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The Effects of Culture on Mental Health Stigma and Modes of Psychological Treatments: Hungarian versus American College Students

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BARRY UNIVERSITY

The Effects of Culture on Mental Health Stigma and Modes of Psychological Treatments: Hungarian versus American College Students

by

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Dedication

To my Grandfather. Papa: I hope that I can make you proud.

A nagyapámnak. Papa: Remélem büszke vagy Rám.

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Abstract

The present study aimed to explore several factors that predict psychological help-seeking attitudes and behaviors among a sample of Hungarian and American college students. The aims of the research were to examine the different attitudes towards mental illness and modes of treatment held by Hungarian and American students, and to compare the two groups on different variables affecting those attitudes. Cultural values were measured by scores from the following: *Vertical Horizontal Individualism-Collectivism Scale* (VHIC; Triandis et. al, 1995), *Community Attitudes Toward Mental Illness* (CAMI; Taylor et al., 1979), *Attitudes Toward Seeking Professional Psychological Help Scale-Short Form* (ATSPPH-SF; Fisher & Farina, 1995), and a demographic questionnaire which included a question on psychotropic medications. The four completely anonymous surveys were distributed to 292 college students through their universities' online systems in Budapest, Hungary and Miami, USA. In order to accurately measure participants stigmatizing behavior and help-seeking attitudes in Hungary, Hungarian translations were provided. It was hypothesized that: a) Hungarian students would be significantly more collectivistic than American students, b) Hungarians would have significantly more stigma toward mental illness and mental health treatment compared to American students, c) have significantly less positive attitudes regarding seeking psychological help compared to American students, and d) Hungarians would significantly disapprove of psychotropic medications compared to Americans. The Individualist-Collectivist framework was applied as a possible explanatory paradigm that could account for differing attitudes toward mental illness stigma. Statistical analyss of the data revealed: 1) Hungarians were significantly more individualistic than the Americans contrary to prediction, 2) Hungarians had significantly higher levels of mental health stigma compared to Americans as predicted, 3)Hungarians had significantly more positive attitudes toward seeking

psychological help, contrary to prediction, 4) Hungarians significantly approved of psychotropic medications compared to Americans, contrary to prediction. Limitations of the research were discussed. Findings have implications for mental health planning in Hungary.

The Effects of Culture on Mental Health Stigma and Modes of Psychological Treatment: Hungarian versus American College Students

Introduction

Understanding cross-cultural differences in the perception of mental illness and its treatment, i.e., the use of psychotherapy and psychotropic medication is crucial in the prevention and treatment of psychiatric disorders within those cultures. Cultural perceptions have an impact on the individual's attitudes and behaviors regarding abnormality. The World Health Organization (WHO) has proposed that social stigma plays a significant role in community attitudes toward mental illness; moreover, they highlighted, that "stigma can hamper the prevention of mental health disorders, the promotion of mental well-being and the provision of effective treatment and care" (WHO, 2011, p.1.). Moreover, social stigma contributes to the abuse of human rights. Social stigma is defined as the degree to which a general community exhibits unfavorable stereotypes and discriminates against a stigmatized group (Corrigan, 2004). Those being stigmatized may suffer from a loss of self-esteem, endure separation from family and friend and have an overall limited socializing potential; mental illness stigma can prevent individuals from seeking help. The WHO European Mental Health action (2013) recognized that mental health reforms are in need to achieve higher confidence in the safety and effectiveness of mental health care (WHO, 2013).

Link and Phelan (2001), warned that perceived stigma and fear of stigma can act as an obstacle to getting care. As a consequence, stigma can delay psychological treatment, which further leads to alienation from society. Stigma intensifies mental distress and may block possible rehabilitation to the extent where stigma is more harmful to the individual than the illness itself (Sartorius, 2012). Link and Phelan (2011) argued, "the stigma of mental illness involves attitudes

and behaviors that reject, exclude, and disapprove based on limited knowledge, fear and prejudice (p.363)" Individuals tend to stigmatize others with mental illness due to a lack of knowledge. Mental health stigma also applies to those who use psychotropic medication to treat mental disorders.

Stigmatizing behavior and help-seeking attitudes have been found to be affected by one's culture in the form of collectivist or individualist values. Cultural values that belong to Western societies are placed under the term of individualism. Eastern societies are more influenced by collectivistic values. Collectivism is often related to solidarity; a unity of feelings, behaviors or attitudes among individuals with a common interest. For example, socialist and communist ideologies have a strong correlation with collectivistic values.

The differentiation of the terms on individualism and collectivism originates back to the 17th and 18th century, known as the time of Enlightenment, when the level of autonomy an individual had in a given society was examined and placed under the concept of individualism. In contrast, the philosopher Georg Wilhelm Friedrich Hegel (1770-1831), and Karl Heinrich Marx (1818-1883) argued that interdependence with others and a subordination of self-interest is more fundamental for the well-being of the society than the individual itself (Grant, 2003). Triandis (1989) was the first psychologist to conduct research on the cultural constructs of individualism and collectivism. He argued that collectivism versus individualism as social attitudes have the psychological properties of allocentrism versus idiocentrism. Allocentrism is defined as a collectivistic personality attribute, used to describe people who tend to center their attention and behavior toward other people, rather than themselves. Allocentric individuals tend to be interdependent and derive similar values and attitudes from their collectivistic culture (Triandis, 1995). On the other hand, idiocentrism characterizes people with more self-oriented, independent

values (Triandis, 1995). Idiocentric individuals focus on their inner self, rather than others. Older, more densely populated cultures tend to be more allocentric (China), whereas newer less dense cultures tend to be more idiocentric (America).

Triandis (1995) conducted studies that revealed that allocentrism and idiocentrism affect how individuals from different cultures perceive abnormality. People from collectivist cultures feel a heightened sense of shame when experiencing mental problems as mental disorders deviate from the norm. People from individualistic cultures, because of their independence, do not experience collective shame regarding mental illness.

Societal views or attitudes clearly influence people as to how mental illness and mental health treatment behaviors are considered. Certain cultures are more likely to stigmatize people with mental health problems than others. Social stigma is a cross-cultural, universal phenomenon, mediated by psychological and historical factors. Therefore, the 'individualism-collectivism' framework may be a good investigatory paradigm to explain the link between culture and mental illness stigma. By location and national character, Hungary would be defined as moderately collectivist. The USA has been long defined as highly individualistic.

The present study aims to investigate the effects of culture on the social stigma attached to attitudes toward psychological help seeking and attitudes towards using psychotropic medications in two different populations, Hungarian versus Americans college students. The purpose of this quantitative study was to assess the degree of difference in mental health stigma across two diverse cultural populations, one from Eastern Europe (Hungary), and the other from the West (America) for treatment planning purposes.

The review that follows seeks to critically evaluate literature regarding social stigma and culturally based attitudes toward psychological help seeking and the willingness to take

psychotropic medications for the treatment of mental disorders. The individualist-collectivist conceptual framework was applied as a possible explanatory paradigm that could account for attitudes towards mental illness stigma. Furthermore, the review discusses summaries and critiques of existing research followed by a proposed study, which addresses contrasting attitudes toward seeking psychotherapy and psychotropic medication in Hungarian versus American college students.

Individualism and Collectivism

Harry Triandis (1926-present) is known for his influential research on culture in terms of the concepts of individualism and collectivism. "Culture is a social construct which is characterized by the behavior and attitudes of a social group. Determined by upbringing and choice, culture is constantly changing and is notoriously difficult to measure" (Vincent, 1994, p. 286). Triandis argued, "the individualism-collectivism cultural syndrome appears to be the most significant cultural difference among cultures" (Triandis, 1996, p. 907). He investigated the relationship between the cultural paradigms of individualism and collectivism and personality traits. Triandis (1998) discussed that the individualism and collectivism framework has corresponding behavioral patterns. Triandis defined five sets of differing attributes of individualism and collectivism: 1) the definition of the self (independent or interdependent), 2) personal goals versus in-group goals, 3) the emphasis on exchange versus communal relationship, 4) the emphasis of rationality versus relatedness, and 5) the importance of attitudes versus norms as determinants of social behavior.

Cultures that share individualistic values focus on attitudes rather than norms, whereas in collectivist cultures norms are more significant than attitudes. Triandis (1998) argued that individuals from a collectivist society are more likely to define themselves as part of the

community and prioritize the goals of the group, whereas those who are from an individualistic society are more like to describe themselves an independent individuals and more likely to emphasize their own goals over the group goals. Those who are part of a collectivistic culture are subordinate to their group and primarily concerned with their relationship to the group. Individualistic cultures are more concerned with individual justice. Consequently, social behaviors and attitudes are found to be influenced by the cultural factors of individualism and collectivism.

Triandis (2001) proposed additional dimensions that may further differentiate and define the constructs of individualism and collectivism. He argued that cultural values, individualism and collectivism might be conceptualized as being horizontal (emphasizing equality) or vertical (emphasizing hierarchy). A horizontal dimension supposes that oneself is similar to every other self, whereas a vertical dimension hierarchically distinguishes the importance of oneself from other selves. Therefore, there are four patterns that result: Horizontal Individualism (HI), Vertical Individualism (VI), Horizontal Collectivism (HC), and Vertical Collectivism (VC).

In HI and VI, individuals are differentiating themselves from the group and exhibit self-supporting attitudes; however, VI people are more competitive and often want to acquire higher status. In Horizontal Individualism (HI) individuals want to be unique and authentic, but in Vertical Individualism (VI) individuals are aiming to emphasize their uniqueness by being the best at it. In HC and VC, people see themselves as equal and closer to others. Yet, only VC individuals would sacrifice their personal values for in-groups' goals. If it is beneficial for the in-group, they are not hesitant to submit to authorities. In Horizontal Collectivist (HC) culture, individuals would entirely merge themselves with their groups, "we are all the same". In Vertical Collectivistic (VC) culture individuals tend to fully yield to a superior force or the authorities of the group and are

willing to sacrifice themselves for the goals of the group, "we are all the same, but some of us are leaders" (Triandis 2001, p. 910).

Triandis (2001) further stated that the horizontal-vertical aspect is important because it describes the differences within cultures. He examined individuals from different cultures and concluded that some cultures, such as Australian, Swedish, and Israeli kibbutzim emphasize equality - a horizontal trait, whereas Indian and American emphasize hierarchy - a vertical trait.

