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CROSS-CULTURAL APPRAISAL OF THE ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE

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CROSS-CULTURAL APPRAISAL OF THE ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE

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For my Family
Past, present, and future

Table of Contents

List of Tables

ABSTRACT

The purpose of this study is to revisit and cross-culturally examine the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS). Despite its long history of use in research studies, there is scarce information on the norming sample of the ATSPPHS, and support of its use with ethnic minority populations. This study will examine the reliability and construct validity of this instrument for use with a Latino population. Two samples of participants – Anglo and Mexican American – were utilized to examine the ATSPPHS' reliable and valid use with the Latino participants. Also, in order to ascertain the effect of culture on response patterns, the results of the ATSPPHS for the two samples were compared to each other following systematic control of confounding variables supported by the literature.

CROSS-CULTURAL APPRAISAL OF THE ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE

Chapter 1

Introduction

In a national study that was conducted in 1994, Kessler et al. found that only a few individuals experiencing mental health distress actually seek professional help. Snowden and Yamada's (2005) study further revealed that a relatively large proportion of those in need of mental health care do not receive it. Kessler et al. reported that an estimated 79% of people with diagnosable mental health concerns do not obtain any type of professional services.

The U.S. Department of Health and Human Services have documented the underutilization of mental health care services by ethnic minority populations (as cited in Dobalian & Rivers, 2008), and thus, are of special concern when it comes to the issue of underutilization of mental health services (Alvidrez, 1999). Moreover, Sue (2003) suggests that despite the increase in national interest in the mental health needs of ethnic minorities, the quality of mental health services for these populations continues to fall short.

Latinos are one such population. Without a doubt, the ever-increasing size of the Latino population has created an urgent need to better understand and address the mental health needs of this population in the United States. The United States' Census shows that Latinos are now the largest ethnic minority group, comprising about 14.4% of the total U.S. population in 2005 (United States Census Bureau, 2005). Yet, research literature that focuses on the Latino population continues to be scarce. A survey

conducted in 2005 with a cross-section of six psychology journals published by the American Psychological Association (APA), and six non-APA journals, revealed that from 1990-1999 only 4.1% of papers were focused on Latinos (Imada & Schiavo, 2005). However, existing research supports the persistence of underutilization of services among the Latino population (e.g., Padgett, Patrick, Burns & Schlesinger, 1994; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Vernon & Roberts, 1982). Also, due to various socioeconomic and cultural variables, Latinos may be at higher risk for the development of mental health issues (Kouyoumdjian, Zamboanga, & Hansen, 2003).

Cross-cultural studies investigating the prevalence of mental health distress have resulted in mixed findings. Some studies have suggested that Latinos experience more mental health distress than Whites. For example, Vernon and Roberts (1982) compared Whites, African Americans, and Latinos, and found that higher rates of depression, depressive symptoms, and diagnosed psychiatric illness were reported in Latinos. Yet, some recent empirical evidence has suggested otherwise. For instance, a study examining the prevalence of major psychiatric disorders in the U.S. conducted through the Epidemiological Catchment Area (ECA) program, reported no differences in the prevalence rates of such disorders between Whites and Latinos. In this study, Kaelber and Regier (1995) indicated that Whites had 32% lifetime and 19% active case rates, while Latinos had 33% lifetime and 20% active case rates.

Kouyoumdjian et al. (2003) have cited several possible explanations for these mixed findings in the prevalence of mental health issues between Latinos and other ethnic groups. One explanation attributes the variability in results to the possible greater within-group differences, which would be anticipated due to the ethnocultural

heterogeneity of the Latino population. Thus, it is likely that Latino samples used in various research studies actually consist of different Latino subgroups. In addition, Kouyoumdjian et al. suggest that Latino samples also vary with respect to acculturation levels and related stress factors. A variety of socioeconomic and cultural factors, such as immigrant status, poverty, and cultural racism can fluctuate from sample to sample, ultimately impacting research results. Furthermore, Flaskerud and Hu (1992) suggest methodological problems such as sampling bias, in addition to lack of attention to the effects of confounding variables, such as age, sex and socioeconomic status (SES), could likewise contribute to inconsistencies in the results of various studies. Finally, many assessments used in research studies have not been restandardized for the Latino population. For example, researchers (e.g., Escobar et al., 1986; Loewenstein, Arguelles, Aguelles, & Linn-Fuentes, 1994; Lopez & Taussig, 1991) have discovered equivalency problems with cognitive measures and psychodiagnostic assessments (Velasquez, Ayala, & Mendoza; as cited in Vega & Lopez, 2001). Rogler, Malgady, and Rodriguez (1989) reiterate that these discrepancies can be fertile ground for possible misinterpretation of meaning when attempts are made to compare scores across ethnic groups. As such, methodological limitations have made ethnic minority mental health research a challenge. One purpose of the current study is to reevaluate the reliability and validity of a widely used instrument, the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) when these ethnocultural and methodological variables are considered. This instrument was administered to two sample groups, one Latino and one Anglo, in order to evaluate

equivalency by investigating possible confounding variables, such as SES, gender and age.

Researchers continue to investigate additional possible explanations for the differential mental health service utilization rates. Past research conducted in this area (e.g., Gourash, 1978; Greenley & Mechanic, 1976; Kelly & Achter, 1995; Kushner & Sher, 1989; Tijhuis, Peters, & Foets, 1990) identified several variables – gender, race, education, socioeconomic status, and religion – that aided the prediction of help-seeking behavior. Recently, however, researchers like Kushner and Sher have considered additional factors that could act as intervening variables, from the onset of a person's recognition of distress through to the point at which that person makes a decision to seek assistance. Such factors include level of distress (Ingham & Miller, 1986), available social support (Sherbourne, 1988), self-concealment (Larson & Chastain, 1990), and attitudes toward professional psychological counseling (Rickwood & Braithwaite, 1994).

A person's attitude toward seeking mental health services has been cited as a theoretical factor that may influence whether or not an individual goes on to participate in such services (Fischer & Farina, 1995). Gonzalez, Alegria, and Prihoda (2005) have suggested that a better understanding of attitude correlates can assist in the development of procedures to influence attitudes in order to encourage utilization of mental health services. However, despite the fact that the relationship of such attitudes to the use of mental health services has been studied for more than three decades, the results have been inconclusive. Some studies support a highly predictive relationship (Cash, Kehr & Salzbach, 1978; Fischer & Farina), while others have indicated a predictive relationship

only under specific circumstances (Leaf, Livingston-Bruce, & Tischler, 1987) and still others have found a lack of relationship altogether (Lefebyre, Lesage, Cyr, Toupin, & Fournier, 1998).

Ajzen's (1985) social psychological Theory of Planned Behavior (TPB) suggests that information about a person's attitudes, subjective norms, and subjective beliefs about control over possible barriers to accomplishing a behavior can help predict a person's behavior when that behavior is not completely volitional. Researchers like Abraham and Sheeran (2000), Godin and Kok (1996), and Sutton (1998) have found this theory to be effective in predicting behavior and behavioral intent in various types of circumstances. Despite this theoretical proposal, few research investigations have considered whether ethnic differences in attitudes can help clarify the ethnic discrepancies in mental health service utilization. Research shows that cultural factors related to religious beliefs, and their association with beliefs about mental illness, can be a barrier to the access of mental health services (Echeverry, 1997). For example, it is well-known that the Latino culture is intertwined with the Catholic religion. This religious belief system is also embedded with folk beliefs, which help to explain and resolve problems (Miranda, Azocar, Organista, Muñoz, & Leiberman, 1996). Furthermore, Landrine and Klonoff (1994) found that more minorities than Anglos tended to endorse supernatural causes of illness as important as compared to natural causes.

Of the existing assessments used to measure attitudes toward seeking mental health assistance, the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) continues to be the most popular assessment used in the literature (Mackenzie, Knox, Gekoski, & Macaulay, 2004). For many years, this

instrument was also the only one developed with a consideration for psychometrics, and has most often been used as "a criterion and dependent variable" (Hatchett, 2006; p. 279). However, although the ATSPPHS has been widely used for over 35 years, Hatchett noted that very little investigation had been conducted on this instrument's construct validity. Mackenzie et al. have cited concerns with conceptual (e.g., language and item content) and methodological issues (e.g., sample, factor structure, and rating scale) that limit the ATSPPHS' utility. In response to these concerns, these researchers created a new measure, the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS), in an attempt to rectify these limitations (Mackenzie et al.). Furthermore, Mackenzie et al. cited the importance of incorporating Ajzen's theories, which did not exist at the time of the ATSPPHS' development, into a current, more comprehensive measure of attitudes to aid in predicting behavior related to the use of mental health services.

This study investigated the reliability and validity of the ATSPPHS with a Mexican American and an Anglo sample. Ultimately, this research is aimed at the expansion of the current, limited knowledge of Latinos' attitudes toward seeking mental health services.

Research Questions

This research investigation quantitatively examined the validity and reliability of the ATSPPHS for use with this Mexican American sample of participants, by addressing the following questions:

1. Is the ATSPPHS a valid instrument, maintaining the original construct validity, for this sample of the Mexican American population?
2. Are the subscales of the ATSPPHS reliable for use with this with this

Mexican American sample?

3. Does the ATSPPHS result in cross-cultural equivalency when the scores of the Anglo and Mexican American samples are methodologically compared?

Chapter 2

Literature Review

Ethnic Minorities and Mental Health Care Access

In the United States, prejudice continues to negatively affect the lives of ethnic minorities (Sue & Sue, 1999) and people in need of psychiatric treatment (Rao, Feinglass, & Corrigan, 2007). America has a history of prejudice and discrimination against African Americans, Asian Americans, American Indians/Alaska Natives, and Hispanic Americans (Abreu, 1999; Balsa & McGuire, 2003). Many Latinos in the U.S., native or immigrant, have likewise reported perceived discrimination (Finch, Kolody, & Vega, 2000). Furthermore, just being a member of an ethnic minority group increases the likelihood of imprisonment and a longer-term sentencing in the legal system (Braithwaite & Arriola, 2003; Dressel & Barnhill, 1994; Freudenberg, 2002; Hartwell, 2001).

