THE EFFECTS OF ACCULTURATION AND RELIGION ON PORTUGUESE-AMERICANS' ATTITUDES TOWARDS SEEKING PROFESSIONAL MENTAL HEALTH CARE

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By
Jesuina Belerique
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CERTIFICATION OF APPROVAL

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Dr. AnaMarie Guichard Associate Professor of Psychology	Date
Dr. Kurt Baker Professor of Psychology	Date
Dr. Gary Williams Assistant Professor of Psychology	Date

DEDICATION

I would like to dedicate my work to the Portuguese-American population, for all the struggles that were endured while immigrating to the United States. My hope was that this study can open up doors for more research to be done in order to help Portuguese-Americans to receive the psychological help they need. I would like to acknowledge my thesis committee members, Dr. Kurt Baker and Dr. Gary Williams, and especially my thesis chair, Dr. AnaMarie Guichard, for all the time and work they put into my thesis. I would also like to show my appreciation to my family and friends without their support and encouragement; I would not have completed my thesis. Last, but certainly not least, I would like to thank God for giving me the strength and power to believe in myself to reach this accomplishment.

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ABSTRACT

The current study investigated the Portuguese-Americans' attitudes towards seeking professional psychological help (i.e., therapy) by evaluating their acculturation and religiosity level. Twenty-two male and 49 female first-generation (being born outside of the United States) or second-generation (being born in the United States) Portuguese-Americans participated in this study. Online surveys were completed by CSU, Stanislaus students and they received experimental credit for their participation. Participants who completed the surveys in person were community members recruited from a local Portuguese bakery or a Portuguese Catholic Church and they received a $5 gift card for their participation. Both online and in-person participants completed three surveys: Attitudes Towards Seeking Professional Psychological Help Short-Survey (ATSPPH-S) measured attitudes towards help-seeking, the Short Acculturation Scale for Hispanics (SASH) measured the acculturation level of the Portuguese-American population, and the Santa Clara Strength of Religious Faith (SCSORF) survey was used to measure the level of religiosity. It was hypothesized that Portuguese-Americans who reported higher levels of religiosity would have less favorable attitudes towards seeking therapy from a mental health professional as compared to those who were not as religious. It was also hypothesized that the generation level (first or second) would influence their attitudes towards seeking professional psychological help as it was associated with their level of acculturation. The researcher hypothesized that less acculturated (first-generation) Portuguese-Americans would have more negative attitudes towards seeking professional help

compared to their (second-generation) who are more acculturated to the American culture. Analyses revealed that religiosity did not significantly impact attitudes towards seeking help. Results also revealed that second-generation Portuguese-Americans were more acculturated than first-generation Portuguese-Americans. Additionally, second-generation Portuguese-Americans had more favorable attitudes towards seeking professional psychological help compared to first-generation Portuguese-American.

CHAPTER I

INTRODUCTION

Each year, many individuals who could benefit from professional psychological help (i.e., therapy) go without it. According to the Surgeon General's report (U.S. Department of Health and Human Services, 1999), approximately 28% of the American adult population experienced mental health problems in any given year; which was approximately 57.7 million Americans in the year 2010 (Substance Abuse and Mental Health Services Administration, 2010). Of those individuals experiencing mental health problems, only 15% sought professional help and, of those, only 6% received mental health service (Chen & Mak, 2008). Similarly, in European countries about one-fifth of the population experiences some type of mental illness in any given year and this population goes without receiving mental health services (Chen & Mak, 2008).

In the literature, there was limited research investigating the specific attitudes of Portuguese-Americans regarding help-seeking behavior for mental health issues. With that in mind, I have designed my research on the Portuguese-American population and have explored the Portuguese-American's attitudes and cultural beliefs towards seeking professional help for mental health issues. Currently, the research most closely related to the Portuguese-American population regarding help-seeking behaviors focuses on other ethnic minority counterparts, such as Latinos and Asian Americans. Due to the limited research on the Portuguese-American population

it was unknown which factors may be impacting their attitudes toward seeking mental health care. The current study was focusing on whether Portuguese-Americans' attitudes are influenced by their level of acculturation and religiosity.

Many studies have investigated the attitudes of individuals from various ethnic minority backgrounds, such as Asian Americans and Latino Americans, regarding the likelihood of seeking professional help (i.e., therapy) for a mental health issue (Abe-Kim, Gong, Takeuchi, 2004; Rogers, 2007; Rojas-Vilches, Negy, Reig-Ferrer 2011). It was found in these studies that ethnic minority group members tend to underutilize mental health services at a substantially higher rate than the general population. For instance, Abe-Kim, Fang Gong, and David Takuchi (2004) found in their study that Filipino-American underutilized mental health services (2.9%) at a substantially lower rate than the general population (5.9%).

Reasons for underutilization of services

There are several reasons for the underutilization of mental health services by ethnic minority individuals, however only a few will be discussed in this paper. A reason for the underutilization of services with the ethnic minority population may misconstrue seeking mental health services as having a severe mental condition. In addition, various ethnic minorities do not pursue professional help because of the trepidation they have with being stigmatized, which was defined as the fear of being disapproved by others for having social problems and seeking help from a mental health professional (Rojas-Vilches et al, 2011). Another plausible explanation for ethnic minority individual's underutilizing professional help for mental illnesses can

be explained by the different perspectives taken by the ethnic minority individual and the mental health provider regarding what constitutes a mental illness.

The ethnic minority individual, raised in a collectivist culture (such as Asian Americans and Latino populations), was more likely to attribute their mental health problems to internal, personal causes or weaknesses (Chen & Mak, 2008). With that being said, it can be deduced that the Portuguese-American population share the same perspective as they also use the collective approach. On the other hand, mental health providers influenced by Western therapy perceived mental illness as arising from interactions between the person and the environment (Chen & Mak, 2008). This research suggests that minority ethnic members, who have collective cultural views, would not find therapy using a Western society approach to be effective or beneficial, which contributes to this population having negative attitudes towards seeking therapy.

