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USING THE ATMHS SCALE TO DETERMINE DIFFERENCES IN ATTITUDES
TOWARD VARIOUS MENTAL HEALTH PROFESSIONALS

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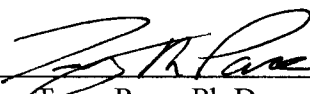
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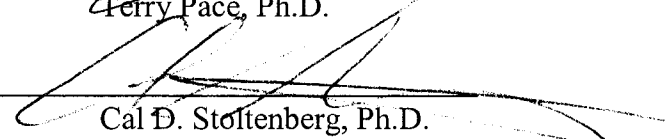
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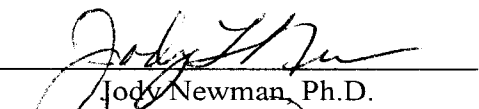
USING THE ATMHS SCALE TO DETERMINE DIFFERENCES IN ATTITUDES
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A Dissertation APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

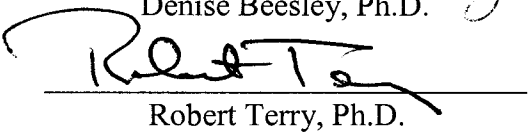
BY


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Abstract

This present study represents a systematic attempt to examine participants' attitudes toward seeking help from psychologists and psychiatrists using a psychometrically sound attitude scale, specifically the Attitude toward Mental Health Services (ATMHS) scale. The design for this experiment was a 2x2 between groups design. A sample of approximately 160 undergraduate students was utilized for this study. Analyses of Variance and a Multivariate Analyses of Variance were used to examine participants' scores on the ATMHS scale. The results of this study suggested that this sample was relatively knowledgeable about the roles and responsibilities of both psychologists and psychiatrists. Additionally, the results also suggested that participants' attitudes toward seeking help did not differ based upon whether or not they were considering seeking help from a psychologist or psychiatrist. However, this result approached significance, and may reflect a meaningful difference given that the power to detect smaller but meaningful differences was limited due to sample size. When examining further it was found that participants significantly differed on two of the three factor scores that make up the ATMHS scale: Internal/External Coping resources and Fear of Stigma. Implications related to this finding for both the professions of psychology and psychiatry was also discussed.

Using the ATMHS Scale to Determine Differences in Attitudes toward Various Mental Health Professionals

It has been suggested that a substantial service gap exists between those in need of mental health services and those who actually seek mental health services (Stefl & Prosperi, 1985). In fact, by conducting an Epidemiologic Catchment Area Survey (ECA) Kushner & Sher (1991) found that at any given time approximately 15% of the United States population is in need of mental health services. However, only approximately 3% of these individuals actually follow through and seek the help that they need (Kushner & Sher, 1991). This begs the question of why. Why do some individuals so readily seek help whereas others refuse to seek help or only seek help after problems become unbearable?

External Barriers toward Help-Seeking

There appear to be numerous barriers that prevent or deter individuals from seeking help from mental health practitioners, one of which appears to be economic. According to Stefl and Prosperi (1985) affordability appears to be a dominant service barrier. Specifically, according to the National Statistics on Psychological Problems (2003) approximately 38% of individuals whose mental health needs were unmet reported that they could not afford the cost of such services. Other researchers have suggested that additional pragmatic issues such as difficulty in transportation, and not being able to spare time prevent help-seeking (Acosta, 1980). It has also been found that availability or more specifically not knowing that services are available and not knowing where services are located can affect mental health utilization (Stelf & Prosperi, 1985). For instance, it has been found that approximately 18% of individuals whose mental

health needs were unmet reported that they did not know where to go for services (“National Institute”, 2003). According to Kushner and Sher (1991) these pragmatic issues have been defined as external barriers toward seeking help. These researchers suggest that there are also certain internal barriers that may prevent individuals from seeking help.

Internal Barriers toward Seeking Help

With respect to internal barriers research has shown that certain attitudes, preconceptions, and beliefs may prevent individuals from seeking help. Attitudes toward mental health services are constructs that have received much attention in the literature. This attention has focused mainly on identifying different dimensions of the construct of attitudes toward help-seeking (Paris & Pace, 2000) and how these dimensions relate to seeking help. For instance, Kushner and Sher (1991) reported that fears, negative judgments and negative expectations can serve as barriers to mental health utilization. Additionally, these attitudes may also affect the course as well as the outcome of psychological treatment (Kushner & Sher, 1991). Below are a number of attitude categories that have received support throughout the literature.

Recognition of Personal Need for Professional Psychological Help

The attitude construct of recognition of personal need for professional psychological help assesses one’s recognition of the value of professional mental health services for alleviating personal or emotional problems (Paris & Pace, 2000). Previous research has shown that recognition of personal need has had tremendous impact on one’s willingness to seek professional help. For instance, many researchers who propose models of seeking psychotherapy claim that the first step in the help-seeking model is the

process of recognizing that a problem exists (Meile & Whitt, 1981). It has likewise been found by Saunders (1993) that this step is the most time-consuming and most difficult to achieve. This initial step has been shown to be more difficult in some cultures as compared to others. For example, Asians have been shown to focus more on the somatic accompaniments of emotional problems, which in turn may lead them to seek help from the traditional medical sector (Sue & Morishima, 1982).

Tolerance of Stigma

The attitude construct of tolerance of stigma has probably been one of the most researched constructs in the literature. This construct pertains to one's concern/fear that others might view the use of mental health services negatively, which in turn would be socially stigmatizing for a mental health client. It has been shown that this fear of being stigmatized affects whether or not one seeks help. Specifically, it has been shown that for those in need of help but not seeking help, the fear of stigma is twice as high compared to those who are utilizing mental health services (Stefl & Prosperi, 1985). Additionally, Farina and Ring (1965) have shown that believing an individual to be mentally ill strongly influences the perception of that individual in a negative way. Specifically, these researchers have shown that individuals who were perceived to be mentally ill were ostracized by their co-workers, meaning that the co-workers were more likely to prefer working alone than with those individuals. Also, co-workers were more likely to blame the perceived mentally ill individual for inadequacies in his or her work even when the perceived mentally ill individual did not warrant such a response. Likewise, Jones, Hester, Farina, and Davis (1959) demonstrated that when participants listened to standardized taped interviews they were more likely to dislike the speaker

(interviewee) when they were told that this individual was maladjusted. This stigma is also evident among different populations. For instance, Esters, Cooker, and Ittenbach (1998) have alluded to the idea that people from rural areas are likely to underutilize mental health services due to the stigma of help-seeking. Additionally, research has also supported the idea that the fear of stigma is a multifaceted construct that is affected by ethnicity (Kushner & Sher, 1991). Studies have also shown that this stigma is very resistant to change. Newcomb (1947) called this phenomenon “autistic hostility.” He explained that the stigma/attitudes that individuals hold toward the mentally ill are resistant to change because the individuals holding these biases cease to communicate with the individual(s) perceived as being mentally ill.

Interpersonal Openness regarding one's Problems

This attitude construct pertains to one's willingness to self disclose and to be interpersonally open. Additionally, this construct pertains to the belief that mental health services are a means to psychological insight, personal growth, and self-awareness. Common sense, and a number of research studies, tell us that individuals who are unwilling to self disclose are less likely to seek psychological services mainly because self-disclosure plays a major part in any type of therapy. For instance, Kelly and Achter (1995) demonstrated that high self-concealers, individuals who tend to keep information secret, have less favorable attitudes toward counseling as compared to low self-concealers, or individuals who tend not to keep information secret. These researchers stated that this is because high self-concealers fear the fact that counseling will require them to reveal highly personal information. What is of interest to note, though, is that both Kelly and Achter (1995) and Cepeda-Benito and Short (1998) have shown that high

self-concealers are more likely than low self-concealers to actually engage in seeking psychological help. There are a few possible explanations for this finding. One is that individuals who keep secrets are more likely to have various psychological problems than those who do not keep secrets (Saffer, Sansone, & Gentry, 1979). Therefore, these individuals would be more likely to seek help simply because they are more likely to have problems which warrant help-seeking. An alternative explanation is that since research has shown that high self-concealers have weaker social support networks (Larson & Chastain, 1990), they may desire to seek counseling as a way to fill the void of having little social support (Kelly & Achter, 1995). Simply put, because these individuals are not likely to have many friends or confidants, their only way to talk to someone and get advice and support may be to see a mental health professional.

Most research seems to suggest that those who end up utilizing mental health services only do so after exhausting all other means. For instance, Kleinke and Kane (1998) found that lay people reported that inner control and understanding are the most useful approaches for overcoming mental health problems. This finding had been substantiated by Furnham and Henley (1988). Additionally, it was found that individuals prefer to rely on themselves first for help. If they are unsuccessful in dealing with their problem internally, only then are they likely to seek counseling (Cook, Park, Williams, Webb, Nicholson, Schneider & Bossman, 1984).

Confidence in Mental Health Professionals

This attitude construct is intended to assess how confident one is in mental health professionals (Paris & Pace, 2000). Many studies have been conducted demonstrating that a gap exists between the need for help and the utilization of mental health services

(Stefl & Prosperi, 1985). Studies also show that this gap varies among populations. For example, Sanchez and Atkinson (1983) demonstrated that Mexican Americans under-use mental health services. Likewise, Dadfer and Friedlander (1982) have shown that western students (European and Latin) have more positive attitudes toward counseling as compared to non-western students (Asian and African). Sue (1977) has also shown that Euro Americans are more likely to seek counseling whereas Asian-Americans and Chicano's are underrepresented. These different rates of utilization are partly due to different populations' confidence in mental health professionals. In general, studies have demonstrated that the younger, the better educated, non-minorities, and the relatively wealthy are more likely to have positive attitudes toward mental health services (Nickerson, Helms, & Terrell, 1994). It has been shown that individuals are more likely to seek counseling when their attitudes/confidence toward counseling are positive (Cramer, 1999). Not only do different populations differ in their level of confidence in mental health professionals, but mental health professionals differ in their level of confidence in the perceived success of therapy in different populations. For instance, Brill and Storow (1960) stated that working-class persons are less likely to be accepted into therapy as compared to middle-class individuals. Likewise, Sue (1977) demonstrated that African Americans received differential treatment from mental health professionals and had poorer outcomes than Euro Americans. Finally, researchers have shown that individuals who have had counseling in the past have a more favorable view of counseling and have been shown to be more likely to seek help in the future (Cash, Kehr, & Salzbach, 1978).

