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An Exploratory Study of the Impact of Stigma and Acculturation on the Perception of Mental Illness in the Black Community

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AN EXPLORATORY STUDY OF THE IMPACT OF STIGMA AND ACCULTURATION ON THE PERCEPTION OF MENTAL ILLNESS IN THE BLACK COMMUNITY

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Abstract

Mental health stigma serves as a chronic barrier to help-seeking and in some cases exacerbates mental health conditions (SAMHSA, 2013). Researchers and clinicians have tried many different methods to reduce these negative attitudes. A popular and usually successful method is education on what mental illness is, its causes, prognosis, and the availability and effectiveness of treatment. Large scale educational efforts have not been adequate in addressing these issues. Therefore, studies are being tailored to find stereotypes within specific communities so as to come up with matching educational protocols (Corrigan & Penn, 2015). The current study explored attitudes among African Americans in comparison to Black immigrants concerning mental illness stigma and accessing mental health services and also examined the effect of acculturation on these attitudes. A convenience sample of African American and Black Immigrant adults completed a battery of inventories including the following: A demographic survey, The Community Attitudes toward the Mentally Ill scale (CAMI), and the Immigrant Bicultural or Multicultural Identity Scale (IBMI). All 68 participants completed the CAMI scale and the demographic survey, and the 44 immigrant participants completed the IBMI scale in addition. Findings indicated that African Americans were equally sympathetic and compassionate as Black immigrants but were more apprehensive of mental health care facilities located in their neighborhoods. Also, Black immigrants who had lived in the U.S longer endorsed more positive attitudes than the recently immigrated.

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To my family and friends, thank you for the love and the laughs, and for believing in me, even when I did not believe in myself.

Dedication

This dissertation is dedicated to my wife, Lawrencia, and my son, Lionel.

“Thank you for making me smile;

thank you for making me laugh;

thank you for pushing me but not letting me fall;

and thank you for being you,

because of you, I can now stand tall.”

(Anonymous)

Chapter I

Statement of the Problem

Researchers have unanimously indicated that stigma has a negative impact on mental health (MH). Mental health stigma serves as a chronic barrier to help-seeking behavior and in some cases exacerbates MH conditions (Substance Abuse and Mental Health Services Administration, 2013). Stigma refers to attitudes and beliefs that lead people to reject those they perceive as different. These attitudes are influenced by factors such as personal knowledge about mental illness (MI), cultural stereotypes, spirituality, media stories, and local institutional practices (Gangi et al., 2016). The fear of or actual experience of stigmatization can lead individuals to delay, avoid, or disengage from treatment. Stigma often persists as a barrier even when access issues such as insurance and transportation are controlled.

Researchers and clinicians have used many different methods to reduce these negative attitudes. A popular and usually successful method is education on what MI is, its causes, prognosis, and the availability and effectiveness of treatment. Education seeks to replace stereotypes and myths with accurate information. However, large public education initiatives and mass media campaigns have reported mixed, limited, or no results (Stuart, 2016). Consequently, studies that are tailored to examine stereotypes within specific communities to come up with matching educational protocols are more effective and preferred (Corrigan & Penn, 2015; Stuart, 2016). Many researchers have studied racial and ethnic differences in attitudes towards MI. Some of the findings were

that, ethnic minorities were more likely than Caucasians to mention spirituality (for example, “I am feeling sad/depressed because I have sinned against God and this is my punishment”) in relation to the causes of MI (Raglin Bignall et al., 2015), and their MH service use was half that of Caucasians. These studies, however, tended to treat minority groups as homogeneous populations. These studies usually listed “Black or African American” to represent everyone who identified as Black, classified them into one group, and reported the same findings for all of them with no attention to sub-groups such as immigrants and the potential differences therein. Considering that 3.8 million individuals who identify as Black are immigrants (United States Census Bureau, 2014) with different cultural backgrounds and institutional practices, significant differences in attitudes towards MI is expected. This is why it is important for researchers to pay attention to and report sub-group differences in studies to help arrive at a better understanding of the MH needs and attitudes of Black immigrants as it compares to African Americans.

For the purposes of this study “Black people” were characterized as individuals who self-identified as Black with respect to racial classification/skin color. “African American” was used to represent Black individuals who identified as American with respect to ethnicity and “Black immigrants” constituted Black individuals who identified as immigrant and/or with an ethnic group outside the United States (U.S).

Chapter II

Literature Review

Public attitudes towards individuals with MI, and their families, have historically been very poor (Alvidrez, Snowden, Rao, & Boccellari, 2009). A study conducted in Australia found that nearly one in four individuals felt depression was a sign of weakness. Additionally, one in five participants said if they had depression, they would not tell anybody. Finally, nearly two-thirds of participants thought individuals with schizophrenia were unpredictable and a quarter felt they were dangerous (Western Australia Mental Health Commission, 2010). Researchers have found that these attitudes were the result of a lack of knowledge about MI and its causes, symptomatology, and prognosis. Some of the popular misconceptions people held about MI were more specific to severe mental illnesses (SMIs) such as: persons with severe mental illness (SMI) should be feared, and therefore, should be kept out of communities, and persons with SMI were irresponsible and their life decisions should be made by others (Corrigan & Penn, 2015). Regarding other MH conditions, such as depression and anxiety, individuals were seen as weak or lazy and those with substance use disorders were seen as having failed morally (Barry, McGinty, Pescosolido, & Golman, 2014).

Corrigan and Penn (2015) indicated that individuals were less likely to hire people labeled mentally ill or to lease them apartments and more likely to falsely press charges against them for violent crimes. These negative attitudes, sometimes referred to as stigma, lead to prejudice and discrimination against individuals who were experiencing

MI. In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that the attitudes and beliefs individuals hold about MI determined how they interacted with and how much support they provided a mentally ill person. People's beliefs and attitudes towards MI also framed how they expressed their own emotional problems and psychological distress, as well as, whether they disclosed these symptoms and sought care. When attitudes were positive, there were supportive and inclusive behaviors, but when they were negative, there was avoidance, exclusion, exploitation, and discrimination (SAMHSA, 2013).

According to The California Mental Health Services Authority (CalMHSA), MI related stigma falls into three categories: public stigma, institutional stigma, and self-stigma. The attitude of the public toward the mentally ill and their family members is known as public stigma. Institutional stigma refers to an organization's policies or culture of negative attitudes and beliefs towards MI. Self-stigma occurs when a mentally ill individual internalizes these negative misconceptions. By internalizing negative beliefs, individuals often experience feelings of shame, anger, hopelessness or despair which keep them from seeking social support and treatment for their MH conditions (CalMHSA, 2017).

A SAMHSA report on MH service use among adults indicated that only 38% of adults with diagnosable MH conditions sought treatment. This report was based on data from the 2008 to 2012 National Surveys on Drug Use and Health (NSDUH). The surveys were administered to a sample of non-institutionalized population of the U.S aged 12 or older and excluded homeless people who did not use shelters. The low percentage of diagnosable persons was in part attributed to negative attitudes and beliefs about MI.

Researchers found that negative attitudes toward individuals with MH problems created barriers to treatment (Gangi, Yuen, Levine, & McNally, 2016; Lannin, Vogel, Brenner, Abraham, & Heath, 2016). Such attitudes also created obstacles for public health primary prevention efforts designed to minimize the onset of MI, as well as for secondary prevention efforts aimed at promoting early treatment to prevent worsening of symptoms (Center for Disease Control and Prevention (CDC), 2012). Negative attitudes towards MI can also have a systemic effect. For example, untreated symptoms can affect the individual's ability to find and keep a job, which often affects their family.

One of the main approaches organizations (e. g. CDC, SAMHSA, National Alliance for the Mentally Ill, & The Center for Mental Health Services) use to help reduce stigma toward the mentally ill is public education (Corrigan & Penn, 2015). Public education addresses stereotypes and prejudice by providing contradictory information. These stereotypes are informed by culture, ethnicity, race, and spirituality (SAMHSA, 2013), and to provide effective education, it is essential to conduct targeted training that is considerate of each community's specific beliefs and attitudes (Alvidrez et al., 2009; Corrigan & Penn, 2015; Stuart, 2016).

Many researchers have studied different racial or ethnic group's corresponding attitudinal differences towards MI. Raglin Bignall et al. (2015), examined attributions of MH disorders among African American, Asian American, Hispanic, and Caucasian participants. They found that ethnic minorities were more likely than Caucasians to mention spirituality in relation to causes of MI. The existing research however, like the study mentioned above, observed/studied attitudes of African Americans or individuals who identify as Black (usually used interchangeably) without considering subgroup

differences and the difference in attitudes this may reveal. The current study explored the attitudes towards MI of African Americans and Black immigrants. This study also examined whether the process of acculturation has any effect on these attitudes.

According to the U.S Census Bureau (2014), 13.4% of the U.S population identify themselves as Black and according to data from the NSDUH (2015), 16.8% of Black adults had a diagnosable MI the year before. SAMHSA estimated MH service use among Black adults to be half that of their Caucasian counterparts. On the other hand, the estimate of inpatient service use among Black adults was double that of Caucasians. Among other factors, Black adults were more likely to delay using MH services until the severity necessitated inpatient services (SAMHSA, 2015). The NSDUH did not report any information on sub-group differences. That is, individuals who identified as Black were categorized as a homogeneous group; there was no information on prevalence of MI among Black immigrant adults or their MH service use.

