Mental Illness: An integrated model of help seeking

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Declaration

I hereby declare that the work herein, now submitted as a thesis for the degree of Doctor of Philosophy of the Charles Darwin University is the result of my own investigations, and all references to ideas and work of other researchers have been specifically acknowledged. I hereby certify that the work embodied in this thesis has not already been accepted in substance for any degree, and is not being currently submitted in candidature for any other degree.

Signed:

Date:
Acknowledgments

This thesis is dedicated to my mother Maria and father Alexis who have always encouraged and helped me achieve everything I wanted. My deepest gratitude to my wife to be Maria and our daughter Katerina who have never complained about being home alone while I finished this thesis.

Most of all, I owe this Thesis to my supervisor; super Professor Kate Moore. Her supervision and endless energy were an inspiration even during the moments when completion of this project felt impossible. She made it possible, and there are not enough words to express my gratitude.
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ABSTRACT

Mental illness affects approximately 20% of all people worldwide at any one time, no less so within Australia yet many people do not seek help for these conditions. While mental health promotion and prevention strategies in Australia are targeting this issue, scant research has considered the level of help-seeking for mental illness among immigrants to Australia and their subsequent generations. Ethnicity has been proposed as a contributing factor to mental illness and help-seeking among immigrants therefore it is important to consider the impact of acculturation and enculturation among immigrants. The aims of this thesis were to explore attitudes to mental illness, diagnosis, social support, perceived barriers, SES, and demographic variables on people’s willingness to seek help. Baseline data from Greek-Cypriots living in their country of origin, and samples of Anglo-Australians, Greek-born Australians, and Greek-Australians (born in Australia) were compared using a model of willingness to seek help synthesised from the literature. In Study One, 196 Greek-Cypriots living in Cyprus (age $M = 34.50$ years, $SD = 14.16$) indicated their mental health status, demographic variables, attitudes, barriers, SES, levels of social support and willingness to seek health help for a mental illness. Approximately 25% of the sample reported being diagnosed with a mental illness within the past 12 months, and around a third of these people were taking prescribed medication. Willingness to seek help was predicted negatively by stigma and positively by openness to help. Five hundred and thirteen volunteers, 184 Anglo-Australians (age $M = 45.60$ years, $SD = 16.13$), 171 Greek-Australians (age $M = 39.60$ years, $SD = 12.46$), and 44 Greek-
Born Greek-Australians) (age \( M = 51.53 \) years, \( SD = 14.97 \), participated in Study Two. Between 20 to 30% of participants across the groups had been diagnosed with a mental illness with 10 to 17% taking prescribed medication for their condition. The majority of participants indicated they would seek professional help for a mental illness with only around 2% indicating they would not seek any help. Openness to help, less stigma, and higher levels of education predicted willingness to seek help among Anglo-Australians and, with the exception of education, among the Greek-Australian sample. For those Greek Australians born overseas, only lower levels of stigma predicted willingness to seek help. Measures related to ethnicity in the Greek groups in Australia were not significant. A third study was conducted to identify any further factors that might influence willingness to seek help. Nine Greek-Australians (six males) (age \( M = 29.84, SD = 8.75 \)) and eight Anglo-Australians (one male) (age \( M = 347.93, SD = 14.10 \)) participated in interviews focused on this issue. Results revealed participants had a poor understanding of mental illness, and in terms of help-seeking suggested factors similar to those reported in the literature and examined in Studies One and Two. In addition, participants indicated embarrassment is associated with mental illness despite ongoing media campaigns and awareness-raising concerning mental illness. While both cohorts acknowledge that professional help may be useful they stressed the importance of a trusting and confidential relationship with the therapist. There were suggestions that Anglo-Australians were somewhat more willing to utilise professional help, while the Greek-Australian participants were likely to seek-out informal support such as from a priest. The outcomes of these studies have implications for community awareness raising programs to promote
open attitudes to mental illness and building a relationship with one’s therapist.

Future directions for research in this area are discussed.
CHAPTER ONE: Introduction

In Australia, approximately 2.38 million adults aged 18 years and over (1.15 million men and 1.23 million women) suffer a mental illness in a 12-month period (National Survey of Mental Health and Well Being, 2007). Yet, Andrews, Henderson and Hall (2001) reported that in a similar 12-month period only 35% of Australians with a mental illness sought help for their disorder. This gap in service provision, referred to by Andrews and Henderson (2000) as the ‘unmet need’ for treatment is in fact a global phenomenon, and may be especially relevant for high prevalence issues such as anxiety and affective disorders (Andrews et al., 2001).

Over the past 30 years, considerable effort has been expended to provide the public with knowledge about mental health problems, to correct false beliefs concerning the mentally ill, and to increase the accessibility of mental health services for those in need (Jorm, 2011; Leaf, Bruce, Tischler & Holzer, 1987). Evidence indicates that over this period the public has become more knowledgeable about mental illness (Crocetti, Spiro & Siassi, 1974; Jorm, 2000, 2011) and while there has been an increase in the proportion of the population seeking help for mental and emotional problems this figure remains low (Andrew & Henderson, 2000; Veroff, Kulka & Douvan, 1981). Research has pointed to socio-cultural issues as a potential influence on the underutilisation of mental health services (Echevery, 1997; Schwarzbaum, 2004; Suan & Tyler, 1990). One such issue might be ethnicity.
The majority of ethnic people living in countries in the new world such as Australia, New Zealand, USA and Canada consist of immigrants and their first born (Australia Census Bureau, 2007; Canadian Census Bureau, 2006; U.S Census Bureau, 2000). Socio-cultural issues that may affect the underutilisation of mental health services by minority groups or immigrants include attitudes, social support, stigma, levels of acculturation and enculturation, and practical barriers in accessing services (Gloria & Rodriguez, 2000; Woodward, Dwinell & Arons, 1992).

Although help-seeking attitudes and behaviours may be contextualised within a variety of cultural frameworks, Miville and Constantine (2006) also suggested that not everyone perceives actual psychological services offered at mental health agencies in the same way. For example services provided by university counselling centres and mental health clinics are likely to be perceived by many minorities as predominantly holding and exercising ‘Anglo-American’ values and needs, or in the Australian context ‘Anglo-Australian’ values and needs. Such services might be perceived as emphasising individual needs without considering family wishes and roles, and de-emphasising the role of religious or spiritual values, thereby discouraging people from seeking help (Miville & Constantine, 2006).

Many traditional cultures consider family ties as the most important value to maintain in life (Miville & Constantine, 2006) and so many of these people may be willing to sacrifice their time in helping the family. There may also be a strong sense of shared responsibility within such families and this may be associated with certain role responsibilities such as that of a mother, father, son,
daughter or grandparents (Miville & Constantine, 2006). This cohesiveness may further reduce a willingness to look outside the family and seek professional help. Families from Culturally and Linguistically Diverse (CALD) communities who have lived in another country for several generations may also have become acculturated into that society but still exhibit these strong family values and responsibilities (Santiago-Rivera, Arredondo & Gallardo-Cooper, 2002). Furthermore, individuals from CALD backgrounds may still be strongly enculturated with their family of origin and so uphold the values and customs of that country and its society. Therefore, it is reasonable to hypothesise that many individuals from traditional cultural backgrounds with strong family ties as their priority may seek informal support and turn to family or close friends first when difficulties arise (Altarriba & Bauer, 1998). The degree of perceived social support gained from family, significant others, and friends might influence whether or not psychological services are actually sought (Miville & Constantine, 2006).

The stigma attached to mental illness is still prevalent and this poses barriers for people seeking professional help for mental illness (Kung, 2001). The attribution among some communities, whether ethnic or indigenous, that mental illness stems from character flaws or hereditary causes (Pearson, 1993; Sue & Morishima, 1982) can be a further impediment to help-seeking.

The aim in this thesis was to assess the willingness of individuals to seek help for mental illness and to consider the impact of acculturation and enculturation on an immigrant group’s willingness to seek help. Greek-Australians, both Greek born and Australia born were compared with Anglo-
Australians on their willingness to seek help for mental illness. The roles of enculturation and acculturation among Greek-born and subsequent generation Greek-Australians were also examined. Baseline data were gathered in Study One from Greek-Cypriots living in Cyprus to assess the predictors of willingness to seek help, and then to ascertain the effects of enculturation and acculturation of emigrants to Australia.
CHAPTER TWO: Mental Illness

Attempts to define mental illness presuppose that we know what constitutes normality (Lemma, 1996). Throughout history, people's comprehension of mental illness has shifted repeatedly, so much so that various cultures and historical periods have named 'mad' those whom other times and societies have considered 'sane' (Cave, 2002). Since the time of ancient Greece, psychopathological manifestations have been labelled and treated by a variety of social organisations including the Church, the legal system, and more recently, medicine and psychology (Lemma, 1996). In modern Western society, the medical and health professions are the main sources for diagnoses and care of people experiencing mental health issues.

Epidemiological research conducted in different parts of the world has provided rich data on the distribution of mental health problems in various populations (Henderson, 2002). While these large population studies have used different assessment tools, there is a level of consistency in the patterns of morbidity reported across studies. In Australia, the age-specific one-year-prevalence rates for mental disorders in the 2007 National Survey of Mental Health and Wellbeing were similar to findings elsewhere in the world overall as well as in gender differences (Henderson, 2002). For example, males have a higher incidence of substance use disorders than females (11.1% versus 4.5%), while females are much more likely than males to have an anxiety-stress disorder (12.1% versus 7.1%) or an affective disorder (7.4% versus 4.2%) (National Survey of Mental Health and Well Being, 2007). Such prevalence rates show that,
approximately 1.15 million men and 1.23 million women (2.38 million Australian adults aged 18 and over) have experienced a mental disorder within the previous 12 months (National Survey of Mental Health and Well Being, 2007).

The figures cited in these epidemiological studies are typically based upon one or other of two internationally recognised classification systems: the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD) which will be discussed next.

2.1 Classification systems

According to Borthwick-Duffy (1994) the diagnosis of mental disorders can be a complicated process and often reflects the theoretical background of the person making the diagnosis and as such, makes the process of diagnosis subjective. For example, based on a phenomenological humanistic point of view “mental illness is a modern myth” (Szasz, 1974) while from a medical perspective mental illness is a ”dysfunction” similar to physical health problems (López & Guarnaccia, 2000). However over the last half-century and more, there have been attempts to reach common ground via two major diagnostic tools, DSM and ICD, to classify mental illness by the symptoms being exhibited. These diagnostic tools are now used by the majority of mental health professionals and epidemiologists around the world.
2.1.1 Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD)

The Diagnostic and Statistical Manual-5 (APA, 2013) had its first iteration as DSM-I (APA, 1952) which was developed to provide a common language and standard criteria for the classification of mental disorders. According to Zimmerman and Spitzer (2005) the DSM, and its subsequent iterations, is used in the United States and in several countries around the world by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, and policy makers because of its objective structure. Many mental health professionals use the manual to determine and help to communicate a patient's diagnosis following clinical evaluation (Zimmerman & Spitzer, 2005).

Hospitals, clinics, and insurance companies in the US also generally require a DSM diagnosis for all patients under their treatment or coverage (Jablensky & Kendell, 2002). Apart from its clinical uses the DSM can be used to categorise patients for research purposes (Kendell & Jablensky, 2003). Studies on specific disorders typically recruit participants whose symptoms meet the criteria listed in the DSM for that disorder (First, Pincus, Levine, Williams, Ustun & Peele, 2004). Therefore the DSM has a strong influence both in the academic and medical worlds (Kendell & Jablensky, 2003).

Another diagnostic tool used to diagnose mental health issues is the International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) which had its first iteration as
List of Causes of Death (LCD) in 1949 (WHO, 2010). The International Classification of Diseases is published by the World Health Organization (WHO) and used worldwide for morbidity and mortality statistics, reimbursement systems and automated decision support in medicine (WHO, 2010). The ICD contains codes to classify a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease in a manner not dissimilar to the DSM.

Under the ICD, each health condition is assigned to a unique category and given a code of up to six characters long. Such categories can include a set of similar diseases such as mental health diseases but also physical diseases. This system is designed to promote international comparability in the collection, processing, classification, and presentation of these statistics.

Both classifications systems are complex. DSM-III/IV and ICD-10 are deliberately atheoretical with chapters and disorder definitions that focused on symptom profiles (Kupfer, Regier & Kuhl, 2008). According to Kupfer et al. the DSM-III/IV and ICD-10 were designed to facilitate clinical care as a first priority, however the classifications and their thresholds were considered too complex for some clinicians to use. Nevertheless, in the hands of an experienced and well-trained clinician these classification systems are very practical and help to facilitate an appropriate diagnosis which then further indicates appropriate treatment. The prevalence of some of the most common disorders is discussed next.
2.1.2 Prevalence rates of mental illness

Among the most common mental illnesses are depression, anxiety, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social anxiety disorder and specific phobias (ESEmED Project, 2004; McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009). All of these disorders are associated with poorer quality of life, reduced social functioning and often disability (Pratt & Brody, 2008). Depression affects almost 121 million individuals worldwide and is the third leading contributor to the total burden of disease (WHO, 2010).

In the three Office of National Statistics (ONS) surveys conducted in 1993, 2000 and 2007 and discussed by McManus, Meltzer, Brugha, Bebbington and Jenkins (2009) it was found that the percentage of adults who met the criteria for at least a single mental health disorder increased between 1993 and 2000 but did not alter between 2000 and 2007 (15.5% in 1993, 17.5% in 2000 and 17.6% in 2007). The largest increase in the rate of disorders (depression, anxiety, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social anxiety disorder and specific phobias) between 1993 and 2007 was found in females aged 45 to 64 years, with an increase of 20%. Overall in 2007, the ONS survey revealed that 16.2% of adults aged 16 to 64 years met the diagnostic criteria for at least one mental health disorder in the week prior to interview (McManus et al., 2009). More than 50% of adults identified with a mental health disorder in the 2007 survey presented with comorbid anxiety and depression. The prevalence for the other mental health disorders alone were 4.4% for General Anxiety Disorder (GAD), 2.3% for a depressive episode, 1.4% for phobia, 1.1%
for Obsessive Compulsive Disorder (OCD), and 1.1% for panic disorder. Another epidemiological study surveying participants from six European countries (Belgium, France, Germany, Italy, the Netherlands and Spain) also showed similar results (ESEmED Project, 2004).

In the USA, Kessler, Berglund, Demler, Jin, Merikangas and Walters (2005a) carried out the National Comorbidity Survey using a representative sample of households and interviews with 9,282 adults aged over 18 years. Their aim was to estimate the duration and 12-month prevalence rates of mental disorders (depression, anxiety, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social anxiety disorder and specific phobias) using the Diagnostic and Statistical Manual of Mental Disorders (4th ed. text-revision; DSM-IV-TR) (APA, 2000). From the data collected they identified that 22.3% of disorders were severe, 37.3% were moderate and 40.4% were classified as mild. Fifty-five per cent of participants with a mental illness had a single diagnosis, 22% had dual diagnoses, and 23% had three or more diagnoses. The researchers concluded that while mental health issues were common, severe cases of mental illness were concentrated within a comparatively small percentage of individuals with high rates of comorbidity.

In Australia, based on a National Survey of Mental Health and Wellbeing (2007) the prevalence of any lifetime mental health problem was 45.5%. The prevalence of any 12-month mental illness was 20%, with generalised anxiety disorders (14.4%) being the most common class of mental disorder followed by affective disorders (6.2%) and substance abuse issues (5.1%). One in four people (25.4%) with a 12-month mental illness had more than one class of mental health
problem. One-third (34.9%) of people identified with a mental disorder in that survey had used health services for mental health problems in the 12 months prior to the interview (National Survey of Mental Health and Wellbeing, 2007) but clearly the majority of those identified with a disorder had not sought professional help.

These studies indicate that around one in five people within the general population suffer a mental health disorder at any given time. Half of these people have moderate to severe symptoms that would necessitate intervention from healthcare professionals (Kendrick & Pilling, 2012).

Numerous demographic and socio-economic factors have been associated with a higher risk of mental illness including, gender (Kessler et al., 2005a; Kessler et al., 1993; Pisinelli & Wilkinson, 2000) age (Kessler et al., 2005a; Kessler et al., 1993) marital status (McManus et al., 2009), ethnicity (Hunter, 2007) and socio-economic status (McManus et al., 2009). These factors will be discussed next along with their potential influence upon willingness to seek help for a mental illness.

2.1.3 Gender

There are more women dealing with depression and anxiety disorders compared with men (Kessler et al., 1993; Pisinelli & Wilkinson, 2000). Prevalence rates for depression are between 1.5 and 2.5 times higher among women than men (Somers, Goldner, Waraich & Hsu, 2004). McManus et al. (2009) found that women in the UK were more likely than men to have a mental disorder (19.7% and 12.5%, respectively), with significantly higher rates for
women across all categories of disorder with the exceptions of panic disorder and OCD, where the rates were higher for men.

Among different ethnic groups surveyed in the UK the greatest reported difference in the prevalence of common mental health disorders between males and females was among adults from South Asia (McManus et al., 2009). The age-standardised rate among South-Asian women (34.3%) was three times that of South-Asian men (10.3%) (McManus et al., 2009). Tata and Leong (1994) argued that the stoic attitude of Asian people especially men, not admitting to experiencing emotional problems might contribute to underreporting of mental illness in comparison with Asian females and their Caucasian counterparts. However the disparity in the figures is substantial and may involve other factors such as coping style, perceived support or culturally determined factors relevant to, in this case, Asian men.

2.1.4 Age

In a replication study of Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey, Kessler et al. (2005a) found that lifetime prevalence estimates were: any disorder 46.4%, anxiety disorders 28.8%; mood disorders 20.8%; impulse-control disorders 24.8% and substance use disorders 14.6%. The median age of onset of mental disorders in that study was much earlier for anxiety (11 years) and impulse-control (11 years) disorders than for substance use (20 years) and mood (30 years) disorders. Half of all lifetime cases were found to be onset by age 14 years and three quarters by age 24 years. Later onset was mostly of comorbid conditions, with the
estimated lifetime risk of any disorder at age 75 years (50.8%) only slightly higher than the observed lifetime prevalence rate (46.4%).

Lifetime prevalence estimates are higher in recent cohorts than in earlier ones which might reflect improved methodology, classifications or willingness to acknowledge mental illness by participants. There are fairly stable inter-cohort differences across the life course that vary among socio-demographic subgroups. For example, Lewinson, Rohde, Seeley and Fischer (1993), using data from three samples of adults (Ns=571, 472, and 989) and a sample of adolescents (N=1,710) supported the possibility that the prevalence of major depression has been increasing in recent birth cohorts, a phenomenon labelled by the authors as the Age-Cohort Effect (ACE). Possible reasons for these findings could be that nowadays there is much more education and awareness around the symptoms of mental illness. This awareness may have reduced the stigma of acknowledging mental illness and people may feel more comfortable to acknowledge and report their symptoms thus making it easier to collect comprehensive data. Another possible reason suggested by Flett, Garshoviz and Martin (1997) could be that mental illness is more prevalent in recent times due modern lifestyles which are influenced and directed largely by ideals of perfectionism where people have unattainable aspirations such as for fame, wealth, beauty, the perfect body, or power.

2.1.5 Marital status

In the UK, McManus et al. (2009) found that female participants across all marital-status categories reported more mental health problems than their male counterparts with the exception of divorced people of both genders in whom the
prevalence rate was similar (26.6% for women and 27.7% for men). Among men, those presently divorced had the highest incidence of a depressive or an anxiety disorder but the differences by other marital status categories for men were less obvious. For females the rate of mental health problems while high for divorced women was even higher for women who were separated (33.0%). This difference between divorced and separated women in that survey might be due to a more recent loss of the marriage, the struggle to adjust to a single state, and issues around the separation including finances, child access and custody. Males and females who were currently married or widowed while still reporting concerning levels of mental health problems, did have the lowest observed rates (10.1% of married men and 16.3% of married women; 10.4% widowed men and 17.4% widowed women). However these differences do not necessarily mean that men are enjoying better mental health than females. It could also be that men are more reluctant than women to admit their symptoms due to the social expectation that men either do not experience such problems or are strong enough to cope with personal problems.

2.1.6 Ethnicity-Immigrants

McManus et al. (2009) in the Mental Health Problems Survey in England found that after age-standardisation of the data, there was no significant difference among samples of Caucasian, Black or South-Asian men on the rate of any mental health problem. However, among females the rates of all disorders (except phobias) were highest among women of South-Asian ethnicity.

According to the National Healthcare Quality and Disparities Reports (NHQDR, 2010) conducted in the USA, African-Americans living below the
poverty line level were three times more likely to report psychological distress than White-Americans. African-Americans in general were 20% more likely to report experiencing serious psychological symptoms than Caucasians, yet Caucasians were more than twice as likely to receive antidepressant prescription treatments as African-Americans. Suicide rate among African-American men was almost five times that for African-American women (NHQDR, 2010) but the suicide rate for African-Americans overall was 60% lower than that of Caucasian-Americans. Despite these findings, a report from the U.S. Surgeon General (1995) found that from 1980-995 the suicide rate among African-Americans aged 10 to 14 years increased 233% compared to a 120% increase among Caucasians in the same age range, suggesting that this gap may be closing.

In terms of mental health among the indigenous population in Australia there is a lack of consistent data (Hunter, 2007). However, the Australian Institute of Health and Welfare data for 1998-1999 reported that Indigenous men and women were hospitalised for ‘mental and behavioural disorders’ at 2.0 and 1.5 times the rates respectively, of their non-Indigenous peers (Hunter, 2007). Furthermore, from 2002-2003 to 2003-2004 not only were admissions for mental disorders twice as high as for the non-Indigenous population, so too were admissions for accidents and injuries with young adult women being particularly vulnerable (Hunter, 2007).

The high incidence of mental illness among the aforementioned ethnicities may be due to the limited access these people have to mental health treatment services especially in systems where the user pays. Such populations also often have lower educational resources, and coping strategies to deal with their
problems. It can also be said that everyday eating habits (food of low nutrition and inadequate calorie intake), every day stress to gain basics for living, and other related stressors may be contributing to higher rates of mental health problems among these populations. Such stressors as well as a lack of resources and cultural beliefs in general might also affect help seeking behaviours.

2.1.7 Socio-economic factors

McManus et al. (2009) found that individuals living in households in the UK with the lowest level of earnings were more likely to have a mental health problem than those living in the highest earning households. Numerous socio-economic factors were associated with these prevalence rates: those with a depressive episode were more likely than those without a disorder to be without a job, to belong to social classes characterised by poverty, to have inadequate formal education, to live in Local Authority or Housing Association accommodation, to have changed their place of living three or more times in the previous two years, and live in an urban environment. Without longitudinal studies it is impossible to say whether the chance of a mental illness being manifested is increased in these situations because of the environmental stressors or whether onset of depression leads one into these circumstances however the weight of evidence can be interpreted to suggest it is most usually the former.

While it is important to know how mental health problems are related to social and economic factors, it is also important to understand other correlations and possible causes of mental illness as this may affect people’s attitudes towards mental illness and their willingness to seek help. Empirical studies which have investigated the causes or triggers of mental health disorders are discussed next.
2.2 Aetiology of mental illness

The causes of mental health problems are multi-factorial and include psychological, social-cultural, and biological factors. According to Brewin, Andrews and Valentine (2000) and Ozer, Best, Lipsey and Weiss (2008) common risk factors which leave people vulnerable to experiencing mental illness, such as Post Traumatic Stress Disorder (PTSD), include a previous personal or family history of anxiety or affective disorders, neuroticism, lower intelligence, and a history of previous trauma. King et al. (2008) identified four possible causes for depression which included a previous history of depression and/or a family member with depression, younger age and lower educational achievement. While the aetiology of mental illness such as depression is usually multifactorial, clinicians often describe depression as endogenous, that is, biologically based, or exogenous, that is, in response to external stimuli (Allen, Lewinson & Selley, 1998). Such biological vulnerability or reactions to events may also be a catalyst for other disorders and are discussed next.

2.2.1 Biological causes of mental illness

There are indications that biological factors play a significant role in the development of many psychological disorders (Allen et al., 1998). Biological influences can include: biochemical, endocrine and neurophysiological factors (Malhi, Parker & Greenwood, 2005) and genetic factors (Kendler & Prescott, 1999) which can be also known as endogenous factors. Alone or as a form of vulnerability these factors can interact with an early experience of trauma that can lead to psychological distress (Heim & Nemeroff, 2001). Support for this assertion comes from family-history studies, such as Angst, Gamma and Endrass’
(2003) study where they identified risk factors for mood disorders in a community sample of individuals aged 20-35 years old. Social characteristics, a family history of mood disorders and some personality features were analysed as risk factors for bipolar and depressive disorders by means of logistic regression. Frequent ‘ups and downs’ of mood were the strongest risk factor for both bipolar and depressive disorders; a further but weaker risk factor for both disorders was emotional/vegetative liability (neuroticism). These authors also observed that an additional risk factor for bipolar disorders was a positive family history of mania, whereas for depression it was a positive family history of depression/fatigue.

A meta-analysis of five studies by Sullivan, Neale and Kendler (2000) found that first-degree relatives of individuals with a Major Depressive Disorder (MDD) have an almost threefold increase in the risk of developing MDD compared with people whose first degree relatives were not affected. They found that the heritability of depressive disorders was approximately 40% to 50%.

According to Kendler and Karkowski-Shuman (1997) mental health issues are mediated at least in part via an interaction with genetic predisposition. Analysing the data from female-female twin pairs on stressful life events and the subsequent development of a major depressive episode, Kendler and Karkowski-Shuman found that monozygotic twins had higher rates of depressive disorders, suggesting that they shared a higher genetic risk than dizygotic twins. They argued that the difference in rates of depression was likely to have been influenced by the shared genetics of the monozygotic twins rather than the shared environment of each twin type.
In a prospective longitudinal study of a birth cohort by Caspi et al. (2003), the 5HTTLPR (serotonin-transporter-linked polymorphic region) polymorphism was found to moderate the impact of stressful life events on depression. The short allele variant identified by the participants’ blood samples was correlated with severe depression in response to stressors. These findings have been replicated in children (Kaufman et al., 2006), adolescents (Eley et al., 2004) and young adults (Zalsman et al., 2006). Zalsman et al. in addition to using tri-allelic genotyping of the 5HTTLPR polymorphism, also used a rating scale of stressful life events, the St. Paul Ramsey Scale, that takes into account both the objective and subjective impact of life events on the individual and not just the number of life events. In doing so, the authors have shown that an interaction effect, between a genetic predisposition to depression and a response to the environment, was related to the manifestation of depression.

The presence of genetic risk factors has been reported also for all major anxiety disorders (Hettema, Neale & Kendler, 2001). There are indications that the gene 5HTTLPR (serotonin-transporter-linked polymorphic region) raises the likelihood of people developing an anxious personality trait through an “anxiety sensitivity” (Stein, Schork & Gelerneter, 2008).

While biological causes of mental health issues are often predisposing factors for mental health disorders to be manifested later in life, social-cultural stressors and life events can act as triggers to these genetic vulnerabilities, or be a reactive force in themselves, thus resulting in a mental health problem.
2.2.2 Social-cultural stressors and life events as causes of mental illness

Social factors may contribute to the expression and development of a mental health disorder and this response, or reaction, is also termed exogenous (Allen, Lewinson & Selley, 1998). Research has indicated perceived financial strain (Weich & Lewis, 1998a), work stress (Stansfeld, Fuhrer, Shipley & Marmot 1999), poor housing (Weich & Lewis, 1998b) and social isolation (Bruce & Hoff, 1994) as significant factors that can contribute to the development of mental health problems. In the UK, Brown and Harris (1978) found the social vulnerability factors for depression among women in Camberwell, south-east London, included having three or more children under the age of 14 years living at home; having no paid employment outside the home; and lack of a confiding relationship with another person. The significance of the lack of a confiding relationship has been supported by Patten (1991) who found that an absence of such a bond or support was a threat factor in the manifestation of depressive disorders among women.

Harris, Cook, Victor, De Wilde and Beighton (2006) argued that adverse life events, mostly those relating to physical health, can also have an influence on the onset and progress of depression and anxiety, however such susceptibilities differ among individuals. Salokangas and Poutanen (1998) identified poor physical health and issues with alcohol use as predictors of anxiety and depression. King et al. (2008) also found that current poorer physical and mental health overall, based on the 12-Item Short Form Health Survey (SF-12) questionnaire, were associated with the development of depression. Clearly not all people react negatively to life circumstances: some people may be more resilient
to life stressors than others (Papadopoulos, 2007), for some it may be accumulative stressors which have an impact on them, while others may have a genetic vulnerability which predisposes them to a mental illness in the face of life stressors (Allen, Lewinson & Selley, 1998).

Early life experiences as well as current social stressors must also be considered as contributing factors for common mental health problems (Allen et al., 1998). Fava and Kendler (2000) showed that a poor parent–child relationship, parental discord and divorce, neglect, and physical and sexual abuse almost certainly increased a person’s vulnerability to depression in later life as well as playing a vital role in the development of GAD.

Conversely, researchers such as Bowlby (1951) and Ainsworth (1977), and more recently Barlow (2000), have found that good parenting experiences are vital in providing toddlers with a safe base from which to explore and discover the world. Problems in child–parent attachment have been linked to feelings of diminished personal control of potentially threatening events (Barlow, 2000) which can in turn increase susceptibility to mental health issues.

The relationship between stressful life events and later post-traumatic stress disorder (PTSD) was investigated by Copeland, Keeler, Angold and Costello (2007) in a prospective study of 1,420 children, aged 9, 11 and 13 years. These participants were followed up annually until they reached 16 years of age. More than two-thirds of those children experienced at least one traumatic event by 16 years, with 13.4% of those children developing at least some PTSD symptoms. Few PTSD symptoms or psychiatric disorders were observed among the participants experiencing a first traumatic event and such effects were short-term
with less than 0.5% of them meeting the criteria of DSM-IV for PTSD. PTSD symptoms were predicted by exposure to multiple traumas: anxiety disorders and family adversity were also significant predictors of PTSD. Lifetime co-occurrence of other psychiatric disorders with traumatic events and PTSD symptoms were high, with the highest rates being for co-morbid anxiety and depressive disorders. Violent or sexual trauma was associated with the highest rate of symptoms of mental illness. Copeland et al. concluded that for children, potentially traumatic events are fairly common and often do not result in PTSD symptoms, with the exception of multiple traumas or where there is a history of anxiety, and that the prognosis after the first lifetime trauma exposure was generally favourable. However, when considering the importance of life events it is essential to remember that events may not have a direct causal impact on the development of symptoms (Allen et al., 1998) instead, they may act as a trigger among people who are biologically or psychologically predisposed to a disorder, for example OCD, depression, anxiety or schizophrenia (Gothelf, Aharonovsky, Horesh, Carty & Apter, 2004; Khanna, Rajendra & Channabasavanna, 1988).

According to Peter, Roberts and Buzdugan (2008) both genetic and environmental risks contribute to the development of psychopathology but there are more factors to add to the equation. For example, other contributing factors could be the time frame in which the environmental risk was experienced during the developmental phase, gender, and other socio-cultural factors (Zalsman, 2010). And while the aetiology of mental illness is not the focus of this thesis, Schlossberg, Massler and Zalsman (2010) speculated that the focus of biopsychosocial research in the next decade will and must be on the field of
genetic predisposition and its interaction with environmental influences, especially within childhood maltreatment and trauma. The course and prognosis of mental health disorders will be discussed next.

2.3 Course and prognosis of mental illness

Anxiety disorders often have a chronic progression and may be linked with a substantial delay in presenting to professional mental health services, with subsequent personal and social damage (Kessler et al., 2005). The early onset of mental health issues is generally associated with poorer outcomes (Kendrick & Pilling, 2012). Kessler et al. (2005a) concluded that interventions aimed at early prevention and treatments are required with the emphasis on accessing young people. However, interventions can only be delivered if people actually seek help. Untreated mental illness can lead to many different kinds of impairment, disability and secondary problems.

2.3.1 Impairment, disability, secondary problems related to mental illness

Kendrick and Pilling (2012) suggested that the personal suffering experienced by those struggling with mental illness, including its impact on social and occupational roles, physical health and mortality is substantial. Mental health disorders have a greater impact on one’s health state than do major chronic physical illnesses such as angina, arthritis, asthma and diabetes (Moussavi, Chatterji, Verdes, Tandon, Patel & Ustun, 2007). In fact, estimates suggest that about 1.5 million Disability-Adjusted Life Years (DALYs) are lost each year in the West as a result of people experiencing a mental health disorder (Murray, Lopez & Jamisson, 1994).
Mental health issues are a major cause of disability worldwide (World Bank, 1993). In 1990 they were the fourth most common cause of loss of DALYs in the world. Mental health disorders account for 4.4% of the global disease burden or the equivalent of 65 million DALYs (Murray & Lopez, 1997; WHO, 2002). By 2020, mental health issues are expected to become the second most common cause of DALY’s (World Bank, 1993).

Impaired emotional, motivational and cognitive functions substantially reduce an individual’s ability to work effectively, and this brings about substantial losses in personal and family income as well as lost contributions to society; tax income, employment skills and production (Beck, Aaron, Hollon, Young, Bedrosian & Budenz, 1985). Extensive social effects also include the individual’s greater dependence upon welfare benefits and an often associated loss of self-esteem and self-confidence; social deficiencies, including reduced capacity to communicate, maintain relationships and longer-term damage in social functioning especially for those who have chronic or persistent mental health disorders are also an outcome (Beck et al., 1985). Some characteristics of mental ill health especially depression, lethargy and confusion may hinder the sufferer’s ability or willingness to seek appropriate healthcare (Kendrick & Pilling, 2012).

Mental health disorders, particularly depression, may lead also to the intensification of pain, distress and disability linked with physical health problems, and this can severely affect physical health outcomes (Bruce, Seeman, Merrill & Blazer, 1994; Robson & Gray, 2007). Mental illness in combination with chronic physical health problems incrementally worsens overall health compared with a physical health problem alone or even a combination of physical
health problems (Moussavi et al., 2007). Moreover, for a range of physical health problems research has suggested an increased risk of death when combined with mental health issues (Cassano & Fava, 2002). A study by Nicholson, Kuper and Hemingway (2006) has shown that people with coronary heart disease and a mental illness, especially major depression, are at an 80% amplified risk of progression and consequent mortality.

According to Sartorius (2001), suicide accounts for nearly 1% of all deaths and nearly two-thirds of these include people who are experiencing some form of mental illness: experiencing a mental health disorder places people at over four-times the risk of suicide in comparison with the general population (Sartorius, 2001) and people most severely affected by a mental health disorder are almost 20 times more at risk of suicide (Bostwick & Pankratz, 2000). Clearly strategies to prevent mental illness and promote help-seeking for mental illness are vital.

2.4 Chapter Summary

In this chapter the definitions of mental illness were discussed followed by a brief overview of the diagnostic and classification systems of mental illness. The statistics available in the literature on the prevalence of mental illness were provided, as well as a brief overview of the aetiology of mental illness including socio-cultural factors. The course of mental illness and its resultant impairments to individuals and possible impact on help-seeking were discussed.
CHAPTER THREE: Treatments for Mental Illness

A significant part of the development of treatments for mental illnesses has been the progress of biological treatments (Trimble & George, 2010) in line with what has been termed the medical model. Biological treatments for psychological disorders are based on the premise that they have a biological aetiology and hence treatment to address this change, whether deficiency or overload, is targeted with pharmacotherapy (Valenstein, 1986). Somewhat in parallel with these advances (McNally, 2007) although many would say pre-dating them (e.g., the work of Freud, Jung and others) has been those of a psychological nature which address cognitions, social learning and behaviours. Current research has shown that the chances of recovery from mental illness are much higher with a combination of biological and psychological treatments (Keller et al., 2000). In the following sections some of the dominant biological and psychological treatments are discussed.

3.1. Biological Approach

Early in the 20th century, phenylalanine deficiencies were found in certain children with mental handicaps and this led to endocrine replacement interventions with thyroxine as one possible drug treatment. This intervention was among the initial attempts of biological interventions to treat mental states (Trimble & George, 2010). In the mid-20th century, lithium was used and is still employed today in cases of Major Depression.
[...] In 1949 John Cade (1912–1980) introduced lithium, the first prophylactic treatment in psychiatry. ‘Librium’, the first of the benzodiazepines, was marketed in 1960. With these new and largely effective treatments, based on medical models of normal and pathological behaviour, the future of biological psychiatry was secure [...] (Trimble & George, 2010, p.20).

According to Papakostas and Fava (2005) the serendipitous discovery of two of the still current antidepressant families in the 1950s by Grunber and Schnitze (1952), iproniazid for the monoamine oxidase inhibitors (MAOIs) and imipramine for the tricyclic antidepressant drugs’ (TCAs), as they were trying to control rheumatoid pain was a major milestone. The seeming coincidence of improved mood among the pain patients on these drugs led to the drugs subsequent use as anti-depressants and provided a foundation for subsequent antidepressant composites. These and subsequent modifications among these agents have generally been governed by aspects of safety and tolerability (Papakostas & Fava, 2005).

For major depressive episodes, antidepressants are the first-line treatment given by psychiatrists or general practitioners (Bauer, Whybrow, Angst & Versiani, 2002). The mechanism behind anti-depressant medications is to increase synaptic levels of the monoamine neurotransmitter serotonin, or boost the levels of two other neurotransmitters: norepinephrine and dopamine (Bauer et al., 2002). The observation of their efficacy led to the monoamine hypothesis of depression
(Van Praag, 1983), which assumes that the shortage of certain neurotransmitters is accountable for the characteristics of depression: norepinephrine may be related to alertness and energy as well as anxiety, attention, and interest in life, while a lack of serotonin is related to anxiety, obsessions, and compulsions. Dopamine is related to attention, motivation, pleasure, and reward, as well as interest in life (Randrup & Braestrup, 1977; Trimple & George, 2010). The proponents of this hypothesis recommend choosing the antidepressant with the mechanism of action that has an impact on the most prominent symptoms being displayed by the individual (Randrup & Braestrup, 1977; Trimple & George, 2010). Patients with accompanying anxiety or irritability are normally treated with selective serotonin reuptake inhibitors (SSRIs) or norepinephrine reuptake inhibitors, while patients with a loss of energy and enjoyment of life are treated with norepinephrine and dopamine enhancing drugs (Randrup & Braestrup, 1977; Trimple & George, 2010).

During the late 1980s and early 1990s, two clinical trials (Danish University Antidepressant Group, DUAG, 1986; 1990) compared clomipramine, a tricyclic antidepressant drug with dual effects on both norepinephrine and serotonin, with a selective serotonin reuptake inhibitor (SSRI) for the treatment of endogenous depression. This form of depression is said to be of a biological cause rather than a situational reaction. These studies showed greater effectiveness for clomipramine than for the SSRIs paroxetine and citalopram. Yet, according to the results of Anderson’s (2000) large meta-analysis of published clinical trials, there are no overall differences in the antidepressant effectiveness of clomipramine individually or the TCAs as a group compared with the SSRIs.
In relation to newer classes of antidepressant drugs, a number of meta-analyses (Anderson, 2000; Smith et al., 2002; Thase, Entsuah & Rudolph, 2001) have suggested that treatment of major depressive disorders (MDD) with the serotonin-norepinephrine reuptake inhibitor (SNRI) venlafaxine results in greater response or remission rates than seen with the SSRIs. However, meta-analyses comparing other newer agents with a combined serotonergic-noradrenergic mechanism of action with the SSRIs have not detected substantial differences in their antidepressant efficacy (Papakostas & Fava, 2006, 2007). According to Papakostas, Thase, Fava, Nelson and Shelton (2007) it is not yet clear whether there are differences in the effectiveness between the SSRIs and a broad and diverse group of antidepressant drugs that improve noradrenergic and serotonergic neurotransmission.

Neither is it clear to what level psychopharmacological interventions affect the brain through a “direct” chemical action that is unrelated to expectancy and side effects (Seidel, 2005). Benedetti et al. (2005) hypothesised that different treatments, including placebos, may affect a common circuitry through different initial sites of action. Liotti et al. (2000) also argued that normal and pathological mood states involve shared activation patterns.

Considerations for prescribing medication

There are various factors that should be considered before patients are prescribed medication. These include any prior experience with such medications (response, tolerability, and adverse effects), concurrent medical conditions and any concomitant use of non-psychiatric medications along with the short and long-term side effects of the antidepressants being prescribed (Bauer, Whybrow,
Angst & Versiani, 2002). Atypical features of the depressive episode, clinical subtype of depression, the physician’s experience with the medication, patient's history of adherence to medication, history of first-degree relatives responding to a medication, patient preferences, and the cost and availability of specific antidepressants are also important considerations according to Bauer et al. (2002).

In next section the impact of placebo effects on patient response will be discussed.

3.2 Placebo studies

A placebo is a simulated or otherwise medically ineffective treatment for a disease or other medical condition intended to deceive recipients that they are in receipt of an active substance (Shapiro & Morris, 1978). Patients given a placebo treatment may have perceived or actual improvements in their condition, and this phenomenon is commonly called the placebo effect (Shapiro & Morris, 1978).

In medical research, placebos are given as control treatments when testing the efficacy of an active substance in either single- or double-blinded trials (Harrington, 1999). Common placebos include inert tablets, sham surgery, and other procedures based on false information (Lanotte, Lopiano Torre, Bergamasco, Colloca & Benedetti, 2005). However Kaptchuk et al. (2010) observed that the psychological impact on people taking a placebo substance can also have a surprisingly positive effect on them even when they know that the given treatment is without any active drug, as compared with a control group who is blind to their treatment condition.

Research has however shown inconsistent results in regard to placebo response rates for different degrees of baseline severity (Ackerman & Greenland,
2002; Gorenstein, Gentil, Melo, Lotufo–Neto & Lauriano, 1998; Khan, Leventhal, Khan & Brown, 2002; Quitkin, Rabkin, Gerald, Davis & Klein, 2000). Yet, there seems to be a greater similarity between drug and placebo effects for a number of psychological disorders than previously stated. Active drugs are effective for 40%–60% of patients diagnosed with a range of mental disorders, whereas placebos have been shown to be effective for 20%–65% of patients (Ackerman & Greenland, 2002; Kupfer & Frank, 2002; Quitkin, 1999).

Some researchers have downplayed placebo effects at high states of distress by assigning the placebo group’s response to a regression toward the mean (Faries, Yalcin, Harder & Heiligenstein, 2001; Sakolangas et al., 1996). Others have downplayed placebo effects at low states of distress by assigning placebo effectiveness to spontaneous remission (Posternak & Zimmerman, 2002). It might also be that the attention given to participants during a drug trial may have some effect. Despite the lack of agreement about what elements may predispose research participants to respond to a placebo, there does appear to be agreement about the tendency for placebos to have some degree of effectiveness.

Many recent studies have pointed to an increasing commonality between drugs and placebo (Ackerman & Greenland, 2002; Walsh, Seidman, Sysko & Gould 2002). In a meta-analysis of 25 placebo-controlled clinical trials for obsessive-compulsive disorder (OCD), Ackerman and Greenland (2002) found that reports of placebo responses were increasing in the literature. Walsh et al. (2002) found the same tendency in a meta-analysis research projects examining treatments for Major Depression. Clearly, an analysis of factors other than “medication” such as attention, support, relationship with the therapist and
communication are all factors which may have an impact upon patients and these effects might prevail over groups receiving both active as well as those receiving inert substances.

