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Attitudes Toward Seeking Counseling of Women Residing in Public Housing

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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Belinda Newkirk

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Walden University
2021

Abstract

Attitudes Toward Seeking Counseling of Women Residing in Public Housing

by

Belinda Newkirk

MA, Liberty University, 2007

BS, East Carolina University, 2001

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2021

Abstract

Women living in public housing projects experience adverse outcomes because they do not seek treatment for mental illness. It is unclear whether such women have attitudes toward voluntarily accessing mental healthcare services affected by their optimism, experienced stigma, self-efficacy, and resilience. The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing based on the self-efficacy, resilience, stigma, optimism, and help-seeking behavior theories. The first research question focused on bivariate correlations among resilience, self-efficacy, experienced stigma, and optimism among women residing in public housing projects. The second research questions focused on how well resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking treatment. Data were collected from 116 women above 18 years old from the Greenville Housing Authority. Openness to Seeking Treatment Scale scores positively correlated to self-efficacy, optimism, and resilience. Openness to Seeking Treatment Scale scores were negatively correlated with Value/Need in Seeking Treatment Scale and Experienced Stigma Scale scores. Self-Efficacy Scale scores were the only statistically significant predictors. For the Value and Need in Seeking Treatment Scale, Self-Efficacy Scale and Optimism Scale scores were statistically significant predictors of the dependent variable. Clinicians can use the findings to increase understandings and develop better programs, offering social implications.

Attitudes Toward Seeking Counseling of Women Residing in Public Housing

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Dedication

I would like to start by thanking God because throughout this journey he has carried me through some of the hardest times in my life. I remember when I started the program I went through a divorce leaving me as a single parent of three children; two of whom where babies. My ex-husband decided not to be involved and didn't provide any monetary nor parental support. I later had unexpected emergency surgery that nearly killed me. For nearly three years my baby boy was in and out of ICU. Internally I was a total wreck; I worked, went to school, and parented full time. There were many times I was stressed and overwhelmed but was determined not to give up. During my first residency in Atlanta, I couldn't hold things in any longer and I burst into uncontrollable tears and couldn't stop crying. One of the professors came to me and kindly said, "You can leave for the rest of the day to get yourself together". At that moment I made up my mind it was too much and I was going to quit and go home. A still voice inside of me said, "the race isn't given to the swift; it's given to those who endure. I then remember someone telling me that, "You can look at a half glass of water as half full or half empty; its' all about your perspective". At that moment I thanked God for my mother, Elisabeth Newkirk, praying and encouraging me, telling me how proud she was of me, and most importantly embedding the word of God in me. I could also hear my dad's voice, Dewiit, Newkirk, saying, "You can do it if you want to it's all up to you". I decided to stay and slow the pace. I also recall some great family and friends that I specifically remember encouraging me through my entire process, you know who you are! This study is dedicated to you all and especially my children. I want to especially thank my oldest son Quadariis Newkirk who has been with me through every degree that I have achieved

from getting my high school diploma, as a teen mom, to now my doctorate. It's because of Quadariis believing in me, being humbleness, encouraging me, love and support with his siblings that I strived to push forward to achieve my goal. To my youngest children, Zaniya and Sean Scott for loving mommy no matter what through all the hard times. To my additional son's Isael Savage and Malcolm Cook, mama made it and I love and appreciate all my children with all my heart. To Grady Hailey who came in during the last couple years of my dissertation showed me how I should be loved, became dad to my children, encourager, and supporter who believed in me no matter the circumstance. To all my family and friends who supported and prayed for me throughout this journey, thank you.

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First I would like to express sincere gratitude to my dissertation chair, Dr. Geneva Gray for motivating me, pushing me to get things done, for understanding when times were difficult, and helping to keep me on track. I would also like to give a special acknowledgment to my methodologist, Dr. Sandra Harris for her continuous support throughout my entire dissertation process. I thank her for going above and beyond to assist me on my journey. Her guidance was the driving force that got me through my dissertation. The process was challenging but I have grown in so many ways from working with her.

I also give a sincere thanks to all my Walden professors and academic advisors that worked with my along the way. Thank you to everyone that provided pivotal support, encouragement, and took interest in my success to complete my doctoral degree.

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Chapter 1: Introduction to the Study

Women make up about 75% of households living in public housing developments. In addition, women make up about 75% of households receiving Section 8 Project-Based Rental Assistance. Women lead about 83% of households part of the Section 8 Housing Choice Voucher Program (Quets, 2016). One reason for the prevalence of households led by women living in public housing options, especially those with children, is that more women live in poverty compared to men, as reported Berlan and Harwood (2018). For example, Quets (2016) reported that in 2013, 14.5% of adult women lived in poverty, while the percentage was only at 1% for adult men. As noted by Berlan and Harwood (2018), even though women make up approximately 50% of the national workforce, they work more in the low-paying domestic, healthcare, and hospitality jobs. Women comprised 60% of the minimum-wage workforce, and an astounding 73% of the workforce surviving on tips (Quets, 2016).

Researchers have revealed that individuals in public housing tend to experience greater health disparities than individuals living in different housing (Ludwig et al., 2013; McCormick et al., 2012). Women in public housing have a higher likelihood of developing psychological disorders, mainly due to stressors induced by poverty and stigma (Anakwenze & Zuberi, 2013; Major et al., 2013). Quets (2016) reported that women in public housing were vulnerable to contracting infectious and chronic diseases (e.g., asthma, accidents, and incurring injuries) and acquiring mental health problems.

According to the U.S. Department of Housing and Urban Development (U.S. HUD, 2019a), leaders of public housing provide people with lower incomes, disabilities, and older ages—all of whom have higher vulnerability levels for mental health

problems—safe and supportive housing. Compared to nonpublic housing residents, public housing residents tend to have more problematic mental health statuses (Marí-Dell'Olmo et al., 2017). Most with mental health problems do not receive mental health services or attention they deserve or need (Marí-Dell'Olmo et al., 2017). If mental illness is left untreated, people with mental health illnesses residing in public housing may commit suicide or homicide, face eviction, or become homeless because of their actions (Marí-Dell'Olmo et al., 2017). As such, there is a need to determine and understand mental health problems in public housing to avoid these scenarios. The literature about mental health in public housing remains limited at the present time.

Researchers should identify attitudes toward seeking help for people with low-income, as they are not as likely to seek professional help for mental health issues as do those with higher income (Santiago et al., 2013). Most women who reside in public housing projects are of lower incomes; thus, they make an interesting study group regarding their attitudes toward seeking professional help and what factors can affect such attitudes. Counselors may use the findings of such a study to design interventions and target women living in public housing projects to increase their participation in counseling for mental health difficulties (Anakwenze & Zuberi, 2013).

This chapter introduces the study, beginning with a discussion of background literature to provide context for the problem statement of the study. Next, the purpose of the study is articulated, followed by the research questions and theoretical framework for the study. Subsequent sections show the nature of the study, definitions of key terms, assumptions, scope and delimitations, limitations, and significance of the study. Finally, I end the chapter with an outline of the key points presented in the chapter.

Background

According to the U.S. HUD (2019a), leaders established public housing to offer eligible low-income families decent and safe rental housing options. Public housing refers to the residential properties owned by government agencies. Leaders of public housing offer subsidized rents to accommodate low-income individuals' and families' financial constraints (Motley & Perry, 2013). The U.S. government has historically offered public housing to meet the needs of two groups: (a) World War II working households and (b) poverty-stricken households (Pollack et al., 2014). Working class families may not afford housing during and immediately after a war, and they struggled to pay rental costs. Thus, the government provided subsidized-rental housing to prevent such families and individuals from becoming homeless (Pollack et al., 2014). A decade or two after World War II, poverty-stricken families utilized public housing to avoid homelessness. Although leaders of public housing offer a solution to homelessness for many low-income individuals and families, housing recipients experience challenges related to poverty, stigma, and mental illness (Ludwig et al., 2013; McCormick et al., 2012).

Researchers have linked mental health issues among public housing residents to many factors. For instance, residents may experience negative stereotypes and stigma associated with their housing statuses (McCormick et al., 2012). Thus, they can experience mental health problems. Because individuals who reside in public housing tend to live in conditions of concentrated poverty (Ludwig et al., 2013; Pollack et al., 2014), the propensity increases for public housing residents to suffer a multitude of social and health disparities (Appio et al., 2013; Santiago et al., 2013). Areas of concentrated

poverty in urban environments have often been characterized by general neighborhood disorder, entailing litter, drug use, and loitering (Anakwenze & Zuberi, 2013). Residents then report a sense of shame or embarrassment when telling others where they live, placing residents at risk for mental health problems and lack of access to the healthcare they need for these issues (Anakwenze & Zuberi, 2013).

Santiago et al. (2013) found numerous systemic, logistical, and attitudinal factors that prevented low-income individuals from seeking help for mental illnesses. For example, high poverty areas are often underserved by mental health professionals and agencies, which represent systemic barriers to seeking help (Shin et al., 2013). Additionally, people living in poverty may have more difficulties with logistical issues when taking time off to attend to mental health issues that involve taking time off work, arranging transportation, or obtaining childcare (Santiago et al., 2013). Negative prior experiences with psychological professionals may also create an attitudinal barrier to seeking help. For example, Appio et al. (2013) found that individuals with lower incomes expressed that class differences between themselves and their therapists adversely influenced their treatment experiences. The participants' expressed that their therapists could not relate to stressors associated with poverty. The participants also explained that their therapists degraded the therapeutic relationship, resulting in participants having skeptical attitudes toward the potential helpfulness of therapy (Appio et al., 2013).

Despite the negative impact associated with mental health issues, those diagnosed with such do not receive the mental health services they need, sometimes due to fear of eviction and homelessness (Jung, 2015). However, the present literature about mental health of women public housing project residents is limited; little is known about factors

or predictors associated with low-income individuals' underutilization of mental health services among public housing residents (Jung, 2015). Therefore, I addressed this problem and literature gap in the current study. There is an increasing need to determine and understand mental health problems among women living in public housing projects and the factors that affect public housing residents' efforts to seek healthcare for mental health issues in a timely manner.

I studied the individual traits that might influence low-income individuals' attitudes about looking for expert assistance. Experts have associated three individual traits with positive adaptation and coping with adversity: optimism, self-efficacy, and resilience (Kapıkıran & Acun-Kapıkıran, 2016; Rajaei et al., 2016). Optimism is an inclination to expect positive outcomes in life, and self-efficacy refers to perceptions that one can accomplish goals and overcome obstacles encountered in daily life (Kapıkıran & Acun-Kapıkıran, 2016; Tirpak & Schlosser, 2015). Scholars have associated resilience with both optimism and self-efficacy. Resilience refers to the ability to adapt successfully after adverse or traumatic events or conditions (Lee et al., 2013).

Researchers have positively associated self-efficacy and optimism with problem-focused coping, referring to methods that actively addressed underlying causes of problems that a person experienced (Rajaei et al., 2016). Resilience similarly reflects an ability to adapt and succeed despite adversities (Lee et al., 2013). Although researchers have associated optimism, self-efficacy, and resilience with lower levels of anxiety, depression, and perceived stress (Lee et al., 2013), researchers have mostly investigated the effects of self-efficacy on attitudes about seeking help (Tirpak & Schlosser, 2015). Understanding how other traits relate to attitudes about seeking professional help may

enhance counselors' abilities to conduct effective outreach with populations who have experienced adversity (Lee et al., 2013), such as women living in public housing.

Problem Statement

The social problem at the center of the study was women living in public housing projects experienced several adverse outcomes because they did not seek treatment for mental illness. Moreover, there was an insufficient focus on determining how variables, such as optimism, experienced stigma, self-efficacy level, and resilience, affected women's help-seeking behaviors when living in public housing. Individual determinants of help-seeking behaviors, such as optimism (Lei & Pellitteri, 2017), experienced stigma (Dyrbye et al., 2015), and level of self-efficacy to coping with mental health issues (Tirpak & Schlosser, 2015; Yang et al., 2019), and resiliency level (Drew & Matthews, 2019), had not been studied concerning treatment seeking for individuals in public housing projects with mental health issues. Instead, financial and logistics limitations were usually studied to understand difficulties in assessing mental healthcare services (Appio et al., 2013; Santiago et al., 2013). To date, no researcher has focused on public housing project women's attitudes about seeking treatment for mental illnesses.

Even though researchers have linked optimism, experienced stigma, self-efficacy level, and resilience to help-seeking behaviors (Kapıkıran & Acun-Kapıkıran, 2016; Warnecke et al., 2014), it is currently unknown whether the same determinants can individually affect attitudes toward voluntary seeking of mental health treatment of women residing in public housing (Suglia et al., 2015). It is currently unclear whether women living in public housing projects with mental issues have attitudes toward voluntarily accessing mental healthcare services affected by their optimism, experienced

stigma, self-efficacy, and resilience to coping with mental illness and living in public housing.

Purpose of the Study

The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing. Voluntarily seeking mental health treatment reflects an ability to adapt to adversity by actively working toward positive outcomes (Tirpak & Schlosser, 2015), which may be consistent with individual help-seeking determinants of self-efficacy, experienced stigma, optimism, and resilience. Understanding how self-efficacy, experienced stigma, optimism, and resilience relate to attitudes toward seeking treatment in women living in public housing may serve as helpful information, spurring action. For instance, counselors may use such information to understand how to conduct effective outreach efforts in these communities and lead interventions that may improve the effectiveness of current counseling services.

Research Questions and Hypotheses

RQ1: What are the bivariate correlations among the independent variables of resilience, self-efficacy, experienced stigma, and optimism among women residing in public housing projects?

$H1_0$: There are no statistically significant correlations among the independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and

Stigma Scale), and optimism (scores on the Life Orientation Test) among women residing in public housing projects.

$H1_a$: There are statistically significant correlations between the independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) among women residing in public housing projects.

RQ2: How well do the independent variables of resilience, self-efficacy, experienced stigma, and optimism predict the dependent variable of attitude toward seeking treatment for mental health issues among women residing in public housing projects?

$H2_0$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are not statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

$H2_a$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

Theoretical Framework for the Study

Several theories were used to support the current study. These theories included Bandura's (1977) self-efficacy theory, Rutter's (1987) resilience theory, Connor et al.'s (2010) stigma theory, Scheier and Carver's (1985) optimism theory, and Liang et al.'s (2005) theory of help-seeking behavior. These theories are discussed below.

Self-Efficacy Theory

According to Bandura (1977), individuals with a strong sense of self-efficacy can adapt to new situations, affecting their task choices, efforts, and persistence when facing difficulties. Bandura's self-efficacy theory includes self-efficacy beliefs, outcome expectations, and behavioral goals. Self-efficacy is described as the perception of confidence that individuals possess about their abilities to engage in behaviors to achieve specific outcomes, instead of their actual abilities to carry out said behaviors. Self-efficacy refers to the conviction that one can effectively carry out the behavior needed to achieve desired outcomes, influencing the outcome expectations of an event or behavior (Bandura, 1977).

Bandura (1977) posited that self-efficacy could be sourced from four different factors of performance accomplishments, vicarious experience, verbal persuasion, and physiological states. Bandura's (1977) theory of self-efficacy was considered for use in this study because the researcher offered an explanatory framework for behavioral changes based on how people perceived their capacities for goal attainment. This selected framework provided a socially and culturally contextualized explanation focused on the behavior of seeking help. The chosen theory also offered a better context for investigating the variables of optimism, self-efficacy, experienced stigma, and resilience. I expected

this theory to support examination of help-seeking attitudes in the stigmatized condition of public housing project residency.

Resilience Theory

Resilience in this research was examined through Rutter's (1987) resilience theory. Resilience is shown as an ordinary adaptation process that can be successfully undertaken with the right resources. Rutter opposed ideas of "super kids" (Rutter, 1987, p. 20) or people without vulnerabilities. The researcher claimed that individual differences in resilience were influenced by the environment and not the person. Environmental factors can alter genes and biological functioning, despite Rutter's belief in biological and genetic influences of risk and resilience.

Rutter (1987) provided a lifespan approach to residence, claiming that levels of resilience could be more evident or higher or lower at different times in one's life. Some people are resilient in relation to certain adverse events or risks but not to others. Moreover, under this theory, individual differences, such as genetics, personalities, and temperaments, can create differences about the manner with which a person responds to risk and protective factors (Rutter, 1987). Rutter (1987) also asserted the importance of casual, mediating, and moderating risk factors in determining resilience. This theory was chosen because of these assumptions and suppositions. I believed that women in public housing projects could have different levels of resilience in relation to coping with mental illness, affecting their attitudes toward seeking help.

Stigma Theory

The factor of experienced stigma was explored through the theoretical lens of stigma theory presented by Conner et al. (2010). The major premise of this theory is that

a person can experience public and internalized stigma in relation to mental illness. According to Conner et al., public stigma refers to negative conceptions, attitudes, and beliefs that the public has on mental illness. Thus, people may engage in stereotyping, discriminating, and being prejudicial against individuals diagnosed with mental health disorders. On the other hand, internalized stigma refers to a person's engagement in unhealthy behaviors, including devaluation, shame, secrecy, and social withdrawal, triggered by applying the usual negative stereotypes linked to mental illness to oneself. According to proponents of this theory, social stigma excludes some populations from seeking mental health services (Conner et al., 2010). This theory was chosen because of these assumptions and suppositions. I believed that women in public housing projects could have different exposure to stigma in relation to living in such settings and perceptions on mental illness, affecting their attitudes toward seeking help.

Optimism Theory

Optimism was analyzed based on Scheier and Carver's (1985) optimism theory. The researchers used the theory to define optimism as a person's generalized motivation. Based on the expectancy value model of motivation, Scheier and Carver highlighted that human behavior was goal-oriented or goal-directed. Optimism is a result, which can influence people's specific thoughts. Essentially, those with higher levels of optimism hold more positive expectations about their lives. When faced with adversity, they handle these challenges more effectively. This theory was chosen because of these assumptions and suppositions. I believed that women in public housing projects could have different levels of optimism in relation to living in such settings and perceptions on mental illness, affecting their attitudes toward seeking help.

Theory of Help-Seeking Behavior

Liang et al. (2005) applied this theory to help-seeking processes for women experiencing intimate partner violence. According to the theory of help-seeking, the three primary processes that may influence help-seeking behaviors include "defining the problem, deciding to seek help, and selecting a source of support" (Liang et al., 2005, p. 71). This theory provided useful explanatory context for an empirical examination of variables, which predicted attitudes toward help seeking for mental illnesses among women living in public housing. As the theory of seeking help pertains to persons living in stigmatized conditions, it was appropriate and applicable to the study of this population, whose housing status was a known source of stigma (see Liang et al., 2005).

Nature of the Study

I conducted a quantitative non-experimental study to explore the predicative relationships between the independent variables of resilience, self-efficacy, experienced stigma, optimism, and the dependent variable of attitude toward seeking professional help by women in public housing projects. Using a quantitative method is appropriate when the objective of a study is to investigate relationships between two or more variables that are measured numerically (Quick & Hall, 2015). Furthermore, a correlational research design is applicable when the objective is to determine relationships between variables or to determine the influence of various independent variables on a particular dependent variable (Quick & Hall, 2015). The non-experimental design was an appropriate match for this study because the research did not involve any manipulation of variables or the use of a controlled experimental research setting (see Quick & Hall, 2015).

Four instruments were used to measure the independent variables of resilience, self-efficacy, experienced stigma, and optimism. A fifth instrument was used to measure the dependent variable of attitude toward seeking professional help. Resilience consists of a person's skill level of adapting and succeeding, despite adverse circumstances; hence, I measured resilience with Connor and Davidson's (2003) 25-item Resilience Scale. Self-efficacy is the capacity to accomplish goals and cope with daily demands. I measured self-efficacy with the 10-item General Self-Efficacy Scale by Schwarzer and Jerusalem (1995). Experienced stigma, which could lead to feelings of shame, blame, hopelessness, distress, secrecy, loneliness, isolation, and social exclusion, was measured using the 32-item Discrimination and Stigma Scale by Brohan et al. (2013). Optimism refers to a tendency to expect positive outcomes. I measured self-efficacy with the 12-item Life Orientation Test by Scheier and Carver (1985). Finally, attitudes toward seeking help reflect the level of acceptance or willingness one feels toward such assistance. I measured attitudes toward seeking help with the 10-item Attitudes Toward Seeking Professional Psychological Help Scale-Short Form by Fischer and Turner (1970).

The targeted population consisted of African women living in public housing projects. The sampling frame entailed housing units located in North Carolina. I computed the optimum sample size with the G*Power 3.1.7 program for two-tailed correlation tests (Faul et al., 2009). To compute sample size, I utilized the following parameters: (a) power of 0.80, (b) medium effect size of 0.3 in order not to be strict, and (c) a level of significance of 0.05 (Gravetter & Wallnau, 2009). The computed sample size needed for this study was $n = 82$. Considering a multiple linear regression analysis with four predictors, a statistical power of 0.8, a medium effect size of 0.15, and a level

of significance of 0.05, the total sample size was calculated at $n = 55$. I used purposive sampling to gather a target of 100 participants, which surpassed the minimum sample size required for this study. The surveys were administered online using SurveyMonkey (2012). I analyzed the data analysis with a Pearson correlation analysis and multiple linear regression analysis to test the null hypotheses for the research question.

Definitions

The following definitions are defined for clarifying key terms in this study.

Attitudes toward seeking professional help: Attitudes toward seeking professional help refer to the level of acceptance or willingness a person feels about getting professional psychological assistance from a counselor or therapist (Fischer & Turner, 1970).

Experienced stigma: Experienced stigma refers to discriminatory behaviors or acts directed at individuals because of specific attributes or conditions (Phillips et al., 2011).

Optimism: Optimism is an individual trait reflecting a tendency to expect positive outcomes in life (Kapıkıran & Acun-Kapıkıran, 2016).

Public housing: Public housing refers to a type of government-subsidized rental property provided to low-income individuals and families, which may be concentrated in multifamily buildings or dispersed throughout mixed-income neighborhoods (Ludwig et al., 2013).

Public housing projects: This slang term in American English refers to government-owned subsidized housing developments for low-income residents. Public housing projects fall under the umbrella of public housing (Ludwig et al., 2013).

Resilience: Resilience represents an individual trait that reflects the ability to adapt successfully to adverse or traumatic events and conditions (Lee et al., 2013).

Self-efficacy: Self-efficacy is an individual trait reflected in the perception that one can accomplish goals and overcoming obstacles encountered in daily life (Tirpak & Schlosser, 2015).

Assumptions

As this study was quantitative, several assumptions were made in relation to the nature of this study. First, this topic was studied objectively, as opposed to subjectively. In relation, I assumed that the objective reality in which I was interested could also be objectively measured and analyzed. I assumed that participants' attitudes could be measured statistically and objectively, and these could be predicted by the specific independent variables and carried out in an objective manner, independent of myself. Moreover, there were assumptions made because multiple linear regression was the analysis method. Multiple linear regression required that the relationship between the independent and dependent variables remained linear. I assumed as such between the dependent and independent variables in this study. Another assumption made was based on the multiple linear regression analysis conducted, as the errors between the observed and predicted values were assumed normally distributed. Moreover, I assumed no multicollinearity in the data, which only occurred when the independent variables were too highly correlated to each other. I assumed that the independent variables in this study were not too highly correlated, and no multicollinearity was possible. Lastly, I assumed homoscedasticity, as the variance around the regression line was similar for all values of the predictor variables.

Scope and Delimitations

The study was delimited in several ways. First, I only focused on the independent variables of resilience, self-efficacy, and optimism because these reflected different psychological aspects of coping and adaptation. Therefore, each might have relevance to the dependent variable of attitudes toward seeking professional mental help. I selected these three independent variables because these were expected to predict positive help-seeking attitudes, either individually or in combination. Other variables (e.g., experienced stigma) were excluded from examination because the aim was to elaborate understanding of individual traits protective of mental health.

The participants for this study were delimited to African American women living in projects of Greenville North, Carolina, who received public housing assistance from the U.S. government. Because men and women have exhibited differences in attitudes toward seeking help (Harris et al., 2015), I excluded men from this study to enhance the specificity of the findings. The reason for this delimitation was that public housing status might introduce additional stressors and sociocultural influences that affected help-seeking processes (see Liang et al., 2005).

External validity is the degree to which findings from the study may be generalized to other situations or people (Wing & Bello-Gomez, 2018). For the current study, the results only stood true regarding women residing in public housing. Results from the current study may not be generalized to additional population groups. The results may not be generalizable for additional age brackets, cultures, or populations of differing ethnic composition. The results of the analysis will only be generalizable to women residing in government housing projects in North Carolina.

The choice of help-seeking theory as the theoretical framework reflected another delimitation of the study. Bandura's (1977) theory of self-efficacy was considered for use in this study because the researcher offered an explanatory framework for behavioral changes based on how people perceive their capacities for goal attainment. This selected framework provided a socially and culturally contextualized explanation specifically focused on the behavior of seeking help. The chosen theory also offered a better context for investigating the variables of optimism, self-efficacy, experienced stigma, and resilience. I expected this theory to support examination of help-seeking attitudes in the stigmatized condition of public housing project residency.

Limitations

One potential limitation of this study emerged from its correlational design. The nature of a correlation examination of isolated variables could reveal correlation but not causation. The inability to manipulate the independent variable to determine the influence on the dependent variable(s) meant that a cause-and-effect relationship could not be established. Therefore, even though evidence of correlation could be used to claim the independent variables predicted the dependent variables, a correlation could not reveal underlying causes. There could have been many possible explanations for the participants' attitudes, and a correlation with the four independent variables did not mean the attitudes were caused by these four determinants of help-seeking behaviors. Thus, one could not assume those participants' levels of self-efficacy, optimism, experienced stigma, and resilience caused their attitudes toward seeking professional help. However, the generalizability of the findings to a specific subset of the population may be high. Although one may not assume that the findings generalize to all persons living in poverty

or all women in public housing nationwide, one may assume that the findings will generalize to women living in public housing in North Carolina. Another limitation was the use of a non-probability sampling plan of purposive sampling, which limited the generalizability of the samples. As a limitation, the results of this study will only be generalizable to the women residing in public housing projects from the Greenville Housing Authority in North Carolina.

Significance

I explored resilience, self-efficacy, experienced stigma, and optimism regarding attitudes toward seeking professional help among women living in public housing projects. The importance of conducting such research lies in the need to provide adequate services to a large and growing population of women in such unfortunate circumstances. By knowing whether the independent determinants of help-seeking behaviors (i.e., resilience, self-efficacy, experienced stigma, and optimism are significantly related to the dependent variable of attitudes toward seeking help, counselors and other mental health experts may experience a stronger impetus to develop effective policies to help residents of public housing projects achieve positive mental health. Understanding the psychological attitudes of the women will allow the government to anticipate psychological issues they may have in the public housing arrangements that can negatively affect their mental health or aggravate mental health issues. Women in public housing are increasing; thus, understanding the factors influencing their mental help-seeking attitudes can lead to better policies imposed in such settings. Therefore, mental health services can be more accessible and acceptable, avoiding negative effects of untreated mental illnesses or issues.

Apart from these practical benefits, the findings of this study reflected women's views, contributing to the enrichment of the academic literature, as there was little information in the literature about the attitudes of women in public housing projects toward accessing and using mental health counseling services. The findings of this research can significantly contribute to current literature on this topic. The findings may help practitioners, offering insights into how to deal with this alarming issue in the field.

Summary

Women who live in public housing experience both poverty and stigma (Manzo, 2014), which experts have identified as risk factors for psychological disorders (Anakwenze & Zuberi, 2013; Major et al., 2013). As people living in poverty are not as likely to look for professional help regarding mental health issues compared with persons with higher incomes (Santiago et al., 2013; Shin et al., 2013), researchers should identify factors possible associated with help-seeking for people living in poverty (Lee et al., 2013). Currently, there is a literature gap on factors affecting attitudes of women in public housing projects toward seeking mental help.

