African American older adults from seeking mental health services as soon as symptoms presented themselves (Conner et al., 2010). Research has found that, in non-clinical samples of African Americans, lack of awareness about mental health services and lack of education about mental illness were commonly reported barriers to seeking mental health services (Conner et al., 2010; Ward & Besson, 2013; Ward, Clark, & Heidrich, 2009). Of note, limited mental health literacy has also been found to hinder psychological help-seeking for Black people living in the United Kingdom and Canada (Nijawji, 2012;

Sisley, Hutton, Goodbody, & Brown, 2011; Waldron, 2002). Although mental health literacy plays a role in mental health service usage, it is not the most cited barrier to seeking mental health services among the Black community (Campbell & Long, 2014; Campbell & Mowbray, 2016; Conner et al., 2010; Conner et al., 2010; Schreiber et al., 1998; Waldron, 2002).

Most research about barriers to seeking mental health services for Black people discusses psychological variables that influence psychological help-seeking intention. Intention has been defined as how hard someone is willing to try in order to perform a behaviour (Ajzen, 1991). Having the intention to perform a behaviour, such as seeking mental health services, is thought to directly predict the performance of the behaviour (Ajzen, 1991; Ajzen & Fishbein, 1980). As such, it is valuable to explore variables that are related to and predictive of one's intention to seek professional psychological help.

Critical Psychological Variables Related to Help-Seeking Intentions

Many psychological variables are thought to be associated with intentions and attitudes toward psychological help-seeking (Nam et al., 2013). However, studies have found conflicting results about how these variables affect or predict an individual's perception of seeking psychological help. Nam and colleagues (2013) conducted a meta-analysis of 19 studies conducted between 1995 and 2011 (combined $N = 7,396$) to explore these conflicting results. The nine psychological factors examined in the analyses were: anticipated benefits of help-seeking, anticipated risks of help-seeking, depression, psychological distress, self-concealment, self-disclosure, social support, public stigma, and self-stigma.

All variables, except psychological distress, were significantly related to attitudes toward psychological help-seeking (Nam et al., 2013). The variables with significant positive correlations, in the order of the highest to the lowest, were anticipated benefits, self-disclosure, and social support. On the other hand, self-stigma, perceived risk, public stigma, self-concealment, and depression had significant negative correlations with attitudes toward help-seeking. Overall, self-stigma had the strongest correlation with attitudes toward seeking help, where individuals with higher self-stigma had more negative attitudes toward seeking help. Anticipated benefits had the next largest effect size followed by self-disclosure, public stigma, self-concealment, social support, perceived risk, and depression. Even though there has yet to be a systematic review to evaluate variables specifically associated with intention to seek psychological help, attitudes toward psychological help-seeking is a close proxy for psychological help-seeking intention (Ajzen, 1991; Ajzen, & Fishbein, 1980; Bohon, Cotter, Kravitz, Cello, & Fernandez y Garcia, 2016; Schomerus et al., 2009). That being said, knowing what variables are associated with psychological help-seeking intention is not sufficient in explaining intentions to seek psychological help.

Theoretical Models for Psychological Help-Seeking

Theoretical models are extremely useful because they provide frameworks that describe how several variables work together to explain or predict a behaviour or a phenomenon. The two most commonly used models that have been proposed to explain psychological help-seeking are the Theory of Reasoned Action (TRA; Ajzen, & Fishbein, 1980), and the Theory of Planned Behaviour (TPB; Ajzen, 1991). In the following

sections, each of these models will be reviewed briefly in view of the purpose of the present study with a focus on psychological help-seeking among Black Canadians.

The Theory of Reasoned Action

The Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980) has been employed to explain a wide variety of human behaviours, including but not limited to voting, abortion, resigning from a job, and eating at a fast food restaurant. The TRA asserts that an individual's intention to perform a behaviour directly determines whether or not the person will perform that actual behaviour. Intentions have been defined as indications of how hard people are willing to try in order to perform a given behaviour (Ajzen, 1991). Therefore, the stronger the intention a person has toward performing a behaviour, the more likely the individual is to engage in the said behaviour. According to the TRA model, the two key determinants of behavioural intention are attitudes toward the behaviour and subjective norms. This means that intention to perform a behaviour is directly influenced by: the degree to which a person views the behaviour to be favourable or unfavourable (attitudes); and the degree of perceived social pressure to perform or not to perform such a behaviour (subjective norms).

Previous research has found that the TRA components (attitudes towards the behaviour and subjective norms) do in fact predict psychological help-seeking intention. Vogel, Wester, Wei, and Boysen (2005) found that attitudes toward psychological help-seeking and subjective norms both predicted intentions to seek psychological help in a sample of White American college students. In a recent study, the TRA was found to explain psychological help-seeking in a sample of Latin-Americans living in Canada (Kuo, Roldan-Bau & Lowinger, 2015). Therefore, the cross-cultural generalizability of

the TRA would make the theory a good candidate for explaining psychological help-seeking among Black Canadians.

The Theory of Planned Behaviour

The TRA explains that attitudes toward a given behaviour and subjective norms predict behavioural intention; however “a behavioral intention can find expression in behaviour only if the behaviour in question is under volitional control” (Ajzen, 1991, p. 181). For behaviours like psychological help-seeking, one must consider that logistic or pragmatic obstacles, such as language barriers, and lack of time and money, may prevent some individuals from seeking psychological help even if they have the intention to do so. Therefore, this current study proposes to apply the Theory of Planned Behaviour model (TPB; Ajzen, 1991) to help explain psychological help-seeking with Black Canadians because this theoretical model accounts for additional critical factors associated with help-seeking.

The TPB is a theoretical model that was proposed to predict and explain any human behaviour in any context (Ajzen, 1991). The TPB is an extension of the TRA (Ajzen & Fishbein, 1980). Similar to the TRA, the central component of the TPB is behavioural intention. In both the TPB and the TRA, behavioural intention is predicted by attitudes toward a behaviour and subjective norms. Still, no matter how strong the intention is, an individual will not perform a behaviour if they believe the behaviour is unachievable (i.e., if there are insurmountable barriers in the way or the individual lacks the necessary resources to perform the behaviour). For this reason, the TPB model takes into consideration individuals’ perceived behavioural control (Ajzen, 1991).

Perceived behavioural control is an individual's perception of how difficult or easy it is to engage in a target behaviour. Perceived behavioural control differs from Rotter's (1966) perceived locus of control, which refers to a general perception of the extent to which one has control over one's behaviour or circumstance. Perceived behavioural control, on the other hand, refers to the extent to which one believes one can perform a specific behaviour. For example, an individual might have a strong internal locus of control (i.e., feeling that in general one's outcomes are determined by one's own behaviour) but low perceived behavioural control over performing a behaviour because it is beyond his or her capabilities.

Bandura's (1982) concept of self-efficacy is most closely aligned with the concept of perceived behavioural control. Bandura (1982) defines self-efficacy as being "concerned with judgements of how well one can execute courses of action required to deal with prospective situations" (p.122). It has been argued that perceived behavioural control, together with behavioural intention, predicts behaviour more accurately than intention alone. The reason for this is that, among those with equally high levels of intention to perform a behaviour, those who believe they can in fact accomplish the behaviour are more likely to persevere than those who doubt their ability (Ajzen, 1991).

The goal of the TPB is to explain behaviour, and not simply predict it. Therefore, Ajzen (1991) argues that it is important to consider the beliefs that determine one's attitudes toward a behaviour, subjective norms, and perceived behavioural control. The TPB proposes that behaviour is caused by three types of beliefs: *behavioural beliefs* which influence ones' attitudes toward a behaviour, *normative beliefs* which determine subjective norms, and *control beliefs* which provide the foundation for the persons'

perceptions of behavioural control. Behavioural beliefs are concerned with the expected outcomes of a behaviour. Whether an individual believes the outcomes of a behaviour will be positive or negative, will determine the persons' attitudes toward that behaviour (either favourable or unfavourable). Normative beliefs have to do with the likelihood that a person's important referent individuals or groups would or would not approve of performing a given behaviour. Subjective norms are determined by normative beliefs and the extent to which an individual is motivated to comply with the opinion of the referential group. Finally, control beliefs refer to whether one has the required resources and opportunities to perform the target behaviour. Control beliefs are influenced by one's perceived obstacles or impediments that might get in the way of performing the behaviour. These beliefs can be based on personal experience, but they are usually influenced by second-hand information about the behaviour, through the experiences of others. Perceptions of behavioural control are produced by considering how much these facilitators or hindrances exert influences over the ease or difficulty of performing the behaviour.

The TPB is one of the most widely used models for explaining health-related behaviours (McEachan, Conner, Taylor, & Lawton, 2011). According to a meta-analysis (Conner & Sparks, 2005), the three main TPB components (i.e., attitudes toward the behaviour, subjective norms, and perceived behavioural control) accounted for 40% to 54% of variance in intention to perform health behaviours. The TPB has predicted various health-related outcomes, such as addictive behaviours, automobile-related behaviours (e.g., wearing a seatbelt or speeding), clinical and screening behaviours (e.g., cancer screening), and eating behaviours (Godin & Kok, 1996). Given that seeking

mental health services is considered a health-related behaviour (Compton & Esterberg, 2005), applying the TPB to study psychological help-seeking is appropriate and would be informative.

The Theory of Planned Behaviour and Psychological Help-Seeking

Several studies have suggested that the TPB is a promising model for explaining psychological help-seeking behaviour. Recently, Bohon, Cotter, Kravitz, Cello, and Fernandez y Garcia (2016) conducted three studies to (1) evaluate scales that measure the components of the TPB (i.e., attitudes, subjective norms, and perceived behavioural control) and (2) to test if the TPB explains psychological help-seeking for depression among American college students. In the first study, the authors found that the reliability for an existing TPB scale was poor. In Study 2, using a TPB template proposed by Ajzen (2006), the researchers constructed a new scale designed to specifically measure psychological help-seeking intention, attitudes, subjective norms, and perceived behavioural control. Results showed that the new scale had higher internal consistency and greater construct validity than the previous TPB measure. Finally, Study 3 applied the newly developed scale to test the TPB model in explaining psychological help-seeking for depression among American college students. The study found that attitudes toward seeking mental health services and perceived behavioural control significantly predicted intentions to seek mental health services. However, subjective norms were not a significant predictor of seeking mental health services in that sample.

A German study used the TPB to analyze intention to seek psychiatric help for depression in a community sample of adults (Schomerus et al., 2009). The study's aim was to assess how well the TPB predicted psychiatric help-seeking with this sample in

Germany. The study also sought to identify which components of the model and what related beliefs were most relevant to psychiatric help-seeking for depression. Participants were asked to imagine the following scenario via an audio recording: their general practitioner recommended that they see a psychiatrist because they are showing symptoms of major depressive disorder. The study found that the TPB was a good model for explaining psychiatric help-seeking behaviour for depression for this sample. Further, it was shown that the explanatory power of the TPB model was even more robust for participants who actually had depression. The results showed that attitudes toward psychiatric help-seeking was the strongest predictor of intention to seek psychiatric help for depression. Perceived behavioural control had the least influence on psychiatric help-seeking intention. As theorized by Ajzen (1991), behaviour beliefs had the largest influence on one's attitudes toward psychiatric help-seeking. The results further supported Ajzen's (1991) model and showed that normative beliefs significantly predicted subjective norms. Contrarily, control beliefs did not significantly predict perceived behavioural control.

The TPB was also found to predict the length of time African American patients and/or their family members waited before they decided to seek psychiatric health services after being diagnosed with psychosis in a hospital setting (Compton & Esterberg, 2005). In this study, participants completed a TPB questionnaire measuring attitudes toward the behaviour, subjective norms, and perceived behavioural control. The study found that only perceived behavioural control significantly predicted how long participants delayed seeking psychiatric health services after their family member was

first hospitalized for psychosis. The higher the perceived behavioural control the shorter the delay in seeking psychological help.

One of the many benefits of the TPB is that it provides a framework to inform mental health campaigns. Demyan and Anderson (2012) used the TPB model to develop and test a 2-minute public service announcement-style, mass media video intervention promoting mental health help-seeking, tailored for college students. Students participated in one of two experimental conditions. In one condition, half of the participants (the media-exposed intervention group) watched media programming in which the media intervention was inserted. In the other condition, the participants (the control group) watched the same programming but with no media intervention. Then, all participants returned for a second session to complete questionnaires that measured belief-based factors (stigma, treatment fears, disclosure distress, self-concealment, treatment risk, and treatment utility). The findings revealed that the intervention failed to change beliefs about stigma, treatment fears, disclosure distress, self-concealment, treatment risk, and treatment utility. Nevertheless, participants in the media intervention group had more positive attitudes toward psychological help-seeking than those in the control group.

The studies reviewed above suggest that the TPB is a suitable model for both explaining and predicting psychological help-seeking attitudes, intentions, and behaviours. Furthermore, the TPB has been found to predict psychological help-seeking intentions in a group of men – a population that is well-known for resisting psychological help-seeking (Smith, Tran, & Thompson, 2008). Thus, it is expected that the TPB model would be an appropriate model for investigating help-seeking intention among Black Canadians.

The TPB and Factors Commonly Associated with Psychological Help-Seeking

As previously discussed, many variables are thought to influence one's decision to seek psychological help. Many of those variables fall under one of the three beliefs of the TPB model (behaviour beliefs, normative beliefs and control belief). The factors associated with behavioural beliefs are variables that can be considered outcomes or consequences of psychological help-seeking. These variables include: fears of psychotherapy, self-disclosure, anticipated risks, and anticipated benefits (Campbell & Long, 2014; Keith-Lucas, 1994; Kushner & Sher, 1989; Pipes, Schwarz, & Crouch, 1985; Shaffer, Vogel, & Wei, 2006). Any variables related to judgement or social influence from friends, family and important others can be considered normative beliefs within the TPB model. Social influence has been found to be an important determinant in White and Black participants' decisions to seek mental health services (Alvidrez, Snowden, & Kaiser, 2008; Barksdale & Molock, 2009; Conner et al., 2010; Deane & Todd, 1996; Vogel, Wade, Wester, Larson, & Hackler, 2007). Control beliefs about psychological help-seeking refer to the perceived resources or opportunities, and obstacles or impediments that hinder one's ability to seek psychological help. It has been observed that control beliefs related to psychological help-seeking among Black Canadians include but are not limited to: cost, lack of insurance, and limited mental health literacy (Conner et al., 2010; Njiwaji, 2012; Sareen et al., 2007; Scheffler & Miller, 1989; Snowden & Thomas, 2000; Steele, Glazier & Lin, 2006). Although these factors are important for predicting psychological help-seeking, many of them are explained by the TPB model, as they can be categorized as behavioural beliefs (e.g., fears of psychotherapy, self-disclosure, anticipated risks, and anticipated benefits), normative beliefs (e.g., social

influence from friends, family and important others), and control beliefs (e.g., cost, lack of insurance, and limited mental health literacy). Therefore, these factors were not directly addressed in the present study.

A variable that is thought to be critical in understanding psychological help-seeking, but is not specified in the TPB model, is mental illness stigma. Mental illness stigma can be thought of as a behavioural belief, because it is a consequence of help-seeking. However, stigma can also be argued and conceived as a normative belief, because it is highly dependent on the views of others. The next section will further discuss how stigma might affect psychological help-seeking in general and specifically for Black Canadians.

Mental Illness Stigma

One of the most widely cited barriers to psychological help-seeking is mental illness stigma. Mental illness stigma refers to the negative stereotypes, prejudice, and discrimination experienced by people with mental illness (Corrigan, 2000). According to Corrigan (2004) there are two types of stigma: public stigma and self-stigma.

Public Stigma

Mental illness public stigma refers to how the public views and treats people who are labeled as mentally ill. Stereotype, prejudice, and discrimination can prevent people with mental illness from achieving important life goals (Corrigan, 2004). For example, public stigma affects access to employment, housing, and general health care.

Researchers suggest that people with a concealable stigma, such as a mental illness, will decide to keep it hidden to avoid the harm associated with being labeled “mentally ill”

(Corrigan & Matthews, 2003). Alternatively, they may decide to avoid the label altogether by avoiding the institutions that mark them as mentally ill, such as a mental health center or a psychologist's office (Corrigan, 2004). Trying to avoid this label is likely the most significant way in which stigma impedes psychological help-seeking.

Schomerus, Matschinger, and Angermeyer (2009) explored two consequences of public stigma and how they interfere with psychiatric help-seeking intentions: anticipated discrimination by others when seeking help; and the desire to avoid social interaction with those seeking help for a mental problem. Their results showed that desire to avoid social interaction with those seeking help for a mental problem had significant negative correlations with intention to seek psychiatric help. Surprisingly, anticipated discrimination was not significantly related to psychiatric help-seeking intention according to Schomerus et al. (2009).

Self-Stigma

People may also avoid the stigma of mental illness because of its potential negative effect on their sense of self (Corrigan, 2004) – this concept pertains to the idea of mental illness self-stigma. Studies have found that people with mental illness often internalize stigmatizing ideas that are widely endorsed by the public, and they believe that they are valued less if they have psychiatric disorders (Link, 1987; Link & Phelan, 2001). It has also been found that people with mental illness experience lower levels of self-esteem, self-efficacy, and self-confidence, than those without mental illness (Corrigan, 1998). Lower self-esteem is often manifested in the form of shame, and low self-efficacy is often associated with failing to pursue achievable work or independent

living opportunities (Link, 1987). Hence, people avoid being labeled as mentally ill to avoid having to experience lower self-esteem and self-efficacy (Corrigan, 2004).

Vogel, Wade, and Haake (2006) conducted five studies to develop and evaluate the creation of a self-stigma scale called the Self-Stigma of Seeking Help (SSOSH) Scale. Those who sought psychological services reported significantly less self-stigma than those who had not sought psychological services. Furthermore, discriminant analyses showed that the SSOSH scale significantly differentiated between those who sought psychological services and those who had not. This suggests that self-stigma predicts individuals' likelihood of seeking psychological help. In another study Vogel, Wade, and Hackler (2007) found that self-stigma and attitudes toward psychological help-seeking mediated the relationship between public stigma and willingness to seek psychological help. Similarly, Lannin, Vogel, Brenner, Abraham, and Heath (2016) examined the effects of self-stigma on people's decisions to seek information for mental health and counselling services. The results showed that people with higher levels of self-stigma were less likely to seek information about mental health concerns and counselling than people with lower levels of self-stigma.

Mental Illness Stigma and the Black Community

As discussed above, stigma is a powerful barrier to psychological help-seeking in general. It is, however, especially the case for the Black community. Gary (2005) described a concept called "Double Stigma": a stigmatizing experience which occurs when a person experiences prejudice and discrimination not only from having mental illness but also being a member of a racial or ethnic minority group. Numerous qualitative research studies have suggested that Black people feel that mental illness is

more stigmatizing than individuals in other ethnic groups (Campbell & Long, 2014; Campbell & Mowbray, 2016; Conner et al., 2010; Conner et al., 2010; Schreiber et al., 1998). In a sample of African Americans with depression, Conner and colleagues (2010) found that participants experienced the stigma of being a racial/ethnic minority as well as of having depression. Similarly, Black Canadian women with mental illness in Waldron's (2002) study reported that they felt ashamed or uncomfortable about admitting that they had psychiatric problems. When compared to White Canadians, West-Indian Canadian women with depression reported that it is much more stigmatizing for them to seek psychiatric help (Schreiber et al., 1998).

