

EMOTIONAL BENEFITS AND BARRIERS OF PROFESSIONAL PSYCHOLOGICAL
SERVICES SCALE: INITIAL CONSTRUCTION AND VALIDATION
AMONG AFRICAN AMERICAN WOMEN

BY

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DISSERTATION

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ABSTRACT

The current study used the Health Belief Model to develop a measure that assesses the emotional benefits and barriers of professional psychological services for African American women. Exploratory factor analysis revealed a two-factor structure of the Emotional Benefits and Barriers of Professional Psychological Services (EBBPPS) Scale: Life Enhancement and Concerns about Distress, respectively. Confirmatory factor analysis confirmed this two-factor solution and demonstrated superior fit compared to a general, unidimensional model as well as a three factor model. Both factors exhibited excellent internal consistency, and test-retest reliability coefficients support the temporal stability. Construct validity was supported given that EBBPPS factors were correlated with theoretically related constructs, like psychological help-seeking attitudes and cultural identity, as well as uncorrelated with theoretically unrelated constructs, like psychological distress. Life Enhancement exhibited unique predictive validity for intentions to seek counseling. These findings support the utility and cultural relevance of the EBBPPS with African American women.

Keywords: Help-seeking attitudes, Health Belief Model, Validation, African Americans

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CHAPTER ONE:

INTRODUCTION

Professional psychological service utilization has been associated with many positive outcomes (Elhai, Schweinle, & Anderson, 2008), and it has grown in popularity and desirability among clients. For instance, two thirds of primary care patients with depression reported a preference for professional psychological treatments compared to pharmacotherapy (Bedi et al., 2000; Churchill et al., 2000; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000). Yet, professional psychological services have been widely underused. Only 20% of patients referred for professional psychological services entered treatment and the majority of those who did initiate treatment terminated prematurely (Brody et al., 1997). Although individuals initially perceive benefits associated with professional psychological services, substantial barriers prevent treatment initiation and adherence (Hollon et al., 2002; Wells et al., 2002). Thus, it is vital to investigate how perceived benefits and barriers both facilitate or hinder professional psychological service engagement.

Although professional psychological service underutilization is a major concern among the general public, racial/ethnic minorities use professional psychological services at even lower rates (U.S. DHHS, 2001). The Health Belief Model (HBM; Rosenstock, 1974, 1990; Henshaw & Freedman-Doan, 2009) posits that perceived benefits and perceived barriers are two salient dimensions that influence professional psychological service engagement. According to the HBM, sociopolitical variables, like race and gender, meaningfully contribute to these dimensions. For example, structural barriers may disproportionately affect racial and ethnic minorities from engaging in professional psychological services (Knapp, Funk, Curran, Prince, Grigg, McDaid, 2006; U.S. DHHS, 2001). Similarly, cultural values impede professional

psychological service engagement (David, 2010; Townes, Chavez-Korell, & Cunningham, 2009; Whaley, 2001). For instance, African American women generally do not seek professional psychological services as a means to manage psychological distress even when they have insurance coverage (Diala et al., 2000). This could be because African American women perceive professional psychological service use as incongruent with culturally-specific coping, such as talking to family members, meeting with religious leaders, and suppressing emotions (Beauboeuf-Lafontant, 2007; Ward, Clark, & Heidrich, 2009; Woods-Giscombé, 2010). To date, little research exists regarding African American women's perceived benefits of professional psychological service use. Given this, it is unclear if African American women perceive benefits associated with professional psychological services, and if so, how they negotiate both perceived benefits and perceived barriers during the professional psychological service engagement process.

The purpose of the present study is to use the HBM to develop a measure that assesses the emotional benefits and barriers of professional psychological services for African American women. Although there are various existing psychological help-seeking scales, one example being Fischer and Turner's (1970) widely used Attitudes toward Seeking Professional Psychological Help (ATSPPH), the newly proposed scale aims to measure attitudes toward help-seeking that have received less attention. There are many benefits and barriers associated with professional psychological services, yet this scale will focus on one commonly viewed benefit of professional psychological services: its ability to facilitate positive emotional outcomes and coping (Edelman, Lemon, & Kidman, 2003). Similarly, this scale will focus on one understudied barrier of professional psychological services: its ability to produce negative emotional outcomes (Mohr, Duffecy, Baron, & Lehman, 2010). The current study followed the

multi-step process and best practices for scale development research (Allen & Yen, 1979; Worthington & Whittaker, 2006). Scale items were generated based on qualitative data from African American women in order to reflect relevant aspects of the help-seeking process for this population. Items were then reviewed by an expert panel and piloted with a focus group of African American women. Based on feedback, the scale was revised, and then administered to two separate samples of African American women across the U.S. in order to conduct exploratory and confirmatory factor analyses as well as to assess construct validity. Lastly, test-retest reliability was calculated to determine the temporal stability of the scale (Allen & Yen, 1979).

CHAPTER TWO:

LITERATURE REVIEW

The Health Belief Model

The HBM proposed four dimensions that impacted whether people were likely to engage in health-related interventions: perceived susceptibility, defined as individuals' beliefs that they could contract the illness or be susceptible to the problem; perceived severity, defined as beliefs that symptoms had serious consequences; perceived benefits, or beliefs that the intervention facilitated benefits; and perceived barriers, or beliefs that the intervention exhibited few barriers. The HBM has been widely used due to its parsimony, comprehensiveness, and utility (Aiken, West, Woodward, & Reno, 1994; Gillibrand & Stevenson, 2006; Rosenstock, 1974, 1990), and because it provides a clear, succinct framework for a variety of constructs (Henshaw & Freedman-Doan, 2009). For example, constructs, such as stigma and cultural mistrust, fit within the perceived barriers dimension. Also, the inclusion of both benefits and barriers provides a “dynamic representation of the decision-making process” (Henshaw & Freedman-Doan, 2009, p. 423); thus, the beneficial aspects of help-seeking are considered alongside the barriers to help-seeking. Moreover, because the HBM model identifies attitudes that affect treatment engagement, clinicians can develop and implement interventions that target unfavorable attitudes that impede professional psychological service use.

Not only is the HBM clinically useful, but it is also empirically supported. Several meta-analyses have demonstrated the HBM's ability to predict behavior across different health behaviors (Harrison et al., 1992; Janz & Becker, 1984; Zimmerman & Vernberg, 1994). Perceived susceptibility was, almost always, unrelated to behavior, both in studies that examined prevention as well as treatment of already diagnosed individuals (Carpenter, 2010). Perceived severity was a weak predictor of negative health outcomes and likelihood of adopting target

behaviors, except for when the target behavior was medication adherence (Carpenter, 2010); that is, individuals were more likely to consider the severity of drug non-adherence than for other health behaviors. Perceived benefits and barriers emerged as the strongest predictors of health-related behaviors (Carpenter, 2010; Zimmerman & Vernberg, 1994). Overall, these findings support the continued use of the HBM, especially with regards to the role of perceived benefits and barriers in predicting targeted health behavior.

Despite the HBM's popularity, no scale, to date, has been developed or modified to measure HBM constructs in psychological health utilization patterns (Henshaw & Freedman-Doan, 2009). In fact, metrics informed by HBM constructs have been limited to medical health-related domains (Champion, 1987; Guvenc, Akyuz, & Açikel, 2011). Champion's Health Belief Model (CHBM) scale has emerged as the most widely used instrument to measure the HBM constructs, and it was developed to assess breast cancer screening behavior (Champion, 1987; 1999). It was later modified to reflect screening behaviors for cervical cancer (Guvenc et al., 2011), colorectal cancer (Rawl, Champion, Menon, and Foster, 2000), and HIV (Basen-Engquist, 1992; Hounton, Carabin, & Henderson, 2005). The current study addressed this limitation by developing a measurement tool that applied the HBM constructs explicitly to professional psychological service utilization.

General guidelines for HBM measurement development include: (a) construct definitions should be consistent with HBM theory, (b) measures need to be specific to the behavior being addressed (e.g., barriers to professional psychological services may be quite different from barriers to mammography), and (c) measures need to be relevant to the population among whom they will be used. In regards to population characteristics, the HBM model explicitly promotes examining the role of culture and context given that factors, such as race, age, and

socioeconomic status, are believed to influence the HBM dimensions. In line with these recommendations, the current study developed a scale that assessed Emotional Benefits and Barriers of Professional Psychological Services, with special attention to how race and gender contribute to these dimensions among African American women.

Perceived Benefits of Professional Psychological Service Use. Professional psychological service use can aid mental health and wellness (Bedi et al., 2000; O'Mahen & Flynn, 2008). One benefit of professional psychological services is learning new skills, which can reduce negative emotions and facilitate positive emotions (Edelman et al., 2003). For instance, in a study about the perceived benefits of a mindfulness-based psychological intervention, women reported that they learned skills to cope with difficult emotions (i.e., anxiety) and that this facilitated positive emotional outcomes (i.e., calm; Abercrombie, Zamora, Korn, 2007). Also, in a CBT group intervention, participants' perceived benefits included learning skills to cope with symptoms, which included negative emotions (Edelman et al., 2003). Second, professional psychological services are often believed to promote emotional recovery – that is, to attenuate the emotional impact of an experience (Zech & Rimé, 2005). Zech and Rimé (2005) found that expressing emotions produced various perceived benefits, like emotional relief, insight, and feeling understood. Experimental studies have also demonstrated that participants who discussed their emotions after an emotion-inducing task, compared to those who did not, had lower perceived stress levels (Lepore, Ragan, & Jones, 2000) and increased feelings of optimism (Mendolia & Kleck, 1993).

According to the HBM, it is important to understand individuals' endorsement of perceived benefits given that individuals are more likely to engage in an intervention if they anticipate benefits. Given that skill development, coping, and emotional expression are benefits

of psychological services, it is imperative to develop an assessment tool that measures individuals' beliefs about these benefits.

Perceived Barriers of Professional Psychological Service Use. Barriers to professional psychological service use have been identified as a major problem in the service delivery process (Hollon et al., 2002; President's New Freedom Commission on Mental Health, 2003). Research has extensively examined economic barriers, like lack of insurance (Snowden, 1999; U.S. Department of Health and Human Services, 2001); moreover, psychological factors, such as stigma concerns (Corrigan, 2004; Nadeem, Lange, Edge, Fongwa, Belin, & Miranda, 2007), discomfort with acknowledging psychological problems (i.e., psychological openness), and cultural mistrust, have also been thoroughly investigated. Yet, individuals' beliefs that professional psychological services exacerbate emotional distress (i.e., by discussing negative emotions), which could hinder or disrupt functioning in other life domains, is limited (Mohr et al., 2010). A brief discussion of each of these factors and how they have been measured is presented below.

Stigma. Stigma has been identified as a primary barrier to professional psychological service use (U.S. Department of Health and Human Services, 1999). Fear of stigmatization was identified as a leading reason for not seeking professional psychological help (Corrigan, 2004) and for terminating services prematurely (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Given the pervasiveness of stigma, various instruments have been formulated to measure this construct. Fischer and Turner's (1970) Attitudes toward Seeking Professional Psychological Help (ATSPPH) – the most widely used scale to assess professional psychological help-seeking attitudes – measured Stigma Tolerance. This scale was later adapted and updated by Mackenzie et al. (2004) to include gender neutral language and subjective norms regarding whether one's

important others condoned certain behaviors. The resulting Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) also measured stigma. The Indifference to Stigma subscale assessed individuals' concerns about being negatively evaluated by important others for professional psychological service use. Additional stigma scales have also been created by Vogel and colleagues (2006); the 10-item Self-Stigma of Seeking Help (SSOSH) scale assessed the extent to which individuals internalized negative judgments about their personal use of psychological help (Vogel et al., 2006; Vogel, Wade, & Hackler, 2007). Moreover, the Social Stigma for Seeking Psychological Help (SSRPH) scale (Komiya, Good, Sherrod, 2000) was also designed to assess perceptions of the public stigma associated with seeking professional psychological help. Therefore, stigma has been widely researched and operationalized through various psychometric scales.

Psychological openness. Psychological openness refers to individuals' openness to acknowledge psychological problems and to seek professional help for those problems (Fischer & Turner, 1970; Mackenzie et al., 2004). Therefore, a barrier to professional psychological help-seeking was the extent to which individuals were *not* open or comfortable speaking with professionals about their concerns. This dimension was assessed via Fischer and Turner's Interpersonal Openness subscale in the ATSPPH (1970), and via Mackenzie's et al. (2004) Psychological Openness subscale in the IASMHS. Psychological Openness demonstrated moderate correlations with past use of professional psychological services and intentions to seek professional psychological services in the future. Also, women have been shown to endorse more psychological openness compared to men.

Cultural mistrust. Cultural mistrust has been viewed as a crucial deterrent of professional psychological service use among racial and ethnic minorities (Terrell & Terrell, 1981; Whaley,

2001). Cultural mistrust refers to African Americans distrust of European Americans (Terrell & Terrell, 1981; Whaley, 2001), and it has been operationalized and measured through existing surveys. For instance, Klonoff and Landrine (1997) developed the African American Acculturation Scale, which included a cultural mistrust subscale. Similarly, Terrell and Terrell (1981) developed an instrument, the Cultural Mistrust Inventory (CMI), which assessed cultural mistrust in African Americans. This 48-item instrument is the most widely used scale of cultural mistrust, and it measures African Americans' mistrust of European Americans in multiple domains, including business, education, interpersonal interactions, and politics.

