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ABSTRACT

ETHNIC IDENTITY SALIENCE, SOCIOECONOMIC STATUS,
AND ATTITUDES TOWARD SEEKING MENTAL HEALTH
TREATMENT AS PREDICTORS OF RECEPTIVITY TO
COMMUNITY-BASED PSYCHOEDUCATION
AMONG AFRICAN AMERICAN MEN

by

Hadiya Suzanne DuBose-Smith

Chair: Elvin Gabriel

ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: ETHNIC IDENTITY SALIENCE, SOCIOECONOMIC STATUS, AND
ATTITUDES TOWARD SEEKING MENTAL HEALTH TREATMENT AS
PREDICTORS OF RECEPTIVITY TO COMMUNITY-BASED
PSYCHOEDUCATION AMONG AFRICAN AMERICAN MEN

Name of researcher: Hadiya Suzanne DuBose-Smith

Name and degree of faculty chair: Elvin Gabriel, Ed.D.

Date completed: July 2020

Problem

Distrust and socioeconomic barriers are widely recognized as contributors to disparities in the healthcare system, particularly as it relates to mental health care (Lindinger-Sternart, 2015; National Alliance on Mental Illness, n.d.). African Americans continually experience societal pressures to disassociate with African American culture and to assimilate into mainstream culture. Perhaps accessing mental health services via a counselor is an extension of that pressure. In this way, the traditional counseling model for mental health intervention is a culturally counterintuitive approach for developing mental health among African American men. Men are a subset of the African American

community that tends to engage in mental health treatment at a significantly lower rate than the general population. Conversely, research suggests that their distress is as significant if not more so than that of majority groups (Mental Health America, n.d.; Roberson & Fitzgerald, 1992; Snowden, 2012). Research shows that cultural and systematic factors drive the underuse of mental health services among African American men (particularly counseling). Community-based psychoeducation spread by community members may be a means of making mental health information more accessible to this population in culturally congruent and enfranchised ways.

Method

A quantitative, non-experimental survey design was employed to examine the relationship between 1) ethnic identity salience, 2) socioeconomic status (the exogenous variables), and 3) attitudes toward seeking mental health treatment (both endogenous and exogenous) as predictors of receptivity toward community-based psychoeducation (the dependent/endogenous variable) among African American men. ANOVA and Structural Equation Modeling were employed to consider the relationship between variables and the latent construct. Convenience sampling was used to recruit a nationally representative sample of 461 African American men from across the country through the employment of Qualtrics data collection service. Following data collection, data were screened and analyzed using SPSS and AMOS software programs to ensure valid interpretation.

Results

The results indicated that African American men are most receptive to discussing/receiving mental health information with counselors, friends, and family, and

in the corresponding settings (in counseling, social settings, or at home, respectively). Receptivity in those settings had no significant difference, which conveys comparable openness to discussing/receiving mental health information (i.e., psychoeducation). Such findings are indicative of community-based psychoeducation as an alternative to counseling. Overall, respondents were somewhat receptive to a variety of identified settings/individuals; however, barbershops/barbers were the least preferred option for discussing/receiving mental health information. Further, the original structural equation model poorly fit the collected data, so it was adjusted as informed by theory and supported by the literature. The final, good-fitting model explained only 18% of the variance in the dependent variable though it yielded unique insight into the relationship of the variables. Ethnic Identity Salience and Socioeconomic Status were meaningful predictors of Receptivity to Community-based Psychoeducation. Help-seeking Propensity was the only assessed Attitude toward Seeking Mental Health Treatment that was meaningful in the empirical model.

Conclusions

The findings support the existing research that African American men are receptive to community-based psychoeducation when administered through the appropriate channels. Given issues with feasibility and access, community-based psychoeducation dispersed through families and friends at home and in social settings may be preferable to counseling as a means of increasing mental health literacy among the general U.S. population of African American men. Future studies should strive to conceptualize mental health intervention in culturally congruent ways, develop community-based intervention modalities, and study African Americans in novel

exploratory ways to generate practical mental health advancement. They should also consider how the changing zeitgeist, individual attitudes, and meaningful personal relationships impact the discussion of mental health and utilization of services among African American men.

Andrews University

School of Education

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A Dissertation

Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

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Hadiya Suzanne DuBose-Smith

July 2020

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APPROVAL BY THE COMMITTEE:

Chair: Elvin Gabriel

Dean, College of Education and
International Services
Alayne Thorpe

Member: Carole Woolford-Hunt

Member: Jimmy Kijai

External: Lionel Matthews

Date approved

I, too, sing America.

I am the darker brother.
They send me to eat in the kitchen
When company comes,
But I laugh,
And eat well,
And grow strong.

Tomorrow,
I'll be at the table
When company comes.
Nobody'll dare
Say to me,
"Eat in the kitchen,"
Then.

Besides,
They'll see how beautiful I am
And be ashamed—

I, too, am America. (Hughes, 2002)

This dissertation is dedicated to "the darker brother."

Theirs is the banner in my hand. And I wish I had the power to tell them that the despair of their hearts was not to be final, and their night was not without hope. For the battle they lost can never be lost. For that which they died to save can never perish. [...] It may sleep, but it will awaken. It may wear chains, but it will break through. (Rand, 1995)

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ACKNOWLEDGMENTS

I must first acknowledge the God who purposed this study from its inception. Its completion is as much a testament to His faithfulness as it is to the very real challenges African American men are facing. I am both humbled by the topic's relevance for such a time as this, and convicted that there is still much to be done.

To my family, my village, my treasure in earthen vessels: thank you. You stood with me through this journey, for better or worse, richer or poorer, in sickness and in health. I am because you are, and you were the inspiration for this study. Further, to The DuBose Family, The Brown Family, Dr. Ilmajean Willis, and Dr. Sandra Powell: thank you for all you sacrificed to make this possible. May this study attest to my commitment to harvesting from seeds you planted.

To my friends and GPC family: thank you for this opportunity, and for taking it with me. You were the holding space in which I evolved alongside this study, and for providing that security, I am forever grateful. I would especially like to thank Nicole Knapp for striving with me against the tide of being “ABD”. As we continue advancing, may our impact outlive us, and may the realities addressed herein give way to better days.

Lastly, to my committee: thank you for partnering with me, for embracing my vision and helping it take shape. Dr. Gabriel, as the chair, you joined this project when it was no more than a concept. Thank you for betting on my willful stubbornness and embracing it as kindred to your own. Dr. Kijai, as methodologist, you patiently answered

every question and walked with me through analysis and interpretation. Thank you for addressing this topic as one worthy of further exploration. Dr. Woolford-Hunt, as content expert, you challenged me to understand this population on their own terms and to consider them in context rather than out of convenience. Thank you for seeing their experiences, and mine, as being meaningful and robust. I would also like to thank Dr. Matthews for joining us in evaluation as the external examiner, and bringing this study to the public. You all demonstrated care for the study and researcher, and it made a world of difference.

To all those who will read this document: there is still a work to be done. Sydney Smith once said, “It is the greatest of all mistakes to do nothing because you can only do little. Do what you can.” So I charge you: Seek knowledge. Affirm faith. Change the world.

Thank you all!

CHAPTER 1

INTRODUCTION

Background of the Study

There is a unique interplay between race/ethnicity and gender as it pertains to mental health intervention among African American men. Studies report that African Americans are markedly underrepresented, understudied, and underserved in psychological research studies and mental health services and treatment (Brown, 2008; Hall et al., 2016; Mackenzie, Gekoski, & Knox, 2006; Yakushko et al., 2016). Issues pertaining to the feasibility of services and the receptivity of African American men to traditional mental health services are significant impediments to representation and utilization of services. However, community-based psychoeducation is a promising intervention modality for circumventing both issues in a way that can reinforce prior existing ethnic resilience factors (Hankerson et al., 2015; Haynes et al., 2017; Hinson & Swanson, 1993; Hipolito-Delgado, 2015; Vogel, Wester, & Larson, 2007).

“According to the Health and Human Services Office of Minority Health, African Americans are 20% more likely to experience serious mental health problems than the general population” (Giorgianni, 2019, p. 1A). However, “only about one-quarter of African Americans seek mental health care, compared to 40% of whites” (National Alliance on Mental Illness, n.d.; Williams et al., 2007). Research also shows that men tend to utilize services less than women regardless of ethnicity/race (Addis & Mahalik,

2003; Galdas, Cheater, & Marshall, 2005). African American men, in particular, utilize mental health services at lower rates. Further, compared to its global counterparts, “The U.S. ranks dead last in life expectancy for men” (Pearl, 2015). African American men “have the highest all-cause mortality rates of any racial/ethnic group in the US” (Hankerson, Suite, & Bailey, 2015); social and economic factors impact this.

One reason the U.S. ranks so poorly globally is that health outcomes for certain racial, ethnic and socioeconomic groups fare so poorly domestically. African-Americans, Latinos and the economically disadvantaged experience poorer health care access and lower quality of care than white Americans. And in most measures, that gap is growing. (Pearl, 2015)

Institutional racism has played a critical role in the socio-economic advancement and ethnic identity development of African American men (essentially evolving from property to person) (Alexander, 2010). The marginalization of African American men is not purely a historical reality; it continues to be a pervasive issue in the U.S. The documented increase in explicit acts of racism and discrimination following the 2016 U.S. Presidential election (Reilly, 2016) highlight this issue. To ethnically identify as an African American man is to identify with a population subjected to ethnic ostracism, socioeconomic marginalization, and prejudicial treatment.

Disclosing information outside of trusted and proven community relationships (such as in counseling) is often understood by ethnic minorities (African American men in particular) as having greater anticipated risks with fewer anticipated benefits (Hinson & Swanson, 1993). This consideration is especially so in light of African American communication norms (Peskin, Tortolero, & Markham, 2006; Smitherman, 2000), which are more likely to be misinterpreted by outgroup members. Additionally, there is a drive in the African American community to “just keep pushing.” This ideology conceptualizes

seeking help, and further seeking help from outgroup members, as stigmatizing and inappropriate (Hinson & Swanson, 1993; Vogel, Wester, & Larson, 2007). Cultural factors such as these are important considerations for developing a well-explored study of African American men and their receptivity to mental health intervention within the United States. Perhaps intervention modalities that provide mental health information via culturally meaningful ways, ethnically empowering those socioeconomically marginalized, would find better traction within this population.

The African American community displays unique cultural means of mediating societal pressures and discrimination, and by extension coping with mental health concerns. Distrust of outgroup members and incidences of clinician bias and misdiagnosis necessitate community reliance and resilience. In-group reliance contributes to the observed underuse of mental health services and an overall lack of receptivity to services. However, ethnically salient extended-kinship relationships act as a basis of socio-emotional and socioeconomic survival for many African Americans (DuVernay, 2016; National Alliance on Mental Illness, n.d.). This interconnectedness suggests that ‘health’ within the African American community may be primarily understood as something cultivated through internal resources rather than external.

The schism between the African American community and seeking mental health services is a complex one, and has resulted in vast underrepresentation. In 1999, “African Americans constitute[d] only 2% of psychiatrists, 2% of psychologists, and 4% of social workers in the U.S.” (U.S. Department of Health and Human Services, 1999). As of 2015, the number of active African American psychologists had more than doubled (5.3%) (Lin, Nigrinis, Christidis, & Stamm, 2015). However, it is still significantly lower

than the percentage of African Americans in the general U.S. population (14.6% of the U.S. population is Black or African American, and 13.6% is Black or African American only; U.S. Census Bureau, 2017). Studies have found that lower rates of counselor ethnicity/race match tend to be more problematic for more Afrocentric (ethnically salient) individuals. In instances where there was ethnicity/race match, clients attended more sessions and experienced more significant improvements in global functioning (Dana, 2002; Kim & Kang, 2018) demonstrating greater receptivity to mental health treatment.

There is a growing body of literature documenting gender, ethnic, and socioeconomic disparities in the utilization of mental health services (Addis & Mahalik, 2003; Galdas et al., 2005; Lindinger-Sternart, 2015; National Alliance on Mental Illness, n.d.; Snowden, 2012; Williams, Priest, & Anderson, 2016). Taken together, the issues mentioned above and factors convey a need for community-based mental health intervention that is congruent with salient ethnic identities, readily accessible by the socioeconomically marginalized and feasible for those with divergent attitudes toward seeking mental health treatment. Hankerson et al. (2015) stated, “Future studies should investigate the efficacy of culturally tailoring empirically supported treatments for African American men” (Taken from Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003).

Rationale for the Study

African American men have dynamic attitudes toward seeking mental health treatment, indicating that contrary to popular thought their underuse of services is not purely due to negative attitudes (Diala, 2000; Hipolito-Delgado, 2015; Shaffer, Vogel, & Wei, 2006; Ward, Wiltshire, Detry, & Brown, 2013). Given the collectivist nature of the

African American community and their disenfranchisement, mental health interventions requiring outgroup reliance can be understood by community members as having more risks than benefits (Vogel, Wester, & Larson, 2007). Many researchers are professing a growing need for community-based interventions that are better suited to this population (Conner, Koeske, & Brown, 2009; Doehring, 2015; Hankerson et al., 2015; Hipolito-Delgado, 2015; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; Luque, Ross, & Gwede, 2014; Shabazz, 2016; Ward, Wiltshire, Detry, & Brown, 2013). Psychoeducation is a form of mental health intervention that is instrumental in various treatment modalities. It is an empirically supported form of mental health intervention among African American men (Crist, 1986; Lukens & McFarlane, 2004; National Alliance on Mental Illness, 2018). With the observed disparities in mental health treatment among African American men, psychoeducation presents itself as a viable option for empowering this population with the information needed to advance the psychological health and support of both the individual and the kinship networks.

Statement of the Problem

African Americans have experienced numerous and layered societal pressures to disassociate with African American culture and to assimilate to mainstream culture (Hipolito-Delgado, 2015; Robin, 2013), thereby reducing their ethnic identity salience. This pressure works through the guise of overt discrimination, and covertly through Eurocentric standards for hairstyle and beauty/complexion, “keeping up with the Jones’,” or simply trying not to live up to the stereotypes of being an *A Mad Black Woman* or a *Menace to Society* (Alexander, 2010; DuVernay, 2016). Perhaps accessing mental health services via a counselor is an extension of that pressure. Speaking with a mental health

professional such as a counselor is largely culturally counterintuitive in the African American community, given the reliance on kinship networks and in-group support. Attitudes characterized by a distrust of the healthcare system and out-group members and socio-economic barriers are widely recognized contributors to the disparities in the healthcare system, particularly as it relates to mental health care (Lindinger-Sternart, 2015; National Alliance on Mental Illness, n.d.). In this way, it would appear that the standard counseling approach to mental health intervention would likely be a culturally insensitive approach toward helping members of the African American community.

Further, men represent a subset of the African American community in that they tend to engage in mental health treatment at a significantly lower rate than the general population. Nevertheless, research suggests that their distress is as significant if not more so than that of majority groups (Mental Health America, n.d.; Roberson & Fitzgerald, 1992; Snowden, 2012). Given the prevalence of mental health concerns such as Depression, Post-traumatic Stress Disorder, and Schizophrenia in the African American community (American Psychological Association, 2018b; DiSanto, 2018; Good Therapy, 2019; Lane, 2010), several questions arise: *Why aren't they using services? What factors might mitigate their underuse? What alternative resilience factors enable them to manage psychological distress?*

A frequent discussion in the existing literature, which informed the context of the study, pertains to African Americans underusing mental health services. Through an exploration of said literature, this study stems from the question, *if they are not going to counseling, how else can we (the mental health profession) empower them in a way that recognizes their culturally embedded resilience factors?* The field of Psychology must

adapt to make interacting with mental health information feasible and culturally relevant for minorities and sensitive populations.

According to *Psychology Today* (Morin, 2018) and the World Health Organization (2018), it is problematic that mental health is a fundamental aspect of livelihood but is considered a secondary area of health. In comparison, it is under-discussed in like manner as sexual health, and yet as crucial to health as basic hygiene. As it relates to mental health in the African American community, attitudes toward seeking mental health treatment often conceptualize counseling and mental health treatment in general as emergency resources only (Hinson & Swanson, 1993; Snowden, 2012). This lack of mental health awareness and information is a vital point of concern. Rather than being a lofty aspiration, knowing mental health information (i.e., information about feelings, communication) is a basic tool for personal development and navigating society; it is essentially a literacy of sorts. For instance, public education began for training citizens (Hipolito-Delgado, 2015). Its origin illustrates the societal demand for literacy and the danger of inadequate or negligent education. One's ability to thrive in society is dependent on fundamental life skills such as these. Literacy and bodily hygiene are necessary skills, and in the same way, basic mental health literacy should be prioritized.

Several researchers have found that community-based mental health intervention may have viability within the African American community in light of the observed underuse of traditional approaches to mental health treatment. Shabazz (2016) reported barbershops as venues for mental health discourse for African American men. Dana (2002) concluded that churches and other support networks are useful tools in developing

culture-specific interventions. Numerous others highlight the importance of community and culturally-based intervention among minority and African American populations (Alvidrez, Areán, & Stewart, 2005; Hankerson et al., 2015; Kreuter et al., 2003).

Hankerson et al. (2015, p 4) reported the following:

A model that integrates community engagement with improved clinical care was recently cited as a promising way to reduce disparities. In line with this care model, we encourage the dissemination of mental health outreach and psycho-education in trusted community settings frequented by men of color, such as barbershops, churches, and fraternities.

Furthermore, the following discussion provides context for considering the unique suitability of psychoeducation as a treatment modality for African American men in light of ethnic identity salience, socioeconomic status (SES), attitudes toward seeking mental health treatment.

Purpose of the Study

The purpose of this quantitative study is to examine how ethnic identity salience, SES, and attitudes toward seeking mental health treatment predict receptivity toward community-based psychoeducation as an alternative to counseling among African American men.

Conceptual/Theoretical Framework and Assumptions

The following model (Figure 1) is the theoretical model for the study:

Figure 1. Theoretical Model.

This theoretical model presents the hypothesized relationship between the variables and supports the interpretive framework.

Three primary modes of thinking provide the interpretive framework for the study: Social Constructivism, Critical Race Theory, and Adult Attachment Theory (Burke, 2007). These theories offer a social interactionist framework for contextualizing and examining the dynamic relationship between the variables: ethnic identity saliency, SES, attitudes toward seeking mental health treatment, and community-based psychoeducation among African American men. This integrated framework assumes 1) human development is socially constructed, 2) not all members of societal groups have the same experience in the society, and 3) individuals develop culturally informed patterns or styles for forming bonds and relationships with others. These assumptions convey practical implications for mental health treatment intervention.

Social Constructivism

Lev Vygotsky developed Social Constructivism which poses that human development is embedded in social interactions that shape knowledge acquisition (Burke, 2007). The premise is that learning cannot be experienced or understood independent of a social context.

Social Constructivism and Ethnic Identity Salience

As it relates to Social Constructivism, Ethnic Identity denotes ethnicity as an aspect of personhood. Ethnicity, stemming from the Greek *ethnos*, refers to a nation, community, or multitude. In this way, an ethnic group is a group with shared and distinct cultural traits (Fenton, 2010). By taking a social constructivist lens for conceptualizing ethnic identity salience, one assumes that ethnic identity salience is 1) created by social interaction, 2) dynamic, and 3) beyond a person's choice. This constructivist view opposes understanding ethnic identity as fixed and lacking diversity (primordialist) or as a unifying device used to choose affiliations (instrumentalist) (Reuter, 2017).

Understanding Ethnic Identity and Ethnic Identity Salience through the detailed Social Constructivist lens brings recognition to the diversity within the population and variations in the formation of their corresponding ethnic identities. Subsequently, this suggests that there are both within-group and between-group differences in receptivity to community-based psychoeducation. This conclusion rests largely on the basis that it will likely be more culturally meaningful for those with greater ethnic identity salience.

Social Constructivism and Socioeconomic Status

Socioeconomic growth in the African American community has been stilted by race relations in the U.S., and the corresponding power differential. Individuals with lower SES develop social identities in drastically different contexts than those from higher socioeconomic groups; this comes with unique challenges. The reality is that those from lower socioeconomic groups may be more likely to have negative, strained, or forced interactions with mental health professionals. This reality leads to idealizing mental health services as something that is either negative or desirable only for the economically well-off (National Alliance on Mental Illness, n.d.). While they are likely to have positive experiences with community-based forms of mental health intervention, individual services can be more stigmatizing and infeasible. Examples of community-based forms are those that are provided by local organizations such as the YMCA (Young Men's Christian Association) or the Boys & Girls Club of America (2018). Ultimately, community-based psychoeducation is congruent with the resources available to those from various socioeconomic backgrounds, and it is less threatening to the social realities of those from lower socioeconomic groups.

Social Constructivism and Attitudes toward Seeking Mental Health Treatment

The sociohistorical context of mental health treatment is essential to understanding the relational disposition of the African American community toward the treatment for psychological issues. African American men have been denigrated historically in diverse ways so as to diminish the public perception of their mental health, stability, and right to self-determination (Alexander, 2010; DuVernay, 2016; Riggs,

1987). Through a social constructivist framework (Burke, 2007), one understands that interactions with society and systems have shaped the mental health attitudes of African American men, both historically and at present. Consequently, intervention becomes more feasible when the amount of direct interaction with the system, and its inherent bias, is lessened.

