Acculturation and Enculturation as Predictors of Psychological Help-Seeking Attitudes (HSAs) Among Racial and Ethnic Minorities: A Meta-Analytic Investigation

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Psychological services are culturally encapsulated for dominant cultural groups, and racial minorities underutilize treatment even though they suffer from more severe psychological distress. Sociocultural factors such as acculturation (one’s adaptation into mainstream group) and enculturation (one’s adherence to culture of heritage) are hypothesized to affect minorities’ attitudes toward seeking psychological services. This meta-analysis examined 3 methods to assess acculturation/enculturation—unidimensional acculturation, bidimensional acculturation, and bidimensional enculturation—as predictors of help-seeking attitudes (HSAs)—both positive and negative attitudes—among racial and ethnic minorities in 207 samples drawn from 111 research reports. The omnibus correlations between acculturation/enculturation variables and HSAs were quite small, but in the predicted direction. Moderator analyses suggested a more nuanced understanding of the association between bidimensional enculturation and positive HSAs: This association was significant ($r = -.14$, $95\%$ CI $[-.18, -.09]$) for Asians and Asian Americans, but very close to zero and nonsignificant for other racial minority groups (African Americans, Latino Americans, and others). In addition, the domain of acculturation/enculturation assessed was predictive of effect size, with enculturation measures containing a higher proportion of cognitive items (e.g., items that assess cultural values and beliefs) showing stronger (more negative) associations with positive HSAs. Post hoc analyses indicated that certain Asian cultural values, including emotional self-control, conformity to social norms, and collectivism, showed especially high negative associations with positive HSAs.

Public Significance Statement
This study suggests that overall, racial and ethnic minorities’ affiliations with their culture of heritage and the mainstream U.S. culture have small associations with their help-seeking attitudes. Further analysis indicates that this conclusion varies for individuals with different racial and ethnic backgrounds. For instance, certain Asian values, such as self-control and conformity to social norms, are associated with less favorable attitudes toward seeking psychological help among people of Asian descent.

Keywords: meta-analysis, acculturation, enculturation, help-seeking attitudes, racial and ethnic minorities

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The health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially-legitimated statuses, roles, power relationships, interaction settings, and institutions. (Kleinman, 1980, p. 26)

Racial and ethnic disparities in mental health care utilization are a growing concern in the U.S. health care system. Despite the high prevalence and severity of mental disorders among racial and ethnic minorities, minorities are less likely to seek psychological help and even when they do, they are more likely to terminate treatment prematurely (Owen, Imel, Adelson, & Rodolfa, 2012; Sue & Chu, 2003; U.S. Surgeon General, 2001; Wierzbicki & Pekarik, 1993), relative to majority group members. Among many factors (i.e., poor access to treatment, mistrust toward health care system, lack of

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1 We acknowledge that racial and ethnic minorities is not a homogenous category; rather, it is a population that encompasses many subcultures, nationalities, and identities. In the context of this study, the term racial and ethnic minorities is used to represent individuals that reside in the United States or other Western countries who identify as non-White and with historical or ancestral heritage in African, Asian, Latino, American Indian/Alaska Native, and Polynesian American communities.
culturally competent providers) that have emerged to explain such disparities, negative attitudes toward seeking psychological help (e.g., stigma) were identified as “the foremost barrier that deter ethnic minorities from reaching treatment” (U.S. Surgeon General, 2001, p. 165). These negative attitudes appear to relate to minorities’ cultural beliefs about mental illness and psychotherapy (Kim, 2007; Schnittker, Freese, & Powell, 2000), as well as to their relationships with potential care providers, who are often White (Jimenez, Bartels, Cardenas, Dhaliwal, & Alegria, 2012). Both belief formation and relationship with the dominant group are processes of acculturations and enculturation. Therefore, it is important to investigate the role of acculturation and enculturation in mental health care utilization disparities, especially their effects on racial and ethnic minorities’ psychological help-seeking attitudes (HSAs).²

Theoretical Conceptualization of Acculturation and Enculturation

Acculturation and enculturation are processes that racial and ethnic minorities engage in daily. Acculturation is often defined as the array of psychological changes that occurs when members of a minority group adapt into a mainstream group, whereas enculturation is the process by which individuals are socialized into their cultural heritage (Berry, 1994; Kim, Atkinson, & Umemoto, 2001; Yoon, Langreh, & Ong, 2011). In psychology, acculturation and enculturation have become helpful predictor variables to understand within-in group variability among racial and ethnic minorities, such as individuals’ HSAs, substance use, preference of counseling styles, and mental health outcomes (Yoon et al., 2011).

