The Moderating Role of Race/Ethnicity and Cultural Factors on the Relationship between Internalized Stigma, Discrimination and Help-Seeking Attitudes

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THE MODERATING ROLE OF RACE/ETHNICITY AND CULTURAL FACTORS ON THE RELATIONSHIP BETWEEN INTERNALIZED STIGMA, DISCRIMINATION AND HELP-SEEKING ATTITUDES

By
Ana Martinez de Andino

A DISSERTATION

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the requirements for the degree of
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THE MODERATING ROLE OF RACE/ETHNICITY AND CULTURAL FACTORS
ON THE RELATIONSHIP BETWEEN INTERNALIZED STIGMA,
DISCRIMINATION AND HELP-SEEKING ATTITUDES

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Research indicates grave underutilization of mental health services among racial/ethnic minorities (REM) as compared to their Caucasian counterparts (SAMHSA, 2012; U.S Department of Health and Human Services, 2001). The current study is aimed at examining reasons that might explain why REMs are less likely to seek mental health services when in need. Some research indicates that internalized mental health stigma and greater experiences with racial/ethnic discrimination may decrease the likelihood that REMs seek professional psychological help. However, little attention has been paid to the study of help-seeking in multicultural individuals, or those who, from birth, belong to more than one minority ethnic/racial group. It is possible that multicultural individuals may be at even greater risk of failure to seek professional help than bicultural REMs, due to competing minority ethnic identities and cultural beliefs/values, which may be at odds with help-seeking behavior. Furthermore, the current literature has yet to consider the moderating role of cultural variables (family cohesion, acculturation/enculturation, multicultural identity), nor the potential impact of specific symptom clusters (depression, anxiety, subclinical psychosis, obsessive-compulsive traits) on help-seeking attitudes. Using multiple regression analyses, ANCOVAs, and path analysis with a non-clinical
sample of 494 college students, the current study tested several hypotheses. In line with hypotheses, results indicated that greater perceived discrimination was associated with *poorer* help-seeking attitudes. Further, findings demonstrated that this relationship was *weakened* for individuals who reported greater levels of enculturation, and *strengthened* for individuals who reported greater levels of subclinical psychosis. Contrary to expectations, greater internalized mental health stigma was related to *more positive* help-seeking attitudes. This relationship was moderated by ethnicity, such that stigma was significantly associated with help-seeking attitudes *only* for Caucasians, but not for REMs. Also contrary to expectations, the relationship between internalized mental health stigma and help-seeking attitudes *decreased* for individuals who reported greater likelihood to compartmentalize distinct cultural identities. Findings suggest that organized efforts to counteract racial discrimination could help to increase the likelihood that minorities will seek professional mental health services when needed. Interestingly, results also suggest that internalized stigma may improve help-seeking attitudes for Caucasians, and that increasing enculturation (e.g., pride and engagement in the culture of origin) may also help to improve the current underutilization of mental health services among REMs. Other study findings and implications will be discussed.

*Key Words: Help-Seeking Attitudes, Internalized Stigma, Discrimination, Race/Ethnicity, Biculturalism*
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CHAPTER ONE: INTRODUCTION

Help-seeking attitudes broadly refer to the likelihood of individuals to seek out mental health services and professional psychological help. Help-seeking attitudes have long been considered an antecedent and predictor of actual help-seeking behavior, such as the utilization of mental health services and psychological treatment (e.g., Cramer, 1999; Nam et al., 2013). Prior research has given considerable attention to the “service gap”, or the discrepancy between those requiring treatment and the actual percentage of those receiving mental health services. In an effort to better understand and minimize “the gap”, researchers have begun to investigate psychosocial factors that may predict poor help-seeking attitudes. Some variables that have been examined include: mental health stigma, perceived discrimination, race/ethnicity, acculturation/enculturation, and cultural beliefs/values (e.g., Abdullah & Brown, 2011; Cheng, Kwan, & Sevig, 2013; Clement et al., 2015; Guo, Nguyen, Weiss, Ngo, & Lau, 2015; Hunt & Eisenberg, 2010; Li, Dorstyn, & Denson, 2014; Nam et al., 2013; Sun, Hoyt, Brockberg, Lam, & Tiwari, 2016).

However, the examination of these factors has largely occurred in separate studies and has not been well integrated. In other words, a large body of research has focused specifically on mental health stigma and perceived discrimination (e.g., Clement et al., 2015; Corrigan, 2004, 2007; Corrigan & Kleinlein, 2005), while a separate body has concentrated on examining racial and cultural factors regarding help-seeking attitudes (Cauce et al., 2002; Cheng et al., 2013; Guo et al., 2015; Li et al., 2014; Sun et al., 2016). Moreover, research has paid little attention to the nation’s growing population of immigrant (binational) or multicultural individuals, or those who, from birth, belong to
more than one minority ethnic/racial group. Of note, all racial/ethnic minorities (REMs) within the United States (U.S.) can be considered bicultural to some degree, as they interact with both their minority culture as well as the dominant Westernized American culture. The overlap and discrepancy between bicultural and multicultural will be reviewed more thoroughly below. However, within the current study, I refer to multicultural as individuals whose parental ancestry comes from two or more distinct minority ethnic groups, and I refer to binational individuals as those whose parental ancestry comes from two or more distinct countries of origin. No studies to my knowledge have investigated help-seeking attitudes and the differential impact of various moderators within multicultural or binational individuals.

The current study aimed to fill an important gap by evaluating the interplay among mental health stigma, perceived discrimination and cultural factors (acculturation, enculturation, family cohesion, and multicultural identity) on help-seeking attitudes in one cohesive model. This study also paid careful attention to help-seeking attitudes in multicultural and binational individuals, which has largely been ignored to date. Furthermore, this study was one of the first to examine the role of different symptom clusters on help-seeking attitudes. For example, we assessed whether specific symptom profiles, such as depression, anxiety, subclinical psychosis, and obsessive-compulsive traits, would moderate the relationships among the aforementioned factors and help-seeking attitudes. While the literature has generally focused its attention on the global nature of help-seeking attitudes and behaviors, this study aimed to illuminate the nuances of seeking help for specific problems and symptoms.
In this thesis, I begin with a literature review on help-seeking attitudes. Specifically, I discuss research regarding the links between mental health stigma and help-seeking attitudes, as well as between perceived discrimination and help-seeking attitudes. Next, I discuss cultural factors (family cohesion, acculturation/enculturation, multicultural identity) and symptom clusters (depression, anxiety, subclinical psychosis, obsessive-compulsive traits) that may moderate the associations between help-seeking attitudes, mental health stigma and perceived discrimination. I then outline the specific study hypotheses and analytic plan used. Finally, I report on the results of the study and discuss their implications.

Mental Health Stigma and Help-Seeking Attitudes

Mental health stigma has been defined as “the devaluing, disgracing, and disfavoring by the general public of individuals with mental illnesses” (Abdullah & Brown, 2011, pg. 935). One dimension of stigma that has been examined in the literature is internalized stigma. Internalized mental health stigma, or self-stigma, refers to the internalization of public stigma, or the potential discriminatory response by the general public to individuals with a mental illness (Corrigan, 2004, 2007; Corrigan & Kleinlein, 2005). While public stigma may affect individuals on a societal level (e.g., housing or employment discrimination), internalized mental health stigma has been found to cause negative emotional reactions, as well as maladaptive thinking patterns within the individual (Corrigan, 2004, 2007). The impact of both public and internalized stigma on help-seeking attitudes and mental health service utilization has been well-documented over the years (e.g., Abdullah & Brown, 2011; Cheng, Kwan, & Sevig, 2013; Clement et al., 2015; Corrigan, 2004, 2007; Corrigan & Kleinlein, 2005; Corrigan & Wassell, 2008;
Han & Pong, 2015; Mendoza, Masuda, & Swartout, 2015; Nam et al., 2013; Pattyn, Verhaeghe, Kortrijk, Sercu, & Bracke, 2014; Vogel et al., 2017; Vogel, Wade, & Hackler, 2007).

Internalized mental health stigma has been consistently associated with lower mental health utilization and less likelihood of seeking help (e.g., Brown et al., 2010; Corrigan & Kleinlein, 2005; Vogel et al., 2007). Specifically, individuals who report a greater sense of internalized stigma regarding mental illness are significantly less likely to seek treatment, as well as more likely to have negative attitudes and beliefs regarding mental illness (e.g., Brown et al., 2010; Clement et al., 2015; Corrigan & Kleinlein, 2005; Pattyn et al., 2014; Vogel et al., 2007). A recent study by Reynders and colleagues (2016) demonstrated that help-seeking attitudes, internalized mental health stigma, and shame were found to be significantly associated with regional suicide rates, underscoring the salience of these relationships. Additionally, in a 2015 meta-analysis which reviewed 144 studies investigating the impact of mental-health related stigma on help-seeking attitudes, Clement and colleagues found internalized mental health stigma to be most often associated with reduced help-seeking attitudes and behaviors with a small to moderate effect size, followed by concerns regarding disclosure and confidentiality.

The relationship between internalized mental health stigma and help-seeking attitudes appears robust, as it has been replicated across numerous and diverse studies (e.g., Anglin et al., 2006; Brown et al., 2010; Han & Pong, 2015; Nam et al., 2013; Vogel et al., 2017). Nonetheless, the role of specific symptom clusters (e.g., depression, anxiety, subclinical psychosis, obsessive-compulsive traits) on help-seeking attitudes is currently unclear. Thus, better understanding moderating factors of the relationship between internalized
mental health stigma and help-seeking attitudes may provide insight into how to improve treatment seeking behaviors and mental health service utilization.

While the relationship between internalized mental health stigma and help-seeking attitudes holds true across racial/ethnic groups, in a 2015 meta-analysis spanning 90,189 participants, Clement and colleagues found Asian Americans, African Americans, as well as other REM groups appear to be disproportionately deterred by mental health stigma to seek psychological help. Furthermore, REMs have been found to express a greater number of stigmatizing help-seeking attitudes, seek treatment less frequently, and receive treatment at lower rates as compared to their Caucasian counterparts (e.g., Abdullah & Brown, 2011; Anglin et al., 2006; Chen & Mak, 2009; Cheng et al., 2013; Clement et al., 2015; Cooper-Patrick et al., 1997; De Luca, Blosnich, Hentschel, King, & Amen, 2016; Eisenberg, Downs, Golberstein, & Zivin, 2009; Hines-Martin, Usui, Kim, & Furr, 2004; Masuda, Anderson, & Edmonds, 2012; Masuda et al., 2009, 2012; Rao et al., 2007; Whaley, 1997). In a sample of 5,555 students from 13 different universities, Eisenberg and colleagues (2009) found Asian Americans to have the highest levels of internalized mental health stigma as compared to all other ethnic minority groups. Nonetheless, several studies have also demonstrated that African Americans and Hispanic/Latinos express more negative attitudes toward mental illness and poorer help-seeking attitudes than their Caucasian counterparts (e.g., Anglin et al., 2006; Clement et al., 2015; Cooper-Patrick et al., 1997; Hines-Martin et al., 2004; Masuda et al., 2009, 2012; Whaley, 1997).

In addition to REMs, the current study aimed to investigate the relationship between internalized stigma and help-seeking attitudes for multicultural and bicultural individuals as well. Thus far, research amongst this population has largely focused on investigating
bicultural identity integration, or “the degree to which a bicultural individual perceives his/her cultural identities as ‘compatible’ versus ‘opposition’” (Benet-Martinez & Haritatos, 2005, p. 1015). Individuals with greater identity integration tend to report better psychological well-being, as well as more positive help-seeking attitudes. However, the majority of these studies have yet to investigate the role of internalized stigma, and use the terms “bicultural” and “multicultural” interchangeably (e.g., Benet-Martinez & Haritatos, 2005). While similarities exist amongst bicultural and multicultural individuals, these terms do, in fact, encompass separate groups of individuals. Bicultural individuals, for example, refer to REMs within the U.S., who share U.S. American culture as well as their culture of origin (e.g., Hispanic, Asian American). Multicultural individuals, on the other hand, refer to individuals who belong to more than one minority ethnic/racial group (e.g., Black Hispanic). Thus, multicultural individuals are navigating two or more cultural identities, as well as U.S. American culture. The current study aimed to extend previous literature by investigating whether the patterns examined in this study differed between these two groups.

In an effort to evaluate multiculturalism across varying categories, we not only investigated multicultural and bicultural individuals as separate groups, but also examined a subgroup of binational individuals. Binational individuals refer to those persons whose parents are from distinct, separate countries (e.g., Peru and Ecuador). While an individual might report their race/ethnicity to be Hispanic, we recognize that cultures vary widely within these ethnic categories. Thus, by capturing specific parental countries of origin, we hope to further illuminate any discrepancies or similarities that may arise amongst these different categorizations (multicultural, bicultural, binational).
Specifically, multicultural and binational individuals may experience even greater levels of bicultural stress, or increased stress due to competing demands or expectations from having two or more minority cultural identities, as compared to bicultural REMs and Caucasians (Romero & Van Campen, 2011). Thus far, research has demonstrated higher levels of bicultural stress to be significantly associated with greater levels of depressive symptoms and suicidal ideation, as well as lower levels of optimism and life satisfaction (Romero & Roberts, 2003; Romero, Carvajal, Valle, & Orduna, 2007). These findings are in line with the broader literature which has also found significant associations with higher levels of acculturative stress and greater suicidal ideation/Attempts, greater depressive symptoms, and poorer quality of life (Gomez, Miranda, & Polanco, 2011; Hovey, 2000; Thoman & Surís, 2004; Torres, 2010). Due to the positive relationship between stress and help-seeking attitudes in general, we might expect multicultural and binational individuals to be at a particular disadvantage for help-seeking, given the conflicting expectations and demands they may experience from each of their cultures or countries of origin. As such, multicultural and binational individuals who experience increased stress as the result of their competing minority or cultural identities, may in turn have greater difficulty seeking help and treatment within the U.S.

**Perceived Discrimination and Help-Seeking Attitudes**

Discrimination refers to unjust or prejudicial treatment an individual may receive numerous factors, such as race/ethnicity, gender, age, sexual orientation, religious affiliation (Pascoe & Richman, 2009). Like mental health stigma, discrimination also appears to be an important predictor of help-seeking attitudes. Negative consequences of discrimination have been well-documented, such that greater discriminatory experiences
have been linked with poorer physical health (e.g., high blood pressure, hypertension), poorer mental health outcomes (e.g., depression, anxiety, psychosis), as well as more negative help-seeking attitudes and less willingness to seek formal treatment (e.g., Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008; Oh, Cogburn, Anglin, Lukens, & DeVylder, 2016; Pascoe & Richman, 2009; Pattyn et al., 2014; Schomerus & Angermeyer, 2008; Zerger et al., 2014). Perceived discrimination, defined as the an individual’s subjective experience of discriminatory behaviors resulting from negative attitudes, judgments, or unfair treatments toward members of another group is an important component of discrimination (Banks, Kohn-Wood, & Spencer, 2006; Pascoe & Richman, 2009). Perceived discrimination has been repeatedly found to directly predict decreased likelihood to engage in treatment seeking behaviors (e.g., Burgess et al., 2008; Pascoe & Richman, 2009; Schomerus & Angermeyer, 2008). In other words, individuals who have greater perceptions of daily or lifetime discrimination are more likely to report negative help-seeking attitudes, and less likely to engage in mental health service utilization.

Although the negative impact of discrimination has been demonstrated across racial/ethnic groups, numerous studies have demonstrated significant racial/ethnic differences. Specifically, a higher prevalence of discrimination has been found among REMs, which has been found to contribute to their poorer help-seeking attitudes, as well as the “service gap”, or their underutilization of health care services (e.g., Burgess et al., 2008; Cheng et al., 2013; Kessler et al., 1999). Burgess and colleagues (2008) explained this association by positing that members of collectivistic cultures, such as REMs, may be especially sensitive to discriminatory experiences due to the importance placed upon
interpersonal relationships within these cultures. As a result, Burgess and colleagues (2008) suggest that the heightened sensitivity to discrimination in this population may lead to greater avoidance of treatment, as well as increased likelihood of poor help-seeking attitudes. In other words, these individuals may feel more comfortable relying on family or social support, rather than seeking professional help largely provided by institutions and/or members of the dominant culture.