Additionally, several focus group and interview studies have revealed that Black people avoid seeking mental health services in order to avoid being perceived as “crazy” or weak” (Alvidrez et al., 2008; Conner et al., 2010; Thompson et al., 2004). Within the African American community, it has been found that any type of mental health issue is associated with being “crazy” (Alvidrez et al, 2008). It was also reported that African American participants with mental illness delayed seeking help in fear of being labeled “crazy” (Campbell & Long, 2014; Conner, et al. 2010; Thompson et al., 2004). Similarly, Caribbean Canadian women felt that they would be labeled as ‘crazy’ or ‘a madwoman’ if they were to seek psychological help (Schreiber et al., 1998). In addition, Thompson and colleagues (2004) observed that the need for mental health services was associated with weakness and shame among Black people. This attitude suggests that seeking psychological help is a sign of defect or inadequacy. Also, Campbell and Long (2014) found that stereotypes about individuals with depression being weak was associated with negative attitudes toward psychological help-seeking.

It has often been reported that members of the Black community hide their mental illness to avoid negative reactions from others (Conner et al, 2010). Participants who have used mental health services have reported experiencing public stigma from family, friends, and others (Alvidrez et al., 2008). In addition, many have experienced self-stigma, including feeling embarrassed and ashamed for needing psychological help, irrespective of what other people think.

Therefore, mental illness stigma is a crucial factor to consider when trying to explain psychological help-seeking in Black Canadians. Since the TPB model does not directly account for stigma, adding public stigma and self-stigma to the TPB model would potentially improve the explanatory power for psychological help-seeking intention among Black Canadians.

Culturally-Specific Variables

The TPB model and mental illness stigma have been shown to predict psychological help-seeking attitudes and intentions in cross-cultural samples (Campbell & Mowbray, 2016; Lannin et al., 2016; Mo & Mak, 2009; Schomerus et al., 2009; Vogel et al, 2006). However, to understand and study psychological help-seeking behaviour in Black Canadians from a culturally-informed perspective, it is important to examine variables that have been noted to be unique to individuals of African decent. In this study, two critical culturally-specific variables were incorporated into the research: Afro-cultural Beliefs and Cultural Mistrust.

Afrocultural Beliefs

Several qualitative studies have identified unique attitudes and beliefs commonly endorsed by the Black community and influence intentions to seek psychological help among the Black population. The following section provides a review of empirical studies pertaining to these reoccurring themes of Black cultural beliefs.

Belief of “Mental Illness Does Not Affect Black People”

Hooks (1993) spoke of the myth common in the Black community that Black people simply do not have mental illness and it is only “silly White people who have all these mental health problems and need therapy” (p. 70). In fact, an interview study with a sample of mentally ill African Americans found that beliefs such as ‘Black people don’t get depressed’ and that mental illness is a ‘White people thing’ are commonly endorsed in the Black community (Alvidrez et al., 2008). The interview study conducted by Campbell and Long (2014) mirrored the sentiment that clinical depression is not something that affects African Americans, and that depression is something that only White people experience. Participants also debated around the issues of whether depression actually exists within the Black community or whether Black people simply refuse to acknowledge its existence (Campbell & Long, 2014). The belief that Black people do not get depressed was also discussed in focus groups with African American older adults with depression (Conner, et al., 2010). One study explored the help-seeking attitudes of adolescent African Americans by presenting them with a hypothetical suicidal crisis involving an African American adolescent boy (Molock, Barksdale, Matlin, Puri, Cammack, & Spann, 2007). All participants agreed that the boy in the vignette had a problem but they were ambivalent about the seriousness of the problem

and whether or not he really needed professional help. Moreover, participants were surprised that the boy was contemplating suicide because they felt that, unlike White people, Black people do not contemplate suicide.

The myth that mental illness does not affect members of the Black community is not unique to African Americans, however. In an interview study with depressed West-Indian Canadian women, the participants discussed whether depression existed among people from the West Indies (Schreiber et al., 1998). Some participants said that depression was not a problem among Caribbean people, while others felt that depression existed but people denied its existence by never talking about it (Schreiber et al., 1998). Njiwaji (2012) examined the structural and cultural factors that affect help-seeking for Black Canadians with gambling problems in Nova Scotia. Participants reported that mental health advertisements further led them to believe that mental illnesses were a ‘White man’s issue’ because these campaigns rarely included Black people or other racial/ethnic minority groups (Njiwaji, 2012).

Belief of “Black People Must Be Strong”

In a focus group study with a sample of African American adults recruited from the community, the participants expressed a strong consensus in the expectation that African Americans must demonstrate strength (Thompson et al., 2004). Correspondingly, an interview study found that African Americans with mental illness reported that they were raised to believe that Black people were expected to be strong and to handle their problems on their own (Alvidrez et al., 2008). In yet another study, African Americans with depression indicated that trying to uphold the ‘image of the strong Black woman or the strong Black man’ forces many African Americans to hide or deny their experience

with depression (Campbell & Mowbray, 2016). Additionally, it was found that adherence to the “strong black woman” stereotype increases the relationship between stress and depressive symptoms (Donovan & West, 2015). Sisley, Hutton, Goodbody, and Brown (2011) explored help-seeking among African and Caribbean women living in the United Kingdom. Participants identified the expectation that individuals of African descent should be strong and not show weakness. Similarly, in a sample of West-Indian Canadian women with depression, participants pointed out that depression was highly stigmatized in the West Indian community because West Indian people are expected to be strong. In addition, admitting to having mental illness is believed to be a sign of weakness (Schreiber et al., 1998). The same group of women also identified ‘being strong’ as a way to manage their depression and move toward recovery.

Belief of “Professional Help is Unnecessary with Enough Faith”

In Conner and colleagues’ (2010) focus group study, African American participants identified culturally accepted coping strategies in dealing with depression. The most culturally acceptable strategy for coping with depression was said to be through prayer and connection to God (Conner et al., 2010). Furthermore, participants reported that going to a professional for help for mental health problem was a sign of lack of faith in God. A sample of African Americans with depression reported that African Americans turn to religion or religious practices for help when they are depressed (Campbell & Long, 2014). Moreover, the same researchers also found that respondents identified several beliefs related to faith and psychological help-seeking, which included: Black people ‘turn to God for everything’; ‘Black people believe more in religion than medicine or therapy.’; and depression is an ‘issue of faith’ rather than a mental health issue. Also,

there was the perception that it is better to pray about mental health issues rather than to seek help from professionals.

One study examined the influences of religious and spiritual beliefs on how African American youth viewed major depressive disorder (Breland-Noble, Wong, Childers, Hankerson, & Sotomayor, 2015). Adolescents in the study expressed that although religion is important for overcoming emotional issues, seeking professional help is also acceptable for them. Although prayer and church were thought to be beneficial, youth in this study also reported that sometimes rigid ideals and values held within the faith communities could be a hindrance for reaching out for help (Breland-Noble et al., 2015). They reported that some people within the church feel that one would not need therapy or medication if they prayed and ‘took their troubles to God’.

Schreiber and colleagues (1998) found that West Indian Canadian women with depression felt that belief in Christian doctrine was a powerful force within West Indian society. All the women in the study indicated they were raised in the church, believed in God, and/or prayed regularly. Some stressed that God would replace their troubles with peace, comfort and compassion (Schreiber et al., 1998). Others felt that they would be able to endure their problems because of the strength given to them by God. Similarly, among African Canadians in Nova Scotia, spirituality was reported to play an important role in deciding whether or not to seek help, as it was often reported that faith in God helps Black Nova Scotians cope with their gambling problems (Njiwaji, 2012).

In sum, cumulative qualitative research has found that beliefs, including “Mental illness does not affect Black people”, “Black people must be strong” and “Black people with faith would not need professional psychological services” greatly impact the Black

community's attitudes towards psychological help-seeking. There is increasing evidence that Black Canadians endorse these Afro-cultural beliefs strongly, yet these beliefs have never been explored systematically and quantitatively in help-seeking research so far. Hence, one of the aims of the present study was to assess and measure these beliefs and to explore and examine their roles in psychological help-seeking intention among Black Canadians.

Cultural Mistrust

Another major hindrance that deters Black people from seeking psychological help is a suspicion of mental health professionals resulting from the concept of 'cultural mistrust' (Conner et al., 2010; Gulliver, Griffiths, & Christensen, 2010; Njiwaji, 2012; Thompson et al., 2004; Thompson, Worthington, & Atkinson, 1994; Waldron, 2002). Cultural mistrust is the idea that Black people have little trust in White society (Terrell & Terrell, 1981). Likewise, members of the Black community view psychological help-seeking less favourably because mental health services are perceived to be an extension of White power and White society. Terrell and Terrell (1981) argued that over the years Black people have developed a mistrust of White people through having experienced direct or vicarious mistreatment by the White community. The tendency to mistrust White people often appears in the educational system, the political and governmental system, work and business interactions, and in interpersonal or social contexts.

One study examined how the race/ethnicity of the counselor and cultural mistrust influence African American women's self-disclosure and perceptions of counselor credibility (Thompson et al., 1994). African American female participants engaged in one-on-one 35- to 45-minute sessions with one of four doctoral-level counseling

psychology students (two African American women and two White American women), during which they discussed an issue they had regarding their experiences on campus. In that study, it was found that participants with elevated levels of cultural mistrust disclosed the least to White counselors as compared to African American counsellors. Similarly, a study by Nickerson, Helms and Terrell (1994) explored the relationships among Black students' levels of mistrust of White people, their opinions about mental illness, and their attitudes toward seeking psychological help from White clinicians. Consistent with the study's hypothesis, higher levels of cultural mistrust were found to be associated with less favourable attitudes toward help-seeking. Furthermore, cultural mistrust was the only variable that accounted for a significant amount of variance in social services satisfaction. Higher levels of cultural mistrust predicted less satisfaction with social services. Lastly, Whaley (2001) conducted a meta-analytic review of the literature on cultural mistrust and psychosocial functioning in African Americans. The analyses revealed that the negative correlations between cultural mistrust and measures of psychological help-seeking attitudes and behaviours were of medium effect size.

Cultural mistrust has also been found to influence psychological help-seeking in Black Canadians. Previous research has found that Black Canadians do not feel comfortable using mental health services because they do not have the level of trust needed for them to disclose private information about their lives to White mental health professionals (Waldron, 2002). Njiwaji's (2012) study revealed that a lack of trust in mental health service providers was a major barrier to psychological help-seeking for African Canadians in Nova Scotia. One participant identified that her experience with racism caused her to have less trust in the treatment services. Another participant reported

that the lack of trust in the system stemmed from service providers not being culturally competent. In a dissertation study by Joseph (2010) it was also demonstrated that cultural mistrust was associated with unfavourable attitudes toward psychological help-seeking and greater desire to receive mental health services from a Black mental health professional in a sample of Black Canadians.

CHAPTER 2

PRESENT STUDY

The aim of the present study was to examine the extent to which the TPB model might be appropriate in understanding and explaining psychological help-seeking intention in community-based Black Canadians. This study further examined: a) an expanded TPB psychological help-seeking model that includes self-stigma and public stigma; and b) a culturally-expanded TPB model of psychological help-seeking that includes cultural variables unique to Black Canadians (e.g., cultural mistrust and afrocultural beliefs). It is hoped that the results of this study will expand and enhance current knowledge about psychological help-seeking among Black Canadians. In turn, it is expected that the study's findings might help better inform mental health initiatives that are designed to address the issues of underutilization of psychological services and mental illness stigma among Black Canadians, and to help encourage Black Canadians to access mental health services.

Research Questions

The specific research questions for the present study were: *“To what extent does the TPB model explain help-seeking intentions among Black Canadians?”*; *“To what extent do other critical help-seeking related psychological variables, such as self-stigma and public stigma, help improve the TPB’s ability to explain help-seeking intentions among Black Canadians?”*; *“To what extent do culturally-relevant variables, such as cultural mistrust and afrocultural beliefs, improve the TPB’s ability to explain help-seeking intentions among Black Canadians?”*; and lastly *“What do Black Canadians think needs to be done to help Black Canadians use mental health services more?”*

In the present study, the outcome variable was intentions to seek psychological help. The predictor variables of psychological help-seeking intentions in the study include: a) the TPB variables including attitudes toward psychological help-seeking, subjective norms, and perceived behavioural control; b) mental health stigma variables, including self-stigma and public stigma; and c) culturally specific variables including afrocultural beliefs and cultural mistrust. Furthermore, other relevant help-seeking related factors as suggested by previous research, including participants' previous experience with seeking psychological and mental health services, levels of psychological distress, and the racial/ethnic background of the mental health professional/service provider they seek help from (Cepeda-Benito & Short, 1998; Demyan & Anderson, 2012; Joseph, 2010; Njiwaji, 2012; Vogel et al., 2005), were also tested as possible covariates in the analyses. Moreover, participants were asked to respond to an open-ended question about what they think needs to be done to help facilitate Black Canadians in seeking professional help for psychological problems. This qualitative component was added to this study to gain a broader perspective on the potential factors that might impede mental health service use among Black Canadians and to provide participants with the opportunity to voice their opinions on this topic.

Hypothesized Path Models

Three path models were proposed to test the research questions posed by the present study.

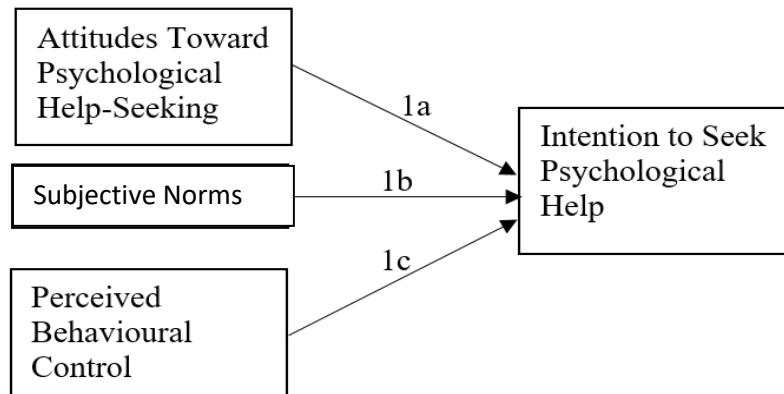
Hypothesized Path Model 1

Figure 1 illustrates the TPB model that was tested for its ability to explain intentions to seek psychological help in Black Canadians. Based on this model the following hypothesized relationships were anticipated:

Hypothesis #1: *It is hypothesized that the TPB model would predict psychological help-seeking intentions among Black Canadians in the study.*

1. *Consistent with the TPB model, favourable attitudes toward psychological help-seeking (1a), subjective norms in favour of psychological help-seeking (1b), and elevated levels of perceived behavioural control (1c) would lead to greater intentions to seek psychological help.*

Figure 1. Hypothesized Path Model 1: The Theory of Planned Behaviour (Ajzen, 1991)



Note. The numbers 1a, 1b, and 1c represent the hypothesized pathways.

Hypothesized Path Model 2

Figure 2 illustrates an expanded TPB model that includes mental health variables that are central for explaining psychological help-seeking, that is public stigma and self-stigma, while controlling for the effects of psychological distress and previous experience seeking psychological and mental health services. Based on findings in previous research (e.g., Nam et al., 2013; Schomerus et al., 2009; Vogel et al., 2006; Vogel et al., 2007), it was predicted that public stigma and self-stigma would negatively affect attitudes toward psychological help-seeking. In addition, since public stigma has been found to impede psychological help-seeking due to individuals' attempts to avoid social judgement (Corrigan & Matthews, 2003), it was anticipated that public stigma would also influence subjective norms.

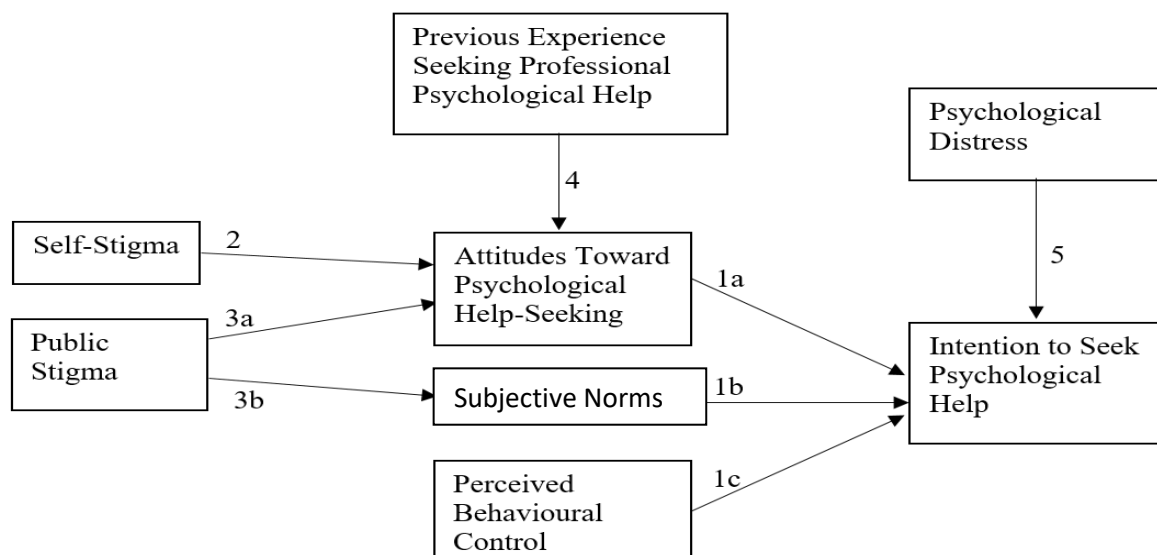
Research has also shown that psychological distress, and previous experience seeking professional psychological help are important predictors of attitudes toward psychological help-seeking and intentions to seek psychological help (Cepeda-Benito & Short, 1998; Vogel et al., 2005; Vogel et al., 2007). Psychological distress is a major determinant in contemplating whether or not to seek mental health services. Previous studies that have investigated the TPB and similar models in explaining psychological intention, have commonly controlled for the influence of psychological distress on psychological help-seeking intention (Compton & Esterberg, 2005; Kuo, et al., 2015; Mak & Davis, 2013; Mo & Mak, 2009). Furthermore, previous studies that have used path analysis to explore psychological help-seeking among Black Canadians (Joseph, 2010) have found that previous experience seeking professional psychological help led to unfavourable attitudes toward psychological help-seeking, while psychological distress

led to greater intentions to seeking psychological help. Thus, the following predictions are made:

Hypothesis #2: *It is hypothesized that this expanded TPB model, with the addition of mental health stigma variables, would predict psychological help-seeking intentions among Black Canadians more effectively than the original TPB model. It is anticipated that:*

2. *Higher levels of self-stigma would lead to unfavourable attitudes toward psychological help-seeking (2).*
3. *Higher levels of public stigma would lead to unfavourable attitudes toward psychological help-seeking (3a) and negative subjective norms that oppose against psychological help-seeking (3b).*
4. *Previous experience seeking professional psychological help would lead to unfavourable attitudes toward psychological help-seeking (4).*
5. *Higher levels of psychological distress would lead to greater intentions to seek psychological help (5).*

Figure 2. Hypothesized Path Model 2: Expanded TPB Model



Note. The numbers 1a, 1b, 1c, 2, 3a, 3b, 4, and 5 represent the hypothesized pathways.

Hypothesized Path Model 3

Figure 3 illustrates a culturally-expanded TPB model that includes culturally relevant variables (afrocultural beliefs, cultural mistrust, and the racial/ethnic background of the mental health professional) hypothesized to impact psychological help-seeking particularly within the Black community. Based on previous research (Nickerson et al., 1994; Thompson et al., 1994), it is anticipated that elevated levels of cultural mistrust would lead to unfavourable attitudes toward psychological help-seeking, less intentions to seek psychological help, subjective norms against psychological help-seeking, and a greater desire to seek help from a Black mental health professional. As found in Joseph's (2010) study, it is also anticipated that willingness to seek help from a Black mental health professional would increase Black Canadians' intentions to seek psychological help.

