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Culture of Honor and intentions to seek mental health support: The mediating role of self-construal, reputation and mental health stigma in Italy

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Master in Psychology of Intercultural Relations

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To my mum,

a woman who had the courage to fight against the cultural ideology of her community.

Thanks to you I'm here today.

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Resumo

A cultura de honra tem sido consistentemente estudada em relação à violência. Recentemente, um novo corpo de pesquisa expandiu o foco para saúde mental, mostrando que a valorização da honra está relacionada com menor utilização de recursos de saúde mental devido a preocupações de que o estigma associado a buscar ajuda para a saúde mental reflete negativamente na própria reputação. Para dar continuidade a essa linha de pesquisa, nosso objetivo é replicar a relação entre preocupações de honra e intenções de buscar ajuda para saúde mental devido à preocupação com a reputação. Além disso, incluímos um novo mediador, o autoconceito, para examinar o impacto de variações interculturais no autoconceito na relação entre a promoção de uma cultura de honra e as intenções de buscar apoio para a saúde mental. Ao investigar essas ligações, podem adquirir uma melhor compreensão de como as diferenças individuais no autoconceito dentro das culturas de honra influenciam atitudes e ações relacionadas ao apoio à saúde mental. Um total de 143 italianos completaram um questionário online que abordou nossas hipóteses. Os resultados confirmaram que a promoção de crenças na cultura de honra se relacionou com menor intenção de buscar ajuda, corroborando estudos prévios. No entanto, a mediação em série foi apenas parcialmente confirmada. Houve um efeito indireto significativo e negativo através do estigma da saúde mental, mas não através do autoconceito. Este estudo fornece novas perspectivas sobre o problema da saúde mental relacionada à cultura de honra e contribui para a análise do fenômeno no contexto italiano.

Palavras-chave: Cultura de Honra; Autoconceitos; Saúde Mental; Estigma; Busca de Ajuda; Sociedades Mediterrâneas;

Abstract

Culture of Honor has been consistently studied in relation to violence. Recently, a new body of research has expanded the focus to mental health issues, showing that honor endorsement is related to lower utilization of mental health resources due to social concerns that the stigma of seeking mental health help reflects poorly on one's reputation. To build upon this line of research, the aim of this study is to replicate whether honor concerns are related to mental health help-seeking intentions due to reputation concerns. Furthermore, we included a new mediator, self-construal, to examine the potential impact of intracultural variations in self-construal on the relationship between the endorsement of a culture of honor and intentions to seek mental health support. By investigating these links, we can acquire a better understanding of how individual differences in self-construal within honor cultures influence attitudes and actions linked to mental health support-seeking. A total of 143 Italians completed an online questionnaire that addressed our hypotheses. The results show that culture of honor beliefs endorsement was associated with lower levels of help-seeking intentions, which was in line with previous research. However, a serial mediation was only partially confirmed. There was a significant indirect effect for the mediator of mental health stigma, but not for the mediator self-construal. This study provides new insights into the social problem of poor mental health related to the culture of honor and, therefore, contributes to the analysis of the phenomenon in the Italian context.

Keywords: Culture of Honor; Self-Construals; Mental Health; Stigma; Help Seeking; Mediterranean Societies;

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Glossary of Acronyms

CI	Confidential Interval
CoH	Culture of Honor
H1	Hypothesis 1
H2a	Hypothesis 2a
H2b	Hypothesis 2b
HS16	Honor Concerns - Short Scale
HS16FAM	Honor Concerns - Short Scale, Family honor
HS16FEM	Honor Concerns - Short Scale, Feminine honor
HS16MASC	Honor Concerns - Short Scale, Masculine honor
HS16SOC	Honor Concerns - Short Scale, Social honor
IoSIS	Importance of Social Image Scale
ISTAT	Italian National Institute of Statistics
MHSIS	Mental Help Seeking Intention Scale
NSCS	The New Self-Construal Scale
NSCS1d	The New Self-Construal Scale - 1st dimension: Difference versus similarity
NSCS2d	The New Self-Construal Scale - 2nd dimension: Self-containment versus connection to others
NSCS3d	The New Self-Construal Scale - 3rd dimension: Self-direction versus receptiveness to influence
NSCS4d	The New Self-Construal Scale - 4th dimension: Self-reliance versus dependence on others
NSCS5d	The New Self-Construal Scale - 5th dimension: Consistency versus variability
NSCS6d	The New Self-Construal Scale - 6th dimension: Self-expression versus harmony
NSCS7d	The New Self-Construal Scale - 7th dimension: Self-interest versus commitment to others
PSOSH	Perceptions of Stigmatization by Others for Seeking Help
SE	Standard Error
SSRPH	Stigma Scale for Receiving Psychological Help

CHAPTER 1.

Introduction

According to Istat (Italian National Institute of Statistics) psychological well-being in Italy has declined among young people and adults in the last two decades, with depression as the most common mental disorder: they exceed 2.8 million (5.4% of people aged 15 and over) those who have suffered from it during 2015 and 1.3 million (2.5%) are those who presented with symptoms of major depression in the two weeks preceding the interview (2018). Suicides in Italy have consistently decreased since the mid-1990s, although there was a considerable spike between 2007 and 2013, corresponding with the country's financial crisis (Mattei & Pistoresi, 2019).

Different studies and reports have shown that mental healthcare resources and services are regulated by different institutions around the Country, encompassing both private and public. Furthermore, these services are generally governed at the regional level. Consequently, the data regarding patient demographics and the services offered by each institution exhibit considerable variations. This fragmented and heterogeneous data framework makes it challenging to properly understand and address mental health issues at a societal level.

Moreover, the most widely provided services are pharmacological, nursing, psychiatric, and rehabilitation, but not of a psychological/psychotherapeutic type (Mental Health Information System, 2016). With regard to help-seeking attitudes, so far only a few Italian studies have been conducted, however not including any cultural psychological perspective, to better indicate factors that can be implied in help-seeking attitudes, intentions and behaviors.

In this context, cultural theories can be used to help build a bridge between academics and professional providers to create more culturally sensitive interventions, by considering the complex interplay between society and patient-centredness which could also be translated to other populations.

Promising cultural theories in this context are the cultural construct of honor and Self-construal. The concept of Culture of honor appeared in Social psychological research in the 1990s thanks to the work of Nisbett and Cohen (1996). Their studies on anger and aggression in defense of male honor in the Southern United States shaped the definition of the “Culture of honor” as a complex set of beliefs, attitudes, and norms about the importance of personal reputation (1996). Today, most social psychological research on honor originates from the United States and focuses primarily on domestic violence and male honor. However, Uskul (2019) emphasizes that within a

single cultural group, there are numerous forms of honor cultures that can be distinguished by variables such as national, ethnic, or religious affiliation. The concept of honor can develop in various ways and be associated with various behaviors and consequences within the same culture. Some people identify honor with physical bravery, while others value family reputation. This variation can result in varied honor-related behaviors and consequences, depending on how individuals within the group prioritize and comprehend the notion of honor. Understanding these distinctions is critical for scholars and policymakers interested in honor and its impact on actions and social dynamics within specific cultural contexts. (Gul, Cross and Uskul, 2021)

Considering the implications of these findings, recent work on this topic has sought to examine the relationship between honor concerns and mental health attitudes and behaviors (i.e. mental health stigma and intentions to seek mental health support). A cultural perspective helps to situate and define both health and illness in a cultural context, how to treat health problems and what motivates people to seek help for them. Previous research showed that honor endorsement is related to lower utilization of mental health resources due to social concerns that the stigma of seeking mental health help will reflect poorly on one's reputation (Brown, Imura, Mayeux, 2014; Foster, Carvallo, Lee, Bernier, 2020).

Because Culture of honor is strongly connected to the self-image and the social image, it appears important to take into consideration the stigma, a sort of "second disease" that lasts a long time, even when the mental disorder is cured, portraying the mental illness as unpredictable, dangerous, incurable. It makes it more difficult for people to look for help, to recover and to be accepted in work, emotional and social contexts. People with mental health problems can internalize the social stigma related to their illness (Carozza, 2021). Different researchers have used the beliefs and values of honor cultures, that have initially been linked to aggression and violence (Nisbett & Cohen, 1996) to explain the stigmatization of mental health (Brown, 2014; Foster, 2020), demonstrating that people who hold honor-related beliefs and values more strongly showed concerns about the use of mental health services, which rotate around the fear of being (and being seen as) weak, inadequate, and unlikable (Brown, 2014).

When researchers unpackage culture (i.e. test the cultural ingredient directly via a psychological variable that is hypothesized to explain the effect of the cultural variable on the outcome variable; Smith et al .), they usually study self-construals which refers to the way individuals define and understand themselves in relation to others (e.g., Singelis, 1994). However, to the best of our knowledge, self-construals have not been studied yet within the same group and in association with the construct of culture of honor. There have been mostly comparative studies between different types of culture, such as honor, face and dignity cultures (Aslani and colleagues,

2016; Smith and colleagues, 2021). However, recently, a study has tried to represent the Mediterranean region, providing nuanced insights into the patterns of independence and interdependence observed among individuals living in this region in comparison to individuals from the Anglo-Western and East Asian regions (Uskul and colleagues, 2023).

Hence, it appeared interesting to investigate forms of selfhood and its connection to culture of honor. This can shed light on how the dynamics of honor cultures can influence how individuals perceive themselves and their roles within their cultural context, impacting their self-construals and consequently to explain behavioral intentions in the mental health domains, such as seeking mental health support.

In order to provide further support to Foster's (2020) recent findings on culture of honor concerns and intentions to seek mental health support, the present study has the aim to examine how culture of honor beliefs and values are related to the use of mental health services, incorporating not only measures of reputation concerns at an individual level, but also self-construals (Vignoles, 2016) as a mediator, therefore, leading to a better understanding about variation of cultural beliefs and norms at the individual level and how they are related to intentions to seek mental health support with a particular focus on the Italian cultural context which is highly relevant when it comes to mental health issues, but has not been studied yet.

Hence, this study can provide new insights into the social problem of poor mental health related to the culture of honor and, therefore, contributes to the analysis of the phenomenon in the Italian context, which has being subject of interest in terms of the anthropological perspective of Mediterranean honor (Pitt-Rivers, 1965) , but has not yet been studied from a social and cultural psychology perspective.

CHAPTER 2.

Theoretical Background

2.1 Culture of Honor

The development of Mediterranean anthropology in the 1960s was an important breakthrough in the research field of anthropology. This anthropological approach intended to investigate the various cultures, societies, and historical processes that have shaped the Mediterranean region. As previously stated, the name "Mediterranean" refers to the landlocked Sea itself, but it likewise encompasses geographic, ecological, political, economic, and cultural components. Gilmore (1987) emphasizes that, while these dimensions are significant, they are unable to define the Mediterranean notion on itself. Instead, it implies that true Mediterranean unity develops from the subtle interplay and convergence of all of these components. In other words, it is the simultaneous consideration of these geographic, ecological, political, economic, and cultural elements across time (diachronically) and at a specific point in time (synchronically) that allows for a comprehensive understanding of the Mediterranean as a distinct and complex construct. Considering the cultural dimension, social anthropologists started to explain the Mediterranean sense of identity using the terms of honor and shame, which play an important role in public life even today. Specifically, Pitt-Rivers (1965) introduced the expression “the value of a person in his own eyes, but also in the eyes of his society” to describe the Mediterranean honor, which is centered on the maintenance of a good reputation in general.

It was only in the 90s that the construct of honor emerged in social psychological research, thanks to the work of Nisbett and Cohen (1996). They attempted to understand the reasons for higher violence rates among men in the U.S. South compared with the U.S. North.

In their book "Culture of Honor: The Psychology of Violence in the South" (1996), they discuss how this phenomenon finds its roots in the historical trajectory of the Southern United States, characterized by a predominantly agrarian economy driven by the cultivation of commercial harvest, such as cotton and tobacco, during the 18th and 19th centuries. The region’s economy heavily relied on these resources, and the success of these cultures was directly related to the protection of property, including both land and enslaved individuals. Wealth in the South was primarily acquired through land and slaves, with the preservation of these assets being considered essential to economic growth. Furthermore, long into the nineteenth century, the United States South was also a frontier region with low population density, and the state had little power to command people to obey the law. As a result, individuals were incentivized to defend

themselves, their families, and their resources with toughness and aggressive retaliation rather than a penal code, giving rise to a culture in which honor became closely entwined with the safeguarding of economic interests. Individuals often believed that their worth was fragile and that it could be quickly taken away. Self-worth can be acquired through competition or aggressiveness, in which one might raise one's honor by taking that of another. Personal moral standards were strongly influenced by the expectations of the family and community in honor-based societies, and individuals who breach these standards shamed themselves and their families (Nisbett & Cohen, 1996).

