Examination of the Reliability and Validity of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) among Jamaican Americans

Geoffrey J. Palmer

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Geoffrey J. Palmer
Candidate
Individual, Family, and Community Education
Department

This dissertation is approved, and it is acceptable in quality and form for publication:

Approved by the Dissertation Committee:

Deborah Rifenbary, Ed.D., Chairperson

Lydia (Gene) Coffield, Ph.D

Allison M. Borden, Ed.D.

Steven P. Verney, Ph.D.
Examination of the Reliability and Validity of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) Among Jamaican Americans

BY

GEOFFREY J. PALMER

B.S., Psychology, Bowie State University, 1996
A.A., General Education, Prince George’s Community College, 1997
A.S., Secondary Education, Prince George’s Community College, 1997
M.A., Counseling Psychology, Bowie State University, 1998

DISSERTATION

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy Counselor Education

The University of New Mexico Albuquerque, New Mexico

August, 2009
DEDICATION

To my dear Uncle Lincoln.

Your devotion to your family and life long commitment to communities here in the United States and Jamaica is a lesson of inspiration.

Lorenzo Lincoln Palmer
1935 - 2009
ACKNOWLEDGMENTS

My purpose for pursuing a terminal degree within the helping professions is to increase my ability to serve others in need. This necessity to help stems from an individual’s desire to grow, develop, heal, teach, and assist others. I did not venture on this journey alone. There are many wonderful human beings from several nurturing communities that supported me through this endeavor.

First and foremost, I want to thank the Good Lord for providing the grace to make all of this possible. I cannot completely express the level of support I received from my family. My father, Dr. Ransford W. Palmer, dedicated his life to being an educator. His passion for helping those in developing countries through research and by providing governments with empirical tools of knowledge provided a model that I am proud to follow. My father may have demonstrated a strong example, but my mother, Sally Williams Palmer, provided the nurturing and teaching which made my development possible. Through great sacrifice and endless love, my Mom made sure I had everything needed to grow into a strong man. My sister Laura’s constant love and encouragement helped me maintain my perseverance, and her beautiful children, my nephew Andrew and niece Elizabeth gave me inspiration to become a model for their generation. My brother Chris supported me through the highs and lows of my quest. The extended Palmer family in Florida, New York, and Jamaica helped motivate me to succeed and gave me the comfort of knowing I was not forgotten during this period of time. I am eternally grateful to my family and thank God for giving me such caring and loving people.

Although I speak of the nuclear and extended Palmer family, my family continued to grow in New Mexico. Several individuals in particular welcomed me into their homes
and made a world of difference in my experience in the American Southwest. The friendship of fellow University of New Mexico doctoral student Evonne Olson helped me to adjust to the New Mexican landscape as well as the terrain of academia.

Connie Maple, another UNM Ph.D. student gave me unconditional friendship. Connie and her daughter Tiana adopted me into both their Hawaiian and New Mexican culture, and I am grateful. My Albuquerque family would not be complete without mentioning Jim and Jill Mocho. Even though they were not formally a part of my studies, my journey through graduate school was easier with their continuous care and support. I am forever grateful for the love I continue to receive from my home away from home, my friends and family in New Mexico.

It is typical for newly minted Ph.D.s, as my father refers to these former students, to discuss their dissertation committee members. This is usually done as a courtesy with little sincerity. However, I have been blessed with a dynamic team of professionals who eagerly pushed me to grow as a scholar and a person.

Dr. Deborah Rifenbary served as my dissertation committee chair and provided the leadership which enabled me to work at a rate that resembled an East Coast pace. An East Coaster herself, Dr. Rifenbary’s support began from my initial interview with the program. She saw positive attributes within me and encouraged me to use my gifts within our field of Counselor Education and beyond. In my earlier days at the University of New Mexico, I had doubts of my own retention in the program. Dr. Rifenbary worked with me on my comfort level and assimilation and it is because of her that I am a Lobo today (Go Lobos!!).
Dr. Gene Coffield served on my committee and is the epitome of love. As program coordinator, Dr. Coffield and I taught together for nearly three years and worked on multiple challenges. Even though her professionalism and ethical principles are unmatched, it is her endless giving, sharing, and nurturing that have made a lasting imprint on how I view the human condition. Dr. C, as she is more affectionately known, is a beautiful human being and has been my spiritual guide through this journey.

Dr. Allison Borden served on my dissertation committee, joining the team from the department of Educational Leadership. My first exposure to Dr. Borden was in her course, the *Impact of Immigration on Education*. It did not take me long to figure out that Dr. Borden’s interests where not in the ivory towers of academia, but with the care of the marginalized, underserved, and poor. Dr. Borden is a true teacher in the sense that her philosophy cannot be taught, it has to be desired. It is only following my defense that I realize that Dr. Borden’s endless teachings were not for my benefit alone, but also intended for my students as well.

Dr. Steven Verney joined my committee as the only member outside of the College of Education. As a professor in the Psychology department, Dr. Verney has a vision of spreading greater levels of multicultural competence and clinician awareness concerning people from diverse backgrounds. His confidence in my abilities and knowledge of student resistance concerning personal power and privilege has allowed us to collaborate on projects outside of my dissertation. Steve has also shown me great respect and friendship, which has taught me to have that same appreciation for others.

My dissertation committee constantly reinforced the importance of my study and the potential impact it can have on the ability of the helping professions to serve
communities not accustomed to mental health services. Their constant reinforcement of
the benefits of my contribution to the existing body of literature has served as a powerful
motivator which I will continue to sustain.

Last, but certainly not least, there is my collegiate family at Bowie State
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on campus. The individual that represents the care of Bowie students is the director
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over a decade ago as a counseling intern and later as an employee serving the Bulldog
community. Since that time Tonya has pushed me to develop to heights that may have
seemed unimaginable. In fact, it is because of Ms. Swanson that I pursued a doctorate.
She wanted me to further develop in order to serve at a higher level, even at the cost of
losing “a counselor with good clinical abilities.” Her support continued to triumph even
when I left for graduate school in New Mexico. An example of this is when
Ms. Swanson traveled two thousand miles to see me present at a conference in
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benefit, but for my students and clients now and yet to come. I am forever grateful for all
of Ms. Swanson’s support. She is a wonderful human being.