Help-Seeking Attitudes

Studies also been conducted to examine the relationship between locus of control (LOC) and individualism and collectivism (Kuo et al., 2007). It has been found that individuals from individualistic societies tend to have a higher internal locus of control and individuals from collectivistic societies manifest higher external locus of control. Those with a higher internal LOC generally believe that they are in control over their lives and have the power to make their own decisions. Therefore, individuals with a higher internal LOC would more likely manifest help seeking behavior. They believe that through seeking help they could control the outcome. On the other hand, those with a higher external LOC believe that external events are in power for what is occurring in their lives. Thus, they may believe that seeking help would not change what is happening to them, especially if there is stigma associated with the help.

Kuo, Kwantes, Towson and Nanson (2007) investigated the relationship between locus and control and culture. The researchers explained that individuals with greater external LOC showed more negative attitudes toward help-seeking than those who had greater internal LOC. The study stated that the ""internality-externality dimension' affects ones' recognition of the need to help, the stigma associated with seeking professional help, how comfortable they may be opening up to a

therapist, and whether they believe a therapist will be able to provide the necessary help" (Kuo et al., 2007, p. 227.)

Papadopoulos, Foster and Caldwell (2013) investigated whether the cross-cultural paradigm 'individualism-collectivism' is a useful explanatory model for mental illness stigma at a cultural level. Papadopoulos et al. (2013) explained that the more "complex" the culture is, the more likely it is to be a "loose" culture, as opposed to a "tight" culture. "Loose" cultures tend to have a higher tolerance for deviation from norms. Individuals do not depend on each other, thus "loose" cultures are more individualistic. The "tight" cultures have clearer and more specific expectations about appropriate behavior and correspondingly have higher surveillance on those individuals who deviate from the norm, thus, these "tight" cultures are more collectivistic. The authors further explain how stigma may affect individuals from "tight" cultures,

> "Therefore, in such cultures where conformity to norms is highly valued, surveillance is high, and there are dense, multiple connections between people, it is not surprising that mental illness is easily perceived as outside of the norm and therefore, devalued, rejected and stigmatized" (Triandis, 2013, p. 272).

Papadopoulos et al. (2013) hypothesized that people from traditionally labeled 'individualistic' cultures (Americans, British) are less likely to hold stigmatizing attitudes towards mental illness compared to more collectivistic cultures (Greek/Greek Cypriots and Chinese). The purpose of their study was to investigate the effects of culture and stigmatizing attitudes toward mental illness. Consistent with previous studies it was important to understand the issues of mental illness stigma and how they affect detection and treatment of psychiatric disorders. Papadopoulos, Foster and Caldwell used culture as the independent variable and stigmatizing attitude toward mental illness as the dependent variable. A total of 305 individuals from the UK participated in the

study: White-English (n = 78), Greek-Greek Cypriot (n = 77), American (n = 78) and Chinese (n = 75). The researchers used the *Community Attitude to Mental Illness Scale (CAMI)* (Taylor and Dear, 1981), which measures: authoritarianism, benevolence, social restrictiveness and community mental health ideology. Questionnaires about previous knowledge of mental health problems, and previous level of contact with mental illness were also administered. The vertical-horizontal individualism-collectivism scale (VHIC) (Triandis, 1995) was used to measure participant's level and type of individualism and collectivism.

The results indicated that the American participants scored the highest individualistic scores, followed by the British, Chinese and Greek/Greek Cypriots. Furthermore, it has been found that the American group scored significantly lower on each of four stigmatizing measures than the other cultural groups. This study suggested that collectivism functions as an indicator for cultures that are more stigmatizing, whereas individualism functions as an indicator for a more positive, less stigmatizing attitudes toward mental illness. Finally, the researchers stated that the likelihood of mental health stigma occurring in a given culture is mediated by a series of complex cultural factors, such as cultural context, norms, history and value systems – individualism/collectivism (Papadopoulos et al., 2013, p. 278).

Hogberg, Magnusson, Lutzen and Ewalds- Kvist (2012) investigated Swedish attitudes toward mental illness. To measure participant's attitudes, researchers relied on the Swedish version of the *Community Attitudes Toward Mental Illness* (Taylor & Dear, 1979) or CAMI, which they titled as CAMI-S. The CAMI-S scale is a 29-item questionnaire, which measures the following mental health attitudes regarding mental illness: "intention to interact," "fear and avoidant," "open-minded and pro-integration," and "community mental health ideology." The study hypothesized

that age, gender, previous experience with the mentally ill and level of education with regards of stigma would have a significant relationship with particular factors on the CAMI-S scale.

Their hypothesis was supported. The results indicated that a substantial number of participants demonstrated negative attitudes toward the mentally ill in the Swedish population. However, gender, age and education seemed to be moderating factors regarding participant's attitudes. Females scored higher on both factors, "fear and avoidant", and "open-minded and pro-integration." Also, women scored twice as high as men on the "community mental health ideology." Participants in the age group of 18-30 years scored significantly higher on "intention to interact" compared to other age groups. However, individuals between 31 and 50 years of age demonstrated higher levels of mental health stigma. People with higher education showed less stigmatizing attitudes of mental illness; yet, education does not necessary imply that the individual would be comfortable to have the mentally ill in his direct relations.

In general, Swedish participants exhibited a lesser amount of stigmatizing attitudes toward the mentally ill compared to other cultures. It may be explained that Nordic and Scandinavian cultures share more individualistic than collectivistic values.

Abnormal behavior may be understood differently in different cultures. There have been findings which indicate that Western cultures (e.g. USA) are more likely to understand abnormality better than Eastern cultures (e.g. China). Research shows cultural variations in the perception of abnormal behavior, collectivist versus individualist, exist. Collectivist cultures tend to rate external qualities as most defining a person and individualist cultures tend to measure internal traits as most defining (Choi, Nisbett, & Norenzayan, 1999). According to Ban et al. (2012), just like there is cultural variation in how normal, everyday behavior is explained, there is a corresponding difference on how abnormality is culturally understood. In individualistic

(Western) cultures, where autonomy and individuality are more valued, abnormality is seen as a personal psychological dysfunction and individual characteristic; therefore, mental distress is mostly related to internal mood states, conflicts and desires. Whereas in collectivist (Eastern) cultures abnormality is believed to be expressed through sociomoral or somatic distress idioms; abnormality is perceived as to the extent the individual's social conditions are changed or his or her cultural, traditional values are affected by the mental distress.

In their study, Ban, Kashima, and Haslam (2012) hypothesized that there would be differential effects of understanding the perceived prevalence, moral responsibility, and stigma associated with abnormal behavior. Moreover, it was predicted that providing casual information about abnormal behavior would increase perceived prevalence and decrease perceived moral accountability and stigma only among Western participants. It was also predicted that people from East Asian backgrounds would moralize deviance to a greater extent, mediated by their more major concern with traditional social values, consistent with their use of a social-moral idiom of distress. The independent variable of the study was the two different cultural groups, with Western European backgrounds versus East Asian origins; the dependent variable was the perceived abnormality. The participants were undergraduate psychology students recruited from Australia and Singapore. The researchers found evidence to support their hypothesis. The central predictions of the study were supported. Australians perceived abnormal behavior as more common, morally acceptable, but Singaporeans did not. Singaporeans expressed less understanding and more desire for social distance and showed more authoritarian attitudes toward abnormality. Moreover, it has been found that behavior that violates rules, and social norms may be seen as uncommon and unacceptable, regardless of psychological comprehensibility.

Tzouvara and Papadopoulos (2014) investigated moderating factors, the type and the degree of mental illness stigma in Greek culture. Their study focused on measuring groups of participants whom may or may not have stigmatizing attitudes toward the mentally ill. The study's hypothesis predicted that Greek culture would likely have more stigmatizing attitudes in different degrees toward the mentally ill, and knowledge of mental illness and personal experience would have a correlation with stigmatizing attitudes. The independent variable was the Greek culture; the dependent variable was the stigmatizing attitude (occurrence and type). The predictor was knowledge of and experience with mental illness, the outcome was the stigmatizing attitude. Socio-demographic data were collected (age, gender, first language, country of birth, country of education, educational level, religion, marital status). The researchers measured participants' knowledge of mental illness and their level of personal experience with people suffering from mental illness. The *Community Attitudes to Mental Illness (CAMI)* scale (Taylor & Dear, 1979) was used to measure the prevalence and type of mental illness. Participants from England and Greece were recruited via snowball sampling. The results indicated that participants with lower experience with mental illness and stronger levels of religiosity held a significantly higher level of authoritarianism on the CAMI scale. Greater knowledge of mental illness significantly correlated with a higher benevolence scores on the CAMI scale. Also, knowledge and experience were significantly related to each other. Tzouvara and Papadopoulos (2014) showed that education about stigmatizing behavior should be culturally tailored.

Demographic variables, ethnicity and casual belief of mental illness are known factors that may affect attitudes towards professional psychological help-seeking. Hamid and Furnham (2013) conducted a study with UK Arab participants to examine factors that tend to affect help seeking attitude likelihood. They hypothesized that ethnicity (Arab versus British Caucasian), demographic

variables, causal belief about mental illness and shame-focused attitude would be significant predictors of negative attitudes toward psychological help seeking (Fischer & Turner, 1970). The researchers relied on the *Attitude Towards Seeking Professional Psychological Help Scale (ATSPPH)* questionnaire to measure shame-focused attitudes, community and family attitudes, external shame and reflected shame. Hamid and Furnham (2013) also used the *Orientation for Seeking Professional Help (OSPH)* scale (Fisher & Turner, 1970) to assess help seeking. OSPH questionnaire measures the likelihood to either seek or withstand professional psychological support during crises or after prolonged psychological distress. The questionnaire assessed four factors: recognition of need for professional help, stigma tolerance, interpersonal openness and confidence in mental health professionals.

Research showed that ethnicity was a significant predictor of ATSPPH scores. Moreover, age, education, previous experience of mental illness tends to be explanatory factors of ATSPPH. Participants with a higher level of education, age and previous experience with mental illness showed a more positive ATSSPH. It might be possible that age interacts with higher education, more experience with mental illness, which results in a favorable understanding and sympathy toward the mentally ill. Additional results indicated that ethnicity had a significant relationship with Western psychological versus Eastern supernatural causal beliefs. Arabs showed significantly higher supernatural beliefs than British Caucasians. Causal beliefs of mental illness, however, were not predictive of negative attitudes towards professional help seeking.