Historically, conceptualizations of acculturation and enculturation have adhered to one of the two frameworks: unidimensional or bidimensional. The unidimensional model was the first to appear in the literature and under this framework, rejection of one’s culture of origin was considered to be an unavoidable consequence of adopting values and customs of the dominant culture, while strong identification with one’s culture of heritage was equated with rejection of mainstream culture (Gordon, 1964). Before 1995, scales based on the unidimensional model were common, such as Suinn-Lew Asian Self-Identity Acculturation (Suinn, Ahuna, & Khoo, 1992). Bidimensional models of acculturation conceptualize adoption of mainstream culture and socialization into one’s heritage culture as independent processes. Many bidimensional scales, such as the Acculturation Rating Scale for Mexican Americans (Cuellar, Arnold, & Maldonado, 1995), consist of two subscales that measure endorsement of mainstream and heritage cultural orientations. Empirical studies have resulted in mixed findings on the dimensionality of acculturation/enculturation. Many studies confirm that individuals can hold two (or more) cultural orientations to different degrees, yet the correlations between the two vary (Flannery, Reise, & Yu, 2001; Lee, Sobal, & Frongillo, 2003; Ryder, Alden, & Paulhus, 2000).

Acculturation and enculturation are multifaceted and complex processes that involve many domains. Salient domains identified by researchers include behaviors (e.g., selective engagement in cultural practices), values, cultural beliefs, attitudes and sense of belonging or identity (Cuellar et al., 1995; Matsudaire, 2006; Yoon et al., 2011). While there is a lack of consensus in the literature regarding the exact number of domains, some researchers (Matsudaire, 2006; Miller, 2007) have suggested to group them into two higher order categories: overt (e.g., behaviors and cultural practices) and internal (e.g., values, beliefs, sense of identity and attachment). Yoon el al.‘s (2011) meta-analysis differentiated four acculturation domains (behaviors, language, identity, and values). Additionally, the function of enculturation and acculturation may vary by cultural group, and certain domains of these dimensions may be more salient for some groups than others. A meta-analysis highlighted the well-being benefits of acculturation for Asian Americans, while enculturation predicted better mental health for African Americans (Yoon et al., 2013). Similarly, a recent study with adolescents from Mexico found that adopting U.S. values predicted higher health risk (e.g., substance use, unprotected sex; Schwartz et al., 2014).

Attitudes Toward Seeking Mental Health Care Among Racial and Ethnic Minorities

HSAs can be categorized into positive and negative (PHSAs and NHSAs, respectively). Scales that measure PHSAs include Attitudes Toward Seeking Professional Psychological Help (ATSPPH; Fischer & Turner, 1970), Intentions to Seek Counseling Inventory (Cash, Begley, McCown, & Weise, 1975), and Willingness to See a Counselor (Gim, Atkinson, & Whiteley, 1990). Among them, ATSPPH has been the most widely used. Scales that measure NHSAs include Thoughts About Psychotherapy Survey (Kushner & Sher, 1989) and scales measuring perceived stigma related to HSAs (such as the Self-Stigma of Seeking Help Scale by Vogel, Wade, & Haake, 2006).

In review of NHSAs, perceived stigma of mental health treatment has emerged as a key attitudinal factor impeding mental health service utilization. There are three main forms of stigma: (a) personal stigma, referring to internalized prejudices against oneself; (b) social stigma, meaning fear of prejudice and judgment from others in one’s social network; and (c) public stigma, referring to negative stereotypes and prejudices about mental illness held collectively by one’s society at large (Corrigan, 2004; Vogel, Wade, & Ascheman, 2009; Vogel, Wade, & Hackler, 2007). Impacts of these three stigma differ: Individuals with more self-stigma were found to place less importance on their mental health care (Pattyn, Verhaeghe, Sercu, & Bracke, 2014). Public stigma toward psychological treatment is associated with premature termination and negative HSAs due to anxiety regarding negative appraisal by others for seeking care (Barney, Griffiths, Jorm, & Christensen, 2006; Kessler et al., 2001). Public stigma can also manifest as societal stereotypes, disparities in care, and myths of mental illness (Gary, 2005; Kranke, Guada, Kranke, & Floersch, 2012).

Though studies have not directly addressed how race and gender may moderate the relationship between acculturation/enculturation and HSAs, racial and gender identities are interwoven components of acculturation and enculturation processes and may affect HSAs as a result. The effect of enculturation and acculturation on HSAs may differ for different racial/ethnic groups due to different reasons of unfavorable HSAs: NHSAs among Asian Americans has been linked to discomfort with self-disclosure (Liao, Rounds, & Klein, 2005; Masuda & Boone, 2011) and endorsement of Asian cultural values