Severity of Problem

The severity of problem attitude construct assesses how the severity of distress that the individual is experiencing influences one's attitudes toward seeking mental health services (Paris & Pace, 2000). It has been shown that individuals are more likely to seek counseling when distress is high (Cramer, 1999). This may be because individuals are more likely to recognize a need for psychological help when they are very distressed. The construct of "severity of problem" is somewhat related to the "recognition of need" construct. Hinson and Swanson (1993) have also shown that related to distress, individuals who perceived their problems to be severe were more likely to recognize a problem as well as more likely to seek help for their problem.

Role of Others

The "role of others" construct assesses how others influence one's attitudes concerning mental health services (Paris & Pace, 2000). Research has shown that the role of others is very important in one's decision to seek help for psychological problems (Saunders, 1996). Specifically, it has been shown that the social support system is an important resource that one utilizes for determining when formal help is needed (Gourash, 1978). Along with this, it is theoretically possible that this attitude may play a more important role in some cultures as compared to others. For instance, as stated previously, Asians have been shown to focus more on the somatic accompaniments of emotional problems, which in turn may lead them to seek help from the traditional medical sector (Sue & Morishima, 1982). Therefore, within this ethnic group the role of the medical sector may be very important in determining whether or not an individual decides to seek mental health services.

As demonstrated by this review, there are many different attitudes that individuals can hold that may affect their willingness to seek, accept or reject mental health services. Research on gender and ethnic differences and how these differences relate to mental health service utilization support the usefulness of studying attitudes. Previous research dealing with men and women's attitudes toward seeking help have shown there to be a gender difference. In general, research suggests that women display more positive attitudes toward counseling (Cook et al., 1984). Specifically, Kessler, Brown, and Broman (1981) have shown that men are less likely to seek help and that women are more likely to perceive themselves to be in need of psychological help. Also, these researchers alluded to the fact that this research may also explain the research done by Tudor, Tudor, and Gove (1977) which has shown that men are more likely to be labeled as mentally ill and to be involuntary committed. Kessler et al. (1981) hypothesized that men are more likely to be involuntarily committed because it takes them so long to recognize that they have problems. Consequently, by the time they recognize their emotional problems, their functioning has degenerated to the point that they need involuntary commitment. Additionally, this research alluded to the fact that women show a greater willingness to seek help before problems become too serious (Cook et al., 1984). Kessler et al. (1981) hypothesized that this could possibly be why self-report and treatment data have shown that women have higher rates of mild psychiatric disorders than men. They hypothesized that women are more sensitive to their feelings. Therefore, women are more likely to recognize less severe psychological problems, and are more likely to act on these feelings.

With respect to ethnic differences, research has shown that there are differences in mental health service utilization among different cultures/races (Horowitz, 1987).

Specifically, research suggests that Asian and Latino/Americans come from cultural backgrounds where discussing emotions with others outside of the family is looked down upon (Garrison, 1977; Lin et al., 1978; Sanchez et al., 1983). Jewish Americans on the other hand hold more favorable attitudes toward help-seeking and are more likely to seek help because their cultural background is congruent with the idea of help-seeking. Additionally, with respect to African Americans, it has been found that this particular ethnic group seriously underutilizes mental health services (Neighbors, 1988).

The body of literature summarized above has demonstrated that attitudes toward help-seeking can differ between people based upon gender, age, prior experience, socioeconomic status and ethnicity. However, these attitudes and perceptions can also vary depending upon what type of mental health professional one is considering seeking help from (Tinsley, Brown, De St. Aubin, & Lucek, 1984). For instance, Kushner and Sher (1991) found that people have different expectations as well as different fears when considering seeking help from different mental health professionals. Further, these researchers explained that these expectations and fears affect the actual process of help-seeking as well as the course and duration of therapy.

The Public's View of the Roles of Psychologists and Psychiatrists

Most research in the area of public's perceptions and attitudes toward mental health services have examined the professions of psychiatrists, psychologists, nonpsychiatric physicians and clergy (Schindler, Berren, Hannah, Beigel, & Santiago, 1987). In general, this literature has not been in much agreement. This is especially true

of the research regarding perceptions and attitudes toward psychologists as compared to psychiatrists. It has been suggested that this is because of the change in roles among these particular professionals over the past two to three decades (Schindler et al., 1987). For example, Schindler et al. (1987) explained that psychologists and psychiatrists have experienced dramatic changes in their roles and responsibilities since World War II and that these changes have caused some public confusion about what types of services these professionals provide.

In the late 1950's the public viewed psychologists to be teachers and scientists whereas they viewed psychiatrists as the healers and the professionals that would be involved in therapy (Tallent & Reiss, 1959). Additionally, these researchers reported that the psychologist would likely be employed in schools, labs or industry (Tallent & Reiss, 1959). In effect, the psychologist was thought to provide the patient with testing whereas the psychiatrist's role was to treat the patient with psychotherapy and medication. It appears that these perceptions were relatively consistent for another decade. In 1967 Thumin and Zebelman conducted a study in which they found that psychologists were viewed as researchers of human behavior whereas psychiatrists were more associated with medicine and helping people to overcome emotional difficulties. According to these researchers, most people reported that they would consult psychologists if they wanted to determine the IQ of their child but would consult a psychiatrist if they felt depressed or were mentally ill (Thumin & Zebelman, 1967). What is interesting to note is that when asked what professional one was likely to seek help from, psychologists were ranked as the least preferred of the six professionals listed (Thumin & Zebelman, 1967). It was commonly found that the more medical the

profession, the more positively the professional was rated (Nunnally & Kittross, 1958). For instance, doctors and nurses were rated as the most positive followed by psychiatrists and then psychologists (Nunnally & Kittross, 1958). It has been suggested that perhaps the more negative ratings of psychologists were due to the fact that little was known about these professionals (Nunally & Kittross, 1985).

Within the last two decades the public's perceptions of psychologists have become more favorable. Webb and Speer (1986) reported that participants in their study viewed psychologists in a favorable light. In fact these researchers reported that participants practically equated psychiatrists with psychologists. The only difference these researchers found was that psychologists were still not viewed to be as scientific as psychiatrists (Webb & Speer, 1986). Likewise, Zytowski, Casas, Gilbert, Lent, and Simon (1988) also found that psychology was consistently viewed as a favorable profession. These researchers suggested that the reasons why this profession is now being viewed more positively may be because knowledge of this field is increasing. However, Zytowski et al. (1988) were quick to point out that though knowledge of this field is on the increase, the public still does not appear to have an accurate understanding of the role of psychologists. Murstien and Fontaine (1993) recently found that knowledge of psychologists was still rather poor and that there still appears to be public confusion in differentiating the roles and responsibilities of various mental health professionals, particularly that of psychologists and psychiatrists. This finding has been supported by numerous authors. For instance, Fall, Levitov, Jennings and Eberts (2000) conducted a study in which they explained various mental health problems and asked participants to rank order the professionals from whom they would be more comfortable

seeking help. What they found was that psychologists were consistently ranked in the middle for all of the various problems listed. They suggested that this consistency reflected a moderate level of confidence and was due to the fact that psychologists still appear to lack a well-defined public identity (Fall et al., 2000). It can be reasoned that the public's view of psychologists are less favorable than their view of medical professionals because of the fact that some public confusion pertaining to the roles and responsibilities of psychologists still appears to exist (McGuire & Borowy, 1979). Specifically, these researchers found that medical professionals are rated more favorably than mental health professionals. It is likely that this is because the public is still confused about the roles and responsibilities of mental health professionals especially between certain specializations within the mental health field.

Actual Differences between Psychologists and Psychiatrists

As can be seen from above, the public's perceptions of psychologists and psychiatrists have drastically changed over the last 50 years. Additionally, research seems to suggest that the public remains somewhat confused as to what the actual differences are between psychologists and psychiatrists (Murstien & Fontaine, 1993).

The term psychiatry comes from two Greek words "psyche" translated as mind and "iatreia" translating as medical specialty (MedFriendly, 2001). Put these two words together and you have psychiatry which is a medical specialty of the mind. Psychiatrists are medical doctors. As such they, unlike psychologists, are able to order medical tests and prescribe medication without requiring supervision (American Psychiatric Association, 2003).

Psychiatrists specialize in the diagnosis, treatment and prevention of mental illnesses (American Psychiatric Association, 2003). More specifically, a psychiatrist is trained to be able to comprehend the biological, psychological and social components of mental illness. Moreover, as a medical doctor they are able to order diagnostic laboratory tests, to prescribe medicine, and to evaluate and treat psychological problems on a long term basis (American Board of Psychiatry and Neurology, Inc., 2003). Though some psychiatrists utilize psychotherapy (talk therapy) most do not (MedFriendly, 2001). Instead most psychiatrists occupy their time interviewing and diagnosing patients and prescribing and monitoring medication levels within patients.

It takes approximately 12 years of formal college and postgraduate training to become a psychiatrist. In order to become a psychiatrist one must graduate from an accredited school of medicine or osteopathy after earning a Bachelor's Degree (ABPN, 2003). Additionally, after graduating from medical school and earning a MD one must complete at least four years of accredited post-graduate (residency) training. Three of these four years must be devoted to training in psychiatry. In order to sub specialize such as in child or geriatric psychiatry one must complete additional training beyond one's four year residency (ABPN, 2003).

Psychologists study the human mind and human behavior and receive training in the basic social and psychological sciences. Psychologists may participate in a number of different activities and occupy a number of different roles depending upon their specialty. For instance, some psychologists are research oriented and spend their time investigating the physical, cognitive, emotional and social aspects of human behavior. Others may

work in more applied fields and provide mental health care in places such as hospitals, clinics, schools or other private sectors (US Bureau of Labor Statistics, 2003).

Psychologists working in more applied settings often interview patients and give diagnostic tests. Additionally, they may provide individual, family or group psychotherapy (talk therapy) as well as design and implement behavior modification programs (US Bureau of Labor Statistics, 2003). Psychologists work with individuals suffering from a wide diversity of pathology. Psychologists may work with individuals suffering from everyday problems of living as well as individuals suffering from more severe problems such as Schizophrenia and Bipolar Disorder.