In a study by Kim and Kendall (2016) intrapersonal and interpersonal frameworks were used to examine Asian values in relation to help-seeking attitudes. Kim and Kendall (2016) proposed that based on interpersonal factors, Asian Americans might find it difficult to share personal problems and struggles with a professional who is an out-group (non-Asian) member. The

study hypothesized that emotional self-control would predict unfavorable help-seeking attitudes; interpersonal shame (external and family shame) would predict help-seeking attitudes, and lastly racism would predict unfavorable help-seeking attitudes. The predictors were: emotional self-control, interpersonal shame, and racism, whereas the outcome variable was help-seeking attitudes. Participant's nationalities were; Chinese, Filipino, Korean, Japanese, Vietnamese, Taiwanese, Indian, Thai, Indonesian, and Cambodian. The researchers assessed *Interpersonal Shame* using the ISI (Wong et al., 2014), and professional help-seeking attitudes with the traditional measure, *Attitudes Toward Seeking Professional Psychological Help-Shortened Form* (ATSPPH-SF; Fisher & Farina, 1995).

The results indicated that emotional self-control, external-shame, and subtle racism were significant individual predictors of professional help-seeking attitudes in a sample of Asian American college students; however, external shame was linked to favorable help-seeking attitudes. The findings further indicated that the greater the emphasis on external shame, the more the individual is likely to find the need to seek psychological help. Favorable help-seeking attitudes can be explained by the individual's fears of experiencing additional shame; therefore, shame could be an external motivator for psychological help seeking.

A body of literature explained that social stigma affects people's attitudes and behaviors towards therapy seeking. Research suggests that "subjective norms (in this case perceived social stigma) can influence an individual's attitudes and that both attitudes and social norms can influence intention to perform a behavior (in this case therapy seeking)" (Digiuni et. al, p. 214). According to the subjective norm theory, the effects of culture would likely impact individuals' attitudes towards taking psychotropic medication, and the willingness to take these medications.

Psychotropic Medication

Several studies have been conducted to investigate the relationship between ethnicity and the use of psychotropic medications. Studies have shown that individuals from different ethnic backgrounds have varying attitudes towards taking psychotropic medications. Different cultures often have different views on medication due to their different belief systems. Givens, Houston, Ford & Cooper (2007) found that African-Americans and Latinos were much more likely to prefer talk therapy over psychotropic medications, while Caucasian Americans preferred psychotropic medications over counseling. Within this study, stigma played a large role in preventing individuals from seeking professional help. Mossakowski (2011) stated that people may have stigmatizing behavior towards those who take psychotropic medication and toward the general idea of taking psychotropic medication due to a lack of knowledge about medication use. Overall, it has been found that individualistic societies are more likely to take psychotropic medication than those raised in a more collectivistic society.

In a study done by Bender, Thomson, Lantry & Flynn (2007), the researchers found that participants who were Caucasian diagnosed with bipolar disorder were greater than six times more likely than Hispanic participants to use medication and seven times more likely to use medication than African-American participants. The same study indicated that Caucasian participants were correspondingly more likely to use antidepressants than Hispanics or African Americans.

Angermeyer, Daumer &Matschinger (1993), and Slovick, Kraus, Lappe, Letzel & Malmors (1987) argued that in European studies the stigmatizing attitude towards psychotropic medication is due to the belief that many Europeans see psychotropic medication as dangerous, unnatural, harmful and addictive. Psychotropic medications are "those medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses. They may include, but are not limited to, anxiolytic agents, antidepressants, mood stabilizers, antipsychotic medications, anti-

Parkinson agents, hypnotics, medications for dementia, and psychostimulants" (California Rules of Court, 2013, JV-222).

Studies show that psychotropic medications are among some of the most commonly prescribed medications in the United States; "...psychiatric drugs have been among the industry's most profitable product in the last several decades...one in five American adults now take at least one psychiatric drug" (Hyman, 2013, p. 5). In a longitudinal study conducted in Britain between 1993 and 2003, it was found that in 10 years the use of psychotropic medication significantly increased, especially the use of antidepressants and anxiolytics (Brugha, Bebbington, Singleton, Melzer, Jenkins, Lewis, Farrel, Bhugra, Lee, & Meltzer, 2004).

Hungarian Cultural Ideas and Mentality

Hungary is a unitary parliamentary republic in Central Europe. The country has more than a thousand years of history. The original Hungarians were nomadic people who were assumed to have moved to the Carpathian basin from the Ural Mountains. The foundation of Hungary was around 895 C.E. when King Arpad took over the land of the Carpathian basin. Arpad's great grandson, King Stephen I founded the state of Hungary and converted the country to a Christian kingdom.

During the middle ages, Hungary became a major power in the Western world. However, in 1526 C.E., the Turkish army defeated the Hungarian royal army at Mohacs, and the country was split into three parts: the Hungarian Kingdom, the Habsburg dominion and the Turkish dominion. It took 150 years for the Hungarians to reunite and drive out the Turks. In 1676 C.E., after the elimination of Turkish power, the Hungarians came under Habsburg domination. In 1848 the Hungarians attempted an independence revolution and tried to regain their freedom from the Habsburg dominion. This revolution failed, but in 1867, the Hungarian and the Habsburg

(Austrian) delegations formed the great and powerful Austro-Hungarian Monarchy under the leadership of Franz Josepf (1830-1916).

In World War I (1914-1918), Hungary allied with Germany and Austria against Serbia and Russia. After losing the war in 1918 the Monarchy broke up and the country became the Republic of Hungary. Hungary's current borders were established in 1919 by the Treaty of Trianon; the country lost 71% of its territory, 58% of its population, and 31% of ethnic Hungarians. The prewar Hungary of more than 20 million became a small country of less than 8 million.

In World War II (1939-1945), Hungary joined the Axis powers (Germany, Italy, Japan). The country fought alongside with the Germans against the Soviets. After the war, Hungary became a part of the Soviet Union, which led to the establishment of a socialist republic government for over 40 years. Hungary gained international attention regarding their revolution against the Soviets in 1956 and for the opening of its restricted border with Austria in 1989, which contributed to the collapse of the Eastern Bloc. On October 23, 1989, Hungary again became a democratic parliamentary republic.

In 1999 Hungary joined NATO, and in 2004 became a member of the European Union. Hungary is a unitary, parliamentary, representative democratic republic. The democratic character of the Hungarian parliament was reestablished with the fall of the Iron Curtain. Today, the historically multiple invasive influences are reflected in the ethnocentric Hungarian political mindset. Hungarians reflect a lack of trust in anybody outside their own nationalist mindset. The parliament is concerned with in-group members, but manifest hostility toward outside-members and non-Hungarian citizens. Corresponding to this political perspective, in 2016-2017, Hungarians established a 'zero refugee strategy' which were harsh policies on immigrants and refugees. The prime minister, Viktor Orban (1963-present) stated that by opening the country to out-group

members "we may lose our European values, our very identity, by degrees like the live frog allowing itself to be slowly cooked to death in a pan of water (kormany.hu)"

Hungarians exhibit a high degree of uncertainty avoidance. Uncertainty avoidance is defined as the extent to which members of a culture feel threatened by ambiguous or unknown situations and have created beliefs and institutions that try to avoid or exclude these beliefs. Countries with high uncertainty avoidance tend to be more collectivistic and less individualistic. (Hofstede, 1991). Therefore, it is hypothesized that Hungarians are a collectivistic society.

Significance/Rationale

The following study was designed to provide an understanding of the severity of mental illness stigma on a socio-cultural level in a little-studied Eastern-European culture. Growing evidence suggests that people who are more likely to stigmatize within cultures unite themselves with collectivist values. To date, no similar study has been conducted to assess the amount of stigma Hungarians might have toward the mentally ill. Prior research involving collectivistic cultures demonstrated that psychological help-seeking attitudes were hindered by cultural values. Hungary has been seen as a socialist, collectivist culture. It is important to determine by research whether Hungary qualifies as an individualist or collectivist society.

Specifically, the present study: 1) examined the cultural differences between Hungarian and American students as measured by *the Individualism-Collectivism Scale*, 2) examined the difference between Hungarian versus American students' psychological help-seeking attitudes measured by the *Attitudes Toward Seeking Professional Psychological Help* Scale, and 3) examined the differences between community attitudes toward mental illness, as measured by the *Community Attitudes Toward Mental Illness Scale*, which explores the societal view of mental

illness and 4) Hungarian versus American attitudes regarding psychotropic medications as measured by an item on the demographic questionnaire.

This study aimed to measure mental illness stigma towards psychological help seeking and attitudes toward the mentally ill in a Hungarian population. This study was motivated by the belief that the results could be beneficial in the future for reducing mental health stigma and assisting Hungarian mental health professionals. Furthermore, it could deliver important information about the individualist/ collectivist paradigm in understanding Hungarian culture. Non-Hungarian professionals could have an advanced knowledge when interacting with Hungarian patients whose values are culturally influenced. Understanding which types of treatment each culture prefers is important in order to individualize preferred treatments and ensure that individuals receive and continue the treatment they need. As a result, the prevalence of mental health stigma might be reduced.

Methods

Participants

The study recruited a total of 292 male and female participants. Among the total participants, 201 (68.8%) were from Hungary and recruited through social media and snowballing. The U.S.-based participants, there were 91 (31.2%) students from a Miami based University recruited through an e-mail from the psychology department. The participant's ages ranged between 21 – 30 years (M = 26.41, SD = 4.65). There were 240 females (82.2%) and 30 males (10.3%). One hundred and seventy-three (59.2%) participants had completed high school, 79 (27.1%) had received a bachelor's degree and 24 (8.2%) had received a master's degree; twenty-six participants (8.9%) were psychology major students. One hundred and one (34.6%) participants sought psychological or psychiatric services in the past. Demographic information for the

participants, such as sex, education, socioeconomic status, marital status, country of residence, and other information can be found in Table 1.