*Cultural Beliefs and Values*

*Family Cohesion.* Collectivistic family values, like family cohesion, stress the importance of the family over and above that of the individual. Research has demonstrated that collectivistic values impact the development of mental illness stigma. When one is mentally ill in more collectivistic cultures, the illness is considered to be a reflection upon the individual’s family (e.g., Abdullah & Brown, 2011; Cauce et al., 2002; Chen & Mak, 2008). Thus, while having family support can be a great resource for the mentally ill (e.g., Gurak & Weisman de Mamani, 2016; Weisman, Duarte, Koneru, & Wasserman, 2006), it can also work against one’s willingness to seek help (Abdullah & Brown, 2011), because seeking professional assistance may bring shame and embarrassment not only to the individual, but also to their loved ones. For example, in a sample of Chinese Americans, Hong Kong Chinese and European Americans, Chen and Mak (2008) found that Chinese Americans and Hong Kong Chinese who endorsed more traditional Asian values were less likely to have favorable help-seeking attitudes as compared to European Americans. A number of studies have found similar results among various Asian American populations, such that greater adherence to Asian cultural values is associated with poorer help-seeking attitudes (e.g., Choi & Miller, 2014; Guo et al.,
Similar to Asian American, African Americans and Hispanic/Latinos also endorse comparable collectivistic family values, such as social support, family cohesion, and interdependence (e.g., Abdullah & Brown, 2011). Surprisingly, greater social support has been linked with more negative help-seeking attitudes in African Americans, Hispanic/Latinos, and Asian American populations (e.g., Masuda & Boone, 2011; Masuda et al., 2012; Morgan, Ness, & Robinson, 2003; Yoo, Goh, & Yoon, 2005). Though counterintuitive, greater levels of social support by family and friends may reduce help-seeking behaviors because informal, family/friend support is cheaper and a more socially acceptable outlet for achieving assistance with mental health problems. In accordance with this idea, Woodward (2011) found African Americans and Black Caribbeans to be significantly less likely to receive professional or informal treatment, as compared to Whites. Similarly, Jimenez and colleagues (2012) found that among REMs, when experiencing mental illness, African Americans were most likely to speak with a family member, Latinos were less likely to speak with a medical doctor, and Asian Americans were most likely to be unwilling to speak with any professional. In other words, REMs were found to be more willing to seek out informal avenues of support, rather than formal professional treatment options. Moreover, in a study of 115 Turkish undergraduates, Bilican (2013) also found seeking informal help from family friends to be one of the most common reasons for not utilizing formal treatment, such as psychotherapy. Thus, it is clear that family cohesion plays a role in the development of help-seeking attitudes, as well as later utilization of mental health services. Specifically,
the links between internalized mental health stigma, perceived discrimination and help-seeking attitudes may be weaker for those individuals who endorse having strong family bonds.

*Acculturation/Enculturation.* Acculturation and enculturation have been found to be important factors to consider in the study of help-seeking attitudes. Broadly, acculturation refers to the psychological change which occurs as the result of contact with a novel culture (Berry, 2005). Berry (2005) refers to assimilation as one aspect of acculturation, in which an individual adopts to the new culture’s beliefs/values whilst relinquishing those of their minority culture. However, the terms acculturation and assimilation are often used interchangeably within the literature. In the current paper, I will refer to assimilation as the adoption of beliefs and values from the host or mainstream culture. Enculturation, on the other hand, is defined by Berry (2005) as the maintenance of the beliefs, values and behaviors associated with one’s minority culture despite contact with a new culture. Through the course of his research, Berry (2006) adopted a multidimensional acculturative framework based upon the intersection of acculturation and enculturation, consisting of four categorical acculturative strategies: integration, assimilation, separation, and marginalization. Each of these categories reflects levels of both acculturation and enculturation. Integration represents high levels of acculturation and enculturation, assimilation represents high levels of acculturation and low levels of enculturation, separation represents high levels of enculturation and low levels of acculturation, and marginalization represents low levels of acculturation and enculturation (Berry, 2006).
Within the help-seeking literature, acculturation and enculturation have been widely studied, with the majority of research demonstrating greater levels of acculturation and lower levels of enculturation to be associated with better, more positive help-seeking attitudes (e.g., Kim & Omizo, 2003; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Liao et al., 2005; Miller, Yang, Hui, Choi, & Lim, 2011; Na, Ryder, & Kirmayer, 2016; Sun et al., 2016; Ting & Hwang, 2009; Zhang & Dixon, 2003). Though in some contexts enculturation is linked to better mental health (e.g., Shim & Schwartz, 2008; Yeh, 2003), and acculturation to poorer mental health (e.g., Koneru, Weisman, Flynn, & Betancourt, 2007), generally, the more an individual takes on the beliefs/values of Westernized, American culture (low enculturation, high acculturation), the more likely this individual is to report positive help-seeking attitudes. This suggests that acculturation/enculturation may be differentially related to mental health symptoms and help-seeking attitudes. In other words, despite their respective relation to mental health symptomatology, greater adherence to Western, individualistic cultural beliefs and values (acculturation) and lower adherence to those of the culture of origin (enculturation) may improve help-seeking attitudes in REMs leading to patterns more similar to those found in Caucasians. In the current study, I took this one step further by proposing that the link between internalized mental health stigma, perceived discrimination and help-seeking attitudes would be weaker in less acculturated individuals and stronger in more enculturated individuals.

**Multicultural Identity.** A growing body of research has investigated bicultural competence, or the degree to which an individual successfully functions within the demands of two distinct cultures, particularly within multicultural individuals (e.g.,
Berry, 2006; Cheng & Lee, 2013; LaFromboise, Coleman, & Gerton, 1993; Yampolsky & Amiot, 2016). It is important to note that integration of competing cultures (high levels of acculturation/enculturation) has been linked with more positive psychological well-being and mental health outcomes (e.g., Berry, 2006; Han, Berry, & Zheng, 2016; Weisman de Mamani, Weintraub, Maura, Martinez de Andino, & Brown, 2017). Though multicultural individuals are integrating competing minority cultures, bicultural ethnic minorities are also integrating Westernized American culture to their culture of origin. Further, binational individuals are similarly integrating two or more heritages in addition to Westernized American culture. Thus, the self-concept and identity for REMs, binational individuals, and multicultural individuals is impacted by their level of affiliation with two or more cultural groups.

In order to better understand the development of multicultural identity amongst multicultural and bicultural individuals, Amiot and colleagues (2007) developed a cognitive-developmental theory of social identity integration. This theory presents four distinct dimensional identity configurations: anticipatory categorization, categorization, compartmentalization, and integration. Anticipatory categorization reflects the anticipation of an individual preparing to join a new group. Categorization refers to identifying with a cultural group over the other, and seeing one’s identity as predominantly of one culture by excluding other identities. Compartmentalization, on the other hand, is characterized by keeping multiple cultural identities in separate, isolated compartments within the self. Finally, integration refers to cohesively connecting and reconciling multiple cultural identities within oneself. Yampolsky and colleagues (2016) then developed the Multicultural Identity Integration Scale (MULTIIS) scale (which is
also used in the current study) to directly assess these separate dimensions. Research has found integrating different cultural identities (integration) to be linked with more positive psychological well-being and adjustment (e.g., Huynh, Nguyen & Benet-Martinez, 2011; Thomas, Brannen & Garcia, 2010; Yampolsky, Amiot, & Sablonnière, 2016), whereas keeping one’s identities separate (compartmentalization) has been linked with poorer psychological well-being (Yampolsky, Amiot, & Sablonnière, 2013; Yampolsky et al., 2016). As far as I am aware, associations between dimensional aspects of multicultural identity and mental help-seeking attitudes have yet to be examined. To the best of my knowledge, this was be the first study to do so. In the current study, it was proposed that the association between internalized mental health stigma, perceived discrimination and help-seeking attitudes would be stronger for individuals who endorse greater levels of compartmentalization and categorization, and lower levels of integration.

**Mental Health Stigma and Symptom-Specific Help-Seeking Attitudes**

The majority of the help-seeking literature has focused on general help-seeking attitudes, or examined help-seeking attitudes and behaviors within a specific mental disorder. However, understanding help-seeking attitudes across different symptom clusters has largely been neglected. Given that help-seeking behaviors are likely to be impacted by the problem or symptoms being experienced, identifying the role of specific symptoms on help-seeking attitudes is important. A few studies have used the Personal Problems Inventory (PPI; Cash, Begley, McCown, & Weise, 1975), a 15-item measure of common psychiatric problems experienced by college students, and did not find significant differences in help-seeking attitudes across various problem types (Kelly & Achter, 1995; Lopez, Melendez, Sauer, Berger, & Wyssmann, 1998; Ponce & Atkinson,
1989). However, the PPI utilizes single word or short phrase descriptors (e.g., “depression”), but does not assess actual symptoms of mental health experienced (Cash et al., 1975). In other words, one’s understanding of “depression” is likely to be different for those who experience depressive symptomatology than those who do not.

More recently, an unpublished dissertation empirically examined symptom-specific help-seeking attitudes in a sample of Latino and Asian American college students and found individuals’ help-seeking attitudes to vary based on symptom constellations of psychiatric disorders (Ting, 2010). Ting (2010) found participants to report more positive help-seeking attitudes for the schizophrenia vignette, as compared to nonpsychotic disorders (e.g., depression and anxiety). Per Ting (2010), schizophrenia and psychotic spectrum disorders may be more likely to be conceptualized as a psychiatric illness, in comparison to more common symptoms, such as depression and anxiety.

In a similar vein, perceived symptom severity has been found to play a role in help-seeking attitudes and behaviors, such that greater perceived symptom severity has been associated with greater likelihood to seek help and treatment (e.g., Abe-Kim, Takeuchi, & Hwang, 2002; Blumenthal & Endicott, 1996; Constantine, Wilton, & Caldwell, 2003; Mojtabai, Olfson, & Mechanic, 2002). This may provide another explanation for the differential impact of symptom clusters, as it may partially depend on the extent to which one’s symptoms are interfering or impacting his or her level of functioning. For example, depression and anxiety may not necessarily impair an individual’s level of functioning to the same degree as subclinical psychosis and obsessive-compulsive traits. Results from a study of 254 university students by Ryan and colleagues (2014) support this idea, as students’ intention to use online interventions increased at higher levels of psychological
distress. Similarly, Belloch and colleagues (2009) found greater perceived interference in patients with obsessive-compulsive disorder to be associated with actively searching for help, and decreased treatment delay. Thus, those illnesses which produce more severe symptomatology and greater impairment in functioning may be associated with more positive help-seeking attitudes due to a greater perceived need for treatment. In other words, the level of impairment caused by mental health symptoms may strengthen the likelihood of one to seek help and treatment. While depression and anxiety can cause significant impairment, these symptoms may be conceptualized as more common and controllable, as compared to illnesses, such as psychotic spectrum disorders and Obsessive-Compulsive Disorder, which may be more likely to cause significant functional impairment that require professional treatment.

The current study aimed to take this line of research one step further, by evaluating whether specific types of mental health symptoms (depression, anxiety, subclinical psychosis, obsessive-compulsive traits) moderate the association between internalized mental health stigma, perceived discrimination and help-seeking attitudes. While more common emotional problems, such as depression and anxiety, may be viewed as treatable with emotional self-control or informal help (e.g., family and friend), more serious psychiatric symptoms, such as subclinical psychosis and obsessive-compulsive traits, may be more likely to be attributed to biomedical causes of severe mental illness requiring formal treatment (e.g., Lawrence et al., 2006; Leong, 1986; Link, Phelan, Bresnahan, Stueve, & Pescolido, 1999; Narikiyo & Kameoka, 1992).
The Current Study

The current study evaluated the relationship between internalized mental health stigma, perceived discrimination and attitudes towards seeking professional psychological help. Specifically, we hoped to gain a more nuanced conceptual understanding of how internalized stigma and perceived discrimination affect help-seeking attitudes by evaluating whether the following cultural factors moderate these relationships: family cohesion, acculturation, enculturation, as well as compartmentalization, categorization, and integration identity. This study also examined the moderating role of race/ethnicity, and is one of the first to examine predictors of help-seeking in multicultural and binational individuals. Finally, this study examined whether psychological well-being as well as the following symptom clusters moderated these relationships: depression, anxiety, subclinical psychosis, and obsessive-compulsive traits.

Hypotheses

Based on the research reviewed above, the current study tested three primary sets of hypotheses:

1) The first set of analyses examined the impact of internalized mental health stigma and perceived discrimination on help-seeking attitudes. In line with prior research, we hypothesized that greater internalized stigma and greater perceived discrimination would be associated with poorer help-seeking attitudes.

2) The second set of analyses investigated the potential moderating role of several variables on the relationships between help-seeking attitudes, internalized mental health stigma, and perceived discrimination. Separate models were run for internalized mental health stigma and for perceived discrimination.
a. *Cultural Factors*: Race/ethnicity, binationality, multicultural identity, acculturation, enculturation, family cohesion, integration identity, compartmentalization identity, and categorization identity were evaluated in each model as moderators. We hypothesized that the inverse relationships between help-seeking attitudes and both internalized stigma and perceived discrimination would be moderated by race/ethnicity, binationality, multicultural identity, acculturation, enculturation, family cohesion, integration, compartmentalization, and categorization, such that these relationships would be strengthened for:

1. REMs as compared to Caucasians,
2. Binational individuals as compared to other REMs and Caucasians,
3. Multicultural individuals as compared to bicultural individuals and Caucasians,
4. individuals who endorse lower levels of acculturation,
5. individuals who endorse greater levels of enculturation,
6. individuals who endorse greater levels of family cohesion,
7. individuals who endorse lower levels of integration,
8. and for individuals who endorse greater levels of compartmentalization and categorization.

b. *Symptom Clusters*: Psychological well-being and specific symptom clusters (depression, anxiety, subclinical psychosis, obsessive-compulsive traits) were evaluated in each model as moderators. We hypothesized that
the inverse relationship between help-seeking attitudes and both internalized mental health stigma and perceived discrimination would be moderated by psychological well-being and specific symptom clusters, such that these relationships would be weakened for individuals with:

1. poorer psychological well-being,
2. greater levels of depression and anxiety,
3. and greater levels of subclinical psychosis and obsessive-compulsive traits.

Although greater symptom severity was expected to attenuate the associations between internalized mental health stigma, perceived discrimination and help-seeking attitudes for all symptoms, the degree of moderation was expected to be strongest for more serious symptoms such as subclinical psychosis and obsessive-compulsive traits.

3) The final set of analyses included both internalized mental health stigma and perceived discrimination as predictors of help-seeking attitudes, as well as any cultural variable or symptom cluster found to significantly moderate these relationships. This allowed for a more comprehensive evaluation of predictors of help-seeking attitudes.
CHAPTER TWO: METHODS

Participants

A total of 494 undergraduates were recruited from the psychology research pool at the University of Miami, a private institution in Miami, Florida with a diverse set of undergraduates. Participants had a mean age of 19.09 years old (SD = 1.53). The majority of the sample were freshman (307, 62.1%) and female (299, 60.5%). Participants self-reported their ethnicity as Caucasian (233, 47.2%), Hispanic/Latino (111, 22.5%), African American (47, 9.5%), Asian American (38, 7.7%), Native American (2, .4%), or Other (63, 12.8%).

