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Duaa Ashoor

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BARRY UNIVERSITY

The Influence of Culture on Mental Health Stigma:

Saudi versus American College Students

By

Duaa Ashoor, B.A.

A THESIS

Submitted to the Faculty of
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شكر وتقدير

أحمد الله جل وعلا وأشكره على ما أمدني به من عون وتوفيق في اعداد هذا البحث وقدرني على الانتهاء منه فإليه سبحانه وتعالى يعود الفضل كله. كما أتشرف بتقديم خالص الشكر والعرفان إلى خادم الحرمين الشريفين الملك سلمان بن عبدالعزيز، وإلى الملحقية الثقافية على ما قدمته لنا من مساعدة وحسن تجاوب واهتمام وإلى الأستاذ المشرف الدكتور كونسول. كما لا أنسى أن أشكر والدي على دعمهما الكبير المستمر الذي كان له الأثر البالغ في شحذ همتي للمضي قدما بعزيمة وثبات نحو تحقيق هدفي في إعداد البحث وإنهائه. أسأل الله عز وجل أن يجزيهما خير الجزاء عما قدماه ويقدمانه لي على الدوام من رعاية وتضحية واهتمام في كل نواحي حياتي وبكل تفان وحب وإخلاص، وإني لأجد نفسي عاجزة عن ترجمة تلك المعاني العظيمة التي تجسدت فيما يغدقانه علي من فيض الحب والعطاء، لكن الله جل وعلا هو القادر وحده على حسن الثواب وخير الجزاء.

Abstract

This study was aimed at measuring the influence of the cultural variables of individualism versus collectivism and their effects on mental health stigma and attitudes toward seeking mental health treatment for Saudi versus American college students in the United States. A total of 287 participants (141 Saudi students, 146 American students) completed five online anonymously self-report questionnaires: a demographic questionnaire*, Horizontal and Vertical Individualism and Collectivism Scale* (VHIC; Triandis & Gelfand, 1998)*, Self-Stigma of Seeking Help Scale* (SSOSH; Vogel et al., 2006)*, Perceived Devaluation-Discrimination Scale* (PDD; Link, 1987)*, Attitudes Toward Seeking Professional Psychological Help Scale (short form)* (ATSPPH-S; Fischer & Farina, 1995). It was hypothesized that Saudi students would be significantly more collectivistic than American students, and the Saudi students would have significantly more self-stigma and public stigma regarding mental health treatment compared to American students. Cultural theory (Triandis, 1988) was applied to conceptualize the findings and provide insight for further research and implications for clinicians and policy makers. The results indicated that Saudi students were significantly more collectivistic than American students. The results also indicated that Saudi students had significantly higher levels of self-stigma regarding mental health treatment versus American students. A third analysis revealed that Saudi students had significantly lower levels of public stigma compared to American students. Analysis also revealed that Saudis had equally positive attitudes regarding seeking psychological help versus American students. The findings also indicated a significant positive correlation between self-stigma and seeking psychological treatment for Saudi students. Limitations of the research were discussed, as well as, the need for future research with Muslims regarding mental health issues and treatment.

The Influence of Culture On

Mental Health Stigma: Saudi versus American College Students

Introduction

The World Health Organization WHO (2011) emphasized the harm caused by mental health stigma recognizing that those stigmatized can undergo: damage to self-esteem, have troubles in their relationships with their families, may be inadequate in their capability to socialize, and cannot maintain housing and employment. The WHO also emphasizes that mental health stigma can deter: a) the prevention of mental health disorders, and b) the delivery of efficient treatment. Mental health stigma can have substantial negative impacts on not only those individuals with a mental health disorder, but also their family members and friends, and mental health provider groups (Corrigan, Kerr, & Knudsen, 2005). More precisely, mental health stigma can prevent individuals from looking for assistance (Thornicroft, 2007), which might then postpone therapy and result in state of social isolation and loneliness-concerns which can worsen problems (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Thornicroft, Brohan, Rose, Sartorius, & Leese 2009) and hinder therapy (Link et al., 1997; Ritsher & Phelan 2004; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Mental health stigma has also been revealed to: decrease employment and education chances (Link et al., 1997; Thornicroft et al., 2009), lead to poorer physical healthcare, suicidality, and higher death rates (Thornicroft, Rose, & Kassam, 2007). Moreover, mental health stigma has been recognized by mental health service workers as a main cause of suicide attempts (Eagles, Carson, Begg, & Naji, 2003), also, as possibly more handicapping than the mental illness itself (Finzen, 1996).

A variety of descriptive factors have been discussed for explaining the reasons behind individuals stigmatizing mental illness. These have involved individuals who are individuals who have a lower level of education (Lauber, Nordt, Falcato, & Rossler, 2004; Crisp, Gelder, Goddard, & Meltzer, 2005), who are from lower social classes (Crisp et al., 2005; Dyduch & Grzywa, 2009; Yoshii, Watanabe, Kitamura, Nan, & Akazawa, 2011; Brockington, Hall, Levings, & Murphy, 1993; Heller, Chalfant, Worley, Quesada, & Bradfield, 1980; Whatley, 1959), who are male (Crisp et al., 2005; Dyduch & Grzywa, 2009), who have fewer mental health services available in the local area (Al-Krenawi, Graham, Dean, & Eltaiba, 2004), and who have low levels of individual contact and experience with mental illness (Crisp et al., 2005; Addison & Thorpe, 2004; Ng & Chan, 2000; Pettigrew & Tropp, 2006; Roman, & Floyd, 1981; Wolff, Pathare, Craig, & Leff, 1996a, b; Yang 1989).

It has also been shown that certain cultures are more likely to stigmatize mental health problems than others. For example, it has been revealed that Greek/Greek-Cypriot UK migrants hold significantly higher levels of stigmatizing attitudes than White-British UK born people on measures of authoritarianism and social restrictiveness (Papadopoulos, Leavey, & Vincent, 2002). Moreover, UK non-Caucasians are much more likely to argue against educational movements about mental illness than UK Caucasians (Wolff et al., 1996a, b, c), as well as less desirable attitudes towards the mentally ill (Bhugra, 1989). Anglin, Link, and Phelan (2006) recruited American representative samples of African Americans and Caucasian Americans and discovered that African American were significantly more likely to admit that people diagnosed with schizophrenia or major depression would perform something destructive to other

individuals. This trend continued even after controlling for age, political views, family income, education, and religion. The Whaley (1997) study showed that the Asian–Pacific Islander, African- American, and Hispanic respondents viewed people with mental illness as significantly more dangerous than Caucasian respondents. This result continued for the African-American group even after controlling for a range of factors, including the level of contact with persons who had mental illness. More research on cross-cultural mental health stigma has involved a recent literature review of quantitative and qualitative studies which have analyzed mental illness stigma and ethno cultural beliefs (Abdullah & Brown, 2011). Their results revealed that Asian American and African American cultural groups hold comparatively higher levels of stigma attitudes than other American cultural groups (particularly Americans of European descent).

Cross-cultural variation of mental illness stigmatization has also been conducted by Al-Krenawi, Graham, Al-Bedah, Kadri, & Sehwail (2009), who discovered that stigma levels significantly differ among Palestinian, Kuwaitis, Israeli Arabs, and Egyptian National student samples.

Investigators have been unable to sufficiently clarify why there is such variation in mental illness stigma levels across cultural groups. The previous studies cited, some of which are highly systematically controlled, have emphasized that cross-cultural stigma differences continue even after controlling for a range of socio-demographic variables. Hence, it seems essential to attempt to demonstrate why and how cultural variation influences mental illness stigma. One of the most widely used frameworks for describing cross-cultural differences (and similarities) is the individualism-collectivism value paradigm. This framework is concerned with how individuals describe themselves and

their relationships with others (Brewer & Chen 2007) It derives from Hofstede's (1980) conception of culture: ''the collective programming of the mind which distinguishes the members of one group from another'' (p. 21). There have been critiques of the framework as being overly inclusive of all forms of cultural differences (e.g. Bond, 2002; Berry, Pootinga, Breugelmans, Chasiotis, & Sam, 2011). Nevertheless, researchers acknowledge that the constructs of individualism and collectivism are significant dimensions of cultural difference (Oyserman, Coon, & Kemmelmeyer, 2002; Schimmack, Oishi, & Diener, 2005; Brewer & Chen 2007). At present, there is only minimal evidence of a potential connection between individualism-collectivism and mental illness stigma. First, cultures that are more greatly individualist, such as the American, White-British, German, and Australian cultures, have formerly been discovered to be less stigmatizing of mental health illness (Jaques, Burleigh, & Lee, 1973; Papadopoulos et al., 2002; Westbrook, Legge, & Pennay, 1993). Compared to collectivist values among Asian, African and Arab cultures (Hill, 2003; Abu-Baker, 2005; Tyler, Uqdah, Dillihunt, Beatty-Hazelbaker, Conner, Gadson, 2008; Al-Krenawi et al., 2009). In addition, analyzing the characteristics of cultural individualism and collectivism showed that for individualistic cultures, personal goals have primacy over in-group goals and also that 'cultural complexity', where there are often more cultural selections and lifestyles (Chick, 1997), is more likely to exist. This is crucial because the more 'complex' a culture, the more likely it is to be a loose (as opposed to tight) culture (Triandis, 2001). Loose cultures is more likely to be found in individualistic cultures, it is claimed that there is a higher level of tolerance to deviate from norms (where several normative systems coexist), where people do not depend on each other so much, and

where population density, and thus the chance for surveillance, is low (Triandis, 1995). It has also been established that tight cultures are more likely to be collectivist (Carpenter, 2000). In these cultures, individuals have stronger ideas about what behaviors are appropriate; they agree among themselves that sanctions are required when individuals do not follow the norms. Tight cultures include members that are highly interdependent, and are to be typically more heavily populated, in the sense that surveillance is high. According to Hall (1976), collectivist cultures are also more likely to be ‘high-context’ in which there are multiple, intersected bonds and connections with others, longer-term relationships are aimed, and the harmoniousness of the group are essential cultural values. In these cultures where conforming to norms is highly valued, surveillance is high, and there are many layers of connections between individuals. It is not astonishing that mental illness is observed as outside of the norm and therefore devalued, rejected and stigmatized.

The present study is aimed at measuring the influence of the cultural variables of individualism versus collectivism as predictors for mental health stigma and attitudes toward seeking mental health treatment for Saudi versus American college students in the United States. In the current study, the hypotheses assume that individuals from individualistic cultures (e.g. Americans) are less likely to have stigmatizing attitudes towards mental illness in comparison to individuals from collectivistic cultures (e.g. Saudis). This difference is grounded in the theory that people from individualistic cultures are more likely to endure diversity and deviation from the norm because their cultures are extremely fragmented, with wide-ranging individuality, with the desire to achieve personal goals. While in collectivistic cultures, there is less diversity and

fragmentation as individuals aspire to in-group goals and norms, individuals who diverge from the norm are more noticeable to the public because of higher levels of surveillance and the existence of multiple intersections and relations between individuals. As a result, collectivist families are more likely to try to hide the existence of anyone who has a mental health issue, and are consequently less likely to try to access the suitable mental health services. In these societies, where there is less contact and knowledge about mental health issues, high level of negative attitudes are likely to exist, in accordance with previous research discussed (Galletly & Burton, 2011; Papadopoulos et al. 2002; Pettigrew & Tropp 2006; Wolff et al. 1996a).

Definition of Key Concepts

The concept of mental health stigma, as used in this study, refers to a group of attitudes held regarding an individual engaged in some psychological activity (e.g. psychotherapy) where the individual is made to feel shame and is isolated from the rest of his/her social group. Labeling someone with a mental disorder can result in that person being negatively stereotyped or stigmatized by the group. Negative attitudes can develop, such as prejudice, which can contribute to pessimistic responses by other group members (Goffman, 2009).