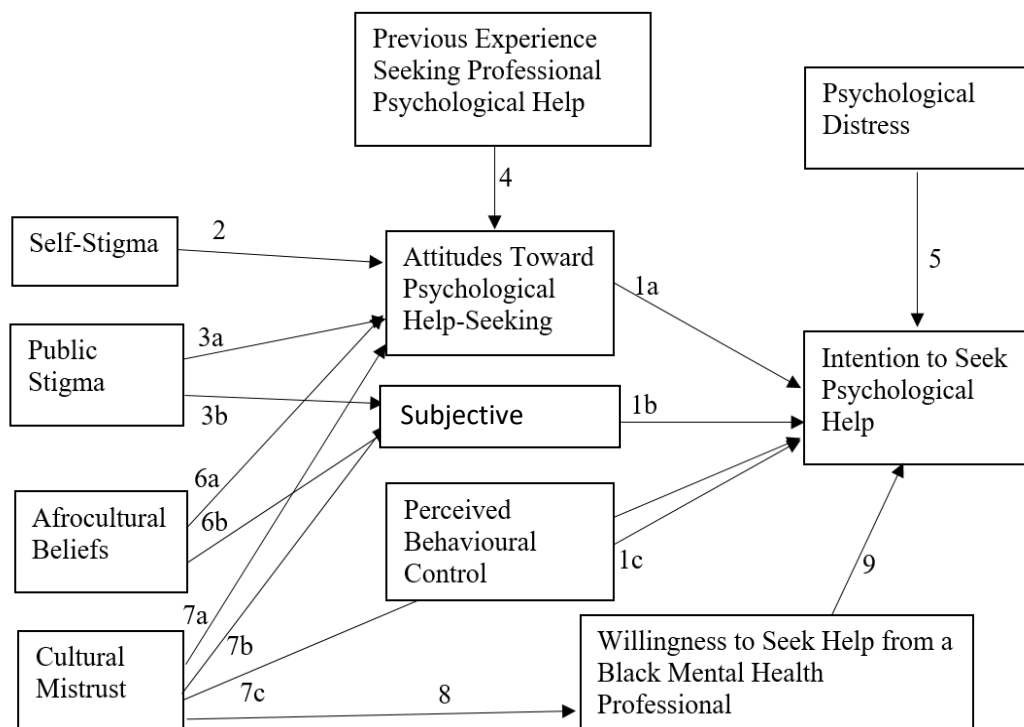
The effects of afrocultural beliefs on psychological help-seeking among Black Canadians has yet to be explored quantitatively. However, based on past qualitative research it is hypothesized that endorsement of afrocultural beliefs would influence attitudes toward psychological help-seeking and subjective norms. Thus, the following hypotheses are made:

Hypothesis #3: It is hypothesized that this culturally expanded TPB model, with the addition of culturally relevant variables, would predict psychological help-seeking intentions among Black Canadians more effectively than the original TPB model.

Specifically:

6. *Endorsement of afrocultural beliefs would lead to unfavourable attitudes toward psychological help-seeking (6a) and negative subjective norms that oppose against psychological help-seeking (6b).*
7. *Higher levels of cultural mistrust would lead to unfavourable attitudes toward psychological help-seeking (7a), negative subjective norms that oppose against psychological help-seeking (7b), and lowered intentions to seek psychological help (7c).*
8. *Higher levels of cultural mistrust would lead to greater willingness to receive psychological help from a Black mental health professional (8).*
9. *Willingness to receive psychological help from a Black mental health professional would lead to greater intention to seek psychological help (9).*

Figure 3. Hypothesized Path Model 3: Culturally-Expanded TPB Model



Note. The numbers 1a, 1b, 1c, 2, 3a, 3b, 4, 5, 6a, 6b, 7a, 7b, 7c, 8, and 9 represent the hypothesized pathways.

CHAPTER 3

METHODS

Recruitment Procedures

The number of participants needed for this present study was determined by using an online power and minimum sample calculator (<http://quantpsy.org>; Preacher & Coffman, 2006). The calculator computed the minimum sample size required to achieve a desired level of power using the degrees of freedom for the hypothesized models and the expected root mean-square error of approximations (RMSEA). Having RMSEA values less than .05 indicate a close fit, while RMSEA values between .05 and .08 indicate an adequate fit (Pituch & Steven, 2015). With this in mind, it was determined that a minimum sample of 310 Black Canadian participants was needed to ensure adequate model estimation.

A variety of recruitment procedures were used to recruit this target cultural sample group. One method of recruitment was implemented through contacting Black cultural and religious organizations. The principle investigator requested permission from organization leaders and directors to forward recruitment emails to their members. In addition, the principle researcher of this study attended gatherings and events of these organizations in person to recruit Black Canadian participants. Recruitment through online social networking sites was also conducted by contacting the organizers of Black Canadian Facebook groups and pages. These groups and organizations allowed the principle investigator to post a poster and promotional video of the study on their group websites.

Furthermore, Black Canadian participants were recruited using the “snowball” technique. Specifically, the researcher of this study, who is a member of the Black Canadian community herself, asked her personal contacts to help recruit individuals who meet the study’s inclusion criteria. These contact individuals were then asked to forward the recruitment information to other Black Canadians they know. Lastly, participants were recruited through the Psychology Participant Pool at the University of Windsor.

Participants had the option to either complete a paper-and-pencil version of the survey or an online version of the survey. Conducting survey research online had several advantages including reduced costs in the use of lab space and in printing paper and mailing, automatically saving data in electronic form, and reaching to demographically more heterogeneous and diverse sample populations (Birnbaum, 2004). Participants were also offered a paper-and-pencil option in case respondents did not have access to computers and/or internet or preferred to complete a paper version of the survey. Prior to the data collection process, the present study received clearance from the Research Ethics Board (REB) of the University of Windsor.

Participants

A total of 387 individuals who self-identified as Black Canadians participated in the present study. Their primary Canadian residences were in Southern Ontario (78.7%; the Greater Toronto Area, Windsor, Ottawa, etc.), British Columbia (9.9%; Vancouver, Victoria, Surrey, Cambridge, etc.), Alberta (4.7%; Calgary, Edmonton, etc.), Quebec (6.2%; Montréal, and Gatineau), and Nova Scotia (0.5%; Halifax). The sample consisted of individuals recruited from the community (89.4%) and individuals recruited from the University of Windsor’s participant pool (10.6%). The participants in this study ranged

from 18 to 80 years of age ($M = 34.2$, $SD = 12.2$). The gender composition of the sample was as follows: 81.7% female, 16.5% male, and 1.3% who neither identified as male or female. A total of 52.2 % of the sample were born in Canada while 47.8% were not born in Canada. A total of 26.6% of the sample were 1st generation Canadian, 20.2% were 1.5 generation Canadian, 45.7% were 2nd generation Canadians, 3.1% were 3rd generation Canadian or beyond, and 2.8% were international students born outside of Canada. A total of 89.7% of the sample were Canadian citizens, 5.2% were permanent residents, 3.1% were on student visas, 1.6% were landed immigrants, and 0.3% were other. The employment status of the participants were: working full-time (55.6%), working part-time (19.1%), unemployed (10.6%), students (22.7%), and retired (3.4%). The maximum levels of education of the sample included individuals who completed graduate or professional school (22.7%), university degrees (31.6%), 2-year college programs (21.7%), high-school (22.7%), and elementary school education (0.8%). The relationship status of the participants were: single (48.1%), married (19.1%), partnered (i.e., had a boyfriend, girlfriend, or significant other; 21.4%), in common-law relationships/cohabitating (7.2%), separated/divorced (7.8%), and widowed (0.3%). The religious affiliations of the sample were: Christian (Protestant, Baptist, etc.; 61.2%), Other (12.7%), Agnostic (9.8%), Catholic (8.3%), Atheist (3.9%), Muslim (3.1%), and Jewish (0.3%). The survey was completed online by 81.1% of the sample, while 18.9% completed the pencil-and-paper of the survey.

Mixed-Methods Research Design

Mixed-methods research has been defined as “the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected

concurrently or sequentially, are given a priority, and involved the integration of the data at one or more stages in the process of research” (Creswell, Plano Clark, Gutmann, & Hanson, 2003, p. 212). According to Creswell (1999) mixed-methods research involves researchers to: (1) decide whether to use an explicit theoretical lens (e.g., post-positivism, constructivism, feminism, etc.); (2) identify the data collection procedures; and (3) identify the data analysis and integration procedures. Recognizing that all researchers bring implicit biases and assumptions to their investigations, the current study was not working from any explicit, a prior theoretical lens. The qualitative and the quantitative data in this study were collected concurrently. Considering that the aim of the study was to evaluate and expand on the TPB there was a greater priority placed on the quantitative data, as the qualitative data would not have been sufficient for achieving this aim. Likewise, the qualitative and quantitative data were analyzed separately, and then compared and contrasted in the discussion section of this paper. Hence, the current mixed-methods study is considered a *concurrent nested mixed-methods research design* (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005).

Procedure

Before completing the survey, participants were asked to read a letter of informed consent to participate; the letter outlined the terms of the study. When the participant completed the questionnaire or exited the online study, a debriefing letter was provided to them describing the general goals of the study, relevant literature references for the study, participants’ rights, and estimated date of announcing the study’s results. The letter also included contact information for the principal researcher and her research supervisor and information for community support services. As a token of appreciation for participating

in the study, all participants had the option of being entered into a draw for one of ten \$50 Walmart gift certificates.

Measures

Measures used in the present study were obtained from publicly available, published articles. Certain measures were adapted for the present study and permission from the authors of the measures was sought before modifications were made. The following section describes measures used in the present study.

- a) Demographic Questionnaire
- b) Hopkins Symptom Checklist-21 (Green, Walkey, McCormick, & Taylor, 1988)
- c) Theory of Planned Behaviour Questionnaire (Mo & Mak, 2009)
- d) Perceptions of Stigmatization by Others for Seeking Help (Vogel, Wade, & Ascheman, 2009)
- e) Self-Stigma of Seeking Help Scale (Vogel, Wade, & Haake, 2006)
- f) Afro-cultural Beliefs Scale
- g) The Cultural Mistrust Inventory (Terrell & Terrell, 1981)
- h) A question asking the effect of seeking mental health services from a Black mental health professional (Joseph, 2010)
- i) An open-ended question asking the participant what they think can be done to help Black Canadians to use mental health services.
- j) The Social Desirability Scale (Crowne, & Marlowe, 1960)
- k) Indiscriminate Response Scale (Meade & Craig, 2012)

Demographic Questionnaire

The demographic sheet included questions about the participant's age, gender, educational attainment, country of birth, income level, generational status, age of migration, religion, level of religious involvement, employment status, and previous mental health service use.

Psychological Distress

Psychological Distress was measured using the Hopkins Symptom Checklist-21 (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988). This scale is an abbreviated version of the Hopkins Symptom Checklist (Derogatis, Lipman, Richels, Uhlenhuth, & Covi, 1974). Participants were asked to rate 21 items such as "nervousness," "feeling low in energy," and "sleep disturbances," on a scale from 1 (not at all) to 4 (extremely). Items were summed such that higher scores reflect higher levels of total distress. In the present study, the HSCL-21 had a Cronbachs alpha of .92.

Theory of Planned Behaviour Questionnaire

The Theory of Planned Behaviour components (psychological help-seeking intention, attitudes toward psychological help-seeking, subjective norms, and perceived behavioural control) was measured using the Theory of Planned Behaviour Questionnaire created by Mo and Mak (2009). This TPB questionnaire was designed by closely following the guidelines created by Ajzen (2006). Prior to completing the TPB questionnaire participants were presented with the following hypothetical situation, adapted from a vignette created by Schomerus, Matschinger, and Angermeyer (2009):

“Please imagine that you go to your family doctor because of the following problems you face. In the past few weeks you have been feeling sad and depressed, without any particular reason for feeling this way. You have a difficult time handling your everyday life. You don’t feel like doing anything anymore, and nothing interests you. You feel that you are no good for anything and that you do everything wrong. Not only that, you feel anxious and worry a lot of the time for no obvious cause. When you’re worrying, you find it hard to stop yourself or to think of anything else. These difficulties are so severe that they are interfering with your work/school, family relationship and social life. You call your family doctor in hope to get some help and he/she tells you that you might need to get mental health services, such counselling or psychotherapy.”

Participants then completed subsequent measures of psychological help-seeking intention, attitudes toward psychological help-seeking, subjective norms, and perceived behavioural control – the components of the TPB. Furthermore, to ensure clarity participants were informed that: “The term *mental health service* refers to services provided by *mental health professionals*, which are individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, therapists, counsellors, and social workers).”

Psychological Help-Seeking Intention

Psychological help-seeking intention was measured by having participants rate three items, indicating their likelihood of seeking mental health services using a 6-point Likert scale ranging from 1 (unlikely) to 6 (likely). A sample item of this brief 3-item scale is: “*I intend to seek mental health service.*” Item scores were summed, where higher scores indicated more intention to seek mental health services. The Cronbach’s alpha for this subscale was 0.91 for this study.

Attitudes Toward Psychological Help-Seeking

Attitudes toward psychological help-seeking was assessed by having participants rate the following statement: “*For me to seek mental health service is:*” using five items

with 6-point Likert scales ranging from 1 to 6. The five items used to rate this item included: very useless – very useful; very worthless – very worthwhile; very bad – very good; very foolish – very wise; and very rare – very common. This item is adopted from the *Attitude Toward Help-Seeking* scale used by Mo and Mak (2009). Item scores were added together, where higher sum scores indicate more favourable attitudes toward seeking mental health services. In the present study the Cronbach's alpha for this measure was 0.85.

Subjective Norms

Subjective norms was assessed using three items based on Mo and Mak's (2009) *Subjective Norms* scale. Respondents were asked to rate on the extent to which they agreed with the following statements on a 6-point Likert scale, ranging from 1 (strongly disagree) to 6 (strongly agree). The scale includes: “*Most people who are important to me think that I should seek mental health service*”; “*Most people who are important to me view mental health service very negatively*”; “*Most people who are important to me will seek mental health service if they are in need*”. In the present study the Cronbach's alpha for the scale was 0.67.

Perceived Behavioural Control

Perceived behavioural control was measured using a three-item scale derived from Mo and Mak's (2009) *Perceived Behavioural Control Scale*. These items measured the extent to which participants felt that seeing a professional for psychological problems is within their control. Each item is rated on a Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). A sample item for this scale is: “*I can seek mental health*

service if I like to do so.” The scores of the individual items were added together for a single score, such that a higher sum score indicates more perceived control over seeking mental health services. The Cronbach’s alpha this scale was 0.65 in the present study.

Afrocultural Beliefs

Afrocultural beliefs were measured by assessing the degree to which participants agreed or disagreed with a number of key beliefs and stereotypes that have been found to hinder Black people from seeking mental health services based on the literature.

However, currently there are no published measures that assesses afrocultural beliefs directly. For this reason, the present measure of afrocultural beliefs was designed by the principle researcher based on an extensive literature review. As discussed in the earlier literature review section, previous qualitative research has found that Black people commonly endorse beliefs that have led them to be less willing to use mental health services. The three beliefs being examined in this study are: “Mental illness does not affect Black people”, “Black people must be strong” and “Black people with faith would not need professional psychological services”.

Mental Illness Denial Beliefs

Mental Illness Denial Beliefs were assessed using the following three items: “*Black people don’t have mental health issues*”; “*Mental illness does not exist in Africa or the Caribbean,*”; “*Anyone can get mentally ill, no matter their ethnicity*” (reverse scored). Respondents were asked to rate on the extent to which they agreed with the following statements on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). In the present study the Cronbach’s alpha for the scale was 0.50.

Strength Beliefs

Strength Beliefs were assessed using the following three items: “*Black people who are strong don’t need mental health services*”; “*Black people should solve their personal and emotional problems on their own*”; “*Black people who seek help from a mental health professional are not weak*” (reverse scored). Respondents were asked to rate on the extent to which they agreed with the following statements on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). In the present study the Cronbach’s alpha for the scale was 0.50.

Faith Beliefs

Faith Beliefs were assessed using the following three items: “*Black people believe more in God than medicine or therapy*”; “*Seeking help from a mental health professional shows a lack of trust in God*”; “*Black people who use mental health services have as much religious/spiritual faith as those who don’t*” (reverse scored). Respondents were asked to rate on the extent to which they agreed with the following statements on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). In the present study the Cronbach’s alpha for the scale was 0.15.

Considering the low internal consistency scores of these measures, factor analyses were conducted to determine the factor structure of the Afrocultural Beliefs scale. It was found that the nine-item scale revealed a three-factor structure. Details of the factor analysis are reported in the results section.

Public Stigma

The Perceptions of Stigmatization by Others for Seeking Help (PSOSH; Vogel, Wade, & Aschman, 2009) measure is a 5-item scale that assesses participants' views of how people in their social network would treat or perceive them if they seek counselling services for an academic or vocational issue. In this study, the test instruction was adopted from Kuo et al., (2015) and reads: *“Imagine that you had a problem that needed to be treated by a mental health professional. If you sought mental health services for this issue, to what degree do you think that people you interact with would...”* This introductory statement was followed by 5 items of the PSOSH; for example, *“...think bad things about you.”* Each item was rated on a scale from 1 (not at all) to 5 (a great deal). All item scores were summed such that higher scores indicate greater perceived stigma from others. The internal consistency for the adapted version of the PSOSH in the current study was = .91.

Self-Stigma

The Self-Stigma of Seeking Help (SSOSH) Scale (Vogel, Wade, & Haake, 2006) has been used frequently in recently published studies that focused on the relationship between self-stigma and psychological help-seeking, attitudes, intentions, and behaviours (for example, Lannin et al., 2016; Tucker, Hammer, Vogel, Bitman, Wade, & Maier, 2013; Vogel et al., 2007). This scale has ten items that are rated on a scale from 1 (strongly disagree) to 5 (strongly agree), with half of the items reverse-scored. An example of the items on the SSOSH is: *“I would feel worse about myself if I could not solve my own problems.”* The full-scale score of the SSOSH is obtained by summing up

the scores of all 10 items; a higher score indicates higher levels of self-stigma for seeking psychological help. The internal consistency of this scale in the present study was 0.86.

Cultural Mistrust

The Cultural Mistrust Inventory (CMI; Terrell & Terrell, 1981) was developed to assess the extent to which Black people hold mistrust attitude towards White people. The CMI includes 48 items that are phrased as statement such as: *“It is best for Blacks to be on their guard among Whites,”* or *“Whites are usually honest with Blacks.”* Each statement is rated on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Full-scale scores were obtained by adding the scores for all items. Higher scores indicated more mistrust of White people.

The CMI includes four subscales: the Politics and Law subscale, the Education and Training subscale, the Business and Work subscale, and the Interpersonal Relations subscale. Only the Interpersonal Relations subscale was used in the present study because this subscale focuses on whether Black people can trust White people in general, while the other subscales focus on the trustworthiness of White people in specific contexts that were not relevant to this study (i.e., politics, law, education, business, and work). An example of one of the 14 items from the Interpersonal Relations subscale reads: *“Blacks should not confide in Whites because they will use it against you.”* The items were revised, such that the term “Blacks” was replaced by “Black people” and the term “Whites” was replaced by “White people”. This revision was made because it is considered offensive to use one’s race/ethnicity as a classification rather than a descriptive characteristic. In the current study the Cronbach’s alpha for this measure was 0.88.

Willingness to Seek Help from a Black Mental Health Professional

In previous research with a sample of Black Canadians, the race/ethnicity of the mental health professional was found to significantly predict the participants' willingness to seek psychological help (Joseph, 2010). Therefore, in this study, as a covariate, participants were asked to rate the following statement adopted from Joseph's (2010) dissertation: *"If I were experiencing serious personal or emotional problems, I would be more willing to seek mental health services if I knew the mental health professional would be Black."* on a 5-point Likert scales ranging from 1 (strongly disagree) to 5 (strongly agree).