Table 1

Socio-demographic Characteristics of American and Hungarian Study Participants

Socio-demographic variable	Group		
	Total	American	Hungarian
	292	91 (31%)	201 (69%)
Gender			
Male (%)	30 (10.3)	13 (14.3)	17 (8.5)
Female	240 (82.2)	74 (81.3)	166 (82.6)
Age			
Mean	26.41	21.53	29.76
Standard Deviation	4.65	3.98	2.7
Marital Status			
Single (%)	136 (46.6)	77 (84.6)	59 (29.4)
Married (%)	121 (41.4)	11 (12.1)	110 (54.7)
Divorced (%)	21 (7.2)	1 (1.1)	20 (10.0)
Widowed (%)	3 (1.0)	0	3 (1.5)
Years of living in US			
2 yrs. (%)	12 (4.1)	8 (8.8)	4 (2.0)
3 yrs. (%)	3 (1.0)	1 (1.1)	2 (1.0)
5 yrs. (%)	2 (0.7)	2 (2.2)	0
6+ yrs. (%)	77 (25.4)	75 (82.4)	2 (1.0)
Never lived in the US but visited (%)	34 (11.6)	2 (2.2)	32 (15.9)
Never lived in the US and never visited (%)	154 (52.7)	3 (3.3)	151 (79.1)
Educational Level			
High school (%)	173 (59.2)	58 (63.7)	115 (57.2)
Bachelor's Degree (%)	79 (27.1)	27 (29.7)	52 (25.9)
Master's Degree (%)	24 (8.2)	5 (5.5)	19 (9.5)
Psychology Major (%)	26 (8.9)	24 (26.4)	2 (1.0)
Ethnicity			
African American (%)	28 (9.6)	28 (30.8)	0
European American (%)	18 (6.2)	18 (19.8)	0
Latin American (%)	39 (13.4)	39 (42.9)	0
Asian (%)	4 (1.4)	4 (4.4)	0
African (%)	2 (0.7)	2 (2.2)	0
Hungarian (%)	191 (65.4)	0	191 (100.0)
Have you ever sought psychological/psychiatric services in the past? (%)	101 (34.6)	24 (26.4)	77 (38.3)
Have you ever taken psychotropic medication? (%)	68 (23.3)	11 (12.1)	57 (28.4)
Religion			
Christian (%)	188 (64.4)	61 (67.0)	127 (63.2)
Jewish (%)	6 (2.1)	4 (4.4)	2 (1.0)
Islam (%)	2 (0.7)	2 (2.2)	0

Hindu (%)	1 (0.3)	1 (1.1)	0
Other (%)	85 (29.1)	23 (25.3)	62 (30.8)

Materials

Demographic Questionnaire. The nine items on the demographic questionnaire included basic information related to: age, gender, ethnicity, level of education, prior utilization of counseling services, and the length of Hungary and U.S. residency. The demographic questionnaire also included the statement "I approve of individuals taking psychotropic medications (e.g. antidepressants and anxiety medications)" measured on a 5-point Likert scale. (see Appendix B).

Individualism-Collectivism Scale. The *Individualism-Collectivism Scale* (Triandis, et al., 1988) is a 29-item scale with subscales of (a) Self-Reliance with Competition, (b) Low Concern for In-Groups, and (c) Distance from In Groups. Participant's responds' will be assessed on a 5-point Likert scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree).* The measure of individualism-collectivism showed to have an acceptable reliability (*Cronbach's alpha*=.74) and is highly correlated to particular values in the theoretically expected direction; high levels of collectivism are correlated with values of equality and cooperation, whereas high levels of individualism are related to social recognition (see Appendix C).

Community Attitudes of Mental Illness Scale. The Community Attitudes Toward Mental Illness (CAMI; Taylor & Dear, 1981) is a 40-item 5-point Likert Scale that measures attitudes toward mental illness. The scale includes 40 items to be rated on a five-point Likert scale from 1 (*strongly agree*) to 5 (*strongly disagree*) and is organized into four a priori subscales of ten items each: Authoritarianism (AU), Benevolence (BE), Social Restrictiveness (SR) and Community Mental Health Ideology (CMHI). *Authoritarianism* refers to a view of the mentally ill person as

someone who is inferior and requires supervision and coercion. *Benevolence* corresponds to a humanistic and sympathetic view of mentally ill persons. *Social Restrictiveness* covers the belief that mentally ill patients are a threat to society and should be avoided. *Community Mental Health Ideology* concerns the acceptance of mental health services and the integration of mentally ill patients in the community. The authors demonstrated good satisfactory (AU, $\alpha = 0.68$) to good values (BE, $\alpha = 0.76$, SR, $\alpha = 0.80$, CMHI, $\alpha = 0.88$) for the internal consistency of the subscales (see Appendix D).

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form. The ATSPPS-SF (Fisher & Farina, 1995) scale consists of 10 items on a 4-point Likert scale ranging from 0 (*disagree*) to 3 (*agree*), measuring the individual's attitudes about mental health services. The scale measures two factors a) Recognition of Need for Psychotherapeutic Help and b) Confidence in Mental Health Practitioner. The total score ranges from 0 to 30, with higher scores indicating more favorable attitudes. The short version of the ATSPPH-SF has been shown to have good internal consistency ranging from 0.82 to 0.84 (Fisher & Farina, 1995). The test-retest reliability is 0.80 (see Appendix E).

Procedure

Participants were invited to participate in the research by an email with a cover letter (see Appendix A). The student's responses to questionnaires were completely anonymous. Participants, Hungarian and American, electronically entered and completed the survey by clicking the Hungarian or English versions of the link that was attached to the email. The study was advertised by flyers that will be posted on campus bulletin boards at psychology department of Barry University, Florida, and in the universities of Budapest, Hungary. Emails from the secretary of the psychology department at Barry University were sent to students taking undergraduate and

graduate courses in psychology, by providing them with a link to the questionnaires. Anonymously obtained information from the Internet survey was analyzed using SPSS version 20.

Translation Using the Varimax Rotation

In order to accurately measure participants stigmatizing behavior and help-seeking attitudes in Hungary, Hungarian translations of the informed consent and questionnaires were required. This was accomplished using the Varimax Rotation; a method by which two translators independently translate a piece of work. Using the Varimax Rotation, one party translates the work from the desired language, and the other party, independently of the first, translates the work from the desired language back to the original language. If the items in the second translation back to the original language have not lost any meaning when compared with the original work, then the translation into the desired language is considered valid and reliable. The Hungarian translation of the measurements is titled as the following: Demographic-H, VHIC-H, CAMI-H, and ATSPPHS-SF. See Appendices F-J for Hungarian translations.

Hypotheses

H1: Hungarian students will score significantly more collectivistic (lower on the Individualism subscale) on the *Vertical-Horizontal Individualism-Collectivism Scale* (VHIC; Triandis et al., 1995) compared to American students.

H2: Hungarians will have significantly more negative community attitudes toward mental illness compared to American students. Therefore, Hungarians will score significantly higher on the *Community Attitudes Toward Mental Illness* scale (CAMI; Taylor et al., 1979) compared to American students.

H3: Hungarian students will show significantly more negative attitude toward seeking professional psychological help compared to American students. Therefore, Hungarian students

will score significantly lower than American students on the *Attitude Toward Seeking Professional Psychological Help Scale-Short Form* (ATSPPH-SF; Fisher & Farina, 1995).

H4: Hungarian students' collectivism scores on the *Vertical-Horizontal Individualism-Collectivism Scale* will be significantly negatively associated with their scores on the *Community Attitudes Toward Mental Illness* scale.

H5: Hungarian student's collectivism scores on the *Vertical-Horizontal Individualism-Collectivism Scale* will be significantly negatively associated with their total scores on the *Attitude Toward Seeking Professional Psychological Help Scale-Short Form* (ATSPPH-SF; Fisher & Farina, 1995).

H6: Hungarians will significantly disapprove of the use of psychotropic medications compared to Americans as measured by a Likert scale question.

Analyses

Analyses of hypotheses 1-3 and 6 were conducted using independent *t*-tests (see Table 2), and analyses of hypothesis 4-5 were conducted using correlational analyses (see Table 3). Anonymously obtained information from the Internet survey was analyzed using SPSS version 20.

Results

Independent t-tests (H1-H3, H6)

An independent samples *t*-test was conducted to evaluate whether Hungarian students had higher levels of collectivism than American students. VHIC scores are calculated as individualism scores. The results indicated that the level of collectivism for Hungarians ($M = 2.74$, $SD = .35$) was significantly lower than the mean for U.S. participants ($M = 2.51$, $SD = .41$); this finding is in the opposite direction predicted. Hungarians scored significantly higher on the individualism

subscale indicating less collectivism compared to Americans, (t *(2, 280)* = 5,00 $p < .001$). H1 was not supported. See Table 2.

An independent samples t-test was conducted to evaluate whether Hungarian students had higher levels of mental health stigma compared to American students, as measured by the four subscales of the CAMI: authoritarianism (AR), benevolence (BN), social restrictiveness (SR), and community mental health ideology (CMHI). The results indicated that the mean scores for the Hungarian students on authoritarianism ($M = 3.77$, $SD = .61$) and social restrictiveness ($M = 3.49$, $SD = .72$) were significantly higher compared to American students on AR ($M = 2.51$, $SD = .61$) and SR ($M = 2.47$, $SD = .73$),(t (2, 280) = 16.00, $p < .001$, t (2, 278) = -12.66, $p < .001$). On the other hand, the mean scores for the Hungarians for benevolence ($M = 4.12$, $SD = .78$) and community mental health ideology ($M = 3.43$, $SD = .82$) were significantly lower than U.S. scores for BN ($M = 3.84$. $SD = .69$,) $p < .001$ and for CMHI ($M = 3.63$, $SD = .68$), (t (2, 279) = -14.21, $p < .001$, t (2, 279) = -2.00, $p < .048$). H2 was supported. See Table 2.

An independent samples t-test was conducted to examine whether Hungarian students had more negative attitudes toward seeking professional psychological help on the *Attitudes Toward Seeking Professional Psychological Help Scale-Short Form* (ATSPPH-SF; Fisher & Farina, 1995) compared to American students. The ATSPPH-SF measured both, recognition of need for psychotherapeutic help and confidence in mental health practitioners. Contrary to the hypothesized direction, Hungarian scores were significantly higher on both subscales compared to the American participants. The results were the following for recognition of need for: a) psychotherapeutic help: Hungarians ($M = 1.18$, $SD = .56$) and Americans ($M = 1.00$, $SD = .59$), (t (2,190) = 2.05, $p < .041$) , b) confidence in mental health practitioners: Hungarians ($M = 3.10$, $SD = .66$) and Americans ($M = 2.88$, $SD = .69$), (t (2, 194) = 2.23, $p < .027$). H3 was not supported. See Table 2.

An independent samples t-test was conducted to assess and compare the difference of approval of individuals taking psychotropic medications. The analysis showed the opposite of our predicted outcome; Hungarians ($M = 3.05$, $SD = 1.15$) significantly approved the use of psychotropic medications compared to Americans ($M = 2.13$, $SD = .90$), (t (2,279) = 6.65, p <.000). H6 was not supported.

