The Role of Culture in Perceptions of Psychological Disorder and Its Treatment

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Abstract

Clinical psychology is changing dramatically due to an increased focus on culture. Cultural differences, which arise in part from differences in ethnic background, influence perceptions of psychological distress and its treatment. One major dimension of culture is individualism-collectivism, which reflects the relative emphasis on the self versus the group for defining oneself and for governing one's actions. This study examined whether residents of and immigrants from Greece, a collectivist culture, have less positive perceptions of psychological distress and its treatment, as compared to non-immigrant Canadians descended from individualist cultures. The OMIS and ATSPPH were used to measure participants' attitudes toward psychological distress and treatment and an Individualism-Collectivism measure was used to assess their orientation towards this cultural dimension. A fourth measure was specifically constructed for this study and used to assess participants' orientation towards the cultural dimension of Uncertainty Avoidance. The results supported the predictions that led to the present study. Non-immigrant Canadians had more positive attitudes toward psychological distress and treatment than did either of the two Greek groups. These differences remained even after adjusting statistically for demographic differences (i.e., age, education, gender) between the groups. Also as predicted, the two Greek groups were more collectivist in their orientation than the non-immigrant Canadians. The central prediction of the thesis, that collectivism would mediate attitudinal differences, was confirmed; entering Collectivism into a regression analysis reduced significantly the differences between groups on measures of attitudes toward psychological disorder and treatment. The addition of

Uncertainty Avoidance to the statistical analyses changed the pattern of results only slightly. Collectivism was positively related to authoritarianism and, consistent with previous findings, negatively related to education level. Other issues that were explored included the measurement of Individualism-Collectivism, cross-cultural measurement issues, and which specific attitudes toward psychological distress and treatment are considered desirable. A better understanding of the relationship between the cultural dimension of individualism-collectivism and attitudes toward psychological distress and its treatment will facilitate both the use of psychological services by culturally-diverse populations (e.g., immigrant groups) and the development of culturally-sensitive therapeutic practices.

CHAPTER 1:

ON THE PLACE OF CULTURE IN PSYCHOLOGY

Clinical psychologists require a deeper understanding of the implications of culture for psychological phenomena related to clinical practice because cultural variation is becoming increasingly common and clients from different cultures bring new and complex challenges to clinical practice. Responding effectively to cultural differences is particularly challenging, not only because of the complexity of the issues, but also because there are differences of opinion about the most appropriate way to accommodate culture in clinical practice. This introductory chapter explores why culture assumes such a central role in contemporary clinical practice and considers alternative ways that psychologists might adapt to the growing importance of culture.

The Importance of Culture

There are several reasons why culture has grown (and continues to grow) in importance within psychology. First, an increasing proportion of the population comes from non-Western cultures and second, psychology as a discipline has an increasingly expansive global presence. These developments necessarily bring psychologists, and their ideas, into more frequent contact with people from diverse cultural backgrounds. Also, cross-cultural interaction has demonstrated that there are unique features of dealing effectively with clients from other cultures.

Population Change

Clinical psychologists in North America are increasingly required to provide services to a culturally diverse population. This diversity results from a variety of factors,

including immigration, growth of ethnic sub-cultures, and increasing globalization of the workplace (i.e., more people are travelling and working in different cultures).

There are high levels of immigration to North America and other developed countries, and the origins of immigrants have shifted from European countries. For example, the 1996 Canadian Census showed that almost 5,000,000 Canadians were born outside the country, and only slightly more than 20% of the one million immigrants coming to Canada from 1991 to 1996 were from European countries or the USA. Asian countries provided the bulk of immigrants to Canada in 1996 (Belanger & Dumas, 1998). Refugees constitute one large group of recent immigrants to Canada. Since 1979, for example, over 37,000 Salvadorans have sought refuge in Canada (Simmons, 1993).

A second element in the growth of non-Western ethnic groups is differential birth-rates among existing residents of Western countries. For example, there is a higher birth-rate among Aboriginal Canadians than European Canadians. In the Canadian province of Manitoba, for example, 11.7% of the population is Aboriginal and 26.6% of Aboriginals are under 10 years of age (Statistics Canada, 1996 Census). It has been estimated that by the end of the 21st century non-Europeans will make up one-third to one-quarter of the population of the USA (Frable, 1997; Yutrzenka, 1995). Forehand and Kotchik (1996) cite census projections that, by 2050, only 53% of the USA population will be Caucasian and similar projections appear true for Canada.

Globalization of the workplace also contributes to cultural diversity, as work becomes more international or global in nature. Transnational companies are increasingly common and generally involve workers who must operate in cultures other than their own.

One consequence of this globalization is that employees working in or visiting foreign countries may require delivery of psychological services from professionals educated in another culture. Thus, Western clinicians may increasingly find themselves treating workers from non-Western cultures.

Internationalization and Diversification of Psychology

The preceding factors are bringing various cultural groups into closer proximity with psychological service providers within Western society. But irrespective of these changes in the distribution of various ethnic groups in the West, psychology itself is becoming increasingly global and diverse in its perspective. Psychology is spreading to other countries and becoming more of a global force. This is illustrated by the growing size and importance of international conferences and regional conferences outside of North America (e.g., the European Congress of Psychology recently held its 6th Annual Meeting).

Historically, academic and clinical psychology have largely been Western enterprises, although not exclusively so. Psychologists are disproportionately concentrated in North America and northern Europe. The most prominent journals in psychology are published in those same places, primarily in the English language (Kim & Berry, 1993). Even within North America, the diversity of cultures (and, consequently, of cultural viewpoints) has not been represented in psychology proportionate to the population, although recent years have seen the introduction of programs to promote more widespread participation by members of under-represented ethnic groups.

As psychological knowledge is spread to diverse cultures and as other cultural

viewpoints are instituted within the discipline of psychology, psychology is being challenged to accommodate different world-views and environmental influences, such as diverse parenting practices (Gonzalez-Ramos, Zayas, & Cohen, 1998). Psychological theory and practice may be required to change and expand to allow generalizations that accurately characterize human experience and behaviour in non-Western cultures. That is, current theories and practices, being based on Western cultures, may not generalize well to other cultures.

In essence, then, the world-wide growth of psychology in Non-Western countries means that essentially Western ideas and theories are being applied and examined more closely than before by psychologists from non-Western backgrounds. Such study by indigenous psychologists challenges all psychologists to ensure that their ideas and practices are culturally appropriate.

Efforts to apply Western clinical practices to other cultures may meet with particular difficulties. Whereas many aspects of experimental psychology involve topics that appear less susceptible to cultural effects (e.g., perceptual processes, language acquisition), the phenomena of most interest to clinical psychologists (e.g., psychological distress, coping strategies) are likely to vary dramatically across cultures. Clinical practices rooted in Western cultures may not "travel well." It is not surprising, therefore, to find that psychology has indeed responded to address the implications of culture for the discipline.

Psychology's Response to Culture

A look at contemporary psychology shows many signs that the importance of

culture is being recognized by professional psychologists. One indication is the increased number of published books and articles on cross-cultural psychology. Another indicator is that numerous conferences emphasize that both scientists and practitioners need to be sensitive to ethnic background, immigration, and related cultural issues.

The importance of cultural sensitivity is evident in the content of conferences on the training of psychologists, in which it has been emphasized that clinicians should be prepared to function in a pluralistic society. This message is also conveyed through various professional standards for clinical psychologists (e.g., APA accreditation standards, ethical principles for psychologists, guidelines for providers of psychological services to culturally diverse populations, and codes of conduct for state and provincial psychology boards). In response to such standards, training programs in clinical psychology increasingly include cross-cultural materials in their curricula (Yutrzenka, 1995). Psychology also has a long history of interest in cross-cultural and related phenomena. For example, the Journal of Cross Cultural Psychology is now in its 30th year of publication.

Despite this long history, however, clinical researchers have noted the relative neglect of culture in clinical psychology and a number of benefits to closer links between cultural and clinical psychologies (e.g., Kazarian & Evans, 1998b). Moreover, no uniform framework exists for the treatment of culture and its incorporation into psychological theory. Part of the motivation of the present work was to offer one scheme for the treatment of culture by clinical psychology. The value of such a scheme, however, depends on showing not only the increased cultural diversity of society and psychology, but also

the clinical relevance of these differences. The mere fact of cultural differences, whether seen as real by psychologists or not, would not in itself necessitate major accommodations in psychological practice unless cultures were indeed associated with differences on important psychological dimensions.

Implications of Culture for Clinical Psychology

There are numerous potential implications of culture for the practice of clinical psychology. Some of the most important differences across cultures are related to how psychological disorders are manifested, rates of specific psychological disorders, the use of mainstream psychological services, and the effectiveness of psychological services for clients from non-Western cultures (Lin, 1994; Parmanand, Ajit, & Avneet, 2000; Soldberg, Ritsma, Davis, Tata, & Jolly, 1994; Tata & Leong, 1994). There is much evidence that cultural differences have implications for many of these central aspects of clinical psychology and that the needs of non-Western clients may be more difficult to meet than those of Western clients.

Manifestations of Disorders

Culture has been shown to be important in how different psychological disorders are manifested. Many writers have noted that clients in non-Western cultures show higher levels of somatization symptoms in psychological disorders (Del Piccolo, Salrini, & Zimmermann, 1998; McGoldrick, Giordano, & Pearce, 1996). Somatic symptoms have been found to be more common in Post-Traumatic Stress Disorder and other anxiety disorders (Good & Kleinman, 1985; Guarnaccia & Kirmayer, in press; Kirmayer, 1984; Kleinman, 1977, 1986; Marsella, Kinzie, & Gordon, 1973), in disaster victims (Escobar,

Canina, Rubio-Stipec, & Bravo, 1992), and in refugees (Hinton, Chen, Du, Tran, Lu, Miranda, & Faust, 1992; Mollica, Wishak, Lavelle, Truong, Tor, & Yang, 1990; Moore & Boehnlein, 1991; Westermeyer, Bonafuely, Neider, & Callies, 1989). During WWII, Indian soldiers demonstrated more conversion disorders than British soldiers (Leff, 1988). Somatization disorder is more common in Puerto Rico than in continental USA (0.7% vs. 0.1%), and occurs equally in males and females (Canino, Rubio-Stipec, Canino, & Escobar, 1992). Dunn, Dunn, Ryan, and Van Fleet (1998) found that African-American participants in a substance abuse program showed a higher incidence of dissociative experiences than their Caucasian counterparts.

The elevated somatization in non-Western cultures appears to be related in part to their less individualist and more collectivist orientation (see later discussion of this dimension). For example, the somatic symptoms of "distress nervios" and "ataques de nervios" in Puerto Ricans are associated primarily with disorders that reflect interpersonal, familial, and social concerns rather than enduring individual psychopathology (Guarnaccia, 1993; Guarnaccia, Rubio-Stipec, & Canino, 1989; Koss, 1990). Cultural prohibitions against confronting interpersonal conflict also leave distressed people with little alternative except to focus on the somatic aspects of their distress (Racy, 1980). Focussing on somatization complaints (i.e., "medical" problems) avoids the stigmatization associated with psychological disorders, stigmatization that attaches to the family in collectivist cultures (Kleinman, 1988). For example, the majority of Greek-American families begin therapy with somatic complaints (e.g., headaches, dizziness, and stomachaches) as the presenting problem. Clients do not readily accept psychological interpretations by the

therapist, especially if the therapist is not Greek-American (Tsemberis & Orfanos, 1996).

Incidence of Psychological Disorders

There is considerable uncertainty about the relative incidence of different psychological disorders, in part because of the definitional issues just described. But there do indeed appear to be some differences between cultures in the prevalence of specific psychological disorders, perhaps because of various culture-related risk factors associated with immigration and acculturation (see Table 1 and Berry, 1999). Immigration-related stress has been observed among diverse groups, including Korean immigrants (Dohrenwend, 1987; Hurh & Kim, 1984; Moritsugu & Sue, 1983; Wong, 1982). According to a study by Kuo (1984), such stress has contributed to the high prevalence of depression among Korean immigrants.

Table 1

Some Culture-Related Factors Contributing to

Increased Risk of Psychological Disorder in Immigrants

Traumatic Experience Prior to Migration
Inability to Speak Host Country's Language
Separation from Family Members
Isolation from Others of Similar Cultural Background
Unfriendly Reception by Host Country
Decreased Socioeconomic Status, Unemployment, Underemployment
Complications of Life Cycle Stage at Time of Migration (e.g., adolescence, old age)

Perceived racism is another factor that can increase risk for psychological

disorders. Clark, Anderson, Clark, and Williams (1999) have recently described a biopsychosocial model of the process by which perceived racism can contribute to differential health outcomes, including depression. Irrespective of their objective basis (i.e., the presence of objective discrimination), such perceptions can have a negative impact on mental health.

Cultural differences have also been reported for the incidence of specific disorders and manifestations of underlying pathology, not always favouring the dominant European culture. With respect to suicide, whites are twice as likely as blacks to commit suicide (Kung, Liu, & Juon, 1998). Moreover, a wide variety of factors that are associated with suicide in whites, such as alcohol use and living alone (Kung et al., 1998; Vilhjalmsson, Kristjansdottir, & Sveinbjarnardottir, 1998), appear to be less strongly associated with suicide in blacks (Kung et al. 1998). The suicide rate has been found to vary widely across cultures and nations (La Vecchia, Lucchini, & Levi, 1994). The rate in Greece, for example, is relatively low (Zacharakis, Madianos, Papadimitriou, & Stefanis, 1998).

The incidence of subtypes of disorders also vary. Although paranoid schizophrenia is the most common type of schizophrenia in Europe, for example, simple or hebephrenic diagnoses are more common in Asia. Tateyama, Kudo, Hashimoto, Abe, Kainuma, Yoshimura, Asaii, Bartels, and Kasper, (1999), however, reported that this results largely from differential diagnosis rather than actual differences in client presentation.

Use of Mainstream Psychological Services

One important issue for treatment concerns help-seeking. Research has generally shown underutilization of mainstream psychological services in outpatient settings by

people from non-Western cultures, although some studies report mixed findings specific to different cultural groups and even overutilization in inpatient settings (Cheung, 1991; Jones & Matsumoto, 1982; Snowden & Cheung, 1990; Vega & Rumbaut, 1991; Vessey & Howard, 1993). The over-representation in inpatient settings may represent the long-term negative consequences of avoiding treatment earlier in the course of the disorder.

A number of studies have demonstrated that American Indians, Asian Americans, Blacks, and Hispanics tend to make less use of mainstream psychological services than do European Americans (Flaskerud, 2000; S. Sue, Allen, & Conaway, 1975; S. Sue & McKinney, 1974; S. Sue, McKinney, Allen, & Hall,1975). Not all findings are this consistent however. S. Sue (1977), for example, studied nearly 14,000 clients in various community mental health centers and reported that Blacks and Native Americans were overrepresented, although Asian Americans and Hispanics were underrepresented.

There is also evidence that immigrant groups are less likely to use psychological services than non-immigrant groups. Studies in the USA have found that Korean (Leong, 1986; S. Sue & McKinney, 1975) and other Asian (Cheung & Snowdon, 1990; S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991) immigrants underutilize psychological services. Similarly, Cochrane (1979, 1985) found that Asian immigrants in Britain from Bangladesh, India, and Pakistan underutilized mental health services, especially in the case of affective disorders. Lower use of mental health services among immigrant groups is especially surprising in light of the fact that immigrants are likely to experience stress during their adjustment to a different culture (see Table 1).

Many factors contribute to the underuse of mainstream psychological disorders

(see Table 2). One reason for underutilization may be a preference for alternatives to conventional mental health services. For example, it has been shown that Korean immigrants tend to turn to Korean churches for support and services (Dearman, 1982; Hurh & Kim, 1984). In addition, first-generation Greek-American families rely on the church, extended family, kin, and home-town based civic organizations for support. The church is used to meet both social and spiritual needs, and parishioners often bring their problems to their priest (Tsemberis & Orfanos, 1996). Another important factor in underuse is cultural differences in attitudes toward psychological disorders and their treatment, a topic that will be explored in depth in Chapter 2 and throughout this thesis.

Table 2

Some Culture-Related Factors Contributing

to Underuse of Mainstream Psychological Services

Information about Services not Available at all or in Native Language
Stigma Attached to Obtaining Services
Anticipate Value Incongruity with Therapist from Different Culture
Providers Unfamiliar with Various Cultural Values
Preference that Problems be Kept in Family
Use of Informal Support Systems (e.g., family members, church)
Cultural Beliefs about Psychological Distress and Its Treatment (e.g., psychopathology is genetic and cannot be treated by talking)
Financial Barriers

Effectiveness of Mainstream Psychological Treatments

The role of culture in treatment effectiveness is less clear. Reviews of the effectiveness of cross-cultural therapy are ambiguous regarding the effects of ethnicity and culture on the efficacy of treatment, although the dominant message in the applied literature on culture and therapy is the need for adapting services to clients from different cultures. Winter and Young (1998) observed that the question of the relevance of psychotherapy to individuals who are socially and culturally distinct from Westerners has been debated for decades (e.g., Dahl, 1989).

S. Sue and Zane (1987) noted that the research and clinical literature on mental health services for ethnic-minority populations has consistently drawn attention to inadequacies in those services. In summarizing the work of special panels that examined Asian/Pacific American, Black-American, Hispanic-American, and Native-American/Alaska-Native groups, the Special Populations Task Force of the President's Commission on Mental Health (1978, p. 73) observed that ethnic minorities "are clearly underserved or inappropriately served by the current mental health system in this country."

D. W. Sue and D. Sue (1990) cited evidence that minority clients tend to terminate therapy at a rate of over 50% after just a single therapy session, versus a rate of 30% for White clients. For example, Asian-Americans, not only underutilize traditional mental health services, but they also, on average terminate sooner than White clients (S. Sue & McKinney, 1975). These effects do not reflect less distress in the Asian population, but rather the lack of culture-sensitive forms of treatment (Flaskerud, 2000; D. W. Sue & D. Sue, 1990; S. Sue & Morishima, 1982). According to D. W. Sue and D. Sue, (1990),

standard psychological services, when applied to people from different cultures: are biassed, are incompatible with life experiences of culturally different clients, lack sensitivity and understanding, and may even be oppressive and discriminating toward minority clients. More generally, culture-bound values constitute one of three major barriers to effective cross-cultural counselling, the other two barriers being class-bound values and language factors (Flaskerud, 2000; D.W. Sue & D. Sue. 1977).

A number of influential writers have argued that mainstream Western verbal therapies are unsuitable for Non-Westerners because of differences in values and other fundamental features (Cheung, 1993; Kinzie et al., 1988). Vace, de Vamey, and Wittmer (1995) similarly noted that such therapies are increasingly unacceptable to or ineffective for a growing segment of the population. They went on to describe more appropriate and culturally-specific forms of therapy with Asian Americans, Mexican Americans, and African Americans. D. W. Sue and D. Sue (1990, p. v) went so far as to argue that "traditional counseling theory and practice have done great harm to the culturally different."

Similar positions have emerged when cultural issues have been explored in the context of particular disorders. In an edited book on ethnocultural aspects of Post-Traumatic Stress Disorder (PTSD), Marsella, Friedman, Gerrity, and Scurfield (1996, p.xvii) commented that "ethnocentric bias in conceptualization, diagnosis, measurement and treatment" has characterized much of the research and clinical work on PTSD. Allen (1998), and Cuellar (1998), and Lindsey (1998), in the same volume, questioned the adequacy of current diagnostic and assessment instruments for American Indian, Alaska

Native, Hispanic, and African American clients, and sought new ways for therapists to perform culturally-sensitive assessments, an important first step in the therapeutic process.

Critical examination of Western therapies as applied to clients from different cultures has often been accompanied by recommendations for how to adapt therapeutic principles and techniques to specific cultures. (e.g., Saeki & Borow, 1985; cited in Henderson & Spigner-Littles, 1996). There are now a number of books that propose how best to perform culture-centered or culture-sensitive therapy (e.g., Goldberger & Veroff, 1995; Kazarian & Evans, 1998a; Pedersen & Ivey, 1993; D. W. Sue & D. Sue, 1999; Waxler-Morisson et al., 1990).

Other authors appear to be skeptical that Western forms of therapy, however modified, can ever fit the needs of Asian-Americans (and presumably other cultural groups). D. W. Sue (1994) observed that the emphasis on how Asian Americans express psychological distress and how psychologists can implement more culturally responsive forms of treatment ignores the fact that the theoretical models and assumptions that researchers in research and practice are themselves often culture-bound. Lee (1993), for example, pointed out that psychology originated with Greek scholars and evolved throughout Europe, and that little has been written about the psychological theories of ancient Chinese scholars (e.g., Lao Tzu, Confucius) and other Asian writers.

Despite the near-universal characterization of present psychological services as inadequate for clients from different cultures, there are dissenting points of view. Patterson (1985) argued that Western therapeutic approaches are not inappropriate for other cultures and do not need to be modified in order to fit characteristics of other

cultures. And S. Sue (1988, p. 304) concluded that "answers to the questions of whether psychotherapy is effective with ethnic individuals and whether ethnic clients receive positive outcomes when working with White therapists include: "yes," "no," "maybe," "it depends," and "cannot tell." Also relevant to this issue is the observation that studies examining the benefits of matching therapists and clients on ethnicity have reported unclear results (Gusman, Stewart, Young, Riney, Abueg, & Blake, 1996; Parloff, Waskow, & Wolfe, 1978). Interestingly, there may also be changes over time in non-European cultures that make standard therapy more acceptable and effective. Neighbors, Caldwell, Thompson, and Jackson (1994) observed that African Americans have become less likely to end therapy prematurely and also that nonminority therapists do not view such clients as negatively now as in the past.

Ways Clinical Psychologists Could Adapt to Culture

It is evident from this brief overview that ethnically-diverse groups, whether immigrants to North America or residents of non-Western countries, will increasingly require psychological services and that such clients will bring special issues and needs. To be effective, clinical psychologists may have to find appropriate ways to adapt their clinical practice to clients from these groups. Efforts to distribute psychological knowledge and practice more widely throughout the world will also require some consideration of how Western knowledge can be applied in non-Western settings. There are three general approaches to the growing importance of cultural factors for clinical practice: practicing indigenous psychology, matching clients and clinicians, and developing culture-sensitive clinicians.

Indigenous Psychology

One response to cultural issues has been to incorporate indigenous elements into clinical practice, notably into therapy (Marsella, Friedmann, Gerrity, & Scurfield, 1996). Krippner and Colodzin (1989) reported positive results using indigenous healers (Native-American and Asian) to treat Vietnam war veterans with post-traumatic stress disorder (PTSD). Therapy included sweat lodges, vision quests, and other indigenous practices. Holm (1982) and Silver and Wilson (1990) reported success with purification rituals and other folk practices for Native-Americans diagnosed with PTSD. Dulancy (1997) proposed a biopsychosocial model of metaphor therapy for use with holistic cultures. Lee and Lu (1989) also recommended folk healing for treating Asian immigrants and refugees with PTSD. There is also similar interest in the development of indigenous approaches to assessment and diagnosis (Cheung & Leung, 1998).

Examples of indigenous therapies include the Japanese psychotherapies of Morita and Naikan (Berry, Poortinga, Segall, & Dasen, 1992; Ley & Smiley, 1989). Morita therapy (Reynolds, 1976) is highly directive, with clients gradually progressing from complete isolation and inactivity, to light manual tasks, and finally to heavy work. The most important component of the therapy is "life-training," in which clients gradually increase interactions and eventually re-enter the larger community. Morita therapy was designed to treat social anxieties, lack of assertiveness, and feelings of inferiority. The ultimate goal is to encourage interactions with others despite anxiety about such involvement.

Another indigenous therapy, Naikan treatment (Berry et al., 1992), is based on

meditation. Clients engage in reflective exercises that focus on interpersonal relationships. A "sensei" serves as therapist, listens to the client's confessions, and is the only person to interact with the client during the initial phases. Therapy emphasizes client responsibility for the trouble that they have caused for significant others, and attempts to develop awareness of the benefits that clients have received from others relative to what clients have given. Present relationships are understood in light of relationships to the parents, particularly the mother.

There are several possible shortcomings in adopting indigenous therapies. One difficulty is that indigenous therapies may not have been validated through research, leaving unanswered questions about their efficacy. Whether this is an important consideration for clients, however, may be questionable. There are also occasions when cultural characteristics may be over-generalized and individual differences among specific members of a given cultural group ignored. For example, acculturated Asian-Americans may be unfamiliar with traditional healing practices. Such clients may also not have difficulty expressing their emotions and accepting minimal structure within the context of Western therapies (S. Sue & Zane, 1987).

Client-Clinician Matching

A second approach to cultural differences is client-clinician matching, an approach that focusses more on therapy than on the full range of psychological services. Some therapists view such matching as important for effective therapy (Howard, 1991; D. W. Sue & D. Sue, 1990) and it has been studied with respect to race (S. Sue, 1988), social class (Carkhuff & Pierce, 1967), sex (Tanney & Birk, 1976), cognitive style (Fry &

Charron, 1980), personal constructs (Landfield, 1971), conceptual level (Stein & Stone, 1978), personality variables (Dougherty, 1976), client-therapist needs (Berzins, 1977), and even epistemologies (Lyddon, 1989). Several reviewers of the empirical literature on matching have pointed out that the findings with respect to personality and demographic variables are generally weak and inconsistent (Gusman, Stewart, Young, Riney, Abueg, & Blake, 1996; Parloff, Waskow, & Wolfe, 1978).

Howard (1991) proposed one explanation for the modest effects of client-clinician matching. He suggested that matching variables are clinically significant only when they are relevant to the client's presenting problem. For example, it may be clinically important for a Black client to work with a therapist of the same race if the presenting problem involves depression that the client attributes in part to racial discrimination. Although the search for clinically significant matching variables has not yet been terribly successful, the modest effects that have been observed demonstrate the potential value of matching and the need for additional research. Another difficulty with client-therapist matching would be the lack of therapists with the the appropriate cultural background (Kazarian & Kazarian, 1998).

In addition to a lack of consistent, robust effects and a shortage of suitable therapists, use of client-therapist matching is further complicated by the numerous variables that would have to be priorized in determining the matching. Clients belong to numerous groups defined by ethnicity, nationality, gender, social role, profession, and a lengthy list of psychological traits. The research on important dimensions of culture (e.g., the individualism-collectivism discussed later) may help identify salient dimensions of

client-therapist matching.

