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The Role of Stigma on Mental Health Service-Seeking Among Armenian-American Men

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DISSERTATION

The Role of Stigma on Mental Health Service-Seeking Among Armenian-American Men

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A Dissertation Defense

Presented to

The School of Nursing and Health Professions

University of San Francisco

San Francisco, California

In Partial Fulfillment

of the Requirements for the Degree,

Doctor of Psychology

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by

Anthony Mampre Saroyan

July 22, 2019

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This dissertation, written under the direction of the candidate's dissertation committee and approved by members of the committee, has been presented to and accepted by the faculty of the PsyD Program in Clinical Psychology in partial fulfillment of the requirements for the degree of Doctor of Psychology. The content and research methodologies presented in this work represent the work of the candidate alone.

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I write this dissertation in memory of all those who perished as well as survived the Armenian Genocide of 1915, amongst them, my great-grandparents who include my namesake, Mampre Saroyan, Ardemis Saroyan, Zenop Ayanian and Zarouhi Ayanian.

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ABSTRACT

This study examined the role of stigma on mental health service-seeking among Armenian-American men who self-identified as having lived through or currently are living with a mental health issue. This qualitative study utilized interpretive phenomenological analysis to ensure that the lived experiences of Armenian-American men are represented through their perspective. A total of six participants engaged in this study. All participants self-identified as male and as having experienced a mental health issue, have utilized mental health services at least once in their lifetime, resided in the San Francisco Bay Area, and as being of Armenian descent. Through exploring the lived experiences and reflections of participants in this study, several themes and sub-themes emerged. These themes included stigma, mental health treatment, gender views, and moving forward to decrease stigma. As expected, stigma emanating from the Armenian community was seen to be a deterrent to seeking mental health services. Furthermore, the role of felt stigma appeared to serve as a significant barrier. Negative views of self and cognitive distortions influenced participants' decisions to pursue mental health services. This study found various factors, such as cultural beliefs and values, socio-economic status, a lack of understanding of mental health issues and resource availability as potential barriers for service-seeking behaviors amongst Armenian-American men.

SPECIFIC AIMS

The purpose of this study is to explore the role of stigma on mental health service-seeking among Armenian-American men in the United States. To acknowledge and accommodate the cultural influences that play a role in Armenian-American men's mental health service-seeking behavior, we must first understand the culture and value system of those men within the Armenian community who have suffered from mental illness. Stigma needs to be explored from a cultural point of view so that we may understand beliefs and traditions held by the Armenian people, regarding the perception of living with and treating mental illness. This study sought to investigate the barriers that Armenian-American men experience with stigma when having a mental illness and the impact it has on their mental health service-seeking behavior. Research on mental health issues related to the Armenian-American population, particularly men, must be further explored to provide them with optimal mental health services.

This qualitative study utilized interpretive phenomenological analysis to ensure that the lived experiences of Armenian-American men are represented through their perspectives. This study explored various factors, in addition to stigma, such as cultural beliefs and values, socio-economic status, a lack of understanding of mental health issues and resource availability which may serve as potential barriers for service-seeking behaviors amongst Armenian-American men.

This study examined the following research questions:

- Question #1: What are the experiences of Armenian-American males that have encountered stigma pertaining to their self-identified mental health issue? How have these experiences impacted help-seeking behavior?

- Question #2: How do Armenian-American males perceive other males from their own ethnic community who have a mental health problem?
- Question #3: How does having a mental health issue change the way that the individual perceives themselves?

LITERATURE REVIEW

Armenians have a unique culture that dates to the Bronze Age era (~3,000-1,200 B.C.), however, they are often misconstrued by others as being members of the dominant Western European culture. This cultural inaccuracy only further misrepresents their ethnic beliefs and practices, thus preventing a true understanding of their distinct culture.

The Armenian-American community, like various other ethnic minority communities, experience culturally based mental illness stigma (Corrigan, 2004; Dagirmanjian, 1996). Studies on the impact that stigma plays on Armenian-American men service-seeking behaviors for mental illness are scarce. Given the lack of information on mental health issues pertaining to Armenian-American men, it is important to investigate issues facing this population so that proper assistance may be provided by culturally competent mental health service providers to members of this community.

According to the United States Census Bureau (2000), California was home to the highest number of Armenians in the United States. At that time, California registered 204,631 Armenians (United States Census Bureau, 2000). In comparison, the second highest number of documented Armenians in the United States was 26,595 in Massachusetts (United States Census Bureau, 2000). It should be noted that the most recent census of the Armenian population residing in the United States dates from the year 2000, therefore these numbers may not reflect the current population. Despite this large community of Armenians, little research regarding mental health issues exists for this population. With a lack of understanding of cultural-specific issues on barriers to mental health services within this population, practitioners will remain uninformed when working with this community.

Armenian Genocide of 1915

The Armenian people come from a unique historical background defined by triumphs, resilience, and devastations. One cannot discuss the history of the Armenian people without acknowledging the Armenian Genocide of 1915 (Dagirmanjian, 1996). The events of the Armenian Genocide occurred from 1915-1922. It is estimated that 1.5 million Armenians were murdered during this time (Van Gorder, 2006; Kloian, 1988; Kuzirian, 2012). With orders from the Turkish Ottoman Interior Minister Talaat Pasha, the Ottoman military forced men out of their homes to be murdered, led women and children on death marches through the desert, and destroyed whole Armenian villages (Kuzirian, 2012; Van Gorder, 2006). This attempted extermination of the Armenian people led to a mass emigration of refugees seeking refuge in neighboring Middle Eastern countries, as well as the distant United States (Kuzirian, 2012; Van Gorder, 2006). Such trauma plays a role in how a culture begins to identify itself as it happened to the Armenian community. To this day, many Armenian community members continue to identify themselves as both as victims as well as a survivor of a near-extinct ethnic and religious annihilation attempt by the Ottoman Turks (Boyajian & Grigorian, 1982; Dagirmanjian, 1996; Kuzirian, 2012).

According to Dagirmanjian (1996), the majority of Armenians who migrated to the United States in the early 1900's fled and survived the Armenian Genocide. According to Malkasian (1984), the US State Department documented approximately 817,873 Armenian refugees in 1921 who fled the Ottoman Empire. This suggests that a large percentage of Armenian-Americans are direct descendants of genocide survivors, thus potentially affected by the genocide through their ancestors' experiences. As natives of their motherland yet considered a minority Christian ethnic group with lesser rights than the ruling Ottoman Muslim Turks,

Armenians felt the weight of discrimination and disadvantage in their homeland (Arlen, 1975). While the horrifying acts of this genocide may have ended, the repercussions linger. The events of these heinous crimes against humanity continue to impact the victims' families, their communities and their culture.

Historical Trauma

Many scars created from the Armenian Genocide are not visible but are internally experienced amongst members of the Armenian community. For example, a common occurrence observed in children of Armenian Genocide survivors is implicit sadness (Boyajian & Grigorian, 1986). This characteristic, which is commonly found among genocide survivors is believed to persist in following generations (Boyajian & Grigorian, 1986). The trans-generational historical trauma experienced by Armenian-Americans may manifest as post-traumatic symptoms, such as suspiciousness, cautiousness, and distrust of outsiders (Garavanian, 2000; Yesayan, 2014). These trans-generational effects of mass trauma, such as genocide, are also seen within Native American populations (Duran & Duran, 1995). For instance, lasting effects of the Native American genocide have led to elevated rates of alcoholism and violent crimes, which were rare prior to the Native American Genocide (Duran & Duran, 1995).

Armenians who survived the genocide of 1915 were observed to experience symptomatology similar to survivors of the Jewish Holocaust (Kellermann, 1999). Common characteristics expressed by both survivor groups included survivor's guilt, anhedonia, anxiety, depression, and a feeling of lost identity (Boyajian & Grigorian, 1986). Although these shared commonalities exist amongst survivors of the Jewish Holocaust, the Native American Genocide, and the Armenian Genocide, an important distinction is that the Armenian and Native American Genocides have remained unacknowledged by their perpetrators. While the Native American

Genocide was acknowledged 'on behalf of the people of the United States' by President Obama, in his 2009 Native American Apology Resolution, the Native American Genocide was still not formally recognized as an act committed by the United States Government. The consistent denial of these crimes against humanity hinders both the Armenian and Native American people's opportunity in making peace with their traumatic past (Duran & Duran, 1995). The genocide scholar, Israel W. Charny (1984) described the use of denial by genocide perpetrators as a tool to attack the collective identity and national cultural continuity of the people victimized. With the Armenian Genocide of 1915 lacking formal recognition, the wounds of Armenians remain unhealed.

Immigration

Armenian-Americans can largely trace their familial existence within the United States in two migration waves during the 1900's (Dagirmanjian, 1996). The first mass migration of Armenian people emigrated from the Ottoman Turkish Empire to the United States around the end of WWI in the 1910's and 1920's. By the year 1922, the population of Armenian in the United States was approximately 125,000 (Malkasian, 1984). Those able to seek refuge in America formed their own communities, most notably in California's central valley. The second significant influx of Armenians into the United States occurred after the fall of the Soviet Union in 1991 (Dagirmanjian, 1996). After WWI, Armenia was included as a member of the Soviet Union and remained a member until its collapse in 1991. Many Armenians then immigrated to the United States in pursuit of a better standard of living (Dagirmanjian, 1996) and most of them settled in dense Armenian enclaves around Los Angeles, such as Glendale and Pasadena (Fittante, 2017).

Religion

The Armenian Apostolic Church is central to the Armenian culture and plays a key role in the development of a modern Armenian Identity (Yesayan, 2014). In the year 301 A.D., Armenia became the first country to adopt Christianity as its national religion (Arlen, 1975). Their church and religion unified its people throughout the ensuing centuries by its unchanging rituals and Christian values. During the 1915 Genocide, Armenians were given two dire options, either convert to Islam or face death (Van Gorder, 2006). Approximately 95,000 Armenians were forced "to embrace Islam" by the Ottoman Turks (Malkasian, 1984). As a result of this religious persecution, Armenians hold Christianity as sacred and important to their ethnic identity and as a symbol of their cultural identity (Van Gorder, 2006).

There is a strong relationship between church and state within the Armenian culture (Dagirmanjian, 1996). With religion being a central element within the Armenian community, the Armenian people utilize their religion as a method of coping and healing (Yesayan, 2014). Prior to seeking mental health services, Armenians tend to seek support from members of their community (Yesayan, 2014). With the Armenian church having a close connection with the community, the Armenian church serves as a potential outlet for those struggling with mental health issues.

Acculturation

Adapting to foreign cultures is nothing new to the Armenian people. Similar to other collectivistic minority cultures, many Armenians have had learned to live within host societies as well as to avoid the pressures of assimilation by creating their own cultural communities (Aghanian, 2007). Those able to integrate their heritage and host culture tend to be better at adapting to the host society than those who acculturate themselves orienting to one, the other, or

neither culture (Berry, 1995). By resisting the pressures of total assimilation into the dominant culture of their adopted nations, Armenians have preserved and maintained their culture for future generations, through the creation of Armenian schools, churches, and organizations (Miller & Miller, 1993). Due to these avenues of inter-generational transmission, the Armenian language, culture, and history has survived (Dagirmanjian, 1996).

According to Gevorkyan (2013), Armenian-Americans who are more acculturated towards the dominant American culture hold significantly more positive attitudes towards psychotherapy when compared to Armenian-Americans who are less acculturated into the dominant American culture. This study helps provide insight into the impact that one's acculturation and ethnic identity may contribute to their attitudes towards psychotherapy. Additionally, the relationship between acculturation and ethnic identity on seeking mental health services has been supported by Ogaryan (2016), who found that ethnic identity served as a risk factor for Armenian-American parents when making decisions on whether to utilize mental health services for their children. In this study, Armenian-American parents who were less acculturated into the American culture were less likely to seek mental health services for their children (Orgaryan, 2016).

Armenian Family Values

The Armenian culture holds traditional values that are passed on into families from generation to generation. Several of these familial values that are heavily placed on family members include obedience, respect, and nobility (Ayvazian, 2009). Generally, the needs of the family supersede individual needs, and that holds true to this day. Armenian families tend to carry a sense of responsibility in maintaining and transmitting their language, culture, and traditions onto future generations. These expectations are highly influenced by feelings of guilt

from the tragedy that their ancestors endured (Boyajian & Grigorian, 1986; Garavanian, 2000; Yesayan, 2014). Many Armenians feel this sense of pressure to pass down their culture to future generations in order to ensure the survival of their historically threatened culture (Saroyan, 2015).

Armenian families are traditionally patriarchal, and men hold a leadership role in the family (Ayvazian, 2008). Children in these families feel an obligation to abide by the needs and desires of their parents and are expected to be obedient (Dagirmanjian, 1996). These values are instilled in many Armenian families with a notion that life is serious and that they should behave in a serious manner (Boyajian & Grigorian, 1986). Armenian parents tend to be highly protective of their children, as a means of protecting their 'investment' for the continued success of their familial lineage (Dagirmanjian, 1996). Children are viewed as the future of their families' continuation and history thus must be protected at all cost (Boyajian & Grigorian, 1986; Garavanian, 2000). The emphasis on children to succeed is overtly expressed by parental pressures while covertly influenced by a sense of communal responsibility.