According to a Pew Research Center report (Anderson, 2015) 3.8 million Black immigrants lived in the U.S. The number of immigrants had quadrupled since 1980, and this rapid growth was expected to continue. A study by Nadeem, Lange, Edge, Fongwa, Belin and Miranda (2007) examined the extent to which stigma related concerns about MI care accounted for the underuse of MH services among low-income Black immigrants, African Americans, and Latina women. The authors found that stigma related concerns were more common among immigrant women compared to African American women. Other researchers found differences in attitudes towards MI when demographic variables such as age (Schomerus, Van der Auwera, Matschinger, Baumeister, & Angermeyer, 2015), gender (Williams & Pow, 2007), and level of

education (Barke, Nyarko, & Klecha, 2011) are considered. According to Anderson (2015), there were significant differences in demographic variables such as educational attainment, average age, poverty status, and marital status among African Americans, and the various groups of Black immigrants (Anderson, 2015). A difference in attitudes towards MI is, therefore, expected.

History of Mental Illness

The World Health Organization (WHO) defines MH as a state of well-being in which individuals realize their own abilities, can cope with the normal stresses of life, can work productively, and are able to make a contribution to their communities (WHO, 2014).

Throughout history, the way the mentally ill are treated has changed in relation to societal values and knowledge of MI. For example, there is evidence of the attribution of MI to biological causes as well as demon possession in the fourteenth century. During that era, ancient civilizations mostly ascribed supernatural causes to MH problems. Most people who exhibited forms of hallucination, delusion, or "deviant" behavior (behavior that was not culturally appropriate) were deemed to have been possessed by the devil or experiencing some form of punishment from a supreme being (Farreras, 2019; Foerschner, 2010). As a consequence, these individuals were often locked away, chained to trees, or even killed through burning or drowning in a ritual exorcism (Foerschner, 2010). Common treatments included prayer rites, relic touching, confessions, and atonement (Farreras, 2019). MI was also thought to have been contagious and hereditary, as a result, affected individuals and their families were shunned and shamed.

Such was the popular view of MI in most parts of the world including the U.S into the 18th century, when the Mental Health Reform Movement (MHRM) began. The MHRM was a concerted effort towards improving the treatment of the mentally ill. The basis of improving the treatment, was first, to change societal thinking as to how the mentally ill were viewed. In the 1840s, the MHRM, led by Dorothea Dix, began lobbying for better treatment conditions for the mentally ill. This resulted in the creation of 32 state psychiatric hospitals and sweeping reforms of asylums across the world (Foerschner, 2010). The advent of the science of psychology has helped to move the public perception of MI from demonology to the biopsychosocial model which considers genetic predisposition, psychological stressors, and sociocultural factors (Farreras, 2019). However, members of some communities still attribute MI to other causes such as moral failings, personal weakness, religious factors, and evil spirits (Knettel, 2016).

History of Mental Illness in African Americans

According to Wilson and Williams (2004), the MH of African Americans has historically been examined using Caucasians as the standard of comparison, and this is reflected in most of the available empirical data on African American MH. This data also reflects the prevailing socio-political ideas at the time (slavery and racism). Census studies from 1840 to 1930 suggested that Black individuals had higher rates of "insanity" than Caucasians (Wilson & Williams, 2004). Due to the absence of empirical data and a standardized definition of insanity, researchers relied on their own judgment, subjectively diagnosing MI. For example, in 1851, American physician Samuel Cartwright, described a mental disorder called "Drapetomania" as a diagnosis of slaves who preferred freedom even when their masters treated them well (Jarvis, 2008; Metzl, 2010). Whipping and the

removal of both big toes were the prescribed treatment methods for this disorder. Medical journals of the era also described "Dysaesthesia aethiopis" as a form of madness that afflicted slaves who were "rascal" and "disrespectful of their master's properties." This was also believed to be cured by whipping (Metzl, 2010). According to Metzl (2010), some leading academic psychiatrists at the turn of the twentieth century continued to posit that "negroes were psychologically unfit for freedom." Researchers from the 1940s to 2000s have defined MI on the basis of psychological distress, psychiatric disorders, or psychological well-being (Wilson & Williams, 2004). Overall, there have been no clear pattern of findings for racial differences in prevalence of MI as some studies have reported higher levels for Black people, while others have reported lower levels for them, or no difference between the two groups (Wilson & Williams, 2004).

The accuracy of the psychological or psychiatric diagnoses of African Americans has also been controversial from the first version of the Statistical Manual for the Use of Institutions for the Insane through the five editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Garretson, 1993; Jarvis, 2008; Metzl, 2010).

Adebimpe (1981), reviewed three main reasons for misdiagnosis of Black patients: Social and cultural distance between the patient and the clinician, cultural bias in the diagnostic process, and stereotypes of Black psychopathology. The subjective nature of data collection by clinicians has been a constant source of error, and when the clinician and the patient come from different cultural, social, or ethnic backgrounds, these errors have been worsened by differences in mode of communication, value systems, and expression of distress. There is a significant negative correlation between social cultural distance between clinician and patient and the rapport needed for a thorough evaluation

(Adebimpe, 1981). Some of the stereotypes of Black patients that can lead to more severe diagnostic errors than white patients are the Black patient's alleged; greater proneness to hostility, lacking in motivation for treatment, primitive character structure, not being psychologically minded, and being impulse ridden (Adebimpe, 1981). Adebimpe also noted the biased nature of diagnostic instruments that do not take racial differences into consideration as one of the causes of misdiagnosis in black patients.

Williams and Williams-Morris (2000), noted that racism in societal institutions could contribute to poor living conditions and limited access to needed resources, which in turn, could affect MH status. Furthermore, experiences of discrimination can induce physiological and psychological reactions that negatively affect an individual's MH status. Finally, the internalization of societal stigma of inferiority and second-class citizenship could lead to elevated rates of MH problems.

Black Immigrant Mental Health

In spite of the growing number of African immigrants, their MH needs and culturally relevant treatment options remain poorly understood (Venters, Adekugbe, Massaquoi, Nadeau, Saul, & Gany, 2011). Difficulties transitioning into the new culture, homesickness, discrimination and racism, financial difficulties and financial responsibility to their families in their home countries, and deportation risk were thought to be some of the causes of MH problems among African immigrants (Nsamenang, 2016).

In 2004, a detailed study called the National Survey of American Life (NSAL) was conducted to study racial, ethnic, and cultural influences on mental disorders and MH. The researchers Jackson, Torres, Caldwell, Neighbors, Nesse, Taylor, Trierweiler

and Williams, explored racial and ethnic differences in stressors, risk and resilience factors, and coping resources. They interviewed 3,570 African Americans, 1,621 Black Caribbean immigrants, and 891 Caucasians aged 18-years and older. A unique component to this study was the inclusion of Black Caribbean immigrant participants. This study had limitations such as the potential inaccuracies in participant self-report of symptoms, it nevertheless, shed some light on the heterogeneity of the Black population in the U.S. There have been additional studies based on the NSAL findings that have provided a little more understanding of the MH needs of Black Caribbean immigrants than what is available for Black African immigrants.

Prevalence of Mental Illness

According to the American Psychological Association (APA), African Americans were no different with respect to the prevalence of MH conditions when compared to the rest of the population (APA, 2019). The National Alliance on Mental Illness (NAMI) reported however that, African Americans were 20% more likely to experience serious MH problems than the general population. This difference was attributed to increased risk factors such as homelessness, and early exposure to violence. African Americans made up 40% of the homeless population and their children were more likely to have been exposed to violence than other children (NAMI, 2019). Lack of information and the misunderstanding about MI, misperceived as personal weakness or some sort of punishment from God, may have contributed to African Americans' reluctance to discuss MH issues and low treatment seeking behavior. Researchers found that African Americans tend to rely more on faith, family, and social communities for emotional support rather than turning to health care professionals when medical or psychological

treatment may be necessary (NAMI, 2019). The lower rate of MH service use among African Americans, compared to Caucasians, has also been attributed to inadequate access to and availability of quality and culturally competent care (APA, 2019; NAMI, 2019; SAMHSA, 2015).

As already stated, The NSDUH and other data collection agencies tend to put all individuals who identify as Black into one category and as such there is little to no current information on the prevalence rates of MH conditions among Black immigrant populations, especially African Immigrants. There are some studies on the use of MH services by immigrants generally. A meta-analysis of peer-reviewed studies on immigrant MH by Derr (2016), revealed that immigrants had an equal or greater need for MH services, but had lower usage compared to non-immigrants. Studies have noted the lack of insurance, high cost, documentation issues, and language difficulties as some of the main barriers to immigrant service use (Bauldry & Szaflarski, 2017; Derr, 2016).

Salas-Wright, Vaughn, Goings, Miller, and Schwartz (2018) reported that immigrants were significantly less likely than U.S born individuals to meet criteria for MH disorders or to report parental history of psychiatric problems. This finding was attributed to the healthy immigrant hypothesis; it posits that "individuals who are inclined to migrate and able to do so successfully are part of a uniquely healthy and psychologically hardy subset." This study was based on the 2012-2013 National Epidemiologic Survey on Alcohol and Related Conditions, a nationally representative survey of 36,309 adults in the U.S. A major limitation of this study is that it was based on the self-report of participants, but the researchers were not able to account nor control for

cross-cultural biases relevant to the diagnosis of MH disorders; this appeared to be an inherent limitation of many studies that supported the healthy immigrant hypothesis.