Four factors have been associated with positive attitudes toward seeking help: resiliency, self-efficacy, experienced stigma, and optimism (Tirpak & Schlosser, 2015). However, researchers have not examined other traits associated with positive coping and adaptation. Given this literature gap, the purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing. The analysis was framed by the theories on resiliency, self-efficacy, optimism, and stigma, as well as that of the theory of seeking

help, showing individual factors based on interpersonal and sociocultural influences on help-seeking behaviors (Liang et al., 2005). I anticipate that this study's findings may enhance counselors' capacities to provide interventions for women living in public housing projects, increasing participation in professional services for this population. Chapter 2 provides a thorough review of the research literature related to this research project's focus.

Chapter 2: Literature Review

Introduction

Among U.S. women, the intersect of three variables, experiencing a mental illness, low rates of access to mental healthcare professionals, and poverty-level circumstances that lead to residing in the public housing sector, informs the need to understand better this vulnerable population's mental health help-seeking attitudes (Anakwenze & Zuberi, 2013; Major et al., 2013). Although previous research showed the influences of resilience, self-efficacy, experienced stigma, and optimism regarding help-seeking behaviors (Kapıkıran & Acun-Kapıkıran, 2016; Rajaei et al., 2016; Warnecke et al., 2014), research involving those influences in a population of women living in public housing settings is lacking (Suglia et al., 2015). The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing.

Approximately 20% of the U.S. adult population or 46.6 million individuals suffer from mental health disorders, with 5% or 10 million adults diagnosed with severe mental illnesses (National Alliance on Mental Illness [NAMI], 2019a). Moreover, research indicates that 12% of children, ages 8 to 15, experience mental health disorders, and more than 20% of adolescents, from 13 to 18 years, experience severe mental disorders, with 50% of lifetime disorders beginning by age 14 (NAMI, 2019a; Powell, 2015). The most common diagnostic categories other than substance abuse disorders include schizophrenia, bipolar disorder, major depression, and anxiety disorders (NAMI, 2019b).

U.S. adults with any mental health illnesses are more likely to live at or below the poverty level than others (Ljungqvist et al., 2015; Topor et al., 2016; Walker & Druss, 2017). Research indicates that mental illness is more prevalent in homeless and sheltered-living populations, with estimates of 26% for any mental illness and 46% of severe mental illness, including disorders associated with psychosis (Benston, 2015; NAMI, 2019a). Similarly, Topor et al. (2016) described characteristics of individuals with severe mental illnesses, such as having difficulty establishing and maintaining a sense of reality accompanied by the lack of capacity for goal-oriented actions, as relative factors that contributed to living in poverty.

Although practitioners of available treatment options aid in controlling or reducing symptoms that impact multiple aspects of life, 60% of adults with any mental health conditions, 50% of adolescents, and 37% of adults with severe mental illnesses remain untreated in the United States (NAMI, 2019b; National Institute of Mental Health, 2018). The evidence further indicates that Black and Hispanic Americans seek mental health care significantly less often than Whites, at rates of 50% and 33%, respectively, of White access to care (NAMI, 2019b). According to Crumb et al. (2019), help-seeking attitudes toward mental health issues of low-income U.S. populations consist of multifaceted perspectives, contributing to higher percentages of untreated mental health conditions in this population.

The organization of Chapter 2 includes a description of the search strategy next, followed by a discussion of the theoretical frameworks. The literature review follows, divided by sections and subsections specific to problems with public housing, including facility and environmental concerns, physical and mental health issues, sociocultural

perspectives, and mental health help-seeking attitudes. The literature also shows the roles of resilience, self-efficacy, experienced stigma, and optimism in help-seeking behaviors. A synthesis of the literature comes next, followed by a critique of the research methods and a summary.

Search Strategy

The literature used in this review was obtained using online databases and search engines, including Google Scholar, PsycINFO, PsychARTICLES, SocINDEX, DeepDyve, ProQuest, Research Gate, Science Direct, Google Books, and Google. I used government-supported websites, such as the National Institute of Health, PubMed, and the World Health Organization. Search limitations included available options per search site, such as peer-reviewed journals, dates of publications focusing on works since 2015, author name searches when needed, access to related and previously cited articles, and the use of full-text or pdf availability for published documents. Literature included information from peer-reviewed journals and relevant books, websites, and dissertations. Search terms included using entries in single terms or Boolean search manners. Terms included *adversity, homelessness, living in poor quality housing, mental health assistance, optimism, poverty, public housing, public housing in the United States, federal housing, housing assistance, self-efficacy, mental health, mental illness, low-economic, resilience, stigma, experienced stigma, help-seeking, help-seeking attitude, help-seeking behavior, self-efficacy theory, resilience theory, optimism theory, theory of help-seeking behavior, help-seeking theory, Bandura, Rutter, stigma theory, Scheier, Carver, sociocultural,* and *sociocultural identities.* Much of the research literature used was published between 2015 and forward.

Theoretical Framework

The chosen theoretical frameworks to guide the study included five theories that facilitated support for individual aspects integrated into the current research, with each theory guiding the study through varying and overlapping perspectives. The five theories included Bandura's (1977) self-efficacy theory, Rutter's (1987) resilience theory, Pescosolido and Martin's (2008) stigma theory, Scheier and Carver's (1985) optimism theory, and Liang et al.'s (2005) theory of help-seeking behavior. The complexities embedded in the goals of the study warranted using multiple theoretical foundations to provide meaningful support for overlapping aspects of the current study.

Self-Efficacy Theory

Bandura (1977) founded the self-efficacy theory (Cherry, 2019). Recognized as an outstanding and influential psychologist, According to Bandura's (1977) theory, self-efficacy reflects a person's belief or confidence in their abilities, thereby serving as a tool when adapting to new, unfamiliar, and challenging situations. Individuals with high levels of self-efficacy exert confidence in approaching tasks as the strength of their beliefs influence choices, strengthen efforts, and promote persistence in times of difficulty. Self-efficacy refers to the central perceptions, convictions, or beliefs of ability held by individuals that evoke confidence in the ability to achieve specific outcomes versus their actual ability to do so. Bandura suggested four factors in developing self-efficacy that included performance accomplishments, vicarious experiences, verbal persuasions, and physiological states. Based on Bandura's theory, an individual who develops self-efficacy experiences some degree of protection from suffering or adverse

outcomes when seeking out situations and engaging in behaviors aligned with their beliefs and confidence.

Williams and Rhodes (2016) applied the self-efficacy theory to study potential causative influences, suggesting close ties between self-efficacy and motivation, while noting differences in desired versus undesired outcomes of a target behavior. The researchers pointed out that negative or unwanted outcomes negated the development of self-efficacy in achieving such outcomes. Applying self-efficacy actions to multiple potential target behaviors, including health-related actions, the researchers introduced aspects of motivation based on desired positive outcomes, thereby promoting an individual's belief in accomplishing a given task based on their desire and motivation to do so. For example, and consistent with the goals of the current study, developing the awareness of a positive outcome specific to a health-related activity, such as feeling better from seeking treatment for mental health problems, might depend on the individual's belief or confidence of their ability to feel better based on the desire to participate in needed target behaviors. In their research, Williams and Rhodes (2016) reported overlap in self-efficacy and motivation as the "desire to accomplish" versus "confidence in accomplishing" (p. 20) as the target behaviors produced different outcomes. For example, an individual might express confidence of improvement in their mental health conditions if treated by a mental healthcare professional yet still maintain the desire not to seek out help (Williams & Rhodes, 2016). Bandura's (1977) self-efficacy theory supported the aims of the current study to explore the target population regarding factors that influenced behaviors, including those central to the theory, regarding help-seeking actions.

Resilience Theory

Although researchers in an array of fields and disciplines pursued knowledge about resilience, insights into resilience viewed through the work and theory put forth by Rutter (1987) guided the current study. Resilience is a process that varies from person-to-person and involves the capacity to positively adapt when facing adversity, trauma, tragedy, threatening circumstances, or significant and real risks (Reid, 2019). Rutter's (1987) resilience theory involves individual traits, characteristics, or mechanisms that protect against psychological risks. Rutter identified four processes associated with resilience: reduction of impact, reduction of unwanted chain reactions, establishing and preserving aspects of self-esteem and self-efficacy, and consideration for opportunities. Central to understanding resilience is the perspective of individual differences regarding protective factors against stressors and adversity, as evidenced by ongoing research to advance understanding of resilience across populations and circumstances (Reid, 2019; Rutter, 1987). According to Rutter (1987), resilience is best understood across the lifespan, as some circumstances may create higher levels of resilience than others. Moreover, individual differences, including genetics, personality, and temperament, can affect resilience or how a person responds to risks and protective factors (Rutter, 1987).

Revilla et al. (2017) reviewed the literature on the resilience theory specific to social processes and strategies used by individuals, families, and small social groups when facing adverse circumstances, including economic difficulties and poverty. The researchers observed the lengthy history of the study of resilience and the recent attention of resilience theories in social work and psychological research. According to Revilla et al., investigating resiliency through research and resulting analysis of study findings

required a perspective of contexts that included more than the individual. Extending the review of resilience to families and social communities showed a more in-depth understanding. Exploring strategies used within the identified contexts resulted in the advancement of knowledge of resilience in the face of economic downturn and poverty. Investigating aspects of resilience from the family and social context provided support for research applications of resilience theories of society and social life developments versus relying on individuals' actions when recovering from such adversity. Consistent with Rutter's (1987) theory, Revilla et al. (2017) found support for resilience not only in individuals but also within families and social groups facing adversity. Rutter's (1987) theory applied to the current study to explore aspects of resilience among women in public housing settings regarding multiple challenges faced by this population.

Stigma Theory

Bringing attention to the importance of reliable, relevant, and updated support for research into stigma, Pescosolido and Martin (2008) established a theory that integrated stigma research across disciplines and brought forward a realistic perspective of the complexities of stigma research to address tailored research approaches involving stigma. Stigma research has shown the need to reconsider the degrees and types of reactions that occur in circumstances that provoke reactions of discrimination and prejudice (Pescosolido et al., 2008). As women in public house faced challenges aligned with the stigma of mental illness, Pescosolido and Martin's (2015) stigma complex theory supported the current study.

Pescosolido and Martin's (2015) theoretical framework for integrating normative influences on stigma encompasses (a) perspectives of stigma that include differences in

distinguishing traits and labeling of groups, (b) associations based on human variances that include negative characteristics and stereotypes, (c) the perspectives of "us" and "them," and (d) resulting losses of status and feelings of discrimination (Pescosolido et al., 2008).

Conner et al. (2009) identified the stigma associated with mental health disorders as a pervasive barrier, contributing not only to negative opinions, discriminatory attitudes, and prejudices but also as an adverse influence toward seeking help. According to Conner et al., the influences of both external and internal stigma impact individuals with mental health disorders. External influences consist of others' behaviors that include stereotyping, discrimination, and prejudice. Internal stigma consists of individuals' negative conceptions, attitudes, and beliefs of mental illnesses. Internalized stigma influences behaviors and causes unhealthy acts, including social withdrawal, adopting self-views of shame, and accepting a devalued perception of self (Conner et al., 2009). I used the framework for integrating normative influences on stigma theory, as supported by the insights from Conner et al. (2009), to support the aims of the current study.

Optimism Theory

Scheier and Carver (1985) established the optimism theory, overlapping with other theoretical models in psychology, including those of goal-directed behaviors, coping processes, psychological stress, psychological well-being, and others. Scheier and Carver proposed that the construct of optimism, considered as a stable personality trait, influences the behaviors and attitudes of individuals with variances possible depending on challenges faced, including health-related outcomes. The researchers emphasized the perspectives of cause and effect in asserting the theory of optimism, noting optimism as a

causal trait that influences outcomes or outcomes in an intrinsically future-oriented construct (Scheier & Carver, 1985).

In a study of 1,792 people living in Norway, Schou-Bredal et al. (2019) investigated the role of optimism on health status, including measures of mental health disorders. Based on the theory of optimism by Scheier and Carver (1985), the researchers established study hypotheses that included expectations of better physical and mental health in populations of individuals considered optimists versus physical and mental health statuses of individuals determined to apply pessimistic thinking (Schou-Bredal et al., 2019). Study findings showed that optimists reported a significantly lower lifetime prevalence of both physical and mental health disorders. Other results indicated that 11.3% of pessimists reported five or more disease states versus the 3.9% reported from the optimist population (Schou-Bredal et al., 2019). Scheier and Carver's (1985) theory of optimism, further supported by Schou-Bredal et al. (2019), aligned with the goals and population of the current study. As I explored factors that influenced help-seeking attitudes in the target population, the theory of optimism supported the aims of the study and provided useful insights into the participants' attitudes.

Theory of Help-Seeking Behavior

According to the authors of the theory of help-seeking behaviors, three stages or steps experienced by the individual contribute to internal cognitive processes in choosing to seek help (Liang et al., 2005). The three stages include problem recognition or awareness and definition, the point of deciding to seek help, and the choice of a help provider. Although Liang et al. (2005) applied the theory to help-seeking processes for women experiencing intimate partner violence, women in public housing also

experienced stigmatizing conditions; therefore, the theory was appropriate to guide the current research.

Liang et al. (2005) developed the theory of help-seeking behaviors to support actions that led to survival through a change of adverse circumstances, indicating that individuals possessed the capacity to initiate behaviors of change, resulting in seeking help. Additional variables, beyond those of the individual, may influence behaviors to seek help, which include interpersonal and sociocultural factors that impact the appraisal and decision-making process. As postulated by the theory, recognition of the condition or situation as a problem is a crucial first step in seeking help. For example, women experiencing abuse must first recognize their situations as aberrant and unacceptable. This realization may be influenced by the individual's awareness and readiness for change or through others' perspectives in their support network, including increased awareness of cultural views on abuse (Liang et al., 2005).

Upon framing the problem or circumstance as undesirable and unacceptable, consideration of their own capacity to recover without assistance and the need for formal assistance to survive or escape the circumstances leads to the second step: deciding to seek help. The decision to seek help involves advancing the individual's awareness of their situations, beliefs, attitudes, and readiness for change. Other influences for the decision to seek help may include perspectives of individuals and groups within the person's support network and increased influence of other sociocultural factors (Liang et al., 2005).

The complexities of sociocultural factors influence decisions to seek help both positively and negatively, which further influences the type of help determined as

appropriate by the individual (Liang et al., 2005). For example, rural communities often endorse a culture of self-reliance, leading to decreased tendencies to seek help for psychological health difficulties (Judd et al., 2006), a perspective relevant to the current study. Therefore, individual and cultural beliefs that emphasize self-reliance may influence people to manage their psychological symptoms independently, rather than seek professional help (Judd et al., 2006).

Moreover, legal, spiritual, psychological, and interpersonal factors contribute to differences in an individual's conceptualization of a situation, thereby influencing their decision to seek help and the type of help determined as appropriate (Liang et al., 2005). People who lean toward problem-focused coping may be more likely to seek help that directly addresses the underlying problem, while people who tend toward emotion-focused coping may find solace from a friend (Liang et al., 2005). Research findings reflected the individual's conceptualization a circumstance and differences in coping strategies linked self-efficacy with both problem-focused coping and a positive mindset regarding seeking mental health assistance (Rajaei et al., 2016; Tirpak & Schlosser, 2015). As the theory of help-seeking behaviors pertains to persons residing in stigmatized conditions, it was appropriate and applicable to the target population of the current study, possibly providing useful explanatory context as I explored factors associated with help-seeking attitudes (see Ludwig et al., 2013). The theory of help-seeking behaviors was useful as the results of the study showed the processes of help-seeking behaviors of persons living in stigmatized conditions, specifically women in public housing with mental health needs. According to the problem, purpose, and design of the current study,

the theories put forth provided the needed foundation for exploring each factor in the study to understand the influence on the target population.

Review of the Relevant Literature

While considering the population of women living in the United States, a Venn diagram with three circles showed the target population aligned with the current study. The first circle showed all women who suffered from any mental illness, the second included women who chose not to seek access to any health services, and the third showed women who lived at or below poverty level, resulting in public housing residences. The intersect of those circles defined the population of interest for the current research. Foundational support for advancing knowledge of the area of intersect was grounded in the five theoretical frameworks chosen to guide the study: Bandura's (1977) self-efficacy theory, Rutter's (1987) resilience theory, Pescosolido and Martin's (2008) stigma theory, Scheier and Carver's (1985) optimism theory, and Liang et al.'s (2005) theory of help-seeking behavior.

Although the HUD (2019b) offered several programs to assist in housing opportunities for low-income individuals and families, the most frequently used program was the Section 8 housing vouchers (Thompson, 2019). Section 8 housing involves subsidies that contribute to the cost of housing, thereby allowing individuals or families to select private residences suitable to their needs (DeDonato, 2019; Thompson, 2019; U.S. HUD, 2019a). Public housing or Section 42 housing involves substantial tax credits offered to contractors and developers that construct a variety of dwelling types to house low-income individuals and families (DeDonato, 2019; U.S. HUD, 2019a). The public housing project developers and contractors benefit from the tax incentives and

government assistance that contribute toward rental payments of those who reside in public housing (DeDonato, 2019; U.S. HUD, 2019a).

The researchers and authors of the literature included in this review showed evidence of the complexities of public housing both domestically and worldwide. Through the review of literature related to aspects of public housing that include sociocultural and health perspectives, the discussions align with the study purpose in exploring the predictive relationships between resilience, self-efficacy, experienced stigma, optimism, and help-seeking attitudes and behaviors. The individual and overlapping support provided by the theoretical foundations interconnects to the literature reviewed.

Global Perspectives on Public Housing

Gaining insights into global perspectives of government-supporting housing policies inform domestic strategies regarding social, economic, and political approaches to providing housing for those in need. According to Quillian and Lagrange (2016), most modern societies reflect a tendency for socio-economic residential segregation. In a review and comparison of data collected between France and the United States, the researchers studied the three dimensions of income, employment status, and education. Study findings showed significantly higher socio-economic segregation in the United States than in France and further indicated that income inequality and assisted housing policy significantly contributed to that difference (Quillian & Lagrange, 2016).

Hananel et al. (2018) focused on public housing differences across three countries: Sweden, the United States, and Israel. The researchers evaluated four areas that included the primary goals and reasons for public housing, quantity and location, quality

and maintenance, and the eligibility criteria for occupancy. Based on the application of the Esping-Anderson typology, the researchers focused on the differing welfare state perspectives of each country; they pointed to decisions within societies regarding public housing with similar significance to policies on social security, health, and education (Hananel et al., 2018). The three typologies described included the liberal, corporatist, and social democratic types of welfare state regimes, with the United States defined as a liberal regime. Such a regime operates by little government control, encouraging private industry and state-level agencies to take responsibility, although the government acts for a limited group that often includes the lowest economic sector, with only modest benefits offered (Hananel et al., 2018). The social democratic welfare state promotes high standards and strives for equality among populations served, as evidenced by the regime in place in Sweden. The public housing policy of Israel consists of corporatist aspects, typical of regimes in Austria and Germany, for example, yet integrated with social democratic drivers, resulting in a unique trajectory for Israeli public housing policy (Hananel et al., 2018).

Study findings regarding each of the four measures showed that Sweden aimed to address overcrowding and housing shortages by establishing quality housing at affordable costs (Hananel et al., 2018). The United States aimed to improve low-income housing conditions and address unemployment while ensuring that the private housing market remained separate by establishing limits to costs allowed for the construction of public housing and low-income criteria for eligibility. Israel's public housing policy established shelter support for the significant waves of immigration, identifying new immigrants as the population in need of housing. Regarding quantity and locations of housing,

Sweden's early efforts resulted in one million dwellings with government funding eventually dwindling yet still in existence. Public housing residences in Sweden made up 28% of all urban residences, with most apartments located in attractive and profitable areas of major cities. Areas of lower real estate value supported only 13% of public housing units. As consistent with other reports, estimates reported by Hananel et al. (2018) for U.S. public housing units indicated a continuing decline caused by unhabitable conditions and demolitions of more than 150,000 dwellings in the HOPE VI project. High-rise and high-density structures in low-income locations reviewed made up about 30% of all public housing. The construction of U.S. housing projects often occurred in areas where land was inexpensive, with public opinion directing many building sites, thereby keeping housing projects away from desirable residential areas. Israel's public housing construction trends followed immigration waves to provide housing options for those migrating. Peripheral districts contained about half of the remaining public housing units, with more than 50% located in developed towns (Hananel et al., 2018).

Sweden takes pride in the country's high-quality public housing, including efforts to maintain the quality of units and meet the needs of tenants (Hananel et al., 2018). Public housing policy in Sweden divided the waiting list population into three sectors, including older adults, young adults, and all others, with each group considered equally in applications for public housing without regard to income. Tenants in Sweden remained in public housing, if desired. In the United States, poor quality of construction and lack of funds for maintenance and upkeep resulted in complaints, continued structural deterioration, and deficits in management priorities lead to disrepair, harmful environments, and eventual demolition for many structures. Eligibility criteria included

older adults, the disabled, and low-income individuals and families, with the maximum allowable income set at 80% of the median income in the surrounding area. Most tenants reportedly experienced low incomes at 30% or below of the surrounding area's median income. Israel adapted to the needs of the rapid influx of immigrants, yet the quality of many structures met low construction standards. Neglect of maintenance and upkeep resulting from political, social, and economic variables contributed to socio-economic gaps between public housing tenants and others. Ove the decades, the Israeli government supported public housing residents by offering the sale of housing units to existing tenants at discounted costs and with financial assistance. Like U.S. units, approximately 65% of public housing units in Israel carried serious health risks. Tenants eligible for public housing, other than in times of mass immigration, consisted of disadvantaged populations that included families with three or more children, low-income, and disabilities (Hananel et al., 2018).

Changes underway in Israel include involvement of public and private industry partnerships with policy intended to resolve public housing issues, introduce maintenance and renovation programs, and develop a flexible criteria structure for eligibility (Hananel et al., 2018). U.S. changes proposed include a renewed interest in addressing public housing policy, with attention to replacing many existing units with high-quality, effectively managed, and mixed-income tenants while addressing socio-economic opportunities for housing in safer areas and neighborhoods. The Swedish government continues to promote public housing projects, including a recently passed bill to renovate public housing toward energy-efficient dwellings, and expand the total number of units further (Hananel et al., 2018).

Problems With U.S. Public Housing

Evolving from federal aid created from the circumstances of the Great Depression, the public housing option appeared in the late 1930s and was supported by the 1937 U.S. Housing Act, with continued support from U.S. HUD (2019a) established by U.S. Congress in 1965 (Thompson, 2019). According to the U.S. HUD (2019b), leaders of public housing provide decent and safe housing to individuals or families, older adults, and individuals with disabilities who meet the established income criteria guided by the median income of the local county or metropolitan area. Over the years, federal oversight faded as state and local agencies began overseeing public housing projects within their jurisdictions (Thompson, 2019).

As of 2017, estimates indicated that 2.1 million Americans lived in federally subsidized public housing units (Center on Budget and Policy Priorities [CBPP], 2017); according to 2019 statistics, the largest portion of public housing residents consisted of adults with children at 31% (U.S. HUD, 2019b). Statistics revealed that 66% of residents were nonelderly adults, children lived with 38% of all residents, 39% of all residents were disabled, and 34% of the households with children were headed by women (U.S. HUD, 2019b). Head of household statistics showed 23% as Hispanic or Latino, 20% White, and 42% Black (U.S. HUD, 2019b). Approximately 52% of residents lived in public housing for 5 to over 20 years (U.S. HUD, 2019b).

Concerns exist related to public housing. For example, researchers established that the selection of low-priced property created negative impacts for residents based on neighborhood and environmental matters (Hayward et al., 2015). The actions by contractors in meeting the minimum construction requirements led to poor structural

integrity of the buildings (Thompson, 2019). Moreover, the number of public housing units continues to drop due to deteriorating structures caused by a significant lack of funding for upkeep and renovations, resulting in demolitions versus repairs, maintenance, upkeep, and renovations (CBPP, 2017). According to several researchers, living in public housing significantly contributes to adverse outcomes for the residents, including negative physical and mental health (Bennett et al., 2015; Haley et al., 2017; Hayward et al., 2015; Popkin et al., 2016).

Facility and Environmental Concerns

Shester et al. (2019) pointed out two consistent themes in their review of public housing that included the location of the buildings often found in areas within cities with the highest crime rates and rapid rates of structural deterioration, leading to demolitions within only decades of initial constructions. Construction practices often used in the building of public housing included inferior equipment, such as knobs that broke upon first use, windows resulting in panes broken blown inside by wind pressure, poorly insulated pipes, and failure to waterproof basement walls (Shester et al., 2019). The lack of funds for upkeep and maintenance led to high rates of vandalism that included graffiti, broken light fixtures, broken windows, urine in public elevators and stairwells, and high rates of crime within the public housing projects, thereby creating an unsafe environment (Shester et al., 2019).

Individuals and families who dwell in U.S. government-supported housing deserve a safe residence, one that is both physically and psychologically restful, while having at least no greater adverse risks than those experienced by people in comparable housing sectors across the county (Bashir, 2002). However, the conditions that exist in

many public housing structures showed direct links to safety concerns, including physical and mental health disorders (Bashir, 2002). According to Bashir (2002), researchers revealed evidence of poor insulation, combustion residue from appliances, rodent and roach infestations, dust mites, and dangerously high levels of lead inside residences caused by paint flakes, deterioration, and dirt tracked in from poorly maintained neighborhoods. Moreover, such living conditions contributed to high rates of childhood asthma, developmental delays, neurological disorders, psychological and behavioral dysfunctions, and heart diseases (Bashir, 2002). The findings by Shester et al. (2019) that showed structural deterioration and lack of upkeep and building maintenance supported the findings by Bashir (2002). Bashir noted that unsafe neighborhoods contributed to individuals and families staying indoors versus outdoor activities, thereby further advancing exposure to contaminants and disease states related to that exposure.

Even though the HUD (2019a) stipulated four basic principles of affordable housing design with which many public housing developments across the country fail to comply (Bloom & Lasner, 2016; Collinson et al., 2015; Garde, 2016; Martín, 2014; Vale et al., 2014). One of the housing principles shows that residential units meet the needs of the users. The second principle of the housing design aligns with the context. The third and fourth principles state that housing units enhance the neighborhood with structural integrity intended to last (Berkowitz et al., 2019). The published research literature showed adverse effects linked to living in unsafe and unsatisfactory quality public housing units, with a focus on physical and mental health concerns evident (Bennett et al., 2015; Haley et al., 2017; Popkin et al., 2016).

Physical Health Concerns in Public Housing

Social and built environments are fundamental mechanisms that impact public housing residents' physical and mental health (Halpern, 2014; Shariff-Marco et al., 2017; Zhang et al., 2013). Hayward et al. (2015) claimed that public housing residents were highly vulnerable to chronic disease, mainly because of neighborhood environmental factors. The researchers examined how public housing residents perceived the social and built environments surrounding their subsidized housing units and how each environment affected their health and well-being. The researchers conducted focus groups of participants living in a low-income public housing community in Baltimore, Maryland. Responses were audio-recorded and transcribed verbatim. The transcripts were later independently coded by two more investigators so that thematic content analysis could be carried out (Hayward et al., 2015). Results indicated that most individuals had lived in public housing for at least 5 years.

Through their responses, data analysis revealed four overarching themes. First, public housing's unhealthy physical environment contributed to destructive effects on health and well-being (Hayward et al., 2015). Second, the city environment restricted opportunities for the residents to make healthy lifestyle choices. Third, the unhealthy environment led to a lack of trust in relationships that contributed to residents' social isolation, noting that the lack of trust might have contributed equally to destructive effects on physical and mental health (Hayward et al., 2015). Lastly, increased neighborhood social capital might improve the residents' well-being. Several subthemes related to how both built and social environments interacted with one another and influenced the health of public housing residents. Most residents claimed that public

housing units had unsanitary conditions that continuously affected their health negatively (Hayward et al., 2015).