Culture-Sensitive Clinicians

A third approach to cultural differences is the training of culture-sensitive clinicians. Perhaps more important and more achievable than either client-clinician matching or culture-specific practice is that clinical psychologists be sensitive to cultural issues that arise in therapy and be able to adapt assessment and therapy to the idiosyncratic needs of clients from diverse backgrounds. Cultural sensitivity can mean having knowledge of the client's culture, being willing to modify aspects of Western techniques that are inappropriate for culturally different clients, or even adopting culture-specific practices in appropriate cases.

S. Sue and Zane (1987) identified the following possible benefits of culture-sensitive therapists: (1) clients do not find therapy so strange, (2) clients believe that therapists understand them and can appropriately relate to them, (3) therapy and therapists become more meaningful to client, (4) knowledge of the cultural background of clients puts therapists in a better position to understand and treat client, and (5) enhanced credibility of therapist and relationship with the client. A number of clinical researchers have described case studies in which clients would appear to have benefitted from greater sensitivity to the role of culture in clinical psychology (e.g., Kazarian & Joseph, 1994, 1995), and there are examples of successful adaptations to clients from different ethnic backgrounds (Kazarian & Kazarian, 1998).

One difficulty in becoming a culture-sensitive therapist is the multiplicity of cultures, which makes it difficult for any one therapist to have enough knowledge about

each client's culture. S. Sue and Zane (1987) also note that general cultural knowledge is not in itself sufficient for effective therapy because such knowledge is not tied directly to particular processes that could strengthen treatment effectiveness. For cultural knowledge to enhance therapy, it must enable therapists to develop specific strategies and concrete therapeutic techniques. To achieve this, therapists must have an appropriate theoretical framework for conceptualizing the diverse clinical implications of the world's numerous cultures. A primary purpose of the present thesis is to propose one broad framework for clinical work with clients from diverse cultures.

Chapter Summary

The multi-cultural nature of contemporary societies introduces growing challenges for clinical psychology. People from an increasingly broad range of cultures are in need of effective and appropriate psychological services. That diversity needs are not currently being met is suggested by evidence that clients from different cultures have reduced levels of use and effectiveness of psychological services. Better preparation of clinicians to practice in a culture-sensitive manner will require a sophisticated model of the various clinical implications of diverse cultures. A first step in developing such a model is to identify mediating variables that may contribute to the association between culture and service (i.e., use and effectiveness). One possible mediating variable is the nature of the attitudes that different cultural groups have about psychological disorders and their treatment. Chapter 2 examines the role of attitudes for clinical practice with clients from different cultural backgrounds.

CHAPTER 2:

CULTURE AND ATTITUDES TOWARD PSYCHOLOGICAL DISORDERS

Chapter 1 documented that culture is important for clinical psychology because societies are becoming more multi-cultural and cultures differ in the use and effectiveness of conventional psychological services. It was also argued that one valuable approach to these cultural differences was to develop culture-sensitive therapists. But developing culture-sensitive clinicians requires a coherent theoretical framework that can accommodate and explain the diverse relationships between culture and clinical phenomena that were reported in Chapter 1. The observed relationships can be symbolized crudely as Culture → Services, where "→" indicates some degree of influence of Culture on the use and effectiveness of psychological services. An understanding of this connection would be furthered by elaborating the mechanisms or processes by which culture influences the use and effectiveness of psychological services.

One step towards such a framework is to recognize that attitudes play a central mediating role in diverse behaviours related to clinical practice (e.g., use of psychological services) and that different cultural groups have more or less favourable attitudes toward psychological disorders and their treatment. Considerable evidence, reviewed in this chapter, is consistent with the following two premises: (1) service use is determined in part by attitudes toward psychological distress and treatment, and (2) attitudes toward psychological distress and treatment vary across cultures. These links suggest that one plausible model for the underlying relation between culture and psychological services could be symbolized as Culture → Attitudes → Services. That is, cultures differ in

attitudes toward psychological distress and treatment, and these attitudes influence actual use and effectiveness of services. The focus of the present research is on the Culture ➜ Attitudes section of this causal path, but I first review evidence for the importance of attitudes in the use and effectiveness of psychological services (i.e., the Attitudes ➜Services connection) so that the value of examining the Culture ➜ Attitude connection is clear.

Importance of Attitudes About Psychological Disorders

Attitudes toward psychological distress and treatment have been investigated at great length because such attitudes are generally negative, attitudes determine how those with psychological disorders are treated (and expect to be treated), and attitudes constitute one important factor in the use and effectiveness of psychological services.

Negative Images of Psychological Disorders and Treatment

The term "images" includes such inter-related constructs as perceptions, attitudes, views, perspectives, and stigma. Generally negative images of psychological disorders are quite widespread and, in turn, influence people's actual use of psychological services, hence the importance of understanding how these images might vary across cultures and why (see the later section on attitudes and culture).

Images of psychological disorder have progressed through history from more to less negative views, although the improvement is a relative one given contemporary indicators of continuing negative attitudes (Corrigan, 2000). Extremely negative attitudes toward psychological disorder were pervasive in early Western culture and can be traced to ancient Greece. Simon (1992) examined the period between 5th century BC and 2nd

century AD in Greece, and described attitudes toward and treatment of people experiencing psychological distress, focussing on the themes of shame, loss of face, and humiliation. Stigma and a sense of shame were attached to mental illness in classic Greek culture. Psychological disorder was regarded as undesirable and as requiring that afflicted persons be ostracized. The psychologically distressed person was regarded as polluted and able to pollute, and therefore stigma was attached not only to the "afflicted" person but also to family members and others associated with him or her. This stigma could lead to ostracism that would be particularly harmful in a socially interdependent culture such as Greece.

Johnson (1990) reviewed how the treatment of psychological disorders in the USA has changed since the 1600s, from workhouses to asylums to community mental health services. The changes in laws and treatment were accompanied by changes in attitudes toward psychological disorders and an increased focus on prevention. But according to Rabkin (1980), the continuing stigma of psychological disorders was documented in several major comparative studies published before 1960. These studies showed that the people with psychological disorders were feared and disliked by a variety of populations. Since 1960, a number of substantive changes have occurred in the public's perception of psychological disorders.

Some of the recent beneficial changes relevant to psychological health include societal pressures to "normalize" psychological disorders, a number of more socially-acceptable theories and treatments (e.g., biological), wide-spread acceptance of the message that "mental illness is an illness like any other," the view of psychological

disorders as a collection of diseases with specific symptoms, courses, and outcomes, many of which can be successfully treated, and the fact that people know more about psychological disorders than they did even 20 years ago (Crocetti, 1974).

Although attitudes have become more progressive over recent decades, attitudes toward psychological disorders are still not overly positive. Research indicates that lay people still know less about psychological disorders than health professionals think is desirable and that, although overt stigma has diminished, negative attitudes seem to have reached a plateau in their descent (Corrigan, 2000; Rabkin, 1980). A recent survey of the perceptions of 778 people with psychological disorders by Read and Baker (1996) reported that 47% felt abused or harassed by other people, with 14% experiencing some form of physical assault in relation to their disorder. A high proportion (34%) had been forced to resign or been terminated from their employment and 26% had moved home because of harassment. Penn, Guynan, Spaulding, Garbin, and Sullivan (1994) confirmed that many members of the public still choose to maintain some social distance between themselves and people with psychological disorders.

Negative attitudes impact, not only on people with psychological disorders, but also on their families (Magliano, Fadden, Madianos, Caldas de Almeida, Held, Guarneri, Marasco, Tosini, & Maj, 1998), an observation that may be of particular relevance to differences across cultures that vary in the importance of family relationships. Magliano et al. (1998) noted the presence of both objective and subjective difficulties for families. Objective problems included disruptions in family relations, constraints in activities when caring for a person with a psychological disorder, and financial challenges. Subjective

difficulties included feelings of loss, depression, anxiety, and embarrassment about the presence of a psychological disorder in a family member.

Advocacy groups, such as the National Association for Mental Illness (NAMI), an American organization, and the Canadian Mental Health Association (CMHA) have also contributed to the growing awareness that stigma affects not only people with psychological disorders, but their families as well (Sommer, 1990). Personal accounts suggest that associative stigma is viewed as a serious problem by many family members, leading to attempts at concealment (e.g., Dearth, Labenski, Mott, & Pellegrini 1986; Group for Advancement of Psychiatry, 1986; Gullekson 1992; Lanquetot 1988; Willis, 1982; Yarrow, Clausen, & Robbins 1955). Studies of high school students, college students, and even mental health workers have all shown that participants perceived relatives of people with psychological disorders in negative terms (Burk & Sher, 1990; Mehta & Farina, 1988).

It is striking that mental health professionals whose relatives have been diagnosed with a psychological disorder appear to have experienced the negative consequences of stigma even within their profession. Lefley (1987) reported that mental health professionals often heard their colleagues make derogatory comments about the families of psychiatric patients, and many therefore concealed their relative's disorder at work.

Stigmatization of psychological disorders has likewise been observed in other professionals who are expected to provide services to people diagnosed with psychological disorders. Sivakumar, Wilkinson, Toone, et al. (1986) found that 28% of medical students believed psychiatric patients were "not easy to like" and this percentage

increased to 56% two years later when the students had become doctors. Sivakumar et al. (1986) also noted that a low proportion of medical graduates choose to specialize in psychiatry and that psychiatrists in general were held in low regard by other medical practitioners. Jenkins (1998) likewise found a dislike of psychiatric patients by general practitioners, despite community prevalence rates of 14% for mental health problems.

Phelan, Bromet, and Link (1998) found that higher educational and socio-economic levels of respondents were associated with greater perceived avoidance, an observation also reported in previous studies (Angermeyer, Link, & Majcher-Angermeyer, 1987; Freeman & Simmons 1961; Yarrow et al 1955). This suggests that people with higher levels of education may be more sensitive to the stigmatizing consequences of psychological disorders.

Even some mental health changes that have been regarded as positive are viewed negatively by mental health researchers with a sociological orientation. These researchers tend to be skeptical about the improvement in public attitudes, do not accept the medical model of psychological disorders, do not view its development positively, and regard labelling itself as harmful. Instead, they see psychological disorders as originating with genetic predispositions and as being precipitated by stressful environmental events, resulting in the exaggeration of behaviours that are common to all people (Colbert, Kalish, & Chang, 1973; Farina & Felner, 1973; Neff & Husaini, 1979; Olmstead & Durham, 1976; Tringo, 1970).

Recent evidence also suggests that, although many recovered psychiatric patients make social recoveries as well, the chronically disabled continue to be avoided and

excluded (Corrigan, 2000). Manifestly disturbed behaviour elicits more stigmatization than does the mental illness label alone. Even today psychiatric patients identified as such by their behaviour or history are not treated as well as ex-medical patients when it comes to housing, school admission, jobs, or general good will. Many people continue to be frightened by major psychological disorders and believe that others are also frightened, although it is now less socially acceptable to say so. A recent community survey by Wolf et al. (1996) found that 43% of respondents viewed people with psychological disorders as more aggressive than the general population.

One indicator of continuing negative attitudes is the public's resistance to the establishment of local facilities for people with psychological disorders (e.g., group homes). Depending on the success of such efforts, there is some risk that the current level of public acceptance will decline because of the presence of increasing numbers of chronically disabled psychiatric patients who are returned to or maintained in the community, supported by government resources.

Consequences of Negative Attitudes

Negative attitudes toward psychological disorders and treatment have a number of important consequences, at least as determined by correlational studies. Byrne (1997) identified some of the many reasons why attitudes to psychological disorders are so important. According to Byrne (1997), the consequences of negative attitudes and stigma include: denial of symptoms, failure to seek help and even refuse help when referred, failures to continue in treatment, noncompliance with treatment regimen, substance abuse (i.e., a form of self-medication), failure of diagnosis leads symptoms to be attributed to

other causes (e.g., laziness) that can decrease self-esteem, loss of employment or educational opportunities, homelessness, decreased social contact that can exacerbate symptoms, delayed treatment carries poorer prognosis, feelings of shame and failure due to self-stigmatization, anticipation of rejection by others, increases in negative automatic thoughts and avoidance behavior, various sorts of personal victimization (e.g., staring, jeering, prejudice), isolation of self and family, community opposition to community facilities, and increased risk of suicide and relapse.

One important consequence of attitudes that is relevant to the Culture ➜ Attitude ➜Services model is the robust relationship between attitudes and use of psychological services, as noted by Byrne in the preceding paragraph. Ben Noun (1996) reported that 82% of 57 patients referred to a psychiatrist refused the referral because of the stigma associated with psychiatric assessment and treatment. Stigma has also been given as one explanation for the underuse of such self-help programs as Alcoholics Anonymous. Many people are simply more likely to use alternative and informal support systems or indigenous practitioners rather than experience the embarrassment of seeing mental health professionals (Flaskerud, 2000; Neighbors and Jackson, 1984).

The relationship between negative attitudes toward psychological disorders and actual services raises the possibility that negative attitudes may contribute to the differential use and effectiveness of psychological services across cultures (i.e., the second link in the causal chain, Culture ➜ Attitudes ➜ Services). This hypothesis would require some connection between cultural variables and attitudes. Indeed, culture is one of several factors that have been associated with differential attitudes toward psychological distress

and treatment. Culture, however, is just one of a number of determinants of attitudes.

Possible Determinants of Negative Attitudes

Although negative images of psychological disorders are pervasive, especially in the media, attitudes towards such disorders do vary across individuals. Some of the factors correlated with individual differences in attitudes toward psychological disorders are education, occupation, and familiarity with people who have experienced psychological disorders. According to Rabkin (1980),

> People with less tolerance for the mentally ill are likely to be: male, older, less educated, less skilled occupational workers, of lower SES, members of relatively recently arrived immigrant groups, and those who report less social contact with the mentally ill. Patients least tolerated are likely to have these characteristics: male, assaultive, of lower SES, members of ethnic minorities, with relatively few social or family ties, with relatively visible disturbed behaviour, and prone to display behavioral rather than physical symptoms. Treatment situations associated with negative attitudes are likely to be: inpatient facilities, public rather than private, and specialized facilities rather than general hospitals. Negative attitudes are particularly associated with longer treatments, frequent treatments, somatic treatments, and treatment by a psychiatrist rather than non-medical personnel.

Higher education and socioeconomic status have been consistently linked to more tolerant attitudes concerning psychological disorders in the general population

(Dohrenwend & Chin-Shong, 1967) and among former patients (Freeman, 1961). Some authors, however, have raised questions about whether highly educated people really have more enlightened attitudes or are just more likely to express socially accepted views (e.g., Phelan et al., 1998). Exposure to psychoeducational programs also contributes to individual differences in attitudes toward psychological disorders. Appropriate interventions can reduce stigma (McFarlane, 1995), although there are still many questions about the nature of effective programs. One mechanism by which higher education may improve attitudes, if indeed it does, is through psychology and related courses that provide information about and exposure to psychological disorders.

Although the possible origins of negative images about psychological disorders are diverse, much attention has been paid to the role of the media (Wahl, 1995). The literature on attitudes toward psychological disorders suggests that public media play an important role in the development of negative attitudes. Much of this research has been summarized in a recent book by Wahl (1995) titled "Media Madness: Public Images of Mental Illness." There is considerable evidence that the popular media are disproportionately concerned with negative and sensationalistic aspects of psychological disorders (Day & Page, 1986; Hyler, Gabbard, & Schneider, 1991; McIlwraith, 1987; Signorielli, 1989).

There is also evidence, however, that media can be used to improve attitudes toward psychological disorders (e.g., Medvene & Bridge, 1990; Mound & Butterill, 1993; Wahl & Lefkowits, 1989). Thornton and Wahl (1996), for example, demonstrated that exposure to a newspaper article could have beneficial effects on perceptions of psychological disorders. Although researchers and community change agents are still

trying to understand better the impact of different approaches to changing attitudes (e.g., Penn et al., 1994), many organizations (e.g., NAMI, CMHA, Schizophrenia Society) are already actively dealing with the issue of stigmatization of psychological disorders and with formal attempts to modify public opinions.

In summary, negative attitudes toward psychological distress are pervasive and have demonstrated relationships with the use and effectiveness of psychological services. A number of factors moderate such attitudes, however, including culture and a number of other variables that will need to be monitored to minimize confounds (e.g., age, sex, education, occupation). We turn now to a closer examination of the relationship between culture and attitudes toward psychological distress (i.e., the first link in Culture ➞ Attitudes ➞ Services).

Culture and Attitudes About Psychological Disorders

Because attitudes are so important for different aspects of psychological services, as just noted, it seems possible that attitudinal differences could contribute to the various ways in which culture is associated with the use and effectiveness of psychological services. There are certainly many findings consistent with the expectation that attitudes vary across cultures, including evidence cited earlier that various cultural groups are less likely to use psychological services. There are also a few studies that have demonstrated that differences across cultures in attitudes may contribute to the use and effectiveness of psychological services.

Culture and Images of Psychological Disorders

As mentioned earlier in Rabkin's quote, culture and ethnicity influence attitudes

toward psychological disorders, in part because the historical changes in attitudes and treatment that have been observed in some countries have not occurred in all cultures to the same degree. In contrast to the historical changes in North America, for example, fundamentally negative beliefs about mental illness continued to be observed in Mediterranean cultures over the same time period (Blum & Blum, 1970). Consequently, researchers have reported that stigma tends to be lower in north-European countries where attitudes became more positive with time (Hall, Brockington, Eisemann, Madianos, 1994; Rossler, & Salize, 1995).

Magliano et al. (1998) studied stigma in five cultures, including Greece. In Mediterranean cultures, parents were the most likely care-givers for people with psychological disorders and they reported numerous unpleasant consequences, some of which they attributed to negative societal attitudes. In addition to feelings of loss, negative effects on family life, and lack of psychoeducational resources, caregivers reported reduced access to social support because of stigma. Mediterranean participants reported receiving lower levels of both practical and emotional support, and also being more resigned, depending more on spiritual help, and having a greater reduction in social interests. The lack of social support in a collectivist culture such as Greece is quite telling about the stigma associated with psychological disorders.

Shokoohi-Yekta and Retish (1991) measured attitudes toward mental illness using the Opinions About Mental Illness Scale (OMIS) for 83 male graduate college students from American and Chinese backgrounds. As shown in Figure 1, Chinese students scored

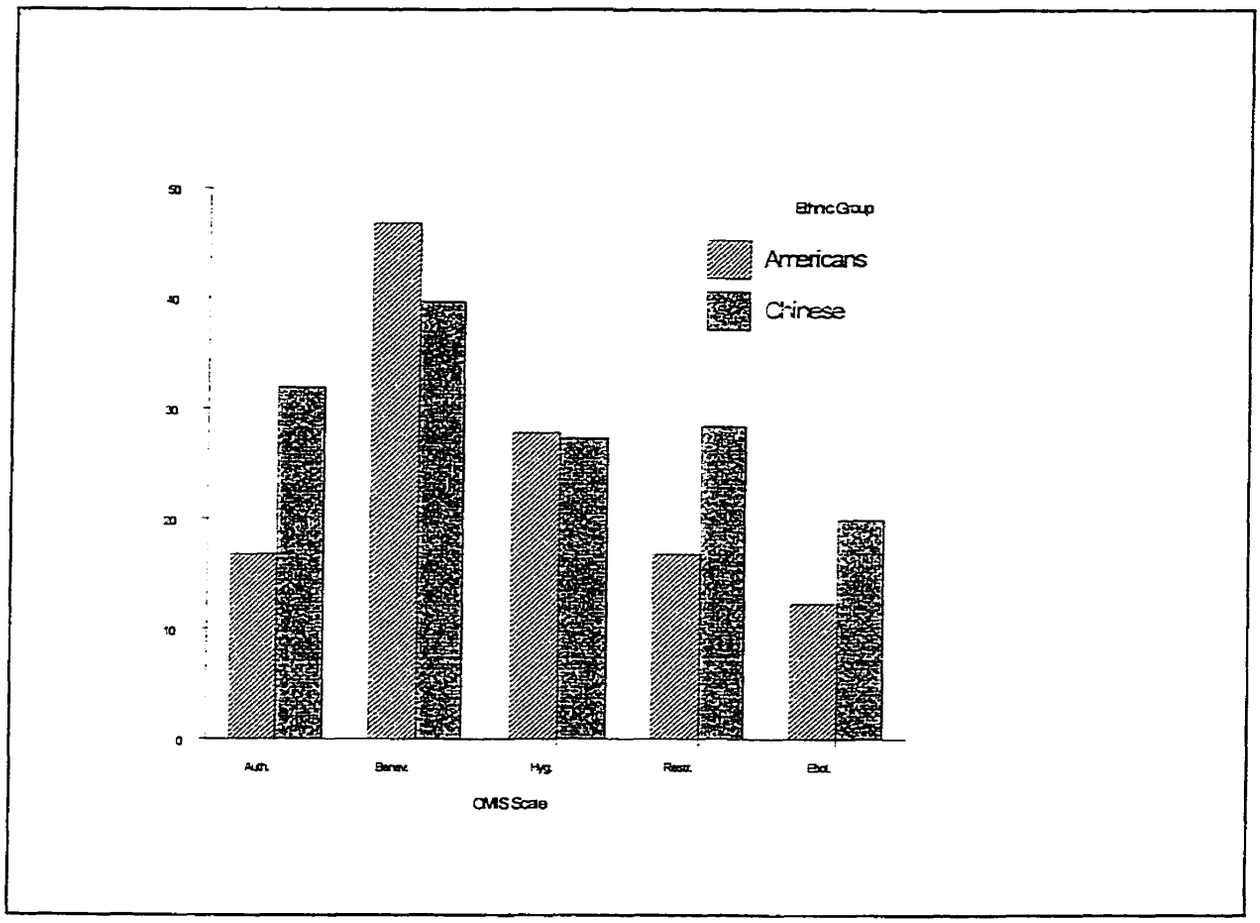

Figure 1. Attitudes of Chinese and American Male Students Towards Mental Illness.

higher than Americans on Authoritarianism and Social Restrictiveness, and lower on Benevolence than American students. The OMIS scales are described more fully later, but in essence the differences indicate less positive attitudes toward psychological disorders among Chinese students. Chinese students also scored higher on the Interpersonal

Etiology scale, which measures a tendency to perceive that mental illness arises from lack of nurturing from significant others during childhood. This finding is consistent with the greater emphasis on relationships and family in Chinese and other collectivist cultures. There was no difference on Mental Hygiene Ideology, a scale that assesses agreement with a need for more psychological services and care.

Culture determines not only how psychological disorders are conceptualized, but also attitudes that individuals have about seeking psychological treatment for psychological distress. Accordingly, cultural attitudes will determine whether individuals seek help within the family unit, from general medical practitioners, from mental health practitioners, or from other mainstream sources. A number of studies have reported that many non-Western cultures (e.g., Asian, Hispanic) prefer to obtain assistance from family members, traditional healers, or professions (e.g., ministry) other than those available from mainstream psychological services (Chang, 1985, 1988; Fernando, 1988; Furnham & Kuyken, 1991; Leff, 1988; Prince, 1990). During their study of Northern Indian patients with schizophrenia, Parmanand et al. (2000) found that 58% of the patients had also received magico-religious treatment.

A few studies have examined views of psychological disorders across successive generations of immigrants from different cultural backgrounds. The results suggest that attitudes toward psychological disorders develop during a person's formative years and are primarily influenced by cultural values and beliefs acquired during that time. Specifically, Furnham and Malik (1994) compared the attitudes toward and beliefs about depression of four groups: middle-aged native Britons, middle-aged Asian immigrants in

Britain, young native Britons, and young second-generation Asian-Britons. The middle-aged Asian immigrants viewed depression as a situational state of being rather than as a psychological disorder. For example, they were more likely to agree that "feeling depressed" is no different from "feeling depressed about something." Middle-aged native Britons, younger native Britons, and second-generation Asian-Britons were similar in their attitudes and beliefs, suggesting convergence of beliefs and attitudes within one generation.

The Mediating Role of Attitudes for the Culture → Services Relationship

The present hypothesis is that differences across cultures in the use and effectiveness of psychological services may result from less tolerant attitudes towards psychological disorders in the groups less likely to seek psychological treatment. Although this model is consistent with the separate observations about lower levels of use and less positive attitudes in non-Western groups, direct examination of cultural differences in use as a function of attitudes has occurred in only a few studies.

Cheung (1987) found that attitudes toward psychological disorders were a significant factor in help-seeking behaviour among Chinese respondents in Hong Kong. Attitudes toward psychological disorders were also a significant factor in help-seeking behaviour among Chinese-Americans (Ying, 1990). In the Furnham and Malik (1994) study that compared native Britons and Asian immigrants in Britain, immigrants believed that depressed people should be able to resolve their own problems, or resolve them within the family confines. Such beliefs prevented immigrants from seeking professional mental health services, as indicated by psychiatric statistics.

One explanation that has been given for the underutilization of psychological services by African Americans is that the stigma associated with seeking psychological help leads African Americans to avoid professional services and prefer informal resources or indigenous practitioners (Neighbors & Jackson, 1984). Another explanation is that African Americans may simply hold negative attitudes toward psychotherapy. It may also be the case that therapists view African American clients with negative attitudes as difficult to work with, and treat such clients negatively, which can exacerbate the initial reluctance to use professional psychological services (Jones & Matsumoto, 1982; Lorion, 1974).

Attitudes may also influence use in less direct ways than simple avoidance. Asian immigrant women in Britain, for example, perceived a condition as a psychological disorder or not depending on factors such as the severity of the condition and its effects on social obligations (Donovan, 1986). These factors determined if and when professional help was sought. The likelihood of seeking help may be reduced in societies where psychological disorder in one family member affects the reputation of the entire family or where individual needs are secondary to group needs (Bal & Cochrane, 1993), an issue central to the present study and examined in Chapter 3.

The attitudes toward psychological disorders held by potential referral sources are another crucial factor in determining the use of psychological services by immigrant groups. Non-Western cultures place more emphasis than others on the "lay referral system." According to this model, distressed individuals will turn for advice first to family and friends, who in turn will either dismiss the concern or will refer the individuals to

professionals (Furnham & Malik, 1994). For example, Korean clergy with a religious view of psychological disorder are less likely than Korean clergy with a psychological view to refer an emotionally distressed parishioner to psychological services (Kim-Goh, 1993). The same phenomenon has been observed with Greek clergy (Tsemberis & Orfanos, 1996).