² In this article, we use HSAs to refer to attitudes toward seeking help for psychological problems (i.e., attitudes toward seeking counseling or psychotherapy). Later, we will differentiate between measures assessing positive attitudes toward help-seeking (PHSAs) and those assessing negative attitudes toward help-seeking (NHSAs) in reporting meta-analytic findings.
Effects. Our meta-analysis of these studies yields summary effect sizes for acculturation and HSAs, and (c) understanding potential moderator variables. (a) synthesizing current research, (b) seeking clarification on the relationship between acculturation/enculturation and HSAs for racial and ethnic minority groups in Western nations, with the goals of (i) investigating the association of acculturation/enculturation with psychological HSAs for racial minorities. Duplicate studies and studies that did not meet inclusion criteria were excluded. Figure 1 provides a flowchart showing how we identified relevant studies. To be included, studies needed to (a) be written in English; (b) include a measure of acculturation or enculturation or other acculturation/enculturation variables and HSAs among racial minorities. We conducted the search in December 2015 using the search terms racial/ethnic minority, Asian, Latino, Mexican, African American, international student, immigrants, help-seeking attitudes, help-seeking intentions, stigma, acculturation, enculturation, cultural values, and cultural identity. This search yielded over 2,700 abstracts, which we reviewed for relevant content. To be included, studies needed to (a) be written in English; (b) include a measure of acculturation or enculturation or unidimensional acculturation–enculturation; (c) include a measure of HSAs, including attitudes toward seeking psychological help, stigma of seeking help, thoughts on therapy, perceived barriers of seeking mental health treatment, openness and willingness to seek help, and intention to seek therapy; (d) have a sample from the United States or another Western society; and (e) report a correlation coefficient ($r$) or equivalent between one or more acculturation/enculturation variables and HSAs for racial and ethnic minorities. Duplicate studies and studies that did not meet inclusion criteria were excluded. Figure 1 provides a flowchart showing how we included studies. To be included, studies needed to (a) be written in English; (b) include a measure of acculturation or enculturation or unidimensional acculturation–enculturation ($r$) as predictors of both PHSAs and NHSAs. Because stigma of help seeking has been of particular interest in the extant literature, we conducted subsidiary analyses on the relations between acculturation/enculturation variables and different types of stigma. Based on acculturation theory and previous findings, we hypothesized that bidimensional enculturation would be negatively associated with PHSAs and positively associated with NHSAs and stigma. Conversely, bidimensional acculturation and unidimensional acculturation–enculturation were hypothesized to be positively associated with PHSAs and negatively associated with NHSAs and stigma.

Moderator analyses are exploratory due to the lack of empirical and theoretical evidence in this area. We speculate that the effects of acculturation/enculturation may vary for different heritage groups, and also by the acculturation/enculturation domain (e.g., values, behaviors) assessed. Thus, race/ethnicity and acculturation/enculturation domain were examined as possible moderators of the relations between acculturation/enculturation variables and HSAs. Because culture is gendered, we also examined gender as a moderator of these effects. As past behavior can impact attitude (e.g., Albarracin, Wyer, & Robert, 2000), previous utilization of counseling services was also tested as a potential moderator. Finally, because culture evolves, we examined age and generational status as potential moderators of the acculturation/enculturation effect on HSAs.

Method

Literature Search Procedure and Selection Criteria

To locate potential studies for inclusion in the analyses, we used PsycINFO, ProQuest, SAGE, Google Scholar, and ProQuest Dissertations and Theses to find published or unpublished English-language studies that reported data on the relationship between any of the three acculturation/enculturation variables and HSAs among racial minorities. We completed the search in December 2015 using the search terms racial/ethnic minority, Asian, Latino, Mexican, African American, international student, immigrants, help-seeking attitudes, help-seeking intentions, stigma, acculturation, enculturation, cultural values, and cultural identity. This search yielded over 2,700 abstracts, which we reviewed for relevant content. To be included, studies needed to (a) be written in English; (b) include a measure of acculturation or enculturation or unidimensional acculturation–enculturation; (c) include a measure of HSAs, including attitudes toward seeking psychological help, stigma of seeking help, thoughts on therapy, perceived barriers of seeking mental health treatment, openness and willingness to seek help, and intention to seek therapy; (d) have a sample from the United States or another Western society; and (e) report a correlation coefficient ($r$) or equivalent between one or more acculturation/enculturation variables and HSAs for racial and ethnic minorities. Duplicate studies and studies that did not meet inclusion criteria were excluded. Figure 1 provides a flowchart showing how the 2,736 initial search results yielded a sample of 113 research participants.

The most recent study included in our sample was an unpublished article, unpublished manuscript, dissertation); and (c) measures of study characteristics such as publication year and type (published vs. article, unpublished manuscript, dissertation); and (c) measures used for acculturation and enculturation. Interrater agreement was assessed following the coding of studies, with high agreement across 207 study samples (intraclass correlation coefficient ranged from 99% to 100%, and Cohen’s kappas were 1.0; see Table 1).