Ms. Aquila Mitchell is another shining product of Ms. Swanson and is part of the
Counseling Services family. Ms. Mitchell provided me with statistical support and
consultation. Her expertise in quantitative research methods helped me to stay calm
when my analysis became challenging. Aquila’s support and understanding assisted my process and gave me the edge to articulate my statistical findings with confidence.

Ms. Sarita Sankey is also a member of Counseling Services and flooded me with encouragement through support and prayer. Whether I was in Maryland, New Mexico, or some conference in between, Ms. Sankey motivated me to keep my focus steadfast. Sarita’s willingness to share her experiences as a graduate student helped me understand facets that reinforced my efforts in the field. I am grateful for her support through her openness and honesty.

Dr. Jacqueline Mothersille Payne is a professor of Nursing at Bowie State University who help me to form relationships with Jamaican organizations within the Washington, D.C. metropolitan area. Dr. Payne’s efforts in networking helped to establish contacts that contributed to the quality of my dissertation. I am grateful for her interest in my research and love for the Jamaican community.

My experience as a doctoral student was enhanced and very much enriched through the support of my many families. Without their love and support the outcome of my journey would not have been as certain. The individuals I acknowledged have shared closely in this venture. However, I was not able to mention all friends, family networks, and people of the BMX community, but you are in my heart and not forgotten. The lessons that I have learned from this experience is to care for those around you because the impact of your goodwill extends far beyond the individuals you reach.

Geoffrey J. Palmer

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ABSTRACT

The purpose of this study was to examine the reliability and validity of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) among Jamaican Americans. The psychometric properties of the ATSPPHS were investigated to identify its appropriateness of measuring attitudes toward seeking mental health services of this Caribbean population. Ninety four Jamaican Americans completed the ATSPPHS which was developed by Fischer and Turner in 1970, and a demographic information form. An estimate of Cronbach’s alpha reliability coefficient for the overall ATSPPHS, and the four attitudinal factors were calculated to determine reliability. Principal components analysis was utilized to examine the structure of the factors and validity. An estimated correlation matrix was used to determine facets of both reliability and validity. The estimate of Cronbach’s alpha reliability coefficient for the overall ATSPPHS with the Jamaican American sample was $\alpha = .87$. This result represented strong reliability for
the overall scores of the ATSPPHS and shared similar findings with Fischer and Turner’s (1970) original standardized population. The principal component analysis revealed only one attitudinal factor differing sharply from Fischer and Turner’s (1970) factor analysis producing four independent factors. Validity of the ATSPPHS was not established with the Jamaican American sample. Implications highlighted the potential for helping professionals to greater serve populations that traditionally underutilize mental health services through a more sophisticated understanding of attitudes toward seeking mental health services. Future research concerning potential barriers to receiving help such as economic influences on culture and characteristics of Afro-Caribbean cultural distinctiveness are recommended.

Keywords: Jamaica, Jamaican, Jamaican American, Afro-Caribbean, attitudes toward seeking mental health services, attitudes toward seeking help, Attitudes Toward Seeking Professional Psychological Help Scale, ATSPPHS, helping professionals, helping professions, underutilize mental health services, reliability, validity
# TABLE OF CONTENTS

LIST OF TABLES ........................................................................................................ xvi

CHAPTER ONE INTRODUCTION ............................................................................ 1

Statement of the Problem .......................................................................................... 3

Purpose of the Study ................................................................................................. 3

Characteristics that Influence Help Seeking Attitudes .............................................. 4

Mental Health Care in Jamaica ........................................................................ 4

Migration to the United States ......................................................................... 7

Psychological Stressors ................................................................................... 8

Need for Counseling Services ............................................................................ 10

Research Hypotheses............................................................................................... 12

Research Questions ................................................................................................. 12

Definitions of Terms ............................................................................................... 12

Summary ................................................................................................................. 15

CHAPTER TWO LITERATURE REVIEW ............................................................. 16

Historical Perspective of Measuring Attitudes ........................................................ 16

Factor Development of Classifying Attitudes ......................................................... 19

Arrival of the Attitudes Toward Seeking Professional Psychological Help Scale
(ATSPPHS) ............................................................................................................. 21

Previous Use of the ATSPPHS ............................................................................ 23

Immigrants from Geographical Regions .......................................................... 23

Immigrants from Specific Countries ............................................................... 27

Intergenerational Populations ............................................................................. 28
Eclectic Immigrant Populations ................................................................. 33
Overseas Populations ..................................................................................... 37
The Need to Assess the Reliability and Validity of the ATSPPHS ................. 40
Summary ................................................................................................................. 42

CHAPTER THREE RESEARCH METHODS ......................................................... 43
Development and Standardization of the ATSPPHS .............................................. 43
Subjects .............................................................................................................. 43
Instrumentation .............................................................................................. 43
Development and Standardization ................................................................. 44
Reliability based on Fischer and Turner’s Research ..................................... 45
Validity based on Fischer and Turner’s Research ......................................... 48
Elements of Measurement ....................................................................................... 50
Reliability in Measurement ............................................................................ 51
Validity in Measurement ............................................................................... 54
Research Questions ................................................................................................. 58
Description of Instrumentation ........................................................................ 58
Attitudes Toward Seeking Professional Psychological Help Scale ............... 58
Demographic Information Form ..................................................................... 59
Participants .............................................................................................................. 59
Data Collection Procedures ............................................................................. 60
Management of Missing Data ......................................................................... 62
Data Analysis .......................................................................................................... 62

CHAPTER FOUR RESULTS OF THE DATA ANALYSIS .................................... 64
APPENDIX A   ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE (ATSPPHS) ......................................................... 94

APPENDIX B   DEMOGRAPHIC INFORMATION FORM ......................................................... 97

APPENDIX C   INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL ................................. 99

APPENDIX D   INFORMED CONSENT AND WELCOME LETTER
(MAILING 1)......................................................................................................................... 102