Even since the Nisbett & Cohen manuscript (1996), numerous researchers have attempted to further conceptualize and operationalize culture of honor, mostly because several social mechanisms have preserved a culture of honor alive, namely interpersonal interaction patterns that result in unexpected displays of aggression in response to insults or affronts, social representations such as laws and media that condone honor-related violence, institutionalized non stigmatization of violence, and socialization processes in which boys and girls grow up learning forms of traditional masculinity and femininity that include honor-related norms (Gull, Cross and Uskul, 2021).

Among the most promising is Rodriguez Mosquera and colleagues' approach who have tried to better define the concept of honor using a multi-facet approach, describing honor as having four different facets, or honor codes: morality-based honor, family honor, masculine honor, and feminine honor (2002). Honor as virtue (moral integrity) emerged as the most valued facet of honor across cultures, regardless of the collectivistic or individualistic leanings of the culture. It focuses on the strengthening of social bonds and the maintenance of interpersonal harmony, such as generosity, honesty or hospitality, and implies wanting to live up to others' expectations (Rodriguez Mosquera et al., 2002b). The family honor is considered as a collective honor, for instance it implies an interdependence between the self-image and the social image. Interdependence is highly valued in Mediterranean cultures not only in the context of family relations, but also in the context of social relations outside the family (Gilmore, 1987).

Moreover, It is important to note that such honor cultures often exhibit gender-specific characteristics, exacerbating traditional gender roles, being highly patriarchal, subordinating women and exerting control over her sexuality (Glick, Sakalli-Ugurlu, Akbas, Metin, & Ceylan, 2015). Women are portrayed through male eyes as a threat, a symbol of disorder and chaos, therefore female chastity is central to maintaining their honor (Gilmore, 1987; Rodriguez Mosquera et al., 2002). The view of masculine honor can foster an environment in which violence

and aggressiveness are not only tolerated, but even expected to defend honor violations (Vandello et al., 2008).

When considering its application to the Italian context, a distinct gap emerges. Existing research on the culture of honor in Italy remains notably limited in scope, primarily focusing on male honor-related values, representing the current state of our knowledge (Travaglino and colleagues, 2014, 2015). Travaglino has examined the construct in criminal organizations, as the Camorra, in which morality is displayed by following 'the code of silence' (omertá), a way to use a masculine honor code of not disclosing details of the criminal organization and to encourage commitment to its activities. His studies are the first to link the ideology of masculine honor to social activism against criminal organizations. The main finding was that individuals who endorsed a masculine ideology expressed a more positive attitude toward criminal organizations (Travaglino et al., 2014).

The attributes of masculine honor, such as strength, physical courage, and the defense of one's group, and their consequences have been predominantly described, also because of the belief of the subordinative and passive role of the women. However, as Gilmore (1987) stated in the 80s when feminist studies are breaking this ground, for example considering the work of Cornelisen, (1976), women's networks in Italy form the structural core of neighborhoods, families are often female-dominated, and women, through gossip, maintain social control through the power of their tongues. Most of the psychological research on culture of honor has ignored its gendered aspect to date or the focus of studies has been uniquely the masculine honor. However, the multifaceted approach could bring new insights and a more systematic comprehension of the endorsement of honor codes and their consequences. Connected to the fact that most of the research conducted until now has the masculine honor as a focus of studies, the issues that have been primarily investigated are related to violence, considering physical aggressions, response to insults, endorsement of heightened risk taking in different settings, such as relations with intimate partner, the family, criminal organizations or the army (Rodriguez Mosquera, 2013; Lopez-Zafra & colleagues, 2020; Barnes, Brown and Michael Tamborski, 2012; Barnes, Brown & Osterman, 2012; IJzerman, Van Dijk & Gallucci, 2007). Yet, more recently a new research endeavor has moved to the sphere of mental health issues (Brown, 2011; Foster, 2020). However, research to date is still very limited in this area and produced only in the Us context (Brown, 2011; Brown, Imura and Mayeux, 2014; Foster, 2020).

2.2 Culture of Honor and Mental Health Stigma

Self-sufficiency and the impression of being tough and capable of caring for oneself in the face of difficulties are important features in honor cultures, particularly for men. As a result, when problems or emotional distress occur, members of honor communities may be hesitant to seek treatment. To do so may imply that the individual is weak, not adequate, and unable to care for himself/herself and family, causing harm to the individual's reputation (Gul, Cross, and Uskul, 2021).

Prior research has shown how culture of honor is associated not only with violence against others, but against the self as well. Osterman and Brown (2011) conducted three studies, in the United States, to see if cultures of honor might also promote values and expectations that could heighten suicide risk. Study 1 and 2, analyzing national data from 2004-2005, revealed suicide rates are noticeably higher in communities characterized by a Culture of Honor, even after controlling for a variety of potentially confounding variables (i.e. mean temperature, economic deprivation, and healthcare access). This relationship tended to be particularly strong in non-metropolitan areas. Additionally, in honor states, the increased suicide risk disproportionately affects White residents and less consistently affects Black citizens. These demographic disparities are consistent with previous research, which show that the historical Scotch-Irish roots of the United States' culture of honor play an important role in driving regional differences among White populations (Nisbett & Cohen, 1996). Furthermore, depression appeared to have a stronger correlation with suicide in honor states than in non-honor states. The combination of higher levels of depression, lower utilization of mental health services, and a stronger relationship between depression and suicide in honor states was described by the authors as a “perfect storm” of suicide risk factors associated with culture of honor status. In Study 3, individual-level data were examined to assess whether the state-level relationship between the culture of honor and depression holded true at the individual level. The study revealed that personal endorsement of honor beliefs and values was linked to self-reports of depression. This effect was consistent across both male and female participants, among European Americans and Hispanics. However, the association was less clear among non-White people. It is worth emphasizing that, while the association between self-reported honor endorsement and depression was statistically significant, it may have been underestimated due to members of honor cultures' reluctance to express feelings of weakness, worry, or emotional pain (Osterman and Brown, 2011). The authors have opened up a significant research direction by suggesting that it could be valuable to survey individuals who endorse honor-based ideologies to assess their expected personal distress and willingness to discuss problems, especially those that may or may not affect their reputation.

To build upon this line of research, in a series of three studies Brown and colleagues (2014) investigated more closely the hypothesis regarding the reluctance to seek help for mental health issues among people and in regions significantly influenced by honor-culture norms, in the US context. Study 1 demonstrated that individuals who strongly endorsed honor-related beliefs displayed heightened worries about seeking help for mental health issues, believing it would reflect personal weakness and jeopardize their reputation. Even after controlling for self-esteem, social desirability bias, and gender, this link remained significant. Moving to Study 2, it was found that honor states in the South and West dedicated fewer resources to mental healthcare than non-honor states in the North. This disparity in mental healthcare investment among honor states cannot be explained entirely to a greater, general shortage of healthcare resources, although some evidence of such a shortage was discovered. Extending the exploration of mental health-related concerns associated with honor values and actual behavior, Study 3 confirmed the findings of Study 1 by showing that children in honor states were less likely to receive mental health services in the previous year compared to non-honor states. This underutilization remained significant even when critical individual-level control variables such as religiosity, poverty, and insurance coverage were taken into account. Notably, the recognition of the need for such services did not exhibit significant regional variation, implying that a lack of access to mental health resources does not fully explain the underutilization of these services among parents living in honor states (Brown, Imura and Mayeux, 2014).

These studies, taken together, exposed a neglected impact of the honor ideology on psychological well-being at the individual, societal, and institutional levels. Hence, the aim of this study is to expand research in this area, examine the connection between Culture of Honor and Intentions to Seek for Mental Health Support at a 'micro level' in the Italian context. Therefore, the first hypothesis was stated in this way:

H1: Individuals who endorse Culture of Honor-related beliefs and values more strongly will show concerns about the intentions and use of Mental Health Services.

These studies constitute a significant initial stride in unveiling the association between mental health stigma, the use of mental health services and this cultural syndrome.

This association appears to make even more sense if we consider the characteristic of culture of honor societies and the different types of stigmas. According to Corrigan, Watson, and Barr (2006), the concepts of stigma tend to develop in a specific sequence: an individual first becomes aware of public stigma, which is referred to as perceived public stigma. Subsequently, they form personal attitudes (i.e., personal stigma) that may or may not correspond with their impressions of public stigma. Individuals then determine whether or not to internalize and apply these

stigmatizing attitudes to themselves, a process known as self-stigma. Stigma can be viewed as a "mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society" (WHO The World Health Report, 2001). As a result, it is not surprising that the link between honor-related beliefs and mental health stigma was explained using the idea that honor cultures value reputation as an important component of both individual and collective identities. As a result, seeking psychological support in such cultures might be considered a sign of weakness (Brown et al., 2014).

While Brown et al. (2014) examined the broad cross-cultural differences in mental health help-seeking, which primarily focused on comparing honor culture states with non-honor culture states in the U.S. , Foster (2020) narrowed its focus to the individual level within a Southern U.S sample of one-hundred and fifty-six participants. Their aim was to examine how personal variations in honor-related values are associated with mental health help-seeking intentions and to uncover the underlying psychological process, namely by incorporating a measure of reputation concerns and psychological help-seeking intentions, at the individual level. The results showed that apprehensions regarding one's reputation were a central driver behind the connection between the cultural concept of honor and the associated stigma surrounding seeking mental health assistance, validating the mechanism outlined by Brown et al. (2014). Moreover, the findings align with the idea that these factors contribute to a reduced willingness to seek psychological support at the individual level (Foster, 2020).

In line with Foster's suggestion (2020), the current study aims to replicate whether honor concerns are related to mental health help-seeking intentions due to reputation concerns, fear of social repercussions and mental health stigma, within a different ethnic group. As a result, we formulated one of our second hypothesis as follows:

H2a: The relation between Culture of Honor beliefs and seeking for mental health support is mediated by reputation concerns and mental health stigma belief.

2.3 Self-construal as a new Mediator

Over the last decades, scholars have increasingly embraced the study of cultural diversity, resulting among others in the development of the concept of self-construal and its operationalization. Markus and Kitayama coined the term "self-construal" in 1991, and it has since become an important concept in psychology, notably in the fields of self-related phenomena, social cognition, interpersonal relationships, and cultural psychology. In essence, self-construal refers to how people define and extract meaning from their own selves (Cross, 2011). While Markus and Kitayama established two fundamental self-construals, independent and interdependent, it's important to note that these are only a portion of the possible self-construal variations. Nonetheless, the term "self-construal" has become virtually synonymous with these two categories - independence and interdependence - thus describing it as a measure of how individuals understand themselves in relation to others (Cross, 2011).

The independent vision is prominently observed in most of American society, together with many Western European cultures. In order to attain the cultural objectives of independence, one first needs to recognize oneself as an individual whose behaviors are primarily guided and given meaning by one's own internal thoughts, feelings, and actions, rather than being heavily influenced by the thoughts, feelings, and acts of others. In contrast, the interdependent approach is dominant in Japanese culture, as well as other Asian countries. However, it is important to emphasize that the interdependent perspective is also embraced by African, Latin American, and many southern European cultures. Interdependence is seeing oneself as a part of a larger social community and recognizing that one's behavior is influenced, contingent on, and primarily structured by what the individual perceives as the thoughts, feelings, and behaviors of others in that relation. This perspective on the self and interpersonal interactions does not isolate the individual from their social setting, but rather promotes a stronger sense of connectedness while minimizing differences from others. In such settings, individuals are motivated to explore ways to harmonize with relevant others, fulfill and foster obligations, and, overall, become part of various interpersonal affiliations. (Markus and Kitayama, 1991).