Other researchers revealed that public housing residents had the worst health among any population in the country, partly because of poor physical conditions in their residences (Arku et al., 2015; Breysse et al., 2015; Chaskin, 2016; Chudyk et al., 2017; Haley et al., 2017; Matthias et al., 2014). With the lack of implementation to steps that attend to the physical conditions of living environments, most public housing residents find themselves living in unsafe environments and facing circumstances that challenge their mental and physical health. Data produced by CBPP showed that more than 1.2 million Americans resided in public housing and, therefore, dealt with this problem. For example, some residents lived for more than 1 year without a lock on the front door, leading to worries about safety. Based on several case studies, the poor quality of public housing negatively affected residents' lives (Castillo, 2015; Fenton et al., 2013; Su, 2016).

Mental Health Concerns in Public Housing

Severe and persistent mental illness can have a critical impact on an individual's ability to conduct or carry out even the most fundamental aspects of daily living, including self-care, employment, and household management (Adair et al., 2016; Aubry et al., 2015; Benston, 2015; Nelson et al., 2015; Stergiopoulos et al., 2015). Having a mental illness can also interfere with having and sustaining stable relationships as symptoms contribute to acting and reacting irrationally, with those behaviors misaligned with the perspectives of those without mental disabilities. The difficulties experienced by individuals with mental illnesses may result in avoiding others, such as caregivers,

friends, and even family, who can prevent homelessness or improve living conditions for those diagnosed (Nelson et al., 2015; Stergiopoulos et al., 2015).

Housing is often unaffordable for many individuals diagnosed and living with severe and persistent mental illness. For a residence to be considered affordable, the individual or household contributes about 30% of their annual incomes toward rent or payments (Craig & Boardman, 2018; Honey et al., 2017; Houle et al., 2017). If costs go beyond this limit, as with many individuals diagnosed with mental illnesses, paying for food, clothing, transportation, and even healthcare becomes difficult or impossible (Craig & Boardman, 2018; Honey et al., 2017; Houle et al., 2017). According to NAMI (2019b), the average supplemental security income payment posted in 2008 was almost 30% under the federal poverty level for a one-person household.

The rate of home foreclosures is often high among people with mental illness, as they predominantly belong to groups with meager incomes. The public housing market is also saturated, partly due to the approximate 200,000 rental housing units destroyed yearly. Moreover, as the cost of rent continues to increase, the income of people in poverty continues to become unsustainable for a decent living (Olivet et al., 2019; Wood et al., 2016). More rental subsidies are necessary, as only about one-third of poverty-level or low-income renter households currently receive subsidies. The waiting list for Section 8 housing vouchers can be several years long, resulting in people becoming homeless or needing to stay in shelters for longer durations. Also, as the economy continues to create difficulties for many, including foreclosures across the housing market, higher demands exist in the rental market (Olivet et al. 2019; Wood et al., 2016). With this heightened demand for renting, those with available vouchers may require patience, as landlords

become more selective among the pool of people wanting to rent. Overall, the availability of affordable rental units has decreased because demand is triggering rental price increases (Olivet et al., 2019; Wood et al., 2016).

Currently, there is a misconception that homeless individuals can easily discontinue homelessness by proving themselves in society (Olivet et al., 2019; Wood et al., 2016). If homeless individuals become employed or gather some funding support, they will no longer be homeless, which is untrue for most. In the 1970s, when de-institutionalization started, there was a significant increase in homeless individuals suffering from mental disabilities (Olivet et al., 2019; Wood et al., 2016).

For some of the most vulnerable of populations in America, including but not limited to people suffering from mental illnesses, chronic health conditions, traumatic experiences, and other life-altering struggles, a home is one factor that may help them get the sufficient and effective treatment that they need so that they can attain recovery (Hinds et al., 2018; Lovasi et al., 2016; Mitchell et al., 2017). However, certain conditions make it difficult for people to have stable homes in the first place or maintain permanent housing without additional help or guidance, particularly from the government. Supportive housing can be a highly effective strategy to help these vulnerable people. Leaders of this strategy mix affordable housing with intensive and coordinated services (Hinds et al., 2018; Lovasi et al., 2016; Mitchell et al., 2017).

Living without a stable home or housing can drastically worsen one's health, making ending substance abuse and other mental health issues challenging. Not having stable housing can also prevent the addressing of chronic physical health problems (Hinds et al., 2018; Lovasi et al., 2016; Mitchell et al., 2017). People with mental health

issues usually tied also to chronic physical health conditions can end up in crises while living on the streets. Whenever they need healthcare, their only options—and maybe not all would even have this alternative—are to access emergency rooms (Hinds, et al., 2018; Lovasi et al., 2016; Mitchell et al., 2017).

Even though mental health service organization leaders have traditionally provided housing to individuals diagnosed with mental health issues, most have led to unfortunate results. As such, access to local authority housing was impeded, even if there were provisions, such as the Housing Acts 1966 to 2009 in place (Honey et al., 2017; Wood et al., 2016). Apart from adversely reinforcing social exclusion, these acts also diverted mental health funds away from giving people with mental health problems proper treatment and care. Researchers have requested ensuring adequate provision for individuals' housing needs when they have mental health difficulties, which translate to having greater efficiency in care and improving community involvement (Olivet et al., 2019). This issue can also destroy the cycle of social exclusion. One crucial factor involves gaining control over one's housing and maintaining a stable home to achieve social inclusion (Olivet et al., 2019).

Researchers have asserted that even though many use mental health services and live independently without any or only minimal housing support, there is a cohort or group of mental health service users who require support services that span a whole spectrum of housing and mental health needs because of their ailments and mental health issues (Honey et al., 2017; Wood et al., 2016). For some individuals with mental health problems, the requirement for housing support may be short term. However, many may require this support for a longer term, although not necessarily in a continuous period,

and may need flexibility concerning the nature and levels of support at a specific time (Honey et al., 2017; Wood et al., 2016).

Researchers have determined that individuals with mental health issues who tend to have a greater need for public housing support fall into five groups. The five groups include long stay-inpatients, discharged long-stay service users, new long-stay service users, new service users with severe and complicated mental health issues, and new service users with less severe symptoms residing in the family home (Honey et al., 2017; Wood et al., 2016). Long stay-inpatients may require more public housing support because they have been in mental hospitals or units for prolonged periods, usually beyond a year, which may affect their housing access and maintenance (Honey et al., 2017; Wood et al., 2016). Discharged long-stay service users are those previously removed from long-stay wards and now reside in staffed-community residences. They would also have a greater need for support to access proper housing. New long-stay service users are those who have transitioned from acute to long-term care. Because they remained in the hospital for a significant amount of time, with some staying in long-stay acute units and some transferred to long-stay wards, they could have a harder time acquiring stable housing (Honey et al., 2017; Wood et al., 2016).

New service users who have suffered from severe illness may not have remained in a long stay ward, but they too may require intensive housing help because they have suffered multiple admissions to acute wards. Some may have avoided admission to a hospital but remained vulnerable to becoming homeless or being sent to prison for criminal acts triggered by their mental health issues (Honey et al., 2017; Wood et al., 2016). Lastly, new severe users who develop fewer symptoms while in the family home

may require housing support, become heavily dependent on their family, or become at-risk of needing high lifetime dependency living arrangements without access to independent public housing options to support their independent living (Honey et al., 2017; Wood et al., 2016).

Living in shelters or on the street is always more complicated than living in a permanent home, with adverse effects on a person's emotional, physical, and mental health, no matter how healthy (Chambers et al., 2014; Lynn et al., 2014). People without adequate housing often experience victimization, resulting from physical, sexual, and emotional assaults. Some researchers have found that homeless people are the most vulnerable to being robbed, threatened, or injured (Chambers et al., 2014; Lynn et al., 2014). Severely mentally ill people without quality homes can become vulnerable to criminals. They are also prone to burglary if they receive social security disability checks (Chambers et al., 2014; Lynn et al., 2014).

Even though affordable housing can serve as a solution, some people may still need housing with supportive services because of their mental health conditions. Without these supportive services, they may not maintain an affordable house (Honey et al., 2017; Wood et al., 2016). For instance, service providers can help people with mental illnesses to pay their rents on time while allowing them to comprehend better their rights and responsibilities outlined in leases. The problem is that affordable housing or public housing usually does not come with these supportive services (Honey et al., 2017; Wood et al., 2016).

People living in public housing are also at-risk of or already suffering from some form of severe mental illness because they do not have homes of their own. The most

common mental health diagnoses that homeless people receive include depression, bipolar disorder, schizophrenia, and personality disorders (Maremmani et al., 2017). In addition to mental and emotional disorders, over 30% of all homeless adults living in shelters have re-occurring substance abuse problems. Homeless people are also found to endure significant rates of sexual and physical assault. One study showed that around 32% of homeless women, 27% of homeless men, and 38% of homeless transferred people experienced being assaulted in a year, whether physically or sexually (Maremmani et al., 2017). Studies on homelessness concerning the plight of women showed that the most common causes of homelessness included mental illness, drug dependence, experiences of domestic violence, and disaffiliation (Whitbeck et al., 2015).

U.S. homeless people in public housing have mostly dealt with some form of mental illness, often severe (Montgomery et al., 2013; Robertson & Greenblatt, 2013; Williams & Baumgartner, 2014). In a 2008 survey sponsored by the U.S. Conference of Mayors, 25 cities reported the three leading causes of homelessness in their communities, with one entailing mental illness. For homeless families, mental illness was cited by around 12% as the top cause of homelessness. Severe mental illness can affect a person's capacity to complete daily tasks such as self-care and household management. Because these tasks were not carried out by people with mental illness, they were barred from forming and maintaining stable relationships, avoiding people who could have prevented them from becoming homeless, such as caregivers, friends, and families. Due to factors and stresses associated with living with mental illness, people with such disorders were the most at risk of becoming homeless (Montgomery et al., 2013; Robertson & Greenblatt, 2013; Williams & Baumgartner, 2014).

A large and growing body of research shows that supportive housing can effectively aid people with disabilities to maintain stable housing, but these programs are quite limited at present. Leaders of public housing, coupled with supportive services, utilize costly systems, such as emergency health services, less frequently and less likely to incarcerated. Supportive housing can also help people with mental health problems and other disabilities in accessing better healthcare, helping senior citizens stay within the community as they age (Bernet et al., 2015; Harris et al., 2018).

There are some guiding principles relevant to the housing needs of individuals suffering from mental health problems, such as citizenship, community care, the coordination of supportive services, and inclusiveness. Citizenship refers to equity of access, while community care includes having access to a mental health specialist or mental health support services. According to researchers, apart from the issues of securing employment, limited access to appropriate housing serves as a structural barrier to mental health (Bernet et al., 2015; Harris et al., 2018). Despite these studies on supportive services, it was unclear how public housing residents' access and use these mental health services—a focus of the current study.

Sociocultural Perspectives and Help-Seeking Attitudes

At present, the National Institutes of Health (2017) have requested new approaches to enhance the precision, accuracy, and effectiveness of existing measurements of behavioral and social phenomena, the contexts they are in, and their impact on health. These recommendations were all part of a much bigger global health equity movement, wherein the primary goal was to reduce health inequities (Marmot et al., 2012). Health inequities often occur because of unequal social determinants of health,

which refer to a broader set of political, economic, and environmental circumstances; forces; and systems that affect the conditions of an individual's daily living, including that of a healthy life (World Health Organization, 2016). The social determinants of health show how significantly related this social structure is to a population's health. The social structure shaped by both political and cultural factors can affect a population's health. These determinants can also be considered from a philosophical perspective, as each serves as a value-based lens through which policymakers, as well as health providers themselves, perceive health and healthcare (Starfield, 2007).

In particular, the cultural concepts within the social determinants of health have emerged as critical factors for healthcare and health outcomes. Cultural beliefs, values, and practices usually support broad ideological and philosophical frameworks that interact with or provide support to other macrolevel institutions. At the same time, these aspects can shape social interactions at the intermediary level. Considering culture within the broad social determinants of health enterprise shows the complications of healthcare.

Most individuals who experience mental health issues never seek treatment in their lifespans, despite all the research findings that psychological treatments can effectively address most health concerns (Wampold & Imel, 2015). Social determinants of help-seeking behavior are at play. For instance, research findings showed gender as a factor. Several researchers found that men tend to report worse help-seeking behaviors and attitudes than women. Studies indicate that men consistently seek help at lower rates for mental health issues related to substance abuse, stress, and depression (Hammer et al., 2013), with many perspectives posited as supporting this trend. One, men hold negative help-seeking attitudes because help-seeking might imply they are bending or

disappointing gender norm expectations. If men believe that they need counseling, there is a high likelihood that they experience a sense of failure as men, associating this need with not having the ability to handle issues on their own (Hammer et al., 2013).

Researchers have detailed the struggles faced by Blacks in public housing when accessing mental health services. However, most have focused on older Black public housing residents and did not delineate experiences between men and women. There is also a lack of studies on Black women's access and utilization of mental health services when in public housing and what factors affect these opportunities and decisions. Most available literature is also dated. For instance, Black et al. (1997) examined both the need and unmet need for mental healthcare among Black older adult public housing residents. Results revealed that 37% of the predominantly Black sample required mental health services, and a significant 58% had their needs unmet. Logistic regression analyses showed a need for increased service utilization, which could only happen with targeted interventions. Increased service utilization can lead to a reduced risk of eviction or placement in restrictive settings. In an earlier study, Black et al. (1998) examined the actual use of formal and informal sources of mental healthcare support among older Black public housing residents. The researchers found that even though 35% of the subjects required mental healthcare, less than 50% (47% to be exact) only received or had accessed mental health care. Moreover, residents in need of mental health services tended to utilize formal care rather than informal sources for care.

Estreet et al. (2018) conducted another relevant study to the current study. The researchers examined depression among urban African American youth living in public housing and how parental factors could serve as a pathway to decrease mental health

issues among this population. Results showed that parent-child relationships and parental monitoring could all help as protective factors against depression for this group.

Mental Health Help-Seeking Behaviors in Public Housing

Jung (2015) defined public housing as a vital resource for people without sufficient incomes, particularly people with disabilities, older adults, single parents, and many more categories of individuals. At the same time, these same people are at higher risks for mental health problems. In comparison to nonpublic housing residents, those who live in public housing units in general also already have poor mental health. Despite high needs to receive mental healthcare, many would not have these care needs met. Untreated mental health problems while in public housing can lead to evictions and homelessness (Jung, 2015). There is a need for residents' mental healthcare needs to be addressed so that the length and quality of their lives can be improved. The problem is that most public housing staff is not well versed in identifying mental health problems among residents. The researcher highlighted the importance of mental health education among public housing staff and social workers to be more actively involved in the mental health education of those working in community settings, such as public housing (Jung, 2015).

Resilience

Resilience is a dynamic process that involves the positive adaptation of a person when faced with significant adversity (Luthar et al., 2000). Ungar (2004) also defined resilience due to negotiations of individuals with their environments for the resources needed to make sure they remain healthy despite dealing with adverse conditions. Resilience is not a straightforward construct. Despite these difficulties, resilience is

commonly and generally known as the ability to bounce back positively amid unwanted and challenging circumstances.

Researchers have discussed resilience as the individual capacity to prevail over the harmful effects of risk exposure, effectively deal with stressful experiences, and circumvent damaging paths associated with specific threats (Smith et al., 2008). Resilience is common in mental health research (Schomerus et al., 2013), often assessed in terms of psychopathology, with higher resilience levels associated with lower levels of depression and anxiety (Carbonell et al., 2002; Gillham et al., 2007). Moreover, researchers have linked low levels of resilience with higher levels of formal help-seeking in depressed individuals (Schomerus et al., 2013).

Evaluating the presence and levels of resilience often occurs when analyzing the impacts of stressful situations, threats to health, including mental health, stigma, and adversity. Smith et al. (2008) defined resilience as a process and not a static trait of prevailing over the dangerous effects of risk exposure and stressing experiences. In the context of health and mental health, resilience generally refers to the ability to avoid and prevail over illness regardless of adversity (Garmezy et al., 1984; Luthar et al., 2000; Powell, 2017; Rutter, 1987). Resilience is also the factor regarded as helpful for one to strive and function above the norm, even when diagnosed with a chronic condition (Smith et al., 2008). Resiliency levels can be measured or assessed by how people can revert to a previous level of functioning after they had gone through a stressful incident or adjusted to a new or stressful situation (Smith et al., 2008).

Optimism

Researchers have studied optimism as significantly concerning mental and physical well-being (Conversano et al., 2010). These researchers concluded that optimism or the positive and negative expectations regarding the future could serve as an essential factor for understanding the vulnerability and reactions to mental disorders and physical illnesses. The researchers established a significant positive relation between optimism and coping strategies focused on social support and positive aspects of stressful situations. They also found that optimism could indirectly influence a person's quality of life, even faced with adversities. As such, optimism may significantly affect mental and physical well-being by promoting a healthy lifestyle and the willingness to engage in adaptive behaviors and better cognitive responses to problems. Optimism generally links to greater flexibility, problem-solving capacity, and a more efficient elaboration of negative information in the face of mental and physical issues.

Numerous scholars have hypothesized that optimism contributes to an improved outcome and reported quality of life among individuals (Thoits, 2013; Wurm & Benyamini, 2014). Many researchers have studied optimism and its effects on quality of life and wellness (Applebaum et al., 2014; Arnett et al., 2014; Blackwell et al., 2013). The goal of this section of the literature review is to provide a close examination of the research currently available about optimism.

Researchers have pointed out that better caregiver involvement, management, and patient-centered care improved not only communication but also patient optimism and recovery (Nelson et al., 2016; Wilde-Larsson et al., 2014). Researchers have suggested that quality of life is vastly affected by the communication established and support given

during treatment (Colby & Shifren, 2012; Fitzpatrick, 2017; Wurm & Benyamini, 2014). The caregiver role is vital to the overall well-being of individuals and their abilities to adopt an optimistic or resilient disposition. Important elements contributing to a patient's ability to adopt an optimistic attitude include their sense of shared communication with their health care providers (Colby & Shifren, 2012; Fitzpatrick, 2017; Wurm & Benyamini, 2014). Many studies have shown that most individuals feel they need to be adequately informed not only of their condition but also of their treatment options (Lusk & Fater, 2013; Sidani & Fox, 2014). Other factors that contribute to an individual's sense of well-being include information about where they can get help, support, and complementary care. Individuals who felt the most adequately informed were most likely to report optimistic feelings and subsequently adopt behaviors that encouraged a better quality of life after discharge (Lusk & Fater, 2013; Sidani & Fox, 2014).

As pointed out at the beginning of the literature review, an individual's and healthcare professional's goals must be aligned. Far too often, physicians focus on extending life in the short term, rather than following an individual's goals of improving quality of life in the short and long term. One's quality of life is a critical component of care for most individuals. Researchers have indicated that individuals are more likely to be optimistic about their care and realize a higher quality of life when their goals align with those of their physicians (Rodriguez & Young, 2006). For this reason alone, it is essential to find out how to improve the quality of life.

Numerous studies have shown a direct relationship between psychosocial factors, including individual psychological characteristics and individuals' reported willingness to access healthcare and change their lives (Triemstra et al., 1998). Psychological variables

make up the strongest determinants of well-being in individuals with chronic, debilitating conditions. Some conditions include Parkinson's disease, multiple sclerosis, HIV, hemophilia, and many more.

Support for optimism as a model for improving one's life is abundant. Lyons et al. (2004) confirmed that optimism might influence the quality of life for individuals with Parkinson's disease because they were more willing to access healthcare. Optimism and pessimism may reflect clinicians' attitudes when dealing with individuals. Clinicians more optimistic about a patient's outcome and quality of life contribute to the optimism of their patients (Lyons et al., 2004). Clinicians who have negative perceptions of an individual's outcome are more likely to work with individuals who realize a poor quality of life. Studies like this one supported the idea that optimism and pessimism were traits that could not only be learned but also shared from one person to the next (Lyons et al., 2004).

Likewise, Lert (2000), while examining HIV individuals, found that pessimism might contribute to poor outcomes. Pessimism may result from many different factors, according to the researcher. The most cited reasons included a dire prognosis, lack of information, lack of treatment options, and the individual's general sense of being ill-informed of available choices. Lert suggested the need for more research regarding optimism and its effects on treatment outcomes. Lert also highlighted the importance of aligning patient goals and communication efforts with those of physicians.

Giltay et al. (2004) concluded that dispositional optimism created a protective relationship in individuals. This optimism may reflect inherent or learned behaviors on the part of the patient. Pessimism may also contribute to increased mortality rates and

poor behaviors. Giltay et al. conducted a unique study as the researcher showed that the more pessimistic an individual, the more likely they were to participate in unhealthy lifestyle habits. These habits may contribute to a lower quality of life and poor prognosis over time. This conclusion supported other studies that indicated that optimism contributed to a better quality of life, in part because optimistic individuals tended to adopt more healthy lifestyle habits both during and after treatment.

Researchers have suggested that optimistic personality traits, while beneficial, may be harmful if unrealistic (Bradley et al., 2017; Stagman-Tyrer, 2014). Researchers have suggested that overly optimistic individuals may feel let down when their perceived quality of life does not improve over time (Bradley et al., 2017; Stagman-Tyrer, 2014). This concept supported the notion that although caregivers should provide individuals with hope, they should share with patients the detailed and correct information about their prognoses. Individuals who feel more fully informed are less likely to suffer negative consequences from being overly optimistic than those with unrealistic expectations because they set reasonable expectations and hopes for themselves (Bradley et al., 2017; Stagman-Tyrer, 2014).

The research indicated that optimism might not improve a patient's outcome but could prolong their lives by making them willing to access needed healthcare. Fording (2004) discussed a study showing that optimism did not extend the life of individuals suffering from debilitating illnesses like cancer. However, individuals with positive attitudes were more likely to report better quality of life by encouraging individuals to take better care of themselves (Fording, 2004).

Experienced Stigma

Experienced stigma is a factor behind coping with mental illness. According to Henderson et al. (2013), the relationship between stigma, discrimination, and access to healthcare is multifaceted. The researchers found that stigma could lead to treatment avoidance and delays, even discontinuance of service use. It promulgated a lack of knowledge about the features and treatability of mental illness and ignorance to availability and accessibility of treatments. Therefore, previous researchers on the topic asserted that addressing public stigma could lead to reducing the impact of experienced stigma among service users and facilitate help-seeking and engagement with mental health care among those who required such services. Beliefs about the effectiveness of treatments and services can influence subsequent or long-term treatment behavior, but stigma may already be significantly experienced by people with mental healthcare requirements long before they have access to these services. The effects can be challenging to reverse.

Self-Efficacy

The concept of self-efficacy refers to the general belief in one's ability to achieve one's plans or perform a task as desired, as well as to perform actions necessary to attain favored or anticipated outcomes (Bandura, 1977). As a result, perceived self-efficacy is linked to an individual’s core beliefs concerning capabilities to achieve a certain level of attainments through their actions. These perceptions are a product of a complex process of self-appraisal and self-persuasion associated with several sources of efficacy information. According to Bandura (1977), the sources of perceived self-efficacy are past performance accomplishments, vicarious experiences, verbal persuasion, and

physiological and emotional states. Instead of a global entity or general phenomenon, self-efficacy can vary according to activity domains, task demands, and situational characteristics (Bandura, 1977). Therefore, one operates according to contextual factors and dependent of these factors. Expectations about efficacy can lie on the task and context that the individual faces. Therefore, it is not right to say that an individual has "high" or "low" self-efficacy; instead, such characterization is only appropriate to a particular behavior and situation (Bandura, 1977; Strecher et al., 2002), such as high self-efficacy to seek mental help. Concerning health issues, people with high self-efficacy tend to possess beliefs that they have better control over their health. They also exhibit better adherence to programs in the bid to improve their health, whether physical or mental (Brannon & Feist, 2000). Researchers asserted that by enhancing self-efficacy beliefs, the successful change and maintenance of various patterns or forms of health-related behaviors could take place (Brannon & Feist, 2000). Brannon and Feist (2000) showed that a stronger relationship existed between self-efficacy and health behaviors compared to other personality variables, such as age or gender.

Summary

Women with mental healthcare issues living in poor public housing projects show an important issue that requires further research to find solutions for problems plaguing society today. The issue of mental health is not one that will be going away without help from the government and concerned citizens. Researchers have revealed both logistical and systemic issues may prevent their access to professional psychological support. People who choose to live in public housing units have certain individual traits and

attitudes that affect their desires to look for assistance with psychological health concerns (Appio et al., 2013; Santiago et al., 2013).

Although researchers have established optimism, self-efficacy, and resilience as three traits that can lead to useful coping and reduced incidences of psychological disorders (Acun-Kapikiran et al., 2014), few evaluated these among women living in public housing projects. Thus, a literature gap exists. Most researchers did not concentrate on individual elements related to attitudes and behaviors about seeking mental health assistance among low-income individuals (Santiago et al., 2013). Moreover, no researchers had yet to focus on women living in public housing projects regarding their attitudes and behaviors about seeking mental health assistance, as the identified research gap for the current study. There was a need for a study on how self-efficacy, optimism, and resilience related to attitudes toward seeking treatment in women living in public housing settings so that counselors could conduct more effective outreach efforts in these communities.

Studies have shown that individuals optimistic in their thought processes are more likely to realize a better quality of life before, during, and after treatment regardless of the severity of their conditions (Applebaum et al., 2014; Arnett et al., 2014; Blackwell et al., 2013; Carver & Scheier, 2014; Colby & Shifren, 2012; Fitzpatrick, 2017). However, none have focused on women in public housing projects. Instead, many researchers suggested that more optimistic individuals were more likely to engage in health-promoting behaviors after treatment and diagnoses of illness (Applebaum et al., 2014; Carver & Scheier, 2014; Colby & Shifren, 2012; Fitzpatrick, 2017).

As such, the objective of this quantitative study was to determine whether the traits of resilience, self-efficacy, and optimism, individually or in combination with each other, predicted attitudes of women residents of public housing toward seeking professional help. I asked if the traits of resilience, measured by Connor and Davidson's (2003) Resilience Scale; self-efficacy, as measured by the General Self-Efficacy Scale by Schwarzer and Jerusalem (1995); and optimism, as measured by the Life Orientation Test by Scheier and Carver (1985), in women residing in public housing projects correlated. Also, I asked if the traits of resilience, self-efficacy, and optimism could individually or in combination with each other predict attitudes toward seeking help, as measured by Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (Fischer & Turner, 1970) in women residing in public housing projects. The next chapter presents the methods used to complete this study.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing. This chapter includes the discussion of research design, targeted population, sample size and sampling measures, processes for recruiting participants, data collection methods, instrumentation, and operationalization of concepts investigated in this study. The discussion also includes procedures of data analysis, threats to validity, and ethical techniques. This chapter ends with a summary of the research methodology used for this study.

Research Design and Rationale

I conducted a quantitative, non-experimental correlational, cross sectional study. I examined the predictive relationships between resilience, self-efficacy, experienced stigma, optimism, and attitudes toward help seeking for mental illness among Black women residing in public housing projects. I chose the quantitative method because statistical calculations were needed to determine the predictive relationships among variables of interest in this study. A researcher conducts a quantitative study when aiming to investigate relationships between two or more variables measured numerically (Babbie, 2012; Bettany-Saltikov & Whittaker, 2014), as with this study. Therefore, the quantitative methodology was appropriate for this research.

I used quantitative measurements and statistical analysis of data collected on the variables to address the objectives of this study. I utilized a correlational research design.

I selected a correlational research because the purpose of my research was to assess the relationships quantitatively between variables using statistical analysis. A researcher conducts a correlational research study when aiming to analyze relationships quantitatively among variables or determine the influence of various independent variables on a particular dependent variable (Gavin, 2013; Leedy & Ormrod, 2013). Researchers cannot determine causality in a correlational research design, but they can when utilizing an experimental research design (Klugh, 2013). The correlational research design was an appropriate design for this research because the objective was to determine the relationships between the quantitative variables of resilience, self-efficacy, experienced stigma, optimism, and attitudes toward seeking help for mental illness in women residing in public housing. Cross-sectional research is a type of research design that involves analyzing the data from a population or a representative subset at a specific time only, instead of within different periods (Harpe, 2017). A cross-sectional design was appropriate as the purpose of this study involved determining the exposure and outcome status at a point in time. Researchers should use a cross-sectional design when the major goal is to find a strong causal inference (Harpe, 2017).