APPENDIX E   REMINDER TO PARTICIPATE LETTER (MAILING 2) ......................... 104

APPENDIX F   THANK YOU LETTER (MAILING 3) ......................................................... 106

APPENDIX G   PARTICIPANT RESPONSE REPORT ....................................................... 108

APPENDIX H   REPLACED VALUES OF MISSING DATA ................................................. 110

APPENDIX I   DATA STRUCTURE CODE BOOK ............................................................. 112

REFERENCES .................................................................................................................. 121
LIST OF TABLES

Table 1. ATSPPHS Subscale Reliability Coefficients among the Standardized, Italian American, and Greek American Samples ............................................................... 30

Table 2. ATSPPHS Items by Factors ............................................................................... 46

Table 3. ATSPPHS Test-Retest Reliability Time Intervals ............................................. 48

Table 4. ATSPPHS Subscale Reliability ......................................................................... 50

Table 5. Participants’ ATSPPHS Overall and Factor Scores .......................................... 65

Table 6. Participants’ Age and Number of Years in the United States ............................ 65

Table 7. Participants’ Occupations .................................................................................. 66

Table 8. Social and Economic Demographics .................................................................. 68

Table 9. Previous Use of and Access to Mental Health Services .................................. 70

Table 10. Comparison of Estimates of Cronbach’s Alpha Reliability Coefficients for the ATSPPHS based on Fischer and Turner (1970) and Palmer (2009) ............... 71

Table 11. Estimated Correlation Matrix of ATSPPHS and Attitudinal Factors (Pearson Correlation) ........................................................................................................... 72

Table 12. Estimated Correlation Matrix of ATSPPHS, Attitudinal Factors, and Selected Demographic Variables (Spearman Correlation) .............................................. 74

Table 13. Principal Component Matrix for the Un-Rotated Solution .............................. 76

Table 14. Comparison of ATSPPHS and Factors Reliability Coefficients of Previous and Current Studies ........................................................................................................ 79

Table 15. Estimated Correlation Matrix of ATSPPHS, Attitudinal Factors, and Selected Occupation Demographic Variables (Spearman Correlation) ..................... 87
CHAPTER ONE
INTRODUCTION

The most widely utilized measures of attitudes toward seeking mental health services is Fischer and Turner’s Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). The ATSPPHS was designed to distinguish between those who are willing to seek psychological services and those who are not (Fischer & Turner, 1970).

Researchers have used the ATSPPHS extensively since it was standardized and published in 1970, with a great deal of emphasis on cross-cultural investigations. Following the ATSPPHS development, an emphasis emerged in the 1970’s for helping professionals to research diverse minority populations (Atkinson, 1985). Historically, minority populations have underutilized mental health services (Sue & Sue, 1977; Sue, 1977). Since the 1980’s, a great deal of attention has focused on research investigating diverse groups and attitudes toward seeking mental health services. Populations that have migrated to the United States, overseas nationals, and subcultures stemming from variations of both have been the center of psychological research incorporating the use of the ATSPPHS (Dadfar & Friedlander, 1982; Al-Darmaki, 2003; Ponterotto, Rao, Zweig, Rieger, Schaefer, Michelakou, Armenia, & Golstein, 2001).

The literature addressing help seeking attitudes has revealed a trend demonstrating that researchers incorporating the ATSPPHS rely on the scale’s standardized reliability and validity when surveying diverse populations (Atkinson & Gim, 1989; Tata & Leong, 1994; Ponterotto et al. 2001; Zhang & Dixon, 2003). The majority of researchers who have conducted cross-cultural research investigating
attitudes toward seeking mental health care have not taken the steps to learn if the 
ATSPPHS is an appropriate measure of people from regions outside of the American 
Northeast where the instrument was standardized.

Jamaican channels for receiving help for issues pertaining to personal problems, 
family matters, and community relations have existed in Jamaica for hundreds of years. 
Throughout the generations, Jamaicans have relied on family members, church leaders, 
and community elders to resolves issues contributing to psychological stress. However, 
an increasing number of Jamaicans now reside in the United States where traditional 
helping networks are no longer available. Counseling is the prominent form of 
therapeutic mental health care in Western societies such as the United States. If 
Jamaicans are in need of help for psychological issues while living in the United States, 
one of the few alternatives may be the unfamiliar method of counseling services. Before 
counselors begin providing therapy for Jamaican immigrants in need of assistance, an 
understanding of help seeking attitudes needs to be investigated. At the present time, 
Jamaican attitudes toward seeking professional psychological help have not been the 
focus of research and relatively little is known about these attitudes.

The importance for pursuing counseling research addressing attitudes toward 
seeking mental health services among Jamaicans in the United States is to create greater 
awareness for practicing professionals. Therapists with a higher level of understanding 
of Jamaican needs can begin to provide therapeutic services that are more appropriate for 
serving this underrepresented Caribbean population.

Before a potential Jamaican client pursues counseling, a willingness to seek care 
must exist. A Jamaican’s willingness to seek counseling is initially based on present
attitudes toward seeking services. To better understand Jamaicans’ willingness to seek counseling, attitudes toward mental health services must be measured and analyzed.

This research study is an investigation of the ATSPPHS utility with a Jamaican population in the United States. The objective is to determine if the ATSPPHS demonstrates reliability and validity when incorporated as a measure of Jamaican attitudes toward seeking mental health services.

**Statement of the Problem**

The Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) was developed to measure an individual’s willingness to seek mental health services (Fischer & Turner, 1970). It was standardized using students from the North Eastern region of the United States. Although the ATSPPHS has been widely employed in research relating to attitudes toward seeking help (Williams, Skogstad, & Deane, 2001), its reliability and validity has not been validated for use with a Jamaican population.

Jamaicans migrating to the United States in search of greater prosperity are confronted with a multitude of psychological stressors (Palmer, 1995, p. 24; Palmer, 1998, p. 70). With their social healing systems no longer present, Jamaicans residing in the United States suffering from any form of psychological issues may need to seek counseling services. Before counselors can provide professional psychological care, Jamaican attitudes toward seeking counseling services must be understood.