Research also indicates that ethnic minorities with symptoms or mental illness histories encounter differential access to services and different results as compared to Anglos (Pescosolido, Gardner, & Lubell, 1998; Rogler, Cortes, & Malgady, 1991). Federal and state proposals to limit access to health care services for immigrants have had negative consequences on help-seeking behaviors for mental health issues. For example, in California, anti-immigrant attitudes, behaviors and policies have resulted in a higher rate of emergency room use and have distanced Latinos from the health care system (Fenton, Catalano, & Hargreaves, 1996). In effect, the long history of maltreatment of minorities appears to have left a deep imprint on American society (Byrd & Clayton, 2001; Smedley & Smedley, 2005)

Stigma. Several factors can thwart people from seeking mental health services,

including the need to avoid discussing distressing information (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Vogel & Wester, 2003) and to circumvent experiencing associated painful emotions (Komiya, Good, & Sherrod, 2000). However, the stigma associated with seeking mental health services is most identified as the key reason people do not seek treatment (Corrigan, 2004; Corrigan & Penn, 1999). Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) underscore that negative attitudes about mental illnesses and individuals living with chronic or substance abuse disorders continue to persist.

Stigma associated with mental health, can be defined as the negative attitudes, beliefs, thoughts and behaviors that convince some people to fear, avoid, or even discriminate against individuals living with mental health disorders. These attitudes, behaviors and ways of relating only function as additional obstacles to individuals already hesitant to seek help (Corrigan, 2004; Corrigan, Green, Lundin, Kubiak, & Penn, 2001). However, the phenomenon of stigma is complex. In one recent study conducted by Anglin, Link, and Phelan (2006), African Americans were more likely than Caucasians to believe that someone with a mental illness would act violently toward others. However, they were less likely than Caucasians to endorse a punishment for such behavior. Furthermore, these results could not be accounted for by sociodemographic factors.

Cooper, Corrigan, and Watson (2003) found that people who endorse public stigma are likewise less inclined to seek mental health treatment. This type of perception reaches still further. Stigma turned inward – also known as self-stigma – has a similarly negative effect on a person's self-esteem (Corrigan, 2004), through identifying with the stigma and labeling one's self as socially undesirable. In effect, if a person decided to seek professional help, the largely negative associations of the western culture could reduce

that person's self-concept, self-esteem, and self-efficacy (Corrigan, 1998, 2004; Holmes & River, 1998). Furthermore, Corrigan (2004) cites that once the individual did attend therapy, this compounded negativity would impact the client's compliance.

There is a long-standing history of discrimination against people living with mental illnesses in American society (Abreu, 1999; Balsa & McGuire, 2003; Szasz, 2003). At one time, it was a regular practice to confine these individuals to large state hospitals, usually in rural areas, for the remainder of their lives (Lamb & Weinberger, 1998). The results of such practices left robust and enduring stereotypes and stigma in our society. Even mental health diagnoses, though intended as compassionate, provide an avenue for possible stigma (American Psychological Association; American Psychiatric Association; as cited in Gary, 2005). Thankfully, recent federal laws like the Americans with Disabilities Act (ADA; 1990) have assisted in alleviating some of these discriminatory acts (http://www.jan.wvu.edu/links/adasummary.htm, 2006). However, Americans still have a long road ahead in this struggle against stigma.

A recent concept introduced by Gary (2005), Double Stigma, aids in the illustration of the layered prejudice and discrimination that ethnic minority group members regularly encounter. People who are described as *prejudiced* hold negative thoughts and feelings about people of a different group, which is a precursor to discrimination (Bettelheim & Janowitz, 1964; Corrigan, 2004; Gary,1991; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Pinel, 1999). *Discrimination* occurs when majority group members express those negative thoughts and feelings about minority groups and act contrary to the best interest of these groups. Such actions effectively afford members of the majority group benefits and opportunities that they deny to

members of minority groups (Byrd & Clayton, 2001; Myrdal, 1996). When such a problem is observed from the perspective of a member of an ethnic minority group who is also struggling with mental distress, the concept of Double Stigma can best describe this person's experience. In sum, minority group members struggling with mental illness are likely to endure discriminatory practices from various parts of society like politicians, researchers, and clinicians (Gary).

Additionally, Atkinson, Morten, and Sue (1998) suggested that minorities may not view mental health services as related to their needs, contributing to their decision not to seek these services. One explanation Austin, Carter and Vaux (1990) and Thorn and Sarata (1998) propose that members of minority groups may not perceive counseling services as personally applicable due to the Western-oriented styles that emphasize intrapsychic processes. Certain practices in the mental health field are even believed to have done harm to minority populations by preserving inaccurate stereotypes, distorting their ways of life, and/or ignoring these populations altogether (Sue & Sue, 1999). There also continues to be too few racial and ethnic minorities in the mental health professions (Hernandez, Isaacs, Nesman, & Burns, 1998). This, in conjunction with the shortage of culturally competent mental health services, contributes to health disparities (U.S. Dept. of Health and Human Services, 1999).

There is evidence of the differential mortality and morbidity rates between ethnic minorities and Caucasians. However, race and ethnicity cannot account for the totality of the health disparities. Socioeconomic status and environmental factors, as covariates, are sometimes substituted in place of race and ethnicity as has been examined by Anderson and Nickerson (2005) and Shields et al. (2005). Research clearly indicates that a person's

illnesses and life and death circumstances are linked to that individual's socioeconomic group membership, ethnicity, gender and age (Hudson, 2005; Rowe, 2005; Smedley & Smedley, 2005). Yet, the social concept of race has assisted in the creation of legal and formal means used as justification for prejudice, discrimination, stigma, health disparities, and dubious forensic results (Anderson & Nickerson; Shields et al.; Cooper, 2005; Myrdal, 1996; Ossorio & Duster, 2005).

Latinos in the United States

The three largest subgroups that make up the heterogeneous Latino population in the United States are people of Mexican (64%), Puerto Rican (9%), and Cuban (3.4%) descent (United States Census Bureau, 2006). Despite the tendency to group them under the categories Latinos and Hispanics, these subgroups differ dramatically on demographic and sociopolitical factors that significantly impact mental health care issues. Each of these subgroups, and many others (e.g., Dominican, Guatemalan), has its own history and cultural characteristics.

Historical perspective. During the age of exploration and *conquistadores*, the indigenous peoples of the North and South American continents endured many experiences of domination and persecution. Native people in these areas were enslaved, and often forced off their homelands. Some native populations that populated these regions, such as the Taíno Indians, no longer even exist today (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). From the intermingling of the Europeans and the First Nations People evolved the *Mestizo* culture. Likewise, the unions of Europeans and the First Nations People and Africans engendered the *Criollo* and *Mulatto* ethos. Although not often cited, Asian heritage may also be a part of Latino inheritance, as the

Philippine islands were subjugated by Spain; there actually are communities of Chinese families in Mexico and other parts of South America (Santiago-Rivera, Arredondo, & Gallardo-Cooper). Thus, the Latino population is not only multicultural, but multiracial.

Migration of the largest Latino subgroups to the United States often paralleled political events. For example, one of the main catalysts for the immigration of Mexicans to the U.S. occurred during the 1900s when the need for low-cost labor rose dramatically. Puerto Ricans' mass migration occurred in the mid 1940s, just after the end of World War II. Conversely, Cuban migration occurred in three waves. The largest Cuban relocation ensued with the annexation of oil refineries and other businesses following the rise of Fidel Castro to power in the mid 1950s (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). However, unlike the Mexicans and Puerto Ricans, many of these families were well-educated and had the necessary means to flee Cuba. Like the first, the second group of Cuban migrants in the 1960s was able to establish small businesses or work in their professions here in the United States. However, the third Cuban wave in the 1980s, was not as privileged (Santiago-Rivera, Arredondo, & Gallardo-Cooper).

Due to such dissimilar histories, these three Latino subgroups continue to experience equally disparate struggles. For example, in 2000 close to one third of Latinos of Mexican and Puerto Rican descent met poverty criteria (U.S. Census Bureau, 2006). Furthermore, among individuals younger than 25 in 2000, only about 50% of Mexican and about 66% of Puerto Rican descendants had finished high school. Likewise, Puerto Rican and Cuban descendants are more likely than those of Mexican and Central American origin to be eligible for public or private health care. On the other hand, Cuban descendants have a higher socioeconomic status than other Latinos. Due to the fact that

many still arrive in the United States with official refugee status, they are eligible for public mental health care upon their arrival. As such, Cuban descendants are most likely to be in managed health care and to have private insurance (De la Torre, Frus, Hunter, & Garcia, 1996).

Aspects of Latino culture. As with other collectivistic cultures, the family is traditionally the core of the Latino American cultural structure. Family orientation, or *familismo,* suggests interdependence and cooperation. So, rather than move away from family members, as the Anglo-American culture tends toward, Latinos conversely move closer to be nearby (Falicov, 1998). Family members maintain a connection to extended family, and have a preference for relying on extended family for financial, and emotional support, as well as shared responsibility for other obligations.

There are variations as to what key components make up *familismo*. However, consistencies have included family needs before individual needs, maintenance of traditional family roles, perceived family support, *respeto* or respect, and *personalismo* or personalism. Traditional family roles are often valued and protected, and there is an explicit *respeto* for authority figures, who are often the elder family members. Even families that have been in the U.S. for many generations, like some Mexican American families, preserve this strong *familismo* value (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). The protection of traditional roles serves to preserve family ties in an organized structure. Familial interests often supersede those of the individual in a traditional Latino family. Members of the family often share responsibilities, like caring for and disciplining children, making decisions, and offering each other financial and emotional support (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Perceived

family support is the vital part of Latino *familismo*. Moreover, many Latinos traditionally believe the family shares responsibility for individual problems (Sabogal, Marín, Otero-Sabogal, Marí, & Perez-Stable, 1987), with the mother most often the main provider of emotional support (Harris, Velásquez, White, & Renteria, 2004). Research with Mexican Americans supports this, indicating that the degree of discomfort in talking about mental health issues with a mental health professional is one of the largest barriers to seeking these services (Vega, Kolody, & Aguilar-Gaxiola, 2001). Fittingly, traditionally oriented Latinos may adhere to the idea that each family member's problems are actually best treated within the family (Edgerton & Karno, 1971).

Owing to another Latino value, *personalismo,* interpersonal relationships are cultivated and strongly valued (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Accordingly, *familismo* quite often extends beyond the nuclear family to include grandparents, aunts, uncles, cousins, and even close family friends. Godparents, or *compadres,* are one example of this extension. This Spanish tradition of selection and subsequent roles of *compadres* originated back when many indigenous children were orphaned, and later adopted by other families. Godparents continue to play an important role in modern Latino families, as they are included in many celebrations and events. However, this role is now more of a social one that is often filled by prominently respected people in the community. Despite this, very often the family and *compadres* are valuable sources of support in times of need (Santiago-Rivera, Arredondo, & Gallardo-Cooper).