According to an analysis of the NSAL (Williams et al., 2007), Caribbean immigrant Black men had higher risks for 12-month rates of psychiatric disorders compared to African American men. These researchers suggested that the Caribbean immigrants were at higher risk for MH problems because they were both immigrant and Black, and as such, faced additional discrimination compared to African Americans or Caucasian immigrants. They concluded that risks varied by immigration history, and generational status within the Caribbean immigrant sample. First generation Caribbean Blacks had lower rates of psychiatric disorders compared with the second or third generations. This finding was also attributed to the healthy immigrant hypothesis. As with the Salas-Wright et al, (2018) study, this study was based on the self-report of participants and the researchers could neither account nor control for cross-cultural biases relevant to the diagnosis of MH disorders. Another limitation of this study was its cross-sectional nature, providing very little generalizability to the current period. The data for this study was gathered from February of 2001 to March of 2003.

Immigration

Immigration is generally defined as the international movement of people into a country of which they are not natives in order to settle as permanent residents, naturalized citizens, or to take up employment as migrant workers. The U.S census bureau (2014) indicated that there were 42.4 million immigrants in the country, and 3.8 million of them were Black. For the purposes of this study, particular attention was paid to Black immigrants, specifically those from Africa and the Caribbean regions. African and

Caribbean immigrants made up approximately 86% of the 2014 Black immigrant population, with South Americans, Central Americans, Europeans, and South East Asians making up the remaining 14%. Jamaica and Haiti were the largest source countries for the Caribbean region and Nigeria and Ethiopia were the largest source countries for Africa.

At the end of the eighteenth century, almost all of the Black people in the U.S were brought in as slaves from Africa. Black people who voluntarily migrated around this time were mostly labor migrants from the Caribbean region. An immigration policy known as the National Origins Quota system was passed in 1921 and revised in 1924. This policy assigned each country a 2% quota of their total number of residents in the U.S per the 1890 census. This policy favored Northern and Western Europeans, with Great Britain, Ireland, and Germany alone qualifying for 70% of all available visas. There was very little immigration of Black people for the next few decades (Anderson, 2015; Center for Immigration Studies, 2019).

In 1965, the U.S congress replaced the quota system with The Immigration and Nationality Act. This new act which was in favor of reuniting families and attracting skilled labor started the modern wave of Black immigration; with Caribbeans immigrating in notably larger numbers. Additionally, the Refugee Act of 1980, an amendment to the Immigration and Nationality Act of 1965, further loosened restrictions, allowing immigrants from conflict areas such as Ethiopia and Somalia to seek Asylum. Also, the Diversity Visa Program, established through the Immigration Act of 1990 has been frequently used by African migrants to gain entry into the U.S. This program was

introduced to encourage immigration from underrepresented countries (Anderson, 2015; Center for Immigration Studies, 2019).

Caribbean immigrants have been more likely to be admitted to the U.S through family ties and more likely to gain U.S citizenship status than their African counterparts. African immigrants were more likely to be admitted as refugees and asylum seekers, and through the diversity visa program (Migration Policy Institute, 2012). Many Black immigrants have migrated to the U.S for reasons such as escape from political conditions and social unrest in their home countries, family reunion, interest in higher education, and economic stability (Kent, 2007).

Rogers-Sirin, Ryce, and Sirin (2014) described Immigration as "a life changing cultural experience that involves dealing with a variety of challenges with MH implications." Immigrants deal with pre-migration stressors such as exposure to trauma, economic hardship, political involvement, disruption of social support, and loss of extended family; migration stressors such as uncertainty about outcome of migration; and post-migration stressors such as unemployment or underemployment, discrimination, inadequate access to resources, concern about family members left behind, loss of family and social support, and difficulties with acculturation (Kirmayer et al., 2011).

Acculturation

Acculturation was originally understood as a unilinear process through which individuals of a minority group adapt the culture of a majority group they are in constant contact with while growing increasingly distant from their own culture of origin (Berry, 1997). With this view, maintenance of one's original culture and adaptation to the host culture were mutually exclusive; an individual was either acculturated or not. The

contemporary view of acculturation is a bilinear one, based on the assumption that members of a minority group can retain their native culture and also adapt to the host culture (Berry, 1997; Yoon et al., 2013). John Berry's model of acculturation is a popular bilinear view. Among other things, Berry enumerated two main issues, acquisition of host culture and retention of culture of origin. Based on these two factors, he posited four acculturation strategies: assimilation, separation, integration, and marginalization (Berry, 1997).

Assimilation occurs when individuals adopt the host culture over their original culture. In contrast, when individuals reject the host culture in favor of their original culture, there is separation. Integration is when individuals are able to adopt the host culture while harmoniously preserving their culture of origin. Berry (1997) noted that individuals experience marginalization when they reject both their culture of origin and the host culture.

In a review of the literature, Schwartz, Unger, Zamboanga, and Szapocznik (2010) presented acculturation as a more nuanced concept that was not fully explained by Berry's model and called for an extension and expansion of the construct. The researchers discussed the role of ethnicity, cultural similarity, and discrimination in the acculturation process. They stated, for example, that, English speaking Jamaicans were likely to experience less acculturative stress and discrimination in the U.S compared to their French speaking Haitian counterparts. Schwartz at al., noted these as some of the major factors that were not discussed/considered in Berry's model. They also noted that many of the studies on acculturation and health outcomes continued to use unilinear anchors such as place of birth and number of years in the host country.

Many researchers have found that the process of acculturation and associated difficulties such as, learning a new language, new norms for social interactions and unfamiliar rules and laws result in psychological stress, which can have a negative effect on an individual's MH (Berry 1997; Pittman, Kim, Hunter, & Obasi, 2017; Wong, Correa, Robinson, & Lu, 2017; Maldonado, Preciado, Buchanan, Romero, & D'Anna-Hernandez, 2017).

In this current study acculturation was explored using both unilinear and bilinear markers.

Attitudes Towards Mental Illness

Gilbert, Bhundia, Mitra, McEwan, Irons and Sanghera (2007) conducted a study in England that explored the differences in shame-focused attitudes towards MH problems in Asian and Non-Asian students. They considered external shame (i.e. beliefs that others will look down on them if they had MH problems), internal shame (i.e. negative self-evaluations), and reflected shame (i.e. beliefs that one can bring shame to their community). The researchers used 186 female University undergraduates, with 89 self-identifying as Asian (42=Hindu, 16=Sikh, 23=Muslim, 8=N/A). Four self-report measures were used; the 35-item Attitudes Towards Mental Health Problems scale, the 36-item Asian Values Scale, the 8-item Disclosure Expectation Scale, and the 7-item Confidentiality Scale. A significant difference was found between the two groups as Asian students were more focused on external and reflected shame than Non-Asian students. The researchers did not make available the racial composition of the Non-Asian students, and their religious backgrounds were not made available either. Also, the demographic variables of the participants used (i.e. female undergraduate students aged

18-46, mean age = 20.93), reduced the generalizability of their results. The current study provided all available demographic information of participants. The participant pool involved non-students and males.

In another study, Knettel (2016) surveyed 158 English speaking authors of scholarly articles in Psychology from 65 different countries to examine beliefs about the causes of MI. The authors reported beliefs they had observed among members of their countries related to attributions of MI. All participants were presented with one qualitative question: "What beliefs do people from your country hold about the causes of MI?" They responded to this question in a paragraph form. Participants were also asked to respond to a series of 52 items including beliefs associated with supernatural causes, interpersonal stress, chance, fate, and substance abuse. They were asked to score each of the 52 items as to its importance for people in their country using a 7-point Likert type scale.

The participants were grouped into nine regions: (a) Latin America and Caribbean, (b) Canada and the U.S., (c) Sub-Saharan Africa, (d) North Africa and the Middle East, (e) Europe, Central Asia, and Russia, (f) South Asia, (g) East Asia, (h) Southeast Asia and Oceania, and (i) Australia and New Zealand. Participants were 53.8% female and 46.2% male, with a mean age of 42.4 years (range 21 - 84). Geographic region was found to significantly predict responses on several categories of the attributions, particularly those related to supernatural forces. The researchers observed that Latin American, Sub-Saharan African, Middle Eastern, and Southern Asian regions were more likely to attribute MI to supernatural causes. Canadian/American (U.S), European, Russian, and Australian regions were more inclined to believe that MI was due

to heredity and social stress. The main limitation of this study was the assumption that the participants were equipped to represent the views of all people in their country.

Raglin Bignall et al. (2015), also sought to find out what various ethnic groups consider as the causes of MI. These researchers conducted focus groups with African American, Asian American, Latinx/Hispanic, and Caucasian participants. A total of 34 participants were involved in one of seven focus groups with each focus group containing three to eleven participants of similar racial/ethnic origin. Out of the 34 participants, eight were African Americans, six Asian Americans, nine Latinx/Hispanics, and 11 Caucasians. The participants were predominantly female (82%), they were all over 18 years, and 49% were members of the community, with the other 51% being college students. The participants were each given 19 case vignettes, with each case representing a disorder from one of the major categories in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).

After reading each vignette, participants were asked to provide explanations for the behaviors of the characters in the vignettes. The researchers categorized participant responses into 12 themes: Biological, Normalization (e.g. older people act that way because they are getting old), Personal Characteristics, Personal Choice, Just World, Spiritual, Family, Social, Other, Environment, Stress, and Diagnosis. They found that ethnic minority groups put more emphasis on spirituality and normalization than Caucasian participants. Caucasian participants also considered trauma more as a factor than minority groups. One of the main strengths of this study was the good representation of members of the community. The main limitation of this study was the heavy female representation. This reduced its generalizability to the male population. The use of

"African American" to represent Black people with no attention to subgroup differences was also noted in this study.

Black African Immigrants. As mentioned earlier, African Immigrants are an under-researched population and there is very little empirical data on their MH needs, attitudes, and practices.