**Purpose of the Study**

The purpose of this study is to test the reliability and validity of the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970) with a
Jamaican population. While all forms of reliability and validity will be considered and explored, construct validity in particular will be examined to determine the appropriateness of using the ATSPPHS with Jamaicans residing in the United States.

Impending results could call for the development of a new instrument with the reliability and validity capable of being utilized with Jamaicans and other communities of Afro-Caribbean descent. Potential barriers to counseling such as societal stigma and personal reluctance to disclosure could be further recognized. Implications could provide counselors with a greater understanding to provide services that are more appropriate for Jamaicans who have migrated to the United States.

**Characteristics that Influence Help Seeking Attitudes**

The ATSPPHS utility will be tested with a Jamaican population in the United States. Characteristics that influence help seeking attitudes of this Caribbean sample are explained through the categories of mental health care in Jamaica, migration to United States, psychological stressors, and the need for counseling services.

**Mental Health Care in Jamaica**

Since the 2001 census, the Jamaican government has addressed issues pertaining to mental health (Statistical Institute of Jamaica, 2004). With the continued growth of the country and Jamaica being one of the most populated countries in the Caribbean, mental health care trends will have to be monitored on an ongoing basis. Efforts have been made through statistical sampling techniques and self reported data collection to better understand the current state of mental health in Jamaica (Statistical Institute of Jamaica, 2004; Planning Institute of Jamaica and Statistical Institute of Jamaica, 2006a; Planning Institute of Jamaica and Statistical Institute of Jamaica, 2006b).
The Jamaican Ministry of Health (2006) has set forth initiatives working toward fulfilling objectives which would contribute to the overall mental health and well-being of the Jamaican people. The Ministry of Health’s recent efforts are based on the World Health Organization’s (WHO; 1948) description of social and mental well-being, which supports overall health stemming from a westernized prospective of providing help. The WHO (1948) defines mental health as a part of complete health and social well-being which is free of illness, disease, and disability.

The Jamaican government, through the Ministry of Health, recognized the growing need for mental health services and recorded limited data on the present state of mental health care in the 2001 census (Statistical Institute of Jamaica, 2004). The Statistical Institute of Jamaica (2004) data collection procedures incorporated both long and short forms and included a qualitative household interview to represent mental illness during the 2001 population census. For the first time, the 2001 Jamaican census introduced a category encompassing types of disabilities (Statistical Institute of Jamaica, 2004). The sections on the census related to mental health were mental illness, mental retardation, slowness of learning and understanding, and multiple disabilities (Statistical Institute of Jamaica, 2004). In 2006, the categories were expanded to include schizophrenic/psychotic disorders, mood disorders, anxiety disorders, substance abuse, and disorders of childhood and adolescence as major diagnoses (Statistical Institute of Jamaica, 2004).

All of the above mentioned diagnoses are also cataloged in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000). The Ministry of Health (Statistical Institute of Jamaica, 2004) shares similar
characteristics with the multiaxial categories of the DSM-IV-TR, but do not involve the
detail of the diagnoses (American Psychiatric Association, 2000).

Jamaica’s recent pursuit of mental health care faces challenges. A reluctance
exists in Jamaican society which may limit an individual’s willingness to disclose having
a disability or sharing information concerning a family member with mental illness
(Statistical Institute of Jamaica, 2004). Therefore, greater awareness about mental health
and psychoeducation is needed to reduce the stigma of those suffering from
psychological problems.

Counseling services and other forms of mental health care have evolved from
westernized approaches to treat psychological distress. These western approaches
regarding the effectiveness of mental health theory and practice have been studied since
the birth of Adlerian Psychology at the beginning of the twentieth century (Sherman and
Dinkmeyer, 1987, p. 4; Sweeney, 1989; p. 1). However, Jamaica is not a westernized
country and struggles to compete with developed nations such as the United States when
providing services to its citizens.

Jamaican values reflect collectivist societal traits with a strong tendency to solve
psychological issues within the family. Although seeking help within the family is a
form of mental health care, it has not been accepted as a western method of psychological
treatment and therefore may not be viable for conducting empirical research.

The reluctance to discuss mental illness and the stigma associated with people in
need of treatment directly relates to Jamaican attitudes toward seeking mental health
services. The current study will focus on the reliability and validity of the ATSPPHS
with an immigrant sample of Jamaicans in the United States.


Migration to the United States

Jamaica is the largest Caribbean English speaking country and the third largest Caribbean country by population. The population of Jamaica has steadily grown to 2.6 million (Ministry of Health, 2003; Statistical Institute of Jamaica, 2007). Since 1961, one third of all Caribbean immigrants to the United States have come from the English speaking countries of Jamaica, Trinidad and Tobago, Barbados, and Guyana (Palmer, 1995, p. 13). During this same period, Jamaica received independence from Britain in 1962. Shortly after granting Jamaica her independence, the British government created the Commonwealth Immigration Act which sharply limited immigration for work from Jamaica (Palmer, 1995, p. 10). With an elimination of British work permits and a growing need for labor in the United States, Jamaican migration patterns began to change (Palmer, 1995, p. 10). Palmer (1995, p. 11) refers to this era in modern Caribbean migration as the “Contemporary Migration to the United States,” and elaborates:

…by far the largest number from this group has come from Jamaica. The magnitude of this migration is underscored when it is calculated as a percentage of the current population…17 percent for Jamaica. (p. 12)

The steady occurrence of migration from Jamaica continues to this day. During the period of 1999-2006 there were over 163,000 expatriates who had emigrated from Jamaica to other countries (Statistical Institute of Jamaica, 2007). This recent eight year period saw a yearly average of 20,400 permanent disembarkations (Statistical Institute of Jamaica, 2007). The majority of Jamaicans’ final destinations were to the United States.