Social Constructivism and Community-based Psychoeducation

As has been mentioned, there are documented disparities in the utilization of counseling services within the African American community. The nature of this community's disengagement from the healthcare systems is a learned response to 1) intergenerational social interactions that have reinforced a dismissing attitude toward outgroup members and 2) a pervasive and systematic rejection of the personhood and contributions of African Americans in U.S. society. Subsequently, they heavily rely on kinship networks for socioemotional support, the acquisition of adaptive skills, and even economic support to a degree (Fiori, Consedine, & Magai, 2008; National Alliance on Mental Illness, n.d.). This interaction renders counseling vastly undesirable, and calls for a paradigm shift in how mental health intervention is understood and transmitted to this population. Recognition of how individuals in this community traditionally acquire knowledge and seek resolution is essential in the discussion of community-based (or culturally derived) alternatives to counseling. While counseling is a prescribed process for improving mental health, psychoeducation can act as content. As content, it can be transmitted through community embedded social interactions (processes) that already serve as primary modes for knowledge acquisition.

Critical Race Theory

Critical Race Theory goes beyond the proposition of Social Constructivism. It poses that “while those on the social margins have less access to opportunities and resources, they also experience different barriers, obstacles, or other forms of individual and societal oppression than those at the center” (Solórzano and Villalpando, 1998, pp. 212–214 taken from Carter & Hurtado, 2007). This theory draws out the unique and compounding challenges faced by African American men and acknowledges the need for considering unique barriers when trying to intervene.

Critical Race Theory and Ethnic Identity Saliency

Research in the social sciences and healthcare highlight the healthcare disparities that exist between the ethnic majority culture and ethnic minorities. As members of an ethnic minority group in the U.S., African American men experience unique societal challenges and lower mainstream validation of their ethnic identity and cultural resources in comparison to ethnic majority members (DuVernay, 2016; Riggs, 1987). For instance, in many U.S. public grade schools, minority historical figures are marginally incorporated into the curriculum, and primarily incorporated during the month or day nationally or locally delegated to their ethnic group. According to the Library of Congress (2020), Black history month is February, multiple ethnic groups share May and October, Hispanics are mid-September through mid-October, Native Americans are November, and so on with individual days assigned to specific figures or cultural celebrations.

Additionally, the narratives and contributions of minorities are often depicted through the lens of majority members (i.e. Caucasian authors, actors, and teachers). At a micro level, this implicitly communicates the societal insignificance of ethnic minorities. Realities such as this directly impact how ethnic minorities understand themselves in relation to others and societal systems, and imply a mutual irrelevance: that their impact is not meaningful, and that the systems that exist cannot meaningfully positively impact them either. For this reason, mental health intervention should be culturally-informed if it is to be relevant in any lasting way among African American men at large (Hankerson et al., 2015; Hipolito-Delgado, 2015; Yakushko et al., 2016).

Critical Race Theory and Socioeconomic Status

Limited access to resources is an identified critical contributor to disparities in service use and quality as it pertains to healthcare, education, and community programming. Further, among ethnic minority groups, discrimination and community disenfranchisement are verified obstacles that impact their SES and mobility within the U.S. For instance, research has shown that African Americans receive less pay for the same work compared to their white counterparts (Alexander, 2010; DuVernay, 2016). Additionally, minorities often perform better at institutions of higher learning in which members of their ethnic group are well represented, such as at Historically Black Colleges and Universities (HBCUs) (Bridges, 2020; Carswell, 2017). Note that historically, Ivy League schools are predominantly white institutions (PWIs). This distinction provides a loose example of how minority group members face unique challenges and pressures to assimilate for socioeconomic gain. This type of dilemma is a

reality that majority culture individuals do not meet in the same way. Psychoeducation is uniquely suited to find traction among African American men in that it can be dispersed in numerous ways, and transmitted by within-group members. It can also have farther reach than one-on-one services since it requires a smaller clinician/professional to individual ratio.

Critical Race Theory and Attitudes toward Seeking Mental Health Treatment

The attitudes of African American men toward seeking mental health treatment and services are diverse (Diala, 2000). That aside, there are many unique barriers these men face in seeking mental health treatment. Barriers include distrust of outgroup members, the financial expense, the limited ability of counseling to address systemic issues that go beyond the individual's control, client/counselor race mismatch, misdiagnosis, and prejudice (Institute of Medicine, 2002; Ward 2005). The social contexts in which they live impact their attitudes, and the barriers they face are both internal and external. Hence, limited access to community mental health resources, discrimination and clinician bias, and micro and macro-level interactions with mental health services work together to cultivate their attitudes (National Alliance on Mental Illness, n.d.). Interventions that reduce the impact of the barriers mentioned above, that are culturally-based and work from a health/strengths perspective rather than being problem-focused, will be uniquely suited to support the enhancement in mental health in the African American community.

Critical Race Theory and Community-based Psychoeducation

Consider the following (Lukens & McFarlane, 2004, p. 206):

Many forms of psychosocial intervention are based on traditional medical models designed to treat pathology, illness, liability, and dysfunction. In contrast, psychoeducation reflects a paradigm shift to a more holistic and competence-based approach, stressing health, collaboration, coping, and empowerment (Dixon, 1999; Marsh, 1992). It is based on strengths and focused on the present.

African American men show receptivity to community based mental health interventions and psychoeducation (Alvidrez, Areán, & Stewart, 2005; Lukens & Mcfarlane, 2004).

African American men are socially stigmatized into hypermasculine roles that reduce the feasibility of help-seeking behaviors toward helping professionals. However, within-group dynamics suggest receptivity and the feasibility of seeking and receiving help from within-group members (Lindinger-Sternart, 2015; National Alliance on Mental Illness, n.d.). Implementing community-based psychoeducation counteracts issues such as access, distrust, and stigma, reducing the risks associated with receiving mental health intervention.

Adult Attachment Theory

Lastly, Adult Attachment Theory poses that people develop attachment patterns through social learning from their early experiences. People develop “strategies as a way to protect themselves in intimate relationships and can become either overly anxious or more distant and avoidant” (American Association for Marriage and Family Therapy, n.d.), or in cases of severe abuse, both. Attachment impacts how people understand themselves, as well as how they relate to others, be it individuals or systems. With roots in object relations theory, adult attachment theory recognizes that people naturally form

relationships. However, when attempts to do so fail, attachment styles (or general patterns of relating) toward the other individual can be problematic (Vogel & Wei, 2005).

Adult Attachment Theory and Ethnic Identity Salience

In consideration of the interplay between Adult Attachment Theory and Ethnic Identity Salience within the community of African American men, it is plausible that those with greater ethnic identity salience might be more distrusting of mental health treatment and the counseling profession as a whole. This is likely due to several factors: 1) the historical conflicts between the African American community and medical and mental health field; 2) the negative media portrayal of African American men; 3) the stigmatizing media portrayal of mental illness and counseling; 4) the reliance within the African American community on kinship networks for support; 5) the lack of African American counselors in the profession (Lindinger-Sternart, 2015; National Alliance on Mental Illness, n.d.). The intergenerational schism between African American men and mainstream society and various U.S. systems (i.e., healthcare, education, housing, and banking) is an indicator of a culturally manifest relational pattern. The reality is that African American men with greater ethnic identity salience may be more relationally predisposed to reject counseling as a feasible mental health option.

Adult Attachment Theory and Socioeconomic Status

Across various socioeconomic levels, racial disparities in health remain. Those who are racially and ethnically stigmatized “experience higher rates of illness, impairment and death than the average of their societies in the U.S. and globally”

(Williams, Priest, & Anderson, 2016). By being in the lower margin of society as it pertains to income, education, or occupation, those in lower socioeconomic groups often experience an even higher demand for code-switching. Code-switching is typically characterized by alternating between colloquial speech and majority culture or professional jargon (Byrd & Clayton, 2001; Elliot, Adams, & Sockalingam, 2016; Kennedy et al., 2007), managing basic needs with fewer and often lower-quality resources, and developing self-esteem through acquiring a contra narrative about their debased social standing. This contra narrative is divergent from the mainstream prejudicial one that could produce a negative self-concept. Ultimately, SES impacts not only one's standing in society but also one's access to and interaction with systems. With many African Americans living in urban and impoverished areas, the most relevant mental health interventions are those that parallel systems that are already paramount within African American culture (i.e., churches, small businesses, etc.) (American Psychological Association, 2018d).

Adult Attachment Theory and Attitudes toward Seeking Mental Health Treatment

African American men, due to gender and ethnicity related issues, are likely to have concepts about mental health professionals that presume that they are only a last resort. They may assume that seeing a counselor is an unnecessary expense reserved for the severely mentally ill (Hinson & Swanson, 1993). In this way, they would interpret seeking help from a professional as high risk and would become avoidant toward or dismissing of counseling. In contrast, other men within the African American community might consider counseling as a viable option for dealing with issues that are deemed

counseling appropriate. Appropriate issues are those too controversial to discuss with those they are close to or that they might be shunned for voicing to those within their support network (Shaffer, Vogel, & Wei, 2006; Robin, 2013; Vogel & Wei, 2005).

Adult Attachment Theory and Community-based Psychoeducation

Adult Attachment Theory highlights the importance of understanding the relational dynamics of African American men (Hipolito-Delgado, 2015; Trembley, 1996). The relational component of counseling could be uniquely disparaging for African American men because it calls for forming relationships with untrusted, majority culture individuals. Such scenarios are challenging because they require making relationships with non-community members and limited reciprocity (Lindinger-Sternart, 2015; National Alliance on Mental Illness, n.d.). Conversely, there might also be unique benefits to counseling or unique alternatives to counseling suited to this population (Conner, Koeske, & Brown, 2009; Doehring, 2015; Yakushko et al., 2016).

Research Questions

The following questions are the basis of the study:

1. To what extent are African American men Receptive to Community-based Psychoeducation as an alternative to Counseling?
2. To what extent is Receptivity toward Community-based Psychoeducation as an alternative to Counseling accounted for by Ethnic Identity Salience, SES, and Attitudes toward Seeking Mental Health Treatment among African American men?

Significance of the Study

There are documented racial disparities in the healthcare system as it pertains to mental health treatment among African American men. By recognizing community-based psychoeducation as a feasible and potentially culturally relevant mental health intervention, this study can fill a gap in the existing body of literature. Through recognizing psychoeducation as a preferred mental health intervention among African American men, mental health information and mental health literacy can become more accessible to African American men (a drastically underserved population). To this end, determining receptiveness to community-based psychoeducation is a useful step toward empowering this population with greater self-understanding. Having necessary psychological information that can improve the daily functioning of those with mental health concerns and their supporters is pivotal for a collectivist community such as this one. Practitioners will also benefit through being provided with information about 1) how ethnic identity, socioeconomic factors, and attitudes toward seeking mental health treatment predict receptivity to community-based psychoeducation, and 2) how unique cultural and racial considerations impact mental health treatment preferences.

Further, as a result of this study, future studies will be better informed to explore:

- How ethnic identity mediates changes in African American male clients' attitudes toward seeking mental health treatment
- Why African American men have comparable or more positive views of Mental Health Treatment before seeking services despite the implied reality of having to talk to an outgroup member

- How identification with the African American ethnic experience stimulates divergent attitudes towards behaviors that the dominant culture has traditionally considered restorative and prosocial (such as seeking mental health treatment)
- If ethnic identity salience contributes to resilience and relational well-being among African American men
- If African American culture divergently endorses and reinforces receptivity to alternative mental health interventions
- How psychologists might differentially promote mental health among members of the African American community through culturally relevant treatment modalities

Definition of Terms

Adult Attachment: the idea that the bonds between children and primary caregivers are motivated by the same mechanism that develops bonds between adults (Fraley, 2010), and thus that as a result of earlier socially embedded development, adults demonstrate internalized patterns for relating to others (Fraley, 2010; Trembley, 1996).

Attachment Style: how an individual uses affective experience to form bonds that ultimately influence their emotional and physical well-being. It functions throughout the lifespan as a behavioral system to assure the formation of reliable relationships that provide psychological and physical protection, affect regulation, and even reproductive success (Sable, 2008).

African American: a descendant of slaves from the African diaspora trafficked through the transatlantic slave trade (typically presenting with phenotypically Black features; i.e., fuller facial features and a darker complexion, etc.), and/or someone who has come to racially and ethnically identify with the experience of those descendants in the U.S. via

their subsequent immigration (as an individual of African descent) to the United States (Alexander, 2010; DuVernay, 2016; Lynch, 2019; Wilson, Hugenberg, & Rule, 2017).

Attitudes Toward Seeking Mental Health Treatment: The extent to which individuals are open to admitting that they have a psychological problem and to the possibility of seeking professional psychological help; the extent to which individuals believe they are willing and able to seek psychological help; the extent to which individuals are concerned about what significant others would think if they discovered that the individual was receiving professional help for psychological problems (Mackenzie et al., 2004 taken from McClure, 2010).

Counseling: “is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (American Counseling Association, 2019).

Culture: Learned and shared values, beliefs, and behaviors of a group of interacting people; which are shared but distinct for each group member, and transmit from generation to generation (Matsumoto, 1996)

Discrimination: “The unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex” (Oxford English Dictionary online, 2018b).

Disenfranchisement: “The state of being deprived of a right or privilege, especially the right to vote” (Oxford English Dictionary online, 2018a).

Ethnic Identity: A social category that has been constructed based on phenotypical characteristics, traditions, and typically a shared cultural/social experience (Bracey et al., 2004).

Ethnic Identity Salience: The extent or depth to which an individual belongs to or identifies with a social category that has been constructed based on phenotypical characteristics, traditions, and typically a shared cultural/social experience (Bracey et al., 2004).

Ethnicity: a connectedness based on commonalities (such as religion, nationality, region, etc.) where specific aspects of unique patterns are shared and where transmission over time creates a shared history (Pinderhughes, 1989).

Hypermasculinization: a “sociological term denoting exaggerated forms of masculinity, virility, and physicality,” whose “archetypes abound in the mass media” (Encyclopedia Britannica, 2018). “Scholars [suggest] the hypermasculine personality: (1) the view of violence as manly, (2) the perception of danger as exciting and sensational, and (3) callous behavior toward women and a regard toward emotional displays as feminine” (Encyclopedia Britannica, 2018).

Literacy: typically thought of as the ability to read and write, though it generally refers to competence or knowledge in a specified area (Cambridge Dictionary, 2019)

Mental Health Literacy: “knowledge and beliefs about mental disorders which aid their recognition, management or prevention,” which also extends to information about prevention, self-help, and first aid (Jorm, 2012)

Mental Health Treatment: professional intervention used for remediating psychological issues. There are numerous types of mental health treatment (Newman, 2020).

Power: the unfair distribution or disproportionate capacity by the dominant white/Anglo group to make and enforce decisions (Byrd & Clayton, 2001).

Psychoeducation: “the process of providing education and information to those seeking or receiving mental health services, [including] people diagnosed with mental health conditions (or life-threatening/terminal illnesses) and their family members” (Good Therapy, 2019). The information itself may act as an independent form of mental health intervention.

Race: A social construct that functions to classify individuals based on phenotypic/physical differences and similarities, most often involving skin pigmentation, head and body shape and form, facial features, stature, and the color, distribution, and texture of body hair (Brown, 1993; Gallardo, 2014; Pinderhughes, 1989).

Racial Microaggressions: “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007).

Racial Identity: “sense of group or collective identity based on one’s perception that he or she shares a common heritage with a particular racial group” (Chavez & Guido-DiBrito, 2001).

Racism: Prejudice + Power = Racism. It is prejudice with a tendency to use societal superiority as a solution to discomfort about differences (Pinderhughes, 1989).

Relational patterns: the unique recurring dynamics that manifest in and are evoked by interaction. They are the enactment of intrapsychic experience (Critchfield & Benjamin, 2010; Trembley, 1996). It is one’s recurrent disposition towards and interpersonal modes of interacting with others based on internalized aspects of one’s identity. These aspects include: 1) personality, attachment, temperament, 2) social, cultural, or societal

interactions, and 3) areas of personhood as it pertains to Age, Disability, Religion and Spirituality, Ethnicity, SES, Sexual Orientation, Indigenous Heritage, Nationality, and Gender.

Self-Disclosure: An individual's ability and comfort in divulging distressing or personal information (Vogel, Wester, & Larson, 2007)

Socioeconomic Status: "social standing or class of an individual or group. It is often measured as a combination of education, income, and occupation" (American Psychological Association, 2018d). It often highlights issues of access, power, privilege, and control (American Psychological Association, 2018d).

Limitations

The study utilized a quantitative survey design to explore ethnicity, SES, attitudes, receptivity, and African American men, all of which are nuanced areas. While the study considered a new way of approaching the intersection of these variables and their implications for mental health intervention, the study did not glean the richness of the variables to the full extent that might have been possible if a qualitative approach was employed. In this way, a quantitative design was a limitation.

The literature on African American attitudes toward mental health mainly focuses on access, distrust, and stigma. The study's results suggest that this is perhaps to the neglect of factors that may be less historically meaningful, but more impactful today. The reliance on historical explanations over searching for new ones giving the changing current zeitgeist was a limitation of this study.

Due to the novelty of the study, the research could not find an instrument that was feasible and standardized for measuring receptivity to community-based psychoeducation

among African American men. Instead, the receptivity items were compiled based on best practice (Krosnick & Fabrigar, 1997) rather than utilizing an established empirical instrument. Thus, the scale for the receptivity to community-based psychoeducation variable cannot be assumed to be empirically reliable or valid though it is empirically supported. Therefore, the lack of prior research in this area among this demographic was a limitation.

Lastly, the survey did not ask for demographic information about respondents' past or present experience with counseling or mental health intervention, their sexual orientation, or their existing social support. Therefore, how receptivity is related to actual participation with psychological services or engagement in social supports was not assessed. These oversights also limit the study and the conclusions drawn from it.

Delimitations

As it pertains to delimitations, finding a nationally representative sample of the population of African American men can be challenging given their minority and largely disenfranchised status. Thus, it employed a host servicer (Qualtrics) so that their national participant pool generated a panel that reflected the national norms for African American men as it pertains to age and education level.

Additionally, there is a common trend in psychological research of focusing on the traditionally understood reasons for disparities in mental health utilization to the neglect of creating solutions. To combat this issue: this study focuses on assessing the commonly identified factors impacting the mental health treatment of African American men and identifying solutions. This was as a means of broaching the gap in the literature about specific, empirically supported, culturally informed mental health interventions for

African American men. Thus, by including the common scapegoats for disparities in psychological services, the study was able to reduce the likelihood of confounding variables while directly posing alternative issues and solutions.

Lastly, existing research typically studies minorities in comparison to White-reference groups. This study chose to take a partially exploratory approach to assess the variables only among African American men as a means of gleaning within-group information. Thus, by focusing on within-group variations only, the study was better able to flush out nuanced characteristics of the sample that deviated from assumed regularities.

Overview of the Research Methodology

This study adopted a Quantitative, Non-Experimental, survey design. It surveyed a representative sample of the U.S. population of African American men aged 18 or older through a third party online host (Qualtrics) following IRB approval and adherence with various ethical guidelines. Following data collection by the third-party host, data was stored separately from identifying information and password protected. SPSS and AMOS statistical software screened and analyzed the data.

Organization of the Study

This document is organized to simplify the readers' experience and to provide a concise development of the context and content of the study. It consists of five chapters. Chapter 1 is the introduction to the study and presents its scope and relevance. A concise review of the related literature concerning the population, variables, and methodology is provided in Chapter 2. This chapter provides context for the research problem by

considering various ways of interpreting existing literature. It also provides context for the position taken in the study and the variables included. Chapter 3 is a detailed description of the chosen methodology of the study (i.e., research questions and design, population and sample, instrumentation, procedures), which delineates under what conditions and considerations the study was carried out. Chapter 4 details the results of the study by reporting a description of the sample, results by research question, and a summary of the findings. Hence, it provides new information about the research problem and questions. Lastly, Chapter 5 provides an overview, discussion, conclusions, and recommendations as a means of becoming a contributor toward and a platform for future study.

CHAPTER 2

LITERATURE REVIEW

Introduction

As was previously stated in Chapter 1, the purpose of this quantitative study is to examine how ethnic identity salience, SES, and attitudes toward seeking mental health treatment predict receptivity toward community-based psychoeducation (particularly as an alternative to counseling) among African American men. The existing research conveys that the underrepresentation of African Americans among those utilizing counseling and non-emergency mental health services is a multifaceted issue. While further exploration into why they seem to use services less could be beneficial, the goal of this discussion is to explore *why* only to the extent that it relates to exposing means of circumventing barriers. Given the importance of mental health in any community, identifying a culturally specific intersection for change and growth is an essential goal in working with this population. Through a discussion of the socio-historical context, ethnic identity salience, SES, and attitudes toward seeking mental health treatment as it pertains to African American men, this chapter provides a concise review of the literature pertinent to the study's population, variables, and methodology.

Contextualizing African American Men

African American men are a subgroup of the U.S. population. They are a demographic of people who are the descendants of slaves from the African diaspora with

ancestors trafficked through the Transatlantic Slave Trade. The term has also grown to include individuals who racially and ethnically identify with the experience of those descendants in the U.S. via subsequent immigration of individuals of African descent. African Americans have experienced numerous civil rights violations, terrorism, slavery, family separation, media demonization, injustice, forced assimilation, and displacement (Alexander, 2010; DuVernay, 2016; Lynch, 2019; Wilson, Hugenberg, & Rule, 2017) over 400 years.

The Disenfranchisement of African American Men

The experience of African Americans in the United States of America is a unique one that has evolved over centuries. From 1619-1865, the citizenship status of African Americans was categorized by Chattel Slavery (Byrd & Clayton, 2001). During that period, the Transatlantic Slave Trade was abolished, yet to date the slave trade represents the largest influx of Black “immigrants” the U.S. has ever experienced. More accurately, their migration was one of the largest human trafficking expeditions in history. While many discuss this topic as though slavery is merely a matter of historical fact, its implications (as intended; conveyed in the Willie Lynch Letter of 1712) have contributed to family separation, hyper sexuality, hypermasculinization, and the overall demography of the African American community as it exists today.