Open-ended Question

Participants were asked if they feel anything should be done to enable Black Canadians to use mental health services more. If they answered yes, they were then asked the following open-ended question: *"Research shows that Black Canadians are not using mental health services as much as other ethnic groups in Canada. What do you think can be done, if anything, to help Black Canadians use mental health services more?"* This question was included because the responses will help inform mental health promotion initiatives of what might be effective in encouraging Black Canadians to use mental health services.

Social Desirability

The Social Desirability Scale (SDS; Crowne, & Marlowe, 1960) is a widely-used measure for detecting socially desirable responding. The SDS is made up of 33 true-false

items describing behaviours that are highly approved of but have low probabilities of occurrence. The scale also includes behaviours that occur frequently but most people disapprove of. Sample items include: *“I’m always willing to admit it when I make a mistake.”* and *“There have been occasions when I took advantage of someone.”* Previous studies have found that the internal consistency of the full scale is $\alpha = .88$. Several short forms of the SDS exist, but Strahan and Gerbasi’s (1972) SDS Form 1 was used in this study because the use of the full scale could promote participant fatigue and is highly correlated with the original scale (Fischer & Fick, 1993). In the present study, Strahan and Gerbasi’s (1972) SDS Form 1 has 10 items and had an internal consistency of .59.

Indiscriminate Response Scale

Using instructed response items is a common method for identifying careless responders (Meade & Craig, 2012). Five questionnaire items for detecting indiscriminate or random responding were incorporated into the current survey. An example of indiscriminate item is: *“To monitor quality, please respond with “strongly agree” for this item.”* In the beginning of the questionnaire there was a statement telling participants that some items will be instructional and direct them exactly how to respond. This was done to prepare the respondents for the indiscriminate response items. Each item had a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Responses from participants who incorrectly answer three or more of the items were deemed unusable.

CHAPTER 4

RESULTS

Path analysis was conducted using SAS University Edition. The method of estimation used was the full-information maximum likelihood estimation method. The path analysis first tested whether the TPB model adequately explained psychological help-seeking among Black Canadians. Path analyses were then performed on the expanded models of help-seeking that included psychological variables (e.g., public stigma and self-stigma) and cultural variables (e.g., cultural mistrust, afrocultural beliefs, and preference for a black mental health professional). These analyses aimed to test whether the addition of psychological and cultural variables improved the models' ability to explain psychological help-seeking among Black Canadians. All models were assessed using multiple model-fit indices, as recommended by Kline (2016).

Factor Analysis Results

Exploratory factor analysis (EFA) was conducted to identify the structure of the Afrocultural Beliefs scale. According to the Kaiser-Guttman rule, a widely-used criterion for factor analysis, researchers should only retain factors having eigenvalues that are greater than one. The Kaiser-Guttman rule is based on the idea that important factors ought to account for at least as much as the variance of a given observed variable. However, in EFA the variance of the observed variables used in the analysis excludes variance unique to each variable, the focus is only on the shared or common variance. Therefore, the variance of the observed variable is smaller when the principle axis factoring is used. As shown in Table 1, the Kaiser-Guttman rule was used in the analysis and the results showed that three factors should be retained in the model.

Table 1. Eigenvalues of the Reduced Correlation Matrix	
	Eigenvalues
1	2.525
2	1.153
3	1.059
4	0.925
5	0.837
6	0.674
7	0.648
8	0.617
9	0.561

The minimum average partial (MAP) test is another reliable method for determining the number of factors in a model. In the MAP test, each factor is partialled out of the correlation matrix and a partial correlation matrix is calculated. The number of factors to be retained is indicated at the point where the average squared partial correlation reaches a minimum. The variance continues to be reduced until there is no more common variance left to extract. As the common variance is extracted the partial correlation values is reduced. When there is no more common variance left to be extracted the partial correlation values begin to increase again. When the values begin to increase again or when the common variance has all been extracted, this is the point when the number of factors should be retained in the model. As seen in Table 2 the MAP test indicates that there are three factors in this model. After looking at the items with the most salient loadings among the multiple solutions, it was determined that a three-factor model was the most conceptually interpretable.

Table 2. Average Partial Correlations

N factors	squared	power4
.0000	.0162	.0009
1.0000	.0069	.0003
2.0000	.0065	.0001
3.0000	.0066	.0001
4.0000	.0073	.0002
5.0000	.0079	.0002
6.0000	.0086	.0003
7.0000	.0093	.0003
8.0000	.0102	.0004
9.0000	.0112	.0004
10.0000	.0122	.0005
11.0000	.0133	.0006
12.0000	.0145	.0008
13.0000	.0158	.0009
14.0000	.0169	.0009
15.0000	.0183	.0012
16.0000	.0201	.0014
17.0000	.0220	.0018
18.0000	.0242	.0021
19.0000	.0265	.0027
20.0000	.0290	.0030
21.0000	.0318	.0036
22.0000	.0348	.0043
23.0000	.0384	.0051
24.0000	.0425	.0059
25.0000	.0472	.0080
26.0000	.0524	.0097
27.0000	.0586	.0123
28.0000	.0663	.0143
29.0000	.0752	.0178
30.0000	.0855	.0224
31.0000	.0983	.0277
32.0000	.1160	.0376
33.0000	.1370	.0488
34.0000	.1714	.0708
35.0000	.2220	.1052
36.0000	.2844	.1584
37.0000	.3547	.2196
38.0000	.5355	.4098
39.0000	1.0000	1.0000

Exclusions

A total of 387 participants were recruited for this study. One participant was excluded from analyses due to a high degree of socially desirable responding relative to the rest of the sample (i.e., a social desirability z-score above 2.5). Another three participants were excluded because there was evidence of indiscriminate responding (i.e., responding incorrectly to 3 or more of the 5 indiscriminate responding items). Lastly, 55 participants were excluded because they withdrew from the study before completing pertinent measures.

Data Screening

Of the remaining participants, missing data analyses revealed that less than 2% of data was missing per item. The data seemed to be missing at random as there was no evidence of a systematic data loss pattern. The traditional maximum likelihood estimation method used in SEM requires complete data sets. Therefore, rather than delete cases or impute missing observations, it was decided that a special form of maximum likelihood estimation, called full information maximum likelihood estimation, would be used to analyze the data. This method of estimation calculates the parameter estimates and the standard errors using the available data without deletion or imputation. Simulation studies employing the full-information maximization likelihood estimation for incomplete data generally performed better than employing classical deletion and imputation methods (Peters & Enders, 2002).

Estimation in SEM using maximization likelihood assumes multivariate normality. Many instances of multivariate normality can be detected by inspecting

univariate distributions. Univariate normality was investigated by examining histograms, and skewness and kurtosis values. Skewness and kurtosis values were divided by their respective standard errors of the skew and standard errors of the kurtosis to derive t-scores. Based on the examination of the histograms and the t-scores it was determined that distributions of the psychological distress, public stigma, self-stigma, cultural mistrust, strength belief, and mental illness denial beliefs were significantly positively skewed. In addition, the distributions of the intention, attitude, perceived behavioural control, and preference for a Black mental health professional were significantly negatively skewed. Furthermore, standardized scores greater than ± 3.29 (Tabachnick & Fidell, 2013) were used to identify a total of nine univariate outliers. Tabachnick and Fidell (2013) assert that unless there are compelling reason not to, it is better to use transformations to make the distributions normal.

The self-stigma distribution differed moderately from normal, therefore a square root transformation was applied. Similarly, the distributions for intention, attitude, and perceived behavioural control differed moderately from normal, therefore the distributions were reflected and then a square root transformation was applied. The distributions for psychological distress, public stigma, and cultural mistrust differed from normal substantially, thus a log transformation was applied. Likewise, the distribution for preference for a Black mental health professional differed substantially from normal, therefore the distribution was reflected and then a log transformation was applied. The distribution for the strength variable differed severely from normal, so the inverse transformation was utilized. The distributions were then re-evaluated, and they no longer significantly deviated from a normal distribution. However, the distribution for mental

illness denial departed so much from normality that it was not amenable to any transformation. Even after dichotomizing the variable, the distribution still severely deviated from normality, therefore it was decided that the mental illness denial variable be removed from further analyses.

After performing the transformations, three univariate outliers were identified (z-scores above 2.5) and removed. The presence of multivariate outliers was then investigated. Two multivariate outliers were identified using a Mahalanobis distance ($\chi^2 = 26.2, p < .01$). These two cases were also deleted. The presence of influential cases was assessed by calculating Cook's distance (values > 1) and standardized Dffit (values $> \pm 2$). There were no influential cases present. Analysis of residuals and bivariate scatterplots indicated that the assumption of linearity and homoscedasticity were met. Inspection of the intercorrelations between variables, condition indexes (VIF < 10) and Tolerance (values > 0.1) revealed that the assumptions of multicollinearity and singularity were met. Finally, the Durbin-Watson statistic was greater than 1.5 and less than 2.5, which indicated that the assumption of the independence of errors was also met.

Descriptive Statistics and Exploratory Analyses

Descriptive statistics and bivariate correlations among the main study variables are presented in Table 3. All variables correlated with intention to seek help were in the expected directions, except psychological distress, cultural mistrust, and preference for a Black mental health professional, which had no significant relationships with intentions to seek help.

The effect of recruitment method (i.e. community versus participant pool) on the dependent variable, intentions to seek psychological help, was then examined. The results from an independent *t*-test revealed a significant effect of recruitment method ($t(354) = -3.97, p < .01, \text{Cohen's } d = 0.64$), where participants from the participant pool had significantly greater intentions to seek help than community participants. Since the effect size of this difference is considered more than negligible (Cohen, 1992), it was decided that the path analyses would only include data from community participants.

Subsequently, the effect of questionnaire format (online versus paper), gender (male, female, other), age group (30 years or less, 31-50 years old, 51 years and older), born in Canada (yes or no), immigration status (Canadian citizen, permanent resident, landed immigrant, student visa, other), generational status (first generation, 1.5 generation, second generation, third generation, beyond third generation, international student), level of education (elementary school, high school degree, completed 2-year college program, completed university degree, completed graduate or professional school), religious affiliation (Christian (Protestant, Baptist, etc.), Catholic, Jewish, Muslim, Atheist, Agnostic, Other), and religious meetings attendance (more than once a week, once a week, more than once a month, once a month, a few times a year, once a year, never) were individually assessed. The results from independent *t*-tests and one-way ANOVA revealed no significant effect of format ($t(313) = 0.69, p = .49$), gender ($F(2, 310) = 0.73, p = .48$), age group ($F(2, 303) = 1.13, p = .33$), immigration status ($F(3, 309) = 0.62, p = .89$), generational status ($F(5, 303) = 1.76, p = .12$), level of education ($F(4, 309) = 0.60, p = .15$), religious affiliation ($F(6, 305) = 0.81, p = .56$), or religious meetings attendance ($F(6, 307) = 0.60, p = .14$) on intentions to seek help. There was a significant

effect of being born in Canada ($t(313) = 0.29, p = .01, \text{Cohen's } d = 0.28$) on help-seeking intention. However, the effect size of this difference can be considered trivial and likely not meaningful (Cohen, 1992).

Then an independent t-test was used to see if there were significant differences in the dependent variable due to the hypothesized covariates (previous use of mental health services). A dichotomous variable was created for psychological distress as recommended by the test developers (Derogatis et al., 1974), such that respondents with mean scale scores above 1.75 were identified as experiencing significant psychological distress (based on community norms). The results revealed that there was no significant difference of intention to seek help between participants reporting significant psychological distress ($M = 2.24, SD = 0.68$) and participants reporting no significant psychological distress ($M = 2.33, SD = 0.82, t(281) = 0.87, p = .36$). These findings suggest that it is not necessary for psychological distress to be included as a covariate in the hypothesized model.

Table 3

Means, Standard Deviations and Pearson Correlations among Model Variables

Variable	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	M	SD
1. Gender ^a	-	-.20**	.11*	.14*	.19**	.07	.07	-.05	-.13*	.22**	-.09	-.03	-.09	.12*	n/a	n/a
2. PMH		-	-.29**	-.30**	-.30**	-.14*	-.03	.10	.22**	-.12*	.24**	.13*	.14*	-.14*	1.36	.48
3. PD			-	.01	.03	.06	-.11*	.27**	.12*	.24**	-.00	.02	-.06	.20**	40.47	12.10
4. Intention				-	.76**	.32**	.37**	-.12*	-.49**	-.04	-.41**	-.23**	-.35**	.05	12.77	3.82
5. Attitude					-	.28**	.30**	-.14**	-.43**	-.04	-.46**	-.17**	-.35**	.08	22.98	4.91
6. SN						-	.03	-.09	-.20**	.02	-.13*	-.15**	-.07	.05	9.72	2.11
7. PBC							-	-.09	-.26**	-.02	-.23**	-.10	-.19**	-.07	14.46	2.63
8. PS								-	.36**	.14*	.20**	.15**	.07	.00	9.92	4.70
9. SS									-	.06	.39**	.21**	.23**	-.02	22.63	7.11
10. CM										-	.16**	.16**	.12*	.43**	35.20	9.00
11. Strength											-	.28**	.40**	-.08	4.81	1.89
12. Faith												-	.21**	.09	7.46	1.86
13. MID													-	-.06	3.64	1.33
14. PBMHP														-	3.67	1.31

Note. ^aGender (1 = male, 2 = female)

PMH = previous mental health service use; PD = psychological distress; SN = subjective norms; PBC = perceived behavioural control; PS = public stigma; SS = self-stigma; CM = cultural mistrust; MID = mental illness denial; PBMHP = preference for a Black mental health professional

* $p < 0.05$, ** $p < 0.01$

Path Analyses

The data from 283 participants were used in main analyses. Three models were tested to explore how well the TPB (Hypothesized Model 1), an expanded TPB Model with mental health stigma variables (Hypothesized Model 2), and a Culturally-Expanded TPB Model (Hypothesized Model 3) explain psychological help-seeking intention among Black Canadians.

The models were assessed using multiple model fit indices such as the chi-squared goodness of fit test, incremental fit indices, and absolute fit indices to determine whether or not each of the hypothesized models fit the data. The chi-squared statistic is quite sensitive to sample size thus it is important to consider other ancillary indices of global fit. Researchers recommend using incremental and comparative fit indices (Fan et al., 1999; Hu & Bentler, 1998, 1999; Jackson, 2007; Marsh, Balla, & Hau, 1996; Marsh, Hau, Balla, & Grayson, 1998); thus, this study examined the Chi-squared statistic, comparative fit index (CFI), centrality index (CI), non-normed fit index (NNFI), the standardized root-mean-square residual (SRMR), and root mean-square error of approximations (RMSEA). To determine whether the fit indices are indicating a good fit, researchers recommend cut-off values ranging from .90 to .97 for incremental fit indices (Bentler & Bonett, 1980; Hu & Bentler, 1999; Schermelleh-Engel, Moosbrugger, & Müller, 2003). For this study, a cut-off value of .90 was used for the CFI, CI and NNFI, while a cut-off of 0.10 was used for the SRMR and a cut-off of 0.08 was used for the RMSEA. The fit indices for each model are displayed in Table 4. In addition to examining fit indices, squared multiple correlations (R^2) for the endogenous variables

were observed to determine what proportion of variability in the data set is accounted for

Table 4

Fit Indices of Study Models

	χ^2	df	p	CFI	CI	NNFI	SRMR	RMSEA	
Model 1	36.95	2	<.001	.90	.95	.90	.11	.14	[.10 .18]
Model 2	347.19	12	<.001	.40	.57	.37	.26	.20	[.19 .22]
Model 3	291.20	28	<.001	.67	.65	.58	.12	.13	[.11 .14]
Model 4	99.94	27	<.001	.93	.91	.90	.07	.06	[.04 .08]

Note. Model 1 = Hypothesized Model 1, Model 2 = Hypothesized Model 2, Model 3 = Hypothesized Model 3, Model 4 = Final Respecified Model. RMSEA values in brackets represent 90% confidence intervals. χ^2 = chi-squared statistic, with degrees of freedom and p-value; CFI = comparative fit index; CI = centrality index; NNFI = non-normed fit index; SRMR = standardized root-mean-squared residual; and RMSEA = root-mean-squared error of approximation.

by the model. The R^2 for each model is shown in Table 5.

Table 5

Squared Multiple Correlations (R^2) for Endogenous Variables

Endogenous Variables	R^2			
	Model 1	Model 2	Model 3	Model 4
Intentions	.59	.59	.57	.62
Attitudes	-	.22	.28	.33
Subjective Norms	-	.15	.18	.18
PBMHP	-	-	.01	.23

Note. PBMHP = Preference for a Black Mental Health Professional; Model 1 = Hypothesized Model 1, Model 2 = Hypothesized Model 2, Model 3 = Hypothesized Model 3, Model 4 = Final Respecified Model.

Hypothesized Model 1

Figure 4 shows the results of how well the TPB model (Ajzen, 1991) explained psychological help-seeking intention among Black Canadians. The chi-squared fit index suggested that the model fit was not adequate ($\chi^2 (2) = 36.95, p < .001$). However, these results often occur with large sample sizes given the test's sensitivity to sample size. The CFI (.90), CI (.95), and the NNFI (.90) suggest a good fit, while the SRMR (.11) and RMSEA (.14) suggest a poor fit. However, as hypothesized, favourable attitudes toward psychological help-seeking (hypothesis 1a) and higher levels of perceived behavioural control (hypothesis 1b) were both associated with greater intentions to seek psychological help. Hypothesis 1c, however, was not supported as subjective norms had no influence on intentions to seek psychological help. Finally, Table 5 shows that the squared multiple correlation for intentions to seek help was high ($r^2 = .59$), indicating that the proportion of variance explained by this model is high.

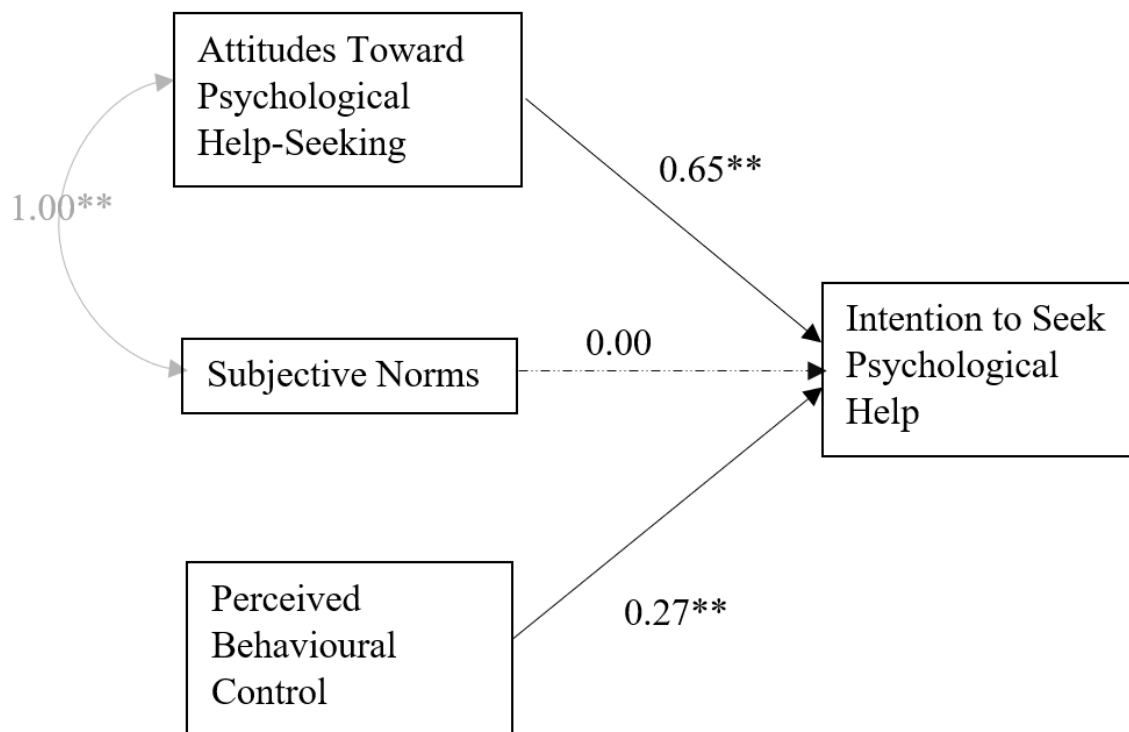


Figure 4. Hypothesized Model 1 Results. Non-standardized path coefficients and covariance estimates are shown. Solid black lines represent significant pathways, while dashed lines represent non-significant pathways. Lighter curved lines represent covariances.