It takes approximately 11 to 12 years of formal college and postgraduate training to become a psychologist. A doctoral degree is usually required for employment as a licensed clinical or counseling psychologist. This degree usually requires 5 to 7 years of graduate study post college. Course work includes classes such as quantitative research methods, psychopathology, theories and techniques of counseling, assessment, and child, family and marriage counseling to name a few. The Ph.D. degree concludes in the professional completing a dissertation which is a research project that adds something new and unique to the field. In the more applied specialties of psychology a requirement of a doctoral degree usually includes a one-year internship which can be completed in a wide diversity of settings (US Bureau of Labor Statistics, 2003). Additionally, in order to sub specialize one may complete one to two years of post doctoral training. Finally, psychologists are then required to work under supervision for one to two years prior to being eligible for full independent licensure as a mental health practitioner.

The Public's Perceptions of Different Mental Health Professionals

It appears that not only is the public confused about the different roles and responsibilities among different mental health professionals but that this confusion also extends to the public's perceptions of stereotypical members of these particular professions (Schindler et al., 1987). Research has found that when comparing psychologists and psychiatrists to clergy, clergy were perceived to be less educated, less skilled, and less experienced than psychologists/psychiatrists. However, at the same time clergy were perceived to be more warm, caring and professional than psychologists and psychiatrists (Schindler et al., 1987). When the perceptions of psychologists and psychiatrists were compared directly, psychologists were perceived to be kinder and more caring. However, psychiatrists were perceived to be significantly more educated (Schindler et al., 1987). The perception that psychologists are more warm and caring and psychiatrists are more intellectual and educated is a trend that is seen throughout the literature. Alperin and Benedict (1985) conducted a study comparing the perceptions that participants held toward psychiatrists, psychologists, and social workers. They found that social workers were thought to be more cheerful and energetic than psychologists and psychiatrists. Additionally, these researchers discovered that psychologists were perceived to be more responsive, appreciative, and warm and caring than psychiatrists. However, psychiatrists were perceived to be more studious, clever, intellectual and analytical than psychologists. Warner and Bradley (1991) also found this same general trend. These researchers found that psychologists were viewed to be more warm and caring and that psychiatrists were again perceived to be more intellectual and more competent to treat problems of the mind (Warner & Bradley, 1991).

The Relationship between Help-Seeking and Perceptions

Research on differing perceptions among professionals has helped to shed some light on the reasons why the public appears to prefer seeking help from different mental health professionals for different problems. Murstien and Fontaine (1993) reported that the public appears to be confused about the differences between psychologists and psychiatrists and in turn perceives them differently. In turn these different perceptions affect the public's actual help-seeking behaviors. For instance, research suggests that people usually utilize the general medical sector first for mental health problems. However, the more severe the problem the more likely these individuals are to utilize specialized services such as psychiatrists (Stefl & Prosperi, 1986). This finding appears to be a rather global one. For example, research has suggested that psychologists were preferred for normal problems in living and that psychiatrists were more preferred for the more disturbed cases (Fall et al., 2000; Murstein & Fontaine, 1993). However, this begs the question of what exactly are more normal problems and what are the "more disturbed cases."

Numerous researchers have tackled this question. Kleinke and Kane (1998) reported that the public appears to be more comfortable working with psychologists for most problems. These researchers reported that the public only preferred to work with psychiatrists for the disorder of schizophrenia (Kleinke & Kane, 1998). Moreover, it has been found that psychiatrists were rated as more competent to treat more chronic, severe and traumatic disorders (Schindler et al., 1987). In essence, psychiatrists appeared to be preferred for more severe disorders that may involve the use of pharmacological therapy (Warner & Bradley, 1991). For instance, if an individual was suffering from major

depression, or wanted a prescription for a sedative, or had some sort of addiction problem, it is likely that he/she would prefer seeking help from a psychiatrist (Warner & Bradley, 1991).

Conversely, it appears that psychologists are viewed as being more competent to treat less pathological disorders (Schindler et al., 1987). For instance, research seems to suggest that psychologists are the preferred help provider for problems related to achieving, self-development, fulfillment, sexual adjustment or just getting along with friends and family (Alperin & Benedict, 1985). Additionally, it was found that psychologists were also the preferred help-seeker if one had marital problems (Warner & Bradley, 1991), or if one wanted to be tested or have their children tested (Thumin & Zebelman, 1967).

Results of these studies suggest that the public appears to be more comfortable seeking help from different professionals for different problems. In general, the trend appears to be that the public is more confident in seeking help from psychologists for more common and less severe type problems whereas they are more likely to seek help from a psychiatrist for more pathological type problems. In relating this to the research on perceptions of different professionals, it appears that one can gain insight into why this trend exists. Remember that research on perceptions seems to suggest that the public perceives psychiatrists to have more education and to be more intellectual than psychologists (Warner & Bradley, 1991). Therefore, it is likely that because the public perceives psychiatrists to be more educated they would be more likely to seek help from psychiatrists for more severe problems. However, why then are psychiatrists not the preferred help-giver for all problems regardless of severity? Again, the answer to this

question appears to lie in research on perceptions of help-givers. Remember that psychologists are perceived to be more warm and caring than psychiatrists (Warner & Bradley, 1991). Additionally, psychiatrists were perceived to be duller and reserved than psychologists (Alperin & Benedict, 1985). Therefore, it seems logical that when dealing with problems of everyday living people would be more comfortable seeking help for this relatively minor problem from a psychologist as compared to a psychiatrist because it appears that the experience with the psychologist would be more enjoyable.

In conclusion, the research up to this point has pertained to the public's views and perceptions of various mental health professionals. As has been shown, the public views the roles and responsibilities of various mental health professionals differently.

Additionally, the public appears to perceive certain characteristics of these professionals differently which in turn appears to have an impact on their help-seeking preferences.

However, is there not something missing in the research up to this point? For instance, where is the research pertaining to how attitudes toward help-seeking differ among mental health professionals? Little if any research has been conducted looking at how attitudes toward help-seeking differ depending on whom one is considering seeking help from. The research that has been conducted on this topic seems to suggest that further exploration may be fruitful. For instance, Kushner and Sher (1991) reported that fear related to seeking help or more globally the stigma associated with-seeking help appears to differ when considering seeking help from members of different professions.

Additionally, research has also suggested that these fears and perceived stigma affect not only the initial help-seeking behavior but also affect the course and outcome of treatment

(Kushner & Sher, 1991). Why then is there not more research in this area? The answer to this question may lie in research regarding attitudes toward mental health services.

Attitudes toward Mental Health Services

Attitudes toward mental health services is a construct that has received much attention in the literature (Clausen & Huffinine, 1975; Farina, 1982; Farina & Ring, 1965). However, the research has seemed to neglect the construction of a psychometrically sound scale that would measure the construct as a whole (Paris & Pace, 2000). This is probably the main reason why attitudes have not really been evaluated systematically between professionals. Essentially, there has been no real systematic way to measure help-seeking attitudes toward professionals.

The construction of a scale that would accurately measure attitudes toward different mental health professionals would have a tremendous impact on the field of psychology as a whole. This instrument would enable practitioners and researchers alike to examine an individual's attitude toward seeking mental health services from numerous professionals. Specifically, this scale would enable researchers to determine certain negative attitudes that are keeping an individual or group from seeking help from different professionals. It is possible that once these negative attitudes are determined, educational/treatment programs could be enacted that would focus on these attitudes and change them in a positive direction. It is hoped that through these programs, suffering individuals who for one reason or another are reluctant to seek help from certain professionals will be reached and helped.

Additionally, the knowledge of attitudes toward help-seeking could be helpful in preventing possible premature termination from treatment services. If an individual is

either mandated to see a psychologist or psychiatrist or if he/she has come to a psychologist or psychiatrist but seems reluctant about the process of therapy, the administration of an attitude scale could be helpful in determining certain attitudes that the client may have that may increase the chances of premature termination. These attitudes can then be focused on via education and modified in a way that will lessen the chance of, or prevent, premature termination. Likewise, with reliable and valid knowledge regarding attitudes, counseling and mental health services in general might be better planned in order to accommodate certain attitudes and enhance treatment acceptability and value.

The Attitude toward Seeking Professional Psychological Help Scale (ATSPPH)

Historically, the most noteworthy attempt of scale development concerning the construct of attitudes toward mental health services was done by Fischer and Turner (1970). This scale consisted of twenty nine items, eighteen negatively and eleven positively phrased. All of these items were arranged along a four point Likert type scale. The final score on the scale represented how favorable the attitudes in question were.

Two different internal consistency estimates were reported by Fischer and Turner (1970). One was $r = .86$ and was based on a sample of $n = 212$, and the other was $r = .83$ and was based on a different sample of $n = 406$. Test-retest reliability was established over five different time periods ranging from six weeks ($r = .73$) to two weeks ($r = .89$). The validity of this scale was established by running a factor analysis. This analysis resulted in breaking the instrument up into four relatively distinct factors. These factors are: recognition of personal need for professional psychological help (8 items; $r = .67$); tolerance of the stigma associated with psychiatric help (5 items; $r = .70$); interpersonal

openness regarding one's problems (7 items; $r = .62$); and confidence in mental health professionals (9 items; $r = .74$).

Though Fischer and Turner's scale is the most widely used scale when it comes to measuring attitudes toward help-seeking it is not without its problems. For instance, in using the ATSPPH in her research, Surgenor (1985) reported that the most common criticism of the scale among her respondents was the format of the scale. The scale utilized in this instrument is a four point Likert-type scale. Because the scale is only four points there is no middle point. Due to this, the neutrality of the attitude in question cannot be measured, and because of this useful information may be lost.

Another commonly cited problem with this scale is that the wording that this scale employs is not gender neutral (Paris & Pace, 2000). Within this scale participants are asked to respond to statements. These statements are written in the third person and often use masculine pronouns such as he, his, and himself. Moreover, Fischer and Turner's scale uses terminology related to psychiatric care and treatment for mental illness versus a more neutral and contemporary terminology such as mental health services.