Cultural mistrust has received much attention in the area of professional psychological services use. In particular, general mistrust of European Americans has been associated with viewing European American counselors as less credible (Poston, Craine, & Atkinson, 1991), having lower expectations of European American counselors (Poston et al., 1991), and disclosing less personal information to European American counselors (Thompson, Worthington, & Atkinson, 1994). Moreover, cultural mistrust has been associated with general negative attitudes toward seeking professional psychological help (Duncan, 2003), especially from predominately European American mental health clinics (Nickerson, Helms, & Terrell, 1994). Overall, cultural mistrust has been widely operationalized and investigated, especially with regards to professional psychological services use.

Negative emotional outcomes. Another psychological factor that could hinder engagement in professional psychological services is the belief that these services produce undesirable and/or deleterious outcomes (Mohr et al., 2010; Watson & Hunter, 2015). For instance, clients have been found to avoid professional psychological services due to beliefs that therapy was painful (Kushner & Sher, 1989). In addition, both fear of emotional expression and

disinterest in sharing personal information have predicted treatment avoidance and negative attitudes toward professional psychological help seeking (Komiya, Good, & Sherrod, 2000).

Emotional concerns have been included to some extent in measures of professional psychological service help-seeking. Mohr et al. (2010) developed a comprehensive measure of perceived barriers to psychological intervention, which included structural barriers (e.g., transportation problems, time constraints, cost) as well as emotional barriers (e.g., concern about what others might think, discomfort talking about problems with a therapist). The “emotional concerns” factor contained three questions that assessed individuals’ expectations that undesirable emotions would emerge in or from therapy. However, this scale did not include beliefs that mental health professionals primarily desired to discuss negative emotions or beliefs that these negative emotions could disrupt one’s routines. Therefore, emotional barriers deserve additional attention.

A Case for African American Women

African Americans comprise 13% of the population in U.S. (U.S. Census Bureau, 2002). Yet, 25% of African Americans have been diagnosed with a mental health disorder, and African American women are disproportionately overrepresented (Davis, 2005). Risk factors, like poverty, poor health, and caregiver strain, place African American women at increased risk for mental illness (Neufeld, Harrison, Steward, & Hughes, 2008). Despite this, African American women use outpatient mental health services at lower rates compared to African American men and European American women (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005), even when they have adequate insurance (Padgett, Patrick, Burns, & Schlesinger, 1994). The discrepancies between need, access, and use suggest that African American women may endorse unfavorable attitudes about professional psychological services that impede utilization. These

unfavorable attitudes may be largely influenced by cultural norms (Cheng, Kwan, & Sevig, 2013; Kim & Park, 2009; Ward, 2005).

First, African Americans were more likely to utilize coping strategies consistent with an African worldview orientation, such as speaking with family members and friends (Chiang, Hunter, & Yeh, 2004; Thompson, Bazile, & Akbar, 2004). Also, African Americans rely on religious leaders more often than mental health professionals (Matthews, Corrigan, Smith, & Rutherford, 2003; Neighbors et al., 2007), and identify church, rather than mental health clinics, as better venues for mental health care (Matthews et al., 2003). Thus, strategies, like talking with important others and religious leaders, as opposed to using professional psychological services, may be regarded as the appropriate means to facilitate emotional recovery, insight, life skills, and symptom relief.

Second, African American women are socialized to be “strong black women” (SBW) who suppress emotions (Beauboeuf-Lafontant, 2007; Black & Peacock, 2011; Settles, Pratt-Hyatt, & Buchanan, 2008; Woods-Giscombé, 2010). Although emotional expression can produce positive outcomes, this contradicts the cultural-mandate of emotional suppression and self-silence promulgated by the SBW. As a result, African American women may believe that discussing their emotions, especially in the context of professional psychological services, produces negative emotional consequences rather than beneficial outcomes. For instance, in Watson and Hunter’s (2015) qualitative study about the SBW, participants reported that discussing emotions exacerbated emotional distress. This might explain why some participants reported that psychotherapy was a “pity party” or a time to “complain” (Watson & Hunter, 2015a). Similarly, Waite and Killian (2008) used the HBM model to understand African

American women's treatment decisions for depression and found that some women did not seek treatment because talking about depression was believed to contradict "staying positive".

Third, the SBW prioritizes caregiving rather than self-care (Beauboeuf-Lafontant, 2007; Black & Peacock, 2011; Settles, Pratt-Hyatt, & Buchanan, 2008; Woods-Giscombé, 2010). African American women reported that fulfilling multiple responsibilities outweighed seeking professional psychological services for increased depressive symptoms (Waite & Killian, 2008). Watson, Black, and Hunter (2016) replicated this finding in a qualitative examination of the HBM constructs and African American women's perceptions of mindfulness-based interventions. Women not only reported that using mindfulness-based mental health services would take time away from multiple responsibilities, but also that stirring up negative emotions could incapacitate them from carrying out their caregiving responsibilities. Therefore, African American women may view utilizing professional psychological services as a maladaptive health behavior (i.e., behavior that exacerbated emotional distress, reduced ability to fulfill responsibilities) rather than an effective one. Hence, talking about and focusing on negative emotions may be perceived as a barrier to professional psychological services.

Overview of the Current Study

Professional psychological services are still underutilized, especially among racial/ethnic minorities, including African American women. This could be because of the types of benefits and barriers to professional psychological service engagement. Perceived benefits that pertain to the emotional outcomes associated with professional psychological service engagement, such as the facilitation of emotional outcomes, require additional examination. Perceived barriers, like stigma, psychological openness, and cultural mistrust have been thoroughly examined, but individuals' beliefs that professional psychological services produce deleterious emotional

outcomes is an important, and understudied, area of inquiry. It is important to consider these benefits and barriers in tandem given that they dynamically contribute to individuals' intentions to engage in professional psychological services. Thus, this project constructed and validated a measurement tool that assessed perceived benefits and barriers that were specific to emotional outcomes – that is, beliefs that professional psychological services either produce coping skills and positive emotions or facilitate negative emotions, which could disrupt life routines. A measurement tool that captures Emotional Benefits and Barriers of Professional Psychological Services, and that also reflect aspects of the help-seeking process for African American women can help to (a) identify additional attitudinal factors that contribute to African American women's professional psychological service underutilization, (b) highlight additional components of professional psychological help-seeking attitudes that predict psychological well-being and treatment outcomes (intentions to seek help, treatment adherence), and (c) inform intervention strategies that facilitate increased perceived benefits and decreased perceived barriers to professional psychological service utilization.

Although the HBM contains four primary dimensions, the perceived benefits and barriers dimensions have been found to be the strongest predictors of individuals' health-related behaviors. Thus, these two dimensions, and their relation to emotional outcomes of professional psychological service engagement, were the focus of the present investigation. The new scale was hypothesized to reflect these two dimensions: individuals' beliefs that professional psychological services produced coping skills and positive emotions (i.e., emotional benefits) and beliefs that professional psychological services facilitated negative emotions, which could disrupt life routines (i.e., emotional barriers). The scale was also expected to be related to outcomes in theoretically expected ways (i.e., lower endorsement of emotional benefits will be

related to decreased intentions to seek professional psychological services). Based on the best practices for scale development research, this project included the following steps: 1) generate items, 2) pilot items with a small subset of African American women, 3) conduct an exploratory factor analysis (EFA) on data from a sample of African American women across the U.S., 4) conduct a confirmatory factor analysis (CFA) on data from an additional sample of African American women across the U.S., and 5) test indices of reliability and validity (Allen & Yen, 1979; Worthington & Whittaker, 2006).

CHAPTER THREE:

SCALE CONSTRUCTION

The scale construction phase aimed to develop items for the Emotional Benefits and Barriers of Professional Psychological Services (EBBPPS) Scale. Items were developed by reviewing relevant literature, and then revised based on feedback from an expert panel and focus group participants in the community.

Item Development

Items were developed to reflect emotional benefits and barriers of professional psychological service use, which emerged in the theoretical and qualitative literature regarding African American women's help-seeking attitudes (Black & Peacock, 2011; Thompson et al., 2004; Watson, Black, & Hunter, 2015a; Watson & Hunter, 2015b; Woods-Giscombé, 2010). Although there are various emotional benefits and barriers associated with professional psychological services, the focus of the current investigation was on emotional benefits and barriers underrepresented by existing help-seeking measures. As a result, items were developed to reflect one understudied benefit of professional psychological services – its ability to foster emotional expression via skill development and coping – as well as one understudied barrier of professional psychological services – its likelihood of exacerbating emotional distress and disrupting functioning in other life domains.

Quotes from qualitative studies that reflected these benefits and barriers were coded, and items were written to reflect the language used in these quotes. For example, the following quote, from a qualitative study about African American women's views about mindfulness-based interventions, was coded because it reflected beliefs that professional psychological services would foster negative emotions and disrupt caregiving responsibilities:

You feel guilty because something else isn't being taken care of. I have a good friend, who wants to come to the yoga class, [but] she's like "No but I gotta take care of my husband and my son and the kids and the house and this." And in so many words she was essentially saying that she was being selfish by putting herself first. I think we have been trained to put ourselves last (Watson, Black, & Hunter, 2015a).

This quote produced the item, "I would feel selfish taking time to meet with a mental health professional for my emotional concerns." Items were written in order to be accessible to those with at least an eighth grade education in order to accommodate diversity in education-levels and literacy. Based on recommendations from Allen and Yen (1979), more items than necessary were written for each domain (N = 20) with the goal of having a final count of 10 or fewer questions per domain. Items were placed on a likert scale reflecting the following numerical weights: 1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Agree, 6 = Strongly Agree.

Expert Panel

Items were reviewed by an expert panel of two African American women: Dr. Angela R. Black and Mrs. Regina Crider. Dr. Angela Black is a Research Fellow in the Complementary & Alternative Medicine program at University of Wisconsin, Madison, who specializes in topics including Black women's health, stress, and coping. Mrs. Regina Crider is a reputable mental health professional in Champaign County who primarily works with African American women caregivers. Expert panelists rated each item on a scale ranging from 1 (not at all) to 5 (extremely well) on the degree to which it assessed beliefs that professional psychological service use would either foster emotional expression via skill development or provoke negative emotions and impair multiple role responsibilities (Vogel, Wade, & Haake, 2006). Only the items that

received at least a 3 (adequate) were retained. In total, 11 items were deleted due to low ratings, and the expert panel recommended 7 additional items.

Community Focus Group

Items were then piloted with one focus group of seven women, which was within the range of the recommended size for focus groups (4-10; Seal, Bogart, & Ehrhardt, 1998). Women were recruited from the university and local community in order to obtain African American women participants from diverse socioeconomic and educational backgrounds. All participants were women from the community. Women were between the ages of 29 and 36 years ($M = 33.17$, $SD = 2.32$). One participant identified as “Divorced” ($n = 1$), but the rest of the women identified as either “Single/Never Married” ($n = 3$) or “Married” ($n = 3$). All women endorsed having children ($n = 7$), having at least some college education ($n = 7$), and being employed ($n = 7$). The majority of the sample reported never discussing concerns with a mental health professional ($n = 4$) although half of the sample reported discussing concerns with a primary care physician ($n = 3$). Most women reported that they did have health insurance ($n = 6$; Table 1).

During the focus group, women provided feedback regarding the content, wording, and appropriateness of each item. Focus group questions included: (1) Do you think the question accurately reflects some African American women’s attitudes toward seeking professional psychological services? (2) Do you feel the question could be worded more clearly? (3) Are there other help-seeking attitudes that African American women may subscribe to that you feel are not captured in the list of questions? Based on the feedback from focus group participants, no items were deleted; however, an additional item was added. Moreover, approximately 20% of the items were edited to reflect clearer wording. For instance, the item, “Talking to a mental health professional would benefit my relationship with others” was revised to state: “Talking to a

mental health professional would help me interact with others better.” Similarly, the item, “Using professional psychological services would not make my life better because mental health professionals would just try to put me on medication” was revised to state: “Mental health professionals would try to make me take medication.” Women were concerned that the original item sounded judgmental and could potentially stigmatize individuals who did take medication. Overall, women reported strong verbal support for the inclusion of the following item: “I would feel selfish if I took the time to meet with a mental health professional for my emotional concerns.”

CHAPTER FOUR:

INITIAL VALIDATION

An exploratory factor analysis (EFA) was conducted in Study 1 to assess the underlying factor structure of the EBBPPS scale. The scale was hypothesized to have a multidimensional factor structure, such that Emotional Benefits and Emotional Barriers, would emerge as two separate factors. The internal consistency reliability estimates were investigated, and correlations among factors were examined. Associations between the EBBPPS scale and demographic variables (e.g., age, socioeconomic status, and religiosity) were also examined.