Religion is another integral part of Latinos' way of life. Originating in the days of the *conquistadores*, the connection with spiritual and religious values, primarily Roman

Catholic, permeates every daily task. Often Latinos call upon spiritual beliefs to make sense of tragic events and to make decisions. One familiar maxim that is common to the culture is, *si Dios quiere*, or if God wills it: this is often said when making future plans. It represents a form of respect through deference to a higher power, and exemplifies the belief that only God has control over the future. However, some researchers have at times labeled this orientation as fatalistic, or as an external locus of control, without giving credence to the total cultural context of this value (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002).

Just as in other cultural aspects, Latinos vary in their religious practices. There are many religious figures that play significant roles in the daily lives of many Latinos. For example *la Virgen de Guadalupe* (the Virgin of Guadalupe), the Virgin Mary, Christ, and other Catholic Saints are often appealed to for healing and fulfillment of life goals. Also, many will make pilgrimages to their shrines in order to express gratitude for answered prayers. The importance of these deities in the lives of many Latinos is evident in the home, through pictures, altars, and statues (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002).

Latinos and mental health. Latinos can face a variety of stressors extending beyond the issues that other U.S. residents confront. Latinos tend to have lower socioeconomic status than non-Latino Whites (U.S. Census Bureau, 2008). Many are immigrants from Mexico trying to find work, leaving support systems in Mexico which can compound their psychosocial concerns (Finch & Vega, 2003). Acculturation stress that accompanies these moves can lead to an even greater increase in their distress

(Ebin et al., 2001; Finch & Vega; Gil, Vega, & Dimas, 1994; Hovey & Magaña, 2000; Kaplan & Marks, 1990).

Professional Help-Seeking

A person's decision to seek help can be influenced by various internal and external sources. In addition to stigma and discrimination, barriers to service access, socioeconomic group membership, gender, previous experience with and/or distrust of the mental health system can have significant influence on help-seeking behavior or intentions (Corrigan, 2004; Corrigan, River, Lundin, Penn, Uphoff-Wasowski, Campion et al., 2001; Lefley, 1989; Rowe, 2005; U.S. Department of Health and Human Services, 1999).

A person's membership in a social class is determined by their level of education, income, and occupation. Research clearly indicates that those who have the least economic resources are the ones who suffer most with psychological distress (Lang, Munoz, Bernal, & Sorenson, 1982). People with less education and a lower income are also the ones often at risk for inadequate mental health care. In many cases, family resources are exhausted and people only have access to care in the public domain (Hudson, 2005), unable to afford the necessary treatments.

Studies to determine gender differences to seeking treatment have resulted in mixed findings. Research by Möller-Leimkühler (2002), for example, suggests that there are gender-role socializations and behaviors that promote differential attitudes. Some people of Latino heritage easily recognize the terms *marianismo* (for women) and *machismo* (for men) as the different cultural values attributed to the genders. Accordingly, women are traditionally encouraged to be humble, acquiescent, nurturing,

and to suffer, while men are socialized to be providers and protectors of the family (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Research generally supports the idea that men and women differ in their treatment-seeking attitudes (e.g., Leong & Zachar, 1999; Nothrman, 1978; Raviv, Sills, Raviv, & Wilansky, 2000; Tishby et al., 2001). For example, females are encouraged to seek mental health services when they perceive a need. However, Blazina and Watkins (1996), and Ortega and Alegria (2002), found that traditionally socialized men who are taught to be self-reliant and emotionally restrictive, as in the Latino culture, have more negative attitudes toward help-seeking. Sanchez and Atkinson's (1983) study, conducted with Mexican-American college students, revealed that students whose scores were lower on the factor of openness on a willingness-to-seek-help scale were those who expressed a strong loyalty to Mexican-American culture. However, in a more recent study conducted by Gonzalez et al. (2005) no gender effect was found in willingness to seek professional assistance with both Latino and African American participants.

Difficulties that are more visible or concrete, as opposed to more ambiguous, have been positively associated with seeking mental health services (Alvidrez, 1999). For example, the idea that mental illness is caused by an imbalance in lifestyle or environment, such as lack of rest, diet, or weather predicted a visit to a mental health service provider. Similarly, individuals who self-reported a substance use problem within the past year, and individuals who recognized a lack of moderation in lifestyle were also more inclined to seek assistance (Alvidrez).

In addition, across ethnic groups, individuals who personally had prior experience with mental health services, or whose family members or friends had, were more likely to

seek services (Padgett et al., 1994). Similarly, increasing length and frequency of use of these services paralleled the likelihood of current service utilization (de Figueiredo & Boerslter, 1988). As such, similar to lack of knowledge, unfamiliarity emerged as a barrier to seeking and utilizing mental health services.

Barriers. Ethnic minorities and clients with a low socioeconomic status perceive more numerous barriers to services (Alvidrez, 1999). Barriers to mental health treatment can range from the nature of a mental illness to governing federal and state laws. The nature of an illness can prevent an individual from being able to access or receive appropriate care (Brown, Schulber, & Prigerson, 2000; Kessler et al., 1994; Roy-Byrne et al., 2000). For Latinos, acculturation level and perceived social support have also been linked with the likelihood of seeking professional help (Miville & Constantine, 2006). Research (e.g., Echeverry, 1997; Schwarzbaum, 2004) indicates that ethnic minorities identify transportation, time, and cost more often than European Americans and people with a higher socioeconomic status as obstacles to accessing treatment. There continues to be a debate regarding the public policy concerns of mental health coverage inclusion in general health insurance as limited access to care persists for many (Pescosolido, Gardner, & Lubell, 1998; Pillay & Sargent, 1999; Rodriguez, Allen, Forngillo, & Chandra, 1999; Schneider, Zaslavsky, & Epstein, 2002). A national research study conducted by Padgett, Patrick, Burns, and Schlesinger (1994) revealed that even among those with equal insurance coverage some utilization differences persisted. More specifically, they found that African Americans and Latinos were less likely to make use of outpatient mental health services than European Americans with the same insurance.

Administrative processes could be another source of accessibility problems due to

language barriers and perceived discrimination. Community research data suggests that Latinos with mental health concerns report not knowing how or where to access mental health providers (Vega, Kolody, & Aguilar-Gaxiola, 2001). This knowledge and information gap may be exacerbated by low education and literacy levels. Ruiz (1985) reports that additional cultural and language barriers may further contribute to the difficulties Latinos have accessing services in the U.S. Furthermore, Taylor, Gambourg, Rivera and Laureano (2006) found that family therapists emphasized the importance of proficiency in Spanish when working with Latinos. For non-English speaking Latino clients, Sue Fujino, Hu, Takeuchi, and Zane (1991) revealed a significant association between ethnic match of therapist and decreased likelihood of dropping out of therapy. Likewise, studies conducted by Loue, Faust, and Bunce (2000), and Ginzberg (1991) revealed that Spanish-speaking immigrants are more likely to report difficulty in obtaining medical services and least likely to have health insurance.

Stress and Coping Among Latinos

Acculturative stress adds another pervasive element of concern to the adjustment of many populations. *Acculturation* makes reference to the bidirectional and interactive process of psychosocial changes that occur within a group or individual when a different culture is encountered (Alvidrez, Azocar, & Miranda, 1996; Berry, 1993). Berry, and Ponce and Atkinson (1989), report that the level of acculturation is determined by the actual changes in cognitions, attitudes, values, and behaviors that result from this interaction. Acosta (1979) and Sandoval and De La Roza (1986) note that, despite these interactions, Latinos tend to maintain close family bonds, and thus preserve their cultural distinctiveness and native language use. This often results, however, in a greater degree

of stress related to the acculturation process when compared to other minority populations (Kouyoumdjian, Zamboanga, & Hansen, 2003).

Likewise, researchers like Guarnaccia and Parra (1996), and Jenkins (1988) reiterate that it is important to look at how Latino communities and families define, understand, react to, and cope with mental health problems. Many Latino families and communities have been promoting coping with severe mental illness without professional care for years. Thus, there is very little information about the treatment experience of Latinos or what they may say to others about it (Pescosolido & Boyer, 1999). As a result, studies like those conducted by Cox and Monk (1993) and Wallace, Campbell, and Lew-Ting (1994) suggest that enhancing natural support systems and family and community caregiving could be an avenue to develop optimal care for Latino families.

Additional dynamics that could help explain underutilization are the varied beliefs about the causes of mental illness. Lower rates of mental health service use by ethnic minorities have been associated with the tendency to attribute causes of mental illness to folk beliefs such as the supernatural, spiritual, bad luck, or the result of a spell (Echeverry, 1997; Landrine & Klonoff, 1994). Likewise, these populations are more likely to ascribe mental health distress to individual responsibility (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002), like lack of strength or weakness of character (Echeverry). Some Latinos believe that some illnesses originate from the environment, due to conditions such as germs and excess cold or heat.

It is common for people to use multiple providers in differing service sectors to address mental health concerns. In a study conducted by Vega, Kolody, and Aguilar-Gaxiola (2001) 19.9% of people with a DSM disorder consulted medical doctors; 11.2%

sought out counselors, ministers/priests, and chiropractors; while 9.3% went to see mental health specialists. Additionally, many people utilized more than one resource (Vega & Lopez, 2001). Over three percent sought the assistance of all three sectors, while only one percent of the sample with recent disorders used only mental health specialists. The majority (73%) received no form of treatment in this particular study (Vega, Kolody, & Aguilar-Gaxiola). In the Latino culture if someone suggests a visit to a mental health professional, the perception is that the person being referred is 'crazy' (Echeverry, 1997). Thus, Latinos may also seek help from folk healers like Mexican *curanderos*, Puerto Rican *espiristas*, or Cuban *santeros* who utilize a variety of rituals that combine prayer and ointments, baths, or candles (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Zea, Quezada, and Belgrave (1997) add that these healers are often perceived as having more authority or power than even medical or psychological professionals.