An additional criticism with this scale is that the amount of explained variance accounted for by this scale was never stated in any of the samples that Fischer and Turner normed the scale on. Additionally, various researchers have shown that the factor structure of the ATSPPH is unstable across populations. For instance, Surgenor (1985) conducted research investigating the factor structure of the ATSPPH. Her research, using a New Zealand sample, did not support the four factor model proposed by Fischer and Turner. From this she concluded that the factor structure of the scale is not stable across populations. Likewise, Dadfer and Friedlander (1982) investigated the factor structure of

the ATSPPH using a sample of 172 international college students. Using a “principal-axis factor extraction and oblique rotation they found a three factor structure instead of the four reported by Fischer and Turner (1970). From this they concluded that underlying factors/domains differ in foreign and American populations. They labeled their three factors confidence/appropriateness, stigma/privacy, and coping alone.

The Attitude toward Mental Health Services Scale (ATMHS)

Paris and Pace (2000) developed their Attitude Toward Mental Health Services Scale for a number of reasons. First, they developed this scale because of the inconsistencies with the way that these attitudes were measured in the literature. Specifically, in the past many researchers have attempted to design their own scales to measure attitudes toward help-seeking (Cook & Tyler, 1989; Leaf, Bruce, Tischler, & Holzer, 1987). Some have even measured this construct without a scale by a free response format (Cohen, 1977). Additionally, they developed this scale due to the criticisms of the ATSPPH noted above.

Development of the ATMHS

The process of designing the ATMHS was a very long and involved venture. The first step in the construction of the scale was the formulation of five a priori categories. These categories consisted of the four defined by Fischer and Turner and the category of pragmatics. The category of pragmatics was included because it has been demonstrated that there are certain pragmatic type issues such as monetary cost, difficulty in transportation, and not being able to spare time that prevent help-seeking (Acosta, 1980). After the five categories were selected a sample of 50 licensed mental health practitioners were surveyed concerning their thoughts on the reasons why clients seek, accept, or reject

mental health services. The 50 practitioners surveyed consisted of 10 individuals in each of the following categories (a). board certified psychologists (b). board certified family practice physicians (c). licensed counseling and clinical psychologists (d). licensed social workers (e). licensed professional counselors. As a result of the survey, two more categories emerged. The two categories that emerged were “severity of problem” and “role of others”.

After the seven categories were established, at least ten items were written for each category. This resulted in 80 items. The 80 items were then given to four psychologists for review, and as a way of conducting member checking. As a result of the review, some items were added and many were revised, resulting in a final total of 77 items. To be sure that social desirability did not play an effect on the respondents' answering of questions in the survey, ten questions concerning social desirability were interspersed among the seventy-seven questions. These 87 items made up the research scale. This 87-item scale was given to 306 undergraduate volunteers. The participant pool consisted of 128 males and 176 females who ranged from 17 to 52 yrs. of age. The mean age of the sample was 24.17. These volunteers were asked to respond to each question by using a 5 point Likert-type scale, with one indicating strongly disagree and 5 indicating strongly agree. After the surveys were collected, item means, variances, and correlations were examined. Items with high means (>4.0) and low item to total correlations ($<.30$) were deleted. The 10 social desirability items were then removed leaving a total of 55 items that were used for the purpose of principle component analysis. The goal of the PCA was to find the best interpretation of the underlying factor structure of the 55 items. The Principle Component Analysis revealed the emergence of

three distinct factors. Twenty-nine of the 55 items did not load above .50 on any of the three factors, and therefore they were deleted leaving twenty-six items. This twenty-six item three factor scale accounted for 20.42% of the total item variance, which was not as high as was expected. However, remember that Fischer and Turner never reported this statistic for their scale. The three factors that emerged were labeled as Factor I.

Confidence in Mental Health Services (16 items): Factor II. Fear of Stigma (6 items): and Factor III. Coping Alone (4 items). This three factor model has received some support in the literature. Dadfer and Friedlander (1982) reported a three factor solution that is very similar to the one found by Paris and Pace. The three factors that they reported were defined as confidence/appropriateness, stigma/privacy, and coping alone. The factor intercorrelations that were found are as follows: for factors 2 and 3 ($r = .35$), for factors 1 and 3 ($r = .35$), and for factors 1 and 2 ($r = .42$) respectively. The Internal Consistency, as measured by Coefficient α (C_x), for the entire ATMHS scale was ($C_x = .93$). For factor 1 ($C_x = .94$), for factor 2 ($C_x = .87$), and for factor 3 ($C_x = .73$). To determine if social desirability had an effect on the respondents answering, a Correlation was obtained between the social desirability scale and the ATMHS. The correlation was relatively low at $r = .26$ implying that the scale is relatively free of response bias with respect to the social desirability dimension.

External Validity of the ATMHS

A number of different measurements were employed to assess the external validity of the scale. In order to assess the external validity of the ATMHS several group comparisons were made. The first of these involved comparing the differences in scores between men and women. Previous research dealing with men and women's attitudes

toward seeking help have shown there to be a gender difference. Specifically, as stated previously, Kessler, Brown, and Broman (1981) have shown that men are less likely to seek help and that women are more likely to perceive themselves to be in need of psychological help. With respect to gender differences, Paris and Pace showed that there was a significant difference between men and women with respect to the ATMHS. As expected, and as previous research supports, Paris and Pace (2000) found that women held more positive attitudes toward mental health services ($\underline{M} = 95.93$, $\underline{SD} = 18.04$, $\underline{n} = 176$) than men ($\underline{M} = 83.02$, $\underline{SD} = 17.61$, $\underline{n} = 128$).

Paris and Pace also tried to demonstrate external validity by making group comparisons between whites and ethnic minorities. Numerous studies have been conducted which have looked at how ethnicity relates to attitudes toward mental health services as well as to likely utilization (Horowitz, 1987; Sue, 1977). These studies have shown that certain ethnic groups have more favorable attitudes toward mental health services than other ethnic groups and also that certain groups are more likely to seek help than other groups. Within Paris and Pace's sample 232 individuals were European American, 23 were African American, 21 were Native American, 11 were Asian American and 3 were Hispanic American. Within this sample Paris and Pace found no significant differences in scores on the ATMHS between ethnic groups.

Finally, the last analysis done to demonstrate external validity dealt with the issue of previous experience with counseling. It was hypothesized that individuals whom had received counseling in the past would hold more favorable attitudes toward seeking help from mental health services. Out of the sample of 306 individuals 85 (28%) had reported receiving prior mental health services and 219 had not. As was expected, there was a

significant difference in that people who had received prior mental health services ($M = 101.08$, $SD = 16.22$, $n = 85$) had more positive attitudes toward help-seeking as compared to people who have not had experience ($M = 103.47$, $SD = 20.26$, $n = 15$).

Extended Validity on the ATMHS

Lawrence, Paris, Pace and Terry (2003) conducted a study in order to further develop and evaluate Paris and Pace's (2000) Attitude toward Mental Health Services scale. Specifically, the purpose of this study was to use a Maximum-Likelihood Factor Analytic approach to assess the goodness-of-fit for the ATMHS, to demonstrate construct validity for the ATMHS, to further assess test-retest reliability with the revised scale, to assess both convergent and discriminant validity, and finally to compare Paris & Pace's (2000) Attitude toward Mental Health Services scale with Fischer & Turner's (1970) Attitude toward seeking Professional Psychological Help scale in order to determine which scale was more psychometrically reliable and valid.

Samples were drawn from two different undergraduate institutions in central and northeastern Oklahoma. This sample consisted of 288 individuals. Of these individuals 187 (65%) were female and 101 (35%) were male. Ages ranged from 18 to 44 years with the average age being 21 years. The ethnicity of the sample was predominately Euro-American. However, 14.5% were Native American, 5.7% were African American, 4.4% were Asian American and 1.3% was Hispanic American. Finally, of the sample approximately 28 percent had reported receiving counseling at some point in time for a mental health problem.

Construct Validity. An unrestricted Maximum-Likelihood Factor Analytic Model was used to provide a confirmatory factor analysis using a new sample for Paris and Pace's ATMHS scale. After dropping 5 items which were redundant with other items in terminology, the results of this analysis resulted in an excellent fitting 3-factor model (RMSEA=.042, Bentler's CFI = .96, TLI = .95, Avg. Standard Residual = .86). After rotating the initial solution using the Promax Procedure, examination of the factor loading matrix suggested that all items had their largest loadings on their primary factors, although non-zero loadings were common across the other two factors. The results also suggest that all three factors were only low to moderately correlated. These between factor correlations are summarized in Table 1.

Test-Retest Reliabilities. Internal consistency estimates (Cx) were then estimated for each of the three scales for both the test and re-test samples, respectively; these were Cx = .84 (test sample) and Cx = .87 (re-test sample) for scale 1; Cx = .84 and Cx = .90 for scale 2; and Cx = .73 and Cx = .69 for scale 3. We then estimated the test-retest correlations for each of the three scales across the two-week period to help further establish reliability for this scale. These were Cx = .58, Cx = .69, and Cx = .62 for scales 1, 2, and 3, respectively. In conclusion, the modified three factor model found in this study is similar to, and supports, the three factor model found by Pace & Paris (2000) and by Dadfer & Friedlander (1982). Specifically, these factors seem related to Confidence in Mental Health Services, the Fear of Stigma associated with help-seeking, and the idea of Internal/External Coping Resources.

External Validity of the ATMHS

In order to assess the external validity of the ATMHS several group comparisons were made. The first of these involved comparing the differences in total scores on the

ATMHS between men and women. With respect to gender differences, it was found that women had significantly more positive attitudes toward mental health services ($\underline{M} = 74.41$, $\underline{SD} = 11.80$, $\underline{n} = 182$) than men ($\underline{M} = 70.66$, $\underline{SD} = 11.35$, $\underline{n} = 100$). Additionally, a t-test was conducted pertaining to scores on the ATMHS and whether or not one has had past experience with mental health services. With respect to past counseling experience, it was found that those individuals who had past experience with mental health services scored significantly higher on the ATMHS ($\underline{M} = 79.84$, $\underline{SD} = 12.64$, $\underline{n} = 80$) than did those individuals who had no experience with mental health services ($\underline{M} = 70.41$, $\underline{SD} = 10.26$, $\underline{n} = 202$). Moreover, those individuals who have had past experience with mental health services were further broken up into two groups, those reporting a positive experience with these services and those reporting a negative experience. With respect to these two groups it was found that those reporting positive experiences ($\underline{M} = 80.95$, $\underline{SD} = 12.92$, $\underline{n} = 64$) scored significantly higher on the ATMHS than did those reporting negative experiences ($\underline{M} = 74.00$, $\underline{SD} = 9.47$, $\underline{n} = 15$). Finally, no significant relations were found between age, ethnicity, and income and the total score on the ATMHS.