Methodology

Population

The targeted population for this study included Black women residing in public housing projects, specifically in North Carolina. Statistics from the Housing Authority of the City of Greenville (2017) showed that 87% of public housing projects households in the city were headed by a female—significantly higher than the national percentage of female headed households at 35%. Moreover, 52% of households in public housing in

North Carolina had children, as compared to the national average of 37%. Statistics further revealed that only 1% of households in public housing in North Carolina had two adults. Regarding ethnicity, 96% of the households in public housing in North Carolina were headed by minorities, with 95% of all heads of households being Black and 1% being Hispanic.

Sample Size

I used G*Power software to calculate the required sample size for this study needed to detect true differences in the data. G*Power is a power analysis program that can conduct a-priori analyses to determine how many subjects are necessary to calculate the optimum sample size for a variety of statistical procedures (Kadam & Bhalerao, 2010). A power of 0.80 is typically used in quantitative research projects to provide valid statistical results (Faul et al., 2009). I used a medium effect size not only to be lenient but also to maintain strictness at the same time in the analysis. Cohen (1992) proposed a medium effect size because the value might be able to approximate the average size of observed effects in various fields.

Two different sample size computations were conducted because this study involved using two statistical analyses of correlation analysis and regression analysis. Results of both computations should be considered wherein the sample size requirements of both statistical analyses should be satisfied. Considering a correlation analysis with a conventional power of 0.8, a medium effect size of 0.30, and a level of significance of 0.05, the total sample size computed equated to $n = 82$ (see Appendix A). Considering a multiple linear regression analysis with four predictors, a statistical power of 0.8, a medium effect size of 0.15, and a level of significance of 0.05, the total sample size was

calculated as $n = 55$ (see Appendix B). I collected data from at least 100 participants who met the inclusion criteria. The 100 number surpassed the minimum sample size generated by the G*Power analysis to have adequate power for determining differences that might exist in the data. The larger sample size considered assumptions of missing data, which provided more accurate mean values, to identify outliers adequately that could skew the data.

Sample and Sampling Procedures

I used a non-probability sampling technique of purposive sampling plan to recruit the participants. Researchers conduct purposive sampling because it is unknown that which individual from the population will participate (Gentles et al., 2015). This sampling process has accessibility advantages, faster speeds in recruitment, and lesser costs to recruit study participants than other non-probability sampling techniques, such as convenience sampling (Gentles et al., 2015). I chose purposive sampling because the participants must meet the specific set of inclusion criteria to be eligible to participate. Researchers can use purposive sampling of individuals to gather in-depth data or information on a chosen population and describe the impact their findings have on the population (Saunders et al., 2012). The inclusion criterions that participants must meet included (a) Black women from age 18 and over, (b) people living in North Carolina, and (c) people receiving public housing projects assistance from the U.S. government. Because men and women have exhibited differences in attitudes toward seeking help (Harris et al., 2015), I decided to exclude men from this study to enhance the specificity of its findings. Women receiving public housing assistance in other states were also excluded.

Recruitment

I sent flyers (see Appendix C) to the Greenville housing authority office of North Carolina that included my contact information for questions or concerns. The Greenville housing authority office sent emails on my behalf to potential participants who met the criteria. Participants' informed consent was obtained electronically on the SurveyMonkey (2012) website. SurveyMonkey is a web-based tool instrument that specializes in providing a platform for developing and deploying surveys. Participants received the consent form as the first page once they accessed the SurveyMonkey website. The consent showed the purpose of the study, significance of the study, time it would take to complete the surveys, and their rights to participate. There were no time restraints so that potential participants could take as much time as needed to determine if they wanted to participate.

I informed participants should they choose to participate or not that there would not be any relationship risks that could alter the dynamics between them and the researcher, their families, nor friends. I also informed participants should they feel distressed in any way, they could skip questions or stop participation at any time. The informed consent was used to obtain a list of counselors in the area should participants feel upset or stressed in any way. My contact information as the researcher was posted on the consent form if the respondents had any questions regarding the study. No signatures were collected, and completion of the survey indicated their consent to protect participant's privacy. Should participants choose to participate, they clicked an "I consent" button, then accessed the demographic questionnaire by clicking the "Next" button.

Participation

Before data gathering commences officially, participants provided consent to participate in the study. Appendix D shows the copy of the consent form. The informed consent form showed details on the following: confidentiality, volunteering for the study and the time to compete it, risks associated with participating, and contact information for me as the researcher. Detailed instructions on how participants could exit the study without repercussions were included in the informed consent form. The informed consent showed participants that (a) they could terminate participation at any time without consequence, (b) there was no compensation from me for participating in the study, (c) no deception was used in the study, and (d) surveys were completed via participants' personal devices in a privacy area of their choosing so that no one else could see their actions, and (e) the survey was inaudible so that others could not hear responses.

Participation in the study remained voluntary, and participants implied consent by completing the data collection processes on the SurveyMonkey (2012) portal. Participants who agreed to be part of the study through the informed consent proceeded to the demographics questionnaire and then to the survey instruments. Participants affirmed that they read and understood the informed consent well enough to decide to participate by signifying their agreement by clicking the appropriated button, labeled "I Consent," or "I Do Not Consent."

After agreeing to participate, participants provided information regarding their demographic characteristic questions. The demographic variables of age, level of education, ethnicity/race, and number of children in the household were obtained from them. Afterwards, they could access the surveys, and data collection began.

Data Collection

I used a survey methodology to collect data to address the research questions. The survey methodology was chosen to quantify the variables of interest. Survey methodology is used to measure the variables of interest in the study quantitatively (Andrews et al., 2012). Likert-type scales were used to quantitatively measure data in this quantitative study to measure the degree level of characteristics of a sample regarding trends, attitudes, or opinions. I used five survey instruments to collect data on the variables. The reason survey design was chosen for statistical analysis of the data collected. Another purpose of using a survey design was because a researcher could generalize from a sample to a population so that inferences could be made about some characteristics, attitudes, or behaviors of this population (Babbie, 2012). Survey research provided the advantage of identifying attributes of a large population from a small group of individuals.

Details regarding these instruments are presented in the instrumentation section of this chapter. There was no time limit allotted for the respondents so that they could take as much time as needed to decide if they would like to participate in online surveys. However, it took approximately 20 to 30 minutes to complete the online surveys in SurveyMonkey (2012). I collected the data in SurveyMonkey and downloaded those data into an Excel spreadsheet. I inputted the data sets in an Excel spreadsheet format and uploaded it to SPSS, a statistical analysis software (see Field, 2013). I then conducted the statistical analyses of my finding.

Instrumentation and Operationalization of Constructs

I asked survey participants to complete five survey instruments to measure the four independent variables of resilience, self-efficacy, experienced stigma, and optimism and the dependent variable of attitude toward seeking professional help. This section contains details regarding each variable and how the variable is operationalized.

Resilience

I measured the independent variable of resilience by utilizing Connor and Davidson's (2003) Resilience Scale (see Appendix E). Resilience is a dynamic process that involves the positive adaptation of a person facing significant adversity. The scale was designed as a valid and reliable measure of resilience to establish reference values for resilience in the general population and clinical samples. The scale consisted of a total of 25 items responded to in a 5-point range of 1 (*not true at all*), 2 (*rarely true*), 3 (*sometimes true*), 4 (*often true*), and 5 (*true nearly all the time*). Respondents were directed to respond to items on the survey based on how they felt over the past month. Appendix E shows the permission to use the Resilience Scale from the original author.

Reliability of the Resilience Scale. Researchers have added empirical information regarding the internal consistency of the instrument. For example, the instrument showed excellent internal consistency reliability with Cronbach's alpha value of 0.91 in one study (Wang et al., 2010). Test-retest reliability over 2 weeks was also high with a value of $r = 0.90$ (Wang et al., 2010). Reliability of the Cronbach's alpha for the full scale was 0.89 for Group 1 (n1⁄4577), and item-total correlations revealed a range from 0.30 to 0.70. Test-retest reliability had a reliability estimate of $r = 0.87$ over two consecutive visits. According to Stoner et al. (2015), scores for the CD-RISC scores were

positively correlated with scores from the Kobasa hardiness measure in psychiatric outpatients; Spearman $r(4) = 0.83$ ($p = 0.0001$). The Sheehan Stress Vulnerability Scale was negatively correlated with the CD-RISC—Spearman $r(4) = -0.32$ ($p = 0.0001$)—in 591 subjects from the combined sample. These results showed that the resilience scale had acceptable construct validity.

Validity of the Resilience Scale. Regarding validity, a confirmatory factor analysis showed an acceptable construct validity of the 25-item Resilience Scale, with statistics of $X^2(35) = 176.10$, $p < 0.001$, RMSEA = 0.050, 90% CI = 0.043-0.057, CFit = 0.50, SRMR = 0.028, CFI = 0.97, and determinacy = 0.93 (Campbell-Sills & Stein, 2007). According to Stoner et al. (2015), scores for the CD-RISC scores were positively correlated with scores from the Kobasa hardiness measure in psychiatric outpatients; Spearman $r(4) = 0.83$ ($p = 0.0001$). The Sheehan Stress Vulnerability Scale was negatively correlated with the CD-RISC—Spearman $r(4) = -0.32$ ($p = 0.0001$)—in 591 subjects from the combined sample. These results showed that the resilience scale showed acceptable construct validity.

Scoring the Resilience Scale. I calculated the score of resilience by getting the total scores and summing the answers from all 25 items. Scores on the Resilience Scale ranged from a minimum of *0* to a maximum of *100*. A greater score showed higher resilience than a lower score. I did not reverse score any items.

General Self-Efficacy Scale

I measured the independent variable of self-efficacy with the 10-item General Self-Efficacy Scale by Schwarzer and Jerusalem (1995; see Appendix G). The scholars created the General Self-Efficacy Scale to assess participants' sense of perceived self-

efficacy, predict their coping capacities for daily hassles, and show their adaptation capabilities after facing various stressful life events. Respondents rated the 10 items on a 4-point Likert scale, ranging from 0 (*not true at all*) to 3 (*exactly true*) about their levels of self-efficacy. Appendix F shows the permission to use the General Self-Efficacy Scale from the original author.

Reliability of the General Self-Efficacy Scale. The instrument showed satisfactory internal and reliability, with Cronbach's alpha values ranging from 0.76 to 0.90, with most in the high .80s (Schwarzer & Jerusalem, 1995). Schwarzer and Jerusalem (1995) stated that the scale was unidimensional or measured the same construct; for this current study, self-efficacy was measured. Cronbach's alpha value greater than 0.70 indicated acceptable internal consistencies among items. According to Schwarzer and Jerusalem (1995), the General Self-Efficacy Scale exhibited good test-retest reliability (r = 0.57-0.71). Nilsson et al. (2015) investigated the psychometric properties of the General Self-Efficacy Scale, using data available from two different projects composed of participants with Parkinson's Disease for at least a year. Results showed that test-retest reliability yielded results ranging from 0.69 and 0.80.

Validity of the General Self-Efficacy Scale. The General Self-Efficacy Scale was correlated with other constructs, including emotion, optimism, and work satisfaction. Negative correlations were found between self-efficacy and other variables of depression, stress, health complaints, burnout, and anxiety (Schwarzer & Jerusalem, 1995), showing acceptable criterion validity. Romppel et al. (2013) found negative associations with symptoms of depression (–0.35 and –0.45), anxiety (–0.35), and vital exhaustion (–0.38) and positive associations with social support (0.30) and mental health (0.36). In addition,

the General Self-Efficacy Scale-6 score was positively associated with active problem-focused coping (0.26) and distraction/self-encouragement (0.25) while being negatively associated with depressive coping (–0.34). These scores showed that the General Self-Efficacy Scale had acceptable criterion validity. Cramm et al. (2013) investigated the psychometric properties of the GSE as well, including its construct validity. Construct validity of the scale was confirmed.

Scoring the General Self-Efficacy Scale. I calculated self-efficacy by summing the answers from all 10 items. The General Self-Efficacy Scale scores ranged from a minimum of *0* to a maximum of *40*. Higher scores indicated stronger beliefs in self-efficacy.

Discrimination and Stigma Scale

The independent variable of experienced stigma was measured using the 32-item Discrimination and Stigma Scale by Brohan et al. (2013; see Appendix I). The Discrimination and Stigma Scale was an interview-based scale that researchers used to measure experiences of mental health-related discrimination (unfair treatment) for important aspects of normal social and life activities. Such activities included seeking employment, nuptials, childrearing, lodging, leisureliness, and religious happenings. Additionally, the scale showed the degree to which participants withdrew from participation in these aspects of living, resulting from predicted discrimination.

Respondents rated the 32 items on a 4-point Likert scale, which included 0 (*not at all/no difference*), 1 (*a little*), 2 (*moderately*), 3 (*a lot*), and 4 (*not applicable*), about their experienced stigma. The survey questions offered a *not applicable* option for instances where the participant did not experience discrimination. The Discrimination and Stigma

Scale was used to measure a global scale and four subscales that included unfair treatment (Items 1 to 21), stopping self (Items 22 to 25), overcoming stigma (Items 26 and 27), and positive treatment (Items 28 to 32). Appendix H shows the permission to use the Discrimination and Stigma Scale from the original author.

Reliability of the Discrimination and Stigma Scale. According to Brohan et al. (2013), the Discrimination and Stigma Scale demonstrated good psychometric properties including inter-rater reliability (weighted kappa range: 0.62-0.95), internal consistency ($\alpha = 0.78$), and test-retest reliability (weighted kappa range: 0.56-0.89). Li et al. (2016) assessed the reliability of the Chinese version of the scale in patients with mental illnesses. The findings showed that the tool had an acceptable internal consistency of 0.70 and acceptable test-retest reliability score of 0.83.

Validity of the Discrimination and Stigma Scale. The face and content validity of the Discrimination and Stigma Scale was established in the scale development through a literature review and pilot testing of the draft scale, including research teams at 28 participant study sites in 27 countries (Brohan et al., 2013). Twenty-five interviews were conducted at each site ($n = 732$), with five of the interviews at each site audio-taped, transcribed verbatim, translated into English, and qualitatively analyzed by members of the study team. The results indicated that negative discrimination was frequently experienced. For example, 344 (47%) reported discrimination in making or keeping friends, 315 (43%) in relationships with family members, and 209 (29%) in finding jobs. Discrimination was also frequently anticipated, with 469 (64%) inhibiting themselves from applying for work, training, or education and 402 (55%) stopping themselves from looking for a close relationship for this reason. The qualitative and quantitative analysis

of the data collected indicated that the Discrimination and Stigma Scale might benefit from further developmental work to improve the relevance and ease of use of items and response options. This information was all that was available regarding the validity of the Discrimination and Stigma Scale. However, Li et al. (2016) assessed the validity of the Chinese version of the scale in patients with mental illnesses. The researchers concluded that the Chinese version of Discrimination and Stigma Scale had good psychometrically validated properties. The researchers recommended the tool for measuring experienced and anticipated stigma and discrimination of people with mental disorders in China.

Scoring the Discrimination and Stigma Scale. I used the global score to measure for experienced stigma. The global or the total score was the summed scores of the scales in the Discrimination and Stigma Scale. The range of possible scores for the global scale was from *0* to *96*; the subscale of unfair treatment was from *0* to *63*, stopping self was from *0* to *12*, overcoming stigma was from *0* to *6*, and positive treatment was from *0* to *15*. No items were reverse coded (see Brohan et al., 2013).

Life Orientation Test

The independent variable of optimism was measured using the 12-item Life Orientation Test by Scheier and Carver (1985). Appendix K contains a copy of the instrument. The Life Orientation Test was created to assess respondents' feelings about their levels of optimism and pessimism. Respondents rated the 12 items on a 5-point Likert scale, ranging from 0 (*strongly disagree*) to 4 (*strongly agree*). Appendix J shows the permission to use the Life Orientation Test from the original author.

Reliability of the Life Orientation Test. The Life Orientation Test had acceptable internal consistency reliability, with a Cronbach's alpha value of 0.71 and

item-total correlation coefficients from 0.27 to 0.73 (Scheier & Carver, 1985). Scheier and Carver (1985) reported an internal reliability coefficient of 0.78 for an undergraduate participant group. The corresponding internal reliability coefficient for the sample in the present study was 0.60. The Life Orientation Test Optimism scale (total of the three positively worded items) and Life Orientation Test Pessimism scale (total of three negatively worded items) were also calculated. Internal reliability coefficients for these subscales were 0.62 (Optimism) and 0.78 (Pessimism). Other studies showed acceptable retest reliability at 4 weeks (0.79; Scheier & Carver, 1985) and 13 weeks (0.72; Carver & Gaines, 1987).

Validity of the Life Orientation Test. The LOT (Scheier & Carver, 1985) was a questionnaire measure of generalized positive outcome expectancies that demonstrated adequate validity. The Life Orientation Test did not appear completely redundant with any of the measures of internality, self-esteem, hopelessness, depression, perceived stress, alienation, and social anxiety (Terrill et al., 2002). Creed et al. (2002) revealed a strong positive relationship ($r = 0.55$) between total Life Orientation Test score and self-esteem. Huprich and Frisch (2004) reported a strong positive relationship between trait hope and Life Orientation Test scores for women ($r = 0.42$) and men ($r = 0.48$). According to Lyrakos et al. (2010), the LOT-R scale exhibited good convergent validity with the single-item optimism scale ($r = 0.73$).

Scoring the Life Orientation Test. For the scoring of optimism, the instrument had four-filler items (Items 2, 6, 7, and 10), and those scores were not added to the final score. Items 3, 8, 9, and 12 were reverse scored. The total score was the sum of Items 1, 3, 4, 5, 8, 9, 11, and 12, with the lowest score being 0 and the highest being 32. The

highest score (above 17) indicated pessimistic trait of personality, and the lowest score (below 17) showed optimistic traits of personality.

Attitudes Toward Seeking Professional Help

I measured the dependent variable of attitude toward seeking professional help using the 10-item Attitudes Toward Seeking Professional Help by Fischer and Farina (1995). Appendix M shows the copy of the instrument. Respondents rated the 10 items on a 4-point Likert scale, ranging from 0 (*disagree*) to 3 (*agree*) about their degrees of agreement with the scale. The permission to use the Attitudes Toward Seeking in Appendix L shows the Professional Help Instrument from the original author.

Reliability of the Attitudes Toward Seeking Professional Help. The instrument showed acceptable internal consistency reliability, with Cronbach's alpha values for the following subscales of Factor I: Need ($r = 0.67$), Factor II: Stigma ($r = 0.70$), Factor III: Openness ($r = 0.62$), and Factor IV: Confidence ($r = 0.74$) based on Fischer and Farina (1995). The overall Cronbach's alpha was 0.85, which showed acceptable internal reliability for the overall measure. Fischer and Farina also showed that the test-retest reliabilities ranged from 0.73 to 0.89 over five groups. Results showed that this instrument had strong reliability.

Validity of the Attitudes Toward Seeking Professional Help. The construct validity of the Attitudes Toward Seeking Professional Help was established wherein the total Attitudes Toward Seeking Professional Help scores were significantly positively correlated ($r = 0.49$) with another help-seeking scale, the Help-Seeking Attitude Scale (Komiya et al., 2000), showing acceptable construct validity. Also, the construct validity of the Attitudes Toward Seeking Professional Help was supported by the finding that the

Attitudes Toward Seeking Professional Help-Shorten Scale displayed acceptable validity. Results in an exploratory factor analysis by Picco et al. (2016) showed a three-factor structure provided a good fit—χ^2(df)= 33.64(15), CFI = 0.978, TLI = 0.966, RMSEA = 0.029, SRMR = 0.028—with high factor loadings. Inspection of eigenvalues >1.0 and scree plot supported the three-factor solution. The findings from the factor analysis revealed that the scale formed three distinct dimensions comprised the following: openness to seeking professional help, value in seeking professional help, and preference to cope on one's own. Picco et al. (2016) used this instrument to assess its factor structure and found strong validity.

Scoring the Attitudes Toward Seeking Professional Help. For the scoring of the Attitude Toward Seeking Professional Help, I calculated the total scores by adding the responses of all 10 items. I reverse coded the responses to Items 2, 4, 8, 9, and 10 before calculating summing the scores. Total scores for the Attitudes Toward Seeking Professional Help Scale ranged from a minimum of *0* to a maximum of *30*. Higher scores indicated greater positive attitudes toward seeking professional help.

Data Analysis Plan

As the first step in the data analysis, I exported the Excel data and inputted the data into IBM SPSS statistical software Version 25, where I analyzed the data. Second, I prescreened the data before data analysis was carried out. I screened for missing data and then examined for outliers. The third step, after I prescreened the data, I checked the reliability of the data collected from the participants. Reliability is a function of scores, not instruments (Vogt, 2007). The scores of an instrument can be different among the

samples. The fourth step involved testing the assumptions of both correlational and regression analysis. The following sections show the actions taken to prescreen the data:

Missing Data

I reviewed the data for any missing information. In carrying out the analysis, missing data, or missing values were discovered, which normally occurred when no data value was stored for the variable in an observation. Missing data are a common occurrence but can significantly affect the conclusions drawn (Hertel, 1976). Missing data can be a problem when conducting research, possibly having a negative impact on the generalizability of the findings and limiting the amount of data used. More importantly, it can lessen the power associated with a statistical test (Mertler & Vanatta, 2005). Missing data were handled first by carrying out a visual scan of the survey responses. Once discovered that a participant failed to answer 15% or more of the items, the participant was dropped, and their responses were removed from the statistical analyses.

Outliers

Next, I investigated potential outliers in the data set. If located, I removed the entire data point if there was a case that had outliers from the data. Outliers were detected using *z*-score investigations. Any *z*-scores greater than 3 or less than -3 were considered outliers. After a regression line was computed for a group of data, a point located far from the line (and thus has a large residual value) might be the outlier, which could represent erroneous data and indicate a poorly fitting regression line. However, before removing outliers from the dataset, I checked that no errors were made in the data cleaning before automatically deleting the outlier data.

Reliability Analysis

Each study variable was computed by getting aggregated scores of different question items of respective survey instruments. The scores of the study variables were obtained by getting the total summed score of the items. The reliabilities regarding internal consistency of the measures of the resilience, self-efficacy, experienced stigma, optimism, and attitude toward seeking professional help were investigated using Cronbach's alpha to assess internal consistency reliability of the different instruments. The Cronbach's alpha values were greater than the minimum required value of 0.70, indicating that these constructs had more than acceptable internal consistency reliabilities

Statistical Assumptions

I tested the statistical assumptions associated to both correlational analysis and multiple regression analysis before conducting the formal data analysis. Assumptions for multiple regression analysis included (a) absence of multicollinearity, (b) normality of residuals, (c) homogeneity of variances, (d) linearity, and (e) independence of error terms.

First, I tested multicollinearity among independent variables by predicting the dependent variable using collinearity diagnostics and correlation analysis. Collinearity statistics of the variance inflation factor (VIF) and tolerance values were calculated to check for the presence of multicollinearity. A VIF value below 10 was acceptable. Also, a tolerance value above 0.2 indicated that no presence of multicollinearity. Also, the results of the correlation analysis for Research Question 1 showed multicollinearity of independent variables in predicting the dependent variable. Independent variables significantly and highly correlated indicated multicollinearity. If this action occurred, one

of the two highly collinear independent variables were removed in the regression model as predictors.

Second, I conducted a test of normality using skewness and kurtosis statistics by examining the normality plots in the histograms. Skewness statistics greater than three may indicate violation of the assumption of normality to determine whether the data follows normal distribution (Kline, 2005). Also, kurtosis statistics with values between 10 and 20 also indicate non-normality (Kline, 2005).

Third, I checked the homogeneity of variances assumption using Levene's test. Fourth, I tested linearity of regression using scatterplot of the standard regression output of standardized predicted values against residuals to test for linearity of the regression. The graph showed that the data points were symmetrically distributed around a diagonal line in the horizontal line in the residuals versus predicted values plot to show linearity of the regression.

Fifth, I tested independence of error terms using Durbin Durbin-Watson (d) statistic. As a rule, values of $1.5 < d < 2.5$ showed no independence of observations in the data. If there were violations of the required assumption, the non-parametric versions of the stated statistical analyses were conducted, which entailed the Spearman correlation for correlation analysis. However, there was a nonparametric version of the regression analysis.

I used descriptive statistics to summarize the data for the demographic variables, and the data did not disclose any of the participant's identifiable information. I analyzed frequencies and percentage tables to summarize categorical or nominal demographics variables, which were the demographic variables of level of education and ethnicity/race.

I calculated means and standard deviations for continuous variables that included the demographic variables of age and number of children in the household and the four independent variables of resilience, self-efficacy, experienced stigma, and optimism and the dependent variable of attitude toward seeking professional help.

Table 1

Variables and Levels of Measurement of Variables

Variables	Name of scale	Level of Measurement	Coding in SPSS
Independent			
1. Resilience	Resilience Scale	Interval (Continuous)	Summed score of all 25 items
2. Self-efficacy	General Self-Efficacy Scale	Interval (Continuous)	Summed score of all 10 items
3. Experienced stigma	Discrimination and Stigma Scale	Interval (Continuous)	Summed score of all 32 items
4. Optimism	Life Orientation Test	Interval (Continuous)	Summed score of 8 items (Items no. 1, 3, 4, 5, 8, 9, 11, and 12)
Dependent			
1. Attitude toward seeking professional help	Attitudes toward Seeking Professional Help Instrument	Interval (Continuous)	Summed score of all 10 items

Note. Items 3, 8, 9, and 12 are reverse scored; Items 2, 4, 8, 9, and 10 are reverse scored.

Research Question 1

RQ1: What are the bivariate correlations among the independent variables of resilience, self-efficacy, experienced stigma, and optimism among women residing in public housing projects?

$H1_0$: There are no statistically significant correlations among the independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) among women residing in public housing projects.

$H1_a$: There are statistically significant correlations between the independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) among women residing in public housing projects.

I tested the null hypothesis for Research Question 1 using a Pearson correlation analysis to test associations or correlations between two interval and ratio variables (see Eisinga et al., 2013). Correlation analysis was used to determine whether and how intensely a pair of variables was related to one another (see Nikolić et al., 2012). A Pearson correlation coefficient (*r*) resulted from correlation analysis on these pairs of variables; the coefficient should range from -1.00 to +1.00 (Eisinga et al., 2013). The *r*-value produced in a correlation test was used to determine the strength (weak, moderate, and strong) and degree (positive or negative) of the correlation between two variables. A negative *r*-value connoted an inverse relationship between two variables, while a positive *r*-value connoted a direct correlation (Eisinga et al., 2013). An inverse relationship meant that the higher the result of another variable, the lower the result was for the other variable, and vice versa. A perfect correlation occurred if the *r*-value equals either +1.00 (*perfect positive*) or -1.00 (*perfect negative*). I used a level of significance of 0.05 in the Pearson correlation analysis to determine the significance of the correlation. In statistical testing, the significant statistical result is attained when the "*p*-value is less than or equal to the significance level" (Eisinga et al., 2013, p. 1).

Research Question 2

RQ2: How well do the independent variables of resilience, self-efficacy, experienced stigma, and optimism predict the dependent variable of attitude toward seeking treatment for mental health issues among women residing in public housing projects?

$H2_0$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are not statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

$H2_a$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

I conducted a multiple linear regression with resilience, self-efficacy, experienced stigma, and optimism as the four independent variables to test the null hypothesis for Research Question 2. In addition, attitudes toward seeking help for mental illness for women residing in public housing was the dependent variable in the regression analysis. A multiple linear regression statistical test was used to measure the size of the effect to assess the overall model and the beta (*b*) coefficients to assess the relative predictive

strength of each independent variable to the dependent variable or the relationship direction of each independent variable on a dependent variable. Woltman et al. (2012) stated that multiple regression was effective in evaluating the prediction influences of the independent variables to the dependent variable.