The primary determinant for Jamaican nationals to migrate to the United States is to pursue a higher standard of living for themselves and their families (Palmer, 1998b, p. 64). In the pursuit of greater prosperity, Jamaican immigrants face many psychological
stressors. The purpose of this research becomes evident because of the occurrence of personal challenges as a result of migration. The usefulness of the ATSPPHS and attitudes toward mental health services among Jamaicans in the United States must be evaluated because of the potential for psychological stressors which may cause individuals to seek counseling services. Therefore, it is imperative that the ATSPPHS be assessed for its reliability and validity before services can be effectively provided.

**Psychological Stressors**

As a result of the migration process, Jamaicans have experienced psychological stress (Palmer, 1995, p. 24; Palmer, 1998b, p. 70; Pottinger, 2005). One form of this psychological difficulty resulting from acculturation is acculturative stress (Castillo, Cano, Chen, Blucker, and Olds, 2008) and generally manifests itself in the form of personal and social difficulties (Berry, Kim, Minde, & Mok, 1987). Attempting to adapt to a new host culture can produce psychological stressors and if left unchecked can have negative ramifications on immigrants’ mental health and state of well-being. Immigrants may be overwhelmed with anxiety concerning their ability to communicate, socialize, and seek education that would lead to gainful employment while trying to assimilate into the culture of the United States.

Berry et al. (1987) state that acculturative stress can lead to somatic symptoms stemming from feelings of isolation and thoughts of being marginalized. Depression is a common outcome for immigrants enduring psychological stress. Constantine, Okazaki, and Utsey (2004) suggest that high levels of acculturative stress can result in depression, and that a relationship exists between acculturative stressors and depression levels. Research with international students found that poor English language fluency had a
positive correlation with depression (Constantine et al. 2004). Consequently, poor English proficiency is a source of acculturative stress that can contribute to depression. Correlations between acculturative stress and depressive symptomatic feelings are a concern for counselors due to the high prevalence of depression in society (Palmer, 1998a).

Jamaicans in the United States may experience acculturative stress while attempting to interact with and adapt to the host culture. In general, immigrants may have symptomatic occurrences of acculturative stress related to failed expectations, language difficulties, self-esteem issues, discrimination, and stress related physical illness. Castillo et al. (2008) suggest that acculturative stress can also be generated from within the family. Research on Latino college students reported family conflict and intragroup marginalization as predictors of acculturative stress (Castillo et al. 2008).

Pottinger (2005) identifies migratory separation as a major cause of poor primary school performance and psychological troubles for children left behind in Jamaica by parents seeking employment in the United States. However, this family disruption can also be a source of psychological stress for working migrating parents in the United States who are no longer the direct guardians of their children in Jamaica. Many Jamaican immigrants who plan to remain in the United States due to employment opportunities make great efforts to reunify the family by having their children join them once the parents are established (Palmer, 1998b, p. 70; Pottering, 2005). This reunification of the family presents a source of psychological stress for both the migrating child and the immigrant parents due to acculturation.
Head of household roles for Jamaican women in the United States often contrast from those in Jamaica and this can lead to tension within the family (Palmer, 1998b, p. 71). Many migrating Jamaican women are employed in health care professions such as nursing and other care giving fields (Palmer, 1998b, p. 70). With well paying jobs, Jamaican women working in the United States acquire elevated economic status which differs from their previous societal positions (Palmer, 1998b, p. 71). The new economic status of Jamaican women may become a psychological stressor due to the contrast with the traditional Jamaican family dynamic (Palmer, 1998b, p. 71).

Because of the potential psychological stressors to which Jamaican immigrants can be exposed, there is risk of poor psychological health. The possibility of personal discomfort in an unfamiliar country warrants the need for counseling services. Further understanding of Jamaican attitudes toward seeking mental health services would help practitioners’ delivery of therapy to this underserved population.

**Need for Counseling Services**

Much of the need for counseling services by Jamaican immigrants may be a result of their migration to the United States. One of the personal and social disturbances resulting from migration is acculturative stress stemming from the acculturation process, as a result of immigrants trying to adapt to their new host culture. As previously stated, acculturative stress manifests in multiple symptoms that affect each immigrant differently. Constantine et al. (2004) have suggested a correlation between acculturative stress and depression. Family conflict and intragroup marginalization have also been found to be indicators of acculturative stress (Castillo et al. 2008).
This recent research concerning the psychological issues that immigrants face following their migration to the United States further reinforces the need for mental health professionals to deliver appropriate therapeutic care (Constantine et al. 2004; Castillo et al. 2008). However, counseling in its present form may not be entirely satisfactory. Jamaicans now living in the United States no longer have direct access to their indigenous healing networks. Immigrants from Jamaica would be forced to rely on westernized forms of psychological care.

Minority populations in general have typically underutilized mental health services (Sue & Sue, 1977; Sue, 1977). In Jamaica there has been a reluctance to disclose information about family members who have psychological disorders due to the stigma attached to mental illness (Statistical Institute of Jamaica, 2004). Research involving children of parents who migrated from Jamaica for employment found that 45% of primary school aged children left behind in Jamaica did not want to discuss the migration of a parent (Pottinger, 2005).

A major challenge for counselors is to develop a greater awareness concerning the cultural differences between the delivery of mental health care in Jamaican society and in the United States. If counseling services are not culturally competent, the therapy may prove ineffective resulting in a diminishing quality of life for the Jamaican immigrants in need of help. Investigators must provide empirical research that examines Jamaican attitudes toward seeking mental health services. This initial step will help counselors to understand why counseling services are not being utilized by diverse groups such as Jamaicans. The assessment of the reliability and validity of the ATSPPHS use with
Jamaicans Americans is the first step for mental health practitioners to understand attitudes that prevent individuals from seeking mental health services.

**Research Hypotheses**

This research concerning the reliability and validity of the ATSPPHS will test the following hypotheses:

1. The ATSPPHS reliability based on the standardized population will not be comparable to reliability generated from a Jamaican sample.
2. The ATSPPHS in its original form will not demonstrate validity for measuring Jamaican attitudes toward seeking mental health services.

**Research Questions**

The following research questions will direct this investigation:

1. Does the ATSPPHS demonstrate reliability when utilized with Jamaicans residing in the United States?
2. Does the ATSPPHS demonstrate validity when measuring Jamaican attitudes toward seeking mental health services?