To date, much of the research in this area has relied on self-report measurements using Likert-type scales. The Self-Construal Scale (SCS), established by Singelis in 1994, is a frequently used measure for assessing self-construal. The SCS is intended to provide separate scores for independent self-construal (IndSC) and interdependent self-construal (InterSC), in accordance with the hypothesis that these two self-construals are orthogonal dimensions rather than opposite ends of a single continuum (Singelis, 1994). However, researchers such as Vignoles and colleagues (2016) contend that the current model, which treats independence and interdependence

as unitary dimensions of individual differences, does not fully capture the original theoretical framework presented by Markus and Kitayama in 1991. They believe that this perspective has persisted due to a neglect of established principles in cross-cultural research methodology. Vignoles and colleagues (2016) have developed and tested a new, seven-dimensional model for self-reported ways of being independent or interdependent. Independence and interdependence, in their views, should be considered characteristics of the cultural contexts in which individuals are situated rather than fundamental characteristics of individuals. Different cultural systems may encourage people to think, feel, or behave independently or cooperatively, but the exact manner in which individuals fulfill these cultural expectations might differ greatly (2016).

According to this new perspective, independent and interdependent self-construals may not necessarily cluster together into unitary dimensions at the individual-level. Instead, they are projected to cluster together at the cultural level into a single bipolar dimension, expressing the larger spectrum of independence vs interdependence within a given society. Despite the emphasis on individual-level constructs that involve self-construal, it is critical to understand that social conceptions of selfhood influence individuals' perceptions of themselves. These social constructs are partially shared perceptions of oneself and one's relationships with others that are shaped and perpetuated through interactions and endeavors within certain cultural contexts (Vignoles, 2016). On an individual level, the seven dimensions are related to various perspectives on oneself and one's relationships with others. On the cultural level, however, they translate to normative cultural constructs of selfhood, which are most likely reinforced by cultural practices and institutions.

The following is a description of each of these seven dimensions, which contrasts a particular way of being independent with a particular way of being interdependent:

Component I: This component highlights the complexity of *self-reliance* against *dependence* by illustrating the contrast between valuing autonomy and the inclination for seeking help from others.

Component II: A difference emerges here between a sense of *self-containment*, in which one's enjoyment is isolated from the happiness of friends and family, and a strong *connection to others*, in which personal harm is felt when someone close is hurt.

Component III: This component shows the tension between wanting to be *distinctive* and wanting to *conform* and fit in with others, indicating the push and pull of self-identity within social circumstances.

Component IV: This component displays a willingness to *commit to others* over *self-interest*.

Component V: The emphasis here is on *consistency* throughout situations as opposed to adaptation and *variability* in response to varied contexts, demonstrating how individuals can see themselves as consistent or adaptable depending on their social environment.

Component VI: This component emphasizes the distinction between *self-directed decision-making* and *receptiveness to outside influence*. It addresses the tension between autonomy and sensitivity to the wishes of others.

Component VII: Finally, this component focuses on the preference for direct *self-expression* vs the necessity of group cohesion. It draws attention to the conflict between assertiveness and interpersonal *harmony*.

A recent study (Uskul, 2023), used the most recent update of Vignoles et al.'s (2016) multidimensional self-construal measure (Culture and Identity Research Network–SelfConstrual Scale–Version 3 [CIRN-SCS-3]; Krys et al., 2021; Yang, 2018) to examine patterns of independence and interdependence among participants from eight societies in the Mediterranean region, in comparison with four societies in the more commonly studied East Asian and Western regions. The goal was to go beyond the traditional comparison of participants from only two world regions—East Asia and the West, and against the assumption that all non-Western (or collectivistic) cultures promote similar models of selfhood. Remarkably, a considerable number of scholars have argued that Mediterranean Countries hold a significant cultural value for honor (Gilmore, 1987; Pitt-Rivers, 1965; Rodriguez Mosquera, Manstead and Fischer, 2002; Uskul & Cross, 2019), which stands in contrast to the prevalent cultural values of face and dignity in East Asian and Anglo-Western societies. These distinct cultural perspectives serve as the foundation for the varying cultural emphases on interdependence and independence in these regions. The authors theorized that members of culture of honor societies may not strictly subscribe to a single template of social orientation, self-construal, and cognitive style. Instead, they may exhibit a composite of both independent and interdependent elements. Their research findings, upon rigorous examination, upheld this hypothesis showing that participants from the Mediterranean region emphasized six types of independence (difference, self-direction, self-reliance, consistency, self-expression, and a decontextualized self) across eight dimensions of explicit self-construal. However, on the two remaining dimensions, they scored toward the interdependent pole, reflecting dispositions toward commitment to others (vs. self-interest) and connection to others (vs. self-containment). Notably, in the explicit measure of self-construal, the Latin European group, which included Italy in its sample, had a strong tendency toward connection to others (vs. self-containment) (Uskul and colleagues, 2023).

While Markus and Kitayama (1991) and Triandis (1989) initially focused on how various self-construals could explain cultural differences in behavior, researchers soon recognized that self-construal variants could also be a useful tool for investigating processes within a single culture (Singelis, 1994). Markus and Kitayama (1991) largely reviewed the concept of self-construal without a focus on mental health stigma, and therefore, there are a few studies reported on the effects of different self-construals on mental health issues.

However, they have distinguished between ego-focused and other-focused emotions in relation to self-construal, as revealed by their comprehensive analysis of prior research. More specifically, Individuals with an Independent Self-Construal (IndSC) are more likely to experience ego-focused emotions, such as anger and pride. Those with an Interdependent Self-Construal (InterSC) are more likely to experience other-focused emotions like shame (Markus and Kitayama, 1991). The comprehension of self-construal and its connection to emotions is fundamental. Furthermore, this observation can be contextualized in light of recent findings by Uskul (2023) discussed above, which indicates that individuals in culture of honor societies exhibit a nuanced blend between the interdependent and dependent self-construal. Notably, there are two emotions that are especially associated with the loss of honor, according to the literature on honor: anger (ego-focused emotion) and shame (other-focused emotion) (Rogriguez-Mosquera, 2002). However, Rogriguez-Mosquera (2002) offers a distinctive perspective on these emotions. Anger in reaction to an offense implies a focus on others' negative behavior, on a lack of respect shown by the offender. This perspective aligns with an other-focused interpretation. Consequently, shame in reaction to an offense implies an inward focus, that is, a focus on one's image being tarnished in the eyes of others. This self-image concern, potentially leading to a decrease in self-esteem, is indicative of an ego-focused emotional response.

In spite of these diverse conceptualizations of the emotions outlined here, what remains consistent is the idea that other types of social motivation, such as concerns about one's reputation in a group or society, are closely tied to self-construal (Cross, 2011).

In light of these considerations, the purpose of this study is to examine the connection between Culture of Honor beliefs and values and intentions to seek mental health support mediated by self-construals, specifically using the dimension related to connectedness to others, since it appears particularly relevant in the Mediterranean region, therefore Italy included (Uskul, 2023). To expand upon this idea, endorsing Culture of Honor values is expected to promote self-construal dimensions related to connections with others, notably within the context of Interdependent self-construal. As a consequence, it is expected that this shift in self-construal will diminish inclinations to seek mental health support, driven by concerns about one's reputation, consistent

with the understanding of how self-construal influences social motivations and emotional experiences (Markus & Kitayama, 1991; Rodriguez-Mosquera, 2002; Cross, 2011; Uskul, 2023).

The study has the purpose of acknowledging the potential impact of intracultural variations in self-construal on the relationship between the endorsement of a culture of honor and intentions to seek mental health support. By investigating these links, we can acquire a better understanding of how individual differences in self-construal within honor cultures influence attitudes and actions linked to mental health support-seeking. Hence, The second hypothesis was stated as follows:

H2b: : The link between Culture of Honor beliefs and values towards intentions to seek mental health support is significantly mediated by self-construal, more specifically, endorsing Culture of Honor values increases self-construal dimensions of connections with others which in turn decrease the Intentions to seek mental health support.

CHAPTER 3.

Methods

3.1 Participants

Participants were recruited through social media, mainly Instagram and Facebook. The total number of people who participated in the questionnaire was 211. However, all those who did not complete at least 95% of the questionnaire were excluded. Thus, the final sample of this study consisted of 143 participants, of which 112 (78.3%) were female and 29 (20.3%) were male. The average age of the sample was 31.8 years old, with the youngest participant being 20 years old and the oldest 69 years old. The regions with the highest proportion of participants were Liguria (10.38%), Emilia Romagna (12.83%),which are located in the north of the Country, and Sardinia (41%), an island in the South. A total of 43.4% of the sample lived in rural areas, while 56.6% lived in urban centers. In terms of educational attainment, 88.9% of respondents had completed at least secondary school. They identify themselves as Catholic Christians (56.6%), although they are not very religious or not religious at all (72.5%). [Detailed description Table 3.1]

Table 3.1

Demographic information

	Frequency	*Percentage*
Gender		
Female	*112*	*78.3%*
Male	*29*	*20.3%*
Prefer not to say	*2*	*1.4%*
Birthplace		
North	*49*	*34.2%*
South	*87*	*60.8%*
Other	*7*	*4.8%*
Current Residency		
North	*66*	*46.1%*
South	*73*	*51%*
Other	*4*	*2.7%*
Type of Area of Residency		
Rural	*62*	*43.4%*
Urban	*81*	*56.6%*
Education		
Less than High School	*13*	*9.1%*
High School	*50*	*35%*
Undergraduate (Bachelor)	*36*	*25.2%*
Graduate degree (Master/PhD)	*41*	*28.7%*

	Frequency		*Percentage*	
Religion				
Christian	*81*		*56.6%*	
Muslim	*1*		*0.7%*	
Atheist	*38*		*26.6%*	
Agnostic	*17*		*11.9%*	
Other	*6*		*4.2%*	
Perceived religiosity				
Not religious at all	*46*		*32.4%*	
Slightly religious	*57*		*30.1%*	
Moderately religious	*28*		*19.7%*	
Quite religious	*8*		*5.6%*	
Very religious	*3*		*2.1%*	
	Min	*Max*	*Mean*	*Std. Dev.*
Age	*20*	*69*	*31.5*	*12.00*

Note. N=143.

3.2 Measures

3.2.1. Honor Scale. To assess the endorsement in Culture of Honor beliefs and values the *Honor Concerns - Short Scale,* (HS16, Guerra at al., 2013) was used. It is a shorter version of the 25-items original version of Honor Scale (Rodriguez Mosquera et al., 2002a) that consider the relevance of honor as a multidimensional construct, consisting of concerns for family (*i.e. you family had a bad reputation*), social (*i.e. you had the reputation of being dishonest with others*), feminine (*i.e. you were known as someone whom it is easy to sleep with*) , and masculine honor (*i.e. you lack authority over your own family*). Each subdimensions is composed of four items. All

responses were measured on a Likert scale from 1 (=Not at all bad) to 7 (=Very bad). The scale was found to have very good reliability (α= .83) in the current sample, hence, a composite measure was created by averaging the items. However, the reliability of every single dimension was computed, which ranged from .41 to .83 (Table 4.1). Therefore, composite variables were also created for every dimension by averaging its items.

3.2.2. Reputation Scale. It appeared important to include a scale that could assess the personal concerns that an individual shows about reputation, since it is a fundamental characteristic of culture of honor (Foster, 2020). Hence, the *Importance of Social Image Scale*, (IoSIS, Rodriguez Mosquera & Imada, T., 2013) was included. The six items were measured on a Likert scale from 1 (=Not important at all) to 7 (=Extremely important). The reliability of the scale on the present study was very good (α= .83). An example of a statement would be *"Please rate how important each of the following are for you: Your social image (i.e. how positively other people think of you)."*

3.2.3. Self-construal Scale. To evaluate the cultural models of selfhood of the sample, *The New Self-Construal Scale*, (NCSC, Vignoles, 2016) was used. It consists of 38 items, related to the following dimensions: Difference versus similarity (i.e. *"Being different from others makes you feel uncomfortable"*); Self-containment versus connection to others (*i.e. "Your happiness is unrelated to the happiness of your family"*); Self-direction versus receptiveness to influence (*i.e. "You always ask your family for advice before making a decision"*); Self-reliance versus dependence on others (*i.e. " You prefer to rely completely on yourself rather than depend on others"*); Consistency versus variability (*i.e. "You behave the same way at home and in public"*); Self-expression versus harmony (*i.e. "You try to adapt to people around you, even if it means hiding your inner feelings"*); Self-interest versus commitment to others (*i.e. "You always put your family first, even if it means giving up your personal goals"*); all rated from 1 (=not at all) to 9 (=exactly). The last three items of each of the seven dimensions were reverse coded so that higher scores always indicate greater endorsement of independent self-construal. The general reliability was .70 and the reliability per dimension ranged from α=.20 (Self-interest versus commitment to others) to 0.71 (Self-reliance versus dependence on others).