Furthermore, several Latino populations, such as Puerto Rican and Cuban Americans', do not believe in seeking therapy from a mental health professional. It was speculated that many Latinos disregard the necessity of professional help because they revert to family guidance and clergy for support during arduous times (Rojas-Vilches et al., 2011). Similar to other ethnicities, when Latino adults receive social support from their family it has been correlated with a decrease in depressive symptoms, acculturative stress, and martial stress (Rojas-Vilches et al., 2011).

Filipino-Americans' and Latinos are not the only ethnic minority groups underutilizing mental health services when experiencing mental health issues, Chinese-Americans' do as well (Chen& Mak, 2008). It was reported only one-fifth of Chinese-American population that sought out mental health services actually received the service (Chen & Mak, 2008). Three general explanations for the Chinese-Americans' underutilization of mental health services were identified as the conflict between the Western society therapy and traditional Asian values, cognitive appraisals of psychological problem, and stigma and shame associated with mental illness (Chen & Mak, 2008). Chinese cultural values go against what one expects to occur in Western therapy; for instance, Chinese "individuals are expected to control and suppress their emotional problems, to place little importance or to have little concern over them" (Chen & Mak, 2008, p. 443). Furthermore, traditional Chinese culture places more value on self-restraint than emotional expression. The Chinese culture values appear to be inconsistent with many Western therapies where the client was usually encouraged to express his or her feelings (Chen & Mak, 2008).

Religious beliefs may be another reason for the underutilization of psychological services from the ethnic minority group members. For some religious ethnic minority individuals, seeking help from a professional mental health practitioner may not be an option as they may feel they are betraying their God by trying to get rid of or ameliorating their mental condition. Many Latinos believe they should endure what their almighty creator, God, has given them, whether good or bad, and suffer with it as God suffers for their sins (Aranda, 2008; Rojas-Vilches et

al., 2011). Therefore, at times ethnic minority group members internalize their distress and decide not to seek psychological help from either mental health provider or religious clergy; this explains the reason for ethnic monitory group members underutilizing both avenues of help-seeking.

Religiosity

Religiosity may influence one's attitude toward seeking mental health services. Although there are several concepts of religiosity, religion was most often conceptualized as an institutionalized form of practices that was determined by the frequency of religious services attended, private devotional activity or religious experience. Religion has the ability to positively impact one's mental health by providing social support, positive healthy behaviors and effective life coping skills, such as meditation and prayer (Abe-Kim et al., 2004). A concept that was similar to religiosity was spirituality. Spirituality was the relationship that fosters a sense of meaningful purpose or mission in life and can be experienced either inside or outside of a place of worship. Many individuals find spirituality through religion; however, some individuals find spirituality through community, with nature, music, the arts, or a set of values and principles.

Similar with Filipino and Portuguese-Americans', a high rate of Latinos are religious and practice Catholicism (Abe-Kim et al., 2004; Arranda, 2008; Scott, 2009). The National Comorbidity Survey (1997) examined mental health across ethnic groups and although they were generally comparable, "Latino adults were found to have the highest prevalence rates of a major depressive episode over their

lifetime" (p. 316). Rather than seeking out professional services, many Latinos believe that practicing or participating in a religion tends to help them manage stressful and difficult experiences, which contradicts earlier findings (Aranda, 2008). Many ethnic minorities feel that attending church weekly provides them with support to deal with their difficulties (Aranda, 2008). For example, religious Latinos consider attending church as an opportunity to place their problems in God's hands, which tends to lower their stress level and thus makes Latinos less likely than the general population to seek professional psychological services from a mental health provider (Rojas-Vilches et al., 2011). Numerous Latino individuals, however, would rather keep to themselves than divulge their problems to others, preventing others from worrying or displaying concerns with their problems (Rojas-Vilches et al., 2011).

Aranda (2008) investigated the benefits of religious involvement on the mental health of Latinos. Religious involvement was described as "encompassing formal, public, and collective involvement at worship-related services as well as more informal, private forms of involvement such as private prayer" (Aranda, 2008, p. 11). The results of the study revealed when Latinos were involved in religious activities it directly correlated with better mental health outcomes, such as reduced likelihood of abuse and dependence of drugs and alcohol, decreased depressive and anxiety symptoms, lower levels of psychological stress and overall better life quality (Aranda, 2008).

Similar to what Aranda (2008) found with the Latino population, Abe-Kim et al. (2004) found a similarity with the Filipino-American population with respects to

religiosity. As the Filipino-American population has a high Catholicism rate (83%), the authors hypothesized that Filipino-American would be more likely to seek professional help from clergy members than a mental health professional. A religious person may seek help from religious clergy due to their core beliefs and values being affirmed and reinforced by the minister (Abe-Kim et al., 2004).

It was found in the Abe-Kim et al. (2004) study that Filipino-American who considered themselves to be highly religious were three times more likely to seek help from religious clergy, as compared with those Filipino-American who were not as religious. However, higher levels of religiosity did not result in less help-seeking from mental health professionals (Abe-Kim et al., 2004). Help seeking from religious clergy was not necessarily related to dissatisfaction with mental health professionals but rather to what was easily accessible to highly religious Filipino-Americans', which explains the reason for Filipino-American to seek mental health services from religious clergy and mental health professionals at similar rates (2.5% vs. 2.9%) (Abe-Kim et al., 2004). From this information it can be concluded that most Filipino-American do not favor receiving therapy from religious clergy over mental health professionals; rather, Filipino-American severely underutilize therapy services from both the clergy and mental health professionals (Abe-Kim et al., 2004).

Acculturation

Acculturation may be an arduous process for many ethnic minority group members and how one acculturates may impact their attitude towards seeking professional psychological help. Acculturation can be broadly explained as a "process

by which people adapt and adjust from their original culture to a new culture, which includes a change in the individual's behaviors, beliefs and values" (Rojas-Vilches et al., 2011, p. 315). Research has found that there was, in fact, an association between attitudes towards seeking professional help and how acculturated an individual was to the new culture (Rojas-Vilches et al., 2011).