The Armenian community's strong values in the family system resemble those of other collectivistic cultures (Dagirmanjian, 1996). The collectivistic culture of the Armenian people stands in sharp contrast to the individualistic American culture. Collectivism is depicted as the value orientation of interdependence amongst members of a group (Katz, 1999). Individuals from collectivistic cultures tend to be more sociable and place an emphasis on family integrity and cohesion (Wu et al., 2011). There is an emphasis on prioritizing the needs of the family or the group over the individual's needs, as well as the honoring of the family unit (Dagirmanjian, 1996). On the other hand, members of an individualistic culture rely primarily on their own abilities and resources, rather than those of others (Rao & Valencia-Garcia, 2014; Triandis,

1995). Characteristics portrayed in individualistic cultures include competitiveness and emotional distance from their peers, which is not the case for collectivistic cultures who are more likely to come together to achieve common goals. Within the Armenian family, the notion of family, community, and honor are prioritized. With most Armenian families holding a collectivistic worldview, issues among family members are generally private and not shared with others. Given this orientation, it can lead to Armenians being hesitant in seeking mental health services or disclosing personal information to others (Arslanian, 2003; Minassian, 2010; Yesayan, 2014).

The Armenian culture, in general, is also characterized as a culture that highly values masculinity (Malakyan, 2013). While the emphasis in masculinity is not unique to the Armenian community, one must note the impact this emphasis has on men from this community. According to Connell (1987), hegemonic masculinity is the dominant notion of masculinity within a specific cultural context. This stereotypic notion of masculinity shapes the socialization and aspirations of young men within their communities (Connell, 1987). Westernized cultures, such as the United States and Europe, tend to place an emphasis on traditionally masculine traits, including competitiveness, inability to express emotions aside from anger, inability to acknowledge weakness, and the devaluation of feminine traits in men (Brittan, 1989; Kupers 2005). The importance of understanding masculinity ideals among men and mental illness is crucial when working with males from communities that historically have under-utilized mental health services.

Cultural Beliefs Towards Psychotherapy

From the Armenian-American perspective, the concept of paying for advice runs counter to centuries of cultural self-reliance and regarded as shameful and dishonorable to many

(Dagirmanjian, 1996). In fact, studies suggest that when some Armenian-Americans accept psychotherapy as an option, they tend to do so only when the problem is causing intense distress or there is pressure from external sources (Dagirmanjian, 1996). In addition, other barriers to seeking psychological services among the Armenian-American population include the lack of culturally competent mental health providers in densely populated Armenian communities (Arzumanian, 2008; Yesayan, 2014). Mental health professionals who work with minority populations, such as Armenian-Americans, should be culturally competent and provide cultural humility in order to understand the role of culture in influencing clinical diagnoses, assessment, and treatment (Dagirmanjian, 1996). According to Tervalon & Murray-Garcia (1998), the term cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-clinician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations. Armenians may encounter this concept of culturally incompetent health care when they perceive that clinicians do not accept and respect their ancestral history (Eron & Lund, 1993). Thus, knowledge of this population's cultural and historical factors is critical to building a therapeutic alliance.

When developing a successful therapeutic alliance with Armenian-Americans, it is important to understand how moving past their elevated wariness of outsiders (referred to as "odar" in the Armenian language, which translates to "stranger") contributes to their potential resistance of receiving mental health services. Even if clinicians of non-Armenian descent can demonstrate their trustworthiness, it may be hard for some Armenian families to accept that the clinician could teach them something that they do not already know about themselves (Dagirmanjian, 1996). This skepticism towards justifying the use of mental health services is a

phenomenon that impedes mental health service-seeking behaviors for necessary and effective psychological services. It is critical that clinicians address these challenges and motivate their clients by providing them with meaningful reasons to continue treatment.

Stigma

The term stigma is commonly believed to originate from marks of crucifixion, appearing on the hands and feet of Christian saints, known as stigmata (Gary, 2005). In modern usage, the term stigma refers to the possession of a trait that is deeply discrediting (Goffman, 1963). Furthermore, individuals who experience stigma are often disqualified from full social acceptance (Goffman, 1963). Stigma is shown to impede treatment participation; it both diminishes self-esteem and robs people of social opportunities (Corrigan, 2004). According to Valencia-Garcia et al. (2008), stigma has also been shown to inhibit access to mental health resources. For those with mental illness, stigma creates a public label which may hinder life opportunities that allow for the achievement of personal goals (Corrigan, 2004). As a result of the prejudices aimed towards those with mental illness, one's access to obtaining good jobs and adequate housing is obstructed (Corrigan, 2004).

Stigma exists both overtly and covertly and has been found to come in various forms. Research focused on exploring the experiences of patients with epilepsy, who experienced stigma as a result of their medical condition, opened the door to the development of two forms of stigma: enacted and felt (Scrambler & Hopkins, 1986). Enacted stigma, also referred to as discrimination, refers to the unfair treatment by others (Gary, 2005). This external stigma expressed both overtly and covertly may lead to the individual internalizing their experience, thus creating a felt stigma. Felt stigma, also referred to as self-stigmatization, refers to the shame and expectations of discrimination that prevents individuals from opening up about their personal

experiences (Gary, 2005). This form of internal stigma may further create barriers to seeking mental health services. Results of felt stigma may lead to further isolation and withdrawal when in need of social support (Gary, 2005).

The existence of stigma for those who experience mental illness can present as being more complicated for those from ethnic minority groups (Ciftci et al., 2012; Rao & Valencia-Garcia, 2014). The relationship between stigma and cultural norms impact perceptions of disease and disability; perceived deviations that run counter to an individual's cultural and social behavioral norms can lead to social punishment or social ostracism in cultural communities (Rao & Valencia-Garcia, 2014). Similar to other ethnic minority groups, the Armenian community holds an intense stigma regarding both mental and emotional issues (Tanielian, 2011). Many Armenian-Americans have an equivocally charged stigma attached to seeking mental health professionals for their mental health issues (Ho et al., 2007; Tanielian, 2011). The importance of raising awareness to existing mental health and emotional issues within the Armenian community is vital to breaking down the barriers that have limited their utilization of mental health services (Tanielian, 2011).

Intersectionality

The concept of intersectionality has been used to understand the interlocking relationship between complex systems of multiple identities and histories of oppression (Collins, 1986; Crenshaw, 1994; McCall, 2008). These multiple layers of one's identity create unique experiences which can often result in the creation of several stigmas from the various layers, or intersections, of one's identity (Berger, 2006). The intersectionality of stigma may be referred to as the interdependence of multiple, co-occurring devalued social identities (Cole, 2009). The distinction of stigma severity differs amongst various cultures and is influenced by various

intersectional factors, that when combined, may create unique clinical presentations (Das, 2001; Yang et al., 2007). The mere existence of intersectionality can significantly contribute to the negative effects of stigma on health outcomes (Rao & Valencia-Garcia, 2014; Reidpath & Chan, 2005). The Armenian identity is complex. Armenians within the United States have multiple sub-identifies, such as place of family origin, place of birth, Armenian language dialect, political affiliation, religion, gender, as well as numerous other factors that define their Armenian identity. While Armenian-Americans may experience stigma and oppression due to their intersectional factors, this pressure is created not only from the dominant American community but also from within the Armenian community itself (Dagirmanjian, 1996).

Mental Health Service-Seeking Behavior

The majority of research on Armenian-American mental health service-seeking behavior has been conducted through dissertations, such as Ayvazian (2008) and Yesayan (2014). In a quantitative study exploring the help-seeking behaviors of 168 Armenian-American women by Ayvazian (2008), it was found that perceptions about mental health as well as knowing someone with mental health issues strongly predicted help-seeking behaviors among Armenian-American women. Furthermore, this study found no relationship between an increase in help-seeking behaviors and higher acculturation levels. This study indicated that the Armenian individuals' acculturation level within the westernized American culture did not show a significant relationship with their decisions to seek mental health services. Overall, this study highlighted that knowing someone who had a mental health issue tended to increase the likelihood of engaging in help-seeking behavior amongst Armenian-American women (Ayvazian, 2008).

According to Yesayan (2014), factors that contributed to positive views of mental health services included knowledge and familiarity with the mental health field, awareness of services

available, knowing someone who received mental health treatment, and knowing someone who works in the mental health field. Armenian women with these forms of exposure were more likely to hold more positive attitudes towards seeking mental health services. Armenian-Americans tended to have more accurate beliefs about psychotherapy when they were provided with knowledge and a clearer understanding of the concept of psychotherapy (Yesayan, 2014).

The phenomenon of utilizing medical services for a mental health issue as a primary resource relates to the tendency by some Armenian-Americans to present somatic symptoms instead of psychological symptoms to primary care providers (Yesayan, 2014). Seeking assistance from medical physicians for mental health issues is common in the Armenian-American community, as well as other minority communities within the United States (Jamin, Yoo, Moldoveanu, & Tran, 1999). According to Yesayan (2014), Armenians tend to be more receptive to visiting their family physician when experiencing a mental health issue rather than a mental health clinician. In addition, Armenians are more likely to accept a referral for psychological serves when referred by their family physician. This avenue of initially seeking medical help for a mental health issue appears to hold less stigma in the eyes of Armenian-Americans (Yesayan, 2014).

Summary

The review of the literature highlights the lack of empirical data relating to the lived experiences of Armenian-American men who have a mental illness and the role that stigma may have on their utilization of psychological services. While research on the Armenian-American population does exist, the literature on mental health primarily targets Armenian-American women and Armenian-Americans non-gender specific. This is an understudied topic that requires further examination by researchers. To address the various gaps in research, this study

examines the experiences of Armenian-American men who have sought mental health services and uncovering the role stigma holds as a potential barrier to their utilization of services. The goal of this study is to explore the phenomenon of stigma and its impact on Armenian-American males with a mental health issue and their decision to seek mental health services.

METHOD

Overview

A qualitative research methods approach was utilized to complete the present study. Qualitative research is an analytical process of insight based on specific methodological traditions of analysis which examines a social or human problem (Creswell, 1998). The qualitative method provides an opportunity to understand the lived experiences of Armenian-American men through examining their stories, statements, descriptions, and meaning-making of what it is like to seek mental health services within this ethnic community. The goal of this study was aimed towards building an intricate comprehensive picture, examine words, report in-depth views of participants, and conduct the study within an organic, natural setting (Creswell, 1998).

Interpretive phenomenological analysis (IPA) is a qualitative analysis approach that aims to understand how individuals make sense of their lived experiences (Smith, Flowers & Larkin, 2009). This form of analysis requires the researcher to obtain thorough, reflective first-person accounts of the participant's experience (Harper & Thompson, 2011). Studies utilizing IPA require small sample sizes with a focus on depth and range of experiences (Smith et al., 2009). IPA focuses on the quality of data over the quantity of data, which allows for the organic development of the individual's narrative as it pertains to the phenomena being studied.

Participants

The participants for the present study included six Armenian-American men. The inclusion criteria for this study included: (1) a history of or a current mental health issue(s), (2) experienced stigma based on their mental health issue(s), (3) a history of or currently receiving mental health services, (4) at least 18 years of age or older, (5) identify as male, (6) reside in California (7) identify as being of Armenian ethnicity (defined as having at least one parent with

that ethnic background), (8) able to speak English fluently. For the purpose of this study, mental health issue(s) were provided via self-report by participants.

Procedures

This study was approved by the Institutional Review Board (IRB) at the University of San Francisco. No major foreseeable risks were anticipated for participants who partook in this study, besides possible emotional discomfort. All human subjects were attended to in compliance with the IRB. Since this study included the topic of mental health and stigma the welfare of the participant always remained the priority. Given this, participants were informed of mental health resources within their respected communities that they could access.

Purposive, convenience sampling techniques were utilized to recruit participants that met the criterion of this study. Purposive sampling methods assisted in locating participants who were able to provide information about the phenomenon being researched. Recruitment of participants for this study occurred through targeted specific avenues including posting virtual recruitment flyers (See Appendix A) on social media (e.g. Facebook) and in-person presentations made to local Armenian organizations. An e-mail address was created and used solely for the purpose of this study. In addition, the researcher's phone number was provided on the flyer as contact information to facilitate participation in the study. The Recruitment Script (See Appendix B) was read to participants who were present at in-person presentations as well as to those who contacted the researcher via-phone. Participants who contacted the researcher of this study via e-mail were provided with the Recruitment Script to review. Potential participants who made contact via e-mail were then asked to provide a contact telephone number if interested in being screened for their appropriateness to participate in this study. The participant Screening Form (See Appendix C) was utilized to decide if each participant met the criteria for the research

study. Participants who met the screening requirements were then scheduled for an in-person interview at one of the various university campus locations based on their preference.

Interviews were conducted in private, reserved rooms at the University of San Francisco campus. The participants were provided with a consent form (See Appendix D) prior to the interview. The researcher reviewed the consent form with the participants and asked if they had any questions. Each participant was notified at the beginning of each interview session of their right to refuse to answer any question or close the interview session at their own will.

Following the completion of the consent form, a semi-structured, face-to-face individual interview was utilized in this study. Data was obtained through verbatim transcriptions of an audio recorded first-person account that was generated by the research participant in response to questions provided by the researcher. All questions followed a sequence as outlined in the Interview Guide and were asked in the same chronological order for each participant (See Appendix E). The researcher aimed to remain neutral and facilitative to ensure that participants had the opportunity to share their personal narratives. At the conclusion of each interview, participants in this study received a $35 cash compensation.

Confidentiality of each participant's identity remained a priority throughout this study. Steps to protect the identities of participants and maintain their anonymity were taken which included providing each participant with a pseudonym during the interview and for data analysis. The pseudonyms are used within all written records. This study utilized the transcription service called Trint for the purpose of transcribing the interviews. Trint is a software that transcribes audio recorded data and was used to transcribe audio recordings of all participants. Following each transcription provided by Trint, the researcher of this study compared each participant's

audio recording to the transcription provided by Trint. To ensure each participant's responses were captured verbatim, edits were then made to the transcriptions.

No identifiable information of participants was used during this process. Only direct study staff, which includes the researcher and the dissertation chair, have access to the actual names, e-mail addresses, and phone numbers of the participants.