Chapter Summary

Attitudes about psychological disorders and treatment are generally negative but vary across people and groups. This variation in attitudes has important consequences for failure to use or benefit from psychological services. People with less positive attitudes are less likely to take advantage of or continue with treatment. Evidence from diverse non-Western cultures demonstrates that attitudes toward psychological disorders and professional treatment are indeed less positive in those cultures. Given these relationships, attitudes may mediate the relationship of culture to service use and effectiveness, as described in Chapter 1. That is, the causal pathway may be Culture → Attitudes → Services. Despite the richness of the empirical literature, however, the broad collection of findings with many different cultures, lack a coherent framework that would allow this mediational model to serve as a basis for the effective training of culture-sensitive clinicians. Much of the challenge lies in the manner in which culture has been treated by researchers, namely, as discrete categories. Chapter 3 describes an alternative approach that allows better for the development of a meaningful theoretical framework for knowledge about culture and clinical psychology, and the possible mediating role of attitudes.

CHAPTER 3:

AN INDIVIDUALISM-COLLECTIVISM FRAMEWORK

Preceding chapters have documented that cultures differ in the use and effectiveness of psychological services and in their attitudes toward psychological disorders. Moreover, attitudes play an important role in the use and effectiveness of psychological services for people in general. Understanding and applying this rich literature to culture-sensitive practice, however, is complicated by the lack of a coherent organizing framework. Numerous cultural differences have been reported for discrete groups (e.g., residents of different countries), with little systematic attempt to relate the observed differences to underlying dimensions that differentiate cultures. That is, the current organization of research on cultural differences, to the extent there is an over-arching organization, is in terms of individual cultures. After describing several problems with that approach and considering the general benefits of an alternative approach to culture, I propose a model in which the dimension of individualism-collectivism plays a central role in explaining the relationship between culture and attitudes toward psychological disorder and treatment. Specifically, cultural differences in attitudes toward psychological disorder and treatment are hypothesized to result in part from variation across cultures on the dimension of individualism-collectivism.

Treatment of Culture

Recognizing the importance of culture in clinical psychology is only a small first step toward effective clinical work in a cross-cultural setting. A major issue that must be addressed early in any research or clinical project is whether to treat different cultures as

discrete categories or as representatives of different locations along some specified dimensions on which countries and cultures differ. The world's cultures differ in many ways, including: language, religion, and family structures and processes. These numerous differences have generated much confusion concerning the definition and empirical treatment of culture, and this confusion has been identified as a major obstacle to progress in the field of cross-cultural psychology (Betancourt & Lopez, 1993; Brislin, 1983; Jahoda, 1984; Rohner, 1984; Segall, 1984; Triandis, Lambert, Berry, Lonner, Heron, Brislin, & Draguns, 1980). Researchers have generally adopted one of two approaches to the operationalization of culture. One approach, the dominant one in research on culture within clinical psychology, treats cultures in a holistic fashion as a set of conditions, and the second attempts to identify and measure specific dimensions along which cultures vary.

Cultures as Discrete Categories

The first approach to cross-cultural research treats culture as a complex set of conditions, somewhat analogous to experimental participants being in different treatment groups. This approach conceptualizes each culture as a separate category, that is, as an organized, holistic, collective system that is greater than the sum of the biological and psychological properties of the individuals who comprise the culture (Kroeber, 1917). Researchers adopting this categorical approach object to the study of isolated cultural variables separate from the cultural context, as discussed later in the dimensional approach (e.g., Jahoda, 1984). Indeed, Jahoda (1984) even questions whether cross-cultural psychology is able to convert cultures to categories that they are amenable to empirical

measurement.

This categorical approach to the treatment of culture raises a number of difficulties. One basic challenge is how to identify the units of culture that define the nominal "treatment" conditions. The categorical approach to cross-cultural research presumes the existence of distinct cultural units with identifiable boundaries. Although a cultural group supposedly refers to a set of individuals who share a common culture, it is often difficult to identify what is common between cultures and what sets one culture apart from others.

Cross-cultural researchers struggle with how such cultural boundaries can be delineated in a valid manner. Although most studies assign individuals according to nationality or ethnicity, such assignment may not reflect cultural groups accurately. Multi-cultural or multi-ethnic groups can often be found in the same country, ethnic groups in different countries may share the same culture, different ethnic groups may share elements of the same culture (e.g., religion), and there can be cultural or sub-cultural diversity within ethnic or national groups.

Cultural boundaries are also difficult to identify because they are unstable and changing, especially in the current age of mass media, immigration, and globalization. These major changes produce fluid and multidimensional identities (Frable, 1997), which further challenge the categorical approach to culture.

In addition, the categorical treatment of culture is problematic because of its inability to provide an analytical approach to the many ways in which cultures have been claimed to differ. Tyler (1871, cited in Sapir, 1994, p. 35) defined culture as "that complex

whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities or habits acquired by man as a member of society." Wissler (1923) provided a lengthy listing of what constitutes culture, including speech, material traits, art, knowledge, religion, society, property, government, and war. Early work was consistent with this broad definition. Linton (1936, p. 78) proposed that culture is "the total social heredity of mankind" and Herskovits (1948, p. 17) asserted that "culture is the man-made part of the human environment."

Later theorists adopted equally inclusive views of culture. Kroeber and Kluckhohn (1952, p. 181) stated that "culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts." Fernando (1991) stated that "culture is conceptualized as shared patterns of belief and feeling toward issues like child-rearing habits, family systems, and ethical values or attitudes."

It is not easy to see how such broad and all-inclusive characterizations of culture can be captured in their entirety in a manner that allows isolation of the identifiable factors contributing to specific differences between cultures. In short, categorical assignment of participants based on cultural group membership: presupposes that bi-cultural and multi-cultural individuals belong to one and only one cultural unit, ignores subcultural variations within-groups arising from other variables (e.g., age, gender, SES), fails to consider within-group individual differences in acculturation and hence in the extent to which culture is internalized, and offers no systematic way to isolate the potent factors within the broadly defined cultural complex.

Despite its inherent limitations, this categorical approach has been the dominant strategy in much of the clinical literature on cultural differences in attitudes about psychological disorders and their treatment, as well as research on cultural differences in the use and effectiveness of psychological services. The fragmented nature of the resultant findings makes them difficult for clinicians to apply without learning much specific detail about particular cultures. This is a barrier to making the practice of clinicians in general more culture-sensitive. Many of the scientific and applied limitations of the categorical approach to culture disappear when culture is examined as a set of multi-dimensional variables, the approach used in the present study.

Culture as a Set of Dimensions

Segall (1984) argued that culture is too diffuse to be used as a holistic independent variable in cross-cultural research, and that it must be divided into its component dimensions (e.g., social institutions, language, and such cultural-level traits as individualism-collectivism and cultural complexity). Advocates of this approach believe that measuring specific cultural elements permits the comparative study of national, ethnic, or cultural groups to contribute more fully to the understanding of culture than do studies that treat culture as a nominal variable. Poortinga, Van de Vijver, Joe, and Van de Koppel (1987) have illustrated this point with the analogy of peeling an onion. Complete analysis involves the uncovering of more and more layers (i.e., attributes) until the cultural variability in behavior has been explained completely by specified independent variables.

Several researchers have proposed classification schemes for the dimensions along which cultures vary. In the most comprehensive and often cited of these research

programs, Hofstede (1980, 1983, 1997) administered over 116,000 attitude and value questionnaires to people working for IBM in 50 different countries and from 66 nationalities. Hofstede identified four psychological dimensions along which cultures varied: power-distance, uncertainty-avoidance, masculinity, and individualism.

Individualism-collectivism. Hofstede's most important dimension measures concern for oneself as opposed to concern for the collectivity to which one belongs. Relative to low-individualism (i.e., collectivist) cultures, high-individualism countries are characterized by: an "I" or "Me" sense of consciousness, an individual-centered identity, being oriented more to the self and concerned primarily about taking care of that self and one's immediate family, an expectation that financial security will be provided by self, and a valuing of variety, pleasure, individual decision-making, privacy, personal opinions, and universal norms. In contrast, collectivist cultures emphasize: a "We" sense of consciousness, an identity based on social systems, a stronger orientation to a collectivity and concern for and loyalty to an extended clan, an expectation of financial help by organizations and clans to which one belongs, and a valuing of outside expertise, order, duty, group decision-making, invasion by groups to which one belongs, pre-determined opinions, and particular standards for ingroup and outgroup members. Individualism-collectivism is examined more fully below.

Uncertainty-avoidance. This dimension, as defined by Hofstede (1980, 1997) measures intolerance for ambiguity and need for formal rules. High- vs. low-uncertainty avoidance cultures demonstrate such differences as: strong vs. weak superegos, more vs. less showing of emotion, less vs. more tolerance of deviance and differences of opinion,

low vs. high risk-taking behaviors, acceptance vs. nonacceptance of aggressive behavior, higher vs. lower anxiety and stress, inherent uncertainty as continuous threat vs. acceptance, intolerant vs. tolerant religions, fear of failure vs. hope of success, preference for specific vs. general guidelines, and less vs. more ambition for individual advancement. The uncertainty avoidance index measures the norm of intolerance of ambiguity. With respect to culture, this norm is related to tendencies toward rigidity, dogmatism, traditionalism, superstition, racism, and ethnocentrism.

Power-distance. This dimension primarily measures the degree of inequality between supervisors and subordinates in an organization. According to Hofstede (1980), the differences between high and low power-distance cultures include: negative vs. positive associations with power and wealth, conformity vs. independence, authoritarianism vs. democracy, directive vs. consultative attitudes, less vs. more consideration of employees, privilege of the few vs. equal rights for all, power based on coercion vs. expertise, conflict vs. harmony between the powerful and the powerless, and less vs. more questioning of authority.

Masculinity. This scale is defined as a measure of the amount of emphasis on work-goals (e.g., earnings, advancement) and assertiveness as opposed to interpersonal goals (e.g., friendly atmosphere, getting along with boss) and nurturance. Endorsement of the former is generally thought to be more associated with masculinity and of the latter with femininity. High- vs. low-masculinity cultures demonstrate: ideal of achievement vs. service, independence vs. interdependence, decisiveness vs. intuition, differentiated vs. fluid sex roles, male domination vs. equal power, live to work vs. work to live, and less vs.

more benevolence.

Identifying theoretically meaningful dimensions of culture allows for more sophisticated investigation and explanation of cultural differences. It now becomes possible not only to measure cultural differences on target outcome variables (e.g., attitudes toward psychological disorders), but also to measure one or more of the dimensions along which the cultures are hypothesized to differ. With information about both criterion variables and cultural dimensions, it becomes possible to determine statistically whether cultural differences on the criterion variables are associated with cultural differences on the dimensions. For example, does inclusion of a cultural dimension in a regression analysis reduce or perhaps even eliminate the magnitude of differences on the criterion variable? If so, then researchers have some evidence that the cultural differences on the criterion may be mediated by the dimension(s) included in the analysis.

This approach was adopted for the present study. Specifically, members of a collectivist culture (Greek-Canadian Immigrants and Resident Greeks) were compared with members of a non-Collectivist culture (Non-Immigrant Individualist Canadians) on attitudes toward psychological disorders and on individualism-collectivism. This allowed for testing whether group differences in attitudes were mediated by the underlying dimension of individualism-collectivism. As with non-experimental approaches in general, however, causal inferences based on such dimensional approaches to culture are limited by the presence of correlated attributes that could constitute alternative explanations for the observed effects.

Correlated Properties of Individualism-Collectivism

One complication with the dimensional approach to cultures is that of correlated variables (i.e., potential confounds in any non-experimental study of cultural dimensions). This problem is exactly the same as that found when individual differences across people are the object of non-experimental studies. Any causal conclusions about the target variables must be tempered by the presence of possible third-variables.

To be specific, several of Hofstede's scales tend to correlate with one another. This is apparent in Table 4 (see Chapter 4), which shows scores on Hofstede's dimensions for 40 countries. Individualism is correlated negatively with power-distance. Countries that are high on individualism (e.g., USA, Australia, Great Britain, Canada) tend to be low to moderate on power-distance, whereas countries that are low on individualism (e.g., Peru, Pakistan, Columbia, Venezuala) tend to be high on power-distance.

Of particular relevance to the present study is the fact that Canada and Greece, the two countries studied in the present thesis, differ widely on Uncertainty Avoidance. Greece is, in fact, the highest-scoring country on this dimension. Because the magnitude of this difference was of the same order as differences on the Individualism-Collectivism scale, Uncertainty Avoidance was also measured in the present study. Canada and Greece differed less on Power-Distance and were quite close on Masculinity-Feminity in Hofstede's norms.

Intercorrelations among dimensions of culture complicate attributing differences between cultures to a single dimension. For example, it would be unclear whether different conceptions of psychological disorders across countries that vary on individualism were

due specifically to variation on that dimension. One way to approach this problem is to limit generalization of results to other countries that share similar profiles with the countries being compared, as opposed to focussing on a single dimension. Countries with profiles similar to Canada include Australia and Great Britain. Countries with profiles similar to Greece include Italy and Turkey. Therefore, the conclusions of the present study might also apply to these comparisons.

It may also be possible to make some tentative assumptions about the importance of different factors on rational grounds. Individualism-collectivism, for example, seems to be the most powerful of the Hofstede dimensions, as indicated by the fact that it has been studied much more than the other dimensions (e.g., Shimmack, 1996). Moreover, individualism-collectivism is particularly relevant to the aspects of psychotherapy explored in the present study (e.g., concern for family). Perhaps the ideal approach would be to conduct a multi-culture study and perform multivariate analyses that would allow greater confidence about the causal role of individualism-collectivism. However, such a study would require extensive resources.

The approach adopted here was to measure both Individualism-Collectivism and Uncertainty Avoidance, the other dimension of Hofstede's scheme that sharply differentiates Canadian and Greek cultures, as well as some demographic variables that also constitute potential confounds (e.g., education level). It was therefore possible to test directly the mediating role of individualism-collectivism in the relationship between culture and attitudes and include uncertainty avoidance in the regression analyses to adjust statistically for the possible role of that dimension. This approach is consistent with much

other research on group differences, research in which possible mediating effects of different factors are examined statistically through regression analyses and related causal modelling methods.

An Individualism-Collectivism Framework

The central dimension in Hofstede's scheme, individualism-collectivism, has been studied under a variety of labels (Kagitcibasi & Berry, 1989): separateness-relatedness, individual vs. group loyalties, idiocentric-sociocentric, and idiocentric-allocentric at the individual level (Ito, 1985; Kagitcibasi, 1985, 1987; Marin & Triandis, 1985; Shweder & Bourn, 1984; Triandis, Leung, Villareal, & Clack, 1985). Although much work remains before the individualism-collectivism construct is understood fully, even the current incomplete conceptualizations have major implications for understanding cultural differences in clinical phenomena and for the development of culture-sensitive clinical practices.

Qualities of Individualism- Collectivism

Fundamental to the distinction between collectivist and individualist cultures is the notion of an in-group or collective. In-groups are groups of people with which individuals identify, and can be defined on the basis of similarity (demographic attributes, activities, preferences, or institutions), proximity, or common fate. In most cultures, the family is the most important in-group. Other ingroups are defined by work, religion, some aesthetic or scientific persuasion, or membership in the same tribal, political, or social collective.

People in individualistic cultures give priority to personal goals over the goals of collections of individuals (i.e., collectives). In collectivist cultures, people make no

distinction between personal and collective goals or, when they do, personal goals are subordinate to collective goals (Triandis, Bontempo, Villareal, Asai, and Lucca, 1988). Moreover, collectivists are concerned with the results of their actions on members of their ingroup (i.e., on groups with which they identify). In collectivist vs. individualist cultures, people are more willing to share resources with, to feel more inter-dependent with, and to be involved in lives of ingroup members (Hui & Triandis, 1986).

Findings indicate that people in collectivist societies confirm to ingroup norms and obey ingroup authorities, whereas they are unwilling to cooperate with members of outgroups (Shweder & Levine, 1984). Overall, behavior is more a function of ingroup norms in collectivist than individualist cultures (Davidson, Jaccard, Triandis, Morales, & Diaz-Guerrero, 1976).

Individualist and collectivist cultures also differ on certain aspects of social relationships, with collectivist cultures putting more emphasis than individualist cultures on communal (vs. exchange) interpersonal functions. Relationships in collectivist cultures are therefore characterized by less clarity about what is to be exchanged and when or where, a greater concern for the other person's needs vs. concern for equity, and an emphasis on maintaining the equality of affect (i.e., if one is sad, the other is sad) as opposed to emotional detachment (Mills & Clark, 1982).

According to Kagitcibasi and Berry (1989), the individualism-collectivism dimension is correlated with a wide variety of psychological variables, including: learning and reinforcement, social perception, conflict resolution methods, reward allocation, and modes of justice. With respect to child-rearing, the primary concern of parents in

collectivist cultures is obedience, reliability, and proper behavior, whereas the primary concern of parents in individualist cultures is self-reliance, independence, and creativity. Greek-American parents often fabricate a social reality in which others are described as jealous or as potential threats. This impedes cooperation with others beyond the in-group or family circle (Tsemberis & Orfanos, 1996).

Some researchers have suggested that cultures evolve from collectivism to individualism, with the latter being a major component in the construct of modernity. For example, Adamopoulos and Bontempo (1986) noted a shift toward individualism and exchange relationships in their analysis of the content of written text across historical periods. One hypothesis is that individualism increases with cultural complexity and affluence. Complexity creates more in-groups to which individuals belong, so that their ties to each group weaken. In-groups are also seen as more transient since they are more likely to change due to physical or social class changes. Affluence also decreases material interdependencies. These factors lead individuals to act more independently and individualistically.

Kagitcibasi and Berry (1989) questioned the claim that cultures progress toward individualism as they become industrialized and develop economically. They noted the existence of individualism in pre-industrial Western Europe and the continuing collectivistic values in such technologically developed countries as Japan. Moreover, modernization theory treats individualism and collectivism as mutually exclusive qualities. But even in individualistic, industrialized cultures, collectivist trends continue to be observed in certain sub-groups. For example, working-class families in industrialized

societies follow the conforming socialization pattern characteristic of collectivism (Kohn, 1969, 1987).

Individualism-Collectivism and Clinical Psychology

Individualism-collectivism has numerous implications and can be used as a general theoretical framework with which to make sense of many existing findings on the role of culture in clinical psychology. The varied implications are summarized in Table 3 and have been described more fully elsewhere (Barbopoulos, 1999). The basic idea is that individualism-collectivism has implications for all aspects of clinical practice, including occurrence of disorders, help-seeking, and therapeutic effectiveness. Of particular relevance here is the hypothesis that people from collectivist cultures may have less positive attitudes toward psychological disorders and their treatment. There are several empirical and theoretical reasons to accept this working hypothesis.

Potentially, the hypothesis about individualism-collectivism provides a unified explanation for many cultural differences reported in the literature. Much of the research showing lower levels of use, less positive attitudes, and the like have used cultures with a collectivist orientation. The cultures that have received the greatest study are Asian, African-American, and Hispanic. Hofstede's norms (see Table 4 in Chapter 4 or Table 3-1, p. 53, in Hofstede, 1997) places various Asian and Spanish cultures on the lower half of the individualism scale. The regions of East and West Africa also obtain low scores on Individualism, and research with contemporary African Americans suggests that, despite the intervening experience of slavery, their collectivist roots remain (Friedman, 1998).

Table 3

Individualism-Collectivism and the Practice of Clinical Psychology

Increased Risk

- Immigrant Separation from Family Members
- Immigrant Isolation from Others of Similar Cultural Background
- Individualism-Collectivism and Psychological Distress (e.g., Happiness)

Lower Likelihood of Seeking Professional Help

- Familial Stigma Attached to Obtaining Services
- Anticipate Value Incongruity with Therapist from Individualist Culture
- Preference that Problems be Kept Within Family
- Prefer In-Group Support Systems
- Collectivist Beliefs about Psychological Distress and Treatment

Therapy Less Effective

- Negative Expectations and Attitudes of Client
- Collectivist Clients View Therapist as "Expert"
- Collectivist Clients Prefer Directive/Active Therapy
- Collectivist Clients Question Value of Individual Self-Exploration and Insight
- Therapist May Not Understand Collectivist Client's Subjective Experience
- Therapist May Misinterpret Client Behaviours (e.g., duty to family)
- Therapist May Adopt Culturally Biassed Conceptualization of the Problem
- Collectivist Clients May Fail to Correct Expert Therapist Misinterpretations

Additional quantitative and qualitative analyses of these cultures confirm that they tend to have a collectivist orientation. For example, Koreans, who tend to show less positive attitudes and lower levels of use of psychological services, obtain markedly higher familism scores than do Korean Americans who are in turn markedly higher than White Americans (Youn, Knight, Jeong, & Benton, 1999). The construct of familism is closely related to that of collectivism. Triandis (1995) describes other studies that demonstrate the collectivist orientation of many of the cultures used in cross-cultural research on attitudes, use, and effectiveness of psychological services.

A second reason for thinking that collectivism would be related to negative attitudes in particular is that Triandis (1995) tentatively linked vertical collectivism (see Chapter 4) to an authoritarian style of governing and parenting. Triandis (p. 19) notes that in early work on individualism, it was the term "authoritarianism" that was placed at the opposite (i.e., collectivist?) pole. Authoritarianism has been linked to a number of attitudes that would suggest a negative evaluation and possibly treatment of people with psychological disorders (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1982; Altemeyer, 1981). A 30-item authoritarianism scale used by Altemeyer (1981, pp. 219-220), for example, included such items as "Some of the worst people in our country nowadays are those who do not respect our flag, our leaders, and the normal way things are supposed to be done" and "If a child starts becoming unconventional and disrespectful of authority, it is his parents' duty to get him back to the normal way." These and other items suggest that deviations from "normal" would be viewed negatively by authoritarian people.

Despite the central role of individualism-collectivism in non-clinical research, there has been little direct research on the hypothesized connection between collectivism and attitudes toward psychological disorders. Tata and Leong (1994) actually found that individualism was negatively correlated with positive attitudes toward help seeking, contrary to the model presented here. From their understanding of Asian culture, Tata and Leong had predicted that Chinese students with weaker collectivistic orientations would be more prone to seek psychological help and less likely to rely on the extended family and the community elders. The authors speculated that part of the inconsistency may arise from the complexity of constructs such as individualism and collectivism, and the various ways in which they can be measured. This issue arose in the present study, as well.

Chapter Summary

The study of culture in the context of clinical psychology raises a number of challenging issues, including whether to treat culture as a categorical predictor variable or in terms of underlying dimensions of culture. The orientation that served as a foundation for the present research was to examine dimensions along which cultures vary to test the role of those dimensions in mediating cultural differences on variables related to clinical phenomena. Specifically, the present study focussed on the relationships between individualism-collectivism, one of the dominant dimensions of culture in the non-clinical literature, and various aspects of people's perceptions of psychological distress and its treatment. Comparisons on these dimensions, as well as some potential confounds, were made between members of collectivist Greek and individualist Canadian cultures.

CHAPTER 4:

A TEST OF THE INDIVIDUALISM-COLLECTIVISM FRAMEWORK

The individualist-collectivist framework hypothesizes that people with collectivist orientations will have less positive attitudes toward psychological disorders and treatment than people with individualist orientations, and that differences in individualism-collectivism explain many of the observed differences in attitudes across cultures. One way to test this hypothesis is to measure individualism-collectivism and attitudes toward psychological disorders in participants from cultures that would be expected to differ on the dimension of individualism-collectivism. Attitudes should differ across cultures, and these differences should be reduced and perhaps even eliminated when cultural differences on individualism-collectivism are adjusted statistically. This same pattern of results should hold even when other, potentially confounding variables (e.g., education levels, uncertainty avoidance) are adjusted statistically.

To test this model, the present study compared three groups of participants who were predicted to differ with respect to individualism-collectivism, as well as with respect to attitudes toward psychological distress and treatment: (a) a group of Non-immigrant Canadians from individualist backgrounds, (b) a group of Greek-Canadian Immigrants to Canada, and (c) a group of Greek Residents (i.e., Greeks living in Greece). Non-immigrant Canadians were predicted to be the least collectivist and the most acculturated to individualism, the Greek immigrant group to be more collectivist and less acculturated to individualism, and the Resident Greek group to be at least as collectivist as the Greek immigrant group, and perhaps even more extreme. It was further predicted that

acculturation to the individualism of Canadian society, as represented by the three groups, would be related to attitudes toward psychological disorders and their treatment, as reviewed in this proposal. Specifically, Non-Immigrant Canadians should have relatively more positive attitudes toward psychological distress and treatment than the two Greek groups.

Most important for the model were expectations about the relationship between collectivism and attitudes. The model predicted that individual differences on collectivism within groups would correlate with differences in attitudes toward mental distress and its treatment. That is, participants with low scores on individualism (high on collectivism) should have less positive attitudes than participants with high scores. As a direct test of the hypothesis that individualism-collectivism mediates the relationship between culture and attitudes, it was also predicted that adjusting statistically for within- and between-group differences in individualism-collectivism would reduce the strength of the relationship between culture and attitudes.

Group and Individual Differences on Individualism-Collectivism

For the present study, it was necessary to classify Greek and Canadian cultures as individualist and collectivist, respectively, and also to assess differences among participants on the individualism-collectivism dimension. The predicted differences between Greek versus non-Greek cultures and participants follow from a number of empirical and rational analyses of Greek culture. As a relatively new construct in psychological research, and a complex one at that, there are still many issues related to the measurement of individualism-collectivism that have not been resolved definitively. These

problems are compounded for cross-cultural comparisons in which constructs can be measured at either the country (i.e., culture) or individual level.

Classification of Countries (i.e., Cultures)

On the basis of questionnaire results from many participants in a large number of countries, Hofstede (1980) assigned four scores to each country, one score for each of the dimensions in his scheme. Hofstede (1997, p. 51) defined individualism as "societies in which the ties between individuals are loose: everyone is expected to look after himself or herself and his or her immediate family" and collectivism "as its opposite pertains to societies in which people from birth onwards are integrated into strong, cohesive ingroups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty."