The second step of coding was to code all items of acculturation and enculturation instruments used in the studies into specific domains, to facilitate moderator analyses. We initially followed suggestions from Matsuda (2006) and Miller (2007) to group them into overt (behaviors, cultural practices) and internal (values, attitudes, sense of belonging) processes of acculturation/enculturation. Through reviewing items, we recognized that the internal process can be further categorized into items that capture the cognitive part, which are often cultural values, beliefs, and ideologies, and items that assess the emotional side of the process, including sense of pride, comfort level, and sense of belonging. Additionally, we coded items assessing background, such as generational status, first language, age when immigrated, into a fourth category called “life history.” In sum, a total of 1,206 items from 47 scales of acculturation and enculturation were coded into the following four domains: (a) intrapersonal-cognition (i.e., cultural beliefs and values), (b) intrapersonal-emotional (i.e., pride, comfort level, and sense of belonging), (c) behavioral (i.e., cultural rituals and practices), and (d) life history (such as generational status, first language, and age when immigrated). Six raters (five doctoral-level students in counseling psychology and one Master’s student in counseling) independently coded all items into one of these four categories. We used Fleiss’s kappa (Fleiss, 1971), an adaption of Cohen’s kappa for more than two raters, to calculate interrater reliability. This yielded a kappa value of .65, reflecting substantial agreement among raters (Landis & Koch, 1977). Each item was finally categorized as representing the domain assigned by the majority of raters and ties of domains were resolved by discussion. We then computed the percentage of items in each acculturation or enculturation scale that fell into each of the four domains, so that each measure had a continuous score (0% to 100%) indicating the extent to which each domain was represented in its item content.

**Analyses**

Six separate meta-analyses were conducted to summarize (a) the relationship between PHSAs among racial or ethnic minorities and bidimensional acculturation (k = 49), bidimensional enculturation (k = 94), and unidimensional acculturation–enculturation (k = 28); and (b) the relationship between NHSAs among racial or ethnic minorities and bidimensional acculturation (k = 10), bidimensional enculturation (k = 21), and unidimensional acculturation–enculturation (k = 5). A random-effects model was used for all of the six analyses, under the assumption that studies were sampled from a larger population of studies (Hedges & Olkin, 1985). To clarify the relationship between acculturation/enculturation and help-seeking stigma (a component of NHSAs), we conducted omnibus tests for three types of stigma (self, social, and public) and for the Stigma Tolerance subscale of ATSPPH (Fischer & Turner, 1970). Due to the high proportion of Asian samples in the dataset, we were able to conduct additional analyses to examine Asian cultural values, as measured by Asian Values Scale (Kim, Atkinson, & Yang, 1999), Asian Values Scale–Revised (Kim & Hong, 2004), Loss of Face Scale (Zane & Yeh, 2002), and Asian American Values Scale–Multidimensional (Kim, Li, & Ng, 2005), as predictors of PHSAs.

When multiple effect sizes could be derived from the same sample, these effect sizes were aggregated prior to analysis following procedures recommended by Hunter and Schmidt (2004). Data analyses
were conducted using the MAc (Del Re & Hoyt, 2012), metafor (Viechtbauer, 2010), and metaplus (Beath, 2015) packages in the R statistical software environment (R Core Team, 2013).

Homogeneity of effect sizes and outlier analysis. To determine whether the effect sizes were consistent across the studies reviewed, we tested the homogeneity of effect sizes using the Q statistic (Hedges & Olkin, 1985; Viechtbauer & Cheung, 2010).

To detect outliers in the data, we used Cook’s distance (Cook, 1977) as well as a finite mixture model presented by Beath (2014). Ultimately, the decision to remove studies was made based on the effect that omitting the study would have on the omnibus effect size and the amount of heterogeneity reduced. Five outliers were identified and removed from meta-analyses on (a) bidimensional acculturation and PHSAs (three samples removed, Q reduced by 10.7%), (b) bidimensional enculturation and PHSAs (one sample removed, Q reduced by 3.0%), and (c) unidimensional acculturation–enculturation and PHSAs (one sample removed, Q reduced by 4.0%) using this method. Results of analyses prior to the removal of outliers are available in supplementary materials. It should be noted that although the removal of outliers reduced the heterogeneity of effect sizes considerably, Q remained significant (p < .0001) in all six primary omnibus analyses. No outliers were identified for removal from the other meta-analyses.

Moderator analyses. We conducted moderator analyses to determine whether effect size heterogeneity was related to factors including race/ethnicity, acculturation/enculturation domain, gender, past counseling experience, age, and generational status (Hedges & Olkin, 1985). A random effects model was used in all analyses.

Results

Descriptive Characteristics

Participant characteristics. The total number of participants across k = 207 study samples was N = 37,631. It is worth noting that Asian group accounted for the majority of samples (k = 130, 62.80%), followed by Latino(a)s (k = 32, 15.46%), African Americans (k = 26, 12.56%), and other groups (e.g., Native Americans, Middle Eastern Americans; k = 19, 9.18%). Sample age means fell between 25 and 30 across the six main sets of analyses (see Table 1).

Study characteristics. Among included studies (n = 111 after removal of outlier), the majority were conducted in the United States (95.40%), four in Canada (3.60%), and one in Australia (0.90%). Studies included 40 journal articles and 71 dissertations. Top journals included Journal of Counseling Psychology (n = 10), Cultural Diversity and Ethnic Minority Psychology (n = 5), Asian American Journal of Psychology (n = 4), Journal of Community Psychology (n = 3), American Journal of Orthopsychiatry (n = 2), Journal of Black Psychology (n = 2), Journal of Counseling and Development (n = 2), Journal of Multicultural Counseling and Development (n = 2), and The Counseling Psychologist (n = 2).