Table 2

Contrast of Hungarian with American University Students for Major Variables of Interest

	American		Hungarian					95% CI		
Variable	*M*	*SD*	*M*	*SD*	*df*	*t*	*p*	*LL*	*UL*	*d*
Individualism	2.51	.41	2.74	.34	280	5.00	.000	.14	.33	0.63
Authoritarianism	2.51	.62	3.77	.63	280	16.00	.000	1.15	1.42	2.02
Benevolence	3.84	.73	2.47	.78	279	-14.21	.000	-1.56	-1.18	1.82
SR	2.32	.72	3.49	.69	278	12.66	.000	.99	1.36	1.66
CMHI	3.64	.68	3.43	.82	279	-2.00	.048	-.39	-.00	0.28
ATSPPSFR	1.01	.59	1.18	.56	190	2.05	.041	0.02	.31	0.29
ATSPPSFC	2.88	.69	3.10	.66	194	2.23	.027	.03	.41	0.33
PM	2.13	.91	3.05	1.15	279	6.65	.000	.14	.65	0.16

Note. N = 292; *df* = Degrees of Freedom; CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit; SR = Social Restrictiveness; CMHI = Community Mental Health Ideology; ATSPPSFR = *Attitudes Toward Seeking Professional Psychological Help Scale-Short Form - Recognition of Need for Psychotherapeutic Help*; ATSPPSFFC = *Attitudes Toward Seeking Professional Psychological Help Scale-Short Form - Confidence in Mental Health Practitioners*; PM = psychotropic medication

Correlations

Correlational analyses for Hungarians were computed among the following variables: *Vertical-Horizontal Individualism-Collectivism Scale* scores and scores from the four subscales of the *Community Attitudes Toward Mental Illness Scale.* A Pearson correlation was conducted to assess the relationship between Hungarian individualism and mental health stigma. The analysis revealed that Hungarians' individualism scores were not significantly associated with their attitudes toward the mentally ill as measured by Authoritarianism (r = -.02, p = .41), Benevolence (r = -.05 p = .30), Social Restrictiveness (r = .05, p = .28), and Community Mental Health Ideology (r = .13, p = .07). H4 was not supported. See Table 3.

Pearson correlations were conducted to assess the relationship between Hungarian individualism and the scores of the two subscales of the *Attitudes Toward Seeking Professional Psychological Help Scale-Short Form.* There was no significant relationship identified between Individualism and recognition of need for psychotherapeutic help (r = -.13, p = .78) nor between individualism and confidence in mental health practitioners (r = -.05, p = .29). H5 was not supported. See Table 3.

Table 3

Correlations between Individualism, Community Attitudes Toward Mental Illness, and Attitudes Toward Seeking Professional Psychological Help for Hungarians

Variable	1	2	3	4	5	6	7
Individualism	-	.02	-.05	.05	.14	1.13	-05
Authoritarianism	-.02	-					
Benevolence	-.05	-.66***	-				
SR	.05	.55***	-.78***	-			
CMHI	.14	.55***	-.56***	.62***	-		
ATSPPSFR	-.13	.19*	-.18*	.16*	.14	-	
ATSPPSFC	-.05	.20*	-.21*	.22**	.22**	.39***	-

Note. $N = 292$. *$p < .05$. **$p < .01$. ***$p < .001$.
SR = Social Restrictiveness; CMHI = Community Mental Health Ideology; ATSPPSFR = *Attitudes Toward Seeking Professional Psychological Help Scale-Short Form - Recognition of Need for Psychotherapeutic Help*; ATSPPSFFC = *Attitudes Toward Seeking Professional Psychological Help Scale-Short Form - Confidence in Mental Health Practitioners*

There were significant correlations for many of the subscales of the *Community Attitudes Towards Mental Illness.* Authoritarianism was significantly negatively correlated with Benevolence ($r = -0.66$, $p < .001$), significantly positively correlated with Social Restrictiveness ($r = 0.55$, $p < .001$) and significantly positively correlated with Community Mental Health Ideology ($r = 0.55$, $p < .05$).

Benevolence was significantly negatively correlated with Social Restrictiveness ($r = 0.78$, $p < .001$) and significantly negatively correlated with Community Mental Health Ideology ($r = -0.56$, $p <$

.001). Social Restrictiveness was significantly positively correlated with Community Mental Health Ideology ($r = 0.62, p < .001$).

There were also significant correlations for the subscales of the Attitudes Towards Seeking Professional Help Scale. Recognition of Need for Psychotherapeutic Help was significantly positively correlated with Authoritarianism ($r = 0.19, p < .05$), significantly negatively correlated with Benevolence ($r = - 0.18, p < .05$), significantly positively correlated with Social Restrictiveness ($r = 0.16, p < .05$) and significantly positively correlated with Confidence in Mental Health Practitioners ($r = 0.39, p < .001$). Confidence in Mental Health Practitioners was significantly positively correlated with Authoritarianism ($r = 0.20, p < .05$) significantly negatively correlated with Benevolence ($r = - 0.21, p < .05$), significantly positively correlated with Social Restrictiveness ($r = 0.22, p < .01$) and significantly positively correlated with Community Mental Health Ideology ($r = 0.22, p < .01$).

Discussion

Individualism-Collectivism and Ethnicity

Several culturally based variables were used in this study to predict mental health treatment attitudes in a Hungarian student population. The purpose of this study was to assess the levels of mental health stigma in Hungarians and compare them with Americans. The Individualist-Collectivist framework was applied as a possible explanatory paradigm that could account for differing attitudes toward mental illness stigma.

In general, our Hungarian sample was considerably less collectivistic than presumed. Contrary to predictions, Hungarians were more individualistic; Hungarians individualism scores were significantly higher on the VHIC scale compared to our American students. This result may reflect the cultural subgroup differences in the U.S. sample. American students' ethnic

backgrounds revealed that the majority of our American college students had Latin American (43%) and African American (31%) backgrounds. Only about 20% of the population had a European American background. Therefore, 74% of the studied American population were not homogeneous Caucasian. Triandis's conducted research on the cultural constructs of individualism and collectivism in sample populations which were predominantly Caucasian. Cultures that share individualistic values focus on individual attitudes rather than group norms, whereas in collectivist cultures group norms are more important than individual attitudes. Triandis (1998) argued that individuals from a collectivist society are more likely to define themselves as part of a community and prioritize the goals of the group, whereas those who are from an individualistic society are more likely to describe themselves an independent individuals and are more likely to emphasize their own goals over the group goals. Those who are part of a collectivistic culture are subordinate to their group and primarily concerned with their relationship to the group. Individualistic cultures are more concerned with individual values. As a result, social behaviors and attitudes are found to be influenced by the cultural factors of individualism and collectivism.

Previous literature has shown that Latin Americans and African Americans are more collectivistic. In collectivistic cultures the way individuals relate to ingroup members tends to be stable over time, however, in individualistic cultures the connection with their ingroups is not as strong as in collectivist cultures. The present findings suggest that today's Hungarians are more Westernized and less collectivistic and that perhaps the individualistic values of the current American media and American politics has changed the once collectivistic nature of Hungarian society. In a recent article in *Zeit Online* Beda Magyar (2019) has stated "Hungary is one of the most individualistic countries of the EU, second only to the United Kingdom"

(https://www.zeit.de/politik/ausland/2019-04/european-union-hungary-democracy-viktor-orban-english/komplettansicht).

Ethnicity and Community Attitudes Toward the Mentally Ill

Societal views or attitudes clearly influence people as to how mental illness and mental health treatment behaviors are considered. Results showed that Hungarians are more individualistic compared to American participants. People from individualistic cultures, because of their independence, do not experience collective shame regarding mental illness. Yet, Hungarians showed significantly more negative attitude toward mental illness compared to the Americans. On the CAMI subscales Hungarians scored significantly higher on both authoritarianism (AR) and social restrictiveness (SR); however, on benevolence (BR) and community mental health ideology (CMHI) Hungarians scored significantly lower. Higher scores on AR reflects that Hungarians may see a mentally ill person as inferior and SR scores indicate that Hungarians share the belief that mentally ill patients are a threat to society. Lower BR and CMHI scores indicate that Hungarian participants have less humanistic and sympathetic views of the mentally ill and that the mentally ill should not be integrated in the community. See Table 2.

Magyar (2019) in his article contrasts Hungarian individualism with the individualism of the United Kingdom and the Netherlands and concludes that for Hungarians' personal responsibility is lower and distrust is higher than in the UK and the Netherlands. Our results on Social Restrictiveness and Community Mental Health Ideology on the CAMI subscales clearly supports Magyar's conclusion. Magyar (2019) added that Hungarian individualism has historical and political backgrounds. Hungarian society has become sharply divided into two separate, parallel cultures. Hungary was occupied by foreign powers from 1926-1920, and from 1945 to 1989. The national traumas have created an "us against them" atmosphere. This mentality reemerged after the

fall of Iron Curtain in 1989; not against foreign rulers but between liberals and conservatives. This divide cuts across contemporary Hungarians. The social and political pressure contributed to the rise of two prominent cultural ideals of the Hungarians: "the betyar and the gentrified hussar, both of whom team up to dominate others but yet value loyalty to each other above all else" (Magyar, 2019). They both follow their own moral code. Triandis argues that high levels of individualism are related to social recognition (Triandis, et. Al., 1988)

Magyar further explains that the "betyar" are the Robin Hoods of the Hungarian puszta; they rob from the wealthy and distribute among the poor. "Hussars" are the wealthy, who have aristocratic privileges. These two cultural ideals embody Hungary's dominant attitudes; the ideas that disobeying laws and outsmarting authorities and each other for personal advantage are the standards. Individualism and distrust could be the result of these strong cultural identities. Therefore, seeing the mentally ill as inferior and a threat to society can be explained by these current shared Hungarian attitudes.

Ethnicity and Psychological Treatment Attitudes

Hungarians were not significantly different in the recognition of the need for psychotherapy compared to Americans, but they were significantly different in their confidence in mental health practitioners. Findings may reflect a contradictory view that 'psychotherapy may be good for other people, but not for me'.

Previous research has shown that ethnicity was a significant predictor of psychological treatment attitudes. Moreover, age, education, previous experience with mental illness tend to be explanatory factors of psychological treatment attitudes. Participants with a higher level of education, age and previous experience with mental illness showed a more positive ATSSPH. It might be possible that age interacts with higher education, more experience with mental illness,

which results in a favorable understanding and sympathy toward the mentally ill. Additional results indicated that ethnicity had a significant relationship with Western psychological versus Eastern supernatural causal beliefs.