Hofstede's individualism score, based on employees in a single organization from many countries, was based on questions about their most important work goals. Personal time, freedom, and challenge were valued by individualist countries and training, physical conditions, and use of skills by collectivist countries. The resulting individualism scores are shown in Table 4 for 40 countries, with countries ordered from high to low on individualism. Scores for Hofstede's other dimensions are also shown. The present study included participants with Canadian and Greek cultural backgrounds. The values for these countries appear in bold in Table 4. Observe that Canada has a relatively high score on individualism ($\underline{M} = 80$), whereas Greece has a relatively low score ($\underline{M} = 35$).

Table 4

National Scores for Individualism (IN), Power Distance (PD), Uncertainty Avoidance (UA), and Masculinity (MA)

	IN	PD	UA	MA
United States	91	40	46	62
Australia	90	36	51	61
Great Britain	89	35	35	66
Canada	**80**	**39**	**48**	**52**
Netherlands	80	38	53	14
Italy	76	50	75	70
Belgium	75	65	94	54
Denmark	74	18	23	16
Sweden	71	31	29	5
France	71	68	86	43
Ireland	70	28	35	68
New Zealand	70	22	49	58
Norway	69	31	50	8
Germany	67	35	65	86
Finland	63	33	59	26
Switzerland	68	34	58	70
South Africa	65	49	49	63
Austria	55	11	70	79
Israel	54	13	81	47
Spain	51	57	86	42
India	48	77	40	56
Argentina	46	49	86	56
Japan	46	54	92	95
Iran	41	58	59	43
Brazil	38	69	76	49
Turkey	37	66	85	45
Greece	**35**	**60**	**112**	**57**
Philippines	32	94	44	64
Mexico	30	81	82	69
Portugal	27	63	104	31
Yugoslavia	27	76	88	21
Hong Kong	25	68	29	57
Chile	23	63	86	28
Singapore	20	74	8	48
Thailand	20	64	64	34
Taiwan	17	58	69	45
Peru	16	64	87	42
Pakistan	14	55	70	50
Colombia	13	67	80	64
Venezuala	12	81	76	73
Means	49.90	51.85	64.48	50.43

Welts (1982) provided an overview of Greek immigrant culture based on Greek-American immigrants who immigrated to North America from 1900 to 1920. The emphasis on collectivism was confirmed, but with some complicating considerations. The immigrants preserved Greek cultural patterns that were the norm at the time that they immigrated to North America. Family roles were particularly important and failure to perform them could be a source of distress. Traditional sex roles in the immigrants were sharply stereotyped, with men helping little with the house-hold or child-rearing. Greek husbands and fathers were authoritarian, and depended less on praise and more on criticism for control. Fathers were masters and expected to be obeyed, believing that they knew best how to lead, protect, and criticize other family members. Generational boundaries were strong; that is, power and authority were held by the eldest and exercised according to traditional rules, a pattern called "lineal." Welts (1982) argued that the Greek collectivist orientation may have strengthened during the Turkish occupation, as families learned to rely on their ingroup (family members, friends, and friends of friends) and to give it unlimited respect, concern, and loyalty.

Despite familial commitments and collectivist values, however, Welts (1982) also characterized the Greek immigrants as taking tremendous pride in individual achievement, and as having difficulty cooperating with others, even other Greeks, in business. They enjoyed competing but not cooperating. Businesses were operated with a strong, controlling, authoritarian hand, and Greeks, according to Welts, were not accustomed to putting aside their individual interests for the sake of the larger group. Jealousy and competitiveness between extended family members could be intense as with Mexican and

Italian cultures (Papajohn & Spiegel, 1975).

In the present study, the collectivist features of traditional Greek culture were expected to be observed for both Greek Canadian Immigrants and Resident Greeks. Welts (1982) noted that Greek immigrants tended to avoid full assimilation into North American culture and to protect their old values. Although they travelled to find better opportunities, Greeks remain nationalistic and culturally apart, and often go to great lengths to maintain the Greek identity (e.g., sending children back to Greece to be raised by relatives).

In describing first-generation Greek-Americans, Tsemberis and Orfanos (1996) noted the continuing presence of collectivist values, especially surrounding the family. The family was the basic social unit, with strong patriarchal control and close extended kinships, including godparents ("koumbari") and people related by marriage ("simpetheri"). Greek-American families are organized hierarchically and interaction among members is tightly cohesive and perhaps even enmeshed. Tsemberis and Orfanos (1996) observed that family members are expected to defer to the greater needs of the family and that individual needs receive less consideration than in North America.

On the basis of such results, Non-immigrant Canadians and the two Greek groups were expected to differ on the dimension of Individualism-Collectivism, with the two Greek groups being more collectivist. Parallel differences in attitudes toward psychological distress were also predicted on the basis of the present model, which hypothesizes that cultural differences in attitudes result from differences on individualism-collectivism.

Individual Measurement of Individualism-Collectivism

Hofstede's scale pertains to countries and the particular items used were relevant primarily to a work setting. There are, however, a number of different measures designed for individuals and more general populations. Triandis (1995), who has done much empirical and theoretical work on individualism, developed a scale that identifies four components of individualism-collectivism: vertical collectivism, horizontal collectivism, vertical individualism, and horizontal individualism. The items of the Triandis measure are shown in Appendix 3, as well as some items used to supplement the Vertical Collectivism scale (see the Results for an explanation).

In essence, vertical Collectivism measures a tendency to value obedience to parents and other forms of authority. Horizontal Collectivism measures a tendency to value the well-being and happiness of co-workers, neighbours, and other equals. Vertical Individualism largely reflects a valuing of competition and seems most relevant to a work setting. Horizontal Individualism reflects a valuing of one's uniqueness and independence as a person.

The literature reveals that there is still much uncertainty about the conceptual structure of the individualism-collectivism construct. Triandis's measure assumes that the four components are all independent of one another, whereas other work (e.g., Hofstede's) makes no distinction between the horizontal and vertical elements, and maintains that individualism and collectivism are opposite poles of a single dimension. Triandis's Vertical Collectivism scale appears to be the most prototypically collectivist of Triandis's four components and, as will be shown later, most closely mapped onto the

present conceptualization. It was also noted above that some experts (e.g., Welts, 1982) have characterized Greek culture as one in which individualist competition is high. We would not expect, therefore, that Vertical Individualism as measured by Triandis's scale, would necessarily produce lower scores for the Greek groups. Recall that the Vertical Individualism scale emphasizes competition.

In the present study, levels of individualism-collectivism were assessed for individual participants by the Triandis Individualism-Collectivism measure, with the Vertical Collectivism scale being particularly important. It was predicted that the Non-immigrant Canadians would score lowest on collectivism, that Greek-Canadian Immigrants would score higher on collectivism, and, depending on the degree of acculturation among Greek-Canadian Immigrants, that Greek Residents would score hightest on collectivism. The test of this hypothesis also served as a "manipulation" check for the theoretical differences on individualism-collectivism among the three groups (i.e., the validity of the classification of Greece and Canada as collectivist and individualist cultures, respectively).

Measurement of Attitudes and Other Psychological Constructs

In addition to individualism-collectivism, the proposed test of the model required measures of attitudes toward psychological disorder and treatment, the primary dependent variable in the study, and of potential confounding variables (e.g., education, uncertainty avoidance).

Measurement of Attitudes

Attitudes toward psychological distress and treatment were measured by two

scales that have been used in previous research, the Opinions about Mental Illness Scale (OMIS, see Appendix 1 for items), and the Attitudes toward Seeking Professional Psychological Help (ATSPPH, see Appendix 2 for items) scale.

The OMIS can be scored for four dimensions. Authoritarianism measures the tendency to perceive people with mental illness as inferior and threatening, and as requiring coercive management. Mental Hygiene Ideology measures the tendency to perceive mental illness as an entity that can be successfully treated. Social Restrictiveness measures a tendency to perceive people with mental illness as threats to society particularly in their social functioning both during and following hospitalization. Interpersonal Etiology measures a tendency to perceive that mental illness arises from lack of nurturing from significant others during childhood. Some refinements in scoring the OMIS were made during preliminary analyses (e.g., orienting the scale scores so that a high score indicated a positive attitude).

The second measure was the Attitudes Toward Seeking Professional Psychological Help (ATSPPH), designed by Fischer and Turner (1970). Fischer and Turner had identified four factors when the instrument was administered to 406 college and university students. However, the factors were not orthogonal and correlated from .25 to .58. Recognition of Need for Professional Psychological Help measures sensitivity to the existence of problems that require a professional. Tolerance of the Stigma Associated with Psychiatric Help measured how sensitive people would be to having received professional help. Interpersonal Openness Regarding Subject's Problems measured how much people were willing to reveal their personal difficulties. Confidence in Mental Health

Professionals measured how likely people were to benefit from professional mental health services.

One unanticipated issue that arose in the use of the OMIS and ATSPPH concerned the direction of scoring. That is, it was not always obvious what responses indicated positive versus negative attitudes. Data were therefore collected from professionally-trained psychologists on the desirability of the various attitudinal statements with respect to the use and effectiveness of psychological services.

The hypothesized relationship between collectivism and attitudes predicted that Non-immigrant Canadians would demonstrate the most accepting attitudes, that Greek-Canadian Immigrants would obtain scores indicating less accepting attitudes toward psychological distress and its treatment, and that Non-immigrant Greeks would have the least accepting attitudes, again depending on the relative degree of collectivism of Greek-Canadian Immigrants and Greek Residents.

There is some evidence consistent with the proposal that Greeks will have less positive attitudes toward psychological disorders and their treatment, although, to my knowledge, no one has directly tested the collectivism hypothesis for the negative attitudes. Welts (1982) asserted that it was unusual for Greek immigrants to seek psychotherapy, unless compelled by some authority, and provided an explanation consistent with the present hypothesis. Specifically, Welts suggested that Greek family members, especially fathers, believe that they know best the causes of and solutions for their problems. They generally make external attributions for their personal difficulties, attempt to exert direct control of their families in terms of rigid roles, and expect little

benefit from appealing to outsiders (Blume & Blume, 1970). "Philotimo" ("love of honour" or "doing what the ingroup expects me to do" [Triandis, 1995, p. 94]) is a major factor in Greek culture, and may contribute to the negative response to psychological disorder and treatment.

Papadopoulos, Stamboulides, Triantaphyllou, and Katakis (1999) reported the results of a large-scale survey of over 3000 Greeks in various parts of the country. They found that respondents had limited knowledge of psychology, which only recently has become an independent academic discipline in Greek universities. For example, over one-third of participants saw psychology and psychoanalysis as identical. A number of findings suggested negative attitudes toward psychotherapy for psychological difficulties. Almost one-half (42.0%) of respondents indicated they would be able to solve their problems themselves or with friends, and over one-quarter (27.4%) indicated that they would not divulge visiting a psychologist, even to relatives and friends. One of the strongest predictors of actually using psychological services was having met a psychologist. Papadopoulos et al. (1999) attributed the lack of knowledge and negative attitudes to inadequate education about psychology and concerns about alienating oneself from social groups. Indeed, the authors speculated that the results for having psychological difficulties would be similar to having committed a crime.

Several studies have directly measured attitudes toward psychological distress and treatment for Greeks and other comparison groups. Koutrelakos, Gedeon, and Streuning (1980) administered the Opinions about Mental Illness Scale (OMIS) to matched Greek and American samples of psychologists, social workers, and business administration

officers. Consistent with predictions of the collectivist model, Greeks tended to have more authoritarian and restrictive (i.e., less positive) attitudes toward psychological distress and treatment than did Americans. Culture accounted for 40% of the variability in attitudes. In both groups, business administration officers had less positive attitudes, but there was no interaction with nationality. The authors attributed the difference between cultures to Greeks being more traditional and authoritarian in their attitudes.

Koutrelakos and Zarnari (1983) used the OMIS to compare attitudes toward psychological distress of Greek and American social work students in 1969 and 1979. Over the ten-year period, there was a decrease of negative attitudes in Greece and positive attitudes in America. But even in 1979, Greek participants still tended to have higher scores with respect to the authoritarian and restrictive treatment of people with psychological disorders. The authors attributed the improvement in Greek attitudes to modernization, a moderation in familialism, and a decline in historically high levels of authoritarianism in Greece. The authors noted that authoritarianism tends to be strongly correlated with stigmatization of various atypical groups. Comparisons with the present study were not possible because of differences in scoring procedures, as described later.

These studies indicate that attitudes toward psychological distress and treatment should be less positive for Greeks than non-Greeks, unless the developmental trends observed by Koutrelakos and Zarnari (1983) have continued and eliminated differences between the two groups. Prior to the present study, there appears to have been no direct test made of whether the cultural differences between Greeks and non-Greeks could be accounted for by differences in collectivism.

Measurement of Potential Confounds

In examining the relationships among cultures, collectivism, and attitudes toward psychological disorders, it was necessary to consider some possible confounding variables that might mask or exaggerate the preceding relationships. Several demographic factors were assessed (e.g., education level) so as to allow statistical adjustment for their effects.

I also measured one of Hofstede's other dimensions that appeared of potential importance for attitudes toward psychological distress and treatment, namely, uncertainty avoidance. A new measure was constructed for this study, based on Hofstede's characterization of high and low uncertainty avoidance countries. Hofstede's norms predicted that Greek and Canadian cultures would differ on this dimension, with Greeks scoring higher than non-Greeks. It was not expected, however, that differences in Uncertainty Avoidance would account for differences in attitudes between cultures.

To summarize, attitudes toward psychological disorders and treatment, collectivism, uncertainty avoidance, and several demographic variables were measured across three groups: Non-Immigrant Canadians, Greek-Canadian Immigrants, and Greek Residents. The latter two groups were expected to have less positive attitudes and higher collectivism scores, even when demographic variables were adjusted statistically. According to the model proposed here, the differences in attitudes would be reduced when the mediating role of collectivism was controlled. Uncertainty Avoidance was not expected to have the same effect. The study also provided an opportunity to examine a number of important, albeit secondary, issues. These issues included the conceptualization and measurement of individualism-collectivism, and the structure of attitudes toward

psychological distress and treatment. With respect to the latter, for example, a novel approach was taken to the issue of what constitutes a "positive" attitude with respect to possible implications for psychological treatment.

To review, the predictions were: (a) non-Immigrant Canadians should have relatively more positive attitudes toward psychological distress and treatment than the two Greek groups, (b) these differences in attitudes should remain even after adjusting statistically for demographic factors (e.g., age, education, gender), (c) non-immigrant Canadians should be the least collectivist, (d) people with high scores on collectivism should have less positive attitudes toward psychological disorders than participants with low scores, and (e) adjusting statistically for within- and between-group differences in collectivism should reduce the strength of the relationship between culture and attitudes.

Method

This section presents basic information about the conduct of the study, including some special considerations that arose in the development, translation, and scoring of some measures.

Participants

The final sample of 129 participants consisted of 59 Non-immigrant Canadians, 44 Greek-Canadian Immigrants, and 26 Greek Residents. Families of Non-immigrant Canadians had been born in Canada and their parents and grandparents had either lived in Canada or emigrated from highly individualist countries according to Hofstede's 1980 and 1997 classification of countries. The majority of these families came from United Kingdom countries.

Greek-Canadian Immigrants were born in Greece but had emigrated to Canada or the USA at some point and were currently residing in North America. Their parents and grandparents had also been born in Greece. The Greek Immigrants had spent an average of 29.14 years living in North America, SD = 8.25. There were several indications that Greek culture continued to be important for these immigrants. Many reported the use of Greek language in their homes and almost all reported their religion as Greek Orthodox.

Greek Residents were born in Greece and resided there at the time of the study. The majority of participants had always resided in Greece, although a few reported having lived in other countries for short periods of time. Their parents and grandparents had also been born in Greece or in Greek communities in the Mediterranean that were once part of or strongly allied with Greece (e.g., Asia Minor).

Because of the difficulty of recruiting participants (see below), it was not possible to match individuals across groups as originally planned (e.g., on age or duration of residency in Canada). Statistical procedures were used to adjust for these differences.

Demographics of the Sample

Table 5 shows descriptive statistics for the three groups. The differences among mean ages was not significant, $F(2, 123) = 2.32$, $MSE = 116.31$, $p = .103$, $R^2 = .036$. However, there were significant differences with respect to education, $F(2, 125) = 12.51$, $MSE = 1.67$, $p < .001$, $R^2 = .167$, and income, $F(2, 120) = 7.66$, $MSE = 2.00$, $p = .001$, $R^2 = .113$. For education, Non-immigrant Canadians had an average level between some post-secondary education (4) and a first post-secondary degree (5), whereas the two Greek groups fell between high school (3) and some post-secondary (4). For income,

Greek Residents had an average income between $20,000 and $29,999, whereas the other two groups had average incomes between $30,000 and $99,999.

Table 5

Demographic Description of Samples

Measure / Group	Mean	SD	N
Age (years)			
Non-Immigrant Canadians	47.07	10.23	59
Greek-Canadian Immigrants	49.84	12.25	43
Greek Residents	44.00	9.18	24
Entire sample	47.43	10.90	126
Education (3=High School, 4=Some Post-Secondary, 5=First PS Degree/Diploma)			
Non-Immigrant Canadians	4.56	.93	59
Greek-Canadian Immigrants	3.49	1.68	43
Greek Residents	3.31	1.26	26
Entire sample	3.95	1.41	128
Income (2=$10-19,999; 3=$20-29,999; 4=$30-49,999; 5=$50-99,999)			
Non-Immigrant Canadians	4.36	1.16	59
Greek-Canadian Immigrants	4.28	1.45	43
Greek Residents	3.00	1.92	21
Entire sample	4.10	1.49	123

There were no significant gender differences among the three groups, although the proportion of women differed somewhat. The percentages (and numbers) of women in each of the groups were 62.71% (n = 37 of 59), 47.73% (n = 21 of 44), and 65.38% (n = 17 of 26) for the Non-Immigrant Canadians, Greek-Canadian Immigrants, and Greek Residents, respectively, X^2 (2) = 3.03, p = .220. Most participants also currently lived in urban centres.

Given these differences on variables that could be correlated with relevant attitudes, later analyses used multiple regression and other statistical techniques to adjust statistically for these confounding factors.

Measures

The primary measures of the present study were: the Opinions about Mental Illness Scale (OMIS), the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) measure, an Individualism-Collectivism measure, an Uncertainty Avoidance measure, and a Background Questionnaire.

Opinions about Mental Illness Scale (OMIS). The OMIS included 58 Likert-type opinion items that were rated on a scale from one to seven, with one being "Strongly Disagree" to 7 being "Strongly Agree". The original measure consisted of five scales, for which reliabilities and validities were published in 1963 (Cohen & Struening, 1965; Struening & Cohen, 1963), although the present scoring system, which is described more fully in the results, used four scales. The OMIS items appear in Appendix 1.

Attitudes Toward Seeking Professional Psychological Help. A measure of attitudes toward seeking professional psychological help for psychological disturbances was

developed and standardized by Fischer and Turner (1970). The items appear in Appendix 2. In the present study, the 29 statements were rated on a seven-point Likert scale, with 1 indicating Strongly Disagree and 7 Strongly Agree. Some items were negatively worded, and these were reversed during scoring. Fischer and Turner (1970) reported that internal reliability was .86 in one study (n = 212) and .83 in a second study (n = 406), and that test-retest reliability was .86 over five days, .89 over two weeks, .82 over four weeks, .73 over six weeks, and .84 over two months.

Individualism-collectivism. Participants completed a measure of individualism-collectivism reported by Triandis (1995). The items appear in Appendix 3. Participants again rated each item on a 7-point Likert scale, with 1 indicating Strongly Disagree and 7 Strongly Agree. Alpha reliabilities for the four scales shown in Appendix 3 were reported to range from .73 to .82. Preliminary analyses reported in the results indicate that some items omitted from the OMIS could be used to supplement the Vertical Collectivism.

Uncertainty-avoidance. Individualism-collectivism and uncertainty avoidance tend to be correlated across countries (Hofstede, 1997), and also demonstrate some conceptual overlap. Because an individual measure of uncertainty avoidance could not be located, one was developed especially for the thesis. Based on definitions and descriptions of uncertainty avoidance in Hofstede (1980, 1997), I generated a final total of 40 items for the measure, half positively worded and half negatively worded. No prior empirical analyses were performed on the scale, which appears in Appendix 4. The internal consistency of the measure was tested in the present study, and a number of items were omitted in the final scoring (see Results).

Background Questionnaire. The background questionnaire elicited demographic information, and also focussed on respondents' cultural background. The questionnaire is presented in Appendix 5. This questionnaire was used to assign participants to the three groups (e.g., to determine that Individualist Canadians were from individualist cultures).

Translation of Measures

All measures were translated into Greek for optional use with Greek participants. I originally planned to use the back-translation method with different translators (Brislin, 1970), but it was not possible to find people sufficiently literate in both languages and willing to perform the demanding task within the time required. After unsuccessful efforts to obtain back-translations from anyone in Canada or in Greece, I decided to pursue data collection and evaluate the quality of translation in other ways. There are several indicators that the quality of translation (i.e., semantic equivalence) of the instruments was very good.

First, it should be noted that I am a fluent bilingual who has lived 16 years in Greece and 16 years in North America. I completed high school in Greece and post-secondary education in North America, including an undergraduate minor in English literature. I spent several weeks translating the materials, several hours each day. Translations were set aside for a period, after which I reviewed the translations. I would read the Greek, translate it into English, and check it against the English originals. I made corrections and repeated the cycle a number of times. My primary objective was to ensure that the Greek statements not only were semantically equivalent to the English statements, even if non-literal translation was necessary, but also were expressed in a natural and

familiar form for Greek readers.

Second, similarity of meaning ratings (see Appendix 12 for instructions) were obtained from 5 raters fluent in Greek and English. Overall the rated similarity on a 7-point scale was very high. Specifically, 98.0% of the 795 ratings (5 raters x 159 items) were 6 or 7, and only 2 ratings were below the midpoint of 4. Three of the raters lived in North America and were of Greek origins. A background language questionnaire was obtained for these raters. All learned Greek first, but learned English at an early age. Their primary education was generally in Greek, and their secondary and university education in English. All reported using both English and Greek in a variety of settings, and all rated their proficiency in performing various language tasks (e.g., reading a newspaper, writing a letter) very high in both Greek and English. These quite fluent and balanced bilinguals found the materials to have very similar meanings in Greek and English.

Third, I have done some analyses of the similarity of item mean ratings in the two languages. Specifically, I calculated two mean ratings for each item, one averaged across all Greek forms and one across all English forms. The correlation between these means across items was quite high ($r = .69$), suggesting general equivalence of "meaning" of the English and Greek versions. Some of the most severe discrepancies were readily accounted for by the predicted differences in Individualism-Collectivism. For item #108 ("I am a unique individual") on Horizontal Individualism, for example, the English mean was higher than average, and the Greek mean was lower than average.

Together these considerations suggest that the semantic equivalence of the Greek and English versions of the measures is quite high, and that any robust differences between

the samples cannot easily be accounted for by gross differences in the meanings of the English and Greek statements. Interestingly, a recent article on creating bilingual measures for cross-cultural research criticized the back-translation approach, and recommended an approach in which bilingual researchers emphasize the meaning of statements, rather than equivalence of wording (Erkut, Alarcon, Coll, Tropp, & Garcia, 1999). Erkut et al. (1999) also recommend the use of cognitive techniques, such as having bilingual judges rate the equivalence of words in the two languages. My approach extended this latter idea to have judges evaluate the overall meaning of the statements, which was ultimately the primary concern for measurement of attitudes.

Recruitment of Participants

Potential participants for the study were solicited widely through newspaper advertisements and postings in community centres, from talks at Greek and Anglican churches, from various organizations, from internet sources that attract large numbers of Greek participants, and from personal referrals by people who knew of the study. Initial contact with the experimenter was either on the telephone, through direct conversation, or in writing. The study was described briefly to potential participants, who were then asked if they were interested in further participation. If their initial response was positive, potential participants were sent a covering letter, a Consent Form (see Appendix 6), the Background Questionnaire (see Appendix 5), and a questionnaire booklet that contained the 159 questions of the various measures. A stamped envelope was provided with which to return completed materials to the researcher. At the conclusion of their participation, participants who had included their addresses were mailed a brief description of the

purpose of the study as feedback (Appendix 7). In addition to direct contact by the experimenter, multiple experimental packages were sent to some contacts who agreed to distribute them to potential participants. Altogether, approximately 400 questionnaires were distributed. Many more people, however, would have been informed about the study and given an opportunity to participate.

Procedures

Participants were instructed to first complete the consent form and then the background questionnaire. A questionnaire booklet contained the 159 items of the four measures in the following order: OMIS, ATSPPH, Individualism-Collectivism, and Uncertainty Avoidance. Items were ordered randomly within each of the measures, with all participants receiving the same random order. Item numbers in Appendices 1 to 4 indicate the position of items in the booklet. A single set of instructions and rating scale was used for all of the experimental questionnaires. The first page of the booklet contained the following instructions (or the Greek equivalent):

> On the following pages are a number of statements related to psychology. Read each statement carefully and indicate your degree of agreement or disagreement. If you strongly agree, enter a 7 on the blank line next to the statement; if you strongly disagree, enter a 1 on that line; if you are unsure, enter a 4. Please express your frank opinion in rating the statements. There are no wrong answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item. In short, use this scale:
>
> Strongly Unsure Strongly

Disagree Agree

1 2 3 4 5 6 7

Rated Quality of Attitudes Toward Mental Illness

A primary concern for the present study was to have an accurate measure of the quality of people's attitudes toward psychological distress and treatment, specifically as such attitudes related to clinical issues. To confirm the appropriate weighting for items related to attitudes to psychological distress and treatment, the 87 items of the ATSPPH and OMIS were rated for quality. The instructions asked raters to assess whether each statement represented a positive or negative attitude toward psychological distress and treatment (see Appendix 8 for the full instructions). Positive attitudes were defined as those that would help people to recognize and cope effectively with psychological distress, including seeking professional treatment when appropriate. Negative attitudes were those that would prevent people from recognizing and coping effectively with psychological distress, and could even prevent people from seeking professional treatment when needed.

Ratings were performed by 6 people with advanced training in psychology (one licensed PhD clinical psychologist, one academic PhD psychologist, one Clinical Psychology Resident, two Clinical Psychology Interns, and two pre-internship PhD-level clinical psychology students).