From 1865-1965, African Americans were citizens with virtually no citizenship rights due to the legalization of segregation and the failure to mandate equal access, resources, and civil liberties. They were essentially freed to nothing, afforded the “opportunity” to attempt to build something out of nothing independently. They were “freed” without possessions, land (which was briefly offered and then seized), or literacy,

many of them with no family or social support. They were denied access to quality (and sometimes basic) healthcare, education, pay, and living conditions, and were often threatened, attacked, or killed for attempting to obtain them (Alexander, 2010; DuVernay, 2016; Riggs, 1987).

From 1965-2001 (and even until 2017), notable progress came through school desegregation, the Civil Rights Movement, the Voting Rights Act of 1965 (Byrd & Clayton, 2001), and the inauguration of the first Black President of the United States of America. These triumphs for the African American community (and the nation) have created platforms for advancement and reform as it pertains to social welfare and civil rights in the U.S. Nevertheless, this progress has not done away with discrimination and institutionalized racism as they exist in the United States of America at various ecological levels.

As was cited in Michelle Alexander's *The New Jim Crow* (2010), the prevalence and pervasiveness of racism in the U.S. have been a matter of "preservation through transformation" (pg. 21). Consider how racism has been able to remain an institutionalized and legal underpinning of society. Its greatest achievements include Slavery, The Three-Fifths Compromise of 1787, Segregation and redlining during the Jim Crow era of the 1950s and 1960s, the "War on Drugs" of Nixon in the 1970s and Clinton in the 1990s, and "Stop and Frisk" and over-policing as mediums for Mass Incarceration in the 21st century (DuVernay, 2016). Through these intentional transformations, racism has been able to thrive both legally and institutionally by disadvantaging minority populations. It has worked even to the extent of reducing their access to due process (via

the 13th Amendment), housing (via “redlining”), education and employment, (Alexander, 2010), which will be expounded upon later in this discussion.

In consideration of institutional racism in the 21st century, the original Jim Crow segregation is a useful type for reference. For example, “Separate but equal” was a well-known mantra of the 20th century. This statement was a demand for a racially motivated division of resources as it pertained to housing, schools, grocery stores, restaurants, restrooms, water fountains, relationships, and a host of other aspects of daily life (Alexander, 2010; Brown, 2008). However, while separation was feasible for mainstream White America and the ever so important White moderate, “equal” was not a reality. This issue of equality played a significant role then and has continued to be an issue in the treatment of minority groups in the U.S.

Literature such as *The Protest Psychosis: How Schizophrenia Became a Black Disease* by Jonathan Michel Metzl (2010) and the aforementioned *The New Jim Crow* by Michelle Alexander (2010), and the award-winning films *13th* directed by Ava DuVernay (2016) and *Ethnic Notions: Black People in White Minds* by Marlon Riggs (1987) denote the evolution of institutionalized and socialized racism. These works depict how racism in the U.S. functions as a catalyst for the ongoing disenfranchisement and dehumanization of African American men. Further, they convey the strategic economic and political targeting, isolation, and debasement of a population. Therein these modern anthologies bring to light disparities in housing, education, banking, healthcare, occupational advancement, civil rights, criminal justice, and a host of other spheres that directly impact the deficits in community advancement and access to resources (i.e., the

crux of oppression) that plague the African American community and disenfranchise African American men.

African American men are continuously met by societal pressures to disassociate with their culture and to assimilate and arrive at an unattainable mainstream standard. This is perpetuated through the guise of overt discrimination and relocation (imprisonment), and covertly through pressures about hairstyle, dress, complexion, keeping up with the Jones', or simply trying not to live up to the stereotypes of a "Buck," a "Coon," an "Uncle Tom," a "Nigger", or a "Menace to Society"). Such culturally embedded prejudices, microaggressions, and discriminatory heuristics lend themselves to systemic injustice and socially embedded power dynamics. The consequences of such ills are evident in unfavorable interactions between African Americans and positively perceived public service and helping professionals. Sue et al. reported:

[...] considerable empirical evidence exists showing that racial microaggressions become automatic because of cultural conditioning and that they may become connected neurologically with the processing of emotions that surround prejudice (Abelson et al., 1998). Several investigators have found, for example, that law enforcement officers in laboratory experiments will fire their guns more often at Black criminal suspects than White ones (Plant & Peruche, 2005), and Afrocentric features tend to result in longer prison terms (Blair, Judd, & Chapleau, 2004).

Research has also indicated that when crimes such as rape, murder, or violence are considered, the presence of danger stereotypes results in a greater attentiveness to Black individuals over White individuals (Donders, Correll, & Wittenbrink, 2008). However, these findings are not surprising given that southern states initially adopted a policing form reflective of slave patrol, which contributes to the over-policing of minorities today (Waxman, 2017). Bearing this in mind, the schism that has long existed between the African American community and the justice system is to be expected. With stark and

compounded realities, there are numerous and unique challenges faced by African Americans as it pertains to existing day-to-day.

Racism Perpetrated by the U.S. Healthcare System

In keeping with the racial zeitgeist of the U.S. and its failure to account for its ongoing oppression of African Americans men, the U.S. health system has acted as a coconspirator of disenfranchisement. The Tuskegee Syphilis Experiment, one of the most infamous atrocities of the healthcare system, was perpetrated against African American men. According to the Center for Disease Control and Prevention (2015), it was a study conducted by the Public Health Service in conjunction with the Tuskegee Institute. It unethically studied 600 African American men void of their informed consent from 1932 to 1972. The study was meant to monitor the effects of administered Syphilis over six months, but continued for 40 years, even after the researchers/physicians discovered a cure in 1946 (i.e., penicillin) (Center for Disease Control and Prevention, 2015). This incident is one of many in which the U.S. utilized minorities as guinea pigs for medical research (Reverby, 2012).

Specifically, as it pertains to mental health, in 1851, Samuel A. Cartwright hypothesized mental illnesses that he thought were unique to “negroes”; i.e., Drapetomania (categorized by a slave fleeing captivity) and Dysaesthesia Aethiopica (a mental illness characterized by laziness among slaves) (Cartwright, 1851). These alleged disorders were direct manifestations of racism aimed at debasing and demoralizing the African American struggle for equality. Later, in the 1960s, with the publication of the DSM-II came the distinction of a paranoid type of Schizophrenia that was at the time seemingly characterized by “masculinized belligerence,” aggression and hostility; an

identification that fit seamlessly well with problematic Black activists and the nations notions of the civil rights movement during that period. The change in the conceptualization of the disorder to fit the zeitgeist resulted in a disproportionate diagnosis of Schizophrenia among African American men (Lane, 2010). These shifts in the conceptualization of mental illness were meant to suit biased ideologies as propagated by the sociopolitical agendas of the period. They are essential points of consideration in understanding the systematic oppression of African American men and the nuanced challenges to providing intervention and treatment planning for this population.

The hypermasculinization, discrimination, dehumanization of African American men has tainted their presence in society and undervalues the importance of their internal experiences and psychological needs. In keeping with the history of offense, media coverage of this population often focuses on aggressive external behaviors to the neglect of their internal experiences, failing to explore the fullness of their individuality and how they relate to others. This is problematic for several interpersonal reasons. First, considering the societal mistreatment of African Americans men, it appears as though society holds an insecure attachment orientation toward them; and this disposition is not without consequence. In response, avoidant and dismissing attachment orientations to others (particularly those of other racial/ethnic groups) may be a culturally reinforced protective factor for African American individuals (Shaffer, Vogel, & Wei, 2006; Robin, 2013; Vogel & Wei, 2005). Subsequently, those who intervene must educate themselves about the unique mental health challenges and risks faced by this population.

Psychological Research on African American Men

Psychological research on African American men focuses on criminal justice issues, intimate partner dynamics, homosexuality, and familial absence and abuse disproportionately. Nevertheless, even those studies suggest the need for further consideration of the unique intersection of race/ethnicity and gender as it relates to the study of mental health within this population.

With the simultaneous increase of racial tension and ethnic diversity in the population following the Obama and Trump presidencies, researchers are tasked with furthering the study of unique inter- and intra-ethnic/racial dynamics (Vakkayil, 2007). Studying how ethnicity shapes self/other dispositions and patterns of interaction is one important yet challenging way of doing that. Relational patterns are the unique reoccurring dynamics that manifest in and are evoked by interaction. They are the enactment of intrapsychic experience (Critchfield & Benjamin, 2010; Trembley, 1996). While the empirical study of relational patterns is still a developing endeavor (Soth, 2013; Smith, 1993), the intersection of race and gender has become an increasingly interesting consideration for psychological research. At the joining of these three domains are the relational patterns of African American men (a stigmatized and poorly represented population in scholarly research).

While some studies focus on the adaptive relational patterns of African American males (such as the one published by Knight in 2014), comparatively little research has been published that study their individual internal experiences via a fundamentally exploratory approach. Even fewer studies consider this population independent of both female counterparts and white comparison groups. In research in the U.S., White (as the

majority) is the normative research sample (Yakushko et al., 2016); this is evident in that research studies that do not give participant racial information typically have predominantly White samples. Thus, through a survey of the existing literature, it is apparent that African American underrepresentation in various facets of American society is paralleled by their underrepresentation in scholarly research.

In their 2016 study, Hall, Yip, & Zarate reported that just over 5% of articles in the *Journal of Culture and Psychology* address racial identity or ethnic identity. They further reported that less than 2% of articles in the *Journal of Culture and Psychology* are on people of color (Hall, Yip, & Zarate, 2016). While these journals represent a small portion of the scholarly research publications that focus on culturally sensitive issues, the findings illustrate the greater issue of multicultural neglect and mistreatment common in psychological research. In many studies, relational variations between men and women are assumed and studied comparatively and independently. However, the same cannot be said of the study of racial/ethnic groups. One population in which the intersection of gender and racial/ethnic identity is meaningful is African American men.

Ethnic Identity Salience

Ethnic Identity is a social category constructed on the basis of phenotypical characteristics, traditions, and typically a shared cultural/social experience (Bracey et al., 2004). Ethnic Identity Salience is the extent or depth to which an individual belongs to or identifies with that social category (Bracey et al., 2004). The inclusion of “Salience” in the terminology has significant implications for research measurement (Nominal v Ordinal or Interval). However, the terms are typically discussed interchangeably, which will be the case in the following discussion. While ethnic identity development is

something many majority culture individuals can overlook, minority culture individuals often go through life with an evolving consciousness of not only their ethnic identity but also of how it interacts with the majority culture. For African Americans, for instance, racial/ethnic identity development is instigated through microaggressions and discrimination, which fosters distrust and division (Behrens, 1997; Cokey, 2002; Miller et al., 2016). This differs for many Caucasian individuals in the U.S. for whom the path to ethnic identity awareness is more easily underexplored, and the path to racial identity development is non-essential to societal advancement (Berry, 1970; Gallardo, 2014).

A Historical Overview of Ethnic Identity

Surging in popular discourse in the 1960s ethnicity has long been both a shaper of geopolitics and collective experiences (Adlparvar & Tadros, 2016),

From political mobilisation that uses the necessity of ethnic homogeneity as the basis for expelling populations of different racial backgrounds, to the conflation of ethnicity with religion (as when people assume Muslims are an ethnic category), and the reduction of complex geostrategic and historic conflicts to 'ethnic strife.'

While society experiences ethnic groups through the lens of the zeitgeist, the internal development of an ethnicity identity is an equally nuanced and reflexive process. Before the work of Jean Phinney, ethnic identity theories focused primarily on ethnic identity development during childhood and adulthood. Forerunner theorists such as Marcia (1980), Erickson, Cross (Cokley, 2002), and Helms aligned their conceptualization with ego theory and social psychology. They proposed that identity developed from crisis to incorporation as a result of exploration, with the conclusion being a commitment to a subjective sense of self and wholeness; this process was thought to be societally impacted and ongoing.

Subsequently, Phinney (1993) developed a three-stage model of Ethnic Identity development. His goal:

Most research on ethnic identity has emphasized the content of ethnic identity, that is, the actual ethnic behaviors that individuals practice, along with their attitudes toward their ethnic group (Phinney, 1990). In contrast, our work has focused on the process of ethnic identity formation, that is, the way in which individuals come to understand the implications of their ethnicity and make decisions about its role in their lives, regardless of the extent of their ethnic involvement.

The first stage in Phinney's model is Unexamined Ethnic Identity. This stage is characterized by a lack of personal evaluation and unawareness, cultivating a greater affinity for the opinions of others. The second stage is Ethnic Identity Search/Moratorium. The second stage is typically initiated by an inciting event that prompts self-evaluation and self-exploration (Phinney, 1992). Hence, an internal dialogue begins. While exploration may be generally positive, it can be detrimental for African Americans who are ushered into it by negative interactions such as discrimination (Brittian, Kim, Armenta, Lee, Umana-Taylor, Schwartz, & Hudson, 2015). The third stage in the model is Ethnic Identity Achievement. An established and secure sense of self characterizes this final stage (Phinney, 1992, 1993). While constructed for adolescents, this model's foundations have proven useful in constructing Ethnic Identity measures that are applicable across age groups and among both bi-racial and single race minorities (Phinney, 1992).

The Role of Ethnic Identity among African Americans

Among African Americans, greater ethnic identity ratings have been indicative of greater competence in social interaction with individuals from other social groups. In a study comparing African American and Caucasian college students, this was attributed to

the lifetime demand on members of the African American community to acculturate and assimilate into mainstream culture (Robin, 2013). According to Robin, within the African American community, those with greater “heterosocial competence” tend to exhibit more positive attachment styles than do their counterparts; they define “heterosocial competence as the social skills that are needed to negotiate and communicate effectively in various social interactions” (Robin, 2013, p. 12).

It has also been found that African Americans tend toward fearful attachment styles and away from preoccupied ones, and toward dismissing and avoidant styles more so than Caucasian individuals (Robin, 2013). One explanation for this is that African Americans, more than other ethnic groups, tend not to follow a nuclear family structure and instead demonstrate extensive kinship networks (National Alliance on Mental Illness, n.d.). This trend is partially a function of slavery’s dismantling of their family structure through family separation. Along with dismissing attitudes toward outgroup members, reliance on in-group members for support may contribute to African Americans with greater ethnic identity salience having more resources for dealing with mental health issues. Their reliance on kinship networks and social resources is a likely factor in why they engage mental health treatment at lower rates, even if they have more positive attitudes toward seeking mental health treatment (Vogel & Wei, 2005).

Additionally, individuals with attachment avoidance tend to devalue the importance of others, experiencing fewer anticipated benefits and more risks (Shaffer, Vogel, & Wei, 2006). Perhaps in context, this devaluing is heightened toward out-group members (counselors included) (Shaffer, Vogel, & Wei, 2006; Vogel, Wester, & Larson, 2007). Similarly, Shaffer et al. (2006) found that fewer anticipated benefits directly

correlated with seeking mental health treatment. Among other things, these findings convey that African Americans with greater ethnic identity salience tend to have more positive attitudes toward seeking mental health services and more “heterosocial competence,” though they may seek mental health treatment less.

The Intersectionality of Ethnicity and Gender Among African American Men

Many characteristics are unique to African Americans, and further African American men given the intersectionality of their ethnicity and sex (Kennedy et al., 2007). Herein, a few of those characteristics will be detailed. The two primary deviations addressed are placement in family structure and social communication norms.

The first unique characteristic discussed is their placement in the family structure (Briscoe, 2000, p 97-122). There is a tendency in African American homes for women to be the head of the home (Riggs, 1987) rather than men, which is somewhat more typical of other American households. Historical data conveys that from the late 1800s to the mid-1900s, the rate of female-headed households in the African American community was due to greater mortality rates among Black men. Contrary to what might be popular belief, it was not due to not marrying, given that until the 1920s though there was a shortage of Black men, they were still married at higher rates than white men (Ricketts, 1989). In fact, female-headed households were at their lowest until the 1950s, at which point there was a drastic increase. From a socio-historical lens, the shift coincides with the Jim Crow era of the 1950s, Nixon’s “War on Drugs” initiated in the 1970s, “black urbanization,” and the origination of “Welfare” (Alexander, 2010; DuVernay, 2016; Ricketts, 1989). This shift in part conveys the necessary function of kinship networks (instead of nuclear families) in the African American community.

A second unique characteristic is communication norms. In communication, African American culture tends to identify animation/emotion as an indicator of credibility. However, such animations among men are less when in mixed groups than when in settings with all in-group members. Additionally, among African Americans, direct verbal communication and body language are interpreted more positively, with subtle/indirect romantic communications from women more likely to be interpreted negatively by male counterparts. Norms for non-verbal cues for turn-taking (i.e., posturing and gesturing), as well as eye contact between listeners and speakers, are markedly different among African Americans as compared to the dominant culture. For instance, among African Americans, the listener makes less eye contact and the speaker makes prolonged eye contact. Touch among friends and children is also greater among African Americans than their European American counterparts (Elliot, Adams, & Sockalingam, 2016); touch among African American men is mediated by issues of hypermasculinity.

Socioeconomic Status and African American Men

Introduction

According to Berzofsky, Smiley-McDonald, Moore, and Krebs (2014),

Broadly, the APA describes SES as the social standing or class of an individual or group, often measured as a combination of education, income, and occupation (APA, 2007). SES also captures an individual's or a group's access to financial, social, cultural, and human capital resources (APA, 2007; National Center for Education Statistics, 2012; Shavers, 2007).

Research has recently surged looking at the correlation between SES, health, and healthcare outcomes. When considering the role of SES in mediating mental health, it is important to consider the various aspects of the domain. Education, Income, and

Occupation are among the most widely used and accepted determinants for socioeconomic status (Sebelius, 2012), and Subjective Social Status is increasingly becoming associated with them (American Psychological Association, 2018c). Consider the following as it pertains to SES:

In most settings and for most populations, high socioeconomic status (SES) is protective,” lead author, Shervin Assari, MD, MPH, told MD Magazine. “For example, high SES protects populations against the risk of depression. However, this seems not to be the case for African Americans, particularly African American men, in whom high SES is found to increase the risk for depression. Researchers have been trying to find the underlying mechanisms behind this counterintuitive phenomenon. (DiSanto, 2018)

Furthermore, the relationship between SES and mental health among African American men is still an area for consideration and research.

African American Men and the Value of Education

Concerning education, a fairly popular narrative purports that African Americans do not believe in or value education (Hipolito-Delgado, 2015). Counter-narratives such as cultural neglect/insensitivity stand in contrast to this ideal. Some have also challenged this narrative by countering that public education (as a medium for the transmission of majority culture) relegates ethnic minority cultures to a position of subservience, disassociating minority students and their cultures from the educational process (Brown, 1993; Hipolito-Delgado, 2015). This dissociation is likely connected to the finding that higher SES (which is often indicative of extended interaction with the education system) is not linked to lower mental health risk among African American men. Through being in an educational system that continuously presents ethnic minorities as inconsequential (i.e., incorporating them only during their designated month), African American students learn that their lives do not contribute to advances in society. Thus, they are covertly

diverted from the learning process. In some ways, African American students may even become isolated as they matriculate through heavily “one-sided and biased” narratives in pursuit of a white-washed American dream (Hipolito-Delgado, 2015).

Another contra narrative exists in the statistics identifying Black women as the most educated group in the U.S. According to The Root, a popular Black publication, “a higher percentage of Black women (9.7 percent) are enrolled in college than any other group, topping Asian women (8.7 percent)” (Helm, 2016) who make up the next highest group. Given the advances of African American women and the multicultural neglect of the public education system, it appears as though an undervaluing of education is not a substantiated explanation for the historically lower (though rising) SES experienced by members of the African American community. Neither is it an explanation for the relative under-representation of African American men in educational institutions of higher learning.

Today, despite continued academic advancement of people of color and nearly 2 million African American men holding degrees, the largest identified challenge to the academic advancement of African American men is the school to prison pipeline. This term denotes the “herd-like,” institutionally reinforced migration of young Black boys from grade school into the U.S. criminal system. As the historical basis of the U.S. economic system (Riggs, 1987), it is not surprising that the movement of Black men through the school to prison pipeline has been a lucrative capitalist endeavor for the U.S. The pipeline process begins as low quality, under-funded schools in urban and low-income areas underdevelop basic literacy and under prepare minority individuals for successful integration into U.S. society (Hipolito-Delgado, 2015). Urban areas remain

disproportionately populated with minorities, particularly African Americans, since the Black urbanization in the 1970s (DuVernay, 2016; Ricketts, 1989). Further, low-income households, which are disproportionately minority households, tend to have fewer economic resources, with Black households having less wealth than their White, same-caste counterparts. It is an issue confounded by racial pay gaps, generational wealth, the housing market, and loan discrimination. With fewer resources and lower quality education, African American males are more likely to have encounters with the criminal justice system, and when they do they experience harsher punishments for the same crimes (Alexander, 2010; DuVernay, 2016). Herein, the education issue amongst African American men is understood to be multifaceted, and a lack of interest in education is a gross over-simplification.