Method

Participants

The sample included 251 women who self-identified as African American and who were between the ages of 18 and 88 years ($M = 30.96$, $SD = 13.70$). The majority of participants ($n = 212$) reported “Some College” or higher educational attainment. Participants’ household income ranged from “under \$24,999” to “\$125,000 or more.” Also, the majority of participants reported being “Heterosexual/Straight” ($n = 240$), “Single/Never Married” ($n = 170$), and not having children ($n = 190$). The sample was largely insured ($n = 222$), and approximately half of the sample reported speaking to a mental health professional about psychological concerns at least once ($n = 127$). Participants also mainly identified as “Christian” ($n = 195$; Table 2).

Procedure

Women were either recruited from the psychology subject pool ($n = 87$) or not ($n = 164$). Non-psychology subject pool participants were recruited from several methods: (a) internet sites (i.e., Facebook, sites targeting African American women), (b) emails to research team’s personal networks, and (c) fliers at community events in Champaign County. All participants were directed to follow a survey URL in order to access the survey electronically at Qualtrics.

Psychology subject pool participants received course credit for their participation, and non-psychology subject pool participants were offered entry into a lottery to win \$50.

The university Institutional Review Board (IRB) provided approval for the research. Participants consented to participate in the study by selecting the following statement: “I affirm that I am at least age 18, the purpose and nature of this research have been sufficiently explained, and that I understand that I am free to withdraw at any time without incurring any penalty. I consent to participate in this study.” Participants were not allowed to move forward with the survey without selecting this option. Given the online format of the survey, participants could complete the survey at their desired location. Participants could also withdraw from the study at any time by closing the survey. Only completed surveys were used for data analysis.

Measures

Demographic questionnaire (DQ). Participants provided information regarding age, education level, marital status, caregiver status, and socioeconomic status.

Service Utilization Assessment (SUA). Past service utilization was assessed by asking participants to respond “Yes” or “No” to the following questions: (a) “Have you ever discussed psychological problems with your family physician?” (b) “Have you discussed psychological problems with your family physician in the past year?” (c) “Have you ever discussed psychological problems with a mental health professional (e.g., psychologist, psychiatrist, social worker)?” and (d) “Have you discussed psychological problems with a mental health professional (e.g., psychologist, psychiatrist, social worker) in the past year?” (Elhai et al., 2008; Mackenzie et al., 2004; Vogel et al., 2006). Individuals’ self-reported SUA has been shown to be accurate when validated against medical records using time-frames less than one year in duration

(Roberts et al., 1996). The SUA has been significantly correlated with the help-seeking attitudes in previous (Elhai et al., 2008), supporting its use in the current study.

Emotional Benefits and Barriers of Professional Psychological Services Scale

(EBBPPS). It is discouraged to administer additional measures during the EFA process given that additional measures can contaminate participants' responses on new scale items (Worthington & Whittaker, 2006). As a result, participants only completed the demographic questionnaire and EBBPPS scale. The original EBBPPS contained 42 items.

Results

Preliminary Analysis

Data were cleaned and checked for missing values. Forty-nine participants completed the demographic questionnaire and the service utilization questions, but did not initiate the EBBPPS scale. These forty-nine cases were omitted, resulting in 251 participants. Of the remaining cases, 91% had no missing data. In addition, all items had less than or equal to 3.8% of missing values. Little's (1988) Missing Completely at Random analysis was not statistically significant, $\chi^2 = 68.62$, $p = .99$, indicating that the data were missing completely at random.

Exploratory Factor Analysis

To determine the factorability of the correlation matrix, the Bartlett's test of sphericity (i.e., probability that correlations in a matrix are 0) was examined; it was statistically significant ($p < .001$). The Kaiser-Meyer-Olkin (KMO), which measured sampling adequacy was also examined, and a value of .92 was determined (i.e., values of .60 and higher are desired; Tabachnick & Fidell, 2001). EFAs were conducted using principal axis factoring to examine the factor structure of the EBBPPS scale. One, two, three, and four factor solutions were examined. Across all EFAs, scree plots suggested a three-factor solution. However, upon further

examination of the three-factor solution, the Emotional Benefits items loaded highly on factor 1 whereas the Emotional Barriers items were spread across factors 2 and 3. Items on factor 2 loaded highly on factor 3, and it was unclear how factor 2 and factor 3 conceptually differed. Following previous scale development recommendations, conceptual interpretability was used as the final criterion for factor-retention. As a result, factor 3 was not retained given that it could not be meaningfully interpreted (Steger, Frazier, Oishi, & Kaler, 2006; Worthington & Whittaker, 2006). The distinction between perceived benefits and perceived barriers was congruent with the theoretical basis for the scales; therefore, a two-factor solution was selected.

The two-factor solution was explored using an oblique (promax) rotation given that factors were presumed to be correlated. The structure matrix was examined, and items were deleted based on the following criteria: (a) a factor loading below .40 (Tabachnick & Fidell, 2001; Worthington & Whittaker, 2006); (b) a cross-loading of less than .15 difference from an item's highest factor loading (Worthington & Whittaker, 2006); and (c) extracted communalities lower than .40 (Tabachnick & Fidell, 2001). With these criteria met, we retained 28 of the original 42 items. In addition, a final EFA was conducted on the 28-item scale to ensure that the factor structure remained the same after deleting the items (Table 3).

Naming the Factors

Factor 1, Life Enhancement, consisted of 17 items and accounted for 41% of the variance. This factor was named based on items that represented beliefs that professional psychological services would enhance life, such as producing positive emotions, reducing negative emotions, and facilitating skills to better relationships with others. Higher scores indicated higher endorsement of these perceived benefits. Factor 2, Concerns about Distress, consisted of 11 items and accounted for 15% of the variance. This factor was named based on

items that reflected the belief that professional psychological services could produce unpleasant emotions and hinder one's ability to manage responsibilities.

Internal Consistency Reliability

Cronbach's alpha coefficients demonstrated strong reliability of the EBBPPS subscale scores: Life Enhancement ($\alpha = .96$) and Concerns about Distress ($\alpha = .91$).

Relationship of EBBPPS to Demographic Variables

The HBM presumes that its dimensions are influenced by demographic variables. Although EBBPPS scale items were developed with special attention to race and gender, we were also interested in the association between the EBBPPS subscales and demographic variables, like age, number of children, education, and annual income. Religiosity was also included given that African Americans consider religious leaders and churches as more appropriate resources than mental health professionals and clinics for managing emotional concerns (Matthews, Corrigan, Smith, & Rutherford, 2003; Neighbors et al., 2007).

Pearson's r correlation analyses were conducted for age and EBBPPS subscales; age was unrelated to Life Enhancement, and inversely correlated with Concerns about Distress ($r = -.25$), indicating that individuals who were older were less likely to endorse beliefs that professional psychological services would elicit distressing outcomes. Spearman's rank-order correlation analyses were conducted with number of children, education, annual income, and religiosity and EBBPPS subscales. On the one hand, number of children was positively correlated with Life Enhancement ($r_s = .13$), meaning that having more children was related to attitudes that professional psychological services contributed to beneficial life outcomes. On the other hand, number of children was negatively correlated with Concerns about Distress ($r_s = -.18$), suggesting that having more children was related to minimal concerns that professional

psychological services contributed to distress. Level of education inversely correlated with Concerns about Distress ($r_s = -.16$), indicating that women with higher levels of education were less likely to endorse beliefs that professional psychological services contributed to undesirable outcomes than women with lower levels of education. Annual income and religiosity were not significantly related to either of the EBBPPS subscales (Table 4).

Independent sample t-tests were conducted to examine the relation between past utilization of professional psychological services (in the lifetime) and the EBBPPS subscale scores. Life Enhancement was compared across individuals who had used and who had not used professional psychological services. There was a significant difference in the scores for past service use ($M = 86.24, SD = 13.39$) and no past service use ($M = 79.11, SD = 14.98$), such that individuals with past service use reported more benefits of professional psychological services $t(238) = 3.89, p = .00$. Similarly, Concerns about Distress was compared across individuals who had used and who had not used professional psychological services. There was a significant difference in the scores for past service use ($M = 22.81, SD = 8.45$) and no past service use ($M = 25.71, SD = 9.21$), such that individuals with past service use reported fewer barriers to professional psychological services $t(239) = 2.55, p = .01$ (Table 5).

Moreover, independent sample t-tests were conducted to examine significant differences on EBBPPS subscale scores between psychology subject pool and non-psychology subject pool participants. There was not a significant difference in Life Enhancement $t(239) = -1.33, p = .18$ among psychology subject pool participants ($M = 81.09, SD = 12.95$) and non-psychology subject participants ($M = 83.71, SD = 15.39$). However, there was a significant difference in Concerns about Distress among psychology subject pool participants ($M = 27.37, SD = 9.58$) and non-psychology subject participants ($M = 22.47, SD = 8.02$), such that psychology subject pool

participants reported more concerns about distress associated with professional psychological services $t(153.84) = 4.04, p = .00$ (Table 6).

CHAPTER FIVE:

FURTHER VALIDATION

Once initial validation is established via EFA, further validation is recommended via confirmatory factor analysis (CFA) (Allen & Yen, 1979). A CFA was conducted in Study 2 to replicate the factor structure of the EBBPPS scale among an additional sample of African American women from across the U.S. CFA results were hypothesized to replicate the EBBPPS two factor structure, Life Enhancement and Concerns about Distress, and to demonstrate superior fit when compared a unidimensional model and a 3-factor model. The internal consistency reliability estimates and associations between the EBBPPS scale and demographic variables (e.g., age, socioeconomic status, and religiosity) were also investigated.

Construct validity was also assessed via convergent, discriminant, and predictive validity. First, convergent validity was measured by examining the EBBPPS scale's association with well-established help-seeking measures, including the Inventory of Attitudes Toward Mental Health Help-Seeking scale (IAMHHS; Mackenzie et al., 2004), the Attitude Towards Seeking Professional Psychological Help-Short Form (ATSPPS-SF; Fischer & Farina, 1995), and the Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975). Life Enhancement was expected to be positively associated with the IAMHHS's subscales, psychological openness and indifference to stigma, as well as with the ATSPPS-SF. Similarly, Life Enhancement was hypothesized to be positively associated all four domains of the ISCI: psychological, interpersonal, drug, and academic. Concerns about Distress was hypothesized to be inversely associated with the IAMHHS subscales, the ATSPPS-SF, and the ISCI's four domains.

Also with regards to convergent validity, we expected the EBBPPS scale to be associated with two measures of cultural identity –SBW schema (Harrington et al., 2010; Thomas et al., 2004) and Ethnic Identity Scale (EIS; Umaña-Taylor et al., 2004). Specifically, we expected that Life Enhancement would be inversely related to SBW and EIS given findings that SBW and EIS are associated with unfavorable attitudes toward professional psychological help-seeking. Conversely, we expected that Concerns about Distress would be positively associated with SBW and EIS given that SBW and EIS promote negative attitudes, like Concerns about Distress, toward professional psychological help-seeking.

Secondly, discriminant validity was assessed vis-à-vis the associations of the EBBPPS scale with theoretically unrelated measures, such as the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec., 1990) and the Hopkins Symptoms Checklist (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988). In order to demonstrate discriminant validity, we anticipated that both Life Enhancement and Concerns about Distress would not be related to the PSWQ and HSCL-21.

Thirdly, predictive validity was assessed by examining if the EBBPPS scale accounted for unique variance above and beyond the IAMHHS subscales, psychological openness and indifference to stigma, with regards to the ISCI's four domains: psychological, interpersonal, drug, and academic concerns. We expected that both Life Enhancement and Concerns about Distress would account for variance over and above the IAMHHS.

Method

Participants

The sample included 208 women who self-identified as African American and who were between the ages of 18 and 59 years ($M = 26.63$, $SD = 9.38$). The majority of participants ($n =$

157) reported “Some College” or higher educational attainment. Participants’ household income ranged from “under \$24,999” to “\$125,000 or more.” Also, the majority of participants reported being Heterosexual ($n = 180$), Single/Never Married ($n = 146$), Christian ($n = 130$), Insured ($n = 168$), and not having children ($n = 155$). Unlike the EFA sample, the majority of the current sample reported never speaking to a mental health professional about psychological concerns ($n = 147$; Table 7).

Procedure

Study 2 procedures mirrored those used in Study 1, and included data collection from Amazon Mechanical Turk (Mturk). Mturk is an online marketplace in which individuals are paid to perform tasks. A 5-item screener form was published on Mturk, and due to a skip logic algorithm, only individuals who identified as African American women were able to access the study survey packet. African American women Mturk users were paid \$3.50 for completing the survey (i.e., Mturk *Bill of Rights* requests .10 cents per minute remuneration. The completed survey packet was estimated to take approximately 35 minutes).

Sample participants included women from the psychology subject pool ($n = 81$) as well as women not associated with the psychology subject pool ($n = 127$). Non-psychology subject pool participants consisted of women from Mturk ($n = 104$) as well women recruited through internet sites (i.e., Facebook, sites targeting African American women) and personal networks ($n = 23$). Both psychology subject pool and Mturk participants were guaranteed compensation (i.e., course credit or payment) immediately following survey completion; thus, they were asked to complete all study measures. Women who were entered into the drawing and not guaranteed compensation were only given the following subset of measures: (a) demographic questionnaire, (b) the 28-item EBBPPS, (c) Service Utilization Assessment, (d) Strong Black Woman Race-

Gender Schema (Harrington et al., 2010; Thomas et al., 2004), (e) Attitude Towards Seeking Professional Psychological Help-Short Scale (ATSPPH-S; Fischer & Farina, 1995), and (f) Hopkins Symptoms Checklist–21 (Green, Walkey, McCormick, & Taylor, 1988).