Based on participants’ self-report of their mother and father’s cultural background, participants were coded as either being multicultural, bicultural, or Caucasian. For example, an individual would be coded as multicultural if his or her mother’s cultural background was reported to be Hispanic/Latino and his or her father’s cultural background was reported to be Asian American. On the other hand, an individual would be coded bicultural if his/her mother’s cultural background was reported to be Hispanic/Latino and his or father’s cultural background was reported to be U.S. American. In addition, an individual would be coded as bicultural if his/her parent’s backgrounds were both reported to be of the same REM group (e.g., both “Black” or both “Hispanic/Latino”), unless two distinct countries of origin were reported (e.g., “Peruvian and Chilean” or “Black Caribbean and African American”), in which case he/she would be coded as multicultural. Finally, an individual would be coded as Caucasian if both his/her parent’s cultural background was reported to be U.S. American. In the current sample, 161 participants were deemed multicultural (32.6%), whereas 333 individuals
were deemed not multicultural (67.4%). Of the latter 321 individuals, 177 were deemed bicultural (35.8%) and 156 were deemed Caucasian (31.6%).

In addition, binationality was coded using the self-reported parent cultural background. Individuals were coded “yes” as binational if they reported their mother or father’s background as two distinct countries (e.g., “Mexican and German” or “Peruvian and Ecuadorian”). On the other hand, individuals who reported their parents to come from the same country or cultural background were coded “no” (e.g., “Cuban and Cuban” or “Caucasian and Caucasian”). See tables 1, 2, and 3 for sample characteristics.

Procedure

The study was reviewed and approved by the Institutional Review Board of the University of Miami. Participants completed all questionnaires online via a Qualtrics survey, and were allowed to work at their own pace. All questionnaires were presented in English, and class credit was awarded for participation in the current study.

Measures

All assessments are described below and attached in the Appendix. Reliabilities were also calculated by ethnicity, demonstrating no significant difference from the reliability calculated using the overall sample (see Table 4)

Demographics: All participants completed a demographics questionnaire in which they provided information on age, gender, race/ethnicity, religion, cultural background of their parents, current year in college, as well as their declared major and current GPA.

Internalized Stigma: The Brief Version of the Internalized Stigma of Mental Illness Scale (ISMI-10; Boyd, Otilingam & DeForge, 2014) is a 10-item self-report questionnaire which measures self-stigma of mental illness on a 4-point Likert Scale
ranging from 1 (strongly disagree) to 4 (strongly agree). It is based on the original 29-item ISMI (Ritsher, Otilingam, & Grajales, 2003), and includes two items from each of the five subscales: Alienation, Discrimination Experience, Social Withdrawal, Stereotype Endorsement, and Stigma Resistance. Responses are rated on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Necessary scale items were reverse coded, such that higher scores are indicative of greater endorsement of internalized stigma. An average score was calculated by adding all item scores together and dividing by the total number of answered items, resulting in average scores that will range from 1-4. The ISMI-10 has demonstrated acceptable internal reliability (Cronbach’s alpha = .75; Boyd et al., 2014), as well as good test-retest reliability ($r = .62-.92$; Chang, Wu, Chen, Wang, & Lin, 2014). The current study similarly demonstrated adequate internal reliability with a Cronbach’s alpha of .77.

**Perceived Discrimination**

The **Daily Life Experiences Subscale** of the Racism and Life Experiences Scale (DLE; Harrell, 1994) is an 18-item self-report questionnaire that assesses the frequency and distress related to “microaggressions” due to race in the past year. The DLE presents a list of discriminatory experiences and asks participants to indicate how often each experience occurred to them within the past year (e.g., “Being treated rudely or disrespectfully” or “Being insulted, called a name or harassed”). Responses are rated on a 6-point Likert scales ranging from 0 (never) to 5 (once a week or more). Higher scores on respective subscales are indicative of greater frequency and distress to microaggression incidents. The overall scale has demonstrated strong internal, split-half, and test-retest reliability with a Cronbach’s alpha ranging from .69 to .96 (Harrell, 1994). Both the DLE
frequency and distress subscales in the current study demonstrated excellent internal consistency with a Cronbach’s alpha of .96.

The Everyday Discrimination Subscale of the Experience of Discrimination Scale (EDS; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005) is a 9-item self-report questionnaire assessing the frequency of discriminatory experiences in day-to-day life (e.g., “People act as if they are afraid of you” or “People act as if they think you are dishonest”). Responses are rated on a 6-point Likert scale ranging from 0 (never) to 5 (almost everyday). Higher scores are indicative of greater frequency of everyday discriminatory experiences. The subscale has demonstrated good internal reliability (Cronbach’s alpha = .81; Krieger et al., 2005), as well as adequate test-retest reliability (alpha = .70; Krieger et al., 2005). The current study exhibited excellent internal consistency with a Cronbach’s alpha of .90.

Help-Seeking Attitudes: The Brief Version of the Attitudes Toward Seeking Professional Psychological Help (ATSPPH-SF; Fischer & Farina, 1995) is a 10-item self-report questionnaire which assesses an individual’s attitudes and beliefs regarding seeking professional help (e.g., “I would want to get psychological help if I were worried or upset for a long period of time”). It is based on the original 29-item scale (Fischer & Turner, 1970). Responses are rated on a 4-point Likert scale ranging from 1 (disagree) to 4 (agree). Necessary scale items were reverse coded, such that higher scores are indicative of more positive attitudes towards seeking professional help. The ATSPPH-SF has demonstrated good internal reliability (Cronbach’s alpha = .87, Fischer & Farina, 1995), and good test-retest reliability (alpha = .80; Vogel, Wester, Wei, & Boysen, 2005).
The current study demonstrated adequate internal reliability with a Cronbach’s alpha of .75.

*Family Cohesion:* The **Family Cohesion** subscale of the Family Environment Scale (FES; Moos & Moos, 1981) is a 9-item self-report questionnaire designed to assess the degree to which participants feel their family provides help, support, and commitment to each other. The FES has strong psychometric properties, which have been demonstrated in English and Spanish (Weisman & Lopez, 1996). Necessary items were reverse coded, after which an overall score was calculated by summing the participant’s scores for each item and dividing by the total number of answered items. Higher scores are indicative of greater perception of cohesion within the family. This scale has demonstrated adequate to good internal reliability with a Cronbach’s alpha ranging from .63-.78, and acceptable test-retest reliabilities ranging from .68-.86 (Moos & Moos, 1981; Weisman et al., 2005). In the current study, the FES demonstrated adequate internal reliability with a Cronbach’s alpha of .72.

*Acculturation/Enculturation:* The **Abbreviated Multidimensional Acculturation Scale** (AMAS; Zea, Asner-Self, Birman, & Buki, 2003) is a 42-item self-report questionnaire that measures three main areas: cultural identity, language competence, and cultural competence. Responses are rated on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree) for the cultural identity subscale, and ranging from 1 (not at all) to 4 (extremely well) for the language and cultural competence subscales. For this study, two overall scores for acculturation and enculturation were calculated. For an overall score of acculturation, all items pertaining to American culture and the English language were averaged, with higher scores indicative of greater adherence to U.S.
culture. Conversely, for an overall score of enculturation, all items pertaining to the culture of origin and the corresponding language were averaged, with higher scores indicative of greater adherence to the culture of origin. The AMAS subscales have previously demonstrated good internal reliability, with Cronbach’s alphas ranging from .90 to .97 (Zea et al., 2003). Later studies have demonstrated similarly high internal consistencies of .92 for acculturation and .95 for enculturation among Mexican American and Asian students (Yoon, Jung, Lee, & Felix-Moora, 2012). The current study similarly demonstrated excellent internal consistency with a Cronbach’s alpha of .94 for both the acculturation and enculturation subscales.

Multicultural Identity: The Multicultural Identity Integration Scale (MULTIIS; Yampolsky et al., 2016) is a 22-item self-report questionnaire which examines three different configurations of multicultural identity: categorization (5 items), compartmentalization (9 items), and integration (8 items). Sample items include “I identify with one culture more than any other” (categorization), “I keep my cultural identities separate from each other” (compartmentalization), and “My cultural identities complement each other” (integration). Responses are rated on a 7-point Likert scale ranging from 1 (not at all) to 7 (exactly). All three subscales have previously demonstrated adequate to good internal reliability with Cronbach’s alphas ranging from .66 to .87 (Yampolsky et al., 2016). Yampolsky and Amiot (2016) have since replicated adequate to good internal consistencies ranging from .74 to .83 across all three subscales. In the current study, all subscales demonstrated good to excellent reliability with
Cronbach’s alphas ranging from .87 (categorization) to .92 (compartmentalization/integration).

**Subclinical Psychosis**

The **Oxford Liverpool Inventory of Feelings & Experiences** (O-LIFE; Mason, Claridge, & Jackson, 1995) is a 104-item self-report questionnaire that assesses schizotypal traits. The measure is composed of four subscales: unusual experiences, cognitive disorganization, introvertive anhedonia, and impulsive non-conformity. Participants were presented with questions to which they answer either “yes” or “no”. In this study, necessary items were reverse coded, after which a total score was calculated by summing participant’s scores for each item. Higher scores are indicative of greater endorsement of schizotypal traits. The O-LIFE has previously demonstrated high internal consistency ranging from .77-.89, as well as adequate test-retest reliability greater than .70 (Mason & Claridge, 2006). The current study demonstrated good internal consistency of the overall scale with a Cronbach’s alpha of .82.

Additionally, the **Schizotypal Personality Questionnaire** (SPQ; Raine, 1991) is a 74-item self-report questionnaire that assesses schizotypal traits. The SPQ consists of 9 subscales: ideas of reference, excessive social anxiety, odd beliefs or magical thinking, unusual perceptual experiences, odd or eccentric behavior, no close friends, odd speech, constricted affect, and suspiciousness. Responses were given in a “yes/no” format, for which items endorsed “yes” received a score of 1 point, such that higher scores were indicative of greater endorsement of schizotypal traits. The SPQ has previously demonstrated strong internal reliability (Cronbach’s alpha = .91; Raine, 1991) and good
test-retest reliability (alpha = .82; Raine, 1991). The current study similarly demonstrated excellent internal consistency with a Cronbach’s alpha of .94.

The **Prodromal Questionnaire-Brief Version** (PQ-B; Loewy, Pearson, Vinogradov, Bearden, & Cannon, 2011) is a 21-item self-report questionnaire that assesses the presence of prodromal positive symptoms of psychosis, as well as the level of distress experienced as a result of this symptom. Each item asked whether the symptom is present in a “yes/no” format, and then the level of associated distress was rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). For this study, a total distress score was calculated by averaging across all distress items, with higher scores indicative of greater levels of distress regarding prodromal positive symptoms of psychosis. The PQ-B has previously demonstrated strong internal reliability (Cronbach’s alpha = .85; Loewy et al., 2011), as well as good test-retest reliability (alpha = .87; Xu et al., 2016). The current study similarly demonstrated good internal consistency with a Cronbach’s alpha of .84.

The **Altman Self-Rating Mania Scale** (ASRM; Altman, Hedeker, Peterson, & Davis, 1997) is a self-report questionnaire that is composed of three factors: mania, psychotic symptoms, and irritability. Only the mania scale of the ASRM was included in the current study, which consists of 5 statements that are rated on a 5-point Likert scale indicating the frequency of each symptom. The five symptoms included in this subscale were elevated mood, increased self-esteem, less need for sleep, pressured speech, and psychomotor agitation. For this study, a total score was calculated by averaging across all items, with higher scores indicative of greater levels of mania. The mania subscale of the ASRM has previously demonstrated good internal consistency (Cronbach’s alpha = .79),
and good test-retest reliability \( r = .86; \) Altman et al., 1997). The current study demonstrated adequate internal reliability with a Cronbach’s alpha of .68.

**Obsessive-Compulsive Traits:** The **Obsessive-Compulsive Inventory** (OCI; Foa, Kozak, Salkovskis, Coles, & Amir, 1998) is a 42-item self-report questionnaire that assesses the distress caused by symptoms of obsessive-compulsive disorder (OCD). The OCI contains seven subscales, based on symptom categories often found within patients with OCD: washing, checking, doubting, ordering, obsessions, hoarding, and mental neutralizing. Responses were rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). For this study, a total score was calculated by averaging across all items, with higher scores indicative of greater levels of distress regarding OCD symptoms. The subscales and full scale have previously demonstrated good to excellent reliability, with a Cronbach’s alpha ranging from .59 to .96, as well as good test-retest reliability \( r = .84-.90; \) Foa et al., 1998). The current study demonstrated excellent internal consistency with a Cronbach’s alpha of .96.

**Depression and Anxiety:** The **Depression and Anxiety Subscales** of the 21-item version of the Depression Anxiety and Stress Scales (DASS 21; Lovibond & Lovibond, 1995) are subscales of a self-report questionnaire composed of three factors: depression, anxiety, and stress. Each factor is comprised of 7 items, and all questions were answered on a 4-point Likert scale of 0 (did not apply to me at all) to 3 (applied to me very much, or most of the time). For this study, a depression and anxiety score were calculated by averaging across the specific items for each respective subscale, with higher scores indicative of greater levels of depression or anxiety. The Depression and Anxiety subscales of the DASS 21 have previously demonstrated excellent reliability for Depression (Cronbach’s
alpha = .91-97) and for Anxiety (alpha = .81-.92; Antony, Bieling, Cox, & Swinson, 1998). The current study demonstrated good internal consistency with a Cronbach’s alpha of .87 for Depression and .82 for Anxiety.

Psychological Well-Being

The Stress Subscale of the 21-item version of the Depression Anxiety and Stress Scales (DASS 21; Lovibond & Lovibond, 1995) is a subscale of a self-report questionnaire composed of three factors: depression, anxiety, and stress. Each factor is comprised of 7 items, and all questions are answered on a 4-point Likert scale of 0 (did not apply to me at all) to 3 (applied to me very much, or most of the time). A stress score was calculated by averaging across items for this specific subscale, with higher scores indicative of greater levels of stress. The Stress subscale of the DASS 21 has previously demonstrated excellent reliability with a Cronbach’s alpha ranging from .91 to .97 (Antony et al., 1998). The current study demonstrated good internal consistency with a Cronbach’s alpha of .83.

The 42-item version of Ryff’s Psychological Well-Being Scale (PWB; Ryff & Keyes, 1995) is a self-report questionnaire that assesses positive aspects of psychological functioning across six components: autonomy, positive relations with others, environmental mastery, personal growth, purpose in life, and self-acceptance. Responses were rated on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). For this study, necessary items were reverse coded, after which a total score was calculated by averaging across all items, with higher scores indicative of greater levels of psychological well-being. The PWB has previously demonstrated good to excellent internal reliability (Cronbach’s alpha = .86-.93), as well as good test-retest reliability.
(alpha = .81-.85; Ryff & Keyes, 1995). The current study demonstrated excellent internal reliability with a Cronbach’s alpha of .93.
CHAPTER THREE: RESULTS

Preliminary Data Analyses

All analyses were conducted using SPSS Statistics software, Version 24, and Mplus, Version 7.4. All study variables had a skewness and kurtosis within the normal range (skewness value of < |3| and kurtosis value < |10| as defined by Kline, 2005), thus no transformations were necessary. There was missing data on the following measures: PWB (n = 3, .006%), AMAS – Acculturation (n = 8, .017%), AMAS – Enculturation (n = 8, .017%), PQ-B (n = 8, .017%), FES (n = 8, .017%), and EDS (n = 8, .017%). Per Little’s test, all data were missing completely at random ($\chi^2(42) = 39.727, p = .571$). For analyses run in Mplus, full information maximum likelihood was used to account for missing data. These cases were excluded from analyses run in SPSS. Categorical demographic variables of ethnicity, multicultural identity, and binationality were dummy-coded. To identify any potential covariates, the relationship between the demographic variables of gender, multicultural identity, binationality, religion, and year in college and help-seeking attitudes were examined (see Tables 5 and 6). There was a statistically significant relationship between help-seeking attitudes and the following variables: gender, ethnicity, and multicultural identity. Specifically, men ($M = 2.60, SD = .52$) reported poorer help-seeking attitudes as compared to women ($M = 2.78, SD = .55$). Bicultural individuals ($M = 2.65, SD = .48$) and REMs ($M = 2.66, SD = .51$) also reported poorer help-seeking attitudes as compared to their Caucasian counterparts ($M = 2.76, SD = .58$). Therefore, gender was included as a covariate in all primary analyses. Ethnicity and multicultural identity were also included as a covariate in primary analyses, except for the moderation analyses testing for group differences amongst these constructs.
Variables of interest were summed and averaged across items, resulting in an overall score. Higher scores are reflective of greater levels of the construct being measured (e.g., greater stigma, greater discrimination).