The three major types of stigma that affect individuals regarding the stigma of mental illness are: public stigma, self-stigma, and social distance. The first type, public or perceived stigma, relates to a person's understanding of what the general public or group thinks about a stigmatized subject i.e., negative attitudes of the person engaged in a psychological activity as perceived by the public (Yap, Wright, & Jorm, 2011). The second type, self-stigma, refers to a belief by someone that he or she is culturally

undesirable, which can reduce self-esteem or self-confidence of the individual (Vogel, Wade, & Haake, 2006). To put it another way, self-stigma was defined as the internalized negative views conceptualized by a culture toward someone who seeks a non-norm activity (e.g. psychotherapy) (Corrigan & Calabrese, 2005). These views can influence individuals to see themselves as inferior, incomplete, and devalued in their group. Because of self-degradation, individuals who have a high level of self-stigma might give up seeking a treatment to maintain good perception about themselves. Social distance a third type is the degree to which other people refrain from communicating with a stigmatized person based on the perception that a mental disorder exists. (Yap et al., 2011; Jorm, & Griffiths, 2008). Social distance will not be a key concern of this research.

Individualism is a cultural attitude. First defined by Triandis (1996), people in individualistic cultures are independent and separate from their in-group. Their first concern is to achieve their personal goals above the goals of their in-group. The attitudes of individualistic people are predominantly based on their own personal beliefs, instead of on their in-group beliefs (Triandis, 2001). An example of an individualistic culture would be American culture.

Collectivism is the opposing cultural attitude. Mills and Clark (1982) showed that individuals in collectivist cultures are: a) merged within their in-groups (family, tribe, nation, etc.), b) yield their first concerns to the in-group aims, c) form their attitudes mainly on the norm' principles of their groups and d) act in a shared style. Collectivists have evolved around relationships. For instance, individuals in collectivistic societies who are in disagreement within their group are mainly worried about sustaining their relationship with others. Meanwhile, people in individualistic cultures are mainly worried

about attaining equity (Ohbuchi, Fukushima, & Tedeschi, 1999). For this reason, individuals in collectivistic cultures favor peaceful solutions and approaches which do not destroy relations (i.e. arbitration), while people in individualistic cultures are more likely to go to court to resolve arguments (i.e. litigation) (Leung, 1997). An example of a collectivistic culture would be Chinese culture.

Two additional concepts are those of vertical and horizontal varieties of collectivism and individualism. There are different types of individualistic and collectivistic cultures. For example, an Israeli kibbutz (collectivistic) culture is different from the Korean (collectivistic) culture. The horizontal-vertical dimension is particularly crucial to discriminate within cultural styles. Some cultures put emphasis on equal opportunity (e.g. Israelis, Swedes, Australians); and others put their emphasis on the desire to do the best (e.g. Indians, Americans). Therefore, four kinds of culture style can exist: Horizontal Individualists (HI), are individuals who desire to be exclusive, and "do things in their own way; Vertical Individualists (VI), are individuals who desire to do things in their own way and in addition to that to be "the best in the group"; Horizontal Collectivists (HC), are individuals who consolidate themselves with the in-group "we are all equal"; and Vertical Collectivists (VC), are individuals who adhere to the authority of the in-group and are prepared to subjugate themselves for their in-group "we are equal, who must obey our leaders" (Triandis, 2001).

Literature Review: Culture, Stigma and Mental Health

The following section will review research related to the topic of the influence of culture on mental health stigma. A range of descriptive factors have been suggested as to why people stigmatize a person with mental illness. In a 2009 study by Eisenberg,

Downs, Golberstein, and Zivin (2009), mental health stigma was recognized by national policy makers as a serious obstacle for seeking mental health treatment. This study was the first empirical research that examined the relationship between help-seeking behavior and both public stigma and self-stigma. The method used was a random sample of 5,555 students from 13 colleges in the United States. The demographics of the students were a mean ethnicity of 66% white. Students were recruited via email surveys. There were three main results: (1) Self-stigma was significantly lower than public stigma; (2) self-stigma was greater among students who had any of the following attributes: male, younger, Asian, international, more religious, or from an impoverished family; and (3) self-stigma was considerably and negatively linked to measures of seeking psychotherapy (recognition of the need and benefit of psychoactive drugs, counselling, and other types of supporting means that were different than the clinical one). Meanwhile, perceived public stigma was not linked to seeking psychotherapy. These results can assist college counselors in attempts to reduce the role of mental health stigma as an obstacle for treatment.

The findings suggested that college students are more likely to seek help if they do not hold any stigma attitudes towards themselves or others' perceptions of them. Above all, the study's findings demonstrate that mental health stigma differs considerably among different subgroups. Thus, designing strategies to reduce stigma for specific subgroups can lead to more favorable attitudes toward help seeking. The study paid careful attention to subgroups, which included international students. The study also showed that students who were born and raised in the U.S tend to have lower levels of stigma than those who came to the U.S. to study.

Another cross-cultural study conducted by Soheilian and Inman (2009) was designed to analyze the mediating impact of self-stigma of psychological disorders on the relation between perceived public stigma and attitudes toward therapy. The number of participants in this study was 102 Middle Eastern Americans (77% woman, 23% men) recruited from clubs and organizations, such as multicultural and Muslim student associations from universities around the U.S. The vast majority of students were graduates, 55%. In terms of their ethnicity, 57% were born in the United States, which is the majority; 17% born in Iran, 6% in Afghanistan, 3% in Egypt, 3% in Palestine, 12% in other Middle Eastern Countries, and 2% in non-Middle Eastern Countries. In regard to religions, 63% were Muslims, 17% were Christian, 6% were identified as other = 4% as Baha'i, and 2% as Jewish. There were three types of questionnaires for measurement. The first questionnaire was the *Perceived Devaluation-Discrimination Scale* (Link, 1987), a 12-item test, which was utilized to evaluate perceived public stigma; it uses a 6-point scale. The second questionnaire was the *Self-Stigma of Seeking Help Scale* (SSOSH; Vogel, Wade, & Haake, 2006). It was utilized to measure self-stigma; it is a 10-item test with a 5-point rating scale. The third questionnaire was the *Attitudes Toward Seeking Professional Psychological Help Scale* (ATSPPH-S; Fischer & Farina, 1995). This 10-item measurement is a revised version of the original 29-item scale (Fischer & Turner, 1970); it uses a 4-point rating scale. Path analyses consisted of multiple regression, which indicated the mediation impact of self-stigma regarding of mental illness on the relationship between perceived public stigma of mental illness and attitudes toward counseling was not seen. Nonetheless, results show that participants with a greater level of self-stigma displayed more negative attitudes toward psychotherapy.

This research has several implications. According to Soheilian and Inman (2009), this research provides the basis for future studies to understand how Middle Eastern Americans perceive mental illness. Particularly, the findings showed the importance of increasing the awareness in terms of mental health demands among Middle Eastern Americans, which can result in the seeking of professional help.

Another implication is that different variables can affect personal stigma. Some of these variables are internalized negative messages, public negative messages and negative messages that are portrayed in the media. Personal stigma can prevent Middle Eastern Americans from seeking professional help. There is a lack of research on this population. Thus, increased research to evaluate the needs of this population will not only allow for an increased awareness of frequency of mental disorders among them, but also give insight into how to encourage Middle Eastern Americans to seek professional help (Soheilian & Inman, 2009).

In another comparison study, (Conner, Copeland, Grote, Koeske, Rosen, Reynolds, & Brown, 2010) researcher found that mental health stigma was shown to be a serious obstacle toward seeking mental health treatment, resulting in negative attitudes toward psychotherapy and hindering people who were in need of psychological treatment. This developmental cross-ethnic research analyzed the influence of public stigma (the public's negative views toward others) and self-stigma (the individuals' negative view about themselves) among African American and White elders with depression who were seeking psychotherapy. The method, random digit telephone dialing, was used to obtain a representative sample of 248 African-American and White elders (older than 60 years) with depression. The symptoms of depression were assessed

by the *Patient Health Questionare-9* (PHQ-9; Kroenke, Spitzer, Williams, & Lowe, 2010). Telephone-based surveys were administered to evaluate their seeking psychotherapy attitudes and behaviors and the agents that influenced their behaviors. The study's results suggested that depressed elders held a high level of public stigma, and also that they were less likely to be involved in seeking psychotherapy. In addition, African-Americans were more likely to have self-stigma and hold less positive attitudes toward seeking psychotherapy than their White equivalents. Multiple regression analysis demonstrated that self-stigma was somewhat mediated by the relation between ethnicity and attitudes toward therapy. The research concluded that mental illness stigma has a negative impact on attitudes and desires toward seeking psychotherapy among elders with depression, especially African American older adults. The authors concluded that a reduction of self-stigma is necessary to assist this community in seeking mental health treatment.

Masuda and Boone (2011) investigated whether mental health stigma (i.e., negative impressions toward individuals with mental illness) and self-concealment are unique predictors of help-seeking decisions in Asian American and European American college students with no history of seeking mental health treatment. Self-concealment was defined as the behavioral inclination to keep hidden upsetting and humiliating private information from others (Cramer & Barry, 1999; Larson & Chastain, 1990). The study took place in a public four-year college located in Georgia, USA. The participants of this study were 122 Asian American college students (42 males, 80 females) and 235 European Americans (71 males, 164 females). For both groups, the mean age was 19.8 years, the age range 17-52 years). All the participants were students taking undergraduate

psychology courses. They were recruited through a web-based research tool, which was created by the department of psychology. Students from all ethnic backgrounds completed anonymous surveys.

The students were given three different scales to complete. The first scale was the *Attitudes Toward Seeking Professional Psychological Help* (ATSPPH; Fischer and Turner, 1970) containing 29-items that were utilized to measure different attitudes toward seeking professional help; it uses a 4-point scale. The statements "psychologist-counselor and psychological counseling center" were replaced for "psychiatrist and mental health center", correspondingly. The changed adaptation was utilized because the study was performed on college students, who were probably going to experience moderate cases of distress rather than severe cases of mental illness. The second scale was the *Stigmatizing Attitudes-Believability Scale* (SAB; Masuda, Price, Anderson, Schemertz, & Calamaras, 2009) which is a 8-item self-report survey, established by Masuda to evaluate mental health stigma toward individuals with disorders. The third questionnaire was the *Self Concealment Scale* (SCS; Larson & Chastain, 1990) used to evaluate an individual's inclination to conceal private information that caused distress or negative-evaluation (Masuda & Boone, 2011).

The results of Masuda and Boone (2011) study confirmed that Asian American college students had: 1) less desire to seek help, 2) a higher level of mental health stigma, 3) a lower level of tolerance to the mental health stigma, 4) a lower level of interpersonal openness, and 5) a higher level of self-concealment compared to the European American students. In fact, in both groups, mental health stigma and self-concealment were unique predictors of help-seeking decisions. Nevertheless, mental health stigma was not a unique

predictor of acknowledgment of the demand for psychotherapy and trust in therapists. The elements of help-seeking decisions were speculated to be most related to actual help-seeking behavior. Self-concealment was a unique predictor of trust in therapists in the Asian-American college students, but not in the European American college students (Masuda & Boone, 2011).

The authors discussed other variables that could influence help seeking attitudes. Knowledge of the benefits of counseling could be such an influence, regardless of the stigma. Some students were willing to seek help if they knew about the counselling services in the school. Thus, the focus of the counseling center should not be confined to preventing the stigma, but instead to make sure that the center's services are well-known to students as well as how they can get access to them. The psychosocial programs targeting Asian Americans and others with no previous history of seeking mental health treatment may induce the use of the mental health services. Also, the psychosocial programs would be more effective if they aim to reduce not only mental health stigma, but also self-concealment (Masuda & Boone, 2011). Masuda's research emphasized the effect of ethnicity on mental health stigma. The research findings used only a sample of college students.

One recent study by Bathje and Pryor (2011) confirmed that the label of mental illness is one of the most influential elements that affects stigma. Public stigma, the most widespread social response for individuals who seek treatment for mental illness, can be differentiated from self-stigma. The research analyzed how awareness and endorsement of public stigma might affect self-stigma. The research analyzed how both kinds of stigma are associated with negative attitudes toward seeking mental health treatment.

The participants of this study were a total of 211 college students (52% female, 48% male, with a mean age of 19.91 years) who were recruited from a Midwestern university. In terms of ethnic identification: 86% were White, 10% were African American, 2% were Hispanic, 1% were Asian American, and 1% were Middle Eastern (Bathje & Pryor, 2011).