** $p < .01$

Hypothesized Model 2

Figure 5 shows the results of Hypothesized Model 2, which expanded on the TPB by including self-stigma and public stigma while controlling for the effects of previous experience seeking psychological help. As predicted by hypothesis 2, elevated levels of self-stigma led to unfavourable attitudes toward psychological help-seeking. Unexpectedly, in this model, elevated levels of public stigma did not affect attitudes toward psychological help-seeking (hypothesis 3a) but it did lead to positive subjective norms in favour of psychological help-seeking (hypothesis 3b). Hypothesis 4 was supported as previous experience seeking professional help was significantly associated with unfavourable attitudes toward psychological help-seeking. All of the fit indices for this model suggested a very poor fit ($\chi^2 (12) = 347.19, p < .001$; CFI = .40, CI = .57, NNFI = .37, SRMR = .26, RMSEA = .20). Lastly, the addition of the stigma variables had no impact on the explanatory power of the model ($r^2 = .59$).

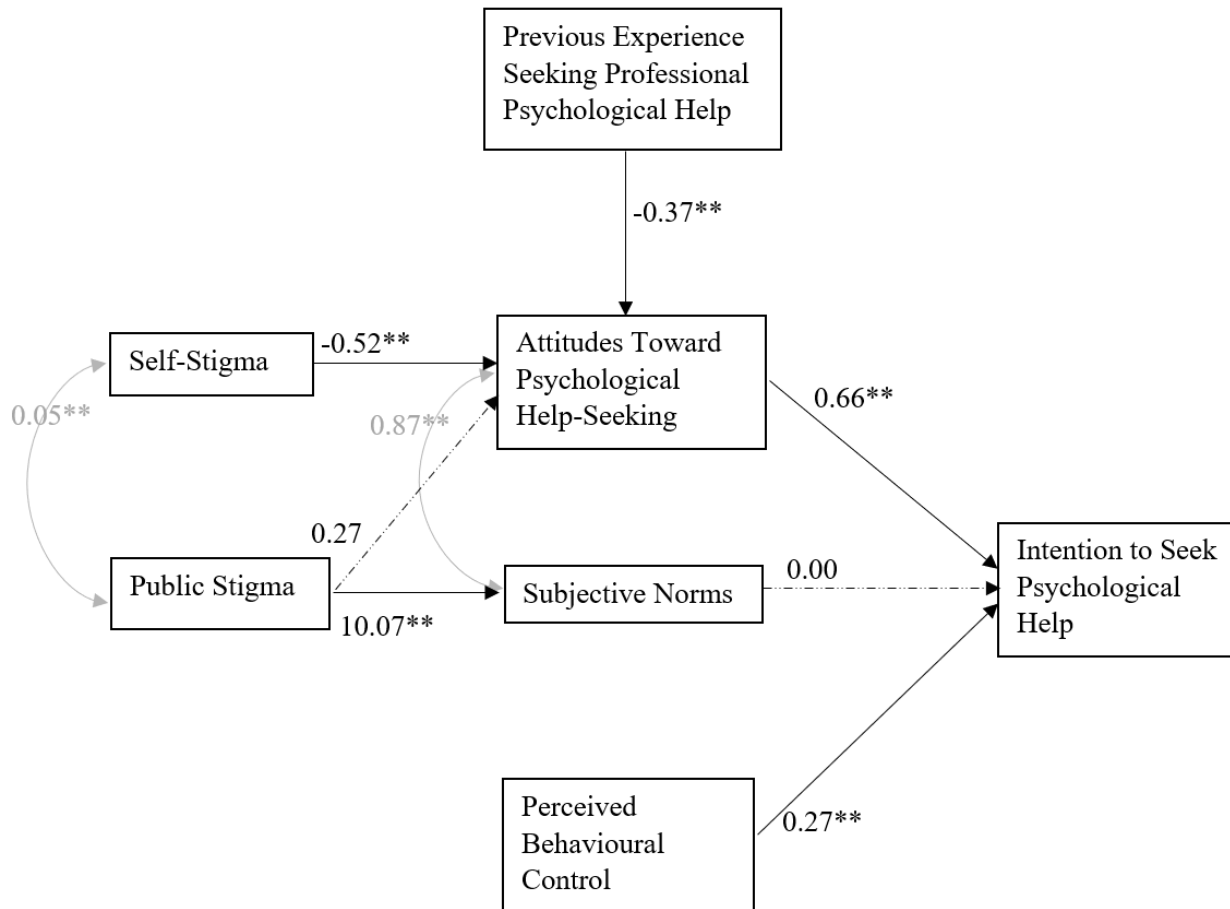


Figure 5. Hypothesized Model 2 Results. Non-standardized path coefficients and covariance estimates are shown. Solid black lines represent significant pathways, while dashed lines represent non-significant pathways. Lighter curved lines represent covariances.

$**p < .01$

Hypothesized Model 3

Figure 6 shows the results of Hypothesized Model 3, which included culturally relevant variables thought to impact psychological help-seeking particularly in the Black community. Hypothesis 6 was not supported, as the afrocultural beliefs did not lead to unfavourable attitudes toward psychological help-seeking (hypothesis 6a) nor negative subjective norms that oppose against psychological help-seeking (hypothesis 6b). Hypothesis 7 was only partially supported. As expected, higher levels of cultural mistrust were significantly associated with unfavourable attitudes toward psychological help-seeking (hypothesis 7a) and lowered intentions to seek psychological help (hypothesis 7c). However, contrary to hypotheses, higher cultural mistrust led to subjective norms in favour of psychological help-seeking (hypothesis 7b). Hypothesis 8 was supported, higher levels of cultural mistrust led to greater willingness to receive psychological help from a Black mental health professional. Hypothesis 9 was not supported, as willingness to receive psychological help from a Black mental health professional did not lead to greater intention to seek psychological help. Similar to Hypothesized Model 2, this model did not seem to fit the data well ($\chi^2(28) = 291.20, p < .001$; CFI = .67, CI = .65, NNFI = .58, SRMR = .12, RMSEA = .13). In addition, Table 5 shows that this model accounted for more variance than Hypothesized Model 2 ($r^2 = .57$). Lastly, Table 6 displays the covariances and p -values for the model variables that were allowed to covary.

It should also be noted that in Hypothesized Model 2 public stigma led to positive subjective norms in favour of psychological help-seeking, however in this model public stigma led to negative subjective norms that oppose against psychological help-seeking, as was originally hypothesized.

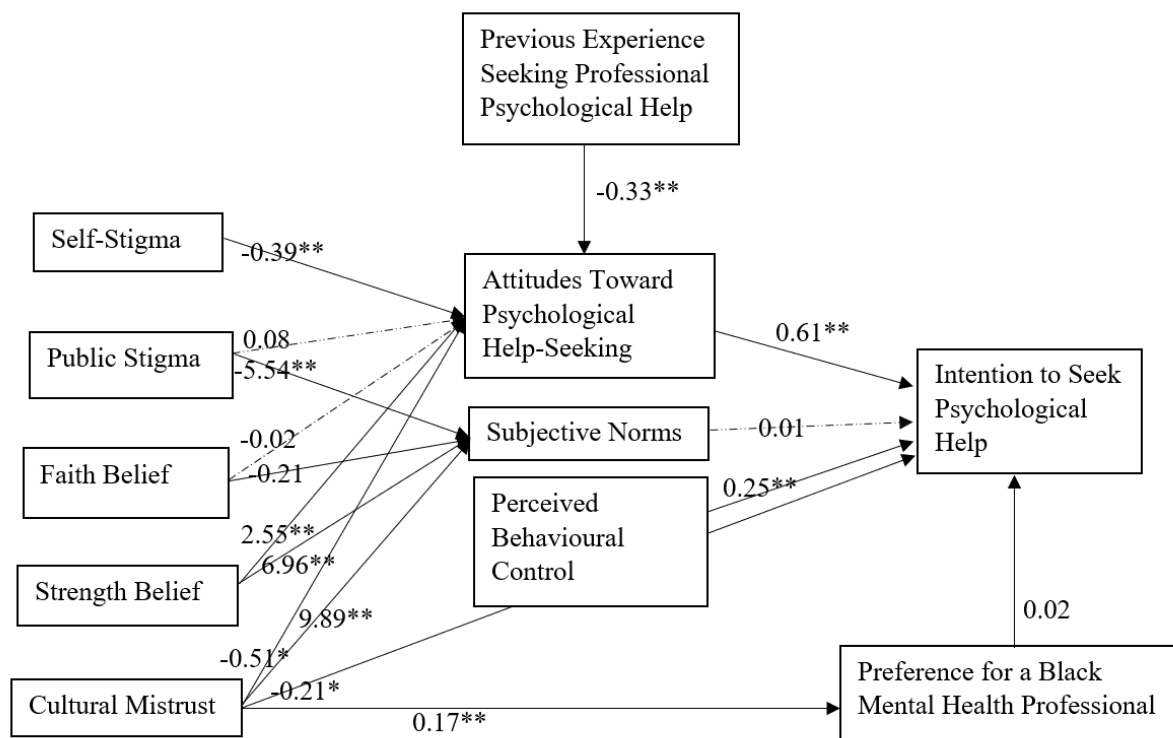


Figure 6. Hypothesized Model 3 Results. Non-standardized path coefficients are shown. Solid black lines represent significant pathways, while dashed lines represent non-significant pathways.

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

Table 6

Covariances of the variables that were allowed to covary in Hypothesized Model 3

		Covariance	p -value
Self-Stigma	Public Stigma	0.050	<.001
Self-Stigma	Faith Belief	0.296	<.001
Self-Stigma	Strength Belief	-0.002	<.001
Self-Stigma	Cultural Mistrust	0.005	<.001
Public Stigma	Faith Belief	0.052	.015
Public Stigma	Strength Belief	-0.003	<.001
Public Stigma	Cultural Mistrust	-0.002	.001
Faith Belief	Strength Belief	-0.033	<.001
Faith Belief	Cultural Mistrust	-0.001	.001
Strength Belief	Cultural Mistrust	0.000	.001
Attitudes	Subjective Norms	0.536	<.001

Note. Attitudes = Attitudes Toward Psychological Help-Seeking

Model 4: Respecified Model

Given the poor fit of the hypothesized path models, model respecification was undertaken. The modification indices (MI's) and standardized residuals were examined to determine areas of model misspecification. The Lagrange Multiplier (LM) test was used to explore what parameters should be added to the model to improve the fit. In addition, the Wald test was used to determine which parameters could be deleted. As recommended by Ullman (2013), first the parameters recommended by the LM test were added in a stepwise fashion, and then stepwise deletions were made based on the results of the Wald test. Modifications were only made if the additions or deletion was also conceptually or theoretically reasonable. Decisions about the addition/removal of paths and covariances were based on the results of previous model testing.

Hypothesized Model 3 was used as the starting point for model respecification. The following paths were added to the model: self-stigma to intention, strength belief to intention, perceived behavioral control to attitude, self-stigma to subjective norms, strength belief to preference for a Black mental health professional, and psychological distress to preference for a Black mental health professional. The following paths were removed from the model: subjective norms to intention, public stigma to attitude, faith belief to attitude, strength belief to subjective norms, cultural mistrust to subjective norms, and cultural mistrust to intention. Covariances were allowed between: self-stigma and perceived behavioural control, public stigma and psychological distress, previous experience seeking help and self-stigma, strength belief and perceived behavioural control, and strength belief and previous experience seeking help. Lastly, covariances between public stigma and cultural mistrust, self-stigma and cultural mistrust, and

strength and cultural mistrust were constrained to zero. Table 7 displays the covariances and p -values for all the variables that were allowed to covary in the respecified model.

The fit indices for the respecified model were $\chi^2 (27) = 99.94, p < .001$; CFI = .93, CI = .91, NNFI = .90, SRMR = .07, RMSEA = .06, suggesting a good fit with the data. This model explained 62% of the variance of intentions to seek psychological help (see Table 5).

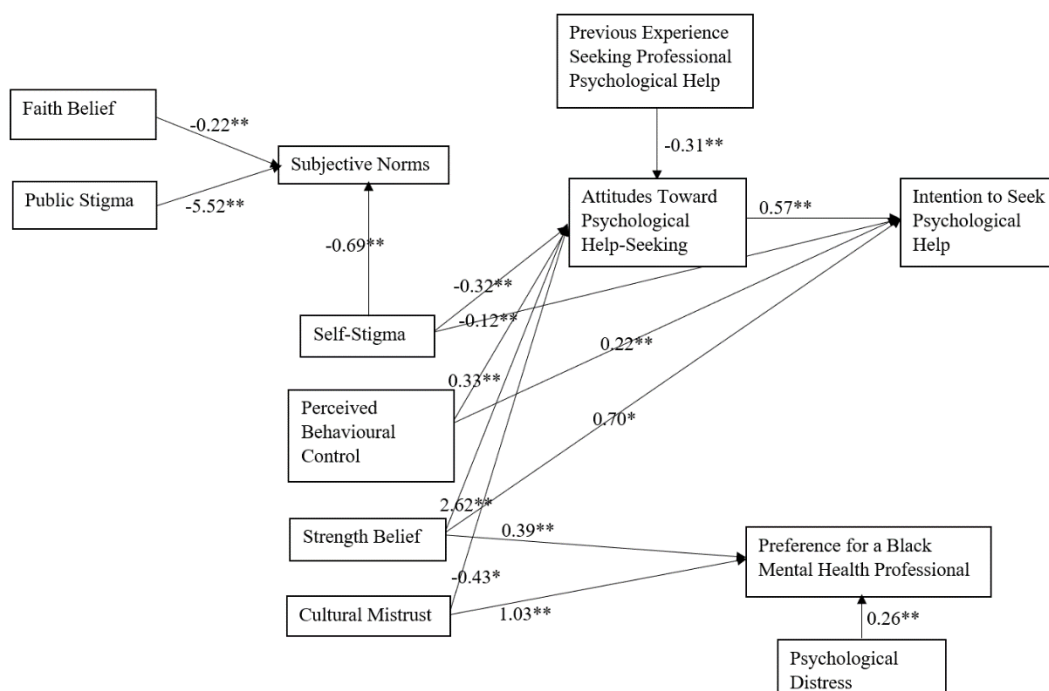


Figure 7. Final Respecified Model Results. Non-standardized path coefficients are shown.

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

Table 7

Covariances of the variables that were allowed to covary in the Final Respecified Model

		Covariance	p -value
Faith Belief	Public Stigma	0.037	.002
Faith Belief	Self-Stigma	0.193	.014
Faith Belief	Strength Belief	-0.024	.004
Faith Belief	Cultural Mistrust	0.037	.002
Public Stigma	Self-Stigma	0.046	<.001
Public Stigma	Strength Belief	-0.003	<.001
Public Stigma	Psychological Distress	0.006	<.001
Self-Stigma	Perceived Behavioural Control	-0.107	<.001
Self-Stigma	Strength Belief	-0.020	<.001
Self-Stigma	Previous Experience	0.039	.040
Perceived Behavioural Control	Strength Belief	0.007	.008
Strength Belief	Previous Experience	-0.004	.039
Attitudes	Subjective Norms	0.617	<.001

Note. Attitudes = Attitudes Toward Psychological Help-Seeking, Previous Experience = Previous Experience Seeking Professional Psychological Help

Model Comparisons

A Chi-Square Difference Test was used to compare the models against each other to determine which of the three hypothesized models fit the data the best. This can be accomplished because all three models are considered nested, as Hypothesized Model 1 is a subset of both Hypothesized Model 2 and Hypothesized Model 3 and that Hypothesized Model 2 is a subset of Hypothesized Model 3. The results of the chi-squared difference test, as seen in Table 8, show that Hypothesized Model 2 and 3 fit the data significantly better than Hypothesized Model 1. Hypothesized Model 3 could not be compared to Hypothesized Model 2 because the chi-squared value for Hypothesized Model 3 was smaller than the chi-squared value for Hypothesized Model 2. Although these results suggest that Hypothesized Model 2 and 3 fit the data better than Hypothesized Model 1, it is important to consider that Hypothesized Model 1's fit indices were superior to those of Hypothesized Model 2 and 3 (see Table 4). Therefore, it cannot be confidently concluded that Hypothesized Model 2 and Hypothesized Model 3 are in fact better fitting models than Hypothesized Model 1.

Table 8

χ^2 Difference Test for the Hypothesized Models

Comparison	χ^2 difference	df difference	p
Model 2 versus Model 1	310.24	10	<.001
Model 3 versus Model 2	--	--	--
Model 3 versus Model 1	254.25	25	<.001

Note. Model 1 = Hypothesized Model 1, Model 2 = Hypothesized Model 2, Model 3 = Hypothesized Model 3.

Summary of Path Analysis

The results of the present study revealed that the TPB model (Hypothesized Model 1) did not adequately fit the data. Contrary to the TPB model, subjective norms had no association with intention to seek psychological help. The second hypothesized model, which included self-stigma and public stigma was an even poorer fit for the data. Public stigma did not relate to the attitude toward help-seeking nor subjective norms as hypothesized. The inclusion of culturally specific variables in Hypothesized Model 3 did little to improve the model fit and only half the variables were significantly associated in the anticipated directions. Lastly, the final respecified model, which was established after modifications were made to Hypothesized Model 3, was found to fit the data well. A summary of which hypotheses were supported or not supported for each hypothesized model is shown in Table 9.

Table 9

Summary of which hypotheses were supported and not supported for each hypothesized model.

	Hypotheses Supported?		
	Model 1	Model 2	Model 3
Hypothesis 1			
1a) Attitudes will positively influence Intention	Yes	Yes	Yes
1b) Subjective Norms will positively influence Intention	No	No	No
1c) Perceived Behavioural Control will positively influence Intention	Yes	Yes	Yes
Hypothesis 2			
Self-Stigma will negatively influence Attitude	-	Yes	Yes
Hypothesis 3			
3a) Public Stigma will negatively influence Attitude	-	No	No
3b) Public Stigma will negatively influence Subjective Norm	-	No	Yes
Hypothesis 4			
Previous Experience will negatively influence Attitude	-	Yes	Yes
Hypothesis 5			
Psychological Distress will positively influence Intention	-	No	No
Hypothesis 6			
6ai) Faith Beliefs will negatively influence Attitude	-	-	No
6bi) Faith Beliefs will negatively influence Subjective Norms	-	-	No
6aii) Strength Beliefs will negatively influence Attitude	-	-	No
6bii) Strength Beliefs will negatively influence Subjective Norms	-	-	No
Hypothesis 7			
7a) Cultural Mistrust will negatively influence Attitude	-	-	Yes
7b) Cultural Mistrust will negatively influence Subjective Norms	-	-	No
7c) Cultural Mistrust will negatively influence Intention	-	-	Yes
Hypothesis 8			
Cultural Mistrust will positively influence Willingness to Seek Help from a Black Mental Health Professional	-	-	Yes
Hypothesis 9			
Willingness to Seek Help from a Black Mental Health Professional will positively influence Intention	-	-	No

Note. Model 1 = Hypothesized Model 1, Model 2 = Hypothesized Model 2, Model 3 = Hypothesized Model 3. Intentions = Intentions to Seek Psychological Help, Attitudes = Attitudes Toward Psychological Help-Seeking

Analysis of Responses to the Open-Ended Question

After completing the demographic information, participants were directed to the statement: “*Research shows that Black Canadians are not using mental health services as much as other ethnic groups in Canada*” They were then asked, “*Do you think this is an issue that needs to be addressed?*” Those who answered “Yes” to this question were then presented with the following question: “*What do you think can be done, if anything, to help Black Canadians use mental health services more?*” Content analysis was used to analyze participants’ responses to this open-ended question.