In a study by McCann, Renzaho, Mugavin, and Lubman (2018) in Australia, the researchers explored the MH and substance use stigma among youth and parents from Black African immigrant communities. They interviewed 28 youths individually and engaged 41 parents in focus group discussions. They found common themes that indicated pervasive negative attitudes towards the mentally ill.

There were also some available studies conducted in African countries which provided some understanding about attitudes towards MI and MH pre-immigration.

In Ghana, Barke, Nyarko and Klecha (2010) conducted a study to assess the attitudes towards MH among the general population in comparison to the views of psychiatric patients. They found pervasive negative attitudes towards MI in both samples. They conducted this study with a convenience sample of 403 participants from the general community (non-patients) in the three cities in Ghana which had psychiatric hospitals and an additional 105 participants who were patients at these hospitals. The mean age of the non-patient participants was 32.4 years, 52.1% were male and 47.9% were female. The mean age of the patient participants was 35.9 years, 27.6% were female and 72.4% were male.

The non-patient participants completed the 40-item CAMI questionnaire and the patients completed the 29-item Perceived Stigma and Discrimination Scale. Majority of

the patients endorsed the feeling that; most people thought less of them because they were in/had been to a psychiatric hospital (79.1%), their opinions were taken less seriously (85.7%), they were regarded as less intelligent (70.5%) and less trustworthy (65.7%). Also, more than half of the patients noted that most people believed that entering a psychiatric hospital was a sign of personal failure.

Regarding perceived personal distance from a person with a MH diagnosis, the patients noted that most young people would be reluctant to marry someone who had been hospitalized for an SMI (80%) or would not accept a former psychiatric patient as a close friend (58.1%). The non-patient participants endorsed high proportions of Authoritarian (i.e. the view of the mentally ill person as someone who is inferior and requires supervision and coercion) and Socially Restrictive (i.e. the belief that mentally ill persons are a threat to society and should be avoided) views. This study had a good representation of members of the community, as only 65 of the non-patient participants were students. The main limitation of this study was the fact that all the non-patient participants lived close to the psychiatric hospitals creating a potential bias and reducing the generalizability of the results to the general population.

A more recent study in 2013 by Igbinomwanhia, James, and Omoaregba surveyed the attitudes of the clergy in Benin City, Nigeria towards persons with MI. A total of 107 participants of Christian and Muslim faiths were surveyed using the CAMI scale. The mean age of the participants was 43.03 years, 12 of the participants were female and 95 were male, and 15 of them were Muslim and the remaining 92 were Christians. The participants endorsed pervasive negative attitudes towards the mentally ill. They noted high proportions of Authoritarian and Socially Restrictive views. Majority of the

participants (80.4%) thought it frightening that mentally ill persons should live in residential neighborhoods and that MH centers should be kept out of residential areas (69.1%).

Black Caribbean Immigrants. Similar to Black African immigrants, the research on MH attitudes of Black Caribbean immigrants was scanty.

Arthur, Hickling, Robertson-Hickling, Haynes-Robinson, Abel, and Whitley (2010) conducted a study on stigma and attitudes towards MI in Jamaica. These researchers recruited participants who reported no previous involvement or involvement of a relative in the MH system. They recruited a total of 127 low, middle, and upper-class adult community residents and engaged them in a total of 16 focus group discussions based on demographic similarities. There were 64 females and 63 males. Participants were asked questions on their opinions on individuals with MI, the causes of MI, and MH stigma. They found that most of the participants described individuals with MI as "mad" and dangerous, and as such avoided contact with them.

These researchers noted that the attitudes people endorsed regarding causality and treatability of MI, behavior and character traits of individuals with MI, and the shame attached to MI informed their decisions to seek professional psychological help.

Treatment-Seeking Behavior

Researchers have noted institutional and structural barriers such as insurance, cost of service, and lack of culturally competent care as some of the main reasons for the significantly lower use of MH services among Black people. It was however, also noted that, when these variables were controlled, stigma persisted (SAMHSA, 2015).

Researchers have also found that Black people were more likely to utilize their social support systems and religious leaders instead of MH professionals.

The significant stigma barrier and the use of community support were common among African Americans as well as Black immigrants (Agyekum & Newbold, 2016; Derr, 2015; McCann et al., 2018). Williams et al. (2007), indicated that Black Caribbean immigrants utilized MH services at about half the rate of their African American counterparts. There was no available data on the rate of Black African immigrant service use.

Purpose of the Current Study

The current manuscript explored some of the existing literature available on racial differences in history, prevalence, help-seeking behavior, and attitudes toward MI, with a concentration on the Black community. Particular attention was paid to the heterogeneous nature of the of the Black population, shedding some light on the MH needs of Black immigrants as they compare or contrast with African Americans. The constructs of immigration and acculturation, and their potential effects on the MH needs of immigrants have been briefly discussed.

Regarding attitudes towards MI, the current manuscript examined the available literature on racial and ethnic group differences in causal attribution, perception of dangerousness, treatability information, and help-seeking behavior in relation to MI. Significant advances have been made in research studies related to attitudes toward MI, but a common and consistent limitation has been the lack of attention to sub-group differences among Black people. That is, most existing research studies group Black people as one homogeneous group paying little attention to potential differences that

could be influenced by factors such as immigration status, country of origin, generational status, and native language. As a result, there is very little understanding of the MH needs of the Black immigrant population.

The current study addresses this limitation by exploring the attitudes towards MH and MI among African Americans as compared to Black African immigrants from Africa and the Caribbean region. This study also sought to learn if higher levels of acculturation to the U.S society had any effects on these attitudes.

The current study hypothesized that there would be significant differences in how the various subgroups that fell under the Black racial category described MH and MI stigma. Immigrant participants were hypothesized to endorse more stigmatizing attitudes than their African American counterparts. Participants with low levels of acculturation were hypothesized to have more negative attitudes towards MI compared to their more acculturated counterparts.

Chapter III

Method

This study explored the attitudes towards MI among African Americans and Black Immigrants. In addition, the study investigated if acculturation to the host culture has any effect on these attitudes among the immigrants. This chapter discusses the specific hypotheses for the study, highlights the procedural information, as well as gives a brief discussion of the measures that were used.

Hypotheses

Hypothesis 1 (H1). Black Immigrant participants will have more negative attitudes towards MI than African American participants.

Hypothesis 2 (H2). Attitudes toward MI among Black immigrants will become more positive as they become more acculturated.

Participants

Participants in this study were individuals who self-identified as Black or African American over the age of 18 in the Dayton and Columbus area. A total of 76 survey responses were received, but only 68 were used in the analysis because seven of the profiles were incomplete and another one was a complete outlier. Twenty-four of the participants identified as African American and the remaining 44 identified as immigrants. Participation was voluntary and a convenience sampling method was employed.

Materials

All participants signed a consent form (Appendix A) before proceeding. The survey battery consisted of a demographic form and the CAMI scale for all the participants and the IBMI scale for the immigrant participants only.

Demographic Information. A demographics questionnaire was designed for this study to gather information about gender, age, marital status, level of education, income, employment status, religion/spirituality, place of birth, and generational status (Appendix B).

Community Attitudes Toward the Mentally Ill Scales (CAMI). The CAMI scale is a 40-item scale which consists of 4 subscales with 10 items each. The subscales are Authoritarianism, Benevolence, Community Mental Health Ideology (CMHI), and Social Restrictiveness (Taylor & Dear, 1981). All items are rated on a five-point Likert-type scale *from 1=strongly agree to 5=strongly disagree*. Five of the items on each subscale are negatively stated. The negatively stated items were reverse scored; *strongly agree=5 and strongly disagree=1*. Subscale scores are calculated as the average of the individual items and range from 1 to 5. High scores on Benevolence and CMHI indicate positive MH attitudes and high scores on Authoritarianism and Social Restrictiveness indicate negative MH attitudes (Appendix C).

The Authoritarianism subscale assesses the degree to which a "view of the mentally ill person as someone who is inferior and requires supervision and coercion" is endorsed. A sample item is "one of the main causes of MI is a lack of self-discipline and willpower." The Benevolence subscale assesses the degree to which a "humanistic and sympathetic view of mentally ill persons" is held. "The mentally ill have far too long

been the subject of ridicule," is a sample item on this subscale. The Social Restrictiveness subscale determines the extent to which "the belief that mentally ill persons are a threat to society and should be avoided" is embraced. "I would not want to live next door to someone who has been mentally ill.," is a sample item. The CMHI provides insight into levels of "the acceptance of MH services and the integration of mentally ill persons in the community." "Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community" is a sample item.

The developers of the scale (Taylor and Dear, 1981) reported high reliability for three of the subscales: CMHI (α = .88), Social Restrictiveness (α = .80) and Benevolence (α = .76), and a satisfactory reliability for Authoritarianism (α = .68). They conducted extensive analysis to insure high levels of internal, external, construct, and predictive validity.

A study conducted by Girma, Tesfaye, Froeschl, Moller-Leimkuhler, Muller and Dehning (2013) in Ethiopia recorded an overall reliability of α = 0.79 for the CAMI. Girma et. al. used 845 Black participants from rural and urban areas in Southwest Ethiopia. A study conducted by Barke et al. (2011), recorded reliability scores as follows: Benevolence, α = 0.71, Social Responsiveness, α = 0.73, CMHI, α = 0.75, and Authoritarianism, α = 0.31. Barke et al., administered the scale to a total of 508 Black African participants.