Previous studies also explained that more favorable attitudes regarding help seeking was accounted for by advanced age and being female, which significantly predicted fewer stigmatizing attitudes and more confidence in psychological help; 83% of the Hungarian population were women with the mean age of 30 years and 40% of Hungarians sought psychological services in the past.

Ethnicity and Psychotropic Medication

Previous European studies demonstrated that Europeans, in general, showed stigmatizing attitudes towards psychotropic medications due to the belief that many Europeans see psychotropic medication as dangerous, unnatural, harmful and additive (Angermeyer et. Al. 1993). An interesting finding was that Hungarians significantly prefer the use of psychotropic medications compared to our American sample. Results from our demographic questionnaire indicate more Hungarians (28%) compared to our Americans (12%) had taken psychotropic medications. Results from our Likert scale indicated significantly greater approval by Hungarians of the use of psychotropic medications. See Table 2. This agrees with our findings that Hungarians are less supportive of outpatient psychotherapy.

Psychotherapy is still a costly and infrequently used therapy; in Hungary it is much easier to get access to medication than to afford outpatient psychotherapy. Clinicians in Hungary could use these findings to promote talk therapy over medications.

Moreover, it is important to note that new research suggests that increasing individualism may actually be a global phenomenon. The findings published in *Psychological Science* show that

increasing socioeconomic development is a significant predictor of increasing individualistic practices and values in a country over time. Statistical models indicated that individualism has increased by about 12% worldwide since 1960 (Individualistic Practices and Values Increasing Around the World, 2017). Researchers also demonstrated that socioeconomic developments have various aspects such as white-collar jobs, educational levels and household income.

Hungary is one of the most individualistic countries of Europe. Even though the country achieved high socioeconomic development after separating from the Soviet Union, the current political and social pressure divided the country's population and weakened its economic health. Thus, Hungary still suffers from economic deprivation, which might lead to stronger individualism. Economic deprivation can also be the answer for lack of psychotherapists in the country and costly outpatient therapy costs; thus, self-medication and psychostimulants are an easier access than psychotherapy.

Limitations of the Current Study

There are several limitations in this current study. First, our American sample used in this research was drawn from Miami, Florida, a multicultural community; 74% of these college students have Latin American and African American ethnicity, which limits generalization regarding individualism or collectivism to a larger population. European Americans accounted for only 24% of the American sample and past research showed that European Americans were the most representative ethnic group used in culturally based variables to predict mental health treatment values and attitudes.

Second, our Hungarian sample was much older than our American sample, American mean age was 23 years and 49% of Hungarians were older than 29 years. Also, the Hungarian sample (n = 201) was larger compared to the American sample (n = 91). Equal numbers should have been used.

Third, the demographic questionnaire demonstrated that most of the American sample enrolled in psychology classes; thus, this may have biased the result in respect to community attitudes toward mental illness.

Lastly, previous research has shown that past experience with psychotherapy strengthens the beliefs, attitudes and behaviors seeking professional help. Favorable attitudes regarding help seeking have been associated with increasing age and being female, which significantly predicts fewer stigmatizing attitudes and more confidence in psychological help; 83% of the Hungarian population were women with the mean age of 30 years. Demographic statistics indicated that 40% of Hungarians sought psychological services in the past.

References

Angermeyer M. C. & Matschinger H. (2003) The Stigma of Mental Illness: Effects of labeling on Public Attitudes Towards People with Mental Disorder. *Acta Psychiatric Scand 108*(4): 304-9.

Ban, L., Kashima, Y. & Haslam, N. (2012) Does Understanding Behavior Make It Seem Normal?: Perceptions of Abnormality Among Euro-Australians and Chinese-Singaporeans. *Journal of Cross-Cultural Psychology.* 43: 286-298. doi:10.1177/0022022110385233

Bender K., Thompson S. J., Lantry J. & Flynn P. M. (2007) Treatment Engagement: Building Therapeutic Alliance in Home-Based Treatment with Adolescent and their Families. *Contemporary Family Therapy 29* (102), 39-55.

Bebbington P. E., Bhugra D., Brugha T., Singleton N., Farrel M., Jenkins R., Lewis G. & Meltzer H. (2004). Psychosis, victimizations and childhood disadvantage: evidence from second British National Survey of Psychiatric Morbidity. *British Journal Psychiatry 185*, 220-226.

Magyar, Beda (2019) Hungary is Lost. *Zeit Online.* Retrieved from: https://www.zeit.de/politik/ausland/2019-04/european-union-hungary-democracy-viktor-orban-english/komplettansicht

Corrigan, P. W., & Watson, A. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1,* 16-20.

Digiuni, M., Jones, W. F., & Camic, M. P. (2013). Perceived Social Stigma and Attitudes Towards Seeking Therapy in Training: A Cross-National Study. *Psychotherapy, 50 (2),* 213-223. doi: 10.1037/a0028784

Givens J. L., Houston T. K., Van Voorhees B. W. & Cooper L. A. (2007). Ethnicity and Preferences for Depression Treatment. *Gen Hosp Psychiatry; 29* (3): 182-91.

Hamid, A., & Furnham, A. (2013). Factors affecting attitude towards seeking professional help for mental illness: a UK Arab perspective. *Mental Health, Religion & Culture, 16*, 741-758. http://dx.doi.org/10.1080/13674676.2012.718753

Högberg, T., Magnusson, A., Lützén, K., & Ewalds-Kvist, B. (2012). Swedish attitudes towards persons with mental illness. Nordic Journal of Psychiatry, 66 (2), 86-96.

Hofstede, G. (1991). *Cultures & organizations; Software of the mind: intercultural cooperation and its importance for survival.* New York: McGraw-Hill.

Hyman S. E. (2013). Psychiatric Drug Development: Diagnosing a Crisis. *Cerebrum: The Dana forum on brain science, 5.*

Family and Juvenile Law Advisory Committee (2013). Juvenile Law: Psychotropic Medications. *Judicial Council of California*: JV-219-INFO, JV-221, JV-222.

Individualistic Practices and Values Increasing Around the World (2017). From: https://www.psychologicalscience.org/news/releases/individualistic-practices-and-values-increasing-around-the-world.html

Kim, Y. P., Kendall, L. D., & Chang, S. E. (2016). Emotional Self-Control, Interpersonal Shame, and Racism as Predictors of Help-Seeking Attitudes Among Asian Americans: An Application of the Intrapersonal-Interpersonal-Sociocultural Framework. *Asian American Journal of Psychology, 7,* 15-24. http://dx.doi.org/10.1037/aap0000032

Link, B. G., & Phelan J. C. (2011). Conceptualizing Stigma. *Annual Review of Sociology, 27,* 363-385.

Papadopoulos, C., Foster, J., & Caldwell, K. (2013). 'Individualism-Collectivism' as an Explanatory Device for Mental Illness Stigma. *Community Mental Health Journal, 49,* 270-280. doi: 10.1007/s10597-012-9534-x

Sarikoc, G., & Oz, F. (2015). The Effects and Stigma of Mental Illness in Turkey. *Community Mental Health Journey (52)*, 353-360. Doi 100.1007/s10597-015-9960-7

Slovick P., Kraus N. N., Lappe H., Letzel H. & Malmors T. (1989). Risk perception of prescribing drugs: Report on a survey in Sweden. *The perception and management of drug safety risks,* 90-111. Berlin: Springer.

Mossakowski M. N. (2011). Unfulfilled expectations and symptoms of depression among young adults. *Soc Sci Med 73*(5), 729-36.

Triandis, H. C. (1995). *Individualism & Collectivism.* Boulder: Westview Press.

Triandis, H. C. (1989). The self and social behavior in differing cultural contexts. *Psychological Review, 96*, 506-520.

Triandis, Harry C. G., Michele J. (1998). Converging Measurement of Horizontal and Vertical Individualism and Collectivism. *Journal of Personality and Social Psychology (74).*

Tzouvara, V., & Papadopoulos, C. (2014). Public stigma towards mental illness in the Greek culture. *Journal of Psychiatric and Mental Health Nursing, 21*, 931-938. doi: 10.1111/jpm.12146

WHO. (2011). Stigma and discrimination. From http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/mental-health/activities/stigma-and-discrimination.

Appendix A

Barry University

Cover Letter

Dear Research Participant:

Your participation in a research project is requested. The title of the study is *The Effects of Culture on Mental Health Stigma: Hungarian versus American College Students*. Szandra Kormendi, a graduate student in the Psychology Department at Barry University, is conducting the research, and is seeking information that will be useful in the field of psychology and treatment planning. The aims of the research are to examine the different attitudes towards mental illness that are held by Hungarian and American students, and to compare the two on different variables affecting those attitudes. It is anticipated that there will be 300 participants in this study.

In accordance with these aims, the following procedure will be used: participants will be asked to complete four questionnaires following this letter. The first questionnaire is a demographic survey with 11 questions. The second is *Vertical Horizontal Individualism Collectivism* (VHIC), a 29-item 5-Likert Scale that measures whether the participant has an individualistic or collectivistic outlook. The third is *Community Attitudes of Mental Illness* (CAMI), a 40-item 5-point Likert Scale that measures attitudes towards mental illness. The fourth is *Attitude Toward Seeking Professional Psychological Help Scale-Short Form*, a 29 4-point Likert Scale that measures attitudes of mental illness. The 109 questions are estimated to take approximately 40 minutes to complete.

Your consent to be a research participant is strictly voluntary and should you decline to participate in the study, 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 any potential risks: participants can skip any questions they do not want to answer and may decline to participate in the study at any time.

There are no direct benefits to you for participating in this study; however, your participation will contribute to research in this area of psychology and treatment planning. If you are an undergraduate student currently enrolled in a psychology course at Barry University, or a student in Hungary, 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 in anonymous, that is, no names or other identifiers will be collected. No IP address will be delivered to the researcher. 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 this study.

If you have any questions or concerns regarding the study or your participation in the study, you may contact me, Szandra Kormendi by email at Szandra.kormendi@mymail.barry.edu or Dr. Stephen Koncsol by telephone at (305) 899-3270 or by email at skoncsol@barry.edu. You may also contact the Institutional Review Board point of contact, Jasmine Trana, by phone at (305) 899-3020 or by email at jtrana@mail.barry.edu.

Appendix B

Demographic Questionnaire

Please complete the following questions. It is important for you to be completely honest. All questionnaires will be kept confidential.