Publication Bias

Publication bias is the tendency of published studies to contain significant effect sizes with large sample sizes, while other unpublished studies that include nonsignificant effects may be omitted from the meta-analysis because they are difficult to retrieve (Duval & Tweedie, 2000). We used funnel plots to determine if publication bias was present (Egger, Davey Smith, Schneider, & Minder, 1997) and calculated possibility of asymmetry with Egger’s regression test method (Egger et al., 1997). The distribution of effect sizes from each set of studies was highly symmetrical and did not indicate evidence of bias.4

Omnibus Tests

Overall positive and negative help-seeking attitudes. Table 2 shows the omnibus results for predicting positive and negative HSAs from bidimensional acculturation, bidimensional enculturation, and unidimensional acculturation–enculturation. All three considered to be significant, meaning that both positive and negative help-seeking attitudes were significantly related to the predictor variables. The Omnibus Tests table summarizes the overall results for both positive and negative help-seeking attitudes, indicating that the predictor variables were significant predictors of help-seeking attitudes in both directions.

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>N</th>
<th>k</th>
<th>Age M (SD)</th>
<th>% Female M (SD)</th>
<th>% First generation M (SD)</th>
<th>% Experienced counseling M (SD)</th>
<th>Race/Ethnicity (k)</th>
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<tr>
<td>DV: Positive help-seeking attitudes</td>
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</tr>
<tr>
<td>Acculturation</td>
<td>9,061</td>
<td>49</td>
<td>29.77 (9.99)</td>
<td>63% (23%)</td>
<td>48% (31%)</td>
<td>30% (14%)</td>
<td>28 12 4 5</td>
</tr>
<tr>
<td>Enculturation</td>
<td>15,661</td>
<td>94</td>
<td>27.95 (9.38)</td>
<td>60% (21%)</td>
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<td>61 10 15 8</td>
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<tr>
<td>Unidimensional acculturation–enculturation</td>
<td>5,240</td>
<td>28</td>
<td>26.17 (7.05)</td>
<td>61% (14%)</td>
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<td>Unidimensional acculturation–enculturation</td>
<td>2,213</td>
<td>5</td>
<td>25.25 (4.99)</td>
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<td>12% (NA)</td>
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Note. DV = dependent variable; NA = not available. For unidimensional acculturation–enculturation, high scores indicate high acculturation and low enculturation, and low scores indicate low acculturation and high enculturation.

Publication bias was not detected in any of the omnibus tests, indicating that the results were not biased by publication bias. The publication bias results are also available in supplemental material.

Table 1

Study Characteristics for the Six Meta-Analyses

| Study characteristics. | | | | | | | |
|------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
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Interrater agreement: Intraclass correlation coefficient | Cohen’s k |
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<tbody>
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<td>100%</td>
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4 Funnel plots are available in supplemental material.
types of measures were weakly predictive of PHSAs, in the expected directions. There are a smaller number of available studies that assessed NHSAs, and only unidimensional acculturation–
enculturation were significantly predictive of negative attitudes. All of these omnibus effect sizes were relatively weak in magnitude: $|r| \leq 0.15$, according to Cohen’s (1988) rule of thumb (small $r = 0.10$, medium $r = 0.30$, large $r = 0.50$). Significant $Q$ statistics indicated the presence of systematic variance in effect sizes in each of the six sets of studies, prompting us to test for the effects of moderator variables in each set, as reported later on.

Help-seeking stigma. We further analyzed the relationship between the acculturation/enculturation variables and NHSAs measures that specifically assessed stigma (see Table 3). Contrary to our predictions, bidimensional enculturation was weakly but negatively related to self-stigma regarding help-seeking ($r = -0.10$ 95% CI[-16, -0.3]). Enculturation was also positively related to perceived public stigma toward psychological help-seeking ($r = 0.27$ 95% CI[14, 40]), a medium correlation in the predicted direction. Bidimensional acculturation was not significantly associated with any of the types of stigma, and there were too few studies of unidimensional acculturation and stigma to include in this analysis.

Moderator Analyses

In this section, we report on the significant moderators of the relations between HSAs and acculturation/enculturation variables. It is important to recognize that sample sizes ($k$) varied widely for the six relations studied (see Table 2) so the power to detect moderators varied, with many studies providing data on bidimensional acculturation and PHSAs, and few providing data on prediction of NHSAs.