Minor adjustments were made to the original scale to reflect gender neutrality and a less pejorative description of the mentally ill. For example, an original statement on the Social Restrictiveness subscale "most women who were once patients in a mental hospital can be trusted as babysitters" was changed to say, "Most people who were once

patients in a mental hospital can be trusted as babysitters." Also, the phrase "mental patients" which appears on a few of the items was changed to say, "the mentally ill." This scale was developed 38 years ago. With the language now dated, an update was necessary to make it more appropriate.

Immigrant Bicultural or Multicultural Identity Scale (IBMI). IBMI scale is 24-item scale which consist of 2 subscales with 12 items each. One subscale covers items related to the "Country of Origin" and the other covers items related to the "Host Country." Each item is rated on a four-point Likert-type scale anchored at *1=Not at all, 2=A little, 3=Quite a bit, and 4=Very Much* (Eytan, Jene-Petschen, & Gex-Fabry, 2007). Subscale scores are calculated as the average of the individual items and range from 1 to 4. High scores on the Country of Origin subscale indicate a high retention of the culture of origin and high scores on the Host Culture subscale indicate a high level of acquisition of the host culture (Appendix D).

This scale was developed in Switzerland with 93 immigrant adult participants from Italy, Portugal, and Spain. Eytan et al., reported adequate internal consistency of $\alpha = 0.77$ and $\alpha = 0.73$ for the country of origin and host culture subscales respectively. They also reported adequate discriminant and convergent validity.

The language in the original scale is specific to Switzerland, as a host country and Italy, Portugal, or Spain as countries of origin. The scale was adapted to reflect the U.S/America as the host country and a more generic "country of origin" was used in place of Italy, Portugal, or Spain. Due to a technical oversight, the final item on the host culture subscale, "How important is it for you to think that you will rest, after your death,

in America?" was omitted from the survey. The necessary scoring adjustments were made; this subscale score was calculated as an average of 11 items.

Procedure

A proposal was submitted to the Institutional Review Board (IRB) of Wright State University (WSU) for approval prior to the start of data collection. Upon approval, several organizations that served Black communities in the Dayton and Columbus area were contacted. Those that responded favorably, were given the survey battery to distribute to their members. The research team also contacted individuals and attended organizational gatherings for recruitment purposes. Qualtrics, an internet-based survey platform was used for data gathering and paper and pencil versions of the study were provided to participants who preferred that method. There was a cover page that explained the aim of the study, consent process, the expectation of participation, and the incentive before the survey items. Participants were entered into a raffle and four winners were picked for a $25 gift card each.

Analysis

The data was analyzed using the SAS version 9.4 (SAS Institute, Inc., Cary, NC) and RStudio version 1.1.463 (RStudio Team (2018). RStudio: Integrated Development for RStudio, Inc., Boston, MA) with a level of significance of $\alpha = 0.05$ throughout.

For H1, a multiple regression was run for each of the CAMI subscales. The given subscale score was the dependent variable (DV) and ethnicity (African American or immigrant) was the independent variable (IV). A variable that quantifies the years a participant has lived in the U.S. was included as a covariate. This value was the age of the African Americans and the number of years the immigrants had lived in the U.S.

For H2, which only included the immigrants, a multiple regression was also run for the CAMI subscales. The given subscale score was the DV and the country of origin and host country IBMI scores were included as IVs. The number of years the participant had lived in the U.S was again included as a covariate.

Chapter IV

Results

This study was conducted to explore individual differences in MH attitudes. It was to determine if there were any significant differences in attitudes between African Americans and Black immigrants and if acculturation had a significant relationship with those attitudes in the immigrant population. The MH attitudes were measured using the CAMI scale and acculturation was measured using the IBMI scale and time spent in the U.S. Descriptive statistics indicating the ethnicities (African American or immigrant), age ranges, gender identities, level of education, marital status, employment status, income, Country of Birth, and generational status are displayed in tables in this section.

Descriptive Profile

As shown in Table 1, 35.3% (n = 24) of the participants identified as African American and 64.7% (n = 44) of them identified as immigrants. Their ages ranged from 18 to 65 with the 25-34 range being the modal and median age range. They identified as female, 58.8% (n = 40), and male, 41.2% (n = 28). They noted their religious/spiritual preferences as: 85.3% (n = 58) Christian, 2.9% (n = 2) other-spiritual, 1.5% (n = 1) Muslim, 5.9% (n = 4) other-unspecified, 1.5% (n = 1) agnostic, 1.5% (n = 1) atheist, and 1.5% (n = 1) Hindu.

Regarding marital status, 8.8% (n = 6) of the participants reported being divorced, 42.6% (n = 29) married, 45.6% (n = 31) single, 1.5% (n = 1) separated, and

1.5% (n = 1) noted "other" but did not specify (other-unspecified). Level of education of the participants were: high school diploma, 17.6% (n = 12), two-year college, 1.5% (n = 1), other-some college, 1.5% (n = 1) associate's degree, 4.4%, (n = 3), four-year college, 44.1% (n = 30), master's degree, 23.5% (n = 16), doctorate, 5.9% (n = 4), and other-unspecified, 1.5% (n = 1).

In regard to employment status, 67.7% (n = 46) of the participants reported that they were employed for wages, 19.1% (n = 13) that they were students, 4.4% (n = 3) that they were "out of work and looking for work," 2.9% (n = 2) that they were self-employed, 1.5% (n = 1) that they were retired, and 4.4% (n = 3) noted other-unspecified. Participants reported $20,001 - $40,000 as the modal, 36.7% (n = 25) and median income range; 26.4% (n = 18) reported less than $20,000, 16.2% (n = 11) $40,0001 - $60,000, 7.4% (n = 5) $60,001 - $80,000, 5.9% (n = 4) $80,001 - $100,000, 1.5% (n = 1) over $100,000, and 5.9% (n = 4) noted other-unspecified.

As regards country of birth, 50% (n = 34) noted Ghana, 39.7% (n = 27) the U.S, 4.4% (n = 3) Cameroon, 1.5% (n = 1) Ethiopia, 1.5% (n = 1) Sierra Leone, 1.5% (n = 1) India, and 1.5% (n = 1) noted Ukraine. Among the immigrants (n = 44), 84.1% (n = 37) indicated first generation status, 13.6% (n = 6) indicated second generation, and 2.3% (n = 1) indicated third generation.

H1: Black Immigrant participants will have more negative attitudes towards MI than African Americans

A multiple regression was run for each of the CAMI subscales. The given subscale score was the DV and Ethnicity was the IV. A variable quantifying the number of years the participant had lived in the U.S was included as a covariate; this value was

the age of the African Americans and the time the Black immigrants had spent living in the U.S. One of the immigrant participants listed time in U.S as “all my life” and had to be excluded from the analysis since the ages were reported in ranges and therefore his exact time spent in the U.S was not known. An interaction term between ethnicity and time spent in U.S was included in the model. A significant interaction between a categorical variable (ethnicity) and a continuous variable (time spent in the U.S.) indicated that the effect of the continuous variable was not constant across all levels of the categorical variable. In this setting, it indicated that the effect of time spent in the U.S. was different for the two ethnic categories. Descriptive statistics for number of years spent in the U.S and each of the CAMI subscales by ethnicity are given in Table 1.

Authoritarianism. All model assumptions were checked and met. In multiple linear regression, the F-test tests the global null hypothesis that all of the predictor variables are equal to zero. There was strong evidence that at least one of the predictors was significantly different from zero [$F(3,63) = 3.32$, $p = 0.03$, $R^2 = 0.14$]. There was evidence of a significant interaction between ethnicity and number of years spent in the U.S [$t(63) = -3.01$, $p = 0.004$]. The estimated coefficient was -0.043. This means that, on average, for every additional year spent in the U.S, Authoritarianism scores decreased by 0.043 points for Black immigrants compared African Americans.

Benevolence. All model assumptions were checked and met. There was strong evidence that at least one of the predictors was significantly different from zero [$F(3,63) = 2.91$, $p = 0.04$, $R^2 = 0.12$]. The interaction between ethnicity and number of years spent in the U.S was significant [$t(63) = 2.52$, $p = 0.01$] with a coefficient of 0.03. This

indicated that, on average, for each additional year spent in the U.S, Benevolence scores increased by 0.03 points for Black immigrants compared African Americans.

Social Restrictiveness. All model assumptions were checked and met. There was strong evidence that at least one of the predictors was significantly different from zero [$F(3,63) = 2.83$, $p = 0.046$, $R^2 = 0.12$]. The interaction between ethnicity and number of years spent in the U.S was significant [$t(63) = -4.20$, $p < 0.0001$] with a coefficient of -0.055. This indicated that, on average, for each additional year spent in the U.S, Social Restrictiveness scores decreased by 0.055 points for Black immigrants compared African Americans.

CMHI. All model assumptions were checked and met. There was strong evidence that at least one of the predictors was significantly different from zero [$F(3,63) = 2.81$, $p = 0.047$, $R^2 = 0.12$]. The interaction term was however not significant [$t(63) = 1.62$, $p = 0.11$], so it was removed from the model and the main effects of ethnicity and time spent in the U.S were directly tested. The overall F-test was on the verge of significance, but not quite there [$F(3,63) = 2.83$, $p = 0.067$, $R^2 = 0.08$]. Ethnicity was significant [$t(64) = 2.37$, $p = 0.02$], with a coefficient of 0.52. This means that, on average, Black immigrants had CMHI scores that were 0.52 points higher than African Americans, with number of years spent in the U.S held constant. There was not sufficient evidence to suggest a linear relationship between number of years spent in the U.S and CMHI [$t(64) = 1.56$, $p = 0.12$].