The Income Gap between African American Men and Caucasian Men

Generally speaking, the wage gap between African American men and Caucasian men is about 22%; among African American women the gap is closer to 34% less than Caucasian men and 11% less than Caucasian women (Wilson & Rodgers III, 2016). This difference is a stark contrast, especially when considering that African Americans tend to have more individuals in the household (Diala, 2000). Further, “completing a bachelor’s degree or more will not reduce the black-white wage gap,” considering that income margins between Black men and White men with lesser degrees are minimal (Wilson & Rodgers III, 2016). This wage gap is comparable to 40 years ago, though the gap was smaller in the 90s and then grew again (American Psychological Association, 2018d; Wilson & Rodgers III, 2016). Furthermore, unemployment rates among African

American men are typically double those of their Caucasian counterparts, partially in light of the drastically higher proportion of African American men incarcerated/institutionalized (American Psychological Association, 2018d; Wilson & Rodgers III, 2016).

In keeping, the findings of Hunt and Ray (2012) reported that “Self-employment has become a more potent predictor of Blacks’ SCI [social class identification] over the past several decades,” as there has been documented growth of the Black middle class since the 1970s. In their study of 1,043 people aged 65 – 86, they found that African Americans with higher incomes were among those more likely to engage in “reciprocal instrumental kin exchange” (Fiori et al., 2008). As it related to health,

The John Henryism (JH) hypothesis argues that prolonged high-effort coping with chronic psychosocial stressors may be associated with elevated risk for negative health outcomes among those without sufficient socioeconomic resources. Early JH studies found a significant association between high JH, low socioeconomic status, and hypertension among African-Americans (Bennett et al., 2004).

Other correlations have been found among African Americans between their disproportionate low income and cardiovascular disease. One, in particular, found an inverse relationship among African American men between annual household income and hormones involved in cardiovascular disease (Davis et al., 2016).

Conversely, Williams, Takeuchi, and Russell (1992) found that SES was unrelated to Depression among African Americans, though studies overall do not clearly depict the relationship between mental health and SES. Similarly, in their 2012 study, Gayman, Cislo, Goidel, and Ueno found that SES was insignificant in altering the impacts of self-esteem and social support in remediating stress. However, it was apparent that “non-Hispanic whites experience greater stress-buffering effects from social support

than African-Americans and African-Americans experience greater stress-buffering effects from self-esteem than Cubans and Nicaraguans” (Gayman et al., 2012). Therein, mediators and moderators should not be assumed to be the same crossculturally.

African American Men and Job Accessibility

African American men are underrepresented in Teaching, Law, Science and Technology professions, and a host of other areas. Discrimination, racism, the pay gap, organizational mobility as alluded to in colloquial terms as the “glass ceiling,” as well as occupational risk, all impact the occupational choices and outcomes of African American men. For instance, disproportionate interaction with the criminal justice system presents obstacles to advanced training by reducing access to financial aid and job opportunities. Additionally, the pursuit of the arts (i.e., music and dance) and athletics and business typically place African American men in industries that demand more financial and social risk and capital. These markets, unlike those such as the humanities, have limited accessibility and job security within the markets. Herein, the highlighted reality is that racism (systematic and individual) and societal traditions are unique barriers to occupational advancement for African American men, though they are present in every industry. With the socioeconomic resources necessary to gain access and capital within a field, one cannot advance (Alexander, 2010; DuVernay, 2016; Riggs, 1987).

High socioeconomic status has been found to correlate with the prevalence of Major Depressive Disorder among African American male youths. This is in large part due to their vulnerability to discrimination. Studies on the intersection of socioeconomic status and attachment have found that within-group socioeconomic status differences may be more meaningful than between-group differences. They have also found that

socioeconomic status impacts cognitive, emotional, and behavioral development (Schechter, 2013). Further, “Minority racial groups are more likely to experience multidimensional poverty than their White counterparts (Reeves, Rodrigue, & Kneebone, 2016)” (American Psychological Association, 2018d).

Social Status and African American Men

Social standing is a multilayered issue among African American men. While social standing can be thought of based on Bronfenbrenner’s Ecological Theory (Brown & Lent, 2008), for this discussion, only two general levels will be considered. A directly personal level of social status is community-based, which can be thought of as one’s standing in their family of origin, extended kinship network, social network, and possibly their church and neighborhood. The second level under discussion, which is as important but less ethnically/individually informative, is standing in U.S. society. In the case of African American men, this can include their job, media, and various systems (economic, educational, political, government). For many African American men, there is a shift in language (i.e., code-switching) and power differential when engaging within their community vs. with outgroup members (Byrd & Clayton, 2001; Elliot, Adams, & Sockalingam, 2016). Nonetheless, despite the history of national disenfranchisement, African American men continue to chart unique paths toward both societal and community esteem.

Summary

Conclusively, the American Psychological Association (2018d) summarized the challenges to socioeconomic advancement among African American men well in the following statement:

The historical and contemporary lack of access to equal education, income, and career options has culminated in African Americans being more likely to receive high cost mortgages, less challenging school curriculums, a schizophrenia diagnosis, and as of 2014, the highest percentage of children living in poverty (39%).

Factoring this in with the unique make-up of family structure, kinship networks, and communication norms among African American men, it is apparent that socioeconomic status among African American men is uniquely constructed, multifaceted, and elicits community involvement and support.

Attitudes toward Seeking Mental Health Treatment

For this study, Attitudes toward Seeking Mental Health Treatment includes three elements. First, it has been defined as the extent to which individuals are open to admitting that they have a psychological problem and to the possibility of seeking professional psychological help. Second, it is the extent to which individuals believe they are willing and able to seek psychological help. Third, it is the extent to which individuals are concerned about what important others would think if they discovered that they were receiving professional help for psychological problems (Mackenzie et al., 2004 taken from McClure, 2010). Henceforth, this tri-part definition is what the term will denote.

General Attitudes of the U.S. Population toward Seeking Mental Health Treatment

Researchers have found that many individuals hold positive attitudes toward counseling though these attitudes do not always translate into seeking mental health treatment. In consideration of the discrepancy, it appears as though many factors play into it. Among them (aside from issues of accessibility or negative attitudes) were beliefs that only certain types of issues are counseling appropriate or severe enough to warrant it (Hinson & Swanson, 1993) and that significant figures in their life would not approve (Conner, Koeske, & Brown, 2009; Vogel, Wester, & Larson, 2007; Ward, Wiltshire, Detry, & Brown, 2013). According to Vogel, Wester, and Larson (2007), though participants had positive attitudes towards counseling, they did not believe their issues were severe enough to warrant it. Another factor is that people would generally prefer to talk to a friend or family member (Vogel, Wester, & Larson, 2007), with a counselor being the last option, preferred only before strangers (Hinson & Swanson, 1993). Only once friends and family are not available or able to provide the support desired would many turn to counselors, and even then, some may still not think pursuing treatment is warranted.

Attitudes Among Men toward Seeking Mental Health Treatment

Vogel et al. (2007) found that “men are more likely to be treated for severe psychiatric disorders, and to rate their level of distress as extreme or severe.” Ultimately, they face unique challenges as it pertains to mental health treatment. Due to traditional gender roles, men are more likely to think they will be stigmatized for seeking a counselor. This is related to greater identification with expectations of independence and

control. Therein they may be more likely to abstain from seeking mental health treatment until their distress is dire due to stigma. Additionally, Berger, Levant, McMillan, Kelleher, & Sellers (2005) found that traditional masculinity was a greater indicator of attitudes than was gender role conflict. Researchers have also found that men with more highly masculine attitudes prefer alternatives to traditional counseling (Robertson & Fitzgerald, 1992), while those who score higher on social aspects of personality tended to hold positive views. Further adding to the considerations, Berger et al. (2005) reported age as a predictor for attitudes in that more positive attitudes tended to be held by older men.

Attitudes Among African Americans toward Seeking Mental Health Treatment

Mental Health treatment is a relatively new class of health, and it is widely assumed and believed that African Americans have pre-existing negative perceptions of mental health treatment (Diala, 2000). Their history of abuse and exploitation by the healthcare system and of psychological stigmatization has provided support for this conclusion. However, some studies have shown that attitudes toward mental health treatment within the African American community are dynamic and varied, much more than mainstream speculation suggests (Diala, 2000). For instance, Diala (2000) found that African Americans' views were comparable and sometimes more favorable than Whites prior to use of services and that they “had more negative view after first use if illness persisted.” Additionally, Ward, Wiltshire, Detry, and Brown in their study (2013) found that African Americans “were not very open to acknowledging psychological problems, but they were somewhat open to seek mental health services” (Mental Health America,

n.d.). This finding calls into question the assumption that African Americans hold more negative pre-existing attitudes toward seeking mental health treatment.

Mishra, Lucksted, Gioia, Barnet, and Baquet (2008) studied African American's preferences for engaging with mental health services. They identified credible sources for conveying mental health information as indicated by participant reports. The respondents deemed the following credible sources: experts, celebrities, those who look like them (are from their ethnic background), individuals they know, and individuals who can relate/have experienced their mental health concern. In consideration of these preferences, perhaps community members are preferable in part because they are more likely to be credible in multiple domains (i.e., look like them and be someone they know). In five focus groups conducted at three churches and a university, the 42 African American respondents conveyed those preferences, along with that health information and/or services are better received if:

1. conveyed in a reassuring manner
2. conveyed by a credible source
3. they are accessible

The participants' self-reports also presented two categories of barriers to receiving mental health services/information: 1) Stigma and 2) Historical and current racism as an aspect of stigma and as an additional barrier. Overall, the study findings suggest that cultural and traditional beliefs and racial dynamics impacted the participants' preferences for seeking mental health services and information (Mishra, Lucksted, Gioia, Barnet, & Baquet, 2008).

Overall, research suggests a widely underreported openness, as well as underserved need. As it pertains to need, Snowden (2012) reported that African Americans are overrepresented in their use of emergency resources and psychiatric hospitals and underrepresented in their use of mental health services. These findings pertained to those “in need” and the general population (Diala, 2000), and suggest that healthcare disparities and the underuse of services evident in the African American community are not due to lesser need. On the contrary, Snowden (2012) further postulated that as a minority group, “African Americans likely have greater mental-illness-induced disease burden.” He continued, “African Americans with mental illnesses experience them for longer periods than do other populations,” and their experiences of mental illness are “especially disabling” (Mental Health America, n.d.; Snowden, 2012). His conclusion is not an uncommon one as medical researchers and practitioners are increasingly coming forward to highlight trauma and distress-induced epidemiological medical issues in minority (particularly African American) communities and populations (Hipolito-Delgado, 2015; Mental Health America, n.d.). The pervasive nature of discrimination in the U.S. and its ongoing effects on the daily lives of African Americans (Sue et al., 2007) provide context to support this conclusion.

Simply put, “access” has a layered meaning for individuals of African descent. There are many institutional challenges, and racial microaggressions that operate at a subconscious level. For African Americans, add to the risks (mental and subsequently physical as alluded to by Robin [2013] and Snowden, [2012]) associated with seeking mental health treatment. This is compounded by African Americans having larger household sizes and fewer economic resources than Whites on average (Diala, 2000).

Taken together with the challenges men face, the healthcare reality is that African American men are markedly underrepresented in both psychological research studies and as participants in counseling services (Brown, 2008; Yakushko, 2016).

Attitudes Among African American Men toward Seeking Mental Health Treatment

Considering the various factors that impact the attitudes of men and those that impact the attitudes of the African American community along with the socio-historical context, the intricacies of the attitudes of African American men emerge. Consider with them the challenge hypermasculinity poses to the African American male population. Existing literature conveys that counseling may be aversive to men and African Americans, and to African American men as a matter of certainty. The reality is that underuse of mental health services in the African American male community is impacted by culture, attitudes (their own and others), access, discrimination, distrust, and kinship networks (Lindinger-Sternart, 2015; Scheppers, Dongen, Dekker, Geertzen, & Dekker, 2006; Vogel et al., 2007). While some issues have historical underpinnings, issues such as hypermasculinity and the inherent assumption of aggression are threatening to the personhood of this population

The Race of the Mental Health Professional and African Americans' Attitudes toward Seeking Mental Health Treatment

Several studies have found evidence to suggest that the race of the mental health professional is a significant factor in the African American community for seeking mental health treatment. Meyer and Zane's (2013) study of 102 participants found that ethnic minority clients were more likely to report racial and ethnic issues as more

important. Ward (2005), in a qualitative study of African American clients in a community counseling agency, found that among African American participants, race/ethnicity was reportedly ranked above all other identified variables during the first session. Diala (2000) reported that individuals tend to prefer a mental health professional who is of their same racial/ethnic group, and further that among African Americans who were mistrustful of whites, the race of the counselor was significant. Not only did these respondents report less willingness to receive mental health treatment from a White clinician, but they also described having less satisfaction with the actual therapeutic experience; the Institute of Medicine (2002) had similar findings. In their 2007 study, Vogel, Wester, and Larson found that within the African American community, counselors are likely to be seen as outsiders who are not a part of the approved kinship network. Herein it is conveyed that having a counselor of another race may be interpreted as an associated risk of seeking mental health treatment, and consequently, a deterrent.

Ethnic Identity, Socioeconomic Status, Attitudes toward Seeking Mental Health Treatment, and Receptivity to Community-based Psychoeducation

As has been communicated throughout this discussion, there is a high prevalence of mental health issues in the African American community yet a low rate of interaction with the mental healthcare system. According to the American Counseling Association, the purpose of counseling is as follows: “Professional counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (American Counseling Association, 2018). Further, according to the American Psychological Association (2018a), “Counseling psychologists help people with physical, emotional and mental health issues,

improve their sense of well-being, alleviate feelings of distress, and resolve crises” (American Psychological Association, 2018a). They present “Counselors and Counseling Psychologists as agents for change and advocacy” (American Psychological Association, 2018a).

If the governing bodies assert that the purpose of counseling is to support individuals, families, and groups (such as African American men) in meeting their emotional and mental health needs and improving their well-being; if existing research indicates that counseling is not adequately meeting the need, and quite possibly is not culturally equipped to do so at the scale needed; rather than continuing to ask why or utilize the same ineffective method, counselors and counseling psychologists may do well to consider how their professions might explore alternative paths to empowerment.

The Role of Psychoeducation in Mental Health Treatment

Psychoeducation is the process of teaching those receiving mental health services and their families about mental health and relevant information. Psychoeducation itself can be an intervention though it is common in conjunction with other interventions/services (Good Therapy, 2017). Psychoeducational topics range from basic information about reducing mental health stigma to information about human cognition and behavior, to information about specific disorders, prevention, treatments, and receiving accommodations (Brown & Lent, 2008). Psychoeducation is useful for family intervention (National Alliance on Mental Illness, 2018) and developing coping skills (Crist, 1986). As an intervention type, psychoeducation is not specific to counselors though the terminology is most prevalent in the counseling profession. The same health

education elements are present in other health settings, including among physicians (Swaminath, 2009). Just as the history and evolution of Counseling have adapted to support the mental health needs of common the citizen (Brown & Lent, 2008), so might psychoeducation be utilized as a matter of public welfare and prevention in the years to come. Today, psychoeducation is a useful and meaningful part of increasing motivation for change and receptivity to mental health services (Haynes et al., 2017).

The Role of Psychoeducation in Increasing Access to Mental Health Information

In consideration of the purpose of counseling and the nature of African American culture and traditions, Psychoeducation emerges as a viable mode of intervention. Consider that within the African American community there are kinship networks and a greater sense of collectivism than is present in the majority culture. According to the National Alliance on Mental Illness (2018): “Family Psychoeducation can often help ease tensions at home, which can help the person experiencing the mental illness to recover.” Further, according to Crist (1986), “Psychoeducation is a viable resource alternative delivery model for developing life skills among those with chronic mental health problems.” Similar findings were reported by Lukens and McFarlane (2004), Alvidrez et al. (2005), and Good Therapy (2019).

Given the prevalence of kinship networks and collectivism within the African American community, there are meaningful relationships between individuals, and there is a greater reliance on those relationships for coping and resilience. These supports can operate as credible sources for the exchange of mental health information. While counseling is the establishment of a therapeutic relationship through which a healing of

sorts is mediated, it is possible that these healing relationships already exist within the African American community between in-group members. However, an important distinction exists in that community-based relationships within the African American community lack the training, knowledge-base, and resources of the mental health professional. The focus then shifts to how the knowledge of the professional might be dispersed within the community in a way that naturally draws on the existing, established relationships.

In recent years, with the growth of literature on resilience, there has been an increased acknowledgment of the culturally embedded resources for managing distress as it exists within the African American community. The study detailed in this document presents this information from the lens of recognizing that it is important for counseling and counseling psychology professionals to progress beyond acknowledging deficits to finding and enacting alternative methodologies that equip African Americans through utilizing their naturally existing strengths. In keeping with this sentiment, in their study of 50 stakeholders in the African American community in the rural south, Haynes et al. (2017) concluded,

Strategies that include conceptualizing mental illness as a normal reaction to stressful living environments, the use of community-based mental health services, and providing mental health education to the general public may improve use of services in this population.

Community-based Intervention: Changing the *Why* to a *What If...*

African American men have dynamic stances on counseling and mental health services. What is consistent in the research is that Counseling and mental health are traditionally understood by African American culture as being meant for “them” rather

than “us” (Hinson & Swanson, 1993; Hipolito-Delgado, 2015; Vogel, Wester, & Larson, 2007). The mere fact that mental healthcare has become a matter of public policy (Alexander, 2010; Pearl, 2015) conveys its susceptibility to issues of marginalization. From a cultural sense, Counseling and traditional mental health interventions may be less suited to address the needs and challenges of African Americans than to address the needs of majority group members (Hinson & Swanson, 1993; Hipolito-Delgado, 2015; Yakushko et al., 2016). The “common” mental health stressors of African American men, though not completely different, are likely to vary from those of “the common U.S. citizen” the Counseling discipline has evolved to serve. Consequently, as a matter of public health, it is pertinent that mental health initiatives become less focused on making counseling feasible (as the esteemed path to mental health) and more on making mental health feasible (by whatever avenues are best suited to do the job). What would the result be if rather than contemplating *Why aren’t they going to counseling?*, as a means of identifying weaknesses, the conversation changed to *What if more treatment modalities were culturally congruent? What if the mental health community invested in the mental health of African American men by recognizing the value of what the community already has to offer them?*

Using the Institutions African American Men Already Use to Deliver Services

An important consideration in examining receptivity to community-based psychoeducation is defining the basis of community. To address this issue, one must clarify the places/institutions that are cornerstones of the African American community in the U.S. The most commonly established cultural hubs for the dissemination of African

American male culture are barbershops, churches, and community-based gyms and recreation centers (Alvidrez, Areán, & Stewart, 2005; Hankerson et al., 2015; Kreuter et al., 2003). Each of these locations already satisfies a unique ethnically salient need, which makes them a candidate for incorporating psychoeducation (Hankerson et al., 2015). For instance, barbershops meet explicit grooming needs and implicit communal needs. They provide opportunities for social engagement and a sense of belonging and community with in-group members. For many African American men, frequenting the local barbershop is a rite of passage experience and weekly ritual. Additionally, Black barbershops are one of the few places known for being a forum for open and free conversation, settings in which African American men can voice their opinions as a majority (Shabazz, 2016).

Another institution that is paramount in the African American community is the church. Like barbershops, churches and religious gatherings provide a sense of belonging, as well as a religious experience. Local churches in the African American community tend to be in low-income areas, providing resources for economic and social support, as well as messages of hope, strength, and a connection to God in the face of societal adversities. Further, these churches also tend to have male pastors, thereby presenting a narrative of African American men as positive and moral. Rooted in both celebration and suffering, these institutions transmit messages of resilience, and sometimes of stigma. African American churches have been charged in the past with stigmatizing mental illness as demonic possession or mental fragility, and due to issues of distrust. Only in more recent years with the growth of mental health awareness has this stigmatizing practice become less common in the African American community

(Doehring, 2015; Hankerson et al., 2015; Markens, Fox, Taub, & Gilbert, 2002; Pinderhughes, 1989; Soaries, Jr., 2010; Vogel, Wester, & Larson, 2007).

As a final setting for detailed examination, local community and neighborhood youth centers in the African American community fulfill needs for recreational activity, social standing, community enrichment, and psychological and public aid (Best, 1992). For instance, the Boys & Girls Club of America (2018) is a national organization whose mission is, “To enable all young people, especially those who need us most, to reach their full potential as productive, caring, responsible citizens.” While such clubs may appear to be purely social, these entities often keep inner-city African American youths from less constructive after school and weekend alternatives. In addition to providing settings for engaging in sports such as basketball, they also often provide tutoring and other classes such as dance and computer that teach lifelong skills. These types of institutions are especially valuable for low income and inner-city African American youths that might not otherwise have opportunities to engage in non-school funded extracurricular activities. The role in these centers in fostering the growth of African American men is evidenced in that the Boys & Girls Club of America mostly serves males (55% of participants) with African Americans being their second largest ethnic population making up 27% of those serviced (Boys & Girls Club of America, 2018).

Each of the aforementioned hubs enables African American men social support, a sense of belonging, and encourages community and identity development through seeing other Black men in positions of leadership, entrepreneurship, and “giving back” (Charles, 2005). As cornerstones, these settings are trusted sites in which they can be themselves and be nurtured in ways the only other place they can is at home. Further, as trusted

gatekeeper establishments, these sites play an important role in disseminating and dictating cultural standards and norms. In light of this, as “community members” and culture bearers, these institutions are mediums primed for relaying health and public service information that promotes community advancement (Dana, 2002; Hankerson et al., 2015; Markens et al., 2002).

Methodological Considerations

Among African Americans, there is a need for the mental health profession to develop methods for making mental health treatment accessible and culturally meaningful. Further, there is also a need for researchers to develop divergent and culturally informed methods for assessment (Vakkayil, 2007).