1. What is your sex?
   a. Male
   b. Female

2. What is your age?
   18 19 20 21 22 23 24 25 26 27 28 29 Older

3. Marital status?
   a. Single
   b. Married
   c. Divorced
   d. Widowed

4. Years of living in the United States?
   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

5. What is your educational level?
   a. High School/Matric
   b. Bachelor's Degree
   c. Master's Degree

6. Are you a psychology major? (Yes/No)

7. What is your ethnicity?

a. African American
b. European American
c. Latin American
d. Asian American
e. Asian (Pakistani/Indian/Chinese etc.)
f. African
g. Hungarian

8. Have you ever sought psychological or psychiatric services in the past?
   a. Yes
   b. No

9. Have you ever taken psychotropic medications (antidepressants, tranquilizers, etc.)?
   a. Yes
   b. No

10. Religion
    a. Christian
    b. Jewish
    c. Islam
    d. Hindu
    e. Other

11. I approve of individuals taking psychotropic medications (e.g. antidepressants and anxiety medications)

Strongly Agree	Agree	Not Certain	Disagree	Strongly Disagree
1	2	3	4	5

Appendix C

Vertical-Horizontal Individualism-Collectivism Scale

Please rate the following statements.

Strongly Agree	Agree	Not Certain	Disagree	Strongly Disagree
1	2	3	4	5

1. If the group is slowing me down, it is better to leave it and work alone
2. To be superior, every man must stand alone
3. Winning is everything.
4. Only those who depend on themselves et ahead in life.
5. If you want something done right, you've got to do it yourself
6. What happens to me is my own doing.
7. I feel winning is important in both work and games.
8. Success is the most important thing in life.
9. It annoys me when other people perform better than I do.
10. Doing your best is not enough; it is important to win.
11. In most cases, to cooperate with someone whose ability is lower than oneself is not as desirable as doing the thing on one's own.
12. In the lung run the only person you can count is yourself.
13. It is foolish to try to preserve resources for future generations.
14. People should not be expected to do anything for the community unless they are paid for it.
15. Even if a child won the Nobel Prize the parents should not feel honored in any way.
16. I would not let my parents use my car (if I had one), no matter whether they are good drivers or not.
17. I would help within my means if a relative told me that she or he is in financial difficulty.
18. I like to live close to my friends.
19. The motto "sharing is both a blessing and a calamity" is still applicable even if one's friend is clumsy, dumb, and causing a lot of trouble.

20. When my colleagues tell me personal things about themselves, we are drawn closer together.
21. I would not share my ideas and newly acquired knowledge with my parents.
22. Children should not feel honored even if the father were highly praised and given an award by a government official for his contributions and service to the community.
23. I am not to blame if one of my family members fails.
24. My happiness is unrelated to the well being of my co-workers.
25. My parents' opinions are not important in my choice of a spouse.
26. I am not to blame when one of my close friends fails.
27. My co-workers' opinions are not important in my choice of a spouse.
28. When a close friend of mine is successful, it does not really make me look better.
29. One need not worry about what the neighbors say about whom one should marry

Appendix D

Community Attitudes of Mental Illness

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

Strongly Agree	Agree	Not Certain	Disagree	Strongly Disagree
1	2	3	4	5

1. As soon as a person shows signs of mental disturbance, he should be hospitalized.
2. More tax money should be spent on the care and treatment of the mentally ill.
3. The mentally ill should be isolated from the rest of the community.
4. The best therapy for many mental patients is to be part of a normal community.
5. Mental illness is an illness like any other.
6. The mentally ill are a burden on society.
7. The mentally ill are far less of a danger than most people suppose.
8. Locating mental health facilities in a residential area downgrades the neighborhood.
9. There is something about the mentally ill that makes it easy to tell them from normal people.
10. The mentally ill have for too long been the subject of ridicule.
11. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.
12. As far as possible mental health services should be provided through community-based facilities.
13. Less emphasis should be placed on protecting the public from the mentally ill.
14. Increased spending on mental health services is a waste of tax dollars.
15. No one has the right to exclude the mentally ill from their neighborhood.
16. Having mental patients living within residential neighborhoods might be good therapy, but the risks to residents are too great.
17. Mental patients need the same kind of control and discipline as a young child.
18. We need to adopt a far more tolerant attitude toward the mentally ill in our society.
19. I would not want to live next door to someone who has been mentally ill.

20. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.
21. The mentally ill should not be treated as outcasts of society.
22. There are sufficient existing services for the mentally ill.
23. Mental patients should be encouraged to assume the responsibilities of normal life.
24. Local residents have good reason to resist the location of mental health services in their neighborhood.
25. The best way to handle the mentally ill is to keep them behind locked doors.
26. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.
27. Anyone with a history of mental problems should be excluded from taking public office.
28. Locating mental health services in residential neighborhoods does not endanger local residents.
29. Mental hospitals are an outdated means of treating the mentally ill.
30. The mentally ill do not deserve our sympathy.
31. The mentally ill should not be denied their individual rights.
32. Mental health facilities should be kept out of residential neighborhoods.
33. One of the main causes of mental illness is a lack of self-discipline and will power.
34. We have the responsibility to provide the best possible care for the mentally ill.
35. The mentally ill should not be given any responsibility.
36. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services.
37. Virtually anyone can become mentally ill.
38. It is best to avoid anyone who has mental problems.
39. Most women who were once patients in a mental hospital can be trusted as babysitters.
40. It is frightening to think of people with mental problems living in residential neighborhoods.

Appendix E

Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

Please write the number which indicates your level of agreement or disagreement with each statement.

Disagree	Partly Disagree	Partly Agree	Agree
0	1	2	3

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 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 the last resort.
10. Personal and emotional troubles, like many things, tend to work out by themselves.

Appendix F

Barry Egyetem

Kísérőlevél

Kedves részvevők!

Egy kutatási projektben való részvételre hívjuk önöket. A vizsgálat címe *A kultúra hatása a mentális betegségekkel kapcsolatos megbélyegzésre: magyar és amerikai egyetemi hallgatók összehasonlítása*. A kutatást Körmendi Szandra, a Barry Egyetem pszichológiai mesterképzésben részt vevő hallgatója vezeti, aki a pszichológia és a kezeléstervezés terén hasznosítható információkat gyűjt. A kutatás célja felmérni azokat a különféle attitűdöket, melyekkel a magyar és amerikai hallgatók a mentális betegségekhez viszonyulnak, illetve összevetni ezeket az adatokat számos olyan változó mentén, amik az attitűdöket befolyásolják. Várakozásaink alapján a vizsgálatban háromszázan vesznek majd részt.

A fenti céloknak megfelelően az alábbi eljárást követjük: a résztvevőket négy kérdőív kitöltésére kérjük, melyeket a jelen levél szövegét követően találnak. Az első egy 11-kérdéses demográfiai kérdőív. A második a *Vertikális-horizontális-individualizmus-kollektivizmus skála* (VHIC), egy 29 tételből álló, ötfokozatú Likert-skála, ami a résztvevők individualista, illetve kollektivista hozzáállását vizsgálja. A harmadik a *Mentális betegségekkel kapcsolatos közösségi attitűdök* (CAMI), egy 40 tételből álló, ötfokozatú Likert-skála, ami a mentális betegségekkel kapcsolatos attitűdöket méri. A negyedik pedig a *Pszichológiai segítségnyújtás igénybevételére irányuló attitűdmérés rövidített változata*, egy 29 tételből álló, négyfokozatú Likert-skála, ami a mentális betegség attitűdjeit méri. A 109 kérdés megválaszolása mintegy 40 percet vesz igénybe.

Az ön részvétele a kutatásban szigorúan önkéntes alapon történik. Ha úgy dönt, hogy nem szeretne benne részt venni, vagy ha közben bármikor félbehagyja, annak semmilyen hátrányos következménye nincs önre nézve. Ha ön tanuló, a jegyeire ez semmilyen hatással nem lesz. A kutatásnak nincsenek előrelátható kockázatai. Az esetleges kockázatok minimálisra csökkentése érdekében az alábbi eljárást követjük: a résztvevők kihagyhatnak minden olyan

kérdést, amit nem szeretnének megválaszolni, és bármikor dönthetnek úgy, hogy nem vesznek részt a kutatásban.

A részvételnek nincsenek közvetlen előnyei, ugyanakkor az ön részvétele hozzájárul a pszichológia és a kezelések megtervezésének ezen területén végzett kutatásához. Ha ön jelenleg a Barry Egyetemen pszichológiai alapképzésben vesz részt, vagy ha egyetemi hallgató Magyarországon, előfordulhat, hogy a részvételért plusz kreditre jogosult. Nyomtassa ki ezt a kísérőlevelet, amivel igazolhatja, hogy részt vett a kutatásban. A résztvevőként megadott adatait anonim módon kezeljük, azaz nem kérjük a résztvevők nevét vagy egyéb személyazonosító adatait. A vizsgálatvezető nem látja az ön IP-címét. Az elektronikus kérdőív kitöltésével és beküldésével ön tanúsítja, hogy elmúlt 18 éves, és hogy önkéntes alapon vesz részt a vizsgálatban.

Ha bármilyen kérdése vagy észrevétele van a vizsgálattal vagy az abban való részvétellel kapcsolatban, kérem keressen engem, Körmendi Szandrát emailben a Szandra.kormendi@mymail.barry.edu címen, vagy Dr. Stephen Koncsolt telefonon a (305) 899-3270 számon, illetve emailben a skoncsol@barry.edu címen. Jasmine Trana, az Intézményi Felülvizsgálati Bizottság kapcsolattartója is rendelkezésükre áll telefonon a (305) 899-3020 számon, illetve emailen a jtrana@mail.barry.edu címen.

Appendix G

Demográfiai kérdőív

Kérjük, válaszolja meg az alábbi kérdéseket. Fontos, hogy teljesen őszinte legyen. Minden kérdőívet bizalmasan kezelünk.