In the same Bathje and Pryor's (2011) study, five types of measurements were used. The first survey, the *Stigma Scale for Receiving Psychological Help* (SSRPH; Komiya, Good, & Sherrod, 2000) consists of five items to evaluate the awareness of public stigma to seek professional help. The second survey, the *Attribution Questionnaire* (AQ; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003) assesses endorsement of public stigma. On the AQ participants had to rate a descriptive scenario of a person with a psychological disorder. The answers to the scenario were graded on a 9-point rating scale. The third survey, the *Self-Stigma of Seeking Help Scale* (SSOSH; Vogel et al., 2006) contains 10-itmes that were utilized to evaluate self-stigma. The fourth survey, the *Attitude Toward Seeking Professional Psychological Help-Short Form* (ATSPPH-S; Fischer & Farina, 1995) assesses help-seeking attitudes. The fifth survey, the *Intentions to Seek Counseling Inventory* (ISCI; Robertson & Fitzgerald, 1992) is a 17-item measurement that requires students to rate their possibility of going to a counselor if they were facing each of 17 problems, among these problems are depression, anxieties and others (Bathje & Pryor, 2011).

Exploratory Factor Analysis (EFA) was implemented to assess the factor structure of the measurements. The awareness and endorsement of public stigma were found to predict self-stigma. Endorsement of empathy for individuals with a psychological

disorder was particularly predictive of self-stigma. At the same time, endorsement of public stigma and self-stigma were independently associated with seeking mental health attitudes. Lastly, attitudes were directly associated with desire to seek counseling. The results indicated that different kinds of stigma act in impacting attitudes regarding seeking-mental health treatment (Bathje & Pryor, 2011).

The implications of this study suggested that sympathy towards a person with mental illness can help to reduce self-stigma. A probable interpretation for the significance of sympathy could be that individuals who are able to sympathize with a person who is psychologically impaired might be more able to apply that same view to themselves in situations of psychological impairment. This type of self-sympathy tends to have a proactive effect on self-esteem and might increase the chance for seeking-mental health treatment. Implementing an anti-stigma campaign can be very effective in reducing self-stigma. Another implication for this study is that the research argues for the benefit of attributing mental illness to uncontrollable causes versus emphasizing controllability. Controllability means the attribution of onset responsibility also known as blame. (Corrigan, 2002; Read & Harre, 2001). The study suggested that controllability does not play a significant role in the formation of self-stigma. Therefore, deemphasizing assumptions about controllability can actually encourage individuals suffering from mental health issues to seek professional help. Lastly, the study encourages counselors to address public and personal mental health stigma and how public and personal mental health stigma can affect the seeking of mental health treatment (Bathje & Pryor, 2011). This study identified and highlighted very important characteristics about understanding

new factors that can affect public and personal stigma such as sympathy, controllability, etc.

A cross-cultural study by Gonzalez, Alegria, Prihoda, Copeland, and Zeber (2011) acknowledged the importance of encouraging the motivation toward psychotherapy, which could then possibly increase mental health treatment rates. Social marketing for psychotherapy needs to be designed to focus on demographic subgroups, since this is a most influential factor. The study explored the impact of interactions between attitudes toward psychotherapy and factors of age, gender, ethnicity/race, and education for both general medical and specialty care patients. A sample survey was conducted on outpatient English speaking U.S residents, for a total of 5,691 individuals (53% women, 47% men, with a mean age of 31.5 years, age range of 18 years and older). Cross-sectional data was used from the 2001-2003 National Comorbidity Survey Replication (NCS-R) which examined multivariate models for related clinical, social and demographic factors. Initially, the survey was designed to offer data for the prevalence of the psychological disorders in the DSM-IV and the use of psychotherapy services. Overall the results were promising when it came to specialty care throughout various ethnic groups. The strongest results for positive attitude toward psychotherapy were from younger non-Latino Whites, but were not strong for those Whites between 50-64 years old. For all demographic groups, the intention to go to psychotherapy was linked with general medical care. Nevertheless, for specialty care, the relationship was much more powerful for men compared to women. In future research, other non-explored variables, such as the level of ease, embarrassment, etc. need to be explored. It is important to consider that discussion with primary care physicians who could be facilitators for

patients seeking psychotherapy or counselling is an important factor. Social marketing messages are also very crucial, not only to increase seeking help, but also to promote mental health services.

A study conducted by Reichert (2012) revealed that many college students suffer from depression, a disorder with powerful consequences if neglected and one which can cause serious problems. A review of the literature uncovered that seeking help for depression is usually stigmatized, eliminating the chances for treatment.

Public stigma does not directly influence help-seeking attitudes, rather self-stigma and social distance are both heavily associated with non help-seeking attitudes (Yap et al., 2011; Barney, Griffiths, Jorm, & Christensen, 2006). The interactions between self-stigma and social distance along with contextual factors such the kind of mental illness, and demographic characteristics, contribute to the global stigma, against mental health services.

Another study conducted by Held and Owens (2013), found that despite the fact that there are a large number of individuals with psychological disorders among armed services members, most military members were reluctant to receive psychotherapy for disorders that were associated with deployment. This study analyzed the relation between public stigma, self-stigma, and treatment-seeking attitudes. A sample of 126 active and retired U.S. military service members (88% male, with a mean age of 43.22 years, with SD= 17.60, and age range of 18-73 years) was gathered via the internet by using an online survey. In terms of ethnic identification, 92% were White, 2% were Hispanic, 2% were African American, 2% were Asian-American, and 2% were multiracial/other. With regard to education, 5% stated having some “some high school, 15% “high school

graduates, 33% some college, and 14% graduate or professional degree. The results of this study suggested that self-stigma was the mediator of public stigma and negative attitudes toward seeking treatment. In order to reduce mental health stigma, there were two variables that required attention: 1) public actions (Corrigan & Calabrese, 2005; Dickstein, Vogt, Handa & Litz, 2010) and 2) encouraging service members to express their feelings, as in the U.S. Army's Comprehensive Soldier Fitness Program (CSF; Cornum, Matthews & Seligman, 2011). The goal of CSF, which builds upon the fundamental of positive psychology, is to boost psychological resilience and the career achievement of service members.

In one study of multiple cultures, authors examine whether the cross-cultural value of approach "individualism-collectivism" was a valuable descriptive model for mental illness stigma on a cultural level. They used snowball sampling, a quantitative survey of 305 individuals from four cultural groups from the United Kingdom (White-English, American, Greek/ Greek Cypriot, and Chinese) was conducted. The scales were the "Community Attitude to Mental Illness" (CAMI) and the "Vertical-Horizontal Individualism-Collectivism" (VHIC). The study found higher scores of collectivism correlated with more stigma toward mental illness attitude. This was found among the Chinese group. On the contrary, the American group was found to be a very individualistic group; this finding can be justify as the higher scores of individualism in this group correlated with less stigma toward mental illness attitude (Papadopoulos, Foster, & Caldwell, 2013)

Individualism Vs. Collectivism

Triandis (1989) first acknowledged that the individualism-collectivism cultural syndromes seem to be the prominent difference in attitudes between cultures. This difference has been called the “deep structure” of cultural difference (Greenfield, 2000). Although there are innumerable cultural differences, this difference appears to be significant both historically and cross-culturally (Triandis, 2001). Furthermore, researchers agree that the constructs of individualism and collectivism are crucial dimensions of cultural differences (Schimmack, Oishi, & Diener, 2005; Brewer & Chen, 2007). Cultures establish agreements about what values to pay attention to and how much evaluation is given to particular behavior within that culture.

Triandis (1989) said that individuals in individualistic cultures, such as those of North and Western Europe and North America probably select components of the personal self as important. In contrast, individuals in collectivistic cultures, such as those of Asia, Africa, and South America, lean toward selecting components of the collective self (i.e., individualism values “I am kind” versus collectivism values “my family and friends believe I am kind.”)

Triandis, Leung, Villareal, and Clack (1985) originally suggested that the personality constructs of *idiocentrism* and *allocentrism* corresponding to individualistic and collectivist groups at the cultural level, respectively. Individuals who are *idiocentrics* pay principal attention to internal attributes, such as their own beliefs, emotions, and the like, rather than to inputs from other people. On the other hand, *allocentrics* are individuals who pay attention to other people. Smith and Bond (1999), and others used this term in their social psychology textbooks. There are a greater numbers of *allocentrics*

than *idiocentrics* in collectivistic cultures and a greater number of *idiocentrics* than *allocentrics* in individualistic cultures.

In Triandis' (2001) theoretical framework, it was explained how ecology shapes culture. He proposed two kinds of cultures, *loose* cultures and *tight* cultures. In *loose* cultures, there is lenience of deviation. This lenience of deviation from the norms is found somewhat in all heterogeneous societies, where several normative systems coexist, and where individuals do not depend on each other greatly. *Loose* cultures are usually less densely populated, so chances for surveillance are low. By way of contrast, isolated societies such as those on islands lean toward being more *tight* cultures. In these cultures, individuals have definite ideas about what attitudes are acceptable. *Tight* cultures are high on collectivism (Triandis, 2001). Without a doubt, it is not surprising that mental disorders are recognized as outside of the norm, so much so that they would be devalued, rejected, and stigmatized in *tight* cultures.

In collectivistic cultures, child upbringing focuses on agreement, obedience, safety, and honesty. In contrast, with individualistic cultures, child upbringing focuses on independence, exploration, creativity, and self-reliance (Triandis, 2001).

The self-focus of allocentrics is on "getting along" rather than on "getting ahead", while the focus of idiocentrics is putting particular emphasis on being the best one (Triandis, 2001).

As stated by Triandis (2001), usually *allocentrics* have a higher level of ethnocentrism, compared to *idiocentrics*. Another distinction between *idiocentrics* and *allocentrics* is that *idiocentrics* lean towards domination, while *allocentrics* lean toward congenial norms (Moskowitz, Suh, & Desaulniers, 1994). The motive element in

collectivistic cultures indicates openness to others, adaptation to the needs of others, and the refraining of one's own needs and desires. The essential motive element in individualistic cultures indicates people's intrinsic desires, integrities and competencies, including the capability to endure social pressure (Markus & Kitayama, 1991).

According to Triandis (1995), individuals in collectivistic cultures are relatively timid, when they have to get into new groups; meanwhile, individuals in individualistic cultures are relatively experienced in getting into new groups and in handling others in superficial ways, for instance, when going to a cocktail party speaking to everyone there.

A Historical View of Saudi Arabia

Saudi Arabia is considered to be the birthplace of Islam and is home to the holy cities of Mecca and Medina. These two cities attract Muslims throughout the entire world. In Islam, five pillars form the theological framework and core beliefs of the religion. The five pillars reveal crucial beliefs, principles, and concepts of how Muslims view the two worlds: the current and the next. The pillars are conceptualized as a clear-cut framework of worship patterns and prescribed orders for social behavior, linking God with every part of everyday life, and describing practical conduct relating to the structure of the community. In accordance with Samovar, Porter, McDaniel and Roy (2013), "Because the pillars are the umbrella under which all Muslims stand, Muslims who are scattered throughout the world are able to see themselves as a family of believers" (P. 147). Since the pillars are interpreted into deeds, it is significant for individuals to be informed of the essence of these deeds. The five pillars of Islam are: (1) the proclamation of faith, *Shahadah*; (2) prayer, *Salat*; (3) almsgiving, *Zakat*; (4) fasting, *Sawm;* and (5)

pilgrimage, *Hajj*. The fifth pillar requires Muslims to visit Mecca at least once in their lifetime.