Continuous moderators. As shown in Table 4, age was a significant moderator of associations between bidimensional enculturation and PHSAs ($B_1 = 0.006$ 95% CI[0.002, 0.01]) and unidimensional acculturation–enculturation and PHSAs ($B_1 = 0.01$ 95% CI[0.004, 0.016]). This means that the effects of bidimensional enculturation (which tend to be negative) were weaker (i.e., closer to zero) as the mean age of the sample increased. In a seemingly contradictory finding, the effects of unidimensional

<table>
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<th>Predictor variable</th>
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<th>$r$</th>
<th>$r$ range</th>
<th>95% CI</th>
<th>Homogeneity analysis</th>
<th>Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>DV: Negative help-seeking attitudes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acculturation</td>
<td>49</td>
<td>-0.05</td>
<td>-0.21, 0.38</td>
<td>-0.01, 0.08</td>
<td>137.62</td>
<td>64.92%</td>
</tr>
<tr>
<td>Enculturation</td>
<td>94</td>
<td>-0.09</td>
<td>-0.51, 0.38</td>
<td>-0.13, -0.05</td>
<td>483.93</td>
<td>82.04%</td>
</tr>
</tbody>
</table>
| Unidimensional acculturation–
enculturation | 28 | 0.14 | -0.12, 0.35 | 0.10, 0.19 | 67.85 | 61.78% | <.0001 |
| DV: Positive help-seeking attitudes | | | | | | |
| Acculturation | 10 | -0.04 | -0.39, 0.07 | -0.13, 0.05 | 22.18 | 65.62% | .008 |
| Enculturation | 21 | 0.09 | -0.28, 0.58 | -0.01, 0.18 | 161.83 | 87.10% | <.0001 |
| Unidimensional acculturation–
enculturation | 5 | -0.15 | -0.40, 0.01 | -0.25, -0.04 | 8.96 | 61.89% | .007 |

Note. $k$ = number of studies; CI = confidence interval; DV = dependent variable; ATSPPH = Attitude Toward Seeking Professional Psychological Help (Fischer & Turner, 1970).
acculturation (which tend to be positive) were stronger for older samples. These moderator effects of age are shown in Figure 2. We consider further the implications of this apparent contradiction in the Discussion section. Past utilization of mental health services was a significant moderator of the association between bidimensional acculturation and PHSAs ($B_1 = -0.40$ 95% CI[$-0.76$, $-0.04$]). Although the overall effect of bidimensional acculturation on PHSAs was weak, acculturation was more strongly (and positively) associated with PHSAs for samples in which relatively few participants reported using counseling services in the past, as shown in Figure 3.

All four item content domains significantly moderated the association between bidimensional enculturation and PHSAs, as shown in Table 4. Due to the statistical dependence of four domains (the sum of the four domain proportions must equal 1 for each of the measures), we conducted a simultaneous moderator analysis to simplify follow-up analyses. When the four domain variables were simultaneously included as predictors, the cognitive domain was the only one that uniquely predicted PHSAs ($B_1 = -0.21$ 95% CI[$-0.31$, $-0.12$]). In addition, the variance explained by the four-predictor model did not differ significantly from that explained by the cognitive domain alone ($p = .51$). We therefore concluded that the proportion of cognitive enculturation items (e.g., values, beliefs) moderates the enculturation-PHSAs association, with stronger associations (in negative direction) for measures including a higher proportion of cognitive items.

**Categorical moderators.** Race/ethnicity was found to be another significant moderator of the association between enculturation and PHSAs, $Q(3) = 12.93$, $p = .005$. As shown in Table 5, Asian group had the strongest effect size ($r = -0.44$ 95% CI[$-0.55$, $-0.32$]), and other racial groups’ effect sizes were close to zero, with significant differences between the effect size derived from Asian samples and those derived from Latino and African American samples.

**Multiple moderator analysis.** The relation between enculturation and PHSAs was significantly moderated by three different study characteristics: age, proportion of cognitive items, and race. To examine the joint effects of these three moderators, we conducted a multiple moderator analysis (see Table 6). Based on the results from Table 5, we collapsed the race variable into a dichotomous variable (Asian vs. Non-Asian) and entered it with age and proportion of cognitive items as moderators of the relationship between enculturation and PHSAs. The proportion of cognitive items in a given measure of enculturation/acculturation was a significant and negative predictor of effect size ($B_1 = -0.14$ 95% CI[$-0.24$, $-0.05$]). Race also emerged as a significant moderator ($B_1 = -0.07$ 95% CI[$-0.10$, $-0.03$]), reflecting the differences in the effect sizes ($r$) for Asian and non-Asian samples when age and proportion of cognitive items were controlled. The three variables together explained nearly half of the observed heterogeneity ($R^2 = 0.463$).