I first assessed the ANOVA results to determine whether the overall prediction model was statistically significant to analyze the results of the regression. I used a level of significance value of 0.05 to determine the statistical significance of results of the regression analysis. The null hypothesis for Research Question 2 was rejected if the *p*-value was less than or equal to the level of significance value of 0.05. The researcher then *r*-changed the value change statistics to determine the overall strength of association or effect sizes captured in the regression model.

Next, I examined the significance of the individual relationship of each independent variable on the dependent variable. There was a significant individual relationship if the *p*-value was less than or equal to the level of significance value of 0.05. Then, the beta coefficient of the individual relationship was analyzed to determine the degree to which each independent variable was related with the dependent variable. Neuman (2009) stated, “A positive regression coefficient means a positive effect or [predictive] relationship indicating that the dependent variable increases as the independent variable increases” (p. 20). Moreover, Neuman (2009) posited, “A negative regression coefficient indicates a negative effect or predictive relationship indicating that the dependent variable decreases as the independent variable increases” (p. 20). The regression equation was written as follows:

$$Y_{\text{Attitudes toward seeking professional treatment}} = \text{constant} + b_1X_{\text{Resilience}} + b_2X_{\text{self-efficacy}} + b_3X_{\text{experienced stigma}} + b_4X_{\text{optimism}}$$

Threats to Validity

Reliability of a construct or measure is defined by its consistency or rather the stability (Heale & Twycross, 2015). The common adage is that a reliable measure will produce the same result when the same experiment or research is repeated with the same participants and under similar conditions. The reliability of measurement of the study variables was investigated in this current study using Cronbach's alpha statistics.

Validity refers to the extent to which a measurement is truthful, accurate, authentic, or free of system error, with evidence supporting the conclusion (Jimenez-Buendo & Miller, 2010). Threats to validity were both external and internal. The internal validity of a quantitative study refers to the degree to which observed changes in a dependent variable can be attributed to changes in an independent variable (Jimenez-Buendo & Miller, 2010). I determined the possible threats to internal validity and how these might influence the study by examining the scheme and the level of control that I had regarding sampling, data collection, and data analyses. For this study, there were no dangers to internal validity, involving history, statistical regression, instrumentation, and mortality (Pedhazur & Schmelkin, 2013). Mertens (2014) stated that these internal threats to validity were relevant only to experimental studies and on other studies that used pretest and posttest data or longitudinal studies. The current study was not a longitudinal study. The current study did not involve the use of pretest and posttest data.

External validity is the degree to which conclusions from a study can be generalized to additional groups of persons, locations, or periods (Wing & Bello-Gomez,

2018). In this study, the results of the study only applied to women residing in public housing. Therefore, the outcomes from this study may not be generalized to additional study population groups. The results may not be generalizable to additional age groups or different cultures (ethnicity or race). The results of the analysis will only be generalizable to a sample of women living in public housing projects in North Carolina.

The data collected involved participants' self-report survey responses; thus, I might encounter some response bias in the form of untruthfulness of the survey responses provided from the participants. I ensured that all participants were aware of their rights to confidentiality and anonymity to safeguard them so that they would not be tempted to misrepresent facts. Despite such measures, self-report data were susceptible to errors in the memories of participants. To mitigate this issue, a large sample size was employed that would evenly distribute and consider possible errors and threats to the validity of the data and analyses. The more the number of samples means that it is more representative to the population, and it will be more confident to generalize to the sample's population (Szijarto, 2014).

The results of the study did not refer to causation among variables. The nature of a correlative examination of isolated variables could reveal correlation but not causation. The inability to adjust the independent variable to determine the impact on the dependent variable(s) meant a cause-and-effect relationship cannot be established.

The analysis accurately discerned whether there was a relationship between the independent variables and the dependent variable to ensure conclusion validity of the findings. Ensuring conclusion validity showed the reliability of the results of the study. I ensured that the instruments used to measure the variables were reliable measures, there

was enough of a sample size to have an adequate statistical power in the analysis; and there were no violations of the required statistical assumptions of the parametric statistical test used to achieve conclusion validity.

Ethical Procedures

I received approval from Walden University's Institutional Review Board (IRB) before contacting any potential participants or collecting data. The university developed IRB policies and procedures to maintain the integrity of Walden University and protect human subjects and students from harm. Participation in the current study remained voluntary, and participants implied consent by completion of the data collection processes on the SurveyMonkey (2012) portal. I made available the following information on the SurveyMonkey portal as part of the sign-in process: (a) procedures for participation, (b) assurances of confidentiality and anonymity, (c) study risks, (d) researcher and IRB contact information, and (e) purpose of the study.

I considered participant welfare throughout the course of conducting this study. The informed consent form was a vital part of this process to ensure participant welfare. Because the informed consent form was part of the invitation letter, the requirements of the study from the participants, time commitments, and policies of the study were clearly communicated to the participants. My contact details were included to maintain open lines of communication with the participants who might have questions or concerns about the study. As such, participants had my contact information to make informed choices on participating in the study.

The participants were not paid nor offered any incentives for participating in the study to avoid the potential for bias. I informed participants that they could remove

themselves from the study at any moment and without consequences. Taking part in this research study was voluntary; thus, the participants could withdraw from the survey process at any point during the study if they did not feel comfortable answering the survey questions.

I did not collect any personally identifiable information from the participants to ensure anonymity. Confidentiality was assured and guaranteed by the following procedures. I will store files of completed survey data on a password-protected external drive and hard copies of the survey information in a locked drawer for 5 years, accessible only by me and committee members. The files will remain in a designated area in the researcher's home office for 5 years, and only I will have access to those files. After maintaining the data for 5 years, all data will be destroyed. Soft copy files will be electronically deleted, while hard copies of the data will be physically destroyed through paper shredding.

Summary

Chapter 3 contained the research methods conducted for the quantitative examination. I used a quantitative correlational study for this study. This chapter included the discussion of the research foundation, populace, sample and sample measures, processes for enlistment of participants, contribution, data gathering, instrumentation, and operationalization of concepts used in this study. The population included women residing in public housing projects. I collected the data for the study using five different survey instruments: Connor and Davidson's 25-item (2003) Resilience Scale, the 10-item General Self-Efficacy Scale by Schwarzer and Jerusalem (1995), the 32-item Discrimination and Stigma Scale by Brohan et al. (2013), the 12-item Life Orientation

Test by Scheier and Carver (1985), and the 10-item Attitudes Toward Seeking Professional Help by Fischer and Farina (1995). I administered the survey online using SurveyMonkey (2012). Data analysis included using Pearson correlation analysis and multiple linear regression analysis to address the research questions.

In the succeeding chapters of this study, I present the results, discuss the findings, and make recommendations. In Chapter 4, I display the outcomes of the data examination. Then, in Chapter 5, I discuss these outcomes and suggestions for practice, exploration, and theory.

Chapter 4: Research Results

Introduction

The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing. The two research questions that were addressed in this study are presented below:

RQ1: What are the bivariate correlations among the independent variables of resilience, self-efficacy, experienced stigma, and optimism among women residing in public housing projects?

$H1_0$: There are no statistically significant correlations among the independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) among women residing in public housing projects.

$H1_a$: There are statistically significant correlations between the independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) among women residing in public housing projects.

RQ2: How well do the independent variables of resilience, self-efficacy, experienced stigma, and optimism predict the dependent variable of attitude toward

seeking treatment for mental health issues among women residing in public housing projects?

$H2_0$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are not statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

$H2_a$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

The goal of this chapter is to review and discuss the statistical analysis and findings for the hypotheses. I present a review of the data collection processes, procedures, and discussions of the study participants. The result section reviews the data analyses, testing of assumptions, and results from correlational analysis and multiple linear regressions. I conclude the chapter with an overview of the results.

Data Collection

The data collection began July 22, 2020, and ended October 26, 2020, lasting over a period of appropriately 19 weeks. Participants were recruited from individuals who were receiving services through Greenville Housing Authority of North Carolina. On my

behalf, the Greenville Housing Authority sent emails containing flyers to potential participants who met the survey criteria. The flyer (see Appendix C) contained information about conducting the study, what the study was about, eligibility criteria for participating in the study, and a link to the surveys.

All data were collected using the online survey collection tool, SurveyMonkey (2012). Once participants accessed the link, they were directed to the SurveyMonkey website to complete the consent form first (see Appendix D). The form included the explanation of the purpose of the study and requirements, significance of the study, time it took to complete the surveys, and their rights to participate. No signatures were collected to protect participants' privacy. They clicked the "I consent" button and then accessed the demographic questionnaire by clicking the "Next" button. The participants then completed a demographic questionnaire (see Appendix D). The participants then completed the Attitude Toward Seeking Professional Help Instrument, General Self Efficacy Scale, Life Orientation Test, Discrimination and Stigma Scale, and Resilience Scale.

There were minor problems in the beginning with getting participants to take the surveys. I believed this situation was because the data collection process took place during the COVID-19 pandemic. My data collection started during the time when there was a peak in the number of COVID-19 cases for the area, which resulted in a slow response rate that caused Greenville Housing Authority to reach out to residents 8 to 10 times with follow-up emails. This delay continued until the end of October, 2020, when the COVID-19 numbers had decreased some in the area. Most data collected from participants occurred toward the latter 3 weeks of the data collection.

Results

Descriptive Statistics of Demographic Variables

A total of 134 participants completed the study. All qualified participants were women residents of Greenville Housing Authority who were 18 and older. A demographic questionnaire was used to further assist in qualifying those appropriate for the study (see Appendix E). All the data were then downloaded from SurveyMonkey (2012) and into an Excel spreadsheet so that I could visually inspect the data for missing data and outliers. There were 18 respondents who did not complete the surveys. These surveys were deleted from the data. These data were visually inspected again in Excel to ensure that there are no missing values. The demographic questionnaire and survey were coded numerically so that the data could be imported and interpreted in SPSS. Numerical coding of demographic characteristics such as race, age, education, and number of children were done in Excel. The data involved many variables and measurements items. Therefore, it is important to keep consistency, while understanding and interpreting the data better before importing into SPSS.

Table 2 shows a summary of the demographic data results. The data showed that most participants (79%) self-identified as being Black. The results revealed that most participants (41%) fell between the age ranges of 25 to 43 years. Regarding education, the data showed 33% participants were high school graduates, and 33% had some college education. Regarding the number of children in the household, most respondents (23%) indicated they had two children.

Table 2

Summary of Demographic Variables

Variable	Frequency	Percent
Race		
Black or American	92	79.3
White or Caucasian	12	10.3
Hispanic or Latino	7	6.0
American Indian / Alaska Native	3	2.6
Asian or Asian American	1	.9
Native Hawaiian or Other Pacific Islander	1	.9
Total	116	100.0
Age in Years		
18-24	28	24.1
25-43	47	40.5
35-44	19	16.4
45-54	12	10.3
55-64	5	4.3
65+	2	1.7
Blank	3	2.6
Total	116	100.0
Education		
Some High School	17	14.7
High School Graduate	38	32.8
Some College	38	32.8
Graduate from College	9	7.8
Some Graduate School	4	3.4
Completed Graduate School	2	1.7
Blank	8	6.9
Total	116	100.0
Number of Children		
None	16	13.8
One	18	15.5
Two	27	23.3
Three	17	14.7
Four	14	12.1
More than Four	20	17.2
Blank	4	3.4
Total	116	100.0

Prescreening Data

Before assessing and evaluating the statistical assumptions for the study, I prescreened the data for accuracy and completeness. Prescreening is important in quantitative studies because the process ensures that data are clean and ready to go before

conducting further statistical analyses (Dong & Peng, 2013). I examined the results for missing data, screened the data for outliers, and assessed the reliability of the data.

Missing Data

I used Microsoft Excel to assess for missing data and outliers. Data entries were visually checked by administering a frequency count for every variable using Microsoft Excel spreadsheet. If participants failed to answer 15% or more of the items on a given survey, that participants' data were removed from further statistical analyses (Dong & Peng, 2013). The data from 18 of the 134 respondents were excluded because of too many missing values in each entry. Blank values also appeared in the demographic data, which were coded with a specific numeric value of 7 to denote a missing value. The missing demographic data did not affect the subsequent statistical analyses.

The data were imported from Microsoft Excel into SPSS for further analysis. I then determined how much missing data occurred for each survey by multiplying the number of participants in the sample (N = 116) by the number of items in each survey (n) to determine the total number of responses for each survey (TR). I then divided the number of missing responses (MR) for each survey by the total number of responses for each survey (TR) to determine how much data were missing for each survey. The results presented in Table 3 show that all the scales had only 1% of missing items. I therefore concluded that there was no discernible pattern to the missing data and that the data were at random. I then moved to conduct the reliability analysis.

Table 3

Frequency Count for Percentage of Missing Data

		Items	Total number of responses	Missing responses	Percent
Scales	Attitude Toward Seeking Professional Psychological Help	10	1,160	7	0.99
	Self-Efficacy Scale	10	1,160	1	0.99
	Life Orientation Test (Optimism)	12	1,398	4	0.99
	Discrimination and Stigma Scale (Experienced Stigma)	32	3,712	19	0.99
	Resilience Scale	25	2,900	11	0.99
	Total	89	10,330	42	

Note. $n = 116$.

Outliers

Outliers in the dataset were identified using the *Z*-score. Any *z*-scores greater than 3 or less than -3 were considered outliers. After a regression line was computed for a group of data, a point located far from the line (and thus has a large residual value) might be the outlier, which could represent erroneous data and indicate a poorly fitting regression line. Visual inspection was conducted to determine whether there were outliers in the dataset. Frequency count function in Excel was used to identify points outside of the range. Before conducting the visual analysis, I checked that no errors were made in the data cleaning before automatically deleting the outlier data. Based on the visual analysis, there were no outliers in the dataset. Thus, no data point was removed from the dataset.

Reliability Analysis Results

The dependent variable in this study was measured using the Attitude Towards Seeking Professional Help Scale. When conducting the reliability analysis, I ran into some problems in the results. When I reverse coded responses to Items 2, 4, 8, 9, and 10

as specified in the scoring procedures, the obtained reliability estimates were poor. Cronbach's alpha value was .41. In addition, each of the recoded items obtained poor or negative inter-item correlations with the remaining items in the scale. The inter-item correlation statistics shows the degree to which a single item correlates with other items on a scale (Mertler & Reinhart, 2016). I reran a reliability analysis of the five items without reverse coding each, as specified in the scoring instructions. The results produced a Cronbach's alpha of .92; thus, interpreting the results was counterintuitive. I then conducted a factor analysis to determine if there was a latent structure underlying the data. Results from a factor analysis generated a two-factor solution, with the reverse-coded items loading on one factor and the nonreverse-coded items loading on a second factor. Therefore, I concluded that the Attitude Towards Seeking Professional Help Scale measured two distinct factors for the sample of individuals in this study.

I then conducted a scan of the literature and located another study in which a two-factor solution emerged for the Attitude Toward Seeking Professional Help Survey. Torres et al. (2020) examined utilization of mental health services among Latino adults. Results showed that two independent factors emerged for the sample. Torres et al. labeled the two factors Openness to Seeking Treatment and Value and Need in Seeking Treatment. Based on suggestions from Torres et al. (2020), I proceeded to treat the Attitude Towards Seeking Professional Help Scale as two unidimensional measures. I preceded to conduct all remaining data analyses by breaking the Attitude Towards Seeking Professional Help Scale into the two separate and distinct scales suggested by Torres et al. (2020)

Table 4

Reliability Analysis Results

Scale	Alpha for standardized items	*N*	Mean	Variance	*SD*
Openness to seeking treatment	.82	5	7.99	14.31	3.78
Value and need in seeking treatment	.73	5	7.19	10.64	3.26
Self-Efficacy Scale	.92	10	17.13	49.75	7.05
Optimism Scale	.63	8	16.84	19.31	4.39
Experienced Stigma	.92	32	55.73	366.12	19.13
Resilience Scale	.95	25	78.85	358.20	18.93

I proceeded to analyze the reliability or internal consistency of the data collected for the dependent and independent variables using Cronbach's alpha, which measured how closely items of an instrument were related as a single group of items (see Taber, 2018). When a value of Cronbach's alpha statistic was above .70, the scale was considered to have good reliability. Values for Cronbach's alpha of .80 were better, and values above .90 were taken as the best value (Garson, 2012). Data from Table 4 from the reliability analysis showed that the values for Cronbach's alpha were greater than the minimum required value of 0.70 for all scales, except for the Optimism Scale, where Cronbach's alpha was .63. According to previous research, .60 was still a fairly good and marginally acceptable internal consistency reliability (see Taber, 2018). The Cronbach's alpha value for Openness to Seeking Treatment and Value and Need in Seeking Treatment were higher in this study than in Fischer and Farina (1995). For the self-efficacy scale, the Cronbach's alpha value of .92 was also higher than the alpha values in Schwarzer and Jerusalem (1995), which was at the range of higher .80s. The Cronbach's alpha value of the Optimism scale was at .63, which was approximately the same in Scheier and Carver (1985) at .62. For the experienced stigma, the Cronbach's alpha value

in this study was at .92, which was higher than Brohan et al.'s (2013) determined at .78. For the resilience scale, the reliability score was at .95, comparing to .91 from Wang et al. (2010). I concluded that the surveys used in this study collected reliable data from the participants.

Descriptive Statistics of Independent and Dependent Variables

Table 5 presents a summary of the descriptive statistics for each instrument. Table 5 shows data for the total scores for both the independent and dependent variables used in this study. For the openness to seeking treatment, the mean score of 7.99 (*SD* = 3.78) was in midrange. The value and need in seeking were also in midrange, with a mean of 7.19 (*SD* = 3.26). The self-efficacy scale had a mean of 17.18 (*SD* = 7.058), which was slightly above the midrange. The Optimism Scale mean score was at 16.84 (*SD* = 4.39). The mean score was also at the midrange. The Discrimination and Stigma Scale had a mean of 57.69 (*SD* = 19.80), while Experienced Stigma was at 78.85 (*SD* = 18.93).

Table 5

Descriptive Statistics of Independent and Dependent Variable for Total Sample

Variable	*N*	Range	Minimum	Maximum	Mean	Std. deviation
Openness to seeking treatment	116	15.00	.00	15.00	7.99	3.78
Value and need in seeking	116	15.00	.00	15.00	7.19	3.26
Self-Efficacy Scale	116	30.00	.00	30.00	17.18	7.058
Optimism Scale	116	31.00	.00	31.00	16.84	4.39
Discrimination and Stigma Scale	116	132.00	.00	132.00	57.69	19.80
Experienced Stigma	116	96.00	29.00	125.00	78.85	18.93

Testing Statistical Assumptions

Before testing the null hypotheses for the research questions, I tested key assumptions for correlational analysis and multiple linear regressions. Assumptions tested

included adequacy of sample size, absence of multicollinearity, normality of residuals, homogeneity of variance, linearity, and independence of error terms. Details regarding the results for each variable are presented in the following paragraphs.

Sample Size

The G*Power software was used to calculate the optimal sample size for regression analysis. Using the conventional values for power of 0.8, a medium effect size of 0.30, and a level of significance of 0.05, the total sample size was estimated at $N = 82$ for obtaining a sample large enough to determine statistically significant differences in the data if existing. The optimal sample size for multiple linear regression analysis with four predictors, using a statistical power of 0.8, a medium effect size of 0.15, and a level of significance of 0.05, required adequate power calculated at $N = 55$. I collected data from 116 participants who met the inclusion criteria. The obtained number of cases surpassed the minimum sample size generated by the G*Power analysis. Therefore, I concluded that the obtained sample size was large enough to have adequate power for detecting any statistically significant differences that existed in the data.

Absence of Multicollinearity

Multicollinearity occurs when two exploratory variables are highly correlated (Statistics Solutions, 2018). I tested the absence of multicollinearity assumption using tolerance values, the variance inflation factor (VIF), and correlation values. The rule of thumb is that tolerance values greater than .2 and VIF values less than 10 indicate absence of multicollinearity (Stephens, 2009; Mertler & Reinhart, 2016). The data presented in Tables 7 and 8 shows that all tolerance values are .2 or greater, and all VIF

values are less than 10. Therefore, I concluded that the assumption of absence of multicollinearity was met.

A correlation analysis shows whether two variables have a strong relationship with each other (Nikolić et al., 2012). I utilized a Pearson correlation analysis to examine whether there was multicollinearity among the dependent and independent variables. Correlation values showed that if data exceeded $r = .80$, this data indicated the possible presence of multicollinearity. Table 6 shows the correlations among the variables. In no case did any of the bivariate correlations reach $r = .80$ or greater. Therefore, I concluded that the assumption for linearity had been met.

Table 6

Correlations Matrix

Variable		Openness to seeking treatment	Value and Need in seeking	SE Scale	Opt. Scale	ES Scale	R Scale
Openness to seeking treatment	*r*	1					
	Sig.	.000					
	N	116					
Value and need in seeking	*r*	-.406**	1				
	Sig.	.000					
	N	116	116				
Self-Efficacy Scale	*r*	.508**	-.526**	1			
	Sig.	.000	.000				
	N	116	116	116			
Optimism Scale	*r*	.273**	.105	.429**	1		
	Sig.)	.003	.264	.000			
	N	116	116	115	116		
Experienced Stigma	*r*	-.243**	.039	-.287**	-.331**	1	
	Sig.	.008	.679	.002	.000		
	N	116	116	115	116	116	
Resilience Scale	*r*	.397**	-.274**	.759**	.508**	-.391**	1
	Sig	.000	.003	.000	.000	.000	
	N	116	116	115	116	116	116

**. Correlation is significant at the 0.01 level (2-tailed).

Table 7

Openness to Seeking Treatment Coefficients

	Unstandardized coefficients		Standardized coefficients			Collinearity statistics	
Model	*B*	Std. error	Beta	*t*	Sig.	Tolerance	VIF
(Constant)	4.468	2.232		2.002	.048		
SE Scale	.259	.067	.482	3.862	.000	.423	2.366
Opt Scale	.042	.082	.049	.513	.609	.717	1.395
ES	-.019	.017	-.102	-1.136	.259	.823	1.216
RS Scale	-.007	.027	-.033	-.249	.804	.366	2.731

Table 8

Value and Need in Seeking Coefficients

		Unstandardized coefficients		Standardized coefficients			Collinearity statistics	
	Model	*B*	Std. Error	Beta	*t*	Sig.	Tolerance	VIF
1	(Constant)	7.213	1.720		4.194	.000		
	SES Scale	-.365	.052	-.786	-7.045	.000	.423	2.366
	OptScale	.277	.064	.373	4.352	.000	.717	1.395
	ES	-.002	.013	-.014	-.178	.859	.823	1.216
	RSScale	.022	.021	.127	1.057	.293	.366	2.731

Normality

I tested the assumption of normality using histograms and P-P plots. When the normality assumption is met, the shape of the histograms of the distribution of scores for a variable should approximate the shape of a normal distribution (Mertler & Reinhart, 2016). Figures 1 and 2 show the residuals for the Openness to Seeking Treatment and Value and Need in Seeking plotted as histograms. The results show the histograms of the data for both variables approximated the shape of the normal distribution. The display of

a bell-shaped curve plotted in each histogram shows how well the outline of the shape of each histogram conforms to the shape of the normal curve. I concluded that the data sets for both Openness to Seeking Treatment and Value and Need in Seeking were approximately normally distributed.

Figure 1

Histogram for Openness to Seeking Treatment Scale

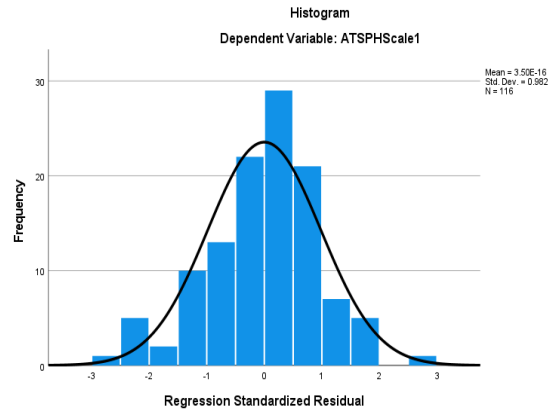
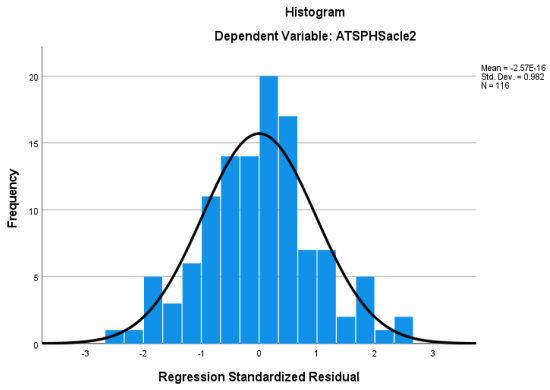


Figure 2

Histogram for Value and Need in Seeking Scale



The P-P plots are used to assess the degree to which the shape of two distribution of scores are aligned (Mertler & Reinhart, 2016). In the case of regression analysis, the P-

P plot is a plot of the standardized regression residuals and indicates the degree to which the scores in a distribution approximate that shape of the normal distribution. When using the P-P plot, the shape of the normal distribution is represented by the degree to which the pattern of scores in a distribution are spread about a 45-degree line plotted on a chart (Mertler & Reinhart, 2016). When the data from a variable are plotted on the graph, the pattern of scores should appear close to and be evenly spread around the 45-degree line. Figures 3 and 4 show that the data plots for the Openness to Seeking Treatment and Value and Need in Seeking Scale scores. Therefore, I concluded that the data for each dependent variable were approximately normally distributed.

Figure 3

Openness to Seeking Treatment

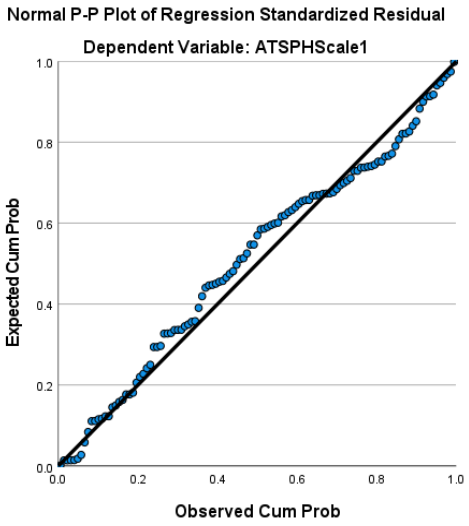
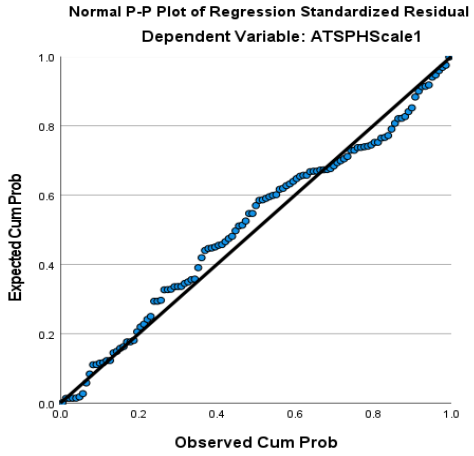


Figure 4

Value and Need in Seeking Scale



Homoscedasticity

In regression analysis, homoscedasticity refers to homogeneity of error variance, which addresses whether the error variance is approximately equal across all independent variables (Mertler & Reinhart, 2016). I tested the assumption of homoscedasticity using scatterplots. When using the P-P plots, homoscedasticity was determined by examining the spread of scores about the regression line. When the homoscedasticity assumption is met, the data points should be approximately evenly distributed about the regression line (Mertler & Reinhart, 2016). Figures 5 to 12 show the scatter plots of the dependent variables across each of the dependent variables. The graphs of the standardized residuals showed that points in each scatterplot were fairly close to and evenly distributed about the reference line. Therefore, I concluded that the assumption of homoscedasticity had been met.