Data Analysis

The aim of interpreting data in IPA is focused on developing an organized, detailed, plausible, and transparent account of the meaning of the data provided (Harper & Thompson, 2011; Smith et al. 2009). In addition, the goal of data collection in IPA is to make sense of everyone's unique experiences (Smith et al., 2009). The five stages of interpretative phenomenological analysis are detailed below (Willig, 2008).

The first stage of IPA began with the researcher conducting a thorough reading of the transcripts. During this stage, the researcher utilized an open coding technique that includes identifying relevant responses and statements within each participant's transcript (Willig, 2008)

The second stage involved identifying themes. This was done by marking major and minor themes that emerged throughout transcripts (Willig, 2008). Through re-reviewing transcripts, the researcher explored the information to gain a more accurate account of each interview. The goal of this stage is to develop brief phrases which hold enough substance to remain grounded in the participants' responses and provide clarity to the material (Smith et al., 2009).

In the third stage, the researcher structured the analysis into major themes. The emerging themes were examined and organized into clusters based on their conceptual similarities. The

goal for this stage was to identify patterns in the themes that emerged to create a structure that assisted in featuring converging themes (Smith et al., 2009).

The fourth stage included the production of a summary table for themes. This table displays key themes and subthemes that were obtained from the data. Quotes or illustrative data were extracted from the transcripts to highlight each theme (Smith et al., 2009). In addition, any themes that were not well-represented were not included in these categorizations.

The fifth and final stage was the construction of a cohesive narrative (Willig, 2008). The narrative's foundation was structured around the summary table and quotations previously extracted were then used to add depth and richness to themes and sub-themes (Willig, 2008). This final stage adds to understanding the lived experiences of the phenomena under study through the participants' personal narratives.

Results

Participants

The participants in this study consisted of six Armenian-American males residing in the San Francisco Bay Area. Clinical diagnoses of participants were not formally assessed during the interview. During the recruitment phase, a total of twelve participants were screened for this study. Of the twelve participants, six participants did not advance to the interview phase of this study. During the recruitment phase, two participants chose not to participate in this study due to personal reasons and four participants did not meet all eligibility criteria required.

A total of six participants advanced to the interview phase of this study. Participant ages ranged from 23 years to 54 years (Refer to Table 1). All participants identified as male and self-identified as having experienced a mental health issue(s), have utilized mental health services at least once in their lifetime, resided in the San Francisco Bay Area, and identified as being of Armenian ethnic descent. Four participants in this study identified as being of only Armenian descent, of these, two participants were born outside of the United States. Two participants identified as half-Armenian and half-Caucasian. Mental health issues reported in the interviews consisted of anxiety, depression, substance use, and adjustment disorder. Pseudonyms were chosen for each participant in this study to ensure their privacy was protected in all stages of the study.

Table 1*: Participant Demographics*

Age	Ethnicity	Pseudonym	Mental Health Issue
30	Full Armenian	Hagop	Anxiety
30	Full Armenian	Suren	Adjustment Disorder/Anxiety
23	Half Armenian	Antranik	Depression
23	Full Armenian	Narek	Anxiety
24	Full Armenian	Saro	Substance Use/Anxiety
54	Half Armenian	Vahe	Anxiety

Below, is a brief synopsis of each participant, based on their descriptions of mental health issues and cultural background factors.

Hagop

Hagop is a 30-year-old Armenian-American male of full Armenian descent. Hagop's primary mental health issue discussed was anxiety. Hagop shared having participated in mental health services during his mid-20's at his university's outpatient counseling center as well as in private practice. He has chosen to minimize his family's involvement in his mental health journey.

Suren

Suren is a 30-year-old Armenian-American male of full Armenian descent. Suren experienced adjustment disorder during his first year of university away from home. Suren later developed what he identified as anxiety during his 20's. Suren shared having utilized medication, individual therapy, and group therapy at outpatient clinics. His family and partners have been very supportive and involved with his mental health journey.

Antranik

Antranik is a 23-year-old male who identified as half-Armenian and half-Caucasian. He expressed questioning his Armenian identity growing up with being a half-Armenian who has an "odar" (non-Armenian) parent. Antranik went to family therapy at the age of 8 due to familial conflicts. Antranik described experiencing embarrassment for utilizing mental health services when he was a child. He also described experiencing symptoms of depression throughout his adolescence and early adulthood. During his time in university, Antranik made the decision on his own to utilize mental health services. Antranik's family is supportive of his mental health struggles.

Narek

Narek is a 23-year-old Armenian male of full Armenian Descent. Narek emigrated to the United States during his childhood. Narek shared that his first exposure to the concept of psychology was during his time in university when he sought treatment for anxiety. Narek's family's involvement with his mental health experiences is intentionally non-existent.

Saro

Saro is a 24-year-old male of full Armenian descent. Saro moved to the United States during his early adolescence. Saro utilized recreational drugs, such as marijuana, during his childhood to cope with stressors unrecognized to him at the time. The finding of Saro's marijuana paraphernalia by his parents led to his parents sending him to see a mental health clinician. Saro shared having continued to utilize mental health services during his early 20's to help control his symptoms of anxiety. Saro shared that his family does not discuss their own mental health experiences. In addition, Saro's involvement in the Armenian community is tenuous due to his internal conflicts with religion which is intertwined within his community.

Vahe

Vahe is a 54-year old male of half Armenian and half Caucasian descent. Vahe shared first utilizing mental health services during his 30's to help control his symptoms of anxiety. Vahe shared having a positive experience with his mental health clinician and actively encouraged his fellow Armenian peers to seek help for their mental health issues. Vahe expressed having an open-door policy with his family regarding both his and their mental health struggles.

Themes

Four major themes were identified: (1) stigma, (2) mental health treatment, (3) gender views, and (4) moving forward to decrease stigma. Additionally, ten sub-themes were identified in the larger themes (see to Table 2).

Table 2*: Themes and Sub-themes*

Theme 1: Stigma
Sub-theme 1: Enacted Stigma
Sub-theme 2: Felt Stigma
Sub-theme 3: Disclosure
Theme 2: Mental Health Treatment
Sub-theme 1: Initial Exposure
Sub-theme 2: Therapeutic Qualities
Sub-theme 3: Therapeutic Experiences
Theme 3: Gender Views
Sub-theme 1: Being Male
Sub-theme 2: Gender Expectations
Theme 4: Moving Forward to Decrease Stigma
Sub-theme 1: Pessimism for the Future
Sub-theme 2: Necessary Steps for Change

Table 3: *Definitions of Themes and Sub-themes*

Stigma Theme 1	refers to a participant's experience of being treated differently as a result of their mental health issue(s) as perceived by others.
Enacted Stigma Theme 1: Sub-theme 1	refers to the participant's experience of receiving unfair treatment by others, both overtly and covertly; or being treated differently based on other's perception of their mental health issues.
Felt Stigma Theme 1: Sub-theme 2	refers to the participant's feelings of shame and discrimination; the expectation that others will treat them differently/discriminatory which may prevent and/or impact the individual from vocalizing their mental health experiences.
Disclosure Theme 1: Sub-theme 3	refers to whom the participants have and have not voluntarily shared their mental health issues/concerns with.
Mental Health Treatment Theme 2	explores the experiences of the participant's utilization of mental health services and barriers to care.
Initial Exposure Theme 2: Sub-theme 1	refers to first encounter experiences with mental health services.
Therapeutic Qualities Theme 2: Sub-theme 2	refers to clinicians' traits both beneficial and detrimental to the participant's perception of treatment and/or preferences.
Therapeutic Experiences Theme 2: Sub-theme 3	refers to the participant's reflection of potential benefits or drawbacks after receiving mental health services.
Gender Views Theme 3	refers to the participant's ideas of male and female roles from their cultural gendered experiences and perspectives.
Being Male Theme 3: Sub-theme 1	refers to the roles and expectations of masculinity within the Armenian-American community.

Gender Expectations Theme 3: Sub-theme 2	refers to the perceived social differences in mental health experiences between males and females. In addition, gender expectations refer to the perceived culturally appropriate roles for men and women.
Moving Forward to Decrease Stigma Theme 4	refers to the participant's expectations for the future of Armenian-Americans who experience mental health stigma.
Pessimism for the Future Theme 4: Sub-theme 1	refers to the participant's low expectations of a decrease in mental health stigma within the Armenian-American community.
Necessary Steps for Change Theme 4: Sub-theme 2	refers to the participant's belief of what is required to decrease mental health stigma within the Armenian community.

Theme 1: Stigma

The theme stigma refers to a participant's experience of being treated differently as a result of their mental health issue(s) as perceived by others. The theme of stigma was broken down into several sub-themes, which include: (1) enacted stigma, which refers to the participant's experience of receiving unfair treatment by others, both overtly and covertly; or being treated differently based on other's perception of their mental health issues, (2) felt stigma, refers to the participant's feelings of shame and discrimination; the expectation that others will treat them differently/discriminatory which may prevent and/or impact the individual from vocalizing their mental health experiences, and (3) disclosure, which refers to whom the participants have and have not voluntarily shared their mental health issues/concerns with.

Throughout each interview, the theme of stigma became a salient focal topic. Topics of enacted stigma, felt stigma, and disclosure emerged. Participants shared stories of experienced stigma from peers, family, and the larger Armenian-American community, as well as stigma

experienced internally, which brought upon emotions of shame and guilt. In addition, participants shared their unique mental health disclosure processes which influenced their decision to access mental health services. Several words were referenced by participants to identify the labels of stigma, these included *crazy, dangerous, different, drug user, and psycho.*

Sub-theme 1: Enacted Stigma. Enacted stigma refers to the participant's experience of receiving unfair treatment by others, both overtly and covertly**.** Participants detailed the events that led to experiences where they were treated differently due to their mental health issue. In addition, participants described actions and statements, committed by those within and outside of their Armenian community, which lead to the stigmatization of those with mental health issues.

Antranik described how those perceived as different at a young age are susceptible to bullying by peers:

> *I think there's a lack of understanding especially when people are younger. I also think people try to get a leg up on you in general so they can't look for any weakness you may have. If it's mental you know you have you say something funny you wear glasses yet you're in a bad mood. You're depressed. That's like, that gives like a bully or someone who likes to make fun of people…(mumbles).*

Hagop acknowledged that mental health stigma may lead to the way friends, peers, and even family members behave around the individual who has a mental health issue. He highlights the discrimination sometimes experienced in these instances by others and even when it may not be negative, he discusses being treated differently:

> *In general, I think when someone expresses a mental health condition, they are definitely discriminated against from bypasses from work people and sometimes even from friends. Now close friends I think, close friends and family I think are obviously there for you so either they're not negatively discriminating but even then they are affected by it and therefore may change their behavior towards you if they know of it or, or, you tell them of it [that you have a mental health issue].*

The fear of being ostracized and losing social status within the Armenian community pushed Suren to suppress mental health symptoms and put on a 'face' to hide any issues he was experiencing. His perception of being well in the eyes of others from the Armenian community was something very salient to him:

> *I would probably add that whenever I saw Armenians it would be kind of sporadic and I would tend to like muster up more energy than I would normally. So, I would tend to hide things more, you know, events like sports weekend or something you know, don't, don't come around that often. So, it's, it's hard to like do an apples to apples because like every time I was with Armenians, I would add that they definitely encouraged me or just intrinsically like I wanted to do my best or be on my best, when I was like around the community. So, I would either like suck up things a little bit more or fake things a little bit more. Probably be a little less open with that type of thing.*

Antranik shares an imprinted memory he holds of his experience with enacted stigma by peers at a middle school party:

> *…but I can't really talk to anyone about it [mental health issues] and only people like I kind of hated that it that they would make fun of me. Specifically, I remember I had like my therapist's business cards in my wallet and I was like a middle school party and I had dropped my wallet. And you know it like [had] a psychotherapist on it and like think like some kids reached down and they go "psycho, you're a psycho."*

With concerns of being discriminated against due to mental health issues, Hagop believes changes in the relationship dynamic may still occur regardless of good intentions:

> *Yeah, I think in general it's kind of a little bit of judgment when. Well it depends. Right. So, I think in the past the traditional thought is that having a mental health condition or seeking therapy for it is kind of a bad thing. There's something wrong with the individual who more recently has become more accepting and in fact encouraged to seek out help. If you do, are you encountering an issue when you may need some guidance? So, I think that's definitely has changed over the past.*

Narek shared harsh stigmatic perceptions held by members in his community and perceptions people have of individuals who suffer from mental illness.

> *They view very negatively to the point where they think it's contagious. It just doesn't make sense right. It's there's such a lack of education on what mental health is or what is mental illnesses. I've heard real horror stories of people with you know just people with*

> *kids with schizophrenia and how their parents are, you know, lock them up in the apartment and just don't let them out... They're really seen as aliens. I don't know, if someone has a mental illness especially if they're, they're just, they're ostracized they're not treated as an equal. And yeah you just get labeled as a crazy person. Yeah. And I think this label goes to everyone pretty much with mental illness.*

Sub-theme 2: Felt Stigma. Felt stigma refers to the participant's expected shame and discrimination (they expect that others will treat them differently/discriminatory) which prevents the participant from vocalizing their mental health experiences and may serve as a barrier to seeking mental health services. Participants' statements revealed the experience of negative self-views of their lived experiences with mental health issues. This internalized stigma may serve as a barrier that projects the anticipation of stigma from others.