3.2.4. Mental Health Stigma Scales. To measure stigma related to mental health, two scales were used, each serving to provide a comprehensive exploration of various facets of stigma. The first one, *Stigma Scale for Receiving Psychological Help*, (SSRPH, Komiya, 2000) was specifically

used to gauge perceptions related to private stigma. The reliability was good with Cronbach's alpha of .71. An example of an item would be: "*It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems"*. The second scale chosen was *Perceptions of Stigmatization by Others for Seeking Help* (PSOSH, Vogel et al., 2009), which focused on capturing insights pertaining to public stigma. It has excellent reliability (α= .93). An example of a statement would be: *"Imagine you had an academic or vocational issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would react negatively to you"*.

Both scales are composed of 5 items rated from 1 (=strongly disagree) to 7 (=strongly agree) and evaluate negative attitudes regarding seeking professional mental health support.

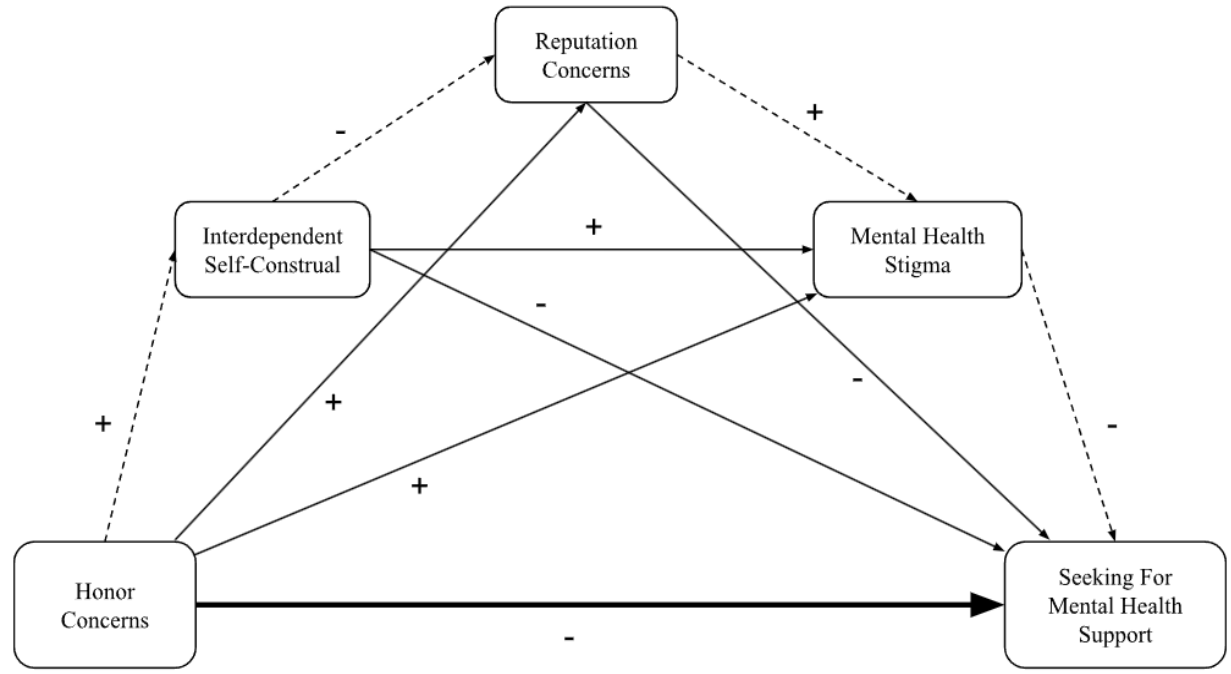
3.2.5. Help-seeking Intention Scale. To assess the individual attitude and intention regarding looking for professional mental health support the *Mental Help Seeking Intention Scale* (MHSIS, Hammer, 2018) was used. It consists of only 3 items rated from 1 (=extremely unlikely) to 7 (=extremely likely). As an illustration, a representative item could be: *"If I had a mental health concern, I would intend to seek help from a mental health professional"*. The internal consistency of this scale was very high, with a Cronbach's alpha of .94.

3.3 Design

The present study used a serial multiple mediation to test the relation between Honor beliefs (independent variable X) and Intention to seek Mental Health Support (dependent variable Y) and if this link can be explained by multiple mediators, which are Self-construal (M1), Reputation (M2) and Mental Health Stigma (M3) (see Figure 3.1).

Figure 3.1

Proposed Sequential Mediation Model



Note. –*:H1;* - - *:H2*

3.4 Procedure

Since the study was conducted on an Italian sample, the questionnaire was translated from English to Italian. To ensure the accuracy of the translation, Italian native speakers who are studying psychology or already psychologists and are fluent in English were contacted to provide a back translation. After that, the study with all the materials was presented to the Ethics Committee of Iscte-Instituto Universitário de Lisboa to obtain the Ethical Approval (Opinion 41/2023). The following step was the development of the questionnaire on Qualtrics and the distribution of it in different social media, predominantly Instagram and Facebook. Participants were able to access the survey through a link. Participation was voluntary, as explained in the Consent Form, that participants had to read and sign before filling in the questionnaire. Participants were first presented with sociodemographic questions (e.g., age, gender, level of education, religion), followed by the remaining measures. First we had the Honor Concerns - Short Scale, HS16, (Guerra at al., 2013), followed by Importance of Social Image Scale (IoSIS, Rodriguez Mosquera, P. M., & Imada, T., 2013); The New Self-Construal Scale. (NSCS, Vignoles, 2016); Stigma Scale

for Receiving Psychological Help (IOSIS, Komiya,2000); Perceptions of Stigmatization by Others for Seeking Help (PSOSH, Vogel et al., 2009). The last section of the questionnaire included the Mental Help Seeking Intention Scale (MHSIS, Hammer, 2018) and three questions related to previous experiences with mental health professionals support. The questionnaire took about 12 minutes to complete. At the end of it a detailed debriefing was presented [Questionnaire, Consent Form and Debriefing are included in the Annexes].

3.5 Statistical Analysis

To test the two hypotheses, data were analyzed using the 29th version of IBM SPSS Statistics, more specifically using PROCESS macro model 6 in SPSS, which referred to sequential mediation analysis. The analysis was run using 5.000 bootstrap samples and 95% confidence intervals (CI), to better respect the irregularity of sampling distribution and to have higher power (Hayes, 2018).

CHAPTER 4.

Results

4.1 Descriptive Analysis

Before proceeding with the analysis the data set was cleaned. Initial boxplot observations revealed the presence of potential outliers. An in-depth analysis of the most extreme data points was conducted, however, demonstrating that these outliers were not the consequence of incorrect data entry, but rather appeared to have actual value. Furthermore, according to Pallant (2007), if there is a considerable difference between the 5% Trimmed Mean and the standard mean, it indicates a need for detailed examination of these specific data points. Given this, in addition to the fact that these values relate quite well with the rest of the data distribution, it was decided to keep these cases in the dataset. This conclusion is supported by the argument that their presence is not detrimental with the overall data representation.

Descriptive statistics, such as means, standard deviations, reliability and correlations are summarized in the tables below (see tables 4.2 and 4.3).

Considering the endorsement of Culture of Honors values on a Likert scale from 1 to 7, we can see that ratings of feminine and masculine honor aspects were not that high ([HS16MASC *M*=3.813; *SD*=1.094]; [HS16FEM *M*=3.327; *SD*=1.438]), compared to the family and social ones ([HS16FAM *M*=5.379; *SD*= 1.177]; [HS16SOC *M*=5.604; *SD*=1.101]). The Importance of social image appeared to be quite relevant (*M*=5.10; *SD*=1.082), while the Stigma for receiving help and the Stigmatization perceived from others appeared low to moderate ([SSRPH *M*=2.339; *SD*=1.192]; [PSOSH *M*=2.047; *SD*=1.299]). Interestingly, seeking mental health support intentions appear quite high (*M*=6.261; *SD*=1.318).

Significant correlations were found in the sample, supporting the proposed model. Culture of Honor was significant and positively correlated with importance of Social Image (r=.512; p<.001), even considering the subdimensions individually, we can still find a significant and positive correlation, meaning that the more a person shows culture of honor endorsement, the more they considers their own social image important. Culture of Honor appeared to be significant and positively correlated to Mental Health Stigma, both the private one (r=.236; p<0.01) and the public one (r=.218; p<0.01), which indicate that an individual with strong Culture of Honor values, possesses strong Mental Health Stigma. In this case, the subdimensions of Culture of Honor related to family and social honor did not show significant correlation with Mental Health

Stigma. Furthermore, there was a significant and negative correlation between Culture of Honor and Self-Construal (r=-.269; p<0.01), meaning that the more a person possesses Culture of Honor beliefs the less that person will feel different and independent from others. Reminding that a lower score in the New Self-Construal Scale indicated Interdependence self-construal, while a higher score indicated Independence self-construal. It is possible to understand this better by looking at the subdimensions, specifically dimension 2 (Self-containment versus connection to others) had the lowest means (M=3.838), indicating that connection to others was particularly relevant for this sample. In conclusion, Culture of Honor has a negative and significant correlation with Intention to seek Mental Health Support (r=-.198; p<0.05), which showed that people who hold Honor-related beliefs were the ones feeling less comfortable to use mental health services. The Intention to seek Mental Health Support negatively correlated with Stigma for Receiving Help (p=-.297; p<0.01) and Stigmatization from Others (p=-.328; p<0.01), indicating that a person with high scores of Mental Health Stigma, will show concerns about the use of mental health services.

However, there were no significant correlations between the Intention of Seeking Mental Health Support and Self-Construal dimensions, or between Mental Health Stigma and self-construal dimensions, except for the dimensions 1 (Difference versus similarity) and 7 (Self-interest versus commitment to others) of the New Self-Construal Scale.

Table 4.1 *Descriptive Statistics of the Study Variables*

Variables	Mean	Std. Dev.	Range	α
HS16	4.501	.906	1-7	.834
HS16FAM	5.379	1.177	1-7	.672
HS16MASC	3.813	1.094	1-7	.411
HS16FEM	3.327	1.438	1-7	.807
HS16SOC	5.604	1.101	1-7	.774
IoSIS	5.10	1.082	1-7	.831
SSRPH	2.339	1.192	1-7	.718
PSOSH	2.047	1.299	1-7	.934
NSCS1d	6.285	1.228	1-9	.576
NSCS2d	3.838	1.275	1-9	.587
NSCS3d	6.179	1.473	1-9	.694
NSCS4d	6.787	1.495	1-9	.716
NSCS5d	5.385	1.799	1-9	.848
NSCS6d	5.145	1.287	1-9	.548
NSCS7d	4.499	.975	1-9	.205
NSCS	5.336	.629	1-9	.708
MHSIS	6.261	1.318	1-7	.945