3.3 Physical Exercise

There are indications from studies with healthy young people that physical activity may have positive effects on mood (Blumenthal et al., 1999; Dimeo, Bauer, Varahram, Proest & Halter, 2001; Lawlor & Hopker, 2001). Furthermore open studies on the short-term effects of an adjunctive daily aerobic exercise program suggest relatively rapid (by day 14) mood improvements in patients with major depression (Dimeo, et al., 2001). In a 16-week program that included 156 elderly patients with Major Depressive Disorders comparing *sertraline* (antidepressant drug) with an aerobic exercise program, Blumenthal et al. (1999) found that exercise was as effective as sertraline in reducing the symptoms of depression although the sertraline group had a faster response time. It might be, however, that those on a sustained exercise program would have longer-term benefits and fewer future relapses than those using medication alone. However from their meta-analysis, Lawlor and Hopker (2001) concluded that the effectiveness of exercise alone in reducing symptoms of depression lacks good quality research in clinical populations. Controlled trials and comprehensive longitudinal studies among people experiencing major depression and anxiety disorders are needed to understand better the role of exercise as an adjunct or monotherapy for reducing symptoms of depression and anxiety disorders (Ströhle, 2009). Ströhle also suggested that the implementation and further effectiveness of exercise training programs for patients with depression or anxiety disorders needs
a multidisciplinary approach comprising scientists and professionals in psychiatry, psychology, sports medicine and health care sources. He also suggested that public funding should support such programs.

Clearly, if such studies demonstrate consistent positive results, they would more than justify the funding investment and the promotion of exercise from an early age as a possible preventative measure. Of course issues of adherence to an exercise regime would need to be addressed.

3.4 Brain stimulation techniques

Vagus Nerve Stimulation is a new technology for indirect brain stimulation that has been commercially available in Europe since 1994 and in the United States since 1997 for the treatment of resistant epilepsy (George et al., 2000). It involves implanting a pacemaker and connecting it to the left vagus nerve which sends autonomic electrical signals via the midbrain to the limbic and cortical areas. While not used widely, VNS has shown promising results in one trial with treatment-resistant depressed patients (Rush et al., 2000) while results from other studies using VNS have been equivocal (Marangel et al., 2002; Nahas et al., 2005; Rush et al., 2000; Sackeim, 2001).

Transcranial Magnetic Stimulation (TMS) is a technology for non-invasively stimulating cortical neurons by magnetic induction using a brief, high-intensity magnetic field (Arthurs & Boniface, 2001; George et al., 1997; Pascual-Leone Rubio, Pallardo & Catala, 1996). Preliminary controlled studies have shown that repetitive TMS (rTMS) used to stimulate the left prefrontal cortex daily for two weeks leads to mood improvement in patients with major depression (George et al., 1997; George et al., 2000). A further study of 70 patients with
recurrent major depression reported evidence for the short-term efficacy of right prefrontal rTMS (Klein et al., 1999). However, 18 patients with treatment-resistant major depression in a double-blind controlled study by Loo et al. (1999) showed that left prefrontal rTMS did not provide significantly greater improvement than did a “fraud” treatment. Yet in a two-week course of left prefrontal rTMS, Berman et al. (2000) found statistically significant, but clinically modest, reductions of depressive symptoms, as compared to fraud rTMS, in a group with unmedicated treatment-resistant major depression.

The side effects and the long-term changes in brain function after rTMS are largely unexplored although the incidence of epileptic seizures has been described in rare cases (Loperbaum & Wassermann, 2000). In the following section, psychological approaches and their effectiveness in dealing with mental illness will be discussed.

3.5 Psychological Approaches

Psychological therapies can be classified into four main categories: 1) cognitive-behavioural therapies which emphasise behaviour and changes in thought pattern; 2) psychoanalytical and psychodynamic therapies which emphasise the effect of unconscious relationship patterns developed in childhood; 3) humanistic therapies which focus on self-development in the 'here and now', and 4) art therapies which use creative arts such as drama, theatre, and plastic arts within the therapeutic process (Chambless & Ollendick, 2001). These categories are broad and counselling or psychotherapy usually overlaps some of these techniques and indeed there are often subtypes within each (Garfield, 1995).
Some counsellors or psychotherapists practice a form of 'integrative' therapy, which means they draw on and blend specific types of techniques (Garfield, 1995). Other practitioners work in an 'eclectic' way, which means they take elements from several different models and combine them when working with clients (Lambert, 1992). There are also a number of specific other therapies that can be used such as family/systemic therapy, group therapy, play therapy, mindfulness, psychosexual therapy and many variations and subtypes of all these (Chambless & Ollendick, 2001). In the following section the focus will be mainly on Psychodynamic and Cognitive Behaviour therapies because the effectiveness of these appear to be the most reported which, in turn, can be interpreted to suggest that they are also the most widely used either alone or in conjunction with other practices.

3.5.1 Psychodynamic and Psychoanalytic Psychotherapy

The terms psychodynamic and psychoanalytic are often used interchangeably. Nevertheless, among the psychodynamic and psychoanalytic workplaces, psychoanalysis is the term used when referring to a psychological treatment where the therapist, called a psychoanalyst or analyst, adheres to standard techniques focused on interpretation leading to patient insight. This change occurs in the context of transference: a psychoanalytic term that means that the client projects onto the therapist the attributes of a parental or an important figure in the client’s life (Levy, 2009). In psychoanalysis, the client typically attends treatment three to five times a week for 45-50 minutes (Freedman et al., 1999). Intervention usually involves clients lying on a couch.
with the therapist sitting behind them while the clients engage in free association basically saying whatever comes to mind (Levy, 2009).

Psychodynamic therapy is characterised by the same basic techniques as psychoanalysis but is more likely to be briefer than and not as intensive as psychoanalysis (Levy, 2009). Even if any given session of psychodynamic psychotherapy may be indistinguishable from a psychoanalytic session, in psychodynamic psychotherapy the therapist tends to be dynamically involved with the client, to resonate emotionally with the client’s emotional condition, and depend more on the interpersonal relationship between client and therapist than in psychoanalysis (Freedman et al., 1999).

The aim of psychodynamic psychotherapy is to make what is unconscious conscious in an effort for the person to better understand their motivations and thus respond to them more honestly (Freedman et al., 1999). Three essential features of the psychoanalytic method are interpretation, including clarification and confrontation, technical neutrality and analysis of the transference (Levy, 2009).

Richard and Huprick (2009) elaborated on these three main techniques: 1) clarifications simply are requests for more information or further elaborations in order to understand better the client’s subjective experience; 2) confrontations sound harsher than they are because they involve tactfully pointing out discrepancies or incongruities in the client’s narrative or their verbal and nonverbal behaviours, and 3) interpretations focus on the unconscious meaning to the client of what has been clarified and confronted.
The psychodynamic psychotherapist uses these three techniques of clarification, confrontation and interpretation in the context of technical neutrality: technical neutrality is a therapeutic strategy in which the therapist avoids communicating any judgment about the client’s conflicts while they are being discussed (Richard & Huprick, 2009).

A cornerstone of psychodynamic theory and practice is the psychological phenomenon of transference: a universal phenomenon in which aspects of important and formative relationships (such as with parents and siblings) are unconsciously ascribed to unrelated current relationships (Richard & Huprick, 2009) including the relationship between the therapist and client (Levy, 2009). Among clients and psychodynamic therapists the analysis of transference (projection of parental feelings from patient towards psychotherapist) and countertransference (acceptance by the therapist of those projections and acting based on them) often takes place in the therapy room. This exchange is a very challenging task for psychodynamic therapists because if they do not recognise and prevent any countertransference an emotional relationship can be formed between client and therapist, which might worsen the condition of the client. Such a relationship oversteps the professional boundaries between client and therapist.

3.5.2 Cognitive Behaviour Therapy (CBT)

Cognitive Behaviour Therapy (CBT) is an inclusive view of human behaviour and mental illness (Beck, 1991). Basically, CBT theorists highlight the contribution of distorted cognitions/thoughts in the aetiology and maintenance of mental illness and argue that emotions and behaviours are a result of our thoughts.
(Beck, 1991). During the course of therapy the therapist involves the client in all phases of the treatment (Bleijenberg, Prins, Bazelmans & Leonard, 2003).

During the therapeutic sessions, clients take an active role towards unfolding their existing problems and are considered the expert of their own life (Hollon & Beck, 2004). The therapist is directive and assists the client to become mindful of cognitive distortions that trigger mental illness issues (Hollon & Beck, 2004). Additionally, the therapist’s expertise in research methods is used to help the client to develop specific interventions (Bleijenberg, Prins, Bazelmans & Leonard, 2003). Often because clients are suffering both deficiencies in practical everyday skills as well as emotional issues, the therapy work can take on a psycho-educational emphasis (Beck, 1991). Throughout the sessions the client and therapist are involved in a process known as collaborative empiricism (Richard & Huprick, 2009). Within this approach, clients are encouraged to develop a scientific point of view in which they make objective analyses of data gathered in the course of therapeutic activities (Hollon & Beck, 2004). The client-therapist engagement leads to the development of hypotheses by which clients challenge their cognitions in session and through structured homework exercises (Beck, 1991). Consequentially, cognitive behaviour therapy is problem-oriented as opposed to being focused on vague complaints and it is solution focused to help the client reach closure and develop sustainable coping skills (Richard & Huprick, 2009).
3.5.3 Efficacy of Psychodynamic Psychotherapy vs Cognitive-Behavioural Therapy (CBT)

Much anecdotal wisdom suggests there is no support for the efficacy of psychodynamic therapy vs CBT however recent studies have begun to compare these therapies with somewhat surprising results. Although the database is not as large for the results of psychodynamic treatments for depression as it is for CBT, there is a growing body of data to suggest that Psychodynamic Psychotherapy is as effective as CBT and that further research is warranted on psychodynamic approaches. This conclusion is based on three sets of findings which are reviewed next: (1) meta-analytic studies; (2) randomised controlled trials (RCT) and, (3) process outcome studies.

Meta-Analytic Studies

A comparison of the effectiveness of Psychodynamic Psychotherapy and CBT is available from several meta-analytic studies (e.g., Churchill, Hunot, Corney, Knapp, McGuire & Tyle, 2002; Gloaguen, Cottraux, Cucheret & Blackburn, 1998; Leichering, 2001; Svartberg & Stiles, 1991). Leichering found no outcome differences between psychodynamic psychotherapy and CBT in the treatment of various mental illnesses, while Churchil et al.; Gloaguen et al.; and Svartberg and Stiles showed that, in several areas, CBT was more effective than psychodynamic therapy. In their review, Churchill et al. found an advantage for CBT in terms of the percentage of people recovered from depression. There were however, no significant differences between recovered persons by group (CBT versus Psychodynamic therapy) on post treatment symptoms or symptom...
reduction. Moreover, there were no differences between recovered persons by group at three months and 1-year follow-up.

**Randomised Controlled Trials**

Gallagher-Thompson and Stefen (1994) in a randomised control trial (RCT) found that 20 sessions of brief psychodynamic psychotherapy were as efficient as 20 sessions of CBT in decreasing depression symptoms in carers of aged family members. In a further comparison, Shapiro et al. (1994, 1995) randomised patients to 8 or 16 weeks of either psychodynamic-interpersonal psychotherapy (IPT) or CBT, respectively. Results from both of these cohorts show that each treatment modality was equally effective for 8 weeks and 16-weeks of treatment and similar effect sizes were found for patient changes for both the psychodynamic and CBT groups. These effects were similar to those reported in other research projects studying the effectiveness of CBT and IPT (Leinchersing, 2001; Rosello et al., 2012). In both of Shapiro et al.’s therapy conditions, those with major depressive disorders responded better to 16 weeks of therapy. There were no differences between the cohorts at 1-year follow-up.

In two other RCT’s comparing psychodynamic psychotherapy with CBT, Bogels et al. (2003) found that both treatments were equally effective and Durham et al. (1994) found that psychodynamic therapy provided substantial progress but to a lesser degree than CBT. It is important to note that in the Durham et al. study, compared to the CBT intervention, the dynamic treatment was not manualised. Nor was there was any specific training of therapists, adherence checks, or treatment fidelity monitoring for the dynamic therapists thus making it difficult to generalise the presentation of the treatment program across clients.
Process Outcome Studies

In a comparison study of psychodynamic therapy vs CBT, Jones and Pulus (1993) found that even if clients in both CBT and psychodynamic psychotherapy treatment groups improved, therapists in both therapy modalities employed the use of psychodynamic techniques such as transference, clarification and technical neutrality. Indirect evidence for the therapeutic significance of psychodynamic process also comes from the findings of Castonguay, Goldfried, Wiser, Raue and Hayes (1996). In analysing the mechanisms of change used in CBT for treating depression, they observed that the concentration on challenging distorted thoughts was inversely linked to effective treatment outcome. However, focusing on feelings related to the self, while explaining and assimilating emotional experience to cultivate in-depth self-understanding, predicted positive intervention outcomes. They argued that the cognitive-behavioural therapists involved in their study indirectly utilised psychodynamic techniques and it may be that these methods are related to positive treatment results for patients of both psychodynamic and cognitive behavioural therapists. Such a proposition is at best controversial and would require further investigation.

There are various other models of psychotherapy which seem effective today (e.g., gestalt, positive psychology approach, existential psychotherapy) but the advantage of CBT lies in its practicality because it is an effective treatment of low cost due to the fact that it is typically a short-term intervention. Also, from the mental health practitioner’s perspective it is easier, cheaper and quicker to train therapists in CBT compared with psychodynamic training and its required self-analyses.
What it is most important and relevant to the current thesis is that people should seek help from a mental health professional and that therapist utilises, or refers them to, an appropriate therapy or therapist.

3.6 Chapter Summary

In this chapter some of the major biological and psychological treatments for mental illness and studies on the efficacy of these treatments were presented. It was concluded that these therapies can only be effective if patients present for help and the therapist provides treatment that is relevant to the condition.
CHAPTER FOUR: Socio-cultural determinants of help seeking attitudes and willingness to seek help from mental health services

Researchers such as Helman (1985, 1990) and Herlizch and Pierret (1987) have shown that the way in which individuals comprehend their mental health issues is strongly related to their wider cultural background. Kleinman (1987) and Helman (1990) found that culture influences people’s explanations of mental illness, their perceptions of its’ aetiology, as well as determining patterns of help-seeking attitudes and behaviours. A review of the extant literature on social and cultural factors that relate to the utilisation of mental health services is provided in this chapter.

4.1 Mental Health Beliefs and Attitudes Towards Seeking Professional Help

According to Furnhma, Akande and Baguma (1999) many societies attribute their problems both physical and mental to either natural or supernatural causes. Aetiological beliefs of a social and supernatural nature are often related to the traditional cultures of non-Western societies in general, while psychosocial and biochemical explanations of distress are more common in Western countries but this latter has only been so over the last 100 or so years (Landrine & Klonoff, 1992; 1994). However some cultures, such as Greek-Orthodox (Faros, 1981) and many Asian cultures (Furnhma et al., 1999), seem to accept both models to varying degrees as valid explanations of a mental health issue.

The link between perceptions of mental illness and the attitudes that people have towards seeking professional assistance for them was demonstrated
by Hall and Tucker (1985) among 513 school teachers (321 caucasian teachers and 192 black\textsuperscript{1} teachers) in the United States. Participants completed the Nunnally Conception of Mental Illness Questionnaire, the Fischer and the Pro-Con Attitude Scales and vignettes that elicited participants’ views about counseling and mental health problems. Their results showed that black teachers’ responses were more biased against mental health services than white teachers while white teachers’ responses were closer to those of mental health professionals. They also showed that significantly more caucasian than black teachers had actually been in therapy. Whether this last was from need or a help-seeking bias was not specified.

Helman (1990) suggested that health beliefs of migrant communities, such as British-Asians in the UK, are related to their views on the aetiology of mental illness and influenced by the values of both their native culture, the host society and the values perpetuated by the health system. There is evidence that beliefs about the causes of mental illness among persons in traditional oriental cultures such as that of India and Islam are more deep-rooted and structured than those that exist within persons in Western societies (Ballard, 1994; Helman, 1985).

In the next section the underutilisation of mental health services by individuals of various cultural backgrounds will be discussed.

\textsuperscript{1}The terms Black Americans or B/blacks are used in the published studies cited and these terms have been maintained when reporting those studies.
4.2 Underutilisation of Mental Health Services

Mental health services are underutilised generally (Andrew & Henderson, 2000; Veroff, Kulka & Douvan, 1981) but it appears that these figures may be exacerbated among ethnic minorities.

The underutilisation of mental health services by various ethnic groups has been well documented over the past four decades (Bui & Takeuchi, 1992; Leong, 1994; Matsuoka, 1997; Mo & Mak, 2009; Miville & Constantine, 2006; Sheikh & Furnham, 2000; Sue & Sue, 1990; Snowden & Cheung, 1990; Sue & McKinney, 1975). While this phenomenon might support the idea that minorities in new world countries like USA, Australia, and Canada are less willing to ask for professional help for mental health issues it is acknowledged that low demand does not necessarily mean that there is low need (Takeuchi, Mokuau & Chun, 1992; Uba, 1994). Mental illness is an issue that affects people independently of their cultural background and even if different cultures have their own methods and ways of recognizing and dealing with mental illness when it comes to a severe mental health episode professional treatment is needed.

While some studies have inquired about actual help-seeking behaviours (Loo et al., 1989; Ying & Miller, 1992) most previous studies observing underutilisation patterns and obstacles to help-seeking fall into three groups. The first group involves studies that compared service utilisation patterns between different ethnic populations in America, using archives from the public mental health system such as the Department of Mental Health, USA. The second group of researchers used college student samples to examine students from ethnic minorities living in the USA on their propensity to use psychological services
based on their attitudes, values, socio-demographic characteristics, and acculturation level. The third group of studies examined community samples’ attitudes and/or perceived barriers to seeking professional help for mental health issues.

**Utilisation patterns with different ethnic populations**

Sue, Fujino, Hu, Takeuchi, and Zane (1991) investigated services received, length of treatment, and outcomes for thousands of Asian-American, African-American, Mexican-American, and Caucasian clients receiving outpatient services in the Los Angeles County mental health system. Results showed that Asian-Americans and Mexican-Americans underutilised services whereas African-Americans overutilised services relative to the population figures. Those clients with an ethnic and language match with the therapist had better length and outcome of treatment. It might be that clients with a similar cultural background to their mental health professionals may feel that their shared cultural background, and perhaps even the context of a problem can be understood better by them and this expectation may be a critical factor for successful interventions.

In another USA study, Bui and Takeuchi (1992) examined the utilisation rates, treatment dropout rates, and length of treatment for adolescents of ethnic background. Participants were 853 African-American, 704 Asian-Americans, 964 Hispanics and 670 White2 Americans, from 1983 to 1988. They found that Asian-Americans and Hispanics were under presented in attending public mental health facilities while African-Americans and Whites were over presented. While it is unlikely the actual incidence of mental health problems differed markedly

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2The terms W/white-Americans or W/whites have been used published studies cited and these terms have been maintained when reporting those studies
between these populations the differential presentation rates could be due to the fact that African-Americans and White-Americans were more informed about the availability of mental health services than were Asian-Americans and Hispanics.

Ying and Hu (1994) studied the use of public outpatient mental health services and treatment outcomes among several minority groups, Chinese, Japanese, Filipino, Korean, and Southeast-Asian Americans in Los Angeles County. They found that Filipinos were underrepresented in the system, whereas in comparison Southeast-Asians had higher utilisation rates but they showed less improvement in their condition over time than the other groups. Again these results might have to do with cultural attitudes to treatment and a lower responsiveness to treatment because of a possible mismatch between the culture of client and the therapist. This suggestion was not addressed by Ying and Hu.

Matsuoka, Breaux and Ryujin (1997), in an effort to ascertain an overall national pattern for the utilisation of mental health services by Asian-Americans/Pacific Islanders (AA/PI) in the United States, analysed 1986 survey data from the National Institute of Mental Health. They focused on overall national utilisation rates, along with rates for states with major (100,000 or more), moderate (50,000 to 99,999), and small (less than 50,000) Asian American/Pacific Islander populations. All AA/PI utilisation rates of services were contrasted with those for Euro-Caucasian Americans. Nationally, these comparisons indicated an extensive pattern of differential usage with AA/PI being three times less likely than their Euro-Caucasian Americans counterparts to use available mental health services. The main reason could be that the majority of mental health professionals were of European background, so that AA/PI may not have felt
comfortable disclosing their personal issues to a mental health professional of a
different cultural background. Other possible reasons for this difference in mental
health service utilisation could be that AA/PI might feel that Caucasian
professionals cannot understand them or it could be because these two specific
cultural groups were not appropriately informed about the availability of mental
health services. It might also be that they avoided seeking help due to a fear of
being stigmatised within their communities.

While the studies comparing utilisation patterns mentioned above include
objective variables such as socio-demographics, psychopathology, and cultural
responsiveness to treatment, people’s subjective perceptions of possible barriers to
seeking help were addressed in the second group of studies.

*Propensity to use psychological services based on attitudes, values, socio-
demographic characteristics, and acculturation level*

Atkinson and Gim (1989) examined the relationship between
acculturation⁴ and attitudes towards seeking professional psychological help
among 557 Asian-American students (263 Chinese Americans, 185 Japanese
Americans, and 109 Korean Americans). They found that the more acculturated
Asian-American students were more likely than less acculturated Asian-American
students to recognise a personal need for professional psychological help, were
more tolerant of any possible stigma associated with seeking psychological help,
and were more open to discussing their problems with a psychologist. In Berry’s
(1997) terms, this might suggest that the attitudes and behaviours of the more
acculturated were in line with the dominant group in the society.

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³ Acculturation is the individual’s level of immersion into a host culture (See Chapter 6
for a comprehensive definition)
Tata and Leong (1994) utilised several culturally based variables to predict help-seeking attitudes among a sample of 219 Chinese-American students in a large mid-western university in the United States. Cultural values of individualism and collectivism, social network orientation, acculturation and gender were used as predictor variables. All four independent variables were found to be significant predictors of attitudes toward seeking professional psychological help; those who were more acculturated had a more positive attitude; people who scored higher on collectivism had a more negative attitude while those who scored high on social network orientation also had a positive attitudes towards seeking professional psychological help. In addition they found that women had a more positive attitude towards professional psychological help than men.

In a more recent Australian based study, Hamid, Simons and Bowles (2009) studied 112 Asian-Australian university students and found that adherence to Asian cultural values inversely predicted attitudes toward seeking professional psychological help. They also found a significant positive relationship between the Asian-Australian students’ level of behavioural acculturation and positive attitudes toward seeking professional psychological help. As in Tang and Leong’s (1994) study, female participants in Hamid et al.’s study indicated more positive attitudes towards seeking help than men although women reported lower levels of acculturation than men. It might be that this cohort of university students was generally more open, perhaps as a function of their willingness to relocate to study in a foreign environment.
Perceived barriers to seeking professional help for mental health issues

Takeuchi, Leaf and Kuo (1988) examined ethnic groups on their perceptions of the barriers to help-seeking. Data from 2503 Caucasian, Filipino, Japanese and native Hawaiian ethnic groups living in USA were drawn from a Hawaii statewide survey conducted in 1984. The dependent variable was the perception of systemic barriers to help seeking including the availability and cost of mental health services, and the services approach to treatment. They examined seeking professional psychological help for two distinct types of problems: alcoholism and severe emotional problems. The authors found that Caucasians patients perceived less systemic barriers to seeking help for both types of problems than did the three ethnic groups including the native-Hawaiians. This result might mean that mental health services promotion or their approaches to treatment are more cultural friendly to Caucasian people than to the other ethnic groups. Whilst it is not clear what indicators have been taken to address any cultural misconceptions in other countries, in Australia there have been initiatives to provide information in various languages and also to provide translators for those in need of such services.

Ying and Miller (1992) examined help-seeking behaviours and attitudes towards psychological problems as mediated by mental health status, acculturation level and socio-demographic characteristics in a community sample of Chinese-Americans. Of the 128 participants, 17 (13.3%) had seen a mental health professional for a psychological problem in the past. Compared to the rest of participants these 17 participants conveyed significantly poorer mental health status, had more health issues, had once come close to experiencing a nervous
breakdown, had someone close to them who had received treatment, and were more likely to be American born. For those who had not previously sought help a positive attitude was mediated by superior English ability, being younger, married, and from a lower SES background. The authors concluded that help-seeking behaviour is primarily mediated by the presence of need whereas attitude reflected a general propensity to seek help. Acculturation was an important predictor of both positive behaviour and attitude, with the less acculturated individuals more in need of education about the availability and utility of mental health services. However the authors did not indicate how many of those experiencing psychological problems did not seek help.

Of particular interest and relevance for the current thesis are the following two studies by Madianos, Madianou and Stefanis (1993) who examined Greek participants and their reasons for seeking help for mental illness.

A nationwide home survey conducted by Madianos et al. identified possible factors affecting help-seeking behaviour for psychiatric problems and the prevalence of psychosocial problems in a sample of 3754 adults in Greece. Of these, 570 respondents reported at interview that they had a serious mental health problem yet only 40.8% of this group reported that they had attended a psychiatrist regarding this problem, although a further 42.5% had sought the help of a General Practitioner. Multivariate analysis revealed two groups of factors that influenced help-seeking behaviour in this sample. Respondents with a serious psychopathological profile (suicidal, depressive with a history of hospitalisation) tended to be under psychiatric care; respondents of lower socio-economic status presenting with psychosomatic symptoms were usually attending a GP due to the
easier access and free cost of this treatment through the health service system of Greece. The seriousness of the presenting problem may also have been a factor that differentiated between attendance at a GP clinic or a psychiatrist. Interestingly 16.7% who reported they suffered from a mental health problem had not sought help.

The relationship between attitudes towards seeking psychiatric help and the duration of untreated mental disorders among residents of Athens in an area served by a Community Mental Health Centre was examined by Madianos, Zartaloudi, Alevizopou, Katostaras, et al. (2011). A sample of 134 individuals on their first visit to the centre, but who had sought help from health or mental health non-sectorised services prior to this visit (group A), and 156 individuals whose visit to the Centre was their first ever contact with a mental health service (group B) were investigated. The length of untreated mental health issues was found to be shorter in group A compared to group B. Males and females in both groups who had visited the Centre within 12 months of the onset of their symptoms stated more positive views towards help-seeking compared to those with a longer duration of untreated mental health issues before their presentation. Being female, younger at age of symptom onset and higher education predicted a shorter duration without psychiatric treatment and more positive views about the necessity of help-seeking. More severe types of diagnoses were associated with a shorter duration before accessing care in both groups. The authors suggested that mental health awareness programs might contribute to strengthening the early recognition of the need to seek help.
4.3 Socio-cultural factors affecting the utilisation of mental health services

In a literature review of the barriers to Asian-Americans seeking mental health services, Leong and Lau (2001) examined cognitive and affective factors, value orientations, and physical barriers. They observed that the first three factors reflect cultural obstacles that can hinder individuals’ intent to seek mental health services while the fourth factor refers to practical barriers to actual use associated with the population’s immigrant and or socio-economic status. Cultural factors associated with help-seeking behaviours for mental illness will be discussed next.

4.3.1. Cultural hindrances to utilising mental health services

Medical anthropologists such as Cheng (2001), Kleinman (1980) and Tseng (2001) have contended that individuals’ cultural beliefs not only influence the way in which they perceive the cause of an illness and interpret the symptoms but also how they act on them. For a number of reasons, Eastern-Collectivistic cultures do not seem to encourage the use of mental health services (Leong & Lau, 2001) as much as do societies in Westernised or more industrialised cultures. The following section contains reasons why these differences may exist.

Whether or not mental health treatment is sought depends on the individual’s assessment of professionals’ helpfulness as well as people’s ideas of what emotional problems actually consist (Kung, 2004; Suan & Tyler, 1990; Sue & Morishima, 1982). Also Cauce et al. (2002) pointed out that the impact of culture and context are very strong across the entire help-seeking pathway for mental illness, from recognising the problem to choosing from whom to seek help.

Yuen and Tinsley (1981) investigated whether students living in USA from diverse cultural backgrounds differed in their expectancies about the
counseling service on the university campus. The participants included 40 Caucasian-Americans, 39 Chinese, 35 African, and 36 Iranian freshmen. Significant differences were observed on 12 of the 17 expectancy scales used. Caucasian-American students expected that the counselor would be less directive and protective and they expected to be more responsible for their own improvement. In contrast, the Chinese, Iranian, and African students expected to assume a more passive role in the treatment process and expected that the counselor would be a more directive and nurturing authority figure. This mismatch of perceptions of mental health professionals by laypersons and clients may, according to Zhang et al. (1998), lead to a distrust of mental health professionals who hold those expectations and when unfulfilled lead to lower service utilisation.

Narikiyo and Kameoka (1992) found that among many Asians and other ethnic minorities in the USA, emotional distress is seen as the result of malingering bad thoughts, a lack of will power, and a personality weakness, which, in their cultural background, is something that is not socially tolerated. This lack of tolerance is in contrast with western cultures where people generally consider that a mental illness is treatable with professional assistance. Narikiyo and Kameoka compared perceived causes of mental illness and help-seeking preferences among Japanese-American and White college students and found that Japanese-Americans were more likely than White students to attribute mental illness to social causes, to resolve problems on their own, or to seek help from family members and/or friends rather than seeking professional help. It might also
be that those behaviours were also related to “saving face” and avoiding possible stigma from within their immediate society.

Narrow et al. (1993) in an analysis of the National Institute of Mental Health Epidemiological Catchment Area (ECA) program, a community-based epidemiologic survey, found that European Americans with mental health issues were more likely to use psychiatric services than African-Americans or Hispanic people. There was also some indication that non-Caucasians were less likely to consider the medical system as a useful source for mental health interventions, possibly reflecting basic prejudices of the health care system. A qualitative study by Matthews, Corrigan, Smith and Rutherford (2003) reported that African-Americans in Chicago stated that the church, rather than the mental health system, was often a better place to receive mental health care. Moreover, Caucasian individuals who were underprivileged with respect to education or income, expressed more worry about their family’s reactions to mental health problems (Leaf et al., 1987).

Nickerson, Helms and Terrell (1994) in a sample of 105 Black college students in the USA, examined their level of mistrust of Whites, their opinions about mental illness, and help-seeking attitudes. Greater mistrust of Whites was associated with more negative general attitudes about seeking help from clinics staffed mostly by Whites and the expectation that the services rendered by White counselors would be less satisfactory for Black students.

Sheikh and Furnham (2000) examined the relationship between cultural beliefs about the causes of mental distress and attitudes associated with seeking professional help for psychological problems. Participants were 287 adults living
in England of different cultural origins: British-Asian, Western-European and Pakistani. Positive attitudes toward seeking professional help for psychological distress were similar for the three cohorts but there were differences among the three groups in their causal attributions of mental distress. Both British-Asians and Pakistanis living in England reported that they would be more likely to attribute mental distress to supernatural causes or “the will of God” than did Western-Europeans. Culture per se, was not a predictor of seeking professional help however causal beliefs of mental distress was a significant predictor of attitudes to seeking help for the British-Asian and Pakistani groups but not for the Western-European group. Sheikh and Furnham concluded that culturally determined causal beliefs of mental distress contribute to negative attitudes towards seeking professional help for psychological problems for Asians living in Britain.

Bhui, Bhugra, Goldberg, Dunn and Desai (2001) investigated how culture influences symptom presentation and help-seeking and how these may influence the general practitioner’s (GP’s) assessment. Bhui et al. recruited Punjabi (Indians) (209) and English (180) attendees at GP clinics in London to complete a survey utilising the Amritsar Depression Inventory, the General Health Questionnaire and the Clinical Interview Schedule as the indicators for a diagnosis of mental illness. They found that the prevalence of common mental disorders and somatic symptoms were the same across both cultures. However, with English clinic attendees, English GPs were more likely to correctly detect mental illness and mixed pathology; but Punjabi attendees, with common mental disorders, were more often diagnosed by Punjabi GP’s as having a ‘sub-clinical’
or ‘physical and somatic’ disorder. In response to the researchers asking attendees if they would seek help for the most subjectively distressing symptom as rated by them on the Clinical Interview Schedule, the English attendees were more likely than Punjabi attendees to seek professional help. There were no significant cultural differences in the type of carer (GP, friends or relatives, other health and social care) sought out as first, second or third carer meaning that, irrespective of cultural background, people did not have a particular preference from whom to seek help.

A study conducted by Lau and Takeuchi. (2001) explored the relationships between cultural values, appraisal of child behaviour problems, and associated help-seeking intentions among Chinese-American parents. Questionnaires were administered to 120 Chinese-American parents of primary-school-aged children. Parents were asked how they might respond if their child exhibited the behavioural issues described in a hypothetical vignette. The influence of Chinese value orientation, severity evaluation, and emotional reactions to help-seeking intentions were examined using regression analyses and structural equation modelling. The study explored three hypotheses concerning the nature of the influence of cultural value orientation on help-seeking intentions: (a) a direct effect model, (b) an indirect effect through cultural dissimilarities in severity appraisal, and (c) an indirect effect through cultural dissimilarities in emotional responding. Results provided evidence to support the hypothesis that cultural value orientation exerted a positive or negative indirect effect on help-seeking intentions through its effect on emotional responding. Those parents who had
more traditional Chinese values responded with more emotions of shame to their child’s behaviour issues and, in turn, reported lower intentions to seek help.

Mallinckrodt, Shigeoka and Suzuki (2005) conducted a study with Asian-American Pacific Island (AA/PI) college students \((n=93)\) who completed scales of acculturation and their mental health world view, in the form of beliefs about the possible causes of 24 typical counselling problems seen by university counsellors. Twenty-seven staff from two university counselling centres were also asked their beliefs about the most likely cause of the same 24 problems for a typical client. A response similarity index was estimated with higher scores reflecting greater resemblance between students’ and counsellors’ mental health worldviews. Results suggested that higher acculturation was related to greater levels of match between the students' aetiological beliefs and those of the counsellors.

Chen and Mak (2008) examined cultural beliefs about the causes of mental health issues and their relationship to seeking help from mental health professionals among college students in four cultural groups: European-Americans, Chinese-Americans, Hong-Kong Chinese, and Mainland-Chinese. Group differences were found in help-seeking history and the likelihood of seeking help in the future with European and Chinese-Americans being more likely to seek help than Hong-Kong and mainland Chinese. Multiple-group path analysis revealed that lay beliefs about the aetiology of mental illness and prior help-seeking history significantly predicted help-seeking likelihood in the future. The aetiology of mental illness was associated positively with environmental/hereditary causes but negatively with social-personal causes. These
findings highlight the importance of understanding help-seeking patterns within specific cultural contexts.

The effect of stigma on mental health help seeking behaviours will be discussed next.

4.4 Stigma: effects on mental health help seeking behaviours

The stigma often attached to mental illness also poses a barrier to people's willingness to seek mental health services (Kung, 2004). The attribution of problems to character flaws as discussed earlier, and to hereditary causes perceived as "genetic taints" and "bad seeds" (Pearson, 1993; Sue & Morishima, 1982), are important impediments to help-seeking.

Definitions of stigma vary enormously (Stafford & Scott 1986). According to Link and Phelan (2001) researchers often provide no explicit psychological definition of stigma, rather they seem to refer to a dictionary like definition ("a mark of disgrace") or to some related aspect such as stereotyping or rejection (e.g., a social distance scale). As Link and Phelan observed when stigma is explicitly defined many authors quote Goffman's (1963) definition of stigma as an "attribute that is deeply discrediting" and which reduces the bearer "from a whole and usual person to a tainted, discounted one" (p. 3). Since Goffman, alternative or expanded definitions have varied significantly (Link & Cheplan, 2001).

Stafford and Scott (1986) suggested that stigma "is a characteristic of a person that is contrary to a norm of a social unit" (p. 80) where a "norm" is defined as a "shared belief that a person ought to behave in a certain way at a certain time" (p. 81). Crocker et al. (1998) pointed out that "stigmatized [sic] individuals possess (or are believed to possess) some attribute, or characteristic,
that conveys a social identity that is devalued in a particular social context" (p. 505).

A further definition comes from Jones et al. (1984), who used Goffman's (1963, p.4) opinion that stigma can be seen as a relationship between an "attribute and a stereotype" to produce a definition of stigma as a "mark" (attribute) that associates a person with undesirable characteristics (stereotypes). Link and Phelan (2001) in their review added discrimination to Jones et al.'s (1984) definition.

Corrigan (2004) suggested that even if the quality and efficiency of mental health care services have increased over the last 50 years there is still a considerable problem for people who might want to seek help, as they may be concerned about the possible stigmatising effects that this will have on them.

According to Corrigan (2000) and Pen and Martin (2008) when lay people stigmatise others it appears to be based on four cues: psychiatric symptoms, social-skills deficits, physical appearance, and labels. Schumacher, Corrigan and Dejong (2003) provided 117 research participants with four vignettes about meeting a person in public who varied in symptom presentation: positive versus negative symptoms and a clean appearance versus an unkempt appearance. After reading each vignette, participants answered questions related to three types of stigmatising attitudes: dangerousness, threat, and social avoidance. Results suggested that the participants rated the person in the vignette as more dangerous, threatening, and worthy of avoidance when positive symptoms were manifested compared to negative symptoms. Physical appearance interacted with symptoms in the vignette such that those who were seen as unkempt were more stigmatised when they manifested negative, rather than positive symptoms. Stigma related to
physical appearance also interacted with the gender of the participants making the judgments, where women were more likely to stigmatise unkempt people in the vignettes than males.

Many of the symptoms of severe mental illness such as psychoses can be obvious and unfortunately have been shown to generate stigmatising responses (Link, Cullen, Frank & Wozniak, 1987; Socall & Holtgraves, 1992). Research by Penn, Corrigan, Bentall, Racenstein and Newman (1997) suggested that how people appear to others might also lead to stigmatising attitudes. For example, a person who does not look very well dressed and who is seen sleeping on a park bench might be perceived or labeled as mentally ill. The fact that they also appear to act improperly in public can lead further to stigmatising them.

According to Corrigan (2004) the prospect of mislabeling someone as mentally ill on the basis of these three cues: stereotype, prejudice and discrimination is high. For example, eccentric behaviours, such as full body piercing or full body tattoo, that are not typical of a mental illness could be misinterpreted by some as indicative of the person having a mental disorder. Just as these signs may yield false positives, so may their absence lead to false negatives. Many people are capable of hiding their experiences of mental illness without their peers finding out (Corrigan, 2004). Juxtaposing concerns about false positives with the idea that the stigma of mental illness may be hidden begs the following question: “What else, then, is the mark that leads to stigmatising responses?” (Corrigan, 2004, p.615). Several authors have proposed labeling as an important contributing factor to stigmatisation (Link & Phelan, 2001; Scheff, 1971). Labels lead to stigma in two ways. People can acquire labels from others (a
psychiatrist can inform another colleague that Ms. X has ‘‘X’’) or by association, such that a person observed coming out of a psychologist’s office may be assumed to be mentally ill (Corrigan, 2004).

Second, stigmas are signals that stimulate stereotypes that the general public holds about a marked social group (Krueger, 1996; Mullen, Rozell & Johnson, 1996). Stereotypes are particularly well-organised means of classifying information about social groups (Devine, 1989). Stereotypes are considered “social” because they epitomise collectively agreed on notions about groups of persons (Devine, 1989). They are “efficient” because people can rapidly generate impressions and expectations of individuals who belong to a stereotyped group (Hamilton & Sherman, 1994). Commonly held stereotypes about individuals with mental illness include violence (people with mental illness are dangerous), incompetence (they are incapable of independent living or real work and blame), and their weak character means that they are responsible for the onset and continuation of their disorders (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999).

Third, according to studies by Devine (1989, 1995) and Krueger (1996) people who are prejudiced approve negative stereotypes and form negative emotional reactions to others as a result. In contrast to stereotypes, which are beliefs, prejudicial attitudes comprise an evaluative and generally negative component (Eagley & Chaiken, 1993). Prejudice, which is fundamentally a cognitive and emotional response, leads to discrimination, which is a behavioural reaction to events or people perceived outside the perceivers’ norm (Crocker, Major, & Steele, 1998).
Discriminatory behaviour manifests itself as negative actions against the out-group or exclusively positive action for the in-group (Tajfel, 1970). Most notably, out-group discrimination may manifest as avoidance that is not associating with people from the out-group (Tajfel & Billic, 1974). For example, employers avoid workers with mental illness by not hiring them; landlords wanting to protect their tenants and property from people with mental illness do not rent to them (Corrigan, 2004).

Corrigan and Pen (1999) and Corrigan and Watson (2002) made an additional distinction about stigma that has been applied to both physical and mental health conditions. They distinguished public stigma as what a naive public does to the stigmatised group when they endorse the prejudice about that group, and self-stigma, what members of a stigmatised group may do to themselves if they internalise the public stigma.

In the following section the systemic-practical barriers to using mental health services will be examined.

4.5 Systemic-Practical Barriers to Using Mental Health Services

The majority of ethnic populations living in countries of the new world such as Australia, New Zealand, USA and Canada consist of immigrants (Australia Census Bureau, 2008; U.S. Census Bureau 2000; Canadian Census Bureau, 2006). Depending on the extent to which immigrants have integrated into these societies, their actual use of mental health services could be hampered by practical barriers such as knowledge of how to access services, time, money, and English-language proficiency (Kung, 2004).
Lack of knowledge about available mental health treatment facilities is prevalent, and more so among Ethnic minorities. Lack of knowledge about services is often cited as a major contributor to low service utilization, as shown by Takeuch, Leaf and Kuo (1988) in a sample of 2503 adults in USA.

In Australia, Ho, Hant and Li (2008) found that the most common barriers to help-seeking reported by Chinese immigrants included a lack of knowledge about available treatments, being unable to afford the cost of treatments, and having no transportation to access the service.

A lack of financial resources was also identified as a potential barrier to help seeking by Sue (1994) and Uba (1994). Long work hours and the possible hassle and shame involved in taking leave to obtain mental health treatment may also be factors which dissuade those in need from seeking help, as might the ongoing nature of treatment (Sue, 1994; Uba, 1994). In the USA the high percentage of medically uninsured immigrant Asian-Americans (Jang, Lee, & Woo, 1998; Takeuchi, Chung & Shen, 1998a; U.S. DHHS, 2001) also acts to reduce their ability or willingness to seek help due to the often high cost of services to them.

Australians though, through the medicare health system and especially though the Access to Allied Psychological Services (ATAPS) program are able to access effective low-cost mental health services irrespective of their ability to pay fees, their cultural and linguistic diversity, being homeless or at risk of homelessness. While these barriers have, to a large extent, been removed through ATAPS, this scheme does not necessarily provide those in need with knowledge of the available services or provoke a willingness among people to seek help.
Some research (Briones et al., 1990; Greenley et al., 1987; Leaf et al., 1988; Tata & Leong, 1994; Tijhuis, Peters, & Foets, 1990; Tischler, Henesz, Meyers & Boswell, 1975) has also shown that demographic and SES variables such as gender, age, marital status, education, and income can be significant predictors of mental health service use, though these findings are often rather mixed.