Coding Method

The aim of content analysis is to achieve a broad condensed description of a target phenomenon (Krippendorff, 1980). Through content analysis, words and phrases that seem to have the same meaning, are summarized by fewer content-related categories. Considering that there is limited knowledge on the focus of the current study on help-seeking among Black Canadians, this research utilised conventional content analysis known as ‘inductive category development’ (Hsieh & Shannon, 2005; Lauri & Kynga” s, 2005; Mayring, 2000) to analyze participants’ responses to the open-ended question indicated above. Therefore, the categories emerged directly from the data are reported, independent of any a priori theory (Kondracki & Wellman, 2002). The responses to the open-ended question were analyzed by a single coder (the principle researcher). The NVivo software was used for the coding purpose. The categories were developed using NVivo’s *text search* function. This function allowed the researcher to observe what terms occurred most frequently in the text. Participant responses were then reviewed again to determine which responses fit under which category.

Results of Qualitative Analysis

Table 10 and Figure 8 display the themes that occurred most frequently in the responses to the open-ended question. Respondents most often discussed topics that related to: accessibility to mental health services; knowledge about mental health and mental illness; stigma; awareness about mental health services; the need for more discussion about mental health and mental illness in the Black community; culture; Black mental health professionals; youth; family; and religion/spirituality. Each of these themes are discussed in more detail below.

Table 10

Themes emerging from responses to the open-ended question.

Theme	# of Participants	% of Participants
Increase accessibility to mental health services	152	47.35
Increase education about mental health and mental illness	141	43.93
Reduce mental illness stigma	120	37.38
Raise awareness about mental health services	93	28.97
Have more discussion about mental health and mental illness in the Black community	77	23.99
Consider the impact of culture	65	20.25
Increase the number of Black mental health professionals	41	12.77
Involve the youth	38	11.84
Consider the role the family	35	10.90
Consider the impact of religion, faith, and spirituality	20	6.23



Figure 8. Word cloud displaying the themes that occurred the most frequently in response to the open-ended question

Accessibility to mental health services. Many respondents stated that mental health services need to be made more available and affordable to Black Canadians. Participants made statements such as *“more services need to be available,” “available and affordable services,”* and *“making it more accessible and available.”* There was also mention of making more available free and low-cost mental health services. Participants stated that *“cost is the major barrier”* and it was suggested *“to make the cost more accessible.”* In addition, respondents advised that mental health services can be made more accessible with government intervention and funding. They mentioned *“funding, make it more accessible,” “provincial government coverage of therapy,” “[providing] government grants to this specific community for non-profit organizations who can create programs and/or services that addresses this topic.”*

Knowledge about mental health and mental illness. Participants also expressed the desire for more education, information, and understanding about mental health and mental illness. One participant stated, *“there needs to be an eradication of ignorance from Black people in our definitions and understanding of mental health.”* Another participant said, *“more education on what mental health issues are and how the impact/effect they have on children, youth, adults and their family.”* Respondents also mentioned wanting *“information regarding the signs of mental health issues...better information on where and how to get help if needed.”*

Stigma. The idea of reducing the stigma around using mental health services also occurred frequently among participant responses. Participants made comments such as *“the stigma surrounding mental health in our community need to be dealt with first!!”* Many respondents simply stated, *“reduce the stigma,” “remove the stigma,” “address*

the stigma". Participants also specified that there is a need to *"break down stereotypes."* One participant explained that *"Black people are always seen as strong by society physically and emotionally, so we don't like to see ourselves as weak by us or by other people so maybe try to acknowledge this stereotype..."*

Awareness about mental health services. Another issue that participants discussed was not being aware of or knowing about what mental health services are available. Many only said, *"awareness,"* or *"more awareness."* One participant went on to make suggestions like *"make them more aware of the services. Promote on social media and other platforms. Send out a flyer to Black dominant neighbourhoods. Hand out in malls and strip plazas. Leave some in brochure cases at Black owned businesses or Caribbean restaurants."* Others mentioned *"more education and awareness campaigns specifically designed for and by Black Canadians."* It was also proposed that one should *"promote services in predominantly Black organizations (churches, community, and cultural centers, etc.)"*

More discussion about mental health and mental illness in the Black community. Participants also acknowledged that it would be beneficial if people in the Black community talked about and had more discussions around mental health and mental illness. One respondent said, *"well we have to start by normalizing it. More of us have to come forward and talk about our experiences with each other."* Others asserted that it would help to *"facilitate more open conversation,"* and have *"more discussions regarding the need for mental health services for Black Canadians and the mental health issues of Blacks."*

Culture. The importance of culture also came up as an important consideration. One participants suggested, *“targeted interventions that are culturally-informed for Caribbean and African communities.”* A different participant explained the need for, *“culturally appropriate services recognizing that Black Canadians is not a catchphrase [catchall] for all Black people because of national and cultural differences. In other words what may work for a West African individual may not work for a Caribbean or [an] East Africa [individual].”* It was also stated that, *“there needs to be culturally specific care [that]provides strategies for dealing with the stigma of mental health with the Black community. There should also be an understanding from practitioners of what the tangible effects of racism are to exacerbate symptoms.”*

Black mental health professionals. Relatedly, several participants expressed the need for a greater number of Black mental health professionals. Respondents made statements such as *“increase awareness of Black mental health professionals,” “include listings of Black health professionals,” “encourage Black professionals in the mental health field,” “hire more Black counsellors,” “more Black/POC [people of colour] counsellors/therapists,” “more Black psychiatrists and psychologists and counsellors accessible for folks.”* One participant spelled out, *“get Black counsellors, psychologists, and psychiatrists because representation and understanding of cultural concepts is pivotal.”*

Youth. Another important topic participants brought up was ensuring that the younger generation be exposed to the topic of mental health and mental illness early on in life. One participant recommended, *“[encouraging] parents to discuss mental health issues with their children and to be open about their issues and teach their children how*

to be attentive to their mental health in the same way that they are taught to be attentive to their physical health.” Another participant offered that, *“older generations may carry stigma around mental health that can influence their children.”* It was also suggested that we *“target young children,”* and have *“programs that educate young people.”*

Family. Similarly, there was notable mention of the role of family and parents. Some participants identified how family members precipitate the stigma around mental illness. For example, it was stated that, *“there is a great deal of shame for those in need, and derision by friends and family,”* *“family member still label those with mental health [concerns] as mad or crazy,”* and *“many Black don’t seek professional help [because] they’re worried that their families will get upset.”* One participant asserted that the solution *“should start at [a] community level, where family members take part [in] mental health.”* Similarly, others suggested *“families pursuing mental health support,”* *“family support,”* and offering *“interventions with family.”*

Religion/spirituality. Lastly, several participants mentioned how spiritual beliefs impact one’s decision to seek help. One participant explained, *“I believe many Black Canadians connect with their religious beliefs in times when there is a mental crisis or challenge. The perception might be that mental health services are for people who lack faith or are not seeking “God” for an answer or their pastor, minister, or imam for counsel...”* Correspondingly, participants pointed out that religiosity at times contributes to the stigma around mental illness. For example, one participant mentioned, *“church/church members discouraging the use of mental health services of medication, instead telling people they are “possessed by demons” or need to “pray away” their mental illness.”* Some also admonished using as prayer the only means of coping with

mental health concerns. For example, it was stated, “*we need to accept that sometimes prayer alone cannot suffice...*”

CHAPTER 5 DISCUSSION

The main purpose of the present study was to examine the ability of the TPB model to explain intentions to seek help in Black Canadians. Furthermore, an additional aim of the present study was to test whether expanding the TPB by including stigma and culturally specific variables would lead to improved explanatory frameworks for psychological help-seeking among Black Canadians. Finally, qualitative analysis was also incorporated to gain further insight into Black Canadians' views about using mental health services. What follows is a summary and discussion of the results for the hypothesized path models tested and the qualitative findings for the present study. Furthermore, limitations of the study, potential directions for future research, and clinical and practical implications of the current study's findings are also discussed.

The Theory of Planned Behaviour Model

One of the main aims of the present study was to assess whether the TPB (Ajzen, 1991) explained help-seeking intention among Black Canadians. Overall, the results of the study showed that the TPB model did not produce a good fit for this sample. However, it is noteworthy that approximately 59% of the variance in Black Canadian help-seeking intention was explained by this model. According to an earlier meta-analysis study by Godin and Kok, (1996), the TPB accounted for on average 40% to 54% of variance in intention to perform various health-related behaviours (e.g., smoking cessation, physical activity, diet, oral hygiene, condom use, etc.) across the studies analyzed. Thus, in this sample the TPB explained the variance in help-seeking intention among Black Canadians relatively better than those found with other health behaviours

based on this meta-analysis study. It is possible that this model did not fit the data well because there were variables in the model that were not relevant to psychological help-seeking intention among Black Canadians, such as subjective norms. Also, the TPB is a theoretical model that was proposed to predict and explain any human behaviour in any context (Ajzen, 1991). Therefore, it might not be possible to account for all the factors that are unique to specific behaviours and specific populations because there are potentially too many relevant factors that could not be accounted for by the TPB alone.

Nevertheless, as expected, attitudes toward help-seeking and perceived behavioural control around help-seeking, as components of TPB, both predicted help-seeking intention in the current Black Canadian sample. This aligns with what is theorized by the TPB model (Ajzen, 1991). These results replicate findings in previous research that attitudes toward seeking mental health services and perceived behavioural control are in fact strong predictors of intentions to seek mental health services (Bohon et al., 2016; Compton & Esterberg, 2005; Mo & Mak, 2009; Schomerus et al., 2009).

However, subjective norms had no effect on intention to seek psychological help. Therefore, among Black Canadians, external social pressures had no apparent effect on deciding whether to seek professional mental health services. This finding is, however, not surprising given that the findings of a previous meta-analysis study of TPB research revealed that across several studies subjective norms was found to be a weak predictor of behavioural intention (Armitage & Conner, 2001). More recently, when the TPB was tested with a White college student sample (Bohon et al., 2016) and an African-American sample (Compton & Esterber, 2005) subjective norms showed no significant effect on intention. In contrast, other research has found subjective norms to be a significant

predictor of help-seeking intention in cultural groups that emphasize interpersonal relationships and strong kinship bond such as Latin-American Canadians (Kuo et al., 2015) and Chinese individuals (Mo & Mak, 2009). Taken together, this suggests that subjective norms may have less influence on individuals who live in more individualistic cultures. Therefore, it is possible that Black Canadians may be a relatively independent-minded group of people when it comes to help-seeking, and consequently their help-seeking behaviour is not as readily affected by the perceptions of others. These findings are important because they provide evidence that the applicability of the TPB may vary depending on cultural differences between groups (e.g., varying levels of collectivism and individualism, and interdependence and independence).

Expanding the Theory of Planned Behaviour to Include Mental Health Variables

Hypothesized Model 2 expanded on the TPB by including self-stigma and public stigma while controlling for the effects of previous experience seeking psychological help and psychological distress. Fit indices suggested that this too was a poor fitting model for this data set; however, again more than half of the variance in Black Canadian help-seeking intention was explained by this model. This model did not fit the data as well as the previous model because it included more variables, but its explanatory power was equivalent to that of the original TPB.

Psychological Distress. Preliminary analyses of the data in this study revealed that psychological distress was unrelated to intention to seek help, and there were no significant differences in help-seeking intention between those with significant psychological distress and those without. Therefore, psychological distress was removed as a covariate for help-seeking intention.

The psychological distress scores for this sample were moderate and did not have a restricted range. Therefore, the non-significant effect was not due to a narrow range of this score. It is possible that psychological distress was unrelated to help-seeking intention because Black people may be less able to recognize when their levels of psychological distress warrant professional help. It was found that a sample of African Americans diagnosed with depression were able to describe a comprehensive list of depressive symptoms but, before being diagnosed, did not realize that these symptoms were out of the ordinary (Conner et al., 2010). Similarly, non-patient African Americans reported that people in their community view psychological distress as a normal part of life and tend to deny that psychological distress is indicative of a need for professional help (Ward, Clark, & Heidrich, 2009). The implication of this finding is that there are likely many Black Canadians who are suffering with significant psychological distress who have no intention to seek psychological services because they do not realize that they might need the help.

Previous experience seeking psychological help. This expanded model also revealed that, as expected, previous experience seeking psychological help led to unfavourable attitudes toward help-seeking. This finding supports the results of previous studies investigating help-seeking intention among Black Canadians (Joseph, 2010). This result suggests that Black Canadians are having negative experiences with mental health services that are making them associate psychological help-seeking with unfavourable outcomes, which would in turn reduce their willingness to seek psychological services in the future. This finding also mirrors research conducted in the United States which found that African Americans seeking psychological treatment from mainstream mental health

services have experiences that are frequently unfavorable (Thompson et al., 2004). In a national U.S. study, researchers found that Black Americans' attitudes toward using mental health services were worse after receiving mental health services compared to before receiving the services (Diala et al., 2000).

It is possible that when seeking help Black clients feel that they are treated more poorly than clients from the dominant culture. For example, a meta-analysis found that compared to White clients, Black clients had a higher rate of inpatient admission (Bhui, Stansfeld, Hull, Preibe, Mole, & Feder, 2003). Furthermore, the same study found that Black clients on inpatient units were four times more likely to experience a compulsory admission than White clients.

In addition, prior research indicates that most racial/ethnic minorities in the U.S. who sought psychological treatment have experienced at least one racial microaggression during the process (Hook et al., 2016; Owen et al., 2011; Owen, Tao, Imel, Wampold, & Rodolfa, 2014). Racial microaggressions are defined as "brief everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (Sue et al., 2007, p. 273). Researchers have observed that microaggressions perpetrated against Black Americans commonly happen when clinicians deny racial/ethnic client-therapist differences (e.g., "I don't see you as Black, I just see you as a regular person"), minimize or dismiss the importance of racial/ethnic issues (e.g., "I'm not sure we need to focus on race or culture to understand your depression"), and/or make assumptions based on racial/ethnic group membership (e.g., "I know that Black people are very religious"; Constantine, 2007; Hook et al., 2016). The negative consequences of racial microaggressions for Black Americans include poorer therapeutic relationships,

lower perceived counsellor competence, and less satisfaction with psychological treatment (Constantine, 2007).

Self-stigma. The study's hypothesis that elevated levels of self-stigma would lead to unfavourable help-seeking attitudes was also supported. It is not surprising that those who believe that using mental health services would cause them to feel worse about themselves for having done so, would be less likely to use mental health services. This finding is supported by research that has found that individuals with high levels of self-stigma are less likely to seek psychological services (Vogel, Wade, & Haake, 2006). Similarly, Lannin and colleagues (2016) examined the effects of self-stigma on people's decisions to seek information for mental health and counselling services. The results showed that people with higher levels of self-stigma were less likely to seek information for their mental health concerns and about counselling services than people with lower levels of self-stigma.

For Black Canadians, the source of self stigma associated with psychological treatment-seeking might stem from perceived personal shortcomings and defects associated with seeking help. For instance, Conner and colleagues (2010) found that African Americans blamed themselves for having mental illness and associate having mental illness with personal weakness. In the same study African American participants reported that many people in their community could endure "hard times", but they could not. As a result, these individuals concluded that they must not be very strong because they needed professional help.

Public stigma. Contrarily, the hypothesis that elevated levels of public stigma would lead to unfavourable help-seeking attitudes was not supported. There was no

significant association between public stigma and attitudes toward help-seeking. This finding may relate to the finding that subjective norms had no influence on help-seeking intention. It could be that in Black Canadian culture one's behaviour does not rely heavily on the opinion of others. This is an encouraging finding because it suggests that Black Canadians would not be negatively affected by public views over their seeking mental health services.

It is unclear if the hypothesis that higher levels of public stigma would lead to negative subjective norms against help-seeking was supported or not. In hypothesized model 2 public stigma had a significant positive influence on subjective norms. That is, elevated levels of public stigma led to positive subjective norms in favour of help-seeking. Whereas, in hypothesized model 3, as expected, public stigma had a significant negative influence on subjective norms. Still, this finding may be inconsequential as subjective norms had no influence on intention to seek help, which suggest that public stigma also had no influence on help-seeking intention. This result seems to imply that Black Canadians' decisions to seek psychological services are unlikely to be swayed by those around them, similar to the notion of subjective norms discussed in the previous section.

Expanding the Theory of Planned Behaviour to Include Culturally Specific Variables

Hypothesized Model 3 built upon Hypothesized Model 2 by including variables measuring help-seeking beliefs commonly endorsed by the Black community, cultural mistrust, and preference for seeking psychological help from a Black mental health professional. Overall, the results also indicated that this model did not fit the data well.

Nevertheless, similar to the previous two models, Model 3 accounted for a sizable amount of variance in help-seeking intention.

Faith Beliefs. Contrary to the hypotheses, the beliefs that Black people do not need professional psychological services if they have strong faith were not significantly related to either help-seeking attitudes or subjective norms. However, the relationships between the faith beliefs and help-seeking attitudes and between the faith beliefs and subjective norms were both in negative directions, as predicted. Interestingly, the association between the faith beliefs and subjective norms was approaching significance ($p = .06$).

The faith beliefs variable was included in the analyses (even though the inter-item reliability was low $\alpha = 0.15$) because previous research has indicated that this is an important construct to explore with regard to help-seeking intention in the Black community (Campbell & Long, 2014; Conner et al., 2010; Njiwaji, 2012; Schreiber et al., 1998). In Conner and colleagues' (2010) focus group study, African Americans in the U.S. reported that the most culturally acceptable strategy for coping with depression was through prayer and connection to God. The same participants further asserted that seeking help from a professional for a mental health concern would suggest a lack of spiritual faith. Likewise, Campbell and Long (2014) found that African American respondents identified several similar faith-based beliefs which included: *'Black people turn to God for everything'*; *'Black people believe more in religion than medicine or therapy.'*; and depression is an *'issue of faith'*. Schreiber and colleagues (1998) found that Black West Indian Canadian women with depression felt that belief in the Christian doctrine was a powerful force within West Indian society. All the participants indicated

that they were raised in the church, believed in God, and/or prayed regularly. Some stressed that God would replace their troubles with peace, comfort, and compassion. Others stated that they would be able to endure their problems because of God-given strength. Similarly, among Black Americans in Nova Scotia, Canada, spirituality was identified as important for deciding whether or not to seek professional help, as faith in God reportedly helped Black Nova Scotians cope with their mental health concerns (Njiwaji, 2012).

The scale reliability for this faith beliefs variable in the current study was, however, very poor ($\alpha = 0.15$). However, the factor analysis conducted on these items did reveal a single factor measure, meaning that they measured a single construct. To the author's knowledge this is the first time this belief has ever been assessed quantitatively in psychological help-seeking research with a Black population. Therefore, this research has laid a foundation upon which future researchers should create more reliable and sensitive scales to measure beliefs in Black individuals and communities within the context of help-seeking intention.

Strength Beliefs. It was also hypothesized that beliefs relating to Black people being strong and thus not needing mental health services would be associated with unfavourable attitudes toward help-seeking and subjective norms against help-seeking. Surprisingly, analyses yielded the reverse finding. Endorsement of the strength beliefs in fact led to favourable help-seeking attitudes and subjective norms in favour of psychological help-seeking.