At times acculturation and assimilation are used interchangeably; to understand there was clear distinction between the two concepts Sam and Berry (2010) explain the difference between them. In the acculturation process the reciprocity of the influences that each cultural group has on the other culture was acknowledged. Assimilation was defined as being a part of the acculturation process. When an individual was assimilating to the host culture his identity diminishes and a close interaction with the host culture takes place in order for adoption of the cultural values, norms, and traditions of the new culture to take place (Sam & Berry, 2010).

I will briefly discuss two processes that are used to conceptualize the acculturation process, the cultural identity development model by Sue and Sue (1990) and acculturation strategies by Sam and Berry (2010). Firstly, the cultural identity development model includes five stages: the conformity stage, the dissonance stage, the resistance and immersion stage, the introspection stage, and the integrative awareness stage. During the conformity stage the individual rejects their own cultural values and prefers the cultural values of the dominant culture. In the dissonance stage the minority individual encounters experiences that challenge their cultural beliefs, values and attitudes. During the resistance and immersion stage the ethnic minority

individual experiences anger, shame, guilt due to the oppression and racism endured during the acculturation process from the dominant culture. In the introspection stage the individual dedicates more energy toward understanding themselves as part of a minority group and what it means at a deeper level. Individuals in the integrative awareness stage have the ability to appreciate positive aspects of both cultures (Sue & Sue, 1990).

Another process used to conceptualize the acculturation process was the acculturation strategies by Sam and Berry (2010). Sam and Berry (2010) suggest the degree to which an individual acculturates to the host culture depends on the individual's desire to maintain the original culture and identity, and the degree to which individuals from the host culture desire interaction with those individuals outside of the host culture. These two issues led to the adoption of four acculturation strategies by Sam and Berry (2010): assimilation, separation, integration and marginalization.

One of the acculturation strategies was assimilation; when the original culture assimilates to the host culture the beliefs and values of the original culture are replaced with those of the host culture. An additional acculturation strategy includes the separation strategy, which was a situation where a high value was placed onto the host culture and interactions with members of the host culture are avoided, which causes the individual to only be involved in the host culture. Yet another acculturation strategy includes the integration strategy, also known as biculturalism, the individual maintains their original culture while integrating into the host culture. The last

acculturation strategy includes marginalization strategy, a lack of interest in one's own culture and little interest in interacting with other ethnic groups; therefore, overtime the individual becomes marginalized from both ethnic groups (Sam & Berry, 2010).

In addition to the four strategies used to explain the acculturation process, Sam and Berry (2010) also explain the acculturation process begins when the two cultures meet; change occurs at two levels, at the group (cultural) and the individual level. According to Sam and Berry (2010), at the individual level, the individual experiences a variety of behavioral shifts, from speaking, dressing and eating habits to more serious behavioral shifts that produce concern, anxiety and depression. When an individual was in the process of acculturating into a new culture, the individual adapts to the language, identity, attitudes and behavior patterns of the new culture and this process may produce anxiety and depression (Sue & Sue, 1990). The acculturation process occurs differently for each individual based on their personal experience and the level in which the new culture accepts the individual into the society.

Acculturation Stress

An individual may experience many stressful situations when undergoing the acculturation process, this was known as acculturation stress. A variety of factors may contribute to acculturative stress. According to Sam and Berry (2010), many individuals that emigrate from their host culture are "refugees, asylum seekers, immigrants, indigenous and ethnic minorities" escaping from something or looking

for a better life somewhere else (p. 473). During emigration some families separate. A few family members stay in the country of origin while other family members migrate to the host country. After family members are settled in the host country, the other family members immigrate to the host country. This separation may cause distress which contributes to acculturative stress.

Another example of acculturation stress was intergenerational conflict. Intergenerational conflict occurred when immigrant parents and children differed in the degree to which they have acculturated to the host culture. Portes and Rumbaut (2001) created a model that uses dissonant acculturation, consonant acculturation and selective acculturation to explain the dynamic between immigrant parents and children when emigrating to the host culture. Portes and Rumbaut (2001) explain dissonant acculturation occurring when children master language and norms of the host culture and disconnect from the ethnic culture more rapidly than their parents. Consonant acculturation was defined when both parents and children acculturate to the host culture, and disconnect from ethnic origin culture at the same time. Similar to Sam and Berry's (2010) integration strategy, selective acculturation occurs when parents and children maintain a healthy connection to both the host culture and the ethnic culture; this was also referred to as bicultural identity, or ethnic identity, as the individual takes on both cultures as their identity.

Acculturation and Generation Level

Another factor that influences the acculturation process and the ethnic minority member's attitude toward seeking psychological help was their generational

level: first (i.e., born outside of the United States) or second (i.e., born in the United States) generation. It was assumed that since first-generation individuals are born outside of the host culture, by the time they emigrate they are older in age than a second-generation individual, who was born within the host culture and raised in the traditions and beliefs.

Research indicates that younger people acculturate to a new culture more quickly than older people (Lee, 2009). A reason for this may be that younger people spend most of their life immersed in the host culture. For example, children who are second-generation spend a majority of their life attending American schools where they are taught English and interact with other children who speak English. Individuals who were born outside of the United States but emigrated at a very young age and attended American schools will also be considered second-generation, even though these individuals were born outside of the United States. Furthermore, while in school the children participate in American cultural activities, such as reciting the Pledge of Allegiance (Lee, 2009).

An individual's behavior, beliefs, values and attitudes are prone to change as more time was spent in the new culture. In other words, it was safe to predict that the longer an individual resides in the United States the more likely he or she will be more accepting of America's behaviors, beliefs, values and attitudes (Rojas-Vilches et. al, 2011). As time goes on, the children see these activities as typical everyday routines and begin to adopt the American culture and belief system as their own. As the American culture tends to be more accepting of individuals seeking professional

psychological help than many other cultures, it was to be expected that second-generation ethnic minority members will most likely share the same positive attitudes towards seeking professional help for a mental illness as the American culture (Lee, 2009).