In the next section the relationship between the prevalence of mental disorders and help-seeking behaviours will be discussed.

4.6 Mental Disorder Prevalence and Help-Seeking

Results from an Australian study by Andrews, Henderson and Hall (2001) who surveyed 10,641 adults demonstrated that approximately 23% of their respondents self-reported at least one disorder in the past 12 months and 14% reported a current disorder. Only 35% of people with a self-reported mental disorder in the 12 months prior to the survey said that they had consulted a mental health professional during that year.

Oliver, Pearson and Coe (2005) conducted a study in England to examine patterns of lay and professional help-seeking in men and women aged 16–64 years in relation to severity of symptoms and socio-demographic variables. They used the 12-item General Health Questionnaire (GHQ-12) distributed to a stratified random sample of 15,222 in Somerset. Of those participants, 22% of people with extremely high GHQ-12 scores (≥8) had sought help from their general practitioner but most (78%) had sought some form of help from relatives, friends or colleagues.
Roness, Mykletun and Dahl (2005) also explored help-seeking behaviour among persons with an anxiety disorder or depression based on self-ratings in a Norwegian population study (the HUNT study) and found that among 60,869 participants only 13% of those with depression and 25% with an anxiety disorder had sought help for their condition. Help-seeking was not significantly associated with demographic variables. The researchers did not explore why the majority of persons with anxiety disorders were reluctant to seek help.

In a sample of Australian adolescents, Rickwood and Braithwaite (1994) found that the predictors of positive attitudes toward help-seeking for emotional problems were higher SES, a strong social network, and the personality characteristic of high private consciousness. These authors found that these same variables predicted the behavioural outcome measure of help-seeking from friends and family (general help-seeking) and from professional services in particular. General help-seeking was predicted by serious psychological symptoms, being female, social support availability, associating with an individual who had sought professional help, and the personality characteristics of high private self-consciousness and willingness to disclose mental health issues. When only those with severe psychological symptoms were considered, only gender and willingness to speak up about personal psychological issues remained significant predictors for help-seeking. These same variables were not present for those who sought professional mental health help but they were present for those who sought help from friends or family. Severity of psychological symptoms was the only significant predictor of seeking professional help. Psychological symptoms and
being female were more relevant predictors of the behavioural measure of help-seeking than network or personality characteristics.

Mojtabai, Olfson and Mechanic (2002) conducted a study with 1792 participants who were diagnosed with a mood, anxiety, or substance disorder of 12 months duration from 1990-1992. They investigated the correlates of participants’ perceived need for professional help and actual help-seeking among those with a need. They found that mood disorders, co-morbid mood and anxiety disorders, and mental disorders associated with impairment in role functioning or suicidality were strong predictors of perceived need. Psychopathology was related to participants’ decision to seek help from a psychologist or a psychiatrist, but it was not associated with seeking help from a GP. After controlling for the nature and severity of psychopathology, various socio-demographic and attitudinal factors such as older age (45-54 years), having a co-morbid physical problem and positive attitudes toward mental health help-seeking were associated with greater seeking of mental health professional help.

According to Christodoulou and Christodoulou (2007) the reason why help seeking behaviours for mental health problems has attracted the attention of mental health researchers and practitioners is largely because of the deleterious and costly effects associated with a long term prognosis. In cases where early intervention takes place the result is less suffering for the patient and a reduction in the devastating effects associated with chronic mental illness (Mai, Lopez-Iboz, Sartorius, Sato & Okasha, 2005). Long-term costs of mental health treatment and interventions during the rehabilitation process can be reduced dramatically (Wang, Aguilar-Gaxiola, Alonso, Angermeyer, Borges & Bromet, 2007) if early
intervention occurs. According to Mo and Mak (2009) “to guide the effective planning and promotion of mental health services it is important to explore factors related to help-seeking and challenges encountered in the process” (p.675).

In the next section the relationship between demographic factors and attitudes toward accessing mental health services will be examined further.

4.7 Demographic factors and attitudes towards accessing mental health services

Over the past century, considerable effort has been expended to provide the public with knowledge about mental health problems, to correct false beliefs concerning the mentally ill, and to increase the accessibility of mental health services to those who need them (http://www.psychology.org.au; http://www.beyondblue.org.au; Leaf, Bruce, Tischler & Holzer, 1987). Evidence indicates that over this period the public has become more knowledgeable about mental illness (Crocetti, Spiro & Siassi, 1974) and indeed, there has been an increase in the proportion of the population seeking help for mental and emotional problems (Veroff, Kulka & Douvan, 1981) although these figures still lag behind the need for help.

Leaf et al. (1987) found that women were more inclined to seek help for mental health problems than men and they were also less concerned about the reactions of their families. Nevertheless, Leaf and Bruce (1987) found that the effect of gender on service use varied with the level of need and with the individual’s attitudes toward using mental health services. According to Leaf et al.’s. (1987) findings, 18- to 24-year-olds were less inclined to seek help for mental health problems and they perceived more problems in accessing mental health services than did older people. The elderly showed less positive attitudes
toward professional mental health services and were particularly concerned with possible family reactions. Those in the sample who were over 65 years expressed markedly more confidence in the family doctor as a mental health provider, than did the younger respondents.

Furthermore, MacKenzie, Gekoski and Knox (2006) investigated age and gender differences in attitudes toward seeking professional psychological help, and examined whether attitudes negatively influence intentions to seek help among older adults and men. In their study, 206 adults completed questionnaires measuring help-seeking attitudes, psychiatric symptomatology, prior help-seeking, and intentions to seek help. They found that older age and being female were associated with more positive help-seeking attitudes in their sample, however age and gender interacted with marital status and education, and had varying influences on different attitude components. Age and gender also influenced intentions to seek professional psychological help. Women showed more favourable intentions to seek help from mental health professionals than men, likely due to their positive attitudes concerning psychological openness. Older adults showed more favourable intentions to seek help from primary care physicians than younger adults, a finding that was not explained by age differences in attitudes. Results from their study suggested that negative attitudes related to psychological openness might contribute to men's underutilisation of mental health services. The findings of these authors suggest the need for education to improve men's attitudes towards seeking help for mental illness and to enhance older adults’ willingness to seek specialty mental health services.
In a survey of 92 outpatients with depression, Shirey et al. (2001) found that patients under 65 years of age perceived more stigma associated with mental illness than people older than 65. However, only the older group exhibited a relationship between perceived stigma and reluctance to take part in therapy.

Corrigan, Swantek, Watson and Kleinlein (2003) also found that individuals over 65 years with negative attitudes about mental health services were less likely to discuss their mental health symptoms with their General Practitioner. It seems that negative attitudes, stigma and service utilisation interact with the age of the potential consumer.

Other research (e.g., Leaf et al., 1987; Parslow & Jorm, 2000; Stefl & Prosperi, 1985) has found that people with the least financial resources or the least education exhibit a lower propensity to seek mental health care. This research also showed that these people are more likely to perceive financial barriers to accessing mental health treatment, and are most sensitive to the reactions of others.

Perceived social support from family and others and how that affects attitudes and behaviours towards mental health services will be discussed next.

4.8 Perceived social support and attitudes toward mental health services

Zimet, Dahlem, Zimet and Farley (1988) defined perceived social support as including both the type of and satisfaction with social support, focusing on the support uniquely provided by family, friends, and significant others. The degree of perceived social support experienced from these sources might be related both to perceptions of mental health services and whether or not psychological services are actually sought (Miville & Constantine, 2006).
Leaf et al. (1987), in the New Haven Catchment Area study (USA), indicated that in a community with a considerable availability of Mental Health Services (M.H.S) important differences were found among residents in their attitudes and beliefs about such services. Although respondents demonstrated an overwhelming willingness to consider mental health services, they differed considerably in their opinion of how helpful family and physicians versus clergy might be in helping them deal with their emotional problems. Over half of the sample (52%) felt that family doctors could be of great help while a significant minority (27%) felt that clergy were as useful as mental health specialists in treating mental and emotional problems. It is also important to note that almost one-quarter (23%) of respondents indicated that their families would get upset if they entered professional treatment for a mental health problem, a view which reflects the impact that immediate social support can have on whether someone would or would not seek professional psychological support. Thus, despite the reported improvement in knowledge about service provisions, service accessibility, and efforts to reduce the psychological barriers in using appropriate treatment services for mental health and emotional problems, considerable psychological and instrumental barriers remain for a substantial portion of the population (Jorm, 2011).

In China, where 173 million adults have a mental disorder, of whom 91.3% have never sought professional help, Wong and Li (2012) investigated three factors: knowledge of mental illness, perceptions of the causes of mental illness, and the influence of an individual’s informal network, to determine their impact on help-seeking attitudes in a sample of 522 Chinese people living in
Shanghai. Shanghai- Chinese people exposed to psychosocial perspectives of mental illness and modern treatment methods used fewer traditional Chinese treatment methods and were more inclined to seek western style professional help than a traditional Chinese treatment. The recognition of depression and the perceived helpfulness of close friends negatively predicted help-seeking for depression, whereas the perceived helpfulness of family members was positively related to the tendency to seek help for schizophrenia. It might be that people experiencing depression feel that they can manage their condition with the support of friends or family, while those affected by schizophrenia acknowledged a need for professional assistance.

Similarly in Australia, Rickwood and Braithwaite (1994) discussed the significance of having a social network that accepts and encourages help seeking for mental health issues. Miville and Constanine (2006) found that individuals scoring high in perceived social support have more negative attitudes towards mental health services than those scoring low in perceived social support, which might mean that mental health professionals could be a source of support for those perceiving they have low social support. However, Horwitz (1977) found that people generally talk to at least four members of their social network about their personal concerns before asking for psychiatric help. Dew et al. (1991) asked 186 individuals experiencing symptoms of depression if they (a) had friends or relatives who suggested they seek help, or (b) had sought mental health services. A discriminant function analysis showed that those who sought help were more likely to have had friends or relatives recommend that they get help than those
who had not sought services. Clearly the results with respect to the role of support on help-seeking are equivocal and require further investigation.

Several health models have been developed and might be useful to predicted help-seeking behaviours, and these are reviewed next.

4.9 Chapter Summary

In this chapter mental health beliefs and attitudes towards seeking professional help were presented. This was followed by a discussion of the reasons for the underutilisation of mental health services and how socio-cultural factors such as stigma and cultural hindrances influence help seeking. The issue of help-seeking behaviours in general but also across different cultures was discussed. The relationship between demographic factors, perceived social support and attitudes towards mental health services were also highlighted.
CHAPTER FIVE: Models of health help seeking

*Mental Health Literacy*

Mental health literacy has been defined as the individual’s motivation to comprehend, utilise and access information in ways which support and maintain balanced mental health (Jorm, 1997a). It points to knowledge and attitudes about mental illness which assist people in the recognition of symptoms and the management or prevention of mental illness (Jorm, 2000; Lauber et al., 2003). It is also related to how we seek mental health information, awareness of risk factors and causes of mental illness, of self-therapies, and knowledge of the professional help available, as well as attitudes that encourage identification of a mental health issue and consequently suitable help-seeking (Jorm et al., 1997a).

The identification of mental health concerns is of crucial importance for two main reasons: 1) it enhances the individual’s help-seeking and 2) it activates the lay support system to provide assistance to those who are burdened (McNair, Hightet, Hickie & Davenport, 2002; Möller-Leimkühler, 2002). Another important issue in regards to the recognition of mental health issues is that this also influences people’s attitudes towards those who are struggling with mental illness (Lauber et al., 2003) therefore promoting an understanding of these symptoms is of vital importance in the context of anti-stigma campaigns (Jorm, 2011; Lauber et al., 2003) and promoting help-seeking behaviour. Various explanatory models of help-seeking behaviour have been developed some based on quantitative and procedural principles while others are of a more dynamic nature (Biddle, Donovan, Sharp & Gunnel, 2007).
Of the numerous health models which have been used to explain behaviour and/or behaviour change, some of these have relevance to help-seeking behaviours and are reviewed below.

5.1 Models of help seeking

Armitage and Corner (2001) in a review of health help-seeking models classified them into three categories (1) motivational, (2) behavioural enaction, and (3) multi-stage. Motivational models focus on the motivational factors (e.g., protection, motivation, threat) that underpin individuals’ decisions to perform (or not to perform) health behaviours. Such models include the Health Belief Model (HBM; Hochbaum, Rosenstock & Kegels, 1950), Protection Motivation Theory (PMT; Rogers, 1983), Social Cognitive Theory (SCT; Bandura, 1986), The Theory of Reasoned Action TRA (TRA; Fishbein & Ajzen, 1975) and the Theory of Planned Behaviour (TPB, Ajzen, 1991).

According to Sheeran and Orbell (1998) motivational models of health behaviour have generally been shown to be successful in predicting health related behaviours. Nevertheless, researchers using these models often use intention as a dependent or mediating variable, implicitly hypothesising near-perfect correspondence between intentions and subsequent behaviours (Armitage & Conner, 2001). Yet there is a gap between intention and behaviour and studies which have used both intention and behaviour show a significantly larger amount of variance is explained in intention than in behaviour (Conner & Armitage, 1988). A good example of this comes from a meta-analysis of condom use conducted by Sheeran and Orbell (1998). They showed the co-efficient of determination between intention and subsequent behaviour was 19% while the
variance explained in intention by the variable in the models was on average 44%.

Armitage and Conner argued that motivational models offer only a partial account of how motivation is translated into action.

It should also be noted that intention is about a future action where, in many studies, behaviour is typically measured in terms of a present behaviour. It can be suggested therefore that if both variables are included in cross-sectional studies the relationship between behavioural intention and actual behaviour is meaningless: intention is future-oriented where actual behaviour is what is going on at the present time.

The behavioural enaction models are social cognition models which aim to explain intention formation. Gollwitzer’s (1993) Implementation Intentions model makes a clear distinction between goals as intentions and implementation intentions which ask when and where will the intention to be put into action. A second behavioural enaction model is Bagozzi’s (1992) Goal Theory, which is basically a theory of goal attainment that suggests motivational influences affect goal intentions and efforts.

According to Bagozzi and Edwards (2000) the motivational and behavioural enaction models are different from multi-stage models because these last conceptualise health behaviour engagement or change across several separate stages. A number of such multi-stage models have been developed which describe the course of behaviour modification and the factors that might influence behaviour change at the different stages (Armitage & Conner, 2001).

Such models include Prochaska and DiClemente’s (1992) Transtheoretical Model of Change, where change is said to occur over five stages:
precontemplation, contemplation, preparation, action, and maintenance; and Schwarzer’s (1992) Health Action Process Approach (HAPA) model where he argued that the adoption, initiation and maintenance of health behaviour is a process involving two separate stages: a motivational stage and a volitional stage.

Heckhausen (1991) argued that an organism chooses a specific behaviour because of expected consequences, and then adopts it with some amount of energy along a particular path. Basically, he suggested a motivational-volitional dual process, not unlike Schwarzer’s (2008) HAPA model. In his Motivation-Action model, Heckhausen postulated four stages: intention formation, post-decision, action and evaluation, even though the only fundamental difference between this and the HAPA is the addition of an evaluative factor.

According to Kuhl (1985), one of the most striking discrepancies between everyday experience and psychological theorising concerns the complexity of motivational states. While many theorists and researchers tend to concentrate on a single behavioural domain (e.g., achievement, affiliation, eating, learning, problem solving, sexual behaviours) it would seem from everyday experience that people rarely have just one behavioural inclination in a given situation (Kuhl, 1985). In everyday life people usually experience several motivational tendencies which can be competing or complementary and more often than not, people can have multiple commitments to a variety of goals. Kuhl’s (1985) Action Control Theory is consistent with stage models but he noted that the choice of an action alternative, through the motivational process does not necessarily lead to its execution. Action control is dealing mainly with the general successful implementation of an intention (Kuhl, 1985). The main difference between multi-
stage models and behavioural enaction models is that multistage models suggest that the social cognitive influences on health behaviour are qualitatively different at each stage (Armitage & Conner, 2001).

In public health, probably the most utilised models are from social psychology: the Health Belief Model (HBM, Hochbaum et al., 1950), Health Action Process Approach (HAPA, Schwarzer, 1992), The Theory of Reasoned Action (TRA, Fishbein & Ajzen, 1975) and its later revision, the Theory of Planned Behaviour (TPB, Ajzen, 1991). Most known from medical sociology and medical anthropology is the Health Care Utilisation or Socio-Behavioural Model (Andersen, 1973). A discussion of the empirical studies where these models have been used follows.

5.1.2 Health Belief Model (HBM)

A group of social psychologists, Hochbaum et al. (1950) at the U.S Public Health Service developed the HBM because they wanted to understand why people do not undertake early screening tests which might prevent them from later serious health problems. The HBM is possibly the most widely used model in public health and also the oldest one stemming from social psychology.

Hochbaum et al. proposed that perceptions related to the severity of and one’s susceptibility to disease as well as modifying factors such as demographic variables, socio-psychological characteristics, and assessments of possible outcomes of the action to be performed predict the likelihood of action (Figure 5.1).
Figure 5.1 Health Belief Model


Action in the HBM is guided by:

1. Beliefs about the influence of the illness and its side effects (threat perception) which are based upon:
   - Perceived susceptibility to the disease, or how helpless people consider themselves to be in relation to a certain illness or health problem
   - Perceived seriousness of the illness or health problems and its side effects
(2) Cues to action include different internal and external factors which influence action. For example: the nature and intensity (organic and symbolic) of illness symptoms, mass media campaigns and advice from relevant others (family, friends, health staff).

(3) Beliefs and health motivation are conditioned by socio-demographic variables (e.g., age, gender, ethnicity) and by the socio-psychological characteristics of the person (personality).

(4) Beliefs about the effects of health practices and about the possibilities and effort to put them into practice. This evaluation depends on:

- Perceived benefits of preventive or therapeutic health practices
- Perceived barriers, both material and psychological (for example ‘will-power’), with regard to a certain health practice.

While the HBM has been used to explain the adoption of several preventive health behaviours (Becker, Kaback & Rosenstock, 1975; Cummings, Jette, Brock & Haefner, 1979; Rundell & Wheeler, 1979), screening behaviours (Hallal, 1982; Kelly 1979; Langlie, 1977; Manfredi, Warnecke & Graham, 1977; Stillman, 1977), sick role behaviours (Alogna, 1980; Hartman & Becker, 1978; Inui, Yourtee & Williamson, 1976) and clinic utilisation (Leavit, 1979; Kirscht, Becker & Eveland, 1976), some studies have also used various of the HBM variables such as 1) beliefs about the influence of illness and its side effects, 2) health motivation, 3) beliefs about the effects of health practices, 4) cues to action and 5) beliefs and health motivation, as predictors of help seeking behaviours for physical and mental illness.
Cerkony and Hart (1980) used the HBM and interviewed 30 insulin dependent individuals with diabetes in their homes 6-12 months after attending education classes on diabetes at a community hospital. Patients’ self-report as well as direct observations were used to assess their level of adherence with their insulin administration, urine testing, diet, hypoglycaemia management, and food care preparations. All patients complied with at least 59% of the 61 areas measured; over half of the group indicated compliance with at least 70% of these points but only 7% complied with every one of the 45 points of the 61 considered necessary for good control of their diabetes. The group adhered most with regard to insulin administration and least regarding urine testing. The level of these patients' beliefs regarding their disease (severity and susceptibility, treatment benefits, and barriers) and cues to action were also measured and a composite measure of their level of health belief motivation accounted for approximately 25% of the variation in compliance\(^4\) in this sample.

Champion (1987) used the Health Belief Model with a sample of 588 women to determine the frequency of breast self-examination. Individual items were developed to measure the frequency of breast self-examination and the method by which breast self-examination was learnt. Multiple regression and discriminant function analyses demonstrated that fewer barriers, better knowledge, and perceived susceptibility were predictors of frequency of breast self-examination \((R^2 = .53, p<.001)\). In addition, women taught BSE by a doctor

\[^4\text{Current terminology refers to adherence not compliance, but the results are reported here are in the terminology of the original authors.}\]
or nurse reported greater frequency of breast self-examination than those instructed in other ways such as via pamphlets or videos.

Becker, Radius, Rosenstock, Drachman, Schubert and Teets (1978) conducted interviews with 111 mothers who normally attended an asthma clinic with their child but who had need to use an emergency paediatric facility for treatment when their child experienced an acute episode of asthma. The aim was to determine how mothers adhered to implementing or ensuring their child implemented relevant treatment. Based on the HBM's socio-behavioural dimensions, the interview included questions about the mother's general health motivations and attitudes, as well as her views regarding her child's asthma condition and its ramifications. Two measures of compliance were employed: (1) laboratory verification of previously prescribed drugs in the child’s blood and (2) a measure combining objectively determined and self-reported information from the mother if laboratory documentation was unavailable. Significant associations were found between the majority of HBM components and the measures of compliance. Mothers' perceptions of the threat of illness, particularly the child's susceptibility to illness, the seriousness of the condition and of difficulties associated with the administration of the medication by the mother were substantial predictors of the mother's adherence with the child’s regime.

Burak and Meyer (1997) utilised the Health Belief Model to predict the perceptions of college women to cervical cancer screening and their screening behaviours. They used a sample of 400 American female university students. The authors concluded that even though the variables in the model explained only 15% of the variance in screening behaviour and 11% in screening perceptions (whether
cervical cancer screening procedure is useful or not), the use of the HBM revealed women had a positive attitude towards cervical cancer screening procedures, although in their sample, these attitudes were not converted into behaviour.

Yarbrough and Braden (2001) also used the HBM to predict breast cancer screening behaviours. The variables in the model explained 47% of the variance in screening behaviours when socio-economic status was included, without it the predictive power was much lower at 17%. The finding that lower SES had negative implications for breast cancer screening behaviours has significant implications for research generally, health promotion strategies and service provisions and more specifically health education. These findings might also suggest that the utilisation of health services is dependent on knowledge and availability of those services. Individuals with higher education and often associated higher annual income live in an environment where services are more available and they are also more able to afford them due to private health insurance or the health benefits provided by their employers. In Australia though, cost is less of an issue due to recent government initiatives (see ATAPS, Chapter 4).

Harrison, Mullen and Green (1992) in their meta-analysis of studies using the HBM found that, while all correlations between variables in the HBM and the behaviours studied were statistically significant, the effect sizes were small to moderate (all $R^2 < .21\%$, see Cohen, 1988; 1992). However Harrison et al.’s analysis did not contain an assessment of the efficacy of the cues to action or health motivation elements because of the scarcity of studies they reviewed which included measures of these constructs. It might be that cues to action in the form
of social support, is an important predictor of attitudes and subsequent behaviours. In another review, Sheeran and Abraham (1996) also found that all HBM variables correlated only weakly with behaviour. They suggested that the weak predictive utility of the HBM overall was a function of weak or inconsistent definitions of the constructs involved and an absence of combinatorial rules.

While there is evidence that perceived susceptibility, severity, benefits and barriers, all factors of the HBM, are relevant but not always substantial considerations in health behaviour (Sheeran & Abraham, 1996), the HBM neglects further determinants such as attitudes towards the behaviour and subjective norms which are present in other models such as the Theory of Planned Behaviour (Ajzen, 1991) and Andersen’s (1995) Model of Health Care Utilisation (Andersen, 1995).

The Health Action Process Approach (HAPA) developed by Schwarzer (1992) addressed some of these limitations.

5.1.3 Health Action Process Approach

The Health Action Process Approach (HAPA) (Schwarzer, 1992) is a social-cognition model of health behaviour in which he proposed that health behaviour modification is a process that comprises a motivational phase and a volitional phase. In the Health Action Process Approach (HAPA) Schwarzer et al. (2003) suggested that the adoption, initiation, and maintenance of health behaviours must be explicitly conceived as a process that consists of at least a motivation phase and a volitional phase. The latter might be further subdivided into a planning phase, action phase, and maintenance phase. Self-efficacy,
originally described by Bandura (1977) also has a crucial role at all stages of the HAPA along with other cognitions.

For example, risk perceptions serve predominantly to set the stage for a contemplation process early in the motivation phase but do not extend beyond that phase. Similarly, outcome expectancies are important in the motivation phase when individuals balance the pros and cons of certain consequences of behaviours, but they lose their predictive power after a personal decision has been made. However, if one does not believe in one’s capability to perform a desired action,

![Health Action Process Approach (HAPA)](image)

Figure 5.2. Health Action Process Approach (HAPA)

one will fail to adopt, initiate and maintain it. Schwarzer included these elements of self-efficacy in his model.

The HAPA has been used in studies on problem drinking (Murgraff & McDermott, 2003), eating salty and high-fat food (Satow & Schwarzer, 1998), therapy compliance (Kühn, Mohs & Schneider, 2001), preventative nutrition (Schwarzer & Fuchs, 1996; Schwarzer & Renner, 2000), low-fat food (Renner, Knoll, & Schwarzer, 2000), and performing regular breast self-examination (Garcia & Mann, 2003; Luszczynska & Schwarzer, 2003).

Barling and Lehmann (1999) conducted a study with 101 Australian male university students aged 18-25 years, with a mean age of 22.9 years. Participants completed a survey on Testicular Self-Examination (TSE), and their understanding of testicular cancer. More knowledge about testicular cancer was held by those men who stated they performed testicular examination than those who did not. The factors affecting performance of testicular self-examination were examined using Schwarzer's (1992) Health Action Process Approach. Results revealed that most of the men were ignorant or misinformed about testicular cancer and testicular self-examination. Eighty-three per cent of respondents did not routinely perform testicular self-examination once per month as per recommendations. Although together, the predictor variables correctly classified 86.14% of the sample (84.44% of testicular self-examination performers and 87.5% of non-performers), the only significant predictors of TSE were intention, outcome expectancies, self-efficacy, and knowledge.

Murgraff, McDermott and Walsh (2006) also used the HAPA to examine factors related to low-risk, single-occasion drinking (LRSOD) among 128 female
undergraduate students. The independent variables were entered in three blocks: (a) a HAPA cognitions score derived from summing self-efficacy, action planning and control and social barriers; (b) behavioral intentions; and (c) a HAPA by intention interaction score derived by multiplying the HAPA cognitions by intention. HAPA cognitions predicted 24% of the variance in single-occasion drinking behaviour, at follow-up two weeks later.

Sutton (2005) criticised the HAPA saying it cannot be regarded as a stage theory like the transtheoretical model (TTM; Prochaska & Velicer, 1997) or the precaution adoption process model (Weinstein & Sandman, 1992). Sutton also noted that the HAPA has a similar structure to the widely used Theory of Planned Behaviour (TPB; Ajzen, 2002) and that the HAPA can best be regarded as an alternative to the TPB. While Sutton’s comments are open to debate, it does seem that the HAPA is a more dynamic model than several others. It might be best applied in longitudinal studies especially when maintenance, recovery and initiative are being considered.

5.1.4 The Health Care Utilisation Model or Andersen’s Socio-Behavioural Model

The Socio-Behavioural or Andersen Model (Andersen & Newman, 1973) has three clusters or categories of factors (predisposing, enabling, and need factors) which can influence health behaviours (Figure 5.3).
Predisposing factors consist of demographic variables illustrating individuals’ social placement and status, which affect how they deal with health conditions and their capability to access resources to address these conditions.

- Enabling resources are factors that facilitate or hinder use of health services. They consist of personal resources such as income and health insurance and structural conditions such as proximity to services.

- Need consist of both perceived and evaluated medical need. Perceived need is how individuals see their own general functional health and how they experience symptoms. Evaluated need represents health professionals’ assessment and diagnosis regarding health status.

Cairney, Boyleb, Lipmanb and Racine (2004) used Andersen’s Socio-Behavioural model to investigate whether the higher rates of mental health service utilisation observed among single-parent mothers was due to greater need (psychopathology) or to other factors, such as predisposing and enabling.
characteristics. They used data from two large surveys in Canada: the 1994–95 National Population Health Survey and the 1990 Ontario Mental Health Supplement to test this hypothesis. The results from both surveys revealed that single-parent mothers were twice to three times more likely than married mothers to have sought professional help for mental health issues over a 12-month period. Multivariate analyses showed that differences in predisposing and enabling characteristics between single and married mothers accounted for very little of the relationship between family structure and service use, rather differences in the greater prevalence of psychiatric disorders accounted for the higher use of services among single mothers. That is, single mothers were more likely than married mothers to seek professional help for mental health concerns as they actually experienced more mental illness. The authors proposed that the use of services appeared equitable in that need (higher rates of psychopathology) was the major factor differentiating use between married and single mothers. It might be that single mothers had to deal with more problems and by themselves and therefore their need for help would then be higher than that of the married mothers.

Vingilisa, Wadeb and Seeleya (2007) used Andersen’s Health Care Utilisation Model to investigate a nationally representative, longitudinal sample of Canadian adolescents on their utilisation of health services. They also examined whether help seeking by these adolescents varied across physicians, non-physicians, and dentists by need. Their results indicated that need and psychological factors were strong positive determinants of service utilisation. They also observed that predisposing factors such as perceived health status,
evaluated health status and consumer satisfaction were related to service utilisation, although few enabling resources such as income and health insurance were used. Differences were found for utilisation of different services. Females, and older adolescents, from single parent families, with lower self-rated health, lower health status, higher disability, higher distress and involved in health compromising practices were more likely to visit both physicians and non-physicians such as acupuncturists and naturopaths. Higher utilisation of dental services was positively related to higher income and negatively related to single parent status, being younger, having lower health status, and higher disability.

From the few studies that have utilised Andersen’s Care Utilisation Model is notable that this model is focused more on structural variables than psychological processes which, it can be suggested, are both important in behaviour and behaviour change. The Theory of Planned Behaviour, which is focused more on psychological processes, will be discussed next.

5.1.5 Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB, Ajzen, 1991) (Figure 5.4) and its precursor the Theory of Reasoned Action (TRA, Fishbein & Ajzen, 1975), were developed for and initially used in HIV/AIDS research. They have subsequently been used to predict behaviour in many other areas of physical and mental health. The TPB differs from the original model (TRA) in that perceived behavioural control and intention to act were added to the TPB with both direct and indirect effects on the behaviour proposed.
In the TPB, behavioural intention is determined by:

- Attitudes towards the behaviour, determined by the belief that a specific behaviour will have a concrete consequence and the evaluation of that consequence.

- Subjective norms or the belief in whether relevant persons will approve one’s behaviour, plus the personal motivation to fulfil the expectations of others.

- Perceived behavioural control, determined by beliefs about access to the resources needed in order to act successfully.

These factors all predict intention which in turn predicts behaviour. Perceived behavioural control is also argued to have a direct effect on behaviour as well as an indirect effect through intention.

Several reviews have provided support for the efficacy of the TRA and TPB to predict a range of behaviours (e.g., Ajzen, 1991; Sheppard, Hartwick &
Warshaw, 1988) and health behaviours in particular (e.g., Conner & Sparks, 1996; Godin & Kok, 1996; Hausenblas, Carron & Mack, 1997). For instance, Godin and Kok (1996) in a meta-analysis of 87 TPB studies found that on average, the variables in the TPB accounted for 41% of the variance in behavioural intentions and 34% of the variance in actual behaviours across a range of health behaviours.

Skogstad, Deane and Spicer (2006) conducted a study to assess whether prisoners’ intentions to seek help for a personal-emotional problem, including suicidal feelings, could be predicted using variables from the TPB. These variables were supplemented by measures of emotional distress and prior contact with a psychologist and demographic variables. Male inmates from six New Zealand prisons were asked to participate in the study, with approximately 50% (n = 527) of those who initially expressed an interest in the study completing the self-report questionnaire. On average, participants reported higher levels of current emotional distress than comparison student samples which, of itself, may not be surprising given their circumstances. TPB variables predicted 44% of the variance in prisoners’ help-seeking intentions for suicidal feelings and 43% of the variance in their help-seeking intentions for personal-emotional problems. Those with prior contact with prison psychologists reported lower intentions to seek help for suicidal feelings than prisoners without such prior contact. Although the authors did not indicate why it might be, it may be because the prisoners felt unsupported during previous sessions or they might have perceived seeking help had been a negative influence on others’ perceptions and treatment of them and may even have influenced subsequent diagnosis. The older prisoners, those with more years of education, and those who had previous contact with a psychologist
outside the prison system had higher intentions to seek psychological help for both conditions.

Mo and Mak (2009) examined the social-cognitive factors that may affect help-seeking intentions using an extended version of the TPB among Chinese in Hong Kong. The severity of mental illness and perceived barriers to help seeking were also included in the model. Nine hundred and forty-one Chinese were recruited in their study via a randomised household design in Hong Kong. Results from a structural equation model showed that a positive attitude, subjective norms, perceived behavioural control, and perceived barriers predicted 58% of variance in help-seeking intentions. Mental health status, assessed using self-report questionnaires, had no significant effect on help-seeking intentions. Subjective norms, for example approval or disapproval of significant others, indirectly predicted intention to seek help from mental health professionals through their influence on attitudes and perceived behavioural control. Further analysis revealed that all path coefficients were invariant across gender. Overall their results support the use of the TPB in understanding help-seeking intentions and highlighted the importance of subjective norms toward help-seeking intentions for mental health help seeking.

Schomerus, Matschinger and Angermeyer (2009) examined attitudes that promote or obstruct help-seeking for depression using the Theory of Planned Behaviour (TPB) comparing respondents with and without depressive symptoms. Telephone interviews were conducted with a representative sample in Germany (n=2303). The researchers screened participants for current depressive symptoms using the mood subscale of the Patient Health Questionnaire (PHQ-9). In non-
depressed respondents (n=2167), a TPB path model predicted 42% of the variance in intention to seek help. For depressed respondents (n=136) a TPB path model predicted 50% of the variance in intention to seek professional psychological help. Path coefficients in both models were similar. In both depressed and non-depressed persons, positive attitudes towards the help-seeking intention had higher explanatory value than the subjective norm, whereas perceived behavioural control had the least explanatory value. Schomerus et al. concluded that willingness to seek psychiatric help for depression can largely be explained by the attitudes and beliefs conceptualised by the factors in the TPB. These findings can be interpreted to suggest that changing attitudes towards mental illness in the general population is likely to positively influence help-seeking if the individual or their family were subsequently to experience depressive symptoms.

It seems from the studies discussed (in this section), that a positive attitude towards health services is a common predictor for seeking help for physical or mental health problems, except in the findings from Mo and Mak (2009) in which they found that subjective norms had better predictive value for help-seeking behaviours for mental illness than personal attitudes.

In the TPB the immediate predictors of behaviour are intentions, which are determined by attitude, subjective norm and perceived behavioural control where in the HBM, threat perception and behavioural evaluation are the two main components assessed to predict health behaviours. The advantages of the TPB are that it takes into account the motivational aspects around control of a personal problem and the influence of social networks and peer pressure. On the other hand, Hausmann-Muela and Riberra (2003) argued that the limitations of the TPB
are a tendency to overemphasise psychological factors while under-valuing structural factors such as the limited access to or availability of resources.

While each of the models reviewed here has varying degrees of support in the literature (e.g., Armitage & Corner, 2001; Sheeran & Orbell, 1998) there is currently no one model among these which is directly relevant to people’s willingness to seek help for a mental illness, and it may be more informative to integrate aspects of models that can be argued to be relevant.

Willingness to seek help for a mental illness might be considered a future behaviour, or in terms of the TPB, it might be considered intention. Attitudes are part of the TPB and can be operationalised here as people’s feelings of stigma towards mental illness which then influence their willingness to seek help. It might also be that, need, whether diagnosed with a mental illness or not, from Andersen’s Socio-Behavioural Model, also influences people’s willingness to seek help.

The barriers to engaging in a behaviour, part of the Health Belief Model, might be considered the antithesis of enabling in Andersens Socio-Behavioural model and it is argued that it can also be considered the opposite of Perceived Behavioural Control which is part of the Theory of Planned Behaviour.

Accordingly, the following integrated model adapted from the models reviewed here, might predict people’s willingness to seek help for a mental illness (Figure 5.5).
When investigating the behaviour of immigrants to a new society, it might also be important to ascertain their level of acculturation into the new society, as well as their ongoing enculturation with their society of origin. These issues will be addressed in the next chapter.

5.2 Chapter Summary

In this chapter approaches to health-seeking behaviour were presented from different theoretical orientations. Some of the most well-known models such as the Health Belief Model (HBM), The Health Action Process Approach (HAPA), Andersen’s Health Care Utilization Model and the Theory of Planned Behaviour (TPB), were reviewed together with an overview of some of the studies which have used them to explain intentions and health behaviours. An integrated model that might explain people’s willingness to seek help for mental illness was

Figure 5.5: Integrated model to predict willingness to seek help for a mental illness.
synthesised from these aforementioned models and presented. The importance of cultural factors in behaviour change among immigrants was suggested, and will be discussed further in the following chapter.
CHAPTER SIX: Acculturation and adaptation among immigrants

*Acculturation Paradigm*

Governments as well as researchers from the various social sciences have tried to define acculturation and according to Thomson and Hoffman-Goetz (2009), each has influenced its comprehension and utilisation. For example, the sociologist Gordon (1964) defined acculturation as a process of accommodation with and subsequent and permanent assimilation into, the dominant culture group. The anthropologist Redfield (1936) described acculturation as a process of interactivity between cultures. However Graves (1967) made a distinction between acculturation as a collective or group-level phenomenon and the individual’s psychological acculturation. According to Berry (1997), in the former acculturation is a change in the culture of the group in the latter acculturation is a change in the psychology of the person. This difference between levels is significant for two reasons: first, to successfully study the systematic relationships between these two sets of variables; and second, because not all people take part to the same degree in the general acculturation being experienced by their group (Berry, 1997). While the general transformations in the group may be profound, individuals are known to vary greatly in the degree to which they take part in these community changes (Berry, 1970; Furnham & Bochner, 1986), and these individual differences may be important in terms of attitudes towards mental illness and behaviours around help-seeking for such.

While the concept of acculturation has been used in numerous cross-cultural psychology studies (e.g., Berry, Kim & Boski, 1988; Berry, Trimble &
Olmedo, 1986) another concept that is frequently discussed and may be of equal relevance is that of enculturation.

6.1 Enculturation

According to Sam (2006) “enculturation” refers to all the learning that occurs in human life without any deliberate effort on the part of someone to impart that learning to others or self, as is the case in each person’s culture of origin. Enculturation is something that occurs because of the possibilities and opportunities that are present and available within an individual’s environment so that much of enculturation occurs through observation, although not all observation entails enculturation (Levine, 1990). In some instances, an individual observes others closely and “imitates” a behaviour. This is socialisation. Enculturation is closely related to socialisation but for one major difference: socialisation can entail deliberate and systematic “shaping” of an individual through teaching. Enculturation does not. Within the social and developmental psychology literature, the term “socialisation” is utilised as a general concept to include both systematic and accidental shaping and learning of the culture of a given society (Levine, 2006). A more official definition of socialisation is “the continuous collaboration of ‘elders’ and ‘novices,’ of ‘old hands’ and ‘newcomers,’ in the acquisition and honing of skills important for meeting the demands of group life” (Bugental & Goodnow, 1988, p.389).

According to Berry (2005) closely related to socialisation is re-socialisation which simply entails “re-shaping” of previously acquired skills necessary for meeting the demands of a particular society. This re-socialisation may occur due to the transition of the individual from one cultural society to
another where new skills may be needed in order to meet the demands of this new society (Berry, 2005). Enculturation, socialisation and re-socialisation are all processes that can occur during acculturation, but they are not in themselves acculturation (Sam, 2006).

In the following sections the term acculturation will be used to refer to the general processes and outcomes both cultural and psychological of intercultural contact while enculturation refers to absorption in one’s culture of origin.

6.2 Multicultural Societies

According to Berry (1997) culturally plural societies have eventuated because of immigration: that is, individuals from various cultural backgrounds come to coexist in a diverse society because of migration, which can occur for numerous reasons. In many cases these societies reflect cultural groups that are unequal in power such as in numeric, economic, or political terms (Berry, 1997). These power differences have given rise to popular and social science terms such as “mainstream”, “minority” and “ethnic group” among others (Kosic, 2004). In this chapter, based on Berry’s (1997) argument about acculturation procedures, and bearing in mind the non-equal effects and changes that occur during acculturation, the term cultural group will be employed to refer across all groups, and the terms dominant and non-dominant to refer to the relative power of groups where such differences exist and it is relevant to the discussion.

According to Berry (1997) many cultural groups may coexist in plural societies because of voluntariness, mobility, and/or permanence. Some groups have moved into the acculturation process voluntarily (e.g., immigrants) while others experience acculturation without necessarily wanting to (e.g., refugees,
indigenous peoples) (Berry, 1997). Some groups are in communication with their native culture often even though they have migrated to a new place (e.g., immigrants and refugees) while others have had the new culture brought to them (e.g., indigenous peoples and “national minorities”) (Kosic, 2004). Among those who have migrated, some are well established in the process of acculturation (e.g., immigrants who moved for good to a host country), while for others the condition of acculturation is a temporary one (e.g., sojourners such as international students and guest workers, or asylum seekers who may eventually return home voluntarily or be deported) (Kosic, 2004).

Regardless of the differences in factors leading to relocation to another country, one of the conclusions drawn by Berry and Sam (1996) is that the process of adaptation seems to be common to all these groups but it is achieved or accepted to varying degrees.

6.3 Acculturation Strategies

In all plural societies, cultural groups and their individual members, in both the dominant and non-dominant conditions, must cope with the issue of how to acculturate, basically how to live together in harmony with common values and goals (Berry, Kim, Power, Young & Bujaki, 1989). Tactics around the two major problems associated with this process are usually worked out by the groups and individuals in their daily encounters with each other. These issues include cultural preservation, that is, to what degree are the cultural identity and features of one’s country of origin deemed to be important and need to be preserved and also, to what level should these newcomers engage with other cultural groups or isolate themselves from such groups (Berry, 1997).
In considering these two issues Berry (1997) proposed a conceptual framework in which he posited four acculturation strategies that are used by immigrants or minorities (whether native or not) to accommodate cultural preservation and adaptation to the host or dominant culture. While there are gradations in each dimension, generally positive or negative (“yes” or “no” responses), these issues intersect to define four acculturation strategies (Figure 6.1).

<table>
<thead>
<tr>
<th>Assimilation</th>
<th>Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Marginalisation</td>
<td>Separation</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Is it considered to be of value to develop relationships with the rest of society?

Is it considered to be of value to maintain one’s cultural heritage?

Figure 6.1: Berry’s Acculturation Model


These strategies can be elaborated as: (1) when members of the non-dominant groups do not desire to maintain their cultural identity and look for daily interaction with the dominant culture they would be considered assimilated; (2) contrariwise, when individuals place a value on holding on to their native culture and simultaneously wish to avoid interaction with others, they would be considered separatist; (3) a concern to maintain both one’s native culture while in
daily interactions with other groups is considered integration, that is, some level of cultural integrity is maintained, while at the same time seeking to participate as an integral part of the larger social network; and (4) when there is a little chance or concern for cultural maintenance, often for reasons of enforced cultural loss and little interest in interacting with others, often for reasons of exclusion or discrimination, this is referred to as marginalisation (Berry, 1997).