**Post Hoc Analysis: Asian Values and PHSAs**

To further understand the negative relationship between bidimensional enculturation and PHSAs for persons of Asian heritage, we summarized studies that reported correlations between PHSAs and subscales of bidimensional enculturation measures, which included the Asian Values Scale (Kim et al., 1999), the Asian Values Scale–Revised (Kim & Hong, 2004), the Loss of Face Scale (Zane & Yeh, 2002), and the Asian American Values Scale–Multidimensional (Kim et al., 2005). Seven components of enculturation to Asian cultural values were identified from these instruments, as shown in Table 7. Enculturation to most of the Asian cultural value variables (except loss of face and filial piety) was found to be significantly negatively associated with PHSAs, with emotional self-control ($r = -0.32$ 95% CI[$-0.45$, $-0.20$]), conformity to social norms ($r = -0.22$ 95% CI[$-0.33$, $-0.10$]), collectivism ($r = -0.20$ 95% CI[$-0.29$, $-0.11$]), and family recognition through achievement ($r = -0.19$ 95% CI[$-0.26$, $-0.11$]) showing the strongest associations.5

5 We also ran omnibus test with African American samples on studies using the Africentricism Scale and African Self-Consciousness Scale, two instruments with a focus on African American values. Results show no reliable association between positive HSAs and African American values ($k = 6$, $r = 0.00$, $p = .93$). Detailed results are available in supplemental material. We did not have enough samples with a focus on Mexican values to detect the specific relationship between enculturation of Mexican values and HSAs.
Discussion

Although racial and ethnic minorities have been shown to endorse less favorable psychological HSAs than Whites (U.S. Surgeon General, 2001), results of this meta-analysis indicate that acculturation and enculturation account for very little of the within-group variation in HSAs. An important caveat relates to the moderator effect for race/ethnicity on the relation between enculturation and PHSAs. For non-Asian heritage groups, there is no evidence that enculturation is predictive of PHSAs; only among respondents of Asian heritage was there evidence that identifica-

Figure 2. Age as a moderator. (a) Age as a moderator of the relation between positive help-seeking attitudes and bidimensional enculturation. (b) Age as a moderator of the relation between positive help-seeking attitudes and unidimensional acculturation–enculturation. Each circle represents one effect size in the analysis; circle diameter is proportional to Study N.
tion with the heritage culture affects attitudes toward psychological help-seeking. Later, we speculate in more detail about this apparent cultural specificity of the enculturation effect.

The overall finding of very weak effects was also qualified to some extent by an examination of specific negative attitudes related to help-seeking. An important form of NHSAs is the stigma associated with help-seeking, which encompasses internal feelings and attitudes (self-stigma), expectations of stigma from family and friends (social stigma), and perceived attitudes among the public at large (public stigma). Contrary to our hypotheses, orienting to one’s heritage culture was unrelated to social stigma, and was negatively associated with self-stigma for psychological help-seeking. Public stigma, on the other hand, was positively predicted by enculturation, suggesting that those who more strongly identify with their heritage cultures are more likely to expect stigmatizing attitudes about their act of help-seeking from society at large. Such expectations are consequential: Sirey et al. (2001) found that clients’ perceptions of public stigma were associated to early termination of treatment. For individuals who have strong racial/ethnic group affiliation, perceived public stigma cannot be separated from the societal and political context of interracial relationships and potential negative stereotypes held by the public about racial minorities’ mental health and need for help. For highly enculturated racial and ethnic minorities, perceived high public stigma of treatment may pose a barrier to help-seeking and to successful outcomes when help is sought.

Moderator analyses identified race/ethnicity, enculturation domain, and age as important moderators. As noted earlier, the negative effect of enculturation on PHSAs seemed to be restricted to Asian identifying participants. Additionally, the predictive effect of enculturation was strongest (and in negative direction) when measures focused on cultural values and beliefs (i.e., a high proportion of cognitive items). We conducted post hoc analyses to examine the importance of specific value dimensions for Asian participants (see Table 7), and found that certain Asian cultural values (especially emotional self-control) had the strongest (most negative) associations with PHSAs. Several cultural factors may explain this finding. Prominent philosophical traditions in Asia such as Confucianism, Buddhism, and Taoism emphasize collective harmony and the suppression of individual emotional expressions to maintain public image and peace (Bond, 1993). Psychotherapy as a practice is rooted in European culture (Wrenn, 1962), and its focus on individual experiences (individualism) and emotional expression as processes of healing might be viewed as incongruent with Asian values. Additionally, emotional control in many Asian cultures is considered to be a virtue and healthy way of coping (Mauss, Butler, Roberts, & Chu, 2010), thus the expression or anticipated expression of emotions in an interpersonal context (i.e., therapeutic relationship) may evoke feelings of shame and failure, which in return contributes to one’s negative attitudes toward therapy.

Moderator analyses for age produced a puzzling pair of findings: bidimensional enculturation was most strongly (and negatively) predictive of PHSAs for young adults, whereas the association between unidimensional acculturation–enculturation and PHSAs was close to zero for young adults but moderate and positive among older adults. A recent meta-analysis of HSAs among college students (Mackenzie, Erickson, Deane, & Wright, 2014) may help explain why acculturation among racial and ethnic minority young adults does not necessarily lead to more PHSAs. In the past 4 decades, students’ attitudes toward seeking psychological help have grown substantially more negative over time, reflecting change in the overall atmosphere of help-seeking on U.S. campuses. Thus racial and ethnic minority students who acculturate to U.S. values may adopt the less positive HSAs of this age cohort, whereas the attitudes among older adults

Table 6

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>p</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>.04</td>
<td>.62</td>
<td>[-12.12,20]</td>
</tr>
<tr>
<td>Age</td>
<td>.0033</td>
<td>.07</td>
<td>[-.0003,.007]</td>
</tr>
<tr>
<td>Cognitive</td>
<td>-.14</td>
<td>.002</td>
<td>[-.24,.05]</td>
</tr>
<tr>
<td>Asian (non-Asian = 0; Asian = 1)</td>
<td>-.07</td>
<td>.001</td>
<td>[-.10,.03]</td>
</tr>
</tbody>
</table>

Note. $Q_m$ (3) for the model is 42.05, $p < .0001$. $R^2$ = 46.30%, Akaike information criterion = -62.55, Bayesian information criterion = -51.38.
may not reflect this trend (e.g., Mackenzie, Gekoski, & Knox, 2006).