Measures

Demographic questionnaire (DQ). Participants provided information regarding age, education level, marital status, caregiver status, and socioeconomic status.

Emotional Benefits and Barriers of Professional Psychological Services Scale (EBBPPS). The 28-item EBBPPS scale, developed in Study 1, assesses individuals' endorsement of Emotional Benefits and Barriers of Professional Psychological Services. The 17-item, Life Enhancement scale measured beliefs that professional psychological services would enhance life, such as facilitating skills to produce positive emotions and reduce negative emotions as well as to better relationships with others. Higher scores indicated higher endorsement of these perceived benefits. The 11-item Concerns about Distress scale assessed beliefs that professional psychological services would produce undesirable and/or harmful outcomes, including feelings of selfishness and limited energy to complete responsibilities due to discussing unpleasant emotions. Higher scores indicated higher endorsement of these perceived barriers. The following Cronbach's alpha estimates were obtained: Life Enhancement (.97) and Concerns about Distress (.93).

The Inventory of Attitudes toward Seeking Professional Psychological Services (IASMHS). The IASMHS (Mackenzie, et al., 2004) is a 24-item scale that measures three dimensions of professional psychological help-seeking: psychological openness, help-seeking propensity, and indifference to stigma. Only the psychological openness and indifference to stigma subscales were used in the current study. Items were rated using a 5-point Likert-type scale ranging from 0 (*disagree*) to 4 (*agree*). The psychological openness subscale assessed the

extent to which individuals were open to acknowledging psychological problems and to the possibility of seeking professional help for them. After reverse scoring, higher scores indicated more openness to acknowledging psychological problems and to the possibility of seeking professional help. An example item was, “People with strong characters can get over psychological problems by themselves and would have little need for professional help.” The indifference to stigma subscale measured the extent to which individuals were concerned about what others might think of their psychological distress and psychological help-seeking behaviors. An example item was, “Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.” After reverse scoring, higher scores on these items indicated that individuals had greater indifference to stigma (i.e., less concern about stigma). The following Cronbach’s alpha estimates were obtained: psychological openness (.79) and indifference to stigma (.80).

Attitudes Toward Seeking Professional Psychological Help Scale, Short Form (ATSPPHS-SF). The shortened, 10-item revision (Fischer & Farina, 1995) of the original 29-item ATSPPHS (Fischer & Turner, 1970) was used. Items were rated from 1 (*disagree*) to 4 (*agree*); five items were reversed scored such that higher scores reflected more positive attitudes. A sample item included, “The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts (R).” The revised, shortened scale correlated with the longer version (.87), indicating that the two measured the same construct (Fischer & Farina, 1995). In the current study, the Cronbach’s alpha estimate was .70.

Intentions to Seek Counseling Inventory (ISCI). The ISCI (Cash, Begley, McCown, & Weise, 1975) measures the intent to seek psychological services for a list of specific problems, including relationship difficulties, depression, personal worries, and drug problems. It is a 17-

item scale, measuring items on a scale ranging from 1 (*very unlikely*) to 4 (*very likely*).

Responses on the ISCI are summed such that higher scores indicate a greater likelihood of seeking services for that issue. The ISCI subscales demonstrated adequate internal consistency reliability estimates: Psychological (.86), Interpersonal Concerns (.75), Drug Concerns (.96), and Academic Concerns (.80).

Service Utilization Assessment (SUA). Past use of professional psychological services was measured by positive responses to any of the following questions: (a) “Have you ever discussed psychological problems with your family physician?” (b) “Have you discussed psychological problems with your family physician in the past year?” (c) “Have you ever discussed psychological problems with a mental health professional (e.g., psychologist, psychiatrist, social worker)?” and (d) “Have you discussed psychological problems with a mental health professional (e.g., psychologist, psychiatrist, social worker) in the past year?” (Elhai et al., 2008; Mackenzie et al., 2004; Vogel et al., 2006). Previous studies have demonstrated that individuals’ self-reported service utilization was accurate when validated against medical records using time-frames less than one year in duration (Roberts et al., 1996). SUA has been significantly correlated with the ATTPHS-SF in previous studies (Elhai et al., 2008), which suggests that it is an appropriate scale to use in assessing validity in the current study.

Stereotypical Roles for Black Women Scale (SRBWS). The Superwoman and Mammy subscales of the SRBWS (Thomas et al., 2004) were combined to assess the SBW race-gender schema construct (Harrington et al., 2010; Watson & Hunter, 2015). This assessed African American women’s endorsement of the need to accomplish multiple tasks successfully and the resulting feelings of weakness associated with not successfully completing these tasks. Example items include, “Black women have to be strong to survive” and “If I fall apart, I will be

a failure.” The Mammy subscale measures African American women’s endorsement of caretaking and selflessness, and an example item includes, “I feel guilty when I put my own needs before others.” Items were rated according to a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores indicated greater endorsement of SBW. A good Cronbach’s alpha estimate was obtained for the SBW race-gender schema subscale (.85) in the present study.

Ethnic Identity Scale (EIS). The EIS (Umaña-Taylor et al., 2004) is a 17-item scale that assesses three dimensions of ethnic identity: Exploration (e.g., “I have not participated in any activities that would teach me about my ethnicity”); Resolution (e.g., “I am clear about what my ethnicity means to me”); and Affirmation (e.g., “I wish I were of a different ethnicity”). Items were rated on a 4-point Likert-type scale ranging from 1 (*Does not describe me at all*) to 4 (*Describes me very well*). Negatively worded items were reversed scored such that higher scores represented higher levels of ethnic identity dimensions. The EIS has demonstrated adequate psychometric properties among young adult and adolescent samples across diverse ethnicities, including European Americans, African Americans, Asian Americans, Native Americans, and Latino/as (Supple et al., 2006; Umaña-Taylor et al., 2004; Yetter & Foutch, 2013). The following Cronbach’s coefficient alphas were obtained in the current study: Exploration (.90), Resolution (.90), and Affirmation (.94).

Penn State Worry Questionnaire (PSWQ). The PSWQ (Meyer, Miller, Metzger, & Borkovec., 1990) is a 16-item self-report measure that assesses trait worry and captures the extent to which participants’ worry is generalized, excessive, and uncontrollable (e.g., “My worries overwhelm me”; “I worry all the time”). Each item is rated from 1 (“*not at all typical of me*”) to 5 (“*very typical of me*”). The PSWQ has demonstrated good internal consistency

reliability and good retest reliability over intervals as long as 8–10 weeks (Meyer et al., 1990) in undergraduate samples. The PSWQ demonstrated excellent internal consistency reliability in the current study (.94).

Hopkins Symptoms Checklist–21 (HSCL-21). The HSCL-21 (Green, Walkey, McCormick, & Taylor, 1988) is an abbreviated form of the Hopkins Symptom Checklist (Derogatis, Lipman, Richels, Uhlenhuth, & Covi, 1974), and it is widely used to measure psychological distress. It demonstrated a replicable three-factor structure (i.e., general, somatic, and performance distress); however, it has been generally used as a single-factor scale measuring ‘total distress.’ Items, like “Blaming yourself for things” are rated on a scale ranging from 1 (*not at all*) to 4 (*extremely*). The HSCL-21 detected changes across therapy, and it was related to other counseling outcome measures (Deane, Leathem, & Spicer, 1992; Vogel et al., 2006). The internal consistency reliabilities for the Total Distress Scale in the current study was .93.

Results

Preliminary Analysis

Data were cleaned and checked for missing values. Missing values were only considered for the EBBPPS scale given that all measures were not administered to all participants. Thirty-eight cases were deleted due to failing to initiate the EBBPPS scale, resulting in a final sample of 208 participants. Of these 208 cases, analysis revealed that 97% of cases had no missing data. Of those cases with missing data, all cases had less than or equal to 2.9% of missing values. Little’s (1988) Missing Completely at Random analysis revealed a not statistically significant chi-square statistic, $\chi^2 = 18.98$, $p = .26$, supporting that the data was missing completely at random.

CFA.

A CFA was conducted using structural equation modeling (SEM) in order to test alternative models of the underlying structure of the EBBPPS. Specifically, the two factor model was compared to a general, unidimensional factor model as well as a three factor model (Kline, 2005; Worthington & Whittaker, 2006), with the hypothesis being that the two factor model would best fit the data. The general factor model consisted of one latent factor onto which all items loaded; the two factor model consisted of two latent factors corresponding to the two factors proposed in the EFA; the three factor model contained three latent factors corresponding to the three factor model that emerged, but was rejected, in the EFA. Analyses were conducted in Mplus (Version 7.1; Muthén & Muthén, 2012) using the Maximum Likelihood Robust (MLR) estimator, which accounted for non-normality in the data. Hu and Bentler (1999) recommend using a two-index combination approach when reporting findings in SEM. In particular, they recommended using the Confirmatory Fit Index (CFI), accompanied by one of the following indices: Root Mean Square Error of Approximation (RMSEA), Standardized Root Mean Square Residual (SRMR), and Tucker-Lewis Index (TLI; non-normed fit index). In this sample, model fit was assessed via the chi-square test with corresponding degrees of freedom and level of significance as well as the CFI, RMSEA, SRMR, and TLI. Parceling techniques were not employed given that the measure was hypothesized to have a multidimensional factor structure (Little, Cunningham, Shahar, & Widaman, 2002).

The chi-square test was significant for all three models. However, additional fit indices were investigated given that the chi-square test is sensitive to sample size (Hu & Bentler, 1999). The two factor model demonstrated superior fit across all fit indices compared to the general, unidimensional model as well as the three factor model (Table 8). In particular, the two factor model had a SRMR of .06 compared to the general model's SRMR of .17 and the three factor

model's SRMR of .07 (values of .08 or less are indicative of acceptable model fit; Hu & Bentler, 1999; Kline, 2005). Similarly, the two factor model had a RMSEA of .08 whereas the general model had a RMSEA of .13 and the three factor model had a RMSEA of .09 (values of .08 or less are indicative of acceptable model fit; Hu & Bentler, 1999; Kline, 2005). Despite acceptable model fit as demonstrated by the SRMR and RMSEA, the two factor model as well as the one and three factor models did not demonstrate the recommended CFI values of .90 or greater; however, the CFI for the two factor model was .86 compared to the CFI value of .53 in the general model and .83 in the three factor model. This was also the case for the TLI; the two factor model TLI was .85 compared to the general model TLI of .50 and the three factor model TLI of .82 (TLI cutoff of .95 is suggestive of acceptable fit).

The fit indices suggested that the two factor model was a superior fit to the one and three factor models. To support these findings, chi-square difference tests were performed comparing the one and two factor models as well as comparing the two and three factor models. In both tests, the two factor model was significantly better than the one factor model (Satorra-Bentler chi-square = 1844.25, $p = .00$) as well as the three factor model (Satorra-Bentler chi-square = 246.25, $p = .00$) (Table 9).

Validity

As stated previously, all participants were given the EBBPPS scale, but not all participants were given every validity measure. This was an effort to reduce the length of the survey packet and to prevent survey taking fatigue. In addition, missing values were only considered for the EBBPPS scale; that is, participants could be included in the study even if they had missing data on validity measures. This resulted in uneven, albeit sufficient, sample sizes across data analyses.

Convergent validity. Convergent validity was assessed by testing whether the factors of the EBBPPS scale were associated with theoretically-related constructs (Table 11-12). The following scales were used for convergent validity analyses: (a) Inventory of Attitudes Toward Mental Health Help-Seeking (Mackenzie et al., 2004), (b) Attitude Towards Seeking Professional Psychological Help-Short Scale (Fischer & Farina, 1995), (c) Intentions to Seek Counseling (Cash, Begley, McCown, & Weise, 1975), (d) Strong Black Woman Race-Gender Schema (Harrington et al., 2010; Thomas et al., 2004), and (e) Ethnic Identity Scale (Umaña-Taylor et al., 2004).

First, we hypothesized that the Life Enhancement factor would be positively associated with professional psychological help-seeking attitudes whereas the Concerns about Distress would be negatively associated with professional psychological help-seeking attitudes. As expected, Life Enhancement was positively associated with psychological openness, indifference to stigma, and general positive attitudes toward professional psychological help-seeking. Life Enhancement was also positively associated with intentions to seek counseling for psychological concerns, interpersonal concerns, and academic concerns. Concerns about Distress was negatively associated with psychological openness, indifference to stigma, and general positive attitudes toward professional psychological help-seeking. Also, Concerns about Distress demonstrated an inverse relationship with intentions to seek counseling for psychological concerns and interpersonal concerns. These results provide initial support for the validity of the EBBPPS scale.

Second, given research on ethnic identity and professional psychological help-seeking attitudes, we hypothesized that Life Enhancement would be negatively associated with cultural identity whereas Concerns about Distress would be positively associated with cultural identity.