1. Az ön neme
   a. Férfi
   b. Nő

2. Az ön életkora
   18 19 20 21 22 23 24 25 26 27 28 29 Idősebb

3. Családi állapota
   a. Egyedülálló
   b. Házas
   c. Elvált
   d. Özvegy

4. Mennyi ideje él az Egyesült Államokban?
   a. 2 éve
   b. 3 éve
   c. 4 éve
   d. 5 éve
   e. 6+ éve
   f. Soha nem éltem az Egyesült Államokban, de jártam ott
   g. Soha nem éltem az Egyesült Államokban, és nem is jártam ott

5. Mi a legmagasabb iskolai végzettsége?
   a. Gimnázium/Érettségi
   b. Főiskola (alapképzés)
   c. Egyetem (mesterképzés)

6. Pszichológus hallgató? (Igen/Nem)

7. Mi az ön etnikuma?
    a. Afrikai amerikai
    b. Európai amerikai
    c. Spanyolajkú amerikai
    d. Ázsiai amerikai
    e. Ázsiai (pakisztáni/indiai/kínai stb.)
    f. Afrikai
    g. Magyar

8. Igénybe vett valaha pszichológusi vagy pszichiátriai ellátást?
    a. Igen
    b. Nem

9. Szedett valaha pszichotróp gyógyszert (antidepresszánst, nyugtatót stb.)?
    a. Igen
    b. Nem

10. Vallás
    a. Keresztény
    b. Zsidó
    c. Muszlim
    d. Hindu
    e. Egyéb

11. Támogatom a pszichotróp gyógyszerek alkalmazását (pl. antidepresszánsok, szorongás elleni gyógyszerek)

Teljesen egyetért	Egyetért	Bizonytalan	Nem ért egyet	Egyáltalán nem ért egyet
1	2	3	4	5

Appendix H

Vertikális-horizontális-individualizmus-kollektivizmus skála

Kérem, értékelje az alábbi kijelentéseket!

Teljesen egyetért	Egyetért	Bizonytalan	Nem ért egyet	Egyáltalán nem ért egyet
1	2	3	4	5

30. Ha a csoport visszahúz, akkor jobb otthagyni őket és inkább egyedül dolgozni.
31. A kiemelkedő teljesítményhez önállónak kell lenni.
32. A győzelem a legfontosabb.
33. Csak azok viszik valamire az életben, akik magukra támaszkodnak.
34. Ha jól akarsz valamit elvégezni, magadnak kell megcsinálnod.
35. Magamnak köszönhetek mindent, ami velem történik.
36. Úgy gondolom, a győzelem a munkában és a játékban is fontos.
37. A siker a legfontosabb dolog az életben.
38. Idegesít, amikor mások jobban teljesítenek nálam.
39. Nem elég a legjobbat nyújtani, hanem győzni kell.
40. A legtöbb esetben nem célszerű a magaménál gyengébb képességű emberekkel együttműködni, jobb inkább egyedül elvégezni a dolgot.
41. Hosszútávon csak magára számíthat az ember.
42. Butaság arra törekedni, hogy a jövő generációi számára megőrizzük az erőforrásokat.
43. Nem kéne elvárni, hogy az ember bármit tegyen a közösségért, ha nem fizetik meg érte.
44. A szülők még akkor se érezzék magukat semennyire megtisztelve, ha a gyerekük elnyeri a Nobel-díjat.
45. Nem engedném, hogy a szüleim vezessék az autómat (ha lenne autóm), függetlenül attól, hogy mennyire vezetnek jól.
46. Lehetőségeimhez mérten segítenék, ha egy rokonom azt mondaná, hogy anyagi nehézségei vannak.
47. Szeretek közel lakni a barátaimhoz.
48. A jelmondat, miszerint „az osztozkodás egyszerre áldás és csapás" akkor is igaz, ha az ember barátja ügyetlen, ostoba és sok bajt okoz.
49. Amikor a kollégáim személyes dolgokat osztanak meg velem, azzal közelebb kerülünk egymáshoz.
50. Nem osztanám meg el a szüleimmel az ötleteimet és az újonnan szerzett tudásomat.
51. A gyerek akkor se érezze magát megtisztelve, ha az apja köztiszteletben áll és a közösségért végzett munkájáért állami kitüntetésben részesül.
52. Nem az én hibám, ha valamelyik családtagom kudarcot vall.
53. A boldogságom nem függ a kollégáim jóllététől.
54. A szüleim véleménye nem számít abban, hogy kit választok házastársnak.
55. Nem az én hibám, ha valamelyik jóbarátom kudarcot vall

56. A kollégáim véleménye nem számít abban, hogy kit választok házastársnak.
57. Ha egy jóbarátom sikert ér el, az nem vet rám különösebben jó fényt.
58. Nem érdemes azzal foglalkozni, hogy a szomszédnak mi a véleménye arról, hogy kivel házasodjon össze az ember.

Appendix I

Mentális betegségekkel kapcsolatos közösségi attitűdök

Olvassa el figyelmesen az állításokat, és a skála értékeivel jelezze, hogy mennyire ért egyet egy-egy kijelentéssel.

Teljesen egyetért	Egyetért	Bizonytalan	Nem ért egyet	Egyáltalán nem ért egyet
1	2	3	4	5

1. Mihelyt a mentális zavar jelei mutatkoznak valakin, elmegyógyintézetbe kell vinni.
2. Többet kéne költeni az adónkból a mentális betegségben szenvedők ápolására és kezelésére.
3. A mentális betegségben szenvedőket el kéne különíteni a társadalom többi részétől.
4. Sok mentálisan beteg ember számára a legjobb terápia a normális közösség részeként élni.
5. A mentális zavar ugyanolyan betegség, mint bármi más betegség.
6. A mentálisan beteg emberek terhet jelentenek a társadalomra.
7. A mentálisan beteg emberek sokkal kisebb veszélyt jelentenek, mint azt sokan hiszik.
8. Ha pszichiátriai intézet létesül egy lakóövezetben, az csökkenti a környék értékét.
9. Van valami a mentális betegségben szenvedő emberben, amit miatt könnyen felismerhető egy normális közösségben.
10. Túl sokáig voltak gúny tárgyai a mentális betegségben szenvedő emberek.
11. Őrültség, ha egy nő olyan emberhez megy hozzá, akinek volt már mentális betegsége, még ha gyógyultnak is tűnik.
12. Amennyire csak lehetséges, a mentális egészségügyi ellátást a közösségi létesítményeken keresztül kéne nyújtani.
13. Kisebb hangsúlyt kéne fektetni arra, hogy megvédjük a lakosságot a mentálisan beteg emberektől.
14. A mentális egészségügyi ellátásra költött még több adóforint csak kidobott pénz.
15. Senkinek nincs joga a mentális betegségben szenvedőket kirekeszteni az adott környékről.
16. Lehet, hogy jó terápia, ha a mentális betegek lakóövezetben élnek, de túl nagy kockázatot jelentenek az ott élőkre.
17. A mentális betegségben szenvedőknek ugyanúgy felügyeletre és fegyelmezésre van szükségük, mint a kisgyerekeknek.
18. Sokkal toleránsabban kellene viszonyulnunk a társadalmunkban élő mentális betegekhez.
19. Nem szeretnék olyan ember szomszédságán élni, akinek volt már mentális betegsége.
20. Jó lenne, ha a lakók elfogadnák a környékükön lévő mentális ellátó intézményeket, hogy azok a helyi közösség érdekeit szolgálhassák.
21. A mentális betegeket nem szabadna a társadalomból kivetettként kezelni.
22. A meglévő ellátás elégséges a mentális betegek számára.
23. A mentális betegeket ösztönözni kéne arra, hogy a normális élettel járó feladatokat ellássák.

24. A helyi lakosoknak jó okuk van arra, hogy tiltakozzanak, ha a környékre mentális ellátó intézményt terveznek költöztetni.
25. A legmegfelelőbb eljárás a mentális betegségben szenvedőkkel szemben, ha elzárva tartjuk őket.
26. Az elmegyógyintézetek inkább tűnnek börtönnek, mintsem olyan helynek, ahol a mentális betegek gondozásban részesülhetnek.
27. Minden olyan ember el kell tiltani közhivatal viselésétől, akinek volt már mentális betegsége.
28. Mentális ellátó intézmény telepítése egy adott lakóövezetbe nem veszélyezteti a helyi lakosokat.
29. Az elmegyógyintézet idejétmúlt módja a mentális betegek kezelésének.
30. A mentális betegek nem érdemelnek rokonszenvet.
31. A mentális betegektől nem szabad megtagadni az egyéni jogokat.
32. A mentális ellátó intézményeket távol kéne tartani a lakóövezetektől.
33. A mentális betegségek egyik legfőbb oka az önfegyelem és akaraterő hiánya.
34. Felelősek vagyunk azért, hogy a lehető legjobb ellátást biztosítsuk a mentális betegek részére.
35. A mentális betegekre nem szabad semmit rábízni.
36. A lakóknak nincs mitől tartaniuk, ha a környéken lévő mentális ellátóhelyre betegek érkeznek.
37. Lényegében bárki válhat mentálisan beteggé.
38. Jobb elkerülni mindenkit, akinek mentális problémái vannak.
39. A legtöbb olyan nő, akit egykor elmegyógyintézetben kezeltek, megbízható gyermekvigyázó.
40. Ijesztő belegondolni, hogy mentális betegségben szenvedő emberek lakóövezetben élnek.

Appendix J

Pszichológiai szakmai segítségnyújtás igénybevételére irányuló attitűdmérés
- rövidített változat

Kérjük, minden állításhoz írja be az egyetértését kifejező értéket!

Nem ért egyet	Részben nem ért egyet	Részben egyetért	Egyetért
1	2	4	5

11. Ha úgy vélném, hogy idegösszeomlásom van, az első gondolatom lenne, hogy szakember segítségét kérjem.
12. Szerintem nem jó módja az érzelmi konfliktusoktól való megszabadulásnak, ha a problémáimról beszélgetek egy pszichológussal.
13. Ha az életem jelenlegi szakaszában súlyos lelki válságot élnék át, biztos vagyok benne, hogy segítséget jelentene a pszichoterápia.
14. Van valami tiszteletreméltó abban, ha az ember úgy küzd meg a konfliktusaival vagy félelmeivel, hogy ehhez nem kér segítséget szakembertől.
15. Ha hosszabb időn keresztül szoronganék vagy zaklatott lennék, akkor örülnék a pszichológusi segítségnek.
16. Elképzelhető, hogy a jövőben pszichológiai tanácsadást veszek majd igénybe.
17. Az ember nem igazán tudja egyedül megoldani a lelki problémáit, szakember segítségével erre jobb esélye van.
18. A pszichoterápia költsége és a ráfordítandó idő alapján nem hiszem, hogy egy magamfajta ember számára ez jó megoldás lenne.
19. Az ember bogozza ki a saját problémáit, a pszichológusi segítség csak a végső eszköz legyen.
20. A személyes és lelki problémák, mint annyi minden más, általában maguktól megoldódnak.