The Saudi population is reported to be 99% Muslim. The majority of Saudi Muslims are Sunnis, approximately 85-90%, and approximately 10-15% are Shias, and < 1% are foreigners. Sunni individuals practice Islam, according to rules of the *Quran* set forth by the prophet Mohammed (570 AD- 632 AD). Shias are another group of individuals who appeared after the death of the prophet Mohammed in 632 AD. The Shia group was a result of the passing of Ali, who is a husband of the prophet Mohammed's daughter. He is one of the first Islamic leaders who gave support to his two sons as his successors. This led to as a division among the Muslim community and the creation of the Shia sector. The major difference between these two subgroups is that Shias believe that the *Caliph* or Islamic leader must be a sinless person, who is a descendent of the prophet Mohammed. Sunnis oppose the Shias on this issue because they believe that the *Caliph* or Islamic leader should not claim hereditary privilege or birthright, but rather, should be someone selected on the basis of merit (i.e. reliability or trustworthiness) and that such a leader can be maintained or removed. The leadership debate was initiated when the community leaders selected Abu Bakr as the first Caliph (Arabic for Successor.) This decision was debated by the Shia sect who believed that Ali ibn Abi Talib should have been the successor. Although Ali was the cousin and son in-law to the prophet Mohammed, he lacked seniority within the Arabian tribal system to be the successor. Initially, the two groups were not split because of different beliefs, but because of undecided leadership. However, throughout history, different doctrinal and religious practices have developed between the two groups. Sunnis have always been the majority.

The Shias have evolved an understanding of history which is very distinct from that of the Sunnis. There are different subgroups among Shias as well such as Twelver, Zaidiyya, Ismaili. The third sector of Islam, called Sufism, follows the abstinence path to fulfill their spirituality (Braswell, 1996). Similarly, such divisions exist in other religions as well (e.g., Christianity has its Catholic versus Protestant divisions; and Judaism has its Orthodox versus Reformed divisions.)

Many religious scholars and Islamic activists endeavor to enlighten readers about the importance of separating tradition from religion (Al-Rasheed, 2013). Predominantly Saudi people are Muslims, but their way of practicing Islam can be vary. Sometimes Islam is called a modern religion. That does not mean Islam was changed to fit modern life. It is called modern because it came around 1400 years ago. The constitution of Saudi Arabia is based on Islamic law (*Shari'a*) which is based on the *Quran* and the *Sunnah*. The *Sunnah* is defined as the behavioral model for others and it provides Muslims examples of the prophet Mohammed's manners, actions, and practices of *Quranic* law in everyday life (Husain, 1998). The *Quran* presents many stories that are common with the *Torah* and the *Bible*. The *Quran* is considered to be the undistorted, straight and direct words from God. All aspects of Saudi life are covered in Islamic rule which does not discriminate among races, socioeconomic classes, etc. Rather, Islam unifies individuals under a monotheistic faith (Braswell, 1996). Islam is a highly collectivistic religion.

Saudi Arabia was founded on September 23, 1932, by King Abdul Aziz bin Abdul Rahman Al Saud, known as Ibn Saud. King Ibn Saud joined his control over the Najd against Al-Rashid in 1922, then he occupied the Hejaz against Sharif Hussain bin Ali in 1925. This followed by uniting his dominions into the kingdom of Saudi Arabia.

This united was supported by a previous movement, called *Wahhabi*, founded by a religious leader named Mohammed ibn Abdul Al Wahhab (1703-1792). Wahhab had traveled extensively around the Middle East countries and studied different religions before returning to Najd, a region centered in Saudi Arabia that was surrounded by deserts. In this region, he joined with the Al Saud family, who were controlling the Najd region. In 1933, oil was discovered, and the Saudi royal family worked to develop the country. The Saudi flag, green with white Arabic characters, declares the first Islam pillar: "There is no God, but Allah and Mohammed is his messenger." Beneath these letters is a sword (Farsy, 1990).

The Geography of Saudi Arabia

The measurement of Saudi Arabia is 2, 149, 690 sq km, and it covers four-fifths of the Arabian Peninsula. It is approximately one-third the size of the United States. Saudi Arabia is bordered by: Iraq, Jordan, and Kuwait to the north; the Red Sea to the west; the Gulf of Arabia, Qatar, and United Arab Emirates to the east; Oman to the southeast; and Yemen to the southwest. The Saudi Arabia official language is Arabic and the capital city is Riyadh. The ethnic groups are varied: 90% Arabs, and 10% Afro-Asian. According to the United Nations data (2014), the total population is 27, 345, 986 people, 30% of whom are foreign (*The CIA World Fact Book*, 2014).

Saudi Arabia's Students in the United States

In the mid-1940's, Saudis first came to the United States as ambassadors and employees for the embassy in Washington, DC. Subsequent to World War II, Saudi students started to come to the U.S. to acquire higher education. The oil resources of Saudi Arabia permitted the government to fund these students. In 1995, the Saudi Arabia

Cultural Mission (SACM) was established by the Saudi government to manage the scholarships of the Saudis and to meet their academic needs. From this time on, students on scholarship were financially supported for tuition, living expenses, health insurance, annual travel tickets and other benefits (Smith & Abut, 2013).

In 2005, the King Abdullah Scholarship Program (KASP) was introduced. It is thought to be the largest fully enriched government scholarship program ever promoted by any country. Saudi students were encouraged financially to be married during their residency in the United States, to reduce the feeling of alienation and homesickness. One intensive or reinforcement is full support of the family financially, such as granting scholarships to the wives and the children as well. Students live so far from their home country, yet many of them are still committed deeply to their religion, family and social life (Smith & Abut, 2013). Recent statistics reported by the Ministry of Higher Education in Saudi Arabia revealed that there are more than 120,000 Saudi students studying abroad (Ministry of Higher Education, 2011). The following section will highlight the distinctions between individualistic and collectivistic cultures. Individualistic cultures do not mind if individuals deviate from the norm. On the other hand, collectivistic cultures want everyone to follow the norm of the in-group.

Cultural Differences between American and Saudi Cultures

In the following paragraphs, some cultural differences between Saudis and Americans in terms of religion, family, gender rule, education, social life, personal appearance, and style of life will be discussed.

One cultural difference is the educational systems of the two cultures. Education in Saudi Arabia is based on more theoretical approaches rather than practical application.

To illustrate, in the United States, children are taught science and math through creative centers, without the use of books. Meanwhile, the educational system in Saudi Arabia is considerably rigid; it does not give the students a chance to think in a creative way. Students depend much more on memorization, rather than creative or critical thinking (Abdul Fattah, 2008).

There are some learned behaviors that identify American culture from Saudi culture. If a foreigner analyzes the culture of the United States for feminism, he/she would easily observe the weight placed on individualism in every aspect of life, from individual apparel to social behaviors. In the same way, a person can gain awareness of Saudi culture by observing the fashion (e.g. *hijab*) and the role of women in Saudi Arabia (e.g., women cannot drive cars) In addition, changing gender roles are found all over the globe, and there is no trouble noticing this in the United States (i.e., women can also be elected to the presidency) (Samovar et al., 2013). Meanwhile, in 2011, Saudi women were only recently granted the right to vote in 2015 in local elections, and they can now be selected as a member of the *Shura* Council for King Salman bin Abdulaziz Al Saud (Epatko, Sept. 2, 2015).

Lately a debate has arisen in Saudi Arabia when newspapers “broke with tradition and … began printing photographs of Saudi women.” Also, articles were written about controversies that highlighted gender matters something not allowed before. One controversy evolved around whether the prohibition of women driving must be changed or not. According to a report from the Associated Press (2006), the matter of women driving is receiving some impetus: The women of Saudi Arabia are occupying different social networks to remove the prohibition on driving. In countries such as Syria, Saudi

Arabia, and Indonesia, women are vigorously protesting and requesting further rights. Meanwhile, not only was Miss United States 2010 a Muslim, but modest Muslim swimsuits are available in the market, so that Muslim women can experience enjoyment at the beach (Samovar et al., 2013).

According to Samovar et al., (2013), the relationship between Islam and gender leaves the readers with two key points: The first point is that when examining any cultural difference, it is crucial not to permit ethnocentrism to affect one's judgment, e.g. the avoidance of prejudice. As an "outsider," individuals might apply Western models to Islamic culture's beliefs toward women. While Westerners may find it unusual for Saudi Muslim women to cover their hair with the *hijab*, Muslim women may have a difficult time reasoning why so many women in the United States wear bikinis. The second point is not to over generalize in face of regional distinctness. For instance, the lifestyle of a country villager is different from the lifestyle of a city, well-educated person who is sophisticated in social and political ways, inside his or her culture (i.e. one rule does not apply to all.)

Islam conceptualizes the Muslim world as a "family of believers." Christianity and modern Judaism (i.e., reformed and reconstructionist) have adopted the idea of "discovering the individual." Before Christianity existed, individuals were perceived as part of clans, tribes, or families, and acted in styles that displayed the collective shape of their existence. The *Bible* displays instances of individualism, especially the New Testament. Bernard McGinn (as cited in Woodward, 1999) said, "Christianity discovers individuality in the sense that it stresses personal conversion."

In the following paragraphs, communication styles of the United States and Saudi Arabia will be compared. Communication standards are culturally varied. Members of different cultures follow different sets of rules when communicating with other people. Samovar et al., (2013) focused on business, educational and health care contexts to contrast communication styles between individuals from different cultures. He believed that individuals recognize their own communication standards, even though they have the same social settings, such as hospitals, classrooms, businesses, and meetings, etc. Individuals often comply with different communication standards when responding to their surroundings according to their cultures. As a consequence, the conception of unspoken attitudes, politeness, language, time, and apparel vary greatly among cultures. Individuals can clearly see the difference between Western and Eastern societies. Notably, direct eye contact between opposite sexes is usually avoided in countries such as Saudi Arabia, where gender segregation is the norm (Sait, 2004). This differs greatly from American culture, where the norm is integration between men and women i.e. direct eye contact is made.

To illustrate the varied communication standards, individuals can see the differences clearly between American and Saudi cultures. In the United States, it is an ordinary thing that women and men greet each other by shaking hands. This is not the case in many Eastern societies; Muslim businessmen will refrain from shaking women’s hands. This must not be seen as disrespectful or degrading; it shows the religious restrictions for men (Samovar et al., 2013).

Furthermore, evidence for cross-cultural stigma variation has been disclosed by the latest literature review of quantitative and qualitative studies which have analyzed

mental illness stigma and ethno-cultural beliefs (Abdullah & Brown, 2011). Specially, the results revealed that Asian American and African American cultural groups hold comparatively higher levels of stigmatizing beliefs than other American cultural groups (specifically Americans of European descent). Cross-cultural differences in mental health stigma have also been recorded by a group of researchers (Al-Krenawi et al., 2009), who recognized that levels of stigma differ significantly among Palestinian, Kuwaiti, Israeli Arab, and Egyptian national student samples.

At this moment, there is not enough evidence to clarify the fact that mental illness stigma varies between Americans and Saudi cultures. As a result, this lack of evidence needs to be explored.

Rationale

The literature review provides evidence that individualistic versus collectivistic views of help-seeking differ across various cultures. It is important to develop a comprehensive understanding of individualistic versus collectivistic cultural attitudes toward mental health stigma in college students and their desires to seek or not to seek psychological treatment based on culture. There is little research from Saudi Arabia which shows that culture plays a role in how individuals demonstrate degrees of mental health stigma. Cross cultural research is needed to develop a better understanding of how individuals from various cultures can be made to benefit from mental health treatment by a minimization of mental health stigma. The word stigma in Arabic (وصمة إجتماعية) *Wah-smah ehg-tih-mah-eyah* is not commonly used; thus very few Saudi individuals even know the meaning of the term stigma. Saudi Arabia is the largest country in the Middle East with a total area size of 2,149, 690 sq. km (The CIA World Fact Book, 2014).

According to Al-Angary (2013), there are about 70,000 Saudi students who are studying in the United States as international students; they are required to have health insurance, which provides 100% coverage for their visits to psychologists or psychiatrists. This insurance is provided by the Saudi Cultural Mission. Therefore, it is important to identify whether Saudi college students, as members of a collectivistic culture, and who are a remarkably underrepresented population in the research literature, vary in their responses to mental health stigma and help seeking for mental problems when compared to American college students. Such information could improve the use of mental health services in Saudi students, mental health providers must take in to account the cross-cultural differences of such students. The present study is designed to assist in this quest.