**Definitions of Terms**

The following terms are used throughout the dissertation and therefore definitions are provided for contextual use within this document:

**Acculturative stress** – Psychological distress from attempting to adjust to a new host country’s culture, practices, and surroundings as a result of migration from another country of origin. The psychological difficulties generally accompany the acculturation process and are usually represented in personal, social, and somatic forms (Berry et al. 1987).

Counseling services – Therapeutic care developed for a variety of personal, family, and community issues stemming from westernized psychological helping theories. The goal of services is to create a positive resolution to improve individual and family functioning or circumstance (U.S. Department of Health & Human Services, 2000). This discipline of therapy is a form of mental health services.

**Eclectic Immigrant Populations** – Groups of individuals representing different countries (e.g. Korea, Panama, Russia, Sierra Leone) and geographical regions (e.g. Africa, Asia, the Caribbean, Europe) who have migrated to the United States, that researchers have studied utilizing the ATSPPHS (e.g. Dadfar & Friendlander, 1982). Comparison studies examining samples from different countries (e.g. Japan and the United States of America) that utilized the ATSPPHS for measurement are also designated as an eclectic immigrant population (e.g. Masuda, Suzumura, Beauchamp, Howells, & Clay, 2005). Research examining this category typically utilizes convenience samples (e.g. colleges and universities).

**Immigrants from geographical regions** – Populations who have migrated to the United States that are representative of a geographical region (e.g. Asia, South America), and have been researched utilizing the ATSPPHS (e.g. Atkinson & Gim, 1989; Zhang & Dixon, 2003).
**Immigrants from specific countries** – Populations from a specific country of origin (e.g. China), who have migrated to the United States who have been researched incorporating the ATSPPHS (e.g. Tata & Leong, 1994; Nguyen & Anderson, 2005).

**Intergenerational populations** – Populations from specific countries (e.g. Germany, the Netherlands) representing multigenerational groups who have migrated to the United States. This includes studies that encompass a combination of generations born in and outside of the United States that have been researched utilizing the ATSPPHS (e.g. Ponterotto, Rao, Zweig, Rieger, Schaefer, Michelakou, Armenia, and Goldstein, 2001).

**Mental health services** – Therapeutic services representing all forms of mental health care used by a variety of helping professionals to overcome issues of emotional disturbances, maladaptive behavior, socialization, learning, and development. (U.S. Department of Health & Human Services, 2000).

**Migration** – The flow of people from one country to another with intentions to reside in a nation other than an emigrant’s country of usual residence (Statistical Institute of Jamaica, 2007).

**Overseas populations** – Populations in specific countries outside of the United States (e.g. Kuwait; Al-Rowaie, 2001) that have been studied utilizing the ATSPPHS (e.g. Al-Darmeki, 2003).

**Professional psychological help** – A form of mental health services that therapy is provided by a trained counselor, psychologist, psychiatrist, etc. Fischer and Turner (1970) used this term for describing orientations of seeking help and
applied it to the name of the ATSPPHS. Many researchers have followed by using this terminology in studies addressing attitudes toward seeking mental health services (Fischer & Cohen, 1972; Dadfar & Friedlander, 1982; Tata & Leong, 1994; Fischer & Farina, 1995; Al-Darmaki, 2003; Masuda, Suzumura, Beauchamp, Howells, & Clay, 2005).

**Summary**

The ATSPPHS has been utilized to measure immigrant populations’ attitudes toward seeking professional psychological help, but the instrument was not developed nor standardized for use with diverse groups that have migrated to the United States. Jamaicans rely heavily on family and church relationships to deal with psychological issues. The values placed on family and religious faith mirrors Jamaica’s collective society. Psychological issues brought on by acculturative stress present challenges affecting the mental health and well-being of Jamaicans who have migrated to the United States. No longer having family for close support, Jamaicans in need of psychological help may be forced to seek counseling services. The first step for helping Jamaicans and other populations that underutilize counseling is to investigate their attitudes toward seeking mental health services. This dissertation is an investigation of the appropriateness of utilizing the ATSPPHS with a Jamaican population through an examination of reliability and validity. Implications of this study may potentially help mental health practitioners to effectively serve Jamaicans in a manner that maintains a high level of cultural competence.
CHAPTER TWO
LITERATURE REVIEW

Among the many obstacles which mental health professionals confront when trying to help those in need perhaps the greatest are the attitudes of potential clients may have toward seeking mental health services. If negative attitudes exist, the probability of clients seeking services diminishes.

The purpose of this study is to investigate the reliability and validity of the ATSPPHS with a Jamaican population. The following areas presented in this literature review provide a foundation supporting the rationale of this study; these include (1) Historical perspective of measuring attitudes, (2) Factor development of classifying attitudes (3) Previous use of the ATSPPHS, and (4) Need to assess the reliability and validity of the ATSPPHS with different populations.

**Historical Perspective of Measuring Attitudes**

The manifestation of an individual’s unwillingness to seek mental health services began to draw the attention of clinicians in the 1950s. Early procedures for measuring attitudes toward mental health services focused on psychiatric treatment (Redlich, Hollingshead, & Bellis, 1955; Reznikoff, Brady, & Zeller, 1959). Reznikoff et al. (1959) recognized the need to study attitudes toward psychiatric treatment and hospitals because of the potential relation to a patient’s duration in therapy.

The Psychiatric Attitudes Battery was developed by Reznikoff et al. (1959) to examine patients’ attitudes toward psychiatric treatment and mental hospitals. The Psychiatric Attitudes Battery was designed to elicit attitudes toward psychiatric hospitals, psychiatrists, and psychiatric treatment (Reznikoff et al. 1959).
The Psychiatric Attitudes Battery consists of the following instruments: the Picture Attitudes Test, the Sentence Completion Attitudes Test, the Multiple Choice Attitudes Questionnaire, and the Souelel (1955) Attitudes Scale (Reznikoff et al. 1959). The battery was completed in the order of the measures listed above with each instrument pursuing more specific information concerning attitudes.