Note. N=143, Std. Dev= Standard Deviation, α= Cronbach's alpha

Table 4.2 *Correlations of the Study Variables.*

Variables	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***	***11***	***12***	***13***	***14***	***15***	***16***	***17***
1 *HS16*	*1*	*.830***	*.667***	*.813***	*.640***	*.512***	*.236***	*.218***	*-.154*	*-.287***	*-.286***	*-229***	*.045*	*-.117*	*.080*	*-.269***	*-.198**
2 *HS16FAM*		*1*	*.413***	*.542***	*.485***	*.444***	*.201**	*0.141*	*-.153*	*-.276***	*-241***	*-.179**	*-.002*	*-.115*	*.086*	*-.257***	*-.152*
3 *HS16MASC*			*1*	*.504***	*.279***	*.351***	*.248***	*.235***	*0.059*	*-.110*	*-.199**	*-.185**	*.061*	*-.078*	*-.055*	*-.127*	*-.119*
4 *HS16FEM*				*1*	*.251***	*.349***	*.236***	*.208**	*-.278***	*-.129*	*-.303***	*-280***	*-.034*	*-.106*	*.054*	*-.311***	*-.270***
5 *HS16SOCI*					*1*	*.329***	*-.045*	*.002*	*.009*	*-.308***	*-.090*	*-.001*	*.171**	*.007*	*.093*	*-.022*	*-.009*
6 *IOSIS*						*1*	*.132*	*.088*	*.029*	*-.367***	*-.251***	*-.241***	*.155*	*-.129*	*.045*	*-.195**	*.047*
7 *SSRPH*							*1*	*.522***	*-.322***	*.023*	*-.020*	*-.189**	*-.132*	*-.058*	*.192**	*-.180**	*-.297***
8 *PSOSH*								*1*	*-.202**	*.053*	*-.051*	*-.094*	*.075*	*.052*	*.166**	*-.006*	*-.328***
9 *NSCS1d*									*1*	*-.055*	*.065*	*.121*	*.267***	*.163*	*.044*	*.513***	*.283***
10 *NSCS2d*										*1*	*.187**	*-.002*	*-.183**	*-.103*	*-.020*	*.241***	*.030*
11 *NSCS3d*											*1*	*.389***	*.089*	*.255***	*.067*	*.560***	*-.016*
12 *NSCS4d*												*1*	*.100*	*.192**	*.055*	*.501***	*.084*
13 *NSCS5d*													*1*	*.162*	*.008*	*.568***	*.022*
14 *NSCS6d*														*1*	*.090*	*.528***	*-.017*
15 *NSCS7d*															*1*	*.309***	*-.102*
16 *NSCS*																*1*	*.104*
17 *MHSIS*																	*1*

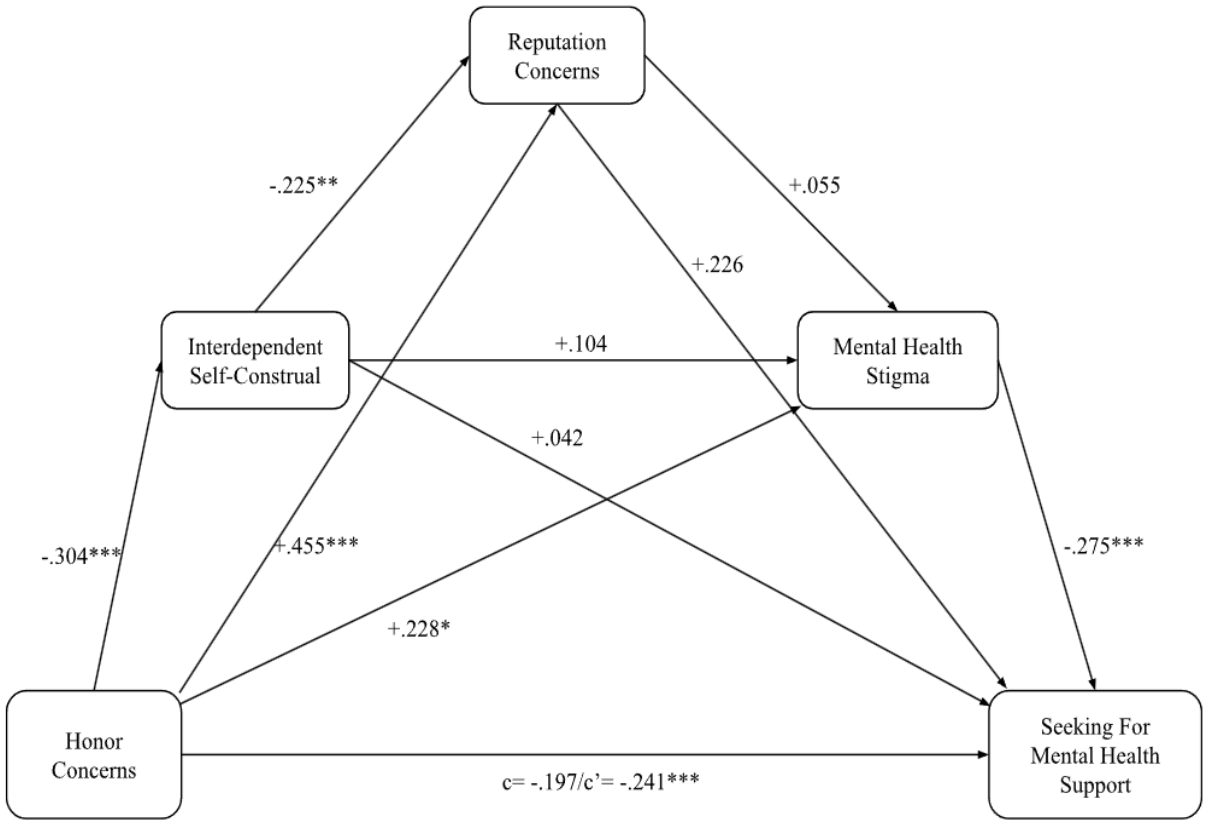
*Note. N=143. .*p<0.5;**p<.01; ***p<.001*

4.2. Sequential Mediation

Multiple sequential mediation models were tested, using the entire culture of honor and self-construal scale or only the subdimensions of the different scales that were more relevant considering the background theory. The final model presented below has HS16 as indicator of the Honor Concerns, which is the predictor (X variable) of Mental Health Seeking Support (variable Y), measured by MHSIS scale. The direct effect remained significant and negative after including the mediating variables (*b*=-.353, *t*=-2.519, 95% *CI* [-.630;-.076]), suggesting that the more someone holds honor-related beliefs and values, the less they are willing to seek professional mental health support, which provided support to the first hypothesis. Secondly, the chosen mediators were the perceived difference or similarity from others (M1), assessed via New Self-Construal Scale dimension 2 (Self-containment versus connection to others); Reputation Concerns (M2), assessed via Importance of Social Image Scale (IOSIS), and perceived Mental Health Stigma (M3), using Stigma Scale for Receiving Psychological Help (SSRPH) as indicator. The total effect appeared to be significant and negative (b=-.289, t=-2.385, 95% CI [-.529;-.050]).

However, the total indirect effect and majority of indirect effects were found to be non-significant (See Table 4.3). Moreover, there were no significant relations between Self-Construal and/or Reputation and intentions to seek mental health support, which indicates that the concerns of asking for Mental Health Support do not depend on how people are connected to others. Only the 3rd indirect effect appeared to be significant and negative (Ind3= -.063, SE= .037, 95% CI [-.145; -.005]), which indicates that Mental Health Stigma significantly mediated the relation between Culture of Honor and Intention to Seek Mental Health Support. This result partially confirmed H2a, because it appeared that there were significant and positive effects between Culture of Honor and Reputation, and between Reputation and Intention to Seek Mental Health Support. However, there is no significant relation between Reputation and Mental Health Stigma, nor a significant mediated relation between Culture of Honor and Seeking for Mental Health Support as indicated in H2a.

Figure 4.2 *Indirect and Direct Pathways of the Sequential Mediation Model*



*Note. c=total effect of X on Y. c'=direct effect of X on Y. *p<.05; **p<.01; ***p<.001*

Standardized results

Table 4.3 *Sequential mediation effects of the tested model*

Variables	*Self-Construal (M1)*			*Reputation (M2)*			*Mental Health Stigma (M3)*			*Intentions to Seek Mental Health Support (Y)*		
	Coefficient	*SE*	*Boot CI*	*Coefficient*	*SE*	*Boot CI*	*Coefficient*	*SE*	*Boot CI*	*Coefficient*	*SE*	*Boot CI*
Culture of Honor (X)	*-.430****	*.114*	*[-.665, -.205]*	*.548****	*.088*	*[.373, .723]*	*.302**	*.129*	*[.046, .558]*	*-.353**	*.140*	*[-.630, -.076]*
Self-Construal				*-.192***	*.063*	*[-.316, -.068]*	*0.97*	*.084*	*[-.068, .262]*	*.044*	*.089*	*[-.133, .221]*
Reputation							*.061*	*.110*	*[-.157, .278]*	*.275**	*.116*	*[.044, .506]*
Mental Health Stigma										*-.304****	*.090*	*[-.483, -.125]*
F	*14.275*			*32.816*			*2.974*			*5.629*		
R2	*.092*			*.321*			*.061*			*.141*		

*Note. N=143. SE=Standard Error; CI= Confidential Interval. *p<.05;**p<.01; ***p<.001*

Unstandardized results.

Table 4.4 *Total, Direct, Indirect Effects of X on Y*

Intentions to Seek Mental Health Support (Y)			
	Boot Effect	*Boot SE*	*CI*
Total Effect of X on Y	*-.289***	*.121*	*[-.049, -.198]*
Direct Effect of X on Y	*-.353***	*.140*	*[-.076, -.241]*
Total Indirect Effect of X on Y through ***Self-Construal, Reputation and Mental Health Stigma***	*.064*	*.100*	*[-.141, .255]*
Indirect Effect of X on Y through ***Self-Construal***	*-.019*	*.037*	*[-.096, .052]*
Indirect Effect of X on Y through ***Reputation***	*.151*	*0.83*	*[-.013, .305]*
Indirect Effect of X on Y through ***Mental Health Stigma***	*-.092*	*.059*	*[-.234, -.006]*
Indirect Effect of X on Y through ***Self-Construal and Reputation***	*.023*	*.019*	*[-.002, .070]*
Indirect Effect of X on Y through ***Self-Construal and Mental Health Stigma***	*.013*	*.012*	*[-.011, .040]*
Indirect Effect of X on Y through ***Reputation and Mental Health Stigma***	*-.010*	*.019*	*[-.048, .030]*

*Note. N=143. *p<0.5;**p<.01; ***p<.001; unstandardized results.*

CHAPTER 5.

Discussion

5.1. Key findings

This research aimed to enrich the scientific literature and offer valuable input for the design of educational and intervention programs. Our primary objective was to examine the relationship between culture of honor beliefs and norms and individuals' intentions to seek support for mental health issues, along with the underlying factors that might influence this connection. To elaborate further, our study aimed to investigate whether the connection between culture of honor and the intention to seek mental health support could be clarified by the mediation of interdependent self-construal, reputation concerns, and mental health stigma.

Within the extensive range of factors on which culture of honor has a substantial influence on individuals' mind and behaviors (Gul, Cross and Uskul, 2021) is the stigmatization of mental health services and their under-utilization. However, it is noteworthy that this has only recently captured the attention of scholars, giving rise to a new body of evidence that uses culture as a lens through which we can gain a deeper understanding into intricate societal problems, such as challenges associated with mental health (Osterman and Brown, 211; Brown, Imura and Mayeux, 2014; Foster, 2020).

Prior research has shown that individuals in honor-based cultures tend to exhibit a reduced tendency to seek help or resort to medication when faced with depression (Brown, Imura, & Mayeux, 2014; Foster, 2020). A similar pattern emerges among parents with children experiencing mental health challenges, as they are less inclined to seek support in honor-driven states in comparison to those in states emphasizing dignity (Brown, Imura, & Mayeux, 2014). Moreover, college students who strongly endorse honor-related values are more likely to agree with statements suggesting that seeking help for mental health concerns signifies inadequacy and could damage their social reputation (Brown, 2014).

The present study aligns with this body of literature and it seeks to broaden the comprehension of the phenomenon by exploring explanatory factors. For this specific purpose, the aim of the study was to examine how culture of honor beliefs and values are associated with the intention to use mental health services in Italy. In order to examine this relation we started from Foster's model (2020), incorporating measures of reputation concerns at an individual level and mental health stigma as mediators. Furthermore, we also included self-construals as an important mediator,

which has not been studied to date in the context of culture of honor research, but allows unpackaging, i.e. explaining, the effects of culture of honor at the individual-level.