Comparison between the ATMHS and the ATSPPH

In order to compare the ATMHS scale to the ATSPPH, a Linear MLFA model was applied to the ATSPPH for the purpose of obtaining fit indices for direct comparison of the model fit indices obtained on the ATMHS. In comparing the ATMHS scale to the ATSPPH, an unrestricted Maximum-Likelihood Factor Analytic Model was used on the 29-item ATSPPH scale. The results of this analysis suggested the best solution to consist of a 4-factor model (RMSEA=.055, Bentler's CFI = .88, TLI = .85, Avg. Standard Residual = 1.00). Table 2 summarizes and compares the fit statistics for both Paris and

Pace's ATMHS scale and Fischer and Turner's ATSPPH scale. As can be seen from Table 2 the ATMHS scale appears to more faithfully represent the data than does the ATSPPH.

A promax rotation procedure was applied to the EFA-MA factor-load matrix. Subsequent examination of the factor loading matrix suggested that all items had their largest loadings on their primary factors, although some non-zero loadings were common across the other two factors. Table 3 reports the correlations between each of the factors on the ATSPPH.

Internal consistency estimates (Coefficient-alpha) were then estimated for each of the four scales. These were $\alpha = .76$ for scale 1; $\alpha = .69$ for scale 2; $\alpha = .58$ for scale 3; and $\alpha = .74$ for scale 4. This four factor model was similar to the four factor model found by Fischer & Turner (1970). In conclusion, comparison of the model fit indices and coefficient alphas suggest a sounder better fit for the ATMHS scale.

As shown above, it was found that the ATMHS scale was a better fit for the data as compared to the ATSPPH scale. Specifically, all of the fit statistics were higher for the ATMHS and the residuals were lower. With respect to the internal reliability, the internal consistencies for the factors on the ATMHS scale ranged from .73-.84, whereas the internal consistencies for the ATSPPH scale ranged from .58-.76. All of the factors on the ATMHS scale were low to moderately correlated as expected. However, when looking at table 1 though most of the factors on the ATSPPH scale were moderately correlated factors 1 and 4 were highly correlated at .73 which seems to suggest that the item content for each of these factors is highly similar and that perhaps these two factors should be collapsed into one. The 2 week test retest reliabilities were for the ATMHS

were between .58- .69 which is acceptable. Likewise, in a sense a confirmatory factor analysis was conducted on the ATMHS and a factor structure very similar to both Paris & Pace (2000) and Dadfer & Friedlander (19822) was found using different statistical analyses in a different sample. Therefore, in conclusion the results of this study suggest that the three factor ATMHS scale is a reliable and valid scale for measuring Attitudes Toward Mental Health Services.

Problem Statement

The current study focused on examining the public's attitudes toward different mental health professionals. Specifically, this research examined the public's attitudes toward seeking help from both psychologists and psychiatrists. The design for this experiment was a 2 X 2 Between Groups design.

A number of different analyses were employed in this study. Specifically, t-tests were conducted, along with a two-way Univariate Analysis of Variance and a two-way Multiple Analysis of Variance. These analyses were run in order to examine attitude differences of people considering seeking help from the professions of psychologists and psychiatrists. Two independent variables (profession vs. informational description) consisting of two levels each (psychologist vs. psychiatrist; information description vs. no informational description) were examined within this study. Additionally, four dependent variables were measured in this study. These consisted of the total ATMHS score as well as the scores on each of the three factors (Confidence in Mental Health Services, Fear of Stigma and Internal/External Coping Resources) which made up the ATMHS scale.

Research Questions

There were a number of major research questions that were examined in this study.

These questions are listed below.

1. Do participants' attitudes toward seeking help differ based upon whether they are given an accurate informational description of the professional they are considering seeking help from, or whether they are simply operating on preconceived notions pertaining to who and what these professionals are and do?
2. If participants' attitudes toward help seeking significantly differ based upon whether or not they are given informational descriptions, are these differences larger for one professional group as compared to the other?
3. Do participants' global attitudes toward help seeking significantly differ depending upon whether they are considering seeking help from a psychologist as compared to a psychiatrist?
4. Do participants' significantly differ on any or all of the three factor scores (confidence, stigma, internal/external coping resources) previously obtained in the 29 item ATMHS scale with respect to whether they are considering seeking help from psychologist as compared to a psychiatrist?

Method

Participants

A sample was drawn from an undergraduate institution in central Oklahoma. This sample consisted of 160 individuals. Of these individuals 115 (71.9%) were female and 45 (28.1%) were male. Ages ranged from 18 to 28 with the average age being 19.2. The

majority of this sample were freshman (54.4%) and single (96.3%). The ethnicity of the sample was predominately Euro-American (83.1%). However, 6.9% were Native American, 3.8% were African American, 3.1% were Asian American and 2.5% were Hispanic American. Of the sample approximately 22.5% had reported receiving counseling at some point in time for a mental health problem, and of these approximately 78% reported this to be a positive experience. Additionally, approximately 6.3% of the sample had reported receiving psychiatric services at some point in time for a mental health problem, and of these approximately 79% reported this to be a positive experience. Finally, approximately 8.8% of the sample reported a past history of taking psychotropic medications for a mental health problem, and of these approximately 85% reported this to be a positive experience.

Procedures

All participants were first given an informed consent form which they were asked to read and sign. An example of this form can be found in Appendix A. Participants were then randomly assigned to a specific condition. There were four conditions within this study consisting of 40 participants per condition. In all conditions participants were asked to complete the same background questionnaire. Depending upon condition participants were then asked to either read a short informational description of a psychiatrist or psychologist and then complete a revised version of the ATMHS reflecting the particular profession that they just read about or simply just complete a revised version of the ATMHS reflecting either psychologists or psychiatrists without reading any informational descriptions about these particular professions. A visual diagram of this design can be found in Figure 1.

Informational descriptions were given to participants in only two of the groups due to the conflicting research which sometimes suggests that the public is unclear of the differences between psychologists and psychiatrists (Murstien & Fontaine, 1993). The informational descriptions for both psychologists and psychiatrists that were given can be found in Appendix B.

Instrumentation

The instrument that was employed in this study was a variation of the Attitudes Toward Mental Health Services scale which was created by Paris and Pace (2000) and revised by Lawrence et al. (2003). This scale offers a valid, reliable and systematic way to measure help-seeking attitudes. As stated above this scale was revised subtly to reflect the profession from which one is considering seeking help. Specifically, in the original scale the phrase “mental health professionals” is used in many of the items. This phrase will be substituted with more specific terminology such as a “psychiatrist,” or a “psychologist.” Examples of the variations of this scale can be found in Appendix C. In addition to the ATMHS scale, participants were also asked to fill out a short demographic questionnaire. An example of this questionnaire can be found in Appendix D.

Results

The major statistical analyses employed in this study consisted of 2 Two-Samples t-tests, a two-way Analysis of Variance (ANOVA), and a two-way Multivariate Analysis of Variance (MANOVA). The t-tests were conducted in order to determine if participants’ attitudes toward seeking help differed based on whether they were given an accurate informational description of the professional they were considering seeking help from. The ANOVA was conducted in order to determine if any of the Independent

Variables (profession vs. informational description) shown in Figure 1 significantly differed with respect to the total score on the Attitudes toward Mental Health Services (ATMHS) scale. The MANOVA was conducted in order to determine if the two levels of the Independent Variable professional (psychologist vs. psychiatrist) significantly differed with respect to some combination of the three factors scores that make up the ATMHS scale (Confidence in Mental Health Services, Fear of Stigma and Internal/External Coping Resources).

Background Variables

Before the t-tests, ANOVA and MANOVA were conducted a number of different statistical analyses were employed to examine all background variables. These analyses examined each background variable among the four conditions to determine if any background variable significantly differed between conditions. Additionally, these analyses were employed to determine if there were any possible confounding variables that needed to be examined as covariates in the major analyses. For categorical variables such as gender, the Chi-Square Test was conducted. Fisher's Exact Test was used to analyze some categorical variables with small sample sizes, such as the variable marriage. Finally, numerical and ordinal variables such as age and income were not normally distributed, and therefore the Kruskal-Wallis Test was employed. Table 4 summarizes the background variables examined, the type of statistical analysis employed, and the significance level of each background variable among the four conditions. In general, the results of these analyses indicated that there were no significant differences in the background variables among the four conditions. This implied that none of these

variables would need to act as covariates within the following ANOVA and MANOVA.

T-Tests

The Two-sample t-tests were conducted in order to determine if participants' attitudes toward seeking help from psychologists and psychiatrists differed based upon whether they were given an accurate informational description of the professional they were considering seeking help from. Two different t-tests were conducted, one examining the participants completing the psychology version of the ATMHS scale and the other examining the participants completing the psychiatry version of the ATMHS scale. With respect to psychologists, it was found that presence or absence of an informational description had no significant effect on participants' attitudes toward seeking help from psychologists $t = -.98$, $p = .33$. With respect to psychiatrists, it was found that the presence or absence of an informational description also had no effect on participants' attitudes toward seeking help from psychiatrists $t = .29$, $p = .77$. Table 5 summarizes the results of the t-tests for both the psychology and psychiatry groups.

Two-Way Univariate Analysis of Variance

A two-way univariate analysis of variance (ANOVA) was conducted to determine if there were any differences between the two independent variables (profession and informational description) with respect to the total score on the ATMHS scale. Additionally, this analysis was also employed to determine if there was an interaction between the two independent variables, profession and informational description. Before the ANOVA could be interpreted it had to be determined that all assumptions were met. A non-significant result was found when looking at Shapiro-Wilk's normality test, which

indicated that the data were normally distributed and that it was appropriate to conduct the ANOVA on this data.