There are methodological issues that exist in the present body of literature as it pertains to studies informed by the relational dynamics of this particular population. As outlined in an article composed by Yakushko et al. (2016), “the field’s continued reliance on quantitative methodologies” is among them. Additionally, many studies on relational patterns and dynamics rely on archival information from questionnaires and inventories such as the Structural Analysis of Social Behavior questionnaire (SASB) as did that of Critchfield & Benjamin (2010). In their study, they analyzed the results of two samples (college and university students and clinical patients), and based on the results, concluded the SASB model is an effective measure for assessing copy processes (or relational patterns). While their results support the use of the instrument, racial/ethnic demographic information was not reported. Thus, in their study and many others, the suitability of instruments not normed on minority populations (and further, not created for minority populations) is a major concern (Brown, 2008). Herein the matter of a tendency toward

quantitative measures is confounded by the lack of study, attention, and instrumentation fitted for studying minority populations from a non-Eurocentric framework (Yakushko et al., 2016). Thus, identifying measures developed for African Americans is an important step in multicultural research.

As mentioned, an additional consideration in light of the Eurocentric focus of related research is the tendency to use white comparison groups as a reference point in studies of minority populations. In so doing, researchers potentially limit the richness of findings and the uniqueness of under-studied groups, and simultaneously set up Eurocentric norms as a general research standard (Dvorakova, 2016; Vakkayil, 2007). Alternatively, if future studies adopt qualitative and culturally derived and sensitive designs, then the unique characteristics and patterns of minority groups such as African American men will become understood in greater depth and better represented in the literature. As an aside, “better representation” requires consideration of the population’s mental states as it pertains to relational patterns as meanings rather than as behaviors (Yakushko et al., 2016). Instruments should consider the nuanced realities of culture in so much as they do the primary variables being examined.

Overall Analysis and Critique of the Literature

Overall, the literature illustrates that the underrepresentation of African American men among those utilizing counseling and non-emergency mental health services is a multidimensional issue (American Psychological Association, 2018d; Lindinger-Sternart, 2015; Scheppers et al., 2006; Vogel et al., 2007). While further exploration into why they utilize services less would likely be beneficial, the discussed literature informs practical solutions to the issue in a way that is destigmatizing the population under evaluation.

Through a discussion of the socio-historical context, ethnic identity salience, socioeconomic status, attitudes toward seeking mental health treatment, and community-based psychoeducation as an alternative to counseling as it pertains to African American men, there was a concise review of the literature pertinent to the study's population, variables, and methodology.

Overall Strengths and Contributions of the Literature

The research identifies African American men as a subgroup of the U.S. population with a unique socio-historical experience. There is a wealth of information about the evolving citizenship of African American men in the U.S., shifting from slave to citizen to inherently criminal in large part due to institutional racism (Alexander, 2010; DuVernay, 2016; Riggs, 1987). This readily and widely available information provides a useful and broad context for understanding African American men and includes essential information about their ethnic identity salience, SES, attitudes toward seeking mental health treatment, and their underexplored receptivity to community-based psychoeducation as an alternative to counseling. Researchers should troubleshoot the issue of underuse, using future studies to explore how the uniqueness of this population lends itself to noncontemporary mental health intervention modalities. This literature review discusses viable options: community-based intervention, psychoeducation, and psychoeducation reconceptualized as mental health literacy. This three-part solution suggests a feasible treatment alternative as a basis from which future studies can build.

Overall Weaknesses and Gaps in the Literature

Contributions and strengths aside, there are a few marked weaknesses and gaps in the literature. First, in their 2016 study, Hall, Yip, & Zarate reported that just over 5% of articles in the *Journal of Culture and Psychology* address racial identity or ethnic identity. They further reported that less than 2% of articles in the *Journal of Culture and Psychology* are on people of color (Hall, Yip, & Zarate, 2016). This speaks to the general underrepresentation of this population in scholarly research. Researchers' should be more attentive to addressing race/ethnicity, and of including minorities in their empirical studies.

Second, as was mentioned as a methodological consideration, in research in the U.S., White (as the majority) is the normative research sample (Yakushko et al., 2016). This is evident in that research studies that do not give participant racial information typically have predominantly White samples with Eurocentric lenses. Researchers should remove white reference groups, and should utilize qualitative designs when possible to take an exploratory approach toward assessing this population.

Third, research on African American men tends to focus on group stigmas, deficits, and antisocial behaviors to the neglect of individual internal experiences. This makes it particularly challenging to find measurement scales suitable for evaluating internal processes within this population, and exploring nuanced individual characteristics quantitatively. Future studies should focus on creating and validating measurement scales normed on minorities rather than revised for them.

Fourth, research suggests a widely underreported openness to mental health treatment, as well as an underserved and greater need (Diala, 2000; Mental Health

America, n.d.; Snowden, 2012). This underreporting could be due to misattributing underuse to negative views rather than feasibility or other external barriers. Researchers should utilize existing studies to inform theory and variable selection, but be wary of making assumptions about attitudes based on past findings as attitudes tend to shift with the times. While these weaknesses take away from the richness of data available on African American men and shape a narrow understanding of them that is too heavily reliant on historical findings and white norms, the existing body of literature is still substantive.

CHAPTER 3

METHODOLOGY

Introduction

This chapter describes the research methodology used to examine how ethnic identity salience, SES, and attitudes toward seeking mental health treatment relate to and predict receptivity toward community-based psychoeducation among African American men in the United States. This study used a quantitative, non-experimental survey design. The dependent variable was receptivity to community-based psychoeducation, while the independent variables were Ethnic Identity Salience, Socioeconomic Status, and Attitudes Toward Seeking Mental Health Treatment. This chapter provides the research questions, type of research, population and sample, and definition of variables. It also includes instrumentation, data collection procedures, and data analysis.

Research Questions

1. To what extent are African American men Receptive to Community-based Psychoeducation as an alternative to Counseling?
2. To what extent is Receptivity toward Community-based Psychoeducation as an alternative to Counseling accounted for by Ethnic Identity Salience, SES, and Attitudes toward Seeking Mental Health Treatment among African American men?

Research Design

A quantitative, non-experimental survey design was used to examine the relationship between Ethnic Identity Salience, Socioeconomic Status (exogenous variables), and Attitudes Toward Seeking Mental Health Treatment (exogenous and endogenous) and Receptivity Toward Community-based Psychoeducation (the dependent, endogenous variable). A Quantitative, Non-experimental design was chosen because it allows the researcher to test the questions and hypothesis via structured statistical evaluations without the manipulation of conditions, thereby drawing from naturalistic observations (Creswell, 2014). The chosen design type allowed for data collection from a broad array of respondents (which increases generalizability) in a timely and resource-efficient manner with researcher bias in data collection moderated (Creswell, 2014). Descriptive questions and rating scales were used to collect data that allow for testing the questions.

Structural Equation Modeling was selected as the primary mode of data analysis to assess the relationship between variables as it relates to latent constructs. Structural Equation Modeling combines a measurement model (typically the instruments and items used to collect the data) with a structural model (the nature of the relationship between items/instruments) to develop a model that is representative of the interaction between latent and observed variables. In this way, the hypothesis was tested in terms of how well the predicted model fit the observed model (Meyers, Gamst, & Guarino, 2013).

Population and Sample

Description of the Population: For this study, the inclusion criteria for the representative sample were adult African American men from around the United States

who were at least 18 years of age. According to the U.S. Census Bureau (2017), 14.6% of the U.S. population was Black or African American, and 13.6% is Black or African American only (does not identify as multiethnic or multiracial). According to their 2013 report, 48% of the Black population was male. Taken together at the time of the study, one could estimate that about 7% of the U.S. population was Black or African American and male, and about 6.5% was Black or African American only and male.

Black or African American. A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black or African American," or report entries such as African American, Kenyan, Nigerian, or Haitian (U.S. Census Bureau, 2017).

For this study, the distinction between Black and African American was an important one, as the U.S. Census data used Black is an umbrella term. There was no report specifically for the population of African Americans as a distinct ethnic group within the Black racial category. However, based on the statistics it was reasonable to estimate that based on previous years' census data, African American men (as defined by this study) made up less than 6.5% of the total U.S. population, or fewer than 21.2 million people in 2018 (Department of Economic and Social Affairs, Population Division, 2017 Revised; U.S. Census Bureau, 2013, 2017).

Sampling: Convenience sampling was used to recruit African American men across the country. Since the population size for African American men was large with an estimate of fewer than 21,239,839 individuals in the population, the sample size required a minimum of 271 respondents for CI₉₀, 385 respondents for CI₉₅, or 664 respondents for CI₉₉ (Qualtrics, 2018). Data collection used "Qualtrics, which is subscription software for collecting and analyzing data for market research, customer satisfaction and loyalty, product and concept testing, employee evaluations, and website feedback. Their samples

come from traditional, actively managed market research panels” (Featherson, 2018, p. 78). This study intended to collect data from 450 participants to ensure a statistically significant effect size at CI_{95} . The target audience included adult males 18 and above, who identified as African American.

Definition of Variables

This study of African American men’s receptivity to community-based psychoeducation looks four primary variables. The conceptual, instrumental, and operational definitions of the variables to be included in this study are outlined hereafter.

Ethnic Identity Salience

Ethnic Identity Salience was conceptually defined as “the extent or depth to which an individual belongs to or identifies with a social category that has been constructed on the basis on phenotypical characteristics, traditions, and typically a shared cultural/social experience” (Bracey et al., 2004). The instrumental definition of Ethnic Identity Salience was the MEIM (Phinney, 1992). Operationally, it is 15 items in total. A 12-item portion of the scale utilizes 4-point Likert scales to measure ethnic identity salience. The responses range from 1 (strongly disagree) to 4 (strongly agree). The other three items require the respondent to select their ethnicity from nominal categories; this was helpful in screening and gathering demographic information and descriptive statistics about the sample. The mean for the 12 Likert scale items was then calculated by summing responses to the 12 items and dividing by 12 for a final score.

Socioeconomic Status

Socioeconomic Status was conceptually defined as social status along with educational, occupational, and income levels. The instrumental definition was the Sociodemographic Questionnaire (MacArthur Network on SES & Health, 2008), which is a 12-item questionnaire with two pictorial items containing ladders. The first ladder is indicative of traditional socioeconomic (standing in the U.S.). The second ladder pertains to one's standing or position in their community (MacArthur Network on SES & Health, 2008). The study utilized a subset of the instrument with an expanded range for household income that better corresponded with Pew report socioeconomic and income ranges. Operationally, it utilizes multiple-choice, rating scales, and fill-in-the-blank.

Attitudes toward Seeking Mental Health Treatment

Attitudes toward Seeking Mental Health Treatment was conceptually defined as an individual's disposition toward receiving professional services for mental health issues. The instrumental definition for Attitudes toward Seeking Mental Health Treatment was the IASMHS, 24 item scale (Mackenzie et al., 2004 taken from McClure, 2010) that describe different aspects of Attitude Toward Seeking Mental Health Treatment; 1) psychology openness, 2) help-seeking propensity, and 2) indifference to stigma. The operational definition for IASMHS uses a 5-point Likert scale on which respondents indicate whether they disagree (0), somewhat disagree (1), are undecided (2), somewhat agree (3), or agree (4). Each score is the sum of the answers items for that scale.

Receptivity to Community-based Psychoeducation

Receptivity to Community-based Psychoeducation was conceptually defined as the extent to which individuals are open to or preferring of learning focused mental health models within their community. In this case, it was essentially the extent to which African American men are open to interacting with community-based psychoeducation (especially as an alternative to psychotherapy/counseling, which is a counter-cultural model). This variable was instrumentally defined as a six-item questionnaire on which respondents were to rate their level of receptivity to receiving treatment through various mediums, ranging from psychotherapy to conversations about mental health in their local barbershop. Operationally, respondents were asked to rate their openness on a scale of one-to-five for all items, and then to rank the items in terms of preference (one-to-six).

Instrumentation

The Multigroup Ethnic Identity Measure (MEIM)

Phinney's MEIM (1992) is a 15-item, 4-point Likert scale questionnaire. Response options range from strongly agree (4) to strongly disagree (1). Twelve of the items assess ethnic identity salience, while the other three pertain to ethnic identity as in a more demographic manner. The 12 items which are designed to measure ethnic identity salience do so through two factors/subscales: ethnic identity search which is items 1, 2, 4, 8, and 10; and affirmation, belonging, and commitment which is items 3, 5, 6, 7, 9, 11, and 12 (Roberts, Phinney, Masse, Chen, Roberts, & Romero, 1999). Phinney found overall reliability over to be .80 for Cronbach's alpha for the MEIM.

The Sociodemographic Questionnaire

The Sociodemographic Questionnaire (MacArthur Network on SES & Health, 2008) is a five-page, 12-item questionnaire. This instrument measures both subjective and objective components of socioeconomic status through consideration of education, occupation, income, and social status. It is composed of four subscales: Income (items 6c, 7, 9, 10, 11a), Education (items 3 and 4), Occupation (items 5, 6a, and 6b), and Social/Subjective: (items 1 and 2) (MacArthur Network on SES & Health, 2008). Item 8 does not distinguishably fit into any of the aforementioned subscales (it pertains to assets), so it was not included in the administered/modified version.

The instrument begins with subjective social status questions developed by the network; (see MacArthur Subjective Social Status Scale in the Psychosocial Notebook). The remaining questions assess educational attainment, occupational status, income and assets. Ideally, all questions would be used; if a subset must be selected, items 1, 2, 3, 4, 6b and 6c, 7 and 9 are recommended (MacArthur Network on SES & Health, 2008).

Income, occupation, and education are among the most widely accepted factors that contribute to SES, particularly as it pertains to how socioeconomic status is defined in the United States (Sebelius, 2012). In a study of English-speakers in Brazil, 159 participants completed the instrument, and it was found to have “moderate concurrent validity ($K_{appaw} = .55 - .67$), and good face validity” (Ferreira, Giatti, Figueiredo, de Mello, & Barreto, 2018).

The Inventory of Attitudes toward Seeking Mental Health Services (IASMHS)

The IASMHS is a three-page, 24-item, 5-point Likert scale questionnaire. Response options range from Disagree (0) to Agree (4). The questionnaire assesses three 8-item subscales: The Psychological Openness subscale measures the extent to which

individuals are open to admitting to a psychological problem and to the possibility of seeking professional psychological help; The Help-Seeking Propensity subscale measures the “extent to which individuals believe they are willing and able to seek psychological help” (Mackenzie et al., 2004 taken from McClure, 2010); The Indifference to Stigma subscale measures the “extent to which individuals are concerned about what important others would think if they discovered that the individual were receiving professional help for psychological problems” (Mackenzie et al., 2004 taken from McClure, 2010).

Each subscale is measured by eight items: Psychological openness is items 1, 4, 7, 9, 12, 14, 18, and 21; Cronbach’s alpha = .82. Help-seeking Propensity is items 2, 5, 8, 10, 13 15, 19, and 22; Cronbach’s alpha = .76. Indifference to stigma is items 3, 6, 11, 16, 17, 20, 23, and 24; Cronbach’s alpha = .79. Overall for all subscales, Cronbach’s alpha = .87. According to Mackenzie et al. (2004; taken from McClure 2010), no permission is required to use this instrument.

Receptivity to Community-based Psychoeducation

The 14-item questionnaire has been created based on six settings/relationships (two traditional psychotherapy/counseling and four novel or culturally informed) and research indicating that rating scales are a reliable and valid measure of receptivity (Krosnick & Fabrigar, 1997). Research on this population conveys that African American men are significantly less likely to attend counseling/psychotherapy, but that their need is just as great if not greater (Diala, 2000; Snowden, 2012). However, research also suggests that there are alternative coping forms and cultural practices that cause them to attend other settings more frequently. These alternatives may foster relationships that can act as mediums for the transmission of mental health information (Conner, Koeske, &

Brown, 2009; Doebling, 2015; Hipolito-Delgado, 2015; Luque, Ross, & Gwede, 2014; Shabazz, 2016; Ward, Wiltshire, Detry, & Brown, 2013), (i.e., church, community centers, and barbershops). Drawing from this information, respondents were required to rate their level of openness to receiving treatment through the various mediums: 1) counseling/therapy office (counselor/therapist), 2) local community agency (social worker or volunteer), 3) local church (pastor or other church personnel), or 4) small local businesses (i.e., shop owner, barber), 5) at home or social setting (friends and family), or 6) other: _____. They were asked to rate their openness on a scale of one-to-five for all items, and then to rank the items in terms of preference (one-to-five; six, including other). As was previously stated, rating scales are a standard item type for accessing openness, which is why items were constructed in this fashion (Krosnick & Fabrigar, 1997).

Procedure

As expressed in the policies of the data collection host service, Qualtrics, no participants were harmed in this study. Data was gathered via an electronic survey through Qualtrics host services. Qualtrics invited potential respondents to complete the survey by informing them of its purpose, length, and incentives via their national web-based platform. Eligible individuals were permitted to participate based on the researcher's specifications as to the target population: African American males 18 and older. The subject matter of the survey was not sensitive. However, participants were informed (a) of the nature of the survey before deciding to participate, and (b) that they could discontinue after starting the survey should they so desire. Those who consented via the informed consent page were then administered screening questions as qualifiers

for participation (e.g., age, sex, and race/ethnicity) since the target population was specific to African American men. After completing screening items, the participants were then administered the full survey and thanked for their participation.

Data Analysis

The data was retrieved from Qualtrics online data collection servicer and analyzed through IBM Statistical Package for the Social Sciences, 21st Edition (SPSS21) and AMOS to ensure that the results were validly interpreted. While individuals who are not part of the target population may have attempted to complete the survey, they were not allowed to proceed in filling out the questionnaire, presuming they responded to initial screening questions truthfully. Data screening of responses was performed along with an analysis of descriptive statistics by assessing frequency, means, and standard deviations. As previously mentioned, Statistical Package for the Social Sciences for Windows and Analysis of a Moment Structures (AMOS) 21 computer software programs were used to analyze the survey data. Structural Equation Modeling was conducted to combine factor analysis and multiple regression analysis “to analyze the structural relationship between measured variables and latent constructs” (Structural Equation Modeling, 2020).

Summary

This chapter discussed the method that was employed to conduct the study. The study utilized a quantitative, non-experimental survey design to examine the relationship between Ethnic Identity Salience, SES, Attitudes toward Seeking Mental Health Treatment, and Receptivity to Community-based Psychoeducation. The research questions, design, and data collection and analysis procedures that were exercised for the study were detailed. Additionally, the population and sample were identified, along with

the four scales that were used to measure the variables: the IASMHS (Mackensie et al., 2004), the Sociodemographic Questionnaire (2008), the MEIM (1992), and the Receptivity to Community-based Psychoeducation ratings.

CHAPTER 4

RESULTS OF THE STUDY

Introduction

This chapter details the results of the study through an analysis of the data. The purpose of this study was to examine how ethnic identity salience, SES, and attitudes toward seeking mental health treatment predict receptivity toward community-based psychoeducation (particularly as an alternative to counseling) among African American men. Correlation analysis, regression analysis, and Structural Equation Modeling were used to determine the nature of the relationship between the variables. The research hypothesized that the theoretical model, presented in Chapter 1, will fit the empirical model. Structural Equation Modeling was used to test this hypothesis and analyze the relationship between and among the variables.

Demographic Characteristics

Survey responses were collected from 461 individuals who identified as African American men (males age 18 years or older) (see Table 1). Potential participants who did not identify as African American men were screened out and not permitted to complete the survey. Of the $N = 461$ respondents, 458 (99.3%) reported they lived in the United States of America at the time of survey completion, 450 (97.6%) indicated that they were either born in the U.S. or lived the majority of their lives in the U.S., and 448 (97.2%)

Table 1
Respondents' Demographic Characteristics

Demographic	N	%
Age		
18-24	83	18.0
25-34	127	27.5
35-44	107	23.2
45-54	51	11.1
55-64	45	9.8
65 or older	48	10.4
Currently same sex as sex at birth		
No	13	2.8
Yes	448	97.2
Currently live in the United States of America		
No	3	.7
Yes	458	99.3
Born in the U.S. or lived majority of life in U.S.		
No	11	2.4
Yes	450	97.6
Highest Education Level Completed		
Less than high school degree (10 years of education)	16	3.5
High school graduate (high school diploma or equivalent including GED) (12 years of education)	124	26.9
Some college but no degree (13 years of education)	100	21.7
Associate degree in college (2-year)(14 years of education)	35	7.6
Bachelor's degree in college (4-year)(16 years of education)	119	25.8
Master's degree (18 years of education)	54	11.7
Doctoral degree (21 years of education)	7	1.5
Professional degree (JD, MD) (21 years of education)	6	1.3

indicated that their sex at the time of completing the survey was the same as the sex they were assigned at birth. As it pertains to age: 83 were between the ages of 18-24 (18.0%), 127 were between the ages of 25-34 (27.5%), 107 were between the ages of 35-44 (23.3%), 51 were between 45-54 years old (11.1%), 45 were 55-64 (9.8%), and 48 were 65 years of age or older (10.4%) (see Table 1). Items pertaining to sex, residence, and age

required responses before continuing, and consequently, there were no missing responses for these items.

As it pertains to education level, all respondents reported their highest completed education level. Of the $N = 461$ participants: 140 respondents (30.4%) reported having a high school diploma, the equivalent, or less; 254 respondents (55.1%) reported some college but no degree, an Associate, or Bachelor's degree; 67 respondents (14.5%) reported having a doctoral, masters, or professional degree (see Table 1). The item for highest completed education level required a response before continuing; consequently, it had no missing responses.