Behavior Prediction Theories

Many researchers attribute underutilization to negative attitudes toward mental health treatment (Dubow, Lovko, Kausch, 1990; Tinsely, Brown, de St. Aubin, & Lucek, 1984; Tinsley, de St. Aubin, & Brown, 1982; Von Sydow & Reimer, 1998). In a recent study, Cramer (1999) found that seeking help was more strongly associated with attitudes toward treatment than with psychological distress. Furthermore, Fischer and Farina (1995) note that cultural affiliation can affect attitudes toward seeking professional mental health services. Theories such as Azjen's Theory of Planned Behavior (1991), suggest that a person's attitude can predict planned behavior and actual behavior. As such, research (e.g., Jorm et al., 2000; Leaf & Livingston-Bruce, 1987; Sutton, 1998) supports the assertion that attitudes are a key consideration in theories concerning help-

seeking. Longitudinal research on this topic (Jorm et al.; Leaf & Livingston-Bruce) suggests that attitudes about mental health services can predict later utilization.

Fishbein and Ajzen (1975) developed the Theory of Reasoned Action (TRA) which posits that behavior is preceded by intention. According to the TRA, intention to perform a behavior is determined by both attitudes toward the behavior and by subjective norms such as cultural context (Sutton, 1998). These pressures may evolve from a perception of social pressure to execute or avoid a specific behavior. In 1985, Ajzen elaborated the TRA to include the concept of perceived behavioral control with the Theory of Planned Behavior (TPB). In this revised theory, he proposed that behavior is best predicted by attitudes, subjective norms, and subjective beliefs about control over possible barriers, when the behavior is not completely under one's personal control. The TPB has been very effective in predicting intentions and behavior in a variety of situations (e.g., Abraham & Sheeran, 2000; Godin & Kok, 1996; Sutton, 1998).

Attitudes Toward Mental Health Services

Past research has resulted in mixed findings among cross-cultural attitudes toward mental health services. No difference between ethnic groups is reported in some studies (Furnham & Andrew, 1996; Hall & Tucker, 1985; Leaf, Livingston-Bruce, Tischler, & Holzer, 1987; Sheikh & Furnham, 2000; Wolkon, Moriwaki, & Williams, 1973), while others report less positive attitudes in ethnic minority groups (Dadfar & Friendlander, 1982; Nickerson, Helms, and Terrell, 1995; Sanchez & King, 1986). One possibility that has been proposed by Nickerson, Helms, and Terrell, as well as Whaley (2001) is that

mistrust of Whites by minority group members mediates the attitude toward seeking

professional help.

Several variables have been found to correlate with attitudes: age, gender, ethnicity, income level, education level, previous use of mental health services, religion, personality (privacy vs. disclosure), and self-esteem. Young adults, age 18-24, tend to report a less positive view of seeking help (Leaf, Livingston-Bruce, Tischler, & Holzer, 1987; Seiffge-Krenke, 1993). A large proportion of young adults does not attempt to obtain mental health services even when there is a psychiatric need (Aalto-Setala, Marttunen, Tuulio-Henriksson, Poikolainen, & Lonnqvist, 2001; Kessler et al., 2001). The understanding of how attitudes toward mental health services vary by characteristics such as ethnicity necessitates the consideration of other correlates observed to vary with such attitudes (Gonzalez, Alegria, & Prihoda, 2005).

Measures of Attitudes. The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) was developed by Fischer and Turner (1970), in an effort to illuminate attitude and personality characteristics applicable to a person's tendency to seek or to avoid professional help for psychological distress. This scale, based on rational and empirical techniques, has been widely utilized for decades as the standard tool to measure attitudes toward seeking mental health services. However, several methodological and conceptual concerns with Fischer and Turner's (1970) scale prompted researchers from Canada to develop an adapted and extended version. The primary concern Mackenzie, Knox, Gekoski, and Macaulay (2004) noted was the outdated research on which the assessment was based. Social psychological theories like the Theory of Reasoned Action and the Theory of Planned Behavior improved prediction of intentions and behavior based on attitudes and were incorporated into the items of the

updated version. Mackenzie et al. also modernized the assessment in the areas of language (e.g., gender-neutral terms), item content, rating scale size, and factor-analytic techniques for the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; 2004). In a study conducted by Sanchez and Atkinson (1983), some of the terminology of the ATSPPHS was modified in order to culturally adapt it to a Mexican-American sample. Hence, the goal of this study is to discern whether the ATSPPHS is valid and reliable for use with a Mexican-American population. Specifically, this study will evaluate the response patterns of a Mexican-American college-student sample on the ATSPPHS, and compare these to an Anglo college-student sample.

Chapter 3

Methods

Procedure and Participants

Research participants for this study were recruited via email at Texas A&M International University, the University of Texas – Pan American and the University of Oklahoma. These universities were selected based on their student population statistics and convenience. Each participant was asked to complete the anonymous demographics questionnaire and the two inventories online.

Instruments

The Attitudes Toward Seeking Professional Psychological Help Scale. The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), developed by Fischer and Turner (1970), is the focus of this study. At the time it was constructed, this instrument was the first of its kind to give appropriate consideration to methodology. The ATSPPHS is a self-report assessment, composed of 29 items, that measures help-seeking attitudes. Four orthogonal factors were found with reliability in the poor to moderate range (.62-.74). Scores range from 0-87; more positive attitudes toward seeking mental health services are gleaned from higher scores. A mean score of 58 was attained from the original standardization sample, composed of students from various educational institutions. However, no data relating to the ethnic demographics of the norming sample were found.

Acculturation Rating Scale for Mexican-Americans II. The Acculturation Rating Scale for Mexican-Americans II (ARSMA-II), developed by Cuellar, Arnold, and Maldonado (1995), was utilized to assess the acculturation level of the participants, due

to Vega, Kolody, and Aguilar-Gaxiola's (2001) findings that U.S. born Mexican Americans have a greater propensity to utilize mental health services. The ARSMA-II is a self-report, 30-item scale which measures acculturation along three primary factors: language, ethnic identity, and ethnic interaction. The ARSMA-II is an orthogonal, multidimensional scale that assesses orientation toward the Mexican culture and the Anglo culture, independently, using two subscales, a Mexican Orientation Subscale (MOS) and an Anglo Orientation Subscale (AOS). The MOS has 17 items and a coefficient alpha of .88, while the AOS has 13 items and a coefficient alpha of .83. Construct validity was established through various analyses examining generational status and acculturation. In regards to the AOS and MOS scales, a pairwise comparison of the five different generations revealed a significant difference. Likewise, a factor analysis was conducted on each of these scales. The 13 items of the AOS scale revealed two factors with eigenvalues above 1.0, while the 17 items of the MOS scale revealed three factors with eigenvalues of at least .94. Response categories to all items on ARSMA-II are based on a five-point Likert scaling format evaluating frequency and/or intensity. The ARSMA-II can generate both linear acculturation categories, Levels 1-5, and orthogonal acculturative categories (Traditional, Low Biculturals, High Biculturals, and Assimilated).

Chapter 4

Results

Descriptive Statistics

A total of 676 college students, ages 18 to 62, participated in this study. From this sample, the Anglo (n = 223) and Mexican American (n = 155) participant groups were extracted. The Anglo participants comprised those who self-identified their ethnicity as one of the following: Caucasian, White, Anglo, White American, Anglo American, or any combination thereof. The Mexican American participant group consisted of those who self-identified as one of the following: Mexican American, American of Mexican Descent, or Mexican *and* were a U.S. citizen. The majority of the participants in each group were female (78.7% female and 21.3% male in the Mexican American group; 56.7% female and 43.3% male in the Anglo group). Respondents averaged an age of 26.1 years in the Mexican American group, while the Anglo group averaged 22.8 years of age. As shown in Table 1, the largest proportion (81.2%) of Anglo participants were fifth generation, while most (43.9%) Mexican American participants were second generation.

Table 1
Generations

	Mexican Americans		**Anglo**	
Generation*	Frequency	Percent	Frequency	Percent
1st	24	15.5	0	0
2nd	68	43.9	6	2.7
3rd	30	19.4	15	6.7
4th	19	12.3	20	9.0
5th	14	9.0	181	81.2
Total	155	100.0	222	99.6

*Generations are defined in Appendix B (Demographics Questionnaire, Item 8).

In keeping with the age means, the majority of the Mexican American participants had achieved an Associate Degree (40.6%), while the majority of the Anglo participants had a High School diploma (52%; see Table 2). Conversely, income levels peaked on the highest end (above $40,000) for the Anglo group, but mainly were spread among the upper three ranges for the Mexican American group (see Table 3). About half (49.7%) of the Mexican American participants were covered by health insurance, and about half (49.7%) were not. Conversely, the majority (87.0%) of the Anglo participants were covered.

Table 2
Education

	Mexican Americans		**Anglo**	
Range	Frequency	Percent	Frequency	Percent
Graduate school	11	7.1	24	10.8
Bachelor Degree (University/College)	33	21.3	40	17.9
Associate Degree (2-year)	63	40.6	37	16.6
Technical School or Trade School	0	0	3	1.3
High School	43	27.7	116	52.0
Other	5	3.2	2	.9
none	0	0	1	.4
Total	155	100.0	223	100.0

Table 3
*Income**

	Mexican Americans		**Anglo**	
Range	Frequency	Percent	Frequency	Percent
none	8	5.2	8	3.6
$0 - $12,000	13	8.4	19	8.5
$12,001 - $20,000	31	20.0	22	9.9
$20,001 - $40,000	49	31.6	38	17.0
above $40,000	54	34.8	136	61.0
Total	155	100.0	223	100.0

*If student was financially dependent on parents, parents' income was reported

Regarding treatment, only a minority of both participant groups had actually visited a professional for mental health concerns (29.7% of Mexican Americans, and

41.7% of Anglo). Of those who responded to whether they voluntarily sought treatment or were mandated, a majority of both groups (25.1% of Anglo, and 21.3% of Mexican American) sought help on their own accord. Only 41.3% of the Mexican American group knew a relative or close friend who had sought professional help for mental health issues, but 67.3% of Anglo participants knew someone who had done so.