There was a high degree of consistency among the quality of attitude ratings by the 7 judges. The mean of the 21 correlations between all-possible pairs of raters was .80, Cronbach's alpha was .96, and a factor analysis of the 7 ratings (one score for each rater) produced a single factor that accounted for 82.7% of the total variability in the ratings.

The mean quality rating was 3.28, SD = 2.06, where 4.00 represents the nominal middle of the 7-point scale. Thus attitude statements were, on average, somewhat lower than the middle in terms of overall quality. The mean rating for each statement was used in preliminary analyses to orient the scoring of the attitude measures (i.e., to determine whether items should be scored in a positive direction or reversed).

CHAPTER 5:

RESULTS AND DISCUSSION

The results turned out to be more complex than expected. Measures that were meant to be aggregated (e.g., the horizontal and vertical components of individualism and collectivism) did not correlate as strongly as expected, and preliminary analyses of the OMIS exposed items that were inappropriate as part of the criterion measure. I first report analyses of the composition of the variables, then factor analytic results that examined the intercorrelations among the various criterion and predictor measures, and finally regression analyses of the causal relationships between attitudes, and culture, residence, collectivism, and other correlated factors.

Composition of Variables

Both the criterion and predictor variables required considerable analysis and conceptualization in order to simplify and ensure the meaningfulness of the factors entered in subsequent analyses. Several questions arose during the course of statistical and conceptual analyses of the items. Were all of the items appropriate indicators of the constructs being examined? Were the chosen items multi-factorial or could they be safely aggregated into single measures?

Criterion Measures: Attitudes About Psychological Disorders and Treatment

With respect to the criterion measures, the OMIS was more difficult to deal with than the ATSPPH. Issues included what to do with items that did not directly measure attitudes, and how to calculate scale scores for participants.

OMIS items not related to attitudes. The OMIS contained 8 items that did not directly measure attitudes toward psychological distress (e.g., #35. The death penalty is inhuman and should be abolished). A close examination of the original papers on the OMIS revealed that 5 of these 8 items in fact had been selected from the California F Scale (Adorno et al., 1982), a measure of authoritarian personality traits. A number of these 8 questionable items appeared to reflect differences in individualism-collectivism (e.g., #5. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents), something that could seriously contaminate the results by conceptual overlap between the attitude measure and both culture and the collectivism measures.

Also, analyses reported later in the results section on predictors demonstrated that 7 of the 8 items were correlated with Vertical Collectivism sufficiently strongly to be used to supplement that scale. Thus, the 8 irrelevant items were omitted from the criterion OMIS measure, but only 1 of the 8 (#35 above) was omitted completely in the final scoring.

OMIS scale scores. Omitting the above 8 items meant that the OMIS scores were based on the 50 remaining items. Some published studies using the OMIS also used a reduced version of the test that included primarily items directly related to mental disorders. For example, Rahav, Struening, and Andrews (1984) used a 51-item version of the test. They included one additional item that was omitted from the OMIS here because it did not directly refer to mental distress and correlated highly with collectivism (#53. Anyone who tries to better himself deserves the respect of others).

The standard scoring of the reduced OMIS produces 4 separate factor scores, some of which can be viewed as positive (e.g., Mental Hygiene Ideology), and some of which appear negative (e.g., Social Restrictiveness). The ratings of the expert judges were used to weight items such that a high score always indicated a more positive attitude in the opinion of the expert judges.

There have been slight variations of scoring for the OMIS, in part because of different items used in different studies. Rahav et al. (1984) used almost the identical set of items as in the present study, and their scoring was therefore used as the basis for generating scale scores in the present study. The Rahav et al. scoring is quite close to that used in other studies.

Rahav et al. identified four scales of the OMIS: Authoritarianism (O-A), Interpersonal Etiology (O-IE), Mental Hygiene Ideology (O-MHI), and Social Restrictiveness (O-SR). Rahav et al. (1984) reported loadings on the four scales for 43 of the OMIS items (a 44th item was one omitted as irrelevant here). Reliability and factor analyses were used to determine the homogeneity of the Rahav scales based on 43 of the 50 items. All scales produced acceptable levels of reliability (alpha = .85 or larger) except for O-MHI (alpha = .44). Three of 8 items were removed from the O-MHI scale to improve its preliminary reliability (alpha = .617).

In a second phase, four scale scores were calculated, and the unused 10 items were examined to determine with which of the scales each correlated most highly. It was possible to allocate all but one item (#50. Even though patients in mental hospitals behave

in funny ways, it is wrong to laugh about them) to a scale without compromising the homogeneity of the scales. Table 6 shows relevant data on the various scale scores.

Table 6

OMIS Scale Scores

Scale	# Items	M	SD	Min	Max	Alpha	%age[1]
O-A	13	4.89	1.20	2.08	6.77	.84	35.79
O-IE	9	4.43	1.43	1.00	6.67	.85	45.92
O-MHI	10	4.98	0.87	1.60	7.00	.69	27.53
O-SR	17	4.89	1.18	1.35	6.94	.88	34.43

Note 1. %age of variability in items on each scale accounted for by first unrotated factor.

The final OMIS scales based on 49 items show a good degree of homogeneity, with the exception of Mental Hygiene Ideology. The homogeneity is also reflected in the SDs and ranges, both of which are quite substantial for 7-point rating scales. The final column (%age) shows the percentage of variability in the items that was accounted for by the first unrotated factor in four separate factor analyses of the scale items. All items loaded positively on the first factor for their scale. The means show that the attitudes tend to be toward the positive end of the scale, 4 being the mid-point. The items loading on the various scales appear in Appendix 1.

The OMIS Authoritarianism scale essentially represents (the absence of) a negative and even discriminatory attitude toward those experiencing psychological disorders (e.g., #11. [-] There is something about mental patients that makes it easy to tell them from normal people). Interpersonal Etiology represents (the absence of) a belief in a central role

for social and other etiological factors in the development of psychological disorders (e.g., #30. [-] If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill). Mental Hygiene Ideology reflected positive views about caring for people with psychological disorders (e.g., #18. More tax money should be spent in the care and treatment of people with severe mental illness). Social Restrictiveness indicated (the absence of) a need to control and protect society from people with psychological disorders (e.g., #17. [-] Patients in mental hospitals are in many ways like children).

Factor analysis demonstrated that the four OMIS scales tended to be inter-correlated, with only O-MHI being somewhat independent of the others. A single factor accounted for two-thirds of the variability in scale scores, with O-MHI loading opposite to the other scales (see Appendix 11). The structure of the scales was also examined in subsequent analyses, which included additional variables. The analyses are discussed later in this chapter.

ATSPPH scale scores. Scoring of the ATSPPH was relatively straightforward compared with the OMIS, although less adequate degrees of internal consistency were observed for the scales. The standard scoring produces four scale scores: Recognition of Need for Psychotherapeutic Help (A-RN), Stigma Tolerance (A-ST), Interpersonal Openness (A-IO), and Confidence in Mental Health Practitioner (A-CP).

The alpha coefficients were particularly low for A-ST (.59) and A-CP (.57). It was possible to improve the reliability of the Confidence in Practitioner scale by omitting two of the nine items on this scale (#59 and #69). The reliability of the Stigma Tolerance scale,

which initially had only 5 items, was not improved markedly by omitting any items and was left intact. The statistics for the final scales are reported in Table 7.

Table 7

ATSPPH Scale Scores

Scale	# Items	M	SD	Min	Max	Alpha	%age[1]
A-RN	8	4.46	1.25	1.00	7.00	.70	33.49
A-ST	5	4.95	1.28	1.60	7.00	.59	39.24
A-IO	7	4.80	1.29	1.86	7.00	.68	34.90
A-CP	7	5.07	1.13	1.71	7.00	.69	36.14

Note 1. %age of variability in items on each scale accounted for by first unrotated factor.

The scales showed moderate degrees of internal consistency and a good range of variability in the scores, as reflected in the substantial SDs and ranges. Average scores were again toward the upper end of the 7-point scale, indicating a generally positive attitude toward seeking professional psychological help. The items loading on the ATSPPH scales appear in Appendix 2. As with the OMIS, the ATSPPH scales were intercorrelated and, when factor analysed alone, were largely accounted for by a single underlying factor (see Appendix 11), an issue that is examined later.

The Recognition of Need scale measures an appreciation of when it is appropriate to seek professional help (e.g., #76. I would want to get psychiatric attention if I was worried or upset for a long period of time). Stigma Tolerance measures (the absence of) a concern about the stigma of seeking help (e.g., #72. [-] Having been a psychiatric patient is a blot on a person's life). Interpersonal Openness measures a willingness to disclose

information about one's self (e.g., #79. [-] There are experiences in my life I would not discuss with anyone). The Confidence in Practitioner scale assesses people's belief in the effectiveness of professional help (e.g., #74. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help).

The OMIS and ATSPPH scales are not independent of one another empirically. Their relationship is examined more closely following consideration of the scoring used for the primary predictor variables.

Predictors: Individualism-Collectivism and Uncertainty Avoidance

Similar analyses to the preceding were performed on the predictor variables, although there was no a priori scoring format for the Uncertainty Avoidance scale as it was newly created for this research. In the present study, individualism-collectivism was assessed by Triandis's measure for a two-dimensional model that produced four scores: Horizontal Collectivism, Vertical Collectivism, Horizontal Individualism, and Vertical Individualism (Triandis, 1996). The first of these four scales assumed particular importance in the following analyses. According to Triandis (1996), these four sub-type scores were thought to be independent. Each of the sub-type measures contained only 8 items and, except for one case, all items were worded positively (i.e., agreement indicates more of the characteristic being measured).

Vertical collectivism. The original Vertical Collectivism measure contained 8 items and showed a moderate degree of internal consistency (Cronbach's alpha = .71). However, the items removed from the OMIS because they were not directly related to psychological disorders included a number of items that seemed closely related to Vertical

Collectivism (e.g., showing love, gratitude, and respect for parents; children learning respect for authority). Five of the deleted OMIS items came from an earlier measure of authoritarianism (Adorno et al., 1982). In general, authoritarians tend to be ethnocentric (i.e., to view the groups to which they belong as superior to others), to have an exaggerated confidence in authority (e.g., parents), and to engage in simple thinking about right and wrong (e.g., to believe that strange and different thinking is dangerous for societal values). It seemed likely that some of these qualities would be associated with vertical collectivism (see General Discussion for more on this issue).

Analysis of the 8 Vertical Collectivism items and the 7 OMIS items revealed that, in addition to having some conceptual rationale, these items in fact constituted a reasonably homogeneous scale. The statistics shown in Table 8 indicate a good level of internal consistency and, because of that, a wide range of variation on Vertical Collectivism. The mean shows that the present sample on average scored at the center of the Vertical Collectivism scale.

Appendix 10 shows some additional statistics relevant to the combining of the 15 items for the revised Vertical Collectivism scale. Item-total scale correlations are shown for all items. The mean correlation was actually slightly higher for the 7 OMIS items (mean $\underline{r} = .51$) than for the original 8 Triandis items (mean $\underline{r} = .43$). Loadings on the first unrotated factor arising from a factor analysis of the 15 items also showed higher values for the new items (mean loading = .60) than for the original items (mean loading = .51). Moreover, separate scores based on the average of the original and added items correlated .59 with one another, and behaved similarly when entered separately in various analyses

reported shortly. For example, the separate scores loaded almost identically on factor analyses of the variables analogous to those reported in Table 9 for the composite vertical collectivism score.

Table 8

Individualism-Collectivism Scales

Scale	# Items	M	SD	Min	Max	Alpha	%age[1]
Vert. Coll.	15	4.25	1.15	1.40	6.60	.840	32.28
Hori. Coll	8	5.79	0.74	3.50	7.00	.617	28.21
Vert. Indi.	8	3.41	1.15	1.00	7.00	.746	36.64
Hori. Indi.	8	5.12	0.92	2.00	7.00	.526	24.65

Note 1. %age of variability in items on each scale accounted for by first unrotated factor.

Other components of Individualism-Collectivism. Table 8 also shows descriptive statistics for the other three scales on the Triandis measure. Vertical Individualism, which measures an appreciation and enjoyment of competition has reasonable reliability and a good range of scores. Interestingly, the present sample scored below average on this dimension.

Horizontal Collectivism and Horizontal Individualism produced lower levels of internal consistency, especially the latter scale. The sample also tended to score relatively high on these dimensions, with a particularly low range of scores being observed for Horizontal Collectivism. Horizontal Collectivism measures an interest in and concern for one's equals (e.g., harmony within group, cooperating with others). Horizontal

Individualism measures a preference for independence (e.g., being direct with others and being unique).

Appendix 3 shows the items of the Triandis measure that were allocated to each of the four scales. As with the OMIS and the ATSPPH, these scales were intercorrelated, and this issue is examined shortly.

Uncertainty Avoidance. The Uncertainty Avoidance measure was specifically developed for this study, which means there was no a priori scoring that would produce scale scores. Nor were there enough participants in the study to do a proper factor analysis of the full 40 items. I therefore focussed on obtaining as homogeneous a measure as possible.

The approach taken was to use an increase in Cronbach's alpha as a criterion for eliminating items. That is, the 40 items were first subjected to analysis, and the item that would most increase alpha by its elimination was identified. That item was then deleted, and the 39 remaining items were analyzed again. This cyclical process was repeated until no appreciable increase in alpha was observed. That happened after the elimination of 16 items, leaving a scale of 24 items as the measure of Uncertainty Avoidance.

Statistics for the final scale of 24 items showed an average rating in the moderate range, M = 4.25, with a good degree of variation across participants, SD = .87 and range from 2.25 to 6.13. There was also reasonable homogeneity, with Cronbach's alpha = .83 and the first unrotated factor accounting for 21.38% of the variation in scores. Appendix 4 shows the 40 original items divided into retained and excluded items. The most obvious

pattern in the separation is that many of the omitted items were negatively worded. That is, disagreeing with the item would demonstrate higher levels of uncertainty avoidance.

The uncertainty items that showed the highest correlation with the average of other items were: #123, I prefer structured learning situations that have specific expectations and require definite correct answers; #130, New and different ideas or ways of doing things are often dangerous; and #135, Generally, people should associate with and marry members of their own culture. These and other items in Appendix 4 seem highly appropriate given Hofstede's conceptualization of uncertainty avoidance, although the third item would appear to overlap somewhat with those aspects of collectivism associated with ethnic identification.

Interrelationship of Measures

The preceding analyses produced 8 measures of attitudes, 4 measures of individualism-collectivism, and one measure of uncertainty avoidance. Additional predictor variables included Culture (Greek vs. Non-Greek) and Residence (Greek-Canadian Immigrants vs. Greek Residents). That is, the three groups (i.e., Non-immigrant Canadians, Greek-Canadian Immigrants, and Greek Residents) were defined by two dimensions: Culture (determined here by country of origin) and place of Residence. To accommodate these factors in the following correlational and regression analyses, an indicator variable (Culture) was created for culture, with the Non-immigrant Canadian group coded -2 and the two Greek groups coded +1. A second indicator variable (Residence) was used to differentiate the two Greek groups, with Greek-Canadian Immigrants coded -1 and Greek Residents coded +1 (Non-Immigrant Canadians were

coded 0). There were also three demographic variables, namely education, age, and gender.

The total of 18 variables was deemed too many for the proposed analyses of causal effects using multiple regression, and therefore factor analysis was first used to identify meaningful groupings of the 8 criterion variables and the relationships between criterion clusters and the various predictors. Several alternative approaches could have been taken to reducing the number of distinct variables. One common approach is to first factor analyse the predictor and criterion sets independently. Several separate analyses of just the criterion measures indeed produced only a few components. Other analyses, however, indicated that doing this might lose some of the specificity in the measures. Specifically, the various scale scores for the criterion measures correlated sufficiently to be collapsed into a single score, even though the scales had unique relationships with the predictor variables.

One analysis that provided a useful conceptualization of the data was a principle components factor analysis with varimax rotation performed on all 18 variables. Three participants were missing data for education or age. To avoid eliminating all of their data, mean substitution was used for those scores. Five factors had eigenvalues greater than one, and accounted for 66.55% of the variation in the data. Table 9 shows the factor loadings for the 18 measures on the five factors (see Appendix 9 for correlations).

Table 9

Rotated Factor Loadings for Criterion and Predictor Variables

	Factor				
	1	2	3	4	5
	OMIS and ATSPPH Scales				
Authoritarian	.862	.223	-.002	.086	-.127
Inter. Etiol.	.799	.134	-.064	.088	-.252
Social Restri.	.761	.351	.060	-.113	-.156
Recog. Need	.586	.130	.486	.251	-.012
Inter. Open.	.610	.423	.162	.066	.038
Stigma Toler.	.215	.727	.208	-.052	-.087
Conf. Practice	.175	.126	.830	-.042	-.048
Mental Hygiene	-.275	-.145	.542	-.192	.480
	Predictors				
Culture	-.775	-.012	-.011	-.010	-.075
Residence	.073	.047	-.057	.120	.881
Vert. Coll.	-.761	-.353	.163	-.022	-.149
Hori. Coll.	-.524	.264	.499	.129	-.155
Vert. Indiv.	-.357	-.770	.042	-.017	-.073
Hori. Indiv.	.039	-.233	.203	.683	-.198
Uncert. Avoid.	-.780	-.218	-.043	-.062	-.144
Education	.679	-.084	.174	.303	.016
Gender	-.057	.379	.045	.458	.264
Age	-.178	-.085	.123	-.716	-.156
%Variance	34.85%	10.22%	8.02%	7.55%	5.92%

The results provide a useful and meaningful reduction of the data. Five of the 8 criterion measures had their highest loading on the first factor, and this was the only factor on which Culture had a substantial (negative) loading. That Vertical Collectivism (and, to a lesser extent, Horizontal Collectivism) loaded negatively on Factor 1 was consistent with

prediction. Horizontal and Vertical Individualism did not load on this factor, but interpretation was complicated by the fact that Uncertainty Avoidance (negative loading) and education (positive loading) did. The unique contribution of these various predictors was examined in regression analyses reported later.

Factor 2 contained substantial loadings for the stigma tolerance criterion measure, as well as some aspects of interpersonal openness not captured by Factor 1 and Vertical Individualism (negative). It appears that people who were competitive and emphasized "winning" in life had exaggerated concerns about the shame of mental disorders. People with an elevated feeling of responsibility to their families (i.e., Vertical Collectivism) also showed lower scores on the stigma tolerance scale (i.e., scores showing more concern with stigma). The moderate loading for Interpersonal Openness suggests that people with high concerns about negative attitudes also were reluctant to reveal themselves to others, perhaps especially professionals. Interestingly, the factor analysis did not show any relationship between this factor and Culture.

On the criterion side, Factor 3 represented primarily confidence in practitioners, although both mental hygiene and recognition of need had moderate loadings. Among the predictor variables, only Horizontal Collectivism had a sizable loading, and this, surprisingly, was positive. Horizontal Collectivism is associated with deriving pleasure and satisfaction from interactions with others, from other people's successes, and from sharing. It appears that such people reported feeling more confident about the value of therapy (e.g., rejecting such statements as #77, [-] "The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts"),

appreciated the value of more resources for mental health services, and valued obtaining psychological treatment for serious problems.

Factor 4 contained no substantial loadings for the criterion measures and appears to represent a negative association between age and Horizontal Individualism. Younger people seem to prefer independence and "doing their own thing" more than do older people. This factor was not considered further.

Factor 5 showed a moderate loading for Mental Hygiene and a substantial loading for residence. Residents of Greece felt that improvements were needed in mental health services (e.g., more trained doctors and other staff, patients having more privacy). This may represent a difference in attitude, or it could represent real differences in the kind of mental health services available in the two countries. That is, there may be more actual need for change in Greece than in North America.

The first factor is the most relevant to the present study, and to a lesser extent, factors two and three. Factor one also contained just over half of the variation accounted for by the full analysis and one-third of the total variation in the data. On the basis of the pattern in Table 9, the planned regression analyses were performed to examine the unique contribution of predictors to a composite attitude measure based on the criterion scales loading on Factor 1. Supplementary analyses were performed to examine other relationships suggested by the overall factor analysis.

Cultural Differences on Criterion Measures

A composite attitude measure (ATT) was calculated for each participant based on an average of the five scales that loaded strongly on Factor 1: OMIS Authoritarianism,

OMIS Interpersonal Etiology, OMIS Social Restrictiveness, ATSPPH Recognition of Need, and ATSPPH Interpersonal Openness. ANOVA and regression analyses were used to determine the relationship between ATT and culture, controlling first for demographic variables and then for Vertical Collectivism and Uncertainty Avoidance, the two predictors that also loaded on Factor 1.

Is Attitude Associated with Culture and Residence?

The primary purpose of the present study was to determine whether the collectivist Greek culture would be associated with less positive attitudes toward psychological distress and treatment than the individualist Canadian culture. As expected the mean ATT score was more positive for Non-Immigrant Canadians ($M = 5.41$, $SD = .61$) than for Greek-Canadian Immigrants ($M = 4.23$, $SD = .96$) or Greek Residents ($M = 3.85$, $SD = .77$). This difference was highly significant by analysis of variance, $F(2, 126) = 47.99$, $MSE = .61$, $p < .001$, and accounted for just under half of the total variability in attitudes, $R^2 = .43$.

Interpreting this result and determining the separate effects of culture and residence were complicated by the non-equivalence of our groups and the different sample sizes. Table 10 shows the correlations between attitude and the various demographic factors, as well as the correlations with collectivism and uncertainty avoidance, which are discussed later. Attitude had a strong negative correlation (-.64) with culture, but it was also correlated positively with education level, which itself was correlated with culture. It was earlier noted that the mean education level was higher for the Non-Immigrant Canadians.

Table 10

Relation of Culture (CUL), Residence (RES), Education (EDUC), Gender (GEN), Age, Collectivism (COL), and Uncertainty Avoidance (UNC) to One Another and to Attitude (ATT)

	ATT	CUL	RES	EDU	GEN	AGE	COL
Culture	-.64						
Residence	-.02	-.19					
Education	.60	-.41	.02				
Gender	.12	-.10	.12	.06			
Age	-.26	.04	-.20	-.32	-.14		
Vertical Collectivism	-.71	.53	-.16	-.42	-.10	.24	
Uncertainty Avoidance	-.70	.62	-.12	-.55	-.09	.20	.66

Note: df = 124, critical rs = .147, .175, and .229 for two-tailed ps of .10, .05, and .01, respectively

To adjust for these factors, several regression analyses were performed. The overall Attitude score was first regressed on the culture and residence predictors. The initial regression equation and relevant parameters appear in Table 11, Model 1. The effect of Culture was highly significant and accounted for much of the differences among the groups ($sr^2 = -.65^2 = .42$). The independent effect of Residence was also significant,

although much weaker than culture. Clearly, the primary effect was the markedly lower attitude scores of the two Greek groups relative to the non-immigrant Canadian group. This result provided strong support for one of the major predictions of the present study.

Table 11

Predictors of Attitude Toward Psychological Distress

		Model 1	Model 2	Model 3	Model 4
Culture	b	**-.68**	**-.53**	**-.34**	**-.28**
	p	*.000*	*.000*	*.000*	*.000*
	sr	-.65	-.46	-.26	-.21
Residence	b	**-.21**	**-.23**	**-.26**	**-.25**
	p	*.037*	*.011*	*.001*	*.001*
	sr	-.15	-.15	-.17	-.17
Education	b		**.24**	**.18**	**.16**
	p		*.000*	*.000*	*.001*
	sr		.29	.21	.17
Gender	b		**.05**	**.04**	**.04**
	p		*.454*	*.460*	*.467*
	sr		.05	.04	.04
Age	b		**-.01**	**-.01**	**-.01**
	p		*.227*	*.101*	*.110*
	sr		-.14	-.08	-.08
Collectivism	b			**-.39**	**-.33**
	p			*.000*	*.000*
	sr			-.35	-.27
Uncertainty	b				**-.20**
	p				*.037*
	sr				-.10
Intercept		4.74	4.45	6.02	6.71
R^2		.43	.58	.70	.71
MSE		.61	.45	.33	.32
F		45.25	33.14	46.22	41.40
p		.000	.000	.000	.00

Is the Relationship Between Culture and Attitude Nonspurious?

Although the groups differed dramatically on attitudes toward psychological distress and treatment, the groups also differed on a number of other dimensions that complicated interpretation of the observed group differences. Specifically, demographic factors, such as age and education, might have accounted for the results rather than culture or residency. If so, the observed relationship between culture and attitudes would be a spurious one, better explained by demographic differences than by culture or residence.

To examine this issue, additional variables were introduced into the regression equation to determine whether the effect of culture was statistically independent of the demographic differences among the groups. Gender was recoded so that -1 indicated Male and +1 Female. Age and Education were included as quantitative predictors. Income was not included in the analyses reported here because a number of people did not answer that question, income correlated highly with education level, cross-cultural comparisons were complicated by the different currencies and economies, and the results were unaffected by the inclusion of income in the analyses.

To evaluate the unique effects of culture and other predictors, independent of demographic differences, demographic predictors were added to the multiple regression equation with culture and residence. The results appear in Table 11 as Model 2. The critical question was whether the significance of Culture that was observed in Model 1 would disappear when demographic differences were corrected. Model 2 shows clearly that the effect of culture was still highly significant, even when its correlations with

Education, Age, and Gender were corrected. Thus, the relationship between attitude and culture could not be accounted for fully by these possibly spurious factors. The overlap with education did, however, reduce somewhat the unique contribution of Culture. That is, the slope and part correlation for Culture were smaller when the other predictors, notably Education, were included in the regression equation. But the effect of Culture clearly remained significant, and its relationship was stronger than that between attitudes and education. Including the demographic predictors also had some effect on the relationship between Residence and Attitudes. If anything, however, that relationship became more significant.

The preceding analyses demonstrated that the differences between Canadian and Greek participants were unlikely to be due to the different education levels, proportions of males and females, ages, and incomes (not reported here) of the three groups. It is still possible that other confounded or spurious variables could have been responsible for the observed correlation, and some possible competing explanations for the effect are considered in the general discussion.

The overall strength of the prediction was also quite impressive. Together, the predictors (primarily Culture and Education) accounted for well over half (58%) of the total variability in attitudes. Psychological studies do not often produce such robust effects, suggesting that the cultural (and educational) differences examined here are of considerable psychological importance.