Present Study

This study is aimed at measuring the influence of the cultural variables of individualism versus collectivism as predictors for mental health stigma and attitudes toward seeking mental health treatment for Saudi versus American college students in the United States. The present research has several components. First, the study investigates whether individuals from collectivistic cultures have a higher level of mental health stigma than those from individualistic cultures. Second, the study examines how individualistic and collectivistic cultures not only affect mental health stigma, but also affect individuals' attitudes toward seeking mental health treatment. In the present study, mental health stigma will consist of both self-stigma and public stigma.

This study is based on the assumption that people from individualistic cultures are more willing to accept value diversification and to deviate from existing norms because their cultures are psychologically fragmented with expanded individualistically and with

the desire for personal goals. On the other hand, in collectivistic cultures, where there is less diversification and fragmentation, i.e., individuals desire in-group goals and adherence to existing norms. In these cultures, individuals who deviate from the norm are more apparent to the society where high levels of control exist for individuals and the existence of many connections between individuals reinforces this control. Consequently, families are often expected to attempt to conceal the presence of a mental disorder in a family member and individuals are less likely to try to access the available public mental health services. Also, in these collectivistic societies there is less awareness of mental disorders; hence, higher levels of stigma attitudes are expected to be present (Galletly & Burton 2011; Pettigrew & Tropp 2006).

Hypotheses

Hypothesis 1: Saudi students will be significantly more collectivistic versus American students.

Hypothesis 2: Saudi students will have significantly more self-stigma regarding mental health treatment versus American students.

Hypothesis 3: Saudi students will have significantly more public stigma regarding mental health treatment versus American students.

Hypothesis 4: Saudi students will have significantly less positive attitudes regarding seeking psychological help versus American students.

Hypothesis 5: There will be a significant negative correlation between self-stigma and seeking mental health treatment for Saudi students.

Hypothesis 6: There will be a significant negative correlation between public stigma and seeking mental health treatment for Saudi students.

Method

Participants and Procedure

A total sample of 287 participants were recruited, ages ranging from 18 years and older. A sample of 141 Saudi students were recruited through online surveys that were sent by the Saudi Arabian Cultural Mission (SACM) in Washington D.C. A sample of 146 American students were recruited by online surveys that were sent by the Department of Psychology at Barry University, Miami, Florida. Those recruited were taken to an online survey after reading a cover letter approved by Barry University's Institutional Review Board. Barry University students were compensated with extra course credit for their participation. All participants were be asked to answer five questionnaires: a demographic questionnaire, *Horizontal and Vertical Individualism and Collectivism Scale* (VHIC; Triandis & Gelfand, 1998), *Self-Stigma of Seeking Help Scale* (SSOSH; Vogel et al., 2006), *Perceived Devaluation-Discrimination Scale* (PDD; Link, 1987), *Attitudes Toward Seeking Professional Psychological Help Scale (short form)* (ATSPPH-S; Fischer & Farina, 1995).

Materials and Procedures

Demographic Questionnaire. A demographic questionnaire was created for the study: The demographic questionnaire obtained data on: age, gender, culture, place of birth, educational levels, marital status, occupation, religiousness, generation, first language, and place of birth. See appendix C

The following section is a review of the history measurement of individualism and collectivism. In agreement with Triandis and Gelfand (1998), in spite of the fact that the constructs of individualism and collectivism have a lengthy history and can be traced

back to ancient Greece, the initial scales were attained by Hofstede (1980) and Hui (1984, 1988). They offered the initial scales at the cultural and individual levels, mutually. Hui's measurement consisted of a 63-item Individualism- Collectivism scale. The validity of this scale was established by correlations with social interest (Crandall, 1980), reactions to different schemes, and the distribution of resource behaviors of those high or low on that scale (Hui, Triandis, & Yee, 1991). Triandis et al. (1985) utilized both the Hui (1984, 1988) items and schemes for the measurements of the constructs and demonstrated that the measurements had validity. Triandis et al. (1986, 1988) introduced cross-cultural measurements of the constructs. The construct of individualism focuses on dependence on one's self, self-indulgence, and emotional distance from in-groups (i.e., "I am not to blame if a member of my family fails"). Meanwhile, collectivism consists of family integrity (i.e., "aging parents should live at home with their children until they die"), socially (i.e., "I like to talk with my neighbors everyday"), and interconnection (i.e., "I like to cooperate with others"). In American (individualistic) samples, independence was associated with competition (i.e., "winning is everything"). In collectivist samples, independence also could be high, but the impetus often is to avoid being a burden on the in-group. Furthermore, second-order factor analyses implied that submission of personal goals to the in-group was a key point of collectivistic cultures (Triandis et al., 1985, 1988). Agreeing with these findings, researchers addressed content analyses of interviews among Americans and discovered acute individualism in the American sample (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985). Other analysts have measured the constructs, utilizing their own procedures. For instance, procedures that included responses to items were utilized (i.e., "I am the kind of person who does X), where X

referred to a common individualistic or collectivistic attitude. In addition, the procedures require individuals to record (using the same attitudes) how members of their own culture commonly act (Sinha, & Verma, 1994). Miller (1984) detected that collectivistic people give more focus to the condition (context) than do individualistic people in making judgments of the appropriate conducts in different circumstances. The focus on context over content is particularly significant (Shweder & Bourne, 1982) in differentiating individualistic from collectivistic cultures and in comprehending cultural variations in communication patterns (Singelis & Brown, 1995; Triandis, 1994). Wagner and Moch (1986) utilized items that conceptually are associated with vertical collectivism (i.e., “people in a work group should be willing to make sacrifices for the sake of the work-group.”) Researchers requested participants to evaluate the significance of 25 principles accordance with family, close friends, colleagues, and outsiders (Weissman, Matsumoto, Brown, & Preston, 1993). Bierbrauer, Meyer, and Wolfradt (1994) developed a measurement that evaluated the normative and measures elements of the constructs that distinguished German from Kurdish participants.

Horizontal and Vertical Individualism and Collectivism Scale (VHIC)**.** This scale was created by Triandis and Gelfand, (1998) to measure the type and level of individualism and collectivism. The VHIC is a 16-item scale consisting of four dimensions and each dimension consists of four exclusive statements: Horizontal Collectivism (HC), includes a sample item such as: “I feel good when I cooperate with others.” Vertical Collectivism (VC), includes an example of a sample item such as: “It is my duty to take care of my family, even if I have to sacrifice what I want.” Horizontal Individualism (HI) includes an item like: “I would rather depend on myself than others.”

Vertical Individualism (VI) includes an item like: “When another person does better than I do, I get tense and aroused.” Participants rate statements using a 9-point Likert-type scale, ranking items from 0 = *strongly disagree* to 9 = *strongly agree*. This scale has been validated in many cross-cultural studies, and was concluded to be accurate across diverse samples (Strunk & Chang, 1999; Lee & Choi, 2005). Due to the multidimensional quality of this scale, it provides more views about individualism and collectivism than the classical uniform dimensional approach. In the current study, horizontal and vertical dimensions will be combined into one score for the principal constructs of individualism and collectivism. See appendix D

Self-Stigma of Seeking Help Scale. Self-stigma (SSOSH; Vogel et al., 2006) was used to measure self-stigma. It was designed to judge the belief that seeking mental health treatment threatens one’s self-respect, fulfillment with oneself, self-reliance, and in general self-worth. The SSOSH is a 10-item scale consisting of such sample items as: “I would feel inadequate if I went to a therapist for psychological help.” Participants rate using a 5-points Likert type scale, ranking items from 1 = *strongly disagree* to 5 = *strongly agree*. Vogel et al. (2006) observed converging validity in significant correlations of the SSOSH with attitudes and desires to seek therapy, positive and negative expectations of revealing conflict to therapists, and awareness of the public stigma related to seeking therapy. Internal consistency ($\alpha = .91$) has been accounted for excellent (Vogel et al., 2006). See appendix E

Perceived Devaluation-Discrimination Scale. This scale (PDD; Link, 1987) is used to measure perceived public stigma. It was designed to assess participants’ impressions of stigma toward ongoing or former psychiatric patients. The PDD is a 12-

item scale consisting of statements, such as “Most people would not hire a former psychiatric patient to take care of their children, even if he or she had been well for some time.” Participants respond using a 6-point Likert-type scale, ranking from 1 = *strongly agree* to 6 = *strongly disagree*. The sum of the 12 items indicates one total score for this instrument; the higher scores reveal greater perceived public stigma. Internal consistency assessed for this instrument have ranged from .76 to .88 among both community and clinical samples (Cullen, Dohrenwend, Link, Shrout, Struening, & 1989; Asmussen, Link, Neese-Todd, Struening, & Phelan, 2001). See appendix F

Attitudes Toward Seeking Professional Psychological Help Scale (Short form). This scale (ATSPPH-S; Fischer & Farina, 1995) was designed to assess attitudes toward seeking psychological help. This is a 10-item one dimensional version of an original 29-item scale for assessing attitudes toward seeking professional help (Fischer & Turner, 1970) consisting of statements such as: “Personal and emotional troubles, like many things, tend to work out by themselves.” Participants respond using a 4-point Likert-type format, ranking from 1 = *disagree to 4 = agree*. One single score is calculated from this measure. Higher scores indicate higher levels of positive attitudes towards seeking psychological help. The shorter and original scales were correlated ($r = .87$), indicating that they measured similar constructs (Fischer & Farina, 1995). Furthermore, the shorter version scale had been shown to correlate with earlier scales measuring seeking of professional help for a problem ($r = .39$). Test-retest reliability at 4 weeks ($r = .80$) and internal consistency ($\alpha = .84$) had been announced for samples of college students (Fischer & Farina, 1995). Fischer and Farina (1995) created this instrument to distinguish between college students with severe emotional disturbances who sought counseling and

another group with similar disturbances who did not. The scale has a positive correlation with desires to seek professional help (r = .56) and a negative relationship (r = -.19) with self-concealment inclinations for college student samples (Vogel, Wester, Wei, & Boysen, 2005). The internal consistency for this sample was .87. See Appendix G

Results

The data was collected from the five online questionnaires and was analyzed to examine the influence of culture (individualism, collectivism) on mental health stigma in a sample of 146 American and 141 Saudi adult men and women. This study attempted to find the differences in mental health stigma between two diverse cultures and the correlations between self-stigma, public stigma and seeking mental health treatment for Saudi versus American students on the basis of individualism-collectivism theory (Triandis, 1988). Version 21 of the SPSS (2012) statistical package was used to analyze the quantitative data. The data was collected from participants anonymously through a Survey Monkey website and then exported onto an SPSS spreadsheet for analysis. All questionnaires were presented in English.

The data collected from the author constructed Demographic Questionnaire was descriptively analyzed and indicated that the majority of participants were between the ages of 18 – 25 years (77.2%). A total sample size of 287 included proportionately about the same percentage of males and females. However, for Americans 146 participants (35 males, 111 females) ratio of males to females was 24 % males, 76% females. For the Saudis 141 participants (107 males, 34 females) there was the inverse ratio of males to females, 76% males, 24% females. The data showed that for ethnicity, the majority of the

Saudis identified as Arab (97.2%), Americans identified as Hispanic (35.6%), African-American (35.6%), Caucasian (17.1) and other (11%). See Appendix H

Four independent sample *t*-tests were conducted to evaluate the hypotheses H1, H2, H3, and H4. Pearson Product Moment correlations were used to test the relationship between self-stigma, public stigma and seeking mental health treatment for Saudis. Chi-Square analyses were conducted to determine specific cultural relationships between the demographic questionnaire variables.

H1: Hypothesis 1 stated that Saudis would be significantly more collectivistic than Americans. For H1, Table 1 revealed that Saudis (M = 111.89, SD = 15.67) had higher levels of collectivism compared to Americans (M = 99.76, SD = 17.41). A t-test was conducted on the scores from the *VHIC* to statistically compare the levels of collectivism for Saudis versus Americans. The analysis revealed that Saudis had significantly higher levels of collectivism compared to Americans, $t(285) = -6.20$, $p \leq 0.00$. See Table 1

H2: Hypothesis 2 stated that Saudis would have higher levels of self-stigma regarding mental health treatment versus Americans. For H2, Table 1 indicates that Saudis (M = 26.67, SD = 5.54) had higher levels of self-stigma compared to Americans (M = 24.78, SD = 6.18). A t-test analysis of the scores from the SSOSH revealed that there was a significant difference between Saudis versus Americans regarding levels of self-stigma, $t(285) = -2.73$, $p < .007$

Table 1

Means and Standard Deviations of all Variables: Individualism, Collectivism, Self-Stigma for Seeking Help (SSOSH), Perceived Devaluation-Discrimination (PDD), and Attitude Toward Seeking Professional Psychological Help (ATSPPH) for American versus Saudi students.