Acculturation and the Portuguese Population

According to U.S. Census Bureau Report, there were approximately 1,173,691indivudals of Portuguese that immigrated to the United States in the year 2000 (Morrison & James, 2009). One of the areas Portuguese individuals emigrated from are the Azores islands, nine islands located in the mid-Atlantic Ocean that were owned and settled by Portugal in the 15th century. Due to rebellion and decline in the Portuguese economy, many Portuguese families immigrated to the United States in the 19th century and continue to today. Initially the migration was due to political and economic factors including relocating for work, such as whaling and fishing, farming and textile, leather and factory work. A massive relocation of Portuguese families to North America occurred in 1957 when a volcano erupted, leaving many families with no other option but to migrate to a safer location (Morrison & James, 2009).

Scott (2009) indicates it was impossible to determine how well the Portuguese immigrant populations acculturate into the American culture as there was limited research investigating this phenomenon. However, research finds that once Portuguese immigrants migrate to the United States, they encountered acculturative stress due to the differences between North American's modern life and their fishing

communities. Additionally, the separation of families from their extended family support systems that remain in Portugal also caused stress.

Research has found the Portuguese immigrant population, like other ethnic minority group members, seems to struggle with language use and acquisition, which influenced their ability to acculturate into the American culture (Scott, 2009). Do to the Portuguese immigrant population not being able to speak English, it takes this population more time to interact and assimilate into the American culture. Those who only speak Portuguese are more likely to attend activities and events with other Portuguese speaking individuals, which do not provide the opportunity for them to learn and acculturate into the American culture (Scott, 2009). In the study conducted by Scott (2009) the results found the Portuguese language remains dominant within the first-generation, due to the limited interaction with the new culture. The second-generation was bilingual, speaking both English and Portuguese; however, by the third generation the individual typically only speaks English due to the limited interaction with the host culture.

Morrison and James (2009) interviewed 21 Azorean women and 28 Azorean men in order to gather data on their immigration experience and how it impacted their acculturation process. When female interviewees were asked about help-seeking behaviors it was indicated that they relied on going to church and prayer, focused on solving the problem, got it off their mind, talked to friends, resolved it alone, and confessed to a priest. Besides these help-seeking behaviors, they would not talk to professionals such as psychologists or psychiatrists.

The Present Study

In the present study, I will be investigating whether the Portuguese-American's level of religiosity and acculturation (first vs. second-generation) influences their attitudes towards seeking mental health care.

Hypothesis 1: It was expected that Portuguese-Americans who reported higher levels of religiosity would have less favorable attitudes towards seeking therapy from a mental health professional, as compared to those who were not as religious.

Hypothesis 2A**:** I expected to find the generation level (first or second-generation) of Portuguese-American participants would influence their attitudes toward seeking psychological help (i.e. therapy).

Hypothesis 2B: I hypothesized that less acculturated (i.e., first-generation) Portuguese-Americans have more negative attitudes towards seeking professional help from a mental health professional than second-generation Portuguese-Americans.

CHAPTER II

METHODS

Participants

Seventy-one Portuguese-Americans participated in the current study. Participants were 30 first- and 36 second-generation Portuguese-American men (*n* = 22) and women (*n* = 49) 18 years of age or older. Participants were recruited from the California State University, Stanislaus campus through SONA, the online participant management system, a local Portuguese bakery and a Catholic Portuguese church in Stanislaus County. For participating in this study, participants who were students at CSU, Stanislaus were given credit that may be used as extra credit to satisfy a requirement for their psychology course. Participants who were not students at CSU Stanislaus were given a $5 Starbucks gift card or a $5 gift certificate to the Portuguese bakery to thank them for their participation.

There were 71 participants used in the current study. Initially, the study had 123 participants, 73 participants completed the online survey and 50 participants completed the paper version of the survey. All data from the 50 participants who completed the paper version of the survey were used in the study. However, only 21 of the 73 online surveys were used in the current study after some were removed for reporting non-Portuguese descent or if they were neither first- nor second-generation. The majority of the online surveys were not completed and that data was, necessarily, removed from analyses.

Materials

Participants were asked to complete a 14-item demographic questionnaire (see Appendix A) assessing general information about the participant: such as gender, age, ethnicity, household income level, highest level of education completed, and previous help-seeking experiences (Lopez-Arias, 2005). The demographic questionnaire utilized in this study was modeled after the demographic questionnaire created and used by Lopez-Arias (2005) and was used with his permission.

Attitudes towards Seeking Professional Psychological Help Scale-Short (ATSPPH-S)

Participants completed the Attitudes towards Seeking Professional Psychological Help Scale-Short Form (ATSPPHS-S; Fischer & Farina, 1995). The ATSPPHS-S (see Appendix B) includes 10 items chosen from the original 29-item Attitudes towards Seeking Professional Help Scale (Fischer & Turner, 1970). Like the longer measure, the short version of the inventory measures the participants' attitudes toward seeking professional psychological help utilizing a 4-point Likert scale, ranging from 1 *(Agree)* to 4 *(Disagree).* An example of a question asked in the ATSPPH-S was "*I might want to have psychological counseling in the future*." Before this scale was scored, reverse coding of some items were needed (2, 4, 8, 9, and 10). The higher the score on this inventory, the more positive the participant's attitude was towards seeking professional help. The ATSPPHS-S criterion validity has been demonstrated by its ability to significantly predict the individual's usage of mental health services (Elhai & Simons, 2007).