With respect to the ANOVA itself, no significant interaction effect was found, $F(1, 156) = .85, p = .36$. Due to the absence of a significant interaction effect the main effects were able to be interpreted. With respect to the main effects, no significant main effect for information was found $F(1, 156) = .29, p = .59$. This suggests that participants who were given an informational description of the roles and responsibilities of psychologists and psychiatrists did not score significantly different on the Attitudes toward Mental Health Services scale than those not given an informational description. Moreover, no significant main effect for professional was found $F(1, 156) = 3.67, p = .057$. This suggests that there were no significant differences in ATMHS scores based upon whether one was considering seeking help from a psychiatrist or psychologist. However, it appeared that this result was close to significance, and given that there was only enough power to detect small to medium differences the group means were examined. Table 6 summarizes the results of the ANOVA discussed above. Table 7 lists the group means, standard deviations, and ranges with respect to the total ATMHS score and the three factor scores which comprise the ATMHS. As can be seen from this table, participants' attitudes toward seeking help from psychologists were higher and more positive than participants' attitudes toward seeking help from psychiatrists.

Two-Way Multivariate Analysis of Variance

A two-way multivariate analysis of variance (MANOVA) was conducted comparing participants who completed the psychology version of the ATMHS scale and participants who completed the psychiatry version of the ATMHS scale. Specifically,

this analysis was conducted in order to determine if these two groups significantly differed on some combination of the three factor scores (Confidence in Mental Health Services, Fear of Stigma and Internal/External Coping Resources). Within this MANOVA, no serious violations of assumptions pertaining to independence of observations, multivariate normality were noted, which suggested that it was appropriate to conduct the MANOVA. The results of MANOVA indicated that the overall profession effect was not significant at the .05 level, $F(3, 156) = 2.19, p = .091$. This suggests that there was no significant difference between the two groups on some combination of the three factor scores which make up the ATMHS scale. Normally, between-subject effects would not be examined on the univariate level when the overall effect was not significant at the multivariate level. However, between-subject effects were examined on the univariate level because the overall effect was close to significance, power was limited, and because each factor score on the ATMHS represents a different theoretical construct that may be examined in isolation. When examining the univariate analysis of variance for each individual factor it was found that the profession effect with respect to the factor Internal/External Coping resources was significant at the .05 level. Additionally, it was also found the variable Fear of Stigma approached significance. Finally, it was found the variable Confidence in Mental Health Services was not significant. Table 8 summarizes the results of the MANOVA at the between-subjects level. When looking at the means in Table 7 it can be seen that the Fear of Stigma factor score was greater (less positive) for the participants responding to the psychiatry version of the ATMHS scale as compared to the psychology version. This suggests that participants felt that there was somewhat more of a stigma attached to seeking help from a psychiatrist as compared to seeking help

from a psychologist. Additionally, according to the means in Table 7 it was also found that the participants responding to the Psychology version of the ATMHS reported more positive Internal/External Coping resources as compared to the participants responding the Psychiatry version of the ATMHS. Essentially, this suggests that participants reported being significantly more comfortable with the idea of self-disclosing and being open and honest with psychologists as compared to psychiatrists. Moreover, participants were also significantly more likely to believe that seeking help from psychologists was less costly, more time efficient and more accessible than seeking help from psychiatrists.

Discussion

This present research study was conducted in an attempt to compare and understand the public's attitudes toward seeking help from the professions of psychologists and psychiatrists. Since the 1950's, researchers have examined differences in the public's attitudes toward, and perceptions of, psychologists and psychiatrists (Tinsley et al, 1984). In general, most research up to this point has not been in agreement. It is thought that this is because of the change in roles and responsibilities among these particular professionals over the past 50 years (Schindler et al., 1987). However, it is also thought that research in this area of study is conflictual because there has been no consistent way to measure and conceptualize attitudes toward, or perceptions of, psychologists and psychiatrists. This current research study attempted to examine participants' attitudes toward seeking help from psychologists and psychiatrists by using a psychometrically sound attitude scale, the Attitudes toward Mental Health Services scale.

In many respects, the overall results of this study were consistent with more recent research that has examined the public's perceptions of psychologists and psychiatrists. Specifically, in this study when participants attitudes toward seeking help from psychologists and psychiatrists were compared on the ATMHS scale it was found that there was no significant overall difference between attitudes toward seeking help based upon whether one was considering seeking help from a psychologist or a psychiatrist. Essentially, participants reported having positive attitudes about seeking help from both professionals. This is somewhat consistent with research that has been conducted which suggests that the public is comfortable and confident with seeking help from both psychologists and psychiatrists for most problems (Klienke & Kane, 1998).

It was also found in this study that the presence of an informational description explaining the educational background, roles and responsibilities of psychologists and psychiatrists made no difference on participants overall attitudes toward seeking help. It was originally thought that this may have an effect because numerous researchers have hypothesized that the public has inaccurate perceptions regarding the roles and responsibilities of psychologists and psychiatrists (Mcguire & Borowy, 1979). Moreover, these researchers have hypothesized that it is these inaccurate perceptions that affect their willingness to seek help from these professionals. Though it was originally thought that the presence of an informational description would have a positive impact on participants' attitudes toward seeking help from psychologists and psychiatrists, it is not surprising that no effect was found. Specifically, it is thought that no effect of informational description was found because of the population examined within this study. It is probable that the college sample examined within this study was more

educated than the public in general with respect to the similarities and differences between psychologists and psychiatrists. Due to this, the presence of an informational description was negligible and had no effect on the attitudes in question.

Though no significant difference was found between participants' attitudes toward seeking help from psychologists and psychiatrists, the difference was close to significance. Given that there was only enough power to detect small to medium differences the group means were examined. When looking at the means it was found that participants had more positive attitudes toward seeking help from psychologists as compared to psychiatrists. It is possible that this trend exists because of the scale that was utilized in this research. Specifically, more recent research has suggested that the public has more positive attitudes toward seeking help from psychologists as compared to psychiatrists for less severe difficulties (Fall et al., 2000; Murstein & Fontiane, 1993). The questions that make up the ATMHS scale do not refer to any specific psychological/psychiatric problem. However, a number of questions on the ATMHS scale pertain to certain problem areas. For instance, some questions refer to family problems, the stresses of life, personal or emotional problems and adjusting to a loss. In general, it can be argued that these questions refer to more minor, less pathological problems, and therefore it would be consistent with recent research that, in this study, participants reported having more positive attitudes toward seeking help for these types of problems from psychologists.

Past research has suggested that participants report being more likely to seek help from psychologists as compared to psychiatrists for problems of everyday living because they perceive psychologists to be more appreciative, warm and caring (Warner &

Bradley, 1991). This is essentially what was found in this study when looking at the between-subjects effects on the Multiple Analysis of Variance. Specifically, it was found that participants scored significantly higher, or more positive, when looking at the factor Internal/External Coping resources. This suggests that participants were more comfortable about self-disclosing and being interpersonally open with psychologists as compared to psychiatrists. Additionally, this also suggests that participants thought that seeing a psychologist would be more cost effective and more time efficient than seeing a psychiatrist.

When looking at the between subjects effects within the MANOVA it was found that unlike the factor score of Internal/External Coping resources, the factor score of Confidence in Mental Health Services was not significant. This suggests that participants reported being as confident in seeking help from a psychologist as they were from a psychiatrist. This finding may also be consistent with more recent research which suggests that when participants are considering seeking help for problems in everyday living they report feeling just as confident in receiving quality services from psychologists as they do from psychiatrists (Klienke & Kane, 1998). This is essentially what was found.

Finally, when looking at the between subject effects within the MANOVA it was found that the factor score of Fear of Stigma was not significant. However, this factor was close to significant, meaning that when looking at the means for this factor it was found that participants reported more of a fear of stigma when seeking help from psychiatrists as compared to seeking help from psychologists. This again can be interpreted in the context of past research which suggests that the public perceives

psychiatrists as being more competent in dealing with more significant and pathological problems. When interpreting the Fear of Stigma factor within this context it makes sense that participants would report more of a stigma attached to seeing a psychiatrist because psychiatrists are thought to be responsible for handling more severe and pathological problems.

Limitations of Study and Recommendations for Future Research

Clearly the greatest limitation within this present study was the sample utilized. The sample that was utilized within this study was a college sample that was not representative of age, ethnicity or gender. The representativeness of this sample poses a problem mainly because of current research which suggests that attitudes toward help seeking differ based upon such factors as age, education, gender and ethnicity (Sanchez & Atkinson, 1983; Cook et al., 1984; Kessler et al., 1981). Additionally, the sample utilized within this study may be more educated than the general population with respect to the educational requirements, roles, and responsibilities of both psychologists and psychiatrists. This is particularly possible due to the fact that many participants were recruited for this experiment through an introduction to psychology class. Due to the above mentioned problems with the sample, that next logical step within this research area would be to replicate this study utilizing a more representative sample.

Additionally, it is possible that different types of measurement instruments may need to be utilized when examining differences between psychologists and psychiatrists with respect to attitudes toward help seeking. Specifically, if more current research is accurate that the public's attitude toward seeking help is not a static construct, but varies based upon what type of problem one is considering seeking help for, then scales need to

be utilized that reflect a more wide range of psychological problem areas. It is possible that a significant main effect for professional was not found within this study because the ATMHS-R scale was more reflective of minor problems of everyday living and excluded more severe and pathological problems.

Finally, when using more representative samples, if it is found that different groups (age, gender, education, & ethnicity) significantly differ with respect to attitudes toward seeking help from psychologists and psychiatrists then researchers can begin to examine certain negative attitudes/factors that are keeping an individual or group from seeking help. It is possible that once these negative attitudes are determined, educational/treatment programs could be enacted that would focus on these attitudes and change them in a positive direction. Likewise, with reliable and valid knowledge regarding attitudes, psychologists and psychiatrists in general might be better able to accommodate certain attitudes and enhance treatment acceptability and value.

Conclusion

Despite the limitations of the present study, this study represents a systematic attempt to examine participants' attitudes toward seeking help from psychologists and psychiatrists using a psychometrically sound attitude scale. This essentially has been the first systematic attempt to utilize an attitude toward help seeking scale as a means of examining differences in participants' willingness to seek help from these specific professionals. From this study, numerous insights can be gleaned concerning how the public's attitudes toward help seeking differ depending upon the professional they are considering seeking help from, as well as the type of problem they need help for.