Variable	Americans		Saudis				
Scores	*M*	*SD*	*M*	*SD*	*t*	*df*	*Sig.*
1. Individualism	55.99	14.46	54.43	14.47	0.91	285	.360
2. Collectivism	99.76	17.41	111.89	15.67	-6.20	285	.000*
3. SSOSH	24.78	6.18	26.67	5.54	-2.73	285	.007*
4. PDD	46.15	8.79	42. 21	7.97	3.98	285	.000*
5. ATSPPH	12.73	5.42	13.80	4.10	-1.90	270	.058

Note. Americans N = 146, *Saudis N* = 141. *p $<$ .01.

H3: Hypothesis 3 stated that Saudis would have higher levels of public stigma regarding mental health treatment versus Americans. For H3, Table 1 indicates that Saudis (*M* = 42. 21, *SD* = 7.97) had lower levels of public stigma compared to Americans (*M* = 46.15, *SD* = 8.79). T-test analysis on the scores from the PDD revealed that there was a significant difference between Saudis versus American level of public-stigma in the opposite direction predicted, t (285) = 3.98, p = 000. Thus, hypothesis 3 was significant in the opposite direction predicted. Americans had significantly higher levels of public stigma.

H4: Hypothesis 4 stated that Saudis would have less positive attitudes regarding seeking psychological help versus Americans. For H4, Table 1 indicated that Saudis (*M* = 13.80,

SD = 4.11) had slightly more positive attitudes regarding seeking psychological help compared to Americans (*M* = 12.73, *SD* = 5.42). A t-test was conducted on the scores from the ATSPPH to compare Saudi versus American students on the level of attitudes regarding seeking psychological help. The resulting analysis of the scores from the ATSPPH showed that there was no significant difference in the scores for the level of the positive attitudes regarding seeking psychological help between Saudis versus Americans, $t(270) = -1.90$, $p = 0.058$. Therefore, H4 was not supported.

H5: Hypothesis 5 stated that there would be a significant negative correlation between self-stigma (SSOSH) and seeking mental health treatment (ATSPPH) for Saudis. For H5, Table 2 indicated that there was a significant positive correlation between self-stigma and seeking mental health treatment for Saudis $r(141) = .437$, $p < 0.00$. This hypothesis was significant in the opposite direction predicted. See Table 2. Therefore, H5 was not supported.

Table 2

Correlation Coefficients for Self-Stigma for Seeking Help (SSOSH) and Attitude Toward Seeking Professional Psychological Help (ATSPPH) Scores for Saudi students.

Variables	1	2
SSOSH		
ATSPPH	.437**	_

Note. *N* = 141. ***p* <0.01

H6: Hypothesis 6 stated that there would be a significant negative correlation between public stigma (PDD) and seeking mental health treatment (ATSPPH) for Saudis. For H6, Table 3 indicated that there was no significant negative correlation between public stigma

(PDD) and seeking mental health treatment (ATSPPH) for Saudis $r(141) = .163$, $p > 0.05$. See Table 3. Therefore, H6 was not supported.

Table 3

Correlations for Self-Stigma for Seeking Help (SSOSH) and Perceived Devaluation-Discrimination (PDD) Scores for Saudis students.

Variables	1	2
PDD		
ATSPPH	.163	_

Note. $N = 141$.

Summary of Findings

In sum, the results indicate that Saudi students were more collectivistic than American students. The results also indicated that Saudi students had higher levels of self-stigma regarding mental health treatment versus American students. A third analysis revealed that Saudi students had lower levels of public stigma compared to American students. Analysis also revealed that Saudis had more positive attitudes regarding seeking psychological help versus American students. The findings also indicated a significant positive correlation between self-stigma and seeking psychological treatment for Saudi students.

Discussion

The results of this study partially supported the hypotheses that the individualism-collectivism model would predict the mental health stigma and attitudes toward seeking psychological help for Saudi students. Data collected for the first hypothesis indicated that there was a significant difference in higher collectivism scores for the Saudi students compared to the American students. However, it was expected that there would also be a

significant difference in individualism scores for the Americans compared to Saudis. The data collected revealed no significant difference between Americans (*M* = 55. 99, *SD* = 14.46) versus Saudis (*M* = 54. 43, *SD* = 14.47) for individualism scores (t (285) = 0.91, *p* = 0.36). See Table 1. This failure to find a significant difference in individualism scores for Americans indicates that the population of Americans was not an individualistic as predicted. Results from chi-square analyses of variables from the demographic questionnaire provided some insights into this finding, see below. Hypothetically, this lack of difference in individualism could be the result of: a) The American population of this study was not as individualistic as the population Triandis explored, b) The Saudis in this study were more individualistic than predicted, or c) a combination of both a and b.

Regarding the American population of this study, Appendix H shows that the sample was only 17% Caucasian. More than one third (36%) was Hispanic, a collectivism culture. A second third was African American (36%), also more collectivistic than Caucasians. Clearly, the population sample was culturally more diverse than the one sampled by Triandis. Hispanics may be presumed to be more collectivistic than Caucasians. Also, in comparison to Caucasians, African Americans culture may be presumed to be more collectivistic.

Another confounding in the demographic data was the imbalance in gender rates between the two populations. There were three times as many females in the American population. See Table 4. A chi-square analysis revealed a significant difference in the ratio of males to females in the two populations χ^2 (3.287) = 77.33, $p < .000$ See Table 5. With a large ratio of Hispanics and African Americans, the American individualism scores may have been confounded.

Table 4

Frequencies and Percentages for the Data from the Demographic Questionnaire: American versus Saudi students for Gender Ratios.

Cultural Background		n	%
	Gender		
Americans	Male	35	24.0
	Female	111	76.0
Saudis	Male	107	75.9
	Female	34	24.1

Note. Americans N = 146, *Saudis N* = 141.

Table 5

Chi-square for American versus Saudi students for Gender Ratios.

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	77.333a	3	.000		
N of Valid Cases	287				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 69.76.
b. Computed only for a 2x2 table

Another demographic difference in the two samples had to do with marital status. Twice as many Saudis (80. 9%) were married compared to Americans (42. 5%). This difference turned out to be significant by chi-square analysis χ^2 (3, 287) = 48. 84, $p < .05$. See Tables 6 and 7. Most of the American population was unmarried (54%) compared to the Saudis (36%). See Appendix H. Family settings tend to be more collectivistic, especially for this American population. Once again indicating that the American population lacked the level of individualism present in the Triandis population.

Table 6

Crosstabulation of American versus Saudi students for Marriage Status.

Cultural background	Parents current status	n	%
Americans	Married	62	42.5
	Divorced or Separated	45	30.8
	Widowed	7	4.8
	Unmarried	32	21.9
Saudi	Married	114	80.9
	Divorced or Separated	11	7.8
	Widowed	7	5.0
	Unmarried	9	6.4

Note. Americans N = 146, *Saudis N* = 141.

Table 7

Chi-Squares tests of American versus Saudi students for Marriage Status.

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	48.837a	3	.000
Likelihood ratio	51.337	3	.000
Linear-by-linear association	29.688	1	.000
N of valid cases	287		

0 cells (0.0%) have expected count less than 5. The minimum expected count is 6.88.

The second hypothesis was that Saudis would have higher levels of self-stigma regarding mental health treatment versus Americans was supported based on the scores from the SSOSH. The findings support previous research showing that more self-stigma in collective cultures. (Triandis, 1995)

The third hypothesis stated that Saudis would have higher levels of public stigma regarding mental health treatment. It was not only not supported, but the results were significant in the opposite direction. The results from the PDD scores indicate that Saudis have less negative attitudes about others with mental health problems versus Americans. The demographic questionnaire data of the current study revealed a possible explanation regarding level of education. The level of education achieved was significantly different between the two populations. Saudis had achieved significantly higher levels of education compared to the Americans, χ^2 (3, 287) = 83.55, $p < 0.00$. See Tables 8 and 9. One may suspect that individuals with higher levels of education would be more tolerant of individuals with mental health problems. Previous research supports this speculation. (Triandis & Singelis, 1995)

Table 8

Crosstabulation of American and Saudi students for levels of education.

Cultural Background	Level of Education	n	%
Americans	High school	98	67.1
	Bachelor	47	32.2
	Master	1	0.7
Saudis	High school	26	18.4
	Bachelor	78	55.3
	Master	33	23.4
	PhD	4	2.8

Note. *Americans* N = 146, *Saudis* N = 141.

Table 9

Chi-Squares tests of American and Saudi students for levels of education.

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	83.55	3	.000
Likelihood ratio	95.88	3	.000
Linear-by- linear association	80.94	1	.000
N of valid cases	287		

2 cells (25.0%) have expected count less than 5. The minimum expected count is 1.97.

The fourth hypothesis was that Saudis would have less positive attitudes regarding seeking psychological help compared to Americans was not supported. Saudi's scores on the ATSPPH revealed that there was no significant difference in attitudes between Americans and Saudis regarding getting better treatment for mental health issues. Data from our demographic questionnaire regarding three questions concerning mental health services may provide more insight into this finding. The Saudis and Americans showed no significant difference in their attitudes toward individuals seeking psychological help according to their responses to these three questions. Three questions were presented to the two populations: 1) Have you ever sought mental health services (psychiatrist, psychologist, mental health counsellor)? The results from this question revealed no significant different by chi-square analysis χ^2 (1, 287) = 0.318, $p > .05$. See Tables 10 and 11.

Table 10

Crosstabulation for American and Saudi students question regarding if the person ever seek mental health services.

Cultural Background	Have you ever sought mental health services (psychiatrist, psychologist, mental health counselor)?	N	%
Americans	Yes	48	32.9
	No	98	67.1
Saudis	Yes	42	29.8
	No	99	70.2

Note. Americans N = 146, *Saudis N* = 141.

Table 11

Chi-Squares Tests of American versus Saudi students a question regarding if the person ever seek mental health treatment.

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.318a	1	.573		
N of Valid Cases	287				

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 44.22.
b. Computed only for a 2x2 Table

2) Have you ever encouraged someone to seek mental health services (psychiatrist, psychologist, mental health counselor)? Results from this question revealed no significant difference by chi-square χ^2 (1.287) = 0. 730, $p > .05$. See Table 12 and 13

Table 12

Crosstabulation for American versus Saudi students for question regarding if they ever encouraged someone to seek mental health services.

Cultural Background	Have you ever encouraged someone to seek mental health services (psychiatrist, psychologist, mental health counselor)?	n	%
Americans	Yes	86	58.9
	No	60	41.1
Saudis	Yes	76	53.9
	No	65	46.1

Note. Americans N = 146, *Saudis N* = 141.

Table 13

Chi-Squares Tests of American versus Saudi students for question regarding if they ever encouraged someone to seek mental health services.

	Value	Df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)
Pearson Chi-Square	.730a	1	.393	
N of Valid Cases	287			

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 61.41.
b. Computed only for a 2x2 Table

3) How would you feel about someone who seek mental health services? Results from this question revealed no significant difference by chi-square analysis χ^2 (1,287) = 0.748, $p > .05$. See Tables 14 and 15.

Table 14

Crosstabulation for American versus Saudi students for question regarding how the person feels about someone who seeks mental health services..

Cultural Background	How do you feel about someone who seek mental health services?	N	%
Americans	Acceptable	140	95.9
	Unacceptable	6	4.1
Saudis	Acceptable	132	93.6
	Unacceptable	9	6.4

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 7.37.
b. Computed only for a 2x2 Table.

Table 15

Chi-Squares tests of American versus Saudi students for question regarding how the person feels about someone who seeks mental health services.