Figure 5

Scatter Plot for Openness to Seeking Treatment and Resiliency Scale

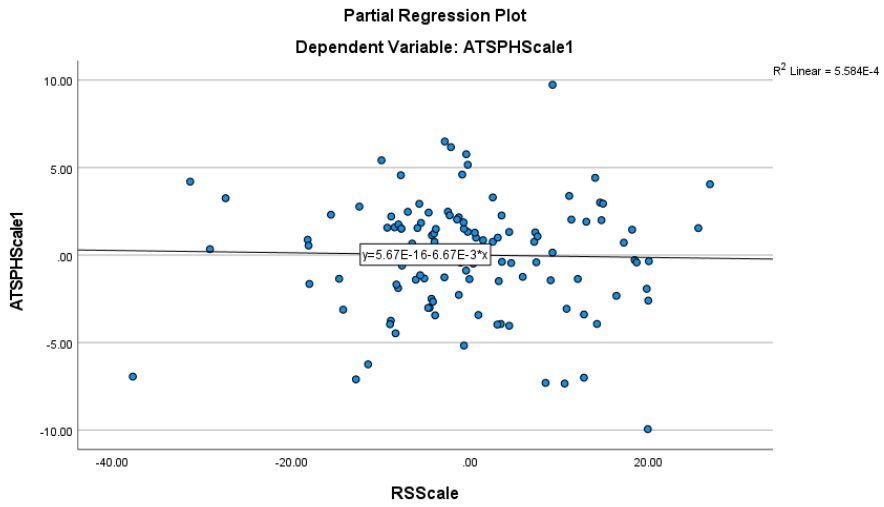


Figure 6

Scatter Plot for Openness to Seeking Treatment and Independent Variables SES

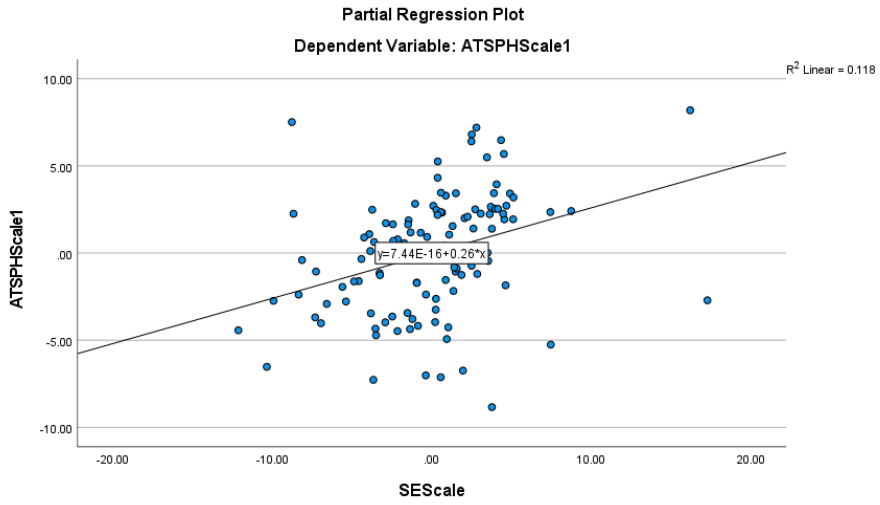


Figure 7

Scatter Plot for Openness to Seeking Treatment and Optimum Scale

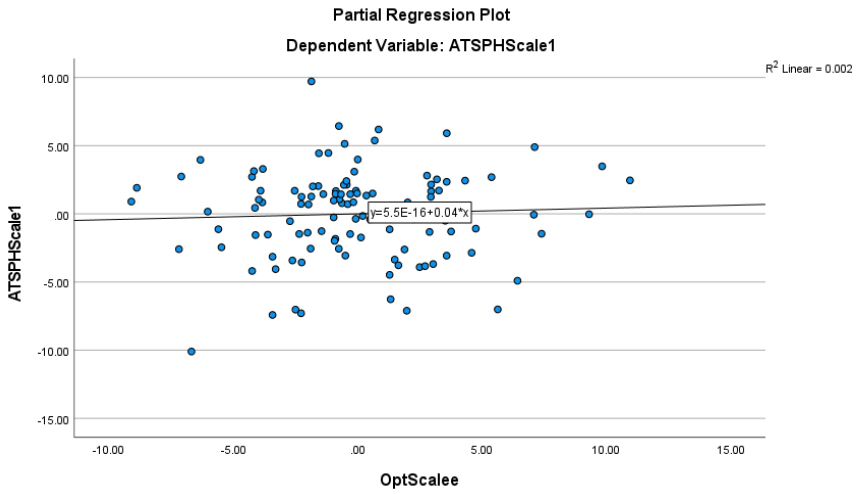


Figure 8

Scatter Plot for Openness to Seeking Treatment and Independent Variable Experienced Stigma

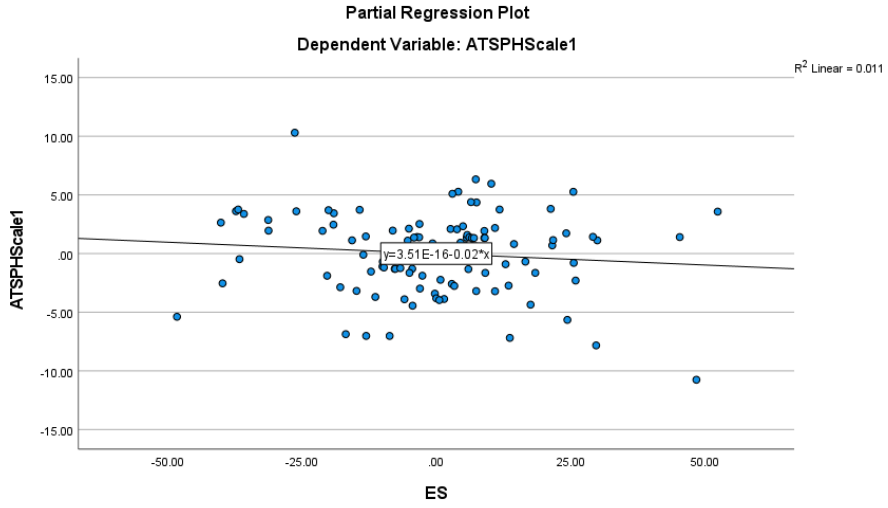


Figure 9

Scatter Plot for Value and Need in Seeking Treatment and Resiliency Scale

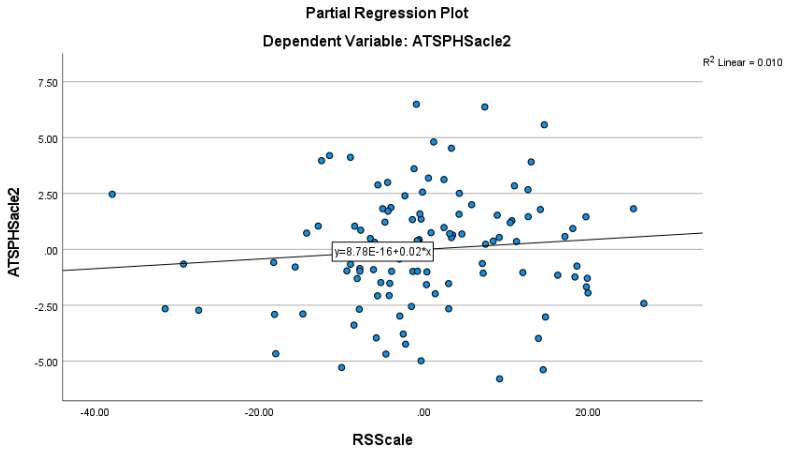


Figure 10

Scatter Plot for Value and Need in Seeking Treatment and SES

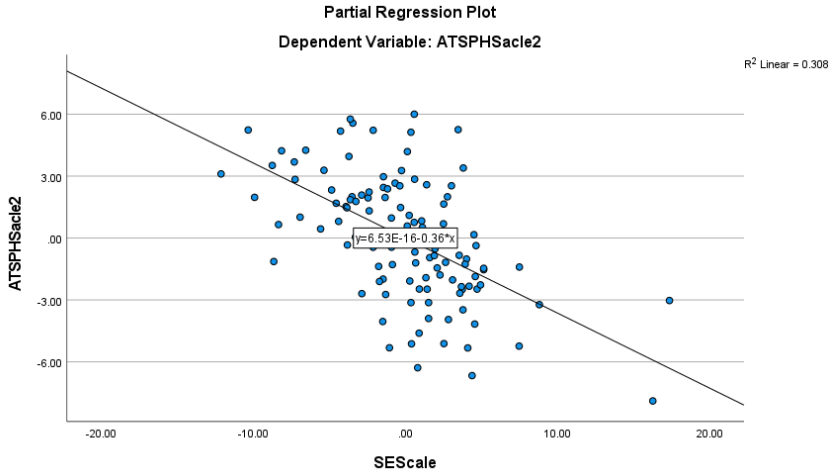


Figure 11

Scatter Plot for Value and Need in Seeking Treatment and Optimum Scale

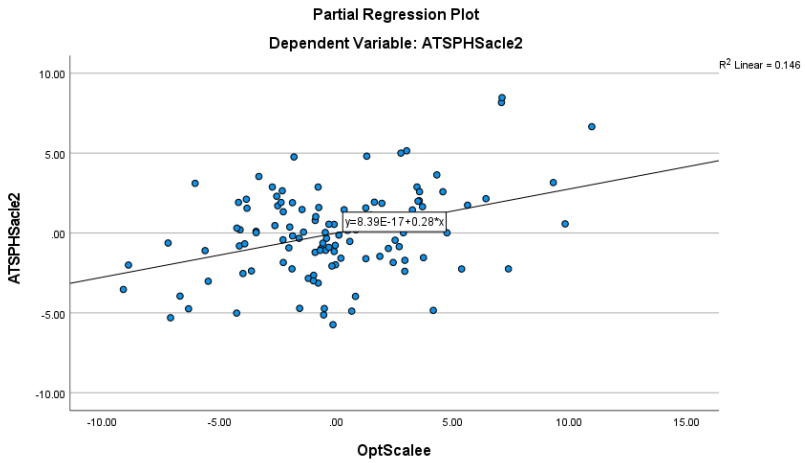
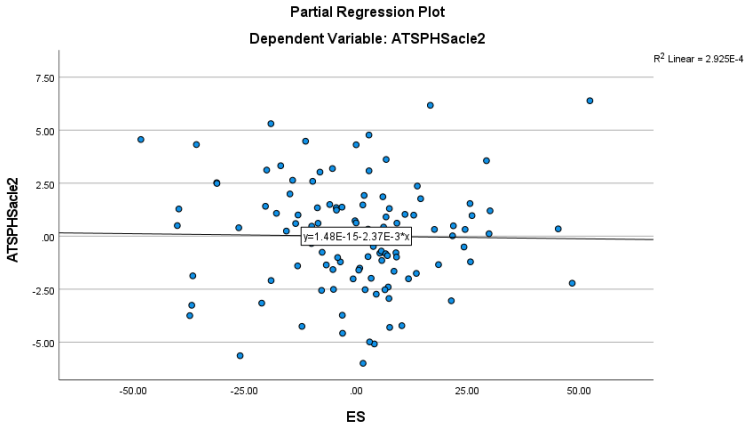


Figure 12

Scatter Plot for Value and Need in Seeking Treatment and Experienced Stigma



Linearity

I tested linearity of regression using scatterplots. Scatterplots were used to display the correlations and relationships between variables. Scatterplots were used to test the linearity assumption. The use of a scatterplot graph provides a visual representation of

relationship between variables (Mertler & Reinhart, 2016). Figures 5, 6, 7, 8, 9, 10, 11, and 12 show the scatterplots of each dependent variable across each of the dependent variables. The scatterplot of standardized predicted values showed that the data met the assumptions of linearity. Each graph showed a straight line of fit indicating assumption of linearity had been met.

Independence of Error

The independence of error assumption indicates that errors associated with the independent variables are not correlated (Mertler & Reinhart, 2016). I tested independence of error terms using the Durbin Durbin-Watson (d) statistic generated in the regression model summary. As a rule, values of $1.5 < d < 2.5$ showed that error terms were unrelated. The obtained Durbin-Watson statistic was 2.12, which was less than 2.5. I therefore concluded that the assumption of independence of errors was met.

Data Analysis

After conducting the preliminary analysis of prescreening data, checking for outliers, and testing statistical assumptions, I then tested the hypotheses for each of the research questions. I also included the dependent variables in the correlation analysis. The results are presented below.

Research Question 1

RQ1: What are the bivariate correlations among the independent variables of resilience, self-efficacy, experienced stigma, and optimism among women residing in public housing projects?

RQ2: How well do the independent variables of resilience, self-efficacy, experienced stigma, and optimism predict the dependent variable of attitude toward

seeking treatment for mental health issues among women residing in public housing projects?

Results from the correlation analysis showed several statistically significant correlations among the variables; therefore, the null hypothesis was rejected. Table 6 presents a summary of the correlation matrix. Although not included in the research question, the scores from the two dependent variables were included in the correlation analysis. The findings showed that the Openness to Seeking Treatment Scale scores were significantly correlated at $p < .01$ with all other scales. The Openness to Seeking Treatment Scale scores were positively correlated with scores from the Self-Efficacy Scale ($r = .51$), the Optimism Scale ($r = .27$), and the Resilience Scale ($r = .40$). The positive scores indicated that high scores on openness to treatment were related to higher levels of self-efficacy, optimism, and resilience. Scores on the Openness to Seeking Treatment Scale were negatively correlated with scores on the Value/Need in Seeking Treatment Scale ($r = -.41$) and the Experienced Stigma Scale ($r = -.24$). The inverse relationship indicated that Openness to Treatment score increased as the Value and Need for Seeking Treatment scores declined. Likewise, higher scores on openness to treatment were related to lower levels of experienced stigma. This result suggests that experiences with stigma decrease an individual's openness to seeking treatment.

Data in the table for the Value/Need in Seeking Treatment Scale showed that there was a statistically significant negative correlation with the Self Efficacy Scale at ($r = -.53$). This finding revealed that those individuals who had higher scores related to the value and need for seeking treatment had lower levels of self-efficacy. There was also a statistically significant negative correlation between the Value/Need in Seeking

Treatment subscale and the Resilience Scale (r = -.27), which also indicated that individuals with high scores related to the need/value in seeking treatment had lower levels of resilience.

Findings for the Self Efficacy Scale showed statistically significant, positive correlations with the Optimism Scale (r = .43) and the Resilience Scale (r = .76). The finding indicated that high levels of self-efficacy were related to high levels of optimism and resilience. However, the scores on the Self-Efficacy Scale were statically significant and negatively correlated with scores on the Experienced Stigma Scale (r = -.29). The inverse relationship indicated individuals with higher levels of self-efficacy reported fewer experiences with stigma.

Data related to the Optimism Scale showed a statistically significant correlation with both the Experienced Stigma and Resilience Scales. The optimism scores were positively correlated with the Resilience Scale (r = .51), which revealed that individuals high in optimism were also high in resilience. On the other hand, the optimism scores were negatively correlated with the Experienced Stigma scores (r = -.33). The inverse relationship indicated that high levels of experienced stigma were related to lower levels of optimism.

The Experienced Stigma Scale scores were significantly and negatively correlated with the Resilience Scale (r = -.39). The inverse relationship indicated that high levels of experienced stigma was related to lower levels of resilience. Further review of the data in the table showed that the Experienced Stigma Scale was significantly and negatively correlated with all variables except the Need/Value in Seeking Treatment Scale.

Research Question 2

RQ2: How well do the independent variables of resilience, self-efficacy, experienced stigma, and optimism predict the dependent variable of attitude toward seeking treatment for mental health issues among women residing in public housing projects?

$H2_0$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are not statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

$H2_a$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

A multiple linear regression analysis was used to determine how well the independent variables predicted each of the dependent variables related to attitudes toward seeking psychological help. Because the Attitude Towards Seeking Professional Help Scale was divided into two scales, a regression analysis was performed for each scale. The four independent variables were included in each regression analysis. The *F*-ratio from the regression analysis indicated whether the combination of independent

variables could predict the dependent variable. If the *p*-value was less than or equal to the significance level (.05).

Results presented in Table 9 from the ANOVA summary of the regression model for the Openness to seeking Help Scale show the independent variables are statistically significant predictors of the dependent variable. The obtained test statistic was $F(4, 111) = 10.23$, $p =< .001$. Table 10 shows the obtained adjusted $R^2 = .24$ value, which indicates that scores for resilience, self-efficacy, optimism, and experienced stigma account for 24% of the variance in the Openness for Seeking Help Scale scores. The regression coefficients in Table 11 reveal that the Self-Efficacy Scale scores ($t = 3.66$, $p < .001$) were the only statistically significant predictor variable model. Using the standardized beta coefficients presented in Table 11, the regression equation for the Openness Toward Seeking Psychological Help is presented below:

*OTSPH Scores = 4.55 + (.49 * Self-Efficacy Scale Scores) – (.10 * Experienced Stigma Scale Scores) – (0.05 * Resilience Scale Scores)*+ (.05 * Optimism Scale Scores)**

Table 9

ANOVA Results for Regression Model 1

Model		Sum of squares	*df*	Mean square	*F*	Sig.
1	Regression	443.095	4	110.774	10.226	.000[b]
	Residual	1202.426	111	10.833		
	Total	1645.521	115			

a. Dependent Variable: OTSPHScale1

b. Predictors: (Constant), RScale, ES, OptScale, SEScale

Table 10

Model Summary OSTPH

Model	*R*	*R* square	Adjusted *R* square	Std. error of the estimate	Change statistics				
					R square change	*F* change	df1	df2	Sig. *F* change
1	.519[a]	.270	.243	3.30	.270	10.161	4	110	.000

a. Predictors: (Constant), OptScale, ES, SEScale, RSScale

Table 11

Regression Coefficients OSTPH Scale

Model		Unstandardized coefficients		Standardized coefficients	*t*	Sig.
		B	Std. error	Beta		
1	(Constant)	4.555	2.243		2.031	0.045
	SEScale	0.262	0.067	0.487	3.879	0.000
	ES	-0.020	0.017	-0.102	-1.140	0.257
	RSScale	-0.008	0.027	-0.039	-0.287	0.775
	OptScale	0.041	0.083	0.048	0.498	0.620

The results in Table 12 from the ANOVA regression model for the Value and Need in Seeking Treatment Scale show the independent variables are statistically significant predictors of the dependent variable. The obtained test statistic was $F(4, 111) = 19.83$, $R^2 = .42$, $p =< .001$. Tale 13 shows data for the model summary that scores for independent variables account for 42% of the variance in the Value and Need for Seeking Treatment scores. The regression coefficients in Table 14 showed that the Self-Efficacy Scale scores ($t = –6.99$, $p < .001$) and the Optimism Scale scores ($t = 4.33$, $p < .001$) were statistically significant predictors of the dependent variable. Using the standardized beta coefficients presented in Table 12, the regression equation for the Value and Need for Seeking Treatment is presented below:

*VANTST Scores = 7.23 – (.79 * Self Efficacy Scale Scores) – (.01 * Experienced Stigma Scale Scores) + (0.13 * Resilience Scale Scores)+ (.37 * Optimism Scale Scores)**

Table 12

ANOVA Results for Value and Need in Seeking Treatment Scale

ANOVA[a]						
	Model	Sum of squares	*df*	Mean Square	*F*	Sig.
1	Regression	509.996	4	127.499	19.825	.000[b]
	Residual	713.870	111	6.431		
	Total	1223.866	115			

a. Dependent Variable: VANTST Scale

b. Predictors: (Constant), RSScale, ES, OptScale, SEScale

Table 13

Regression Model Summary VANTST

Model	*R*	*R* square	Adjusted *R* square	Std. error of the estimate	Change statistics					Durbin-Watson
					R square change	*F* Change	df1	df2	Sig. *F* change	
1	.646[a]	.417	.396	2.53599	.417	19.825	4	111	.000	1.843

a. Predictors: (Constant), RScale, ES, OptScale, SEScale

b. Dependent Variable: VANTST

Table 14

Regression Coefficients VANTST

		Unstandardized coefficients		Standardized coefficients		
	Model	*B*	Std. error	Beta	*t*	Sig.
1	(Constant)	7.234	1.731		4.179	0.000
	SEScale	-0.364	0.052	-0.785	-6.992	0.000
	ES	-0.002	0.013	-0.014	-0.179	0.858
	RSScale	0.022	0.021	0.125	1.038	0.302
	OptScale	0.276	0.064	0.372	4.328	0.000

Summary

The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing. There were two research questions addressed:

RQ1: What are the bivariate correlations among the independent variables of resilience, self-efficacy, experienced stigma, and optimism among women residing in public housing projects?

$H1_0$: There are no statistically significant correlations among the independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) among women residing in public housing projects.

$H1_a$: There are statistically significant correlations between the independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) among women residing in public housing projects.

RQ2: How well do the independent variables of resilience, self-efficacy, experienced stigma, and optimism predict the dependent variable of attitude toward seeking treatment for mental health issues among women residing in public housing projects?

$H2_0$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are not statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

$H2_a$: The independent variables of resilience (scores on the Resilience Scale), self-efficacy (scores on the General Self-Efficacy Scale), experienced stigma (scores on the Discrimination and Stigma Scale), and optimism (scores on the Life Orientation Test) are statistically significant predictors of attitudes toward seeking professional treatment for mental health issues (scores on the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form) among women residing in public housing projects.

A total of 116 women, above 18 years old, and residents of Greenville Housing Authority was included in the study. Correlation analysis and regression analyses were conducted to test the hypotheses and address the research questions posed in this study. The findings showed that the Openness to Seeking Treatment Scale scores were significantly correlated at $p < .01$, with all other scales. Positive correlations were determined between the Openness to Seeking Treatment Scale scores and self-efficacy, optimism, and resilience. Scores on the Openness to Seeking Treatment Scale were negatively correlated with scores on the Value/Need in Seeking Treatment Scale and the Experienced Stigma Scale. The results indicated that higher Openness to Seeking Treatment Scale scores resulted in lower Value/Need in Seeking Treatment Scale and Experienced Stigma Scale scores.

Regarding the Value/Need in Seeking Treatment Scale, there was a statistically significant negative correlation with the Self Efficacy Scale. There was also a statistically significant negative correlation between the Value/Need in Seeking and the Resilience Scale. The result of the correlation also determined that high levels of self-efficacy were related to high levels of optimism and resilience. However, scores on the Self-Efficacy Scale were statically significant and negatively correlated with scores on the Experienced Stigma Scale. Conversely, the Optimism Scale had a statistically significant correlation with both the Experienced Stigma and Resilience Scales. The Optimism scores were negatively correlated with the Experienced Stigma scores. The Experienced Stigma Scale scores were significantly and negatively correlated with the Resilience Scale. Moreover, the Experienced Stigma Scale was significantly and negatively correlated with all variables except the Need/Value in Seeking Treatment Scale.

For Research Question 2, the regression coefficients determined that the Self-Efficacy Scale scores were the only statistically significant predictors in the variable model. For the Value and Need in Seeking Treatment Scale, the regression coefficients showed that the Self-Efficacy Scale scores and the Optimism Scale scores were statistically significant predictors of the dependent variable. The results of this study will be further discussed in Chapter 5. Chapter 5 includes a discussion of the results with reference to existing studies, implications, and recommendations for future practices.

Chapter 5. Discussion, Implications, and Recommendations

Introduction

The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing. Results from the bivariate correlation analysis revealed several statistically significant correlations. One of the key findings was that the Openness to Seeking Treatment Scale scores were significantly and positively correlated with scores on the Self-efficacy, Optimism, and Resilience Scales. Results further revealed that scores of openness to seeking treatment were negatively correlated with scores on the Value/Need in Seeking Treatment Scale and the Experienced Stigma Scales.

For Research Question 1, the result of the correlation also determined that high levels of self-efficacy were related to high levels of optimism and resilience. However, scores on the Self-Efficacy Scale were statistically significant and negatively correlated with scores on the Experienced Stigma Scale. Conversely, the Optimism Scale had a statistically significant correlation, with both the Experienced Stigma and Resilience Scales. The optimism scores were negatively correlated with the Experienced Stigma scores. The Experienced Stigma Scale scores were significantly and negatively correlated with the Resilience Scale. Moreover, the Experienced Stigma Scale was significantly and negatively correlated with all variables except the Need/Value in Seeking Treatment Scale.

For Research Question 2, the results showed the Self-Efficacy Scale scores were the only statistically significant predictor variable model. For the Value and Need in

Seeking Treatment Scale, the regression coefficients indicated that the Self-Efficacy Scale scores and the Optimism Scale scores were statistically significant predictors of the dependent variable.

This final chapter outlines the interpretation of the results of the study in the context of the literature presented in Chapter 2, as well as in the context of the theories used to guide this research: Bandura's (1977) self-efficacy theory, Rutter's (1987) resilience theory, Conner et al.'s (2010) stigma theory, Scheier and Carver's (1985) optimism theory, and Liang et al.'s (2005) theory of help-seeking behavior. The chapter concludes with a discussion of the limitations, implications for practice, and recommendations for further research.

Interpretation of Findings

The first research question addressed the bivariate correlations among the independent variables (resilience, optimism, self-efficacy, and experienced stigma). Data were analyzed using Pearson correlation coefficients. The findings showed that there were statistically significant correlations between scores among the independent variables of resilience, self-efficacy, experienced stigma, and optimism. A further discussion and summary of results is presented in the following paragraphs.

Self-Efficacy

One key finding from the results showed that high levels of self-efficacy were significantly and positively related to high levels of optimism and resilience. Mache et al. (2014) found similar results about work engagement among healthcare professionals. The results from the quantitative study showed a significant relationship between self-efficacy, optimism, and resilience (Mache et al., 2014). Karademas (2006) conducted an

early study that addressed the relationships between individuals' levels of self-efficacy, optimism, and social support. Karademas (2006) found that self-efficacy significantly predicted high levels of optimism.

Findings regarding the relationship between self-efficacy and resilience were consistent with other research which found that individuals with high levels of self-efficacy were more resilient than those with lower levels of self-efficacy (Herbert 2011; Schwarzer & Warner, 2013). Herbert (2011) explored the relationships between psychological capital (hope, optimism, self-efficacy, and resilience), occupational stress, burnout, and employee engagement among permanent employees and support staff who worked in a mid-sized construction company. The researcher found significant negative relationships between hope, optimism, self-efficacy, resilience, and occupational stress and burnout (Herbert, 2011). Herbert's (2011) findings also indicated that optimism and self-efficacy were related to self-efficacy and resilience. Schwarzer and Warner (2013) found a similar relationship been resilience and optimism. The authors concluded that individuals with higher self-efficacy levels were more likely to be capable dealing with stressors in life.

Additional findings showed that scores of self-efficacy were statistically significant and negatively correlated with scores of experienced stigma. The findings were consistent with outcomes from a study by Kleim et al. (2008) which also found that stigma was significantly predictive of low levels of self-efficacy. In a more recent study, Jahn et al. (2020) found that adults with serious mental illness who experienced stigma also had decreased levels of individual self-efficacy. The authors found that overall,

experiences of stigma resulted in decreases in both self-esteem and self-efficacy, which were linked to poor recovery outcomes (Jahn et al., 2020).

In the context of the self-efficacy theory by Bandura (1977), resilience is viewed as a protective factor that buffers individuals from stressors and adversity. Therefore, I anticipated that the scores related to openness to help-seeking would be positively related to resilience scores. Results from this study supported the premise of openness to seeking help being a protective factor related to resilience, as scores on the two scales were significantly and positively related.

Optimism

Results from this study showed that scores of optimism were positively and significantly correlated with scores of self-efficacy and scores of resilience. The significant findings between optimism and resilience are consistent with findings from previous research. For instance, Antúnez et al. (2015) found in their study of healthy adults that resilience and optimism were positively correlated, Gómez Molinero et al. (2018) also reported from findings of a study of university of students that optimism explained the students' resilience, which allowed them to successfully increase their overall well-being, Pathak and Lata (2018) also noted in a quantitative study of perceived stress among young adults that optimism and resilience were positively and strongly associated.