Analyses

Is the ATSPPHS a valid instrument, maintaining the original construct validity, for this sample of the Mexican American population? The Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS) was scored: scores range from 0-87 with higher scores suggesting a more positive attitude toward seeking professional help for mental health concerns. The means (with standard deviations in parentheses) for the scores on the ATSPPHS were 55.17 (13.42) for the Mexican American group and 52.02 (13.20) for the Anglo group, with scores ranging from, 15 to 83 and 21 to 81, respectively. A Principal Component Analysis (PCA) with a Varimax rotation (eigenvalues set at 1.00) was conducted on each of the groups' – Anglo American and Mexican American – responses to the ATSPPHS, in order to investigate the factor structure results for each group. The PCA yielded seven factors which accounted for 59.56% of the total variance for the Anglo group, and eight factors which accounted for 61.85% of the total variance for the Mexican American group (see Tables E1 - E4 in Appendix E). Item loadings for the Mexican American sample ranged from .810 to .628 on factor one, .648 to .523 on factor two, .720 to .387 on factor three, .779 to .599 on factor four, .657 to .402 on factor five, and .829 to .530 for the remaining three factors which were only composed of two items. Item loadings for the Anglo sample ranged

from .670 to .452 on factor one, .820 to .423 on factor two, .649 to .433 on factor three, .724 to .534 on factor four, .761 to .533 on factor five, .685 to .439 on factor six, and .782 to .519 on the remaining factor of only two items. It should be noted that item 28 cross loaded on factors three and six for this group.

The original four factors that were derived by Fischer and Turner (1970) were named as follows: “Recognition of personal need for professional psychological help” – items 4, 5, 6, 9, 18, 24, 25, and 26; “Tolerance of the stigma associated with psychiatric help” – items 3, 14, 20, 27, and 28; “Interpersonal openness regarding one’s problems” – items 7, 10, 13, 17, 21, 22, and 29; and “Confidence in the mental health professional” – items 1, 2, 8, 11, 12, 15, 16, 19, and 23 (Fischer & Turner, p. 84). An examination of the items that loaded on each factor for the Mexican American group (Table 4) revealed some similar constructs. The first factor appears to tap the concept of stigma, similar to the original first factor. Likewise, factors three and five mirror two other original factors, namely recognition of need for professional services and interpersonal openness (self-disclosure), respectively. These three factors are in keeping with research that suggests Mexican-Americans are concerned about stigma, privacy issues and may not be familiar with professional psychological services and their availability.

However, factor two appears to be tapping the ratio of return on investment in professional psychological services as it compares to the degree of need. This seems fitting as research on coping indicates that this group is more likely to seek the assistance of family and close friends prior to professional services. Viewed in this way, professional services would be sought in times of dire need. Finally, factor four seems to be capturing thoughtful consideration of therapy and, possibly, intent to seek it. Fishbein

and Ajzen's (1975) Theory of Reasoned Action (TRA) hypothesizes that behavior is preceded by intention. If Mexican-Americans would seek professional psychological help, it would probably be after exhausting other sources and after much consideration given the costs of stigma and self-disclosure.

It should be noted that several items that originally loaded on residual factors were moved based on secondary factor loadings (in parentheses): item 29 was placed under factor one (.336), item 17 was moved to factor 5 (.331), and item 12 to factor 2 (.378). Finally, three items that loaded on residual factors did not appear to fit, and did not load on, the retained factors, so they were not included: specifically, item 1 – "Although there are clinics for people with mental troubles, I would not have much faith in them." – did not load higher than .135 on a retained factor; item 27 – "Had I received treatment in a mental hospital, I would not feel that it ought to be 'covered up.'" – did not load above .196; and item 11 – "A person with a serious emotional disturbance would probably feel most secure in a good mental hospital." – did not load higher than -.169. It appears that these three items should be reworded or removed from the instrument.

Are the subscales of the ATSPPHS reliable for use with this with this Mexican American sample? A Cronbach's Alpha was conducted to examine reliability for each of the factors retained for each participant group. Reliabilities were in the acceptable range for both sample groups (see Tables 4 & 5). Also, a Kolmogorov-Smirnov test was conducted to assess normality of each factor distribution. As Table E5 indicates, all factors for both Anglo and Mexican American samples were significant, indicating lack of normality. Notably, three factors were significantly negatively skewed at $\alpha = .05$, and two were at $\alpha = .01$ level, for the Mexican American group, while only one ($\alpha = .05$) was

for the Anglo group. Significant kurtosis was not noted for the Mexican American group, but the Anglo group revealed two factors that were platykurtic, one at $\alpha = .05$ and one at $\alpha = .01$ (see Table E6). As a result, these findings should be interpreted with caution.

Some similar factors were derived for the Anglo group (see Table 5), which appear to parallel the original norm group factors. However, two items were moved, specifically items 6 and 27. They were included with the secondary factors in which they loaded, factors one and four, respectively. Again, several items (1, 11, 13, 14, 20, and 28) were not included in the final factors, as they did not originally load on them, and did not load on a secondary factor.

Does the ATSPPHS result in cross-cultural equivalency when the scores of the Anglo and Mexican American samples are methodologically compared? Factors extracted for each group were compared to each other, in a Pearson Product moment (*r*), yielding the results in Table 6. None of the factors correlated with each other across groups, but did correlate significantly with the other factors within their sample group. This finding suggests that these factors are not measuring similar phenomena, across groups.

Table 4

ATTSPPHS Factors for Mexican American Group

Factor 1: Tolerance of Stigma (Cronbach's α = .7738)
3. I would feel uneasy going to a psychiatrist because of what some people would think.
14. Having been a psychiatric patient is a blot on a person's life.
20. Having been mentally ill carries with it a burden of shame.
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
Factor 2: Personal Investment Verses Return (Cronbach's α = .7590)
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.
7. I would willingly confide in intimate matters to an appropriate person if I thought it might help me or a member of my family.
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.
18. I would want to get psychiatric attention if I was worried or upset for a long period of time.
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
Factor 3: Recognition of Need for Professional Psychological Help (Cronbach's α = .7513)
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.
9. Emotional difficulties, like many things, tend to work out by themselves.
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.
16. A person with an emotional problem is not likely to solve it alone; he *is* likely to solve it with professional help.
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help.
26. A person should work out his own problems; getting psychological counseling would be a last resort.
Factor 4: Consideration of Professional Psychological Services (Cronbach's α = .6494)
5. There are times when I have felt completely lost, and would have welcomed professional advice for a personal or emotional problem.
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
25. At some future time I might want to have psychological counseling.
Factor 5: Self –Disclosure (Cronbach's α = .7015)
10. There are certain problems which should not be discussed outside of one's immediate family.
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
17. I resent a person – professionally trained or not – who wants to know about my personal difficulties.
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
21. There are experiences in my life I would not discuss with anyone.
22. It is probably best not to know *everything* about oneself.

Table 5

ATTSPPHS Factors for Anglo Group

Factor 1: Recognition of Need for Professional Psychological Help (Cronbach's α = .8022)
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist..
9. Emotional difficulties, like many things, tend to work out by themselves.
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.
16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.
26. A person should work out his own problems; getting psychological counseling would be a last resort.
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
Factor 2: Faith in Professional Psychological Services (Cronbach's α = .8026)
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.
5. There are times when I have felt completely lost, and would have welcomed professional advice for a personal or emotional problem.
7. I would willingly confide in intimate matters to an appropriate person if I thought it might help me or a member of my family.
20. I would want to get psychiatric attention if I was worried or upset for a long period of time.
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
25. At some future time I might want to have psychological counseling.
Factor 3: Tolerance of Stigma (Cronbach's α = .7819)
3. I would feel uneasy going to a psychiatrist because of what some people would think.
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.
17. I resent a person – professionally trained or not – who wants to know about my personal difficulties.
21. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.
Factor 4: Self-Disclosure (Cronbach's α = .6138)
10. There are certain problems which should not be discussed outside of one's immediate family.
21. There are experiences in my life I would not discuss with anyone.
22. It is probably best not to know everything about oneself.
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."

Table 6
Intercorrelations Between Similar Factors

			Mexican American					Anglo			
	Factor		1	2	3	4	5	1	2	3	4
	1	*r*	--	.431**	.487**	.297**	.559**	.024	.024	-.010	.029
		N		150	149	150	151	150	149	149	149
	2	*r*		--	.531**	.505**	.493**	.005	.021	-.087	-.108
		N			152	153	153	153	152	152	152
Mexican	3	*r*			--	.408**	.510**	.000	.068	-.016	-.033
American		N				152	152	152	151	151	151
	4	*r*				--	.369**	-.043	.071	-.108	-.011
		N					153	153	152	152	152
	5	*r*					--	.041	.068	.087	.050
		N						153	152	152	152
	1	*r*						--	.668**	.604**	.351**
		N							219	220	219
	2	*r*							--	.609**	.280**
Anglo		N								218	217
	3	*r*								--	.534**
		N									218
	4	*r*									--

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

Finally, each participant's score on the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS) was correlated (Pearson's *r*) with age, sex, generation level, prior use of mental health services, and acculturation level for that group. Results on Table E7 display several demographic factors for the Anglo group that correlated with their score on the ATSPPHS. Conversely, none of the demographic factors for the Mexican American group correlated with their score on the ATSPPHS (see Table E8). However, number of years in the U.S., generation, and income correlated significantly with acculturation level.

Discussion

For years, researchers (e.g., Escobar et al., 1986; Loewenstein, Arguelles, Aguelles, & Linn-Fuentes, 1994; Lopez & Taussig, 1991) have discovered equivalency

problems with cognitive measures and psychodiagnostic assessments (Velasquez, Ayala, & Mendoza; as cited in Vega & Lopez, 2001). Many emphasize that these discrepancies can lead to possible misinterpretation of meaning when efforts are made to compare scores across ethnic groups (Rogler, Malgady, & Rodriguez, 1989). This study provides further support for this assertion. The scores on the ATSPPHS for the Mexican American group in this study appeared similar, even slightly higher than, those for the Anglo group. However, the original factor structure of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) did not appear to hold for the Mexican American sample, but did seem to do so for the Anglo sample. Findings revealed a five factor structure for the first group, rather than the original four derived from the norming and Anglo sample groups. Furthermore, when factors were compared between groups, none of the factors of the Mexican American sample correlated with the factors of the Anglo sample. These findings suggest that this instrument measured different constructs for each group. Mackenzie, Knox, Gekoski, and Macaulay (2004) observed that studies often use distinctive attitude assessments in order to measure varying aspects of the help-seeking process. Yet, researchers often pay little attention to the cross-cultural equivalency of these measures.

Research supports the fact that minority populations may not view psychotherapy as relevant to their needs (Atkinson, Morten, & Sue, 1998), which can add to their decision not to seek these services. Specifically, Mexican Americans often utilize other sources of support to meet their mental health needs. In this sample, the top three mental health resources Mexican Americans sought were first, a family member, followed by a family friend, then a family doctor. The Anglo group similarly ranked the first two, but

their third choice for mental health concerns was a counselor. These findings would suggest a more positive attitude for the Anglo group, as compared to the Mexican American group.