The most frequently endorsed participant characteristics were male from birth, age 25-44, residing in the U.S., with education level ranging from either a high school diploma or equivalent to a Bachelor's degree.

Description of the Variables

Table 2 presents a description of the variables, including means, standard deviations, skewness, and reliability coefficients. The Ethnic Identity Salience variable scores were obtained from the MEIM (1992) for the Ethnic Identity Search and the Affirmation, Belonging, and Commitment subscales. The socioeconomic status variable scores were obtained from a modified version of the Sociodemographic Questionnaire (2008) for Social/Subjective, Income, and Education; the Occupation subscale was omitted from the analysis due to 24.5% of respondents reporting their occupation as "not otherwise listed." The Attitudes toward Seeking Mental Health Treatment variable scores were obtained from the IASMHS (2010) for Psychological Openness, Help-seeking Propensity, and Indifference to Stigma. The Receptivity to Community-based

Table 2

Variable and Scale Descriptive Statistics and Reliability

Variable	M	SD	Skewness	#items	Cronbach's α
Ethnic Identity Salience	3.191	.520	-.569	12	.707
Ethnic Identity Search	2.950	.602	-.351	5	.736
Affirmation, Belonging, and Commitment	3.363	.580	-.876	7	.884
Attitude Toward Seeking Mental Health Treatment	54.627	13.760	.536	24	.808
Psychological Openness	14.805	7.00	-.115	8	.790
Help-seeking Propensity	21.994	6.690	-.420	8	.844
Indifference to Stigma	17.829	7.320	-.026	8	.805
Receptivity to Community-based Psychoeducation	2.448	1.545	-.090	10	.767
Openness to Individuals	2.439	.837	-.110	5	.669
Openness to Settings	2.456	.838	-.078	5	.653

Psychoeducation variable scores were obtained from self-report items for Openness (10 rating items) and Preference (2 ranking items).

Ethnic Identity Salience

Ethnic Identity Salience was assessed using the MEIM (1992). Variable scores for the MEIM (1992) resulted from the subscales Ethnic Identity Search (five items in total) and Affirmation, Belonging, and Commitment (seven items in total). The overall variable Ethnic Identity Salience was a composite (12 items in total) (see Table 3). The Ethnic Identity Search subscale used items 1,2,4,8, and 10; it had a reliability of Cronbach's

Table 3
Ethnic Identity Salience Item Level Statistics

Variable	M	SD	Skewness
Ethnic Identity Search	2.950	.602	-.351
1. I participate in cultural practices of my own group, such as special food, music, or customs.	3.09	.841	-.685
2. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	3.09	.801	-.680
4. In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.	3.02	.887	-.597
8. I think a lot about how my life will be affected by my ethnic group membership.	2.92	.891	-.439
10. I am active in organizations or social groups that include mostly members of my own ethnic group.	2.62	.897	-.079
Affirmation, Belonging, and Commitment	3.363	.580	-.876
3. I have a clear sense of my ethnic background and what it means for me.	3.31	.774	-1.012
5. I am happy that I am a member of the group I belong to.	3.49	.687	-1.358
6. I have a strong sense of belonging to my own ethnic group.	3.34	.765	-1.034
7. I understand pretty well what my ethnic group membership means to me.	3.34	.745	-.956
9. I have a lot of pride in my ethnic group.	3.47	.747	-1.447
11. I feel a strong attachment toward my own ethnic group.	3.25	.814	-.929
12. I feel good about my cultural or ethnic background.	3.35	.750	-.982

$\alpha = .736$. Affirmation, Belonging, and Commitment subscale used items 3, 5, 6, 7, 9, 11, and 12; it had reliability of Cronbach's $\alpha = .884$.

Ethnic Identity Salience options ranged from 1 = strongly disagree to 4 = strongly agree, with higher scores indicating greater Ethnic Identity Salience. Overall, Ethnic Identity Salience had a $m = 3.19$ (moderate to high Ethnic Identity Salience), $SD = .52$, and skewness = $-.35$. The Ethnic Identity Search subscale had $m = 2.95$, $SD = .60$, and skewness = $-.35$. Item means for this subscale ranged from 2.62 to 3.09; item standard

deviations ranged from .80 to .90; item skewness ranged from -.08 to -.69. This indicates that the Ethnic Identity Search subscale is normally distributed (given that skewness statistics were between -1 and 1), with respondents on average reporting moderate salience. The Affirmation, Belonging, and Commitment subscale had $m = 3.36$, $SD = .58$, and skewness = $-.88$. Item means for this subscale ranged from 3.25 to 3.49; item standard deviations ranged from .69 to .81; item skewness ranged from $-.96$ to -1.36 . This indicates that the Affirmation, Belonging, and Commitment subscale is not normally distributed (given that skewness statistics were not between -1 and 1), with respondents on average reporting moderate to high salience.

Socioeconomic Status

Socioeconomic status was assessed using a subset of The Sociodemographic Questionnaire (SQ; MacArthur Network on SES & Health, 2008) (see Table 4) and utilizing an expanded income range so that cutoffs would correspond more with Pew statistics for household income and socioeconomic status. The variable scores for The SQ were obtained for Social/Subjective (SS; two items in total), Household Income (one item in total), and Education (one item in total). The Social/Subjective aspect used items 1 and 2 (which together had a Cronbach's $\alpha = .781$).

Education was reported as ordinal data and recorded as ordinal and interval (years of education) (see education levels in Table 1). For years of education, the mean score was 14.29 ($SD = 2.46$); with the lower level corresponding with having a high school diploma, its equivalent, or less (≤ 12 years of education); middle-level corresponding with undergraduate experience or degree (13 to 16 years of education); and upper level denoting a graduate degree (> 16 years of education). Educational categories were further

Table 4
Socioeconomic Status Item Level Statistics

Item	M	SD	Skewness
Slide the rung where you think you stand at this time in your life, relative to other people in your community.	6.41	2.20	-.66
Slide the rung where you think you stand at this time in your life, relative to other people in the United States.	5.89	2.36	-.37
What is the highest level of school you have completed or the highest degree you have received?	14.29	2.46	.63

presented in Table 1, which once again denote that respondents most frequently reported their education level as ranging from either a high school diploma or equivalent to a Bachelor's degree, with a greater leaning toward a college degree. The results also indicate that Education is normally distributed given a skewness statistic of .17 (Table 4).

As it pertains to Social/Subjective ratings, respondents reported their standing in their community and then in the U.S. from 1 to 9; scores from 1 to 3 (low), scores 4 to 6 (middle/average), and 7 to 9 (high). The respondents rated their standing in their community as follows: $m = 6.41$ (middle to high), $SD = 2.20$, and skewness = $-.66$. Their ratings for their standing in the U.S.: $m = 5.89$ (middle), $SD = 2.36$, and skewness = $-.37$. Social/Subjective ratings for both community and U.S. were normally distributed, though there was a significant difference between the ratings (low effect sizes). Respondents reported their subjective standing in their community as statistically higher than their standing in the U.S. (see Table 5).

Table 5

Socioeconomic Status Social/Subjective Rating Paired-Sample Test

	Test Value = 0								
	<i>N</i>	<i>M</i>	<i>SD</i>	CI ₉₅ (mean difference)		<i>t</i>	<i>df</i>	<i>p</i>	ES(d)
				Lower	Upper				
Community	461	6.41	2.20	.339	.693	5.73	460	<.001	.27
United States	461	5.89	2.36						

Household Income was interpreted in two ways; first based on household income range (see Table 6), then based on household income bracket as defined by three categories corresponding with lower, middle, and upper class in keeping with bracketing used in census data and Pew statistics. For household income range, 12 individuals (2.6%) reported: “prefer not to answer.” The series median was \$35,000 - \$44,999, reported by 41 (8.9%) of the respondents. The series mode was \$25,000 - \$34,999, reported by 61 (13.2%) of the respondents. The least frequent household income range selected was \$150,000 or more, which was reported by 31 (6.7%) of the respondents. As

Table 6

Household Income Frequency Distribution

		Frequency	%	Valid %	Cumulative %
Valid	less than \$5,000	37	8.0	8.0	8.0
	\$5,000 - \$11,999	40	8.7	8.7	16.7
	\$12,000 - \$24,999	53	11.5	11.5	28.2
	\$25,000 - \$34,999	61	13.2	13.2	41.4
	\$35,000 - \$44,999	41	8.9	8.9	50.3
	\$45,000 - \$54,999	39	8.5	8.5	58.8
	\$55,000 - \$74,999	51	11.1	11.1	69.9
	\$75,000 - \$99,999	56	12.1	12.1	82.0
	\$100,000 - \$149,999	40	8.7	8.7	90.7
	\$150,000 or more	31	6.7	6.7	97.4
	Prefer not to answer	12	2.6	2.6	100.0
	Total	461	100.0	100.0	100.0

it pertains to income brackets, bracketing was informed by the limits utilized by Pew statistics for determining lower, middle, and higher income ranges. The groupings used were: lower is \$34,999 or less; middle from \$35,000 to \$99,999; upper is \$100,000 or more. Herein, 41.4% of respondents are in the lower household income bracket; 40.6% are in the middle-income bracket; 15.4% are in the upper household income bracket.

Taken together, Social/Subjective ratings, Education levels, and Household income suggest that socioeconomic status within this population is varied. The most common socioeconomic status endorsements were average to high community standing, average standing in the U.S., some college but no degree (55.1%), with the vast majority having household incomes under \$100,000 (82%).

Attitudes toward Seeking Mental Health Treatment

Attitudes toward Seeking Mental Health Treatment was assessed using The Inventory of Attitudes toward Seeking Mental Health Services (IASMHS; McClure, 2010) (see Table 7). The variable scores for the IASMHS (2010) were obtained for subscales Psychological Openness (PO; eight items in total), Help-seeking Propensity (HP; eight items in total), and Indifference to Stigma (ID; eight items in total). The Psychological Openness subscale used items 1-8; it had a reliability of Cronbach's $\alpha = .790$. The Help-seeking Propensity subscale used items 9-16; it had reliability of Cronbach's $\alpha = .844$. The Indifference to Stigma subscale used items 17-24; it had reliability of Cronbach's $\alpha = .805$.

Attitudes toward Seeking Mental Health Treatment options ranged from 0 = Disagree to 4 = Agree, with higher scores indicating more positive attitudes. Overall, Attitudes toward Seeking Mental Health Treatment reported $m = 54.63$ (2.28; undecided

Table 7

Attitudes Toward Seeking Mental Health Treatment Item Level Statistics

	M	SD	Skewness
Psychological Openness	14.81	7.00	-.12
1. Psychological Openness: the extent to which individuals are open to admitting that they have a psychological problem and to the possibility of seeking professional psychological help	2.27	1.48	-.20
4. It is probably best not to know everything about oneself.	2.16	1.40	-.12
7. People should work out their own problems; getting professional help should be a last resort.	2.13	1.37	-.07
9. Psychological problems, like many things, tend to work out by themselves.	2.10	1.39	-.07
12. People with strong characters can get over psychological problems by themselves and would have little need for professional help.	1.71	1.35	.30
14. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.	1.60	1.33	.46
18. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	1.47	1.32	.53
21. There are experiences in my life I would not discuss with anyone.	1.37	1.36	.69
Help-seeking Propensity	21.99	6.69	-.42
2. If I were to experience psychological problems, I could get professional help if I wanted to.	2.90	1.20	-.97
5. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	2.83	1.13	-.76
8. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.	2.80	1.22	-.74
10. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.	2.78	1.13	-.73
13. I would want to get professional help if I were worried or upset for a long period of time.	2.76	1.17	-.73
15. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.	2.74	1.23	-.70
19. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.	2.66	1.25	-.64
22. It would be relatively easy for me to find the time to see a professional for psychological problems.	2.52	1.34	-.48
Indifference to Stigma	17.83	7.32	-.03
3. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."	2.56	1.19	-.43
6. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.	2.36	1.45	-.29
11. Having been diagnosed with a mental disorder is a blot on a person's life.	2.25	1.43	-.18

Table 7—*Continued*

16. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.	2.24	1.45	-.17
17. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.	2.23	1.42	-.18
20. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.	2.19	1.43	-.11
23. I would feel uneasy going to a professional because of what some people would think.	2.10	1.48	-.06
24. Having been mentally ill carries with it a burden of shame.	1.91	1.38	.14

with a slight leaning toward openness), $SD = 13.76$, and skewness = .54. Additionally, of the three subscales, the overall statistics most closely align with the Indifference to stigma subscale, which suggests that it may be the best single subscale measure of openness.

The Psychological Openness subscale had $m = 14.81$ (1.85), $SD = 7$, and skewness = -.12. Item means for this subscale ranged from 1.37 to 2.27; item standard deviations ranged from 1.32 to 1.48; item skewness ranged from -.20 to .69. This indicates that the Psychological Openness subscale is normally distributed (skewness statistics between -1 and 1), with respondents on average reporting undecided with a slight leaning away from openness for this subscale.

The Help-seeking Propensity subscale had $m = 21.99$ (2.75), $SD = 6.69$, and skewness = -.42. Item means for this subscale ranged from 2.52 to 2.90; item standard deviations ranged from 1.13 to 1.34; item skewness ranged from -.97 to -.48. This indicates that the Help-seeking Propensity subscale is normally distributed (skewness statistics between -1 and 1), with respondents on average reporting moderate openness.

The Indifference to Stigma subscale had $m = 17.83$ (2.23), $SD = 7.32$, and skewness = -.03. Item means for this subscale ranged from 1.91 to 2.56; item standard deviations ranged from 1.19 to 1.48; item skewness ranged from -.43 to .14. This indicates that the Indifference to Stigma subscale is normally distributed (skewness statistics between -1 and 1), with respondents on average reporting undecided with a slight leaning toward openness for this subscale.

Testing Research Questions

The following questions were the basis of the study and analyses:

1. To what extent are African American men Receptive to Community-based Psychoeducation as an alternative to Counseling?
2. To what extent is Receptivity toward Community-based Psychoeducation as an alternative to Counseling accounted for by Ethnic Identity Salience, SES, and Attitudes toward Seeking Mental Health Treatment among African American men?

Question #1

Receptivity to community-based Psychoeducation as an alternative to counseling was assessed using 12 items that focused on Openness and Preference (toward individuals and settings) for discussing and receiving mental health information (i.e., psychoeducation). The results demonstrate significant and non-significant differences in receptivity in various settings and with various professionals. The analysis used the ten Openness Items that allow respondents to rate openness to settings, and openness to the corresponding individuals (five-point rating in which 0 is Opposed, 4 is Open) (see Table 8). Then the two Preference items were analyzed (which utilize a ranking format).

Table 8

Receptivity to Community-based Psychoeducation Item Level Statistics

	M	SD	Skewness
Openness to Settings	2.46	.84	-.08
Rate your level of openness to discussing and receiving mental health information in each of the following settings:			
At Home or Social Setting	2.87	1.24	-.88
Counseling/Therapy	2.85	1.20	-.88
Church	2.46	1.38	-.46
Local Community Agency	2.17	1.25	-.14
Barbershop	1.92	1.40	-.02
Openness to Individuals	2.44	.84	-.11
Rate your level of openness to discussing and receiving mental health information through each of the following individuals:			
Counselor/Therapist	2.86	1.20	-.82
Family and Friends	2.72	1.20	-.74
Social Worker or Agency Volunteer	2.45	1.27	-.47
Pastor or Church Member	2.40	1.30	-.44
Barber	1.76	1.39	-.15

Respondents indicated the greatest receptivity to the following settings (mean values are provided respectively): At Home or Social Setting (2.87) and Counseling/Therapy (2.85); they are somewhat open to them. After those is Church (2.46), then Local Community Agencies (2.17); they were only neutral toward them with slight leaning toward openness. Last was Barbershops (1.94) with ratings on average that were neutral with a slight leaning toward somewhat opposed.

In rating receptivity to Individuals, respondents indicated the greatest receptivity to Counselor/Therapist (2.86) and Family and Friends (2.72); they are somewhat open to them. They reported being significantly more receptive to them than to Social Worker or Agency Volunteer (2.45) and Pastor or Church Member (2.40), to which they are slightly neutral and slightly somewhat open. They reported the least receptive to Barbers (1.76)

with ratings on average that were neutral with a slight leaning toward somewhat opposed. The two ranking items (one for setting and one for individual) were scored by participants (see Table 9 for descriptive statistics). Each rank item had five options with lower mean scores corresponding with higher rank and greater preference).

Table 9

Receptivity Preference Descriptive Statistics					
	N	Minimum	Maximum	M	SD
Rank Setting					
RankAtHomeorSocSet	461	1	6	2.93	1.420
RankCounseling/Therapy	461	1	6	2.94	1.452
RankChurch	461	1	6	3.00	1.413
RankLocalCommAgency	461	1	6	3.03	1.416
RankBarbershop	461	1	6	3.19	1.496
RankOtherAsListed1	461	2	6	5.91	.371
Rank Individual					
RankCounselorTherapist	461	1	6	2.77	1.455
RankPastorChurchMem	461	1	6	2.98	1.446
RankFamilyAndFriends	461	1	6	3.00	1.451
RankSocWorkAgVol	461	1	6	3.01	1.377
RankBarber	461	1	6	3.41	1.486
RankOtherAsListed2	461	1	6	5.83	.597

Paired samples tests were used to determine the significance of the observed difference. As it pertains to the type of setting: there was no significant difference between At Home or Social Setting (2.87) and Counseling/Therapy (2.85) ($p = .801$) though ratings for At Home or Social Setting were on average higher. All other differences were statistically significant (see Table 10), conveying they were less preferred. As it pertains to the type of individual: there was no significant difference in receptivity to Counselor/Therapist (2.86) and Family and Friends (2.72) ($p = .025$). There

was no significant difference between Social Worker or Agency Volunteer (2.45) and Pastor or Church Member (2.40) ($p = .530$) though they rated Social Worker or Agency Volunteer higher. All other differences were statistically significant (see Tables 10 & 11) conveying they were less preferred.

Table 10
Paired Samples Test for Receptivity to Settings

		Paired Differences						t	df	Sig. (2-tailed)
		M	SD	SEM	CI ₉₅ of Diff.					
					Lower	Upper				
Pair 1	Counseling/Therapy - LocalComAgency	.68	1.36	.0636	.5553	.8051	10.702	460	.000	
Pair 2	Counseling/Therapy - Church	.39	1.61	.0751	.2468	.5418	5.253	460	.000	
Pair 3	Counseling/Therapy - Barbershop	.93	1.83	.0851	.7627	1.0973	10.924	460	.000	
Pair 4	Counseling/Therapy - AtHomeOrSocSet	-.02	1.34	.0623	-.1382	.1068	-.252	460	.801	

Table 11
Paired Samples Test for Receptivity to Individuals

		Paired Differences						t	df	Sig. (2-tailed)
		M	SD	SEM	CI ₉₅ of Diff.					
					Lower	Upper				
Pair 1	CounselorTherapist - SocWorkAgVol	.41	1.24	.0578	.3013	.5286	7.175	460	.000	
Pair 2	CounselorTherapist - PastorChurchMem	.46	1.53	.0712	.3198	.5995	6.460	460	.000	
Pair 3	CounselorTherapist - Barber	1.11	1.80	.0841	.9400	1.2704	13.148	460	.000	
Pair 4	CounselorTherapist - FamilyAndFriends	.146	1.40	.0651	.0181	.2740	2.243	460	.025	

Thus, in response to the first research question, the analysis indicates that Receptivity to Community-based Psychoeducation, as discussed with or received from Family/Friends, is statistically comparable to via Counselors. While Social Workers and

Pastors/Church Members elicit less openness, it is more than Barbers and Other.

Additionally, reported receptivity when discussed or received At Home or in a Social Setting is comparable to a Counseling/Therapy setting. Preference ranking data appears to support Openness rating scale data. However, ranking data demonstrated fewer significant differences, suggesting that the Preference items for measuring Receptivity may be less sensitive to sample variations.

Question #2

Structural Model

The conceptualized model previously discussed in Chapters 1 and 3 included the predictor variables, Ethnic Identity Salience, SES, and Attitudes toward Seeking Mental Health Treatment, and the outcome variable Receptivity toward Community-based Psychoeducation. Structural Equation Modeling was used to measure the relationship between the variables based on data from 461 African American men. Three respecified models were produced to improve model fit and replicability.

The first model tested was the original four-factor first-order model (Model 1) with all items included (see Figure 2). The latent variable Receptivity to Community-based Psychoeducation (composed of two subscales: Openness to Individuals and Openness to Settings), used as the outcome variable in the model, as indicated by two subscales of Openness: Openness to Individuals and Openness to Settings. Please note that in this analysis, Counseling (individual and setting) was not included among the Openness subscale items since the goal was to access the alternative items. There were three exogenous (predictor) latent variables: Ethnic Identity Salience (two subscales: Ethnic Identity Search and Affirmation, Belonging, and Commitment), SED (Social

Figure 2. Initial Model of Receptivity, Model 1.

Subjective Subscale, Household Income, and Education), and Attitudes toward Seeking Mental Health Treatment (three subscales: Psychological Openness, Help-seeking Propensity, and Indifference to Stigma). The hypothesized model proposed that the three exogenous variables would directly affect the outcome variable and that Attitudes toward Seeking Mental Health Treatment would be affected by Ethnic Identity and Socioeconomic Status (which were believed to be correlated). Information about cut-offs for Model Fit Indices is available in Table 12 (Schreiber, Nora, Stage, Barlow, & King, 2006, p 330; Shadfar & Malekmohammadi, 2013, p 587).