Short Acculturation Scale for Hispanics (SASH)

In addition to filling out the ATSPPHS-S form, the participants also completed the Short Acculturation Scale for Hispanics (SASH; Marin et al., 1987). The SASH (see Appendix C) was originally developed by Marin et al. (1987) to assess acculturation levels within a Hispanic population. For the purpose of this study, the wording on the original scale was altered to address the Portuguese sample. For example, the word Hispanic was changed to the word Portuguese. This measure has been translated from English to Portuguese. I acquired permission from Marin to use this scale and to translate it to Portuguese for the purpose of my study.

The SASH was a twelve-item inventory that examines the participant's level of acculturation. Specifically, it assesses three factors related to acculturation: 1) language use, 2) media (preference for TV/radio stations), and 3) ethnic relations (Marin et al., 1987). The SASH uses a five point Likert style response scale ranging from 1 *(Only Portuguese),* 2 *(More Portuguese than English),* 3 *(Both Equally)*, 4 *(More English than Portuguese)*, 5 *(Only English)* (Lopez-Arias, 2005). Examples of questions asked on the SASH are, "*What language do you usually speak at home?"* and "*What language are the TV programs you usually watch in?"* The survey was scored by averaging the items then averaged for the overall score.

Santa Clara Strength of Religious Faith Questionnaire (SCSORF)

To assess the participant's strength of religious faith, the participants completed the Santa Clara Strength of Religious Faith questionnaire (SCSORF;

Plante, 1997). The SCSORF (see Appendix D) questionnaire was a 10-item inventory measuring the religious strength of the participant, regardless of their denomination. The items were scored on a 4-point Likert scale where "1" means *strongly Disagree*, "2" means *Disagree*, "3" means *agree* and "4" means *strongly agree*. Examples of the questions asked are "*I pray daily*" and "*My religious faith was extremely important to me.*" The score for each question was summed to obtain a total for the overall survey.

Procedures

Online data collection

Participants who were students at CSU, Stanislaus were recruited online via SONA, the Psychology Department's online participant management system (http://csustan.sona-systems.com). A brief description of the study was posted on SONA as well as instructions limiting participation to first and second-generation Portuguese-Americans. After agreeing to participate in the study, participants were directed to Qualtrics to complete the online questionnaires. Once directed to Qualtrics, participants read the informed consent, signed the form to agree to participate by typing their name in the box provided and then clicked the next button to precede.

Once the participant gave informed consent, they were then prompted to complete the demographic form. After completing the demographic questionnaire, participants filled out the Attitudes Towards Seeking Professional Psychological Help-Short Form (ATSPPH-S), followed by the Acculturation survey (SASH), and

the Santa Clara Strength of Religious Faith (SCSORF) questionnaire. The questionnaires were counterbalanced by Qualtrics to randomize the order the surveys were presented. Finally, participants were presented with the debriefing form (see Appendix G), which they were encouraged to print out and keep for their records. The online forms were only provided in English.

Community data collection

These participants completed the questionnaires via pen and paper, either in English or in Portuguese, at a local Portuguese bakery or a Portuguese Catholic church within Stanislaus County. The researcher received permission from the priest to conduct the study at the church prior to recruiting participants. The researcher had the announcer mention the study in the community bulletin weeks prior to the study occurring to allow enough time for participants to decide whether or not to participate in the current study. The researcher obtained a room at the church in which to conduct the study, to provide confidentiality and prevent any distractions.

As the participants walked into the reserved room, the researcher asked if the participant preferred to complete the survey in Portuguese or in English in order to provide participant with the most appropriate survey. Surveys in Portuguese were labeled with a "P" on the manila envelope and surveys in English were labeled with an "E" on the manila envelope. Twenty participants completed surveys in Portuguese and 34 participants completed surveys in English. In order to counterbalance the information, both Portuguese and English surveys were labeled with either a "1", "2" or a "3" to indicate which order the surveys were presented. The order in which the

surveys were completed depended on which manila envelope the participant received. Participants were instructed to complete the questionnaires in the order in which they were placed in the envelope.

The participants were instructed to take the informed consent out of the manila envelope, read and sign it. The researcher offered to assist participants who had difficulties reading the informed consent or any of the other documents. However, the researcher did not assist in answering any of the questions for the participant. The researcher then collected the signed informed consent forms from the participant and instructed them to retain the extra copy of for their own records. Participants were then instructed to complete all study materials. If the participants had a question, the researcher answered the question in the most non-directive manner possible. The participants were asked to put all the documents back into the manila folder once they had completed all forms. Once the participant had completed all surveys, researcher reviewed the debriefing form with the participant. Participants were reminded that their information would remain confidential.

When the participant handed the manila envelope to the researcher it was labeled with a "C" if it was completed at the church and a "B" if the survey was completed at the bakery. Finally, the non-student participants were given a $5 gift card to Starbucks or a $5 gift card to the Portuguese bakery as a thank you for participating in the study. Participants signed a form indicating they received the $5 gift card and were thanked for their time.

CHAPTER III

RESULTS

The hypotheses being examined in the current study were: (1) Portuguese-Americans who reported higher levels of religiosity would have less favorable attitudes towards seeking therapy from a mental health professional, as compared to those Portuguese-Americans who are not as religious; (2a) the generational level (i.e., first or second) of the individual would influence the attitude towards seeking psychological help (i.e., therapy). (2b) Less acculturated Portuguese-Americans have more negative attitudes toward seeking professional psychological help from a mental health professional.

A correlation analysis was used to analyze religiosity and attitudes towards seeking professional psychological help in order to determine if Portuguese-Americans who reported higher levels of religiosity have less favorable attitudes towards seeking therapy. The correlation between religiosity and attitudes towards seeking help was found to be non-significant, r (69) = -.20, $p > .05$, two-tailed.