On the other hand, optimism scores were negatively correlated with the scores related to experienced stigma. This finding was consistent with past literature which noted how optimism and stigma were inversely related (Ammirati et al., 2015; Oliver et al., 2014). Ammirati et al. (2015) concluded this outcome when studying individuals

living with HIV. The authors aimed to determine the relationships between optimism, psychological well-being, and stigma through a cross-sectional research (Ammirati et al., 2015). Additionally, Oliver et al. (2014) examined the relationship between stigma and optimism in adolescents and young adults with cystic fibrosis. Overall, their results showed that greater stigma was associated with lower levels of physical health, lower optimism, and decreased quality of life (Oliver et al., 2014).

Resilience

Results from bivariate correlations revealed that scores of resilience were positively and significantly correlated with scores of self-efficacy and optimism, while being negatively correlated with scores of experienced stigma. The finding regarding the negative correlation between resilience and experienced stigma is consistent with results from previous research that experiences of stigma were related to decreased help seeking and decreased resilience (Crowe et al., 2016; Link et Ral., 1989; Link & Phelan, 2013). Stigma also leads to lowered resilience, while help seeking leads to increased resilience and decreased stigma (Crowe et al., 2016; Link et al., 1989; Link & Phelan, 2013). The findings of this research extend the premises of resilience theory, specifically in providing more information regarding the aspects of resilience among women in public housing settings and multiple challenges faced by this population.

Experienced Stigma

The Experienced Stigma Scale scores were significantly and negatively correlated with the scores on the Resilience Scale. According to Henderson et al. (2013), the relationship between stigma, discrimination, and access to healthcare is multifaceted. The

researchers found that stigma could lead to treatment avoidance and delays, even discontinuance of service use.

Predictors of Help Seeking

The measure of help-seeking was divided into two scales prompted by results from the reliability analysis and substantiated by the article found in the additional literature search (Crowe et al., 2016; Schomerus et al., 2013). Therefore, a regression analysis was conducted for each scale. The four independent variables were included in each regression analysis. Results from each regression analysis are presented separately, addressing findings related to self-efficacy and openness to seeking treatment for mental illness.

Findings from this research regarding the relationships between resilience and formal help-seeking contradicted findings from some of the existing literature (Crowe et al., 2016; Schomerus et al., 2013). For example, Schomerus et al. (2013) found that low levels of resilience were linked with higher levels of formal help-seeking in depressed individuals. Similarly, Crowe et al. (2016) noted that help-seeking was associated with lower levels of resilience among full-time university employees regarding mental illness stigma and seeking help for mental illness. In a more recent study, Drew and Matthews (2019) noted how student athletes with high levels of resilience were more likely to seek informal support than student athletes with lower levels of resilience. This pool of existing studies showed inconsistent and thus inconclusive results based on the past studies' findings.

Value/Need in Seeking Treatment

Findings from the regression analysis showed that for the Value and Need in Seeking Treatment Scale, the Self-Efficacy Scale scores and the Optimism Scale scores were statistically significant predictors of the dependent variable. Currently, I did not find research regarding the relationship between self-efficacy, optimism, and one's value and need in seeking treatment. Past researchers have focused on the attitudes of individuals in seeking mental health treatment (Crowe et al., 2016; Link et al., 1989; Link & Phelan, 2013; Schomerus et al., 2013). However, results from the bivariate correlations between the dependent and independent variables showed that scores were related to the Value/Need in Seeking Treatment Scale and the Self-efficacy Scale. Scores were also related to the Resilience Scale. The findings pertaining to the value/need in seeking treatment represents an area for future research opportunities.

Openness to Seeking Treatment

The findings from the regression model for the Openness to Seeking Help Scale showed that of the four independent variables, only self-efficacy was statistically significant. Results from a bivariate correlation showed that scores related to openness to seeking treatment were significantly correlated with scores of resilience, optimism, and self-efficacy, but resilience and optimism were not significant predictors in the regression model. Findings from this study were consistent with previous findings regarding the relationship between openness to seeking treatment and resilience. For instance, past findings had shown that resilience was a factor that was correlated with the behaviors in seeking needed medical help (Butler-Jones, 2013). Gillispie et al. (2016) found similar results in their study regarding occupational stressors among extreme (military) and

typical (civilian) work environment employees. Results from a Gillispie et al. (2016) study revealed that seeking mental health treatment was significantly associated with resilience among all employees.

Results from this study concerning the relationship between openness to seeking treatment and optimism are consistent with findings from past research. For instance, research had shown that the perceived ability to manage one's emotions predicted using meditation/exercise and substance use as coping methods (Lei & Pellitteri, 2017). This predictor strongly overlapped with optimism (Lei & Pellitteri, 2017). Spendelow and Jose (2010) also found a significant relationship between optimism and self-reported treatment seeking. The authors sought to determine whether optimism impacts the intentions of help-seeking for people with depression (Spendelow & Jose, 2010).

Interpretation of Findings Relative to Theory

Self-Efficacy Theory

Bandura's (1977) self-efficacy theory was used as one of theories that guided this study. According to Bandura (1977), self-efficacy can drive the person's motivation to partake in a specific behavior. Self-efficacy is described as the perception of confidence that individuals possess about their abilities to engage in behaviors to achieve specific outcome. The concept of self-efficacy is task specific, and levels of self-efficacy can vary from task to task (Bandura, 1977). In the context of this study self-efficacy pertained to a person's perceived efficacy in coping with daily hassles and the ability to adapt in the aftermath of stressful events (Swarzer & Jerusalem, 1995). Although some inferences can be made regarding the literature reviewed and the findings of the current study, the researcher must mention that minimal research is available on this topic, making it

difficult to compare findings with other studies. The literature available on the topic is discussed in the following subsections.

Openness to Seeking Treatment

Findings from the regression analysis showed that self-efficacy was the only statistically significant predictor of openness to seeking treatment. This finding is consistent with premises of general self-efficacy. Bandura (1977) posited that self-efficacy provides individuals with the conviction that one can effectively carry out the behavior needed to achieve desired outcomes. Premises of self-efficacy theory would indicate that individuals with high self-efficacy would be expected to actively seek solutions to resolve personal problems. In addition, results from the bivariate correlations showed a statistically significant relationship between self-efficacy scores and the openness to treatment scores. Consequently, it was expected that scores on general self-efficacy would be statistically significant predictors of openness to seeking treatment for mental illness. Results from this study align with premises of self-efficacy theory.

Value/Need for Seeking Treatment

For the Value and Need in Seeking Treatment Scale, the regression coefficients showed that the Self-Efficacy Scale scores and the Optimism Scale scores were statistically significant predictors of the dependent variable. The findings of this study aligned with the self-efficacy theory. Bandura (1977) posited that individuals with self-efficacy might have more motivations to achieve desired outcomes, as shown in this study. Williams and Rhodes (2016) reported an individual might express self-efficacy and optimism about improving their mental health conditions if treated by a mental healthcare professional yet still avoid seeking help.

Optimism Theory

Further, this study's findings extend premises of the theory of optimism by Scheier and Carver (1985). Scheier and Carver proposed that the construct of optimism, considered as a stable personality trait, influences the behaviors and attitudes of individuals. The researchers emphasized optimism was a causal trait that influences outcomes or outcomes in an intrinsically future-oriented construct (Scheier & Carver, 1985). Although some inferences can be made regarding the literature reviewed and the findings of the current study, the researcher must mention that minimal research is available on this topic, making it difficult to compare findings with other studies. The literature available on the topic is discussed in the following subsections.

Openness to Seeking Treatment

One of the key findings in this study indicated that in the regression model, optimism was not a statistically significant predictor when all independent variables were included. Positive correlations were determined between the Openness to Seeking Treatment Scale scores and optimism. Scheier and Carver (1985) highlighted that optimism is a trait that influences behaviors and outcomes in an intrinsically future-oriented construct. Based on the theory of optimism by Scheier and Carver (1985), Schou-Bredal et al. (2019) showed that optimists reported a significantly with more openness to seeking treatment. Thus, findings from this study aligned with premises of Scheier and Carver's (1985) theory of optimism.

Value/Need for Seeking Treatment

The results showed that self-efficacy and optimism were negatively correlated with the scores on the measure of optimism. For the Value and Need in Seeking

Treatment Scale, the regression coefficients showed that the Self-Efficacy Scale scores and the Optimism Scale scores were statistically significant predictors of the dependent variable. Scheier and Carver (1985) proposed that the construct of optimism, considered as a stable personality trait, influences the behaviors and attitudes of individuals, with variances possible depending on challenges faced, including health-related outcomes. The results of this study aligned with the optimism theory regarding a person's value/need for seeking treatment. For example, Schou-Bredal et al. (2019) investigated the role of optimism on health status, including measures of mental health disorders. Based on the premises of theory of optimism by Scheier and Carver (1985). Findings from the study showed that 11.3% of pessimists reported five or more disease states versus the 3.9% reported from the optimist population (Schou-Bredal et al., 2019). The results also showed that optimists were more likely to see the value/need for seeking treatment for health issues compared to pessimists, aligning with the findings of this study.

Resilience Theory

Insights into resilience were viewed through the work and theory by Rutter (1987). Resilience is a process that varies from person-to-person and involves the capacity to positively adapt when facing adversity, trauma, tragedy, threatening circumstances, or significant and real risks (Reid, 2019). Rutter's (1987) resilience theory involves individual traits, characteristics, or mechanisms that protect against psychological risks. Rutter identified four processes associated with resilience: reduction of impact, reduction of unwanted chain reactions, establishing and preserving aspects of self-esteem and self-efficacy, and consideration for opportunities. Although some

inferences can be made regarding the literature reviewed and the findings of the current study, the researcher must mention that minimal research is available on this topic, making it difficult to compare findings with other studies. The literature available on the topic is discussed in the following subsections.

Openness to Seeking Treatment

Positive correlations were determined between the Openness to Seeking Treatment Scale scores and resilience, supporting the premises of Rutter's (1987) resilience theory. Revilla et al. (2017) found support for resilience not only in individuals but also within families and social groups facing adversity. This resilience would make individuals more open to seeking treatment than those without resilience, as shown in this study.

Value/Need for Seeking Treatment

There was a statistically significant negative correlation between the Value/Need in Seeking and the Resilience Scale. Rutter's (1987) resilience theory applied to the current study to explore value/need for seeking treatment versus resilience among women in public housing settings. Women with lower levels of resilience may place more value on seeking help, which may contradict some research that has shown that stigma leads to decreased help seeking and decreased resilience (Crowe et al., 2016; Link et al., 1989; Link & Phelan, 2013), aligning with the current study.

Experienced Stigma

The Experienced Stigma Scale scores were significantly and negatively correlated with the scores on the Resilience Scale. Experienced stigma is a factor behind attitudes toward seeking treatment for mental illness. Minimal research is available on this topic,

making it difficult to compare findings with other studies. However, according to Henderson et al. (2013), the relationship between stigma, discrimination, and access to healthcare could lead to treatment avoidance and delays. Beliefs about the effectiveness of treatments and services can influence subsequent or long-term treatment behavior, but stigma may already be significantly experienced by people with mental healthcare requirements long before they have access to these services.

Openness to Seeking Treatment

The findings from the regression model for the Openness to Seeking Help Scale showed experienced stigma was a statistically significant predictor of openness to seeking treatment. The findings of this study align with other research about experienced stigma. For example, Henderson et al. (2013) found that stigma could lead to treatment avoidance and delays, even discontinuance of service use. Beliefs about the effectiveness of treatments and services can influence subsequent or long-term treatment behaviors, such as experienced stigma that influences such beliefs (Henderson et al., 2013). This finding aligns with the finding of this study that experienced stigma can predict openness to seeking treatment.

Value/Need for Seeking Treatment

The Experienced Stigma Scale was significantly and negatively correlated with all variables except the Need/Value in Seeking Treatment Scale. Thus, experienced stigma may lower one's desire to seek treatment. This finding was supported by the literature. Researchers have found that women who live in public housing experience both poverty and stigma (Manzo, 2014). People living in poverty are not as likely to look for professional help regarding mental health issues compared with persons with higher

incomes, facing more stigma due to their monetary status than others (Santiago et al., 2013; Shin et al., 2013). Minimal research is available on this topic, making it difficult to compare findings with other studies. Thus, researchers have asked future researchers to identify factors possible associated with help-seeking for people living in poverty (Lee et al., 2013), which this research attempted.

With minimal previous literature exploring the attitudes toward seeking help of women residing in public housing, the results from this quantitative research study might serve as an initial reference for further researchers. Future researchers can use this study as reference regarding the relationships between resilience, self-efficacy, experienced stigma, optimism, and attitudes toward seeking professional treatment for mental health issues. Overall, the findings of the current study extended current knowledge on the attitudes toward seeking professional treatment for mental health issues.

Limitations of the Study

There are several things that serve as limitations of this study. The first limitation was related to the demographics of the sample. The majority (92%) of the respondents were Black/African Americans. This demographic of the study population limits the generalizability of the results with other populations. Moreover, the sample included women living in public housing in North Carolina. As such, the findings of this study cannot be generalizable to all persons living in poverty or all women in public housing nationwide. The results are also not generalizable to women not living in poverty or men in or out of poverty.

Also, the selected participants lived in public housing, which was a second limitation. That is, only women living in public housing in North Carolina were recruited

for this study sample. As such, the findings of this study may not be generalizable to all persons living in poverty or those not living in public housing.

The ages of the participants were primary early 18 to 43 years; thus, it is possible that results may have appeared differently if older adults (50 and older) were added to the sample. The sample size could be expanded to include older adults only to see if results differ. This study's age group may have limited the generalizability of the results to other populations, such as older age groups.

The third limitation was due to the correlational design used for this research. That is, the use of the correlational design places a limitation on the generalizability of the results. The correlational design was a limitation as I cannot determine the reasons behind the results. Additionally, there are other variables which were not included in this study, which might influence the correlations between the independent and dependent variables of this study. Several other factors could have impacted the participants' attitudes regarding help-seeking. Thus, this limitation may influence the generalizability of the results.

Recommendations

This quantitative research study provided information regarding the predictive relationships between independent variables of resilience, self-efficacy, experienced stigma, and optimism and the dependent variable of attitudes toward seeking professional mental health services of public housing project residents. Recommendations for further research include expanding the sampling scope of the targeted population. For this study, only women residing in public housing projects from the Greenville Housing Authority in North Carolina were included as participants. Future researchers could extend this

research by replicating the study with women residing in public housing projects in other housing areas and other states. I also recommend a study that includes a broader racial/ethnic mix of women, as well as a broader age group.

Another recommendation for future research includes using another research methodology to examine the lived experiences of women residing in public housing projects. Most of the past studies on women in public housing have been quantitative in nature. Exploration by gathering the firsthand accounts of participants could provide more in-depth information about how their experiences of stigmas impacted them and their help-seeking. Using another research approach, such as a qualitative study, may increase the current understanding of women's attitudes toward seeking treatment for mental health issues.

Implications

Findings from this study regarding the attitudes of women residing in public housing projects toward seeking treatment for mental health issues have several implications. The findings of this study also have implications for positive social change, as the study provides an expanded knowledge base of women's help-seeking behaviors when in public housing. Mental health professionals and related professionals in the field may use the results from this study to understand how self-efficacy, resilience, optimism, and experienced stigma affect attitudes toward seeking treatment for mental illness. For instance, clinicians may use information that shows self-efficacy and optimism as promoting factors for openness to seeking treatment for women residing in public housing projects. Conversely, the negative correlations represent inhibiting factors that decrease openness to treatment.

This study also has implications for the extending the use of the theories that guided this research topic: Bandura's (1977) self-efficacy theory, Rutter's (1987) resilience theory, Conner et al.'s (2010) stigma theory, Scheier and Carver's (1985) optimism theory, and Liang et al.'s (2005) theory of help-seeking behavior. Findings from this study extended the applicability of these established frameworks and theories by using the theories to explore how the combined effects of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women residing in public housing project.

As the number of individuals diagnosed with mental health issues continues to increase, especially as they are provided housing, the need will persist among counselors and mental health practitioners to understand how to support and address the needs of individuals living in public housing adequately (Honey et al., 2017). With increased knowledge of unique determinants of help-seeking behaviors of this population, clinicians or others in a position to work with this cohort of women or develop mental health programs to assist them will be better prepared. This study may serve as helpful information and spur action. Clinicians can use the study to increase understanding of self-efficacy, experienced stigma, optimism, and resilience relating to help-seeking behaviors.

Conclusion

The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing. Current literature on women living in public housing project residents was

scarce. I did not find much literature related to attitudes toward seeking professional mental health services and determinants of help-seeking behaviors. Little information was available in previous research and academic literature regarding this topic.

This non-experimental correlational study revealed several major findings: Openness to Seeking Treatment Scale scores were significantly correlated at with all other scales. Positive correlations were found between the Openness to Seeking Treatment Scale scores and self-efficacy, optimism, and resilience. Scores on the Openness to Seeking Treatment Scale were negatively correlated with scores on the Value/Need in Seeking Treatment Scale and the Experienced Stigma Scale. Regarding the Value/Need in Seeking Treatment scale, there was a statistically significant negative correlation with the Self Efficacy Scale. There was a statistically significant negative correlation between the Value/Need in Seeking and the Resilience Scale, while scores on the Self-Efficacy Scale were statistically significant and negatively correlated with scores on the Experienced Stigma Scale. Conversely, the Optimism Scale had a statistically significant and negative correlation with both the Experienced Stigma and Resilience Scales.

These various key findings supported the original assumption that individual factors would predict women's attitudes living in project houses toward getting professional help from a counselor or therapist. The findings supported the notion that attitudes toward seeking professional help might best be explained through premises of Bandura's (1977) self-efficacy theory, Rutter's (1987) resilience theory, Conner et al.'s (2010) stigma theory, Scheier and Carver's (1985) optimism theory, and Liang et al.'s (2005) theory of help-seeking behavior. However, although there were several

statistically significant correlations between pairs of variables, only self-efficacy predicted openness to seeking treatment for mental illness. Both self-efficacy and optimism were statistically significant predictor of the value/need for seeking treatment. Self-efficacy was negatively correlated with the value/need for seeking treatment and optimism was positively correlated with the value/need for seeking treatment.

This study provides a baseline for acquiring knowledge about the attitudes toward seeking help for mental illness among women residing in public housing. There is much more to learn about this cohort of women in other areas around the United States and how other factors may increase their help-seeking behaviors. The findings of this study showed significant information, which might be used to conduct more effective outreach efforts and programs in these public housing communities than before.

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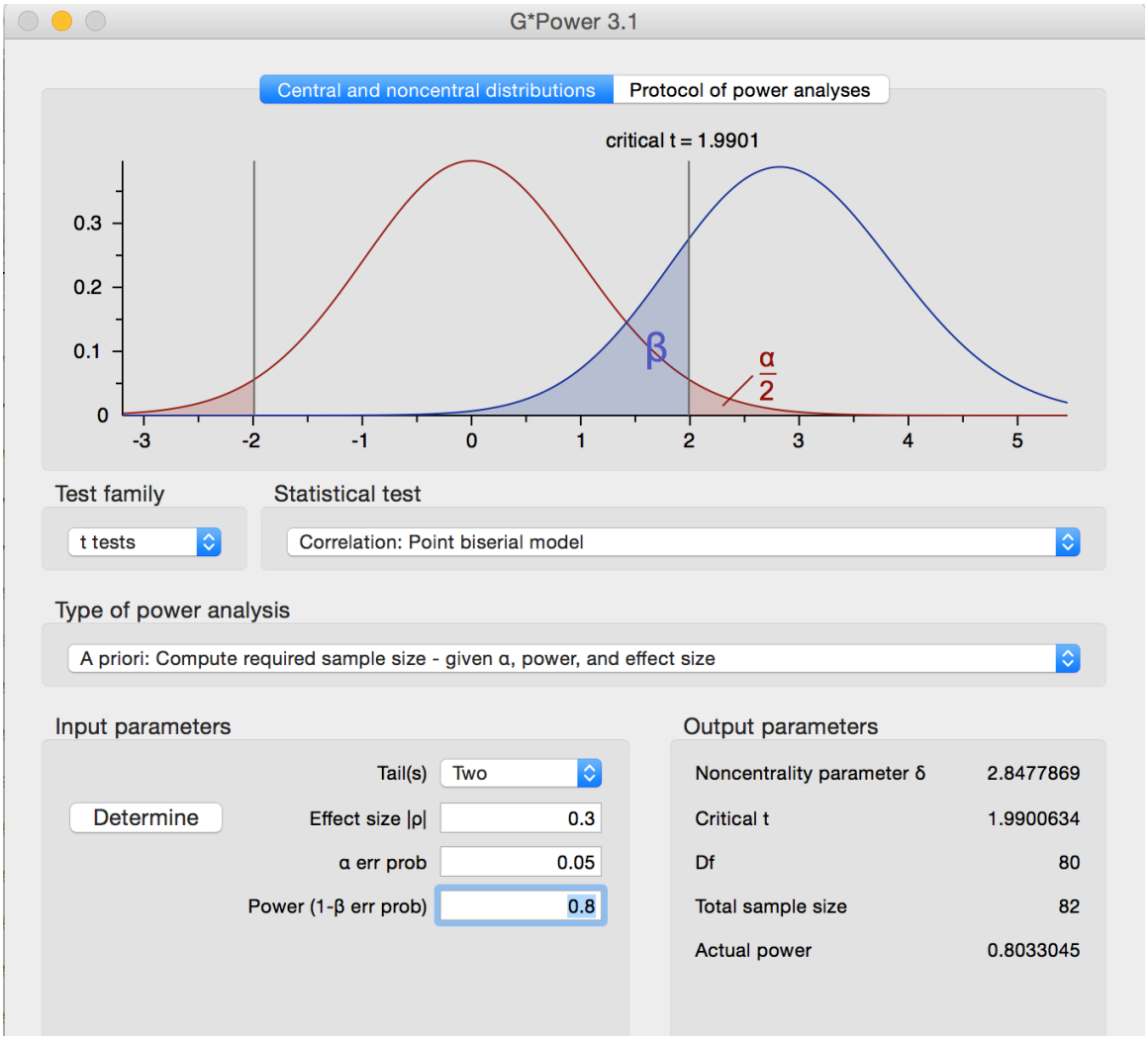
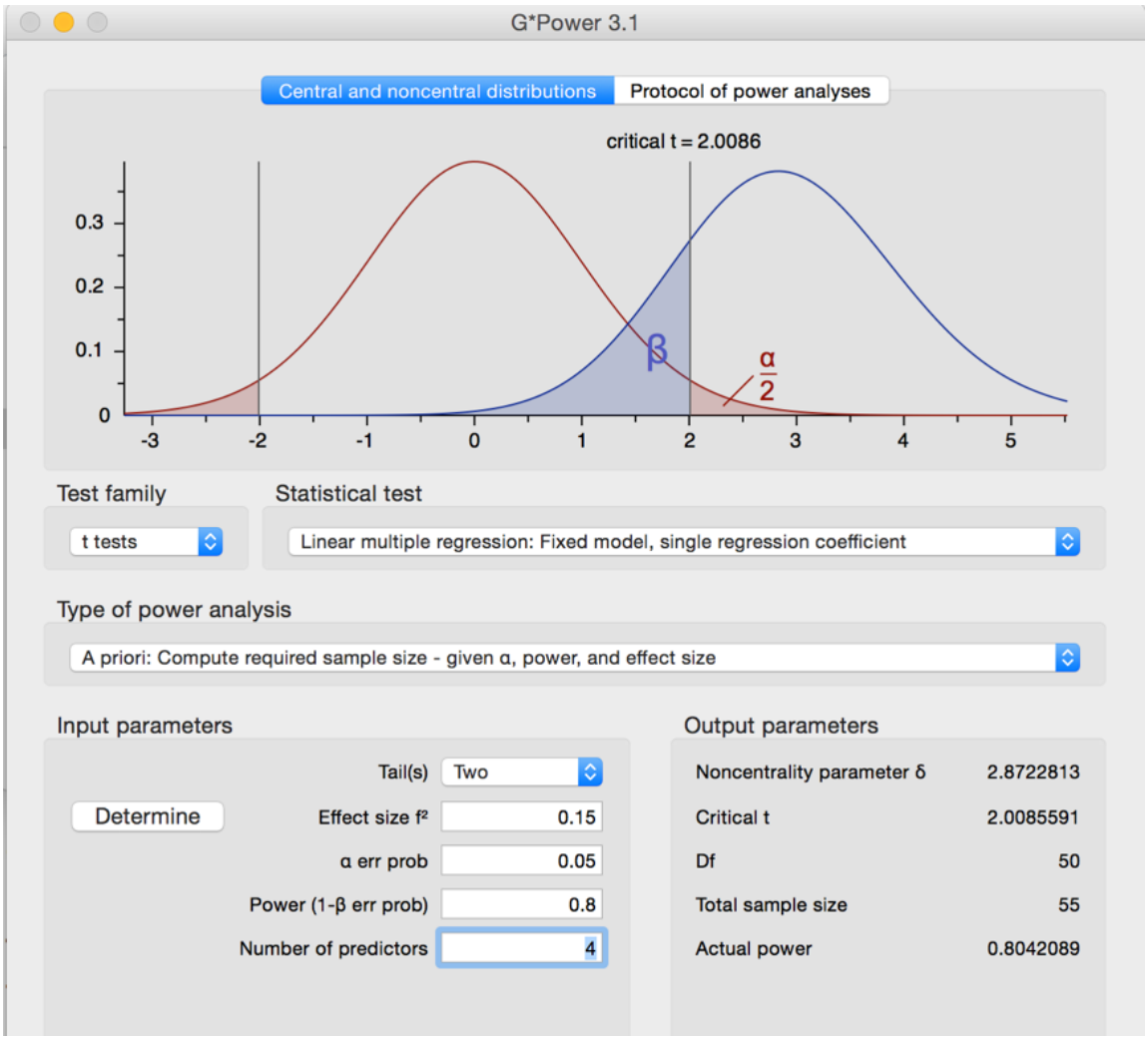
Appendix A: G*Power Sample Size Computation Using Correlation Analysis



Appendix B: G*Power Sample Size Computation Using Regression Analysis



Appendix C: Flyer

VOLUNTEERS WANTED

Volunteers Wanted for a Research Study

This study is being done by Belinda Newkirk, a PhD student at Walden University for dissertation, to learn more about women who live in public housing attitudes towards seeking counseling.

How to Participate:

Participants will complete 5 online surveys

Location:

In a place of your choice utilizing your own computer, laptop, or cell phone.

Who is Eligible?

- African American ages 18 and older
- Live in North Carolina
- Receive public housing assistance from the U.S. government

If you're interested, please go to the website below for more information about the study and how it can benefit you!

Survey Link: https://www.surveymonkey.com/r/AofWRPH

Appendix D: Informed Consent Form

(to be completed on SurveyMonkey)

You are invited to take part in a research study by Belinda Newkirk, a PhD student at Walden University to help determine whether or not women who live in public housing have personal behaviors that relate to attitudes toward seeking professional help. The study was offered to you because you are a woman who is (a) African American age 18 and older, (b) live in North Carolina, and (c) receive public housing project assistance from the U.S. government within the state of North Carolina. This form is part of a process called "informed consent" which helps you understand the study and decide if you want to participate.

Background Information

Research Purpose and Procedures

The purpose of this quantitative study was to determine whether the individual determinants of resilience, self-efficacy, experienced stigma, and optimism predicted attitudes toward seeking professional mental health services of women living in public housing.

If you agree to be in this study, you will be asked to complete a five-part survey in the online survey tool called SurveyMonkey. There will be no time limit to complete the online surveys. However, it may take approximately 30 to 45 minutes to complete them all.

Voluntary Nature of the Study

If you feel there is a conflict of interest, please know that your participation in this study is voluntary. This means that everyone will respect your decision of whether you

want to participate, and no one will treat you differently if you decide not to be in the study. If you decide to join the study, you can still change your mind during the study at any time. The surveys can be completed via your own personal devices in a privacy area of your choosing so no one can see what your responses are, and the survey is not audible so others cannot hear responses.