**Model Fit Analyses**

Primary analyses were conducted using structural equation modeling (SEM) in Mplus, as well as multiple linear regression in SPSS Statistics software, version 24. Model fit was determined based on Kline’s (2011) criteria: a non-significant Chi-square test of model fit, a comparative fit index (CFI) greater than or equal to .95, a root mean square error of approximation (RMSEA) less than or equal to .09, and a standardized root mean square residual (SRMR) less than or equal to .06. Additionally, any indicator that does not demonstrate a factor loading of 0.8 or greater was removed from the model.

Latent variables were created for subclinical psychosis and perceived discrimination. The subclinical psychosis latent included four measures: the ASRM, the SPQ, the PQ-B, and the O-LIFE. This model created good model fit: $\chi^2(1) = .168, p = .68, \text{CFI} = 1.0, \text{RMSEA} = .00, \text{SRMR} = .003$. Each indicator significantly loaded onto the latent ($p$ ranging from .015 – .029). The perceived discrimination latent included three measures: the Frequency subscale of the DLE, the Distress subscale of the DLE, and the EDS. This model also created good model fit: $\chi^2(1) = .266, p = .07, \text{CFI} = .964, \text{RMSEA} = .07, \text{SRMR} = .068$. Each indicator significantly loaded onto the latent (all $p < .01$). However, the measurement model for the psychological well-being latent could not be identified due to inadequate degrees of freedom. Therefore, primary analyses examined the moderation of the PWB and the Stress subscale of the DASS 21 separately, rather than as a latent construct.
Internalized Mental Health Stigma and Help-Seeking Attitudes

To test the first hypothesis, internalized mental health stigma was regressed on help-seeking attitudes controlling for gender, ethnicity, and multicultural identity. While the overall model was significant ($F(4,489)=5.702, p<.01$) internalized stigma was not a significant predictor of help-seeking attitudes ($b=.079, SE=.053, p=.132$). Thus, the hypothesis was not supported.

Next, interaction terms were created in order to test the potential moderating roles outlined in hypothesis 2. Specifically, internalized stigma, as well as all continuous moderating variables (acculturation/enculturation, family cohesion, integration, compartmentalization, categorization, stress, psychological well-being, specific symptom clusters) were centered at their means. All continuous moderating variables were also centered at one standard deviation above and below their means. In this way, the relationship between internalized mental health stigma and help-seeking attitudes was tested at varying levels of acculturation, enculturation, family cohesion, integration, compartmentalization, and categorization, as well as at varying levels of stress, psychological well-being and specific symptom clusters. Below is a depiction of the centering equations using the OCI as an example:

(cOCI) Mean Centered OCI: Average OCI – 1.46 ($M$)

(OCIa) Standard Deviation Above: Mean Centered OCI + .48 ($SD$)

(OCIb) Standard Deviation Below: Mean Centered OCI - .48 ($SD$)

Three interaction terms were created for each continuous moderator (e.g., StigmaxcOCI, StigmaxOCIa, StigmaxOCIb) in order to test at three levels of each moderating variable.
Once all interaction terms had been created, a series of multiple linear regression analyses were run. For each continuous moderating variable, two sets of regression analyses were run. First, internalized stigma and the centered continuous moderating variable were regressed on help-seeking attitudes, controlling for covariates. Next, the interaction term was added to this analysis in order to determine whether it significantly changed the model. The same process was performed at one standard deviation above and below the centered variable. Below is a depiction of these regression equations using OCI as an example:

Mean Centered OCI (cOCI):

Equation 1: Help-seeking = α + β₁(Stigma) + β₂(cOCI)
   + βₙ(potential covariates…e.g., gender)

Equation 2: Help-seeking = α + β₁(Stigma) + β₂(cOCI) + β₂(StigmaxcOCI)
   + βₙ(potential covariates…e.g., gender)

Standard Deviation Above (OCIa):

Equation 1: Help-seeking = α + β₁(Stigma) + β₂(OCIa)
   + βₙ(potential covariates…e.g., gender)

Equation 2: Help-seeking = α + β₁(Stigma) + β₂(OCIa) + β₂(StigmaxOCIa)
   + βₙ(potential covariates…e.g., gender)

Standard Deviation Below (OCIb):

Equation 1: Help-seeking = α + β₁(Stigma) + β₂(OCIb)
   + βₙ(potential covariates…e.g., gender)

Equation 2: Help-seeking = α + β₁(Stigma) + β₂(OCIb) + β₂(StigmaxOCIb)
   + βₙ(potential covariates…e.g., gender)
Compartmentalization significantly moderated the relationship between internalized mental health stigma and help-seeking attitudes, however, in the opposite direction than predicted. The overall model ($F(6,487)=5.452, p=.000$) as well as the relationship between internalized mental health stigma and help-seeking attitudes were statistically significant ($b=.118, SE=.054, p=.030$). The interaction term was statistically significant when added to the overall model ($b=-.096, SE=.034, p=.005$), indicating that when compartmentalization was higher, internalized stigma was less likely to be associated with poorer mental health seeking attitudes. Amongst our sample, the relationship between internalized stigma and help-seeking attitudes was moderated by ethnicity, such that this direct relationship existed for Caucasians, but not REMs within our sample. As REMs may have a more multifaceted cultural identity than Caucasians, we evaluated whether REMs were also more likely to report greater levels of compartmentalization. As expected, we found that REMs ($M = 2.42, SD = 1.49$) expressed significantly greater levels of compartmentalization compared to their Caucasian counterparts ($M = 2.02, SD = 1.17$).

Contrary to hypotheses, specific symptom clusters (depression, anxiety, obsessive-compulsive traits), stress, psychological well-being, acculturation, enculturation, categorization, integration, and family cohesion did not significantly moderate the relationship between internalized mental health stigma and help-seeking attitudes (see Table 7). Interestingly, the relationship between internalized mental health stigma and help-seeking attitudes became statistically significant when depression was added to the regression equation, with internalized stigma being positively related to help-seeking attitudes ($b=.128, SE=.059, p=.031$). The same was true when obsessive-compulsive
traits were added \( (b=.131, SE=.058, p=.024) \), and when psychological well-being was added \( (b=.162, SE=.056, p=.004) \). Further, greater levels of psychological well-being \( (b=.151, SE=.040, p=.000) \) and lower levels of obsessive-compulsive traits \( (b=-.117, SE=.055, p=.035) \) were associated with more positive help-seeking attitudes (see Table 8).

For the interaction between internalized mental health stigma and the subclinical psychosis latent variable, interaction terms were created using Hayduk’s (1987) and Bollen’s (1989) SEM approach in Mplus. First, three versions of the subclinical psychosis latent were created using (1) centered means (cASRM, cSPQ, cO-LIFE, cPQ-B), (2) one standard deviation above the mean (ASRMa, SPQa, O-LIFEa, PQ-Ba), and (3) one standard deviation below the mean (ASRMb, SPQb, O-LIFEb, PQ-Bb). All three versions of the subclinical psychosis latent demonstrated excellent model fit: \( \chi^2(1)=.168, p=.68 \), \( CFI=1.0 \), \( RMSEA=.00 \), \( SRMR=.003 \). Next, a path analytic model was run in which internalized mental health stigma, the subclinical psychosis latent, gender, ethnicity, and multicultural identity were regressed on help-seeking attitudes (see Figure 1). This model demonstrated good fit: \( \chi^2(22)=49.614, p=.00 \), \( CFI=.971 \), \( RMSEA=.050 \), \( SRMR=.031 \), although neither internalized mental health stigma nor subclinical psychosis were significantly related to help-seeking attitudes. Then, three interaction models were run in which an interaction term was included using each version of the subclinical psychosis latent, respectively. Contrary to hypotheses, subclinical psychosis did not significantly moderate the relationships between internalized mental health stigma and help-seeking attitudes at all three levels of the moderation (see Figure 2 for an example). Of note, the relationship between internalized mental health stigma and help-seeking
attitudes became marginally significant ($p=0.054$) when the subclinical psychosis latent 
was added to the model, such that greater internalized stigma was related to more positive 
help-seeking attitudes.

To test the potential moderating role of categorical variables (race/ethnicity, 
multicultural identity, binationality), a series of ANCOVAs were conducted in SPSS, 
Version 24. For these analyses, only gender was included as a covariate, since ethnicity 
and multicultural identity were being analyzed as moderators. Race/ethnicity 
significantly moderated the relationship between internalized mental health stigma and 
help-seeking attitudes ($F(4,489)=1.803, p=.000$). The interaction term between ethnicity 
and internalized mental health stigma was significant ($b=-.222, SE=.105, p=.035$) and 
improved the overall model ($R^2 \text{ change}=0.009$). Contrary to hypotheses, greater levels of 
internalized mental health stigma were associated with more positive help-seeking 
attitudes for Caucasians ($b=.187, SE=.081, p=.023$), whereas there was no significant 
relationship between internalized stigma and help-seeking attitudes for REMs ($b=-.024, 
SE=.068, p=.724$). Contrary to hypotheses, multicultural identity and binationality did not 
significantly moderate the relationship between internalized mental health stigma and 
help-seeking attitudes. However, there were significant differences on help-seeking 
attitudes amongst multicultural identity groups ($F(2,491)=3.865, p=.022$) and specific 
racial/ethnic groups ($F(5,488)=2.617, p=.024$). Bicultural individuals ($p=.029$) and 
African Americans ($p=.017$) reported significantly poorer help-seeking attitudes as 
compared to their Caucasian counterparts.

*Perceived Discrimination and Help-Seeking Attitudes*

To test the hypothesis of the inverse association between perceived discrimination
and help-seeking attitudes, path analysis in Mplus was used. The perceived discrimination latent variable was regressed on help-seeking attitudes controlling for gender, ethnicity, and multicultural identity (see Figure 3). This model demonstrated good fit: $\chi^2(11)=42.345, p=.00$, CFI=.930, RMSEA=.076, SRMR=.040. In addition, the path coefficient for perceived discrimination on help-seeking attitudes was significant ($b=-0.125$, SE=.064, $p=.049$). In line with our hypothesis, greater levels of discrimination were significantly associated with poorer help-seeking attitudes.

For all analyses involving continuous moderators (acculturation/enculturation, family cohesion, integration, compartmentalization, categorization, stress, psychological well-being, specific symptom clusters), Hayduk’s (1987) and Bollen’s (1989) SEM approach in Mplus was used again. For each variable, three interaction terms were created with the perceived discrimination variable using the centered moderator (e.g., cOCI), the moderator centered at one standard deviation above the mean (e.g., OCIa), and the moderator centered at one standard deviation below the mean (e.g., OCIb). For all continuous moderators, a path analytic model was run in which the perceived discrimination latent, centered moderator, and interaction term were regressed on help-seeking attitudes, controlling for covariates. Below is a depiction of this equation, as well as the respective syntax, using OCI as an example:

Equation: \[ \text{Help-seeking} = \alpha + \beta_1(\text{Perceived Discrimination}) + \beta_2(\text{cOCI}) + \beta_3(\text{DiscxcOCI}) + \beta_4(\text{potential covariates...e.g., gender}) \]

Syntax: Disc by Freq Dist EDS;

  AT on Disc Interact Gender Eth Multi Bi;

  Interact | Disc xwith cOCI;
Contrary to hypotheses, enculturation significantly moderated the relationship between perceived discrimination and help-seeking attitudes in the opposite direction to our prediction (see Figure 4). Specifically, greater levels of enculturation weakened, rather than strengthened, the inverse relationship between perceived discrimination and help-seeking attitudes ($b=-0.1$, $SE=0.081$, $p=0.044$). Contrary to hypotheses, the interaction between subclinical psychosis and perceived discrimination on help-seeking attitudes was significant ($b=2.343$, $SE=1.211$, $p=0.053$) in the opposite direction to our prediction, such that greater levels of subclinical psychosis appeared to strengthen, rather than weaken, the inverse relationship between perceived discrimination and help-seeking attitudes (see Figure 5).

Contrary to hypotheses, specific symptom clusters (depression, anxiety, obsessive-compulsive traits), stress, psychological well-being, acculturation, compartmentalization, categorization, integration, and family cohesion did not significantly moderate the relationship between perceived discrimination and help-seeking attitudes (see Table 9). However, psychological well-being ($b=0.118$, $SE=0.039$, $p=0.002$) and acculturation ($b=0.114$, $SE=0.042$, $p=0.007$) were significantly related to help-seeking attitudes when added to their respective models, such that greater psychological well-being and greater levels of acculturation were significantly associated with more positive help-seeking attitudes (see Table 10).

To test the potential moderating role of categorical variables (race/ethnicity, multicultural identity, binationality), Baron and Kenny (1986) and Little and colleagues’
(2007) multi-group analysis SEM approach was used in Mplus. For each categorical variable, two models were run and then compared to each other. First, structural parameters were constrained to be equal across groups, and then these constraints were removed. The moderator effect was then statistically tested by taking the difference in the two Chi-Square values. Only gender was included as a covariate in these analyses, since ethnicity and multicultural identity were being analyzed as moderators. Contrary to hypotheses, ethnicity, multicultural identity, and binationality did not significantly moderate the relationship between perceived discrimination and help-seeking attitudes (see Table 11).

**Overall Model**

Lastly, a path analytic model was run in Mplus in which internalized mental health stigma and the perceived discrimination latent were regressed on help-seeking attitudes, controlling for covariates. This model demonstrated good fit: $\chi^2(7)=28.719, p=.00$, CFI=.953, RMSEA=.079, SRMR=.033. In line with our hypotheses, the path coefficient for perceived discrimination on help-seeking attitudes was significant ($b=-0.112$, SE=.057, $p=.049$) in the predicted direction, such that greater perceived discrimination was significantly related to poorer help-seeking attitudes. Further, the path coefficient for internalized mental health stigma on help-seeking attitudes was significant ($b=0.145$, SE=.061, $p=.017$), but opposite the predicted direction, such that greater internalized mental health stigma was significantly related to more positive help-seeking attitudes, rather than poorer help-seeking attitudes.

To test our final hypothesis of an overarching model with all significant moderating variables, the interaction terms of perceived discrimination with enculturation, perceived
discrimination with subclinical psychosis, internalized mental health stigma with compartmentalization, and internalized mental health stigma with ethnicity were added to the model. In line with hypotheses, the interaction terms for the moderating variables remained significant when evaluated in the overall model, except for internalized stigma with ethnicity (see Figure 6). The interaction term of internalized mental health stigma and compartmentalization was significant ($b=-.099$, $SE=.033$, $p=.003$), such that greater levels of compartmentalization weakened the direct relationship between internalized mental health stigma and help-seeking attitudes. In addition, the interaction term of perceived discrimination and enculturation was significant ($b=-.164$, $SE=.080$, $p=.041$), such that greater enculturation weakened the inverse relationship between perceived discrimination and help-seeking attitudes. Finally, the interaction term of perceived discrimination and subclinical psychosis was significant ($b=3.707$, $SE=1.565$, $p=.018$), such that greater subclinical psychosis strengthened the inverse relationship between perceived discrimination and help-seeking attitudes. However, the interaction term of internalized mental health stigma and ethnicity became non-significant ($b=-.017$, $SE=.015$, $p=.273$) when evaluated in the overarching model (see Table 12 for all betas and p-values).