This study lends support to more recent research which suggests that the public's attitudes toward seeking help from various professionals may vary depending upon the type of difficulty one is considering seeking help for. If this hypothesis is in fact true, then it appears that this would have some practical implications for both psychologists and psychiatrists. In the past the field of psychology has mainly focused on increasing the public's confidence in psychologists, while at the same time somewhat neglecting issues related to stigma and internal/external coping resources. According to the results of this present study, the public appears to be just as confident in seeking help from psychologists as they do in seeking help from psychiatrists for problems of everyday living. However, it is possible that the public still views psychologists as less adept at treating more severe pathology. Therefore, psychologists' efforts might want to be aimed at showing the general public that they, as a profession, are effectively able to treat individuals with severe pathology. It is thought that the field of psychology is already attempting to do this. Specifically, it is possible that the recent push of many members within the field of psychology to gain prescription privileges is an attempt to increase their effectiveness in treating individuals with more severe pathology. If prescription privileges are granted to psychologists, it will be interesting to see how this change will affect the profession of psychology as a whole. Additionally, it will also be interesting to see how this change will impact the public's perceptions of the roles and responsibilities of both psychologists and psychiatrists, as how in turn this change will impact the public's attitudes toward seeking help from these professionals.

With respect to psychiatrists, the current study suggests that the general public may feel less comfortable in engaging in a relationship with these professionals.

Additionally, it appears that the general public may also believe that the stigma associated with seeking help from psychiatrists is greater than that of seeking help from psychologists. Therefore, psychiatrists may wish to aim their efforts at showing the public that they can be friendly and easy to relate to. Additionally, they may also wish to address the issues related to stigma by somehow normalizing the act of taking medication for psychological problems. Again, it seems as if this is already being done to some extent. Specifically, one has to look no further than television commercials to see how the field of psychiatry is attempting to normalize the act of taking psychotropic medication for psychological problems.

Table 1

Correlations between Factors on the ATMHS Scale

	Factor I	Factor II	Factor III
Factor I	1.00	.26	.41
Factor II	X	1.00	.44
Factor III	X	X	1.00

Table 2

Fit Statistics for both the ATMHS and the ATSPPH Scale

	RMSEA	Bentler's CFI	TLI	Avg. standard residual
Paris & Pace's ATMHS Scale	.042	.96	.95	.86
Fischer & Turner's ATSPPH Scale	.055	.88	.85	1.00

Table 3

Correlations between Factors on the ATSPPH Scale

	Recognition	Stigma	Interpersonal openness	Confidence
Recognition	—	.48	.45	.73
Stigma		—	.38	.47
Interpersonal Openness			—	.39
Confidence				—

Table 4

Significance of Background Variables among the Four Different Conditions

Variable examined	Test or method	p-value
Age	Kruskal-Wallis Test	0.52
Gender	Chi-Square Test	0.35
Marital status	Fisher's Exact Test	0.33
Race	Fisher's Exact Test	0.08
Income	Kruskal-Wallis Test	0.65
Educational level	Chi-Square Test	0.68
Past counseling service	Chi-Square Test	0.63
Counseling experience	Fisher's Exact Test	0.82
Past psychiatric service	Fisher's Exact Test	0.24
Past psychiatric experience	Fisher's Exact Test	0.28
Past history of medication usage	Fisher's Exact Test	0.20
Experience with past medication	Fisher's Exact Test	0.73

Table 5

t-test Summaries for the Effect of Informational Description on the Psychology and Psychiatry Versions of the ATMHS Scale

	df	F	t	p
Psychology group	78	.049	-.979	.331
Psychiatry group	78	.129	.29	.773

Table 6

Summary of Main Effects for the Two-Way Univariate Analysis of Variance

Source	df	F	η^2	p
Profession	1	3.67	.023	.057
Information	1	.287	.002	.593
Interaction of profession and information	1	.851	.005	.358
Error	156	(150.23)		

Note. Values enclosed in parentheses represent mean square error.

Table 7

Mean Scores, Standard Deviations and Ranges per Condition for the Total ATMHS and its Three Contributing Factors

	Psychology condition (N=80)			Psychiatry condition (N=80)		
	Mean	Standard Deviation	Range	Mean	Standard Deviation	Range
Total ATMHS score	75.2	12.9	59	71.5	11.5	64
Confidence in mental health services	30.5	6.1	27	30.0	5.7	29
Fear of stigma	17.8	4.3	18	16.4	4.4	19
Internal/External coping resources	26.9	5.3	26	25	5.0	28

Note. Higher scores on the Total ATMHS scale indicate more positive attitudes toward help seeking. Higher scores on Confidence factor indicate more confidence in mental health services. Higher scores on Fear of Stigma factor indicate less of a fear of being stigmatized. Higher scores on Internal/External Coping Resources indicate more positive attitudes toward help seeking.

Table 8

Between-Subjects Effects for the Collapsed Multivariate Analysis of Variance

	Df	F	P	η^2
Overall Model	3	2.216	.091	.041
Confidence in Mental Health Services	1	.32	.572	.002
Fear of Stigma	1	3.70	.056	.023
Internal/External Coping Resources	1	5.20	.024	.032

Figure 1

2 X 2 Between Groups Design

	ATMHS reflecting psychologists	ATMHS reflecting psychiatrists
Informational Description	N =40	N =40
No Informational Description	N =40	N =40

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Appendix A

Example of the Informed Consent Form

INFORMED CONSENT FORM

TITLE OF PROJECT: Using the ATMHS Scale to Determine Differences in Attitudes among Various Mental Health Professionals

INVESTIGATOR(S): Michael Lawrence B.A., Doctoral Student, Department of Educational Psychology, Counseling Psychology Program, University of Oklahoma, 405-325-5974.

CONSENT TO PARTICIPATE: This is to certify that I _____, hereby agree to participate as a volunteer in a scientific study designed to systematically examine and compare attitudes toward seeking help from various mental health professions as part of an authorized research program at the University of Oklahoma under the supervision of Dr. Terry Pace.

PURPOSE OF THE STUDY: The purpose of the present study is to systematically examine and compare attitudes toward seeking help from various mental health professions, specifically psychologists and psychiatrists. Attitudes play a crucial role in the decision to seek or not seek professional help for emotional and/or personal problem. Although numerous studies have examined attitudes toward mental health professionals, there has been no consistency in the measurement of these attitudes.

DESCRIPTION OF THE STUDY: After securing informed consent, participants will be asked to complete a brief demographic form and an attitude questionnaire.

RISKS OF PARTICIPATION: I understand that the potential risks to participants is minimal. If for any reason I become uncomfortable with the questions I am asked to respond to, I can withdraw from participating with no repercussions.

BENEFITS OF PARTICIPATION: I understand that there are no direct personal benefits, but that I may receive some extra-credit points for participation in this study. The only other benefit is in being able to contribute to research advancing the measurement of attitudes toward professional mental health services. To date, there has been no systematic study conducted comparing help-seeking attitudes toward various mental health professionals.

SUBJECT ASSURANCES:

Conditions of Participation: I understand that I am free to refuse to participate and to withdraw from the study at any time without prejudice to me. I also understand that, if I am participating in this study to obtain course credit and decide to withdraw from participating, I may not receive the course credit associated with the experiment.

Confidentiality: I understand that any information collected from me will remain strictly confidential. I understand that any and all identifying information will be removed and code numbers will be assigned to each participant. I further understand that all information will be stored in a locked file cabinet by the principal investigator, Michael Lawrence. I also understand that no individual will be identified in any public report of this research.

Legal Rights: I understand that by agreeing to participate in this research and signing this form I do not waive any of my legal rights.

Contacts for Questions: I understand that if I have any questions about this research or need to report any adverse effects from my participation, I may contact Michael Lawrence or Dr. Terry Pace at the University of Oklahoma, Department of Educational Psychology, 820 Van Vleet Oval, Norman, OK 73019. I may call Dr. Pace at (405) 325-5974. Likewise, if I have questions regarding my rights as a research participant I may contact the Office of Research Administration at (405) 325-4757.

SIGNATURES:

Signature of Research Participant

Date

Signature of the Principal Investigator

Date

APPENDIX B

Explanations of Psychologists and Psychiatrists

Roles and Responsibilities

Directions: Below you find a description of the roles, responsibilities and training of psychiatrists. Please read this description carefully and then answer the accompanying questionnaire pertaining to your willingness to seek help from psychiatrists.

The term psychiatry comes from two Greek words "psyche" translated as mind and "iatreia" translating as medical specialty (MedFriendly, 2001). Put these two words together and you have psychiatry which is a medical specialty of the mind. Psychiatrists are medical doctors. As such they, unlike psychologists, are able to order medical tests and prescribe medication without requiring supervision (American Psychiatric Association, 2003).

Psychiatrists specialize in the diagnosis, treatment and prevention of mental illnesses (American Psychiatric Association, 2003). More specifically, a psychiatrist is trained to be able to comprehend the biological, psychological and social components of one's mental illness. Moreover, as a medical doctor they are able to order diagnostic laboratory tests, to prescribe medicine, and to evaluate and treat psychological problems on a long term basis (American Board of Psychiatry and Neurology, Inc., 2003). Though some psychiatrists utilize psychotherapy (talk therapy) most do not (MedFriendly, 2001). Instead most psychiatrists occupy their time interviewing and diagnosing patients and prescribing and monitoring medication levels within patients.

It takes approximately 12 years of formal college and postgraduate training to become a psychiatrist. In order to become a psychiatrist one must graduate from an accredited school of medicine or osteopathy after earning a Bachelor's Degree (ABPN, 2003). Additionally, after graduating from medical school and earning a MD one must

complete at least four years of accredited post-graduate (residency) training. Three of these four years must be devoted to training in psychiatry. In order to sub specialize such as in child or geriatric psychiatry one must complete additional training beyond one's four year residency (ABPN, 2003).

Directions: Below you find a description of the roles, responsibilities and training of psychologists. Please read this description carefully and then answer the accompanying questionnaire pertaining to your willingness to seek help from psychologists.

Psychologists study the human mind and human behavior and receive training in the basic social and psychological sciences. Psychologist may participate in a number of different activities and occupy a number of different roles depending upon their specialty. For instance, some psychologists are research oriented and spend their time investigating the physical, cognitive, emotional and social aspects of human behavior. Others may work in more applied fields and provide mental health care in places such as hospitals, clinics, schools or other private sectors (US Bureau of Labor Statistics, 2003).