Berry grounded his formulation of these acculturation strategies in his hypothesis that non-dominant groups and their individual members have the freedom to choose how they want to acculturate. Although he did acknowledge that this choice is not always possible in every case (Berry, 1974). For instance when the dominant group imposes certain practices of acculturation or constrains the choices of non-dominant groups or individuals, then other terms need to be used (Berry, 1991) as are discussed below.

Individuals may sometimes choose to follow the Separation option but when this is required of them by the dominant society, the situation is one of Segregation (Berry, 1991). Likewise, when persons choose to Assimilate, a view of a “Melting Pot” may be suitable but when forced to do so, according to Berry (1997), it becomes more like a “Pressure Cooker”. In the case of Marginalisation, individuals hardly ever choose such an option rather they usually become marginalised as a result of efforts at enforced assimilation (Pressure Cooker) combined with forced exclusion from the cultural or dominant group (Segregation) thus the term of Marginalisation would be appropriate (Berry, 1997).
Integration can only be "freely" chosen and successfully followed by non-dominant groups when the dominant society is open and inclusive in its positioning towards cultural diversity (Berry, 1991). Thus a reciprocal accommodation is essential for integration including the support of all in order for all groups to have the right to live as culturally diverse. This tactic requires the non-dominant groups to embrace the basic principles of the dominant society while at the same time the dominant group must be prepared to adapt national institutions (e.g., education, health, labour) to better achieve the needs of all groups living together simultaneously in the plural society (Berry, 1997).

It is reasonable to assume that an Integration strategy can only be achieved in societies that are explicitly multicultural and in which certain psychological pre-conditions are established (Berry & Kalin, 1995). These pre-conditions are the widespread acceptance of the value to a society of cultural diversity (i.e., the presence of a positive "multicultural ideology") relatively low levels of prejudice (i.e., minimal ethnocentrism, racism, and discrimination), positive mutual attitudes among cultural groups (i.e., no specific intergroup hatreds); and a sense of attachment to, or identification with, the larger society by all groups (Berry & Kalin, 1997). Integration (and separation) can only be reached when other members of one's ethno-cultural group have the same wish to maintain the group's cultural heritage. In this sense, these two strategies are "collective", whereas assimilation is more "individualistic" (Lalonde & Cameron, 1993). Other limitations on one's individual adoption of an acculturation strategy have also been noted. For example those whose physical characteristics stand out from the society of settlement (e.g., Koreans in Canada, or Turks in Germany) may
experience prejudice and discrimination, and thus be reluctant to pursue assimilation (Berry, Kim, Power, Young & Bujaki, 1989).

Yet, Berry’s (1987) proposal of acculturation types has not been fully supported by all other researchers. For example, Ward and Rana-Deuba (1999) suggested that although these quadri-modal acculturation assessments have been utilised broadly across cultures, they are worth further examination on both conceptual and methodological grounds. From a conceptual base, there are problems around the measurement of two dimensions versus four types of acculturation. Berry for example highlighted that the two central questions supporting acculturation tactics are: “Is it considered to be of value to maintain one’s identity and characteristics?” and “Is it considered to be of value to maintain relationships with the larger society?” (Berry et al., 1989).

Other orientations to acculturation strategies have been studied, including ways that occupy intermediate places in the two-dimensional acculturation space. For example, Mishra, Sinha and Berry (1996) in a study of Adivasi peoples in India conceptualised an orientation situated between integration and assimilation called coexistence: this orientation represents more a willingness to live with both cultures, rather than a positive valuing of them. Their study revealed that coexistence and integration were positively correlated, and that each was preferred equally. The finding of what might be termed a “fifth” orientation shows that there are other possibilities or places in the acculturation space. A further acculturation orientation examined by Mishra et al. was the degree to which adolescents were oriented not just to their own heritage but also to the national culture in which they had settled. They also looked at the level of possible
orientation to some ‘global culture’ or ‘pan-human culture’ subsumes both and where the two specific cultures are not the focus. For example, Adivasi teenagers would feel connected to their own tribe and to India as their national culture but at the same time they felt part of the whole world: such an ecumenical perspective helps to avoid any conflict of national identity about being more Indian or more Adivasi.

Rosenthal, Bell, Demetriou and Efklides (1989) examined whether Greek immigrants in Australia have preserved traditional Greek values and behaviours or shifted to an integration of these with Anglo-Australian values and behaviours. Their sample comprised Anglo- and Greek-Australian parents and young adolescents and a comparison group of Greeks resident in Greece. Assessments were obtained of values and behaviours considered to be suitable for family members in the culture. Results indicated that Greek-Australians preserved the collectivistic values of their cultural inheritance while Anglo-Australians demonstrated a more individualistic orientation. There were however indications of convergence between Anglo- and Greek-Australians’ views of appropriate behaviours which can be interpreted to suggest that acculturation might be more likely to be expressed in behaviours than in central values. However, such a proposition seems to be counter to basic human principles where one is guided by one’s mortality (Kohlberg, 1981) and belief systems. Clearly these results suggest divergence between cultural beliefs and behaviours and further investigation of Greek immigrants, as well as their subsequent generations would yield more insight into the stability or not, of this apparent disparity.
6.3.1 Attitudes towards acculturation strategies

Individuals and groups may embrace different attitudes towards acculturating, and it seems their actual behaviours may differ correspondingly (Berry, 1997). Such attitudes towards or preferences for acculturation type (Marginalization, Separation, Integration and Assimilation) have been measured in numerous studies (Berry, 1997; Berry et al., 1989; Cuellar, Arnold & Maldonado, 1995; Donna & Berry, 1994; Krishnan & Berry, 1992; Ward & Kennedy, 1994; Ward & Rana-Deuba, 1999).

Ward and Rana-Deuba (1999) conducted research where they employed a scale developed to study the two dimensions of host and co-national identification, Berry's four types of acculturation, and their association with sojourner adjustment. Results revealed that strong co-national identification predicted enhanced psychological well-being, whereas strong host national identification was related to better socio-cultural adaptation. Furthermore, sojourners who adopted an integrated style managed better psychologically than others, whereas those who assumed an assimilationist perspective experienced fewer social difficulties. It may be that some combination of these styles would yield better adjustment overall.

National policies and programmes may also be analysed in terms of the four approaches in Berry's Acculturation model. Some policies and programmes are assimilationist in focus and it is expected that immigrant and ethno-cultural groups will become like those in the dominant society. Others are integrationist in nature demonstrating a willingness to accept and unite all groups to a large extent on their own cultural terms, yet others follow segregationist policies.
From an overview of Australian Government Immigration sites it seems that the policy in place at the moment belongs more to the spectrum of the integrationist than the assimilationist or the segregationist approach. A highlight of this policy can be seen in the following sentence which is part of the Australian values statement *Australian citizenship is a shared identity, a common bond which unites all Australians while respecting their diversity* (http://www.immi.gov.au/living-in-australia/values/statement/) which must be signed by any person over 18 years old applying for Australian citizenship.

Two further issues need to be considered. First, researchers use of one acculturation strategy over another has differed depending on the context and the time period under study (e.g., length of residence, or generational status) (Berry, 1997). As far as governments are concerned there is usually an overall coherent preference from governments for one particular strategy. However, there can also be differences according to location: in more private spheres or domains such as the home, the extended family and the ethnic community more cultural maintenance may be pursued than in more public spheres such as the workplace or in politics and there may be less intergroup contact pursued in private spheres than in the more public ones (Berry, 1997).

Second, the larger national context may affect acculturation strategies such that in explicitly multicultural societies persons may look to match such a policy with a personal preference for integration or, in assimilationist societies, acculturation may be at ease by adopting an assimilation strategy for oneself (Krishnan & Berry, 1992). That is, individuals may well be limited in their choice of strategy to the point where there is limited role for personal preference (Berry,
1997). Indeed, when personal preferences are in conflict with national policies, stress may well be the result (Horenczyk, 1996).

6.3.2 *Psychological Acculturation*

Three main points of view around psychological acculturation can be found in acculturation research, each signifying a different degree of difficulty for the person. The first is one that considers that psychological adjustment is easy to achieve: this approach has been referred to variously as “behavioural shifts” by Berry (1980), “culture learning” by Brislin, Landis and Brandt (1983) and “social skills acquisition” by Furnham and Bochner (1986). Here, psychological adaptations to acculturation are thought to be a matter of acquiring a new behavioural repertoire that is suitable in the new cultural context. This process is also argued to include some “culture shedding” (Berry, 1992) that is, the deliberate abandonment of aspects of one’s previous repertoire that are no longer suitable. Such shedding may be accompanied by moderate “culture conflict” where incompatible behaviours create difficulties for the individual. In cases where serious conflict occurs a second term would be used “culture shock” (Oberg, 1960) or “acculturative stress” (Berry, 1970; Berry, Kim, Minde & Mok, 1987) where people cannot easily alter their repertoire or find it in conflict with their own values. Although the “culture shock” concept is older and has wide popular acceptance, the term “acculturative stress” is perhaps more appropriate for three reasons.

One is that acculturative stress is closely connected to theoretical models of stress (e.g., Lazarus & Folkman, 1984) where stress occurs as a response to environmental stressors, which, in the current situation, relate to the demands
associated with acculturation. The second reason is that “shock” presupposes the presence of only deleterious experiences and outcomes from intercultural contact. The “shell shock” notion was popular early in the 20th century as a psychological outcome of war experiences (Berry, 1997). During acculturation a range of outcomes might be experienced from minor to more serious, and also individuals will likely have a range of coping strategies accessible to them (Vega & Rumbaut, 1991). The third reason is the source of the issues that arise are often not cultural, but intercultural, residing in the process of acculturation (Jayasuriya, Sang & Fieldin, 1992). When major problems are experienced, then a psychopathology or mental illness perspective is most appropriate (Malzberg & Lee, 1956; Murphy, 1965; WHO, 1991). Here alterations in the cultural context surpass the individual’s capacity to cope because of the scale, speed, or some other aspect of the change, leading to severe psychological disturbances, such as denial, levels of anxiety and depression (Berry & Kim, 1988; Jayasuriya et al., 1992).

Malzberg and Lee (1956) suggested that acculturation inevitably brings social and psychological problems but such a negative and wide generalisation is no longer considered valid (Berry & Kim. 1988). Social and psychological consequences are now known to be highly variable as demonstrated by the following evaluation of Australasian and international studies. Jayasuriya et al. (1992) found that immigration alone does not necessarily harm mental health. However, they observed that the mental health of immigrants does become a worry when additional risk factors, such as employment problems, language difficulties and non-recognition of qualifications, combine with the stressors of immigration. They also found evidence that certain groups namely refugees,
women, children and the elderly within the immigration population had a high risk of mental health issues.

Jang and Chiriboga (2004) examined the role of acculturation in the manifestation of depressive symptoms among 230 older Korean-Americans (\(M_{\text{age}} = 69.8\) years) in Florida. Given the cultural importance of modesty and self-effacement in traditional Korean society, the authors’ hypothesised that older Korean-Americans, who were less acculturated to American culture when compared to those more acculturated, would be more likely report more symptoms of depression. It is not clear from the study’s design what other factors, for example work, finances, social support, recognition of qualifications, might have influenced acculturation and hence the more positive mood of those more acculturated.

Kaplan and Marks (1990) examined the relationship between acculturation and psychological distress in young (20–30), middle aged (31–50), and older (51–74) Mexican-Americans (n = 3084) using data from the Hispanic Health and Nutrition Examination Survey (HHANES). Acculturation was measured with items on spoken and written language and ethnic identification, and psychological distress was measured by the Centre for Epidemiologic Studies Depression Scale (CES-D). They found that as acculturation increased distress significantly increased in young adults but tended to decrease in older adults and this general pattern held for males and females and was independent of income and education. These results might suggest a longitudinal process whereby acculturated younger Mexican-Americans attempting to advance themselves economically and socially in the dominant society, strip themselves of traditional resources and ethnically
based social support. Over time as people attempt to acculturate or ‘fit in’ and where they have been successful in this, they may re-establish ties to their native culture which then contributes to positive mental health in the older cohort. Conversely the older cohort, although reporting similar levels of acculturation, may not have neglected their native culture and that has given them a stable sense of identity and stability as the basic elements of their mental health (Kaplan & Marks, 1990).

Kovacev and Shute (2004) studied various types of acculturation and perceived social support and their relationship to teenager refugees’ psychosocial adjustment using measures of global self-worth and peer social acceptance. Their 83 participants, aged between 12 and 19 years and then resident in Australia, were from the former Republic of Yugoslavia. Those who had the most positive attitudes toward both cultures obtained the highest ratings of self-worth and peer social acceptance. Contrariwise those who had negative attitudes toward both cultures had the lowest scores on these measures of psychosocial adjustment. They also found that the effect of acculturation on adjustment was positively mediated by social support from peers.

Yangmurlu and Sanson (2009) examined the acculturation attitudes of Turkish immigrant mothers in Australia and the relationships between their interaction levels with Australian society and their parenting values and behaviours. Turkey is traditionally a collectivist society and punishment of the child by the parents is more common than verbal reasoning (Yangmurlu & Sanson 2009). In Australia, which is predominantly individualistic, normative parenting goals emphasise independence over obedience and induction-based discipline
over punishment (Yangmurlu & Sanson, 2009). Participants were 58 Turkish mothers living in Melbourne and each had a child attending a child-care centre situated in a generally lower socio-economic suburb of Melbourne. Results indicated that the mothers, who had a propensity to integrate with Australian society while they reported higher levels of self-directive goals with their children, also used more inductive reasoning and compliance goals than obedience-demanding behaviour. The authors suggested that their results indicate that the behaviours of immigrants can, at least in part, be shaped by exposure, that is acculturation in cultural norms that differ from those of their country of origin.

A further Australian study by Sondergger and Barrett (2004) examined the cultural adjustment patterns of ethnically diverse migrants to Australia. Participants were 273 primary and high school students from the former Yugoslavia and from China. Participants completed self-report measures of acculturation, internalising symptoms, social support, self-concept/esteem, ethnic identity, and future outlook, and were compared by gender, school level, cultural group, heterorganic ethnicity, and residential duration. Results from their study revealed that: (1) patterns of cultural adjustment were different for children and adolescents according to cultural background, gender, age, and length of stay in the host culture; (2) Yugoslavian migrants generally reported more identification and participation with Australian cultural norms than Chinese migrant youth, possibly due to more common western ideas and values than those held by the Asian cohort. These differential results between western and Asian immigrants to western countries support reports from other countries around the world,
including the UK (Bhui, Bhugra, Goldberg, Dunn & Desai (2001) and the USA (Hall & Tucker, 1985).

In the following section, the process of adaptation will be discussed in relation to psychological acculturation.

6.4 Adaptation

In its most general meaning, adaptation indicates changes in persons or groups that occur in response to environmental stressors: these adaptations can happen instantaneously, or they can occur over the longer term (Kosic, 2004). Short-term modifications during acculturation, such as travelling for family reasons back to one’s country of origin for visits, can sometimes be harmful (Kosic, 2004) as such visits might delay adaptation to the host country. However, for most acculturating people, after a period of time, some long-term positive adaptation to the new cultural context usually occurs (Beiser et al., 1988). Depending on a range of factors, these adaptations can take various forms. Sometimes there is a greater than before “fit” between the acculturating individual and the new context. For example, when assimilation or integration strategies are followed and when attitudes in the dominant society are accepting of the acculturating individual and group (Kosic, 2004). Sometimes, however a “fit” is not attained as in separation/segregation and marginalisation strategies, and the groups settle into a pattern of conflict, with resultant acculturative stress or psychopathology (Beiser et al., 1988).

Factors forecasting these two types of adaptation are often diverse (Ward, 1996). Psychological adaptation may best be analysed within the context of stress and psychopathology, while socio-cultural adaptation is more closely linked to a
social skills context (Ward & Kennedy, 1993a). A third adaptive product which is economic adaptation was introduced by Aycan and Berry (1996) and it refers to the level to which work is obtained, is satisfying, and offers an effective role in the new culture in which one lives.

Jasinskaja-Lahti (2008) conducted a longitudinal study on the three different dimensions of long-term immigrant adaptation (i.e., psychological, socio-cultural, and socio-economic adaptation) and the relationships between them in an 8-year panel study. The 282 participants were immigrants to Finland, born between 1961 and 1976, from the former Soviet Union. Overall the results suggested that the adaptation of these immigrants was favourable. After eight years, the respondents had improved their Finnish language skills and their position in the labour market, and their psychological well-being remained stable over time. Of the three adaptation dimensions assessed, socio-cultural adaptation, measured as proficiency in understanding, speaking, reading, and writing Finnish, was the most significant predictor of the other two long-term outcomes of immigrant adaptation (i.e., socio-economic and psychological). In particular, the better the initial command of the Finnish language, the better were their socio-economic and psychological adaptation outcomes after eight years of residence.

Another study by Tonsing (2013) among Pakistani and Nepalese immigrants (N = 447) in Hong-Kong investigated the association of socio-demographic factors age, education, employment, income and length of stay in the host culture with acculturative stress, perceived discrimination, and perceived social support on their psychological adaptation in terms of life satisfaction and psychological distress. Comparison of hierarchical regression analyses revealed
different patterns of predictors between these two groups. For Pakistanis high levels of life satisfaction were strongly predicted by high levels of perceived social support, and low psychological distress was predicted by low perceived discrimination, lack of acculturative stress and high levels of perceived social support. For the Nepalese group, predictors of high levels of life satisfaction were low perceived discrimination and high levels of perceived social support, while high levels of perceived discrimination together with high acculturative stress were significantly related to psychological distress.

Bektaş, Demir and Bowden (2009) investigated how acculturation factors affected psychological adaptation of Turkish students (n=124) studying in the U.S.A. Regression analyses revealed that high levels of social support and self-esteem were predictors of good psychological adjustment. The authors suggested that these Turkish students, as shown in other studies with international students, have a strong network of co-national students as well as other social connections which help them adapt quicker and better in the new culture.

Leung (2001) examined the psychological adaptation of overseas and migrant students and Anglo-Australian students using individual variables such as social self-efficacy, locus of control, loneliness, age, sex, and acculturation among 382 students from different universities in Melbourne, Australia. The sample comprised Anglo-Australian students, Southern-European second-generation migrant students, Asian migrant students and Chinese students. The authors found that for non-migrant students a sense of control was vital to their psychological and academic adaptation whereas for overseas students, supportive social relationships were crucial for their psychological and academic adaptation.
Leung, Pe-pua and Karnilowicz (2006) study examined the psychological adaptation and autonomy among 426 adolescents in Australia by comparing Anglo-Celtic and three Asian groups, Vietnamese, Chinese and Philippinno. The results showed all three Asian groups scored higher on parental authority values. Chinese-Australians reported higher school adjustment scores than Anglo-Celtic-Australians and were lower on gender relationship/children's rights values and behaviour problems. Only the Vietnamese-Australians scored lower on life satisfaction than the Anglo-Celtic-Australians and only the Chinese-Australians reported a lower sense of mastery than Anglo-Australians. There were no group differences on self-esteem. Generation status did not exert an influence on values but there was an interaction effect of ethnicity with self-esteem, life satisfaction and school adjustment.

It seems that each study that has tried to link acculturation with psychological distress, independent of the country in which the study took place and the population studied, the outcomes typically indicate a strong association between low levels of acculturation and psychological distress.

In the aforementioned studies the relationships among ethnicity, acculturation, immigration and different life attitudes were presented in order to determine how people living in a country with different cultural values than their own are either preserving their traditional attitudes and/or adapting their values and attitudes to those of the host culture. Even when these studies are not directly related to help seeking for mental illness they offer insight into the impact that acculturation and immigration can have on people’s lives. These effects can also have an impact on immigrants’ attitudes towards help-seeking for mental illness.
Furthermore the importance of peer and social support is a theme common across several studies where better adjustment was shown.

6.5 Other Factors Influencing Acculturation

6.5.1 Age

People start the acculturation process with numerous personal characteristics of a demographic and social nature. In particular, people’s age has a known relationship to the way acculturation will proceed (Berry, 1997). As Beiser et al. (1988) suggested, when acculturation begins early in age (e.g., prior to entry into primary school), the process is generally smooth.

A study conducted by Burnam et al. (1987) showed that among first generation Mexican-Americans, those who were younger and male, acculturated more rapidly than those who were older. There are few clear reasons for why this might be so but possibly full enculturation into one’s parents’ culture is not sufficiently advanced to necessitate much culture shedding or to generate any serious culture conflict or, possibly, personal flexibility and adaptability are maximal during these early years (Burnam et al., 1987). However, older youth often experience substantial problems with drugs and alcohol (Ghuman, 1991; Sam & Berry, 1995) particularly during adolescence.

Berry (1997) suggested that it is possible that acculturation difficulties occur because conflicts between parents and peers are highest during adolescence, or the difficulties of life transitions between childhood and adulthood are compounded by cultural transitions. For example, developmental issues of identity come to the fore at this time and intermingle with questions of ethnic identity, thus multiplying the questions about who one really is (Phinney, 1990).
If acculturation starts later on in life (e.g., on retirement or when older parents migrate to join their adult offspring under family reunification programmes) there appears to be an increased risk of mental health issues (Beiser et al., 1988; Ebrahim, 1992). Possibly the same factors, that is the extent of enculturation and adaptability, suggested for children are also relevant for older immigrants where many life years lived in one cultural background cannot easily be overlooked when one is trying to live in a new setting (Berry, 1997).

6.5.2 Gender

There is substantial evidence to show that females may be more at risk for problems during the acculturation process than males (e.g., Beiser et al., 1988; Carballo, 1994). Burnam et al. (1987) showed that among first generation Mexican-Americans, females acculturated at a slower rate than males. Naidoo (1992) proposed that such differences might depend on the relative status and differential treatment of females in the two cultures. Where there is a substantial difference in efforts by females to take on new roles accessible in the society of settlement this might bring them into conflict with a more traditional or gender stereotypical cultures thus putting them at risk for emotional and even physical abuse. Conversely, some males might maintain the traditional male role and thus limit females’ integration into the ways of the new society.

6.5.3 Education

Jayasuriya et al. (1992) reported that for Australian immigrants education is a factor that has been reliably associated with positive adaptation and lower levels of stress. A number of reasons have been proposed for this relationship. Berry (1997) suggested this relationship might be because education is a personal
resource facilitating problem-solving and analysis which might contribute to better adaptation. Further, education is correlated with other resources such as income, occupational status, and support networks, all of which are protective factors or buffers against stress (Berry, 1997). For many migrants, education may help them adjust to features of the society into which they have chosen to settle that is it can be a kind of pre-acclimatization to the language, history, values, and norms of the new culture (Berry, 1997).

Also related to education is one's economical well being. Although education is typically a resource and therefore a potential source of economic status, a common experience for migrants is a combination of status damage and limited status flexibility (Aycan & Berry, 1996). According to Cumming, Lee and Oreopoulos (1989) usually immigrants’ departure status is higher than their entry status with credentials, educational and work experience often devalued on arrival into the new country. Sometimes this is because of real differences in qualifications, but it could also be the result of ignorance and/or prejudice in the society of settlement, leading to status loss, and the risk of stress (Berry, 1997). Such losses of themselves can lead to emotional distress and even mental illness.

According to Beiser, Johnson and Turner (1993) the usual main goal of migration, upward status mobility, is often not satisfied and this can be a risk factor for various illnesses, such as depression. In a way, these problems lie in the personal qualities brought to the acculturation process, but they also exist in the interaction between the migrant and the institutions of the society of settlement hence, issues of status damage and limited flexibility can and should be addressed during the path of acculturation (Berry, 1997).
6.5.4 Reasons for migration

Reasons for migrating have long been studied using the concepts of push/pull motivations and expectations. Richmond (1993) suggested that a reactive-proactive continuum of migration motivation be employed in which push motives including involuntary or forced migration and negative expectations characterise the reactive end of the dimension, while pull motives (including voluntary migration and positive expectations) cluster at the proactive end.

Interestingly, Kim (1988) found that those with high “push” motivations had psychological adaptation problems, yet those with high “pull” motivations had almost as great a number of problems due to the negative psychological effects of immigration process.

6.5.5 Adaptation process among immigrants

If stress and acculturation need to be understood it would follow that the phase of acculturation needs to be taken into account (Berry, 2001). That is, the duration that an individual has been going through acculturation strongly affects the kind and extent of difficulties of adaptation. The mainstream picture of positive adaptation in relation to time has been in terms of an inverted U-curve (Berry, 2001). Only a few issues are present early, followed by more severe difficulties later, until finally a more positive long-term adaptation is attained (Berry, 2005). However, there is scant empirical support for such a generalised course, or for fixed times in terms of months or years when this process will occur (Berry, 2005).

Church (1982) argued that support for the U-curve is "weak, inconclusive and overgeneralised" (p.452) According to Ward and Kennedy (1999) there are
some longitudinal studies which although not necessarily reflecting an U curve have suggested fluctuations in stress and anxiety over time. According to Ho (1995) a substitute for a fixed, stage-like theorisation of the association between the extent of acculturation and difficulties experienced, is to reflect on the exact nature of the experiences and difficulties encountered as they alter over time (e.g., initially acquiring a language, gaining employment and housing, followed by establishing social relationships and recreational prospects) and the relationship of such issues to the personal resources of the migrant and to their chances in the society of settlement.

This view emphasises the high degree of changeability to be expected over time from first contact to longer-term adaptation. Of the acculturation tactics shown to have significant relationships with positive adaptation, integration is usually the most effective, marginalisation is the least successful, and assimilation and separation strategies are in between (Berry, 1997). This pattern has been found in virtually every study and is present for all types of acculturating groups (Berry, 1990a; Berry & Sam, 1996). Why this is the case, is not clear. In one version, the integration strategy unites many defensive factors: a readiness for reciprocal accommodation (i.e., the existence of reciprocal positive attitudes, and lack of prejudice and discrimination - having two social support systems), participation in two cultural communities, and being flexible in personality (Berry, 1997). In contrast, marginalisation contains rejection by the prevailing society in conjunction with own-culture loss that can mean the manifestation of hostility and much less social support (Berry, 1997).
Another potential reason for the finding that integration is the most adaptive strategy is that most studies on the relationship between acculturation strategies and adaptation have been in societies with multicultural orientations (Berry, 1997). That is, there could be positive potential for people matching their acculturation strategies to that generally supported environment and recognised in the larger society. However, some research among Indian immigrants to the USA (Krishnan & Berry, 1992) that is more “Melting Pot”, and of Third World immigrant youth in Norway (Sam & Berry, 1995) that is more assimilationist, has shown that the integration tactic was the most adaptive and contrariwise marginalisation was the least adaptive tactic.

6.6 Effects of Acculturation on Mental Health

A study by Gaffarian (1998) of Iranian immigrants in the United States showed a significant relationship between acculturation and mental health. As cultural resistance to acculturation increased, scores on mental health decreased: as cultural incorporation and cultural shift increased, scores signifying better mental health increased. Also, Iranian men were found to have higher levels of cultural shift, lower levels of cultural resistance, and higher scores signifying better mental health than Iranian women.

A study in Australia by Alati, Najman, Shuttlewood, Gail and William (2003) showed a relationship between migrants’ region of origin, length of stay in Australia and indicators of impaired mental health. These researchers used the data from the Mater-University of Queensland Study of Pregnancy (MUSP), a longitudinal study of mothers and children with a cohort of over 5,000 women, Australian and overseas born. Results revealed no significant differences among
the mental health of ‘second generation’ children and their Australian counterparts. For mothers, length of stay in Australia was not associated with internalising symptoms (anxiety and depression) but there was a positive association between the length of stay in Australia and increased externalising problems (aggression and delinquency) amongst their children at both 5- and 14-years follow-up.

A study of acculturation and psychiatric disorders by Mavreas and Bebbington (1990) using 291 Greek-Cypriot immigrants in Camberwell, south London found that, of the acculturation factors, only previous knowledge of English was associated with a reduced prevalence of mental illness. Difficulties in the settling-in period were clearly related to the current disorder but there was no association between their current level of acculturation and mental health. In males, a mental disorder was most prevalent in those highly acculturated while in females those with mental illness were the least acculturated. These findings seem counter-intuitive, and it might be that mental illness in these males was related to factors outside acculturation, such as endeavouring to be high performers in their new country, or the stress of dealing with their partners’ situation. Clearly these people would suffer less and adapt better and quicker into their host society if they were to seek help from some kind of mental health services available where they live.
6.7 The relationship between Acculturation-Enculturation and Attitudes Toward Mental Health Services

Acculturative and enculturative processes are argued to shape critical aspects of psychological functioning, including core beliefs, choice of language, attitudes, and expectations of behaviours (Berry, 1997; Miville & Constantine, 2006). Indeed, inconsistencies and conflicts between acculturation and enculturation are often a source of stress for many people (Kim & Abreu, 2001). Thus, acculturative stress itself may lead to the presence of psychological symptoms that may be associated with a need to seek professional help however, whether individuals struggling with acculturative stress seek help appears to be questionable for a number of reasons. Among these reasons might be a preference for seeking traditional healing, social stigma, and cultural mistrust of the new environment (Constantine, Okazaki & Utsey, 2004). Also, according to Jorm (2011) mental health literacy, that is the individual’s motivation to comprehend, utilise and access information in ways which support and maintain balanced mental health, is a prerequisite for someone to seek help. He also stated that this is a western scientific construct that may come in conflict with traditions or religious beliefs about mental illness that may be stronger in people from cultural minorities or developing countries.

Alternatively, Garza and Gallegos (1995) suggested that interactions between acculturation and enculturation could have positive outcomes including psychological adjustment. It is reasonable to suggest that the attitudes and behaviours of many people of different cultures regarding wellness and health, including mental health, are likely to be guided by acculturative processes in their adopted country (Berry, 1997; Kim, Yang, Atkinson, Wollé & Hong, 2001).
Cultural beliefs about the causes and treatment of mental illness may be related to positive or negative attitudes about seeking professional help, while cultural beliefs resulting from acculturation and enculturation might lead to different help-seeking attitudes and behaviours. For example these may include seeking psychological services from mental health agencies or visiting a traditional healer (e.g., a curandera, priest) (Constantine, Myers, Kindaichi & Moore, 2004).

Several researchers have explored the relationships between acculturation/enculturation processes and attitudes and behaviours toward seeking professional help. For example, Kim, Atkinson and Umemoto (2001) explored these relations among Asian-Americans and suggested that enculturation, as measured by adherence to Asian cultural values, may either enhance or detract from the counselling process, depending on a number of variables such as dissatisfaction with the outcome of the intervention and absence of deeper communication because of cultural differences with the therapist. With respect to Latinos/as living in the USA, Pomales and Williams (1989) found that acculturation not enculturation was significantly positively predictive of the ratings of a counsellor’s trustworthiness and understanding among their sample of mostly Puerto Rican college students.

Although help-seeking attitudes and behaviours may be contextualised within a variety of cultural frameworks, it is plausible to consider that psychological services traditionally offered at mental health agencies, such as university counselling centres and mental health clinics, are likely to be perceived by many minorities as predominantly oriented toward ‘Anglo-American’ values and needs (Miville & Constantine, 2006) or in the Australian context ‘Anglo-
Australian’ values and needs. Such services might be perceived as emphasising an individual’s needs without considering family wishes and roles, and de-emphasising the role of religious or spiritual values (Miville & Constantine, 2006).

Psychological acculturation is a basic concept in mental health research among minority ethnic groups. Substantial evidence has linked psychological acculturation to mental health (Dyal & Dyal, 1981; Murphy, 1977; Shin & Shin, 1999), psychiatric symptoms (Hsu, 1999; Yeh, 2003; Kim, Li & Kim, 1999; Kirmayer, 2001), conceptualisation of illness (Kim-Goh, 1993; Murguia, Zea, Reisen, & Peterson, 2000; Pang, 1998; Ying, Lee, Tsai, Yeh & Huang, 2000) and attitudes towards professional psychological care (Juon, Choi & Kim, 2000; Tata & Leong, 1994; Woodward, Dwinell & Arons, 1992). Thus, the measurement of psychological acculturation can be useful for researchers and mental health clinicians who are considering providing ‘western style’ services to immigrants and people who have close ties with their traditions. In fact, it might be that such is an ethical consideration whereby practitioners have to decide whether or not they have the required skills to work with such patients.

It is important however to consider Jackson et al.’s. (2007) finding that when the severity of any mental health problem increases, socio-cultural variables such as acculturative and enculturative processes among others, cannot predict help-seeking behaviours. That is, they found that the socio-cultural barriers towards seeking professional help collapse in cases where the symptoms are severe, which suggests that individuals of any cultural background will seek a western form of treatment when this is the situation. But in cases when symptoms
are not so severe or not so obvious, socio-cultural variables play an important role in seeking or not seeking professional psychological treatment: this can happen due to the fact that some psychosocial support can be gained from the surrounding socio-cultural resources. Thus multicultural research on help seeking behaviours and attitudes towards mental illness in Australia helps us to understand better the mental health issues of minority immigrants living in this country and their help seeking intentions, so to be able to promote more accessible mental health services to CALD people.

While several studies have addressed the effects of acculturation and enculturation on mental health (Dyal & Dyal, 1981; Murphy, 1977; Shin & Shin, 1999), responses to treatment, and attitudes towards treatment, it is argued that including these factors in a model of help-seeking for immigrant groups in a dominant society may yield a greater understanding of the factors which influence help seeking for their groups. Hence, acculturation and enculturation are included in the integrated model of help seeking proposed here (Figure 6.2).
In this chapter, acculturation and enculturation were defined and their impact on mental health and on attitudes towards mental health services were discussed. The effect of factors such as age, gender and education were discussed with respect to their impact on immigrants’ acculturation process. A review of how enculturation/acculturation processes affect help-seeking behaviours and attitudes towards mental health services was also presented. The importance of adding acculturation and enculturation to a model of willingness to seek help was highlighted.
CHAPTER SEVEN: Aims

In the preceding chapters, the high prevalence of mental illness was discussed and juxtaposed against the low levels of help seeking for a mental illness.

A discussion of the factors that have been shown to influence help seeking behaviour was presented, as was a discussion of theoretical models, which might be used to determine factors to predict willingness to seek help. Within these various models, social norms, barriers and demographic variables have been shown to predict behaviour. Social support, having a diagnosis of mental illness, SES and gender might also be predictive of willingness to seek help. In migrants and subsequent generations, it is also suggested that their levels of enculturation with their country of origin as well as their level of acculturation to the new country, might also influence their willingness to seek help.

It was the aim in this thesis to use a model integrated from elements of the Theory of Planned Behaviour, Andersen’s Socio-behavioural Model, the Health Belief Model, the Health Action Process Approach and the literature to determine people’s willingness to seek help.

In order to assess the impact of culture, this model was tested in a sample of Greek-Cypriots living in their native Cyprus (Study One) and in three Australian samples: Greeks born in Greece or Cyprus who had immigrated to Australia permanently, children of Greek or Cypriot immigrants born in Australia, and Anglo-Australians, accounting for levels of acculturation and enculturation within the two Greek-Australian samples (Study Two). These samples were also
compared for similarities on the factors predictive of willingness to seek help for a mental illness.

The results of these studies will inform promotion strategies to enhance individuals’ willingness to seek help for a mental illness in two countries: Cyprus and Australia; as well highlight in a novel investigation the impact of acculturation and enculturation on willingness to seek help.
CHAPTER EIGHT: Study One, Aims and Hypotheses

8.1 Aims of Study One

Despite much research on attitudes towards help seeking for mental illness and on actual help seeking behaviours no research to date has examined willingness to seek help and attitudes among Greek-Cypriots living in Cyprus. Therefore the aims of Study One are (1) to investigate these attitudes and willingness to seek help for mental illness in a Greek-Cypriot sample and (2) to use the integrated model of behaviour (Figure 5.5) to explore the effects of socio-economic status (SES), gender, diagnosis, barriers, and perceived social support and attitudes towards mental health services on willingness to seek help as well determine the type of person from whom help would be sought.

From the literature it is hypothesised that:

1. Of the participants, 20%-30% will report being diagnosed with a mental illness over the past 12 months, and just one third of those so diagnosed will be taking medication for their condition.

2. Participants diagnosed with mental illness would rather seek help from a mental health professional (General Practitioner, Psychiatrist, Psychologist) rather than a non-professional (e.g., Priest, Family, Friends).

3. There will be gender differences on attitudes towards mental illness and the use of mental health services: specifically, females will be more likely to have more positive attitudes towards mental health than males.
4. There will be differences on SES and stigma related to mental illness: specifically (a) more educated participants will report lower scores on stigma than those less educated (b) participants with higher incomes will report lower scores on stigma than those on lower incomes and (c) older participants will report higher scores on stigma than younger participants and the majority of older participants would rather see a priest for a mental health issue than a mental health professional.

5. Participants with no diagnosis of mental illness within the past 12 months will report higher scores on stigma, perceived barriers to being willing to seek help (as a surrogate for control in the TPB) and be less open to seeking treatment from mental health services compared to people who have been diagnosed with a mental illness, within the past 12 months.

6. Participants with a diagnosis of mental illness will perceive less social support available to them than those who do not report having been diagnosed.

7. Finally a model of willingness to seek help, as a surrogate for intentions, based on an integration of factors from the TPB, HBM, Socio-Behavioural Model, the HAPA and the literature generally, will be tested (Figure 8.1 from Figure 5.5).

Perceived social support; being female; of higher SES, that is, more highly educated with an higher income; a diagnosis of mental illness, as well as an attitude that is open to treatment of mental illness will positively predict willingness to seek help for mental health issues, while perceived barriers to accessing help and an attitude of stigma related to mental illness and health services will be negative predictors of participants willingness to seek help.
Figure 8.1 *Integrated model to predict willingness to seek help for a mental illness.*
CHAPTER NINE: Study One, Method

9.1 Design

A cross sectional design was used to test a model of willingness to seek help for a mental illness and the factors influencing this willingness in a sample of Greek-Cypriots. This study was conducted according to the National Health and Medical Research Council Ethical Guidelines and approved by Charles Darwin University Ethics Committee (Appendix A).

9.2 Translation of Scales and Pilot Study

As none of the scales used in this study or any equivalents were available in the Greek language, it was necessary to undertake a forward/backward translation of the scales selected, following the recommendations of Beaton, Bombardier, Guillemin and Ferraz (2000) and Stalikas et al. (2012).

The first step was the translation of the English version of the scales into Greek by an academic fluent in both English and Greek. A second academic fluent in both Greek and English subsequently back translated the scales. The two professionals then discussed and evaluated any discrepancies and produced the final version of the scales in Greek (Appendix B).

The translated items were administered to a pilot sample of 33 undergraduate students (14 males, 19 females, $M = 21.1$ years, $SD = 2.31$), during a scheduled class at the University of Pafos to evaluate their face validity and receive feedback on the clarity of the translated questions. There was no requirement to make changes following this process.
9.3 Participants Study One

One hundred and ninety-nine participants (150 females, 46 males; age $M = 34.15$ years; $SD = 14.16$) participated in this study. Their age ranged from 18 to 85 years.

9.4 Procedure

Participants for the main part of this study were recruited from two sources: the Neapolis University of Pafos (Cyprus) and the local church community in Pafos, a major city in Cyprus.

Participants from Neapolis University were undergraduate and masters students who were emailed an invitation to participate in a study looking at Attitudes Toward Help-Seeking Behaviours for Mental Illness. Those interested were instructed to visit a website (http://cduhes.asia.qualtrics.com/SE/?SID=SV_8IalisggQ7ObQ56) which contained a Plain Language Statement (Appendix C) providing further information about the study, including an advice that they could withdraw from the study at any time by closing their web browser. They were also informed that the submission of the completed online questionnaire would be deemed to be their informed consent.

An invitation to participate in the study was distributed also to members attending a Religious Education course in Pafos, Cyprus by the local priest (Appendix D). Participants were invited to complete an online Questionnaire (as above for the University students) or to take a hard copy of the questionnaire and return it anonymously in the envelope provided to a locked box located in the church. The hard copy also contained the Plain Language Statement (Appendix C)
and informed participants that their completion and return of the questionnaire would constitute their informed consent.

Participants in the major study were asked to provide demographic data on their age, gender, educational status, annual income, and whether they had been diagnosed with a mental illness over the past 12 months. They also indicated to whom they would turn for help if experiencing a mental illness and then completed the following scales in the Greek language.

9.5 Instruments

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) (MacKenzie, Knox, Gegoski & McCaulay, 2004) is a 24 item scale which contains three factors: psychological openness (e.g., Psychological problems, like many things, tend to work out by themselves); help seeking propensity (e.g., I would want to get professional help if I were worried or upset for a long period of time), and stigma (e.g., having been mentally ill carries a burden of shame). Questions are answered on a 5-point Likert scale from 1 = Do not agree to 5 = Agree completely. MacKenzie al. reported Cronbach’s alpha for the summated scale as .87 and for the factors of psychological openness, help-seeking propensity, and stigma, alphas were .82, .76, and .79, respectively.

Multidimensional Scale of Perceived Social Support (MSPSS) (Canty-Mitchell & Zimet, 2000) is a 12-item scale that measures respondents’ perceptions of perceived social support from family, friends, and a significant other (e.g., My family/friends/significant other really try to help me). Items are scored on 5 point Likert scale from 1 = Do not Agree to 5 = Agree completely. Canty-Mitchell and Zimet reported that the MSPSS and its factors were correlated
with the Adolescent Family Caring Scale (AFCSC). Internal reliabilities for the three factors were reported as .91, .89, and .91, respectively.

Practical Barriers in Seeking Mental Health Services (PBMHS) (Kung, 2004) is a 6-item scale (e.g., I don’t know where to seek mental health services), which can also be considered a surrogate measure of perceived control (or lack of) in the TPB. Questions are answered on a 5-point Likert scale from 1 = Do not agree to 5 = Agree completely. The reported Cronbach’s alpha for this scale was .72.

The alphas in the current study using the Greek translations of each scale will be reported in the results section.
CHAPTER TEN: Study One, Results

The results for Study One will be presented in three sections: 1) descriptive statistics of the sample, 2) factor structure on the instruments in the Greek translation, and 3) inferential analyses of differences and the test of the hypotheses relating to predictors of willingness to seek help. All statistical analyses were conducted using SPSS (Version 19).