The results revealed that culture of honor beliefs endorsement was associated with lower levels of help-seeking intentions, which was in line with Foster's findings (2020). However, the mediated association via reputation and mental health stigma was not significant, and therefore, did not replicate Foster's findings. One plausible explanation may stem from the utilization of diverse scales in both his model and our own. Foster (2020) analyzed a primarily white sample from one Southern U.S. state and examined concerns for personal reputation, with statements such as "I often think about things I could do to enhance or maintain my reputation", which participants had to rate on a scale from 1 (Strongly Disagree) to 9 (Strongly Agree). In his study, reputation concerns were identified as the driving mechanism behind the honor-stigma link, providing support to Brown et al.'study (2014). In the present study, we used a measure assessing perceived social image (Importance of Social Image Scale, IoSIS, Rodriguez Mosquera and Imada, 2013) to understand the importance attributed to reputation. Reputation appeared to be highly valued in this sample and positively correlated with culture of honor, demonstrating that individuals who endorse in culture of honor beliefs care about their social image. This correlation was observed even with each of the four subdimensions of culture of honor. However, we were not able to replicate Foster's findings, because we discovered a non-significant association between Reputation and Seeking Mental Health Support and Reputation did not mediate the relation between Culture of Honor and Seeking Mental Health Intention. Conversely, in our model the association between culture of honor and mental health stigma was significant, which in turn was non-significant in Foster's model. The scales chosen in the present study were identical to those employed in Foster's model, which were Stigma Scale for Receiving Psychological Help (Komiya, 2000) and Perceptions of Stigmatization by Others for Seeking Help (PSOSH, Vogel et al., 2009). Nevertheless we decided to use only the Stigma Scale for Receiving Psychological Help in our final model, which had a higher correlation with Seeking for Mental Health Support. This choice was motivated by Vogel's findings, in which public stigma appeared to lead to an internalization of negative external messages as self-stigma, and self-stigma was linked to attitudes toward psychological services (2007). Internalized stigma would be more relevant in the context of a culture of honor society, such as the Italian one, in which collective honor and social interdependence are highly valued (Rodriguez-Mosquera, 2002) and individuals may be more influenced by the opinions of others, to the extent that others' views may become internalized as one's own. In fact, in line with these observations, family honor was the dimension that scored the highest in our sample.

Furthermore, the study highlights the importance of mental health as a stigma, which seems to be the most important finding in our study. To our knowledge, there has not been a study investigating this type of Stigma connected to the construct of culture of honor in the Italian context. Nonetheless, a substantial body of literature related to mental health stigma exists in Italy, encompassing its prevalence, contributing factors, repercussions, and initiatives aimed at mitigating stigma, with much of the theory focusing on psychiatry and mainstream psychology (Dagani at al., 2023; Entilli at al., 2023; Serra at al., 2013; Munizza al al, 2013; Villotti al al., 2018). Hence, the goal of this study was to acknowledge the intersection of cultural and personal factors to better understand mental health issues.

In light of this, the present study found support for the first hypothesis regarding the association between Culture of Honor and Seeking Mental Health Support. Demonstrating that honor beliefs and values increase aversion to help-seeking, as previously demonstrated by studies in the U.S. (Foster, 2020; Osterman & Brown, 2011, Brown 2014). However, the second hypothesis, in which we expected a serial mediation with self-construal, reputational concern and stigma as mediators for the link between culture of honor and mental health seeking intentions, was only partially confirmed. Specifically, we hypothesized that culture of honor would predict an interdependent self-construal, which consequently would increase the importance of reputation, resulting in feeling less comfortable to utilize mental health services and increasing their stigmatization. While there was a significant indirect effect for the mediator of mental health stigma, but not for the mediator self-construal. To our knowledge the present study was the first to suggest an association between Culture of Honor and Seeking Mental Health Support mediated by self-construals. Even though this was not confirmed, interestingly, we could observe other significant findings. Our sample had nuances of independence and interdependence self-construal, supporting Uskul's (2023) findings. Consequently, choosing only the second of the seven dimensions of the New Self-Construal Scale in our model came across as theoretically relevant. Furthermore, Vignoles (2016) suggested that researchers should strive to uncover which forms of independence and which forms of interdependence dominate in different cultural contexts, in order to theorize and test plausible explanations and implications of the patterns that they identify. Instead of categorizing any culture as "independent" or "interdependent" in a general sense. As expected, our sample showed high interdependence in the dimension that we chose for our model. This underscores the significance of interpersonal connections and amplifies the perception of the importance of maintaining one's reputation. Nonetheless, valuing connection to others did not relate to mental health stigma and the utilization of mental health services.

Furthermore, the follow up analysis, testing different plausible model alternatives, did not yield statistically significant results. In addition, we conducted an isolated test for the second dimension of the New Self-Construal Scale by considering it as the only mediating variable for the link between the independent and dependent variable, however, it too failed to demonstrate statistical significance. One explanation might be the limited statistical power for the indirect pathways due to the relatively low sample size as well as the potential influence of correlations among variables on mediation outcomes which is why a potential sequential mediation effect may not have been detected (Agler & De Boeck, 2017).

5.2. Limitations

Even though this study provided valuable insights into the honor syndrome associated with mental health issues, this study also had its limitations. An important limitation already referred to above is the sample size. It was, in some cases, insufficient for in-depth analyses, such as moderated mediation analysis. One of our initial intentions was to test gender and regional identification as moderators. Moreover, the small sample size is an important limitation in terms of generalizing findings to a broader population. Additionally, the data here cannot support firm causal conclusions, because we conducted mediation analyses based on correlational data.

A notable observation in our study was the limited participation of male Italians, who exhibited lack of willingness to engage in the research. It posed a noteworthy challenge, potentially impacting the representativeness and comprehensiveness of our findings. Further investigation into the underlying factors contributing to this reluctance may offer valuable insights into the dynamics of participant recruitment and engagement. Considering the context of culture of honor, we can hypothesize that since men have to confirm oneself as a strong and fearless provider and defender they can not be put in situations where this representation of their self may fail, reluctance to participate in such a study, and also potentially generating great distress leading to a reduced propensity to seek assistance in alleviating this distress, because it could potentially emphasize their vulnerability and draw attention to their perceived failures (Osterman & Brown, 2011).

Additionally, the current study did not include a direct assessment of psychological distress. Dagani (2023) recently found that high levels of psychological distress trigger specific coping strategies, including acceptance, emotional support and positive reframing. Consequently, it could have provided valuable insights into participants' experiences of mental health stigma and their willingness to seek mental health support. However, the study did inquire about participants' attendance at psychological health services, which was suggested by Foster (2020) to be included

in further studies. The findings revealed that at the time of the study, 23 individuals were actively engaged in therapy.

Another limitation of this study was the utilization of anonymous online surveys. Web-based surveys may be performed faster and at lower cost than more traditional approaches with personal interviews (Heirvarg, 2011), but they carry the inherent risk of encountering a substantial number of missing responses, as observed in our study. Initially, our sample comprised 220 participants; however, due to the presence of missing data (more than 5% in 86 cases), we were compelled to reduce the final sample size to 143 for the purposes of analysis and interpretation.

Furthermore, it is imperative to recognize that the validity of our study was constrained by the exclusive use of a Likert-Scale format, which operates on the assumption of equidistant intervals between response categories. However, the interpretation of these intervals can be influenced by various factors, such as the cultural background and unique characteristics of the respondents themselves (von Davier et al., 2010).

Another limitation of this study involves the order of the scales presented in the questionnaire. This order did not perfectly align with the order of the variables as indicated in our model. Specifically, in the questionnaire, Importance of Social Image Scale (IoSIS) came before The New Self-Construal Scale, which is the other way around on our model. This presents a limitation for several reasons, such as causal inference, interpretation, validity and generalizability of the results, making any deviation from this order a notable limitation (Preacher, 2015).

Despite these limitations, the present study's results contributed to the existing literature on culture of honor in the realm of mental health issues.

5.3. Future Directions and Conclusion

To our knowledge the present study was the first to suggest an association between culture of honor and mental health stigma and seeking for mental health support within the Italian context. Past research on culture of honor has employed Italy in between countries comparisons and with a focus on interpersonal violence (Rodriguez Mosquera, 2013) or within the Italian context when studying criminal organization (Travaglino, 2014; Travaglino, 2015).

The present study provided further support to previous research that demonstrates the link between honor endorsers and seeking psychological services (Foster, 2020; Osterman & Brown, 2014; Brown, 2011).

Moreover, this endeavor tried to deeper examine the mechanism behind the honor-stigma association, including the concept of self-construal in the equation. Although the intended connection did not concretize as anticipated, it informs future research that connects culture,

models of selfhood and mental health, improving our ability to predict factors that influence individual well-being, both positively and negatively.

Considering the limitations mentioned above, future research could include measures of identification within the sample, to gain a better understanding of participants' identification with their respective cultural contexts and how such identification might correlate with their endorsement of honor-related values and attitudes towards mental health stigma. For instance, findings derived from a study involving young individuals from southern Italy (N = 170) revealed that a stronger sense of regional identification exhibited a positive association with the endorsement of male honor-related values. Conversely, a greater national identification demonstrated an inverse relationship with male honor-related values, which, in turn, was associated with a heightened determination to oppose criminal organizations (Travaglino, 2015).

Future research could try to deeper analyze the Italian context, by doing comparisons between regions. We would hypothesize that there are greater endorsements of culture of honor beliefs in the South compared to the North. This should also be reflected in the model of selfhood, with more Interdependent self-construals in the South compared to the North. Hence, the model we tested in the current study might show stronger associations with a Southern Italian sample compared to a sample from the North. Yet, a multidimensional approach to self-construal would be valuable in order to capture which dimensions will be most relevant in the particular groups.

As Leung (2011) affirmed, understanding the niches people occupy within a culture or subculture is a promising area for research. This study fits within studies on the Mediterranean Region. As addressed by Uskul and colleagues (2023), the intent is not to create a Mediterranean ideology, but to better examine the complexity of the cultural area and to go beyond the East-West dichotomy in cultural psychology.

Another future direction could be to examine the level of culture of honor endorsement in adolescents and see how this affects their beliefs and behaviors in the realm of mental health.

In the future, it would be valuable to consider the utilization of a qualitative approach to broaden the complex aspects related to honor endorsement and multifaceted factors that shape individuals' inclination to seek mental health support. Furthermore, such a qualitative investigation can serve a dual purpose by identifying crucial elements that should be considered when formulating intervention programs. By delving into the firsthand experiences, perspectives, and socio-cultural environments of individuals within honor-based cultures, researchers can detect valuable and indispensable insights for designing culturally sensitive and effective interventions that promote mental health support-seeking behaviors.

However, what should be taken in consideration is that concern about the stigma of seeking mental health care is also reflected in community resources, which may be absent (Brown and his colleagues, 2014). Consequently, it is crucial to engage in collaboration with policymakers who are dedicated to addressing mental health needs of the community, be it at the local or national level.

Moreover, Gul, Cross and Uskul (2021) have identified noteworthy recommendations for mental health promotion that can be applied in different honor-based societies, such as incorporating mental health services into teams of primary health care providers, instead of mental health clinics; the use of trusted local leaders, such as promoters of health or religious leaders to to encourage the community to seek professional help when needed. As a general rule, solutions rest largely at the family and community level, rather than at the individual level (2021).

Furthermore, a substantial body of research has consistently called attention to psychoeducation and disseminating information as fundamental components shared by various approaches aimed at mitigating self-stigma associated with mental illness (Yanos at al.,2015).

The present study highlighted the importance of mental health stigma. Thereby, also suggesting directions for future research and intervention programs, in order to create mental health awareness and combating the pervasive challenge of mental health stigma, using a cultural perspective. The differences in cultures have a range of implications for mental health practice. For example, it could be important in the future to include measures about coping strategies, since gaining a deeper comprehension of how diverse cultural groups navigate adversity holds significant implications for promoting mental health, preventing mental illness, and shaping the nature and intensity of mental health issues (US Surgeon General, 2001).

This study has the aim not only to contribute to the scientific literature, by creating new insight on how culture of honor beliefs and values relate to intentions for seeking mental health support, yet it also aims to lay the foundation for a more culturally sensitive orientation regarding mental health services.

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Annexes

Annex A: Informed consent - English Version

This study is part of a master thesis research project taking place at Iscte – Instituto Universitário de Lisboa.

The study aims to examine people's beliefs, attitudes and opinions related to seeking psychological help. Your participation in the study, which is highly valued as it will contribute to the advancement of knowledge in this field of science, consists of completing an online survey with multiple choice questions, which will take approximately 12 minutes.

Iscte is responsible for the processing of your personal data that are collected and processed exclusively for the purposes of the study, legally based on Article 9(2)(a) of the GDPR.

The study is conducted by Chiara Vitiello (cvoah1@iscte-iul.pt), under the supervision of Dr Christin-Melanie Vauclair. Please feel free to send an email to clear up any doubts, share comments or exercise your rights in relation to the processing of your personal data. You may use the contact indicated above to request access, rectification, erasure or limitation of the processing of your personal data.