Table1

Descriptive Statistics for CAMI Subscale Scores by Ethnicity

Ethnicity	Variable	N	M	SD	Min.	Max.
African	Number of years in the US	24	39.46	21.33	3.00	65.00
American	Authoritarianism	24	2.30	0.57	1.10	3.40
	Benevolence	24	4.17	0.53	3.20	5.00
	Social Restrictiveness	24	2.20	0.55	1.40	3.80
	CMHI	24	3.52	0.50	2.80	4.70
Immigrant	Number of years in the US	43	10.26	7.07	1.00	27.00
	Authoritarianism	44	2.22	0.65	1.00	3.60
	Benevolence	44	4.25	0.51	2.90	5.00
	Social Restrictiveness	44	1.99	0.64	1.00	3.50
	CMHI	44	3.81	0.67	2.70	5.00

H2: Attitudes toward mental illness among Black immigrants will become more positive as they become more acculturated.

A multiple regression was run for each of the CAMI subscales. The given CAMI subscale score was the DV and IBMI subscales country of origin (CO) and host country (HC) scores were the IVs. The number of years the participant had lived in the U.S was again included as a covariate. Two participants who identified as immigrants did not complete the IBMI and so were excluded from this section of the analysis. Descriptive statistics for the IBMI subscales are given in table 2.

Authoritarianism. All model assumptions were checked and met. There was strong evidence that at least one of the predictors was significantly different from zero [$F(3,37) = 4.46$, $p = 0.009$, $R^2 = 0.27$]. There was strong evidence to suggest that there was a linear relationship between number of years spent in the U.S and Authoritarianism [$t(37) = -3.09$, $p = 0.004$]. The estimated coefficient was -0.04. This means that, on

average, for every additional year spent in the U.S, Authoritarianism scores decreased by 0.04 points for Black immigrants with CO and HC held constant. There was also sufficient evidence to suggest a linear relationship between HC and Authoritarianism [t (37) = 2.20, p = 0.03]. The estimated coefficient was 0.43, which means, on average, as HC scores increased by one point, Authoritarianism increased by 0.43 points with all else held constant. There was not sufficient evidence to suggest a significant relationship between CO and Authoritarianism [t (37) = -0.87, p = 0.39] with all else held constant.

Benevolence. All model assumptions were checked and met. There was sufficient evidence that at least one of the predictors was significantly different from zero [F (3,37) = 3.01, p = 0.043, R^2 = 0.20]. There was sufficient evidence to suggest a linear relationship between number of years spent in the U.S and Benevolence [t (37) = 2.65, p = 0.01]. The estimated coefficient was 0.03. This means that, on average, for each additional year a Black immigrant lived in the U.S, their Benevolence scores increased by 0.03 points with all else held constant. There was not sufficient evidence to suggest a significant relationship between HC and Benevolence [t (37) = -1.21, p = 0.23] or CO and Benevolence [t (37) = -0.02, p = 0.98].

Social Restrictiveness. All model assumptions were checked and met. There was strong evidence that at least one of the predictors was significantly different from zero [F (3,37) = 4.63, p = 0.008, R^2 = 0.27]. There was strong evidence to suggest a linear relationship between number of years spent in the U.S and Social Restrictiveness [t (37) = -3.48, p = 0.001]. The estimated coefficient was -0.04. This means that, on average, for each additional year a Black immigrant lived in the U.S, their Social Restrictiveness scores decreased by 0.04 points with all else held constant. There was not sufficient

evidence to suggest that a significant relationship between HC and Social Restrictiveness [t (37) = -0.31, p = 0.76] or CO and Social Restrictiveness [t (37) = 0.14, p = 0.89].

CMHI. All model assumptions were checked and met. There was not sufficient evidence that at least one of the predictors was significantly different from zero [F (3,37) = 1.15, p = 0.34, R^2 = 0.09]. This indicated that there was not sufficient evidence of a significant relationship between any of the predictor variables and CMHI.

Table 2

Descriptive Statistics for IBMI Subscale Scores

Variable	N	M	SD	Min.	Max.
Country of Origin	42	3.31	0.47	1.80	3.90
Host Country	42	2.92	0.48	2.00	4.00

Table 3

Descriptive Statistics for Ethnicity by age

Ethnicity	Age						
	18-24	25-34	35-44	45-54	55-60	Over 60	Total
African American	4	5	1	6	3	5	24
Immigrant	8	31	5	0	0	0	44
Total	12	36	6	6	3	5	68

Table 4

Descriptive Statistics for Ethnicity by Gender

Ethnicity	Gender		
	Female	Male	Total
African American	15	9	24
Immigrant	25	19	44
Total	40	28	68

Table 5

Descriptive Statistics for Ethnicity by Religious/Spiritual Preference

Ethnicity	Religious/Spiritual Preference							
	Christian	Other-Sp	Muslim	Other-Uns	Other-Agnostic	Atheist	Hindu	Total
African American	21	1	0	1	1	0	0	24
Immigrant	37	1	1	3	0	1	1	44
Total	58	2	1	4	1	1	1	68

Note. Other-Sp = Other Spiritual; Other-Uns = Other Unspecified

Table 6

Descriptive Statistics for Ethnicity by Level of Education

Ethnicity	Level of Education								
	DR	MR	4YC	OA	O2YC	OSC	OU	HSD	Total
African American	2	3	8	1	0	1	1	8	24
Immigrant	2	13	22	2	1	0	0	4	44
Total	4	16	30	3	1	1	1	12	64

Note. DR = Doctorate; MR = Master's; 4YC = 4-year-college; OA = Other-Associate's; O2YC = Other-2-year-college; OSC = Other-Some college; OU = Other-Unspecified, HSD = High School Diploma.

Table 7

Descriptive Statistics for Ethnicity by Marital Status

Ethnicity	Marital Status					
	Divorced	Married	Other – Unspecified	Separated	Single	Total
African American	5	9	0	1	9	24
Immigrant	1	20	1	0	22	44
Total	6	29	1	1	31	68

Table 8

Descriptive Statistics for Ethnicity by Employment Status

Ethnicity	Employment Status						
	Employed for wages	Retired	Other-Unspecified	Out of work and looking for work	Self-Employed	Student	Total
African American	16	1	3	0	1	3	24
Immigrant	30	0	0	3	1	10	44
Total	46	1	3	3	2	13	68

Table 9

Descriptive Statistics for Ethnicity by Income

Ethnicity	Income							
	<20,000	20,000-40,000	40,000.01-60,000.	60,000.01-80,000.	80,000.01-100,000.	Over 100,0000.	OU	Total
African American	6	7	5	1	2	1	2	24
Immigrant	12	18	6	4	2	0	2	44
Total	18	25	11	5	4	1	4	68

Note. All income is in U.S dollars ($). OU = Other-Unspecified

Table 10

Descriptive Statistics for Ethnicity by Country of Birth

Ethnicity	Country of Birth							
	Cameroon	Ethiopia	Ghana	India	Sierra Leone	USA	Ukraine	Total
African American	0	0	3	0	0	20	1	24
Immigrant	3	1	31	1	1	7	0	44
Total	3	1	34	1	1	27	1	68

Table 11

Descriptive Statistics for Ethnicity by Generational Status

Ethnicity	Generational Status				
	1st	2nd	3rd	N/A	Total
African American	0	0	0	24	24
Immigrant	37	6	1	0	44
Total	37	6	1	24	68

Chapter V

Discussion

The goal of this study was to explore the attitudes towards MI of Black immigrants as it compared to African Americans as well as examine if those attitudes changed among the immigrants as they acculturate to the U.S. Although a review of literature revealed several studies that addressed the MH attitudes of Black people, most of those studies covered Black people as a homogenous group. Those studies typically used African Americans as a representation of the Black population and compared their attitudes to other racial groups. As a result, there was a significant dearth of research on the MH attitudes and needs of Black immigrants.

Black immigrants present with their unique set of needs and attitudes as influenced by the culture in their native countries, pre-immigration stressors, migration stories, and post-immigration and acculturation difficulties (Kent, 2007; Kirmayer et al., 2011; Rogers-Sirin, Ryce, & Sirin, 2014). Accordingly, this study sought to bridge this gap in research on Black immigrant MH and illuminate the diversity that exists within the Black population.

Researchers have noted negative MH attitudes and stigma toward the mentally ill as significant and chronic barriers to help-seeking. Since these attitudes are mostly influenced by cultural stereotypes, spirituality, media stories, and local institutional practices (Gangi et al., 2016), it is imperative for stigma reduction efforts to be tailored and more targeted to specific communities (Corrigan & Penn, 2015; Stuart, 2016). This

study therefore endeavored to contribute to the foundation for future MH literacy programs in the Black community, especially among Black immigrants.

This current study hypothesized that (1) African Americans will have more positive attitudes towards MI than Black immigrants and (2) attitudes towards MI among immigrants will become more positive as they become more acculturated. Similar to other studies that have used the CAMI scale, a positive MH attitude in this study included disagreeing with stereotypical views such as the mentally ill are inferior, a threat to the society, and need to be excluded (Authoritarianism and Social Restrictiveness); and instead endorsing sympathetic and compassionate views and appreciating the therapeutic advantage of de-institutionalized community-based care (Benevolence and CMHI). Consistent with literature and previous studies, an acculturated individual is one who has adapted to and acquired the culture of the U.S. Acculturation was assessed using time spent in the U.S and participant scores on the IBMI scale.

The results did not indicate any significant differences in Authoritarianism, Benevolence, and Social Restrictiveness scores between African Americans and Black immigrants. There was, however, a significant difference in CMHI scores, with the scores of Black immigrants being higher than the scores of their African American counterparts. This suggests that African Americans were equally sympathetic and compassionate but were more apprehensive of MH care facilities being located in their neighborhoods.