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.748a	1	.387		
N of Valid Cases	287				

b. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 7.37.
b. Computed only for a 2x2 Table.

The fifth hypothesis was that for Saudi students there would be a significant negative correlation between self-stigma and seeking mental health treatment based on correlation of the SSOSH and ATSPPH scores. This hypothesis was not supported. Again, not only was this hypothesis not supported, but it was significant in the opposite

direction from what was predicted. That is for the Saudis, the more self-stigma they felt the more likely they were to seek mental health treatment.

The sixth hypothesis stated that for Saudis there would be a significant negative correlation between public stigma (PDD) and seeking mental health treatment (ATSPPH) scores. The data did not support this hypothesis. See Table 3

The study's previous findings regarding hypothesis 3 and 4 help to explain the failure of significance in hypothesis six. The Saudi population had significantly less public stigma regarding mental illness compared to the Americans. See Table 1. There was also no significant difference between Saudis and Americans regarding seeking mental health treatment. See Table 1. Therefore, it is understandable that there was no significant correlation between public stigma and seeking mental health treatment for the Saudis.

As previously mentioned, the current study's results from the demographic questionnaire also revealed that the Saudis population had a higher rate of marriage and less divorce rate than Americans. These results support the finding that collectivistic cultures tend to have longer and more stable relationships than individualistic ones (Triandis, 1995). See Tables 6 and 7.

Traveling and living abroad can increase the chances to make decisions on one's own life style, and could lead to greater individualism. This observation may also help explain the unexpected high individualism scores for Saudis. Those who travel a lot become exposed to different point of views, including increasing individualism attitudes.

Another variable that may have contributed to these results is acculturation. Previous studies have shown that Asian Americans are more tolerant of the stigma

associated with mental health issues and are more open to seeking professional help (Atkinson & Gim, 1989). Moreover, in a study of individualistic versus collectivistic of college students in Lebanon, Ayyash-abdo (2001) found that participants who spoke mainly Arabic were more collectivistic than those who were bilingual. The Saudi population tested was completely bilingual. All the questionnaires were presented in English. It is not certain that Saudi acculturated since many Saudis associate with other Saudis when they travel abroad.

As previously mentioned, the results from the demographic questionnaire revealed that Saudis had a higher levels of education. Education generally leads to greater exposure to cultural diversity and tends toward individualism. In a study by Triandis and Singelis (1995), where education and another 11 variables of subjective collectivism were used among American students, education was the most important factor in the degree of individualistic attitudes. The Saudi population was significantly more educated. See Tables 8 and 9

As previously mentioned, there was no significant difference in individualism scores between Saudi versus American students. Hence, this may explain the positive attitude toward seeking mental health treatment for Saudis. People from individualistic cultures are more likely to accept diversity and deviation from the norm because such cultures are more disjoined because of the desire to achieve personal goals. Specifically, higher levels of individualism in groups is correlated with less stigmatizing attitudes. Individualism plays an illustrative role in higher levels of positive attitudes toward seeking mental health treatment (Triandis, 1995).

Collectivistic cultures have higher levels of self-stigma because of low levels of diversity and fragmentation. Those who deviate from the norm are more likely to be visible to the society because of higher levels of surveillance. Individualists tend to seek the advice of professional therapists and counselors, whereas collectivists go to informal third-party mediators, such as relatives and work supervisors. Problem solving must be individual-based for individualists and group- based in collectivistic cultures.

Results of this study supported the observation that people from a collectivistic culture (i.e. Saudi Arabia) had a higher level of self-stigma. However, it seems the Saudi population had also assimilated some individualistic attitudes regarding mental services.

Individuals in collectivistic cultures may yield their first concerns to the in-group goals, this may lead to the belief that someone is culturally undesirable if they seek mental health treatment. These views can influence individuals to see themselves as devalued and/ or fail to seek treatment from professionals.

Triandis, Bontempo, Villareal, et al. (1988) proposed that collectivists may be physically healthier than individualists because stress in individualist cultures weakens the immune system, and that is a precursor of heart disease and other infections. There is little doubt that social support is a significant factor in good health. For instance, House, Landis, and Umberson (1988) showed that the chances of death are much higher for both animals and humans who do not have social bonds. One can look at data about individuals who are married versus those who are unmarried and who have or do not have an extended family and see that those with social bonds have fewer accidents, fewer psychotic episodes, and more of a sense of life’s meaning; they are more likely to take of themselves and live longer.

An important contribution to this topic was made by anthropologist Hsu (1983). He compared Chinese and Japanese cultures on the one hand and American culture on the other. He emphasized the importance of harmony within the in-group collectivistic culture and noted less crime, fewer hospital admissions (possibly because home care is more available), and less drug abuse among the collectivists compared to the individualists. He noted more scientific achievements, democratic situations, conquests of new frontiers, domination of things (owning objects) and animals (pets), and attempts to proselytize among individualists. Hsu (1983) highlighted the link between individualism and competition. According to Hsu, the link between individualism and competition results in aggressive creativity and large military expenditures and increases in prejudice toward racial and religious minorities as the dominant group puts down minorities in order to boost its self-concept.

Limitations

The current study was aimed at understanding how culture influences mental health stigma and its effects on awareness of individuals to seek psychological assistance. There are some limitations which need to be considered when interpreting the results of the current study. First, since the study used a Saudi sample who studied in the United States, it is difficult to generalize the data beyond this population. In addition, all the data was collected through self-reported measures. This brings up the issue of mono method bias, which is a threat to construct validity (Heppner, Kivlighan, & Wampold, 1999). Second, acculturation was not directly examined for the Saudis. The level of acculturation might have been a crucial factor on attitudes toward seeking professional psychological help. Third, the instruments used in this study were not culture specific.

They were not constructed for a Saudi population. All questionnaires were administered in English. Future research may incorporate culturally appropriate measurements.

It is interesting to note that the attitudes toward seeking psychological treatment are also impacted by patient-therapist compatibility on demographic variables. Flaskerud and Liu (1991) found that client-therapist agreeableness on language and ethnicity significantly increased number of sessions with Asian clients. Jerell (1995) also found that therapists whose ethnicity was congruent with their patients showed longer lengths of stay in therapy. Furthermore, Kelly and Aridi (1996) found that 56.2% of American Muslims in their study considered it “very crucial” that the therapist be well-informed about Islam.

Pilot study data from our investigation revealed that some Saudis indicated a preference for a Muslim therapist who would follow the teaching of the Qur’an. Client-therapist match on religion may influence attitudes toward counseling within the Saudis population. In future research, using open-ended questions through qualitative methods to investigate Saudi attitudes regarding psychological assistance may highlight the importance of cultural congruity as a variable and its effects on attitudes toward psychotherapy (i.e., client-therapist congruency on ethnicity and religion). Moreover, conducting qualitative research with the Saudi population may initially prove more helpful than quantitative methods in obtaining more information about help-seeking attitudes and mental health needs.

Implications

The current study offers a foundation on which future theory, practice and research can grow and prosper in relation to mental health stigma for Saudis. There are

several implications for this study. The first implication would be the direct importance of religious influence in Saudi culture. Future research can explore the relationship between mental health stigma and indigenous healing or alternative ways for seeking mental health treatment (e.g., seeking consultation from a family member, religious leaders, religious books, or seeking help from God). Identifying these alternative more acceptable ways of help seeking within Saudi society and employing them in the therapy may result in lower levels of mental health stigma.

The second implication, which is a practical implication, is that informal methods of therapy or natural support systems have been found to be strongly therapeutic for many minority groups. There are some alternative forms of therapy that might work more effectively with the Saudi population. For instance, some experts have suggested the usefulness of indigenous healing methods for this group of people as a substitute to traditional Western therapy approaches (e.g. Quranic therapy, family support). Traditional Western therapy might not work as effectively for Saudis; thus, it is significant to have knowledge about Muslim values and norms when working with Saudis population.

Mental health clinicians should keep in their mind the individualistic-collectivistic model, so that they can be as sensitive, knowledgeable, and as competent as possible when trying to understand a culture they are not congruent with it. Clinical training and supervision must take the principal of cultural congruency into account.

Furthermore, it is important to spread awareness about mental health services since many individuals may be confused between psychiatrists, psychologists, mental health counselors, and social workers. Education on the role of medication is also

necessary, some individuals may decide not to seek therapy because they may think they have to take medications no matter what psychological problems they have. They do not realize that a psychologist can provide help without medications. Thus, educating people can help them to make better decisions regarding seeking psychological help.

Finally, there has been too little research that is associated with mental health stigma and Saudis. The word stigma is unknown to the majority of Saudis. It may be essential to foster much more education regarding the phenomena of stigma itself.

The lack of mental health information provided to Saudis plays a role in seeking or not seeking mental health treatment. Saudis may not realize the importance of going to a professional therapist. Hence, informing them about the benefits should be discussed educationally at community Arab meetings. Future research may be directed to developing a new cultural congruent attitude scale that matches Muslims, and Saudis in particular values and norms. This would give better opportunities to researchers to have a clearer understanding of Saudis mental health needs.

Future research that is looking for the factors that contribute to mental health stigma should give consideration to the role of both individualistic and collectivistic as traits, as both traits exist in every culture. The results collected from the present research show both traits existed within the two populations.

It can be proposed that psychological well-being is related to the balance between individualistic and collectivistic tendencies. Many stressful issues of modern life can be related to high levels of individualism. The variation between collectivist and individualist cultures can lead to major gaps in international relations. International relations have become increasingly antagonistic. It is widely held that roughly 70 percent

of the population around the globe, is collectivist, and many in these groups disagree with Western values.

For people who are collectivistic and live in individualistic cultures or vice versa, it is advisable to self-monitor behaviors when they are in a culture that is different than their own. If a collectivistic person lives in an individualistic culture and vice versa, it would be recommended to assimilate with the host culture.

In the final analysis, good mental health rests on considering both individualistic and collectivistic propensities which influence human behavior and psychological well-being. Furthermore, it is important to know when to perform the individualistic and the collectivistic approaches situationally. In conclusion, furthering the study of mental health stigma must be supported so that empirical results and implications might be considered by policy makers and health care professionals, and ultimately mental health stigma may be reduced in collectivist cultures.

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Appendix A

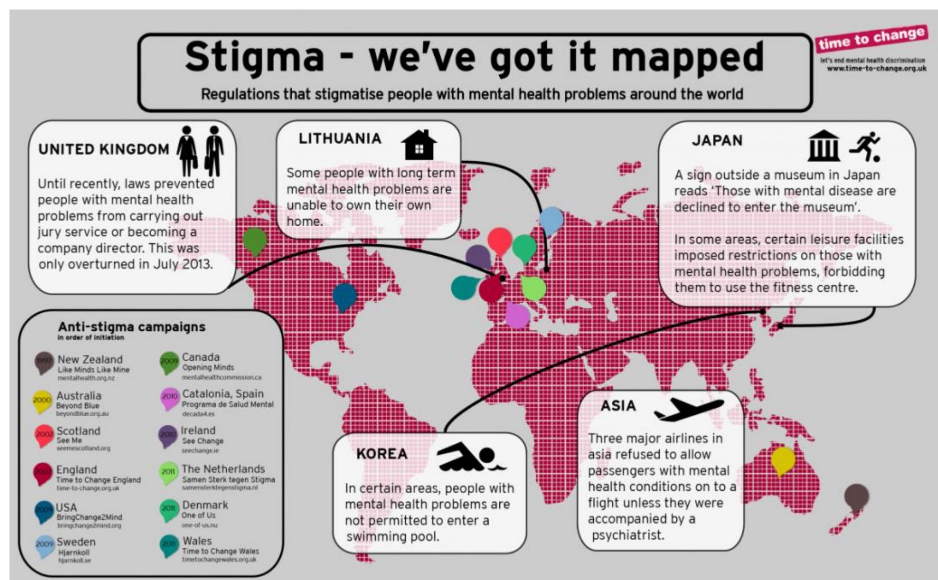
Announcement Letter

Hey undergraduate students! Would you be interested in participating in a study that assesses the influence of culture on mental health stigma: Saudi versus American college students. **<u>The participation requirement:</u>**

Barry University students, 18-25 years of age.