10.1 Demographics

The demographic data from this Cypriot sample are presented in Table 10.1. Participants’ mean age was 34.15 years ($SD = 14.16$) and ages ranged from 18 to 85 years. The educational level of participants ranged from completion of primary school (1%) to PhD level (2%) with the majority of participants (75.5%) reporting that they held an undergraduate or postgraduate degree. The majority of respondents were either single (47.8%) or married (42.9%), 6% were separated and 2.7% were widowed. The income of participants ranged from less than 20,000 Euros to more than 61,000 euros per annum, with the majority of respondents earning less than 20,000 Euros (68%), followed by those earning 21,000-40,000 (19.6%), with only 4.6% of respondents earning more than 61,000 euros per annum.
Descriptive Statistics for Greek-Cypriot Sample

<table>
<thead>
<tr>
<th></th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>46</td>
<td>24</td>
</tr>
<tr>
<td>Females</td>
<td>150</td>
<td>76</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>94</td>
<td>47.8</td>
</tr>
<tr>
<td>Married</td>
<td>85</td>
<td>42.9</td>
</tr>
<tr>
<td>Separated</td>
<td>12</td>
<td>6.6</td>
</tr>
<tr>
<td>Widow</td>
<td>5</td>
<td>2.7</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Some High School</td>
<td>9</td>
<td>4.6</td>
</tr>
<tr>
<td>Graduate High School</td>
<td>37</td>
<td>18.9</td>
</tr>
<tr>
<td>Degree</td>
<td>75</td>
<td>44.9</td>
</tr>
<tr>
<td>Master Degree</td>
<td>69</td>
<td>28.6</td>
</tr>
<tr>
<td>PhD</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Income (Euros) thousands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 20</td>
<td>123</td>
<td>68.0</td>
</tr>
<tr>
<td>21 - 40</td>
<td>66</td>
<td>19.6</td>
</tr>
<tr>
<td>41 - 60</td>
<td>3</td>
<td>7.8</td>
</tr>
<tr>
<td>Over 61</td>
<td>4</td>
<td>4.6</td>
</tr>
</tbody>
</table>

10.2 Factor Analyses

Exploratory Principal Components Analyses (PCA) with oblique rotation were used to ascertain the factor structure of the translated measures in the current sample. Inventory of Attitudes Toward Seeking Mental Health Services

The Kaiser-Myer Olkin Measure of Sampling Adequacy (KMO = .799) and Bartlett’s Test of Sphericity ($\chi^2 = 166.24, p<.001$) both indicated the factorability of the correlation matrix for the initial 24 questions. PCA revealed

5 While the scales were completed in Greek (Appendix B) their English translations are used consistently in reporting results in this Thesis.
seven factors with eigenvalues greater than one (Gorsuch, 1983) while Cattel’s Scree Plot, Tabachnick and Fidell’s (2001) criterion of choice, suggested the presence of two factors in the current data. After successive extractions and the removal of four items, the final solution produced simple independent structure with a two-factor solution. These two factors explained 39% of the variance and were labelled stigma (13 items), Cronbach’s Alpha = .82, and openness to help (seven items) Cronbach’s Alpha = .73. The factor structure, factor loadings, eigenvalues, per cent of variance explained and descriptive statistics are presented in Table 10.2.

Table 10.2

*Factor Structure of the Inventory of Attitudes Towards Seeking Professional Psychological Help Scale (IATSPHS)*

<table>
<thead>
<tr>
<th>Questions</th>
<th>Stigma</th>
<th>Openness</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel uneasy going to a professional because some people would think less of me</td>
<td>.70</td>
<td></td>
</tr>
<tr>
<td>I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it</td>
<td>.77</td>
<td></td>
</tr>
<tr>
<td>Psychological problems like many things tend to dissolve by themselves</td>
<td>.50</td>
<td></td>
</tr>
<tr>
<td>Important people in my life would think less of me if they were to find out that I was experiencing psychological problems</td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td>I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems</td>
<td>.65</td>
<td></td>
</tr>
<tr>
<td>I would not want my significant other (spouse, partner) to know if I were suffering from psychological problems</td>
<td>.50</td>
<td></td>
</tr>
<tr>
<td>People with strong characters can get over psychological problem by themselves and would have little need for professional help</td>
<td>.58</td>
<td></td>
</tr>
<tr>
<td>There are experiences in life I would not discuss with anyone</td>
<td>.54</td>
<td></td>
</tr>
<tr>
<td>It is probably best not to know everything about one’s self</td>
<td>.44</td>
<td></td>
</tr>
</tbody>
</table>
People should work out their own problems; getting professional help should be a last resort. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help. Being diagnosed with a mental health disorder is a blot in someone’s life. Mental illness carries with it a burden of shame.

If good friends asked my advice about a psychological problem I might recommend that they see a professional. I would want to get professional help if I were worried or upset for a long period of time. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy. If were to experience psychological problems, I could get professional help if I wanted. If I believed I were having a mental breakdown, my first inclination would be to get professional attention. It would be relatively easy for me to find the time to see a professional for psychological problems. I would willingly confined intimate matters to an appropriate person if I thought it might help me or a member of my family.

| Eigenvalue | 4.51 | 3.36 |
| % variance explained | 2.57 | 6.80 |

Correlation matrix

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.00</td>
<td>0.04</td>
</tr>
<tr>
<td>M</td>
<td>7.38</td>
<td>5.27</td>
</tr>
<tr>
<td>SD</td>
<td>9.18</td>
<td>6.03</td>
</tr>
<tr>
<td>α</td>
<td>0.82</td>
<td>0.73</td>
</tr>
</tbody>
</table>

Loadings less than .20 were suppressed.

Multidimensional Scale of Perceived Social Support (MSPSS)

The Kaiser-Myer Olkin Measure of Sampling Adequacy (KMO = .896) and Bartlett's Test of Sphericity ($\chi^2 = 2256.61, p <.001$) both indicated the factorability of the correlation matrix for the initial 12 questions. PCA revealed
three factors with eigenvalues greater than one as did Cattel’s Scree Plot. These
three factors explained 83.3% of the variance and were labelled support from
family (four items), support from friends (four items), and support from a special
person (four items). All internal reliabilities using Cronbach’s Alpha were ≥ .90.
The factor structure, factor loadings, eigenvalues, per cent of variance explained
and descriptive statistics are presented in Table 10.3.

Table 10.3

**Factor Structure of the MSPSS**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Family</th>
<th>Friends</th>
<th>Special Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get emotional help from family</td>
<td>.95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My family is willing to help me to make decisions</td>
<td>.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can talk about my problems with my family</td>
<td>.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My family really tries to help me</td>
<td>.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get the emotional support and help that I need from</td>
<td></td>
<td>.98</td>
<td></td>
</tr>
<tr>
<td>my friends</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My friends really try to help me</td>
<td>.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have friends with whom I can share my joys and</td>
<td></td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>sorrows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can talk about my problems with my friends</td>
<td></td>
<td>.90</td>
<td></td>
</tr>
<tr>
<td>There is a special person who is around when I am in</td>
<td></td>
<td></td>
<td>.91</td>
</tr>
<tr>
<td>need</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a special person with whom I can share my</td>
<td></td>
<td></td>
<td>.96</td>
</tr>
<tr>
<td>joys and sorrows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a special person who is a real source of</td>
<td></td>
<td></td>
<td>.88</td>
</tr>
<tr>
<td>comfort to me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a special person in my life who cares about</td>
<td></td>
<td></td>
<td>.76</td>
</tr>
<tr>
<td>my feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>7.03</td>
<td>1.86</td>
<td>1.13</td>
</tr>
<tr>
<td>% variance explained</td>
<td>58.40</td>
<td>15.50</td>
<td>9.40</td>
</tr>
<tr>
<td>Correlation Matrix</td>
<td>1.00</td>
<td>.46</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>.64</td>
<td>.58</td>
<td>1.00</td>
</tr>
<tr>
<td>( M )</td>
<td>14.66</td>
<td>14.33</td>
<td>16.02</td>
</tr>
<tr>
<td>( SD )</td>
<td>4.81</td>
<td>4.76</td>
<td>4.21</td>
</tr>
<tr>
<td>( \alpha )</td>
<td>.95</td>
<td>.94</td>
<td>.91</td>
</tr>
</tbody>
</table>

Loadings less than .20 were suppressed
Perceived Barriers for Mental Health Services (PBMHS)

The Kaiser-Meyer Olkin Measure of Sampling Adequacy (KMO = .718) and Bartlett’s Test of Sphericity ($\chi^2 = 209.16, p < .001$) both indicated the factorability of the correlation matrix. Cattel’s Scree Plot suggested the presence of one factor, one item failed to correlate $\geq .3$ with another item and it was removed from the analysis. The five remaining items revealed one factor with an eigenvalue greater than one which explained 41.8% of the variance and was labelled practical barriers. These items demonstrated good internal reliability, Cronbach’s Alpha = .72. The factor structure, factor loadings, eigenvalues, percent of variance explained and descriptive statistics are presented in Table 10.4.

Table 10.4
Factor Structure of the PBMHS

<table>
<thead>
<tr>
<th>Questions</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The whole process of mental health takes a long time</td>
<td>.82</td>
</tr>
<tr>
<td>The whole process of mental health is complicated</td>
<td>.80</td>
</tr>
<tr>
<td>I think it is hard to find a mental health service that is suitable for me</td>
<td>.74</td>
</tr>
<tr>
<td>I don’t know where to seek mental health service</td>
<td>.53</td>
</tr>
<tr>
<td>I can’t afford the money needed for mental health service</td>
<td>.54</td>
</tr>
</tbody>
</table>

| Eigenvalue | 2.44 |
| % variance explained | 48.75 |
| $M$         | 11.46 |
| $SD$       | 4.12  |
| $\alpha$  | .72   |

10.3 Diagnosis, Source of Help and Attitudes Towards Mental Health Services

Forty-seven (24.9%) of the 196 participants reported that they had been diagnosed with a mental illness in the past 12 months. Of these 47 respondents, 30 (64%) reported that they had an Anxiety Disorder, 10 (21%) a Depressive
Disorder, one (4%) a Drug and Alcohol Abuse Disorder, and five (11%) reported various other disorders. Of these 47 participants, 15 (32%) stated they were taking prescribed medication for their mental health condition (Table 10.5).

Table 10.5

*Frequency and Percentage of those with a Current Diagnosis and Prescribed Medication for Mental Illness among Greek-Cypriots*

<table>
<thead>
<tr>
<th>Current Diagnosis</th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorder</td>
<td>30</td>
<td>64.0</td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td>10</td>
<td>21.0</td>
</tr>
<tr>
<td>Drug and Alcohol</td>
<td>2</td>
<td>4.0</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>11.0</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>32.0</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>68.0</td>
</tr>
</tbody>
</table>

*Source of Help*

In terms of the sources from whom participants seek help for a mental illness whether now or in the future, Chi square $\chi^2 = 11.29, p = .257$ revealed no association by type of help sought/would be sought by diagnosis status. The majority of participants in each category indicated they would seek help from a psychologist although many indicated that they would not seek help (Table 10.6).

Table 10.6

*Sources of Help by Diagnosis*

<table>
<thead>
<tr>
<th>Source of Help</th>
<th>No Diagnosis n (%)</th>
<th>Diagnosis n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner</td>
<td>8 (5.5)</td>
<td>4 (8.3)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>7 (4.8)</td>
<td>7 (14.6)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>61 (42.1)</td>
<td>18 (37.5)</td>
</tr>
<tr>
<td>Family Member</td>
<td>14 (9.7)</td>
<td>1 (2.1)</td>
</tr>
<tr>
<td>Phone Support</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lover</td>
<td>6 (4.1)</td>
<td>2 (4.2)</td>
</tr>
<tr>
<td>Teacher</td>
<td>2 (1.4)</td>
<td>-</td>
</tr>
<tr>
<td>Close Friend</td>
<td>15 (10.3)</td>
<td>3 (6.3)</td>
</tr>
<tr>
<td>Priest</td>
<td>17 (11.7)</td>
<td>5 (10.4)</td>
</tr>
<tr>
<td>No Help Sought</td>
<td>14 (9.7)</td>
<td>8 (16.7)</td>
</tr>
</tbody>
</table>
Gender Differences

A Multivariate Analysis of Variance (MANOVA) was conducted to compare attitudes towards help-seeking by gender. Box’s $M (F 2.64, p>.05)$ revealed multivariate homogeneity and Levene’s test of homogeneity confirmed that both dependent variables were univariately homogeneous. Pillai’s Trace $F_{2,183} 2.65, p=.074$ revealed no global difference by gender on Attitudes Towards Help Seeking. The univariate comparisons are presented in Table 10.7.

Table 10.7

<table>
<thead>
<tr>
<th>Attitudes Towards Help Seeking by Gender</th>
<th>Male</th>
<th>Female</th>
<th>$F_{2,183}$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Openness to Help</td>
<td>$M$</td>
<td>23.88</td>
<td>25.51</td>
<td>2.75</td>
</tr>
<tr>
<td></td>
<td>$SD$</td>
<td>6.13</td>
<td>5.99</td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>$M$</td>
<td>29.23</td>
<td>26.67</td>
<td>2.97</td>
</tr>
<tr>
<td></td>
<td>$SD$</td>
<td>9.99</td>
<td>8.75</td>
<td></td>
</tr>
</tbody>
</table>

Educational Status

A Multivariate Analysis of Variance (MANOVA) was used to compare participants’ attitudes (levels of stigma and openness to help) towards mental health services by their educational status. Box’s $M (F 25.57, p>.01)$ revealed multivariate homogeneity and Levene’s test of homogeneity confirmed that both dependent variables were univariately homogeneous. Pillai’s Trace $F_{12,364} 2.67, p=.002$ revealed a global difference among the dependent variables by group. Univariate analyses revealed that participants with lower education (Primary School; Some High School; Graduate High School) did not differ from each other but they reported significantly higher levels of stigma than the participants with
higher educational status attainments (Bachelors, TAFE, and Post Graduate degrees) who, in turn, did not differ from each other. There was no difference across educational levels of respondents’ openness to seek help (Table 10.8).

Table 10. 8

*Groups sharing a superscript do not differ at $p < .05$

**Income**

A Multivariate Analysis of Variance (MANOVA) was used to compare participants’ attitudes (levels of stigma and openness to help) towards mental health services by Income. Box’s $M (F 10.13, p > .01)$ revealed multivariate homogeneity and Levene’s test of homogeneity confirmed that the dependent variables were univariately homogeneous. Pillai’s Trace $F_{8,338} 1.04, p = .404$ revealed no global difference among income groups on the attitude variables (Table 10.9).

Table 10. 9

*Attitudes Towards Help Seeking by Income in Euros (in thousands)*

<table>
<thead>
<tr>
<th></th>
<th>≤20</th>
<th>21-40</th>
<th>41-60</th>
<th>≥61</th>
<th>$F_{8,338}$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Openness to help</td>
<td>$M$</td>
<td>25.08</td>
<td>25.72</td>
<td>26.31</td>
<td>26.00</td>
<td>1.83</td>
</tr>
<tr>
<td></td>
<td>$SD$</td>
<td>5.83</td>
<td>6.58</td>
<td>6.08</td>
<td>5.39</td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>$M$</td>
<td>26.96</td>
<td>29.16</td>
<td>23.23</td>
<td>27.87</td>
<td>.735</td>
</tr>
<tr>
<td></td>
<td>$SD$</td>
<td>8.56</td>
<td>10.63</td>
<td>5.70</td>
<td>10.13</td>
<td></td>
</tr>
</tbody>
</table>
Age

In order to determine if there was an age difference on attitudes towards help-seeking, the sample was divided into those participants less than 40 years and those older than 40 years of age. This dichotomous split was chosen because of the substantial generational differences created among residents after the 1974 war in Cyprus\(^6\). Box’s \(M (F 6.42, p >.01)\) revealed multivariate homogeneity and Levene’s test of homogeneity confirmed that the dependent variables were univariate homogeneous. Pillai’s Trace \(F_{2,134}= 3.81, p<.05\) revealed a global difference by age on attitudes towards help seeking (Table 10.10). Participants over 40 years of age reported higher scores on stigma regarding mental illness than those less 40 years of age. There was no difference across the two age groups on openness to help.

<table>
<thead>
<tr>
<th>Attitudes Towards Help Seeking by Age by Group</th>
<th>Over 40</th>
<th>Under 40</th>
<th>(F)</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Openness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 38)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(M)</td>
<td>26.36</td>
<td>24.71</td>
<td>2.00</td>
<td>.16</td>
</tr>
<tr>
<td>(SD)</td>
<td>5.39</td>
<td>6.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 108)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(M)</td>
<td>31.29</td>
<td>26.97</td>
<td>5.79</td>
<td>.02</td>
</tr>
<tr>
<td>(SD)</td>
<td>11.10</td>
<td>8.65</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In terms of the people from whom participants would seek help for a mental illness whether now or in the future, the majority of participants older than 40 years indicated that they would seek help from a priest, while majority of those younger than 40 years indicated that they would seek help from a psychologist.

\(^6\) The last 40 years, after the Turkish invasion in Cyprus, there has been a push towards more education and westernisation of Cyprus and its citizens in order to align better with the politico-economical demands of the European-Union (Sharpley, 2004).
Chi square \( \chi^2 \), 42.10, \( p < .001 \) revealed an association by type of help sought/would be sought by age.

Table 10.11

**Sources of Help sought by Age**

<table>
<thead>
<tr>
<th>Source of Help</th>
<th>Under 40 years</th>
<th>Over 40 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>GP</td>
<td>5 (4.8)</td>
<td>5 (13.9)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>4 (3.8)</td>
<td>4 (11.1)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>55 (52.4)</td>
<td>5 (13.4)</td>
</tr>
<tr>
<td>Family Member</td>
<td>5 (4.8)</td>
<td>5 (13.4)</td>
</tr>
<tr>
<td>Phone Support</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lover</td>
<td>7 (6.7)</td>
<td>-</td>
</tr>
<tr>
<td>Teacher</td>
<td>1 (1.0)</td>
<td>-</td>
</tr>
<tr>
<td>Close Friend</td>
<td>8 (7.6)</td>
<td>3 (8.3)</td>
</tr>
<tr>
<td>Priest</td>
<td>6 (5.7)</td>
<td>13 (36.1)</td>
</tr>
<tr>
<td>No Help Sought</td>
<td>14 (13.3)</td>
<td>1 (2.8)</td>
</tr>
</tbody>
</table>

**Diagnosis**

A Multivariate Analysis of Variance (MANOVA) was used to compare participants’ attitudes (levels of stigma and openness) and practical barriers towards mental health services by whether or not they had been diagnosed with a mental illness during the past 12 months. Box’s \( M (F 7.63, p > .01) \) revealed multivariate homogeneity and Levene’s test of homogeneity confirmed that the dependent variables were univariately homogeneous. Pillai’s Trace \( F_{3,160}, 1.66, p > .05 \) revealed no global difference by diagnosis (Yes/No) on barriers toward help seeking, openness to help or stigma (Table 10.12).
Table 10.12

*Attitudes and Perceived Barriers Toward Help Seeking by Diagnosis*

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Yes</th>
<th>No</th>
<th>$F_{3,160}$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Openness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>11.44</td>
<td>11.42</td>
<td>.75</td>
<td>.98</td>
</tr>
<tr>
<td>$SD$</td>
<td>3.59</td>
<td>4.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stigma</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>27.15</td>
<td>24.90</td>
<td>4.20</td>
<td>.04</td>
</tr>
<tr>
<td>$SD$</td>
<td>6.27</td>
<td>5.89</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Social Support**

A Multivariate Analysis of Variance (MANOVA) was used to compare participants’ perceived social support by Diagnosis. Box’s $M F$ 10.16, $p > .01$ revealed multivariate homogeneity and Levene’s test of homogeneity confirmed that the dependent variables were univariately homogeneous. Pillai’s Trace $F_{3,184}$ 3.40, $p > .05$ revealed no global difference between those with and those without a diagnosis of mental illness on Perceived Social Support (family, friend, special person), however, there was a tendency for those who reported having a diagnosis, to also report lower levels of support (Table 10.13).

Table 10.13

*Perceived Social Support by Diagnosis: (Yes/No)*

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>$F_{3,184}$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>12.82</td>
<td>15.28</td>
<td>9.82</td>
<td>.02</td>
</tr>
<tr>
<td>$SD$</td>
<td>5.13</td>
<td>4.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Friends</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>13.82</td>
<td>14.64</td>
<td>.93</td>
<td>.33</td>
</tr>
<tr>
<td>$SD$</td>
<td>4.87</td>
<td>4.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Special</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$M$</td>
<td>15.04</td>
<td>16.47</td>
<td>4.11</td>
<td>.04</td>
</tr>
<tr>
<td>$SD$</td>
<td>4.69</td>
<td>4.05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Predicting Willingness to Seek Help

Prior to testing the hypothesised model (Figure 8.1) based on an integration of factors from the Theory of Planned Behaviour (TPB), Health Belief Model (HBM), Andersen’s Socio-behavioural Model and the Health Action Process Approach (HAPA), a Pearson’s Product Moment correlations were calculated to confirm that the independent variables correlated with willingness to seek help.

Pearson Product Moment correlation revealed no multicollinearity or singularity in the data. Only four of the independent variables correlated with willingness to seek help: stigma ($r = -0.29$), openness to help ($r = 0.57$), support from friends ($r = 0.16$) and being diagnosed with a mental illness in the past 12 months ($r = 0.17$) (Table 10.14). There were no correlations between willingness to seek help and support from family or a special person, or practical barriers as a measure of perceived control. Accordingly, only the variables which correlated significantly to willingness to seek help in the correlation matrix were included in the test of the model: stigma, openness to help, support from friends, and whether or not the person had been diagnosed with a mental illness during the previous 12 months.
Table 10.14

Correlation Matrix for Greek-Cypriots

<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>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Willingness to seek help</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Stigma</td>
<td>.29***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Openness</td>
<td>.57***</td>
<td>.08</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Special P</td>
<td>.12</td>
<td>.01</td>
<td>.22**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Family</td>
<td>-.05</td>
<td>.04</td>
<td>.08</td>
<td>.64***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Friends</td>
<td>.16*</td>
<td>-.06</td>
<td>.20**</td>
<td>.57***</td>
<td>.46***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Barriers</td>
<td>-.09</td>
<td>.34*</td>
<td>-.03</td>
<td>.01</td>
<td>.09</td>
<td>-.07</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Diagnosed#</td>
<td>.17*</td>
<td>.13</td>
<td>.17*</td>
<td>.15*</td>
<td>.21**</td>
<td>.08</td>
<td>.03</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Gender</td>
<td>.05</td>
<td>.12</td>
<td>.13</td>
<td>.10</td>
<td>.05</td>
<td>.02</td>
<td>.08</td>
<td>.07</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Education</td>
<td>-.15</td>
<td>-.20</td>
<td>.02</td>
<td>.09</td>
<td>.25</td>
<td>.09</td>
<td>-.14</td>
<td>.02</td>
<td>.54***</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11. Income</td>
<td>.08</td>
<td>.04</td>
<td>.08</td>
<td>.01</td>
<td>.04</td>
<td>.07</td>
<td>.25</td>
<td>.02</td>
<td>.19*</td>
<td>.15*</td>
<td>1</td>
</tr>
</tbody>
</table>

Diagnosed # Coded 0 = No; 1 = Yes
p < .05 ** p < .01; *** p < .001
A multiple regression analysis was then conducted to test the hypothesis that willingness to seek help would be predicted by these variables.

Openness, stigma, friends’ support and diagnosis were entered into the regression model and accounted for a significant 37% of the variance in willingness to seek help, $R = .61$, $R^2 = .37$, Adjusted $R^2 = .36$, $F_{4,173} = 26.11, p < .001$. Openness to seek help and stigma were the only significant predictors of willingness to seek help uniquely explaining 24% and 5% of the variance, respectively. A further 7% of variance was shared between openness, stigma, diagnosis and friends support.

The remaining 64% of variance in willingness to seek help was unexplained. Standardised ($\beta$) regression coefficients correlations and squared semi-partial correlations for each predictor are presented in Table 10.15.

### Table 10.15

**Multiple Regression Predicting Willingness to Seek Help among Greek-Cypriots**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$R^2$ Adjusted</th>
<th>Beta</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>-.23***</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>Openness</td>
<td>.50***</td>
<td>.24</td>
<td></td>
</tr>
<tr>
<td>Diagnosis#</td>
<td>-.10</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Friends’ Support</td>
<td>.08</td>
<td>.006</td>
<td></td>
</tr>
</tbody>
</table>

# Coded 0 = No; 1 = Yes.

*** $p < .001$
CHAPTER ELEVEN: Study One, Discussion

The aims of Study One were to investigate attitudes towards mental illness and willingness to seek help among Greek-Cypriots and to explore the predictive utility of perceived social support, gender, SES, attitudes, barriers as a surrogate for control, and diagnosis on participants’ willingness to seek help for mental illness.

The scales used in this study were not available in the Greek language. It was necessary therefore to undertake forward / back translations following the recommendations of Beaton et al. (2000) and Stalikas et al. (2012), and to conduct analyses to ensure their suitability for use with this sample. A preliminary review by 33 Greek-Cypriot university students confirmed the readability of the items in Greek and their face validity for use in the current study.

The participants ranged in age from 18 to 85 years but most of them were younger than 40 years of age and were female (77%). The majority of people were highly educated, in that 80% hold a Bachelor’s level degree or higher, a finding which reflects the current trend of Cypriots to pursue higher and postgraduate education. Despite their youth and high level of education, the majority of respondents reported an income of less than 40,000 Euro per annum, with 68% of the sample earning less than 20,000 Euro per annum. While these low figures are in accord with current wages in Cyprus-

http://www.wageindicator.org/main/salary/minimum-wage/cyprus/cyprus-minimum-wage-faq-it must also be acknowledged that some participants were students probably with little or no income, while others may have been unemployed. In Cyprus, the current rate of unemployment is 16.4%
but also many people are underemployed in terms of their skills or education level, thus earning less than their qualifications might suggest they could. Neither employment nor student status data were collected in the current sample. Yet overall, the sample can be argued to be more representative of the generations since the Turkish Invasion of 1974, of well-educated young people, more so than in previous years.

Prior to using the translated scales in the current study it was essential to investigate their construct validity and reliability. Principal Component Analysis (PCA) conducted on the Inventory of Attitudes Toward Seeking Mental Health Services (IATSMHS) (McKenzie et al., 2004) revealed simple independent structure with a two-factor solution. These factors were labelled stigma and openness and together explained 39% of the variance. Internal reliability of each factor was good, stigma $\alpha = .82$, openness $\alpha = .73$.

PCA on the Greek translation of the Multiple Perceived Social Support (MPSS) (Canty-Mitchell, & Zimet, 2000) revealed three independent factors which explained 83% of the variance. They were labelled support from family, support from friends, and support from a special person. All internal reliabilities were strong $\alpha \geq .90$.

PCA on the Greek translation of Perceived Barriers for Mental Health Services (PBMH) (Kung, 2004), revealed one factor explaining 41.8% of the variance. Internal reliability was good, $\alpha = .72$. 
These results from the factor analyses indicate the suitability of these instruments for use in Cyprus and other countries where Greek is spoken.

The hypothesis, in line with world-wide epidemiological data, that 20-30% of respondents would report a diagnosis of a mental illness over the preceding 12-months was supported. Approximately 25% of the sample reported that they had been diagnosed with a mental illness within the past 12-months, and also in support of the hypothesis, 32% of them were taking prescribed medication for their condition. These figures reflect those in the international literature (Kessler et al., 1993; Pisinneli & Wilkinson, 2000; ONS, 2007; Waraich & Hsu, 2004) in which, at any given time, almost 20% of the population is reported to be struggling with some form of mental illness and only one third of them are actually taking medication for their condition (ESEMeD, 2004).

The hypothesis that most participants would seek help from a non-professional was not supported. The data show that 38% of participants with a diagnosis of mental illness (DMI) stated they would seek help from a psychologist in a case of mental illness and 42% who did not report having a diagnosis (NDMI) also indicated they would seek help from a psychologist. Twelve percent of participants with NDMI reported that they would consult a priest as did 10% of those with a DMI. Some 14% with a DMI and 5% NDMI would seek help from a psychiatrist and 5% and 8% respectively, reported they would seek help from their GP or Psychiatrist. Interestingly some 10% of participants with NDMI and 17% of those with a DMI reported that they would not seek help, although the reasons for this were not explored in the current survey. There was no statistical association between groups (DMI and NDMI) and type of help they would seek. Therefore the fact that it
is unclear from the current data whether those with a diagnosed mental illness would or are seeking help from their nominated source seems irrelevant. These findings can be seen to reflect the current modernisation and westernisation of Cyprus since independence from British colonialism in 1960 (http://en.wikipedia.org/wiki/Modern_history_of_Cyprus) as 50%-60% of all respondents indicated that they would seek some form of professional help (GP, psychologist, psychiatrist). One reason for the finding that such a high percentage would seek help from a mental health professional might be that Cyprus was a traditionally rural, group-oriented society as was Greece (Bouhoutsos & Roe, 1984) which, over the last 30 years has become industrialised, urbanised, and oriented to the nuclear family (Macri, 2001).

At the same time, it is clear that a further 22%-35% of all participants, both those with a DMI as well as those without, indicated that they would turn, at least initially, to a non-professional such as family, close friends or their priest for help. These findings highlight the importance of family and the active role of the Orthodox Church in the lives of Greek-Cypriot people and support the earlier findings from Ware (1997) with respect to the priesthood and Faros (1981) with respect to family and friends. It is unclear from the current data why this might be so. Did they have an unsatisfactory encounter with an health professional, are they now feeling better and inferring that they could manage in the future with non-professional help, or are these self-report data in error? Whatever the reasons, it does seem that these respondents especially those in the DMI group who indicated they would seek help outside professionals, such as their General Practitioner, a psychiatrist or a psychologist, may be at great risk.
The hypothesis that females would have a more positive attitude towards mental illness than males was not supported. There was a tendency for females to have a more open attitude towards mental health professionals than males but this was not significant. This finding does not support those of Andrews et al. (2001), Leaf et al. (1987), or McKenzie et al. (2006) who found that women were significantly more open to seek help for mental health problems than men and they were also less concerned about the reaction of their families. Neither did females report lower scores on stigma towards mental illness and those experiencing it, although the current data did trend in that direction. These findings are contrary to those of Husaini et al. (1994), McKay et al. (1996), Padesky and Hammen (1981), Thom (1986), and Weissman and Klerman (1977) who reported that women have less stigmatised attitudes than men to seek professional help for problems as diverse as depression, substance abuse, physical disabilities, and stressful life events. Their findings rather than those of the current study can also be interpreted to echo popular stereotypes which portray men less open to seeking help, such as being reluctant to ask for directions when they are lost, having difficulty sharing vulnerable feelings with friends and family, and avoiding seeking needed help from professionals.

The hypothesis that people with the least years of education would report higher levels of stigma than those more educated was supported. This finding supports the work of Stefl and Prosperi (1985) and Parslow and Jorm (2000) who found that the people with the lowest education level exhibited higher scores on stigma related to mental health care. A possible reason why less educated individuals exhibited higher levels of stigmatised attitudes towards mental health services (e.g., I would feel uneasy going to a professional because some people would think less of
me) could be due to the fact that individuals with lower education are less likely to read or hear about the benefits of mental health services in their work or personal environments and may hold more rigid expectations about mental illness (e.g., People with strong characters can get over psychological problem by themselves and would have little need for professional help). There was no difference across educational levels on respondents’ openness to seek help, and these same reasons might apply.

The hypothesis that people with the lower income would be less open to help was not supported. In fact, there was no difference by income level on participants’ scores for stigma or for openness to help. These results refute the findings of Leaf et al. (1987) who found that people with the lowest income exhibited higher stigma to seeking mental health care. One of the reasons why this hypothesis was not supported in the current study may be because even though many participants had a relatively low income, this does not mean that they also had a low education level. In fact, in the current study, most people were highly educated and, as reported earlier, individuals with lower education have reported more stigmatised attitudes towards mental health services than those with higher level of education.

In order to compare participants by age, the sample was divided into those younger than 40 years and those older. It is argued that this division by age represents very different historical and societal conditions for those born and raised in Cyprus. Cypriots younger than 40 have grown up in a modernised and urbanised environment while those over 40 more typically have grown up in a rural and traditional environment. However, the results indicate no difference across these two age divisions on openness to seeking help, but those over 40 years of age reported
higher scores on stigma associated with mental illness. This latter result aligns with Leaf et al. (1987) who found that the elderly showed less positive attitudes toward professional mental health services.

Chi Square revealed an association by these two age groups on the source of help they would seek for a mental illness. The older group of Greek-Cypriot people tended to specify their priest and family/friends as their choice to speak with about personal issues, while those younger than 40 years demonstrated a preference to seeking help from a psychologist. These findings reflect changing attitudes in Cyprus and suggest a shift from more traditional sources of help to those of a professional nature. There was a greater tendency for the younger group to report that they would not seek any help. Why this last is so is unclear. It might be they see themselves as independent and self-reliant however, this premise requires empirical testing before any conclusions can be reached.

In looking of whether participants with a current diagnosis of mental illness were more open in their attitudes to mental illness and perceived less barriers and less stigma towards mental illness than those without a diagnosis, there were no differences. Therefore the current data refute the findings of Mojtabai et al. (2002) who found a positive association between mental illness, less stigma and positive attitudes toward mental health help-seeking in people with a mental illness compared to those without a mental illness. It must be acknowledged that neither group scored high on barriers to seeking help (\(M \sim 11.00\), from a range 5-25) (e.g., I don’t know where to seek mental health services; I can’t afford the money needed for mental health services) suggesting few actual impediments or barriers to seeking professional help in the current sample.
The hypothesis that those with current diagnosis would perceive less social support from their family, friends, and their special person than those not having a diagnosis was not supported although the data do show a tendency in those directions. This trend is especially notable for perceived support from family and special other, but not for friends. George et al.’s (1989) finding that lower social support is related to people having a diagnosis of mental illness is not supported by the present data but, as mentioned, the data do trend in that direction. The current data are also not congruent with common wisdom that suggests individuals who feel more supported by their social network might also feel their well-being is enhanced but again, the trend is there. To this end, studies by David et al. (1998) and Prositano and Keller (1983) have shown significant association between high perceived social support and high subjective well being. Similarly, Prositano and Keller (1983) found a significant negative association between perceived social support and lower stress, and a significant negative association between low perceived social support and higher anxiety symptoms. However, the current results are encouraging in that they suggest that persons with a mental illness are not unsupported or abandoned by their social networks, whether this is confined to Greek-Cypriot people warrants further investigation.

Aside from the comparisons above, a major aim in this study was to test an integrated model of willingness to seek help based on the factors of the Theory of Planned Behaviour, Health Belief Model, Andersen’s Socio-Behavioural model, the Health Action Process Approach, and the literature.

Preliminary correlational analysis revealed that only four of the independent variables: stigma, openness to help, support from friends and diagnosis, actually
correlated with willingness to seek help. Accordingly, they were the only variables entered into the regression equation. Support from family and from a special person, barriers to seeking help, and the SES variables of gender, educational level and income all failed to correlate with the dependent variable, willingness to seek help. These null findings refute the earlier works of Leaf et al. (1987) and MacKenzie et al. (2006) who reported that being female was associated with more positive help-seeking attitudes, in this case, willingness to seek help. These results are also contrary to Kung (2004), Sue (1994) and Uba (1994) who found that perceived barriers such as money (income), time, and lack of knowledge of facilities are implicated in not seeking-help. Accordingly, only the independent variables that correlated significantly with willingness to seek help were entered into the regression equation.

These variables explained 36% of the variance in willingness to seek help. Openness to help was a significant positive predictor and stigma was a negative predictor of willingness to seek help. These variables uniquely explained 24% and 5%, respectively of the variance in willingness to seek help. Neither diagnosis nor support from friends predicted willingness to seek help. A further 7% of the variance in the dependent variable was shared among the four independent variables. These findings are not aligned with Rickwood and Braithwaite (1994) who found that having a social network was a predictive factor for help seeking. Neither are the findings of Dew et al. (1991) supported as they found that those who sought help were more likely to have had friends or relatives recommend that they get help than those who had not sought services. The current analysis left 64% of variance in willingness to seek help unexplained. Other
possible reasons that could explain willingness to seek help among the Greek-Cypriot participants might relate to the severity of the mental illness, a factor that Jackson et al. (2007) considered important; and the incidence or the absence of mental health literacy which is the motivation to comprehend, utilise and access information in ways which support and maintain balanced mental health (Jorm, 2007). These findings should however be seen in the light of the complexity of behaviour and behavioural intention. While the Theory of Planned Behaviour’s (TPB, Ajzen, 1991) basic framework of intention was used to provide a context to predict willingness to seek help as a surrogate for intention, such willingness to seek help, or intentions, may not be aligned with the reality of behaviours. Certainly, even among those in the current study who reported they had been diagnosed with a mental illness in the past 12 months, only some 60% indicated they would (or had) seek professional help from a General Practitioner, Psychiatrist or Psychologist. Clearly, this question of what promotes people’s willingness to seek help remains largely unresolved.

Limitations and future directions

While the current study incorporated both people with and without a diagnosis of mental illness, these categories were based upon self-report and a non-clinical sample. While all interpretations are based upon participants’ self-report the figures with respect to the incidence of mental illness and of those taking medication for their mental illness, are in line with world-wide reports (Kessler et al., 1993; Pisinneli & Wilkinson, 2000; ONS, 2007; Waraich & Hsu, 2004). However, care needs to be taken before generalising these results to all individuals who are
experiencing a diagnosed mental illness. It is also important to note that a generic question on willingness to seek help was presented to all participants, which might have been misinterpreted by those already attending treatment.

Future research might investigate willingness to seek help against actual help seeking through the use of longitudinal studies or observational methods although this does presuppose one would know one’s mental state or be willing to be tracked over time by researchers using appropriate assessments. Future studies might also investigate if, in the last few years in Cyprus and Greece, there has been any kind of collaboration between mental health professionals and the local parish priests as a way to bridge between the traditional ways of seeking help with the modern ways, that is, to seek help from a mental health professional.

**Conclusion**

Despite the limitations of the current study, this study appears to be among the first to study willingness to seek help for a mental illness among Greek-Cypriots living in Cyprus. The findings extend the previous limited understanding of factors affecting willingness to seek help or intentions towards the use of mental health services among Greek-Cypriots. The relationships between gender, social support, perceived barriers, attitudes (stigma and openness) and willingness to seek professional help for mental health issues have not been studied previously in Cyprus.

The current results can be used to inform policy formation in Cyprus for mental health promotion and interventions especially with respect to fostering an open attitude towards mental illness. Mental illness is a factor in the lives of a significant number of people, and promoting their use of appropriate help can not
only benefit them as individuals, but also benefit their families and the community in general.

These results also provide a baseline to compare emigrant’s willingness to seek help in a new society; specifically, Greeks and Greek-Cypriots living in Australia, and the factors influencing their willingness to seek help and the possible impact of ongoing enculturation with their country and society of origin, as well as their level of acculturation into the new society. This premise forms the basis for the following study.
CHAPTER TWELVE: Study Two, Introduction

In Study One variables from several well-known health models and the literature were integrated into a model to predict willingness to seek help for a mental illness among Greek-Cypriots living in Cyprus.

Results of that study indicated people’s attitudes, in particular openness to seeking help for a mental illness compared with negative feelings of stigma associated with mental illness, each predicted willingness to seek help, albeit in different directions. The results also indicated that approximately 40% of respondents whether they had been diagnosed with a mental illness or not, they would seek help from a psychologist, with a further 10% to 20% (NDMI, DMI, respectively) reported they would seek help from a GP or a Psychiatrist. However, some 11% overall indicated they would consult with a priest and more disconcertingly, 10% (NDMI) to 17% (DMI) reported that they would not seek help.

While these results were discussed in terms of traditional versus more modern or western philosophies, it was questioned whether these same predictors and seeking of help would prevail in an emigrant population.

As outlined in the introduction to this thesis, immigrants to a new country typically have to adapt in many ways and thus acculturate themselves to the new dominant society (Berry, 1997). Whether such acculturation aligns these non-dominant groups’ intentions and behaviours, in this case, in their willingness to seek help for a mental illness, is equivocal (Milville & Constantine, 2006).

It might also be that these groups remain enculturate in the values, ideals and practices of their country and society of origin. Such a proposition does not appear to
have been tested in the literature to date with respect to Greeks and Greek-Cypriots, many of whom especially those over 40 years of age in Study One indicated that they would seek other than professional help for a mental illness (e.g., priest or no help at all), and their willingness to seek help in their new country. Accordingly, it was the aim in this study to test the model in Australian samples and to incorporate the levels of acculturation and enculturation reported by Australians of Greek and Greek-Cypriot heritage.

12.1. Aims and Hypotheses

Study Two was designed to investigate an integrated model of willingness to seek help based on the Theory of Planned Behaviour (TPB, Ajzen, 1991), Health Belief Model (HBM; Hochbaum et al., 1950) Andersen’s Socio-behavioural model (Andersen, 1973), Health Action Process Approach (HAPA, Schwarzer, 1992) and the literature as tested in Study One but with the inclusion of Enculturation and Acculturation, among (1) Greek-born Australians, (2) Greek-Australians, and (3) Anglo-Australians.

Specifically the aims of the study are to investigate levels of acculturation and enculturation among Greek-born Australians and Greek-Australians; levels of perceived social support, gender, diagnosis of a mental illness (Yes/No), SES (income, education) practical barriers to help-seeking, stigma, and openness to help seeking across the three groups: Greek-Australians, Greek-Born Australians and

---

7 The terms Greek-born Australian will be used to refer to people born in either Greece or Cyprus who have immigrated to Australia. The term Greek-Australian will be used to refer to people of Greek heritage born in Australia. Anglo-Australians will refer to people of UK descent.
Anglo-Australians and to assess the impact of acculturation and enculturation on willingness to seek help for the two Greek cohorts.

From the literature, it is hypothesised that:

1. There will be no association between the frequencies of reported diagnosis for mental illness or use of medication for such an illness across the three groups and these rates of mental illness and medication use will be in line with the literature. That is, 20%-30% of participants will report having a diagnosed mental illness and one third of them will be taking medication for their condition

2. There will be no difference between the three cohorts on their nominated source of help for dealing with a mental illness

3. Anglo-Australians will be more willing to seek help than Greek-Born and Greek-Australians

4. Greek-born Australians will report lower levels of perceived social support, and a less positive attitude towards professional help-seeking for mental illness than either Greek-Australians or Anglo-Australians

5. Greek-Australians will report high levels of acculturation than Greek-born Australians and lower levels of enculturation

6. Finally, the integrated model of willingness to seek help will be tested across the three groups (Figure 12.1). Perceived social support, diagnosis (DMI and NDMI) and openness to help seeking will positively predict willingness to seek help for mental health issues, while perceived barriers to accessing help as a surrogate for control, and stigma will be negative predictors for each of the three cohorts. Being female, SES, that is having an higher income and education level, will positively predict willingness to seek help. The additive effect of levels of acculturation and
enculturation on willingness to seek help for mental illness will be included in the test of the model for each of the two Greek samples. It is anticipated that acculturation will be a positive predictor for Greek-born Australians and Greek-Australians, and enculturation will demonstrate opposite effects.

Figure 12.1: *Integrated model to predict willingness to seek help for a mental illness.*

NB: Acculturation and Enculturation are not applicable to the Anglo-Australian Sample.
CHAPTER THIRTEEN: Study Two, Method

13.1 Design

A cross-sectional design was utilised to compare diagnosis, attitudes, barriers, social support, sources of help, SES, and willingness to seek help for mental illness among Greek-Australians, Greek-born Australians and Anglo-Australians and to investigate which of these factors predict help willingness to seek help among these three cohorts. The levels of enculturation and acculturation were added to the model of willingness to seek help for the two Greek samples.