Saro shared his internal need to keep his mental health appointments private at work and would go to great lengths to make "new excuses" to leave early for his therapy sessions:

> *I kept it very much under wraps. I was working at the time and I would need to take an hour and a half off of like a Tuesday to go and I would come up with a new excuse every time. I did not make it clear. Maybe I should have actually… That's also another part of like perception of mental health. Never wanting to admit that you have a doctor's appointment.*

Stigma also showed up as fears of burdening family, of being treated as different, and fears of their own discomfort about telling others influenced Narek's decision to keep his mental health symptoms private from his family:

> *I don't know. I feel like they would have over, overreacted to some extent and made it a big deal, bigger deal than it is… It would be very weird talking about it. Maybe like I don't know if they'll see me as different or they will or they will tell people about it or, or it maybe it would be a burden for them to hear it because then they're going to be like this poor kid has something like mental health issue and that's a burden. And so, I just felt like not causing anything. I just kept it to myself. I have said to friends who are Armenian but they're more, you know, they're educated here [United States] they're my age, they get it.*

Growing up experiencing mental health issues Suren shared his experience of feeling unique or marked in some way, like that of an outsider. With age and growth in awareness, Suren learned of the commonness of mental health struggles and was able to gain a sense of normality in his personal struggles with mental health:

> *Because it's not anything to be ashamed about anymore. It's not a, actually, I think the more you grow up, the more you realize everybody has those kinds of problems. It's funny how when you are younger, the experience, kind of feels like unique… Something about it makes it feel like I guess that's just how growing up is. Everything that's like happened to you feels so unique to you and then sometimes you feel like possibly alone with the problem because you couldn't imagine other people in a similar situation, because it feels so foreign.*

Hagop provided insight into his own experiences with being socially distanced by those in his community while reflecting upon his own social distancing of those with mental health issues as well:

> *I'm not sure. I don't know. And to be honest it's possible that I do the same thing. I mean having gone through it I think I understand giving people the space but making sure that I'm there for them. I don't know why people are treated differently when it happens obviously you want to help others, so you make a change in how you interact with them. At the same time if you feel like you're not responsible for helping that person you probably take a more indifferent stance. And I think something that could have been a very natural interaction turns into a little bit more distance.*

Subtheme 3: Disclosure. Disclosure refers to whom the participant has and has not voluntarily shared his mental health issues/concerns with. Participants discussed their decisions to both disclose and hide their mental health issues from family and peers. In addition, participants discuss whether they opened up with members within or outside of the Armenian community. Additionally, as evidenced by some of the quotes above, stigma and the perception that others will treat you different because of mental health issues were a common co-occurrence.

Narek described having a wariness on disclosing his mental health issues within the Armenian-American community due to the small size of the community. With concerns of losing his privacy in the community, Narek shared his preference with disclosing to his non-Armenian peers outside of his community.

> *Outside I was more free to talk with people, especially you know, they also shared their experiences. And I was more comfortable sharing. So yeah but, but like when it came to like the inner circle and because the community was small, I felt like everyone knows each other. So, what if they tell people. The word gets out.*

Echoing Narek's notion of the Armenian community's closeness, Saro explains the risk of disclosure within the community:

> *…They don't stigmatize it by any means but it's definitely not something that is advertised or broadcasted that's very much just within the family and even within like the immediate family. I don't think the extended family knows at all, like anything. Especially if there's any risk for the greater community to know about something then it's almost 100% under wraps because the tightly networked community and yeah that news can spread fast and given what we know about the stigma within the community I think just not something that we want to deal with.*

The act of disclosure is not inherently a negative event. For some, relief and support may receive, while for others, isolation and stress may ensue. In Hagop's situation, he experienced both positive and negative repercussions of his disclosure process. Hagop shared his discussions with peers about his mental health issues being positive. Hagop described how his experience with disclosing his mental health issues to his parents led to an increase in worrying and anxious feelings on their behalf:

> *I talked to some close friends who encouraged it and weren't judgmental at all. But then when I think people like my parents found out about it I think they were extremely worried. Even though I'm sure everyone goes through it and everyone goes and handles it a different way, I think they thought that they needed to help more than I needed them to help.*

Saro discusses the perceived norm within the Armenian community for friends not to disclose their mental health issues to each other unless the friends are considered to be extremely close.

> *Like if I had a friend that I was that close or at like the same amount of closeness to that friend I would also expect that friend to not tell me about these things. But it's just it's another factor about Armenians not talking about this at all unless they're like very, very close.*

Theme 2: Mental Health Treatment

The theme mental health treatment explores the experiences of the participant's utilization of mental health services and barriers to care. The theme of mental health treatment included sub-themes of (1) initial exposure, refers to first encounter experiences with mental health services, (2) therapeutic qualities, which refers to clinicians' traits both beneficial and detrimental to the participant's perception of treatment and/or preferences, and (3) therapeutic experience, which refers to the participant's reflection of potential benefits or drawbacks after receiving mental health services.

Subtheme 1: Initial Exposure. Initial exposure refers to first encounter with mental health services. Participants discussed the situations that led to their initial exposure to mental health services. For some participants, this decision was voluntarily made while for others, their decision was involuntary or mandated by others. The methods of accessing initial mental health services varied and obtaining treatment included recommendations from peers, accessing university counseling services to surpass familial involvement, and parental decisions.

Antranik shares his initial exposure to mental health therapeutic services as a child due to intense family conflicts:

> *Well my mom had my sister when I was 7 and afterwards she had postpartum depression, and she was on a mix of medications like Paxil, and she had some very negative side effects from that, and she also developed like alcoholism with it, so the police came to our house a few times and there is some like traumatic sort of things that happened, so like probably a year after that my parents put me into a weekly, bi-monthly counseling about that.*

Saro expressed non-congruence with his decrease of external stressors and his continuing to feel mental health symptoms leading him to explore further help:

> *So, my first time was, I didn't end up like pursuing it very well… I think it was when I realized that I was in a situation that didn't have that much stress and I had everything going for me,… I knew something was off. That was the point. So, it was always like, oh, okay, this makes sense because I'm in this stressful situation but the moment all those stresses were gone, I realized everybody that I talk to was like, damn you have everything. And I was like yeah, I kind of do. But I would still feel the same symptoms. That was the point where I thought, oh, okay, I should probably go check it out.*

Hagop shared having an openness with peers' feedback when discussing his mental health state through his ability to self-reflect on their noticeable changes on his presentation. The social mirror provided by his peers allowed for his ability to connect the dots on his symptom manifestation. Hagop provided an example of his experience which influenced his initial exposure to mental health services:

> *I think it was the inability to sleep and being pointed out that some of my actions were common symptoms of anxiety, and then the light bulb clicking and being like, you know, I think that, that there is some anxiety in my current state. I think that you know what to do. And some friends, they mentioned that, they had mentioned it [therapy] a while ago, and when that clicked that I was like, you know, maybe I should go check it out.*

With the unfamiliarity of seeking mental health services, Narek sought services at his university's counseling center despite concerns of the perceived stigma from family and peers that may have ensued as a result. In an attempt to minimize being seen as "inferior or different or weird," Narek limited those who he discussed his mental health issues with to "a very good

friend." He described his processes of utilizing services while emphasizing his need for privacy in order to protect himself from social backlash:

> *I was seeking services, but I did not tell people. Didn't tell my family, didn't tell my friends, only told a person, just a very close friend. Yeah, but the fear was kind of being judged and seen as inferior or different or weird. So yeah, I didn't really talk about it in the first place.*

Narek revealed his barriers to treatment, which included concerns of not having his Armenian background being understood by a clinician of a different ethnicity and the therapeutic dialogue being focused on anxiety induced by educational factors, which allowed for him to control the therapeutic dialogue while avoiding his true internal conflicts. Furthermore, Narek's held belief of therapy not being an activity that Armenian men typically engage in suggests he was initially concerned with losing a part of his masculine identity by his utilization of therapeutic services:

> *It's just not a thing Armenian guys do. So yeah, I decided to give it a try and, but, it was under the umbrella of 'I have anxiety from school' and you know, assignments and performing and I kept getting involved with a bunch of things just to compensate for say low grades so yeah, but I never, through therapy, I never got to talk about what I wanted to talk about. And like, what that is causing and what my thoughts are about. I was having a lot of issues, but I only kept it to a level, like just school. Maybe that's because I didn't feel like the therapist would understand. The therapist was not Armenian, she was Hispanic, so I never really went into therapy with like an open mind, like just being free, so I just, I was really conserved in the therapy room and it was weird, so that's kind of how I got there.*

Further into the interview, Narek described the conflict he believes that many Armenians experience, of being both "emotional creatures" and avoidant in addressing their emotions. He continued to share how emotions may lead to maladaptive coping responses by those who are unwilling to accept and address their emotions. Narek described his development in gaining confidence to "own" his emotions occurred while in college. Narek identified that the exposure

to the field of psychology during his time in college served as an important "stepping-stone" in his decision to seek mental health services.

> *I don't know, I'm going to go with the [university counseling] center because I think maybe there's something there. As much as I like, as much as Armenians avoid talking about emotions or avoid feeling something, they feel a lot, and I feel like they just haven't given the attention. They don't really use that emotion the right way. A lot of it, you know, it gets used up maybe like unhealthy ways or they just don't express it. They don't show anything in public but internally I think they feel what they see. And they could be very emotional creatures. So, I think from my perspective, I think it really, I had to really own that and accept the fact that you know I could be emotional… I could have strong feelings towards something or about something and I could be affected by a certain event. And I feel like what I feel, maybe other Armenians are feeling they're just not using it the right way. And I think I got that kind of confidence to really go with it. And like okay, I'm experiencing distress and anxiety. What do I do with this? Do I just keep it inside of me? Pretend it doesn't exist? Do I just talk to a friend or do I actually go seek professional help? So, I have sought professional help. And I think that ties back into what I've learned what psychology is and what therapy is and kind of using it as a stepping-stone. Like my education, it's a stepping-stone into actual service-seeking.*

Saro's initial use of mental health services was initiated by his parents' reaction to finding drug paraphernalia in his car. Saro expresses his disagreement with his parents' reaction to learning of his marijuana use and believes their misunderstanding of the substance led to an unwarranted response.

> *It was my parents finding a bong in my car and they were convinced that I needed to go to therapy, and that was interesting. Right at the end of high school and yeah, I'd been smoking weed with my friend… My parents were mortified, and they were like, to them, like weed is the equivalent of heroin and that means they don't really know the spectrum of what is dangerous and what's not or what is at this point acceptable or even legal now… They really thought I needed to go see someone because I think they thought that if you're smoking or if you're taking any kind of drugs excluding alcohol or coffee because I don't think they consider those drugs, which they are, they think, you know, you need help with, there is something going on mentally.*

Vahe's inability to manage his anxiety symptoms in social settings pushed him to make the decision to seek mental health services. In addition, Vahe shared cost of treatment was a

consideration prior to receiving services. Vahe suggests his decision to utilize services was partially influenced by his ability to afford costs, at this point in his life.

> *Once it (anxiety) started to get to the point where you know, I couldn't be in places, that was when I was like, okay, I got to, I got to get my shit together and that's when I finally, finally decided, and that I could afford it… I was making enough money at that point that I could afford to go.*

Vahe later expressed the ease he experienced when seeking a clinician to treat his symptoms of anxiety:

> *Uh, it wasn't hard. I needed to pick a therapist. I don't remember exactly. I got a referral through somebody… The first person I went to was, she was the one and she was great and there was no problem. I got a referral to her somehow, I just don't remember how. I went in and that was it. So that wasn't a problem.*

Different from Vahe's experience, Suren shared his process of seeking mental health services was "very confusing" given his prior lack of familiarity with mental health services. His navigation of the mental health system was described as being a foreign experience, which led to confusion and uncertainty in services access, such as type of treatment and cost of services.

> *Uh, very confusing. I would say like I didn't know a lot of the facts. I didn't have a lot of support, not because I didn't have it, but I didn't necessarily like ask people for advice on stuff. I kind of felt like I was in an unknown land, as far as you know, knowing what type of treatments there are and you know, how much stuff costs. For example, just information about it, so… I didn't know a lot.*

Subtheme 2: Therapeutic Qualities. Therapeutic qualities refer to clinician traits both beneficial and detrimental to participant's preference. Participants identified clinician qualities that contributed to both positive and negative experiences during their utilization of mental health services. Common qualities discussed that were valued by then men included: professionalism, affordability, cultural competency, nonjudgmental approach, clinician gender, confidentiality, empathy, and development of therapeutic alliance. Having been to two clinicians,

Hagop shared his polar experiences between the two therapists:

> *Yeah, I think what differentiates them was the second person was a little bit more telling me what to do and a little bit more. They were older. I had been doing it for a while and they were a little bit dismissive of some things so when I would bring up, for example family or friends and how I didn't necessarily agree with their philosophies, this person was dismissive of those individuals and those individuals I obviously care for a lot and I respect their opinions so I don't appreciate someone dismissing their opinions just immediately. For him that's one thing.*
>
> *The other person was younger, was thinking might I say this, was a student psychologist. Yeah, I think she was a doctoral student and she was incredibly good and I think part of it was just the general calmness about it, the willingness to listen, being open to the fact that it was my first time, so willing to take it at whatever pace I wanted. Not really telling me what to do but providing resources for what… I was feeling.*

Echoing Hagop's statement, Narek believes that an effective clinician is one who is aware of the Armenian culture. In addition, Narek emphasized the need for clinicians to acknowledge the various dynamics of the Armenian community and culture that adds a "unique element" to their therapeutic experiences:

> *Someone who is able to actively listen, have a sense of humor that is aligned with, you know, a sense of humor that's more familiar with my culture and like knowing some cultural history or norms and values of the certain culture that I belong to. Yeah and just you know asking questions that don't really push me away like invite me into the conversation and create a space where I am able to talk about things like family. So it's not just keeping it to the school level…And there are certain things it's not written into books. It's not in psychology books but just it's maybe it's like a unique element that only people within our culture can understand. Just like the way you say something or dialect or like I don't know something that really stands out and kind of signifies that yeah this person is very, a person and they're going to get you and they've probably been through the same experience as you and they know like they would know how my parents think they know how our relatives think and they kind of understand that, and also kind of being mindful of things they shouldn't talk about things or being mindful of, I don't know, faith or religion, intergenerational trauma or all sorts of things just yet, just knowing, and so I think having a mental health provider that is like you and is from here, same ethnicity or culture I think it's a huge benefit.*

While Narek prefers a clinician familiar with his own culture, he recognized that his clinician's unfamiliarity with the Armenian community served as a protective factor in his ability to keep his usage of mental health services a secret and aided his openness in therapy:

> *And I guess I was comfortable because it was at school it's like maybe I don't have to tell people about it. And the therapist, I mean, it would have been better if she was Armenian-American, but she wasn't. But I was like, okay, then there's no way that she'll know me. There's no way anything I say will matter. It won't get out. So, I was like, under that kind of unfamiliar setting, unfamiliar situation I was more comfortable, yeah just using what my culture has provided like the emotional level.*

The clinician's gender was important to some of the participants, for example some participants preferred a male clinician while others were either indifferent or preferred a female clinician. Narek discussed his perception about the lack of male clinicians from his culture background to be problematic for Armenian males who feel uncomfortable opening up to females in psychotherapy. As a result of cultural norms, Armenian men may be hesitant to discuss topics such as mental health and other internal conflicts females due to fears of losing part of their masculine identity. With psychotherapy being a female dominated field, Narek describes this factor to be a potential barrier to men accessing services.