One other aspect of the significant effect of education is worth noting. Previous studies have demonstrated that attitudes toward psychological distress and treatment were

more positive with higher levels of education (Rabkin, 1980). The present study replicated that effect, adding confidence in the overall design of the study and in the measures used. The effect was present in all three groups, and there was no evidence of an interaction between group and education. The absence of interaction was determined by centering education (i.e., subtracting out its mean) and computing interaction predictors for the culture by education interaction and the residence by education interaction. The interaction components did not add significantly to a regression equation containing culture, residence, and education, $F(2, 122) = .39$, $p = .678$, for the change when interactions were entered into the equation. The positive effect of education provides some evidence for the construct validity of our attitude measures in this particular study.

Does Collectivism Vary with Culture and Residence?

As predicted, Greeks were more collectivist than non-Greeks. Mean Vertical Collectivism scores were 3.59 for non-immigrant Canadians, 4.93 for Greek Immigrants, and 4.63 for Greek Residents, $F (2, 126) = 26.06$, $MSE = .95$, $p < .001$, $R^2 = .29$.

Although robust, the relationship between Culture and Collectivism might again have been due to intercorrelations with other variables. The simple correlations of the Vertical Collectivism score with other variables are shown in Table 10. Collectivism correlated not only with culture, but also with education level. However, a regression analysis confirmed that the relationship between Culture and Collectivism was still highly significant, $b = +.50$, $SE = .094$, $t(119) = 5.26$, $p < .001$, even when the correlated variables of gender, age, and education were included in the regression analysis. As with Attitudes, Collectivism was predicted by Education level, $t(119) = -2.20$, $p = .030$, as well

as by culture. People with higher levels of education tended to be less Collectivist than people with lower levels of education.

Is the Association Between Attitude and Culture Mediated by Collectivism?

To test the hypothesis that the relationship between attitudes and culture was due in whole or in part to collectivism, Vertical Collectivism was added to the regression equation of Model 2 in Table 11 to see whether or not its inclusion would reduce the effect of Culture. Model 3 in Table 11 shows the regression results with the Vertical Collectivism measure in the equation. The importance of Vertical Collectivism to attitudes was demonstrated clearly by the 12% increase in the overall R^2, from .58 to .70. This unique contribution of Collectivism was highly significant.

Adding Vertical Collectivism to the equation also had the predicted effect of weakening the relationship between attitude and culture. The regression coefficient for culture was reduced by 36.36% (from -.528 to -.388) when Collectivism was added to the equation, and the squared part correlation, which represents the unique contribution of Culture, was reduced by 67.28%, from .210 to .069. It seems clear that a substantial proportion of the association between culture and attitude could be attributed to or mediated by the relationship between culture and collectivism, and the relationship between collectivism and attitude.

The significance of the mediating (or indirect) effect of culture can be determined (Baron & Kenny, 1986). In essence the full effect of Culture on Attitude (b = -.53 in Model 2 of Table 11) can be partitioned into its direct effect (b = -.34 in Model 3) plus the indirect or mediated effect, which can be obtained by multiplying the coefficient for

Collectivism in Model 3 ($\underline{b}$ = -.39) by the coefficient for the regression of Collectivism on Culture ($\underline{b}$ = +.50, as reported above); that is, -.53 = -.34 + -.39 x +.50. Note that this equality affirms that the magnitude of the reduction in the slope of culture with the inclusion of collectivism in the regression equation was exactly equal to the product term (i.e., the path from Attitude to Collectivism controlling for Culture times the path from Collectivism to Culture). The standard error of the product term is known and allowed for a test of the mediating or indirect component, $\underline{Z} = 4.19$, $\underline{SE} = .046$, $\underline{p} < .001$. In addition to being highly significant, the mediating effect of Collectivism accounted for over one-third of the relationship between Attitude and Culture.

Although reduced substantially, the effect of Culture was not completely eliminated when Collectivism was included in the equation (i.e., partial-mediation has been demonstrated). Several possible explanations could account for the continued significance of Culture. First, it may be that cultural differences in attitudes toward psychological distress and its treatment represent the contribution of other factors, in addition to Individualism-Collectivism. Second, the measure of Collectivism used in the present study was undoubtedly an imperfect index of underlying differences in the myriad properties associated with Collectivism. Additional broad measures of Collectivism would be expected to do a better job of capturing the construct more fully. In analyses not reported here, it was found that the Horizontal Collectivism measure of the present study did not explain any of the residual effect of Culture. Indeed, the effect of Culture became slightly stronger when Horizontal Collectivism was added to Vertical Collectivism in the equation, despite the moderate negative loading of Horizontal Collectivism on Factor 1.

Is Collectivism Separate from Uncertainty Avoidance?

One issue in cross-cultural research on such qualities as collectivism is the extent to which these qualities are independent of other characteristics of cultures, that is, other dimensions along which cultures vary. The present study included a measure of Uncertainty Avoidance to at least partly address this question. The three groups differed significantly on Uncertainty Avoidance, with the Non-immigrant Canadians having a lower score, $M = 3.68$, $SD = .60$, than both the Greek-Canadian Immigrants, $M = 4.78$, $SD = .73$, and the Greek Residents, $M = 4.65$, $SD = .85$, $F(2, 126) = 36.55$, $MSE = .49$, $p < .001$.

To determine whether Vertical Collectivism had independent effects on attitudes toward psychological distress, a final regression equation was determined with Uncertainty Avoidance also added to the equation. The results appear as Model 4 in Table 11. The effect of Uncertainty Avoidance was significant, and there was a modest decrease in the contributions of the culture and collectivism variables. But the pattern of results of Model 3 were only slightly changed by the addition of Uncertainty Avoidance and the increase in R^2 was slight.

Other Dimensions of Attitudes

The factor analysis in Table 9 showed that three of the 8 attitude scales loaded on separate factors unrelated to Culture. These scales were examined more closely for differences between the groups and for their relationship with various predictors, especially collectivism. Because the relationships were not as clear as with the aggregate scale, some exploratory analyses were undertaken in order to identify clues and

suggestions for guiding further research on the relationships among attitudes toward psychological distress and treatment, culture, and individualism-collectivism.

Stigma Tolerance

This 5-item and somewhat unreliable scale showed little difference across groups, with non-immigrant Canadians having only slightly higher scores, $M = 5.15$, $SD = 1.31$, than Greek immigrants, $M = 4.84$, $SD = 1.23$, and Resident Greeks, $M = 4.69$, $SD = 1.30$, $F(2, 126) = 1.39$, $MSE = 1.64$, $p = .252$. Analysis of the individual items showed that only one of the five items demonstrated the predicted effect. Non-immigrant Canadians rated item #72 ([-]"Having been a psychiatric patient is a blot on a person's life") more positively, $M = 5.64$, $SD = 1.86$, than the Greek-Canadian Immigrants, $M = 4.57$, $SD = 2.11$, and the Greek Residents, $M = 3.35$, $SD = 2.65$, $F(2, 124) = 10.98$, $MSE = 4.51$, $p < .001$. The two Greek groups also differed significantly from one another on this item, $F(1, 125) = 4.62$, $MSE = 4.58$, $p = .034$.

This result suggests that indeed the Greek groups did tend to see more stigma associated with psychological difficulties than do the Non-immigrant Canadians, consistent with the findings for the aggregate attitude measure. However, this stigma did not appear to be translated into attitudes reflecting a desire to hide such difficulties, at least not as assessed by the overall Stigma Tolerance measure.

The predictor that did load on Stigma Tolerance was Vertical Individualism (simple $r = -.48$ between the two variables). People with a strong sense of competitiveness tended to have lower levels of tolerance for stigma. That is, they would try to avoid the stigma associated with psychological distress and treatment. A supplementary factor

analysis of just the Stigma Tolerance score and the individual Vertical Individualism items revealed that the negative relationship was present for all items, but was strongest for the two items related to feeling annoyed, tense, or aroused when others do better (i.e., #s 95 and 110). Other items on this scale did not mention negative emotions associated with losing a competition. It appears that people with an individualist orientation who are particularly sensitive to losing in general may be less tolerant of the stigma associated with mental health problems and treatment, although their intolerance may hold for any dimension interpreted by some people in terms of personal inadequacies.

Confidence in Practitioner

A second ATSPPH scale that failed to load with culture and the other attitude components was the Confidence in Practitioner scale. The groups differed in the expected direction, with Non-immigrant Canadians scoring highest, $\underline{M} = 5.27$, $\underline{SD} = .95$, followed by Greek-Canadian Immigrants, $\underline{M} = 4.97$, $\underline{SD} = 1.10$, and Greek Residents, $\underline{M} = 4.79$, $\underline{SD} = 1.48$. But the differences were not significant, $\underline{F}(2, 126) = 1.91$, $\underline{MSE} = 1.27$, $\underline{p} = .153$.

Examination of the 7 items on this scale showed that only two items differed significantly across the three groups, and both of these showed the predicted pattern. Non-immigrant Canadians scored higher than Greek immigrants and Resident Greeks on item #73 ([-] "I would rather be advised by a close friend than by a psychologist, even for an emotional problem"), $\underline{M}s = 4.76$, 3.88, and 3.58, respectively, $\underline{F}(2,123) = 4.09$, $\underline{MSE} = 4.19$, $\underline{p} = .019$, and also on item #77 ([-] "The idea of talking about problems with a

psychologist strikes me as a poor way to get rid of emotional conflicts"), Ms = 6.14, 4.49, and 4.31, respectively, $F(2,123) = 12.32$, MSE = 3.78, $p < .001$.

Perhaps more than other items on this scale (see Appendix 2), these items elicited concerns about talking with out-group members about personal problems, something with which people from collectivist cultures might have more difficulty. This hypothesis, however, was weakened by the failure of this scale to load on the factor associated with collectivism and cultural differences. In fact, Horizontal Collectivism had a positive loading of .50 on this dimension. A supplementary factor analysis of Confidence in Practitioner and the individual items of Horizontal Collectivism suggested that the items showing this positive effect reflected positive concern for the well-being of others and enjoying their company (#s 98, 101, 109 in Appendix 3).

Mental Hygiene Ideology

The final scale that demonstrated some unexpected relationships was the OMIS Mental Hygiene Ideology. Greek Residents obtained the highest scores on this scale, M = 5.59, SD = 1.03, with the Non-immigrant Canadians, M = 4.73, SD = .64, and Greek-Canadian Immigrants, M = 4.97, SD = .89, obtaining similar scores, $F(2, 126) = 10.10$, MSE = .67, $p < .001$. This was the only attitude scale for which there was a consistent and significant difference favouring Greek Residents.

The items showing the largest differences on this scale involved assertions about improvements needed in the treatment of people with psychological disorders (#33. The patients of mental hospitals should be allowed more privacy. #23. If our hospitals had enough well-trained doctors, nurses, and aides, many of the patients would get well

enough to live outside the hospital. #56. The patients of a mental hospital should have something to say about the way the hospital is run.). As noted previously, it may be that there are substantial differences between Canada and Greece in the provision of mental health services. If so, these items may reflect such realities more than differences in attitudes between the different groups.

The only hint that any predictors other than residence were related to Mental Hygiene Ideology was moderate loadings for this scale and for Horizontal Collectivism. Factor Analysis of the scale score and individual items revealed that this association was largely due to two items having to do with assisting relatives financially or being happy for the good fortune of others (#s 103 and 107 in Appendix 3).

Chapter Summary

In summary, the results provided clear support for the predictions that led to the present study. Non-immigrant Canadians had more positive attitudes toward psychological distress and its treatment than did either of the two Greek groups. These differences could not be accounted for by demographic differences between the groups. The two Greek groups were also more Collectivist in their orientation than were the Non-immigrant Canadians. Adjusting statistically for Vertical Collectivism reduced the strength of the relationship between Culture and Attitudes, confirming the presence of a significant mediating effect of Collectivism. Possible explanations for a residual direct effect of Culture on Attitudes included imperfect measurement of collectivism. Adding Uncertainty Avoidance to the equation changed the pattern of results only slightly. The attitude scales that did not load on the first general factor showed complex patterns of relationships with

the various predictors. Meaningful patterns emerged when analyses of specific items were undertaken, but these must be viewed cautiously given their post hoc nature.

CHAPTER 6:

GENERAL DISCUSSION: CULTURE AND CLINICAL PSYCHOLOGY

The present study was designed to further our understanding of the relationships among culture, individualism-collectivism, images of mental health and mental illness, attitudes towards seeking psychological treatment, and views of the therapeutic process. This general discussion will examine advances made in the present study, suggest ways in which future research could better extend our current knowledge about the relationship between culture and attitudes toward psychological distress, and consider other implications for clinical practice of individualism-collectivism.

Advances in Present Research

The present study has contributed several new findings related to the cross-cultural literature on attitudes toward psychological distress and its treatment. It has also confirmed and extended some existing findings with new measures and participants. At the same time, the results have revealed some difficulties with the standard conceptualization of individualism-collectivism and current approaches to cross-cultural investigation.

Cultural Differences Mediated by Individualism-Collectivism

The present study confirmed many of the predicted differences. Greek-Canadian immigrants and Greek Residents demonstrated less positive attitudes toward diverse aspects of psychological distress and its treatment than did Canadians descended from individualist cultures. The differences were observed on a broad attitudinal factor that included a number of different scales from the OMIS and the ATSPPH. Greeks tended to obtain lower scores on dimensions related to nonauthoritarian and nonrestrictive treatment

of people with psychological disorders, being open to talking about personal difficulties with professionals, recognizing the need for assistance with psychological problems, and not blaming psychological disorders on family and other interpersonal causes. These differences were not accounted for by differences between the groups on demographic variables (i.e., gender, age, education), since the effects remained significant when demographic factors were included in the regression analysis.

The factor analysis of all variables demonstrated that this general attitude dimension and culture were associated with Vertical Collectivism, as well as with several other variables, namely Uncertainty Avoidance and Education. Participants who had positive scores on the aggregate attitude measure tended to be Individualist Canadian, to score low on Vertical Collectivism and Uncertainty Avoidance, and to have higher levels of education. This pattern of results is consistent with the findings of earlier psychological studies and with predictions, although the expected effect of Uncertainty Avoidance was uncertain.

Regression analyses were consistent with the hypothesized mediating role for collectivism. Including Vertical Collectivism in the regression equation markedly reduced the magnitude of the Culture effect. That is, partialling out the covariation in vertical collectivism from culture (i.e., "controlling" or adjusting statistically for collectivism) resulted in smaller differences between the Greek and non-immigrant Canadian participants. One can cautiously conclude that the cultural groups would have differed less in attitudes had their collectivism scores been more similar.

The analyses also demonstrated that the mediating effect of Vertical Collectivism was not due to the correlated property of Uncertainty Avoidance. The moderating effect of collectivism was virtually unchanged when Uncertainty Avoidance was included in the regression equation. It is possible, nonetheless, that other confounded variables, not measured in the present study, might be responsible for some or all of the observed relationships. This issue will need to be resolved by future research.

How Vertical Collectivism Affects Attitudes

As noted below, there are a number of complications in the interpretation of individualism-collectivism, but the nature of the Vertical Collectivism dimension that correlated so strongly with attitudes and culture appears consistent with hypothesized differences between individualist and collectivist cultures (see Appendix 3). The items on this dimension were selected from the original Triandis measure and from the OMIS items that were not specifically about mental health. The emphasis in many of these items is duty to family (#s 5, 90, 94, 100, 104, 111, 114, 118), the importance of proper behaviour (#s 25, 34, 53, 54, 116), and respect for authority (#s 13, 52), including parents and religious authority.

The theoretical rationale for the present study placed considerable emphasis on strong concerns about the in-group and family among collectivists, something that could lead to excessive concerns about stigma and negative attitudes toward psychological distress and treatment. The importance of Vertical Collectivism suggests that other elements of collectivism may be as important or even more important in mediating negative attitudes.

One way to conceptualize the role in mental health attitudes of collectivism, as defined here, is in terms of violation of societal norms or, equivalently, in terms of disappointing familial (i.e., societal) expectations. If people truly adopted the collectivist commitment to family and societal expectations, then people would not demonstrate the dysfunctional and often disruptive behaviours associated with psychological disorder, nor would they reveal their failure to meet widely accepted standards (e.g., to mental health professionals).

The strong emphasis in collectivism on compliance with norms, family requests, and like obligations means that members of collectivist cultures who deviate from these norms (or equivalently the deviant behaviour) will be viewed more negatively than in individualist cultures that place less value on obedience to and respect for parents, family, and other forms of authority. The failure to comply (i.e., act in an accepted fashion) would be seen as a transgression of a major element in the social cohesion that characterizes collectivist cultures.

The Horizontal Collectivism scale (see Appendix 3) did not correlate with these attitudinal measures as strongly as Vertical Collectivism and did not show any evidence of mediating the relationship between culture and overall attitudes. Horizontal Collectivism contains items that refer more to friendly, congenial, and supportive relationships with equals than to the hierarchical kind of order characteristic of Vertical Collectivism. A supplementary factor analysis with the aggregate attitude score and the individual Horizontal Collectivism items revealed that several Horizontal Collectivism items that implicate group harmony and dependence did have sizable negative loadings on the

aggregate attitude scale (#s 89 and 96). If anything, however, Horizontal Collectivism had moderate positive relationships with other components of attitudes discussed shortly.

Other issues complicated straightforward interpretation of the Vertical Collectivism dimension (e.g., its relationship to authoritarianism). These issues are discussed in a later section that focusses on measurement questions raised by the present study.

Other Dimensions of Attitudes Toward Psychological Distress

The aggregate attitude measure was the only dimension that showed robust differences between non-immigrant Canadians and Greek immigrants. Surprisingly, the Stigma Tolerance showed little or no differences between these two groups, although one item related strongly to stigma (#72) did in fact show the predicted difference. One possible explanation for this lack of an effect is the quality with which this particular dimension was measured. The Stigma Tolerance scale contained only five items and was not highly reliable.

Confidence in practitioners also differed little across the three groups, although two items expressing concern with talking about problems to professional psychologists did vary across groups as expected.

The final dimension that did not differ as a function of culture (i.e., Greek versus non-Greek), Mental Hygiene Ideology, did produce higher scores for the Greek Resident group than for the Greek Immigrant and Individualist Canadian groups. None of the cultural trait measures loaded on this same factor. Before this difference can be attributed to attitudinal differences, however, it would be useful to determine the contribution of real

differences that might exist in mental health facilities and practices between the two countries.

Role of Acculturation in Attitudes

The present study was not originally designed to compare Greek immigrants and residents, so any conclusions with respect to the relationship between residency and attitudes must be made cautiously. Overall, residency (Canada vs. Greece) showed more modest effects than culture and education. Greek-Canadian immigrants demonstrated more positive attitudes than Greek residents on some items, but the reverse pattern occurred for other items.

According to Ng (1999), acculturation refers to the learning of new knowledge, skills, and values of a culture at a later stage of life. Changes in values could include such things as attitudes toward mental disorder and even fundamental characteristics of individualism-collectivism. Some previous studies have shown that acculturation is associated with more positive attitudes toward mental health (Atkinson & Gim, 1989). Other studies (Gonzalez-Ramos et al., 1998) have found that acculturation to North America correlated positively with values associated with individualism (e.g., independence). Quine et al. (1986) also reported that immigrant groups to the USA valued individualist values more than groups who remained in the country of origin. The question remains, however, whether groups that immigrated had a more individualist orientation even before immigrating.

There was some evidence in the present study for the assumption of differential acculturation of the two Greek groups, at least with respect to their attitudes toward

psychological services. The regression analyses in Table 11 produced a reliable effect of residence on the aggregate attitude scale, with the Greek-Canadian immigrants demonstrating more positive attitudes than the Greek Residents. The most striking differences, however, were between the non-immigrant Canadians and the two Greek groups. Moreover, the differences between Greek-Canadian immigrants and Greek Residents were not weakened by the inclusion of vertical collectivism and other attitudinal measures in the analysis. That is, the effects of residence do not appear to be mediated by changes in Individualism-Collectivism or Uncertainty Avoidance.

Role of Other Factors in Attitudes

The present study confirmed a number of previous findings, in particular the associations between attitudes toward psychological distress and two demographic predictors, specifically education and gender. The effects of education were relatively robust and highly significant. People with higher levels of education had more positive attitudes toward psychological distress and its treatment. The effects of gender were surprisingly small, especially for the aggregate attitude measure, although any observed effects were consistent with expectations in that women had more positive attitudes than did men. The relatively few male and female participants in the groups (e.g., only 9 males in the Greek Resident group) might have worked against finding significant gender differences.

These findings confirm and extend previous results. The positive relationship between education and attitude has now been observed reliably in people from the Greek culture. The findings are also important for demonstrating that the present study could

successfully replicate previous findings, lending some support to the validity of the dependent measures.

Interestingly, the effect of education did not interact with culture. That is, there was no tendency for the cultural differences to be moderated by higher levels of education. This suggests that even when people have higher levels of education, their fundamental cultural differences will still be manifested. Therefore, one cannot depend on general increases in education to eradicate cultural differences, although such increases in education would be expected to produce improved attitudes. A larger number of participants, perhaps with more extreme variation in education levels, would be necessary to validate this conclusion.

That the effects of education were shown to be independent of culture, residence, and psychological traits (i.e., individualism-collectivism, uncertainty avoidance), at least as measured in the present study, may be helpful in identifying the underlying locus for the effect. One fundamental question about mechanisms is whether the differences in attitude across education levels are due to pre-existing differences or are acquired through the process of education. Given the importance of knowledge about and experience with psychological disorders in the development and modification of attitudes, it appears possible that exposure to these topics in such courses as psychology could have some direct effect on attitudes.

Measurement Issues

The present study revealed a number of important methodological and practical difficulties that complicate studies of attitudes toward psychological disorders (Brockman,

D'Arcy, & Edmonds, 1979), especially in a cross-cultural context. A number of issues were related to the measurement of attitudes toward psychological distress and treatment. The present study indicated that the present level of research on attitudes toward psychological distress and its treatment is primitive. The measures that were available are rather dated, and not much is known about the fundamental structure of attitudes. Relative to the amount of work done on measurement of personality or psychological disorders, there has been relatively little research on the construct validity of the attitude measures or on a meaningful conceptual structure for attitudes toward psychological distress.

Quality of Attitudes

An important first step was taken towards correcting one of the many gaps in our knowledge about attitudes regarding psychological distress. A basic question in the measurement of attitudes, especially as they apply to clinical practice, concerns which statements represent psychological healthy attitudes that will promote positive interactions with people experiencing psychological distress and positive attitudes toward the use of psychological services for one's self and others.

The present study determined empirically the relative quality of attitudes toward psychological distress by asking trained psychologists to rate attitudes with respect to their value for clinical practice. There was strong agreement with respect to the positive or negative nature of different attitudinal statements. That is, there was little variation among the psychologists about whether an attitude was or was not desirable from the perspective of psychological services. The judges rated positively and negatively scored items on the

ATSPPH in a corresponding manner, confirming that the traditional scoring of the ATSPPH was meaningful.

The OMIS results were more complicated. The retained OMIS items (see below) have typically been scored in terms of several dimensions, some of which can be viewed as positive and others as negative. The quality ratings allowed for a meaningful aggregation of the usual sub-scores.

One issue requiring further research concerns the scoring of the OMIS items related to the role of the family. The judges generally viewed these attitudinal items in a negative way. But one limitation of these quality ratings is that all of the raters were Canadian (i.e., probably individualist in their general orientation) and contemporary psychology tends to emphasize individualist values in psychotherapy (e.g., sense of an autonomous and independent self). It is likely that at least some of the attitude statements were rated as low or high quality because of their compatibility with the individualist orientation. Perhaps the most obvious example of this would be statements concerning the role of the family in the etiology of mental illness.

A number of statements that attributed psychological disorder to family background (e.g., "Mental patients come from homes where the parents took little interest in their children.") were rated as unhealthy by the expert judges. This may represent a desire to avoid blaming the family, but is somewhat surprising given contributions of early childhood environment to psychological distress. Such items were endorsed more highly by Greek (i.e., collectivist) participants than by non-collectivist Canadians, contributing to the observed differences between cultures. Interestingly, it is likely that such beliefs (i.e.,

attributing psychological distress to family factors) could exacerbate concerns about the stigma associated with mental disorder. That is, family members might correctly expect that others in collectivist cultures will indeed stigmatize families of people with psychological disorders.

It is also possible, however, that family factors are actually more important in collectivist cultures than in individualist cultures. Given greater emphasis on positive family relationships, duty to the ingroup, and interpersonal harmony, it may be that failure in these areas produces more psychological distress than in cultures with less emphasis on collectivist values. From this perspective, the ratings of Canadian psychologists might be erroneous when applied to collectivist cultures.

Structure of Attitudes Toward Psychological Distress and Treatment

The present study also contributed some interesting findings with respect to the structure of attitudes toward psychological distress and its treatment. There was evidence for both the generality and specificity of attitudes.

One important finding was the contaminated nature of the OMIS scales. A number of items did not directly address attitude issues, including some items that were in fact originally selected from existing measures of authoritarianism. These items were shown to correlate highly with vertical collectivism (see following discussion). Any study that included such items as part of the OMIS measure would be using a contaminated measure. It would have been a clear confound, for example, in the present study, as any correlation between individualism-collectivism and attitudes could have been accounted for by these overlapping items.

With some slight modifications and exceptions, there was reasonable empirical justification for the standard scales of the OMIS and the ATSPPH. The number of participants did not permit a factor analysis of all the individual items, but separate analyses of the scales did demonstrate considerable homogeneity of the items in most cases. Nonetheless, factor analyses of the 8 scales of the OMIS and ATSPPH revealed a high degree of overlap among the various "dimensions." Two factors were found adequate to account for much of the variation among participants on the scales.

A different picture emerged, however, when the attitude scales were factor analysed with the various predictors. More specificity was demonstrated, although a single attitudinal factor did load highly on 5 of the 8 scales. Supplementary analyses revealed also that even for scales not showing overall differences among groups (e.g., Confidence in Practitioner), several items on the scales showed the expected differences.

The approach of analysing dependent and independent measures together thus proved useful in demonstrating the unique relationships between various attitude scales and the predictors and demonstrates the need for further research on the dimensionality and quality of attitudes toward psychological distress. Such research will require sufficient numbers of participants to do the kinds of item analyses that were not possible in the present study.