Your participation in this study is **confidential.** Your personal data will always be processed by authorized personnel bound to the duty of secrecy and confidentiality. Iscte assures the use of appropriate techniques, organizational and security measures to protect personal information. All investigators are required to keep all personal data confidential.

In addition to being confidential, participation in the study is strictly **voluntary**: you may choose freely whether to participate or not. If you have decided to participate, you may stop your participation and withdraw your consent to the processing of your personal data at any time, without having to provide any justification. The withdrawal of consent shall not affect the lawfulness of processing based on consent before its withdrawal.

Your personal data will be kept for a period of 5 months, starting in April 2023 till September 2023, after which they will be destroyed or anonymised, with their anonymity being assured in the study's results, being disclosed only for purposes of statistics, teaching, communication in scientific meetings, books or articles.

There are **no expected significant risks** associated with participation in the study (if they do exist, indicate what they are and which measures have been taken to mitigate/control their effects).Iscte does not disclose, or share with third parties, information related to its personal data. Iscte has a Data Protection Officer who may be contacted by email: dpo@iscte-iul.pt. If you consider this

necessary, you also have the right to submit a complaint to the Portuguese Data Protection Authority (CNDP).

I declare that I have understood the aims of what was proposed to me, as explained by the investigator, that I was given the opportunity to ask any questions about this study and received a clarifying reply to all such questions. **I accept** participating in the study and consent to my personal data being used in accordance with the information that was given to me.

Yes No

Annex B: informed consent - Italian Version

Questo studio fa parte di un progetto di ricerca di tesi magistrale in Psicologia delle Relazioni Interculturali che si svolge presso Iscte – Instituto Universitário de Lisboa.

Lo studio si propone di esaminare le convinzioni, gli atteggiamenti e le opinioni delle persone relative alla ricerca di aiuto psicologico. La tua partecipazione allo studio, che è molto apprezzata in quanto contribuirà al progresso delle conoscenze in questo campo della scienza, consiste nel completare un sondaggio online con domande a scelta multipla, che richiede circa **12 minuti**.

Iscte è responsabile del trattamento dei Suoi dati personali raccolti e trattati esclusivamente ai fini dello studio, ai sensi dell'articolo 9(2)(a) del GDPR.

Lo studio è condotto da Chiara Vitiello (cvoah1@iscte-iul.pt), sotto la supervisione della dott.ssa Christin-Melanie Vauclair. Non esitare a inviare una mail per chiarire ogni dubbio, condividere commenti o esercitare i tuoi diritti in relazione al trattamento dei tuoi dati personali. È possibile utilizzare il contatto sopra indicato per richiedere l'accesso, la rettifica, la cancellazione o la limitazione del trattamento dei propri dati personali.

La tua partecipazione a questo studio è **riservata.** I Suoi dati personali saranno sempre trattati da personale autorizzato e tenuto al dovere di segretezza e riservatezza. Iscte assicura l'uso di tecniche adeguate, misure organizzative e di sicurezza per proteggere le informazioni personali. Tutti gli investigatori sono tenuti a mantenere riservati tutti i dati personali.

Oltre ad essere riservata, la partecipazione allo studio è strettamente **volontaria**: puoi scegliere liberamente se partecipare o meno. Se hai deciso di partecipare, puoi interrompere la tua partecipazione e revocare il consenso al trattamento dei tuoi dati personali in qualsiasi momento, senza dover fornire alcuna giustificazione. La revoca del consenso non pregiudica la liceità del trattamento basata sul consenso prestato prima della revoca.

I Suoi dati personali saranno conservati per un periodo di 5 mesi, a partire da aprile 2023 fino a settembre 2023, dopodiché saranno distrutti o resi anonimi, garantendone l'anonimato nei risultati dello studio, essendo divulgati solo per finalità statistiche, didattiche, comunicazione in convegni scientifici, libri o articoli.

Non sono previsti rischi significativi associati alla partecipazione allo studio (se esistono, indicare quali sono e quali misure sono state adottate per mitigare/controllare i loro effetti). Iscte non divulga, né condivide con terzi, informazioni relative a suoi dati personali.

Iscte ha un responsabile della protezione dei dati che può essere contattato via e-mail: dpo@iscte-iul.pt. Se lo ritieni necessario, hai anche il diritto di presentare un reclamo all'Autorità portoghese per la protezione dei dati (CNDP).

Dichiaro di aver compreso le finalità di quanto mi è stato proposto, come spiegato dal ricercatore, che mi è stata data la possibilità di porre qualsiasi domanda in merito a questo studio e di aver ricevuto una risposta chiarificatrice a tutte queste domande. **Accetto** di partecipare allo studio e acconsento all'utilizzo dei miei dati personali in conformità con le informazioni che mi sono state fornite.

Si, acconsento No, non acconsento

Annex C: Materials - English Version

Personal Data

Please indicate the following information:

1. *How old are you? __ years*
2. *birthplace: [Region]*
3. *Current Residence: [Region]*
4. *In which area do you live? A. Rural B. Urban*
5. *Gender:*
6. *Educational Level: 1. Less than High School 2. High School 3. Undergraduate (Bachelor) 4. Graduate degree (Master/Phd)*
7. *Religion: Perceived religiosity: not at all religious 1 2 3 4 5 6 very religious*
8. *Are you currently seeing a mental health professional? Yes No*
9. *Have you seen a mental health professional in the past? Yes No*
10. *Has someone among your friends or family members been seen as a mental health professional? Yes No*

Honor Concerns - Short Scale, HS16, (Guerra et al., 2013)

Using the 7-point rating scale, please rate the extent to which behaving or having the reputation described in the item would make you feel bad about yourself. (1=Not at all bad; 7=Very bad)

How bad would you feel about yourself if…

1. *… your family had a bad reputation?*
2. *… you lack authority over your own family?*
3. *… you were known as someone who has had many different sexual partners?*

4. *... you did something to damage your family's reputation?*
5. *... you had the reputation of being dishonest with others?*
6. *... you lied to others?*
7. *... you had the reputation of being someone without sexual experience?*
8. *... you were known as someone who lacks authority over your own family?*
9. *... you change boyfriend/girlfriend often?*
10. *... you let other people insult your family?*
11. *... you were hypocritical?*
12. *... your sister or mother had the reputation of sleeping around?*
13. *... you did not keep your word?*
14. *... you were known as someone who cannot support a family?*
15. *... you were known as someone whom it is easy to sleep with?*
16. *... you slept with someone without starting a serious relationship with that person?*

Importance of Social Image Scale, IoSIS, (Rodriguez Mosquera, P. M., & Imada, T., 2013)
Please rate how important each of the following are for you. Likert scale from 1=Not important al all to 7=Extremely important

1. *Your social image (i.e., how positively other people think of you).*
2. *The reputation of your family.*
3. *Respect (i.e., how much other people respect you)*
4. *Social image of your family (i.e., how positively other people think of your family).*
5. *Your reputation.*
6. *Respect towards your family (i.e., how much others respect your family).*

The New Self-Construal Scale. (Vignoles, 2016)

"How well does each of these statements describe you?" Rate from 1 to 9, where 1=not at all, 3=a little, 5=moderately, 7=very well, 9=exactly.

1. *You like being different from other people*
2. *You see yourself as unique and different from others*
3. *You like it when people notice you in a group*
4. *Being different from others makes you feel uncomfortable*
5. *You try to avoid being noticeably different from others*
6. *Being praised in front of others makes you feel uncomfortable*
7. *Your happiness is unrelated to the happiness of your family*
8. *When you talk about yourself, you don't say very much about your family*
9. *If someone insults a friend, you rarely feel insulted yourself*
10. *If someone in your family is sad, you feel the sadness as if it were your own*
11. *"When someone in your family achieves something, you feel proud as if you had achieved something yourself"*
12. *Your happiness depends on the happiness of your friends*
13. *You prefer to do what you want without letting your family influence you*
14. *You make decisions about your life on your own*
15. *You always ask your family for advice before making a decision*
16. *Other people have great influence over the choices you make*
17. *You prefer to rely completely on yourself rather than depend on others*
18. *You try to avoid being reliant on others*
19. *You prefer to ask other people for help rather than rely only on yourself*

20. You feel uncomfortable in situations where you have to rely only on yourself

21. You behave in the same way even when you are with different groups of people

22. You always see yourself in the same way even when you are with different people

23. You behave the same way at home and in public

24. You act very differently at home compared to how you act in public

25. You see yourself differently in different social environments

26. You behave differently when you are with different groups of people

27. You prefer to say what you are thinking, even if it is inappropriate for the situation

28. You show your inner feelings even if it disturbs the harmony in your family

29. You are comfortable expressing disagreement with friends

30. You try to adapt to people around you, even if it means hiding your inner feelings

31. You feel uncomfortable when you express disagreement with members of your family

32. You try to maintain harmony among the people around you

33. You value personal achievements more than good relations with the people close to you

34. Your own success is very important to you, even if it disrupts your friendships

35. You follow your personal goals even if they are very different from the goals of your family

36. You value good relations with the people close to you more than your personal achievements

37. You always put your family first, even if it means giving up your personal goals

38. You are more concerned with your friends' happiness than your own success

Stigma Scale for Receiving Psychological Help. Komiya (2000)

each question is rated from 1 (strongly disagree) to 5 (strongly agree)

1. *Seeing a psychologist for emotional or interpersonal problems carries social stigma*
2. *It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems*
3. *People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.*
4. *It is advisable for a person to hide from people that he/she has seen a psychologist*
5. *People tend to like less those who are receiving professional psychological help.*

Perceptions of Stigmatization by Others for Seeking Help (PSOSH, Vogel et al., 2009)

"Imagine you had an academic or vocational issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would __." Responses to the above items are as follows: 1=Not at all; 2=A little; 3=Some; 4=A lot; 5=A great deal.

1. *React negatively to you*
2. *Think bad things of you*
3. *See you as seriously disturbed*
4. *Think of you in a less favorable way*
5. *Think you posed a risk to others*

Mental Help Seeking Intention Scale (MHSIS, Hammer, 2018)

For the purposes of this survey, "mental health professionals" include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, "mental health concerns" include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression). Please mark the box that best represents your opinion. Likert scale from 1 (=extremely unlikely) to 7(=Extremely likely).

1. *"If I had a mental health concern, I would intend to seek help from a mental health professional"*

2. *"If I had a mental health concern, I would try to seek help from a mental health professional"*

3. *"If I had a mental health concern, I would plan to seek help from a mental health professional"*

Annex D: Materials - Italian Version

Dati personali

Per favore inserisci le seguenti informazioni

1. Età: __ anni
2. Luogo di Nascita: [Regione]
3. Residenza attuale: [Regione]
4. In che area vivi? A. Rurale/Paesana B. Urbana
5. Genere sessuale:
6. Livello di Istruzione finora conseguito: A. Inferiore all'istruzione secondaria B. Istruzione Secondaria (Scuole Superiori/ Istituto Tecnico) C. Laurea Triennale D. Laurea Magistrale E. Dottorato
7. Religione: Percezione della propria religiosità: per niente religioso 1 2 3 4 5 6 molto religioso
8. Stai attualmente vedendo un professionista della salute mentale (es. psicologo, psicoteraupa, psichiatra)? Si No
9. Ti sei mai rivolto ad un professionista della salute mentale in passato? Si No
10. Qualcuno tra i tuoi amici o membri della tua famiglia ha mai richiesto e/o è stato accompagnato da un professionista della salute mentale? Si No

Honor Concerns – HS16

Per favore, indica su una scala che va da 1 a 7 il grado con cui i comportamenti o avere tale reputazione presenti nelle domande ti fanno sentire a disagio. (1= Per niente a disagio; 7= Molto a disagio).

Quanto ti sentiresti a disagio con te stesso se…

1… la tua famiglia avesse una brutta reputazione?

2. … mancassi di autorità sulla tua famiglia?

3. … fossi noto come qualcuno che ha avuto molti partner sessuali?

4. … avessi fatto qualcosa per danneggiare la reputazione della tua famiglia?