A one-way ANOVA was used to determine if there was a significant difference between the three generation levels (first, second or other) and the rate at which the participant acculturates in each condition. There was a significant effect of generation level on acculturation at a $p = .05$ level for the three conditions (first, second or other), $F(2, 67) = 22.89$, $p < .001$. Post hoc comparisons using the Fisher LSD test indicated that the mean score for the first-generation level ($M = 2.25$, $SD = 1.12$) was significantly different than the second-generation level ($M = 3.61$, $SD =$

.79) and other generation level (M = 4.60, SD = .16). All three conditions are statistically significant different from each other (See Table 1 on page 24). The results suggest that the second-generation was more acculturated than the first-generation.

A correlation analysis was used to analyze the participant's acculturation level (i.e., low or high) on their attitudes towards seeking psychological help. The correlation between acculturation level and attitudes towards seeking psychological help was found to be statistically significant, r (71) = .27, p = .02, two-tailed.

Portuguese-Americans' who had been diagnosed with a mental health illness were hypothesized to have more favorable attitudes towards seeking help from a mental health professional, as compared to those individuals who did not report having a mental illness. Portuguese-Americans' who reported having been diagnosed with a mental illness in the past or who were currently diagnosed with one (n = 8) had more favorable attitudes towards seeking help from a mental health professional (M = 3.312, SD = 0.562), as compared to the participants who indicated they had not been diagnosed with a mental condition (n = 45, M = 2.844, SD = 0.50), t(51) = 2.40, p = .02.

Table 1
The Effects of Generation Level on Acculturation.

Generation Level	Acculturation Level		*F*	*p*
	N	Mean		
First	30	2.25 (1.12)	22.89	<.001
Second	36	3.61 (.79)		
Other	4	4.60 (.16)		

Note. Standard deviations appear in parentheses below means. Post hoc tests showed all means are different from each other.

CHAPTER IV

DISCUSSION

Previous research has found that ethnic minority group members endure stressful experiences that the general population typically does not, such as stress due to acculturation. Furthermore, this population tends to underutilize mental health services. As there was limited research on the Portuguese-American population, the current study was designed to contribute to the research investigating Portuguese-American's attitudes towards seeking psychological help (i.e., therapy), while also exploring whether their level of religiosity and acculturation influences their attitudes toward seeking psychological help.

Inconsistent with my expectations, the data collected in the current study indicated a non-significant relationship between religiosity and attitudes towards seeking mental health services from a mental health professional. The current study did not support the hypothesis that, as compared to less religious Portuguese-Americans', highly religious Portuguese-Americans' would have less favorable attitudes towards seeking therapy from a mental health professional. The findings of the current study were consistent with the findings in Abe-Kim et al.'s (2004) study, which found that Filipino-Americans' were not less likely to seek mental health services from mental health professionals as compared to clergy members.

Although there are similarities in the findings, there are differences in the design of the two studies. It is important to note that Abe-Kim et al. (2004) investigated the *behavior* of Filipino-American's seeking mental health services from

a clergy member versus a mental health professional, whereas the current study was examining the *attitudes* of Portuguese-American's towards seeking professional psychological help from a mental health professional or a clergy member. It was understood that attitudes impact one's behaviors; therefore, if an individual has a favorable attitude towards seeking psychological help from a mental health provider and negative attitudes towards seeking help from clergy members, it was expected that the individual most likely will seek mental health services from the mental health provider rather than the clergy member.

The data from the current study supported the hypothesis that generation level (first or second) and level of acculturation influenced the Portuguese-Americans' attitude towards seeking professional psychological help. It was hypothesized that first-generation Portuguese-Americans, meaning those Portuguese-American's born outside of the United States, would have less favorable attitudes towards seeking professional psychological help, as compared to the second-generation Portuguese-Americans who were born in the United States and therefore more acculturated to the American culture.

I expected to find that the second-generation Portuguese-Americans, who were born in the United States, having lived the majority if not their whole life in the United States, most likely to be more acculturated and accepting of the American traditions and values compared to the first-generation Portuguese-Americans. It was speculated that the first-generation Portuguese-Americans were less acculturated into

the American culture, tradition and values as they have spent less time immersed in the culture than the second-generation Portuguese-Americans' have.

When discussing hypothesis 2a, the results of the current study corresponded with the results other researchers have found in respects to generation level (first or second) and the rate of acculturating into another culture. The findings of the current study demonstrate that second-generation Portuguese-Americans; were, in fact, more acculturated to the American culture, as compared to their first-generation Portuguese-American participants. Similarly to the findings of the current study, the findings in Lee's (2009) study demonstrated that second-generation individuals acculturated at a faster rate than those of the first-generation.

The findings of the current study also supported hypothesis 2b; the level of acculturation (high or low) positively correlates with Portuguese-American's attitudes towards seeking professional psychological help (i.e. therapy) as a significant correlation was found, $r(71) = .27$, $p = .02$). In other words, the Portuguese-American's who rated themselves to being more acculturated were more likely to have favorable attitudes towards seeking professional psychological help compared to those Portuguese-Americans' that reported lower levels of acculturation.

During exploratory analyses, the findings revealed that participants who were diagnosed with a mental health disorder in the past or who currently were diagnosed with a mental disorder had more favorable attitudes towards seeking professional psychological help than those who did not have a mental health diagnosis. This may be due to the fact that those who were diagnosed with a mental health diagnosis must

have sought out mental health services in order to have been diagnosed with a mental health diagnosis. Although the data demonstrated a clinical significance in attitudes between participants who currently have a diagnosis or had a diagnosis in the past, it was important to bring to attention that only eight of the 72 participants in the study indicated they had been diagnosed with a mental health condition at some points.

Limitations

One weakness of the current study was the small sample size. The sample size decreased, from 123 participants to 71 participants, after dropping those participants who were not of Portuguese-American descent, of first or second-generation, or did not fully complete study materials.