The Initial (Hypothesized) Model configured did not represent an adequate fit to the data. The chi-square test was statistically significant, 332.580 (38, $N = 461$), $p = .000$, indicating the model did not fit. Further, the model fit indices confirmed poor model fit: the RMR was 1.027, GFI was .883, the NFI was .772, the RFI was .669, the IFI was .792,

Table 12
Model Fit Indices Cut-offs

Indexes	Shorthand	General rule for acceptable fit if data are continuous	Categorical data
Chi-Square	χ^2	Ratio of χ^2 to df ≤ 2 or 3, useful for nested models/model trimming	
Root mean square residual	RMR	Smaller, the better; 0 indicates perfect fit	
Standardized RMR	SRMR	$\leq .08$	
Goodness-of-fit index	GFI	$\geq .95$ Not generally recommended	
Normed fit index	NFI	$\geq .95$ for acceptance	
Relative fit index	RFI		
Incremental fit index	IFI	$\geq .95$ for acceptance	
Tucker-Lewis index	TLI	$\geq .95$ can be $0 > TLI > 1$ for acceptance	0.96
Comparative fit index	CFI	$\geq .95$ for acceptance	0.95
Root mean square error of approximation	RMSEA	$< .06$ to $.08$ with confidence interval	$< .06$

*note: taken from Schreiber et al. (2006, July/August)

TLI was .696, the CFI was .790, and the RMSEA was .130. With model fit indices below .9, SRMR = .1114, and an RMSEA over .08, it was determined that the model did not fit and was respecified using AMOS software-suggested modifications (see Table 13 for estimates). Modifications were made by adding to the model correlations between errors associated with indicator variables both within and between factors (see Figure 3).

Respecified Structural Models

The first respecified model (Model 2) (see Figure 3) was configured by including four error correlations: e2 and e4; e3 and e4; e3 and e23; and e6 and e7. However, the chi-square for this model did not represent an adequate fit. The chi-square test was statistically significant, 156.297 (34, N = 461), $p = .000$ (see Table 14 for estimates).

Table 13
Model 1 Estimates

			Estimate	S.E.	β	P
Attitude	<---	EthnicIdentity	-3.135	1.013	-.113	.002
Attitude	<---	SES	-2.225	1.730	-.064	.198
Receptivity	<---	SES	.466	.291	.148	.109
Receptivity	<---	EthnicIdentity	.654	.139	.259	***
Receptivity	<---	Attitude	-.002	.003	-.024	.510
PsychOpenness	<---	Attitude	1.000		1.292	
IndiffStigma	<---	Attitude	.426	.112	.526	***
HelpSeekProp	<---	Attitude	-.162	.054	-.219	.003
AffirmBelongCommit	<---	EthnicIdentity	1.000		.561	
EthnicIDSearch	<---	EthnicIdentity	1.808	.357	.976	***
YrsEduc	<---	SES	1.000		.106	
IncomeH2	<---	SES	.549	.308	.189	.075
LadderUS2	<---	SES	7.613	3.798	.843	.045
LadderCom1	<---	SES	6.425	3.179	.760	.043
RecepSet2	<---	Receptivity	1.000		.914	
RecepPerson2	<---	Receptivity	.808	.117	.747	***

Figure 3. The First Respecified Model, Model 2.

Table 14
Model 2 Estimates

			Estimate	S.E.	β .	P
Attitude	<---	EthnicIdentity	-3.578	1.132	-.110	.002
Attitude	<---	SES	-3.067	2.627	-.069	.243
Receptivity	<---	SES	.558	.421	.146	.184
Receptivity	<---	EthnicIdentity	.476	.146	.169	.001
Receptivity	<---	Attitude	-.005	.004	-.062	.133
PsychOpenness	<---	Attitude	1.000		1.273	
IndiffStigma	<---	Attitude	.424	.104	.524	***
HelpSeekProp	<---	Attitude	-.183	.055	-.242	***
AffirmBelongCommit	<---	EthnicIdentity	1.000		.488	
EthnicIDSearch	<---	EthnicIdentity	2.282	.624	1.033	***
YrsEduc	<---	SES	1.000		.082	
IncomeH2	<---	SES	.666	.399	.177	.094
LadderUS2	<---	SES	9.639	6.225	.825	.122
LadderCom1	<---	SES	8.520	5.485	.779	.120
RecepSet2	<---	Receptivity	1.000		.867	
RecepPerson2	<---	Receptivity	.891	.109	.779	***

Further, the model fit indices confirmed poor model fit: the RMR was 1.044, GFI was .945, the NFI was .893, the RFI was .826, the IFI was .914, TLI was .859 the CFI was .913, and the RMSEA was .088. With most model fit indices around .9, the SRMR was .0761, and an RMSEA below .1 this model demonstrated improvement but not fit and was respecified using the modification estimates to improve model fit.

The second respecified model (Model 3) (see Figure 4) was configured by removing Education from Socioeconomic Status, and removing Attitudes toward Seeking Mental Health Treatment (but retaining the Help-seeking propensity subset). Education was removed because it was not significant in the model as indicated by it accounting for only 8% of the variance in Socioeconomic Status and correlating at .33 with Household Income, suggesting that much of the variance it explained was already accounted for by

Figure 4. The Second Respecified Model, Model 3.

income. Attitudes toward Seeking Mental Health Treatment was removed because the path coefficient between the latent variable Attitudes and the observed variable Receptivity was only $-.06$ (conveying nonsignificance). However, there appeared to be an unexplained relationship given the significant covariation between the error term for Help-seeking and the Attitudes variable ($.27$). A canonical correlation was performed between the Attitudes subscales and Receptivity subscales, revealing Help-seeking behavior as the only attitude significant in predicting receptivity. Thus, Attitudes was removed though Help-seeking was retained.

Consequently, for Model 3, the only error correlation retained was between the error for Help-seeking and the error for Affirmation, Belonging, and Commitment. Statistical analysis of Model 3 indicated that the model fit. Chi-square was 15.490 (21 , $N = 461$), $p = .417$, indicating model fit since $p > .05$. Additionally, the model fit indices

confirmed model fit: the GFI was .992, the NFI was .983, the RFI was .968, the IFI was .999, TLI was .999, and the CFI was .999. The RMSEA was .008 (well below .1), which also indicated good model fit. Though the RMR was .222, the SRMR was .0296, which is below the < .05 standard. While the model fit, it was determined that it could be improved to generate the “best” model possible in terms of both fit and replicability. Thus, the model was respecified again using the modification estimates (see Table 15).

The third respecified model (model 4) (see Figure 5) was configured by removing the error correlation between Help-seeking and error for Affirmation, Belonging, and Commitment (per software-suggested modifications). The chi-square was not statistically significant, 25.367 (16, N = 461), $p = .064$, indicating model fit since $p > .05$. Model fit indices confirmed fit: the GFI was .986, the NFI was .972, the RFI was .951, the IFI was .989, TLI was .981 the CFI was .989, and the RMSEA was .036. While RMR = .122, the SRMR = .0320 indicating model fit. With model fit indices within acceptable ranges and an RMSEA below .05, this model demonstrates fit and increased replicability/simplicity.

Table 15
Model 3 Estimates

			Estimate	S.E.	β	P
HelpSeekProp	<---	EthnicIdentity	6.974	.932	.330	***
Receptivity	<---	SES	.805	.403	.140	.046
Receptivity	<---	EthnicIdentity	.413	.134	.168	.002
Receptivity	<---	HelpSeekProp	.033	.006	.283	***
AffirmBelongCommit	<---	EthnicIdentity	1.000		.547	
EthnicIDSearch	<---	EthnicIdentity	1.903	.517	1.001	***
IncomeH2	<---	SES	1.000		.178	
RecepSet2	<---	Receptivity	1.000		.867	
RecepPerson2	<---	Receptivity	.897	.098	.786	***
LadderUS2	<---	SES	13.925	4.211	.800	***
LadderCom1	<---	SES	13.049	3.948	.802	***

Figure 5. The Third Respecified Model, Model 4.

In summary, from the First Respecified Model (Model 2) to the Third Respecified Model (Model 4): (1) Attitudes toward Seeking Mental Health Treatment was removed along with Education from SES, and (2) the error correlation between Help-seeking and Affirmation, Belonging, and Commitment was removed. Attitudes toward Seeking Mental Health Treatment was removed because it accounted for only 2% of the variation in Receptivity. The error correlation was removed to increase the simplicity of the model (and thereby its replicability) in light of the modification indices. See Table 16 for a summary of direct and indirect effects, and Table 17 for a summary of fit indices and chi-square values for each model.

Table 16
Summary of Direct and Indirect Effects

Outcome	Predictors	Effects		
		Indirect	Direct	Total
Receptivity	Ethnic Identity Salience	.122	.180	.262
HelpSeekProp	Ethnic Identity Salience	.000	.486	.330
Receptivity	HelpSeekProp	.000	.251	.283
Receptivity	Socioeconomic Status	.000	.136	.140

Table 17
Chi-Square and Goodness of Fit for Models

Factor Model	X^2	<i>df</i>	RMR	SRMR	GFI	NFI	CFI	RMSEA
Hypothesized	332.580	38	1.027	.1114	.883	.772	.790	.130
Model 2	156.297	34	1.044	.0761	.945	.893	.913	.088
Model 3	15.490	21	.222	.0296	.992	.983	.999	.008
Model 4	25.367	16	.122	.0320	.986	.972	.989	.036

Summary of Findings

First, the study proposed that African American men are receptive to Community-based Psychoeducation, specifically as an alternative to counseling. The results for this question indicate a few things about respondents' receptivity to receiving/discussing mental health information. First, At Home or Social Setting and Counseling/Therapy are not statistically different. Second, from Family or Friends and a Counselor/Therapist are not statistically different. Third, as administered via Social Workers or Pastors/Church Members, or in Local Community Agencies or Church, is less preferred than the aforementioned, but more preferred than Barbers/Barbershops and unidentified Others. Ultimately, this conveys receptivity to community-based psychoeducation as an alternative to counseling as it pertains to discussing and receiving mental health information with friends and family.

Then the study hypothesized that the theoretical covariance matrix proposed would be equal to the empirical covariance matrix developed from the collected data. The fit statistics gathered from the structural equation model disproved the hypothesis, which resulted in numerous respecified models. Through incorporating various software-suggested modifications, a respecified model with good fit and replicability was identified. Although some low-level correlations were present, they were necessary for higher-order items and to the overall fit of the respecified model. The final respecified model explained 18% of the variance of Receptivity to Community-based Psychoeducation, with Psychological Openness, Indifference to Stigma, and Education not impacting receptivity as initially theorized. A more detailed discussion of the findings, as well as the influence of other contributing factors, will be discussed in the next chapter.

CHAPTER 5

SUMMARY, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Introduction

This chapter provides an overview of the document by summarizing the study. First, it will restate the research problem, the purpose of the study, and questions. Next, it will discuss the significance of the study and a summary of the literature review, first recalling the issue and its interaction with the variables, and then denoting the need for and utility of a culturally sensitive intervention type. Then will be followed by a synopsis of the methodology and the findings. Finally, the chapter will conclude with a discussion of the implications, limitations, and recommendations for future psychological research.

Research Problem

African American men (as a minority population) are underrepresented in their access to and utilization of mental health services (Lindinger-Sternart, 2015; Mental Health America, n.d.; National Alliance on Mental Illness, n.d.; Roberson & Fitzgerald, 1992; Snowden, 2012). They tend to engage in mental health treatment at a significantly lower rate than the general population. Nevertheless, research suggests that their distress is as significant if not more so than that of majority groups (Mental Health America, n.d.; Roberson & Fitzgerald, 1992; Snowden, 2012). The prejudicial practices of the

healthcare system and out-group members, which necessitate in-group support, foster mental health treatment disparities (Lindinger-Sternart, 2015; National Alliance on Mental Illness, n.d.). Further confounding the issue is that mental health services can be experienced as an extension of societal pressure to assimilate further into mainstream Eurocentric culture, a pressure that African Americans already manage daily (Hipolito-Delgado, 2015; Robin, 2013).

Psychology, Counseling, and Healthcare have a responsibility to make receiving mental health services feasible and culturally relevant for disenfranchised and sensitive populations. Given the prevalence of mental health concerns such as Depression, Post-traumatic Stress Disorder, and Schizophrenia in the African American community (American Psychological Association, 2018b; DiSanto, 2018; Good Therapy, 2019; Lane, 2010), the mental health community must strive to address this growing public health issue. *Psychology Today* (Morin, 2018) and the World Health Organization (2018) recognize that it is problematic that mental health is a fundamental aspect of livelihood but is considered a secondary area of health. As it relates to mental health in the African American community, attitudes toward seeking mental health treatment often conceptualize counseling and mental health treatment in general as emergency resources only (Hinson & Swanson, 1993; Snowden, 2012). This lack of mental health awareness and knowledge is a vital point of concern. Knowing mental health information (i.e., information about feelings, communication, decision making, and setting boundaries) is a basic tool for personal development and navigating society; it is essentially a literacy of sorts. This knowledge deficit is especially damaging when one's ability to thrive in society is largely dependent on basic life skills such as these (Hipolito-Delgado, 2015).

Researchers have found that community-based mental health intervention may have viability within the African American community in light of the observed underuse of traditional approaches to mental health treatment. Shabazz (2016) reported barbershops as venues for mental health discourse for African American men. Dana (2002) concluded that churches and other support networks are useful tools in developing culture-specific interventions. Numerous others highlight the importance of community and culturally-based intervention among minority and African American populations (Alvidrez, Areán, & Stewart, 2005; Hankerson et al., 2015; Kreuter et al., 2003).

Hankerson et al. (2015, p 4) reported the following:

A model that integrates community engagement with improved clinical care was recently cited as a promising way to reduce disparities. In line with this care model, we encourage the dissemination of mental health outreach and psycho-education in trusted community settings frequented by men of color, such as barbershops, churches, and fraternities.

Taken together, it is evident that there is a pronounced need among African American men for community-based treatment modalities that will increase their mental health literacy. These modalities would do well to consider their ethnic identity salience, socioeconomic status, attitudes toward seeking mental health treatment.

Research Questions

The first research question assessed if African American men are receptive to community-based psychoeducation, particularly as an alternative to counseling. Second, the study hypothesized that the proposed theoretical covariance matrix developed from theory and previous research would be satisfactorily fit the empirical covariance matrix developed from the collected data. It was expected that the hypothesized model would demonstrate good fit with the observed data, thereby validating the explanation of the

phenomenon receptivity to community-based psychoeducation (particularly as an alternative to counseling) among African American men through the predicted relationships of the latent variables.

Purpose of the Study

The purpose of this study was to examine how ethnic identity salience, SES, and attitudes toward seeking mental health treatment predict receptivity toward community-based psychoeducation (particularly as an alternative to counseling) among African American men.

Significance of the Study

There are documented racial disparities in the healthcare system as it pertains to mental health treatment among African American men. By presenting community-based psychoeducation (re-conceptualized as a literacy area) as a feasible and culturally relevant mental health intervention, this study fills a gap in the existing literature. Further, through identifying modality for psychological enrichment, intervention, and education, an opportunity is created for mediating issues of mental health service incongruence and underuse among African American men in identity affirming ways. This is an important gain since serving minority populations through developing feasible, preventative, culturally relevant mental health interventions is an ongoing public health concern.

Ultimately, determining receptiveness to community-based psychoeducation is a useful step toward equipping this population with greater self-understanding, and basic psychological information that can improve the daily functioning of those with mental health concerns, the mentally ill, and their supporters. Practitioners will also benefit

through being provided with information about 1) how ethnic identity, socioeconomics, and attitudes toward seeking mental health treatment predict receptivity to community-based psychoeducation among African American men, and 2) how unique cultural and racial considerations impact mental health treatment openness and preferences.

Summary of the Literature Review

There is a unique interaction between race/ethnicity and gender as it pertains to mental health treatment among African American men. African American men are significantly less likely to attend counseling/psychotherapy and are underserved (Brown, 2008; Hall et al., 2016; Mackenzie, Gekoski, & Knox, 2006; Yakushko, 2016) but their need is just as great if not greater (Diala et al., 2000; Snowden, 2012). Many factors that inform this discussion in its entirety: ethnic identification as a minority member with marginalized societal capital; socioeconomic factors that impact the feasibility of health services; dynamic attitudes toward seeking mental health services that are impacted by socio-historical context; the opportunity for culturally congruent mental health intervention. Ultimately there is a need for research that considers this population and seeks to mediate these common barriers in culturally-sensitive ways, an essential step toward combating the disparities in the access to and utilization of services.

Ethnic Identity Salience

Many writers acknowledge that ethnic identity is something majority culture individuals can overlook. At the same time, minority culture individuals often go through life with an evolving consciousness of not only their ethnic identity but also of how it interacts with the majority culture. For African Americans, racial/ethnic identity

development is instigated through microaggressions and discrimination, which fosters distrust and division (Behrens, 1997; Cokey, 2002; Miller et al., 2016). The body of existing knowledge has done well in investigating differences in ethnic identity salience. For instance, the research conveys that African Americans, more than other ethnic groups, tend not to follow a nuclear family structure. It clarifies that contrary to popular thought, this finding is not adequately accounted for by lower marriage rates. Instead, a thorough review of the existing literature conveys that the disproportionate prevalence of single-mother households is a consequence of both slavery's family separation agenda, and of the continued socioeconomic dismantling of this community through the Jim Crow era of the 1950s, Nixon's "War on Drugs" initiated in the 1970s, "black urbanization," the origination of the "Welfare" system which instigates single mother households, and "Mass Incarceration" (Alexander, 2010; DuVernay, 2016; Ricketts, 1989). The literature also recognizes that this institutionalized dismantling of the nuclear family structure has resulted in extensive reliance on kinship networks and social resources, which have become culturally salient resilience factors. These findings 1) debunk myths about why African American men tend to engage mental health treatment in lower rates, even if/when they have more positive attitudes toward seeking mental health treatment (National Alliance on Mental Illness, n.d.; Vogel & Wei, 2005), and 2) highlight ethnic identity salience as an important consideration in developing mental health interventions for this population.

Socioeconomic Status

The correlation between SES, health, and healthcare outcomes among minorities is becoming a popular topic in social sciences. When considering the role of

socioeconomic status in mediating mental health, it is important to consider the various aspects of the domain. Education, Income, and Occupation are among the most widely used and accepted determinants for socioeconomic status (Sebelius, 2012), and Subjective Social Status is increasingly becoming associated with them (American Psychological Association, 2018c). This burgeoning acknowledgment of the role of social capital in shaping socioeconomic status is a pivotal understanding when it comes to assessing socioeconomic status among a collectivist demographic such as African Americans. Further, with regard to SES, a popular narrative has been purported conveying that African Americans do not value and are disinterested in education. Numerous research-based contra-narratives address and debunk this ideology. In doing so, they highlight the thoughtlessness and ignorance of surmising that the inequity within public systems is merely a matter of disinterest among the disenfranchised. They further illustrate that marginalization fundamentally functions to the benefit of others (Alexander, 2010; Brown, 1993; DuVernay, 2016; Hipolito-Delgado, 2015; Riggs, 1987).

Attitudes Toward Seeking Mental Health Treatment

Mental Health treatment is a relatively new class of health, and it is widely assumed and believed that African Americans have pre-existing negative perceptions of mental health treatment (Diala, 2000). However, research indicates that African American men display dynamic attitudes toward seeking mental health treatment (Berger et al., 2005; Diala, 2000; Mental Health America, n.d.; Robertson & Fitzgerald, 1992; Ward et al., 2013). According to Vogel, Wester, and Larson (2007), though participants had positive attitudes towards counseling, they did not believe their issues were severe enough to warrant it. The “credibility” of the source providing services or information

was also meaningful (Mishra et al., 2008). Hinson and Swanson (1993) found that only once friends and family are not available or able to provide the support desired will many seek counselors (strangers), and even then, some may still not think pursuing treatment is warranted. Many studies also reported stigma and distrust as shapers of African American men's attitudes toward seeking mental health treatment, along with access and feasibility as major barriers (Conner et al., 2009; Vogel et al., 2007; Ward et al., 2013). Stigma, in this case, refers to issues of sex and ethnicity, as there is stigma toward mental health both among men and among African Americans, and unique at the intersection of African American men (Diala, 2000; Kelleher & Sellers, 2005; Lindinger-Sternart, 2015; Scheppers et al., 2006; Vogel et al., 2007).

Community-based Psychoeducation

“As agents for change and advocacy” (American Psychological Association, 2018a), Counselors and Psychologists are specially equipped to provide services such as psychoeducation (Good Therapy, 2017). While this discussion largely considers “psychoeducation as an alternative to counseling,” this terminology is simply meant to convey that it may be better suited to reach non-clinical minority populations. Therein, it can act as a preventative buffer for more acute mental illness, perhaps even acting as a bridge to more invasive and focused mental health intervention. Just as Counseling has adapted to support the mental health needs of the common citizen (Brown & Lent, 2008), so might psychoeducation be utilized as a matter of public welfare and prevention in the years to come. Today, psychoeducation is a useful and meaningful part of increasing motivation for change, receptivity to mental health services, and developing life skills

(Alvidrez et al., 2005; Good Therapy, 2019; Haynes et al., 2017; Lukens & McFarlane, 2004).

Strategies that include conceptualizing mental illness as a normal reaction to stressful living environments, the use of community-based mental health services, and providing mental health education to the general public may improve use of services in this population. (Haynes et al., 2017)

Thus, future research should explore and describe how psychoeducation can be introduced to community-based settings in destigmatizing ways.