**Summary of Key Results**

Regarding the study’s main effects, we found greater perceived discrimination to be associated with poorer help-seeking attitudes. On the other hand, greater internalized mental health stigma was associated with improved help-seeking attitudes when controlling for symptoms of depression, obsessive-compulsive traits, subclinical psychosis, and psychological well-being, respectively.
For internalized mental health stigma, race/ethnicity and compartmentalization identity were the only significant moderators on the observed association with help-seeking attitudes. Specifically, greater internalized stigma was associated with improved help-seeking attitudes for Caucasians, while no significant association was found for REMs. In addition, at higher levels of compartmentalization identity, internalized stigma was less likely to be associated with help-seeking attitudes.

For perceived discrimination, enculturation and subclinical psychosis were the only significant moderators on the observed association with help-seeking attitudes. Specifically, at greater levels of enculturation, greater perceived discrimination was less likely to be associated with poorer help-seeking attitudes. Further, at greater levels of subclinical psychosis, greater perceived discrimination was more likely to be associated with poorer help-seeking attitudes. Finally, when evaluated in an overall model, most of these relationships remained significant; except for the interaction between internalized stigma and race/ethnicity, which became non-significant.
CHAPTER FOUR: DISCUSSION

The goal of this study was to examine how cultural factors interact with internalized stigma and perceived discrimination to impact mental health help-seeking attitudes in different racial/ethnic groups. Interestingly, while past literature has found greater internalized stigma to be associated with poorer help-seeking attitudes (e.g., Brown et al., 2010; Corrigan & Kleinlein, 2005; Vogel et al., 2007), the current study found the opposite pattern in certain analyses. For example, we found greater levels of internalized stigma to be associated with more positive help-seeking attitudes for Caucasians; however, there was no relationship found for REMs. Although unexpected, it appears that for Caucasians, help-seeking attitudes may remain normative and even increase in the presence of higher levels of internalized mental health stigma. Caucasians who internalize stigma towards mental illness may be more likely to seek professional psychological help, as the stigma may lead them to withdraw from other potential supportive networks (e.g., family, friends) out of fear of being rejected or judged for their illness/symptoms. As Caucasians typically endorse more positive help-seeking attitudes, it may be that greater internalized stigma pushes this group towards seeking more professional avenues of support when they feel stigmatized for their symptoms.

Further, our results suggest that internalized mental health stigma does not appear relevant to help-seeking attitudes for REMs. This finding is especially important as REMs have notoriously lower rates of mental health utilization as compared to their Caucasian counterparts. While REMs reported more negative help-seeking attitudes as compared to Caucasians, internalized stigma did not appear to influence their help-seeking attitudes. It is possible that other factors, such as low expectations that
psychotherapy would be effective, may account for this pattern among REMs instead.

Future research on culture and help-seeking attitudes would benefit from also examining how attitudes of therapy efficacy impact help seeking behavior.

In this study, we also found that compartmentalization (e.g., the degree to which an individual keeps multiple cultural identities in separate, isolated compartments within the self) moderated the relationship between stigma and help-seeking. In other words, at higher levels of compartmentalization identity, the relationship between internalized stigma and help-seeking attitudes was less pronounced. Thus, it appears that one’s ability to compartmentalize and isolate cultural identities reduces the extent to which internalized stigma is associated with poorer help-seeking attitudes. Individuals who report greater ease with keeping their cultural identities separate and distinct may overcome their stigma when in need of professional mental health. While our findings appear to be inconsistent with the broader literature, it could be that compartmentalization may speak to an individual’s ability to dichotomize their experience in a beneficial way.

Further, the direct relationship between internalized stigma and help-seeking attitudes also appeared when depression, obsessive-compulsive traits, subclinical psychosis, and psychological well-being were included in their respective analyses. Our results suggest that these specific symptom clusters had a suppressing effect on the relationship between internalized stigma and help-seeking attitudes. A suppressor is defined as a variable whose inclusion strengthens the effect of another independent variable (internalized stigma) on the dependent variable (help-seeking attitudes; Conger, 1974). In these cases, greater levels of internalized stigma were associated with more positive help-seeking
attitudes when controlling for levels of depression, obsessive-compulsive traits, subclinical psychosis, and psychological well-being, respectively. Depression and other mental health symptoms may make people more lethargic and less attuned and responsive to their internal thoughts and perceptions. Thus, when these symptoms are controlled, the relationship between internalized stigma and help-seeking attitudes may re-emerge.

In line with our hypotheses and previous literature, greater levels of perceived discrimination were associated with more negative help-seeking attitudes (e.g., Burgess et al., 2008; Oh et al., 2016; Pascoe & Richman, 2009; Pattyn et al., 2014; Schomerus & Angermeyer, 2008; Zerger et al., 2014). Although REMs broadly reported poorer help-seeking attitudes as compared to their Caucasian counterparts, greater perceived discrimination was strongly related to poorer help-seeking attitudes across all racial/ethnic categories. Nonetheless, REMs report greater levels of discrimination and greater distress from these experiences. Thus, in an effort to reduce the current disparities in mental health utilization (minorities are much less likely to seek mental health services than are Caucasians), there is a great need to target discrimination at the public level and to address perceptions of discrimination in REMs in the settings to which they do present themselves (e.g., schools, doctors’ offices, etc).

One such avenue may be to implement public service campaigns designed to challenge stereotypes and misconceptions with the hopes of reducing societal levels of discrimination, as well as demonstrating tolerance and acceptance within the mental health system. In addition, increasing the number of racial/ethnic mental health professionals may be particularly beneficial for REMs seeking or receiving psychological treatment. By increasing the level of diversity seen within the field, REMs may feel more
comfortable seeking professional help, as they may see other REMs as less likely to
discriminate against them as compared to Caucasian mental health professionals.
Similarly, REMs may perceive racial/ethnic minority mental health professionals as more
likely to understand their perspective and the discriminatory experiences they are going
through. For all practitioners, inquiring about discriminatory experiences during
treatment or assessment procedures may showcase the mental health professionals’
empathy and recognition that these experiences are common and disproportionately affect
REMs. In other words, having more therapists of color and having all therapists
sensitized to societal experiences that disadvantage minorities may encourage REMs to
attend psychotherapy, even when they internalize high degrees of mental health stigma
and experience greater levels of discrimination.

Surprisingly, only levels of subclinical psychosis and enculturation moderated the
relationship between perceived discrimination and help-seeking attitudes. Broadly,
enculturation refers to an individual’s level of adherence to the beliefs and values of
one’s culture origin (Berry, 2005). Previous research has found that the more an
individual takes on the beliefs/values of Westernized, American culture (low
enculturation), the more likely this individual is to report positive help-seeking attitudes
(e.g., Kim & Omizo, 2003; Lara et al., 2005; Liao et al., 2005; Miller et al., 2011; Na et
al., 2016; Sun et al., 2016; Ting & Hwang, 2009; Zhang & Dixon, 2003). Contrary to
hypotheses, for individuals with greater levels of enculturation, the relationship between
perceived discrimination and help-seeking attitudes was weaker. It may be that people
with higher levels of enculturation have greater ethnic pride, as well as greater cultural
resources and opportunities of support from their community that encourage healthy
behaviors such as seeking professional psychological help, even in the face of discrimination. Moreover, individuals with greater levels of enculturation may also be more likely to spend time with members of the same cultural background, decreasing their likelihood of having discriminatory experiences, which are often perpetuated by individuals of a different racial/ethnic background. Thus, for individuals with greater enculturation, the relationship between perceived discrimination and help-seeking attitudes may be weakened due to a reduction in discriminatory experiences.

Contrary to expectations, for individuals with greater levels of subclinical psychosis, the inverse relationship between perceived discrimination and help-seeking attitudes was stronger. While we originally hypothesized that greater functional impairment and symptom severity may increase the likelihood of one to seek professional help, our findings indicate that this is not the case. Rather, our findings indicate that greater levels of perceived discrimination are more strongly associated with negative help-seeking attitudes for individuals with greater reported subclinical psychosis. It may be that individuals with greater levels of subclinical psychosis experience a greater disconnection with reality, as well as greater impairment in judgment, thus decreasing their likelihood to seek help. Further, individuals with greater levels of subclinical psychosis, may also perceive discriminatory experiences as related to symptoms of psychosis, such as suspiciousness and paranoia. Thus, for individuals with greater levels of subclinical psychosis, the symptoms experienced may explain the stronger association between perceived discrimination and poorer help-seeking attitudes. Future research would benefit from investigating whether this moderation remains intact across all
symptoms of psychosis, or largely in the presence of specific symptoms (e.g., paranoia, suspiciousness, disorganized thought disorder).

To our knowledge, this is the first study to explore the role of multicultural identity and binationality, as well as to examine the relationship between help-seeking attitudes, internalized stigma, and perceived discrimination in a multicultural sample. In the current study, we separated REMs into two sets of categories: bicultural and multicultural, as well as binational and of one nationality. Interestingly, though we found bicultural individuals to have poorer help-seeking attitudes as compared to Caucasians, this did not extend to multicultural or binational individuals. Contrary to expectations, our findings indicate that multicultural and binational individuals do not appear to be at greater risk for poorer help-seeking attitudes or lower mental health utilization, as compared to their Caucasian counterparts. Moreover, the relationships between help-seeking attitudes, perceived discrimination, and internalized stigma were not influenced by multicultural background or binationality.

Although preliminary, our findings are encouraging for multicultural individuals. Results from the current study indicated that multicultural and binational individuals did not have significantly different help-seeking patterns as compared to Caucasians. Thus, contrary to expectations, these individuals may not be at greater risk for poorer help-seeking attitudes. Rather, multicultural and binational individuals appear to exhibit similar help-seeking attitudes as their Caucasian counterparts, indicating that they may be as likely as Caucasians to seek professional psychological help when in need. Although we found broadly that REMs may continue to be at increased risk for underutilization of mental health services, within the specific subgroup categories, only bicultural
individuals demonstrated this pattern. For multicultural and binational individuals this was not the case. With a broader set of cultural beliefs and values to draw from, multicultural and binational individuals may have more support systems and cultural resources in place, leading to more flexible attitudes about mental illness and more beneficial beliefs about seeking professional help when needed.

Nonetheless, due to the nature of our study’s coding system for multicultural and binational individuals, our findings should be taken with a grain of salt. Binationality and multicultural identity were coded post-hoc by researchers based on participant self-report of parent cultural background and nationality. Thus, the variables themselves may not truly capture the constructs of interest. While an individual’s parents may come from diverse backgrounds or nations, this does not necessarily indicate how an individual may identify his or her nationality, cultural background, or ethnic identity. Moreover, number of years lived within the U.S. and outside the U.S. was not assessed. Without this information, we were unable to categorize an individual’s lived experience with other cultures or countries, which may also impact how they identify their own race/ethnicity or multicultural identity.

In line with hypotheses, many of the aforementioned relationships held true when evaluated in our overarching model, which incorporated all relationships of interest. Specifically, greater levels of perceived discrimination remained associated with more negative help-seeking attitudes. Further, the moderating effect of compartmentalization identity, enculturation, and subclinical psychosis all held firm within the overall model. However, internalized stigma and ethnicity were no longer associated with help-seeking attitudes when added to the overall model. Importantly, our findings speak to the
robustness of the individual relationships, which remained significant when evaluated in the overarching model.

In addition, in our sample, when evaluated concurrently, results suggest that perceived discrimination may have greater impact on help-seeking attitudes than internalized stigma. In this young, nonclinical sample, it may be that internalized stigma was less meaningful than it might be in a clinical population, as few individuals reported experiencing mental health symptoms. Thus, the majority of our sample may not have had the opportunity to internalize stigma because they have yet to experience mental health symptoms. Perceived discrimination, on the other hand, can be experienced regardless of mental health status. Thus, perceived discrimination may have more relevance in the current sample.

There were a number of limitations in the present study. First and foremost, the categorization of individuals as binational, bicultural, or multicultural was completed post-hoc by the researcher. Despite our attempt to examine nuances within a multicultural sample, future research should more accurately identify individuals as bicultural, multicultural, or binational by using both demographic data as well as self-reported identity as viewed by study participants. In addition, future researchers may consider other facets of multicultural identity, such as years lived within and outside the U.S., as well as specific cultural values (e.g., collectivism, familismo). Due to the current study’s categorization process, it is possible that our created categories may not be truly capturing bicultural, multicultural, or binational individuals.

Further, our study is limited by its cross-sectional design, which does not allow for longitudinal prediction. To confirm our causal hypotheses with greater confidence, it will
be necessary to examine the impact of internalized stigma and perceived discrimination on help seeking attitudes over time. Additionally, our use of a largely young and healthy, non-clinical, sample may have limited our ability to detect the moderating effect of symptom profiles. In our study, few participants endorsed experiencing high levels of depression, anxiety, stress, obsessive-compulsive traits, or subclinical psychosis and hence our range was limited. Future research would benefit from examining the relationships amongst help-seeking attitudes, internalized stigma, and perceived discrimination within a clinical sample.

Finally, the current study did not assess for previous utilization of mental health services. As past treatment or experience can influence attitudes and future behavior, the inclusion of this variable could be insightful. It may that a past positive experience with a mental health professional holds greater influence over one’s attitudes and future behavior, than internalized stigma or discrimination. Moreover, a past negative experience in tandem with internalized stigma and perceived discrimination may more greatly reduce one’s likelihood to seek professional help, and increase one’s negative attitudes towards help-seeking behavior. Thus, future research should examine how prior treatment utilization interacts with internalized stigma, discrimination, and help seeking behaviors.
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<tr>
<th>Sample Characteristics</th>
<th>N = 494</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>$M = 19.09, SD = 1.53$</td>
</tr>
<tr>
<td><strong>GPA</strong></td>
<td>$M = 3.30, SD = 0.80$</td>
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<tr>
<td><strong>Gender (n, % female)</strong></td>
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<tr>
<td><strong>Ethnicity (n, %)</strong></td>
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Table 2
*Cultural Background by Self-Reported Parent Nationality*

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<th>n</th>
<th>%</th>
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<td>Not binational</td>
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<tr>
<td>Binational</td>
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Table 3
Multicultural Identity by Self-Reported Parent Race/Ethnicity

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<tr>
<td>Bicultural</td>
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<td>Caucasian</td>
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<td>156, 31.6%</td>
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Table 4
**Reliability of all Measures by Self-Reported Ethnicity**

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<tr>
<th>Measure</th>
<th>Caucasian (n = 233)</th>
<th>Hispanic (n = 111)</th>
<th>African American (n = 47)</th>
<th>Asian American (n = 38)</th>
<th>Native American or Other (n = 65)</th>
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<td>MULTIIS – Comp</td>
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<td>.94</td>
<td>.94</td>
<td>.94</td>
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<tr>
<td>PQ-B</td>
<td>.86</td>
<td>.80</td>
<td>.87</td>
<td>.78</td>
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<td>.84</td>
</tr>
<tr>
<td>ASRM</td>
<td>.69</td>
<td>.63</td>
<td>.64</td>
<td>.67</td>
<td>.72</td>
<td>.68</td>
</tr>
<tr>
<td>OCI</td>
<td>.95</td>
<td>.95</td>
<td>.97</td>
<td>.97</td>
<td>.95</td>
<td>.96</td>
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<tr>
<td>DASS – Dep</td>
<td>.87</td>
<td>.88</td>
<td>.89</td>
<td>.85</td>
<td>.87</td>
<td>.87</td>
</tr>
<tr>
<td>DASS – Anx</td>
<td>.82</td>
<td>.82</td>
<td>.83</td>
<td>.82</td>
<td>.83</td>
<td>.82</td>
</tr>
<tr>
<td>DASS – Stress</td>
<td>.82</td>
<td>.86</td>
<td>.83</td>
<td>.86</td>
<td>.80</td>
<td>.83</td>
</tr>
<tr>
<td>PWB</td>
<td>.94</td>
<td>.93</td>
<td>.94</td>
<td>.91</td>
<td>.91</td>
<td>.93</td>
</tr>
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</table>