Mexican Americans also perceive more barriers to professional services than Anglos. These barriers include not only stigma and discomfort in talking about mental health issues (Vega, Kolody, & Aguilar-Gaxiola, 2001), but also lower socioeconomic status (U.S. Census Bureau, 2008), previous experience with and distrust of the mental health system (Corrigan, 2004; Corrigan, River, Lundin, Penn, Uphoff-Wasowski, Campion et al., 2001; Lefley, 1989; Rowe, 2005), and health insurance (De la Torre, Frus, Hunter, & Garcia, 1996). In this sample about half (49.7%) of the Mexican American sample had health insurance, as compared to the majority (87%) of the Anglo sample. Sixty-one percent of the Anglo sample fell in the $40,000 or more income bracket, while only 34.8% of the Mexican American sample did so, although the latter sample was generally older and more educated. Findings from this study appear to support previous findings related to barriers, despite the slightly higher level of education.

Bearing in mind all obstacles, the costs associated with seeking services may be much higher for the Mexican American group. It seems that two of the factors extracted, "Factor 4: Consideration of Professional Psychological Services" and "Factor 2: Personal Investment Verses Return" are tapping into these concepts. Mexican Americans may perceive more cost in seeking professional services than what they may obtain from them. Furthermore, the more visible or concrete the difficulty, the more inclined to seek mental health services the person will be (Alvidrez, 1999). So, they may also take more

time to consider the costs and benefits of professional psychological services after utilizing culturally appropriate alternatives, especially when confronted with an ambiguous issue such as depression or anxiety.

In addition, across ethnic groups, individuals who personally had prior experience with mental health services, or whose family members or friends had, were more likely to seek services (Padgett et al., 1994). In this sample, the Anglo group had comparatively more experience with professional psychological services, both personally and by association. However, their scores on the ATSPPHS did not reflect this difference as compared to the Mexican American sample, further suggesting that this instrument is assessing differing constructs for each group.

Research also indicates that age, generational influences and acculturation can have an impact on the decision to seek professional mental health services. Researchers (Leaf, Livingston-Bruce, Tischler, & Holzer, 1987; Seiffge-Krenke, 1993) have found that young adults, age 18-24, tend to report a less positive view of seeking help. For both sample groups in this study, the older the individual, the more likely they were to have had experience with professional psychological services. The Anglo group averaged 22.8 years of age, while the Mexican American group averaged 26.1 years. This difference could have actually contributed to the lower scores on the ATSPPHS for the Anglo group. Age was significantly correlated with scores on the ATSPPHS for the Anglos, but not the Mexican Americans. This could have been due to the lower proportion of males in the Mexican American sample.

It is noteworthy that age, years in U.S. and level of education significantly correlated with seeking professional psychological services for the Mexican American

sample (see Table E8). Meanwhile for the Anglo group, age and sex, and years in the U.S. and level of education correlated with seeking these services (see Table E7). These findings are consistent with research that indicates that older and more educated individuals are more likely to seek professional psychological services. These same demographics (among others) correlated significantly with the Anglo group's scores on the ATSPPHS, which seems fitting. However, similar correlations were not found for the demographic characteristics in the Mexican American group, which would again lead to the consideration that the ATSPPHS was measuring something different for this sample.

There also was a significant generational difference between groups. However, generational differences might not help explain the difference in ATSPPHS scores, as the majority of the Anglo sample was fifth generation, while the Mexican American group was mostly second generation. With this kind of difference, one might expect a more positive attitude from the Anglo group. However, generation also was not significantly correlated with scores on the ATSPPHS for either group. It is possible, though, that different generations within each group vary non-linearly in their view of professional psychological services. In effect, it may be that a middle generation (2^{nd} or 3^{rd}) views psychological services opposite that of either extreme generation (1^{st} or 5^{th}). Furthermore, this significant generational gap between groups could be a contributing factor to the lack of correlating constructs between groups. However, given the obtained correlations previously noted, it seems less likely so.

Regarding acculturation, the Mexican American group scored an average of .560, in Level III (Slightly Anglo Oriented, Bicultural) range, while the Anglo group averaged 2.75, in Level IV (Strongly Anglo Oriented), out of a possible five levels on the

Acculturation Rating Scale for Mexican Americans – II (ARSMA-II; Cuellar, I., Arnold, B. & Maldonado, R., 1995). As expected, the Anglo group was more Anglo oriented as compared to the Mexican American group. Interestingly, contrary to previous findings (e.g., Miville & Constantine, 2006) acculturation level did not significantly correlate with mental health service seeking behavior for either group. Also, acculturation levels for the Mexican American individuals were not significantly correlated with their scores on the ATSPPHS, as they were with the Anglo group. However, it is also possible that the prorated scores on the acculturation scale may have had an impact on these findings.

Mackenzie, Knox, Gekoski and Macaulay (2004) have named other concerns with the conceptual make up (e.g., language and item content) and methodological approach (e.g., sample, factor structure, and rating scale) to the ATSPPHS' that limit its effectiveness. Reiterating the fact that family physicians provide half of all mental health services, Mackenzie et al. raise concerns about the use of only "psychologist" and "psychiatrist") in identifying mental health professionals. In their study, Sanchez and Atkinson (1983) modified some of the terminology of the ATSPPHS in order to culturally adapt it to a Mexican-American sample. Mackenzie et al. also advocate the inclusion of social psychological theories like the Theory of Reasoned Action and the Theory of Planned Behavior, which have improved prediction of intentions and behavior based on attitudes. Research advances such as these could help alleviate some of these conceptual issues.

Limitations

The sample of participants was selected from only three Southwestern Universities in Oklahoma and Texas, which limits the representative sample groups to

college students within these geographic locations. This could have contributed to the lack of normality of factors for both groups. In addition, due to researcher error in data collection, the scores on the Acculturation Rating Scale for Mexican Americans – II had to be prorated based on 24 items (out of 30). However, the items that were omitted were balanced on the two subscales: three from the Anglo Orientation Subscale, and three from the Mexican Orientation Subscale.

Future Considerations

Future research in the development of such measures of attitudes could qualitatively seek to clarify and incorporate ethnic-bound issues, such as considerations in the decision to seek professional psychological services, as well as the various barriers to services that many Mexican Americans perceive. In fact, these various barriers could serve as a construct within an attitudes assessment.

In addition, culturally appropriate methods of support should be taken into account. Due to the fact that Mexican Americans strongly rely on family and close friends for various forms support, there may be less of a need for outside support such as professional mental health services. Furthermore, these services may not be viewed as culturally appropriate. For example, the western orientation of psychological services tends to focus on the individual, leaving out the family. Also, much of the western orientation lacks inclusion of other culturally suitable coping or healing methods. Some of these alternatives include other-focused activities, such as community service and social gatherings, which may be viewed as maladaptive in some western-oriented perspectives of psychology. Such cultural considerations could help mold appropriate assessments and professional services for populations such as Mexican Americans.

Conclusion

Little is known about Mexican Americans' attitudes to seeking psychological services, and the lack of culturally appropriate measures contributes to the inconsistent findings to date. Many researchers have utilized the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) to assess attitudes with various groups, without credence to its construct equivalency. Findings from this study appeared to support the original four factor structure for the Anglo group, but not the Mexican American group. In fact, evidence from this study supports the conjecture that the assessment measures entirely different constructs for each sample group. Given the cultural differences between the two groups, one might actually expect a difference in the factor structure. These findings coincide with prior research which advocates that assessments be normed for different cultural groups, as there may be no single measure which can reflect the various cultural contexts of our society.

In sum, future research must attend to these cross-cultural concerns by utilizing culturally appropriate constructs, in conjunction with research developments in various fields of social sciences, in efforts to assess attitudes to seeking professional psychological services with diverse ethnic groups.

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Appendix A
Recruitment Script for Participants

My name is Teresa Chapa-Cantú, and I am a doctoral student in the Department of Educational Psychology at The University of Oklahoma-Norman Campus. I invite you to participate in a research study I am conducting under the auspices of the University of Oklahoma-Norman Campus, entitled Cross-Cultural Appraisal of the Attitudes Toward Seeking Professional Psychological Help Scale (ATTSPHS). The purpose of this study is to evaluate the reliability and validity of this scale with Latino participants to determine its potential usefulness with this population.

You must be 18 years to 64 years of age to participate in this study. Your participation will involve completing three questionnaires, which should take no more than 15-20 minutes. Your involvement in the study is voluntary, and you may choose not to participate or to stop at any time. Your involvement in the study is voluntary, and you may choose not to participate or to stop at any time. The results of the research study may be published, but your name will not be used. In fact, the published results will be presented in summary form only. All information you provide will remain strictly anonymous.

The findings from this project will provide information on the utility of the ATTSPHS with a Latino population, at no cost to you other than the time it takes to complete the survey.

Upon completion of the questionnaires, you will have the opportunity to place your name in a drawing for three gift certificate cards valued at $25, which can be used anywhere. Your name and information for this drawing will not be associated in any way to the questionnaires you complete.

To participate in this study, please click on the following link: (insert link here).

Appendix B
Demographics Questionnaire

1. Age: _____

2. Sex: Male Female

3. Marital Status:
   a. married c. widowed e. never married
   b. separated d. divorced f. living with boyfriend/girlfriend

5. Which country(s) are you a citizen of? _____

6. What ethnicity do you identify yourself as? _____ (Please give only one answer.)

7. How long have you lived in the U.S.? _____ years, _____ months

8. Please indicate which generation you believe describes you best.
   a. *1st Generation* = you were born in another country, not the U.S.
   b. *2nd Generation* = you were born in the U.S., but your parents were born in another country
   c. *3rd Generation* = you and your parents were born in the U.S., but your grandparents were born in another country
   d. *4th Generation* = you and your parents were born in the U.S., but at least one of your grandparents was born in another country
   e. *5th Generation* = you, your parents, and your grandparents were all born in the U.S.

9. Family Income: (if you still depend on your parents, please use their income)
   a. $0 - $12,000 c. $20,001 - $40,000
   b. $12,001 - $20,000 d. above $40,000

10. Do you have health insurance? Yes or No

11. a. What is the highest level of education you have **completed**?
   ___ High School
   ___ Technical School or Trade School
   ___ Associate Degree
   ___ 4-Year Degree (University)
   ___ Graduate school
   b. In which country? _____

12. Have you ever visited a professional for your mental health concerns? Yes or No
   a. **If yes**, who did you visit? _____

13. Has a **family member** or a **close friend** ever visited a professional for mental health concerns? Yes or No
    a. **If yes**, who did they visit? _____

14. Please list the order in which you would visit the following for mental health concerns:

    For example, if you would visit a family member first, then a friend, then a curandera(o), you would place a **1** next to 'family member', a **2** next to 'friend', and a **3** next to 'curandera(o)'.