All together, twenty-four individuals declined to complete surveys during data collection (17 individuals declined to complete surveys when data was collected at the Portuguese bakery and seven individuals declined when data was collected at the Portuguese church). Some of these individuals indicated to me that the completion of the survey was not possible due to not having enough time to complete the survey. In addition, another issue I noticed was that several older Portuguese-American males refused to complete the surveys because they could not read, either in Portuguese and/or in English and refused assistance with survey completion. Some of the participants shared with the researcher they felt some of the questions were too intrusive and did not want to provide what they felt was sensitive information to an individual they did not know. Although the surveys were translated from English to Portuguese to make it convenient for the participants to read and understand, the

surveys were still challenging for the participants to comprehend as they were not written at a third grade level, which may have caused the participants to leave many questions unanswered.

Another important factor to discuss was that data was collected at a local Catholic church, it is most likely that the participants that completed the surveys at this location were more likely to identify as being highly religious. This may be problematic, as it may have influenced the participants to answer the questions from a more religious perspective; for instance, compared to if they completed the survey in a neutral location, such as a bakery.

Future Directions

Several directions can be taken to further investigate the current study's findings regarding the attitudes of the Portuguese-American population towards seeking professional psychological help. The current study examined the attitudes of highly religious Portuguese-Americans towards seeking professional psychological help from a mental health professional; a future direction would be to conduct research regarding attitudes of Portuguese-American's who do not identify as being highly religious or to collect data in different locations than a Catholic church or a bakery.

The researcher suggests further research explore other reasons, besides religion and acculturation, that influence Portuguese-Americans attitudes towards seeking professional psychological help from a mental health professional. Some of these reasons may include fear of being stigmatized, or being labeled as "mentally

ill", "crazy" or "weak". Once the reasons for Portuguese-American's underutilization of mental health services are identified, then ways to overcome these barriers can be assessed and addressed. Once addressed, Portuguese-Americans' would, hopefully, have more positive attitudes towards seeking psychological help and would be more likely to seek out mental health services when needed.

Conclusion

Overall, this study suggests that there is a possibility for the Portuguese-American population to have a more favorable outlook toward seeking professional psychological help from a mental health professional, especially the highly religious Portuguese-Americans. This indicates there is hope for the Portuguese-American population to be able to develop the attitude necessary to seek out the mental health care services when that may be needed. Although the findings in the current study suggest that second-generation Portuguese-Americans are more acculturated and have more favorable attitudes towards seeking therapy than the first-generation Portuguese-Americans; I believe first-generation Portuguese-American's can develop more favorable attitudes towards seeking therapy if provided with information regarding the benefits and effectiveness of therapy, and if it were more socially acceptable within the culture. Further research is needed to explore how to develop these positive attitudes towards seeking therapy so that a greater amount of the Portuguese-American population would be more likely to receive mental health services when needed and how to make it more socially acceptable within this specific culture.

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APPENDICES

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

1. What is your age? _____ years

2. What is your gender? _____Male _____Female

3. Where is your family from?

____Portuguese from Mainland Portugal
____Portuguese from the Azores Islands
____Portuguese from Africa (Angola, Mozambique)
Other, please specify_____

4. Where is your mother from?

____Portuguese from Mainland Portugal
____Portuguese from the Azores Islands
____Portuguese from Africa (Angola, Mozambique)
Other, please specify_____

5. Where is your father from?

____Portuguese from Mainland Portugal
____Portuguese from the Azores Islands
____Portuguese from Africa (Angola, Mozambique)
Other, please specify_____

6. Where were you born? City/Village _____

State/Region _____
Country _____

7. Which Portuguese generation level are you?

_____ First-generation (you were born in another county and moved to the United States)

_____ Second-generation (you were born in the United States and your parents were born outside of the United States)

_____ Other

8. How many years have you lived in the United States? _____

9. What is your relationship status?
_____Single/Not in a relationship
_____In a relationship
_____ Married
_____Divorce
_____Widowed

10. What is your highest educational level?
_____ Elementary school
_____ High School
_____ College
_____ Graduate Degree

11. What is your annual household income?

_____Less than 11,000
_____11,000- 18,999
_____19,000-26,999
_____ 27,000-34,999
_____35,000-42,999
_____43,000-50,999
_____51,000-58,999
_____59,000-66,999
_____67,000-or greater

12. Have you previously received professional therapy or counseling? _____ Yes _____ No

If **NO**, please continue with next question.
If **YES**, for what reason?
_____
If **YES**, did you find it helpful? _____ Yes _____No
If **YES,** would you be willing to seek professional therapy again? _____ Yes _____No
If **YES,** how long did you receive professional therapy? _____

13. Indicate if you have been diagnosed with a mental illness.

_____ Depression _____ Bipolar
_____ Schizophrenia _____ Borderline Personality
_____ Anxiety _____ Social Phobia
_____ PTSD _____ Other _____

14. Indicate if a member of your family has been diagnosed with a mental illness.

_____Depression _____ Bipolar
_____Schizophrenia _____ Borderline Personality
_____Anxiety _____ Social Phobia
____ PTSD _____ Other _____

APPENDIX B

ATTITUDES TOWARDS SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE –SHORT (ATSPPHS-S)

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

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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.**

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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

   Agree *Partly Agree* *Partly Disagree* *Disagree*

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

    Agree *Partly Agree* *Partly Disagree* *Disagree*

APPENDIX C

THE SHORT ACCULTURATION SCALE (SASH)

The statements listed below pertain to your language use and other preferences. Please circle the answer that best applies.

1. In general, what language(s) do you read and speak?

    a. Only Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

2. What language(s) did you speak as a child?

    a. Only Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

3. What language(s) do you usually speak at home?

    a. Only Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

4. In which language(s) do you usually think?

    a. Only Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

5. What language(s) so you usually speak with your friends?

    a. Only Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

6. What language(s) are the T.V. programs that you usually watch?

    a. Only Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

7. What language(s) are the radio programs you usually listen to?

    a. Only Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

8. In general, what language(s) are the movies, T.V., and radio programs that you *prefer* to watch and listen to?

    a. Only Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

9. In general, your close friends are?

    a. All Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

10. You prefer going to social gatherings/parties in which the people are:

    a. All Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

11. The persons you visit or who visit you are:

    a. All Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

12. If you could choose your children's friends, you would want them to be:

    a. All Portuguese
    b. More Portuguese than English
    c. Both equally
    d. More English than Portuguese
    e. Only English

APPENDIX D

SANTA CLARA STRENGTH OF RELIGIOUS FAITH QUESTIONNAIRE

(SCSORF)

Please answer the following questions about religious faith using the scale below. Indicate the level of agreement (or Disagreement) for each statement.