<u>Study Details:</u>

- This is an anonymous online study through Psych Surveys.
- Study takes approximately 20-30 minutes to complete.
- You are free to withdraw your participation at any time without penalty of you choose not answer any question.
- You may be able to receive extra credit for your participation if you are currently enrolled in a psychology course.
- If you want to participate, please click on this link: https://www.surveymonkey.com/r/WPHLCLT



If you have any questions, feel free to contact Duaa Ashoor: duaa.ashoor@mymail.barry.edu or my supervisor: Dr. Stephen Koncsol:

skoncsol@barry.edu or the Institutional Review Board point of contact, Barbra Cook, at (305)8993020 or bcook@barry.edu.

Appendix B

Barry University
Cover Letter

Dear Research Participant:

Your participation in a research project is requested. The title of the study is *The Influence of Culture on Mental Health Stigma: Saudi versus American College Students*. The research is being conducted by Duaa Ashoor, a graduate student in the psychology Department at Barry University, and it is seeking information that will be useful in the field of psychology and treatment planning. The goals of the research are to examine the influence of culture on mental health stigma between individuals from different ethnicities. In accordance with these goals, the following procedure will be used: five questionnaires follow this letter; these questionnaires are a self-report questionnaires, follow this letter. I anticipate the number of participants to be 300.

If you decide to participate in this research, you will be asked to do the following: Answer the questions on the first 12-item demographic questionnaire; the second is the *Horizontal and Vertical Individualism and Collectivism Scales (VHIC)* a 16-item 9-point Likert scale, measuring the type and level of individualism and collectivism; the third questionnaire is the *Self-Stigma of Seeking Help Scale (SSOSH)* the 10-item 5-points Likert, measuring self-stigma; the third questionnaire is the *Perceived Devaluation-Discrimination Scale (PDD) a* 12-item 6-point Likert scale, measuring perceived public stigma; and the fifth questionnaire is the *Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) (short form)* a 10-item 4-point Likert attitudes toward seeking psychological help. The questionnaires are estimated to take no more than 30 minutes to complete.

Your consent to be a research participant is strictly voluntary and should you decline to participate or should you choose to drop out at any time during the study, there will be no adverse effects. If you are a student there will be no effect on your grades.

There are no foreseeable risks associated with this study. The following procedures will be used to minimize these risks: You can skip any questions you do not want to answer. There are no direct benefits to you for participating in this study; however, your participation will contribute to research in the area of psychology and treatment planning.

If you are an undergraduate student currently enrolled in a psychology course at Barry University, you may be able to receive extra credit for your participation. Print a copy of this cover letter as proof of your participation.

As a research participant, information you provide is anonymous, that is, no names or other identifiers will be collected. SurveyMonkey.com allows researchers to suppress the delivery of IP addresses during the downloading of data, and in this study no IP address will be delivered to the researcher. However, SurveyMonkey.com does collect IP addresses for its own purposes. If you have concerns about this you should review the privacy policy of SurveyMonkey.com before you begin.

By completing and submitting this electronic survey you are acknowledging that you are at least 18-years-old and that you voluntarily agree to participate in the study.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Duaa Ashoor, by email at duaa.ashoor@mymail.barry.edu or Dr. Stephen Koncsol, by phone at (305) 899-3270, or by email at skoncsol@barry.edu. You may also contact the Institutional Review Board point of contact, Barbara Cook, by phone at (305) 899-3020 or by email at bcook@mail.barry.edu.

Thank you for your participation.

Sincerely,
Duaa Ashoor, B.A.

Print this page if you need proof of participation.

Appendix C

Demographic Questionnaire

These questions are a biographical questionnaire that is mandatory for the next questionnaires. Authenticity will affect our result, so please consider the importance of being genuine. Please circle one of the following answers:

1. Gender
a) Male b) Female
2. Age between
a) 18-25 years b) 26-35 years c) 36-45 years d) 45+
3. Marital status
a) Single b) Married
4. Ethnicity:
a) Caucasian b) African American c) Hispanic d) Arab e) Other
5. Level of education
a) High school b) Bachelor c) Master d) PhD e) Post Doctorate
6. Years of living in the United State
a) 2 years b) 3 years c) 4 Years d) 5 years e) 6+ years
f) Never lived in the United States, but visited g) Never lived in the United States and never visited
7. Current living Situation
a) With Family b) By myself c) With others
8. Parents current status
a) Married b) Divorced or separated c) Widowed d) Unmarried
9. Your annual income in Dollar
a) Less than 25,000 b) 25,000- 50,000 c) 50,000- 75,000 d) More than 75,000
10. How often do you stay in touch with your family?
a) Daily b) Weekly c) Monthly d) Yearly e) Do not communicate
11. Have you ever sought mental health services (psychiatrist, psychologist, mental health counselor)?
a) Yes b) No
12. Have you ever encouraged someone to seek mental health services (psychiatrist, psychologist, mental health counselor)?
a) Yes b) No
13. How do you feel about someone who seek mental health services?
a) Acceptable b) Unacceptable
14. Religion
a) Christian b) Jewish c) Islam d) Other

Appendix D

Horizontal and Vertical Individualism and Collectivism Scale-16 (VHIC-16)

Read each statement carefully and indicate your degree of agreement using the scale below.

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Strongly agree agree				**Unsure**				**Strongly disagree**

1. I prefer to be direct and forthright when I talk with people.
2. My happiness depends very much on the happiness of those around me.
3. I would do what would please my family, even if I detested that activity.
4. Winning is everything.
5. One should live one's life independently of others.
6. What happens to me is my own doing.
7. I usually sacrifice my self-interest for the benefit of my group.
8. It annoys me when other people perform better than I do.
9. It is important for me to maintain harmony within my group.
10. It is important to me that I do my job better than others.
11. I like sharing little things with my neighbors.
12. I enjoy working in situations involving competition with others.
13. We should keep our aging parents with us at home.
14. The well-being of my co-workers is important to me.
15. I enjoy being unique and different from others in many ways.
16. If a relative were in financial difficulty, I would help within my means.
17. Children should feel honored if their parents receive a distinguished award.
18. I often do "my own thing".
19. Competition is the law of nature.
20. If a co-worker gets a prize I would feel proud.
21. I am a unique individual.
22. To me, pleasure is spending time with others.
23. When another person does better than I do, I get tense and aroused.
24. I would sacrifice an activity that I enjoy very much if my family did not approve of it.
25. I like my privacy.
26. Without competition it is not possible to have a good society.
27. Children should be taught to place duty before pleasure.
28. I feel good when I cooperate with others.
29. I hate to disagree with others in my group.
30. Some people emphasizes winning; I am not one of them.
31. Before taking a major trip, I consult with most members of my family and many friends.
32. When I succeed, it is usually because of my abilities.

Appendix E

Self-Stigma of Seeking Help Scale-10 (SSOSH-10)

1	2	3	4	5
Strongly agree	**Agree**	**Neither**	**Disagree**	**Strongly disagree**

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Appendix F

Perceived Devaluation-Discrimination Scale-12 (PDD-12)

Read each statement carefully and indicate your degree of agreement using the scale below. (PDD)

1	2	3	4	5	6
Strongly agree	**Agree**	**Agree slightly**	**Slightly disagree**	**Disagree**	**Strongly disagree**

1. Most people would willingly accept a former psychiatric patient as a close friend.
2. Most people believe that a person who has been in a psychiatric hospital is just as intelligent as the average person.
3. Most people believe that a former psychiatric patient is just as trustworthy as the average citizen.
4. Most people would accept a fully recovered former psychiatric patient as a teacher of young children in a public school.
5. Most people feel that entering a psychiatric hospital is a sign of personal failure.
6. Most people would not hire a former psychiatric patient to take care of their children, even if he or she had been well for some time.
7. Most people think less of a person who has been in a psychiatric hospital.
8. Most employers will hire a former psychiatric patient if he or she is qualified for the job.
9. Most employers will pass over the application of a former psychiatric patient in favor of another applicant.
10. Most people in my community would treat a former psychiatric patient just as they would treat anyone.
11. Most young people would be reluctant to date someone who has been hospitalized for a serious psychiatric disorder.
12. Once they know a person was in a psychiatric hospital, most people will take his or her opinions Iess seriously.

Appendix G
Attitudes Toward Seeking Professional Psychological Help Scale (Short form-10) (ATSPPH-10)

Read each statement carefully and indicate your degree of agreement using the scale below.

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

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counseling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
9. A person should work out his or her own problems; getting psychological counseling would be a last resort.
10. Personal and emotional troubles, like many things, tend to work out by themselves.

Appendix H

Frequencies and Percentages for the Data from the Demographic Questionnaire: American versus Saudi students and Mental Health Stigma.

Cultural Background		n	%
	Gender		
Americans	Male	35	24.0
	Female	111	76.0
Saudis	Male	107	75.9
	Female	34	24.1
	Age range		
Americans	18-25 years	140	95.9
	26-35 years	5	3.4
	36-45 years	1	0.7
Saudis	18-25 years	80	56.7
	26-35 years	57	40.4
	36-45 years	4	2.8
	Marital Status		
Americans	Single	141	96.6
	Married	5	3.4
Saudis	Single	102	72.3
	Married	39	27.7
	Ethnicity		
Americans	Caucasian	25	17.1
	African American	52	35.6
	Hispanic	52	35.6
	Arab	1	0.7
	Other	16	11.0
Saudis	Caucasian	1	0.7
	Arab	137	97.2
	Other	3	2.1
	Level of Education		
Americans	High school	98	67.1
	Bachelor	47	32.2

	Master	1	0.7
Saudis	High school	26	18.4
	Bachelor	78	55.3
	Master	33	23.4
	PhD	4	2.8
	Years of living in the United State		
Americans	2 years	9	6.2
	3 years	6	4.1
	4 years	2	1.4
	5 years	3	2.1
	6 + years	125	85.6
Saudis	2 years	43	30.5
	3 years	34	24.1
	4 years	24	17.0
	5 years	22	15.6
	6 + years	12	8.5
	Never lived in the United States, but visited	5	3.5
	Never lived in the United States and never visited	1	0.7
	Current living Situation		
Americans	With family	79	54.1
	By myself	36	24.7
	With others	31	21.2
Saudis	With family	50	35.5
	By myself	53	37.6
	With others	38	27.0
	Parents current status		
Americans	**Married**	62	42.5
	Divorced or Separated	45	30.8
	Widowed	7	4.8

	Unmarried	32	21.9
Saudi	Married	114	80.9
	Divorced or Separated	11	7.8
	Widowed	7	5.0
	Unmarried	9	6.4
	Your annual income in Dollar		
Americans	Less than 25,000	122	83.6
	25,000- 50,000	14	9.6
	50,000- 75,000	7	4.8
	More than 75,000	3	2.1
Saudis	Less than 25,000	79	56.0
	25,000- 50,000	50	35.5
	50,000- 75,000	7	5.0
	More than 75,000	5	3.5
	How often do you stay in touch with your family?		
Americans	Daily	96	65.8
	Weekly	39	26.7
	Monthly	11	7.5
Saudi	Daily	67	47.5
	Weekly	62	44.0
	Monthly	12	8.5
	Have you ever sought mental health services (psychiatrist, psychologist, mental health counselor)?		
Americans	Yes	48	32.9
	No	98	67.1
Saudis	Yes	42	29.8
	No	99	70.2
	Have you ever		

	encouraged someone to seek mental health services (psychiatrist, psychologist, mental health counselor)?		
Americans	Yes	86	58.9
	No	60	41.1
Saudis	Yes	76	53.9
	No	65	46.1
	How do you feel about someone who seek mental health services?		
Americans	Acceptable	140	95.9
	Unacceptable	6	4.1
Saudis	Acceptable	132	93.6
	Unacceptable	9	6.4
	Religion		
Americans	Christians	88	60.3
	Jewish	2	1.4
	Muslims	5	3.4
	Others	51	34.9
	Muslims	136	96.5
	Others	5	3.5

Note. Americans N = 146, *Saudis N* = 141.