13.2 Participants

Five hundred and thirteen participants of whom 184 (91 males) were Anglo-Australians with an age $M = 45.60$ years ($SD = 16.13$); 171 (74 males) were Australian born Greek-Australians age $M = 39.60$ years ($SD = 12.46$); and 44 (22 males) were Greek-born Australians, age $M = 51.53$ years ($SD = 14.97$). All groups were significantly different from each other on age ($F_{2,501} = 8.79, p < .001$) with the youngest on average being the Greek-Australians, followed by the Anglo-Australians, and then the Greek-born Australians constituted the oldest group.

13.3 Procedure

The study was approved by the Charles Darwin University Ethics Committee (Appendix A) and conducted according to the National Health and Medical Research Council’s Ethical Guidelines.

Participants were recruited by several means but in each instance interested parties were provided with a Plain Language Statement in either Greek or English (Appendix E) outlining the aims of the study and what was required of them. The
president of the Greek-Cypriot community in Darwin, NT (Appendix F) invited attendees at regular meetings to take and complete a hard copy of the questionnaire. Once completed, these could be returned at the next meeting and placed in the sealed box available for this purpose. These attendees also had the opportunity to complete the survey online at the web address provided in the Plain Language Statement (http://cduhes.asia.qualtrics.com/SE/?SID=SV_cMWZwVZfycJgxrT). The hardcopy of the questionnaire and the online version were available in both Greek and English and respondents could choose in which language to answer the questions. They were advised that completion and return or submission of the questionnaire would be deemed to be their informed consent (Appendix G).

Invitations to participate in this study were also placed on the researcher’s “FACEBOOK” page in English and in Greek with a link to the survey inviting Greek and Anglo-Australians to participate in the study, and a request to pass on the link to any interested friends or family who met the criteria.

A final method involved “Permission Corps Agency” a commercial body that specialises in the recruitment of volunteers for research. They advertised the study through their network, specifying only Anglo-Australians and Greek-Australians (whether born in Australia or Greece or Cyprus) were required. Interested parties were referred to the same website as above where they also had the option to complete the questionnaires in either Greek or English.

When participants logged onto the ‘Qualtrics’ website where the surveys resided, they were prompted “Greek or English” version: the English version contained a further prompt “Greek-born/Greek-Australian born or Anglo-
Australian.” This choice was necessary as the Anglo-Australians did not complete the Enculturation and Acculturation scales but both Greek cohorts did so.

13.4 Instruments

All participants were asked to provide their country of birth, gender, age, their marital and educational status, range in which their annual income fell, if they had been diagnosed with a mental illness in the past 12 months and if so diagnosed, were they taking prescribed medication for their illness. All participants were also asked to indicate if they would be willingly now, or in the future if they were to experience mental illness to seek professional help. In addition all participants completed the following scales which were described fully in Chapter Ten.

- Inventory of Attitudes Toward Seeking Professional Psychological Help Scale (McKenzie, Knox, Gegoski & McCaulay, 2004)
- Perceived Barriers in Seeking Mental Health Services (PBMHS) (Mo & Mak, 2009).

Greek participants also completed the following two instruments:

- Enculturation to Greek Identity Scale (EGI) (Harris & Herven, 1996) which was developed based on Landrine and Klonoff’s (1994) African American Acculturation Scale and Mendoza’s (1989) Cultural Life Style Inventory. The EGI consists of 35 items divided into five subscales: Greek language (e.g., Most of my close friends speak Greek), traditional Greek religious beliefs and superstitions (e.g., Australian-Greeks should be married in the Greek Church), Greek school attendance (e.g., When I have children they will attend Greek school), ethnic identity (e.g., I’m
lucky to have been born Greek), and interracial attitudes (e.g., My friends and I have conversations in Greek so that non-Greeks around us won't know what we're saying), and inter-marriage and dating behaviour (e.g., I would not marry someone who is not Greek). Questions are answered on a 5-point Likert scale from 1 = Do not agree to 5 = Agree completely. High agreement with each statement indicates a more traditional Greek perspective. The internal reliability of the EGI’s subscales ranges from $\alpha = .70$ to .92.

Vancouver Index of Acculturation Modified (VIAM) (Karapanagiotis, 2008) was originally developed by Ryder, Alden and Paulhus (2000) to measure the extent of an individual’s ethnic and mainstream acculturation. This scale was modified to 11 items by Karapanagiotis (2008) for Greek-Americans and in the current study these items were modified for use with both Greek samples by changing the country of reference from America to Australia. Items are rated on a 5-point Likert scale (e.g., I enjoy typical Australian jokes) from 1 = Do not agree to 5 = Agree completely. The alpha coefficient reported by Kalopanagiotou (2008) was .92.
CHAPTER FOURTEEN: Study Two, Results

The results for Study Two will be presented in three sections: 1) descriptive statistics, 2) factor structures of the scales used in the previous study and the enculturation and acculturation instruments used here and 3) inferential statistics comparing the three groups and the tests of the model of willingness to seek help across each of the three groups.

All statistical analyses were conducted using SPSS version 19.

14.1 Demographic and Background Characteristics of the Sample

The marital and educational statuses of participants by group are presented in Table 14.1. The majority of participants in each group was married, followed by single, and last of all separated. One Greek-Australian and one Anglo-Australian reported that they were widowed. The majority of all participants were educated at Technical or University level. Of the Greek-Australians, 44.1% reported holding a University degree or higher compared with 34.89% for Greek born-Australians and 29.8% for Anglo-Australians. The Anglo-Australians represented the cohort with the largest percentage to not complete High School, 19.5%. The majority of all participants reported an income of $20,000 dollars or less. Of the Greek-born Australians, 20.5% reported an income up to $100,000 compared with 17.4% for Greek-Australians and 14.1% for Anglo-Australians.

Chi square revealed no association between country of birth and marital status ($\chi^2_{6, 4.18, p = .652}$) or between country of birth and educational level ($\chi^2_{12}$
17.87, \( p = .120 \) or between country of birth and annual income (\( \chi^2_{12} = 10.56, p = .532 \)).

Table 14.1

**Descriptive Statistics of Marital and Educational status by Three Groups**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Greek-Australian Born n(%)</th>
<th>Greek-Born - Australian n (%)</th>
<th>Anglo-Australian n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Single</td>
<td>56 (31.5)</td>
<td>11 (25.0)</td>
<td>52 (28.3)</td>
</tr>
<tr>
<td>-Married</td>
<td>98 (55.1)</td>
<td>26 (59.1)</td>
<td>114 (62.0)</td>
</tr>
<tr>
<td>-Separated</td>
<td>22 (12.4)</td>
<td>7 (15.9)</td>
<td>17 (9.2)</td>
</tr>
<tr>
<td>-Widow</td>
<td>1 (1.0)</td>
<td>-</td>
<td>1 (5.5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Greek-Australian Born n(%)</th>
<th>Greek-Born - Australian n (%)</th>
<th>Anglo-Australian n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Primary</td>
<td>4 (2.2)</td>
<td>2 (4.5)</td>
<td>1 (5.5)</td>
</tr>
<tr>
<td>-Some High School</td>
<td>19 (10.7)</td>
<td>5 (11.4)</td>
<td>35 (19.0)</td>
</tr>
<tr>
<td>-High School</td>
<td>30 (17.0)</td>
<td>9 (20.5)</td>
<td>38 (20.7)</td>
</tr>
<tr>
<td>-Technical School</td>
<td>46 (26.0)</td>
<td>15 (34.1)</td>
<td>55 (29.9)</td>
</tr>
<tr>
<td>-Degree</td>
<td>67 (37.9)</td>
<td>10 (22.7)</td>
<td>44 (23.90)</td>
</tr>
<tr>
<td>-Masters</td>
<td>10 (5.6)</td>
<td>2 (4.5)</td>
<td>8 (4.30)</td>
</tr>
<tr>
<td>-PhD</td>
<td>1 (.6)</td>
<td>1 (2.3)</td>
<td>3 (1.60)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Aust $</th>
<th>Greek-Australian Born n(%)</th>
<th>Greek-Born - Australian n (%)</th>
<th>Anglo-Australian n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Up to 20, 000</td>
<td>50 (28.1)</td>
<td>11 (25.0)</td>
<td>55 (29.9)</td>
</tr>
<tr>
<td>-20 000 – 40, 000</td>
<td>33 (18.5)</td>
<td>12 (27.3)</td>
<td>46 (25.0)</td>
</tr>
<tr>
<td>-40 000 - 60, 000</td>
<td>38 (21.3)</td>
<td>10 (22.7)</td>
<td>37 (20.1)</td>
</tr>
<tr>
<td>-61 000 – 80, 000</td>
<td>25 (14.0)</td>
<td>2 (4.5)</td>
<td>20 (10.9)</td>
</tr>
<tr>
<td>-81 000 – 100, 000</td>
<td>31 (17.4)</td>
<td>9 (20.5)</td>
<td>26 (14.1)</td>
</tr>
</tbody>
</table>

14.2 Factor Analyses

All participants completed the scales available to them in their choice of English or Greek. As some Greek participants elected to answer the English version, the data from each source were combined and the total data for each scale then submitted to Principal Component Analysis (PCA) with oblique rotation rather than attempt multiple confirmatory analyses. It is argued that this is a more meaningful and parsimonious approach (Tabachnik & Fidel, 2013).
The PCAs with oblique rotations are reported below for the scales completed by all participants as well as for the Acculturation and Enculturation scales completed only by the two Greek-Australian samples.

**Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)**

The Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO = .907) and Bartlett’s Test of Sphericity ($\chi^2$ 5493.52, $p<.001$) both indicated the factorability of the correlation matrix for the initial 24 questions. PCA revealed three factors with eigenvalues greater than one while Cattel’s Scree Plot, Tabachnick and Fidell’s (2001) criterion of choice, suggested the presence of two factors in the current data. After successive iterations and the removal of four items, the final solution produced simple independent structure with a two-factor solution. These two factors explained 47.30% of the variance and were labelled stigma (13 items) and openness to help (seven items). Internal reliabilities for these two factors were $\alpha = .90$ and .85, respectively. The factor loadings, eigenvalues, per cent of variance explained descriptive statistics and correlations are presented in Table 14.2.

Table 14.2

<table>
<thead>
<tr>
<th>Question</th>
<th>Stigma</th>
<th>Openness to Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel uneasy going to a professional because of what some people think less of me</td>
<td>.77</td>
<td></td>
</tr>
<tr>
<td>I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it</td>
<td>.76</td>
<td></td>
</tr>
<tr>
<td>Important people in my life would think less of me if they were to find out that I was experiencing psychological problems</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>It is probably best not to know everything about one self</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems</td>
<td>.72</td>
<td></td>
</tr>
</tbody>
</table>
People with strong characters can get over psychological problems by themselves and would have little need for professional help.

Being diagnosed with a mental disorder is a blot on a person’s life.

Psychological problems, like many things, tend to work out by themselves.

People should work out their own problems getting professional help should be a last resort.

I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.

Mental illness carries with it a burden of shame.

There are experiences in my life I would not discuss with anyone.

There is something admirable about people who are willing to cope with their conflicts and fears without resorting to professional help.

If I were to experience psychological problems, I could get professional help if I wanted.

If I believed I were having a mental breakdown, my first inclination would be to get professional help.

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

If good friends asked my advice about a psychological problem, I might recommend that they see a professional.

It would be relatively easy for me to find the time to see a professional for psychological problems.

If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief from psychotherapy.

I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

| Eigenvalue | 6.76 | 4.58 |
| % variance explained | 28.20 | 19.10 |
| Correlation Matrix | 1.00 |
| | .09 | 1.00 |
| M | 28.13 | 23.98 |
| SD | 10.90 | 6.88 |
|α | .90 | .85 |

Loadings less than .20 were suppressed.

Multidimensional Scale of Perceived Social Support (MSPSS)

The Kaiser-Myer Olkin Measure of Sampling Adequacy (KMO = .92) and Bartlett’s Test of Sphericity ($\chi^2$ 6773.21, $p < .01$) both indicated the factorability of the correlation matrix for the initial 12 questions. PCA revealed three factors with eigenvalues greater than one as did Cattel’s Scree Plot. These three factors explained 85% of the variance and were labelled support from family (four items), support from friends (four items), and support from a special person (four items). The
Internal reliability for each of these factors was strong (Cronbach’s α all ≥ .94). The factor structure, factor loadings, eigenvalues, per cent of variance explained and descriptive statistics are presented in Table 14.3.

Table 14.3

**Factor Structure of the (MSPSS)**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Family</th>
<th>Friend</th>
<th>Special Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>My family really tries to help me</td>
<td>.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My family is willing to help me make decisions.</td>
<td>.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get the emotional help and support I need from my family</td>
<td>.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can talk about my problems with my family</td>
<td>.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can count on my friends when things go wrong</td>
<td></td>
<td>.96</td>
<td></td>
</tr>
<tr>
<td>I can talk about my problems with my friends</td>
<td></td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>My friends really try to help me</td>
<td></td>
<td>.91</td>
<td></td>
</tr>
<tr>
<td>I have friends with whom I can share my joys and sorrows</td>
<td></td>
<td></td>
<td>.87</td>
</tr>
<tr>
<td>There is a special person with whom I can share my joys and sorrows</td>
<td></td>
<td>.96</td>
<td></td>
</tr>
<tr>
<td>There is a special person who is around when I am in need</td>
<td></td>
<td>.94</td>
<td></td>
</tr>
<tr>
<td>There is a special person in my life who cares about my feelings</td>
<td></td>
<td>.92</td>
<td></td>
</tr>
<tr>
<td>I have a special person who is a real source of comfort to me</td>
<td></td>
<td>.88</td>
<td></td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>7.54</td>
<td>1.69</td>
<td>1.13</td>
</tr>
<tr>
<td>% variance explained</td>
<td>62.86</td>
<td>14.12</td>
<td>9.42</td>
</tr>
<tr>
<td>Correlation Matrix</td>
<td>1.00</td>
<td>.51</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>.66</td>
<td>.60</td>
<td>1.00</td>
</tr>
<tr>
<td>M</td>
<td>12.94</td>
<td>12.14</td>
<td>13.95</td>
</tr>
<tr>
<td>SD</td>
<td>4.82</td>
<td>4.58</td>
<td>5.06</td>
</tr>
<tr>
<td>α</td>
<td>.94</td>
<td>.95</td>
<td>.96</td>
</tr>
</tbody>
</table>

Loadings less than .20 were suppressed.

**Perceived Barriers for Mental Health Services (PBMH)**

The Kaiser-Meyer Olkin Measure of Sampling Adequacy (KMO = .77) and Bartlett’s Test of Sphericity ($\chi^2 = 765.77, p < .001$) both indicated the factorability of the correlation matrix for the six items. PCA revealed one factor with an eigenvalue
greater than one as did Cattel’s Scree Plot. After the removal of one item, which failed to load \( \geq .4 \), a final unifactorial solution was present. This factor explained 46\% of the variance and was labelled perceived barriers. Internal reliability for this factor was good, Cronbach’s \( \alpha = .71 \). The factor loadings, eigenvalue, per cent of variance explained and descriptive statistics are presented in Table 14.4.

Table 14.4

<table>
<thead>
<tr>
<th>Questions</th>
<th>Perceived Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The whole process of mental health treatment is too complicated.</td>
<td>.82</td>
</tr>
<tr>
<td>The whole process of mental health treatment takes a long time</td>
<td>.78</td>
</tr>
<tr>
<td>I think it is hard to find a mental health practitioner who is suitable for me</td>
<td>.75</td>
</tr>
<tr>
<td>I can not afford the money needed for mental health visits</td>
<td>.74</td>
</tr>
<tr>
<td>I do not know where to seek help for mental health problems</td>
<td>.52</td>
</tr>
</tbody>
</table>

Eigenvalue | 2.76 |
% variance explained | 45.99 |
M | 11.51 |
SD | 4.15 |
\( \alpha \) | .71 |

The factors extracted in each of the above scales represent the same factors and questions loading on these factors, as reported in Study One using data from the Greek-Cypriot sample. The stability of the factor structures will enable comparison across countries.

The Enculturation and Acculturation scales were only relevant to participants with a Greek heritage. Data from these two groups only inform the following factor analyses.

Enculturation to Greek Identity Scale (EGIS)

The Kaiser-Myer Olkin Measure of Sampling Adequacy (KMO = .95) and Bartlett’s Test of Sphericity \( (\chi^2 = 8233.76, p < .001) \) both indicated the factorability of
the correlation matrix for the 34 items. PCA revealed one factor with an eigenvalue greater than one as did Cattel’s Scree Plot. One item failed to load ≥.30 on this factor and was removed. This one factor explained 50% of the variance and was labelled Enculturation to Greek Values. Internal reliability of this scale was excellent, Cronbach’s α = .97. The factor loadings, eigenvalues, per cent of variance explained and descriptive statistics are presented in Table 14.5.

Table 14.5

<table>
<thead>
<tr>
<th>Questions</th>
<th>Enculturation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want my children to be raised as a Greek</td>
<td>.85</td>
</tr>
<tr>
<td>Most of my close friends speak Greek</td>
<td>.83</td>
</tr>
<tr>
<td>It is/was important to me that the person(s) I dated know how to speak Greek</td>
<td>.82</td>
</tr>
<tr>
<td>It is important for Greek-Australian children to attend Greek school</td>
<td>.82</td>
</tr>
<tr>
<td>When I have children they will attend Greek school</td>
<td>.82</td>
</tr>
<tr>
<td>I have conversations in Greek with my friends</td>
<td>.81</td>
</tr>
<tr>
<td>It is important that the person I marry knows to speak Greek</td>
<td>.80</td>
</tr>
<tr>
<td>Australian-Greeks should be married in the Greek Church</td>
<td>.80</td>
</tr>
<tr>
<td>I feel more comfortable around Greeks than non-Greeks</td>
<td>.80</td>
</tr>
<tr>
<td>Greek parents should insist that their children attend Greek church</td>
<td>.79</td>
</tr>
<tr>
<td>Given the choice, I’d rather speak Greek than English</td>
<td>.79</td>
</tr>
<tr>
<td>It is important to me that my children know how to speak Greek</td>
<td>.77</td>
</tr>
<tr>
<td>Greek school was an important part of my childhood development</td>
<td>.76</td>
</tr>
<tr>
<td>I read Greek newspapers</td>
<td>.76</td>
</tr>
<tr>
<td>I read Greek magazines</td>
<td>.75</td>
</tr>
<tr>
<td>It bothers me that some Greek-Australians do not know how to speak Greek</td>
<td>.72</td>
</tr>
<tr>
<td>My best friends are Greek</td>
<td>.72</td>
</tr>
<tr>
<td>I can have a conversation about anything in Greek</td>
<td>.72</td>
</tr>
<tr>
<td>It is better to marry a poor Greek than a rich non-Greek</td>
<td>.72</td>
</tr>
<tr>
<td>Most of my close friends attended Greek school</td>
<td>.71</td>
</tr>
<tr>
<td>I would not date anyone who is not Greek</td>
<td>.71</td>
</tr>
<tr>
<td>I would not like for a child of mine to date someone who is not Greek</td>
<td>.70</td>
</tr>
<tr>
<td>I believe in the teachings of the Greek Church</td>
<td>.68</td>
</tr>
<tr>
<td>Greek should be the language of the world</td>
<td>.68</td>
</tr>
<tr>
<td>I have conversations in Greek with my family</td>
<td>.67</td>
</tr>
<tr>
<td>My friends and I have conversations in Greek so that non-Greeks around</td>
<td>.64</td>
</tr>
<tr>
<td>us won't know what we're saying</td>
<td></td>
</tr>
</tbody>
</table>
The Kaiser-Meyer Olkin Measure of Sampling Adequacy (KMO = .94) and Bartlett’s Test of Sphericity ($\chi^2$ 2252.41, $p < .001$) both indicated the factorability of the correlation matrix for these 11 items. PCA revealed one factor with an eigenvalue greater than one and Cattell’s Scree Plot also suggested the presence of one factor, which explained 63.25% of the variance. It was labelled Acculturation to Australian values. Internal reliability for this scale was excellent, Cronbach’s $\alpha = .94$. The factor loadings, eigenvalue, per cent of variance explained and descriptive statistics are presented in Table 14.6.
Table 14.6

Acculturation to Australian Values

<table>
<thead>
<tr>
<th>Questions</th>
<th>Acculturation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I enjoy social activities with typical Australian people</td>
<td>.89</td>
</tr>
<tr>
<td>I am interested in having Australian friends</td>
<td>.85</td>
</tr>
<tr>
<td>I am comfortable working with typical Australian people</td>
<td>.85</td>
</tr>
<tr>
<td>I enjoy Australian entertainment (for example, movies and music)</td>
<td>.84</td>
</tr>
<tr>
<td>It is important for me to maintain or develop Australian cultural practices</td>
<td>.83</td>
</tr>
<tr>
<td>I enjoy typical Australian jokes</td>
<td>.82</td>
</tr>
<tr>
<td>I often behave in ways that are typically Australian</td>
<td>.81</td>
</tr>
<tr>
<td>I would be willing to marry an Australian person</td>
<td>.78</td>
</tr>
<tr>
<td>I often participate in mainstream Australian social activities</td>
<td>.70</td>
</tr>
<tr>
<td>In order to succeed I need to be fluent in English</td>
<td>.70</td>
</tr>
<tr>
<td>In order to succeed I need to be fluent in English</td>
<td>.50</td>
</tr>
</tbody>
</table>

Eigenvalue: 6.96
% variance explained: 63.25
M: 37.32
SD: 9.73
α: .94

14.3 Current Diagnosis, Help Seeking and Source of Help

The number of persons who reported having been diagnosed with a mental illness over the last 12 months and the number of these who reported taking their medication for their mental illness are presented in Table 14.7. Chi square revealed no significant association between the number of participants who reported that they had a diagnosis of a mental illness by ethnic group ($\chi^2$ 8, 10.90, $p = .207$) although there was a tendency for Greek-born Australians to have a higher incidence of mental illness. Neither was there any association by the number of participants who reported taking medication and group ($\chi^2$ 6, 5.46, $p = .243$), although Anglo-Australians demonstrated a tendency towards greater use of medication as a treatment option than either of the other two groups.
Table 14.7

Mental Illness Status and Medication Treatment among Three Groups

<table>
<thead>
<tr>
<th></th>
<th>Greek-Australian n (%)</th>
<th>Greek-Born Australian n (%)</th>
<th>Anglo-Australian n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>35 (19.7)</td>
<td>13 (29.5)</td>
<td>39 (22.2)</td>
</tr>
<tr>
<td>Medication</td>
<td>18 (10.1)</td>
<td>5 (11.4)</td>
<td>31 (16.8)</td>
</tr>
</tbody>
</table>

To test whether there was an association by group in terms of preference for a source of help for a mental illness a Chi Square analysis was conducted. Chi Square revealed no association between groups (Anglo-Australians, Greek-Australians, and Greek-born Australians) by type of assistance they would seek for a mental health problem ($\chi^2_{20, 25.61, p = .179}$) (Table 14.8). It seems that the majority of all participants, despite their current grouping endorsed seeking help from a General Practitioner followed by a close friend and then a lover/partner.

Table 14.8

Source of Help by Group

<table>
<thead>
<tr>
<th></th>
<th>Anglo-Australians n(%)</th>
<th>Greek-Born Australians n(%)</th>
<th>Greek-Australians n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner</td>
<td>119 (64.7)</td>
<td>26 (59.1)</td>
<td>84 (47.5)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>6 (3.3)</td>
<td>3 (6.8)</td>
<td>9 (5.1)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>11 (6.0)</td>
<td>3 (6.8)</td>
<td>10 (5.6)</td>
</tr>
<tr>
<td>Family member</td>
<td>7 (3.8)</td>
<td>3 (6.8)</td>
<td>19 (10.7)</td>
</tr>
<tr>
<td>Phone support services</td>
<td>6 (3.3)</td>
<td>2 (4.5)</td>
<td>3 (1.7)</td>
</tr>
<tr>
<td>Lover or partner</td>
<td>12 (6.5)</td>
<td>4 (9.1)</td>
<td>19 (10.7)</td>
</tr>
<tr>
<td>Teacher</td>
<td>-</td>
<td>-</td>
<td>2 (1.1)</td>
</tr>
<tr>
<td>No help</td>
<td>3 (1.6)</td>
<td>-</td>
<td>4 (2.3)</td>
</tr>
<tr>
<td>Close friend</td>
<td>15 (8.2)</td>
<td>2 (4.5)</td>
<td>20 (11.3)</td>
</tr>
<tr>
<td>Priest</td>
<td>-</td>
<td>1 (2.3)</td>
<td>2 (1.1)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (2.7)</td>
<td>-</td>
<td>5 (2.8)</td>
</tr>
</tbody>
</table>
Analysis of Variance (ANOVA) was used to determine if the three groups differed on their willingness to seek help. ANOVA revealed a univariate difference across the three groups $F_{3, 505} = 4.32, p < .005$. The Anglo-Australians reported being more open to seek help for a mental illness than Greek-Australians but there was no difference between Greek-born Australian and Anglo-Australians in their willingness to seek help for mental illness or between Greek-born Australians and Greek-Australians (Table 14.9).

Table 14.9
Willingness to Seek Help for Mental Illness

<table>
<thead>
<tr>
<th></th>
<th>Anglo Australians</th>
<th>Greek-born Australians</th>
<th>Greek-Australians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=184</td>
<td>n = 44</td>
<td>n = 177</td>
</tr>
<tr>
<td>$M$</td>
<td>3.45$^a$</td>
<td>3.30$^{ab}$</td>
<td>3.03$^b$</td>
</tr>
<tr>
<td>$SD$</td>
<td>1.24</td>
<td>1.02</td>
<td>1.23</td>
</tr>
</tbody>
</table>

Groups sharing a superscript do not differ at $p < .05$

Perceived Social Support

A Multivariate Analysis of Variance (MANOVA) was used to compare the three groups on their levels of perceived social support, perceived barriers to help seeking, openness and stigma. Box’s $M (F 1.60, p > .01)$ revealed multivariate homogeneity and Levene’s test of homogeneity confirmed all dependent variables were univariately homogeneous. Pillai’s Trace $F_{6,482} = 1.86, p = .015$ revealed a global difference on the combined dependent variables by group (Table 14.10). Univariate analyses revealed that Greek-Australians were less open to seeking help than either Greek-born Australians or Anglo-Australians, who did not differ on the levels of openness to help. There were no differences across the three groups on their scores for stigma, barriers and social support (family, friends, special person).
Table 14.10

Levels of Perceived Social Support, Perceived Barriers to Help Seeking, Openness and Stigma by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Stigma</th>
<th>Perceived Barriers</th>
<th>Perceived Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Anglo-Australians</td>
<td>24.77*</td>
<td>9.84</td>
<td>25.20*</td>
</tr>
<tr>
<td>Greek-Born Australians</td>
<td>21.93*</td>
<td>6.24</td>
<td>21.28*</td>
</tr>
<tr>
<td>Greek-Australians</td>
<td>11.43*</td>
<td>4.43</td>
<td>11.33*</td>
</tr>
<tr>
<td>- Family</td>
<td>13.51*</td>
<td>4.79</td>
<td>13.04*</td>
</tr>
<tr>
<td>- Friend</td>
<td>12.63*</td>
<td>4.74</td>
<td>12.09*</td>
</tr>
<tr>
<td>- Special Person</td>
<td>14.62*</td>
<td>4.72</td>
<td>13.61*</td>
</tr>
</tbody>
</table>

*Groups sharing a superscript do not differ at p <.05

Multivariate Analysis of Variance (MANOVA) was used to compare the two Greek samples on their levels of Enculturation and Acculturation. Box’s M (F 1.91, p >.01) revealed multivariate homogeneity and Levene’s test of homogeneity confirmed that both dependent variables were univariately homogeneous. Pillai’s Trace revealed no global difference by group, F 4, 518 .561, p = .69. This null finding remained constant after controlling for generation in Australia (1st, 2nd generation) (Table 14.11).
Table 14.11

Enculturation/Acculturation Levels by Greek-Australian Groups

<table>
<thead>
<tr>
<th></th>
<th>Greek-Born Australians n = 37</th>
<th>Greek-Australians n= 170</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enculturation</td>
<td>M 70.18 SD 37.98</td>
<td>66.73 28.72</td>
<td>.59</td>
<td>.55</td>
</tr>
<tr>
<td>Acculturation</td>
<td>M 37.47 SD 9.23</td>
<td>37.64 9.55</td>
<td>.64</td>
<td>.52</td>
</tr>
</tbody>
</table>

Model Testing by Group

Intercorrelations and Multiple Regression Analyses (MRA)

Anglo-Australians

Prior to testing the hypothesised model (Figure 12.1) for Anglo-Australians, Pearson’s Product Moment correlations were calculated to confirm that the independent variables correlated with the dependent variable willingness to seek help and that there was no multicollinearity among the independent variables.

The variables in the model that positively correlated with willingness to seek help were the three factors of perceived social support: family (r = .16), friends, (r = .20), special person (r = .17), openness (r = .46), diagnosis (r = .18) and education (r = .25) and negatively correlated with stigma (r = -.27) and perceived barriers (r = -.18).
Table 14.12

*Correlation matrix for Anglo-Australians*

<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>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Willingness to</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>seek help?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Stigma</td>
<td>-.27**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Openness</td>
<td>.49**</td>
<td>.46*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Special P</td>
<td>.17*</td>
<td>.61*</td>
<td>.54**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Friends</td>
<td>.20*</td>
<td>.06</td>
<td>.01</td>
<td>.01</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Family</td>
<td>.16*</td>
<td>.36*</td>
<td>.33**</td>
<td>.46**</td>
<td>.01</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Barriers</td>
<td>-.18*</td>
<td>.03</td>
<td>.02</td>
<td>.02</td>
<td>.53**</td>
<td>.53**</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Diagnosis#</td>
<td>-.03</td>
<td>.09</td>
<td>.19**</td>
<td>-.07</td>
<td>-.05</td>
<td>.02</td>
<td>.13</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Gender</td>
<td>.11</td>
<td>.02</td>
<td>-.01</td>
<td>.05</td>
<td>.22</td>
<td>.09</td>
<td>.05</td>
<td>.20</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Education</td>
<td>.25*</td>
<td>-.15</td>
<td>.10</td>
<td>.12</td>
<td>.02</td>
<td>.06</td>
<td>-.10</td>
<td>.04</td>
<td>.05</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11. Income</td>
<td>-.03</td>
<td>-.02</td>
<td>-.02</td>
<td>.19</td>
<td>.13</td>
<td>.08</td>
<td>.03</td>
<td>-.18</td>
<td>.28*</td>
<td>.20</td>
<td>1</td>
</tr>
</tbody>
</table>

*p < .05  **p < .01, Diagnosis #1 = Yes; 0 = No
The independent variables which correlated with willingness to seek help, were entered in a MRA to test the model.

The MRA for Anglo-Australians revealed that the variables in the model explained 32% of the variance in willingness to seek help, \( F_{7,155}=10.13, p <.001; R^2 = .57, R^2 = .33, \text{adjusted } R^2 = .32 \). However, the only significant predictors of willingness to seek help were openness which uniquely explained 16% of the variance, stigma which predicted 6%, and education which predicted 3% percent of the variance in willingness to seek help, a further 7% of the variance was shared among the predictors, however, 67% of the variance in willingness to seek help was unexplained by the variables in the model. Standardised (\( \beta \)) regression coefficients and squared semi-partial correlations for each predictor are presented in Table 14.13.

Table 14.13

*Multiple Regression Analysis Predicting Willingness to Seek Help for Anglo-Australians*

<table>
<thead>
<tr>
<th>Predictors</th>
<th>( R^2 )</th>
<th>( \beta )</th>
<th>( sr^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Openness</td>
<td></td>
<td>(.46^{**})</td>
<td>(.16)</td>
</tr>
<tr>
<td>Stigma</td>
<td></td>
<td>(-.22^{**})</td>
<td>(.06)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>(.16^{*})</td>
<td>(.03)</td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Family</td>
<td>(.01)</td>
<td></td>
<td>(.00)</td>
</tr>
<tr>
<td>-Friends</td>
<td>(.11)</td>
<td></td>
<td>(.01)</td>
</tr>
<tr>
<td>-Special Person</td>
<td>(-.08)</td>
<td></td>
<td>(.00)</td>
</tr>
<tr>
<td>Barriers</td>
<td>(-.02)</td>
<td></td>
<td>(.00)</td>
</tr>
<tr>
<td>Diagnosis#</td>
<td>(.12)</td>
<td></td>
<td>(.02)</td>
</tr>
</tbody>
</table>

* \( p < .05, \; ** p < .01; \; \text{Diagnosis } \#1=\text{Yes}; \; 0=\text{No} \)
**Greek-Australians**

Prior to testing the hypothesised model for the Greek-Australians, Pearson’s Product Moment correlations were calculated to confirm that the independent variables correlated with the dependent variables, and that there was no multicollinearity among the independent variables.

Only the variables which contributed significantly to willingness to seek help in the correlation matrix were included in the test of the model: Willingness to seek help among Greek-Australians was positively correlated with openness \((r = .39)\) and negatively correlated with stigma \((r = -.26)\). Neither of the SES variables (education and income) nor social support (family, friends, special person), diagnosis, barriers, gender, enculturation and acculturation were correlated with willingness to seek help and were omitted from the subsequent analysis.
Table 14.4

Correlation Matrix for Greek-Australians

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
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<tbody>
<tr>
<td>1.Willingess to seek help</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2.Stigma</td>
<td>.25&quot;</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3.Openness</td>
<td>.38&quot;</td>
<td>-.20</td>
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<tr>
<td><strong>Support</strong></td>
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<td></td>
</tr>
<tr>
<td>4.-Family</td>
<td>.12</td>
<td>.09</td>
<td>.70**</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>5.-Friends</td>
<td>.06</td>
<td>.44**</td>
<td>.38</td>
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<td></td>
</tr>
<tr>
<td>6.-Special P</td>
<td>.09</td>
<td>.70**</td>
<td>.60**</td>
<td>1</td>
<td>.09</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Barriers</td>
<td>-.13</td>
<td>-.11</td>
<td>-.16*</td>
<td>-.13</td>
<td>.50**</td>
<td>.14</td>
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</tr>
<tr>
<td>8.Enculturation</td>
<td>.03</td>
<td>.18*</td>
<td>.19*</td>
<td>.14</td>
<td>.42**</td>
<td>.24**</td>
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<td>9.Aculturation</td>
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<td>-.15*</td>
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<td>11.Gender</td>
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<td>-.03</td>
<td>.08</td>
<td>.10</td>
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<td>12.Education</td>
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<td>-.01</td>
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<td>13.Income</td>
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<td>-.00</td>
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<td>.08</td>
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</table>

Diagnosis #1=Yes; 0= No; *p<.05; **p<.01
The multiple regression analysis for Greek-Australians shows that stigma and openness explained 19% of the variance in willingness to seek help $F_{2, 171} = 22.46$, $p < .001$; $R = .46$, $R^2 = .21$, adjusted $R^2 = .19$. Stigma negatively predicted willingness to seek help, while openness was a positive predictor. They uniquely explained 7% and 14% of the variance, respectively. The remaining 79% of variance in willingness to seek help was unexplained. Standardised ($\beta$) regression coefficients and squared semi-partial correlations for each predictor are presented in Table 14.15.

Table 14.15.

*Multiple Regression Analysis Predicting Willingness to Seek Help for Greek Australians*

<table>
<thead>
<tr>
<th>Predictors</th>
<th>$R^2$</th>
<th>$\beta$</th>
<th>$sr^2$</th>
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<tr>
<td>Stigma</td>
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</tr>
<tr>
<td>Openness</td>
<td></td>
<td>.36**</td>
<td>.14</td>
</tr>
</tbody>
</table>

*Greek-born Australians*

Prior to testing the hypothesised model, for the Greek-born Australians, Pearson’s Product Moment correlations were calculated to confirm that the independent variables correlated with the dependent variable, and that there was no multicollinearity among the independent variables.

Only stigma ($r = -.35$, $r^2 = 12\%$) was correlated significantly with willingness to seek help. No multiple regression analysis was conducted for this sample.
Table 14.16 *Correlation Matrix for Greek-born Australians*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<td>3. Openness</td>
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<td>Support</td>
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<td>4. Special Person</td>
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<td>5. Friends</td>
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<td>6. Family</td>
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<td>.44**</td>
<td>.72**</td>
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<td>7. Barriers</td>
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<td>8. Diagnosis#</td>
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<td>9. Enculturation</td>
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<td>.14</td>
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<tr>
<td>10. Acculturation</td>
<td>-.08</td>
<td>.05</td>
<td>.03</td>
<td>-.23</td>
<td>.03</td>
<td>-.22</td>
<td>.10</td>
<td>-.01</td>
<td>-.43**</td>
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<tr>
<td>11. Gender</td>
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<td>.07</td>
<td>-.21</td>
<td>.22</td>
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<td>.05</td>
<td>.06</td>
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<td>-.28</td>
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<tr>
<td>12. Education</td>
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<td>.13</td>
<td>.05</td>
<td>-.18</td>
<td>.07</td>
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<td>.01</td>
<td>-.01</td>
<td>.30</td>
<td>-.28</td>
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</tr>
<tr>
<td>13. Income</td>
<td>-.12</td>
<td>.12</td>
<td>.17</td>
<td>-.10</td>
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<td>-.07</td>
<td>-.11</td>
<td>-.05</td>
<td>.48*</td>
<td>-.13</td>
<td>.05</td>
<td>.49*</td>
<td>1</td>
</tr>
</tbody>
</table>

Diagnosis #1 = Yes; 0 = No; *p<.05; **p<.01
A Comparison of Cypriot Data with Australian Data

In order to determine whether there are any differences across the groups of people living in two different countries, comparisons of the Cypriot data and Australian data were undertaken. An Analysis of Variance (ANOVA) was used to compare the four groups: Anglo-Australians, Greek-born Australians, Greek-Australians, and Greek-Cypriots on their willingness to seek help. The focus of the interpretation will be on comparing the Greek-Cypriot sample to the three Australian samples.

ANOVA ($F_{3,604} = 4.37 \ p < .001$), using a Bonferroni Correction Factor, indicated that the Cypriot sample do not differ from the Anglo-Australians or from the Greek-born Australians on their willingness to seek help. These three groups all scored higher on willingness to seek help than the Greek-Australians.

Table 14.17

Descriptive Statistics for Willingness to Seek Help by Groups

<table>
<thead>
<tr>
<th></th>
<th>Anglo-Australians</th>
<th>Greek-born Australians</th>
<th>Greek-Australians</th>
<th>Cypriots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willingness to seek help</td>
<td>M 3.45$^a$</td>
<td>3.30$^a$</td>
<td>3.03</td>
<td>3.41$^a$</td>
</tr>
<tr>
<td></td>
<td>SD 1.24</td>
<td>1.02</td>
<td>1.23</td>
<td>1.21</td>
</tr>
</tbody>
</table>

Groups sharing a superscript do not differ at $p < .05$.

Multivariate analysis of Variance (MANOVA) was used to compare the four groups: Anglo-Australians, Greek-born Australians, Greek-Australians, and Greek-Cypriots on the dependent variables: age, stigma, openness to help, support and
barriers to help. Pillai’s Trace ($F_{7,493} = 6.07, p < .001$) revealed a global difference among the groups. Univariate ANOVAs confirmed that the Cypriot sample was younger than the Anglo-Australians and Greek-born Australians but not the Greek-Australians. The Cypriot sample was more open to help than the three Australian groups and there was a tendency for them to perceive more support from family, friends, and a special other. The Cypriot groups did not differ from the three Australian groups on their level of stigma towards mental illness or on perceived barriers to help-seeking.

Table 14.18 Descriptive Statistics by Country

<table>
<thead>
<tr>
<th></th>
<th>Anglo-Australians</th>
<th>Greek-born Australians</th>
<th>Greek-Australians</th>
<th>Cypriots</th>
<th>$F$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ($M$)</td>
<td>45.42</td>
<td>50.88</td>
<td>39.61</td>
<td>36.25</td>
<td>15.47</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Age ($SD$)</td>
<td>16.04</td>
<td>14.60</td>
<td>12.26</td>
<td>16.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma ($M$)</td>
<td>24.70</td>
<td>25.63</td>
<td>26.24</td>
<td>27.60</td>
<td>2.20</td>
<td>.087</td>
</tr>
<tr>
<td>Stigma ($SD$)</td>
<td>9.86</td>
<td>10.41</td>
<td>9.45</td>
<td>9.07</td>
<td></td>
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</tr>
<tr>
<td>Openness ($M$)</td>
<td>21.95</td>
<td>21.53</td>
<td>19.91</td>
<td>25.62</td>
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<td>&lt;.001</td>
</tr>
<tr>
<td>Openness ($SD$)</td>
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<td>5.31</td>
<td>5.85</td>
<td>6.15</td>
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<tr>
<td>Support Family ($M$)</td>
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<td>13.07</td>
<td>12.83</td>
<td>15.02</td>
<td>4.78</td>
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<tr>
<td>Support Family ($SD$)</td>
<td>4.79</td>
<td>4.45</td>
<td>5.31</td>
<td>4.86</td>
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<td>Support Friends ($M$)</td>
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<td>11.86</td>
<td>14.12</td>
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<td>4.09</td>
<td>4.70</td>
<td>4.85</td>
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<tr>
<td>Support Special ($M$)</td>
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<td>13.65</td>
<td>13.53</td>
<td>16.24</td>
<td>9.95</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Support Special ($SD$)</td>
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<td>5.29</td>
<td>5.34</td>
<td>4.27</td>
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<tr>
<td>Barriers ($M$)</td>
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<td>11.41</td>
<td>11.55</td>
<td>11.25</td>
<td>.041</td>
<td>.989</td>
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<tr>
<td>Barriers ($SD$)</td>
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<td>4.14</td>
<td>4.32</td>
<td>3.98</td>
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</table>

Groups sharing a superscript do not differ at $p < .05$

8 It was not possible to compare countries on income (Euros Vs $Aust) or education. Gender and marital status were presented in the Methods of Studies One and Two were not indicative of willingness to seek help.
CHAPTER FIFTEEN: Study Two, Discussion

The aim of this study was to examine a model of the factors influencing willingness to seek help among Greek-born Australians, Greek-Australians and Anglo-Australians and to test whether enculturation and acculturation levels added to the prediction of willingness to seeking help for a mental illness in the two Greek groups.

Of the participants, approximately 50% of Anglo- and of Greek-born Australians were male, and 43% of Greek-Australians were male. The Greek-Australians were significantly younger than the Greek-born Australians and Anglo-Australians.

The majority of respondents in each of the three groups was married, followed by a substantial number who were single, and a lesser percentage separated. One Greek-Australian and one Anglo-Australian reported they were widowed. While the Anglo-Australians had the highest percentage of respondents to not have completed high school, similar numbers across the three groups reported holding a technical diploma or university degree. In fact, Chi Square analyses revealed no association between the three groups on either educational status or marital status. The range of reported income was also not associated with group, there being a tendency overall for most participants (approximately 805%) to earn less than $A80,000.

While the current study is comprised of presenting samples, according to the Australian Bureau of Statistics the gender split is approximately reflective of the
population (99.1 males : 100 females); the average Australian yearly income is $A58,396 which is approximated in the current data; the percentage of the population who is married is approximately 49% which is lower than reported by the current participants (http://www.indexmundi.com/australia/age_structure.html; http://www.abs.gov.au/ausstats/abs@.nsf/mf/6302.0). It is difficult to compare the current educational status of participants by population statistics but overall, it does seem that the current data reflect a range of levels. On balance, it can be argued that the participants in the current samples are approximately representative of the Australian population overall albeit they are not random samples.