This finding contradicts previous research with African Americans, which found that this group's tendency to demonstrate personal strength actually hinders their

psychological help-seeking intention (Thompson et al., 2004). Similarly, in a sample of West-Indian Canadian women with depression, participants pointed out that seeking help for depression was especially difficult because West Indian people are expected to be strong, while admitting to having mental illness is believed to be a sign of weakness (Schreiber et al., 1998). Therefore, this research finding is quite unexpected.

There are a few possible explanations for this unexpected result. Firstly, prior to completing the measures of psychological help-seeking intention, attitudes toward psychological help-seeking, subjective norms, and perceived behavioural control, participants in this study were presented with a hypothetical situation detailing the account of an individual experiencing symptoms of depression and anxiety. They were then asked to respond to the help-seeking intention, attitude, subjective norms, and perceived behavioural control items while imagining that they are in the situation described. It is possible that participants perceive the Black community to be strong in general but thought that showing personal weakness, such as the individual in the vignette, and seeking help is socially acceptable. Similar to the variable of faith beliefs, further investigation is needed to better assess and understand the relationship between strength beliefs and intentions to seek help among Black Canadians.

Cultural mistrust. Consistent with hypotheses, the current results showed that cultural mistrust was significantly associated with unfavourable help-seeking attitudes, lower intentions to seek help, and a greater preference to seek help from a Black mental health professional. These results support the findings of previous research (Joseph, 2010; Nickerson et al., 1994; Thompson et al., 1994). For instance, in Nickerson and colleagues' (1994) study that higher levels of cultural mistrust among African Americans

were found to be related to less favourable attitudes toward help-seeking. In addition, a meta-analysis of the literature on cultural mistrust and psychosocial functioning in African Americans by (Whaley, 2001) revealed negative correlations between cultural mistrust and measures of psychological help-seeking attitudes and behaviours.

Unexpectedly, however, in the present study cultural mistrust was significantly associated with subjective norms in favour of psychological help-seeking. This finding may have occurred because elevated levels of cultural mistrust tends to resemble symptoms of paranoia (e.g., self-consciousness and suspiciousness; Whaley, 2001). Therefore, individuals with high levels of cultural mistrust may present as paranoid to those around them. It is possible that the friends and family of these individuals might recognize that this type of paranoid behaviour is not normative and that they may be more inclined to suggest the individual to seek help. As such, as an individual's level of cultural mistrust increases, the person's perceived subjective norms in favour of help-seeking might increase also. This is because those who are important to the individual might be more motivated to encourage the person to seek help due to the presentation of the 'paranoia-like' characteristics of mistrust of the dominant culture. Thus far, no other study known to the author has explored cultural mistrust's effect on the degree of perceived social pressure to seek mental health services for Black populations, thus more research is needed to further examine this relationship.

Willingness to seek help from a Black mental health professional. Lastly, it was hypothesized that willingness to seek help from a Black mental health professional would have a positive association with intentions to seek psychological help. This hypothesis was not supported, as willingness to seek help from a Black mental health

professional was not related to help seeking intention. This finding contradicts the results of previous research. Thompson and colleagues (2004) found that African Americans preferring to be treated by a Black mental health professional because they doubted mainstream mental health professionals' ability to adequately understand their circumstances or address their concerns. This observation was further validated by Joseph's (2010) study with Black Canadians, which found that participants would be more willing to seek psychological services if the mental health professional treating them was also Black.

It is possible that the lack of association between willingness to seek help from a Black mental health professional and intentions to seek psychological help in the present research is due to the fact that the participants in this do not believe that seeking help from a Black mental professional would even be a possibility. Ajzen (1991) explains that one's willingness to perform a behaviour is inconsequential if they believe the behaviour is not achievable. In this sample many participants responded to the open-ended question by stating that there are not enough Black mental health professionals available. Therefore, participants may feel that it is inconceivable and hence irrelevant whether they would prefer a Black mental health professional or not, because Black mental health professionals are simply not available to them. The belief that Black mental health professionals are available and accessible might be a moderator variable, in that the relation between willingness to seek help from a Black mental health professional and intention might be stronger for Black Canadians who believe that Black mental health professionals are available to them, but weaker or nonexistent for Black Canadians who believe that Black mental health professionals are not available to them. Future research

should test this supposition and explore the relationship between the belief that the availability and accessibility of Black mental health professionals and Black individuals' willingness to seek help if such a mental health professional is Black.

The Respecified Help-Seeking Model

Considering that none of the three hypothesized models fit the sample data well, hypothesized model 3 underwent model respecification. The new respecified model included the same variables as hypothesized model 3 with the removal of several paths, and the addition of several other new paths. These specifications were based on the results of previous model testing. The respecification process yielded a model that was a good fit for the data and explained more variance in psychological help-seeking intention than the previous three models.

One of the new paths that were added was a path indicating the positive association between the strength beliefs and preference for a Black mental health professional. This finding makes sense conceptually because in previous research Black individuals have expressed greater comfort with self-disclosure when being treated by a Black counsellor compared to a White counsellor (Thompson et al., 1994). It is possible that Black Canadians believe that a Black mental health professional would be better able to understand norms and beliefs commonly endorsed by the Black community, (e.g. "*Black people must be strong*") and would therefore be better able to understand their experiences. This speculation is supported by research demonstrating that African Americans doubt mental health professionals' ability to adequately understand their circumstances or address their concerns (Thompson et al., 2004).

Other interesting findings from the respecified model include paths showing that intention is positively influenced by strength beliefs and negatively influenced by self-stigma. Correspondingly, Vogel, Wade, and Hackler (2007) found that self-stigma mediated the relationship between public stigma and willingness to seek psychological help. That is, removing the effects of self-stigma would result in no relationship between public stigma and help-seeking intention. This further underscores the importance of this variable in explaining psychological help-seeking.

In addition, perceived behavioural control was found to positively influence help-seeking intention and attitudes toward help-seeking. This finding is corroborated by research of Compton and Esterberg (2005) who found that only perceived behavioural control significantly predicted how long African American participants delayed seeking psychiatric health services after their family member was first hospitalized for psychosis. This implies that perceived behavioural control is a variable that potentially has a lot of influence on Black Canadian help-seeking intention.

These findings are important because in this model, strength beliefs, self-stigma, and perceived behavioural control all influence help-seeking intention directly and, in addition, influence help-seeking intention via attitudes toward help-seeking. Considering that these three variables all have two pathways to intention, they are crucial to understanding psychological help-seeking among Black Canadians.

Addressing Black Canadian Mental Health Service Underutilization

When participants were asked how to improve mental health service utilization for Black Canadians, many of the topics mentioned corresponded with the results of

previous qualitative research studies (e.g., Alvidrez et al, 2008; Campbell & Long, 2014; Campbell & Mowbray, 2016; Conner et al., 2010; Schreiber et al., 1998; Thompson et al., 2004). Notably, the two themes mentioned the most frequently by the participants were both associated with having the necessary resources and opportunity to use mental health services. Respondents stated that mental health services need to be made more available and affordable to Black Canadians. Participants also expressed the desire for more education, information, and understanding about mental health and mental illness. Another issue that participants discussed was not being aware of or knowing about what mental health services are available to them. According to the TPB model, these concerns fall under the element of ‘control beliefs’. Control beliefs refer to whether one has the required resources and opportunities to perform the target behaviour (Ajzen, 1991). Control beliefs directly predict one’s perceived behavioural control (i.e., the degree to which an individual feels capable of performing the behaviour they wish to perform). This further supports the importance of promoting favourable perceived behavioural control among Black Canadians in order to address the current underutilization of mental health services situation with this population.

The notion of needing to reduce the stigma around using mental health services also occurred frequently in participants’ responses. This finding concurs with the previous qualitative research studies which suggested that Black people perceive mental illness to be more stigmatizing than individuals in other ethnic and cultural groups (Campbell & Long, 2014; Campbell & Mowbray, 2016; Conner et al., 2010; Schreiber et al., 1998). This finding suggests that addressing stigma in the Black community will effectively improve help-seeking attitudes and intentions.

In the responses to the open-ended question, participants also stated that it would be beneficial if people in the Black community talked about and had more discussions around mental health and mental illness. Again, this response finds support in previous research. In one study with West-Indian Canadian women, the researchers observed that Caribbean people denied their susceptibility to mental illness by never talking about it (Schreiber et al., 1998). Similarly, research has found that African American participants also debated whether depression truly exists within the Black community or whether Black people simply refuse to acknowledge its existence (Campbell & Long, 2014). Therefore, it makes sense that the participants in the present study felt that having more discussions about mental health and mental illness in the Black community would allow Black Canadians to be more comfortable seeking mental health services.

The importance of considering culture by mental health professionals and within the larger mental health system was also highlighted by the participants. For instance, participants discussed that it is important to recognize the within-group cultural differences among the various Black Canadians communities. In a 2004 report Milan and Tran (2004) noted that approximately 48% of Black Canadian immigrants are born in Africa while about 47% are born in the Caribbean, or Central and South America. Furthermore, the experience of Canadian-born Black Canadians is quite different from the experience of foreign-born Black Canadians. Black Canadians born and raised in Canada are typically more acculturated to Canadian society and would therefore have different views about mental health and help-seeking than foreign-born Black Canadian immigrants.

Lastly, several participants mentioned how spiritual beliefs impact one's decision to seek help. Participants pointed out that religiosity at times contributes to the stigma around mental illness. Some even admonished the idea that for some Black Canadians using prayer is the only means of coping with mental health concerns. This aligns with research suggesting that African American participants identified prayer and connection to God as the most culturally accepted coping strategy for dealing with depression (Conner et al., 2010). Schreiber and colleagues (1998) found that West Indian Canadian women with depression felt that belief in Christian doctrine was ubiquitous within West Indian society. Similarly, among African Canadians in Nova Scotia, spirituality was reported to play a key role in deciding whether or not to seek help, as it was often reported that faith in God helps Black Nova Scotians cope with their gambling problems (Njiwaji, 2012). Hence, a blind reliance on religious faith to overcome mental health difficulties and emotional distress continues to be a concern in negatively affecting intention and willingness to seek professional help for Black Canadians.

Limitations

The present study contributes to the current help-seeking literature for Black individuals and communities by identifying multiple, critical antecedents to help-seeking intentions for Black Canadians. Despite this contribution, the findings of the current investigation need to be viewed with certain methodological limitations in mind.

Black Canadians have historically been a relatively hard to reach population. Therefore, this study used a variety of recruitment methods. This study was advertised via a poster and promotional video that was posted on several Facebook groups and pages designed for the Black Canadian community. The principle investigator also made

announcements at Black religious and community organizations' events and gatherings to recruit participants in person. The principle investigator also sent emails to members of Black community organizations encouraging them to participate. In addition, the principle investigator (who is a member of the Black Canadian community) invited her personal contacts to share information about the study with other Black Canadians who might be interested in participating. Although, using multiple methods of recruitment allowed for the gathering of a sizable sample, it also introduced potential confounds into the study. Considering that most participants completed the study online via an anonymous link, it is not possible to know which participant came from which recruitment source. It is also not possible to know if the recruitment source had any effect on the dependent variable (i.e., help-seeking intention). It is conceivable that face-to-face interaction with participants as compared to seeing a promotional video or a poster about the project or having a personal contact tell them about the study by word-of-mouth may have in some ways influenced the participants' survey responses. This is despite the fact that the researcher had made every effort to ensure that consistent information was provided to all participants through all recruitment methods.

A related limitation of this study is the self-selection bias of the sample. It is possible that those who chose to participate in this study are people who tend to have more favourable attitudes toward psychological help-seeking and who felt that this is an important issue to be addressed in the Black community. This means that Black Canadians who have unfavourable attitudes toward help-seeking and/or have no interest in improving mental health service utilization in the Black community might not have been represented in this study. As such, the current sample may or may not be

representative of the general population this study intended to examine. In addition, this study was advertised as a survey about Black Canadian mental health, and research shows that the stigma surrounding mental health and mental illness is quite prevalent in the Black community, such that many people are uncomfortable talking about the topic (Campbell & Long, 2014; Campbell & Mowbray, 2016; Conner et al., 2010; Schreiber et al., 1998; Waldron, 2002). Furthermore, in the current sample only a few participants reported elevated levels of stigma, thus it is possible that those with significant mental illness stigma might have opted out completely from participating in this research. Future research should seek to overcome this limitation by perhaps making the focus of mental health and professional help-seeking research with Black population subtler and less stigmatizing. For example, future help-seeking research may be promoted as a general survey about Black Canadian attitudes and opinions about health issues.

Additionally, the afrocultural beliefs scale used in the present study had relatively low inter-item reliability. While the measure seemed to be measuring three constructs, the lack of internal consistency calls into question the validity of this scale. This in turn has effects on the interpretability of the results relating to these beliefs. It is suspected that the inter-item reliability of this scale was low because the items may lack clarity and may have resulted in ambiguous interpretations by the respondents. For example, participants may have felt that an item stating, “Black people who are strong don’t need to seek mental health services” is synonymous with “Black people don’t have mental health issue.” Even though the principle researcher conceptualized these two items as measuring two distinct constructs. Furthermore, the subjective norms and perceived behavioural control measures also showed relatively low inter-item reliabilities. It is possible that this

occurred because these measures were adapted from a study designed to explore the TPB model with a Chinese sample (Mo & Mak, 2009). Therefore, the wording of the items in these scales may have been more appropriate for Chinese sample population than Black Canadian sample population. Despite that the current study's results still show that the strength beliefs and perceived behavioural control were strongly associated with help-seeking intention in Black Canadians. Thus, future research should work towards improving and refining measures of social and cultural beliefs about mental health, mental illness, and mental health service use for Black individuals and community.

Lastly, the outcome measure used in the study was intentions to seek help and it was developed based on the TPB model (Ajzen, 1991). The TPB model suggests that intentions to seek help are the direct predictors of help-seeking behaviour. However, the research design of the current investigation is a cross-sectional study; thus, participants' actual help-seeking behaviour, should it ever occur in the future, was not assessed in such a design. Therefore, a fruitful avenue for future research would be to conduct a longitudinal help-seeking study with Black Canadians, so that the long-term effects of the psychological and cultural antecedents of both help-seeking intentions and actual help-seeking behaviour can be evaluated simultaneously and directly. Such a study would help clarify the temporal relationship between these important help-seeking antecedents and help identify additional barriers to actual help-seeking behaviour for Black Canadians. It is possible that a Black Canadian's intentions to seek help may change over time and other factors may impede this individual's from taking acting following their intentions. For instance, individuals may report high intentions to seek help for psychological

distress but may then encounter difficulties navigating the Canadian healthcare system, which would impede them from seeking the needed treatment.

Future Research Directions

The final re-specified path model in the present study fit the data well and identified various variables, including self-stigma, perceived behavioural control, and strength beliefs, as important antecedents to help-seeking intentions in the current sample. However, because this model was statistically derived and generated post-hoc, future replication of this model is needed to determine the validity of the model and its various pathways. Kline (2016) recommends that post-hoc models should be replicated using different samples and compared to other potential equivalent models. This is particularly relevant for this study because the proportion of the variance explained was relatively large (i.e., $R^2 = .62$). This, in turn, suggest that the variables included in this re-specified model have important effects on the help-seeking process among Black Canadians, and it warrants further re-testing and re-examination.

In addition, the present study revealed the important role of perceived behavioural control in predicting psychological help-seeking in the current Black Canadian sample. This study also identified that greater awareness and accessibility to mental health services are important factors to be considered when trying to address underutilization of mental health service among Black Canadians. Therefore, future studies should examine how providing Black Canadians with information about low cost, accessible mental health services would improve their intentions to use mental health services. This could be examined experimentally. For example, an experimental study design can include a portion of the sample with whom information about where they can access local low cost

mental health services is provided; another portion of the sample with whom information about relatively costly and inaccessible mental health services is given; and a final portion of the sample with whom no mental health service information is provided, as the control group. The researcher can then compare the levels of help-seeking attitudes and intention among these three groups.

To further examine the applicability of the TPB in diverse cultural contexts, future research should explore if different levels of collectivism and individualism influence the effects of subjective norms on help-seeking intention. This current study found that subjective norms had no effect on help-seeking intention among Black Canadians. Yet, previous research has found subjective norms to be a significant predictor of help-seeking intention in several other cultural groups, which value interpersonal relationships and strong kinship bond, including Latin-American Canadians (Kuo et al., 2015) and Chinese individuals (Mo & Mak, 2009). Contrarily, when the TPB is tested with a White college student sample (Bohon et al., 2016) and an African-American sample (Compton & Esterber, 2005) subjective norms have no significant effect on intention. In sum, this implies that subjective norms may have less influence on individuals who live in more individualistic cultures as compared to individuals in more collectivistic cultures. Testing this supposition in the future would be invaluable in improving our understanding of the cross-cultural application of the TPB model.

Future help-seeking research should also examine within-group cultural differences among multiple subgroups of Black Canadians. The participants in the present study identified that it is important to consider cultural differences among Black Canadians from the Caribbean, East African, West African, South African backgrounds

and from those born in Canada. For example, Black Canadians that are more acculturated to Canadian society may have greater willingness to seek psychological services than those who are less acculturated. It is possible that certain more traditional African cultures might put greater emphasis on holistic healing methods and would be less amenable to the Western-based psychological or psychiatric methods in treating mental health concerns. It would be valuable for future empirical investigation to examine if and how within-group differences among Black Canadian communities affect the psychological help-seeking intention of cultural subgroups.

Additionally, more research is needed to explore tangible methods of improving help-seeking attitudes and intentions among Black Canadians, given the fact that previous studies have indicated that mental illness stigma is especially prominent in the Black community (Campbell & Mowbray, 2016; Conner et al., 2010; Schreiber, Stern & Wilson, 1998). Furthermore, mental illness stigma is likely particularly stigmatizing to the Black community because of the strongly-held normative beliefs that Black community is a community of strength and is invulnerable to mental illness or mental health concerns, as revealed in the earlier literature review. For this reason, researchers have recognized that culturally-informed psychoeducational strategies are more effective than generic psychoeducational interventions for reducing stigma among African Americans (Alvidrez, Snowden, Rao, & Boccellari, 2009). However, current mental health promotion interventions do not address how one's cultural characteristics contribute to the impact of mental illness stigma on psychological help-seeking attitudes. For instance, Canada has a national anti-stigma campaign called *Bell Let's Talk*, which is designed to reduce mental illness stigma among Canadians by encouraging the

conversation about mental health (CTV News, 2012). However, recent research by Ahmed and Dere (2017) critiqued that this campaign pays little to no attention to the role culture, race, or ethnicity play in affecting individuals' help-seeking intention from mental health professionals. Therefore, future research should compare the efficacy of current generic mental health campaigns with the efficacy of culturally-informed mental health campaigns for improving Black Canadians' and Black Americans' attitudes toward psychological help-seeking. This can be achieved, for example, through designing an experimental study that compares help-seeking attitudes among Black Canadians before and after being shown a generic mental health campaign with help-seeking attitudes among Black Canadians before and after being shown a culturally-informed mental health campaign.

Lastly, there should be more research on the utilization of mental health services among Black individuals who live outside of the U.S. Currently, there is a paucity of research about the help-seeking experiences of Black communities residing in predominantly White majority societies outside of the U.S., such as Canada and the U.K. It cannot be assumed that findings from research conducted with African Americans in the U.S. can be generalized to the experiences of Black communities in other countries. Specifically, future help-seeking research would benefit from exploring and evaluating the extent to which different societal and contextual factors--such as differences in healthcare systems, multiculturalism/immigration policies, and/or histories of slavery across different national contexts (e.g., U.S., Canada, U.K., France, etc.) -- may impact the mental health conditions and help-seeking attitudes of the Black populations residing in various countries.