The literature identifies the most commonly established cultural hubs for the dissemination of African American male culture are barbershops, churches, and community-based gyms and recreation centers (Alvidrez et al., 2005; Hankerson et al., 2015; Kreuter et al., 2003). Each of these locations already satisfies a unique ethnically salient need, which makes them candidates for incorporating psychoeducation (Hankerson et al., 2015). Each endows African American men with social support, a sense of belonging, and encourages community and identity development through seeing other Black men in positions of leadership, entrepreneurship, and “giving back” (Charles, 2005). In light of this, as “community members” and culture bearers, these institutions are mediums primed for relaying health and public service information that promotes community advancement (Dana, 2002; Hankerson et al., 2015; Markens et al., 2002). As such, they are inherently destigmatizing and are worthy of consideration for empirical study as psychoeducational sites.

Conclusion

Many contextual factors give shape to the ethnic, socioeconomic, and attitudinal identities of African American men (Alexander, 2010; DuVernay, 2016; Riggs, 1987).

Consequently, disclosing personal, and further health, information outside of trusted and proven community relationships (such as in counseling) can be understood by African American men as having greater anticipated risks with fewer anticipated benefits (Hinson & Swanson, 1993) especially given their culture's unique communication norms (Peskin, Tortolero, & Markham, 2006; Smitherman, 2000). Alternatively, African American men display unique cultural means of mediating societal pressures and discrimination, and coping with mental health concerns. A prominent mode of coping in this population is the utilization of extended kinship networks (National Alliance on Mental Illness, n.d.). Herein it is apparent that interventions that draw on existing culturally derived forms of support and coping are better suited to meet their unique mental health needs (Yakushko et al., 2016). Further, perhaps transmitting mental health information (i.e., developing mental health literacy) via culturally established and trusted networks would find greater traction within this community.

Methodology

A quantitative, non-experimental survey design will be used to examine the relationship between ethnic identity salience, SES, and attitudes toward seeking mental health treatment (the exogenous variables) as predictors of receptivity toward community-based psychoeducation (the endogenous variable) among African American men. ANOVA and Structural Equation Modeling were employed to consider the relationship between variables and the latent construct. Convenience sampling was used to recruit a nationally representative sample of 461 African American men from across the country through the employment of Qualtrics data collection servicer.

Findings and Discussion

A sample of 461 African American males age 18 or older reported about their ethnic identity salience, socioeconomic status, attitudes toward seeking mental health treatment, and receptivity toward community based psychoeducation as an alternative to counseling. Frequencies and percentages for age and education level reflected national averages. Further, the most commonly endorsed demographic characteristics were male from birth, age 25-44, residing in the U.S., with an education level ranging from high school diploma or equivalent to a Bachelor's degree.

Reliability coefficients within this study ranged from acceptable to good which is comparable to previous studies. Overall, reliability coefficients were as follows: for Ethnic Identity Salience Cronbach's $\alpha = .707$, for Attitudes toward Seeking Mental Health Treatment Cronbach's $\alpha = .808$, and for Receptivity to Community-based Psychoeducation Cronbach's $\alpha = .767$. Thus, the results reliably indicated information about the sample. First, that for Ethnic Identity Salience ($m = 3.19$; scale 1 to 4) there was salience with a slight leaning toward strong salience. Ratings for Education ($m = 14.29$ years) and Income (median = \$35,000 - \$44,999) were consistent with national averages, though standing in the U.S. was rated significantly lower than one's standing in their community. For Attitudes toward Seeking Mental Health Treatment ($m = 2.28$) there was a minimal leaning toward positive attitudes. As a reference, existing literature is inconsistent on this point. Lastly, for Receptivity to Community-based Psychoeducation, results indicated moderate openness (comparable to their openness to counseling) with several settings/individuals.

Skewness statistics were predominantly indicative of a normal distribution. The Ethnic Identity Search subscale was normally distributed though the Affirmation, Belonging, and Commitment subscale was not. This negatively skewed subscale was indicative of moderately high ratings suggesting greater connectedness. For Socioeconomic Status, Education and Social/Subjective were normally distributed. For Attitudes toward Seeking Mental Health Treatment, all subscales (Psychological Openness, Help-Seeking Propensity and Indifference to Stigma) were normally distributed. For Receptivity to Community-based Psychoeducation, subscales Openness to Individuals and Openness to Settings were normally distributed as well.

According to the results for Question 1, African American men are most receptive to discussing/receiving mental health information with counselors, and friends and family, and in the corresponding settings. The lack of significant difference between Family/Friend and Counselor/Therapist (and the corresponding settings) suggests they are receptively comparable options among African American men. Which is not to say psychoeducation is sufficient for treating severe mental illness or that it can act as a replacement to counseling/counselors. Instead, it conveys that friends and family members may be preferable to Counselors/Therapists for non-severe mental health intervention via community-based psychoeducation. This is especially so given the comparable receptivity and reduced issues of feasibility and access that are outline in the literature. While respondents were somewhat receptive with a leaning toward neutrality to other settings, barbershops/barbers were the least preferred option.

According to the results for Question 2, while elements of Attitudes and Socioeconomic Status are meaningful predictors, their overall factors were not as

instrumental in the model as was overtly conveyed by the existing body of literature. The final fitted model requires further thought and exploration. Though the structural equation model explains only 18% of the variance in the dependent variable, the model does convey unique insight into the relationship of the variables and implications for future study.

The removal of the attitudes Indifference to Stigma and Psychological Openness through respecification processes informed by small loadings for the overall Attitudes variable was unexpected. The extensive body of literature and empirical research identifying them as factors that impact the disposition and practices of African American men as it pertains to mental health cultivated the researcher's belief that they were instrumental in shaping receptivity. However, the high reliance on community-based resources among African Americans supports the prominence of Help-seeking Propensity in predicting receptivity.

Through subsequent consideration of the existing literature and theory, there are a few considerations that arise as possible explanations for this deviation. The first point of consideration is: the study looked at the receptivity variable as a conversational type of mental health learning rather than assessing mental health intervention in its traditional contexts. Second, it is also possible that Help-seeking is the most culturally fundamental component of Attitudes, and thus the biggest predictor of receptivity (in contrast to actual participation). Lastly, another likelihood suggested by the results is that while historically African American men's attitudes were heavily impacted by stigma and psychological openness, perhaps today, those factors are less significant determinants than is commonly thought.

Limitations

This study utilized a quantitative design to broach a fairly novel area: community-based psychoeducation. It did by reconceptualizing psychoeducation as a means of mental health literacy and exchange. Thereby, it presented it as an alternative to counseling as a means of increasing the feasibility and cultural congruence of mental health services. Broaching this novel area brought unique limitations. The prominent limitations of this study are: (1) it utilized a quantitative self-report design rather than a qualitative design; (2) utilized an evidence-based rather than empirically validated measure for assessing the dependent variable; and (3) it did not ask respondents about past or current mental health service utilization.

Implications

The mental health field has an expressed need to address mental health deficits as it pertains to minority and disenfranchised populations. Through acknowledging the unique mental health needs of African American men and the unique role the intersectionality of ethnicity, sex, and socioeconomic status play in shaping those needs, this study adds to the discussion of enfranchisement by posing community-based psychoeducation as a culturally sensitive intervention modality among African American men. While past studies have posed psychoeducation due to its feasibility, bringing in the literacy component of it is a new way of conceptualizing it among this demographic.

Additionally, through reframing counseling as one mode of intervention rather than as the gold standard, this study encourages future studies to explore culturally sensitive and congruent mental health interventions. The results support the literature on

the feasibility of psychoeducation as a form of mental health intervention among African American Men. Conclusively it does so by (1) challenging the discipline to develop programs that utilize the identified interventions, and (2) calling in to question the underfunding of community-based programs and its ties to institutional racism and discrimination.

Through prescribing friends and family members as more suitable (in the outlined ways) than Counselors/Therapists for non-severe mental health intervention via psychoeducation this study conveys that it is the mental health field's job to align itself with the culture. It is not the culture's job to align itself with the standards of the profession. Given the comparable receptivity and reduced issues of feasibility and access, this alternative is worth further consideration and integration. Vehemently, this study demonstrates practical implications for bridging the gap in the study of mental health among African American men and the development of culturally-meaningful interventions.

Recommendations for Future Research

There are some things future studies can focus on to build upon the body of knowledge that is presently available on this subject:

- Move toward/utilize qualitative and experimental research designs.
- Study African American men independent of White or Female reference groups.
- Destigmatize mental health by reframing it as a literacy area about which all members of society should be knowledgeable.
- Understand psychoeducation as a medium for increasing mental health literacy.

- Identify culturally salient ways of conceptualizing mental health as a means of reducing the stigma surrounding mental health intervention.
- Examine the role of help-seeking in mental health treatment among African American men.
- Clarify if stigma is a cause, or a cause and effect of the actual use of mental health services.
- Challenge traditional views on providing mental health.

These aims are critical undertakings in this area of study and practice given 1) the growing platform for mental health in society and media, 2) the unique impact institutional racism has in shaping public perceptions and chronic stress, and 3) the gaps in the empirical study and treatment of African American men.

APPENDIX A
IRB APPROVAL

IRB <irb@andrews.edu>
to me, Elvin ▾

Wed, May 22, 2019, 2:46 PM

Dear Hadiya,

Congratulations! Your IRB application for approval of research involving human subjects entitled: *"Ethnic identity salience, socioeconomic status, and attitude toward seeking mental health treatment as predictors of receptivity to community-based psychoeducation among African American men"* IRB protocol # 19-033 has been evaluated and determined Exempt from IRB review under regulation CFR 46.101 (b) (2). Please find attached your letter of determination.

Thank you.

Mordekai Ongo

Research Integrity & Compliance Officer
Andrews University
4150 Administration Dr
Berrien Springs, MI 49104-4910
Tel. Office: 269-471-6361
Email: irb@andrews.edu

APPENDIX B

INFORMED CONSENT

Graduate Psychology & Counseling
4195 Administration Drive, Bell Hall, Room 167
Berrien Springs, MI 49104-0104
Phone: (269) 471-3473 Email: gpc@andrews.edu

Research Participant Informed Consent

You are invited to participate in a research project that explores the preferences of African American men toward interacting with mental health information. If you choose to participate in this research, you will be asked to complete a survey that enquires about your ethnicity, socioeconomic status, attitudes about seeking mental health services, and openness to interacting with mental health information. This research is being conducted by Hadiya DuBose-Smith, a PhD student in the department of Graduate Psychology and Counseling at Andrews University in Berrien Springs, Michigan. Dr. Elvin Gabriel, ED.D, is supervising the research. Results from this research will be used in Hadiya DuBose-Smith's dissertation and may be published in professional journals or presented at conferences.

In order to participate, you must be over 18 years of age and be an African American male. It will take 10 -15 minutes to complete this survey. Your participation in this study is completely voluntary, and as such it is your choice whether to participate or not. You may quit the survey at any time. There are no foreseeable risks or benefits associated with participation. However, some of the questions may be triggering as it relates to highlighting unique cultural experiences.

Your survey responses will be strictly confidential and data from this research will be reported only in the aggregate. Your information will be coded and will remain confidential for the purpose of maintaining your right to privacy. If you have questions at any time about the survey, your participation in this research, or your rights as a participant, you may contact the principle investigator, Hadiya DuBose-Smith at [REDACTED] or hadiya@andrews.edu. You may also contact her research advisor, Dr. Elvin Gabriel at [REDACTED] or gabriel@andrews.edu.

Thank you very much for your time and consideration. You may start the survey by clicking on the Continue button below. By clicking this button, you are giving your consent to participate in the research described above.

APPENDIX C
INSTRUMENTS

Demographic Questionnaire

How old are you?

Do you consider yourself African American?

Do you currently live in the United States?

Were you born in the United States, or have you lived the majority of your life in the United States of America?

Are you a male who was assigned a different sex at birth? If so, has your biological sex been male for at least half your life?

The Multigroup Ethnic Identity Measure (MEIM)

In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Hispanic or Latino, Black or African American, Asian American, Chinese, Filipino, American Indian, Mexican American, Caucasian or White, Italian American, and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____

Use the numbers below to indicate how much you agree or disagree with each statement.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

1- I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs. ____

2- I am active in organizations or social groups that include mostly members of my own ethnic group. ____

3- I have a clear sense of my ethnic background and what it means for me. ____

4- I think a lot about how my life will be affected by my ethnic group membership.

5- I am happy that I am a member of the group I belong to. ____

6- I have a strong sense of belonging to my own ethnic group. ____

7- I understand pretty well what my ethnic group membership means to me. ____

8- In order to learn more about my ethnic background, I have often talked to other people about my ethnic group. ____

9- I have a lot of pride in my ethnic group. ____

10- I participate in cultural practices of my own group, such as special food, music, or customs. ____

11- I feel a strong attachment towards my own ethnic group. ____

12- I feel good about my cultural or ethnic background. ____

13- My ethnicity is:

- (1) Asian or Asian American, including Chinese, Japanese, and others
- (2) Black or African American
- (3) Hispanic or Latino, including Mexican American, Central American, and others
- (4) White, Caucasian, Anglo, European American; not Hispanic
- (5) American Indian/Native American
- (6) Mixed; Parents are from two different groups
- (7) Other (write in): _____

14- My father's ethnicity is (use numbers above) _____

15- My mother's ethnicity is (use numbers above) _____

Sociodemographic Questionnaire

The MacArthur Network on SES and Health has developed a sociodemographic questionnaire which is currently being used in a number of network sponsored projects. The instrument begins with subjective social status questions developed by the network; (see MacArthur Subjective Social Status Scale in the Psychosocial Notebook). The remaining questions assess educational attainment, occupational status, income and assets. Ideally, all questions would be used; if a subset must be selected, items 1, 2, 3, 4, 6b and 6c, 7 and 9 are recommended.

Question 1.

Think of this ladder as representing where people stand in their communities.

People define community in different ways; please define it in whatever way is most meaningful to you. At the **top** of the ladder are the people who have the highest standing in their community. At the **bottom** are the people who have the lowest standing in their community.

Where would you place yourself on this ladder?

Please place a large "X" on the rung where you think you stand at this time in your life, relative to other people in your community.

Question 2.

Think of this ladder as representing where people stand in the United States.

At the **top** of the ladder are the people who are the best off – those who have the most money, the most education and the most respected jobs. At the **bottom** are the people who are the worst off – who have the least money, least education, and the least respected jobs or no job. The higher up you are on this ladder, the closer you are to the people at the very top; the lower you are, the closer you are to the people at the very bottom.

Where would you place yourself on this ladder?

Please place a large "X" on the rung where you think you stand at this time in your life, relative to other people in the United States.

Question 3. What is the highest grade (or year) of regular school you have completed? (Check one.)

Elementary School	High School	College	Graduate School
01____	09____	13____	17____
02____	10____	14____	18____
03____	11____	15____	19____
04____	12____	16____	20+____
05____			
06____			
07____			
08____			

Question 4. What is the highest degree you earned?

- ☐ High school diploma or equivalency (GED)
- ☐ Associate degree (junior college)
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate
- ☐ Professional (MD, JD, DDS, etc.)
- ☐ Other specify
- ☐ None of the above (less than high school)

Question 5. Which of the following best describes your current main daily activities and/or responsibilities?

- ☐ Working full time
- ☐ Working part-time
- ☐ Unemployed or laid off
- ☐ Looking for work
- ☐ Keeping house or raising children full-time
- ☐ Retired

Question 6. With regard to your current or most recent job activity:

a. In what kind of business or industry do (did) you work?

(For example: hospital, newspaper publishing, mail order house, auto engine manufacturing, breakfast cereal manufacturing.)

b. What kind of work do (did) you do? (Job Title)

(For example: registered nurse, personnel manager, supervisor of order department, gasoline engine assembler, grinder operator.)

c. How much did you earn, before taxes and other deductions, during the past 12 months?

- ☐ Less than \$5,000
- ☐ \$5,000 through \$11,999
- ☐ \$12,000 through \$15,999
- ☐ \$16,000 through \$24,999
- ☐ \$25,000 through \$34,999
- ☐ \$35,000 through \$49,999
- ☐ \$50,000 through \$74,999
- ☐ \$75,000 through \$99,999
- ☐ \$100,000 and greater
- ☐ Don't know
- ☐ No response

Question 7. How many people are currently living in your household, including yourself?

- _____ Number of people
- _____ Of these people, how many are children?
- _____ Of these people, how many are adults?
- _____ Of the adults, how many bring income into the household?

Question 8. Is the home where you live:

- _____ Owned or being bought by you (or someone in the household)?
- _____ Rented for money?
- _____ Occupied without payment of money or rent?
- _____ Other (specify)_____

[Some might try to get a "market value" estimate of the value of owned homes and an estimate of how much principal was outstanding on the mortgage.]

Question 9. Which of these categories best describes your total combined family income for the past 12 months? This should include income (before taxes) from all sources, wages, rent from properties, social security, disability and/or veteran's benefits, unemployment benefits, workman's compensation, help from relatives (including child payments and alimony), and so on.

- _____ Less than \$5,000
- _____ \$5,000 through \$11,999
- _____ \$12,000 through \$15,999
- _____ \$16,000 through \$24,999
- _____ \$25,000 through \$34,999
- _____ \$35,000 through \$49,999
- _____ \$50,000 through \$74,999
- _____ \$75,000 through \$99,999
- _____ \$100,000 and greater
- _____ Don't know
- _____ No response

Question 10. If you lost all your current source(s) of household income (your paycheck, public assistance, or other forms of income), how long could you continue to live at your current address and standard of living?

- _____ Less than 1 month
- _____ 1 to 2 months
- _____ 3 to 6 months
- _____ 7 to 12 months
- _____ More than 1 year

Question 11. Suppose you needed money quickly, and you cashed in all of your (and your spouse's) checking and savings accounts, and any stocks and bonds. If you added up what you would get, about how much would this amount to?

- _____ Less than \$500
- _____ \$500 to \$4,999
- _____ \$5,000 to \$9,999
- _____ \$10,000 to \$19,999
- _____ \$20,000 to \$49,999
- _____ \$50,000 to \$99,999
- _____ \$100,000 to \$199,999
- _____ \$200,000 to \$499,999
- _____ \$500,000 and greater
- _____ Don't know
- _____ No response

If you now subtracted out any debt that you have (credit card debt, unpaid loans including car loans, home mortgage), about how much would you have left?

- _____ Less than \$500
- _____ \$500 to \$4,999
- _____ \$5,000 to \$9,999
- _____ \$10,000 to \$19,999
- _____ \$20,000 to \$49,999
- _____ \$50,000 to \$99,999
- _____ \$100,000 to \$199,999
- _____ \$200,000 to \$499,999
- _____ \$500,000 and greater
- _____ Don't know
- _____ No response

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)

The term professional refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term psychological problems refers to reasons one might visit a professional. Similar terms include mental health concerns, emotional problems, mental troubles, and personal difficulties.

For each item, indicate whether you disagree (0), somewhat disagree (1), are undecided (2), somewhat agree (3), or agree (4):

	Disagree ----- Agree				
1. There are certain problems which should not be discussed outside of one's immediate family.	0	1	2	3	4
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.	0	1	2	3	4
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.	0	1	2	3	4
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	0	1	2	3	4
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.	0	1	2	3	4
6. Having been mentally ill carries with it a burden of shame.	0	1	2	3	4
7. It is probably best not to know everything about oneself.	0	1	2	3	4
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3	4
9. People should work out their own problems; getting professional help should be a last resort.	0	1	2	3	4
10. If I were to experience psychological problems, I could get professional help if I wanted to.	0	1	2	3	4
	0	1	2	3	4

11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.					
12. Psychological problems, like many things, tend to work out by themselves.	0	1	2	3	4
13. It would be relatively easy for me to find the time to see a professional for psychological problems.	0	1	2	3	4
14. There are experiences in my life I would not discuss with anyone.	0	1	2	3	4
15. I would want to get professional help if I were worried or upset for a long period of time.	0	1	2	3	4
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.	0	1	2	3	4
17. Having been diagnosed with a mental disorder is a blot on a person's life.	0	1	2	3	4
18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.	0	1	2	3	4
19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3	4
20. I would feel uneasy going to a professional because of what some people would think.	0	1	2	3	4
21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.	0	1	2	3	4
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	0	1	2	3	4
23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."	0	1	2	3	4

24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.

0

1

2

3

4

Note. No permission is required to use this inventory.

Receptivity to Community-based Psychoeducation Questions

1. On a scale of one-to-five, rate your level of openness to discussing and receiving mental health information in each of the following settings.

Counseling/Therapy	1	2	3	4	5
Local Community Agency	1	2	3	4	5
Church	1	2	3	4	5
Barbershop	1	2	3	4	5
At Home	1	2	3	4	5
Other: _____	1	2	3	4	5

2. On a scale of one-to-five, rate your level of openness to discussing and receiving mental health information through each of the following individuals.

Counselor/Therapist	1	2	3	4	5
Social Worker/Agency Volunteer	1	2	3	4	5
Pastor or Other Church Member	1	2	3	4	5
Barber	1	2	3	4	5
Family and Friends	1	2	3	4	5
Other: _____	1	2	3	4	5

3. Please rank each of the above Settings and Individuals in order of your preference for discussing and receiving mental health information. Rank them from 1-to-6, with 1 corresponding with your first pick, 2 with your second, and so on.

SETTINGS

Counseling/Therapy	_____
Local Community Agency	_____
Church	_____
Barbershop	_____
At home or Social setting	_____
Other (as you listed above)	_____

INDIVIDUAL

Counselor/Therapist	_____
Social Worker or Agency Volunteer	_____
Pastor or other Church Personnel	_____
Barber	_____
Friends and Family	_____
Other (as you listed above)	_____

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