Prior to testing for differences and testing the model, Principal Component Analyses were conducted on the Inventory of Attitudes Toward Seeking Professional Psychological Help Scale (IATSPHS), the Multidimensional Scale of Perceived Social Support (MSPSS), and the Perceived Barriers to Seeking Mental Health Services (PBMHS). Results revealed the same factor structures as extracted in Study One among the Greek-Cypriot participants, making a discussion of the correlations and model testing comparable.

An exploration of the Enculturation to Greek Identity Scale, using only the data from the two Greek cohorts in Study Two, revealed one factor which explained 50% of the variance and which demonstrated strong internal reliability ($\alpha = .97$).

The Vancouver Index of Acculturation modified to reflect Australian terms and references, also yielded one factor which explained 63% of the variance with strong internal reliability ($\alpha = .94$). These scales were then used in the tests of the hypotheses.
The hypothesis that there would be no association between the frequency of reported diagnosis for mental illness and use of medication across the three groups was supported. In the current study, 20% of Greek-Australians, 22% of Anglo-Australians and and 30% of Greek-born Australians reported being diagnosed with a mental illness. The current findings are aligned with reports from the Black Dog Institute (http://www.blackdoginstitute.org.au/docs/Factsandfiguresaboutmentalhealthandmooddisorders.pdf) which indicate that at least 20% of Australians experience a mental illness in any one year. These figures support past research. It seems that in each epidemiological study (ESEmED project, 2004; Kessler, et al., 2005a; 2005b; Somers et al, 2004) conducted around the world, the prevalence of mental illness is between 20-30% of the population. As recent discussions list mental illness as one of the major causes of death world-wide (WHO, 2010) it is clear that the promotion and adoption of high quality mental health services are needed.

Also supporting the hypothesis, and past research from Paulose-Ram, Safran, Gu, Jonas and Orwig (2007) is the low medication rate reported by participants in each group (10%, 11% and 17%) for their condition. Of course, it might well be that other participants are seeking psychological treatments which were not recorded in this study.

The hypothesis that there would be no difference among the three cohorts in terms of the sources of help participants might utilise for a mental health issue was supported. In fact, the majority of participants (47%-65%) in each of the three groups stated they would approach their General Practitioner (GP). Although the sources of help differed somewhat after that, some 74% of Anglo-Australians, 79% of Greek-
born Australians and 56% of Greek-Australians reported that they would seek professional help (GP, Psychologist, Psychiatrist). These results particularly with respect to (GPs) should not be unexpected because in Australia’s health system the GP is the initial point of contact and referral. In addition, public health care rebates make it both convenient and financially viable to receive high quality mental health services from psychologists and psychiatrists. These results support the findings of Bhui et al. (2001) who also found no significant cultural differences among English and Indian patients in the type of carer (GP, friends or relatives, other health and social carers, or `other’) sought out as first, second or third carer. But unlike the current participants, the cultural background of the people in their study did not have a particular preference from whom to seek help in a case of a mental health crisis.

The hypothesis that Anglo-Australians would be more willing to ask for professional mental health help than Greek-Australians and Greek-born Australians was partially supported. Anglo-Australians were significantly more willing than Greek-Australians to ask for mental health professional help but not significantly more willing than Greek-born Australians whose level of willingness lay between the other two groups. One of the reasons that Anglo-Australians might be more willing to ask for a professional help for mental illness could be due to the fact that professional mental health services as we know them today have been developed in countries with people of Anglo-Saxon background. Therefore seeking professional help for a mental illness might be a more culturally familiar construct for someone with an Anglo-Saxon background than for people with a Greek background in Australia. However, the finding that Greek-born Australians were also more prepared to seek professional mental health help than Greek-Australians runs counter to this
suggestion. It might be therefore, that the Greek-born Australians who are, on average, the oldest cohort in this study might be of an age when they can see the merits of seeking help for a mental illness or, alternatively, they may themselves or their family members have experienced a need for such services.

The hypotheses that Greek-born Australians would report lower levels of perceived social support and a less positive attitude towards professional help-seeking for mental illness than either Greek-Australians or Anglo-Australians were not supported. While there were no differences on perceived support from friends, family and a special person, or on the stigma related to mental illness, it is the Greek-Australians who scored significantly lower on openness to mental health and mental health services than either of the other two groups. This last result seems at odds with expectations and the literature where typically, people of a different ethnic background to the dominant society have reported less openness to mental health services (Hamid et al., 2009; Takeuchi et al., 1988; Ying & Hu, 1994). It is encouraging that all groups perceived similar levels of support albeit contrary to previous literature regarding immigrants into the dominant society (Miville & Constantine, 2006) and from that perspective, it can be suggested that neither of the Greek groups felt marginalised from their support systems (Berry, 1997).

The hypothesis that Greek-Australians would exhibit higher levels of acculturation than Greek-born Australians was not supported even after accounting for generation in Australia. However, it is important to note that both groups scored highly on acculturation ($M'$s= 37.47; 36.64) from a possible range of 10-50. Similarly, Kovacev and Shute (2004) found that Yugoslavian immigrants in Australia scored high in acculturation, as did Yangmurlu and Sanson (2009) in their
study of Turkish immigrant mothers living in Australia. While firm conclusions cannot be drawn from these data, it might be the Australian government’s policy (Australian citizenship is a shared identity, a common bond which unites all Australians while respecting their diversity http://www.immi.gov.au/living-in-australia/values/statement/) is conductive to the acculturation of migrants into society.

The hypothesis that Greek-Australians would score lower on enculturation than Greek-born Australians was not supported. Interestingly, both groups reported quite low scores on enculturation. Overall, the Ms = 70.18 and 66.73 in a possible range of 34-170 are relatively low. These low scores while not indicative of respondents denying their culture of origin can be interpreted to suggest that these values are of less relevance now they have made Australia their home. Also, people living in a multicultural country like Australia will attend school, university, and work with others of multicultural backgrounds thus contributing to their integration into the new society (Berry, 1997). It will also be that many will enhance their integration or, in Berry’s (1997) terms, the “Melting Pot” by marriage with someone from a different cultural background. Such a proposition is encouraging for unity within the society and ultimately, the well-being of all persons in the “Melting Pot”.

The final hypotheses in this study were related to testing a model of willingness of help-seeking for each of the three groups: for the two Greek samples, the variables of acculturation and acculturation were added to the list of independent variables. In summary, the variables in the models variously explained 32% of the variance for the Anglo-Australians and 19% for the Greek-Australians. The model for the Greek-born Australians could not be tested because only one variable, stigma,
was significantly correlated with the dependent variable of willingness to seek help ($r = -0.35; r^2 = 12\%$).

Of the variables entered into the MRA for the Anglo-Australian cohort after determining their univariate correlations with the dependent variable, only openness and education were positive predictors and stigma a negative predictor of willingness to seek help for mental health issues. These variables uniquely explained 16\%, 3\%, and 6\% of the variance, respectively. Openness to help is clearly an encouraging first step in actually seeking help when needed, likewise lower perceptions of stigma attached to mental illness or help. Higher education was also a positive predictive of willingness to seek help and although not a direct hypothesis of this study, education was not related to stigma as reported by Stefl and Prosperi (1985) and Parslow and Jorm (2000). The findings with respect to stigma and education support past research by Corrigan (2004), Kung (2004), and Pen and Martin (2008).

Perceived support, barriers, income, gender and diagnosis failed to predict of willingness to seek help in this cohort. While it might be considered encouraging that barriers to help and a diagnosis (or not) of mental illness did not influence willingness to seek help, it is perhaps disappointing that perceptions of support from others was not conducive to being willing to seek help. This last finding does not support Dew et al. (1991) who found that those who sought help were more likely to have friends or relatives recommend that they get help than those who had not sought services.

In the Anglo-Australian sample, 68\% of variance in willingness to seek help is unexplained. Other possible reasons that might explain willingness to seek help for the Anglo-Australian sample which were not tested in the current study might be the
severity of a mental illness, as mentioned in the results for Study One, and the absence of mental health literacy, which is the motivation to comprehend, utilise and access information in ways which support and maintain balanced mental health (Jorm, 2007).

In testing the integrated model with each of the two Greek samples, the variables Enculturation and Acculturation were added to the model. For the Greek-Australian cohort, openness to help and stigma were the only predictors of willingness to seek help and in the same positive and negative directions, respectively as for the Anglo-Australians. For Greek-Australians, 21% of the variance in willingness to seek help was explained by openness and stigma, uniquely 7 and 13%, respectively. In fact, barriers, perceived support, diagnosis gender, SES that is education and income, and even acculturation and enculturation did not even correlate with willingness to seek help and were not included in the regression.

For the Greek-born Australians only stigma was correlated (negatively) with willingness to seek help ($r = -0.35, r^2 = 12\%$), and hence no regression was conducted.

Clearly a significant amount of variance was unexplained in each of these analyses, 79% and 88% respectively. Other possible reasons that can explain the remaining variance in willingness to seek help for the two Greek cohorts might also be the reasons mentioned for the Anglo-Australian cohort such as the severity of the mental illness and the absence of mental health literacy (Jorm, 2011). Those findings reasonate with a study by Link et al. (1989) on perceived stigma that they included in their study as a proxy for shame, and where they found that those who communicated a sense of shame from personal experiences with mental illness were less likely to be engaged in treatment. In their research Leaf et al. (1986) showed that respondents
with psychiatric diagnoses were more likely to shun services if they assumed family members would have an undesirable response to these services. That is, if they learnt or inferred from their family’s attitude that seeking help would be perceived negatively, even branding or labeling them as mentally ill, and the associated assumption that others might condemn them, then they would shun help. While again not a focus of this study, examination of each of the correlation matrices indicates that support from family, a friend or a significant other was not, or was minimally, correlated with diagnosis.

Contrariwise, constructive attitudes of family members have been related to greater mental health service use in a sample of more than 1,000 drawn from a representative community sample and a group from a mental health clinic by Greenley et al. (1987) although this was not the case in the current samples. Self-stigma can also lead to avoidance and hence lessen participation in or willingness to seek treatment. It can be said that self-stigma here is clearly influenced by public stigma and so the importance of educating the public about mental illness issues and the promotion of mental health services cannot be over-estimated. A study conducted in Australia by Barney et al. (2006) found that self- and perceived-stigmatising responses to help-seeking for depression were prevalent in the general community and were associated with a reluctance to seek professional help. Based on their findings, these authors suggested that interventions should focus on minimising expectations of negative responses from others and negative self-responses to help-seeking.

The hypothesis that acculturation and enculturation would predict willingness to seek help for mental illness among the two Greek cohorts was not tested in either
model because neither of these variables correlated significantly with the dependent variable: willingness to seek help. As mentioned earlier, both groups were quite high on acculturation and low on enculturation, which, contrary to the hypotheses and much literature cited in this thesis, suggests that they are indeed integrated into Australian society: a multicultural society.

Interestingly, income, gender and diagnosis failed to correlate with willingness to seek help for any of the three groups which refutes past findings of Parslow and Jorm (2000) where they found that people with the least financial resources exhibit a lower propensity to seek mental health care. MacKenzie et al.'s (2006) finding that being female is associated with more positive help-seeking attitudes and Mojtabai et al.'s (2002) finding that mental disorders are strong predictors of perceived need of seeking help were also not supported.

Also of interest, is that higher education was correlated with (and predictive of) willingness to seek help only among the Anglo-Australian group. This differentiation might be because of the higher percentage of Greek participants reporting a higher education status, hence creating what might have been a ceiling effect. Nevertheless, past research (Leaf et al., 1987; Parslow & Jorm, 2000; Stefl & Prosperi, 1985) supports the notion that people with higher education exhibit a higher propensity to seek mental health care.

A post-hoc comparison of data from the two countries revealed that Greek-Cypriots, Greek-born Australians and Anglo-Australian reported greater willingness to seek help than did Greek-Australians. Greek-Cypriots were younger and more open to mental health issues and help than the three Australian groups and generally reported more perceived support than Anglo-Australians and Greek-Australians but
not Greek-born Australians. These few similarities between Greek-Cypriots and Greek-born Australians might be interpreted to reflect the socio-cultural literature which suggests that these patterns of community and support are carried into the new society (Bui & Takeuchi, 1992; Gloria & Rodriguez, 2000; Leong, 1994; Matsuoka, 1997; Mo & Mak, 2009; Miville & Constantine, 2006; Sheikh & Furnham, 2000; Snowden & Cheung, 1990; Sue & McKinney, 1975; Sue & Sue, 1990; Woodward, Dwinell & Arons, 1992).

Overall, a comparison of the regression equations revealed little difference between Greek-Cypriots in the country of origin and those in their new country, Australia and Anglo-Australians, which as mentioned earlier, is encouraging in terms of an integrated ‘melting pot’.

**Limitations and future directions**

While the current data were collected from samples which were approximately representative of the Australian population overall with respect to age, income, and gender split, they are self-reports which are always open to subjective bias. A large number of participants were recruited with the help of a research agency and their motivation to participate may have been influenced by the Agency’s points system of rewards. It was not possible to compare sources of participant recruitment due to the confidential structure of the web surveys. This and the self-report questionnaires may have an impact on the interpretation of the results especially as they relate to acculturation and to enculturation.

Furthermore, the survey was completed via an online survey or pencil and paper questionnaire rather than by interviews or accessing actual mental health records. Self-report measures are vulnerable to responses that reflect false or biased
memories and socially desirable responses. This makes it difficult to confirm participants’ use of mental health services, any current or past diagnoses, and any current symptoms. It is also difficult to confirm the true measurements from the various questionnaires which themselves are subject to some error with respect to their internal reliability. Even though Cronbach’s alphas were all acceptable for each instrument, there is always an error component and well as true measure.

The Greek-Australian sample in the study was not widely diverse in terms of generational status with most respondents reporting they were first generation, and smaller numbers indicating second and third generation. It is important to note that an analysis of covariance did indicate that generational status was not relevant to willingness to seek help.

Since these are not psychiatric samples, the results related to stigma and attitudes and/or willingness to seek mental health treatment may not be generalisable to a more needs-based population. In addition, the study was cross-sectional only and could not assess whether attitudes and/or willingness to seek help would predict actual behaviour to seek help. Previous literature does demonstrate that there can be a link between attitudes and behaviours although this was not always strong. Perhaps using Gollwitzer’s (1993) Implementation Intentions, where people nominate when and where they will engage in a behaviour, would strengthen this relationship in future research and certainly, as has been demonstrated, in actual practice.

Additional research is also needed in order to understand better mental health literacy. In order to develop a valid measure of mental health literacy, a more precise definition of the construct is needed. Currently, the definition references knowledge and beliefs about disorders as well as the recognition, management, and prevention
of these disorders. However, ideas about the recognition, management, and prevention of mental health issues is somewhat subjective and may vary by culture, context, or other factors that are not accounted for in any existing measurement of mental health literacy.

Implications and Conclusions

This study has been a novel investigation of two Greek immigrant groups compared to their Anglo-Australian counterparts on their prevalence of mental illness, medication for such illness, sources of help, and the factors influencing their willingness to seek help for a mental illness. Clearly, these groups exhibited more similarities than differences with respect to the prevalence of mental illness and medication for that illness, the sources of help to which they would turn, and the variables which predict their willingness to seek help. They also shared many similarities with Greek-Cypriots in their home country. The common negative indicator of willingness to seek help was feelings and thoughts of stigma associated with mental illness and mental health services.

Clearly health promotion campaigns need to address further this deterrent to seeking help, and also the possible effects that stigma may directly or indirectly have on worsening people’s mental health. Also increasing the awareness of mental illness symptoms among GPs and Nurse Practitioners in primary care settings, and their knowledge of the mental health care services available to their patients, may facilitate the recognition and treatment of psychiatric disorders, especially in culturally diverse patient groups.
Openness to mental health and mental health services was a key variable in predicting willingness to seek help for the Greek-Australians and Anglo-Australians but not the Greek-born Australians. In many ways, this openness might be construed as an opposite construct to stigma, however, promoting and encouraging a positive approach may well have different effects than attempting to reduce negative, that is, an attitude of stigma.

Despite argument to the contrary, neither acculturation to Australia nor enculturation to their country and society of origin, namely Cyprus and Greece, were related to participants in the Greek samples’ willingness to seek help for mental illness.

In summary, the present findings are encouraging in the Australian context as with only minor differences, they are indicative of a relatively homogeneous population, at least in terms of Greek- and Anglo-Australians. This homogeneity is suggestive of what Berry (1997) termed the “Melting Pot”, and also suggests that, at least in terms of the current variables in the current study with respect to mental illness, the Australian Government’s policy of integration for immigrants is effective.

While the current studies have indicated somewhat similar predictors of willingness to seek help for mental illness, the variance unexplained in each of the four cohorts in Studies One and Two was substantial. In order to try and address this deficiency, it is important to explore further the factors that might influence willingness to seek help and attitudes towards mental illness so as to inform future prevention and mental health promotion strategies. Accordingly, this thesis will be extended to include interviews with Anglo-Australians and Greek-Australians in order to determine any further factors that might affect willingness to seek help.
CHAPTER SIXTEEN: Study Three, Aims and Method

16.1 Aim

Despite utilising a model integrated from factors in the Theory of Planned Behaviour (TPB, Ajzen, 1991), the Health Belief Model (HBM; Hochbaum et al., 1950), Andersen’s Socio-behavioural model (Andersen, 1973), the Health Action Process Approach (HAPA, Schwarzer, 1992) and the literature, the only variables to predict willingness to seek help in the previous studies were an openness to help and a less stigmatised view of mental illness and mental health services. While recommendations were presented in the discussion of Studies One and Two regarding variables which might contribute to the unexplained variance, these are but suggestions. It was decided therefore to interview several Anglo-Australians and Greek-Australians to explore these factors further.

Specifically, the aim of this study was to explore people’s understanding of mental illness, their attitudes to mental illness and their perceptions around seeking help for mental health issues.

16.2 Method

16.2.1 Participants

Eight Anglo-Australians (one male aged 57; seven females age $M = 38.86$ years, $SD = 12.59$), and nine Greek-Australians (six males, age $M = 32$ years, $SD = 9.50$; and three females, age $M = 27.67$ years, $SD = 5.13$) participated in the study.
16.2.2 Procedure

This study was conducted according to the National Health and Medical Research Council Ethical Guidelines and approved by Charles Darwin University Ethics Committee (Appendix H).

Participants comprise a convenience sample drawn from the Greek-Cypriot community in Darwin with permission from the president of the community. Those attending a function at the Greek-Cypriot hall were invited to participate in an interview regarding their knowledge of mental illness and their attitudes to mental illness and help seeking. Interested parties were asked to contact the researcher when an arrangement was made for these people to be interviewed one-on-one in a private room at the hall. Prior to interview they were provided with a Plain Language Statement (Appendix I) and signed a consent form (Appendix K).

The Anglo-Australian participants were recruited from the administration staff at the university and with permission from a local organisation. These participants responded to an email invitation to participate in the current study.

All participants were asked their permission to audio-record the interviews as well as the researcher taking notes. They were advised that these recordings were confidential and no identifying information was sought or recorded.

At the conclusion of the interviews a summary of points discussed was presented to each participant to ensure accuracy of the data recorded. Once the interviews were transcribed the audio recordings were destroyed.
16.2.3 Interviews

Participants’ age and gender were recorded, followed by a series of open-ended questions based on their knowledge of mental illness/health, whether they would seek professional help if they were to experience a mental illness, and possible factors that could influence their decision to seek help or not. Participants were also asked their views on whether they thought professional help was beneficial to those with a mental illness. Participants were encouraged to provide any further comments they chose.
CHAPTER SEVENTEEN: Study Three, Results and Discussion

The audio recordings were transcribed and participants’ responses are summarised in Table 17.1 by broad question categories and by ethnicity of the respondents: Anglo-Australians and Greek-Australians.

Participants in both cohorts lacked a clear understanding of what constitutes mental illness, but in both groups there was the suggestion that mental illness is a physical imbalance or deficiency in the brain. This latter comment about deficiencies might explain why some of the public think mental illness is a stigma. There was also the suggestion, especially by Anglo-Australians, that mental illness has a negative effect on social functioning and coping and that mental illness is a disability. These comments support Mueser et al.’s (1991) findings that the lay public perceives mentally ill individuals to have poor social skills as well as research that has related mental illness to disability, including DALYs (Murray & Lopez, 1997; Murray et al., 1994; World Bank, 1993). Some Greek participants suggested that people with mental illness do not think logically, they are not in a correct state of mind as mental illness affects how people think. Certainly this last echoes part of the diagnostic criteria for a Major Depressive Disorder: ‘diminished ability to think or concentrate’ as outlined in DSM-V (APA, 2013).

When asked why they thought people do not seek help for a mental illness, common responses included stigma, embarrassment, denial, stigma and a desire to avoid being labelled. All of these reasons have been identified in the literature as factors preventing people from seeking professional help for a mental illness (Atkinson & Gim, 1989; Bui & Takeuchi, 1992; Corrigan, 2000; 2004; Corrigan &
Dejong, 2003; Douglas, & Morrison, 1991; Link, Cullen, Frank & Wozniak, 1987; Penn & Martin, 1998; Penn, Mueser & Doonan, 1997; Socall & Holgraves, 1992) and these were, to some extent assessed in Studies One and Two. Certainly stigma, which to some extent might be argued to include embarrassment (e.g., I would feel uneasy going to a professional because some people would think less of me) and denial (e.g., It is probably best not to know everything about one's self) as assessed by the Inventory of Attitudes Towards Seeking Professional Help Scale, was a significant negative predictor of willingness to seek help in those studies. The mention of stigma was especially relevant among the Greek-Australians. For example, one person stated: "In the Greek-Community there is a lot of stigma around mental illness" and another said: "European culture there is a huge stigma…. to seek anyone’s help”.

For Greek males, it was stated that they should “just get on with work” and discussing mental illness or seeking help for it by Greek males was said to be a sign of weakness. It can be suggested that this attitude might reflect the null finding in the previous studies with respect to social support as a predictor of of willingness to seek help and although not tested, might be an attitude of those who stated they would not seek help. While some Anglo-Australians also suggested that men are expected to cope while women talk with each other, the expectation that males need to be “tough” was more dominant in the Greek-Australian cohort than among Anglo-Australians. These findings are aligned with Leaf et al. (1987) who found that women were more inclined to seek help for mental health problems than men and they were also less concerned about the reactions of their families. However, Leaf and Bruce (1987) found that the effect of gender on service use varied with the level
of need and with the individual’s attitudes toward using mental health. However, gender was not predictive of willingness to seek help in either of the current two studies.

**Table 17.1**

*Responses of Anglo-Australians and Greek-Australians*

<table>
<thead>
<tr>
<th>What is mental illness?</th>
<th>Anglo-Australians</th>
<th>Greek-Australians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical imbalance in the brain; brain pushed to its limit</td>
<td>Many forms - severe and light - people are not in correct state of mind - someone who doesn’t think logically - physiological deficiency with the brain - affects the brain how they think - ranges from depression to fear, lack of understanding</td>
</tr>
<tr>
<td></td>
<td>Psychological absence of psychological health</td>
<td>Physical absence of mental health - range from depression to fear, lack of understanding</td>
</tr>
<tr>
<td></td>
<td>Social - affects relationships - functioning - social deviation - reduced coping - disability</td>
<td>Social phenomena - affects relationships - functioning - social deviation - reduced coping - disability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Many people with a mental illness do not seek help. Why do you think this is so?</th>
<th>Anglo-Australians</th>
<th>Greek-Australians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embarrassing - to have a label - affects your position in relation to others</td>
<td>Embarrassed - to admit symptoms - to seek help</td>
<td>Stigma - especially among Greeks - he’s mad - degrading</td>
</tr>
<tr>
<td>Fear - of how you will be perceived Self-assessments - people make own decisions on whether they need help or not - might discuss with a colleague</td>
<td></td>
<td>Culturally embedded-to cope Avoid labels - men should be tough</td>
</tr>
<tr>
<td>Denial - that they have an issue - lack of knowledge of symptoms Little support from others Stigma-negative connotations</td>
<td></td>
<td>Want to believe they are ok, that nothing is wrong, seeking help means someone is not strong enough, not normal</td>
</tr>
<tr>
<td>Cultural expectations to cope People, including family, are judgmental</td>
<td></td>
<td>Scared of no confidentiality European culture-high stigma, especially among males - just get on with work</td>
</tr>
<tr>
<td>Do not know where to go Men expected to cope,</td>
<td></td>
<td>Greek males-a weakness Pressure from family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scared to admit something is wrong</td>
</tr>
</tbody>
</table>
There was also an element of denial expressed by one Greek-Australian “want to believe they are OK” and “seeking help means [one] is not strong enough”. An echo of this last statement can be seen in a comment from one Anglo-Australian “how you will be perceived by others”. These comments are also indicative of
perceptions of stigma, which was a significant negative predictor of willingness to seek help in the previous two Studies.

Other comments included not knowing where or how to access help, and feeling scared that there would be a lack of confidentiality or lack of trust between clients and therapist, factors that can be considered as barriers to seeking help. But again, barriers to seeking help (e.g., I don’t know where to seek mental health services; I think it is hard to find a mental health service that is suitable for me) failed to predict willingness to seeking help in the previous studies in this thesis. Yet, these comments are similar to Atkinson et al. (1991) who also found that distrust of a counsellor and perceived lack of the effectiveness of the treatment are shaped by socio-cultural factors and can be impediments for seeking effective professional help.

In terms of what factors would enable seeking help for a mental illness were non-judgmental support from friends and family; education about mental illness and the services available, including media campaigns that indicate seeking help is OK: this last was mentioned only by the Greek-Australian participants. These results support previous studies (Horwitz, 1978; Pescolido, 1992; Rickwood & Braithwaite, 1994) where help seeking attitudes and intentions to seek mental health professional help were enhanced by support from family, being educated or informed about mental illness and the availability of services. Interestingly though, support from family, friend, or a special other were not predictive of willingness to seek help in the current studies.

One Greek-Australian suggested that people might attend a General Practitioner (a medical doctor) as there is no stigma associated with this, while another stated that informal support, from family and friends, is crucial not only to
provide direct help but to encourage seeking professional assistance. Informal support was also stated to sometimes be more useful as it was “relaxed and comfortable”, while another Greek-Australian stated that professional help offered “is not always the best” (e.g., medication). These findings resonate with the work of Narrow et al. (1993) who reported that European-Americans with mental health issues were more likely to use professional mental health services than ethnic minorities in the USA, such as Hispanic people, whose culture shares some similarities with that of Greek people. However, in their study there was an indication that Hispanic people were less likely to consider the medical system as a useful source for mental health interventions, possibly reflecting basic prejudices in the health care system. Yet, Narrow et al.’s findings were rejected in the previous two studies where several respondents noted, as in this study, that they would attend a General Practitioner for mental illness but many also indicated seeking non-professional help from family, friends and even their priest.

Both Anglo- and Greek-Australians in this study referred to elements that indicated it was important to have an openness and commitment to therapy as well as the importance of having a trusting relationship with the therapist. This component of openness to help, which might also imply “want help” was the common predictor across all samples in this thesis.

One Anglo-Australian participant indicated that the brain “is just a muscle pushed beyond its capacity” and as such needed treatment. However, a Greek-Australian male implied that people would seek therapy as a last resort: “to have hit bottom, no choice” while another indicated that people need to ask for help - clearly this is also indicative of openness to help. As Cauce et al. (2002) noted, the impact of
a socio-cultural context can be very strong across the entire help-seeking pathway for mental illness from recognising the problem to choosing from whom to seek help.

Again these social factors (e.g., income, gender) were not predictive of willingness to seek help in any of the cohorts studied in this thesis (see Studies One and Two) and neither were the acculturation nor enculturation factors implicated in the two Greek-Australian samples’ willingness to seek help.

When participants were asked if they thought seeking help could be useful for people with a mental illness, most agreed, however, there were some contrasts. Members of each group stated that it was important to have the right therapist in a trusting relationship where the client can be open and where the therapist outlines the process of therapy “therapist should suggest limiting the number of sessions”. This idea of trust with the right therapist resonates with the findings from Zhang et al. (1998) who reported that the mismatch of perceptions of mental health professionals by laypersons and clients may lead to a distrust of mental health professionals and thus lower service utilisation.

Some Greek-Australian participants suggested that it is easier for Anglo-Australians than Greek-Australians to seek professional help and also that sources of help beyond professionals, such as friends, family colleagues or special leaders such as their priest whom they trust, are also important sources of help. Both groups stated that “it is an individual thing”. These findings support Bhui et al. (2001) who found that English participants were more likely to seek help from mental health professionals than participants from other ethnicities such as English-Indians. The current comments and the findings from Bhui et al. aside from openness, support and type of therapist, were not directly explored in the earlier studies of this thesis and
may be important inclusions in future research. However, the fact that the majority of participants in both Study One and Study Two indicated they would seek professional help (General Practitioner, Psychologist, Psychiatrist) suggests some level of confidence at least in these practitioners’ ability to help, clearly though, a significant percentage of people may not share these feelings of confidence or trust.

Clearly though, the current findings are limited by the small, self-selected sample, and by limited demographic data about these participants. Furthermore, it is not known whether they or any family member or close friend had ever been diagnosed with a mental illness and whether this may have influenced their views.

Despite these limitations, these data suggest that help seeking is influenced negatively by perceptions of stigma associated with having a mental illness and, especially among the Greek-Australian cohort, being a male. Other stated barriers to help seeking were poor family support or, alternatively, good family and peer support as well as openness to therapy, could be positive predictors. There was a suggestion from the Greek-Australians that it was more difficult for them than Anglo-Australians to seek professional help and that others, such as their priest, might be valid alternate sources of help. This comments reflects the view of some of the Study Two participants.

While these participants cannot be said to be representative of their respective populations, these data do provide some insight into reasons why people may or may not seek professional help for mental illness, and these reasons reflect both the literature and the factors studied, albeit many were not significant predictors, in Studies One and Two.
CHAPTER EIGHTEEN: General Discussion

Mental illness is a major problem but not all persons affected seek treatment. There is an emerging body of research which suggests that willingness to seek help for mental health issues is determined by barriers and various socio-cultural factors such as SES, acculturation into a host culture and enculturation into the culture of origin, stigmatised attitudes and social support (Bui & Takeuchi, 1992; Leong, 1994; Matsuoka, 1997; Mo & Mak, 2009; Millville & Constantine, 2006; Sheikh & Furnham, 2000; Snowden & Cheung, 1990; Sue & McKinney, 1975; Sue & Sue, 1990). While such past research has compared the prevalence of mental illness and numbers of people seeking help for mental illness across cultures, the effects of acculturation and enculturation have been poorly addressed, especially in Australia.

The aim of the current series of studies was to address that deficiency and to provide a comprehensive socio-cultural framework to explain willingness to seek help among Greek-Cypriots living in their country of origin, and Greek-Australians, Greek-born Australians and Anglo-Australians living in Australia.

Study One involved 196 participants from Cyprus of whom 25% reported that they had been diagnosed with a mental illness (DMI) but only 32% of those so diagnosed were taking medication for their condition. Another finding was that 38% of participants with a DMI stated they would seek help from a psychologist and 42% who did not report having a diagnosis also indicated they would seek help from a psychologist. Twelve per cent of participants not diagnosed with a mental illness (NDMI) reported that they would seek help from a priest, as did 10% of those with a DMI. Certainly over the last few decades Cypriot society has become more
westernised, highlighting the choice of help, but at the same time people maintain
many of the traditional social structures, such as deferring to the local priest in times
of need. This difference was especially noticeable among participants over 40 years of
age.

Some 14% of participants with a DMI and 5% NDMI indicated that they
would seek help from a psychiatrist and 5% and 8%, respectively reported they
would seek help from their GP or Psychiatrist. Interestingly some 10% of
participants NDMI and 17% of those with a DMI reported that they would not seek
help.

In a test of the integrated model to predict willingness to seek help for mental
health issues, only openness and stigma towards mental health services predicted
willingness to seek help in this Greek-Cypriot sample. This finding suggests that
people willing to seek help are not just open to help but they have feelings of stigma
associated with mental illness - while these attitudes are experienced at the same
time, clearly they reflect different directions. Other variables such as social support,
SES diagnosis, barriers and gender did not predict willingness to seek help for this
sample as was hypothesised.

Study Two examined three groups consisting of Greek-Australians that is
those of Greek descent born in Australia, Greek-born Australians, that is, people born
in Greece or Cyprus who migrated to Australia, and Anglo-Australians. In Study
Two, 20% of Greek-Australian, 30% of Greek-born Australian, and 22% of Anglo-
Australian participants reported being diagnosed with a mental illness; these figures
on mental illness diagnosis are similar to those from Cypriot participants in Study
One and the literature generally. Ten per cent of Greek-Australians, 11% of Greek-
born Australians and 17% of Anglo-Australians who were diagnosed with mental illness were taking prescribed medication for their condition; figures that overall are much lower than reported by participants in the Cypriot study (32%). It might be that the Australian groups were being treated other than with medication, such as, cognitive behaviour therapy or other psychological therapies. The majority of participants (47%-65%) in the three Australian groups stated they would seek help from their General Practitioner. Although the sources of help differed somewhat after that, in total some 74% of Anglo-Australians, 79% of Greek-born Australians and 56% of Greek-Australians reported that would seek professional help (GP, Psychologist, Psychiatrist). In comparison, the majority of Cypriot participants in Study One indicated that they would seek help from a psychologist, while others indicated that they would seek out a priest or family-friends.

In a test of the integrated model to determine the factors to predict willingness to seek help for mental health issues across each of the three groups, the independent variables variously explained 32% for the Anglo-Australians, 19% for the Greek-Australians. The model for the Greek-born Australians could not be tested because only stigma was significantly correlated with the dependent variable of willingness to seek help.

For the Anglo-Australian cohort openness and higher educational level were positive predictors and stigma a negative predictor of willingness to seek help for mental health issues. No forms of support, barriers, income, or being diagnosed with a mental illness were predictive of willingness to seek help in this cohort.

For the Greek-Australians cohort, openness to help and stigma also predicted willingness to seek help and in the same positive and negative directions
respectively, explaining 19% of the variance in willingness to seek help. No other independent variable was indicative of willingness to seek help for this sample.

For the Greek-born Australians only stigma correlated with willingness to seek help ($r^2 = 12\%$).

Despite the argument presented in this thesis, neither acculturation to the new society nor enculturation with the society of origin were predictive of willingness to seek help for either of the two Greek Australian samples. In fact, scores on acculturation were relatively high while those for enculturation were modest. Again, this can be interpreted to suggest that Greeks and Greek-Cypriots, as least those participating in this study, are integrated with the broader Australian community. Clearly such apparent cohesion is a desirable outcome for the emotional and physical well-being of both the immigrant population and Australian society in general, and this finding can be argued to support the Australian Government’s policy of integration (http://www.immi.gov.au/living-in-australia/values/statement).

The results from both Study One and Study Two have yielded similar results despite being conducted in different countries, with openness to mental health services and stigma towards mental illness predicting willingness to seek help. The consistency of this finding among all four groups might reflect, as stated above, that people can and probably do, hold competing attitudes and values.

That the variance explained in willingness to seek help was not substantial for any group in the two studies, might be because of other possible reasons not tested in this thesis, such as, the severity of the mental illness, any co-morbidity physical or psychological, past experience with therapy, and whether or not others they might know with a mental illness have modelled appropriate help-seeking behaviour. In
order to ascertain what other factors might be relevant, a series of interviews were conducted in Study Three.

Study Three involved a series of interviews with eight Anglo-Australians and nine Greek-Australians. These were designed to investigate attitudes towards mental illness and intentions towards mental illness help-seeking that had not been identified in the literature or the earlier studies of this thesis. Responses were very similar across both groups, which is not really surprising given the discussion on integration above.

Most people were unclear about ‘what is mental illness, and whether professional help is necessary for someone to recover from a mental illness was not always clear, especially among the Greek-Australian participants. Anglo-Australian participants seemed more open and more appreciative of professional help, while Greek-Australians seemed to be more appreciative of informal support such as, from family, friends and special leaders such as a priest whom they trust. Partial support for this premise was found in Studies One and Two.

Nevertheless, participants from both groups independent of their age or gender suggested that it is easier for females to seek professional help than is for males. Also females enjoy a more supportive social support network that makes it easier for them to share emotional issues and find solutions to their problems in comparison with males. In addition, most of the participants stated that overall society has negative and stigmatised views of individuals with a mental illness and those seeking help for a mental illness. While the comments about support reflect many findings in the literature, they were not found to be relevant in the empirical studies reported
here. It was, unfortunately, the case that stigma was a common negative predictor of willingness to seek help.

Many of the themes which emerged from this study such as social support, gender and practical barriers related to help-seeking intentions and attitudes towards mental illness were tested in Study One and Study Two but found not to be significant. Several important points to emerge are concerned with patients needing a trusting relationship with the therapist, the need for the therapist to set goals and timelines, for others not to be judgemental, and for high profile persons to act as role models.

Clearly more of these factors can be made in health promotions and future research although some agencies, such as beyondblue (beyond.org.au) and the Australian Psychological Society (http://www.psychology.org.au/) have already instigated initiatives involving significant role models. Clearly though more needs to still be done in this and related areas.

16.1 Conclusions

The current series of studies has provided a novel investigation into a diverse set of socio-cultural factors and their association with willingness to seek help, across two countries, including the acculturation and enculturation in the non-Anglo-Saxon groups. The studies reveal commonalities with respect to the incidence of mental illness across the current samples and with previous epidemiological studies, the sources of help people would access, and the factors that are significantly predictive of a willingness to seek help for a mental illness.
A major focus of these studies was to examine the impact of acculturation and enculturation on Greek immigrants and subsequent generations as possible additive predictors to willingness to seek help. However, results failed to indicate such an effect and, in fact, suggest that, at least, the people comprising the current samples are well integrated in Australian society — surely a desirable outcome that, at the same time, does not negate the richness of their heritage.

Overall, the current studies have provided insights into the relationship of socio-cultural factors and attitudes towards mental illness and help seeking attitudes. Future research might investigate willingness to seek help against actual help-seeking through the use of longitudinal studies or observational methods although this does presuppose people would know their mental state. These findings have both theoretical and practical implications that support the promotion of more comprehensive and cultural informed campaigns. Not only should these focus on reducing stigma towards mental illness and help-seeking but also aim to increase more open attitudes towards mental illness and help-seeking and ensure that practitioners themselves are open and provide trusting therapeutic relationships.
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APPENDIX A

Ethics Approval: Study One and Study Two

10 April 2012

Mr Nicholas Alcid
PHD Student
School of Health
Charles Darwin University
DARWIN NT 0800

Dear Mr Alcid

RE: H10384 - Mental Health: Socio-ethnic determinants of help seeking
Human Research Ethics Committee Project Application Approval

The Charles Darwin University Human Research Ethics Committee considered your application for ethics clearance for the aforementioned project at meeting H1.2, held on 4/10/2012. It was approved out of session by the Chair.

Please find attached a Notice of Clearance.

The expiry date of ethics approval for your project is April 10 2013. It is the responsibility of the researcher to ensure that ethics approval is re-issued prior to the expiry date. If renewal is necessary, you will need to submit a progress report including a statement of compliance with ethical requirements, and detailing any proposed or actual changes to the project, which may affect its ethical acceptability. Renewal/Final Report forms are available from the Web at: http://www.cdu.edu.au/research/office_of_research&innovation or from the Office of Research & Innovation.

If any significant situations to your project are contemplated or if any matters arise which may conceivably affect the continued ethical acceptability of the project, you are required to immediately notify the Human Research Ethics Committee by letter.

Our best wishes for the success of your project.

Yours sincerely

[Signature]

Professor Sharon Ball
Chair, Human Research Ethics Committee
Appendix B

Translation of the Scales into Greek

Φύλο (κυκλώστε): Άντρας ή Γυναίκα

Ηλικία: —

Εθνικότητα: —

Χώρα Γέννησης: —

Εκπαίδευση (κυκλώστε):

1) Νηπιαγωγείο
2) Δημοτικό
3) Μερικές Τάξεις Γυμνασίου
4) Απόφοιτος Γυμνασίου
5) Πιστοποιητικό Τεχνικής Σχολής
6) Πτυχίο
7) Μεταπτυχιακό
8) Διδακτορικό

Το ετήσιο μου εισόδημα κυμαίνεται (κυκλώστε):

1) λιγότερο $20,000
2) $21,000 - $40,000
3) $41,000 - $60,000
4) $61,000 - 80,000
5) $81,000 - $100,000
6) περισσότερο από $100,000

Τους τελευταίους 12 μήνες διαγνωστήκατε με (κυκλώστε ισχύει):

➤ Αγχώδη Διαταραχή: Ναι / Όχι
Καταθληπτική Διαταραχή: Ναι/Όχι
Κατάχρηση αλκόολ ή άλλων ναρκωτικών: Ναι/Όχι
Άλλη Διαταραχή: Ναι/Όχι
Αν ναι, Ποια;
Καμιά διαταραχή

Λαμβάνεται φαρμακευτική αγωγή για τη διαταραχή αυτή (κυκλώστε εφόσον ισχύει); Ναι / Όχι

Τους τελευταίους 12 μήνες μέλος της οικογένειας σας ή κοντινός φίλος, διαγνώστηκε με (κυκλώστε εάν ισχύει):
Αγχώδη Διαταραχή: Ναι/Όχι
Καταθληπτική Διαταραχή: Ναι/Όχι
Κατάχρηση αλκόολ ή άλλων ναρκωτικών: Ναι/Όχι
Άλλη Διαταραχή: Ναι/Όχι
Αν ναι, Ποια;
Καμιά διαταραχή

Αν υπέφερες από κάποιο ψυχολογικό πρόβλημα (π.χ. άγχος, καταθληπτική διάθεση, στρες) θα ζητούσες βοήθεια (κυκλώστε);
1. Όχι
2. Μπορεί
3. Πιθανότατα ναι
4. Ναι
5. Σίγουρα

Αν ζήτησες βοήθεια, σε ποιον θα απευθυνόσασταν (κυκλώστε); Μπορείτε να επιλέξετε περισσότερες από μία επιλογές. Σε ανάλογη περίπτωση παρακαλώ σημειώστε με σειρά προτεραιότητας.
1. Γενικό γιατρό (παθολόγο)
2. Ψυχολόγο
3. Ψυχίατρο
4. Μέλος της οικογένειας
5. Κοντινός φίλος
6. Ιερωμένο
7. Άλλο (παρακαλώ δεικτικά)
8. Δεν θα αναζητούσα βοήθεια απο κανένα
9. Απο τηλεφωνική γραμμή ψυχολογικής στήριξης
10. Ερωτικό σύντροφο
11. Απο δάσκαλο ή κάποιον άλλο παιδαγωγό

Σχετικά με την προηγούμενη ερώτηση μπορείς να διαλέξεις περισσότερο απο μια επιλογή άλλα γράψε στο πάρακατω κουτάκι την σειρά προτεραιότητας.
Πόσες επισκέψεις έχεις κάνει στον ειδικό ψυχικής υγείας? (απάντησε μόνο αν ισχύει)

Πόσο βοηθητική ήταν για σένα αυτή η επίσκεψη - (απάντησε μόνο αν ισχύει).
1. Εξαιρετικά μη χρήσιμη
2. Καθόλου χρήσιμη
3. Δεν ήταν χρήσιμη
4. Πολύ χρήσιμη
5. Εξαιρετικά χρήσιμη

Εάν τύχει κάποιος φίλος ή συγγενής να βιώσει πρόβλημα Ψυχικής Υγείας (π.χ., συμπτώματα άγχους, κατάθλιψη, στρές) θα αναζητούσε βοήθεια?
1. Σε καμιά περίπτωση
2. Μπορεί
3. Μάλλον ναι
4. Ναι
5. Σίγουρα

Εάν αναζητούσε βοήθεια σε ποιον θα του σύστηνες να απευθυνθεί?
1. Γενικό γιατρό (παθολόγο)
2. Ψυχολόγο
3. Ψυχιατρό
4. Μέλος της οικογένειας
5. Κοντινό φίλο
6. Ιερομένο
7. Άλλο (παρακαλώ διευκρινίστε)
8. Δεν θα αναζητούσα βοήθεια απο κανένα
9. Από τηλεφωνική γραμμή ψυχολογικής στήριξης
10. Ερωτικό σύντροφο
11. Από δάσκαλο ή κάποιον άλλο παιδαγωγό

Σχετικά με την προηγούμενη ερώτηση μπορείς να διαλέξεις περισσότερο απο μια επιλογή αλλά γράψε στο πάρακατο κουτάκι την σειρά προτεραιότητας.