> *I don't know if there are too many. There probably are but especially with guys. I think guys prefer speaking with, meaning guys as therapists and most therapists are females. So, I think that also comes in for like many Armenian men. Maybe they want Armenian-American male therapists and there aren't too many so many.*

Suren placed emphasis on his clinicians being present and in the moment during sessions. Suren shared that clinicians who come to session ill-prepared and do not cater the session uniquely to the client are less professional:

> *I would say not so much authentic as just professional and well-prepared. I mean like, you can totally show up to a session and be like, okay, yeah, I've done this a million times*

> *and you kind of ask some questions and get it done with or you can tell when they're kind of all there now. They're ready for you to carry some of your load with you.*

Qualities such as warmth, empathy, attentiveness, and ability to provide insight are priorities for Saro when seeking a mental health clinician. In his case, gender and ethnicity did not appear to be salient factors when choosing a clinician:

> *I think conscientiousness is like probably very high up. To feel that person is like more empathetic than the average person. I think is probably some, a quality you should have. Almost like, not a maternal or paternal thing but like. Yeah. You need to feel that they are very warm and open, and they are, they're going to be attentive and like. More on the empathetic side than anything else. But also like, they shouldn't just be people that just sit back and take notes. But if you ask for advice, they should be able to kind of at least guide you, you know in a sense for that. Those are probably the qualities that I would look for. I don't. I don't know if race or gender has a very big thing out. I wouldn't, I wouldn't want, I wouldn't go, I wouldn't pick a male or a female. I wouldn't pick a male over a female or I would have a female over a male therapist. I think I'd love to meet them and just see how, like if our personalities can jive and if I can if I feel that I can truly like, indulge in their personality.*

The cost of mental health services was an important factor to consider and served as a potential barrier for some of the participants seeking mental health services. Suren expresses his focus on finding a therapist who has a "reasonable price:"

> *Decent reasonable price too. Yeah, I mean, I know there's, there is just like a pretty wide range there. I mean, the minimum is pretty high. But like you know it can get, it can get distracting sometimes if it's like too high. I'm just like, sometimes I'll be going to a session or something, and you're like, God Damn! This is going to cost me like three dollars a minute. And you're just like, you kind of feel like thrown off, so definitely though. The price is there.*

Subtheme 3: Therapeutic Experience. Therapeutic experience refers to the participant's reflection of potential benefits or drawbacks after having received mental health services. Participants reflect upon their overall experiences with receiving mental health services and its impact on their future decisions in utilizing mental health services.

Antranik discussed how the therapy he received met his expectations:

> *I think, I think that they've almost all largely done what I've sought out, which is to help me kind of cope with and develop strategies to deal with situations, emotions, and life events.*

Hagop shared positive experiences while in therapy with his clinician and his development in awareness of being able to label his own mental health symptoms because he had received therapy:

> *I chose to take it back into something that had been an experience in the past by other people and providing a little bit of definitions for what I was feeling, so I was feeling anxiety from explaining the feeling. She would tell me 'Oh this is this kind of emotion.' And she actually gave me a worksheet which had all these feelings and was like 'This is because of X since the symptoms because of X emotion.' So just labeling it was helpful.*

Hagop was able to maintain a positive perception of therapy, even though he described a negative experience with one of his providers. He discussed his ability to connect with his younger clinician at his university counseling center while struggling to connect with his older clinician who he met with at their private practice:

> *…It was a good experience despite the second person I think it is just like anyone that any professional you see. Some people are better at their jobs but different on how they do their job, so some people probably would have clicked better with that second person than I did. Just, I think the reason why the first person was better was, in the university setting I think people are more in-tune with the current trend, where they can be older in private practice, they are so in tune with whatever they've learned in the last 20 years.*

Saro shared his experiences of increased comfortability with his clinician, following the first session, allowed for the development of a therapeutic alliance. Additionally, Saro's confidence in the confidential aspect of therapy led to his openness and eventual growth in self-exploration,

> *It's a positive because I did, I don't think I went through that phase of like needing to like be broken in with the person that I'm where to feel like I'm opening up, like I'm sure you know I was probably less open the first time than the second time. But I see I'm already like, if I'm having a one-on-one conversation with someone, I'm probably will I'm willing to offer much more vulnerability in that conversation than, than I perceive others to just*

> *the general basis at least. It's all based on like my perceptions of how people interact. So, like I know about the confidentiality that therapists have, and I also know that this was like a trained professional that I could just bounce ideas off of.*

After one of his sessions, Narek described his surprise in being able to connect with and benefit from a clinician who was not from his cultural background. Narek's belief of not being able to connect with a non-Armenian clinician was changed. Furthermore, he shared other similar surprises, such as the holistic aspect of therapy and feeling safe rather than 'attacked' by the clinician:

> *Well I remember walking out of the room with a big smile for sure. It was just so nice, to just be there and listened to although she was not an Armenian. I still felt connected. But you know, it didn't reach the point where I would fight to get my story across. But still it's just nice to have someone there just to talk about you know what's causing the anxiety or some stress to experience itself. I think it was nice. Nothing too confrontational I would say. I thought it would be worse, but it was just a free space. I thought people would question me and interrogate me and ask me things I'm not ready to disclose. But it was more of a safe place to be and to say what you are how you want it. The therapist was a good listener. And you know it's just dimly lit rooms and just really comforting and yeah I've never had that experience, so like at that moment it was all about me. Not in a narcissistic way but just like how you know, she was all ears and ready to hear me out.*

Theme 3: Gender Views

This next section explores perceptions of gender views held by the Armenian-American males in this study. Gender views refer to the participant's ideas of male and female roles from their cultural gendered experiences and perspectives. The theme of gender views had two subthemes: (1) being male refers to the expectations of masculinity within the Armenian-American community and (2) gender expectations, refers to the perceived social differences in mental health experiences between males and females as well as the perceived culturally appropriate roles for each gender. Participants shared beliefs and personal experiences of social and cultural impacts of both having a mental illness and being male. Perceptions revealed both

differences and similarities in how the Armenian community view males and females who experience mental health issues. In addition to differences discussed by participants, parallels between perceptions of both genders emerged.

Subtheme 1: Being Male. Being male refers to the roles and expectations of masculinity within the Armenian-American community. Several participants discussed the feeling of not living up to their communities' expectations of masculinity because of their mental health issue. In addition, participants shared a need to suppress mental health issues to maintain their gender social roles.

Antranik described the perception of Armenian-American males with mental health issues with a one-word description: "weak." His description of "weak" is symbolic of internalized oppression that potentially influences Antranik's view of self.

I'd say weak and... yeah weak.

Saro shared his perceptions about the incongruence in the Armenian community with having a weakness and 'being Armenian.' He described his viewpoint of Armenian men displaying physical strength and the perception of mental health issues being symbolic of weaknesses in various other personal attributes.

> *It's a hard question, I don't know. I guess given what I know in terms of like how hush hush it is like maybe could be seen as weak. I think that's really a factor. I just like, your mentality. Yeah, you just, Armenian men are very like mentally strong people and like physically strong and like pain tolerance is viewed to be high and like they lift a lot of weights and they box, like they wrestle, like those are very, very masculine things. For a man not be, be fit mentally is like for sure viewed as like you're not fit in other ways.*

Narek discussed the internal dialogue in what he perceived would be acceptable for him to share while in therapy as a male from his cultural background. Concerns of confidentiality and acceptable emotions to display while in therapy led to his initial guardedness in therapy.

Furthermore, Narek discussed how the stigma of males being emotional in front of females may serve as a barrier for other males seeking therapeutic services form a female clinician:

> *…there is a lot of rumors like that if I speak to an Armenian mental health provider, they're going to like break confidentiality and tell someone. It is a small community. There is also that and again when it comes to males, it is like when a male is in therapy, can they cry? Can they be really emotional? Can they express it, like feminine ideology or their feminine side? It doesn't always have to be tough and masculine and you know just helping them understand that it's okay you know if something bothers you it's okay for struggling in a relationship, it's ok if you have anger, you know, just, help is out there, and they will understand you. But a lot of them I think with the stigma, they don't feel comfortable saying that to a female, they're oppressed because then it kind of goes back to gender roles, like okay, I'm going to be seen as weak if I talk about emotional distress.*

Hagop shared the importance of presenting himself in a certain way within the Armenian community. He described the need to put his best foot forward to maintain an image amongst family, peers, and potential mates:

> *I think the Armenian community … is a community that tries to impress one another. So, I think we don't want to show their negatives whether or not it's their family-related families, family-friends, relatives. I don't think they want to show any disadvantage or weakness. And I think that goes with especially with males they don't want to show their female counterparts.*

Vahe shared that topics of mental health are not part of the dialogue amongst members of his Armenian men's organization due to the non-normality of this topic amongst his Armenian male peers:

> *I mean, I don't, I mean it's not like it's a normal topic of conversation [the topic of mental health]. So, it's like you know I mean most the Armenians, I mean outside of family, that I know are in my [Armenian] fraternity. And you know that's not normally what we're talking about [amongst each other]. So, I mean, I, I really don't know.*

Suren shared his view that strength is an inherent attribute of Armenian males. In addition, Suren shared his belief that mental illness is indicative of an individual's increase in emotional susceptibility, which he believes marks the individual as being labeled as "different,

odd:"

> *… Armenians are kind of brutally strong you know. It's not part of our culture to be super, like the emotional type. And I feel like people associate, I don't mean that they associate wrongly, People tend to just associate mental health issues with like being overly emotional and stuff like that. And that doesn't necessarily align with the average Armenian male or just Armenian in general. They are very passionate but not necessarily emotional. And it's the emotion part of it that, that kind of people look at mental health a lot because in order to be affected by certain types of mental health you have to be a little bit more emotionally susceptible. So, I would say, a little bit different, odd.*

Subtheme 2: Gender Expectations. Gender expectations refers to the perceived social differences in mental health experiences between males and females. While exploring the gender role perceptions of Armenian-American men with mental health issues, discussions of both similarities and differences between Armenian-American males and females possess emerged.

Suren shared that Armenian men and women are perceived to be very similar with regards to emotions in the Armenian community. Suren's believes that both Armenian men and women who are emotional lose their ability to be productive, thus may not be able to fulfill their gender roles:

> *Because Armenian men and women are kind of viewed in similar respect when it comes to being strong, I would almost say more so with the females because they are more so viewed like a strong character. Because in our culture, the female has a certain role that needs to be a very leadership type and it is not very productive to be like an emotional type of human being.*

When asked how Armenian woman with mental health issues are viewed in the Armenian community, Suren's response mimicked that of his previous views of males:

> *[Females are viewed as] different, weak… [or experiencing some sort of discomfort from their ancestral past.*

Narek shared his perception of the difference between men and women's experiences

with mental health issues. He discussed that men are thought of by the community as being different due to external factors, such as substance use, and provide with "excuses." Women, on the other hand, are judged by community members as having internal factors leading to their mental health issues and are "blamed" and "shamed" as a result:

> *I think it's worse [for women]. Like with males, they just get it. I feel like with the males, it's like they're crazy and they're just bad people. But I think with women, it's like more derogatory words I feel like. I think they still get negative labels but it's more of like shaming, guilt, having them feel guilt whether it's through, you know, the words that they call them or how they treat that other person. Like really pushing them away and really just guilt and a lot of shame. Shame in all capital letters. Because again, blaming in a way, like blaming the victim. It's their fault they are that way. It's maybe, it's something they have done. Yeah and maybe for guys also I think they assume the person has done drugs. 'That is why he drinks a lot.' If he did cocaine or some type of drugs he uses, like why should a guy be that way, but they're all possible but not really. So yeah, excuses. But then when it comes to women, they don't really find excuses but rather jump to conclusions.*

Hagop shared his belief that women with mental health issues as being generally more accepted by the community, while men are often ignored:

> *They're [Armenian community] generally more inclusive, I think. I think they're generally, they're generally more helpful [towards Armenian females with mental health issues]. And I think they provide more of a support system. I think we [Armenians] do still ignore a little bit. They [Armenian community members] don't think of the individual [with a mental health issue] when they're planning an event or eating more and, but they are still hard, still hard because everyone is different. There are different mental health conditions. Yeah, I think my experience is towards men. They're [Armenian community] less willing to accept them they're more willing and more ready to do that with women that they're OK accepting it and are more helpful. But still a little bit ignored.*

Theme 4: Moving Forward to Decrease Stigma

This section explores the theme of moving forward, specifically to address and decrease stigma for men suffering with mental illness. Moving forward to decrease stigma refers to the individual's expectations for the future of Armenian-Americans who experience mental health stigma. In this section, participants discussed their personal viewpoints regarding the direction

of mental health acceptance of Armenian-American males within the Armenian community. The primary theme of moving forward to decrease stigma includes two sub-themes that emerged from the data: (1) pessimism for the future, which refers to individual's low expectations of a decrease in mental health stigma within the Armenian-American community and (2) necessary steps for change, which refers to the individual's belief of what is required to decrease mental health stigma within the Armenian community.