Risks and Benefits of Being in the Study

Risks are minimal; you are welcome to skip any questions that you feel are stressful, personal, and uncomfortable and you can stop at any time during the study. Here is a list of counselors in the area if you feel upset or stressed in any way from the surveys; this list consist of but is not limited to: East Coast Counseling, Behavioral health Services, Side by Side Counseling, Port Health, Pride in North Carolina, Integrated Family Services, and Pitt Counseling. The benefits of participating are having your views be a part of the study results. Also, the study will give you the chance to explore your own thoughts and experiences which could be a part of the solution to improving educational writings for this area.

Compensation

No payment will be provided.

Confidentiality

Any information you provide will be kept confidential. I will not use your information for any purposes outside of this research project. The surveys do not include your name or anything else that could identify you in any reports of the study. To maintain privacy, I will store the files of completed survey data on a password-protected external drive and any hard copies of the survey information in a locked drawer for five

years, accessible only by the researcher or my committee members. The files will be in a designated area in the researcher's home office for five years, and only the researcher will have access to the files. After maintaining the data for a period of five years, it will be destroyed.

Contacts and Questions

If you have any questions, you may contact me, the principal researcher, Belinda Newkirk, via email at [redacted]. If you want to talk privately about your rights as a participant or have general questions about the study, you can call Walden University's Research Participant Advocate at [redacted] or email [redacted].

Statement of Consent

I have read the above information and I feel that I understand the study well enough to decide to participate. By clicking "Agree to Participate" below, I am agreeing to participate in the study.

☐Agree to Participate ☐Do Not Agree to Participate

*You have the right to print a copy of this consent for your records.

Appendix E: Demographic Questionnaire

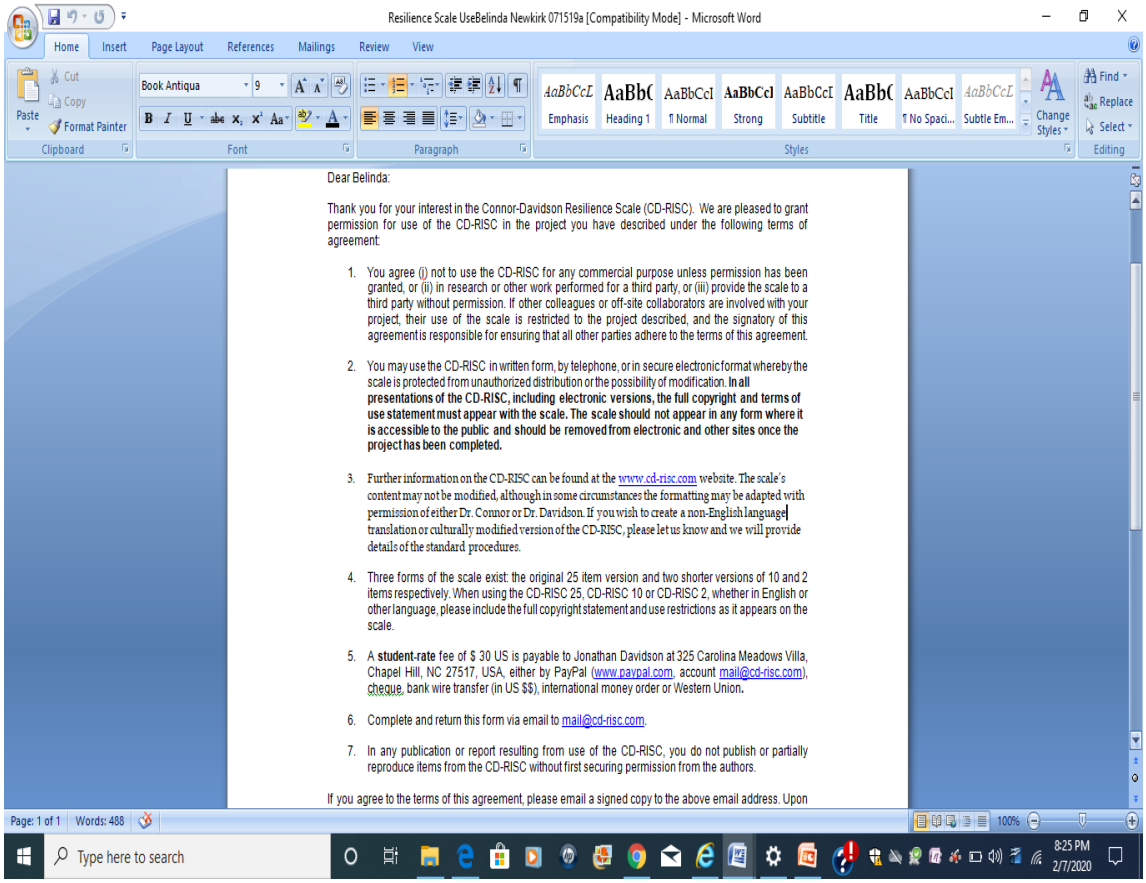
1. What is your race/ethnicity?
   - ○ White or Caucasian
   - ○ Black or African American
   - ○ Hispanic or Latino
   - ○ Asian or Asian American
   - ○ American Indian or Alaska Native
   - ○ Native Hawaiian or other Pacific Islander

2. What is your age?
   - ○ 18-24
   - ○ 25-34
   - ○ 45-54
   - ○ 55-64
   - ○ 65+

3. What is the highest level of education you have completed?
   - ○ Some High School
   - ○ High School Graduate
   - ○ Some College
   - ○ Graduated from College
   - ○ Some Graduate School
   - ○ Completed Graduate School

4. How many children are you parent or guardian for that live in your household?
   - ○ None
   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ More than 4

Appendix F: Copy of the Permission to Use the Resilience Scale



Resilience Scale UseBelinda Newkirk 071519a [Compatibility Mode] - Microsoft Word

Dear Belinda:

Thank you for your interest in the Connor-Davidson Resilience Scale (CD-RISC). We are pleased to grant permission for use of the CD-RISC in the project you have described under the following terms of agreement:

1. You agree (i) not to use the CD-RISC for any commercial purpose unless permission has been granted, or (ii) in research or other work performed for a third party, or (iii) provide the scale to a third party without permission. If other colleagues or off-site collaborators are involved with your project, their use of the scale is restricted to the project described, and the signatory of this agreement is responsible for ensuring that all other parties adhere to the terms of this agreement.

2. You may use the CD-RISC in written form, by telephone, or in secure electronic format whereby the scale is protected from unauthorized distribution or the possibility of modification. **In all presentations of the CD-RISC, including electronic versions, the full copyright and terms of use statement must appear with the scale. The scale should not appear in any form where it is accessible to the public and should be removed from electronic and other sites once the project has been completed.**

3. Further information on the CD-RISC can be found at the www.cd-risc.com website. The scale's content may not be modified, although in some circumstances the formatting may be adapted with permission of either Dr. Connor or Dr. Davidson. If you wish to create a non-English language translation or culturally modified version of the CD-RISC, please let us know and we will provide details of the standard procedures.

4. Three forms of the scale exist: the original 25 item version and two shorter versions of 10 and 2 items respectively. When using the CD-RISC 25, CD-RISC 10 or CD-RISC 2, whether in English or other language, please include the full copyright statement and use restrictions as it appears on the scale.

5. A **student-rate** fee of $ 30 US is payable to Jonathan Davidson at 325 Carolina Meadows Villa, Chapel Hill, NC 27517, USA, either by PayPal (www.paypal.com, account mail@cd-risc.com), cheque, bank wire transfer (in US $$), international money order or Western Union.

6. Complete and return this form via email to mail@cd-risc.com.

7. In any publication or report resulting from use of the CD-RISC, you do not publish or partially reproduce items from the CD-RISC without first securing permission from the authors.

If you agree to the terms of this agreement, please email a signed copy to the above email address. Upon

Appendix G: Resilience Scale

For each item, please mark below what best indicates how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.

1. I am able to adapt when changes occur.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

2. I have at least one close and secure relationship that helps me when I am stressed.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

3. When there are no clear solutions to my problems, sometimes fate or God can help.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

4. I can deal with whatever comes my way.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

5. Past successes give me confidence in dealing with new challenges and difficulties.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

6. I try to see the humorous side of things when I am faced with problems.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

7. Having to cope with stress can make me stronger.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

8. I tend to bounce back after illness, injury, or other hardships.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

9. Good or bad, I believe that most things happen for a reason.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

10. I give my best effort no matter what the outcome may be.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

11. I believe I can achieve my goals, even if there are obstacles.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

12. Even when things look hopeless, I don't give up.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

13. During times of stress/crisis, I know where to turn for help.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

14. Under pressure, I stay focused and think clearly.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

15. I prefer to take the lead in solving problems rather than letting others make all the decisions.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

16. I am not easily discouraged by failure.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

17. I think of myself as a strong person when dealing with life's challenges and difficulties.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

18. I can make unpopular or difficult decisions that affect other people, if it is necessary.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

19. I am able to handle unpleasant or painful feelings like sadness, fear, and anger.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

20. In dealing with life's problems, sometimes you have to act on a hunch without knowing why.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

21. I have a strong sense of purpose in life.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

22. I feel in control of my life.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

23. I like challenges.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

24. I work to attain my goals no matter what roadblocks I encounter along the way.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

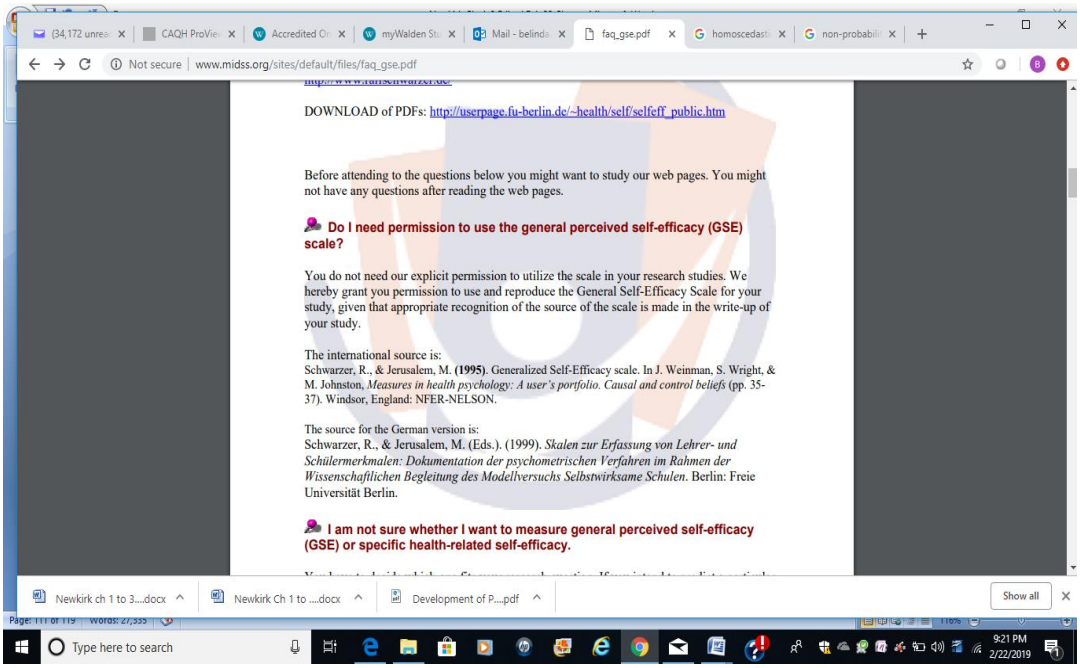
25. I take pride in my achievements.

□Not true at all □Rarely true □Sometimes true □Often true □True nearly all the time

Appendix H: Copy of the Permission to Use the General Self-Efficacy Scale

http://www.midss.org/sites/default/files/faq_gse.pdf

http://userpage.fu-berlin.de/~health/engscal.htm



DOWNLOAD of PDFs: http://userpage.fu-berlin.de/~health/self/selfeff_public.htm

Before attending to the questions below you might want to study our web pages. You might not have any questions after reading the web pages.

Do I need permission to use the general perceived self-efficacy (GSE) scale?

You do not need our explicit permission to utilize the scale in your research studies. We hereby grant you permission to use and reproduce the General Self-Efficacy Scale for your study, given that appropriate recognition of the source of the scale is made in the write-up of your study.

The international source is:
Schwarzer, R., & Jerusalem, M. **(1995)**. Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 35-37). Windsor, England: NFER-NELSON.

The source for the German version is:
Schwarzer, R., & Jerusalem, M. (Eds.). (1999). *Skalen zur Erfassung von Lehrer- und Schülermerkmalen: Dokumentation der psychometrischen Verfahren im Rahmen der Wissenschaftlichen Begleitung des Modellversuchs Selbstwirksame Schulen*. Berlin: Freie Universität Berlin.

I am not sure whether I want to measure general perceived self-efficacy (GSE) or specific health-related self-efficacy.

Appendix I: General Self-Efficacy Scale

Please respond to the statements below. Please be as honest and accurate as you can throughout. There are no "correct" or "incorrect" answers.

1. I can always manage to solve difficult problems if I try hard enough

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

2. If someone opposes me, I can find the means and ways to get what I want.

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

3. It is easy for me to stick to my aims and accomplish my goals.

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

4. I am confident that I could deal efficiently with unexpected events.

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

5. Thanks to my resourcefulness, I know how to handle unforeseen situations.

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

6. I can solve most problems if I invest the necessary effort.

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

8. When I am confronted with a problem, I can usually find several solutions.

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

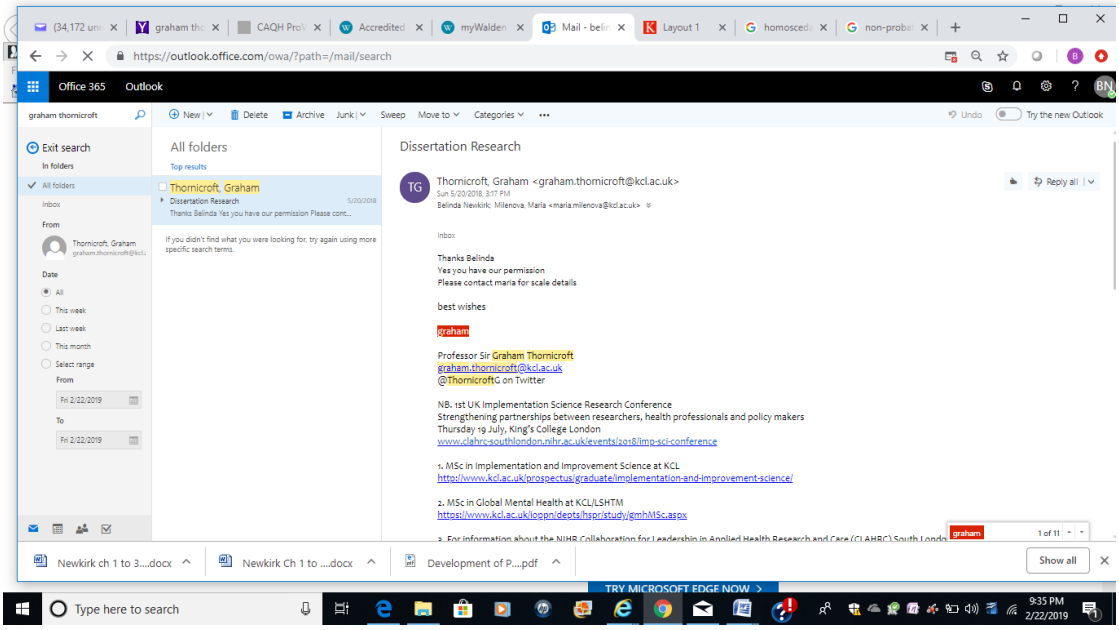
9. If I am in trouble, I can usually think of a solution

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

10. I can usually handle whatever comes my way.

□ Not at all true □ Hardly true □ Moderately true □ Exactly true

Appendix J: Copy of the Permission to Use the Discrimination and Stigma Scale



Appendix K: Discrimination and Stigma Scale

Discrimination and Stigma Scale Attitudes Toward Seeking Counseling of Women Residing in Public Housing Discrimination and stigma occur when people are treated unfairly because they are seen as being different from others. These questions ask about how you've been affected by discrimination and stigma because of mental health problems. There are four parts to this scale. Each part asks about how you have been treated or what you have done in different situations. The first part, ask about times when you have been treated unfairly because of mental health problems.

1. Have you been treated unfairly in making or keeping friends?

□Not at all □A little □Moderately □A Lot □Not applicable

2. Have you been treated unfairly by the people in your neighborhood?

□Not at all □A little □Moderately □A Lot □Not applicable

3. Have you been treated unfairly in dating or intimate relationships? (excluding treatment by spouse or cohabiting partner)

□Not at all □A little □Moderately □A Lot □Not applicable

4.Have you been treated unfairly in housing?

Not at all A little Moderately A Lot Not applicable

5. Have you been treated unfairly in your education? (example school, college, university, on the job training, vocational courses)

□Not at all □A little □Moderately □A Lot □Not applicable

6. Have you been treated unfairly in marriage or divorce?(including co-habiting or civil partnership)

□Not at all □A little □Moderately □A Lot □Not applicable

7. Have you been treated unfairly by your family? (parents, brothers, sisters and other relations as well as any children)

□Not at all □A little □Moderately □A Lot □Not applicable

8. Have you been treated unfairly in finding a job?(this means finding full or part-time paid work)

□Not at all □A little □Moderately □A Lot □Not applicable

9. Have you been treated unfairly in keeping a job?

□Not at all □A little □Moderately □A Lot □Not applicable

10. Have you been treated unfairly when using public transport? (when using free travel pass, passengers, drivers, etc.)

□Not at all □A little □Moderately □A Lot □Not applicable

11. Have you been treated unfairly in getting welfare benefits or disability pensions?(or applying for benefits (e.g. income support, disability living allowance, level of benefits, support)

□Not at all □A little □Moderately □A Lot □Not applicable

12. Have you been treated unfairly in your religious practices?(attending church, other church members, church leaders)

□Not at all □A little □Moderately □A Lot □Not applicable

13. Have you been treated unfairly in your social life (socializing, hobbies, attending events, leisure activities)

□Not at all □A little □Moderately □A Lot □Not applicable

14. Have you been treated unfairly by the police?(by any contact with police because of mental health problems or any other reasons)

□Not at all □A little □Moderately □A Lot □Not applicable

15. Have you been treated unfairly when getting help for physical health problems? (dentist, nurses and emergency treatment)

□Not at all □A little □Moderately □A Lot □Not applicable

16. Have you been treated unfairly by mental health staff?(feeling disrespected or humiliated by contact with mental health staff)

□Not at all □A little □Moderately □A Lot □Not applicable

17. Have you been treated unfairly in your levels of privacy?(privacy in hospital and in community settings, private letters or phone calls, medical records, Criminal Records Bureau check)

□Not at all □A little □Moderately □A Lot □Not applicable

18. Have you been treated unfairly in your personal safety and security? (verbal abuse, physical abuse, assault)

□Not at all □A little □Moderately □A Lot □Not applicable

19. Have you been treated unfairly in starting a family or having children? (ask about the behavior of health professionals, friends and family, as well as how they or their partner were treated during pregnancy or childbirth)

□Not at all □A little □Moderately □A Lot □Not applicable

20. Have you been treated unfairly in your role as a parent to your children? (ask about behavior of other parents, teachers, family or mental health staff)

□Not at all □A little □Moderately □A Lot □Not applicable

21. Have you been avoided or shunned by people who know that you have a mental health problem?

□Not at all □A little □Moderately □A Lot □Not applicable

In this section, I would like to ask about times when you have stopped yourself from doing things that are important to you because of how others might respond to your mental health problem. There are 4 questions in this section. Please choose one answer only for each question.

22. Have you stopped yourself from applying for work?

□Not at all □A little □Moderately □A Lot □Not applicable

23. Have you stopped yourself from applying for education or training courses?

□Not at all □A little □Moderately □A Lot □Not applicable

24. Have you stopped yourself from having a close personal relationship?

□Not at all □A little □Moderately □A Lot □Not applicable

25. Have you concealed or hidden your mental health problem from others?

□Not at all □A little □Moderately □A Lot □Not applicable

In this section, I would like to ask you about examples of overcoming stigma and discrimination because of mental health problems. There are 2 questions in this section. Please choose one answer only for each question.

26. Have you made friends with people who don't use mental health services?

□Not at all □A little □Moderately □A Lot □Not applicable

27. Have you been able to use your personal skills or abilities in coping with stigma and discrimination?

□Not at all □A little □Moderately □A Lot □Not applicable

In this section, I would like to ask about times when you have been treated more positively because of mental health problems. Being treated "more positively" means

receiving special or favorable treatment. I would like to know if you have experienced any favorable treatment compared with how you were treated before you developed a mental health problem or compared with how people who don't have a mental health problem are treated. There are 5 questions in this section. Please choose one answer only for each question.

28. Have you been treated more positively by your family?(include family of origin, spouse or partner, children, relatives)

□Not at all □A little □Moderately □A Lot □Not applicable

29. Have you been treated more positively in getting welfare benefits or disability pensions?

□Not at all □A little □Moderately □A Lot □Not applicable

30. Have you been treated more positively in housing?

□Not at all □A little □Moderately □A Lot □Not applicable

31. Have you been treated more positively in your religious activities?

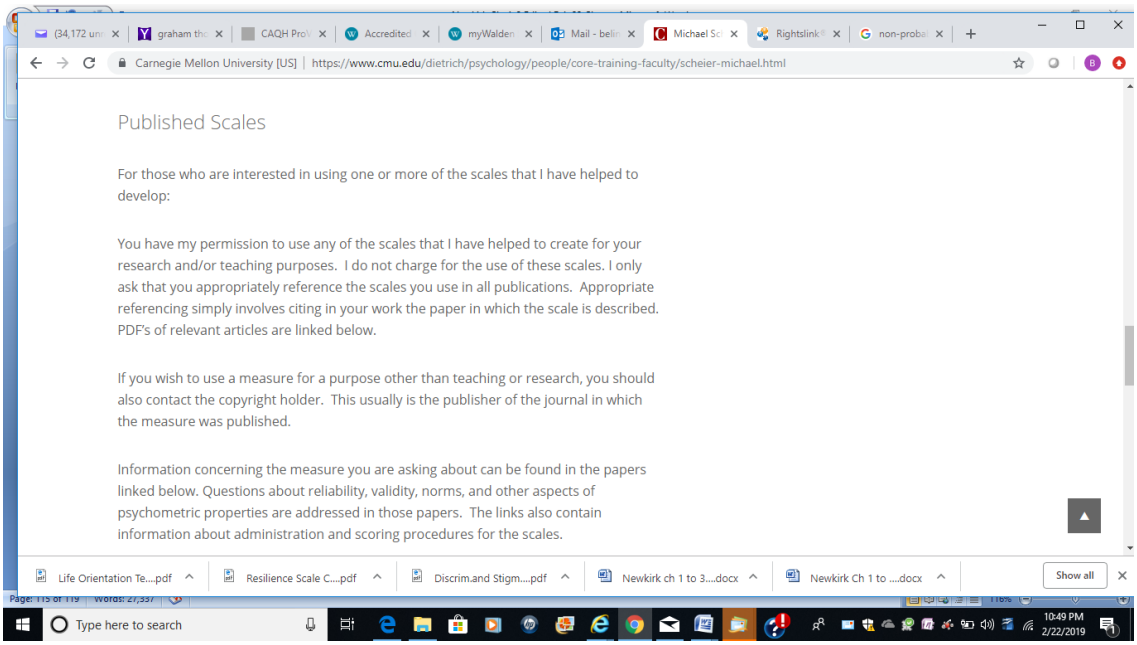
□Not at all □A little □Moderately □A Lot □Not applicable

32. Have you been treated more positively in employment?(ask about finding work, keeping work and adjustments in the workplace)

□Not at all □A little □Moderately □A Lot □Not applicable

Appendix L: Copy of the Permission to Use the Life Orientation Test

https://www.cmu.edu/dietrich/psychology/people/core-training-faculty/scheier-michael.html



Appendix M: Life Orientation Test

Please respond to the statements below. Please be as honest and accurate as you can throughout. Try not to let your response to one statement influence your responses to other statements. There are no "correct" or "incorrect" answers. Answer according to your own feelings, rather than how you think "most people" would answer.

1. In uncertain times, I usually expect the best.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

2. It's easy for me to relax.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

3. If something can go wrong for me, it will.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

4. I always look on the bright side of things.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

5. I'm always optimistic about my future.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

6. I enjoy my friends a lot.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

7. It's important for me to keep busy.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

8. I hardly ever expect things to go my way.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

9. Things never work out the way I want them to.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

10. I don't get upset too easily.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

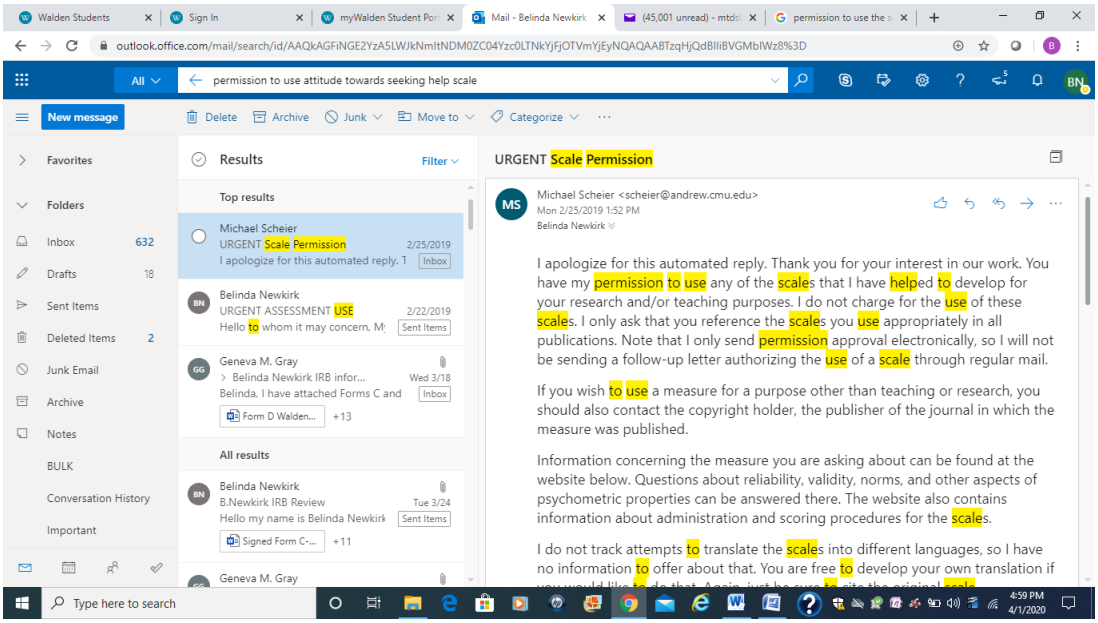
11. I'm a believer in the idea that "every cloud has a silver lining".

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

12. I rarely count on good things to happen to me.

□Strongly Disagree □Disagree □Neutral □Agree □Strongly Agree

Appendix N: Copy of the Permission to Use Attitudes Toward Seeking Professional Help Instrument



Appendix O: Attitudes Toward Seeking Professional Help Instrument

Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

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

□Disagree □Partly disagree □Partly agree □Agree

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

□Disagree □Partly disagree □Partly agree □Agree

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

□Disagree □Partly disagree □Partly agree □Agree

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

□Disagree □Partly disagree □Partly agree □Agree

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

□Disagree □Partly disagree □Partly agree □Agree

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

□Disagree □Partly disagree □Partly agree □Agree

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

□Disagree □Partly disagree □Partly agree □Agree

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

□Disagree □Partly disagree □Partly agree □Agree

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

□Disagree □Partly disagree □Partly agree □Agree

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

□Disagree □Partly disagree □Partly agree □Agree