Measurement of Individualism and Collectivism

The present study revealed several important points about the nature of individualism-collectivism, about cultural differences on this dimension, and about some factors and measurement issues that complicate this construct. Although Individualism-

Collectivism was viewed as a bipolar characteristic in Hofstede's original work, subsequent work has identified distinct dimensions. The measure used in the present study (Triandis, 1995) conceptualized the properties associated with this construct in terms of four, putatively orthogonal, components: Vertical Collectivism, Horizontal Collectivism, Vertical Individualism, and Horizontal Individualism.

The present study provided some support for the importance of separating different aspects of individualism-collectivism. Differences in attitudes among the three groups were primarily related to differences on the Vertical Collectivism scale, a scale that measures primarily duty to the family and other in-groups. The study also found that there was no simple bipolar dimension of individualism and collectivism.

Recent research on individualism and collectivism confirms some of the complexities observed in the present study. Buda and Elsayed-Elkhouly (1998) used a measure of individualism that supported Hofstede's classification. They did not, however, include a separate measure of collectivism. Kozan and Ergin (1998) reported recent Turkish studies demonstrating that Turkish culture, which traditionally is collectivist, showed signs of both individualism and collectivism, although there was a trend towards individualism. This ambivalence was attributed to a combination of urbanization and industrialization. Kagitcibasi (1994) argued that not all dimensions of culture were equally affected by these long-term processes.

Other research has documented the malleable nature of the individualist and collectivist sense of self. Gardner, Gabriel, and Lee (1999), for example, demonstrated that independent or interdependent selves could be primed by reading a story that primed

consideration of individual or familial concerns or searching for pronouns that primed a similar distinction (e.g., searching for "I" and "mine" versus "we" and "ours"). These effects were observed in participants from both an individualist USA culture and a collectivist Hong Kong culture. Simon, Pantaleo, and Mummendey have reported similar priming effects on perceived similarity of the self to one's in-group (1995). Still others have questioned whether it is worthwhile to even use such gross categorizations as collectivist and individualist. Dien (1999), for example questions the wisdom of such gross characterizations of cultures, illustrating his point by noting the dramatically different ways in which collectivism is manifested in Chinese and Japanese culture.

Individualism-Collectivism and Authoritarianism

A second issue that emerged in the present results was the unexpected correlation between Vertical Collectivism and items related to Authoritarianism. The OMIS items that originated in measures of authoritarianism correlated quite strongly with vertical collectivism. Examination of the items showed that, in addition to the empirical correlation, the relevant OMIS items were indeed conceptually related to collectivism (e.g., #5 in Appendix 3).

Although there has been at least one study that examined the perceived conceptual relationships between collectivism and authoritarianism (Gelfand, Triandis, & Chan, 1996), this is the first study, to my knowledge, to actually measure both constructs in the same people (although inadvertently and with marginal adequacy in the case of authoritarianism). Gelfand et al. (1996) found that university students in the USA perceived constructs representative of authoritarianism (e.g., punish deviates, patriotism,

respect for established authority) as being the opposite of constructs related to individualism (e.g., choosing own goals, detachment, broadminded) and independent of collectivist concepts (e.g., honouring parents and elders, self-discipline, respect for tradition). However, some of the collectivist qualities did lie in the authoritarian region of the multidimensional space.

The Gelfand et al. (1996) study measured participants' conceptions of authoritarianism, individualism, and collectivism, and did not address directly the actual relationships among levels of these constructs in people. Irrespective of the limitations of the authoritarianism measure used in the present study, it is important to note that the conceptual overlap and the positive correlation of the authoritarianism items with vertical collectivism were sufficient to warrant incorporation of the authoritarianism items into the vertical collectivism scale. It may be then that authoritarianism and collectivism are more strongly tied than suggested by the Gelfand et al. (1996) analysis.

This is clearly a relationship that merits much deeper investigation. The dimension of authoritarianism has generally been viewed as a negative one because of its association with prejudice and discrimination (Altemeyer, 1981). No such negative connotations have attached themselves to collectivism and indeed the dimension is often promoted as a healthy correction to what is perceived as excessive individualism in many Western countries. A positive association between these traits, if confirmed by future research, should lead to greater appreciation of the potential negative consequences of extreme identification with any in-group. Other researchers have similarly noted a possible relationship between in-group identification and ethnocentrism (Perreault & Bourhis,

1999), and ethnocentrism was an important element in the early work on authoritarianism (Adorno et al., 1950).

The relationship between vertical collectivism and authoritarianism also has implications for interpretation of the cultural differences in attitudes. It may be that the more negative attitudes shown by collectivist Greeks in the present study were due to the aspects of vertical collectivism that overlap with authoritarianism, rather than to the full dimension of collectivism. A definitive answer to this question must wait upon further research on the relationships among collectivism, authoritarianism, and attitudes toward psychological distress and its treatment. That Horizontal Collectivism was positively associated with Confidence in Practitioners (see Table 10) provides further support for the importance of deeper analysis.

Caution is needed in interpreting the present findings, however. Only some of the items from the original (and dated) authoritarianism measure were used and those items showed empirical and conceptual links with vertical collectivism. It may be that collectivism has a limited degree of overlap with authoritarianism, as could be revealed by fuller measurement of the latter construct.

A plot of the separate Collectivism and Authoritarianism means mentioned in the results provided suggestive data relevant to the possible relationship between these constructs, assuming that they are not equivalent. The plot of Authoritarianism as a function of Collectivism showed few individuals who were low on collectivism and high on authoritarianism (see Figure 2). People with high scores on collectivism demonstrated a wide range of authoritarianism, including what high scores did occur on this dimension.

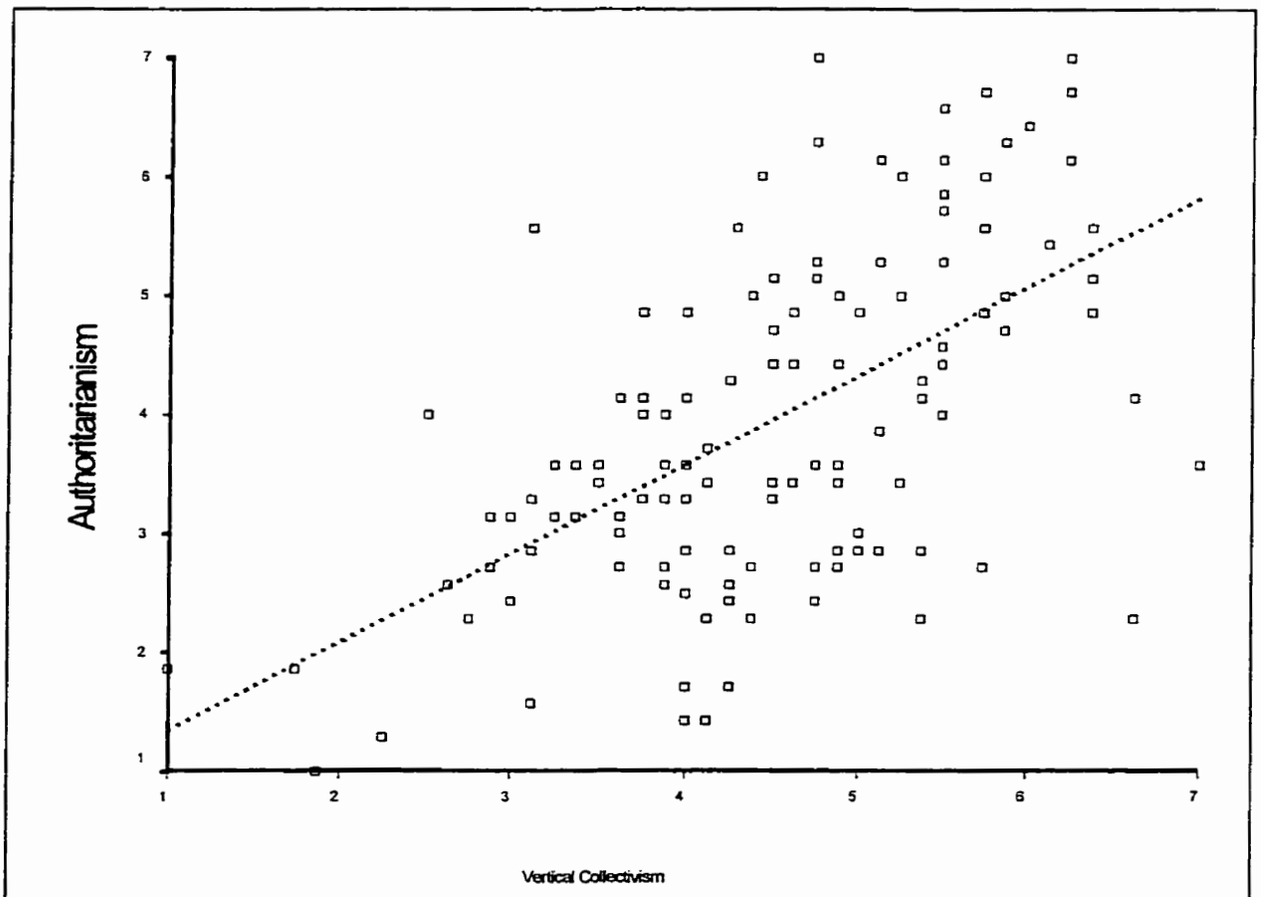

Figure 2. Relationship between Authoritarian and Vertical Collectivism items.

This pattern suggests that, within this group, collectivism is a necessary component of

authoritarianism, but not a sufficient one. That is, being low on vertical collectivism and having a weak identification with one's cultural group generally precludes being high authoritarian (i.e., rejecting out-groups), whereas being high on vertical collectivism may under some unspecified circumstances be associated with rejection of out-groups. Figure 2 also shows the best-fit regression line. The considerable variability about this line indicates that the two constructs are far from identical.

Cross-Cultural Measurement Issues

A number of basic issues related to cross-cultural measurement also became apparent during the course of this research. One under-studied issue concerns the possible role of differential response tendencies (e.g., acquiescence) in cross-cultural comparisons. That is, differences across cultures could represent differences in response biases, rather than differences on other underlying traits. The psychometric limitations of existing measures contribute to this problem. Specifically, there appears to be limited concern for measuring and avoiding these biases, for example, by having equal numbers of positive and negative worded items. Recently, greater interest has been demonstrated in the possible role of response bias (e.g., Kaiser, Katz, and Shaw, 1998).

The importance of response bias for the present study, and for most similar research, is that the Greek respondents may have been more or less susceptible to response acquiescence, presentation of a positive self, or other response sets that could produce differences across groups despite no differences in actual attitudes or values. This possibility again points to the need for more serious psychometric examination of attitudinal measures used in cross-culture research. This could involve more careful

balancing of positive and negative worded items (as was the case for the present experimental measure of Uncertainty Avoidance), inclusion of scales to measure different response sets, and careful item analyses with sufficient participants to develop purer scales (i.e., aggregate scores across multiple items that largely reflect the contribution of a single construct). Such studies will be quite challenging, especially when undertaken in a multi-language context.

With respect to response bias and collectivism, early work by Eysenck on the use of his personality scales with Greek and British children and adults (e.g., Eysenck & Dimitriou, 1984) provided some evidence that Greeks do obtain higher scores on scales measuring social desirability and other response biases. Other research, however, has failed to show evidence for response bias differences between collectivist and individualist cultures in general. Meston, Heiman, Trapnell, and Carlin (1999), for example, reported no differences in either conscious or unconscious response biases in Asian- and non-Asian-Canadians. Response bias scores were also unrelated to self-reports of childhood abuse.

A second issue that has received much attention concerns translation equivalence. The present study used a novel approach in asking bilingual raters to judge the semantic equivalence of the English and Greek versions of the statements. Sperber, Devellis, and Boehlecke (1994) also used ratings of semantic equivalence, but between original and back-translated English versions. The present approach more directly assesses the translation equivalence of the actual measures, but suffers from possible priming effects. That is, raters may have been biassed in their interpretation of statements in one language by prior exposure to the other language. The extent of such effects could be determined by

more extensive experimental work on the effects of exposure to statements in one language on interpretation of statements in another language.

A final concern related to measurement is that the study only included quantitative rating data. Some authors (e.g., Harari & Beaty, 1990) have argued that cross-cultural studies should generally include qualitative measures in order to confirm the validity of and to complement quantitative results. Although such additional data would have been ideal in the present study, practical considerations made it a challenge. Much effort was required to obtain quantitative data from sufficient numbers of participants and more-than-expected analyses, including supplementary data collection (e.g., ratings of translation equivalence, ratings of attitude quality), were required to complete the quantitative part of the research. The apparent reluctance of Greeks to complete questionnaires, let alone discuss personal attitudinal issues, also raised questions about the feasibility, representativeness, and response biasses of any qualitative results, although it may have been that Greeks would have been more amenable to verbal interactions than they were to written questionnaires, possibly a less familiar task for them.

Other Limitations and Extensions

The present study furthered our understanding about the nature and complexity of relationships among attitudes toward psychological distress, culture, and collectivism. The study suffered from a number of limitations, some of which have already been alluded to (e.g., the difficult measurement issues), but also identified some worthwhile directions for future research.

Nonequivalence of Groups

It was not possible to match exactly non-immigrant Canadians, Greek-Canadian Immigrants, and Greek Residents on age and education. As these demographic variables correlated with the primary measures, they could have contaminated comparisons across the groups. Multiple regression was used to control statistically for such confounding variables, but it would be desirable to examine more comparable participants, such as university students or other matched groups.

It was also necessary to use different methods to recruit participants in the various groups. As mentioned earlier, Non-immigrant Canadians and Greek Immigrant participants were solicited through newspaper advertisements, postings in community centers, social organizations, and church groups. As these sources did not produce a sufficiently large number of Greek-Canadian Immigrant participants, more such participants were solicited through internet sources to which Greek Immigrants (or their relatives) subscribe and from informal social networks.

Although firm statistics are not available because of the broad way in which participants were solicited, it seems quite clear that there was a lower "response rate" among Greek Immigrants than other groups. It was generally the case that any distribution of packages of questionnaires resulted in more returns from the non-immigrant Canadians. In one extreme case, distribution of 20 packages to one Greek contact, who in turn distributed them to 20 acquaintances, resulted in only one or two questionnaires being answered. If these different response rates reflect attitudes toward psychological distress

and treatment, then they would be consistent with the questionnaire results in demonstrating less positive attitudes among Greek respondents.

Any inferences about the implications of what seems like an exceptionally low response rate, however, must be speculative. Although it is possible that the Greek Immigrant respondents were, if anything, less aversive to questions related to psychological distress and treatment, and also less deterred by the size of questionnaire booklets than were nonrespondents, another possibility is that potential Greek participants were simply less familiar with or less inclined to participate in research of this kind than were non-immigrant groups. Results from Greek Residents were collected entirely through personal contacts in Greece (i.e., acquaintances who distributed questionnaires), again making it difficult to determine response rates in light of the much larger number of potential Greek respondents and the informal procedures followed.

Any artifact due to these selection factors, however, would appear to work against the differences predicted and found in the present study. It seems plausible that potential respondents who chose not to participate in the study would have even less positive attitudes than Greeks who chose to participate in the study, knowing full well the nature of the questions and issues being addressed. For subject selection to have produced the present differences between cultural groups, the higher degree of selection for Greeks would have had to produce Greek samples with more negative attitudes than the less-selective non-immigrant Canadians.

Differential selection, as observed here, may also be an intrinsic feature of research on groups with strikingly different attitudes towards mental health issues and their

discussion. That is, differential response rates could be observed any time one assesses some sensitive (to the potential respondent) topic. The most successful methods to recruit Greek immigrants were through the Greek church or personal contacts, perhaps because Greek culture values the in-group and authority. It might be possible to make greater use such qualities to obtain wider representation from the Greek community.

One strength of the informal and diverse procedures used in the present study was the broad range of participants included in the present study. The average age was 47.43 with a standard deviation of 10.90, and education and income levels varied widely. Demographically, this is a much more representative group of people than the typical university student sample; hence the findings might be more generalizable than if they had been obtained with narrowly defined groups of participants. Nonetheless, it would be worthwhile to replicate the study using more comparable sources for the various groups (e.g., university students in Canada and Greece) and, if possible, with groups that were less susceptible to self-selection factors.

Modification of Attitudes

Another direction for future research is to examine ways in which attitudes toward psychological distress and treatment can be ameliorated. Moreover, such efforts might be more effective if cultural differences in attitudes and values are taken into consideration.

In a pilot study done independently of this thesis, performed in collaboration with Karen Dyck of Health Sciences Center, we have shown that attitudes toward psychological disorder and treatment improved significantly following exposure to a 30-minute video on psychological disorders. That study used the same attitude measures as

the present study. Although the results are limited by the absence of a necessary control group, they do show some evidence that attitudes might be modified with quite brief interventions. This is consistent with evidence that negative attitudes are often associated with a lack of information about and experience with psychological disorders.

The dimension of collectivism has a number of implications for how attitudes might best be modified in different cultural groups. One possibility is to take advantage of the values associated with collectivist cultures. One way to do that would be to make appeals to seeking treatment for the family's sake, in order to better fulfill one's social responsibility. This hypothesis is consistent with some research on the relationship between culture and attitude change. Han and Shavitt (1994) found that Americans were persuaded more by advertisements that stressed independence (e.g., an ad for shoes said "It is easy when you have the right shoes"), whereas Koreans were more persuaded by advertisements that emphasized interdependence (e.g., "The shoes for your family"). Analysis of actual advertisements also showed that American ads emphasized individuality and self-improvement, and Korean advertisements tended to emphasize family, concern for others, and benefits for one's social group.

In appealing to collectivist motives, the demonstrated role of cognitive dissonance in attitude change (Eagly & Chaiken, 1993) could also be exploited. That is, recipients could be informed about the incongruity between their concern about other family members and their failure to take the steps necessary to remediate a psychological difficulty that is causing distress in others (as well as themselves). Whether the source of persuasive messages is an in-group or out-group member has also been found to influence

attitude change (Petty & Wegener, 1998). It seems possible that this factor could interact with individualism-collectivism, with collectivist recipients being more sensitive to this dimension. Self-monitoring is another relevant personality characteristic that has been related to attitude change (Petty & Wegener, 1998). High self-monitors are more sensitive to cues that suggest socially appropriate behaviour, whereas low self-monitors are more dependent on their internal beliefs and values. Low self-monitors may be more sensitive to dissonance effects. High self-monitors to appeals to status and societal image. Self-monitoring appears to be a characteristic that could be related to collectivism, perhaps with collectivist people being more sensitive to social cues.

The tentative relationship between collectivism and authoritarianism also has implications for attitude change. One hypothesis about attitude change with people who have authoritarian values would be that such people might be more influenced by a communication source who has a high degree of authority. Consistent with this hypothesis, people who score high on dogmatism, a construct that overlaps with authoritarianism, appear to be especially vulnerable to persuasion by high status sources (Eagly & Chaiken, 1993). In the case of Greeks, for example, messages might be constructed using figures respected in that culture (e.g., Greek Orthodox priests, in-group spokespersons). Having highly respected individuals within the Greek community acknowledge their personal experiences with psychological distress and treatment might be expected to have an even more profound influence in a collectivist culture than in an individualist culture.

Regarding attitude change in immigrant groups, researchers should study more closely the acculturation process, and determine to what extent and how mental health attitudes become more like those of the dominant culture (if indeed they do). Factors that could influence modification of mental health attitudes include residency duration, family influences, residential area, and the need to form relationships with members of the dominant culture for either professional or social purposes. At least in the present study, one potential equalizing factor, education, did not interact with culture in terms of its effect on attitude towards psychological distress and treatment.

Extension to Other Cultures

No study with just two or even several cultures can adequately address the many methodological issues that complicate interpretation of differences or non-differences. Ultimately, it would be desirable to obtain results analogous to those here on multiple cultures. That is, refinements of the present methods for the cross-cultural study of perceptions of psychological distress and its treatment could be applied to other cultures varying on individualism-collectivism and other important dimensions of culture. Obtaining data from multiple cultures will permit more sophisticated statistical analyses that could allow stronger conclusions about the causal factors underlying the observed differences.

Historically, multiple culture studies have involved considerable expense and complexity, because participants must be solicited in multiple countries. The increasing multi-cultural nature of countries like Canada make such studies more manageable, although complications do remain (e.g., reluctance of some groups to participate in studies

on certain topics). But even studies involving a few cultures, such as the present one, make it feasible to eventually answer subtle questions by meta-analytic methods that combine results from different studies. Such work would be facilitated by the development of standard measurement instruments for attitudes toward psychological distress and treatment, individualism and collectivism, uncertainty avoidance, and other relevant qualities (e.g., authoritarianism). Any such work should consider the relevance of the measurement issues discussed previously.

Such understanding ultimately will facilitate the use of psychological services by such culturally-diverse populations as immigrant groups. But clearly much additional research is needed to address these difficulties and to develop further the proposed model.

Clinical Implications of Individualism-Collectivism

The present study has documented cultural differences on attitudes toward psychological distress and treatment, and has provided some evidence that collectivism (or closely related characteristics) may contribute to these differences. A basic premise of the present study was that understanding attitudes toward psychological distress and its treatment would ultimately facilitate the use of psychological services by immigrants and other culturally-diverse populations as, as well as the development of culturally-sensitive therapeutic practices. As cited in the introduction, other research has shown additional clinical implications of these differential attitudes. Moreover, differences in degree of collectivism have potential implications for much more than just attitudes toward psychological distress and treatment. Various aspects of clinical practice are likely to be affected by differences in individualism-collectivism, perhaps only in part because of

different attitudes. Here I examine briefly some of the clinical implications of the present work.

Use of Mainstream Psychological Services

The present study has confirmed some strong cultural differences in beliefs about the causes and treatability of psychological distress, the appropriateness of discussing such issues with outsiders, and similar matters related to help-seeking. Given the confirmed predictions, one direction for future research would be to examine ways of changing negative perceptions of psychological distress and its treatment, and to determine whether changes in attitudes are accompanied by corresponding changes in use of psychological services. General education can be expected to have some positive effects, although the magnitude of cultural differences were unaffected in the present study.

One important implication of the present study is that it may be necessary to target messages to particular cultural groups. People from collectivist cultures, for example, might benefit from the message that talking to a mental health professional is not a betrayal of the family and would be expected to have beneficial effects for the family as a whole.

Special attention could also be paid to how attitudes originally develop. Longitudinal and cross-sectional studies may be needed to identify the process by which children develop positive or negative mental health attitudes. Individualism-collectivism has strong links with family processes (e.g., Georgas, Christakopoulou, Poortinga, Angleitner, Goodwin, & Charalambous, 1997) and could provide specific direction for future research. For example, research could examine how processes that strengthen

concern for the family unit and the ingroup might produce the possibly undesirable side effects observed here (i.e., negative images of seeking psychological help). Knowledge about these underlying processes could then provide the bases for programs designed to prevent the development of negative attitudes.

Research should also examine more closely some of the societal factors that influence mental health attitudes, and determine whether these factors are stronger or weaker in different cultures. For example, it may be important to examine how portrayals of mental illness in the media and deinstitutionalization (i.e., more direct experience) affect the mental health attitudes of the public. Much is known about the portrayal of psychiatric disorders in the media (e.g., McIlwraith, 1987; Wahl, 1995), but there appears to be little work with cross-cultural comparisons.

Individualism-Collectivism and Therapy

The present study has confirmed some predicted differences with respect to factors that could be capitalized on in developing more effective culture-sensitive therapy, or other kinds of clinical services, such as community supports ((Kazarian, Joseph, & McCabe, 1996; Kazarian, McCabe, & Joseph, 1997). Individualism-collectivism in particular appears to have considerable significance for the practice of therapy. That is, individualism-collectivism may provide a framework that can help therapists to interpret in more culturally-valid ways what might seem like significant therapeutic events. Rather than viewing a reluctance to talk as resistance, for example, therapists might examine whether cultural values, such as collectivism, provide an alternative explanation. Educating therapists about the characteristics of clients from collectivist cultures (e.g.,

reluctance to self-disclose to non-family members) may permit therapists to adopt therapeutic techniques to overcome cultural barriers to effective psychotherapy.

Although therapy is complex and there are many nominally different forms of psychotherapy, the success of most therapies appears to depend on some basic shared elements, specifically the quality of the client-therapist relationship and of therapeutic structuring (i.e., problem-solving). In one study that quantified the contribution of these factors, Alexander, Barton, Schiavo, and Parsons (1976) reported that they accounted for 60% of the measured effectivenesss of therapy. Both of these delicate processes can be influenced by client differences on individualism-collectivism, and can be made even more difficult when individualist therapists work with collectivist clients.

Many clinical writers from quite diverse theoretical backgrounds have emphasized the fundamental role of the therapeutic relationship for client progress (Frank, 1974, 1982; Goldfried, 1980; Martin, 1983; Rogers, 1957; Weinberg, 1996). A primary determinant of a positive therapeutic relationship is the ability of the therapist to convey accurate empathy. Such empathy involves listening to the client's explicit and implicit messages, imparting to the client that the therapist has listened and "understood" the message, and helping the client to recognize and articulate unclear thoughts and feelings. Establishing a close therapeutic relationship would seem to be more difficult when the client and the therapist originate from different cultural backgrounds.

An understanding of the client's subjective experience is fundamental to accurate empathy. Martin (1983) has noted that it is virtually impossible for one person to know what it is like to be another person. This difficulty is exacerbated when people come from

different cultural backgrounds and consequently, have different life experiences, values, and attitudes. That differences in culture can complicate many aspects of the client-therapist relationship has been noted by many mental health professionals (Bulhan, 1985; Carkhuff & Pierce, 1967; Ruiz & Padilla, 1977; S. Sue, Ito, & Bradshaw, 1982; Trimble, 1981; Vontress, 1971). A therapist from an individualist culture, for example, may have difficulty appreciating the importance of family to a client from a collectivist culture.

As mentioned earlier, therapists often use successive approximations in order to achieve accurate empathy, especially when misunderstandings are anticipated. This method may be implemented less successfully with clients from collectivist cultures who will avoid interpersonal conflict and would therefore be reluctant to provide the necessary corrective feedback. In a cross-cultural context, therapists may have to take exceptional steps (e.g., double-checking, repeating questions, asking for paraphrases) to ensure that their reflections are accurate.