Limitations

Several limitations restrict the generalizability of our findings. First, our findings are most relevant to HSAs among racial and ethnic minorities in the United States, as 96% of the studies included in our analyses were conducted in the United States. Second, study samples were mainly comprised of Asians, Latinos, and African Americans, with 62.44% of the studies in the dataset investigating individuals of Asian heritage. It is also worth noting that Asian participants in these studies were primarily East Asian (Chinese, Japanese, or Korean). Third, although Asian values were found to be negatively associated with PHSAs, we want to caution its application with the large, heterogeneous Asian American communities, as Asian values scales may disproportionately reflect Confucianism-based values (e.g., emotional control, humility, filial piety, conformity to social norms) and may not generalize to other Asian cultures (e.g., Indonesia, India, Mongolia) where Confucianism had little influence and cultural value systems are distinct from those in China, Japan, and Korea. Finally, studies often did not report on the sample’s income and educational level. Thus, we do not know how socioeconomic status may affect the relations of acculturation/enculturation and HSAs.

Summary and Conclusions

Psychological treatment is a culturally encapsulated practice that may be well suited for populations with worldviews and values that resonate with those propagated by dominant culture. There is some evidence that culturally adapted treatments may be more effective than traditional approaches for groups that do not share these dominant cultural values (e.g., Benish, Quintana, & Wampold, 2011; Huey, Tilley, Jones, & Smith, 2014). This meta-analysis summarizes the results of decades of research that sought to extend this cultural fit hypothesis to the prediction of attitudes toward psychological help-seeking. This line of research is based on the assumption that individuals who identify strongly with a heritage culture (high enculturation) will espouse less favorable HSAs, and those who identify strongly with the mainstream culture (high acculturation) will espouse more favorable HSAs.

Our findings suggest that, with some exception for Asian identifying individuals, enculturation and especially acculturation have little effect on HSAs. Where these effects were found, they were attributable to identification with heritage culture values and beliefs that may be perceived as conflicting with the implicit values underlying psychological helping relationships (e.g., openness, emotional expression, individualism). Thus, we cautiously conclude that associations between enculturation and HSAs are likely to be strongest when (a) research focuses on cultural groups in which heritage culture values do not align with values central to counseling and psychotherapy and (b) enculturation measures focus on culturally congruent values (rather than emotions and behaviors).

In considering the implications of these findings, it is important to bear in mind that most participants in these 207 samples did not have previous experience with counseling, so their attitudes about help-seeking were based on assumptions or hearsay about what counseling is like, not actual experience. Attitudes of persons who have not previously participated in counseling are important to study, as a goal of this line of research is to understand barriers to help-seeking for members of minority groups: Attitudes in the absence of personal experience are an important predictor of an inexperienced consumer’s likelihood of seeking professional services for the first time (e.g., Jagdeo, Cox, Stein, & Sareen, 2009). The fact that most participants in these studies were naïve consumers of mental health services may partly explain the low magnitude of correlations observed between acculturation/enculturation and HSAs, as the extent to which these services will be culturally congruent will be less obvious to respondents who have little experience.

The fact that these studies assessed HSAs mainly among inexperienced consumers of mental health services also serves as a reminder not to draw an erroneous conclusion from the present findings. Namely, we should not assume that the small correlations between acculturation/enculturation and HSAs in these studies means that culture and worldview are unimportant factors in treatment outcomes. Counselors and psychotherapists working with racial and ethnic minority clients should be aware of the
empirical support for the value of culturally adapted treatments (Benish et al., 2011), the value of sensitivity to the client’s worldview in articulating a therapeutic approach (Wampold, 2007), and the importance of conscious awareness of one’s own cultural assumptions and modification of the approach to treatment based on information gathered from the client (e.g., Cuéllar & Paniagua, 2000; Sun, Hoyt, & Zhao, 2016).

Finally, we note that within-group differences in HSAs may also be well explained by variables other than acculturation and enculturation (e.g., cultural mistrust, spirituality, and perceived campus/community climate; Moreno & Cardemil, 2013; Nickerson et al., 1994; Whaley, 2001), particularly in non-Asian minority groups. Future research should continue to seek to identify predictors of HSAs for members of cultural minority groups, in an effort to reduce barriers to help-seeking for these populations.

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