This was not supported. Life Enhancement was not related to the SBW race-gender schema, and surprisingly, was positively associated with two dimensions of ethnic identity: exploration and resolution. Concerns about Distress was also not related to the SBW race-gender schema, and unexpectedly, inversely related to three dimensions of ethnic identity: affirmation, exploration, and resolution.

Discriminant validity. Discriminant validity was assessed via the correlation between the EBBPPS scale and two measures of current functioning with which the EBBPPS scale should be unrelated: worry (PSWQ; Meyer, Miller, Metzger, & Borkovec., 1990) and overall psychological distress (HSC-21; Green, Walkey, McCormick, & Taylor, 1988). Neither Life Enhancement nor Concerns about Distress were correlated with these outcomes, which provide additional support for the validity of the EBBPPS scale.

Predictive validity. Simple linear regressions were conducted to examine whether the EBBPPS scale predicted intent to seek psychological services for all four concern types: psychological, interpersonal, drug, and academic. As expected, Life Enhancement predicted increased intentions to seek psychological services for all four domains: psychological (Table 13), interpersonal (Table 14), drug (Table 15), and academic (Table 16). Further, Concerns about Distress predicted decreased intentions to seek psychological services for all concerns (Tables 17-19), except academic concerns (Table 20).

In addition, hierarchical multiple regressions were conducted to examine if the EBBPPS scale demonstrated unique predictive ability regarding intent to seek psychological services for all four concern domains. No evidence of multicollinearity among the variables was suggested given tolerance levels over 0.1 and VIF (variance inflation factor) values under 10 (Aiken & West, 1991). In all models, psychological openness and indifference to stigma were entered in

the first step; Life Enhancement was entered into the second step; Concerns about Distress was entered in the third step; Intentions to seek psychological help was the dependent variable. For psychological (Table 21), interpersonal (Table 22), and academic concerns (Table 24), Life Enhancement, but not Concerns about Distress, demonstrated unique predictive ability over both psychological openness and indifference to stigma. Neither Life Enhancement nor Concerns about Distress predicted intentions to seek psychological help for drug concerns in the context of psychological openness and indifference to stigma (Table 23).

Relationship of EBBPPS to Demographic Variables

Pearson's r correlation analyses were obtained for age and EBBPPS subscale scores. Unlike, study 1, age was not significantly correlated with either Life Enhancement ($r = .09$) or Concerns about Distress ($r = -.01$). Spearman's rank-order correlation analyses were conducted with level of education, religiosity, number of children, and annual income as well as the EBBPPS subscale scores. Level of education was positively correlated with Life Enhancement ($r_s = .16$), but it was not correlated with Concerns about Distress ($r_s = -.09$), indicating that women with higher levels of education were more likely to endorse beliefs that professional psychological services contributed to overall life enhancement. Religiosity was also positively correlated with Life Enhancement ($r_s = .16$) but not with Concerns about Distress ($r_s = .08$), suggesting that women who identified as more religious were more likely to agree that professional psychological services were beneficial. Number of children and annual income were not significantly correlated with either Life Enhancement or Concerns about Distress (Table 25).

Similar to Study 1, independent sample t-tests were performed to examine the relation between past utilization of professional psychological services (in the lifetime) and the EBBPPS subscale scores. In the first model, Life Enhancement was compared across individuals who had

used and who had not used professional psychological services. Similar to Study 1, there was a significant difference in the scores for past service use ($M = 76.03$, $SD = 14.11$) and no past service use ($M = 69.11$, $SD = 19.43$), such that individuals with past service use reported more benefits to professional psychological services $t(75.63) = 2.23$, $p = .03$. In the second model, Concerns about Distress was compared across individuals who had used and who had not used professional psychological services. Unexpectedly, there was no significant difference in the scores for past service use ($M = 27.43$, $SD = 11.49$) and no past service use ($M = 30.45$, $SD = 12.36$); thus, the groups did not differ in their perceptions of barriers to professional psychological service use $t(177) = 1.34$, $p = .18$ (Table 26).

We were also interested in if there were significant differences on EBBPPS subscale scores between psychology subject pool and non-psychology subject pool participants. Independent sample t-tests demonstrated that there was not a significant difference in Life Enhancement $t(170) = -.20$, $p = .84$ among psychology subject pool participants ($M = 73.05$, $SD = 16.90$) and non-psychology subject participants ($M = 73.60$, $SD = 19.03$). Similarly, there was no significant difference in Concerns about Distress $t(170) = -.46$, $p = .65$ among psychology subject pool participants ($M = 28.30$, $SD = 10.71$) and non-psychology subject participants ($M = 29.12$, $SD = 12.79$).

Independent sample t-tests were also conducted to examine significant differences between psychology subject pool and non-psychology subject pool participants on validity measures (Table 27). Only two significant differences emerged. First, there was a significant difference in indifference to stigma $t(137) = 2.11$, $p = .04$ among psychology subject pool participants ($M = 29.05$, $SD = 6.35$) and non-psychology subject participants ($M = 26.54$, $SD = 7.70$), such that psychology subject pool participants reported more indifference to stigma (i.e.,

less stigma concerns) with regards to professional psychological services. Second, there was a significant difference in total distress $t(159) = 2.91, p = .00$ among psychology subject pool participants ($M = 45.48, SD = 14.93$) and non-psychology subject participants ($M = 38.93, SD = 13.67$), such that psychology subject pool participants reported more overall distress (Table 27).

CHAPTER SIX:

TEST-RETEST RELIABILITY

Method

Participants

The sample included 25 women who self-identified as African American and who were between the ages of 18 and 55 years ($M = 28.76$, $SD = 10.99$). The majority of participants identified as Single/Never Married ($n = 15$), not having children ($n = 14$), “Heterosexual,” ($n = 20$), “Christian” ($n = 21$), “Insured” ($n = 20$), and attaining at least “Some College” education ($n = 18$). Moreover, most participants endorsed never speaking with a mental health professional about psychological concerns ($n = 14$; Table 28).

Procedure

For the test-retest data collection, participants were recruited from the psychology subject pool ($n = 30$), classes in the African American Studies Department at a local university ($n = 10$), and websites that target African American women ($n = 19$). At Time 1, psychology subject pool participants and women recruited from websites were directed to follow a survey URL in order to access the survey electronically at Qualtrics. At Time 2, three-weeks later, they were emailed a new Qualtrics survey to complete. At both time points, participants completed the demographic questionnaire and the EBBPPS scale. Classroom data collections took place at the beginning of class time, and participants completed paper-pencil versions of the survey at both Time 1 and Time 2. A data key was created to record all participant ID numbers so that participants’ Time 1 data could be linked with their Time 2 data. At Time 1, a total of 59 individuals participated; at Time 2, 25 women participated (42% retention rate).

Measures

Demographic questionnaire (DQ). Participants provided information regarding age, education level, marital status, caregiver status, and socioeconomic status.

Service Utilization Assessment (SUA). Women were asked to report past professional psychological service use by responding to the following questions: (a) “Have you ever discussed psychological problems with your family physician?” (b) “Have you discussed psychological problems with your family physician in the past year?” (c) “Have you ever discussed psychological problems with a mental health professional (e.g., psychologist, psychiatrist, social worker)?” and (d) “Have you discussed psychological problems with a mental health professional (e.g., psychologist, psychiatrist, social worker) in the past year?” (Elhai et al., 2008; Mackenzie et al., 2004; Vogel et al., 2006).

Emotional Benefits and Barriers of Professional Psychological Services Scale (EBBPPS). The 28-item EBBPPS scale, developed in Study 1, was used to assess individuals’ endorsement of Emotional Benefits and Barriers of Professional Psychological Services. The 17-item, Life Enhancement scale assessed beliefs that professional psychological services would enhance life, such as facilitating skills to produce positive emotions and reduce negative emotions as well as to better relationships with others. Higher scores indicated higher endorsement of these perceived benefits. The 11-item Concerns about Distress scale assessed beliefs that professional psychological services would produce undesirable and/or harmful outcomes, including feelings of selfishness and limited energy to complete responsibilities due to discussing unpleasant emotions. Higher scores indicated higher endorsement of these perceived barriers. The following Cronbach’s alpha estimates were obtained: Life Enhancement (.97) and Concerns about Distress (.93).

Results

Bivariate correlations were conducted to obtain the test-retest reliability for the EBBPPS scale. Life Enhancement ($r = 0.90, p < .01$) demonstrated excellent test-retest reliability and Concerns about Distress ($r = 0.84, p < .01$) exhibited good test-retest reliability. These results support the temporal stability of this scale.

CHAPTER SEVEN:

GENERAL DISCUSSION

The purpose of this study was to construct and validate a new measure of attitudes toward professional psychological services – the Emotional Benefits and Barriers of Professional Psychological Services (EBBPPS) Scale – that was guided by the HBM. The HBM provides a parsimonious and clinically useful framework for understanding how individual-level and contextual-level factors inform professional psychological service use. The findings provide initial psychometric support for the EBBPPS scale among an African American women sample. African American women were the target sample in this study given that they use outpatient mental health services at lower rates compared to African American men and European American women despite experiencing myriad stressors that place them at increased risk for mental illness (Neufeld, Harrison, Steward, & Hughes, 2008). As hypothesized, the EBBPPS demonstrated two conceptually meaningful factors, Life Enhancement and Concerns about Distress, which collectively accounted for approximately 56% of the variance. This factor structure was shown to provide a modest fit for the data and superior fit compared to a general, unidimensional model as well as a three-factor model. Internal consistency reliability estimates as well as test-retest reliability of subscale scores were excellent. Support for the construct validity of the EBBPPS scale was also reinforced through the significant correlations between the EBBPPS scale and conceptually related psychological help-seeking measures. Specifically, Life Enhancement was positively related to psychological openness, indifference to stigma, and general positive attitudes toward psychological help-seeking whereas Concerns for Distress was inversely related to psychological openness, indifference to stigma, and general positive attitudes toward psychological help-seeking. Both Life Enhancement and Concerns for Distress predicted

intentions to seek psychological services for psychological, interpersonal, drug, and academic concerns, and Life Enhancement demonstrated unique predictive ability over and above existing attitudes toward professional psychological service use. Together, these findings support the added value of the EBBPPS scale in understanding the professional psychological service use process, especially among African American women.

Below, the findings from this investigation are discussed in light of the extant literature about the HBM constructs – perceived benefits and perceived barriers – and professional psychological utilization patterns, with special attention to the help-seeking process for racial/ethnic minorities. The EBBPPS factors are discussed with regard to their connection to the relevant theoretical and empirical literature. The findings supporting the convergent and predictive validity of the scale are reviewed, and the few unexpected null findings regarding the EBBPPS factors and cultural identity variables are contextualized. Lastly, the limitations of the study as well as the implications for research and practice are discussed.

Perceived Benefits: Life Enhancement

The perceived benefits HBM dimension has been identified as one of the strongest predictors of health-behavior (Carpenter, 2010), and the current study extends these findings to professional psychological service use, especially with regards to perceived emotional benefits. In particular, the current findings demonstrated that perceived emotional benefits in general, and Life Enhancement in particular, exhibited unique predictive ability regarding intentions to seek psychological services for psychological, interpersonal, and academic concerns over and above indifference to stigma and psychological openness. Although the investigation of perceived barriers has dominated the conversation on the professional psychological help-seeking process, the current findings highlight the importance of examining perceived benefits.

African American women were expected to demonstrate low endorsement of perceived emotional benefits of professional psychological services. Existing research suggests that African American women view familial and religious support, as opposed to professional psychological service use, as essential for well-being and symptom reduction (Budescu, Taylor, & McGill, 2011; Fowler, 2004; Thompson, Bazile, & Akbar, 2004). The item-means and standard deviations in the EFA and CFA samples indicated relatively ambivalent endorsement of perceived emotional benefits of professional psychological services. For instance, the item-means for most items were 4 (*slightly agree*), and item-standard deviations were 1, meaning that the range for most items was Slightly Disagree to Agree. Although women did not emphatically disagree with items, their minimal agreement with perceived emotional benefits of professional psychological services warrants additional examination.

The HBM model promotes examination of sociocultural variables, and consistent with this approach, we examined the relation between Life Enhancement and cultural identity variables. Contrary to what we expected, Life Enhancement was not related to the SBW race-gender schema. Only one study has quantitatively examined the relation between the SBW race-gender schema and help-seeking attitudes; SBW race-gender schema was not related to indifference to stigma, but it was inversely related to psychological openness and help-seeking propensity (Watson & Hunter, 2015b). Although the current study did not find an association between SBW race-gender schema and perceived emotional benefits, additional research is needed to examine the ways in which the SBW race-gender schema influences the professional psychological help-seeking process for African American women. Although the SBW race-gender schema may not be associated with African American women's perceived emotional

benefits and barriers of professional psychological service use, future research may examine its associations with therapeutic rapport, treatment satisfaction, and treatment adherence.