Table 5
Relationships Among All Variables with Help-Seeking Attitudes

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Help-Seeking Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>( r = .053, p = .243 )</td>
</tr>
<tr>
<td>Gender</td>
<td>( t(492) = -3.708, p = .000^{**} )</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>( t(492) = 2.038, p = .042^{*} )</td>
</tr>
<tr>
<td>Binationality</td>
<td>( t(492) = -2.900, p = .772 )</td>
</tr>
<tr>
<td>Multicultural Identity</td>
<td>( F(2, 491) = 3.865, p = .022^{*} )</td>
</tr>
<tr>
<td>Language</td>
<td>( F(2, 491) = 1.751, p = .175 )</td>
</tr>
<tr>
<td>Year in College</td>
<td>( F(3, 490) = .938, p = .422 )</td>
</tr>
<tr>
<td>GPA</td>
<td>( r = .069, p = .128 )</td>
</tr>
<tr>
<td>Religion</td>
<td>( F(4, 483) = .251, p = .909 )</td>
</tr>
<tr>
<td>ISMI-10</td>
<td>( r = .077, p = .089 )</td>
</tr>
<tr>
<td>DLE – Frequency</td>
<td>( r = -.102, p = .023^{*} )</td>
</tr>
<tr>
<td>DLE – Distress</td>
<td>( r = .022, p = .631 )</td>
</tr>
<tr>
<td>EDS</td>
<td>( r = -.060, p = .185 )</td>
</tr>
<tr>
<td>FES</td>
<td>( r = .002, p = .967 )</td>
</tr>
<tr>
<td>AMAS – Acculturation</td>
<td>( r = .127, p = .005^{**} )</td>
</tr>
<tr>
<td>AMAS – Enculturation</td>
<td>( r = .016, p = .730 )</td>
</tr>
<tr>
<td>MULTIIS – Categorization</td>
<td>( r = -.033, p = .464 )</td>
</tr>
<tr>
<td>MULTIIS – Compartmentalization</td>
<td>( r = -.066, p = .141 )</td>
</tr>
<tr>
<td>MULTIIS – Integration</td>
<td>( r = .028, p = .531 )</td>
</tr>
<tr>
<td>O-LIFE</td>
<td>( r = -.025, p = .582 )</td>
</tr>
<tr>
<td>SPQ</td>
<td>( r = -.055, p = .226 )</td>
</tr>
<tr>
<td>PQ-B</td>
<td>( r = .026, p = .569 )</td>
</tr>
<tr>
<td>ASRM</td>
<td>( r = -.045, p = .317 )</td>
</tr>
<tr>
<td>OCI</td>
<td>( r = .069, p = .128 )</td>
</tr>
<tr>
<td>DASS – Depression</td>
<td>( r = -.047, p = .296 )</td>
</tr>
<tr>
<td>DASS – Anxiety</td>
<td>( r = -.026, p = .564 )</td>
</tr>
<tr>
<td>DASS – Stress</td>
<td>( r = .011, p = .809 )</td>
</tr>
<tr>
<td>PWB</td>
<td>( r = .154, p = .001^{**} )</td>
</tr>
</tbody>
</table>

*\( p \leq .05 \)

**\( p \leq .01 \)

### Table 6

*Help-Seeking Attitudes Means by Ethnicity and Multicultural Identity*

<table>
<thead>
<tr>
<th></th>
<th>Help-Seeking Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Mean (SD)</strong></td>
<td>2.71 (.54)</td>
</tr>
<tr>
<td><strong>Ethnicity (SD)</strong></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>2.76 (.58)*</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2.74 (.49)</td>
</tr>
<tr>
<td>African American</td>
<td>2.48 (.49)*</td>
</tr>
<tr>
<td>Asian American</td>
<td>2.64 (.50)</td>
</tr>
<tr>
<td>Native American</td>
<td>2.25 (.49)</td>
</tr>
<tr>
<td>Other</td>
<td>2.68 (.53)</td>
</tr>
<tr>
<td><strong>Multicultural Identity (SD)</strong></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>2.81 (.58)*</td>
</tr>
<tr>
<td>Bicultural</td>
<td>2.65 (.48)*</td>
</tr>
<tr>
<td>Multicultural</td>
<td>2.67 (.56)</td>
</tr>
</tbody>
</table>

**Range in this study** 1-4

**Possible range** 1-4

*p ≤ .05*
Table 7
Interaction Effects for Internalized Mental Health Stigma and Help-Seeking Attitudes

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>SE</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS - Depression</td>
<td>.024</td>
<td>.089</td>
<td>.789</td>
</tr>
<tr>
<td>DASS - Anxiety</td>
<td>-.087</td>
<td>.106</td>
<td>.412</td>
</tr>
<tr>
<td>DASS - Stress</td>
<td>-.058</td>
<td>.088</td>
<td>.513</td>
</tr>
<tr>
<td>PWB</td>
<td>.114</td>
<td>.081</td>
<td>.156</td>
</tr>
<tr>
<td>OCI</td>
<td>-.099</td>
<td>.100</td>
<td>.323</td>
</tr>
<tr>
<td>MULTIIS - Categorization</td>
<td>-.009</td>
<td>.030</td>
<td>.760</td>
</tr>
<tr>
<td>MULTIIS - Compartimentalization</td>
<td>-.096</td>
<td>.034</td>
<td>.005*</td>
</tr>
<tr>
<td>MULTIIS - Integration</td>
<td>-.025</td>
<td>.031</td>
<td>.413</td>
</tr>
<tr>
<td>AMAS - Acculturation</td>
<td>.048</td>
<td>.090</td>
<td>.593</td>
</tr>
<tr>
<td>AMAS - Enculturation</td>
<td>-.013</td>
<td>.086</td>
<td>.880</td>
</tr>
<tr>
<td>FES</td>
<td>-.256</td>
<td>.323</td>
<td>.429</td>
</tr>
<tr>
<td>Subclinical Psychosis Latent</td>
<td>-1.053</td>
<td>1.857</td>
<td>.571</td>
</tr>
</tbody>
</table>

* p ≤ .01

Note. DASS = Depression Anxiety Stress Scale. PWB = Psychological Well-Being Scale. OCI = Obsessive-Compulsive Inventory. MULTIIS = Multicultural Identity Integration Scale. AMAS = Abbreviated Multidimensional Acculturation Scale. FES = Family Environment Scale.
Table 8  
**Direct Effects of Continuous Moderating Variables on Help-Seeking Attitudes with Internalized Mental Health Stigma**

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>SE</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS - Depression</td>
<td>-.085</td>
<td>.047</td>
<td>.072</td>
</tr>
<tr>
<td>DASS - Anxiety</td>
<td>-.061</td>
<td>.052</td>
<td>.243</td>
</tr>
<tr>
<td>DASS - Stress</td>
<td>-.038</td>
<td>.047</td>
<td>.419</td>
</tr>
<tr>
<td>PWB</td>
<td>.151</td>
<td>.040</td>
<td>.000**</td>
</tr>
<tr>
<td>OCI</td>
<td>-.117</td>
<td>.055</td>
<td>.035*</td>
</tr>
<tr>
<td>MULTIIS - Categorization</td>
<td>-.016</td>
<td>.014</td>
<td>.269</td>
</tr>
<tr>
<td>MULTIIS - Compartmentalization</td>
<td>-.024</td>
<td>.018</td>
<td>.199</td>
</tr>
<tr>
<td>MULTIIS - Integration</td>
<td>.005</td>
<td>.015</td>
<td>.728</td>
</tr>
<tr>
<td>AMAS - Acculturation</td>
<td>.114</td>
<td>.048</td>
<td>.017*</td>
</tr>
<tr>
<td>AMAS - Enculturation</td>
<td>-.001</td>
<td>.038</td>
<td>.989</td>
</tr>
<tr>
<td>FES</td>
<td>-.038</td>
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<td>.811</td>
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<tr>
<td>Subclinical Psychosis Latent</td>
<td>.363</td>
<td>.369</td>
<td>.326</td>
</tr>
</tbody>
</table>

*p ≤ .05  
**p ≤ .01

*Note. DASS = Depression Anxiety Stress Scale. PWB = Psychological Well-Being Scale. OCI = Obsessive-Compulsive Inventory. MULTIIS = Multicultural Identity Integration Scale. AMAS = Abbreviated Multidimensional Acculturation Scale. FES = Family Environment Scale.*
Table 9

Interaction Effects for Perceived Discrimination and Help-Seeking Attitudes

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>SE</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>DASS - Depression</td>
<td>.078</td>
<td>.075</td>
<td>.299</td>
</tr>
<tr>
<td>DASS - Anxiety</td>
<td>-.046</td>
<td>.112</td>
<td>.679</td>
</tr>
<tr>
<td>DASS - Stress</td>
<td>.077</td>
<td>.097</td>
<td>.428</td>
</tr>
<tr>
<td>PWB</td>
<td>-.065</td>
<td>.088</td>
<td>.462</td>
</tr>
<tr>
<td>OCI</td>
<td>-.009</td>
<td>.085</td>
<td>.916</td>
</tr>
<tr>
<td>MULTIIS - Categorization</td>
<td>-.043</td>
<td>.035</td>
<td>.225</td>
</tr>
<tr>
<td>MULTIIS - Compartmentalization</td>
<td>-.053</td>
<td>.036</td>
<td>.144</td>
</tr>
<tr>
<td>MULTIIS - Integration</td>
<td>-.057</td>
<td>.041</td>
<td>.169</td>
</tr>
<tr>
<td>AMAS - Acculturation</td>
<td>.003</td>
<td>.089</td>
<td>.976</td>
</tr>
<tr>
<td>AMAS - Enculturation</td>
<td>-.164</td>
<td>.081</td>
<td>.044*</td>
</tr>
<tr>
<td>FES</td>
<td>.325</td>
<td>.250</td>
<td>.193</td>
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<td>Subclinical Psychosis Latent</td>
<td>2.343</td>
<td>1.211</td>
<td>.053*</td>
</tr>
</tbody>
</table>

*p ≤ .05

Note. DASS = Depression Anxiety Stress Scale. PWB = Psychological Well-Being Scale. OCI = Obsessive-Compulsive Inventory. MULTIIS = Multicultural Identity Integration Scale. AMAS = Abbreviated Multidimensional Acculturation Scale. FES = Family Environment Scale.
Table 10  
*Direct Effects of Continuous Moderating Variables on Help-Seeking Attitudes with Perceived Discrimination*

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>SE</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td>DASS - Depression</td>
<td>-.031</td>
<td>.045</td>
<td>.496</td>
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<tr>
<td>DASS - Anxiety</td>
<td>-.002</td>
<td>.055</td>
<td>.965</td>
</tr>
<tr>
<td>DASS - Stress</td>
<td>.030</td>
<td>.045</td>
<td>.507</td>
</tr>
<tr>
<td>PWB</td>
<td>.118</td>
<td>.039</td>
<td>.002*</td>
</tr>
<tr>
<td>OCI</td>
<td>-.046</td>
<td>.057</td>
<td>.417</td>
</tr>
<tr>
<td>MULTIIS - Categorization</td>
<td>-.006</td>
<td>.015</td>
<td>.686</td>
</tr>
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<td>MULTIIS - Compartmentalization</td>
<td>-.014</td>
<td>.018</td>
<td>.444</td>
</tr>
<tr>
<td>MULTIIS - Integration</td>
<td>.011</td>
<td>.016</td>
<td>.481</td>
</tr>
<tr>
<td>AMAS - Acculturation</td>
<td>.114</td>
<td>.042</td>
<td>.007*</td>
</tr>
<tr>
<td>AMAS - Enculturation</td>
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<td>.037</td>
<td>.673</td>
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<tr>
<td>FES</td>
<td>.008</td>
<td>.165</td>
<td>.961</td>
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<td>Subclinical Psychosis Latent</td>
<td>.189</td>
<td>2.233</td>
<td>.933</td>
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</tbody>
</table>

*Note. DASS = Depression Anxiety Stress Scale. PWB = Psychological Well-Being Scale. OCI = Obsessive-Compulsive Inventory. MULTIIS = Multicultural Identity Integration Scale. AMAS = Abbreviated Multidimensional Acculturation Scale. FES = Family Environment Scale.*
<table>
<thead>
<tr>
<th>Table 11</th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-Square Difference Values of Categorical Moderating Variables on Help-Seeking Attitudes with Perceived Discrimination</td>
<td>χ²</td>
<td>df</td>
<td>p</td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constrained</td>
<td>74.575</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free</td>
<td>71.757</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>χ² Difference</td>
<td>2.818</td>
<td>4</td>
<td>.589</td>
<td></td>
</tr>
<tr>
<td>Binationality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constrained</td>
<td>69.659</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free</td>
<td>65.818</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>χ² Difference</td>
<td>3.841</td>
<td>4</td>
<td>.428</td>
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</tr>
<tr>
<td>Multicultural Identity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constrained</td>
<td>53.703</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free</td>
<td>52.998</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>χ² Difference</td>
<td>.705</td>
<td>2</td>
<td>.703</td>
<td></td>
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</table>
Table 12
Path Coefficients on Help-Seeking Attitudes from Overarching Model

<table>
<thead>
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<th>Path</th>
<th>b</th>
<th>SE</th>
<th>p</th>
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<tr>
<td>Perceived Discrimination</td>
<td>-0.085</td>
<td>0.068</td>
<td>.210</td>
</tr>
<tr>
<td>Discrimination x Enculturation</td>
<td>-0.164</td>
<td>0.080</td>
<td>.041*</td>
</tr>
<tr>
<td>Enculturation</td>
<td>-0.013</td>
<td>0.036</td>
<td>.730</td>
</tr>
<tr>
<td>Discrimination x Subclinical Psychosis</td>
<td>3.707</td>
<td>1.565</td>
<td>.018*</td>
</tr>
<tr>
<td>Subclinical Psychosis</td>
<td>-1.546</td>
<td>1.840</td>
<td>.401</td>
</tr>
<tr>
<td>Internalized Mental Health Stigma</td>
<td>.150</td>
<td>0.060</td>
<td>.012**</td>
</tr>
<tr>
<td>Stigma x cCompartmentalization</td>
<td>-0.099</td>
<td>0.033</td>
<td>.003**</td>
</tr>
<tr>
<td>cCompartmentalization</td>
<td>-0.016</td>
<td>0.017</td>
<td>.343</td>
</tr>
<tr>
<td>Stigma x Ethnicity</td>
<td>-0.017</td>
<td>0.015</td>
<td>.273</td>
</tr>
<tr>
<td>Gender</td>
<td>.159</td>
<td>0.048</td>
<td>.001**</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>-0.009</td>
<td>0.016</td>
<td>.566</td>
</tr>
<tr>
<td>Multicultural Identity</td>
<td>-0.059</td>
<td>0.031</td>
<td>.060</td>
</tr>
</tbody>
</table>

* $p \leq .05$

** $p \leq .01$
Figure 1
Path Analytic Representation of the Effect of Internalized Mental Health Stigma and Subclinical Psychosis on Help-Seeking Attitudes

**p ≤ .01
Figure 2
Path Analytic Representation of the Interaction Effect of Subclinical Psychosis on the Relationship between Internalized Mental Health Stigma and Help-Seeking Attitudes

* $p \leq 0.05$
** $p \leq 0.01$

Figure 3
Path Analytic Representation of the Effect of Perceived Discrimination on Help-Seeking Attitudes

* $p \leq 0.05$

** $p \leq 0.01$

Figure 4
Path Analytic Representation of the Interaction Effect of Enculturation on the Relationship between Perceived Discrimination and Help-Seeking Attitudes

* $p \leq 0.05$
** $p \leq 0.01$

Figure 5
Path Analytic Representation of the Interaction Effect of Subclinical Psychosis on the Relationship between Perceived Discrimination and Help-Seeking Attitudes

* $p \leq .05$
** $p \leq .01$

Figure 6

Overall Path Analytic Representation of the Interaction Effect of Enculturation, Subclinical Psychosis, and Compartmentalization on the Relationship between Internalized Mental Health Stigma, Perceived Discrimination, and Help-Seeking Attitudes

* $p \leq .05$

** $p \leq .01$

References


Development, 31, 205-222.
Appendix

Demographic Questionnaire

1. Email Address: __________________________

2. Age (years) ___________

3. Birthdate ___ ___ ______ mon. day year

4. Gender _____ male _____ female

5. What is your background?
   _____Caucasian _____African American _____Native American
   _____Hispanic _____Asian American _____Other

6. What is your mother’s cultural background? ___________

7. What is your father’s cultural background? ___________

8. What is your primary language? _______________

9. How much formal education do you have? Circle that which best applies:
   1. 1st year in college
   2. 2nd year in college
   3. 3rd year in college
   4. 4th year or beyond in college

10. What is your GPA? _______________

11. What is your primary major? _______________

12. What religion are you?
    _____Christian/Catholic _____Jewish _____Muslim
    _____Atheist/Agnostic _____Other
**Internalized Stigma of Mental Illness Inventory – 10-item Version (ISMI-10)**

We are going to use the term “mental illness” in the rest of this questionnaire, but please think of it as whatever you feel is the best term for it.