Relationship factors are also important for the self-exploration that occurs as the client is encouraged to express and examine feelings and thoughts. Clients from collectivist cultures often demonstrate resistance to such self-exploration and insight approaches (D. W. Sue & Sue, 1990). Many non-Western clients see no purpose in talking about their problems (S. Sue & Zane, 1987). Indeed, Lum (1982) reported that Asian elders advise their children to "not think about it" when they experienced frustration, anxiety, depression, and other negative emotions. The elders believe that people may continue to experience such emotions when they think about their problems too much. Self-

exploration is discouraged in part because it focuses on the individual rather than on the family or other social group valued in collectivist cultures.

A related difficulty with the standard Western approach to therapy is its emphasis on self-disclosure. Self-disclosure is viewed as a primary characteristic of a healthy personality (Jourrard, 1964) and also as a major tool for effective therapy. Not all cultural groups share this orientation towards self-disclosure, however, and members of collectivist cultures may view self-disclosure as appropriate only within the contexts of the family or life-long friendships. Thus, collectivist cultures may discourage disclosure of personal difficulties because such difficulties reflect not only on the individual but also on the entire family, Therefore, the family may exert pressure on the Asian-American (D. W. Sue & Sue, 1990), Hispanic (Laval, Gomez, & Ruiz, 1983), and the Native-American (Everett, Proctor, & Cortmell, 1983) not to reveal intimate aspects of life. In the case of Black clients, Calia (1966) suggested that therapists use an externally focused as opposed to an intra-psychic approach. Others have recommended a de-emphasis of methods based on introspection and self-disclosure with Philipino (Ponce, 1974) and Hispanic (Cortese, 1979) clients, both collectivist cultures.

A second component of effective therapy is effective structuring, which involves conceptualizing the problem, developing specific goals, and determining an action plan (Frank, 1974, 1982; Strupp, 1983). In standard Western therapies, especially those following a person-centered approach, the basic elements of structuring and problem-solving are also very much client-driven processes. These processes can be complicated by cultural differences between clients and therapists. The conceptualization of the problem

proposed by the therapist may be culturally biassed and therefore inappropriate. The individualist orientation of North American society emphasizes competition, individual responsibility, and personal identity (Pedersen, 1987, 1988). Many non-Western cultures, however, have a collectivistic orientation that emphasizes cooperative goals, concern for others, and group identity. For example, the personal pronoun "I" does not seem to exist in the Japanese language, and the concept of "atman" in India, which is defined as union with all things physical and spiritual, has no comparable term in many languages (D. W. Sue & Sue, 1990). In many non-Western cultures, the primary psychosocial unit is the family, group, or collective society. Traditional Asian-American cultures, for example, define a person's identity in terms of the family unit (S. Sue & Morishima, 1982). The individualist-collectivist contrast is shown clearly by different greetings in Western society (i.e., "How are you today?") and in traditional Asian-American and Hispanic cultures (i.e., "How is your family today?") (D. W. Sue & Sue, 1990).

Differences between individualistic and collective world-views can complicate conceptualization of client problems and appropriate courses of action. For example, Western therapists may view traditional Asian clients as "dependent, unable to make decisions on their own, and lacking in maturity" (D. W. Sue & Sue, 1990, p. 36). However, the behavior of these clients may represent the Asian value of consultation with family members before making decisions, rather than immaturity or dependency. Misattributing the behavior to dependency may lead therapists to propose inappropriate interventions, such as assertiveness training.

The standard Western form of therapy is relatively indirect, with the therapist encouraging clients to discover solutions to their problems. Other cultural groups may prefer different therapy styles (S. Sue, 1977; D. W. Sue, 1981). The literature on cross-cultural therapy indicates that clients from Native-American, Asian-American, Hispanic-American, African-American, and other collectivist cultures often favour a more active and directive therapy style, rather than the non-directive, person-centered approach (Pedersen, Draguns, Lonner, & Trimble, 1981; Ruiz & Ruiz, 1983; D. W. Sue, 1981; D. W. Sue & Sue, 1990; Trimble, 1981; Vontress, 1981). Therapists from individualistic cultures often perceive a client's request for advice as a sign of dependency or immaturity.

It has been suggested that structure, guidance, an action-orientation, and direction, rather than non-directiveness and self-disclosure (i.e., an authoritative rather than egalitarian style), are preferred for client-therapist interactions with various collectivist cultures: Asian-American (Atkinson, Maruyama, & Matsui, 1978; Henkin, 1985; Mau & Jepson, 1988), Philippino-American (Ponce, 1974), Hispanic (Cortese, 1979; Meadow, 1982), and Black (Calia, 1966). Atkinson et al. (1978), for example, found that Asian-American students rated a directive therapist more credible and approachable than a non-directive therapist in two tape recordings of a contrived session. Structured interactions are consistent with the culturally-determined view of helping and other relationships. In the collectivist Hispanic culture, for example, clients may have been reared with structured social relationships and interaction patterns (D. W. Sue & Sue, 1990). Confusion and anxiety may occur in unstructured and ambiguous client-therapist interactions. See Leong (1986) for a review.

In appropriate circumstances, therapists working with collectivist clients might want to adopt indigenous approaches to treatment, a number of which make more sense when considered within the collectivist framework. Several indigenous therapies (e.g., Naikan, Morita) that are practiced in collectivist cultures emphasize relationships with others and reveal the underlying orientation toward collectivity. There are many indicators of a collectivist orientation in these therapies: the initial isolation, a gradual increase in interactions, responsibility for disrupting social harmony, relationships with parents, and the treatments being designed for interpersonal problems. Despite some similarities with Western therapy (e.g., relationship with sensei), the Japanese therapies appear to place a more explicit emphasis on family relationships, social responsibility, and improving interpersonal functioning. Western therapies generally focus more on individual clients and their needs and how clients can develop independence and self-reliance.

The present recommendations are consistent with observations by other clinical researchers interested in cultural issues. Kazarian and Kazarian (1998), for example, stated that culturally appropriate and effective services must address both knowledge of acculturation processes and the individual, familial, and societal factors that influence use of services, such as feelings of shame and guilt, family and community unity, ostracism, compatibility with ethnic practices, confidentiality, and family- versus individual-oriented services. They noted the fundamental importance of collectivist versus individualist orientation. Abused women, the client population on which they focussed, were largely concerned about the emphasis in Western treatment on individual versus community

rights, individual versus family treatment, and support of individual rather than family or partner.

Although the above approaches have been presented in the context of cross-cultural therapy with collectivist clients, sensitivity to collectivist (i.e., interpersonal) issues is probably appropriate in all therapeutic situations, whether they involve clients from other cultures or not. Clients within cultures vary greatly with respect to qualities related to collectivism (e.g., the extent to which obedience and honouring tradition are important, value placed on family relations). It is likely that these within-culture differences across clients have important implications for the origins, manifestation, conceptualization, and treatment of psychological disorders, and that therapist sensitivity to these issues will improve the quality and effectiveness of treatment. Such an approach would fit well with approaches that emphasize interpersonal factors in therapy (e.g., Hilliard, Henry, & Strupp, 2000).

An appreciation of individual differences is also important for therapists working with clients from collectivist backgrounds. Therapists must be sensitive to the possibility that particular clients in fact do not share the same values as their respective cultures and, hence, may not require the kinds of accommodations suggested here. Treatment must be individualized, with suitable adjustments made only under appropriate circumstances. Otherwise, stereotypical and ineffectual treatment of clients can occur.

Conclusions

In summary, non-immigrant Canadians, as predicted by an individualism-collectivism framework, held more positive attitudes toward psychological distress and

treatment than did Greek-Canadian Immigrants and Greek Residents. These differences were reduced in part when group differences on Vertical Collectivism were adjusted for statistically. The observed differences appear to have been due to the importance of obedience and in-group responsibilities in collectivist cultures and to have important implications for the use and effectiveness of psychological services. The findings shed some light on the important implications of culture for clinical psychologists and identify several directions for future research, including ways to address some limitations of the present study. The value of collectivism as a general framework for thinking about cultural and other individual differences in therapy was explored.

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Appendix 1

Opinions About Mental Illness Scale (OMIS) Items

Authoritarian Attitude 13 items

2. Mental illness is an illness like any other.

6. It is easy to recognize someone who once had a serious mental illness. [-]

7. People who are mentally ill let their emotions control them; normal people think things out. [-]

9. When a person has a problem or a worry, it is best not to think about it, but to keep busy with more pleasant things. [-]

11. There is something about mental patients that makes it easy to tell them from normal people. [-]

15. People would not become mentally ill if they avoided bad thoughts. [-]

19. A heart patient has just one thing wrong with them, while a mentally ill person is completely different from other patients. [-]

27. Many mental patients are capable of skilled labour, even though in some ways they are very disturbed mentally.

36. Every mental hospital should be surrounded by a high fence and guards. [-]

39. Mental illness is usually caused by some disease of the nervous system. [-]

43. College professors are more likely to become mentally ill than are businessmen. [-]

46. Sometimes mental illness is punishment for bad deeds. [-]

49. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well-fed. [-]

Interpersonal Aetiology (9 items)

1. Mental patients come from homes where the parents took little interest in their children. [-]

10. If parents loved their children more, there would be less mental illness. [-]

12. People who are successful in their work seldom become mentally ill. [-]

14. The mental illness of many people is caused by the separation or divorce of their parents during childhood. [-]

22. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill. [-]

30. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill. [-]

48. One of the main causes of mental illness is a lack of moral strength or will power. [-]

57. Although they are usually not aware of it, many people become mentally ill to avoid the difficult problems of everyday life. [-]

58. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for. [-]

Mental Hygiene Ideology (10 items)

18. More tax money should be spent in the care and treatment of people with severe mental illness.

20. Many patients in mental hospitals make wholesome friendships with other patients.

23. If our hospitals had enough well-trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

28. Most mental patients are willing to work.

33. The patients of mental hospitals should be allowed more privacy.

38. Nervous breakdowns usually occur when people work too hard.

44. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

47. Our mental hospitals should be organized in a way that makes the patient feel as much as possible like he is living at home.

55. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

56. The patients of a mental hospital should have something to say about the way the hospital is run.

Social Restrictiveness (17 items)

3. Most patients in mental hospitals are not dangerous.

4. Although patients discharged from mental hospitals may seem alright, they should not be allowed to marry. [-]

8. People who were once patients in mental hospitals are no more dangerous than the average citizen.

16. The small children of patients in mental hospitals should not be allowed to visit them. [-]

17. Patients in mental hospitals are in many ways like children. [-]

21. People with mental illness should never be treated in the same hospital as people with physical illness. [-]

24. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered. [-]

26. People who have been patients in a mental hospital will never be their old selves again. [-]

29. Anyone who is in a hospital for mental illness should not be allowed to vote. [-]

31. The best way to handle patients in mental hospitals is to keep them behind locked doors. [-]

32. To become a patient in a mental hospital is to become a failure in life. [-]

37. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe problem. [-]

40. Regardless of how you look at it, patients with severe mental illness are no longer really human. [-]

41. Most women who were once patients in a mental hospital could be trusted as baby-sitters.

42. Most patients in mental hospitals don't care how they look. [-]

45. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill. [-]

51. All patients in mental hospitals should be prevented from having children by a painless operation. [-]

Appendix 2

Attitudes Toward Seeking Professional Psychological Help (ATSPPH) Items

Recognition of Need for Psychotherapeutic Help

62. A person with a strong character can get over mental conflicts by himself or herself, and would have little need of a psychiatrist. [-]

63. There are times when I felt completely lost and would have welcomed professional advice for a personal or emotional problem.

64. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. [-]

67. Emotional difficulties, like many things, tend to work out by themselves. [-]

76. I would want to get psychiatric attention if I was worried or upset for a long period of time.

82. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts or fears without resorting to professional help. [-]

83. At some future time, I might want to have psychological counselling.

84. A person should work out his or her own problems; getting psychological counselling would be a last resort. [-]

Stigma Tolerance

61. I would feel uneasy going to a psychiatrist because of what some people would think. [-]

72. Having been a psychiatric patient is a blot on a person's life. [-]

78. Having been mentally ill carries with it a burden of shame. [-]

85. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."

86. If I thought I needed psychiatric help, I would get it no matter who knew about it.

Interpersonal Openness

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

68. There are certain problems which should not be discussed outside of one's immediate family. [-]

71. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns. [-]

75. I resent a person - professionally trained or not - who wants to know about my personal difficulties. [-]

79. There are experiences in my life I would not discuss with anyone. [-]

80. It is probably best not to know everything about oneself. [-]

87. It is difficult to talk about personal affairs with highly educated people, such as doctors, teachers, and clergymen. [-]

Confidence in Mental Health Practitioner

59. Although there are clinics for people with mental troubles, I would not have much faith in them. [-]

60. If a good friend asked my advice about a mental problem, I might recommend that he or she see a psychiatrist.

66. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment. [-]

69. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.

70. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

73. I would rather be advised by a close friend than by a psychologist, even for an emotional problem. [-]

74. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

77. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. [-]

81. 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.

Appendix 3

Individualism - Collectivism Items

(Triandis, 1995)

Vertical Collectivism (plus 7 items from OMIS 5, 13, 25, 34, 52, 53, 54)

90. I would do what would please my family, even if I detested that activity.

94. I usually sacrifice my self-interests for the benefit of my group.

100. We should keep our aging parents with us at home.

104. Children should feel honored if their parents receive a distinguished award.

111. I would sacrifice an activity that I enjoy very much if my family did not approve of it.

114. Children should be taught to place duty before pleasure.

116. I hate to disagree with others in my group.

118. Before taking a major trip, I consult with most members of my family and many friends.

5. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents.

13. Obedience and respect for authority are the most important virtues children should learn.

25. If people would talk less and work more, everybody would be better off.

34. Every person should make a strong attempt to raise his social position.

52. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

53. Anyone who tries hard to better himself deserves the respect of others.

54. A person who has had bad manners, habits, and breeding can hardly expect to get along with decent people.

Horizontal Collectivism

89. My happiness depends very much on the happiness of those around me.

96. It is important for me to maintain harmony within my group.

98. I like sharing little things with my neighbours.

101. The well-being of my coworkers is important to me.

103. If a relative were in financial difficulty, I would help within my means.

107. If a coworker gets a prize, I would feel proud.

109. To me, pleasure is spending time with others.

115. I feel good when I cooperate with others.

Vertical Individualism

91. Winning is everything.

95. It annoys me when other people perform better than I do.

97. It is important that I do my job better than others.

99. I enjoy working in situations involving competition with others.

106. Competition is the law of nature.

110. When another person does better than I do, I get tense and aroused.

113. Without competition, it is not possible to have a good society.

117. Some people emphasize winnning; I'm not one of them. [-]

Horizontal Individualism

88. I prefer to be direct and forthright when I talk with people.

92. One should live one's life independently of others.

93. What happens to me is my own doing.

102. I enjoy being unique and different from others in many ways.

105. I often do "my own thing."

108. I am a unique individual.

112. I like my privacy.

119. When I succeed, it is usually because of my abilities.

Appendix 4

Uncertainty Avoidance Items

Items Retained

120. I would feel nervous or tense working in ambiguous circumstances.

122. I would not like changing jobs on a regular basis.

123. I prefer structured learning situations that have specific expectations and require definite correct answers.

124. Most groups (e.g., families, organizations) would be better off if conflicts could be eliminated forever.

125. It is acceptable for authority figures to respond "I don't know" to a question. [-]

126. If you want a competent person to do a job properly, it is often best to provide him or her with very precise instructions on how to do it.

129. I would enjoy living for an extended time in a different country. [-]

130. New and different ideas or ways of doing things are often dangerous.

132. Having rules helps society to operate well.

133. Parents should teach their children clear guidelines for appropriate behavior.

135. Generally, people should associate with and marry members of their own culture.

137. I prefer to socialize with friends who I know well.

139. I dislike it when people don't say what they mean clearly.

140. I am comfortable working in new and different situations. [-]

141. Rules should not be broken even when people think that it is in everyone's best interest.

142. I would enjoy the excitement of a new job. [-]

144. Conflicts in groups are not necessarily harmful. [-]

145. Parents, teachers, managers, and other authority figures should have at hand precise answers to most of the questions that may be asked of them.

149. I would dislike living in a foreign country with different traditions and habits.

151. I prefer to know what the future holds, so that I can plan ahead.

154. It is better to have rules that don't work than no rules at all.

155. It is desirable for people to have friends from different cultures. [-]

156. People should stand up for traditional values and ways of doing things.

158. I worry about not doing well when I try new things.

Items Eliminated

121. It is acceptable for people to avoid rules they do not like. [-]

127. Even complex organizations can operate well without elaborate rules and descriptions of people's duties. [-]

128. I would dislike a job in which I had to report to two direct bosses. [-]

131. I would be happy to live day by day, not knowing what tomorrow might bring. [-]

134. Rules that are not effective should be changed.

136. Experimenting with new beliefs and manners helps a person to mature. [-]

138. Usually I expect to succeed when I try something for the first time. [-]

143. I would like open-ended learning situations with vague objectives, broad assignments, and no timetables at all. [-]

146. Qualified people do not require much or any direction in performing a new job. [-]

147. When the respective roles of the members of any organization become complex, detailed job descriptions are a useful way of clarifying.

148. Working for different managers in a company would make the job interesting. [-]

150. Societal progress generally results from radical new ideas. [-]

152. There should be as few rules as possible. [-]

153. Parents should avoid strict regulation of behavior in their children. [-]

157. Meeting new and different people gives me pleasure. [-]

159. Ambiguous statements simply make me try harder to understand. [-]

Appendix 5

Background Questionnaire **Page 1**

Name: _____

Sex: ____ Male ____ Female

Age (in years): ____

What is the highest education level that you have achieved?

____ Less than elementary
____ Elementary School
____ High School
____ Some post-secondary (college or university)
____ First post-secondary degree or diploma
____ Graduate degree

Occupation: _____

What is your approximate family income?

____ less than $10,000
____ $10,000-19,999
____ $20,000-29,999
____ $30,000-49,999
____ $50,000-99,999
____ $100,000 or more

Identify all people living in your household on a regular basis (e.g., father, daughter, daughter, husband).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What is your marital status:

____ Never married
____ Married (or equivalent)
____ Divorced/Separated
____ Widowed

What country were you born in? _____

Background Questionnaire **Page 2**

What do you see as your primary cultural or ethnic background (from strongest to weakest)?

1. _____
2. _____
3. _____
4. _____

What language(s) is/are spoken in your home (from most to least used)?

1. _____
2. _____
3. _____
4. _____

What is your religious affiliation? _____

Complete your family tree indicating the country of birth of each person specified.

You: _____

Spouse: _____

Mother: _____

Father: _____

Mother's Mother: _____

Mother's Father: _____

Father's Mother: _____

Father's Father: _____

In which countries have you lived and for how many years in each?

Country	Number of Years
Canada	_____
_____	_____
_____	_____
_____	_____
_____	_____

Appendix 6

Consent Form

If you agree to participate in my study on attitudes toward psychological distress and its treatment, you will complete a background information questionnaire and a questionnaire about psychological issues. Your involvement will take approximately one hour of your time.

Your participation is completely voluntary, and you are free to refuse or stop at any time. All information will be number coded and kept strictly confidential. Your identity will be known only by me (the researcher), Anastasia Barbopoulos.

If you have any questions, please feel free to call me collect at (204) 989-2412. If you agree to participate in the study, please sign below and return this consent form and the completed questionnaires in the envelope provided.

Signature: _____

Date: _____

Phone: (____)_____

Mailing Address: _____

_____

_____

Appendix 7

Feedback Sheet

Participant Feedback:

Implications of Culture for

Perceptions of Psychological Distress and its Treatment

Dear Participant

I wish to thank you for participating in the present study. The primary purpose of the present study is to examine the relationship between culture and perceptions of psychological distress and its treatment. Cultures differ from one another in many ways, and one primary difference is in terms of a dimension called Individualism-Collectivism (Triandis, 1995). Individualist cultures tend to emphasize independence and the individual self, whereas collectivist cultures tend to emphasize shared responsibility and the social group. Previous research (Hofstede, 1980) suggests that Greeks are more collectivist, whereas Canadians in general are more individualist. The present study compared Greek immigrants to Canadians with a non-Greek background. Some of the questions to which you responded measured individualism-collectivism.

Other questions attempted to determine your attitudes about psychological distress and its treatment (e.g., who you would seek help from, impact of psychological distress on the family). I predict that perceptions will differ between the two groups (i.e., Greek immigrants and Canadians with a non-Greek background). For example, Greeks, being more collectivist, may be more concerned about the impact of psychological distress on the family and may therefore be more reluctant to seek professional help or may be more likely to seek help from family sources. Ultimately I hope that this research will help us to understand how culture influences the use and effectiveness of psychotherapy, so that

psychological services can be made more appropriate and more effective for everyone, irrespective of their cultural background.

Sometimes answering questions about psychological distress can itself be distressing. If you have any lingering worries aroused by the present study, please do not hesitate to call me at (204) 989-2412. Again, thank you very much for your contribution to this research and to the improvement of psychological services for all Canadians. If you know Greek immigrants who may be willing to participate in this study, please give them my name and phone number so that they can contact me.

Anastasia Barbopoulos, MA (204) 989-2412

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References

Hofstede, G. (1980). Culture's consequences: International differences in work-related values. London: Sage.

Triandis, H. C. (1995). Individualism and collectivism. Boulder, CO: Wakefield.

Appendix 8

Instructions for Rating Quality of Attitude Statements

On the following pages are a number of statements that describe attitudes related to psychological distress and its treatment. Your task is to rate each attitude statement as to whether it represents a positive or negative attitude toward psychological distress and its treatment. Positive attitudes are defined as those that would help people to recognize and cope effectively with psychological distress, including seeking professional treatment when appropriate. Negative attitudes are those that would prevent people from recognizing and coping effectively with psychological distress, and could even prevent people from seeking professional treatment when needed.

Read each statement carefully and use the following scale to indicate the degree to which you think that the described attitude would be positive or negative. If you feel that the attitude is definitely positive, then enter a 6 or 7 in the appropriate space on the answer sheet. If you feel that the attitude is definitely negative, then enter a 1 or 2 in the appropriate space. If you are unsure whether an attitude would be positive or negative, or believe that its helpfulness could vary across people, then enter a neutral score of 4. Please express your frank opinion in rating the statements. There are no wrong answers, and the only right ones are whatever you honestly feel or believe about how positive or negative the attitudes would be. It is important that you answer every item, so please give a rating for each item.

Quality of Attitude

Definitely Negative Definitely Positive

1 2 3 4 5 6 7

Appendix 9

Correlation Matrix and Descriptive Statistics (N = 129)

	OMAUTH	OMINTE	OMSOCI	RECNEE	INTOPE	STITOL	CONPRA	OMMENT	C1	C2	VC	HC	VI	HI	UNC	EDUC	GEND	AGE
OMINTE	.799																	
OMSOCI	.773	.672																
RECNEE	.504	.473	.473															
INTOPE	.553	.440	.534	.483														
STITOL	.336	.280	.442	.298	.426													
CONPRA	.161	.109	.115	.529	.300	.220												
OMMENT	-.242	-.330	-.156	-.059	-.233	-.005	.178											
C1	-.639	-.604	-.551	-.373	-.437	-.141	-.161	.272										
C2	-.031	-.094	-.095	.053	.102	-.014	-.030	.201	-.177									
VC	-.682	-.591	-.658	-.437	-.538	-.324	-.098	.281	.533	-.186								
HC	-.298	-.357	-.210	-.107	-.121	.047	.269	.246	.321	-.084	.416							
VI	-.478	-.369	-.479	-.252	-.453	-.477	-.188	.209	.327	-.156	.573	-.008						
HI	.064	.123	-.062	.098	-.068	-.038	.152	-.032	-.112	-.009	.050	.128	.088					
UNC	-.682	-.578	-.604	-.379	-.572	-.297	-.130	.166	.604	-.156	.675	.274	.450	-.050				
EDUC	.587	.408	.460	.491	.481	.149	.151	-.104	-.404	.024	-.421	-.209	-.193	.171	-.547			
GEND	.075	.038	.033	.195	.092	.138	.060	.077	-.085	.140	-.096	.054	-.192	.124	-.096	.058		
AGE	-.225	-.165	-.097	-.283	-.220	-.054	.013	.116	.031	-.186	.222	.063	.119	-.189	.186	-.314	-.129	
Means	4.89	4.43	4.89	4.46	4.80	4.95	5.07	4.98	.09	-.14	4.25	5.80	3.41	5.12	4.25	3.95	1.58	47.43
Sds	1.20	1.43	1.18	1.25	1.29	1.28	1.13	.87	1.00	.73	1.15	.74	1.15	.92	.87	1.40	.50	10.77

Appendix 10

Reliability Analyses for Vertical Collectivism Items (alpha = .840)

Item Number	Corrected Item-Total rs	Unrotated Factor Loadings
Eight Original Vertical Collectivism Items		
90	.556	.623
94	.300	.363
100	.454	.553
104	.492	.589
111	.383	.442
114	.598	.692
116	.404	.471
118	.233	.307
Seven New OMIS Authoritarianism Items		
5	.653	.751
13	.640	.734
25	.510	.616
52	.463	.555
54	.409	.519
34	.624	.719
53	.252	.321

Appendix 11

Preliminary Factor Analyses of Criterion Measures

Opinions About Mental Illness Scale

Scale	Factor Loading
Authoritarian	.929
Interpersonal	.908
Mental Hygiene Ideology	-.411
Social Restrictiveness	.866
h^2	.652

Attitudes Toward Seeking Professional Psychological Help

Scale	Factor Loading
Recognition of Need	.814
Stigma Tolerance	.765
Interpersonal Openness	.634
Confidence in Practitioner	.701
h^2	.535

Appendix 12

Similarity of Meaning Instructions

The following booklet contains 159 statements, presented once in Greek and once in English. Your task is to read the corresponding statements in Greek and English (e.g., the two statements numbered 1) and rate the similarity of their meanings using a 7-point scale. If the two statements mean basically the same thing to you, then give them a high rating of 6 or 7. If the two statements mean quite different things to you, then give them a low rating of 1 or 2. Use intermediate ratings of 3 to 5 for similarities of meaning that fall between these extremes. Write your ratings on the answer sheet provided.

The rating scale you are to use is shown below and also appears on the answer sheet. There are no correct answers; simply record a number that indicates how similar you find the meanings of the corresponding Greek and English statements. Feel free to refer back to these instructions at any time.

How Similar in Meaning are the English and Greek Statements?

Not at All Somewhat Extremely

1 2 3 4 5 6 7