Also contrary to what we expected, Life Enhancement was positively associated with two dimensions of ethnic identity: exploration and resolution. There are mixed findings regarding the role of ethnic identity and attitudes toward professional psychological service use. Some studies have found that adherence to ethnic/cultural values was associated with more negative attitudes toward seeking psychological help in African Americans (Obasi & Leong, 2009) whereas African Americans were the only racial/ethnic group, compared to Asian and Latino/a peers, in which higher levels of ethnic identity predicted lower levels of self-stigma of seeking psychological (Cheng et al., 2013). Based on these mixed findings, it is unclear if ethnic identity involves greater identification with traditional ethnic values, which in turn, contributes to unfavorable attitudes toward seeking psychological help or if ethnic identity fosters a sense of identity security, which in turn, contributes to fewer concerns about being stigmatized by others and increased beliefs in the beneficial emotional outcomes associated with professional psychological services use (Phinney, 1992; Cheng et al., 2013).

Perceived Barriers: Concerns about Distress

Barriers to engagement have been the primary foci of much of the existing research on professional psychological service use. This research has included a review of system-level barriers, such as transportation concerns and lack of health insurance, as well as individual-level barriers, such as stigma and cultural norms (Cristancho, Garces, Peters, & Mueller, 2008). Identifying barriers to professional psychological service use is vital given that perceived barriers are a strong predictor of health-behavior (Carpenter, 2010). The current study enriches the present research on barriers by highlighting an additional barrier, Concerns about Distress, which

predicted decreased intentions to seek psychological services for psychological concerns and interpersonal concerns. Although Concerns about Distress did not exhibit unique predictive power over and above indifference to stigma and psychological openness, it still helps to explain why African American women are deterred from using professional psychological services. Future investigations are encouraged to examine whether Concerns about Distress impacts other aspects of the psychological help-seeking process, like therapeutic rapport, disclosure, and treatment adherence.

Concerns about Distress was also not related to the SBW race-gender schema. This was surprising given that the SBW race-gender schema promotes self-silence and emotional suppression (Beauboeuf-Lafontant, 2007; Black & Peacock, 2011; Watson & Hunter, 2015b). In particular, the qualitative literature has thoroughly described the connection between the SBW race-gender schema and unfavorable attitudes toward professional psychological help-seeking, such that professional psychological services are believed to engender emotional experiences that rupture the SBW façade and pressure to “stay positive”. (Beauboeuf-Lafontant, 2007; Waite & Killian, 2008; Watson, Black, & Hunter, 2016; Watson & Hunter, 2015a). Moreover, many African American women may distrust non-African American therapists to appropriately respond to emotional expression (Thompson, Worthington, & Atkinson, 1994). Overall, the research on the association between SBW race-gender schema and professional psychological service use is nascent and requires additional quantitative examination.

Further, unexpectedly, the Concerns about Distress factor was inversely related to three dimensions of ethnic identity: affirmation, exploration, and resolution. As stated in the above section, the findings about ethnic identity and attitudes toward professional psychological service use are mixed (Obasi & Leong, 2009). Although there are cultural norms, such as strong Black

womanhood and John Henryism, within the African American community that discourage emotional expression, African Americans in advanced ethnic identity development stages may be critical of rigid, and often stereotypic, cultural norms. Thus, these individuals may exhibit flexibility in their adherence of cultural norms and may be more open to behaviors, such as professional psychological service use, that are traditionally viewed as inconsistent with these cultural norms.

Limitations

The current study's findings contribute to the existing research regarding African Americans women's underutilization of professional psychological services, especially with regards to emotional benefits and emotional barriers. However, several limitations exist. First, the online data collection method privileged women who had computer access; thus, limiting the educational and socioeconomic diversity of the sample. Although EFA and CFA samples included socioeconomic diversity, both samples largely included women who at least had some college education. Moreover, online data collection allowed for geographical diversity, but additional recruitment strategies are needed to include women from lower socioeconomic backgrounds who do not have computer access. Second, women self-selected into the study. It could be that women who participated had more positive attitudes toward professional psychological services than the general public of African Americans, which limited the generalizability of the findings. Third, in the EFA sample, approximately fifty percent of the women endorsed past professional psychological utilization, which is more than the help-seeking rates among African Americans in the general public, further suggesting that the women in the current study were not representative of a national sample of African Americans. Despite this limitation, including women with past help-seeking provided opportunities to examine

differences between women who have and who have not sought help, especially with regards to perceived emotional benefits and emotional barriers.

Implications for Clinical-Community Psychology Research and Practice

Interventions can only address African American women's myriad psychological health concerns insofar as they are able to successfully recruit and retain them in services (Lau, 2006). First, the current study's findings suggest that strategies should be undertaken to enhance the perceived benefits and to minimize the perceived barriers. Marketing campaigns are one such tool for increasing the professional psychological service use among groups that have traditionally been underserved (Andreasen, 2004; National Institute of Mental Health, 2005; Rochlen & Hoyer, 2005). King and colleagues (1994) used printed materials and telephone calls to explicitly enhance the perceived benefits and to reduce the perceived barriers for mammography screening. For instance, telephone counselors called women and asked, "What might keep you from having a mammogram?" and delivered tailored messages to reduce the specified barrier. Mammography rates were more than twice as large as those of a no-intervention comparison group. Parallel to this process, when individuals are referred for professional psychological services, tailored messaging can be provided based on their perceived benefits and barriers, and such efforts can be investigated to ascertain if they increase recruitment and retention in services.

Second, meta-analytic findings demonstrated that clients who received their preferred treatment were more willing to participate in treatment, less likely to terminate prematurely, and more likely to experience improvement (Swift & Callahan, 2009; Swift, Callahan, Ivanovic, & Kominiak, 2013). This suggests that not only is it vital to understand individuals' perceived benefits and barriers, but also to use these perceptions to select compatible treatments. For

instance, if individuals desire to learn skills in therapy, then skill-based approaches may be more appropriate than process-oriented approaches. Thus, understanding women's perceived benefits and barriers during the initial assessment process can aid treatment selection.

Third, African American women may perceive more benefits and fewer barriers associated with culturally-specific interventions compared to treatment as usual. Kohn et al. (2002) implemented a cultural adapted manualized CBT treatment for African American women with major depression. Eighty-three percent of women opted for the adapted cognitive-behavioral treatment group for African American women compared to the standard, non-adapted cognitive-behavioral therapy group. Although no data were reported on whether women in the adapted group were more likely to remain in treatment compared to women in the non-adapted group, women in the adapted group exhibited an alleviation of symptoms at twice the magnitude of women in the non-adapted group. Thus, it appears that African American women not only prefer culturally-adapted groups and view them as more beneficial, but also experience greater health benefits when in culturally-adapted groups than in non-adapted groups.

Overall, the current study provides vital insights regarding how to highlight benefits and translate barriers into opportunities for increased engagement in professional psychological service use among African American women. This scale is an additional tool that can be used to positively impact various aspects of the psychological help-seeking process for African American women. Such insights and tools are vital in order to address the multiple factors that contribute to African American women's psychological health and well-being.

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TABLES

Table 1.
Demographic Characteristics for Focus Group Participants (N=7)

| Characteristics | Participants <i>N</i> =7 |
|--|-----------------------------|
| Marital Status | |
| Single/Never Married | 3 |
| Married | 3 |
| Divorced | 1 |
| Number of Children | |
| 1 | 2 |
| 2 | 3 |
| 3 or more | 2 |
| Education | |
| Associate Degree | 2 |
| Some College | 2 |
| Bachelor Degree (B.A, B.S) | 3 |
| Current Employment Status | |
| Working part-time | 1 |
| Working full-time | 6 |
| Annual income | |
| Under \$24,999 | 1 |
| \$25,000- \$49,999 | 1 |
| \$50,000- \$74,000 | 4 |
| Have you discussed psychological problems with your family physician in the past year? | |
| No | 4 |
| Yes | 2 |
| Have you discussed psychological problems with a mental health professional? | |
| No | 4 |
| Yes | 2 |

Table 2.
Demographic Characteristics for Exploratory Factor Analysis Sample (N = 251)

| Characteristics | Participants N = 251 |
|--------------------------------------|-------------------------|
| Education | |
| High School/GED | 27 |
| Associate Degree | 12 |
| Some College | 77 |
| Bachelor Degree (B.A., B.S.) | 45 |
| Master's Degree (M.A., M.S.) | 57 |
| Doctoral Degree (Ph.D., M.D., J.D.) | 33 |
| Income | |
| Under \$24,999 | 47 |
| \$25,000- \$49,999 | 61 |
| \$50,000- \$74,000 | 47 |
| \$75,000- \$99,999 | 28 |
| \$100,000-\$124,999 | 19 |
| \$125,000 or more | 23 |
| I don't know | 24 |
| Insurance | |
| Yes | 222 |
| No | 22 |
| Don't Know | 7 |
| Sexual Orientation | |
| Heterosexual/Straight | 240 |
| Bisexual | 6 |
| Lesbian/Gay | 3 |
| Other | 1 |
| Marital Status | |
| Single/Never Married | 170 |
| Partnered | 11 |
| Married | 48 |
| Divorced | 17 |
| Widowed | 2 |
| Separated | 2 |
| Number of Children | |
| 0 | 190 |
| 1 | 21 |
| 2 | 21 |
| 3 or more | 19 |
| Visited a Mental Health Professional | |
| Yes | 127 |
| No | 123 |
| Missing | 1 |

Table 3.

Item Means, Standard Deviations, and Factor Loadings for the Life Enhancement and Concerns about Distress Subscales

| Item | <i>M (SD)</i> | 1 | 2 |
|---|----------------|------------|------------|
| Life Enhancement | | | |
| 36. I would feel more capable at handling life as a result of seeking support from a mental health professional. | 4.44 (1.10) | .85 | -.32 |
| 24. Mental Health professionals would help me overcome my emotional concerns. | 4.49 (1.03) | .81 | -.41 |
| 33. Talking to a mental health professional would make me feel more hopeful about my life. | 4.41 (1.19) | .80 | -.33 |
| 35. I would feel more encouraged as the result of discussing my emotional concerns with a mental health professional. | 4.47 (1.14) | .80 | -.40 |
| 26. Discussing my emotional concerns with a mental health professional would help me come to terms with things that have happened in my life. | 4.70 (1.05) | .79 | -.35 |
| 28. Mental health professionals could help me develop skills to overcome my emotional concerns. | 4.8 (.97) | .77 | -.33 |
| 37. Discussing my emotional concerns with a mental health professional would benefit my overall happiness. | 4.61 (1.05) | .77 | -.31 |
| 41. Discussing my emotional concerns with a mental health professional would help me feel more at peace in my life. | 4.52 (1.09) | .76 | -.30 |
| 9. Talking with a mental health professional about my problems would help me confront negative thoughts and emotions. | 4.91 (.88) | .75 | -.34 |
| 13. Talking to a mental health professional would help me relate to others better. | 4.40 (1.08) | .75 | -.28 |
| 16. Talking to a mental health professional would help me interact with my family members better. | 4.39 (1.17) | .74 | -.22 |
| 14. Talking to a mental health professional would help me interact with others better. | 4.43 (1.12) | .74 | -.21 |
| 22. Mental health professionals would help me deal with my emotional concerns better. | 4.71 (1.03) | .71 | -.35 |
| 8. Talking with a mental health professional would help me let go of negative thoughts and emotions. | 4.65 (1.01) | .69 | -.44 |
| 4. Using mental health services would help me be better at resolving my problems. | 4.71 (1.05) | .67 | -.29 |
| 3. Using mental health services would help me understand myself better. | 4.71 (1.11) | .63 | -.25 |
| 38. I would be willing to make the sacrifice to obtain the lifelong skills gained by seeing a mental health professional. | 4.56 (1.05) | .62 | -.34 |
| Concerns about Distress | | | |
| 17. Talking to a mental health professional involves too much time talking about negative emotions. | 2.48 (1.64) | -.36 | .76 |
| 18. Talking to a mental health professional involves too much time talking about childhood trauma. | 2.32 (1.16) | -.37 | .75 |

Table 3 Cont.

| | | | |
|---|----------------|-------|------------|
| 27. I would be concerned that mental health professional would dig into my personal business | 2.57 (1.34) | -.29 | .74 |
| 15. Talking to a mental health professional involves too much time talking about negative past experiences. | 2.41 (1.12) | -.43 | .73 |
| 19. Talking to a mental health professional about emotional concerns is just like having a “pity party”. | 2.09 (1.17) | -.31 | .72 |
| 21. Talking about my emotional concerns with a mental health professional would make me feel like I was dwelling on the negative. | 2.29 (1.24) | -.17 | .71 |
| 42. Discussing my emotional concerns with a mental health professional is just a way to feel sorry for myself. | 1.82 (.97) | -.30 | .70 |
| 25. Mental health professionals would only want to talk about negative things going on in my life. | 2.11 (1.03) | -.23 | .63 |
| 31. I would not have the energy to handle my responsibilities (e.g., family, school, work) after talking about my emotions with a mental health professional. | 2.15 (1.12) | -.29 | .63 |
| 32. I would feel selfish taking time with a mental health professional for my emotional concerns. | 2.06 (1.11) | -.17 | .59 |
| 10. Talking with a mental health professional about my negative experiences would make my situation worse. | 1.94 (.914) | -.41 | .56 |
| Eigenvalue | | 11.60 | 4.16 |
| % variance | | 41.42 | 14.85 |

Note. $N = 251$. Item means and standard deviations are based on the sample used for the exploratory factor analysis (EFA). Boldfaced factor loadings indicate highest loading for each item. The Structure Matrix was used to decide factor loadings. In the EFA, the correlation between Life Enhancement and Concerns about Distress was $r = -.43$.