    Note: You **do not** have to include all of them in your list.

    ____ counselor
    ____ curandera(a)
    ____ friend
    ____ family doctor
    ____ family member
    ____ psychiatrist
    ____ psychologist
    ____ religious leader
    ____ social worker
    ____ teacher
    ____ other (specify)_____

Appendix C

The Attitudes Toward Seeking Professional Psychological Help Scale

1. Although there are clinics for people with mental troubles, I would not have much faith in them.

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

3. I would feel uneasy going to a psychiatrist because of what some people would think.

4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.

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

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

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

8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.

9. Emotional difficulties, like many things, tend to work out by themselves.

10. There are certain problems which should not be discussed outside of one's immediate family.

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

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

13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

14. Having been a psychiatric patient is a blot on a person's life.

15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.

(*Appendix C continued*)

16. A person with an emotional problem is not likely to solve it alone; he w likely to solve it with professional help.

17. I resent a person — professionally trained or not — who wants to know about my personal difficulties.

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

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

20. Having been mentally ill carries with it a burden of shame.

21. There are experiences in my life I would not discuss with anyone.

22. It is probably best not to know *everything* about oneself.

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

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

25. At some future time I might want to have psychological counseling.

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

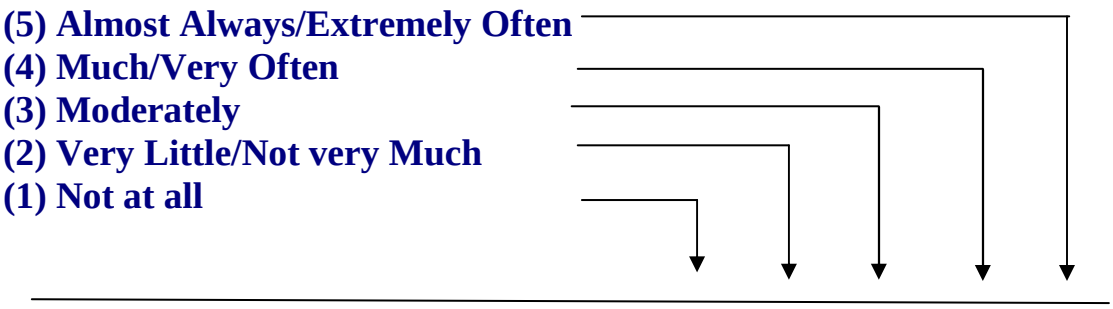
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."

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

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

Appendix D

Acculturation Rating Scale for Mexican-Americans II, Latino Version

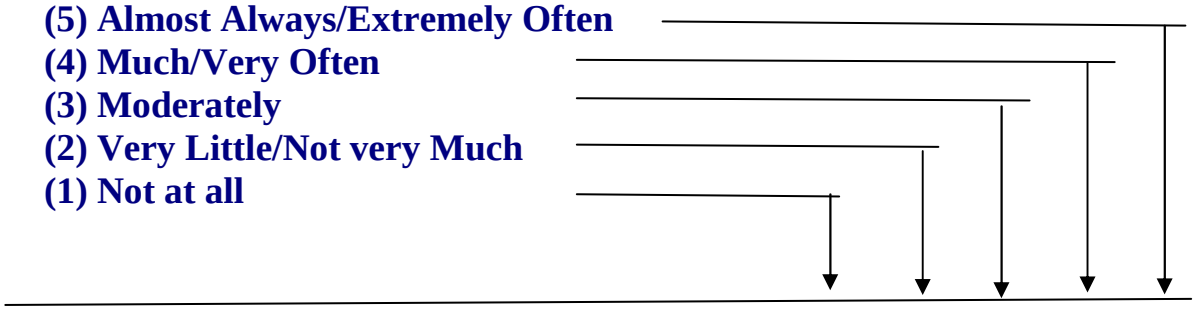


1. I speak Spanish……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
2. I speak English……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
3. I enjoy speaking Spanish……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
4. I associate with Anglos……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
5. I associate with Latinos and/or Latino American ……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
6. I enjoy Spanish language music…..……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
7. I enjoy listening to English language music……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
8. I enjoy Spanish language TV……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
9. I enjoy English language TV……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
10. I enjoy English language movies……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
11. I enjoy Spanish language movies……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
12. I enjoy reading books in Spanish……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
13. I enjoy reading books in English……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**

(*continues)*

(*Appendix D continued)*

(5) Almost Always/Extremely Often
(4) Much/Very Often
(3) Moderately
(2) Very Little/Not very Much
(1) Not at all

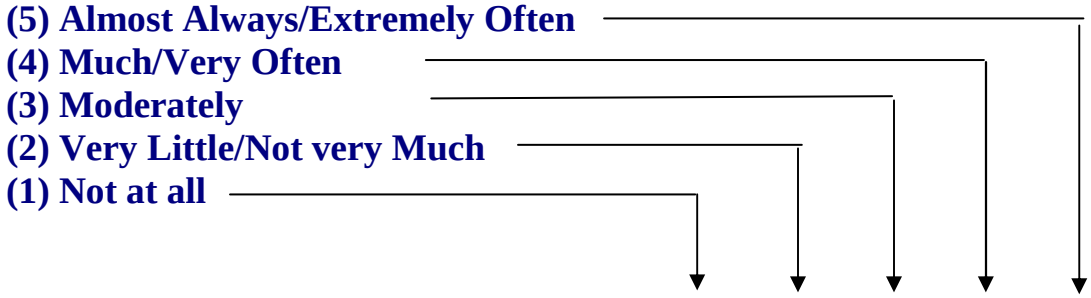


14. I write letters in Spanish……..…	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
15. I write letters in English ……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
16. My thinking is done in the English language……..……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
17. My thinking is done in the Spanish language……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
18. ..My contact with Mexico/Puerto Rico, or Other Latin American country has been……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
19. My contact with the USA has been……..…	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
20. My father identifies or identified himself as "Latino"….……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
21. My mother identifies or identified herself as "Latina'……..……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
22. My friends while I was growing up were of Latino origin ……..……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
23. My friends while I was growing up were of Anglo origin …….……..……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
24. My family cooks Latino foods ……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**

(*continues)*

(*Appendix D continued)*

(5) Almost Always/Extremely Often
(4) Much/Very Often
(3) Moderately
(2) Very Little/Not very Much
(1) Not at all



25. My friends now are of Anglo origin……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
26. My friends now are of Latino origin……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
27. I like to identify myself as an Anglo American……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
28. I like to identify myself as Latino American……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
29. I like to identify myself as Latino……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**
30. I like to identify myself as American ……	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**

The term Latino is not gender specific and is used here to designate both genders. This version substitutes the word Latino for Mexican so that this scale can be administered to subLatino groups other than Mexican.

My experience is that these modifications and other minor modifications can generally be made without losing reliability or validity. Israel Cuellar

Appendix E
Tables

Table E1
Factor Analysis of ATSPPHS for Anglo Sample

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	8.367	28.852	28.852	8.367	28.852	28.852	3.634	12.531	12.531
2	2.376	8.192	37.044	2.376	8.192	37.044	3.246	11.192	23.722
3	1.730	5.966	43.010	1.730	5.966	43.010	2.547	8.784	32.507
4	1.398	4.820	47.830	1.398	4.820	47.830	2.229	7.688	40.195
5	1.305	4.500	52.330	1.305	4.500	52.330	2.142	7.385	47.580
6	1.073	3.700	56.030	1.073	3.700	56.030	1.770	6.102	53.682
7	1.025	3.534	59.564	1.025	3.534	59.564	1.706	5.882	59.564

Extraction Method: Principal Component Analysis

Table E2
Factor Analysis of ATSPPHS for Mexican American Sample

Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	7.657	26.403	26.403	7.657	26.403	26.403	3.179	10.963	10.963
2	2.182	7.523	33.926	2.182	7.523	33.926	2.818	9.718	20.680
3	1.750	6.034	39.959	1.750	6.034	39.959	2.714	9.357	30.037
4	1.523	5.252	45.212	1.523	5.252	45.212	2.359	8.135	38.173
5	1.394	4.807	50.019	1.394	4.807	50.019	2.144	7.393	45.566
6	1.180	4.070	54.088	1.180	4.070	54.088	1.608	5.544	51.109
7	1.149	3.963	58.052	1.149	3.963	58.052	1.591	5.487	56.596
8	1.102	3.800	61.852	1.102	3.800	61.852	1.524	5.256	61.852

Extraction Method: Principal Component Analysis.

Table E3

ATSPPHS Rotated (Varimax) Component Matrix for Anglo Sample

	Component						
Item	1	2	3	4	5	6	7
1. Although there are clinics for people with mental troubles, I would not have much faith in them.	9.425E-02	8.768E-02	.216	7.960E-02	.185	8.486E-02	.782
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.	.134	.423	-.290	-1.972E-02	.181	.298	.350
3. I would feel uneasy going to a psychiatrist because of what some people would think.	.323	.293	.457	.313	.283	.228	.109
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.	.597	.179	-4.338E-02	-2.282E-02	.218	-2.523E-02	.265
5. There are times when I have felt completely lost, and would have welcomed professional advice for a personal or emotional problem.	.208	.820	5.703E-02	-6.441E-02	-7.847E-03	9.135E-05	-2.916E-02
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	.419	.375	.203	.170	2.955E-02	6.009E-02	.516
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	4.883E-02	.440	.348	.235	.252	-6.542E-02	3.355E-02
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.	.267	.202	.625	3.439E-02	.143	.161	.194

(table continues)

Table E3 (continued)