The Picture Attitudes Test was a projective test with the purpose of having the patient disclose attitudes concerning psychiatric care that were at the lower level of one’s consciousness (Reznikoff et al 1959). The Picture Attitudes Test employed the use of three cards. Cards A and B portrayed the patient-doctor relationship and was evaluated in regard to eight set parameters. Card C depicted a psychiatric hospital and was evaluated by four parameters (Reznikoff et al. 1959).

The Sentence Completion Attitudes Test was designed to elicit attitudes toward the psychiatric treatment and hospitals with greater configuration in order to gain more precise responses than the Picture Attitudes Test (Reznikoff et al. 1959). Seven items were used for each of the three attitudinal categories of the psychiatric hospital, the psychiatrist, and psychiatric treatment, resulting in a total of 21 incomplete sentences. Subjects were asked to complete the incomplete sentences resulting in the display of conscious attitudes toward psychiatry (Reznikoff et al. 1959).

The Multiple Choice Attitudes Questionnaire was created to identify attitudes toward psychiatry (Reznikoff et al. 1959). The questionnaire had a total of 12 items complete with four items in each of the categories of psychiatric hospital, the psychiatrist, and psychiatric treatment. Each item on the questionnaire received an attitude rating of favorable, neutral, or unfavorable. Scoring for the Multiple Choice Attitudes
Questionnaire could be interpreted for each of the individual attitudinal categories or as an overall score (Reznikoff et al. 1959).

The Soulem Attitude Scale was developed to measure patients’ attitudes toward mental hospitals (Soulem, 1955; Reznikoff et al. 1959). Soulem (1955) standardized the scale and the instrument was tested in different mental hospital settings (Klopfer & Wylie, 1956). Soulem’s (1955) design was a biphasic rating scale containing two sets of 36 items. Subjects completing the Soulem Attitude Scale would be asked to agree or disagree with statements representing some form of the mental hospital environment. The score was based on the total number of agreed responses from the subject (Soulem, 1955).

The purpose of the attitudinal battery was to assess attitudes toward psychiatric treatment and hospitals. The overall intention was to develop a battery that reported a reliable attitude profile reflecting psychiatric patients (Reznikoff et al. 1959). Reznikoff et al. (1959) summarized:

…by virtue of its objective and quantitative nature, will permit a more systematic study of the influence of attitudes on the patient’s behavior and the clinical course of his illness. The procedures are so constructed that they can be used to assess attitudes of non-patient populations as well. (p. 265)

Soulem (1955), Klopfer & Wylie (1956), and Reznikoff et al. (1959) presented a starting point for research concerning attitudes toward psychiatry and mental hospitals. Reznikoff et al.’s (1959) suggestion that the Psychiatric Attitude Battery’s development would serve as a reliable measure for “non-patients” may be unfounded considering that the majority of people in the United States are not and may never have been patients in a psychiatric institution or have been overcome with a mental illness.
Nevertheless, Fischer & Turner (1970) applied Reznikoff et al.’s. (1959) proposition to the development of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) by developing it to be appropriate for individuals regardless of their knowledge of therapeutic care. The major difference between the Psychiatric Attitudes Battery and the ATSPPHS is the use of attitudinal factors. Reznikoff et al. (1959) believed that future study needed to involve research based on factors of attitudes and further summarized:

The method of quantifying attitudinal data described in this paper should make possible comparative studies of group attitudes and the study of factors relating to attitudinal change. (p. 266)

Researchers in the 1960s began to investigate a host of factors that influenced clients and potential clients’ attitudes toward seeking psychological help. The development of factors during this time period was later incorporated into Fischer and Turner’s (1970) attitude scale, the ATSPPHS.

**Factor Development of Classifying Attitudes**

Following the 1950s, interest in psychotherapy and the possible implications of attitudes affecting a client’s willingness to seek mental health services began to arise. The role of stigma could be brought on by seeking help from a psychotherapist and was found to affect interpersonal and community relationships (Farina, Holland, & Ring, 1966; Farina, Allen, & Saul, 1968). For example, Farina and Ring (1965) suggested that even the perception of an individual having a mental illness could affect interpersonal relationships. These positions not only refer to the consciousness of the person with mental illness, but also to the perceptions of people surrounding an individual considered to be maladjusted and labeled inadequate (Farina & Ring, 1965). Therefore, Farina and
Ring (1965) stated that an unfavorable attitude toward mental illness has a negative effect on interpersonal interaction. This discernment was reinforced by those surrounding the patient and further adopted by the individual seeking help (Farina & Ring, 1965).

Phillips (1963) referred to stigma as a form of rejection, which was considered a perceived risk to clients seeking help for a mental disorder. Therefore stigma has the potential to interfere with personal interactions negatively influencing interpersonal relationships (Farina et al. 1966). This perception has reinforced stigma as a factor that prevented individuals from seeking therapy.

An individual’s willingness to be open to mental health professionals has been viewed as a factor in developing attitudes toward seeking psychotherapy. In addition to stigma, self-disclosure is a major component to the counseling dynamic, and without it change is not possible in therapy. Jourard and Lasakow (1958) suggested that early features of self-disclosure indicated greater openness to therapy. Fischer and Turner (1970) expanded upon this to create the factor of interpersonal openness.

Researchers in the 1970s believed there were additional factors to help seeking behaviors in addition to stigma and self-disclosure. Fischer and Turner (1970) suggested that the need for psychological aid and a potential client’s confidence in the mental health care provider contributed to overall attitudes toward seeking mental health services. Regardless of the level of care needed an individual who has awareness of the need for counseling will have more positive attitudes toward seeking mental health services.

Fischer and Turner (1970) maintained that the awareness by an individual who acknowledges a need for psychological help was found to be a motivator for seeking psychotherapy. Individuals with this awareness were considered to have more positive
attitudes toward seeking professional psychological help than those who did not. Calhoun, Dawes, and Lewis (1972) found a negative correlation between psychological severity and positive attitudes toward seeking help for psychological care. Nevertheless, this does not conflict with Fischer and Turner’s (1970) suggestion that personal recognition of a psychological problem is a major factor toward help seeking attitudes regardless of the level of severity of the illness. These developmental conclusions supported the incorporation of the recognition of the need for psychotherapeutic help as the first factor of the ATSPPHS (Fischer & Turner, 1970).