5. … avessi la reputazione di essere disonesto con gli altri?
6. … mentissi ad altre persone?
7. … avessi la reputazione di non avere alcun tipo di esperienza sessuale?
8. … avessi la reputazione di non avere potere sulla tua propria famiglia?
9. … cambiassi fidanzato/a spesso?
10. … lasciassi altre persone insultare la tua propria famiglia?
11. … fossi ipocrita?
12. … tua sorella o tua madre avessero la reputazione di andare a letto con chiunque?
13. … non fossi capace di mantenere la parola data?
14. … fossi conosciuto come qualcuno che non supporta la propria famiglia?
15. … fossi conosciuto come qualcuno con il quale è facile andare a letto?
16. … fossi andato a letto con qualcuno senza iniziare una relazione seria con tale persona?

Importance of Social Image Scale, IoSIS

Per favore, indica su una scala da 1 a 7, quanto sono importanti per te le seguenti affermazioni. 1= Per niente importante; 7= Estremamente importante

1. La tua immagine sociale (es. quanto positivamente gli altri pensano di te).
2. La reputazione della tua famiglia.
3. Rispetto (es. quanto gli altri ti rispettano).
4. L'immagine sociale della tua famiglia (es. quanto positivamente gli altri pensano della tua famiglia).
5. La tua reputazione.
6. Rispetto verso la tua famiglia (es. quanto gli altri rispettano la tua famiglia).

The New Self-Construal Scale, NSCS

"Quanto accuratamente ti descrivono le seguenti frasi? Per favore indica da una scala da 1 a 9, dove 1= per niente, 3= un leggermente, 5= moderatamente, 7= molto bene, 9= perfettamente.

1. Ti piace essere diverso dalle altre persone
2. Vedi te stesso come unico e diverso dagli altri

3. Ti piace quando le persone ti notano all'interno di un gruppo
4. Essere diverso dagli altri ti fa sentire a disagio
5. Cerchi di evitare di essere notato come diverso dagli altri
6. Essere apprezzato di fronte ad altri ti fa sentire a disagio
7. La tua felicità è indipendente dalla felicità della tua famiglia
8. Quando parli di te stesso, non parli tanto della tua famiglia
9. Se qualcuno insulta un tuo amico, raramente ti senti tu insultato
10. Se qualcuno nella tua famiglia è triste, senti la loro tristezza come se fosse tua
11. Se qualcuno nella tua famiglia raggiunge un traguardo, ti senti orgoglioso come se fossi stato tu a raggiungerlo
12. La tua felicità dipende dalla felicità dei tuoi amici
13. Preferisci fare quello che vuoi senza che la tua famiglia ti influenzi
14. Prendi decisioni sulla tua vita per conto tuo
15. Chiedi sempre consiglio alla tua famiglia prima di prendere una decisione
16. Le altre persone hanno una forte influenza sulle decisioni che prendi
17. Preferisci contare esclusivamente su te stesso invece di dipendere dagli altri
18. Cerchi di evitare di dipendere dagli altri
19. Preferisci chiedere aiuto ad altri invece di contare solo su te stesso
20. Ti senti a disagio in situazioni in cui devi contare solo su te stesso
21. Ti comporti allo stesso modo anche quando sei con differenti gruppi di persone
22. Vedi te stesso sempre allo stesso modo indipendentemente da con chi sei
23. Ti comporti allo stesso modo in casa e in pubblico

24. Ti comporti in modo diverso in diversi contesti sociali

25. Vedi te stesso diversamente nei diversi contesti sociali

26. Ti comporti diversamente quando sei in diversi gruppi di persone

27. Preferisci dire quello che pensi, anche se può essere inappropriato per la situazione

28. Mostri le tue emozioni interne, anche se potrebbero disturbare l'armonia della tua famiglia

29. Ti senti a tuo agio ad esprimere disaccordo con i tuoi amici

30. Provi ad adattarti alle persone attorno a te, anche se questo significa nascondere le tue proprie emozioni

31. Ti senti a disagio quando esprimi disaccordo con membri della tua famiglia

32. Cerchi di mantenere armonia tra le persone attorno a te

33. Valorizzi i traguardi personali molto più delle buone relazioni che hai con le persone a te vicine

34. Il tuo successo personale è molto importante per te, anche se compromette le tue amicizie

35. Persegui i tuoi traguardi personali anche se sono molto diversi da quelli della tua famiglia

36. Valorizzi le buone relazioni con le persone vicino a te molto più dei tuoi traguardi personali

37. Metti sempre la tua famiglia al prima posto, anche se questo significa rinunciare ai tuoi obiettivi personali

38. Ti preoccupi molto di più della felicità dei tuoi amici invece che della tua propria felicità.

Stigma Scale for Receiving Psychological Help, SSRPH

Indica su una scala da 1 a 5 quanto concordi con le seguenti affermazioni. 1=totalmente disaccordo 5= totalmente d'accordo

1. Vedere un psicologo per problemi emotivi e interpersonali comporta uno stigma sociale

2. È un segno di debolezza o inadeguatezza vedere uno psicologo per problemi di tipo emotivo e interpersonali

3. Le persone vedono un individuo in una maniera meno positiva se vengono a sapere che quest'ultimo vede/ha visto uno psicologo

4. È consigliato per una persona di nascondere agli altri che quest'ultima vede uno psicologo

5. Le persone tendono ad apprezzare meno chi sta ricevendo un aiuto psicologico da parte di professionisti.

Perceptions of Stigmatization by Others for Seeking Help, PSOSH

"Immagina che tu abbia un problema accademico o professionale che non riesci a risolvere da solo. Se tu ti rivolgessi a un servizio di orientamento/terapia per risolvere tale problema, in quale grado pensi che le persone con le quali ti relazioni… [Le risposte alle seguenti domande vanno da una scala da 1= per niente 2= leggermente 3= moderatamente 4= Considerevolmente 5= Decisamente

1. .. Reagirebbero negativamente a te

2. … Penserebbero cose negative su di te

3. … Ti vedrebbero come seriamente disturbato

4. … Penserebbero a te in una maniera meno positiva

5. … Penserebbero che hai posto altri a rischio

Mental Help Seeking Intention Scale, MHSIS

Per le finalità di questo questionario, "Professionisti della salute mentale" include psicologi, psichiatri, assistenti sociali, clinici e terapeuti. Allo stesso modo, "Problemi di salute

mentale" includono problematiche che vanno da difficoltà personali (es. perdita di una persona cara) a disturbi mentali (come ansia, depressione). Per favore, segna con una crocetta la casella che meglio rappresenta la tua opinione. Likert scale da 1= Estremamente improbabile a 7=Estremamente probabile.

1. "Se io avessi un problema di salute mentale, avrei le intenzioni di cercare aiuto da parte di professionisti della salute mentale"

2. "Se io avessi un problema di salute mentale, proverei a cercare aiuto da parte di professionisti della salute mentale"

3. "Se io avessi un problema di salute mentale, pianificherei di cercare aiuto da parte di professionisti della salute mentale"

Annex E: Debriefing/Explanation of the research - English Version

Thank you for having participated in this study. As indicated at the onset of your participation, the study is about people's beliefs, opinions and attitudes related to seeking psychological help. More specifically, the study aims to reveal if people who hold honor-related beliefs and values are more reluctant to seek mental health services and whether this can be explained with different cognitive representations that people hold about themselves.
In the context of your participation, if you have felt any type of discomfort or you think that you need to talk to someone about your psychological well-being, at the end of this document you will find information on how mental health services work in Italy. If you feel that it is not enough and you need extra clarification, you can contact the researcher via email.
We remind that the following contact details can be used for any questions that you may have, comments that you wish to share, or to indicate your interest in receiving information about the main outcomes and conclusions of the study: Chiara Vitiello cvoah1@iscte-iul.pt .
If you wish to access further information about the study topic, once the master thesis is complete, you could consult the research and fundings in iscte's repository: https://repositorio.iscte-iul.pt/?locale=en

Click *continue,* to finish your questionnaire.

How to Ask for Psychological Support in Italy?

It’s important to know that in Italy the National Health System has created a system to support everyone, regardless of one’s economic situation.
The first step is to talk to your family doctor, who will provide you with the prescription and information about terms and locations of the psychological consultations. Usually every ASL offers to citizens the possibility of doing up to 8 sessions just at the cost of 1 ticket, which is 35 euro, and the first consultation is free. There is the possibility of renovation of the prescription and there is no limit to the number of consultations. Even in the case of psychological consultations, there exists the right to exemption from payment in particular income situations associated with age or social status, in the presence of certain pathologies and rare conditions, in case of recognition of the state of invalidity. If you want more details you can talk directly with your local ASL. Access to this service requires waiting quite some time, except for emergencies.
An alternative could be to try to contact a private psychologist or psychotherapist, which could take place in a physical office or online. The access to this service is faster and you can personally choose your specialist, however the cost is higher, a singular consultation has a cost between 50 and 100 euro. You can look for registered psychologists directly on the website of Regional Orders of Psychologists.
As mentioned before, you could have your session at the comfort of your home, because of the growing spread of apps and websites dedicated to psychological support, in which you can find psychologists from all over Italy that work online. At the moment the most famous app is *Unobravo*, which has created a matching system between clients and psychologists, thanks to the development of personal questionnaires.

Once again, thank you for your participation.

Annex F: Debriefing/ Explanation of the research - Italian Version

Grazie per aver partecipato a questo studio.
Come indicato all'inizio della tua partecipazione, lo studio riguarda le convinzioni, le opinioni e gli atteggiamenti delle persone relative alla ricerca di aiuto psicologico. Più specificamente, lo studio mira a rivelare se le persone che detengono credenze e valori legati all'onore sono più riluttanti a cercare servizi di salute mentale e se questo può essere spiegato con diverse rappresentazioni cognitive che le persone hanno di se stesse.
Nell'ambito della tua partecipazione, se hai avvertito qualsiasi tipo di disagio o pensi di aver bisogno di parlare con qualcuno del tuo benessere psicologico, alla fine di questo documento troverai informazioni su come funzionano i servizi di salute mentale in Italia . Se ritieni che non sia sufficiente e hai bisogno di ulteriori chiarimenti, puoi contattare il ricercatore via email.
Ricordiamo che i seguenti recapiti possono essere utilizzati per eventuali domande, commenti che si desidera condividere o per indicare il proprio interesse a ricevere informazioni sui principali risultati e conclusioni dello studio: Chiara Vitiello cvoah1@iscte-iul .pt .
Se desideri accedere a ulteriori informazioni sull'argomento di studio, una volta completata la tesi di laurea, puoi consultare la ricerca e i finanziamenti nel repository di iscte: https://repositorio.iscte-iul.pt/?locale=en

Clicca su *continua* per terminare il questionario.

Come Richiedere Supporto Psicologico in Italia?

È importante sapere che in Italia il Sistema Sanitario Nazionale ha creato un sistema di supporto per tutti, indipendentemente dalla situazione economica.
Il primo passo è parlare con il medico di famiglia, che ti fornirà la prescrizione e le informazioni sui termini e i luoghi delle consulenze psicologiche. Solitamente, ogni ASL offre ai cittadini la possibilità di effettuare fino a 8 sessioni al costo di un solo ticket, che ammonta a 35 euro, e la prima consulenza è gratuita. C'è la possibilità di rinnovare la prescrizione e non c'è limite al numero di consulenze. Anche nel caso delle consulenze psicologiche, esiste il diritto all'esenzione dal pagamento in determinate situazioni di reddito associate all'età o allo status sociale, in presenza di determinate patologie e condizioni rare, o in caso di riconoscimento dello stato di invalidità. Se desideri ulteriori dettagli, puoi parlare direttamente con la tua ASL locale. L'accesso a questo servizio richiede un certo tempo d'attesa, ad eccezione delle situazioni di emergenza.
Un'alternativa potrebbe essere cercare di contattare uno psicologo o uno psicoterapeuta privato, che può svolgersi in uno studio fisico o online. L'accesso a questo servizio è più rapido e puoi scegliere personalmente il tuo specialista, tuttavia il costo è più elevato: una singola consulenza ha un costo compreso tra 50 e 100 euro. Puoi cercare psicologi registrati direttamente sul sito web degli Ordini Regionali degli Psicologi.
Come accennato in precedenza, puoi avere le tue sessioni comodamente da casa tua grazie alla crescente diffusione di app e siti web dedicati al supporto psicologico, nei quali puoi trovare psicologi provenienti da tutta Italia che lavorano online. Al momento, l'app più famosa è *Unobravo*, che ha creato un sistema di abbinamento tra clienti e psicologi grazie allo sviluppo di questionari personali.
Ancora una volta, grazie per la tua partecipazione.