For each question, please mark whether you strongly disagree (1), disagree (2), agree (3), or strongly agree (4).

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mentally ill people tend to be violent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. People with mental illness make important contributions to society.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I don’t socialize as much as I used to because my mental illness might make me look or behave “weird.”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Having a mental illness has spoiled my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I stay away from social situations in order to protect my family or friends from embarrassment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. People without mental illness could not possibly understand me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. People ignore me or take me less seriously just because I have a mental illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I can’t contribute anything to society because I have a mental illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I can have a good, fulfilling life, despite my mental illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Others think that I can’t achieve much in life because I have a mental illness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Daily Life Experiences Subscale of the Racism and Life Experiences Scale

These questions ask you to think about experiences that some people have as they go about their daily lives. Please first determine how often you have experienced each event because of your race or racism in the past year. Use the scale in the first column and circle the appropriate number in the first column. Next, use the scale in the second column to indicate how much it bothers you when the experience happens. Circle the appropriate number.

<table>
<thead>
<tr>
<th>Event Description</th>
<th>How often because of race?</th>
<th>How much does it bother you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Being ignored, overlooked, or not given service (in a restaurant, store, etc.)</td>
<td>Never or twice</td>
<td>Doesn't bother me at all</td>
</tr>
<tr>
<td>2. Being treated rudely or disrespectfully</td>
<td>A few times</td>
<td>Bothers me a little</td>
</tr>
<tr>
<td>3. Being accused of something or treated suspiciously</td>
<td>About once a month</td>
<td>Bothers me somewhat</td>
</tr>
<tr>
<td>4. Others reacting to you as if they were afraid or intimidated</td>
<td>A few times a month</td>
<td>Bothers me a lot</td>
</tr>
<tr>
<td>5. Being observed or followed in public places</td>
<td>Once a week or more</td>
<td>Bothers me extremely</td>
</tr>
<tr>
<td>6. Being treated as if you were &quot;stupid,&quot; being &quot;talked down to&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Your ideas or opinions being minimized, ignored, or devalued</td>
<td></td>
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<tr>
<td>8. Overhearing or being told an offensive joke or comment</td>
<td></td>
<td></td>
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<tr>
<td>9. Being insulted, called a name, or harassed</td>
<td></td>
<td></td>
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<tr>
<td>10. Others expecting your work to be inferior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Not being taken seriously</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Being left out of conversations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Being treated in an &quot;overtly&quot; friendly or superficial way</td>
<td></td>
<td></td>
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<tr>
<td>14. Other people avoiding you</td>
<td></td>
<td></td>
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<tr>
<td>15. Being mistaken for someone who serves others (i.e. janitor, bellboy, maid)</td>
<td></td>
<td></td>
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<tr>
<td>16. Being stared at by strangers</td>
<td></td>
<td></td>
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<tr>
<td>17. Being laughed at, made fun of, or taunted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Being mistaken for someone else of your same race</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Everyday Discrimination Scale

In your day-to-day life, how often do any of the following things happen to you?

0 = Never
1 = Less than once a year
2 = A few times a year
3 = A few times a month
4 = At least once a week
5 = Almost everyday

1 2 3 4 5 1. You are treated with less courtesy than other people are.
1 2 3 4 5 2. You are treated with less respect than other people are.
1 2 3 4 5 3. You receive poorer service than other people at restaurants or stores.
1 2 3 4 5 4. People act as if they think you are not smart.
1 2 3 4 5 5. People act as if they are afraid of you.
1 2 3 4 5 6. People act as if they think you are dishonest.
1 2 3 4 5 7. People act as if they’re better than you are.
1 2 3 4 5 8. You are called names or insulted.
1 2 3 4 5 9. You are threatened or harassed.
Attitudes Toward Seeking Professional Help

Instructions
Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

0 = Disagree     1 = Partly disagree     2 = Partly agree     3 = Agree

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

5. I would want to get psychological help if I were worried or upset for a long period of time.

6. I might want to have psychological counseling in the future.

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

10. Personal and emotional troubles, like many things, tend to work out by themselves.
Abbreviated Multidimensional Acculturation Scale

The following section contains questions about your culture of origin and your native language. By culture of origin we are referring to the culture of the country either you or your parents came from (e.g., Puerto Rico, Cuba, China). By native language we refer to the language of that country, spoken by you or your parents in that country (e.g., Spanish, Quechua, Mandarin). If you come from a multicultural family, please choose the culture you relate to the most. Answer questions based on the last 3 months or since your last assessment.

Instructions: Please mark the number from the scale that best corresponds to your answer.

1 = Strongly disagree
2 = Disagree somewhat
3 = Agree somewhat
4 = Strongly agree

1. I think of myself as being U.S. American.
2. I feel good about being U.S. American.
4. I feel that I am part of U.S. American culture.
5. I have a strong sense of being U.S. American.
6. I am proud of being U.S. American.
7. I think of myself as being __________________ (a member of my culture of origin).
8. I feel good about being __________________ (a member of my culture of origin).
9. Being __________________ (a member of my culture of origin) plays an important part in my life.
10. I feel that I am part of __________________ culture (culture of origin).
11. I have a strong sense of being __________________ (culture of origin).
12. I am proud of being __________________ (culture of origin).

Please answer the questions below using the following responses:

1 = Not at all
2 = A little
3 = Pretty well
4 = Extremely well

How well do you speak English:

13. at school or work
14. with American friends
15. on the phone
16. with strangers
17. in general.

How well do you understand English:

18. on television or in movies
19. in newspapers and magazines
20. words in songs
21. in general

Please answer the questions below using the following responses:

1 = Not at all
2 = A little
3 = Pretty well
4 = Extremely well

How well do you speak your native language:

22. with family
23. with friends
24. on the phone
25. with strangers
26. in general

How well do you understand your native language:

27. on television or in movies
28. in newspapers and magazines
29. words in songs
30. in general

How well do you know:

31. American national heroes
32. popular American television shows
33. popular American newspapers and magazines
34. popular American actors and actresses
35. American history
36. American political leaders

How well do you know:

37. national heroes from your native culture
38. popular television shows in your native language
39. popular newspapers and magazines in your native language
40. popular actors and actresses from your native culture
41. history of your native culture
42. political leaders from your native culture
The Multicultural Identity Integration Scale (MULTIS)

Note: It is important to administer the MULTIS only after gathering participants’ information about their cultural origins and identities. The items should be administered in a random order.

This questionnaire looks at your cultural identities and cultural contexts. While completing this questionnaire, please keep the following information in mind:

Cultural identity refers to (1) the feeling of being a member of a particular cultural group, and (2) the experience of aligning with values, beliefs, behaviours, etc., of a particular culture.

Cultural context refers to an environment that contains the values, beliefs and practices specific to a particular culture, and involves the company of members from that particular cultural group.

We would like to know how you think about your cultural identities. The following is a series of statements about how you see your different cultural identities. Please read each item carefully. Please indicate how much each statement represents your experience using the following scale:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Slightly</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Mostly</td>
<td>Exactly</td>
<td></td>
</tr>
</tbody>
</table>

Categorization items:

I identify with one culture more than any other.

One cultural identity predominates in how I define myself.

One of my cultures is more relevant in defining who I am than the others.

While I come from different cultures, only one culture defines me.

I identify exclusively with one culture.

Compartmentalization items:

When I'm in one cultural context, I feel like I should play down my other cultural identities.

I keep my cultural identities separate from each other.

Each of my cultural identities is a separate part of who I am.

When I am in a particular cultural context, I feel that I should not show my other cultural identities.

I identify with one of my cultures at a time.

I only really experience my different cultures if I identify with them one at a time.

I only experience each of my cultural identities in their own context.

The differences between my cultural identities cannot be reconciled.

The differences between my cultural identities contradict each other.

Integration items:

My cultural identities fit within a broader identity

My cultural identities are connected.

The differences between my cultural identities complete each other.

My cultural identities complement each other.

I have an identity that includes all my different cultural identities.

My cultural identities are all part of a broader group identity.

My cultural identities are part of a more global identity.

I draw similarities between my cultural identities.
Family Cohesion Subscale of the Family Environment Scale

The following are statements about families. Circle T if the statement is true or mostly true for most members of your family. Circle F if the statement is false or mostly false for most members.

1) T  F  Family members really help and support one another.
2) T  F  There is a feeling of unity and cohesion in our family.
3) T  F  We often seem to be killing time at home.
4) T  F  We put a lot of energy into what we do at home.
5) T  F  We rarely volunteer when something has to be done at home.
6) T  F  Family members really back each other up.
7) T  F  There is very little group spirit in our family.
8) T  F  We really get along well with each other.
9) T  F  There is plenty of time and attention for everyone in our family.
Oxford Liverpool Inventory of Feelings & Experiences

Please read these instructions before completing the questionnaire:
These questions relate to your thoughts, feelings, experiences and preferences. There are no right or wrong answers or trick questions so please be as honest as possible. For each question please choose either YES or NO. Please do not spend too much time thinking about it – choose the answer closest to your own.

1. Do you often hesitate when you are going to say something in a group of people whom you more or less know?
2. Do you often overindulge in alcohol or food?
3. Are the sounds you hear in your daydreams really clear and distinct?
4. Do you enjoy many different kinds of play and recreation?
5. Do your thoughts sometimes seem as real as actual events in your life?
6. Does it often happen that nearly every thought immediately and automatically suggests an enormous number of ideas?
7. When in a group of people do you usually prefer to let someone else be the center of attention?
8. Do you frequently have difficulty in starting to do things?
9. Has dancing or the idea of it always seemed dull to you?
10. When you catch a train do you often arrive at the last minute?
11. Is trying new foods something you have always enjoyed?
12. Do you often change between intense liking and disliking of the same person?
13. Have you ever cheated at a game?
14. Are there very few things that you have ever really enjoyed doing?
15. Do you at times have an urge to do something harmful or shocking?
16. Do you often worry about things you should not have done or said?
17. Are your thoughts sometimes so strong that you can almost hear them?
18. Are you usually in an average sort of mood, not too high and not too low?
19. Would you take drugs which may have strange or dangerous effects?
20. Do you think you could learn to read other's minds if you wanted to?
21. When in a crowded room, do you often have difficulty in following a conversation?
22. No matter how hard you try to concentrate do unrelated thoughts creep into your mind?
23. Are you easily hurt when people find fault with you or the work you do?
24. Do you stop to think things over before doing anything?
25. Have you ever felt that you have special, almost magical powers?
26. Are you much too independent to really get involved with other people?
27. Do ideas and insights sometimes come to you so fast that you cannot express them all?
28. Do you easily lose your courage when criticized or failing in something?
29. Can some people make you aware of them just by thinking about you?
30. Does a passing thought ever seem so real it frightens you?
31. Have you ever blamed someone for doing something you know was really your fault?
32. Are you a person whose mood goes up and down easily?
33. Does your voice ever seem distant or faraway?
34. Do you think having close friends is not as important as some people say?
35. Are you rather lively?
36. Are you sometimes so nervous that you are 'blocked'?
37. Do you find it difficult to keep interested in the same thing for a long time?
38. Do you dread going into a room by yourself where other people have already gathered and are talking?
39. Does it often feel good to massage your muscles when they are tired or sore?
40. Do you sometimes feel that your accidents are caused by mysterious forces?
41. Do you like mixing with people?
42. On seeing a soft thick carpet have you sometimes had the impulse to take off your shoes and walk barefoot on it?
43. Do you often have difficulties in controlling your thoughts?
44. Do the people in your daydreams seem so true to life that you sometimes think they are real?
45. Are people usually better off if they stay aloof from emotional involvements with people?
46. Can just being with friends make you feel really good?
47. Is your hearing sometimes so sensitive that ordinary sounds become uncomfortable?
48. Have you often felt uncomfortable when your friends touch you?
49. When things are bothering you do you like to talk to other people about it?
50. Do you have many friends?
51. Would being in debt worry you?
52. Do you think people spend too much time safeguarding their future with savings and insurance?
53. Do you ever have the urge to break or smash things?
54. Do you often feel that there is no purpose to life?
55. Do you worry about awful things that might happen?
56. Have you ever felt the urge to injure yourself?
57. Would it make you nervous to play the clown in front of other people?
58. Have you felt that you might cause something to happen just by thinking too much about it?
59. Have you had very little fun from physical activities like walking, swimming, or sports?
60. Do you feel so good at controlling others that it sometimes scares you?
61. Are you easily distracted from work by daydreams?
62. Are you easily confused if too much happens at the same time?
63. Do you ever have a sense of vague danger or sudden dread for reasons that you do not understand?
64. Is it true that your relationships with other people never get very intense?
65. Have you sometimes had the feeling of gaining or losing energy when certain people look at you or touch you?
66. Do you worry too long after an embarrassing experience?
67. Do you love having your back massaged?
68. Do you consider yourself to be pretty much an average kind of person?
69. Have you ever taken advantage of someone?
70. Would you like other people to be afraid of you?
71. Have you ever thought you heard people talking only to discover that it was in fact some nondescript noise?
72. Have you occasionally felt as though your body did not exist?
73. Do you often feel lonely?
74. Do you often have an urge to hit someone?
75. Do you often experience an overwhelming sense of emptiness?
76. On occasions, have you seen a person's face in front of you when no one was in fact there?
77. Is it fun to sing with other people?
78. Do you often have days when indoor lights seem so bright that they bother your eyes?
79. Have you wondered whether the spirits of the dead can influence the living?
80. Do people who try to get to know you better usually give up after a while?
81. Do you often feel `fed up'?
82. Have you felt as though your head or limbs were somehow not your own?
83. When you look in the mirror does your face sometimes seem quite different from usual?
84. Do people who drive carefully annoy you?
85. Would you call yourself a nervous person?
86. Can you usually let yourself go and enjoy yourself at a lively party?
87. Do you ever suddenly feel distracted by distant sounds that you are not normally aware of?
88. Do you sometimes talk about things you know nothing about?
89. When in the dark do you often see shapes and forms even though there's nothing there?
90. Have you sometimes sensed an evil presence around you, even though you could not see it?
91. Is it hard for you to make decisions?
92. Do you find the bright lights of a city exciting to look at?
93. Does your sense of smell sometimes become unusually strong?
94. Do you usually have very little desire to buy new kinds of food?
95. Do you ever feel that your speech is difficult to understand because the words are all mixed up and don't make sense?
96. Do you often feel like doing the opposite of what other people suggest, even though you know they are right?
97. Do you like going out a lot?
98. Do you feel very close to your friends?
99. Do you ever feel sure that something is about to happen, even though there does not seem to be any reason for you thinking that?
100. Do you often feel the impulse to spend money which you know you can't afford?
101. Are you easily distracted when you read or talk to someone?
102. Do you feel that making new friends isn't worth the energy it takes?
103. Do you believe in telepathy?
104. Do you prefer watching television to going out with other people?
Schizotypal Personality Questionnaire

Instructions: Select "Yes" if you agree or mostly agree OR "No" if you disagree or mostly disagree with the statement.