Πόσες επισκέψεις έχεις κάνει ο φίλος ή συγγενής σε ειδικό ψυχικής υγείας (απάντησε μόνο αν ισχύει)?

Πόσο βοηθητική ήταν αυτή η επίσκεψη για τον φίλο ή συγγενή (απάντησε μόνο αν ισχύει).
1. Εξαιρετικά μη χρήσιμη
2. Καθόλου χρήσιμη
3. Δεν ήταν χρήσιμη
4. Πολύ χρήσιμη
5. Εξαιρετικά χρήσιμη
Κλίμακα Στάσεων σε σχέση με την Αναζήτηση Επαγγελματικής Ψυχολογικής Βοήθειας
(Mc Kenzie, Knox, Gegoski & Mc Caulay, 2004)

<p>| Κυκλώστε τον αριθμό που αντιπροσωπεύει καλύτερα την άποψη σας για τις ακόλουθες δηλώσεις. |</p>
<table>
<thead>
<tr>
<th>Διαφωνώ</th>
<th>Συμφωνώ λίγο</th>
<th>Συμφωνώ αρκετά</th>
<th>Συμφωνώ πολύ</th>
<th>Συμφωνώ απόλυτα</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Υπάρχουν κάποια προβλήματα που δεν πρέπει να συζητιούντα έξω από τον στενό οικογενειακό κύκλο</td>
<td>1</td>
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<tr>
<td>2. Θα γνώριζα πολύ καλά τι να κάνω και σε ποιον να μιλήσω στην περίπτωση που αποφάσιζα να ζητήσω επαγγελματική βοήθεια για ψυχολογικά προβλήματα</td>
<td>1</td>
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<tr>
<td>3. Δεν θα ήθελα ο σημαντικός μου άλλος (σύζυγος, σύντροφος, κτλ) να γνωρίζει αν στο παρελθόν υπέφερα από ψυχολογικές δυσκολίες</td>
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<td>4. Η εργασία είναι μια καλή λύση για να διατηρηθεί το μυαλό κάποιου απασχολημένου και να αποφευχθούν προσωπικές ανησυχίες και προβλήματισμοί</td>
<td>1</td>
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<td>5. Αν καλοί φίλοι ζητούσαν τη συμβουλή μου για ένα ψυχολογικό πρόβλημα, ίσως τους πρότεινα να δουν ένα ειδικό</td>
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<td>6. Η ψυχική ασθένεια συνοδεύεται από ντροπή</td>
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<td>7. Είναι πιθανότατα το πιο καλό να μην γνωρίζει τα πάντα για τον εαυτό σου.</td>
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<td>8. Αν αντιμετώπιζα ένα σοβαρό ψυχολογικό πρόβλημα σε αυτή τη φάση της ζωής μου, θα ήμουν σίγουρος/ σίγουρη ότι θα έβρισκα ανακούφιση στη ψυχοθεραπεία</td>
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<td>9. Οι άνθρωποι πρέπει να λύνουν μόνοι τους τα προβλήματά τους. Η αναζήτηση επαγγελματικής βοήθειας θα πρέπει να αποτελεί την τελευταία επιλογή</td>
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<td>10. Αν θα αντιμετώπιζα ψυχολογικά προβλήματα, θα μπορούσα αν ήθελα να</td>
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<td>Παράγραφος</td>
<td>Μητρώος Πληροφοριών</td>
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<td>11. Οι σημαντικοί άνθρωποι στη ζωή μου θα με υποτιμούσαν, αν ανακάλυπταν ότι έχω ψυχολογικά προβλήματα</td>
<td>1 2 3 4 5</td>
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<td>12. Τα ψυχολογικά προβλήματα, όπως και πολλά άλλα πράγματα, τείνουν να λύνονται από μόνα τους</td>
<td>1 2 3 4 5</td>
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<td>13. Θα μου ήταν σχετικά εύκολο να βρω το χρόνο για να επισκεφτώ ένα ειδικό ψυχικής υγείας</td>
<td>1 2 3 4 5</td>
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<tr>
<td>14. Κάποιες εμπειρίες μου δε θα τις συζητούσα με κανένα</td>
<td>1 2 3 4 5</td>
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<tr>
<td>15. Θα ήθελα να πάρω επαγγελματική βοήθεια αν ανησυχούσα ή ήμουν αναστατωμένος για μεγάλο χρονικό διάστημα</td>
<td>1 2 3 4 5</td>
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<tr>
<td>16. Δε θα ένιωθα άνετα να αναζητήσω επαγγελματική βοήθεια για ψυχολογικά προβλήματα γιατί τα άτομα στο κοινωνικό ή επαγγελματικό μου περιβάλλον μπορεί να το ανακάλυπταν</td>
<td>1 2 3 4 5</td>
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<tr>
<td>17. Η διάγνωση ενός ατόμου με ψυχική διαταραχή στιματίζει τη ζωή του</td>
<td>1 2 3 4 5</td>
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<td>18. Υπάρχει κάποιοι άνθρωποι που έχουν την θέληση να αντεπεξέλθουν τις συγκρούσεις και τους φόβους τους χωρίς να αναζητήσουν επαγγελματική βοήθεια</td>
<td>1 2 3 4 5</td>
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<tr>
<td>19. Εάν πίστευα ότι βρισκόμουν στα πρόθυρα ψυχικής κατάρρευσης η πρώτη μου σκέψη θα ήταν να ζητήσω επαγγελματική βοήθεια</td>
<td>1 2 3 4 5</td>
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<td></td>
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<tr>
<td>20. Αν ήμουν ανησυχούσα έναν επαγγελματικό ψυχικής υγείας, λόγο των όσων κάποιοι θα σκέφτονταν για μένα</td>
<td>1 2 3 4 5</td>
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<tr>
<td>21. Αν ήμουν οικογόνος/πρόθυμη να ζητήσω επαγγελματική βοήθεια μονάχα με δυνατές χαρακτηριστικές ικανότητες</td>
<td>1 2 3 4 5</td>
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<td>22. Θα ήμουν πρόθυμος/πρόθυμα να εμπιστευτώ προσωπικά ζητήματα στο κατάλληλο άτομο αν πίστευα ότι αυτό θα βοηθούσε εμένα ή ένα μέλος της οικογένειας μου</td>
<td>1 2 3 4 5</td>
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<td>Έχοντας λάβει θεραπεία για ψυχολογικά προβλήματα, δε θα ένιωθα ότι οφείλουν να κρατούνται κρυφά</td>
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<td>Θα ντροπιαζόμουν αν ο γείτονας μου με έβλεπε να πηγαίνω στο γραφείο ενός επαγγελματία ψυχικής υγείας</td>
<td></td>
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</tbody>
</table>

**Multidimensional Scale of Perceived Social Support**

Πολυδιάστατη Κλίμακα Λαμβανόμενης Κοινωνικής Στήριξης (Zimet, Dahlem, Zimet & Farley, 1988)

<table>
<thead>
<tr>
<th></th>
<th>Κυκλώστε τον αριθμό που αντιπροσωπεύει καλύτερα την άποψή σας για τις ακόλουθες δηλώσεις.</th>
<th>Διαφωνώ</th>
<th>Συμφωνώ</th>
<th>Συμφωνώ</th>
<th>Συμφωνώ</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Υπάρχει ένα συγκεκριμένο άτομο που βρίσκεται κοντά μου όταν χρειάζομαι βοήθεια</td>
<td>1       2       3       4       5</td>
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<tr>
<td>2</td>
<td>Υπάρχει ένα συγκεκριμένο άτομο με το οποίο μπορώ να μοιραστώ τις χαρές και τις λύπες μου</td>
<td>1       2       3       4       5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Η οικογένεια μου προσπαθεί πραγματικά να με βοηθήσει</td>
<td>1       2       3       4       5</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Παιρνώ τη συναισθηματική βοήθεια και την υποστήριξη που χρειάζομαι από την οικογένεια μου</td>
<td>1       2       3       4       5</td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>Έχω ένα συγκεκριμένο άτομο με το οποίο αισθάνομαι άνετα</td>
<td>1       2       3       4       5</td>
<td></td>
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<tr>
<td>6</td>
<td>Οι φίλοι μου πραγματικά προσπαθούν να με βοηθήσουν</td>
<td>1       2       3       4       5</td>
<td></td>
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<tr>
<td>7</td>
<td>Μπορώ να στηρίζομαι στους φίλους μου όταν τα πράγματα δε πάνε καλά</td>
<td>1       2       3       4       5</td>
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</tbody>
</table>
Μπορώ να συζητώ τα προβλήματα μου με την οικογένεια μου

Έχω φίλους με τους οποίους μπορώ να μου ρατσίστω τις χαρές και τις λύπες μου

Υπάρχει ένα οξικοφροσύνη άτομο στη ζωή μου που νοιάζεται για το πως νιώθω

Η οικογένεια μου με βοηθά πρόθυμα στη λήψη αποφάσεων

Μπορώ να συζητώ τα προβλήματα μου με τους φίλους μου

Πρακτικές δυσκολείες αναζήτησης βοήθειας από υπηρεσίες ψυχικής υγείας

*Practical Barriers in Seeking Mental Health Services (PBMHS) (Kung, 2004)*

<table>
<thead>
<tr>
<th>Πρακτικής δυσκολείας</th>
<th>Κυκλώστε τον αριθμό που αντιπροσωπεύει καλύτερα την άποψη σας για τις ακόλουθες δηλώσεις.</th>
<th>Διαφωνώ</th>
<th>Συμφωνώ λίγο</th>
<th>Συμφωνώ</th>
<th>Συμφωνώ πολύ</th>
<th>Αρκετά</th>
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<tbody>
<tr>
<td>1</td>
<td>Πιστεύω ότι μπορώ εύκολα να πάρω πληροφορίες για τις υπηρεσίες ψυχικής υγείας.</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Δε ξέρω που και πως μπορώ να έχω πρόσβαση σε υπηρεσίες ψυχικής υγείας</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Πιστεύω ότι είναι δύσκολο να βρω υπηρεσίες ψυχικής υγείας που να μου ταιριάζουν.</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
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### Vancouver Index of Acculturation Modified (VIAM) (Kalopanagiotou, 2008)

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<th>Διαφωνώ</th>
<th>Συμφωνώ λίγο</th>
<th>Συμφωνώ</th>
<th>Συμφωνώ πολύ</th>
<th>Συμφωνώ πλήρως</th>
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<td>Συχνά συμμετέχω στις τυπικές Αυστραλιανές κοινωνικές δραστηριότητες</td>
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<td>5</td>
<td></td>
<td></td>
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<td>3</td>
<td>Θα παντρευόμουν κάποιον Αυστραλό/Αυστραλή</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Απολαμβάνω κοινωνικές δραστηριότητες με τυπικούς Αυστραλούς</td>
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<td>5</td>
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<td>2</td>
</tr>
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<td>5</td>
<td>Νιώθω άνετα να δουλεύω με τυπικούς Αυστραλούς</td>
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<td>5</td>
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<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Απολαμβάνω την Αυστραλιανή διασκέδαση (για παράδειγμα, ταινίες και μουσική)</td>
<td>4</td>
<td>5</td>
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<td>7</td>
<td>Συχνά συμπεριφέρομαι με τρόπους που θεωρούνται «τυπικοί Αυστραλοί»</td>
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<td>5</td>
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<td>2</td>
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<td>8</td>
<td>Είναι σημαντικό για μένα να διατηρώ ή να αναπτύσσω Αυστραλιανές πολιτισμικές και πολιτιστικές πρακτικές</td>
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<td>10</td>
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Enculturation to Greek Identity Scale (EGI) (Harris & Herven, 1996)

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<th>Κυκλώστε τον αριθμό που αντιπροσωπεύει καλύτερα την άποψη σας για τις ακόλουθες δηλώσεις.</th>
<th>Διαφωνώ</th>
<th>Σίγουρο</th>
<th>Συμφωνώ</th>
<th>Συμφωνώ</th>
<th>Συμφωνώ</th>
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<tbody>
<tr>
<td>1</td>
<td>Οι Ελληνοαυστραλοί θα πρέπει να παντρεύονται σε Ελληνορθόδοξη Εκκλησία</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>2</td>
<td>Όταν αποκτήσω παιδιά θα τα στείλω σε Ελληνικό σχολείο</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<td>3</td>
<td>Δε θα παντρευτώ κάποιον/ κάποια που δεν είναι Έλληνας/ Ελληνίδα</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>4</td>
<td>Οι καλύτεροι μου φίλοι είναι Έλληνες</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>Νιώθω πιο άνετα όταν βρίσκομαι με Έλληνες παρά όταν βρίσκομαι με άτομα που δεν είναι Έλληνες</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>6</td>
<td>Είναι σημαντικό το άτομο που θα παντρευτώ να μιλά Ελληνικά</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Οι γονείς μου επέμειναν να μάθω να μιλώ Ελληνικά καθώς μεγάλωνα</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Η γυναίκα δεν πρέπει να λαμβάνει τη Θεία Κοινωνία κατά το διάστημα που διαρκεί η έμμηνος ρήση της</td>
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<td>10</td>
<td>Είναι/ Ήταν σημαντικό για μένα το άτομο ή τα άτομα που έχω/ είχα ερωτική σχέση μιλά/ ή μιλούν Ελληνικά</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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<tr>
<td>11</td>
<td>Είναι καλύτερο να παντρευτώ ένα φτωχό/ φτωχά Έλληνα/ Ελληνίδα παρά ένα πλούσιο/ πλούσια μη Έλληνα/ Ελληνίδα</td>
<td>1 2 3 4 5</td>
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<td>13</td>
<td>Πιστεύω στις διδασκαλίες της Ελληνορθόδοξης Εκκλησίας</td>
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<td>14</td>
<td>Συνομιλώ στα Ελληνικά με τους φίλους μου</td>
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<td>Οι περισσότεροι από τους κοντινούς μου φίλους μιλούν Ελληνικά</td>
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<td>16</td>
<td>Δεν είναι πρόβλημα για έναν Ελληνοαυστραλό ή Ελληνοαυστραλή να παντρευτεί κάποιο/ κάποια που δεν είναι Έλληνας/ Ελληνίδα</td>
<td>1 2 3 4 5</td>
<td></td>
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<td>17</td>
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<td>1 2 3 4 5</td>
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<td>18</td>
<td>Δε θα μου άρεσε το παιδί μου να έχει ερωτική σχέση με κάποιο/ κάποια που δεν είναι Έλληνας</td>
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<td>21</td>
<td>Είμαι τυχερός που γεννήθηκα Έλληνας/ Ελληνίδα</td>
<td>5 1 2 3 4</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Είναι σημαντικό για τα παιδιά των Ελληνοαυστραλών να πηγαίνουν σε Ελληνικό σχολείο</td>
<td>5 1 2 3 4</td>
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<tr>
<td>23</td>
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<td>5 1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Είναι σημαντικό για μένα, τα παιδιά μου να μιλούν Ελληνικά</td>
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<td>5 1 2 3 4</td>
<td></td>
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<td>Το ελληνικό σχολείο ήταν ένα σημαντικό κομμάτι της εξέλιξης μου κατά την παιδική μου ηλικία</td>
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</tr>
<tr>
<td>31</td>
<td>Δεν θα έβγαινα ραντεβού με κάποιον/κάποια που δεν θα ήταν Έλληνας/Ελληνίδα</td>
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<td>3</td>
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<td>36</td>
<td>Τα Ελληνικά θα έπρεπε να είναι η διεθνής γλώσσα</td>
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<td>27</td>
<td>Με τους φίλους μου συνομιλούμε στα Ελληνικά ώστε οι μη Έλληνες που βρίσκονται γύρω μας να μην καταλαβαίνουν τι λέμε</td>
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<td>3</td>
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<td>29</td>
<td>Διαβάζω Ελληνικές Εφημερίδες</td>
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<td>3</td>
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<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>33</td>
<td>Οι Έλληνες είναι πιο κοντά στο Θεό σε σύγκριση με τους μη Έλληνες</td>
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<td>3</td>
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<tr>
<td>34</td>
<td>Όταν ήμουν παιδί η μητέρα μου κρέμαζε μια εικόνα της Παναγίας και/ή του προστάτη Αγίου μου μέσα στα ρούχα μου</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>26</td>
<td>κοντινούς μου φίλους πήγαν σε Ελληνικό σχολείο</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>
Appendix C

Participants Plain Language Statement: Study One

Ψυχική Υγεία: Κοινωνικό-πολιτισμικοί καθοριστικοί παράγοντες συμπεριφορών βοήθειας.

ΥΠΕΥΘΥΝΟΣ ΕΡΕΥΝΗΤΗΣ
Νεκτάριος Άρης Αλέξη, Πτυχίο Ψυχολογίας, Μεταπτυχιακό Κλινικής Ψυχολογίας, Υποψήφιος Διδάκτωρ Ψυχολογίας.

ΥΠΕΥΘΥΝΗ ΕΠΟΠΤΡΙΑ
Καθηγήτρια Κέιτ Μούρ, Υπεύθυνη Τμήματος Ψυχολογίας του Πανεπιστημίου Τσάρλς Ντάργουιν της Αυστραλίας.

ΣΚΟΠΟΣ ΑΥΤΗΣ ΤΗΣ ΕΡΓΑΣΙΑΣ
Ο σκοπός αυτής της εργασίας είναι να εξερευνήσει τους κοινωνικό-πολιτισμικούς παράγοντες που εμπλέκονται σε στάσεις και συμπεριφορές βοήθειας σχετικά με την χρησιμοποίηση των επαγγελματικών υπηρεσιών προσφοράς Ψυχολογικής στήριξης.

ΩΦΕΛΟΣ ΠΟΥ ΘΑ ΠΡΟΚΥΨΕΙ ΑΠΟ ΤΗΝ ΕΡΕΥΝΑ
Τα αποτελέσματα αυτής της έρευνας δεν θα έχουν άμεση ωφέλεια προς το πρόσωπο σου, αλλά θα καταβάλει στην περαιτέρω θεωρητική κατανόηση των στάσεων και συμπεριφορών βοήθειας για προβλήματα ψυχικής υγείας μέσα στο κοινωνικό-πολιτισμικό πλαίσιο, αυτές οι πληροφορίες θα ενημερώσουν μελλοντικά σχέδια πρόληψης και επέμβασης για θέματα Ψυχικής Υγείας έτσι ώστε να προωθηθούν θετικά οι στάσεις και συμπεριφορές βοήθειας για προβλήματα Ψυχικής Υγείας.

ΤΙ ΠΡΟΣΔΟΚΟΥΜΕ ΑΠΟ ΕΣΕΝΑ?
Σε καλούμε να λάβεις μέρος σε αυτή την έρευνα και εάν συμφωνήσεις θα πρέπει να συμπλήρωσες ένα ερωτηματολόγιο, το οποίο θα πάρει 5-10 λεπτά από τον χρόνο σου. Επίσης θα πρέπει να δηλώσεις πληροφορείς σχετικά με την ηλικία σου, φύλο, ετήσιο εισόδημα, εκπαίδευση, κατάσταση της ψυχικής υγείας σου, παράδειγμα άλλων ερωτήσεων η δηλώσεων της έρευνας αυτής είναι: ''Έχω φίλους με τους οποίους μπορώ να μοιραστώ τις χαρές και τις λύπες μου'' και ''Δεν ξέρω απο που να αναζητήσω βοήθεια για παροχή υπηρεσίων ψυχικής υγείας''.

ΡΙΣΚΑ
Δεν υπάρχουν ειδικά ρίσκα που να σχετίζονται με τη συμμετοχή σου σε αυτή την έρευνα.

ΕΜΠΙΣΤΕΥΤΙΚΟΤΗΤΑ
Απόλυτη εμπιστευτικότητα είναι εγγυημένη μιάς και δεν θα σου ζητηθεί να παραχωρήσεις κάποιες εμπιστευτικές πληροφορίες σε καμιά φάση της συμμετοχής σου. Μόνο ομαδικές πληροφορίες θα χρησιμοποιηθούν που θα προκύψουν απο αναλύσεις και πιθανές δημοσιεύσεις που μπορεί να προκύψουν απο αυτή την έρευνα.

Η ΣΥΜΜΕΤΟΧΗ ΣΟΥ
Η συμμετοχή σε αυτή την έρευνα είναι εθελοντική και μπορείς να αρνηθείς να λάβεις μέρος. Όπως και να έχει, έχεις την επιλογή να αποσύρεις την συμμετοχή σου απο την έρευνα πρίν να παραδώσεις το ερωτηματολόγιο. Επειδή δεν ζητάμε προσωπικές πληροφορίες δεν θα είναι δυνατό να αποσύρουμε τις πληροφορίες σου σχετικά με την έρευνα εάν το παραδώσεις και μετά αλλάξεις γνώμη. Η συμπλήρωση και η παράδοση του ερωτηματολογίου στον γενικό για θέματα Ηθικής Δεοντολογίας που σχετίζεται με έρευνα στο 1800 466 215 η γράψε σε αυτή την ηλεκτρονική διεύθυνση:
cdu-ethics@cdu.edu.au

Εάν νιώσετε στρές σχετικά κατά την διάρκεια της συμπλήρωσης του ερωτηματολογίου μπορείτε να αποταθείτε στον γενικό σας ιατρό.

ΣΧΕΤΙΚΑ ΜΕ ΤΗΝ ΗΘΙΚΗ ΔΕΟΝΤΟΛΟΓΙΑ
Αυτή η έρευνα θα ολοκληρωθεί βάση του Αυστραλιανού Κωδικού Ηθικής Δεοντολογίας για Υπεύθυνη Διεξαγωγή 'Έρευνας, όπως έχει αριστευτεί από το Εθνικός Υγείας και Ιατρικής Τμήματα Συμβούλιο για θέματα Υγείας, της Αυστραλίας.
Ψυχική Υγεία: Κοινωνικοπολιτισμικοί παράγοντες που διαμορφώνουν τις συμπεριφορές και στάσεις αναζήτησης βοήθειας.

Ονομάζομαι Νεκτάριος Αλέξη, και κάνω αυτή την εργασία σαν υποψήφιος Διδακτορικού υπό την επίβλεψη της Καθηγήτριας Κέιτ Μούρ. Η εργασία αυτή έχει να κάνει με τις στάσεις σε συμπεριφορές αναζήτησης βοήθειας για ψυχολογικά προβλήματα μέσα στα κοινωνικοπολιτισμικά πλαίσια και το πώς διαφέρουν από κουλτούρα σε κουλτούρα. Εάν είσαι 18 χρονών και άνοι σε προσκαλούμε να συμμετάσχεις σε αυτή την εργασία. Εάν συμφωνήσεις να συμμετάσχεις θα σου πάρει μόνο 10-15 λεπτά από τον χρόνο σου. Δεν είναι ανάγκη να δώσεις οποιαδήποτε στοιχεία ταυτότητας μιας και θα αναλυθούν μόνο ομαδικά οποιαδήποτε στοιχεία που θα τύχει να αναφερθούν. 

Ηλεκτρονική σελίδα συμμετοχής: http://cdumes.asia.qualtrics.com/SE/?SID=SV_8IalisggQ7ObQ56

Εάν έχεις οποιαδήποτε άπορία σχετικά με την έρευνα αυτή μπορείς να επικοινωνήσεις μαζί μας σε αυτούς τους αριθμούς 0061424192277 ή 006189466511 ή σε αυτές τις ηλεκτρονικές διευθύνσεις Nektarios_Alexi@cdu.edu.au, Kate_Moore@cdu.edu.au

ΕΥΧΑΡΙΣΤΟΥΜΕ ΘΕΡΜΑ ΓΙΑ ΤΗΝ ΣΥΜΜΕΤΟΧΗ
Appendix E

Participants Plain Language Statement: Study Two

Mental illness: Socio-cultural determinants of help seeking.

CHIEF RESEARCHER
Nektarios Aris Alexi, BA Psychology, MA Clinical Psychology, PhD student, Charles Darwin University.

SUPERVISOR
Professor Kate Moore, Head of Psychology Theme, Charles Darwin University.

PURPOSE THE STUDY
The purpose of this study is to explore the socio-cultural determinants involved in help-seeking attitudes and actual behaviours for the utilization of professional mental health treatment.

BENEFITS OF THE STUDY
The results of this study will have no direct benefit to you personally, but will extend our theoretical understanding of help-seeking attitudes and actual behaviours for mental health problems in a sociocultural context, this information will inform future mental health care prevention and intervention plans to enhance help-seeking attitudes and behaviours and hence the mental health of Australians.

WHAT WOULD BE EXPECTED OF YOU?
You are invited to participate in this research and if you agree you are asked to complete an online questionnaire, which will take about 5 to 10 minutes of your time. As well as providing information on your age, gender, annual income, education, mental health status, examples of other questions or statements include: ‘‘I have friends with whom I can share joys and sorrows’; and ‘I don’t know where to seek mental health service’’.

RISKS
There are no specific risks associated with your participation in this study. If you feel any level of distress it is recommended that you contact lifeline on 131144.

CONFIDENTIALITY
Complete confidentiality is assured as you are not requested to provide any identifying information at any stage. Only group data will be used in the analyses and in any publications that arise from this study.

YOUR PARTICIPATION
Participation is voluntarily and you are free to refuse to participate. Moreover, you have the choice to withdraw from the research at any time before submitting the online questionnaire, you can do this by exiting the webpage. As we have no identifying information it will not be possible to remove your data once submitted. Completion and submission of the questionnaires will be deemed to be your informed consent to participate in this study.

RESULTS OF THE STUDY
It is not possible to provide an individual feedback but a summary, of the results will be available on a CDU website after the completion of the study.

PERSONS TO CONTACT
If you have any questions about the project, please contact the primary researcher, Nektarios Alexi, on email: Nektarios.Alexi@cdu.edu.au or Professor Kate Moore the supervisor of the project on email: Kate.Moore@cdu.edu.au. If there is an emergency or if you have any concerns before commencing, during, or, after the completion of the project, please contact the Executive Officer of the CDU Human Research Ethics Committee on (08) 8946 6498, toll free number 1800 466 215, or email cdu-ethics@cdu.edu.au. The Executive Officer can pass on any concerns to appropriate officers within the University.

ETHICAL GUIDELINES
This project will be carried out according to the Australian Code for the Responsible Conduct of Research, as defined by the National Health and Medical Research Council of Australia.

Thank you for considering this project. If you decide to continue we welcome your contribution. Please note that by submitting the completed questionnaire you will be deemed to give your informed consent to participate in this study. Should you wish to withdraw simply close your web browser.
Appendix F

Invitation of participation for Greek Australians in Study Two and Three at the Cypriot hall, Darwin

November 09/2011
Nikolaou Alexi
3 Nikasma Cres Lyons
Darwin NT

Dear Nikolaou,

I am delighted at the opportunity to have you visit our Greek-Cypriot community in order to gather data for the surveys that you have prepared for your dissertation. I will encourage and approach Greek-Cypriot immigrants of Darwin to fill out the surveys by personal and by a post of the aim of your research project in the hall where we hold our gatherings every week and I wish all the best for you as you continue your research.

Sincerely Yours,

Evan Zisis

Cyprus Community of the NT Inc.
GPO Box 841
Darwin NT 0801
Appendix G

Thank you for agreeing to participate in this study. Please answer all the following questions. (There are not right or wrong answers, we are interested in the range of answers from different people.)

Demographic Data

Gender (circle one): Male or Female

Age: _______

What is your ethnic background? ______________________

In which country were you born? ______________________

If you are Greek-Australian are you: (please circle)

1st generation? (you were born outside of Australia)

2nd generation? (you were born in Australia and have one, or both parents born out of Australia)

3rd generation? (you were born in Australia, and both of your parents were also born in Australia)

What level of education did you complete? (please circle)

1) Grade school (1-7 years)

2) Some high school (10-11 years)

3) High school graduate (12 years)

4) Tafe certificate (1-2 years)

5) Bachelor degree (3-4 years)

6) Master's degree

7) PhD

My annual income is (circle one):

1) less than $20,000

2) $21,000 to $40,000

3) $41,000 to $60,000
4) $61,000 to $80,000

5) $81,000 to $100,000

6) more than $100,000

**Mental Health Status**

1. In the last 12 months have you been diagnosed with (circle if applicable)
   - anxiety disorder: Y/N
   - depression: Y/N
   - other mental health problem: (please specify) _______________________

2. Are you receiving treatment for this disorder?: Y/N (if applicable)

3. If you were to experience a mental health problem (e.g. feeling anxious, depressed, stressed) would you seek help? (1 Not at all, 2 maybe, 3 probably yes 4 yes 5 certainly ) (Please circle)

4. If you would seek help, from whom would you seek help? (circle)
   1) General Practitioner_____________________
   2) Psychologist __________________________
   3) Psychiatrist __________________________
   4) Family member _________________________
   5) Close friend __________________________
   6) Priest ________________________________
   7) Phone Help line _______________________
   8) Partner ______________________________
   9) Teacher (year advisor, classroom teacher)
   10) I would not seek help from anyone _______
   11) Other (Please specify) __________________

You may choose more than one, but if you do please list from 1st preference downwards. (e.g 1,2,3)
5. In the past 12 months or more has any close family member or very close friend been diagnosed with: (if applicable)

- anxiety disorder: Y/N
- depression: Y/N
- other mental health problem (please specify): Y/N

6. If any of the family member or close friends were to experience a mental health problem (e.g. feeling anxious, depressed, stressed) would they seek help? (1 Not at all, 2 maybe, 3 probably yes 4 yes 5 certainly) (Please circle)

7. If they would seek help, from whom they would seek help? (circle)

1) General Practitioner
2) Psychologist
3) Psychiatrist
4) Family member
5) Phone Help line
6) Partner
7) Teacher (year advisor, classroom teacher)
8) I would not seek help from anyone
9) Close friend
10) Priest
11) Other (Please specify)

You may choose more than one, but if you do please list from 1st preference downwards.

8a) If the questions 1) and 5) were not applicable, you have finished with this section. If they were applicable please complete the last three questions.

8b) How many visits did you or the family member/close friend have with the mental health professional? __________

8c) How helpful was the visit to the mental health professional? (Please circle)

1) Extremely Unhelpful 2) Very Unhelpful 3) Unhelpful 4) Very Helpful 5) Extremely helpful

Thank you for your participation.
### Attitudes Toward Seeking Professional Psychological Help Scale.
(McKenzie, Knox, Gegoski & Mc Caulay, 2004)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Do not agree</th>
<th>Agree a little</th>
<th>Agree quite a lot</th>
<th>Agree very much</th>
<th>Agree completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There are certain problems which should not be discussed outside one's immediate family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I would have a very good idea what to do and who to talk to if I decided to seek professional help for psychological problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Mental illness carries with it a burden of shame</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. It is probably best not to know <em>everything</em> about oneself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. People should work out their own problems; getting professional help should be a last resort</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. If I were to experience psychological problems, I could get professional help if I wanted</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Psychological problems, like many things, tend to work out by themselves</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>13.</td>
<td>It would be relatively easy for me to find the time to see a professional for psychological problems</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>14.</td>
<td>There are experiences in my life I would not discuss with anyone</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>15.</td>
<td>I would want to get professional help if I were worried or upset for a long period of time</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>16.</td>
<td>I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>17.</td>
<td>Being diagnosed with a mental disorder is a blot on a person’s life</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>18.</td>
<td>There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help</td>
<td>1 2 3 4 5</td>
<td></td>
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</tr>
<tr>
<td>19.</td>
<td>If I believed I were having a mental breakdown, my first inclination would be to get professional attention</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>20.</td>
<td>I would feel uneasy going to a professional because of what some people would think</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>21.</td>
<td>People with strong characters can get over psychological problems by themselves and would have little need for professional help</td>
<td>1 2 3 4 5</td>
<td></td>
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<tr>
<td>22.</td>
<td>I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Had I received treatment for psychological problems, I would not feel that it ought to be “covered up.”</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
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<tr>
<td>24.</td>
<td>I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems</td>
<td>1 2 3 4 5</td>
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</tbody>
</table>
**Multidimensional Scale of Perceived Social Support** (Zimet, Dahlem, Zimet & Farley, 1988)

Circle the number that represents you the best for the following statements.

<table>
<thead>
<tr>
<th></th>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>There is someone close to me when I need help</td>
<td></td>
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<tr>
<td>2</td>
<td>There is someone that I can share happy and sad moments in my life</td>
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<td></td>
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</tr>
<tr>
<td>3</td>
<td>My family really tries to help me</td>
<td></td>
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<tr>
<td>4</td>
<td>I receive the emotional support and assistance that I need from my family</td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>I have a special someone, with whom I feel comfortable</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6</td>
<td>My friends really try to help me</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I can find support upon my friends when things are not so good</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>I can discuss problems with my family</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>9</td>
<td>I have friends that I can share my sad and happy moments</td>
<td></td>
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<tr>
<td>10</td>
<td>There is a special someone in my life that cares regarding how I feel</td>
<td></td>
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<tr>
<td>11</td>
<td>My family helps me willingly with my decision making</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I can discuss my problems with my friends</td>
<td></td>
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</tbody>
</table>
**Vancouver Index of Acculturation Modified** (Karapanagiotis, 2008)

Circle the number that represents your opinion the best regarding the following statements.

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>In order to succeed I have to be fluent with English.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>I usually participate in typical Australian activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>I would marry an Australian citizen</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>I enjoy social activities with typical Australians.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I feel comfortable working with typical Australians.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>I enjoy the Australian entertainment (For example movies and music)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>I usually act in ways that are considered «typical» Australian</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>It is important for me to preserve and develop Australian social and cultural practices.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>I believe in typical Australian values</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>I enjoy Australian typical jokes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>I am interested in having Australian friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
**Enculturation to Greek Identity** (Haris & Herven, 1996)

Circle the number that represents your opinion the best regarding the following statements:

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The Greek-Australians should be married in a Greek Orthodox Church</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>When I have kids, I will send them to a Greek school</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>I will not marry someone that is not Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>My best friends are Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>I feel more comfortable when I am with Greeks rather when I am not with Greeks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>It is important for me, the person I will marry to be able to speak Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>My parents insisted in me learning Greek while I was growing up</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>The woman should not receive holy communion while she is menstruating</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>The Greek parents should make sure that their kids go to a Greek orthodox church</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>It is/was important for me the person/persons that I have/had romantic relationship to speak Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>It is better to marry a poor Greek rather a rich non Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>Given I have the opportunity, I prefer to speak Greek rather than English</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>I believe in the teachings of the Greek Orthodox Church</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>14.</td>
<td>I speak in Greek with my friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>Most of my closest friends speak in Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>It is not an issue for a Greek-Australian to marry someone that is not Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>I need my kids to grow up and be Greeks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>I wouldn’t like it if my child had romantic relationship with someone that is not Greek.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>I enjoy being Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>While I was growing I used to go to a greek school</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>I am lucky for being born Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>It is important for the children of Greek-Australians to go to a Greek school</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>With my family I speak in Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>It is important for me that my kids speak in Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>It bothers me that some Greek-Australians don’t speak Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26.</td>
<td>Most of my closest friends went to a Greek school</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27.</td>
<td>With my friends we speak Greek so that non-Greeks being around us won’t be able to understand what we say</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28.</td>
<td>I can discuss all subjects using the Greek language</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29.</td>
<td>I read Greek newspapers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30.</td>
<td>Greek should be the national language</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31.</td>
<td>I wouldn’t date a non-Greek</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32.</td>
<td>I read Greek magazines</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33.</td>
<td>The Greeks are closest to god rather then non-Greeks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34.</td>
<td>When I was a child my mother used to hung a picture of Holy Mary or my Saint Keeper inside my clothes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>35.</td>
<td>The Greek school was an important part of my childhood development</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
**Perceived barriers in seeking mental health service** (Phoenix & Mak, 2009)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Agree a lot</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I believe I can easily access information regarding mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I don’t know where and how I can get access with mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I can’t afford to pay the expenses for mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. The procedures for access and use of mental health services are time consuming.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. The procedures for access and use of mental health services are complicated.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I believe is hard to find mental health services that suit to my needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix H

Ethics Approval for Study Three

17 November 2014

Miktoris Alexi
School of Health
Via email

Dear Miktoris,

RE: HL2024 - Mental Health: Socio-cultural Determinants of Help Seeking

Human Research Ethics Committee - Variation Approval

The Chair of the Charles Darwin University Human Research Ethics Committee (HREC) considered your variation request regarding the above mentioned project out of session.

The HREC Chair has approved the variations to undertake interviews as part of the approved protocol.

The expiry date of ethics approval for your project is 08/06/2015. It is the responsibility of the researcher to ensure that ethics approval is renewed prior to the expiry date. If further renewal is necessary, you will need to submit a progress report that outlines a statement of compliance with ethical requirements and details of any planned or actual changes to the project that may affect its ethical acceptability. Renewal/First Report forms are available from the Web at: http://www.cdu.edu.au/research/our/human-ethics or from the Office of Research & Innovation.

If any significant alterations to your project are contemplated, or if any matters arise which may in any way affect the continued ethical acceptability of the project, you are required to immediately notify the Human Research Ethics Committee by letter or email.

Yours sincerely,

[Signature]

Dr Bey Turnbull
Chair, Human Research Ethics Committee
Appendix I

Participants Plain Language Statement: Study Three

Research project
Mental illness: Socio-cultural determinants of help seeking

Chief Researcher
Nektarios Alexi: Doctor of Philosophy candidate, Charles Darwin University.

Supervisors
Professor Kate Moore, Charles Darwin University
Associate Professor Cindy Wall, Charles Darwin University

Purpose of the study
The purpose of this study is to explore the socio-cultural determinants involved in help-seeking attitudes and intentions to seek professional help for a mental health issue. We are looking to explore these factors among a range of people who may, or who may not, have experienced a mental health problem.

Benefits of the study
The results of this study will have no direct benefit to you personally, but will extend our theoretical understanding of help seeking attitudes and intentions for mental health problems in a sociocultural context. This information will inform future mental health care promotions and interventions to enhance help seeking attitudes and behaviours.

What will be expected of participants?
If you decide to take part in this study you will be asked to attend a one-on-one interview with the researcher at a location suitable to you. This will involve speaking about your ideas and understanding of mental health help seeking.

This interview will take approximately 10-15 minutes. With your permission, the researcher will audio tape the discussions and transcribe the tape soon after the interview. If you feel you do not want conversations taped, please inform the researcher. The tapes will be destroyed once the discussions have been transcribed. No names will be recorded and no information will be identifiable.

Before the interview you will be asked to sign an informed consent statement. Participation in the study is voluntary and you can refuse to answer any questions or withdraw from the study at any stage. Any information you had contributed would then be deleted.

Participants will not be identifiable in the thesis and any publications that result from this research as pseudonyms will be used to maintain confidentiality.

Risks
There are no specific risks for participants taking part in this project however should you feel discomfort as a result of discussing the interview content, counseling support is available from the following organizations at no cost to yourself:

Danila Dilba Darwin: (08) 8927 9335, 13 Malak Place, Malak 0812
Anglicare: (08) 8985 0000, 5 Nemarluk Dr Darwin 0800
Sommerville Community Services: (08) 8945 0945, 147 Lee Point Road Wagaman 0810
Relationships Australia NT: (08) 8923 4999, 43 Cavenagh Street Darwin 0800
Lifeline: 24 hr support Ph. 13 11 14

Confidentiality
The researcher will maintain full confidentiality of your details. No names or other identifying material will be sought or recorded. The signed consent form will be maintained separately from the interview data. The audiotapes will be kept secure in a locked cabinet and they will be destroyed once transcription of the discussions is completed.

Your participation
As mentioned above your participation in this project is voluntary.

Results of the study
A summary of the project findings will be available early in the New Year to participants who request these.

Persons to contact
If you would like to take part or have any questions about the project, please do not hesitate to contact the researcher, Nektarios Alexi on 088947462 or by email: Nektarios.Alexi@cdu.edu.au

If there is an emergency or if you have any concerns before, during or after the project has finished please contact the Executive Officer of the CDU Human Research Ethics Committee by phone: (08) 8946 6498 or email: cdu.ethics@cdu.edu.au. The Executive Officer will pass on any concerns to the appropriate officers at Charles Darwin University.
Appendix J

Consent form: Study Three

CHARLES DARWIN UNIVERSITY
CONSENT FORM: INTERVIEWS AND USE OF AUDIOTAPE

I, (full name of participant), _______________________________,
Of (address) ___________________________________________

Herewith consent to participate in the project undertaken by Nektarios Alexi- Doctor of Philosophy candidate at Charles Darwin University and understand that the purpose of the research is to extend our theoretical understanding of help seeking attitudes and intentions for mental health problems in a sociocultural context. This information will inform future mental health care promotions and interventions to enhance help seeking attitudes and behaviours.

Please tick the box if you give consent:

☐ Yes, I give consent to undertake one on one interviews with Nektarios
AND
☐ Yes, I give consent to have my responses (during the interview) audiotaped
OR
☐ No, I do not give consent to have my responses (during the interview) audiotaped

I acknowledge

1. That the aims, methods and anticipated benefits and possible research of this study have been explained to me by Nektarios Alexi.
2. That I freely and voluntarily give consent for my participation in this study.
3. All interview information will be coded and my name will be kept separately from this information.
4. Any information that I provide will not be released in an identified form.
5. The audiotape recording will be destroyed when transcription is made maintaining confidentiality.
6. I understand that aggregated results will be used for research purposes and may be reported in professional journals.
7. Individual results will not be released to any person, except at my request and on my authorisation.
8. That I am free to withdraw consent at any time during the study, resulting in all my information being destroyed.

Signature of participant : ________________________________ Date ___/___/____