Participants in this section were asked questions regarding their beliefs of the future of mental health acceptance within their Armenian communities. In addition, participants were asked questions of what steps would be needed for positive change within their Armenian communities.

Subtheme 1: Pessimism for the Future. Pessimism for the future refers to the individual's low expectations of a decrease in mental health stigma within the Armenian-American community. Participants in this section describe their low expectations for positive growth and acceptance of mental illness in their cultural communities in decreasing mental health stigma.

Vahe illustrates his perceived differences between the 'American' Armenian community and the 'traditional' Armenian community. Within the 'American' Armenian community, Vahe sees a potential for change and attributes their less-stigmatizing approach towards mental health to the adoption of American culture and values. With regard to the more 'traditional' Armenian community, Vahe believes that negative attitudes and beliefs of men with mental health conditions will remain stigmatized:

> *I think the Armenian-American community is a little bit more socially aware. It depends. I think the Armenian-American community is fairly segregated in their philosophies.*

> *Some of them adopt a little bit more of an American mentality with both social and cultural factors. And I think that part of the community would be more willing to, I was already in a place where they're more accepting and willing to help. I think the Armenian part of the Armenian-American community, which is more old-fashioned traditional will, I don't know if they will ever change their, the way they treat men with mental health conditions.*

Suren shared his viewpoint that while the Armenian community is not necessarily accepting of mental health issues for men, this attitude can serve as a tool to provide toughness for those individuals with mental health issues:

> *I want to add that because part of the thing that makes it hard to deal with mental health within the Armenian community, also makes being Armenian so cool. So I would be like, to add to those, and just generally being tough because when people are tough around you, okay, yeah, they were too tough, but actually the whole time, if you, if you know you were able to sustain, you generally become like a tough resilient person in the end. So it's only bad for the people that maybe fell off the wagon along the way. So I'd be like super resilient too, like you know, doing some sort of like, you know, big change, like, oh, okay, well, you know that's kind of how California is like. We're very, very, very, we pay a lot of attention to like the extremes.*

While acknowledging his own struggles with mental health acceptance in the community, Suren further illustrates his concerns with making a change to the community's cultural perspectives. He acknowledges the risk of altering perceptions of mental health may lead to a chain reaction of changes within the community, thus potentially losing an aspect of the culture:

> *I would, I would say even though I've been part of the community that's been affected by mental health issues, I wouldn't necessarily want it to change because I still feel like I am, it's more of an outlier. And the way the community is structured with being tough, and this, it's more helpful than it is harmful. So I wouldn't necessarily, even having gone through stuff myself, I wouldn't ever want things to, quote and unquote, improve in that area because improving in that area, I feel I could take away other aspects that make it what it is.*

Subtheme 2: Necessary Steps for Change. Necessary steps for change refer to the participant's belief of what is required to decrease mental health stigma within the Armenian

community. Although participants provided answers referring to both optimism and skepticism for future change within the Armenian-American community, all participants were able to identify steps needed to allow for mental health acceptance of men with mental health issues within their communities.

Antranik shared that change needs to occur from a systemic level within the Armenian community. The Armenian church holds a foundational role within the community, as well as organizations that branch from the church, such as the Armenian Church Youth Organization (ACYO) and Armenian General Benevolent Union (AGBU). Antranik believes change may begin through the utilization of these outlets to assist in setting new norms:

> *I think that I think they absolutely can. I think it needs a need to start with like cultural foundations, which are often the Church and like this are groups AGBU and ACYO. It needs to be kind of talked about early on. And when we're all together so that there's a common understanding of these issues and how it affects us instead of just these perceptions.*

Antranik continues to describe how differences in intersectional identities within the Armenian community, such as: place of birth, socio-economic status, educational obtainment, and acculturation pose as factors that serve as both barriers and influencers to the deconstruction of stigma:

> *I'd like to, yeah, I'd like to add that I think it's hard, too hard to quantify what exactly leads to stigma, regarding mental health and in our community. I just know it's there and that we also have a lot of different micro-cultures in the Armenian community. So I think different Armenian-Americans have different reactions to various things in this kind of a more wealthy Bouji Armenian society that in a way is more accepting of this stuff because I think they're like more educated now. I say it like that and then there's a lot of like more relatively recent immigrant Armenians that I've met that, like their families moved here from Russia, Azerbaijan, they moved, then they came to the United States and they have like a different culture. And I've noticed they're more racist there, more, yeah, I don't know. I've noticed that at least in my experiences. So it's like that group that like I grew up with, that were really from Russia or had like Russian roots, they tended to be like very hostile about these subjects, whereas like kids I went to church with, parents were on like the parish council and whatnot, are more sympathetic.*

Hagop described the need for more acceptance and understanding of both the community and family members. Hagop shares his belief that through exposure to peers with mental health issues, one may become more aware and accepting of their experience:

> *I'll think about it. It's hard. I think though I think that people need to just be more aware. So, I think instead of hiding it, family members that hide it, they need to talk a lot more openly about it but not in a derogatory way or from a point of view of I think X person has Y or I have Y and I'm trying to work through it… I think when it becomes more of a personal thing let's say someone has a negative view of mental health but someone of their closest friends or one of their family members opens up to them. I think people understand that the next time they're confronted with someone with a mental condition they'll be more accepting of it. And I think there needs to be a personal aspect to it. If it's just this concept people will not be willing to say we are seeing someone somewhere as a familiar. And then once people are more familiar with it before and then, then they kind of normalize it to be something personal. So, for example you're driving down the street and someone cuts you off. You get pissed because you can't put a face that is so great. And then once you see that person and you see that they are like I don't know. Once you put a face to that area like a little bit more understanding and willing to it. So, I think that needs to happen.*

While Armenian mental health organizations currently exist, Narek believes that further development of these organizations is crucial for outreach services. In addition, Narek is optimistic that the next generation of mental health professionals will build upon the previous generation's attempts to decrease stigma within the Armenian community:

> *Well I'm hopeful that, you know, as younger generations take their role, like become provider and advocates and you know, run organizations. I think a lot of it will change because they will think of creative ways to really reach out and normalize the mental illness and mental health issues. And I think well even the organizations now who are trying to help out they aren't really active. They try to do things, but each person has their own practice or obligations, so they can't really give it 100 percent. I think that's why things haven't been moving forward at a quick pace. But yeah, I think, I don't know because a lot of times younger generations, their, as their parents get older the younger generations are usually the ones you know, maybe taking care of their elders, or are there to help, or you know, kind of have this cultural obligation to be there for their parents. And I feel like if they notice or they're familiar with a struggle or mental health struggle then they would really encourage their parents to seek services and I think Armenian men are also, maybe it has to do with assimilation to western values but they're being more open to expressing a feeling or expressing an idea. Yeah, I think there will*

come a time in the future where you know services will be available and there will be no shame in seeking it. I don't know maybe it'll take longer for them to like talk about it, like a big family gathering. Maybe not, but I mean it could still be a private thing but at least they get to help but yeah, I think I'm hopeful.

Saro believes that media platforms will allow for the world to become more connected, thus further acculturation and assimilation into the dominant western culture. Saro shared that this move towards the westernized view of mental health will allow for positive changes to occur in the decrease of stigma:

Yeah, I think I think they can improve. In what ways. I think popular culture I think was probably like a big is probably one of the first ways that people get to will be exposed to the normal normalcy of like mental health. That's I think that's how cultures progressed is through like things through exposure and exposure or if it's it isn't coming from like people talking about it in real life. It all comes from TV shows and movies of people talking about it. I think popular culture and, and I say mental health as like a, as a theme in popular culture is growing and that trickles down to like the subcultures, which are like Armenians or one of them, I think. And I think probably all people our age, if we grow to be the middle-aged people and I mean it's like I can imagine the relationship of children to their parents in terms of mental health being different unless you know we're growing up exactly the same way that our parents did and which there might be some people like that.

...I think there's, yeah, I'm hopeful for the future I think our cultures are never static. They're also dynamically changing and given what I see with like now with what's happening with our culture, I think it's probably a positive way forward.

Suren shared his belief that improvement of mental health perceptions is accomplishable. With similarities to Saro's perspective above, Suren believes that natural, non-forced acculturation and assimilation processes into the dominant culture may provide Armenians with an accepting attitude towards men with mental health issues:

Well everything can always improve. The more generations someone has been in a country I think would naturally make it, make it better. People gain knowledge of, of the land that they're living in, and if, I know for example, like the Bay Area is very high with percentage of mental health and someone new to the Bay Area would be, even though they would be experiencing the same type of stresses and stuff, they wouldn't be used to

the culture of being able to go get help. And I think over the generations you kind of just get acclimated a little bit better and options just naturally become available.

It's not necessarily something you have to like push on the community, like you know, put on billboards that like church or something, you know, say hey, you know your kid needs help. Something that I think is, it's something that naturally will happen over time without like direct action.

DISCUSSION

This study aimed to explore the lived experiences of Armenian-American males with self-identified mental health issues and the role that stigma played in their mental health service-seeking behavior. This research utilized interpretative phenomenological analysis (IPA) to code the six qualitative interviews employed in this study. IPA provided the opportunity for this study to explore the lived experiences of each research participant and interpret the meaning of their unique experiences (Smith et al., 2009). In total, four distinct themes emerged within this study: stigma, mental health treatment, gender views, and moving forward to decrease stigma.

The themes of stigma and mental health treatment were particularly evident throughout the participants' experiences. Stigma refers to the participants' experiences of being treated differently as a result of their mental health issue. Mental health treatment refers to the experiences of the participants' utilization of mental health services. Within both themes, several subthemes emerged, which brought clarity to the experiences of these participants' processes of seeking and utilizing mental health services (See Appendix F). While previous research on Armenian-American mental health is limited when pertaining strictly to the male population, the findings of this study support previous studies, such as Ayzazian (2009), which investigated the phenomenon of mental health services-seeking in relation to stigma within this community.

Stigma was shown to be multifaceted in its impact on participants' service-seeking behaviors. Participants ascertained the presence of outside pressures that were influenced by family, friends, and community members who minimized mental health symptoms. They did so to protect themselves as well as those close to them from being perceived and treated as different. Participants shared their experiences of feeling strong emotions, such as guilt and

shame, when processing their mental health issue(s). These negative views of the self appeared to derive from internal needs and desires to protect their immediate family's reputation, shield family members from over-identifying with their mental health worries, honor familial ancestors, live up to cultural expectations and maintain their social status within the Armenian community.

The personal stigma of accessing mental health services, which serves as a potential obstacle to utilizing mental health services, may be linked to the perception of anticipated disclosure outcomes by participants. Decisions of disclosure, regarding mental health issues, varied amongst participants. Several chose to disclose their mental health issues to family and friends on their own terms, while others were directed or expected by their parents to utilize mental health services. For some, disclosing personal struggles with mental health was a vulnerable moment. The risk of rejection versus acceptance weighed on several participants' shoulders before disclosing their struggles to family or friends.

In this study, several participants shared experiences of being more open about their mental health with friends when compared to family members. While most participants discussed their mental health issue with family members, several participants opted to keep the discussions at a minimum while feeling more secure in conversations with peers about their mental health issue. For example, Hagop described his experience of feeling accepted by peers when speaking of his mental health issue while disclosing to his parents lead to their "extreme worrying." This decision to keep conversations about mental health issue(s) minimal with family members appeared to be driven by concerns over negative familial reactions as well as shielding family members from experiencing distress as a result of the participant's personal mental health struggles. In addition, participants, such as Saro, shared their perspective that Armenian-Americans who are further removed from the traditional Armenian culture are more

likely to express a more open-minded stance on mental health issues as a result of their assimilation into the westernized, American culture.

Several therapeutic qualities sought by participants, when choosing a mental health clinician, included: empathy, professionalism, confidentiality, the gender of the clinician, clinician age, cost of services, non-judgmental approach, mastery of skills, and sensitivity to Armenian cultural values. This desire for authentic engagement by the clinician while in therapy reflects the importance of therapeutic alliance for therapy to succeed. According to Grencavage & Norcross (1990), the most significant factor, regardless of therapeutic intervention, that predicted therapeutic success was the therapeutic alliance between clinician and client. This alliance allows for factors such as trust in therapy to develop. One of the participants shared a desire to seek more services and gain therapeutic tools to utilize outside of therapy, which additionally allowed for the reduction of expenses by limiting the need for future therapeutic services. In some cases, the financial burden related to therapeutic services may potentially hinder one's ability to organically progress throughout the therapeutic process (Rowan, McAlpine, & Blewett, 2013). Conversely, this factor may serve as a motivational factor for maximizing experiences within one's utilization of therapeutic services **(**Rowan et al., 2013**).**

Several participants shared that their first exposure to mental health services was through their universities' counseling centers. The university counseling center is an affordable, confidential setting where participants may independently access mental health services. Rather than being concerned over the cost of services, having to rely on familial economic support or insurance, or run the risk of unwanted disclosure, the university counseling center appeared to serve as a relatively safe and less burdensome introduction to accessing mental health services. Participants described their limited exposure to the concepts of mental health prior to

attending college. Through university courses and awareness of community diversity outside of his immediate ethnicity, Narek emphasized the role of the university setting in providing a more welcoming introduction and exposure to psychological services.