	Component						
Item	1	2	3	4	5	6	7
9. Emotional difficulties, like many things, tend to work out by themselves.	.670	.162	.208	.201	1.661E-03	-1.733E-02	-.130
10. There are certain problems which should not be discussed outside of one's immediate family.	.376	.135	-.192	.554	.179	-5.040E-02	-1.378E-02
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.	.160	-3.837E-02	-5.421E-02	-8.368E-02	4.071E-02	.685	5.021E-02
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	.452	.179	.175	-.105	-5.519E-02	.444	.271
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	9.442E-02	8.914E-02	1.048E-02	.243	.533	-.482	.242
14. Having been a psychiatric patient is a blot on a person's life.	4.285E-02	9.998E-02	.256	6.064E-02	.719	.101	5.422E-02
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.	.601	.180	.205	5.656E-02	-4.602E-02	9.511E-02	.294
16. A person with an emotional problem is not likely to solve it alone; he *is* likely to solve it with professional help.	.648	.111	1.584E-02	6.332E-02	-8.240E-02	.207	.121
17. I resent a person - professionally trained or not - who wants to know about my personal difficulties.	7.463E-02	5.877E-02	.649	.158	.261	-.151	9.120E-02
18. I would want to get psychiatric attention if I was worried or upset for a long period of time.	.241	.646	.255	4.142E-02	-5.983E-02	4.120E-02	.324
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	.269	.419	.433	.294	.116	-6.952E-02	.218
20. Having been mentally ill carries with it a burden of shame.	.115	-.102	.143	3.237E-02	.761	.148	7.110E-02

(table continues)

Table E3 (continued)

	Component						
Item	1	2	3	4	5	6	7
21. There are experiences in my life I would not discuss with anyone.	.152	2.148E-02	.107	.685	9.475E-02	3.775E-02	-2.748E-02
22. It is probably best not to know *everything* about oneself.	-6.891E-02	7.294E-02	.184	.724	-6.593E-02	-3.390E-02	.111
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	.318	.488	.460	4.552E-02	1.268E-03	.181	.298
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help.	.656	.202	.213	.147	.255	-6.306E-02	-9.351E-02
25. At some future time I might want to have psychological counseling.	.381	.772	5.763E-02	.151	-1.123E-02	2.377E-02	8.201E-02
26. A person should work out his own problems; getting psychological counseling would be a last resort.	.576	.347	.137	.112	.341	-1.078E-02	6.740E-02
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."	-.157	6.949E-02	6.377E-02	.346	.262	.582	.158
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.	4.719E-02	.372	.439	.166	.275	.439	-8.415E-02
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.	.172	-3.876E-02	.460	.534	.114	1.504E-02	9.529E-02

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 11 iterations.

Table E4
ATSPPHS Rotated (Varimax) Component Matrix for Mexican American Sample

	Component							
Item	1	2	3	4	5	6	7	8
1. Although there are clinics for people with mental troubles, I would not have much faith in them.	.135	5.703E-02	.127	9.502E-02	-.160	.796	1.119E-02	.214
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.	-8.626E-02	.648	.168	9.252E-02	-9.677E-02	6.127E-02	-4.586E-03	.130
3. I would feel uneasy going to a psychiatrist because of what some people would think.	.673	2.404E-02	.367	.145	8.191E-02	-9.084E-02	6.916E-02	4.320E-02
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.	.138	7.489E-02	.720	4.503E-02	3.362E-02	.409	5.523E-03	-6.439E-02
5. There are times when I have felt completely lost, and would have welcomed professional advice for a personal or emotional problem.	-.118	.218	7.384E-04	.718	.130	8.408E-02	-1.463E-02	-.184
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	.418	6.507E-02	.131	.599	1.736E-03	.122	2.318E-02	1.722E-02
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	.110	.523	-7.359E-02	3.804E-02	.203	.293	.317	-8.923E-02
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.	.399	.600	.174	.120	.134	4.912E-02	-3.667E-02	-.118

(table continues)

Table E4 (continued)

	Component							
Item	1	2	3	4	5	6	7	8
9. Emotional difficulties, like many things, tend to work out by themselves.	6.820E-02	.182	.720	4.179E-02	7.998E-03	-2.342E-02	.264	-.187
10. There are certain problems which should not be discussed outside of one's immediate family.	.113	-2.975E-02	6.239E-02	.193	.657	-.134	.311	4.548E-03
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.	-1.219E-02	-1.732E-03	-.169	-7.362E-02	-2.517E-02	8.054E-02	4.253E-02	.829
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	.200	.378	.222	.288	.154	-8.973E-04	6.310E-02	.530
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	.154	-.205	.119	-.123	.576	.170	-.105	4.481E-02
14. Having been a psychiatric patient is a blot on a person's life.	.730	9.217E-02	.173	-5.879E-02	.211	.187	.141	-2.942E-02
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.	.312	.330	.551	.204	.145	-.105	4.048E-03	7.948E-02
16. A person with an emotional problem is not likely to solve it alone; he *is* likely to solve it with professional help.	4.212E-03	.269	.387	.260	.353	-3.872E-02	-.295	.265
17. I resent a person - professionally trained or not - who wants to know about my personal difficulties.	2.891E-02	.326	-.124	.154	.331	.634	.108	-.127
18. I would want to get psychiatric attention if I was worried or upset for a long period of time.	.131	.602	.193	.246	-.153	.156	-8.977E-02	2.675E-02
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	.251	.306	.178	.253	.402	.310	.298	-.156
20. Having been mentally ill carries with it a burden of shame.	.810	6.704E-02	-9.517E-02	6.206E-02	7.992E-02	2.909E-02	1.696E-02	-2.303E-02
21. There are experiences in my life I would not discuss with anyone.	.423	.245	8.271E-02	.207	.435	3.458E-02	.168	4.160E-03

(table continues)

Table E4 (continued)

	Component							
Item	1	2	3	4	5	6	7	8
22. It is probably best not to know *everything* about oneself.	.218	.478	.159	-4.132E-02	.509	-5.014E-02	.171	9.253E-02
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	.223	.555	.162	.490	2.050E-02	1.848E-02	6.970E-02	.162
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help.	.260	2.260E-03	.478	.133	.430	-3.972E-02	-.269	-.127
25. At some future time I might want to have psychological counseling.	9.142E-02	.126	.223	.779	2.517E-02	5.711E-02	.158	.162
26. A person should work out his own problems; getting psychological counseling would be a last resort.	7.848E-02	.203	.558	.262	.255	-4.710E-02	.107	.162
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."	.106	-3.655E-02	5.691E-02	.170	9.932E-02	1.462E-02	.754	.196
28. If I thought I needed psychiatric help, I would get it no matter who knew about it.	.628	.204	.187	9.316E-02	.162	.172	.183	.292
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.	.336	.177	.293	-6.992E-02	.100	.135	.558	-.219

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 16 iterations.

Table E5

Normality of ATSPPHS Factors

	Kolmogorov-Smirnov					
Factor	**Anglo**			**Mexican American**		
	Statistic	df	Sig.	Statistic	df	Sig.
1	.090	214	.000	.121	147	.000
2	.102	214	.000	.106	147	.000
3	.093	214	.000	.088	147	.007
4	.106	214	.000	.134	147	.000
5	--	--	--	.106	147	.000

a. Lilliefors Significance Correction

Table E6

Skewness and Kurtosis for ATSPPHS Factors

	Anglo American						**Mexican American**					
Factor	Skewness			Kurtosis			Skewness			Kurtosis		
	Stat.	Std. Error	Sig. Level	Stat.	Std. Error	Sig. Level	Stat.	Std. Error	Sig. Level	Stat.	Std. Error	Sig. Level
1	.227	.166	1.37	-.399	.331	-1.20	-.569	.200	-2.845*	-.147	.397	-.370
2	-.207	.166	-1.25	-.918	.331	-2.77**	-.758	.200	-3.79**	.587	.397	1.48
3	-.333	.166	-2.01*	-.375	.331	-2.01*	-.126	.200	-.63	-.675	.397	-1.700
4	-.296	.166	-1.78	-.114	.331	-.344	-.618	.200	-3.09**	.086	.397	.217
5	--	--	--	--	--	--	-.211	.200	-1.055	-.552	.397	-1.39

*significant at the .05 level

**significant at the .01 level

Table E7

Intercorrelations for Anglo Americans

		Age	Sex	Years in U.S.	Generation	Income	Level of Education	Visited Professional	Family / Friend Visited	Acculturation[1]	ATSPPHS Score
Age	*r*	--	-.089	.895**	-.215**	-.153*	.535**	.179**	.207**	.139*	.209**
	N		223	216	222	215	220	222	221	211	223
Sex[2]	*r*		--	-.033	.107	.030	-.094	-.299**	-.159*	-.061	-.273**
	N			216	222	215	220	222	221	211	223
Years in U.S.	*r*			--	-.106	-.053	.462**	.142*	.150*	.130	.229**
	N				215	209	214	216	215	204	216
Generation	*r*				--	.169*	-.130	-.031	-.077	.057	-.067
	N					214	219	221	220	210	222
Income	*r*					--	-.188**	-.015	-.067	-.021	-.158*
	N						214	215	215	203	215
Level of Education	*r*						--	.171*	.166*	.041	.245**
	N							220	219	208	220
Visited Professional	*r*							--	.429**	.019	.408**
	N								221	210	222
Family / Friend Visited	*r*								--	-.017	.276**
	N									209	221
Acculturation[a]	*r*									--	.055
	N										211
ATSPPHS Score	*r*										--

1. Score prorated based on 24 (of 30) items.
2. Female coded as 1, Male coded as 2

* Correlation is significant at the 0.05 level (2-tailed).

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

Table E8

Intercorrelations for Mexican Americans

		Age	Sex	Years in U.S.	Generation	Income	Level of Education	Visited Professional	Family / Friend Visited	Acculturation[1]	ATSPPHS Score
Age	*r*	--	-.004	.794**	.044	.166*	.419**	.218**	.138	.033	.117
	N		155	154	155	147	155	155	153	146	155
Sex[2]	*r*		--	-.078	-.059	-.040	.062	.042	-.013	-.100	-.089
	N			154	155	147	155	155	153	146	155
Years in U.S.	*r*			--	.193*	.214**	.286**	.215**	.142	.251**	.101
	N				154	146	154	154	152	145	154
Generation	*r*				--	.354**	-.009	-.067	.089	.531**	.013
	N					147	155	155	153	146	155
Income	*r*					--	.176*	.168*	.125	.310**	.065
	N						147	147	145	139	147
Level of Education	*r*						--	.234**	.124	.001	.097
	N							155	153	146	155
Visited Professional	*r*							--	.253**	.103	.084
	N								153	146	155
Family / Friend Visited	*r*								--	.143	.118
	N									144	153
Acculturation[a]	*r*									--	-.060
	N										146
ATSPPHS Score	*r*										--

1. Score prorated based on 24 (of 30) items.
2. Female coded as 1, Male coded as 2

* Correlation is significant at the 0.05 level (2-tailed).

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