Table 4.

Exploratory Factor Analysis Summary of Intercorrelations, Means, and Standard Deviations for Key Study Variables (N = 251)

| Measure | <i>M</i> | <i>SD</i> | α | 2 | 3 | 4 | 5 | 6 | 7 |
|----------------------------|----------|-----------|----------|--------|--------|-------|-------|------|-------|
| 1. Life Enhancement | 82.76 | 14.58 | .96 | -.43** | .07 | .10* | .07 | -.03 | -.01 |
| 2. Concerns about Distress | 24.23 | 8.91 | .91 | -- | -.25** | -.18* | -.16* | .04 | -.06 |
| 3. Age | 30.96 | 13.70 | -- | -- | -- | .60** | .39** | -.01 | .22** |
| 4. Number of Children | -- | -- | -- | -- | -- | -- | .12 | .11 | .13* |
| 5. Education | -- | -- | -- | -- | -- | -- | -- | .02 | .10 |
| 6. Annual Income | -- | -- | -- | -- | -- | -- | -- | -- | .08 |
| 7. Religiosity | -- | -- | -- | -- | -- | -- | -- | -- | -- |

Note. * $p < .05$. ** $p < .01$; Age represents a Pearson's (r) correlation coefficient, and all other variables represent Spearman's rank-order (r_s) nonparametric correlation coefficients. Minimum value for Life Enhancement = 17; Maximum Value for Life Enhancement = 102. Minimum value for Concerns about Distress = 11; Maximum Value for Concerns about Distress = 66.

Table 5.

Results of T-test and Descriptive Statistics for Life Enhancement and Concerns about Distress by Past Psychological Service Use Utilization

| | Past Psychological Service Utilization | | | | | | 95% CI for Mean Difference | t | df |
|-------------------------|--|-------|-----|-------|-------|-----|----------------------------|---------|-----|
| | Yes | | | No | | | | | |
| | M | SD | n | M | SD | n | | | |
| Life Enhancement | 86.24 | 13.39 | 122 | 79.11 | 14.98 | 118 | -10.74, -3.52 | -3.89** | 238 |
| Concerns about Distress | 22.81 | 8.45 | 123 | 25.71 | 9.21 | 118 | 0.66, 5.14 | 2.55** | 239 |

*Note: * $p < .05$. ** $p < .01$.*

Table 6.

Results of T-Test and Descriptive Statistics for Life Enhancement and Concerns about Distress by Psychology Subject Pool Recruitment in Exploratory Factor Analysis Sample

| | Psychology Subject Pool | | | | | | 95% CI | | |
|---|-------------------------|-------|----|-------|-------|-----|--------------------|--------|--------|
| | Yes | | | No | | | Mean Difference | t | df |
| | M | SD | n | M | SD | n | | | |
| Life Enhancement | 81.09 | 12.95 | 87 | 83.71 | 15.39 | 154 | -2.62, 1.95 | -1.34 | 239 |
| Concerns about Distress ⁺ | 27.37 | 9.58 | 87 | 22.47 | 8.03 | 155 | 2.50, 7.29 | 4.04** | 153.84 |

Note: * $p < .05$. ** $p < .01$. ⁺ Levene's Test for Equality of Variances was significant, indicating equal variances not assumed. Satterthwaite approximation employed due to unequal group variances.

Table 7.
Demographic Characteristics for Confirmatory Factor Analysis Sample (N = 208)

| Characteristics | Participants N = 208 |
|-------------------------------------|-------------------------|
| Education | |
| Some High School | 2 |
| High School/GED | 22 |
| Associate Degree | 18 |
| Some College | 88 |
| Bachelor Degree (B.A., B.S.) | 44 |
| Master's Degree (M.A., M.S.) | 20 |
| Doctoral Degree (Ph.D., M.D., J.D.) | 5 |
| Missing | 9 |
| Income | |
| Under \$24,999 | 61 |
| \$25,000- \$49,999 | 41 |
| \$50,000- \$74,000 | 31 |
| \$75,000- \$99,999 | 21 |
| \$100,000-\$124,999 | 5 |
| \$125,000 or more | 12 |
| I don't know | 28 |
| Missing | 9 |
| Insurance | |
| Yes | 168 |
| No | 22 |
| Don't Know | 9 |
| Missing | 9 |
| Sexual Orientation | |
| Heterosexual/Straight | 180 |
| Bisexual | 13 |
| Lesbian/Gay | 4 |
| Other | 2 |
| Missing | 9 |
| Marital Status | |
| Single/Never Married | 146 |
| Partnered | 21 |
| Married | 25 |
| Divorced | 8 |
| Widowed | 0 |
| Separated | 0 |
| Missing | 8 |
| Number of Children | |
| 0 | 155 |
| 1 | 18 |
| 2 | 16 |

Table 7 Cont.

| | |
|--------------------------------------|-----|
| 3 or more | 11 |
| Missing | 8 |
| Visited a Mental Health Professional | |
| Yes | 38 |
| No | 147 |
| Missing | 23 |

Table 8.
Confirmatory Factor Analysis (N = 202).

| Index | Model | | |
|-----------------|--------------|----------------|--------------|
| | 1 | 2 ⁺ | 3 |
| SRMR | .17 | .06 | .07 |
| CFI | .53 | .86 | .83 |
| TLI | .50 | .85 | .82 |
| RMSEA | .13 | .08 | .09 |
| 90% CI of RMSEA | (0.13, 0.14) | (0.07, 0.09) | (0.08, 0.09) |
| χ^2 | 2518.65** | 801.75** | 1036.82** |
| df | 594 | 349 | 431 |

Note. ⁺Best fitting model. * $p < .05$. ** $p < .01$. DF = Degrees of Freedom. SRMR = Standardized Root Mean Square Residual, CFI = Comparative Fit Index, TLI = Tucker-Lewis Index, RMSEA = Root Mean Square Error of Approximation.

Table 9.
Chi-Square Difference Test Comparing the 1, 2, 3-factor models.

| Index | Model | |
|-----------------------------------|-----------|----------|
| | 1 vs. 2 | 2 vs. 3 |
| Satorra-Bentler Scaled Chi Square | 1844.25** | 246.26** |
| df | 245 | 82 |
| Sig. | .00 | .00 |

Note. * $p < .05$. ** $p < .01$. DF = Degrees of Freedom.

Table 10.
Item Loadings for Confirmatory Factor Analysis

| Life Enhancement | | Concerns about Distress | |
|------------------|------|-------------------------|------|
| Item 2 | 0.86 | Item 1 | 0.64 |
| Item 3 | 0.75 | Item 6 | 0.86 |
| Item 5 | 0.86 | Item 9 | 0.85 |
| Item 4 | 0.84 | Item 22 | 0.59 |
| Item 7 | 0.85 | Item 24 | 0.62 |
| Item 8 | 0.78 | Item 15 | 0.71 |
| Item 10 | 0.74 | Item 20 | 0.82 |
| Item 14 | 0.81 | Item 11 | 0.64 |
| Item 16 | 0.69 | Item 12 | 0.74 |
| Item 18 | 0.85 | Item 13 | 0.65 |
| Item 19 | 0.82 | Item 17 | 0.91 |
| Item 21 | 0.83 | | |
| Item 23 | 0.88 | | |
| Item 25 | 0.76 | | |
| Item 26 | 0.82 | | |
| Item 28 | 0.78 | | |
| Item 27 | 0.82 | | |

Note. All loadings are standardized and significant.

Table 11.
Summary of Intercorrelations between EBBPPS Scale and Validation Measures.

| | <i>N</i> | Life Enhancement | Concerns about Distress |
|-------------------------------------|----------|------------------|-------------------------|
| Psychological Help-Seeking | | | |
| [†] Psychological Openness | 134 | .31** | -.48** |
| [†] Indifference to Stigma | 151 | .30** | -.55** |
| General Help-Seeking | 22 | .65** | -.50* |
| Intentions to Seek Counseling | | | |
| Psychological Concerns | 154 | .45** | -.48** |
| Interpersonal Concerns | 154 | .42** | -.24** |
| Drug Concerns | 154 | .14 | -.15 |
| Academic Concerns | 154 | .26** | -.08 |
| Cultural Identity | | | |
| Strong Black Woman Schema | 177 | .06 | .13 |
| Ethnic Identity - Affirmation | 155 | .15 | -.29** |
| Ethnic Identity - Exploration | 155 | .32** | -.34** |
| Ethnic Identity - Resolution | 155 | .34** | -.33** |
| Symptomatology | | | |
| Worry | 156 | .13 | .04 |
| Total Distress | 175 | .10 | .11 |

Note. * $p < .05$. ** $p < .01$. In the CFA sample, Life Enhancement and Concerns about Distress were significantly correlated, $r = -.37$, $p < .01$. [†]Psychological Openness and Indifference to Stigma were combined to produce a total score. This total score was not correlated with the Intentions to Seek Counseling Subscales.

Table 12.
Summary of Intercorrelations between All Measures.

| | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|--------|--------|--------|-------|--------|--------|--------|--------|-------|--------|-------|--------|------|--------|
| 1. Life Enhancement | -.44** | .31** | .30** | .65** | .06 | .15 | .32** | .34** | .26** | .42** | .14 | .45** | .13 | .09 |
| 2. Concerns about Distress | - | -.48** | -.55** | -.50* | .13 | -.29** | -.34** | -.33** | -.08 | -.24** | -.15 | -.29** | .04 | .11 |
| 3. Psychological Openness | - | - | .61** | - | -.15 | .30** | .30** | .22* | .02 | .11 | .05 | .10 | .00 | -.19* |
| 4. Indifference to Stigma | - | - | - | - | -.26** | .28** | .25** | .27** | .08 | .16 | .02 | .12 | -.15 | -.18* |
| 5. General Help-Seeking | - | - | - | - | -.15 | - | - | - | - | - | - | - | - | .27 |
| 6. SBW Schema | - | - | - | - | - | -.06 | .18* | .17* | -.02 | .11 | .09 | .15 | .59* | .39** |
| 7. Ethnic Identity – Affirmation | - | - | - | - | - | - | .34** | .35** | -.14 | -.13 | -.02 | -.13 | .02 | -.34** |
| 8. Ethnic Identity – Exploration | - | - | - | - | - | - | - | .64** | .02 | .15 | .31** | .21** | .12 | -.08 |
| 9. Ethnic Identity – Resolution | - | - | - | - | - | - | - | - | .01 | .19* | .12 | .13 | .09 | -.10 |
| 10. Intentions to Seek Counseling – Academic | - | - | - | - | - | - | - | - | - | .65** | .13 | .56** | .01 | .29** |
| 11. Intentions to Seek Counseling – Interpersonal | - | - | - | - | - | - | - | - | - | - | .36** | .80** | .11 | .33** |
| 12. Intentions to Seek Counseling – Drug | - | - | - | - | - | - | - | - | - | - | - | .48** | .03 | .11 |
| 13. Intentions to Seek Counseling – Psychological | - | - | - | - | - | - | - | - | - | - | - | - | .17* | .42** |
| 14. Worry | - | - | - | - | - | - | - | - | - | - | - | - | - | .42** |
| 15. Total Distress | - | - | - | - | - | - | - | - | - | - | - | - | - | - |

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

Table 13.
*Simple Linear Regressions Predicting African American Women's Intentions to Seek
 Psychological Services for Psychological Concerns (N = 154)*

| Predictor | <i>B</i> | <i>SE B</i> | β | t | Sig. | 95% CI |
|------------------|----------|-------------|---------|------|------|------------|
| Life Enhancement | .25 | .04 | .45** | 6.16 | .00 | [.17, .33] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. $R^2 = .20$

Table 14.
*Simple Linear Regressions Predicting African American Women's Intentions to Seek
 Psychological Services for Interpersonal Concerns (N = 154)*

| Predictor | <i>B</i> | <i>SE B</i> | β | <i>t</i> | Sig. | 95% CI |
|------------------|----------|-------------|---------|----------|------|------------|
| Life Enhancement | .12 | .02 | .42** | 5.72 | .00 | [.08, .16] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. $R^2 = .18$

Table 15.

Simple Linear Regressions Predicting African American Women's Intentions to Seek Psychological Services for Drug Concerns (N = 167)

| Predictor | <i>B</i> | <i>SE B</i> | β | t | Sig. | 95% CI |
|------------------|----------|-------------|---------|------|------|-------------|
| Life Enhancement | .03 | .02 | .15* | 1.95 | .05 | [-.00, .07] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. $R^2 = .02^*$

Table 16.
*Simple Linear Regressions Predicting African American Women's Intentions to Seek
 Psychological Services for Academic Concerns (N = 167)*

| Predictor | <i>B</i> | <i>SE B</i> | β | t | Sig. | 95% CI |
|------------------|----------|-------------|---------|------|------|------------|
| Life Enhancement | .07 | .02 | .26** | 3.44 | .00 | [.03, .10] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. $R^2 = .07^{**}$.