Psychologists working in more applied settings often interview patients and give diagnostic tests. Additionally, they may provide individual, family or group psychotherapy (talk therapy) as well as design and implement behavior modification programs (US Bureau of Labor Statistics, 2003). Psychologists work with individuals suffering from a wide diversity of pathology. Psychologists may work with individuals suffering from everyday problems of living as well as individuals suffering from more severe problems such as Schizophrenia and Bipolar Disorder.

It takes approximately 11 to 12 years of formal college and postgraduate training to become a psychologist. A doctoral degree is usually required for employment as a licensed clinical or counseling psychologist. This degree usually requires 5 to 7 years of graduate study post college. Course work includes classes such as quantitative research

methods, psychopathology, theories and techniques of counseling, assessment, and child, family and marriage counseling to name a few. The Ph.D. degree concludes in the professional completing a dissertation which is a research project that adds something new and unique to the field. In the more applied specialties of psychology a requirement of a doctoral degree usually includes a one-year internship which can be completed in a wide diversity of settings (US Bureau of Labor Statistics, 2003). Additionally, in order to sub specialize one may complete one to two years of post doctoral training. Finally, psychologists are then required to work under supervision for one to two years prior to being eligible for full independent licensure as a mental health practitioner.

APPENDIX C

The Original ATMHS and the Two Revised Versions

The Attitude toward Mental Health Services Scale

Instructions: Below are a number of statements pertaining to mental health issues. Read each statement carefully and indicate your level of agreement or disagreement. Please express your personal opinion in rating the statements. There are no "wrong" answers, and the only right ones are whatever you honestly think, feel or believe. It is important that you answer every item.

Using the key below, mark all responses on the scantron card. Please do not write on the questionnaire.

Note: This Questionnaire uses a 5-point rating scale, from 5 (*strongly agree*) to 1 (*strongly disagree*).

- 5 = strongly agree
- 4 = moderately agree
- 3 = neither agree nor disagree
- 2 = moderately disagree
- 1 = strongly disagree

1. Having insight into my own thoughts and behaviors is appealing to me.
2. I believe many family problems would be helped by a mental health professional.
3. I would feel uneasy about going to see a mental health professional because of what some people would think.
4. I would fear that others might think of me as "crazy" if I sought professional mental health services.
5. I would avoid going to see any mental health professional because of what people might think.
6. I would exhaust all other means before I sought help from a mental health professional.
7. Having been a mental health patient reflects negatively on a person's life.
8. Professional mental health services are too costly for what you get.
9. If I saw that a close friend or family member had been helped by mental health services, it would positively influence my attitude about professional mental health services.
10. I would be more likely to see a mental health professional if I knew no one would find out about it.

- 5 = strongly agree**
- 4 = moderately agree**
- 3 = neither agree nor disagree**
- 2 = moderately disagree**
- 1 = strongly disagree**

- 11. In most cases, mental health problems can be overcome by a strong character.
- 12. Sometimes the stresses of life can be too much and a mental health professional could be helpful at such times.
- 13. The idea of talking with a mental health professional strikes me as a positive way to solve personal or emotional problems.
- 14. I am confident that many mental health problems can be helped with counseling.
- 15. Given the expense of mental health services, they would have little value for someone like myself regardless of circumstances.
- 16. Most mental health problems can be solved alone, without the assistance of a mental health professional.
- 17. Professional mental health services require too much time before you see improvement.
- 18. I would rather talk to a close friend than a mental health professional about a mental health problem.
- 19. In times of severe crisis, I can see the value of getting professional mental health services.
- 20. Mental health services would be useful if one was having a hard time adjusting to a loss, such as a death or a divorce.
- 21. I would be embarrassed to admit to needing professional mental health services.

Attitude Toward Seeking Help from Psychologists Scale

Instructions: Below are a number of statements pertaining to *psychologists*. Read each statement carefully and indicate your level of agreement or disagreement. Please express your personal opinion in rating the statements. There are no "wrong" answers, and the only right ones are whatever you honestly think, feel or believe. It is important that you answer every item.

Using the key below, mark all responses on the scantron card. Please do not write on the questionnaire.

Note: This Questionnaire uses a 5-point rating scale, from 5 (*strongly agree*) to 1 (*strongly disagree*).

5 = strongly agree
4 = moderately agree
3 = neither agree nor disagree
2 = moderately disagree
1 = strongly disagree

1. Having insight into my own thoughts and behaviors is appealing to me.
2. I believe many family problems would be helped by a psychologist.
3. I would feel uneasy about going to see a psychologist because of what some people would think.
4. I would fear that others might think of me as "crazy" if I sought help from a psychologist.
5. I would avoid going to see any psychologist because of what people might think.
6. I would exhaust all other means before I sought help from a psychologist.
7. Having been a patient of a psychologist reflects negatively on a person's life.
8. Psychologists are too costly for what you get.
9. If I saw that a close friend of family member had been helped by a psychologist, it would positively influence my attitude about psychologists.
10. I would be more likely to see a psychologist if I knew no one would find out about it.
11. In most cases, mental health problems can be overcome by a strong character.

- 5 = strongly agree**
- 4 = moderately agree**
- 3 = neither agree nor disagree**
- 2 = moderately disagree**
- 1 = strongly disagree**

12. Sometimes the stresses of life can be too much and a psychologist could be helpful at such times.

13. The idea of talking with a psychologist strikes me as a positive way to solve personal or emotional problems.

14. I am confident that many mental health problems can be helped by seeing a psychologist.

15. Given the expense of psychologists, they would have little value for someone like myself regardless of circumstances.

16. Most mental health problems can be solved alone, without the assistance of a psychologist.

17. Services rendered through a psychologist require too much time before you see improvement.

18. I would rather talk to a close friend than a psychologist about a mental health problem.

19. In times of severe crisis, I can see the value of seeing a psychologist.

20. Services rendered by a psychologist would be useful if one was having a hard time adjusting to a loss, such as a death or a divorce.

21. I would be embarrassed to admit to needing to see a psychologist.

Attitude Toward Seeking Help from Psychiatrists Scale

Instructions: Below are a number of statements pertaining to *psychiatrists*. Read each statement carefully and indicate your level of agreement or disagreement. Please express your personal opinion in rating the statements. There are no "wrong" answers, and the only right ones are whatever you honestly think, feel or believe. It is important that you answer every item.

Using the key below, mark all responses on the scantron card. Please do not write on the questionnaire.

Note: This Questionnaire uses a 5-point rating scale, from 5 (*strongly agree*) to 1 (*strongly disagree*).

5 = strongly agree
4 = moderately agree
3 = neither agree nor disagree
2 = moderately disagree
1 = strongly disagree

1. Having insight into my own thoughts and behaviors is appealing to me.
2. I believe many family problems would be helped by a psychiatrist.
3. I would feel uneasy about going to see a psychiatrist because of what some people would think.
4. I would fear that others might think of me as "crazy" if I sought help from a psychiatrist.
5. I would avoid going to see any psychiatrist because of what people might think.
6. I would exhaust all other means before I sought help from a psychiatrist.
7. Having been a patient of a psychiatrist reflects negatively on a person's life.
8. Psychiatrists are too costly for what you get.
9. If I saw that a close friend of family member had been helped by a psychiatrist, it would positively influence my attitude about psychiatrists.
10. I would be more likely to see a psychiatrist if I knew no one would find out about it.
11. In most cases, mental health problems can be overcome by a strong character.

- 5 = strongly agree**
- 4 = moderately agree**
- 3 = neither agree nor disagree**
- 2 = moderately disagree**
- 1 = strongly disagree**

12. Sometimes the stresses of life can be too much and a psychiatrist could be helpful at such times.

13. The idea of talking with a psychiatrist strikes me as a positive way to solve personal or emotional problems.

14. I am confident that many mental health problems can be helped by seeing a psychiatrist.

15. Given the expense of psychiatrists, they would have little value for someone like myself regardless of circumstances.

16. Most mental health problems can be solved alone, without the assistance of a psychiatrist.

17. Services rendered through a psychiatrist require too much time before you see improvement.

18. I would rather talk to a close friend than a psychiatrist about a mental health problem.

19. In times of severe crisis, I can see the value of seeing a psychiatrist.

20. Services rendered by a psychiatrist would be useful if one was having a hard time adjusting to a loss, such as a death or a divorce.

21. I would be embarrassed to admit to needing to see a psychiatrist.

APPENDIX D

Example of the Background Questionnaire

PERSONAL INFORMATION QUESTIONNAIRE

Please fill in the blank or make a check in the space next to the choice that best describes you. We ask that you answer all questions and to do the best of your ability.

Age: _____

Gender: Male _____ Female _____

Current Marital status: ☐ Single
 ☐ Married
 ☐ Divorced
 ☐ Separated
 ☐ Widowed
 ☐ Other (please specify _____)

Race/ethnicity that you most identify with. If you identify with more than one please rank them in order (1,2,3...)

☐ White/Caucasian
☐ African American
☐ Native American (please specify _____)
☐ Asian American
☐ Hispanic American
☐ Other (please specify _____)

College level: ☐ Freshman
 ☐ Sophomore
 ☐ Junior
 ☐ Senior
 ☐ Other (please specify _____)

College Major: _____

Please specify your occupation if presently employed: _____

I graduated from _____ high school in _____, _____
City State

Have you ever received any type of professional counseling or psychotherapy from a psychologist?

Yes _____ No _____.

If you answered yes to the previous question, would you consider your counseling experience to have been a positive one? Yes _____ No _____.

Have you ever seen a psychiatrist for a psychological problem?

Yes ____ No ____.

If you answered yes to the previous question, would you consider this experience to have been a positive one? Yes ____ No ____.

Have you ever received any type of psychotropic medication from a psychiatrist or medical doctor for a psychological problem?

If you answered yes to the previous question, would you consider to experience to have been a positive one? Yes ____ No ____

I would estimate my family's annual income to be:

- ____ \$0-\$10,000
- ____ \$10,001 - \$20,000
- ____ \$20,001 - \$30,000
- ____ \$30,001 - \$40,000
- ____ \$40,001 - \$50,000
- ____ \$50,001 - \$60,000
- ____ \$60,001 - \$70,000
- ____ \$70,001 - \$80,000
- ____ \$80,001 - \$90,000
- ____ \$90,001 - \$100,000
- ____ more than \$100,000 annually