Do you sometimes feel that things you see on TV or read in the newspaper have a special meaning for you?

I sometimes avoid going to places where there will be many people because I will get anxious.

Have you had experiences with the supernatural?

Have you often mistaken objects or shadows for people, or noises for voices?

Other people see me as slightly eccentric (odd)?

I have little interest in getting to know other people.

People sometimes find it hard to understand what I am saying.

People sometimes find me aloof and distant.

I am sure I am being talked about behind my back.

I am aware that people notice me when I go out for a meal or to see a film.

I get very nervous when I have to make polite conversation.

Do you believe in telepathy (mind-reading)?

Have you ever had that sense that some person or force is around you, even though you cannot see anyone?

People sometimes comment on my unusual mannerisms and habits.

I prefer to keep myself to myself.

I sometimes jump quickly from one topic to another when speaking.

I am not good at expressing my true feeling by the way I talk and look.

Do you often feel that other people have it in for you?

Do some people drop hints about you or say things with a double meaning?

Do you ever get nervous when someone is walking behind you?

Are you sometimes sure that other people can tell what you are thinking?

When you look at a person or yourself in a mirror, have you ever seen the face change right before your eyes?

Sometimes other people think that I am a little strange.
I am most quiet when with other people.
I sometimes forget what I am trying to say.
I rarely laugh or smile.
Do you sometimes get concerned that friends or coworkers are not really loyal or trustworthy?
Have you ever noticed a common event or object that seemed to be a special sign for you?
I get anxious when meeting people for the first time.
Do you believe in clairvoyance (psychic forces, fortune telling)?
I often hear a voice speaking my thoughts aloud.
Some people think that I am a very bizarre person.
I find it hard to be emotionally close to others.
I often ramble on too much when speaking.
My "nonverbal" communication (smiling and nodding during conversation) is not very good.
I feel I have to be on my guard even with my friends.
Do you sometimes see special meaning in advertisements, shop windows, or in the way things are arranged around you?
Do you often feel nervous when you are in a group of unfamiliar people?
Can other people feel your feeling when they are not there?
Have you ever seen things invisible to other people?
Do you feel that there is no one you are really close to outside of your immediate family, or people you can confide in or talk to about personal problems?
Some people find me a bit vague and elusive during conversation.
I am poor at returning social courtesies and gestures.
Do you often pick up hidden threats or put-downs from what people say or do?
When shopping, do you get the feeling that other people are taking notice of you?
I feel very uncomfortable in social situations involving unfamiliar people.
Have you had experiences with astrology, seeing the future, UFOs, ESP, or a sixth sense?
Do everyday things seem unusually large or small?
Writing letters or messages to friends is more trouble than it is worth?
I sometimes use words in unusual ways.
I tend to avoid eye contact when conversing with others.
Have you found that it is best not to let other people know too much about you?
When you see people talking to each other, do you often wonder if they are talking about you?
I would feel very anxious if I had to give a speech in front of a large group of people.
Have you ever felt that you are communicating with another person telepathically (by mind-reading)?
Does your sense of smell sometimes become unusually strong?
I tend to keep in the background on social occasions.
Do you tend to wander off the topic when having a conversation?
I often feel that others have it in for me.
Do you sometimes feel that other people are watching you?
Do you ever suddenly feel distracted by distant sounds that you are not normally aware of?
I attach little importance to having close friends.
Do you sometimes feel that people are talking about you?
Are your thoughts sometimes so strong that you can almost hear them?
Do you often have to keep an eye out to stop people from taking advantage of you?
Do you feel that you cannot get "close" to people?
I am an odd, unusual person.
I do not have an expressive and lively way of speaking.
I find it hard to communicate clearly what I want to say to people.
I have eccentric (odd) habits.
I feel very uneasy talking to people I do not know well.
People occasionally comment that my conversation is confusing.
I tend to keep my feelings to myself.
People sometimes stare at me because of my odd appearance.
Prodromal Questionnaire – Brief Version

Please indicate whether you have had the following thoughts, feelings and experiences in the past month by checking “yes” or “no” for each item. Do not include experiences that occur only while under the influence of alcohol, drugs or medications that were not prescribed to you. If you answer “YES” to an item, also indicate how distressing that experience has been for you.

1. Do familiar surroundings sometimes seem strange, confusing, threatening or unreal to you?
   ☐ YES ☐ NO
   **If YES:** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

2. Have you heard unusual sounds like banging, clicking, hissing, clapping or ringing in your ears?
   ☐ YES ☐ NO
   **If YES:** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

3. Do things that you see appear different from the way they usually do (brighter or duller, larger or smaller, or changed in some other way)?
   ☐ YES ☐ NO
   **If YES:** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

4. Have you had experiences with telepathy, psychic forces, or fortune telling?
   ☐ YES ☐ NO
   **If YES:** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

5. Have you felt that you are not in control of your own ideas or thoughts?
   ☐ YES ☐ NO
   **If YES:** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
6. Do you have difficulty getting your point across, because you ramble or go off the track a lot when you talk?
   □ YES  □ NO
   If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
   □ Strongly disagree  □ disagree  □ neutral  □ agree  □ strongly agree

7. Do you have strong feelings or beliefs about being unusually gifted or talented in some way?
   □ YES  □ NO
   If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
   □ Strongly disagree  □ disagree  □ neutral  □ agree  □ strongly agree

8. Do you feel that other people are watching you or talking about you?
   □ YES  □ NO
   If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
   □ Strongly disagree  □ disagree  □ neutral  □ agree  □ strongly agree

9. Do you sometimes get strange feelings on or just beneath your skin, like bugs crawling?
   □ YES  □ NO
   If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
   □ Strongly disagree  □ disagree  □ neutral  □ agree  □ strongly agree

10. Do you sometimes feel suddenly distracted by distant sounds that you are not normally aware of?
    □ YES  □ NO
    If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
    □ Strongly disagree  □ disagree  □ neutral  □ agree  □ strongly agree

11. Have you had the sense that some person or force is around you, although you couldn’t see anyone?
    □ YES  □ NO
    If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
    □ Strongly disagree  □ disagree  □ neutral  □ agree  □ strongly agree
12. Do you worry at times that something may be wrong with your mind?

☐ YES  ☐ NO
If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

13. Have you ever felt that you don't exist, the world does not exist, or that you are dead?

☐ YES  ☐ NO
If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

14. Have you been confused at times whether something you experienced was real or imaginary?

☐ YES  ☐ NO
If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

15. Do you hold beliefs that other people would find unusual or bizarre?

☐ YES  ☐ NO
If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

16. Do you feel that parts of your body have changed in some way, or that parts of your body are working differently?

☐ YES  ☐ NO
If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

17. Are your thoughts sometimes so strong that you can almost hear them?

☐ YES  ☐ NO
If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

18. Do you find yourself feeling mistrustful or suspicious of other people?

☐ YES  ☐ NO
If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
19. Have you seen unusual things like flashes, flames, blinding light, or geometric figures?
   ☐ YES ☐ NO

   If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

20. Have you seen things that other people can't see or don't seem to see?
   ☐ YES ☐ NO

   If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

21. Do people sometimes find it hard to understand what you are saying?
   ☐ YES ☐ NO

   If YES: When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
Altman Self-Rating Mania Scale

There are five statement groups on this questionnaire; read each group of statements carefully. Choose the one statement in each group that best describes the way you have been feeling for the past week. Please note: The words “occasionally” when used here means once or twice; “often” means several times or more and “frequently” means most of the time.

Question 1
1. I do not feel happier or more cheerful than usual.
2. I occasionally feel happier or more cheerful than usual.
3. I often feel happier or more cheerful than usual.
4. I feel happier or more cheerful than usual most of the time.
5. I feel happier or more cheerful than usual all of the time.

Question 2
1. I do not feel more self-confident than usual.
2. I occasionally feel more self-confident than usual.
3. I often feel more self-confident than usual.
4. I feel more self-confident than usual.
5. I feel extremely more self-confident than usual.

Question 3
1. I do not need less sleep than usual.
2. I occasionally need less sleep than usual.
3. I often need less sleep than usual.
4. I frequently need less sleep than usual.
5. I can go all day and night without any sleep and still not feel tired.

Question 4
1. I do not talk more than usual.
2. I occasionally talk more than usual.
3. I often talk more than usual.
4. I frequently talk more than usual.
5. I talk constantly and cannot be interrupted.

Question 5
1. I have not been more active (either socially, sexually, at work, home or school) than usual
2. I have occasionally been more active than usual.
3. I have often been more active than usual.
4. I have frequently been more active than usual.
5. I am constantly active or on the go all the time.
Obsessive Compulsive Inventory

The following statements refer to experiences which many people have in their everyday lives. In the column labelled DISTRESS, please indicate the number that best describes HOW MUCH that experience has DISSTRESSED or BOTHERED YOU DURING THE PAST MONTH. The numbers in this column refer to the following labels:
0 = Not at all  1 = A little  2 = Moderately  3 = A lot  4 = Extremely

<table>
<thead>
<tr>
<th></th>
<th>DISTRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unpleasant thoughts come into my mind against my will and I cannot get rid of them</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>2. I think contact with bodily secretions (perspiration, saliva, blood, urine, etc) may contaminate my clothes or somehow harm me.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>3. I ask people to repeat things to me several times, even though I understood them the first time.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>4. I wash and clean obsessively.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>5. I have to review mentally past events, conversations and actions to make sure that I didn’t do something wrong.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>6. I have saved up so many things that they get in the way.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>7. I check things more often than necessary</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>8. I avoid using public toilets because I am afraid of disease or contamination.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>9. I repeatedly check doors, windows, drawers etc.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>10. I repeatedly check gas and water taps and light switches after turning them off.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>11. I collect things I don’t need.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>12. I have thoughts of having hurt someone without knowing it.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>13. I have thoughts that I might want to harm myself or others.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>14. I get upset if objects are not arranged properly.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>15. I feel obliged to follow a particular order in dressing, undressing and washing myself.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>16. I feel compelled to count while I am doing things</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>17. I am afraid of impulsively doing embarrassing or harmful things.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>18. I need to pray to cancel bad thoughts or feelings.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>19. I keep on checking forms or other things I have written.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>20. I get upset at the sight of knives, scissors and other sharp objects in case I lose control with them.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>21. I am excessively concerned about cleanliness.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>22. I find it difficult to touch an object when I know it has been touched by strangers or certain people.</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td>23. I need things to be arranged in a particular order</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24.</td>
<td>I get behind in my work because I repeat things over and over again.</td>
</tr>
<tr>
<td>25.</td>
<td>I feel I have to repeat certain numbers.</td>
</tr>
<tr>
<td>26.</td>
<td>After doing something carefully, I still have the impression I have not finished it.</td>
</tr>
<tr>
<td>27.</td>
<td>I find it difficult to touch garbage or dirty things.</td>
</tr>
<tr>
<td>28.</td>
<td>I find it difficult to control my own thoughts.</td>
</tr>
<tr>
<td>29.</td>
<td>I have to do things over and over again until it feels right.</td>
</tr>
<tr>
<td>30.</td>
<td>I am upset by unpleasant thoughts that come into my mind against my will.</td>
</tr>
<tr>
<td>31.</td>
<td>Before going to sleep I have to do certain things in a certain way.</td>
</tr>
<tr>
<td>32.</td>
<td>I go back to places to make sure that I have not harmed anyone.</td>
</tr>
<tr>
<td>33.</td>
<td>I frequently get nasty thoughts and have difficulty in getting rid of them.</td>
</tr>
<tr>
<td>34.</td>
<td>I avoid throwing things away because I am afraid I might need them later.</td>
</tr>
<tr>
<td>35.</td>
<td>I get upset if others change the way I have arranged my things.</td>
</tr>
<tr>
<td>36.</td>
<td>I feel that I must repeat certain words or phrases in my mind in order to wipe out bad thoughts, feelings or actions.</td>
</tr>
<tr>
<td>37.</td>
<td>After I have done things, I have persistent doubts about whether I really did them.</td>
</tr>
<tr>
<td>38.</td>
<td>I sometimes have to wash or clean myself simply because I feel contaminated.</td>
</tr>
<tr>
<td>39.</td>
<td>I feel that there are good and bad numbers.</td>
</tr>
<tr>
<td>40.</td>
<td>I repeatedly check anything which might cause a fire.</td>
</tr>
<tr>
<td>41.</td>
<td>Even when I do something very carefully I feel that it is not quite right.</td>
</tr>
<tr>
<td>42.</td>
<td>I wash my hands more often or longer than necessary.</td>
</tr>
</tbody>
</table>
Depression Anxiety Stress Scale – 21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement. The rating scale is as follows:
- 0 Did not apply to me at all - NEVER
- 1 Applied to me to some degree, or some of the time - SOMETIMES
- 2 Applied to me to a considerable degree, or a good part of time - OFTEN
- 3 Applied to me very much, or most of the time - ALMOST ALWAYS

<table>
<thead>
<tr>
<th>Statement</th>
<th>N</th>
<th>S</th>
<th>O</th>
<th>AA</th>
</tr>
</thead>
<tbody>
<tr>
<td>I found it hard to wind down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I was aware of dryness of my mouth</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I couldn’t seem to experience any positive feeling at all</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I found it difficult to work up the initiative to do things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I tended to over-react to situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I experienced trembling (eg, in the hands)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt that I was using a lot of nervous energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt that I had nothing to look forward to</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I found myself getting agitated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I found it difficult to relax</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt down-hearted and blue</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I was intolerant of anything that kept me from getting on with what I was doing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt I was close to panic</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I was unable to become enthusiastic about anything</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt I wasn’t worth much as a person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt that I was rather touchy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt scared without any good reason</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I felt that life was meaningless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Psychological Well-Being – 42-item Version

Please indicate your degree of agreement (using a score ranging from 1-6) to the following sentences.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Strongly disagree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>In general, I feel I am in charge of the situation in which I live.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I am not interested in activities that will expand my horizons.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Most people see me as loving and affectionate.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I live life one day at a time and don't really think about the future.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>When I look at the story of my life, I am pleased with how things have turned out.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>My decisions are not usually influenced by what everyone else is doing.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The demands of everyday life often get me down.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I think it is important to have new experiences that challenge how you think about yourself and the world.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Maintaining close relationships has been difficult and frustrating for me.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I have a sense of direction and purpose in life.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>In general, I feel confident and positive about myself.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I tend to worry about what other people think of me.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>I do not fit very well with the people and the community around me.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>When I think about it, I haven't really improved much as a person over the years.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I often feel lonely because I have few close friends with whom to share my concerns.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>My daily activities often seem trivial and unimportant to me.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I feel like many of the people I know have gotten more out of life than I have.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I tend to be influenced by people with strong opinions.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>I am quite good at managing the many responsibilities of my daily life.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>I have the sense that I have developed a lot as a person over time.</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td>---</td>
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</tr>
<tr>
<td>22. I enjoy personal and mutual conversations with family members or friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. I don't have a good sense of what it is I'm trying to accomplish in life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. I like most aspects of my personality.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. I have confidence in my opinions, even if they are contrary to the general consensus.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. I often feel overwhelmed by my responsibilities</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. People would describe me as a giving person, willing to share my time with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. I enjoy making plans for the future and working to make them a reality.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. In many ways, I feel disappointed about my achievements in life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. It's difficult for me to voice my own opinions on controversial matters.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. I have difficulty arranging my life in a way that is satisfying to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33. For me, life has been a continuous process of learning, changing, and growth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34. I have not experienced many warm and trusting relationships with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35. Some people wander aimlessly through life, but I am not one of them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36. My attitude about myself is probably not as positive as most people feel about themselves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37. I judge myself by what I think is important, not by the values of what others think is important.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. I have been able to build a home and a lifestyle for myself that is much to my liking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39. I gave up trying to make big improvements or changes in my life a long time ago.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40. I know that I can trust my friends, and they know they can trust me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. I sometimes feel as if I've done all there is to do in life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. When I compare myself to friends and acquaintances, it makes me feel good about who I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>