The results also indicated significant increase in Benevolence scores and significant decrease in Authoritarianism and Social Restrictiveness scores with time among immigrants. There was no significant change in CMHI scores with time. There was a significant increase in Authoritarianism scores as immigrant participant scores on

the HC subscale of the IBMI increased but there was no relationship with the CO subscale. There was no significant relationship between any of the other CAMI subscales and the IBMI subscales. This suggests that, when acculturation was assessed using time, more acculturated Black immigrants were less likely to view the mentally ill as inferior and requiring supervision, less likely to view them as a threat to society, and more likely to be understanding and kind to them. These results also suggest that more acculturated Black immigrants were equally likely as their less acculturated fellows, to be at ease about MH care facilities being situated in their localities.

The following sections will explore the significance of the results from the current study and the pertinence to the study of MH attitudes in the Black community. Additionally, clinical implications of the findings of this study will be explored. Lastly, the limitations of this study will be discussed as well as suggestions for future research in this area and in research generally.

Ethnicity and Mental Health Attitudes

According to Soltani, Moayerri, and Raza (2016), low and middle-income countries face significantly increased structural challenges with respect to MH literacy and awareness-raising. Policy makers in these countries tend to be pre-occupied with infectious conditions and other higher mortality concerns due to limited resources. Also, several studies have reported cultural perceptions and stereotypes as one of the main factors that influence MH attitudes. These studies in the literature informed the hypotheses in this study, considering that most Black immigrants hail from low and middle-income countries and have different cultural practices from that of the U.S.

Although not overwhelmingly and quite opposite to H1, the results from this study indicate some significant differences in MH attitudes between African Americans and Black immigrants. As noted earlier, African Americans were more likely to be concerned about MH care facilities being located in their neighborhoods than their Black immigrant counterparts. This particular finding could be the result of the specific history of African American MH. Historical and contemporary instances of negative treatment of African Americans have created a mistrust of authorities; hence the apprehension (Metzl, 2010; NAMI, 2019).

A possible explanation for the similarities in MH attitudes is the number of years the participants in this study had lived in the U.S (Average = 10.26 years). Considering the influence of media and local institutional practices on MH attitudes (Gangi et al., 2016), it is understandable that there are several similarities in MH attitudes between the Black immigrants and African Americans in this study.

Acculturation and Mental Health Attitudes

This study assessed acculturation using both unilinear and bilinear markers. There was only a marginal difference in attitudes when the bilinear marker was used. Participants who reported higher levels of assimilation into the U.S culture were more likely to view the mentally ill as inferior. There was no significant relationship between MH attitudes of the Black immigrant participants and any of the other acculturation strategies; separation, integration, and marginalization.

However, when using a unilinear marker, time spent in the U.S, this study's findings were consistent with the existing literature that higher level of acculturation

predict more positive MH attitudes among immigrants (Leon & Kim, 2011; Luu, Leung & Nash, 2009; Obasi & Leong, 2009).

This inconsistency appears to support the views of Schwartz et al. (2010) that acculturation is a more nuanced construct that requires further research and expansion.

Clinical Implications

The findings from this study contribute to the rather limited body of research on the MH needs and attitudes of the Black community especially among Black immigrants. The findings from this study and literature from previous studies indicate a need to bring more awareness to the heterogenous nature of the Black community and how this diversity influences stigma, expression of psychological distress, and treatment-seeking behavior.

Stigma Reduction. Literature from previous studies indicate differences in MH attitudes between individuals of different races (Gilbert et al., 2007; Knettel, 2016; Raglin Bignall et al., 2015), immigrants and non-immigrants (Bauldry & Szaflarski, 2017; Derr, 2016; Williams et al., 2007) as well as acculturated and non-acculturated immigrants (Leon & Kim, 2011; Luu, Leung & Nash, 2009; Obasi & Leong, 2009). The findings from this study support these existing studies and bring attention to intra-racial differences. That is, since Black people consist of U.S born and foreign born, acculturated and unacculturated immigrants, it is necessary for organizations in charge of stigma reduction efforts to be aware of these attitudinal differences so as to create matching interventions and literacy programs (Corrigan & Penn, 2015; Stuart, 2016). Knowledge of these attitudes is also important for clinicians who work with the Black population as these attitudes inform their expression of distress, attendance, and

compliance with treatment recommendations (CalMHSA 2017; Nadeem et al., 2007; SAMHSA, 2013).

Expression of Psychological Distress and Diagnosis. It is important for researchers and clinicians to remember that people of different cultures may have different languages. In some of these languages, words or phrases do not exist for some MH conditions. For example, in a study by Ward, Sellers, and Pate (2005) on depression among Black African immigrant women, most of the participants reported that there was no word for depression in their language. Even among English speaking immigrants, more psycho-somatic descriptions such as, "my body is heavy, I have headaches, my body aches, and I do not feel like getting up" were more common than "I feel depressed." This difference in language and the significantly lower availability of MH care facilities in source countries of Black immigrants means they were not likely to be aware of or to report a family history of MI (Salas-Wright et al., 2018; Soltani et al., 2016).

With these points in mind, it is expected that even among Black people, there will be differences in symptom expression, and report of psychological distress and history. Clinicians therefore need to do their due diligence to reduce instances of misdiagnosis. Researchers also have to keep this in mind when creating questionnaires so as to capture the intended constructs.

Treatment Seeking Behavior. As noted earlier, African Americans, as well as Black immigrants are more likely to use their social support systems and religious leaders instead of MH professionals. Barriers such as insurance costs, lack of culturally competent care, and stigma are also shared among Black people (Derr, 2015; McCann et al., 2018; SAMHSA, 2015). One main difference, however, is the history of maltreatment

of African Americans by MH authorities and the mistrust therein. Black immigrants do not necessarily share this mistrust, and this is a distinction worth noting for clinicians and researchers.

Limitations

In interpreting these results, the limitations below should be taken into account.

Sample. Due to the relatively small sample size, and the sampling method used (convenience sampling), the results may not be generalizable to Black people outside the general Ohio area. Also, with most of the immigrant participants (81.8%, n=36) noting African countries as their place of birth and no one noting a Caribbean country, the results are not to be generalized to the Black Caribbean immigrant population. It is also worthy of note that the ages of the immigrant population ranged from 18 to 44 and the longest amount of time spent in the U.S was 27 years. This makes the results not generalizable to immigrants over 45 years-old or immigrants who have lived in the U.S for more than 27 years.

Measures Used. A significant limitation of the CAMI scale was that it does not define MI and does not differentiate between different diagnostic classes. It is therefore possible that participant attitudes were based on different disorders, that is, one participant may have answered the questions with Depression in mind while another answered them with Schizophrenia in mind.

The IBMI scale has not been normed on the Black population, therefore, there was no strong support for its ability to capture relevant constructs among African Americans and Black immigrants.

Attitudes versus Actual Behavior. As noted by Angermeyer and Dietrich (2006), there was no empirical evidence on the relationship between attitudes towards the mentally ill and actual behavior towards them. A study investigating attitudes was therefore inherently limited.

Future Direction

The limitations noted above and the findings from this study provide opportunities for future research on MH attitudes generally, MH attitudes in the Black community more specifically, and research with the Black community overall.

First, it is very important for researchers to always report as much detail as possible on their participants instead of lumping them in homogenous groups. For example, in this study descriptive statistics were reported on the level of race, immigrant status, and country of origin. This makes it possible to make further analysis on other variables such as age and country of birth.

Second, given the limitations that come with the CAMI scale and similar quantitative tools, more qualitative studies will be useful to address some of the nuances of language, and to further explore participant's definition of MI and the contextual issues that inform their attitudes. Qualitative approaches will also help reduce the potential effects that differences in language competence could have on the results.

Third, given the marked paucity of empirical data on the needs of Black immigrants, more studies are needed to explore further their unique attitudes and needs and effects of immigration history, generational status, and acculturation on these needs.

Fourth, research on acculturation and immigration need expansion. There was no consistency in the literature with regard to topics such as models of acculturation, and the

healthy-immigrant effect. Additional studies are needed in these areas to provide clarity. Also, considering the current political climate, it will be helpful for clinicians to know what additional concerns immigrants have and if the climate encourages help-seeking behavior or otherwise.

Lastly, as research on attitudes continue to grow in psychological and psychiatric literature, it is imperative that studies follow it up with how attitudes influence actual behavior.

Appendices

Appendix A

Subject Informed Consent Document

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Introduction

You are invited to participate in a research study conducted by Louis Appiah-Kubi, Psy.M. under the supervision of Janeece Warfield, Psy.D., RPT-S.

Purpose

The aim of this study is to explore individual attitudes towards mental illness and the effects (if any) that acculturation has on these attitudes. I am defining acculturation as how an individual adapts to a new culture. Your participation will help add to existing research on stigma and attitudes towards mental illness with particular attention to the Black community and its heterogeneity.

Procedure

You will be asked to participate in a survey on attitudes towards mental illness. The survey will take approximately 30 minutes to complete. Taking part in this study is voluntary. By completing this survey, you agree to take part in this study, please answer all questions.

Potential Risks, Discomforts, and Inconveniences

There are no conceivable risks to your participation in this study. Safeguards will be in place to protect your responses and they will be kept in a locked drawer marked confidential.