1= strongly Disagree 2= Disagree 3= agree 4= strongly agree

_____1. My religious faith was extremely important to me.
_____2. I pray daily.
_____3. I look to my faith as a source of inspiration.
_____4. I look to my faith as providing meaning and purpose in my life
_____5. I consider myself active in my faith or church.
_____6. My faith was an important part of who I am as a person.
_____7. My relationship with God was extremely important to me.
_____8. I enjoy being around others who share my faith.
_____9. I look to my faith as a source of comfort.
_____10. My faith impacts many of my decisions.

APPENDIX E

INFORMED CONSENT

1. This study was interested in investigating the attitudes of Portuguese-Americans regarding seeking professional help from a mental health practitioner. If I agree to participate, I will be asked to answer survey questions related to this topic.

2. I understand that I am free to discontinue my participation at any time without penalty. I may also skip any questions that make me feel uncomfortable. Even if I withdraw from the study, I understand that I will receive any entitlements that have been promised to me in exchange for my participation, such as extra credit.

3. I understand that if I agree to participate, the study will last about 20 minutes.

4. I understand that I will be given additional information after my participation was complete.

5. I understand that all data from this research study will be kept from inappropriate disclosure and that the data will only be accessible to the researcher, Jesuina Belerique, and the research supervisor, Dr. AnaMarie Guichard. I understand that the researchers are not interested in my individual responses, only the average response of everyone in the study.

6. I understand that, if I wish, I may obtain written information about the results of the research by emailing Dr. Guichard at aguichard@csustan.edu or Jesuina Belerique at jbelerique@csustan.edu.

7. The present research has been designed to reduce the possibility of any negative experiences as a result of participation. However, if I am a student at CSU, Stanislaus and my participation in this study causes me concerns, anxiety, or otherwise distresses me, I understand that I may contact the Student Counseling Center (209) 667-3381 at CSU, Stanislaus for an appointment. If I am a participant who was not a student at CSU, Stanislaus, I understand I may contact Stanislaus County Behavioral Health at 1-888-376-6246 for counseling services.

8. I understand that the possible benefits of participation in the present research are that I may learn more about psychology research procedures and hypotheses, and how psychological research was conducted.

9. I understand that I will be provided with an unsigned copy of this informed consent form to keep for my own records.

10. I understand that I may contact the researcher, Jesuina Belerique (jbelerique@csustan.edu), and the research supervisor, Dr. AnaMarie Guichard, (aguichard@csustan.edu) in the Department of Psychology at CSU, Stanislaus, if I have any questions or concerns regarding my participation in this study. If I have any questions about my rights as a research participant, I understand I may contact the Campus Compliance Officer at IRBadmin@csustan.edu.

11. By signing below, I attest that I am 18 years of age or older.

12. By signing below, I am indicating that I have freely consented to participate on this research.

PARTICIPANT'S SIGNATURE: _____
DATE: _____
PRINT NAME: _____

APPENDIX F

DEBRIEFING FORM

Thank you for participating in this study! I am interested in investigating the attitudes of Portuguese-Americans towards seeking professional help from a mental health practitioner (e.g., therapist). I am interested in this topic because past research has shown that ethnic minority groups, such as the Portuguese-American population, underutilize professional mental health services, even when they would likely benefit from therapy (Rojas-Vilches, 2011). I expect to find that Portuguese-Americans have negative attitudes towards seeking professional mental help, and these attitudes influence whether they are willing to seek professional mental help. In addition, I am investigating whether religiosity and acculturation influence attitudes towards seeking help. Once it was understood why the Portuguese-American population has negative attitudes towards seeking professional help, further research can be conducted to find ways to make therapy more accommodating to the Portuguese-American population.

All the information I collected in this study will be kept safe from inappropriate disclosure, and there will be no way of identifying your responses in the data archive. I am not interested in any one's individual responses; rather I want to look at the general patterns that emerge when all the participant's responses are put together. I ask that you do not discuss the nature of this study with others who may later participate in it, as this could affect the validity of my research conclusions.

Your participation today was greatly appreciated and will help me learn more about the attitude of the Portuguese-American population toward help seeking behavior. If you have any questions about the study or would like to learn about the results of the study, you may contact the researcher, Jesuina Belerique (jbelerique@csustan.edu), or the research supervisor, Dr. AnaMarie Guichard (aguichard@csustan.edu). If you have questions about your rights as a research participant you may contact the Campus Compliance Officer, at IRBadmin@csustan.edu. If participation caused you any concern, anxiety or distress, you may contact the Student Counseling Center at (209) 667-3381, if a student, or the Stanislaus County Behavioral Health at 1-888-376-6246, if not a student.

If you would like to learn more about this research topic, I suggest these references:

Abe-Kim, J., Gong, F., & Takeuchi, D. (2004). Religiosity, spirituality, and help-seeking among Filippino-American: Religious clergy or mental health professionals? *Journal Of Community Psychology*, *32*(6), 675-689. doi:10.1002/jcop.20026

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THANK YOU AGAIN FOR YOUR PARTICIPATION!

APPENDIX G

PARTICIPATION VERIFICATION FORM

By signing this document, I acknowledge that I received a $5.00 Starbucks gift card for participating in the study.
Name (print): ____
Signature : ____
Date: ________

By signing this document, I acknowledge that I received a $5.00 Starbucks gift card for participating in the study.
Name (print): ____
Signature : ____
Date: ________

By signing this document, I acknowledge that I received a $5.00 Starbucks gift card for participating in the study.
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