Clinical and Practical Implications

The results of the present study have several implications for clinicians, educators and policy makers. One of the study's findings showed that self-stigma strongly influenced help-seeking intentions among Black Canadians. This finding can be very useful for mental health practitioners. Therapists can openly and gently address stigmatizing beliefs Black clients might have about seeking professional psychological help, for examples beliefs that *"Seeking professional help will make people think I am crazy or weak,"* or *"Seeking help from a professional means I am not strong enough to handle my own problems"*. It is important for the therapist to discuss with Black clients that seeking help for mental health concerns is nothing to be ashamed of. In fact, Alvidrez and colleagues (2008) observed that African American participants in their study identified that it was beneficial for them when mental health professionals normalized mental health problems by drawing the analogy that illness can afflict the mind the way it can afflict the physical body. Secondly, when providing psychotherapy for Black clients, a clinician should proactively work to reduce the potential shame and stigma by 'complimenting' and/or 'praising' the decision or the courage the clients took to seek help despite the stigma.

Thirdly, providing Black Americans with accurate education about the parameters, the nature, and the process of psychotherapy can also help reduce resistance to seeking help. This observation is supported by Alvidrez and colleagues' (2010) study, in which the authors found that providing clear explanations about what psychotherapy or psychological treatment entails worked to diminish stigma surrounding help-seeking for African Americans. Specifically, clinicians should make clear to their clients that

confidentiality for the client is the top priority for mental health professionals. As such, concrete information provided by the therapists should help to relieve Black clients from any concern they might have, such whether or not their family, friends, co-workers, or employers would find out about their use of psychological services. Lastly, educating Black clients about the benefits of treatment can also help lessen mental health stigma (Alvidrez et al., 2010). African American respondents from Alvidrez and colleagues' (2008) study reported that prioritizing their health and well-being above the opinions and reactions of others was a valuable strategy for coping with mental illness stigma. Hence, reducing stigma associated with using mental health services is paramount in promoting more positive attitudes towards psychological help-seeking among Black individuals.

In a similar vein, normative beliefs such as *'Black people don't get mental illness,'* *'Black people must be strong,'* and *'Black people who seek help from a professional have less faith in God,'* are commonly perpetuated and endorsed by the Black community and should be addressed in therapy. These beliefs were found to impede psychological help-seeking by creating a social pressure (subjective norms) to avoid mental health services. Clinicians can promote help-seeking with Black clients by providing psychoeducation and/or by inviting clients to critically evaluate the truthfulness of these normative beliefs and also the extent to which these beliefs may hinder them from getting much-needed treatment and support.

In a previous study with African Americans by Alvidrez and colleagues (2008), the study found that approximately half of the African Americans interviewed in the study indicated that seeking treatment became easier when they reminded themselves that mental health problems affect all types of people. Therefore, psychoeducation about

mental health with Black population should include explaining to clients that mental illness can in fact affect anyone, regardless of race and ethnicity. In addition to psychoeducation, should a client endorse beliefs similar to those strength beliefs and faith beliefs above, clinicians should openly and gently explore with clients the evidence, logic, and suppositions behind their beliefs. For example, the belief that *'Black people must be strong,'* implies that Black individuals can never display vulnerability or ask for help. Clinicians should encourage their clients to discuss and explore the origin and reasonability of such a belief. With respect to the belief that *'Seeking help from a professional shows a lack of faith in God,'* a therapist may respectfully challenge this rigid thinking. Again, Black clients who hold such a belief may be encouraged to consider the compatibility of seeking help from professionals and, at the same time, placing trust in God. In short, through informative psychoeducation and gentle but critical reflection/evaluation in psychotherapy, Black American clients can be encouraged to reconsider the validity of these culture-bound normative beliefs. This approach can help equip Black clients in responding to and managing the anti-help-seeking social pressures that may be impinging upon them from their family, peers, and community.

The results from the open-ended question also hint that Black Canadians lack sufficient knowledge and awareness about mental health or mental illness. As suggested by participants in this study, more needs to be done to educate the Black community about mental health and mental illness, and it should start early with Black youth. Similarly, as young children are educated about physical health and wellness early in life, education about mental health and wellness should be incorporated into elementary school curriculums with all children, including Black children.

Finally, for Black Canadians in the present study, perceived behavioural control appeared to be more important than an individual's attitudes when deciding whether or not to seek psychological help and treatment. Similarly, previous qualitative research results indicated that participants felt that greater availability and opportunity for Black Canadians to access mental health services can help to address the problem with mental health service underutilization for Black individuals and families (Thompson et al., 2004, Conner et al., 2010). That is to say, participants in the study stressed the importance of factors that could significantly increase the ease for Black Canadians to seek psychological help (i.e., increase perceived behavioural control). As such, policy makers should consider making changes that will make it easier for Black Canadians to seek help for mental health concerns. For example, having psychological services covered by Canada's universal health insurance plan would enable all Canadians, including Black individuals, to access to a wider range of affordable mental health care services.

Summary and Conclusions

The current study represents one of the first studies to use path analysis to test the ability of the TPB model (Ajzen, 1991) to explain help-seeking intentions with Black Canadians. The results showed that the TPB did not adequately explain Black Canadian help-seeking intention. It was found that only help-seeking attitudes and perceived behavioural control influenced help-seeking intentions, while subjective norms did not. The expanded models that included stigma variables and culturally relevant variables suggested the important roles of self-stigma and strength beliefs as the antecedents to help-seeking intention. The final respecified model showed that perceived behavioural control, self-stigma, and strength beliefs may be the most important factors to consider

when trying to understand psychological help-seeking intention among Black Canadians. Finally, this research study included an open-ended question to gain a greater understanding of how Black Canadians would improve utilization of mental health services in their community. Participants emphasized making mental health services more available and accessible to Black Canadians; educating Black Canadians more about mental health and mental illness; and reducing the stigma surrounding the use of mental health services.

The present study contributes to the literature on the applicability and generalizability of the TPB model in explaining psychological help-seeking intention. This research suggests that the TPB model cannot fully explain this behaviour in this context. The current findings also contribute to the literature by emphasizing the impact of other psychological and cultural variables on help-seeking among Black Canadians. Taken together, the present study provides a new understanding of the way in which psychological and cultural variables influence psychological help-seeking among Black Canadians. Given that this is the first study to examine help-seeking intentions among Black Canadians, more research is needed in this area to ensure that the needs of this community can be effectively and comprehensively addressed. Racial/ethnic disparities in the use of mental health services is a serious concern. Resolving such a challenging problem is no easy task. That said, knowing why Black Americans are less willing to use mental health services is a crucial first step for ensuring that necessary action is taken to promote psychological help-seeking in this population. It is, therefore, imperative for practitioners and researchers who are committed to improving mental health services and

help-seeking intention for Black Americans to approach the issue with culturally-responsive and informed perspectives.

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APPENDIX

Demographic Questionnaire

Please complete the following information as accurately as possible.

1. What cultural group do you most closely identify with (e.g., West-Indian, African, Jamaican, Ghanaian, African Canadian, etc.)?

2. Gender (*specify if necessary*):
 Male
 Female
 Other: _____
3. Age: _____
4. Current Immigration Status:
 Canadian Citizen
 Landed Immigrant
 Student Visa
 Refugee
 Other: _____
5. Were you born in Canada?
 Yes
 No
If NO, please specify your country of birth:

If NO, how many years have you lived in Canada?

6. What is your generation status in Canada?
 1st generation (born outside of Canada & immigrated to Canada **after** the age of 12)
 1.5 generation (born outside of Canada & immigrated to Canada **before** the age of 12)
 2nd generation (born in Canada & at least one of your parents was born outside of Canada)
 3rd generation (born in Canada and both parents were born in Canada)
 Beyond 3rd generation or later (you, your parents and grandparents were born in Canada)
 I am an international student who was born outside of Canada
7. Where was your mother born?

8. Where was your father born?

9. Your mother's ethnic background is:

- Black
 - White
 - Latino
 - Aboriginal/First Nations
 - East Asian (e.g. China, Korea, Taiwan, etc.)
 - Southeast Asian (e.g. Cambodia, Indonesia, Laos, Vietnam, etc.)
 - South Asian (e.g., India, Pakistan, Sri Lanka etc.)
 - Middle Eastern (e.g., Iraq, Syria, Egypt etc.)
 - Multiracial (specify):
 - Other (specify):
-

10. Your father's ethnic background is:

- Black
 - White
 - Latino
 - Aboriginal/First Nations
 - East Asian (e.g. China, Korea, Taiwan, etc.)
 - Southeast Asian (e.g. Cambodia, Indonesia, Laos, Vietnam, etc.)
 - South Asian (e.g., India, Pakistan, Sri Lanka etc.)
 - Middle Eastern (e.g., Iraq, Syria, Egypt etc.)
 - Multiracial (specify):
 - Other (specify):
-

11. Current Relationship Status

- Single
- Married
- Common-Law/Cohabiting
- Separated or Divorced
- Widowed

12. Employment Status

- Full-time
- Part-time
- Unemployed
- Student
- Retired

13. What is your estimated highest level of education completed (specify if necessary):

- No schooling or did not complete elementary school
- Elementary School Education
- High School
- Completed 2-year college program
- Completed University degree
- Completed graduate or professional school

14. Religious Affiliation:

- Christian (Protestant, Baptist, etc.)
- Catholic
- Jewish
- Muslim
- Other:

15. How often do you attend church, temple or other religious meetings?

- More than once a week
- Once a week
- Once a month
- A few times a year
- Once a year
- Never

16. In what city your primary Canadian residence?

17. Have you ever used mental health services (e.g., psychotherapy, counselling, psychiatry, etc.)?

- Yes
 - No
-

Hopkins Symptom Checklist-21

How have you felt in the previous 7 days? Use the following scale to describe how distressing you have found these things over this time.

Not at all A little bit Quite a bit Extremely
1 2 3 4

Be sure to answer all the questions. There are no right or wrong answers.

	Not at all	A little bit	Quite a bit	Extremely
Difficulty in speaking when you were excited	1	2	3	4
Trouble remembering things	1	2	3	4
Worried about sloppiness or carelessness	1	2	3	4
Having to do things very slowly in order to be sure you're doing them right	1	2	3	4
Having to check and double check what you do	1	2	3	4
Your mind going blank	1	2	3	4
Trouble concentrating	1	2	3	4
Blaming yourself for things	1	2	3	4
Feeling lonely	1	2	3	4
Your feelings being easily hurt	1	2	3	4
Feeling others do not understand you or are unsympathetic	1	2	3	4
Feeling that people are unfriendly or dislike you	1	2	3	4
To monitor quality, please respond with "Extremely" for this item.	1	2	3	4
Feeling inferior to others	1	2	3	4
Pains in the lower part of your back	1	2	3	4
Soreness of your muscles	1	2	3	4
Hot or cold spells	1	2	3	4
Numbness or tingling in parts of your body	1	2	3	4
A lump in your throat	1	2	3	4
Weakness in parts of your body	1	2	3	4
Heavy feelings in your arms and legs	1	2	3	4
Feeling blue	1	2	3	4

Theory of Planned Behaviour Questionnaire Instructions

The questions in this section make use of rating scales with 6 places; you are to circle the number that best describes your opinion. For example, if you were asked to rate “The weather today” on such a scale, the 6 places should be interpreted as follows:

	The weather today is:						
good	1	2	3	4	5	6	bad
	Extremely	Quite	Slightly	Slightly	Quite	Extremely	

If you think the weather today is extremely good, then you would circle *number 1*, as follows:

	The weather today is:						
good	①	2	3	4	5	6	bad

If you think the weather today is quite bad, then you would circle *number 5*, as follows:

	The weather today is:						
good	1	2	3	4	⑤	6	bad

If you think the weather today is slightly good, then you would circle *number 3*, as follows:

	The weather today is:						
good	1	2	③	4	5	6	bad

Please read this description before answering the following questions:

Imagine that you go to your family doctor because of the following problems you face. In the past few weeks you have been feeling sad and depressed, without any particular reason for feeling this way. You have a difficult time handling your everyday life. You don't feel like doing anything anymore, and nothing interests you. You feel that you are no good for anything and that you do everything wrong. Not only that, you feel anxious and worry a lot of the time for no obvious cause. When you're worrying, you find it hard to stop yourself or to think of anything else. These difficulties are so severe that they are interfering with your work/school, family relationship and social life. You call your family doctor in hope to get some help and he/she tells you that you might need to get mental health services, such counselling or psychotherapy.

The term *mental health service* refers to services provided by *mental health professionals*, which are individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, therapists, counsellors, and social workers).

Theory of Planned Behaviour Questionnaire

While imagining that you are in the situation described above, please answer each of the following questions by circling the number that best describes your opinion. Some of the questions may appear to be similar, but they do address somewhat different issues. Please read each question carefully. There are no wrong answers. It is important that you answer every question.

I intend to seek mental health service.

Strongly Disagree

1	2	3	4	5	6
---	---	---	---	---	---

 Strongly Agree

For me to seek mental health service is:

Very Useless

1	2	3	4	5	6
---	---	---	---	---	---

 Very Useful

To monitor quality, please respond with “Strongly Disagree” for this item.

Strongly Disagree

1	2	3	4	5	6
---	---	---	---	---	---

 Strongly Agree

For me to seek mental health service is:

Very Worthless

1	2	3	4	5	6
---	---	---	---	---	---

 Very Worthwhile

For me to seek mental health service is:

Very Bad

1	2	3	4	5	6
---	---	---	---	---	---

 Very Good

Most people who are important to me will seek mental health service if they are in need.

Definitely False

1	2	3	4	5	6
---	---	---	---	---	---

 Definitely True

For me to seek mental health service is:

Very Foolish

1	2	3	4	5	6
---	---	---	---	---	---

 Very Wise

Most people who are important to me view mental health service very negatively.

Strongly Disagree

1	2	3	4	5	6
---	---	---	---	---	---

 Strongly Agree

I will try to seek mental health service.

Extremely Unlikely

1	2	3	4	5	6
---	---	---	---	---	---

 Extremely Likely

For me to seek mental health service is:

Very Rare

1	2	3	4	5	6
---	---	---	---	---	---

 Very Common

Most people who are important to me think that I should seek mental health service.

Strongly Disagree

1	2	3	4	5	6
---	---	---	---	---	---

 Strongly Agree

I plan to seek mental health service.

Extremely Unlikely

1	2	3	4	5	6
---	---	---	---	---	---

 Extremely Likely

The Perceptions of Stigmatization by Others for Seeking Help

Imagine that you had a problem that needed to be treated by a mental health professional. If you sought mental health services for this issue, to what degree do you think that people you interact with would...

	Not at all	A little	Some	A lot	A great deal
React negatively to you	1	2	3	4	5
Think bad things of you	1	2	3	4	5
See you as seriously disturbed	1	2	3	4	5
Think of you in a less favourable way	1	2	3	4	5
Think you posed a risk to others	1	2	3	4	5

The Self-Stigma of Seeking Help Scale

Please indicate the degree to which you agree with each of the following statements using the scale below.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I would feel inadequate if I went to a therapist for psychological help.	1	2	3	4	5
My self-confidence would NOT be threatened if I sought professional help.	1	2	3	4	5
Seeking psychological help would make me feel less intelligent.	1	2	3	4	5
My self-esteem would increase if I talked to a therapist.	1	2	3	4	5
My view of myself would not change just because I made the choice to see a therapist.	1	2	3	4	5
To monitor quality, please respond with "Agree" for this item.	1	2	3	4	5
It would make me feel inferior to ask a therapist for help.	1	2	3	4	5
I would feel okay about myself if I made the choice to seek professional help.	1	2	3	4	5
If I went to a therapist, I would be less satisfied with myself.	1	2	3	4	5
My self-confidence would remain the same if I sought help for a problem.	1	2	3	4	5
I would feel worse about myself if I could not solve my own problems.	1	2	3	4	5

Cultural Mistrust Inventory

Below are some statements concerning beliefs, opinions, and attitudes about Black people. Read each statement carefully and give your honest feelings about the beliefs and attitudes expressed. Indicate the extent to which you agree by using the following scale:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

There are no right or wrong answers, only what is right for you. If in doubt, circle the number which most closely expresses your present feelings about the statement. Please answer all items.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Black people should be suspicious of a White person who tries to be friendly.	1	2	3	4	5
Whether you should trust a person or not is not based on his or her ethnicity.	1	2	3	4	5
There are some White people who are trustworthy enough to have as close friends.	1	2	3	4	5
Black people should not have anything to do with White people since they can not be trusted.	1	2	3	4	5
It is best for Black people to be on their guard when among White people.	1	2	3	4	5
White friends are least likely to break promises.	1	2	3	4	5
Black people should be cautious about what they say around White people since White people will try to use it against them.	1	2	3	4	5
White people can rarely be counted on to do what they say.	1	2	3	4	5
White people are usually honest with Black people.	1	2	3	4	5
White people are as trustworthy as members of any other ethnic group.	1	2	3	4	5
White people will say one thing and do another.	1	2	3	4	5
White people will usually keep their word.	1	2	3	4	5
Black people should not confide in White people because they will use it against you.	1	2	3	4	5

Afrocultural Beliefs Scale

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Black people who are strong don't need to seek mental health services.	1	2	3	4	5
Black people believe more in God than medicine or therapy.	1	2	3	4	5
Black people don't have mental illness issues.	1	2	3	4	5
Black people should solve their personal and emotional problems on their own.	1	2	3	4	5
Seeking help from a mental health professional shows a lack of trust in God.	1	2	3	4	5
Anyone can get mentally ill, no matter their ethnicity.	1	2	3	4	5
Black people who use mental health services have as much religious/spiritual faith, as those who don't.	1	2	3	4	5
Black people who seek help from a mental health professional are not weak.	1	2	3	4	5
Mental illness does not exist in Africa or the Caribbean.	1	2	3	4	5

Black Mental Health Professional Item

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
If I were experiencing serious personal or emotional problems, I would be more willing to seek mental health services if I knew the mental health professional would be Black.	1	2	3	4	5

Indiscriminate Response Scale

When responding to the survey questions, there are no “wrong” answers, the only right ones are whatever answers are true for you. That said, for quality assurance purposes, some items in this questionnaire will be instructional, and will direct you exactly how to respond. For example, an item might read “*To monitor quality, please respond with ‘Agree’ for this item*”, in this case you would select the option that says “Agree.”

(This will be stated at the beginning of the questionnaire)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
To monitor quality, please respond with “strongly agree” for this item.	1	2	3	4	5
To monitor quality, please respond with “strongly disagree” for this item.	1	2	3	4	5
To monitor quality, please respond with “agree” for this item.	1	2	3	4	5
To monitor quality, please respond with “neutral” for this item.	1	2	3	4	5
To monitor quality, please respond with “disagree” for this item.	1	2	3	4	5

Social Desirability Scale

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is *true* or *false* as it pertains to you personally. Remember, there are no “wrong” answers, and the only right ones are whatever is true for you. Circle the response that seems to best apply to you. It is important that you answer every item.

I like to gossip at times.	True	False
There have been occasions when I took advantage of someone.	True	False
I’m always willing to admit when I have made mistake.	True	False
I always try to practise what I preach.	True	False
I sometimes try to get even rather than forgive and forget.	True	False
At times, I have really insisted on things my own way.	True	False
There have been occasions when I felt like smashing things.	True	False
I never resent being asked to return a favour.	True	False
I have never been irked when people expressed ideas very different from my own.	True	False
I have never deliberately said something that hurt someone’s feelings.	True	False

Open-ended Question

Research shows that Black Canadians are not using mental health services as much as other ethnic groups in Canada. Do you think this is an issue that needs to be addressed?

Yes

No

If yes, what do you think can be done, if anything, to help Black Canadians use mental health services more?

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