Table 17.
*Simple Linear Regressions Predicting African American Women's Intentions to Seek
 Psychological Services for Psychological Concerns (N = 154)*

| Predictor | <i>B</i> | <i>SE B</i> | β | t | Sig. | 95% CI |
|-------------------------|----------|-------------|---------|-------|------|--------------|
| Concerns about Distress | -.23 | .06 | -.29** | -3.69 | .00 | [-.36, -.11] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. $R^2 = .08$

Table 18.

Simple Linear Regressions Predicting African American Women's Intentions to Seek Psychological Services for Interpersonal Concerns (N = 154)

| Predictor | <i>B</i> | <i>SE B</i> | β | <i>t</i> | Sig. | 95% CI |
|-------------------------|----------|-------------|---------|----------|------|--------------|
| Concerns about Distress | -.10 | .03 | -.24** | -3.01 | .00 | [-.17, -.04] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. $R^2 = .05$

Table 19.
Simple Linear Regressions Predicting African American Women's Intentions to Seek Psychological Services for Drug Concerns (N = 167)

| Predictor | <i>B</i> | <i>SE B</i> | β | t | Sig. | 95% CI |
|-------------------------|----------|-------------|---------|-------|------|--------------|
| Concerns about Distress | -.05 | .02 | -.17* | -2.20 | .03 | [-.10, -.01] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. $R^2 = .03$ *

Table 20.
Simple Linear Regressions Predicting African American Women's Intentions to Seek Psychological Services for Academic Concerns (N = 167)

| Predictor | <i>B</i> | <i>SE B</i> | β | t | Sig. | 95% CI |
|-------------------------|----------|-------------|---------|------|------|-------------|
| Concerns about Distress | -.03 | .03 | -.07 | -.86 | .39 | [-.08, .03] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. $R^2 = .00$.

Table 21.

Summary of Hierarchical Multiple Regression Predicting Intentions to Seeking Services for Psychological Concerns in Study 2 (N = 140)

| Predictor | <i>B</i> | <i>SE B</i> | β | <i>t</i> | Sig. | 95% CI |
|-------------------------|----------|-------------|---------|----------|------|-------------|
| Step 1 | | | | | | |
| Psychological Openness | .03 | .16 | .02 | .17 | .87 | [-.28-.33] |
| Indifference to Stigma | -.16 | .14 | -.12 | -1.15 | .25 | [-.45, .12] |
| Step 2 | | | | | | |
| Life Enhancement | .23 | .05 | .40** | 4.70 | .00 | [.13, .33] |
| Step 3 | | | | | | |
| Concerns about Distress | -.09 | .08 | -.11 | -1.12 | .27 | [-.25, .07] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. General positive attitudes toward psychological help-seeking as measured by the General Help-Seeking attitudes could not be included due to insufficient sample size. Step 2: $R^2 = .18$, change $\Delta R^2 = .16^{**}$. Step 3: $R^2 = .19$, change $\Delta R^2 = .01$.

Table 22.

Summary of Hierarchical Multiple Regression Predicting Intentions to Seeking Services for Impersonal Concerns in Study 2 (N = 140)

| Predictor | <i>B</i> | <i>SE B</i> | β | <i>t</i> | Sig. | 95% CI |
|-------------------------|----------|-------------|---------|----------|------|-------------|
| Step 1 | | | | | | |
| Psychological Openness | -.04 | .08 | -.06 | -.45 | .66 | [-.20, .13] |
| Indifference to Stigma | .02 | .08 | .02 | .21 | .83 | [-.14, .17] |
| Step 2 | | | | | | |
| Life Enhancement | .13 | .03 | .41** | 4.85 | .00 | [.08, .18] |
| Step 3 | | | | | | |
| Concerns about Distress | -.02 | .04 | -.04 | -.36 | .72 | [-.10, .07] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. General positive attitudes toward psychological help-seeking as measured by General Help-Seeking attitudes could not be included due to insufficient sample size. Step 2: $R^2 = .17$, change $\Delta R^2 = .16^{**}$. Step 3: $R^2 = .17$, change $\Delta R^2 = .00$.

Table 23.

Summary of Hierarchical Multiple Regression Predicting Intentions to Seeking Services for Drug Concerns in Study 2 (N = 140)

| Predictor | <i>B</i> | <i>SE B</i> | β | <i>t</i> | Sig. | 95% CI |
|-------------------------|----------|-------------|---------|----------|------|-------------|
| Step 1 | | | | | | |
| Psychological Openness | -.01 | .07 | -.02 | -.15 | .88 | [-.14, .12] |
| Indifference to Stigma | -.03 | .06 | -.05 | -.45 | .66 | [-.15, .09] |
| Step 2 | | | | | | |
| Life Enhancement | .03 | .02 | .12 | 1.32 | .19 | [-.01, .07] |
| Step 3 | | | | | | |
| Concerns about Distress | -.05 | .03 | -.15 | -1.40 | .16 | [-.12, .02] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. General positive attitudes toward psychological help-seeking as measured by General Help-Seeking attitudes could not be included due to insufficient sample size. Step 2: $R^2 = .02$, change $\Delta R^2 = .02$ Step 3: $R^2 = .04$, change $\Delta R^2 = .01$

Table 24.

Summary of Hierarchical Multiple Regression Predicting Intentions to Seeking Services for Academic Concerns in Study 2 (N = 140)

| Predictor | <i>B</i> | <i>SE B</i> | β | <i>t</i> | Sig. | 95% CI |
|-------------------------|----------|-------------|---------|----------|------|-------------|
| Step 1 | | | | | | |
| Psychological Openness | -.04 | .08 | -.06 | -.52 | .60 | [-.19, .11] |
| Indifference to Stigma | .01 | .07 | .02 | .18 | .86 | [-.13, .15] |
| Step 2 | | | | | | |
| Life Enhancement | .08 | .02 | .31 | 3.42 | .00 | [.04, .13] |
| Step 3 | | | | | | |
| Concerns about Distress | .03 | .04 | .08 | .76 | .45 | [-.05, .11] |

Note. * $p < .05$. ** $p < .01$. CI = Confidence Interval. General positive attitudes toward psychological help-seeking as measured by General Help-Seeking attitudes could not be included due to insufficient sample size. Step 2: $R^2 = .08$, change $\Delta R^2 = .08^{**}$. Step 3: $R^2 = .08$, change $\Delta R^2 = .00$.

Table 25.

Exploratory Factor Analysis Summary of Intercorrelations, Means, and Standard Deviations for Key Study Variables (N = 199)

| Measure | <i>M</i> | <i>SD</i> | α | 2 | 3 | 4 | 5 | 6 | 7 |
|----------------------------|----------|-----------|----------|--------|------|-------|-------|--------|------|
| 1. Life Enhancement | 72.07 | 18.54 | .97 | -.35** | .09 | .09 | .16* | -.11 | .16 |
| 2. Concerns about Distress | 29.13 | 12.03 | .93 | -- | -.01 | .00 | -.09 | .10 | -.08 |
| 3. Age | 26.63 | 9.38 | -- | -- | -- | .59** | .28** | -.25** | -.00 |
| 4. Number of Children | -- | -- | -- | -- | -- | -- | .14 | -.11 | .06 |
| 5. Education | -- | -- | -- | -- | -- | -- | -- | -.05 | .11 |
| 6. Annual Income | -- | -- | -- | -- | -- | -- | -- | -- | .09 |
| 7. Religiosity | -- | -- | -- | -- | -- | -- | -- | -- | -- |

Note. * $p < .05$. ** $p < .01$; Age represents a Pearson's (r) correlation coefficient, and all other variables represent Spearman's rank-order (r_s) nonparametric correlation coefficients. Minimum value for Life Enhancement = 17; Maximum Value for Life Enhancement = 102. Minimum value for Concerns about Distress = 11; Maximum Value for Concerns about Distress = 66.

Table 26.

Results of T-test and Descriptive Statistics for Life Enhancement and Concerns about Distress by Past Psychological Service Use Utilization

| | Past Psychological Service Utilization | | | | | | 95% CI for Mean Difference | t | df |
|-------------------------------|--|-------|----|-------|-------|-----|----------------------------|--------|-------|
| | Yes | | | No | | | | | |
| | M | SD | n | M | SD | n | | | |
| Life Enhancement ⁺ | 76.03 | 14.12 | 37 | 69.70 | 19.44 | 142 | -11.97, -.67 | -2.23* | 75.63 |
| Concerns about Distress | 27.43 | 11.49 | 37 | 30.45 | 12.36 | 142 | 1.42,7.46 | 1.34 | 177 |

Note: * $p < .05$. ** $p < .01$. ⁺ Levene's Test for Equality of Variances was significant, indicating equal variances not assumed. Satterthwaite approximation employed due to unequal group variances.

Table 27.

Results of T-Test and Descriptive Statistics for all Study Variables by Psychological Subject Pool Recruitment in Confirmatory Factor Analysis Sample

| | Psychology Subject Pool | | | | | | 95% CI | t | df |
|--|-------------------------|-------|----|-------|-------|----|-------------|--------|-----|
| | Yes | | | No | | | Mean | | |
| | M | SD | n | M | SD | n | Difference | | |
| Life Enhancement | 73.05 | 16.90 | 87 | 73.60 | 19.03 | 85 | -5.97, 4.86 | -.20 | 170 |
| Concerns about Distress | 28.30 | 10.71 | 87 | 29.12 | 12.79 | 85 | -4.37, 2.73 | -.46 | 170 |
| Psychological Openness | 31.32 | 6.65 | 68 | 29.67 | 6.78 | 58 | -.72, 4.03 | 1.38 | 124 |
| Indifference to Stigma ⁺ | 29.05 | 6.35 | 76 | 26.54 | 7.70 | 63 | .16, 4.87 | 2.11* | 137 |
| SBW Schema | 56.85 | 10.24 | 79 | 57.64 | 9.80 | 83 | -3.90, 2.32 | -.50 | 160 |
| Ethnic Identity - Affirmation | 21.77 | 3.94 | 77 | 21.79 | 3.62 | 66 | -1.28, 1.24 | -.03 | 141 |
| Ethnic Identity - Exploration | 21.91 | 5.12 | 77 | 22.53 | 4.95 | 66 | -2.29, 1.05 | -.73 | 141 |
| Ethnic Identity – Resolution | 12.79 | 3.12 | 77 | 13.06 | 2.72 | 66 | -1.24, .70 | -.54 | 141 |
| Intentions to Seek Counseling – Psychological Concerns | 25.87 | 10.34 | 77 | 24.86 | 10.21 | 66 | -2.40, 4.41 | .58 | 141 |
| Intentions to Seek Counseling – Interpersonal Concerns | 12.77 | 5.66 | 77 | 11.61 | 5.34 | 66 | -.67, 2.99 | 1.25 | 141 |
| Intentions to Seek Counseling – Drug Concerns | 6.14 | 4.04 | 77 | 6.47 | 3.90 | 66 | -1.65, .99 | -.49 | 141 |
| Intentions to Seek Counseling – Academic Concerns | 9.09 | 4.69 | 77 | 7.64 | 4.51 | 66 | -.08, 2.98 | 1.88 | 141 |
| Worry | 57.86 | 14.27 | 77 | 55.21 | 14.44 | 66 | -2.12, 7.40 | 1.10 | 141 |
| Total Distress | 45.48 | 14.93 | 80 | 38.93 | 13.64 | 81 | 2.10, 10.99 | 2.91** | 159 |

Note: * $p < .05$. ** $p < .01$. ⁺ Levene's Test for Equality of Variances was significant, indicating equal variances not assumed. Satterthwaite approximation employed due to unequal group variances. General positive attitudes toward psychological help-seeking as measured by the General Help-Seeking attitudes was not included due to insufficient sample size. Sample sizes differ for study variables given that not all participants were given all study measures.

Table 28.

Demographic Characteristics for Test-Retest Reliability Participants (N=25)

| Characteristics | Participants N = 208 |
|--------------------------------------|-------------------------|
| Education | |
| Some High School | 1 |
| High School/GED | 3 |
| Associate Degree | 0 |
| Some College | 6 |
| Bachelor Degree (B.A., B.S.) | 7 |
| Master's Degree (M.A., M.S.) | 1 |
| Doctoral Degree (Ph.D., M.D., J.D.) | 3 |
| Missing | 4 |
| Income | |
| Under \$24,999 | 5 |
| \$25,000- \$49,999 | 2 |
| \$50,000- \$74,000 | 9 |
| \$75,000- \$99,999 | 1 |
| \$100,000-\$124,999 | 1 |
| \$125,000 or more | 2 |
| I don't know | 1 |
| Missing | 4 |
| Insurance | |
| Yes | 20 |
| No | 0 |
| Don't Know | 1 |
| Missing | 4 |
| Sexual Orientation | |
| Heterosexual/Straight | 20 |
| Bisexual | 1 |
| Missing | 4 |
| Marital Status | |
| Single/Never Married | 15 |
| Partnered | 2 |
| Married | 2 |
| Divorced | 2 |
| Missing | 4 |
| Number of Children | |
| 0 | 14 |
| 1 | 2 |
| 2 | 4 |
| 3 or more | 1 |
| Missing | 4 |
| Visited a Mental Health Professional | |
| Yes | 14 |