The preference of a clinician's gender varied amongst participants. For example, Hagop shared having a positive therapeutic encounter with his younger, female clinician and had a negative experience with his older, male clinician. Suren, however, preferred a male clinician due to his concerns of potential attraction to a female clinician, which he described as possibly interrupting the focus of therapy. Narek described a preference for an Armenian, male clinician while reflecting upon his positive experience with his Hispanic, female clinician. Narek showed conflict in his experience of wanting an Armenian provider by having a non-Armenian clinician. Narek shared that having an Armenian therapist would allow for cultural nuances to be understood and an appreciation of the role of his historical factors in influencing his current identity as an Armenian male. In stark contrast to this, he also described the benefit of having a non-Armenian provider as a form of safety towards maintaining confidentiality within the Armenian-American community. This dialectic of wanting one's Armenian identity to be acknowledged yet to remain anonymous poses as a barrier for Armenian-American males who would like to seek an Armenian mental health clinician. Armenian-American males with similar views as Narek may shy away from utilizing available non-Armenian providers based on the perceived expectations of not being understood on a cultural level and thus posing a barrier to the utilization of mental health services.

The theme of gender views emerged with two sub-themes, being male and gender expectations. Gender views refer to the individual's ideas of male and female roles within their cultural gendered experiences. This theme captured participants' perspectives on the impact that

one's mental health issues have on culturally held gender roles and expectations for both males and females, thus leading to potential disruption in social status and reputation. Gender roles are routinely expressed throughout the Armenian culture. In this culture, women are deemed as the glue that holds their family unit together. In Armenian symbolism, 'Mother Armenia' is a statue standing over the Armenian capital of Yerevan who is representative of peace through strength (Suciu, 2018).

The concept of 'being male' emerged as a noticeable sub-theme and varied amongst participant responses when pertaining to notions of masculinity. Several participants expressed the perceived gender role of the Armenian male as possessing stereotypical traits of masculinity, such as physical toughness and strength. These descriptions of males within the Armenian community may be reflective of their experience within both Soviet-Armenia and post-Soviet Armenia, where sports such as Olympic weightlifting and wrestling are domains that Armenian males have historically excelled in (Krawietz, 2016).

Participants illustrated the differences in community responses to Armenian males vs. Armenian females experiencing mental health issues. Within the Latinx culture, gender stereotypes, such as 'machismo' for males, and 'marianismo' for females, are used to describe how males and females are expected to fulfill their gender roles (Valencia-Garcia et al., 2008). This perceived loss of one's 'manhood' within the Armenian-American community has parallels to males within the Latinx community (Valencia-Garcia et al., 2008). Suren's belief of males within the Armenian-American community who experience mental health illness as possessing more traditionally stereotyped 'feminine traits' is reflective of this perceived loss of one's 'manhood' (Valencia-Garcia et al., 2008). Additionally, Armenian males are raised with familial expectations of developing into representatives of the family 'tribe,' thus one's desire to protect

of their family reputation may lead to avoidance of fulfilling personal needs, such as mental health services (Dagirmanjian, 1996).

Several participants shared their held gendered perceptions within the Armenian-American community of women with mental health illnesses as being labeled with characterological traits, such as crazy, weird, and odd. Saro shared his view that while males and females are both treated differently due to their mental health issues, males appear to be provided by community members with external causes for their mental health issues, such as alcohol and substance use. Women, however, are often deemed as having an internal cause such as a characterological flaw. In order to maintain the masculine gender roles, several participants described the importance of minimizing their mental health symptoms to appear 'presentable' to potential mates. This threat of losing one's ability to be seen as a potential mate, due to the stigma of mental illness, may potentially lead to the avoidance of utilizing mental health services to limit social repercussions. Additionally, several participants described the experience of Armenian females undergoing mental health issues as being more stigmatic than for Armenian males. Participants shared their belief that women were less likely to receive community support and would be deemed as characterologically flawed as a result of their mental health issues. Conversely, several participants had identified Armenian males as experiencing increased stigma in comparison to their female counterparts. These participants shared that males with mental health issues experience a noticeable reduction in community support. Overall while responses varied, all participants acknowledged that mental health stigma exists for Armenian-American males and females.

The theme moving forward to decrease stigma was chosen to capture participants' beliefs of future barriers and changes needed to decrease mental health stigma within the Armenian

community. Most participants in this study acknowledged the potential for decreasing mental health stigma for Armenian-American males within the Armenian community. Suren acknowledged his experience with mental health stigma while sharing his skepticism of the need for change within the Armenian community. Suren described the factors that promote stigma within the Armenian community, such as males portraying toughness and not adding shame to his culture, while sharing his desire for not wanting to change cultural components based on 'outliers', such as himself, who have experienced mental health issues. Vahe shared his belief that change needs to occur both within and outside of the Armenian-American community.

Participants shared various responses to their beliefs on the need for change, in regard to mental health stigma within the Armenian-American community, yet all participants were able to acknowledge routes to spark progress in the reduction of mental health stigma. These opportunities to decrease mental health stigma within the community, according to participant responses, included: acculturation and assimilation into a westernized culture, psychoeducation via education and media platforms, collaboration with Armenian community pillars, such as the church and various other organizations, Armenian-American mental health outreach services, and normalization of mental health via exposure and conversations with those experiencing mental health issues.

According to Ciftci et al. (2012), stigma causes those who experience mental health illnesses to be commonly ineligible from complete acceptance by their social communities. This ineligibility created through stigma led to several participants describing their intentional isolation from Armenian peers in order to avoid both direct and indirect rejection. As discussed in Rao & Valencia-Garcia (2014), the influence of mental health stigma on one's membership status within a collectivistic community, such as the Armenian community, poses a risk of an

alteration in social status. Members within the Armenian community, such as Narek, may either avoid or delay mental health treatment to protect their social position within the Armenian-American community. Within that community, as has been found in Latinx communities, the risk of social ostracizing and isolation from familial and community members may follow (Rao & Valencia-Garcia, 2014). While attempting to appease family and peers with participation in Armenian events, participants such as Suren described their need for wearing a social mask to cover internal struggles.

This study revealed the lack of psychoeducation and confusion with regards to navigating the mental health system by Armenian-American males. In studies conducted by Ayvazian (2008) and Yesayan (2014) exploring mental health service-seeking for Armenian-American women, their findings revealed similar behaviors and beliefs that led to the lack of use and avoidance of mental health services. Factors that have shown to contribute to mental health service-seeking and utilization within the female Armenian-American community have included: psychoeducation, awareness, and knowledge of others using mental health services (Yesayan, 2014). The factors contributing to Armenian-American female utilization of mental health services found in Yesayan (2014) parallel participant responses in this study.

A frequent discussion brought forth by participants was the influence of acculturation and assimilation into the dominant American culture. Most participants discussed that the greater a connection an Armenian has to the American culture, the more accepting of mental health illnesses they tended to be. Armenian-Americans who have acculturated into the dominant American culture have shown to be more receptive to the concept of receiving mental health services when compared to those who have yet to acculturate (Gevorkyan, 2013). Participants, such as Vahe, shared his belief that the progressive culture of America differed from the more

'traditional' Armenian culture. Most participants were able to acknowledge the connection between acculturation and assimilation into the American culture as constituting significant factors for the future potential in decreasing mental health stigma for Armenian-American males.

Through exposure to those with mental health struggles, participants such as Narek and Hagop displayed a sense of optimism that the mysticism and irrational fears held by members of the Armenian community towards those who are labeled as mentally ill will eventually decrease. Echoing responses of participants Hagop and Narek in this study, research by Ayvazian (2008) identified Armenian-American females who have been exposed to fellow community members who have mental health issues are more likely to hold less stigma in their views in the seeking of mental health services. Previous research has found through exposure to peers with mental health struggles, members of this community are expected to increase the normalization of mental health service-seeking behaviors due to an enhancement in familiarity (Ayvazian, 2008).

With the Armenian people having a history marked with suffering, (e.g. the 1915 Armenian Genocide, the 1975 Lebanese Civil War, the 1988 Armenian Earthquake, 1991 Fall of the Soviet Union, the 2011 Syrian Civil War, etc.), most, if not all participants had either a direct or indirect connection to various historical traumas endured within the past several generations. Participants, such as Suren, disclosed their internal conflict and sense of guilt in seeking mental health services when comparing themselves to ancestors who perished and those who survived in these modern-day calamities. Suren expressed what can be categorized as guilt when he compared his personal struggles to the life and death struggles of his ancestors.

Lastly, external factors, such as the cost of therapy and ensuring confidentiality, served as therapeutic qualities sought out by participants. Both Vahe and Suren listed the cost of therapy

as leading to the delay in seeking mental health services. Furthermore, several participants shared that they sought their university counseling centers for mental health services. The university counseling center serves as an opportunity for individuals to avail themselves of mental health services for minimal cost and without the involvement of family members. This ability to be independent when accessing health services provided them with the opportunity to keep their mental health issues private or contained from family and their cultural community.

Implications for Clinical Practice

With the Armenian community making up less than 1% of the United States population, it is no surprise that clinicians may be unfamiliar with its culture. Often under-represented by the media and various outlets, Armenians, such as Narek and Hagop, share a belief of being misunderstood and of being judged by therapists for their cultural beliefs and practices. This feeling of being unable to relate with mental health professionals serves as a barrier to Armenian-American males reaching out and utilizing mental health services.

Clinicians are encouraged to allow space for Armenian-American males to express their cultural values and beliefs in sessions by using a culturally sensitive approach to psychotherapy. The use of a culturally sensitive approach to psychotherapy places a priority on the client's multi-layered background, such as culture and ethnicity, etc. (Barnett & Bivings, 2002). This approach allows space for the clinician to identify how their own values and beliefs may influence their relationship to their client's values and beliefs as well as how these difference may influence the therapeutic experience (Barenett & Bivings, 2002). Eron & Lund (1993) suggested that issues in therapy tend to arise when the client's views of self are not acknowledged by their clinician. The use of a culturally sensitive approaches to psychotherapy may serve as an opportunity for Armenian-American men to feel heard and understood through

their viewpoint via validation of their multi-layered backgrounds. For example, the ecological model may be one model to use when implementing a culturally sensitive approach to psychotherapy (American Psychological Association, 2017). The ecological model prioritizes the clinician's ability to recognize their client's multi-layered background (American Psychological Association, 2017). This emphasis on the clinician's practice of cultural competency would benefit Armenian-American clients who hold various identities.

Lastly, the client's family involvement may serve as the 'third party' in the room which contributes to the client's decision-making process. Being able to respect the client's family values and wishes while looking after the best interest of the client is important to create balance in the session.

Limitations and Implications for Future Research

This study was limited to the San Francisco Bay Area. Future studies would benefit from expanding the geographical population of participants interviewed to various Armenian communities throughout the United States. While there is an Armenian community within the San Francisco Bay Area, both Central and Southern California house large Armenian communities **(**Fittante, 2017**)**. Cities such as Fresno in the California Central Valley is home to approximately 10,000 Armenian-Americans, while in Southern California, locations such as the San Fernando Valley, within Los Angeles County, is home to approximately 215,000 Armenian-Americans (Fittante, 2017). With various identities existing within the Armenian-American community, such as place of birth, familial history, political and religious affiliation, socio-economic status, acculturation level, sexual orientation, and educational attainment, future studies would benefit from targeting participants with similar backgrounds. Generally speaking,

more diverse demographics may have helped elucidate both more generalizable themes and demographic themes and demographic sub-themes.

As an active member within the Armenian-American community, the researcher's personal involvement may have influenced decisions for potential participants to either contribute to or reject involvement in this study. Additionally, the researcher's familiarity with the San Francisco Bay Area's Armenian community may have allowed for participants to feel a sense of personal connection to the success of this study, while conversely may have also provided wariness amongst potential contributors due to concerns of confidentiality within this small community.

Lastly, the researcher in this study was provided with a unique opportunity to find shared experiences with most of the participants. With the ability to identify with most participants, efforts were made through consultation with the dissertation chair as well as a personal reflection to reduce the influence of personal beliefs and perceptions when coding participants' responses. While attempting to remain objective, this researcher was mindful of the inevitable subjectivity that might exist within this study.

Conclusions

This study aimed to examine the role stigma played in Armenian-American male's lived experiences and their decisions to utilize mental health services and found that perceived stigma emanating from the Armenian community served as a common deterrent to seeking mental health services. Furthermore, the role of felt stigma appeared to serve as a significant barrier. Negative views of self and cognitive distortions were seen to influence participants' decisions to pursue mental health services. Although growth has occurred in the research of Armenian-American mental health, research targeting males remains scarce. The aspiration for this study is

to serve as a tool for future researchers aiming to assist in the de-stigmatization of mental health issues for males within the Armenian-American community by providing a glimpse of insight to the barriers, such as stigma, that influence one's decision to seeking-services for a mental health issue.

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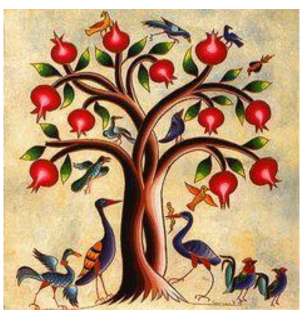
Appendix A: Recruitment Flyer

ATTENTION ARMENIAN MALES

- **Are you 18 years of age or older?**
- **Are you of Armenian descent?**
- **Have you seen a mental health professional?**
- **Do you live in or around the San Francisco Bay area?**

WE NEED YOU!

Your input is needed on a psychological study examining mental health issues among the Armenian community.



Receive $35 for your participation.

Call Anthony Saroyan at
(310) 971-XXXX
or e-mail us at
HyeHealth360@gmail.com

This research study will be conducted at the University of San Francisco.

Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com	Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com	Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com	Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com	Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com	Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com	Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com	Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com	Hye Health Study at USF (310) 971-XXXX HyeHealth360@gmail.com

Appendix B: Recruitment Consent Script

Hye Health Study

Hello, my name is Anthony Mampre Saroyan and I am a Health Service Psychology Doctoral Student from the University of San Francisco in the School of Nursing and Health Professions. I am conducting a research study on the experiences of stigma connected to mental health service seeking, among Armenian-American men. I, Anthony M. Saroyan, will be the Principal Investigator of this study. Dr. Dellanira Garcia, an Assistant Professor and licensed Clinical Psychologist in the School of Nursing and Health Professions, is serving as the committee chair overseeing this research study.

In the study you, as the participant, will be asked to discuss any experiences related to being treated differently because of any mental-health struggles. The one-time, in-person interview will take no longer than 90 minutes to complete and you will be offered a cash compensation of $35 for your time and participation. You will correspond via phone with me prior to the interview for the purpose of eligibility screening and scheduling the interview. Your participation in this research is voluntary and if you decide to participate in the study, you may withdraw your consent and stop participation at any time without penalty.

To assure your confidentiality, we will ask you to choose a pseudonym at the beginning of the study to protect your identity. When we report and share the data with others, we will combine all the data from all participants and will not identify anyone by their true name at any time. There are no known risks or direct benefits to you, but you may gain more insight into your own experiences or perhaps think more critically about stigma. In addition, we hope the results of this study will help mental health care providers develop better anti-stigma strategies to reach members of your community seeking services.

If you are interested in participating in the study, please contact Anthony M. Saroyan via e-mail HyeHealth360@gmail.com or phone (310) 971-1456. We can schedule a meeting according to your availability.

Appendix C: Participant Screener Form

(in-person and phone)

About the Study:

- This study will help us understand access to mental health services for Armenian-American men.
- In-person, individually audio-recorded interview.
- Topics discussed are views and experiences related to mental health, access to health care services, and connections w/in the Armenian-American community.
- You will be offered $35 cash at the end of the discussion for your participation and time.

Would you like to see if you are eligible to participate?

If Yes -> Ask eligibility questions

If No -> Thank them for their time and end the interaction

Eligibility Questions:

Today's Date: _____Screener's Initials: _____ Recruitment Location: _____

1. How old are you? [If under 18 years old: INELIGIBLE]
   - Age_____
2. Are you fluent in English? [If NO: INELIGIBLE]
   - Yes
   - No
3. Do you identify as an Armenian-American? [If NO: INELIGIBLE]
   Which parent(s) are of Armenian descent? [If NONE: INELIGIBLE]
   - Mother
   - Father
   - Both
   - Neither/None
4. Do you have a history of or current mental health issue? [If NO: INELIGIBLE]
   - Yes
   - No
5. Have you ever received or sought any type of mental health services? [If NO: INELIGIBLE]
   - Yes
   - No

   If Yes, what type of setting did you receive mental health services at?

- Hospital
- Private-practice
- Community Clinic
- University Counseling Center
- Other: _____

6. Have you had an experience where you were treated differently or seen as different because of your mental health condition? [If NO: INELIGIBLE]
   - Yes
   - No
7. What city do you currently live in? [If outside greater San Francisco Bay Area: INELIGIBLE]
   - _____

☐ **Eligible**	☐ **Ineligible**

If ELIGIBLE → You are eligible to participate in this study. Your participation in this study is very important to us. Proceed to scheduling of in-person interview.
If INELIGIBLE → Thank you for your time. Unfortunately, you are not eligible to participate in this study.

Appendix D: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.

You have been asked to participate in a research study entitled The Role of Stigma on Mental Health Service-Seeking Among Armenian-American Men.

This study will be conducted by Anthony Saroyan, a graduate student in the School of Nursing and Health Professions at the University of San Francisco (USF). The faculty supervisor for this study is Dr. Dellanira Garcia, PhD, an assistant professor in the School of Nursing and Health Professions at the University of San Francisco.

WHAT THE STUDY IS ABOUT:

The purpose of this study is to explore the lived experiences of mental health stigma (i.e., being seen or treated differently because of mental health issues) for Armenian-American men.

WHAT WE WILL ASK YOU TO DO:

During this study, you will be asked to talk about your own mental health; share your thoughts and experiences you may have had of being treated different because of your mental health struggles; and discuss your decisions to seek help for mental health struggles.

DURATION AND LOCATION OF THE STUDY:

Your participation in this study will involve one session that lasts no longer than 90 minutes. The study will take place in a private room at one of the USF campuses based upon your availability and location. The following locations include:

- **The University of San Francisco, Hilltop Campus** 2130 Fulton St, San Francisco, CA 94117
- **The University of San Francisco, Presidio Campus** 920 Mason St, San Francisco, CA 94129

- **The University of San Francisco, Downtown San Francisco Campus** 101 Howard St., San Francisco, 94105
- **The University of San Francisco, Sacramento Campus** 1 Capitol Mall, Sacramento, CA 95814
- **The University of San Francisco, San Jose Campus** 125 S Market St., San Jose, 95113
- **The University of San Francisco, Santa Rosa Campus** 416 B St., Santa Rosa, CA 95401
- **The University of San Francisco, Pleasanton Campus** 6120 Stoneridge Mall Rd. #150, Pleasanton, CA 94588

POTENTIAL RISKS AND DISCOMFORTS:

The research procedures described above may involve minimal potential discomfort in discussing some issues while you participate in this study. There are no anticipated risks to you that are greater than those encountered in everyday life. The issues discussed during this interview have each been selected by the researcher and his dissertation committee to minimize the potential for psychological discomfort. Due to the nature of this research topic, you potentially may encounter intrusive memories or thoughts while responding to questions. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

BENIFITS:

You will receive no direct benefit from your participation in this study; however, the possible benefits to others include increased cultural awareness and insight for mental health professionals who provide services to Armenian-American men.

PRIVACY/CONFIDENTIALITY:

Any data you provide in this study will be kept confidential unless disclosure is required by law. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. Specifically, we will keep private all research records that identify you, to the extent allowed by law.

For this study, the researcher will ask you to select a pseudonym so that the only place your name will appear in our records is on the consent form and in our data spreadsheet, which links your name to a pseudonym and your data. The only exceptions to this are if we are asked to share the research files for audit purposes with the USF Institutional Review Board ethics committee, if necessary.

The researcher has created a new email account for the sole purpose of this research. This email account will be used to communicate with participants and will be deactivated following the completion of this study.

The researcher will utilize a recording device to capture the responses of the participants. The recordings of this session will be kept in a locked cabinet at the University of San Francisco. Participant's names will not appear in the transcribed records of this study.

Certain people may need to see the study records. The only person(s) who will have access to see these records are: the study staff, and the USF Institutional review board, and its staff.

The researcher will inform the participants that the study may be published. If published, identifying information will not be available in reports, manuscripts, or presentations.

The researcher will destroy confidential information, such as the participant's emails, phone number, audio recordings, and other personal information provided within 1 years following the completion of this study.

COMPENSATION/PAYMENT FOR PARTICIPATION:

You will receive a cash compensation of $35 for your participation in this study, following the completion of the interview. If you choose to withdraw before completing the study, you will receive no monetary compensation.

VOLUNTARY NATURE OF THE STUDY:

Your participation is voluntary and you may refuse to participate without penalty or loss of benefits. Furthermore, you may skip any questions or tasks that make you uncomfortable and may discontinue your participation at any time without penalty or loss of benefits. In addition, the researcher has the right to withdraw you from participation in the study at any time.

OFFER TO ANSWER QUESTIONS:

Please ask any questions you have now. If you have questions later, you should contact the principal investigator: Anthony Saroyan at (310) 971-XXXX or AnthonySaroyanDissertation@gmail.com. You may also reach the faculty sponsor of this study, Dr. Dellanira Garcia, at dgarcia12@usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu.

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.

_____

PARTICIPANT'S SIGNATURE *DATE*

Appendix E: Interview Guide

Hye Health Study

By: Anthony M. Saroyan

Script:

I will be asking you a series of questions regarding your experience with mental health. There are no right or wrong answers. The right answer is the one that comes from your experience. I may be stopping you at times to ask follow-up questions or redirect you back to the original question. If at any time you feel uncomfortable answering a specific question, please do not hesitate to inform me, and we will move onto the following question. If at any time you decide to discontinue the interview, please inform me and I will immediately halt the interview. Do you have any questions or concerns before we continue?

Interview Questions

1. Why did you choose to participate in this project?
2. Can you tell me of a time where you felt that you were treated differently or negatively by other people you know because of your mental health issue?

    Follow-up: Why do you think you were treated differently or negatively by other people you know?
    Probe: were the "other people" from within your community or people from outside of your community?
3. What were the events that led you to seek your first experience with mental health services?

    Follow-up: What was the experience like for you to seek your first mental health services?
    Follow-up: How old were you the first time when you decided to seek mental health services? What impressions did this experience have on you?
    Probe: did you see an Armenian provider?

4. What qualities do you consider when seeking help from mental health professionals?
5. Describe your overall experiences with mental health professionals?

    Follow-up: Please explain further.

Follow-up: In what context did you receive services in?

Read: The interview is shifting here. Now I would like to ask you questions related to your experience with mental health within the Armenian culture.

6. In your experience, how does the Armenian culture view mental health issues or problems?

   Follow-up: Why do you believe that mental health issues are viewed in this way?

7. Has your Armenian cultural background impacted your decision to seek mental health support?

   Follow-up: In what ways has your Armenian cultural background impacted your decision to seek mental health support?

8. To what extent have you shared your mental health issues with your family?

   Follow-up: What have you shared with your family?

   Follow-up: Why have you not shared with your family?

   Follow-up: How did they respond?

9. How have your Armenian-American peers responded to your mental health experience(s)?

Read: Thank you for sharing your experiences. Next, I would like to ask you some questions regarding to your view of mental health issues within the Armenian community.

10. How do Armenian-Americans view males that have mental health issues or problems?

    Follow-up: How do they view females with mental health issues or problems?

11. Has your mental health issue or problem impacted your involvement within the Armenian-American community?

    In what ways has your involvement within the Armenian-American community been impacted?

12. Do you believe that mental health perceptions of men experiencing mental health issues in the Armenian-American community can improve?

Follow-up: If yes, in what ways?

Follow-up: If no, what would need to change for this to occur?

Read: At this time, the interview has concluded. Do you have any questions that you would like to be addressed before we end our meeting together? And, is there anything else that you would like to add about what we have discussed today?

Thank you for taking the time to participate in this research study. If you have any questions or concerns, please contact me at the email or phone number listed on your copy of the consent form.

Appendix F: Tables

Table 1*: Participant Demographics*

Age	Ethnicity	Pseudonym	Mental Health Issue
30	Full Armenian	Hagop	Anxiety
30	Full Armenian	Suren	Adjustment Disorder/Anxiety
23	Half Armenian	Antranik	Depression
23	Full Armenian	Narek	Anxiety
24	Full Armenian	Saro	Substance Use/Anxiety
54	Half Armenian	Vahe	Anxiety

Table 2: *Themes and Sub-Themes*

Theme 1: Stigma
Subtheme 1: Enacted Stigma
Subtheme 2: Felt Stigma
Subtheme 3: Disclosure
Theme 2: Mental Health Treatment
Subtheme 1: Initial Exposure
Subtheme 2: Therapeutic Qualities
Subtheme 3: Therapeutic Experience
Theme 3: Gender Views
Subtheme 1: 'Being Male'
Subtheme 2: Gender Expectations
Theme 4: Moving Forward to Decrease Stigma
Subtheme 1: Pessimism for the Future
Subtheme 2: Necessary Steps for Change

Table 3: *Definitions of Themes and Sub-themes*

Stigma Theme 1	refers to a participant's experience of being treated differently as a result of their mental health issue(s) as perceived by others.
Enacted Stigma Theme 1: Sub-theme 1	refers to the participant's experience of receiving unfair treatment by others, both overtly and covertly; or being treated differently based on other's perception of their mental health issues.
Felt Stigma Theme 1: Sub-theme 2	refers to the participant's feelings of shame and discrimination; the expectation that others will treat them differently/discriminatory which may prevent and/or impact the individual from vocalizing their mental health experiences.
Disclosure Theme 1: Sub-theme 3	refers to whom the participants have and have not voluntarily shared their mental health issues/concerns with.
Mental Health Treatment Theme 2	explores the experiences of the participant's utilization of mental health services and barriers to care.
Initial Exposure Theme 2: Sub-theme 1	refers to first encounter experiences with mental health services.
Therapeutic Qualities Theme 2: Sub-theme 2	refers to clinicians' traits both beneficial and detrimental to the participant's perception of treatment and/or preferences.
Therapeutic Experiences Theme 2: Sub-theme 3	refers to the participant's reflection of potential benefits or drawbacks after receiving mental health services.
Gender Views Theme 3	refers to the participant's ideas of male and female roles from their cultural gendered experiences and perspectives.
Being Male Theme 3: Sub-theme 1	refers to the roles and expectations of masculinity within the Armenian-American community.

Gender Expectations Theme 3: Sub-theme 2	refers to the perceived social differences in mental health experiences between males and females. In addition, gender expectations refer to the perceived culturally appropriate roles for men and women.
Moving Forward to Decrease Stigma Theme 4	refers to the participant's expectations for the future of Armenian-Americans who experience mental health stigma.
Pessimism for the Future Theme 4: Sub-theme 1	refers to the participant's low expectations of a decrease in mental health stigma within the Armenian-American community.
Necessary Steps for Change Theme 4: Sub-theme 2	refers to the participant's belief of what is required to decrease mental health stigma within the Armenian community.