Potential Benefits

This study will add to existing research on stigma and attitudes towards mental illness with particular attention to the Black population and its heterogeneity. In addition, the study will inform the empirical knowledge base on how acculturation to the U.S culture affects these attitudes among the immigrant population. The information gathered in this study will add an additional layer of culturally accurate attitudes towards mental illness to inform researchers and organizations in developing more appropriate educational protocols.

Compensation

After you fully complete the survey you will be entered into a draw for a chance to win one of four $25 gift cards.

Confidentiality

We will protect your privacy to the extent permitted by law. If the results from this study are published, your information will not be made public. Your information may be shared with the following:

- The Wright State Institutional Review Board (IRB) and Office of Research and Sponsored Programs
- Office for Human Research Protections

Security

You will be assigned a unique identification numbers before analyses are performed. No identifying information will be collected, and your IP address will not be recorded. Your

demographic information such as age, gender, race/ethnicity, etc. will be collected. All data will be organized, managed, and stored in a secure data file in a locked file drawer. Security measures used to protect study data from loss or inappropriate use will include random quality checks and protection from inadvertent modification or loss. Hard copies of information and data will always be kept in a secured place and only study team members will be able to access them on as-needed basis. Key personnel may not alter the data in the database without specific cause and approval of the investigator. Study databases will be password protected and no data will be sent over the internet.

Voluntary Participation

Taking part in this study is voluntary. You may choose not to take part at all. If you decide to be in this study, you may stop taking part at any time. If you decide not to be in this study or if you stop taking part at any time, you will not lose any benefits for which you may qualify. You will be informed about any changes that may affect your decision to continue in the study.

Research Subject's Rights, Questions, Concerns, and Complaints

If you have any questions about your rights as study participant, concerns, or complaints, you may call the IRB Office at 937-775-4462. You may discuss any questions with a member of the IRB or staff. The IRB is an independent committee composed of members of the university community, as well as community members not connected with the university. The IRB has reviewed and approved this study.

This form tells you what will happen during the study if you choose to take part. Your agreement means that this consent has been reviewed, your questions have been answered, and that you will take part in this study. This informed consent document is not a contract, you are not giving up any legal rights by signing it.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Principal Investigator	Date

Appendix B

Demographic Survey

Please answer the following items:

- What is your gender?
    - Female
    - Male
    - Non-Binary
    - Prefer not to say
    - Other _____
- How old are you?
    - 18 to 24 years old
    - 25 to 34 years old
    - 35 to 44 years old
    - 45 to 54 years old
    - 55 to 60 years old
    - Over 60 years old (Please enter) _____
- Highest level of education completed
    - Did not complete High School
    - High School/GED
    - 4 - Year College

    - Master's Degree
    - Doctorate
    - Other _____
- Marital status
    - Single, Never Married
    - Married/Domestic Partnership
    - Separated
    - Divorced
    - Other _____
- Employment status: Are you currently
    - Employed for Wages
    - Self-Employed
    - Out of work and looking for work.
    - A homemaker
    - A student
    - Unable to work
    - Other _____
- Income
    - Under $20,000
    - $20,001 - $40,000
    - $40,001 - $60,000
    - $60,001 - $80,000
    - $80,001 - $100,000

    - Other _____

- Religious/Spiritual affiliation
    - Islam
    - Christianity
    - Judaism (Jewish)
    - Hinduism
    - Atheism
    - Other _____
- Country of birth (Please print) _____
- Number of years in the U.S _____
- Generational Status
    - 1st (First to immigrate to the U.S)
    - 2nd (Born in the U.S to at least one immigrant parent)
    - 3rd (Born in the U.S to U.S born parents and had at least one grandparent who was an immigrant)
    - Not Applicable (I identify as African American)

Appendix C

Community Attitudes Toward the Mentally Ill Scales (Taylor & Dear, 1981)

Please read each statement and indicate the degree to which it reflects your own thoughts and feelings using the 5-point scale below (1=Strongly agree, 2=Agree, 3=Neutral, 4=Disagree, 5=Strongly Disagree). There are no right or wrong answers, base your responses on your opinion at the present time. To ensure that your answers can be used, please respond to the statements as written by selecting the option that matches level of agreement.

1=Strongly agree, 2=Agree, 3=Neutral, 4=Disagree, 5=Strongly Disagree

Authoritarianism					
One of the main causes of mental illness is a lack of self-discipline and willpower.	1	2	3	4	5
The best way to handle the mentally ill is to keep them behind locked doors.	1	2	3	4	5
There is something about the mentally ill that makes it easy to tell them from healthy people.	1	2	3	4	5
As soon as a person shows signs of mental disturbance he should be hospitalized.	1	2	3	4	5
The mentally ill need the same kind of control and discipline as a young child.	1	2	3	4	5
Mental illness is an illness like any other.	1	2	3	4	5
The mentally ill should not be treated as outcasts of society.	1	2	3	4	5
Less emphasis should be placed on protecting the public from the mentally ill.	1	2	3	4	5
Mental hospitals are an outdated means of treating the mentally ill.	1	2	3	4	5
Virtually anyone can become mentally ill.	1	2	3	4	5

Benevolence					
The mentally ill have too long been the subject of ridicule.	1	2	3	4	5
More tax money should be spent on the care and treatment of the mentally ill.	1	2	3	4	5
We need to adopt a far more tolerant attitude toward the mentally ill in our society.	1	2	3	4	5
Our mental hospitals seem more like prisons that the places where the mentally ill can be cared for.	1	2	3	4	5
We have a responsibility to provide the best possible care for the mentally ill.	1	2	3	4	5
The mentally ill don't deserve our sympathy.	1	2	3	4	5
The mentally ill are a burden on society.	1	2	3	4	5
Increased spending on mental health services is a waste of tax dollars.	1	2	3	4	5
There are sufficient existing services for the mentally ill.	1	2	3	4	5
It is best to avoid anyone who has mental health problems.	1	2	3	4	5
Social Restrictiveness					
The mentally ill should not be given any responsibility.	1	2	3	4	5
The mentally ill should be isolated from the rest of the community.	1	2	3	4	5
An individual would be foolish to marry someone who has suffered from mental illness, even if the person seems fully recovered.	1	2	3	4	5
I would not want to live next door to someone who has been mentally ill.	1	2	3	4	5
Anyone with a history of mental illness should be excluded from taking public office.	1	2	3	4	5
The mentally ill should not be denied their individual rights.	1	2	3	4	5
Mental patients should be encouraged to assume responsibilities of normal life.	1	2	3	4	5
No one has the right to exclude the mentally ill from their neighborhood.	1	2	3	4	5

The mentally ill are less of a danger than most people suppose.	1	2	3	4	5
Most people who were once patients in a mental hospital can be trusted as babysitters.	1	2	3	4	5
Community Mental Health Ideology					
Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.	1	2	3	4	5
The best therapy for mental health patients is to be part of the general community.	1	2	3	4	5
As far as possible, mental health services should be provided through community-based facilities.	1	2	3	4	5
Locating mental health services in residential neighborhoods does not endanger local residents.	1	2	3	4	5
Residents have nothing to fear from people coming into their neighborhoods to obtain mental health services.	1	2	3	4	5
Mental health facilities should be kept out of residential neighborhoods.	1	2	3	4	5
Local residents have good reason to resist the location of mental health services in their neighborhood.	1	2	3	4	5
Having the mentally ill live within residential neighborhoods might be good therapy but the risks are too great.	1	2	3	4	5
It is frightening to think of people with mental health problems living in residential neighborhoods.	1	2	3	4	5
Locating mental health facilities in a residential area downgrades the neighborhood.	1	2	3	4	5

Appendix D

Immigrant Bicultural or Multicultural Identity Scale (Eytan et al., 2007)

Please read each statement and indicate the degree to which it reflects your own thoughts and feelings using the 4-point scale below (1 = Not at all, 2 = A little, 3 = Quite a bit, and 4 = Very Much). There are no right or wrong answers, base your responses on your opinion at the present time.

1 = Not at all, 2 = A little, 3 = Quite a bit, and 4 = Very Much

Country of Origin				
How much are your country of origin values part of your life?	1	2	3	4
How important is it to you to celebrate holidays in your country of origin way?	1	2	3	4
How important is it to you to raise your children with your country of origin values?	1	2	3	4
How comfortable would you be in a group of people from your country of origin who don't speak English?	1	2	3	4
How proud are you of being from your country of origin?	1	2	3	4
How much do you enjoy speaking your native language?	1	2	3	4
How much do you enjoy TV programs, Radio shows, or newspapers in your native language?	1	2	3	4
How much do you like to eat your native food?	1	2	3	4
Do you think people from your country of origin are kind and generous?	1	2	3	4
How important would it be to you for your children to have friends from your country of origin?	1	2	3	4
How comfortable do you feel to express your feelings in your native language?	1	2	3	4
How important is it for you to think that you will rest, after your death in your country of origin?	1	2	3	4

Host Culture (U.S.A/America)				
How much are American values part of your life?	1	2	3	4
How important is it to you to celebrate holidays the American way?	1	2	3	4
How important is it to you to raise your children with American values?	1	2	3	4
How comfortable would you be in a group of Americans (who don't speak your native language)?	1	2	3	4
How proud are you of an American identity?	1	2	3	4
How much do you enjoy speaking English?	1	2	3	4
How much do you enjoy TV programs, Radio shows, or newspapers in English?	1	2	3	4
How much do you like to eat American food?	1	2	3	4
Do you think Americans are kind and generous?	1	2	3	4
How important would it be to you for your children to have American friends?	1	2	3	4
How comfortable do you feel to express your feelings in English?	1	2	3	4
How important is it for you to think that you will rest, after your death, in America?	1	2	3	4

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