An individual’s confidence in the psychological professional has a direct effect on one’s attitude toward seeking mental health services. Reznikoff et al.’s (1959) study concerning perceptions of psychiatrists and mental hospitals yielded attitudes not consistent with seeking help. The contradictory findings of Reznikoff et al.’s (1959) examination stems from research based on mental hospitals providing treatment for individuals with psychological disorders. Fischer and Turner’s (1970) attention focused primarily on mental health care in general instead of psychiatry alone, but strongly supported client confidence in professional practitioners as a major component in attitudes toward seeking mental health services.

**Arrival of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS)**

A major breakthrough in research focusing on attitudes and perceptions toward seeking mental health care arrived with the development of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). The purpose of the instrument designed by Fischer and Turner and standardized using
students enrolled in high school, college nursing school, and a male liberal arts college, was to measure an individual’s willingness to seek mental health services.

The ATSPPHS incorporated four factors to determine an attitudinal score: (1) Recognition of need for psychotherapeutic help, (2) Stigma tolerance, (3) Interpersonal openness, and (4) Confidence in mental health practitioner. Each factor generated a subscore that contributed to an overall attitude score (Fischer & Turner, 1970).

Since the development of the ATSPPHS, the instrument has been widely used by researchers interested in attitudes toward seeking psychological help. The instrument has been used extensively with immigrant populations from regions around the world and in multiple, cultural group settings within the United States. A population that has never been studied using the ATSPPHS is Jamaican immigrants living in the United States.

However, Yorke (2004) did incorporate the shortened form of the ATSPPHS in research pursuing help seeking attitudes of Jamaican immigrants. Yorke’s (2004) social work based dissertation further modified the scale and used it in conjunction with other measures. Fischer and Farina (1995) developed the shortened form. It was designed to produce a single attitudinal score instead of incorporating the four separate factors in the design, as was the case with its predecessor the ATSPPHS (Fischer & Turner, 1970; Fischer & Farina, 1995). The rationale for the short form of the ATSPPHS was to create a scale based on the full version that was a single dimensional instrument capable of measuring attitudes toward seeking professional psychological help. The short version was also intended to simplify the analysis for researchers due to its single attitudinal factor (Fischer & Farina, 1995).
Although the ten item version of the ATSPPHS was utilized with a Jamaican sample residing in New York (Yorke, 2004), no study examining Jamaicans using the full four factor ATSPPHS has been conducted. Furthermore, no research has been conducted to examine the reliability and validity of either the short or complete four factor version of the ATSPPHS when utilized with a Jamaican population.

**Previous Use of the ATSPPHS**

The ATSPPHS final version was developed and standardized almost 40 years ago. Since the initial examination of the ATSPPHS utility by Fischer and Turner (1970), the instrument has become the most widely used scale designed to measure attitudes toward seeking professional psychological help. The ATSPPHS has been used to investigate a multitude of samples to better understand different group attitudes toward seeking help. This section will explore published research that utilized the ATSPPHS among non-westernized and multigenerational populations. The terminology of help seeking attitudes will reflect previous researchers use and discipline focus while utilizing the ATSPPHS. For purposes of this study existing published research was categorized into the following sections: 1) Immigrants from geographical regions; 2) Immigrants from specific countries; 3) Intergenerational populations; 4) Eclectic immigrant populations; and 5) Overseas populations. Attention was given to the research topic, sample, hypotheses, additional independent variables, results, and the establishment of reliability and validity with the sample being studied.

**Immigrants from Geographical Regions**

Since the 1980’s the majority of studies using the ATSPPHS on samples in the United States have focused on immigrants. These are individuals who have migrated
from their country of origin and are now living in the United States. Additional independent variables such as acculturation are often researched concurrently to uncover potential characteristics that may have an effect on immigrants’ attitudes toward seeking psychological help (Atkinson & Gim, 1989; Tata & Leong; 1994).

Atkinson and Gim (1989) studied Asian-Americans focusing on the relationship between cultural identity and attitudes toward seeking mental health services. Acculturation served as the construct that represented cultural identity. Atkinson and Gim (1989) hypothesized that Asian-Americans who have higher levels of acculturation would have positive attitudes toward seeking mental health services. The study sampled 557 Chinese-American, Japanese-American, and Korean-American students who were grouped together as Asian-Americans. The procedure involved the mailing of surveys which resulted in a 68.3% response rate (Atkinson & Gim, 1989). Acculturation was measured by the Suinn-Lew Asian Self-Identity Acculturation Scale which focused on Asian language use, identity, friendship choice, behaviors, generation/geographic history, and attitudes (SL-ASIA; Suinn, Rickard-Figueroa, Lew, & Vigil, 1987) and attitudes toward seeking mental health services was measured by the ATSPPHS (Fischer & Turner, 1970).

The results were consistent with Atkinson and Gim’s (1989) hypothesis. Asian-Americans who reported higher levels of acculturation scored higher on the ATSPPHS factors of recognizing the need for psychological services, stigma tolerance, openness, and confidence in mental health professional, than Asian-Americans with lower levels of acculturation.
Concerning the reliability and validity of the ATSPPHS, the research investigating Asian-Americans only referred to the original test-retest reliability estimates of .83 (Fischer & Turner, 1970; Atkinson & Gim, 1989). No evaluation of the ATSPPHS was made to demonstrate validation with use among the sampled group of Chinese-American, Japanese-American, and Korean-American students.

Zhang & Dixon (2003) examined acculturation and attitudes toward seeking psychological help among Asian international students. Acculturation was defined as the process of adopting another society’s mainstream behaviors and values through gradual interaction with the new culture. Zhang & Dixon (2003) hypothesized that there would be a relationship between acculturation and attitudes toward seeking psychological help among Asian international students. The hypotheses stated that the four factors of the ATSPPHS representing recognition for need, stigma tolerance, interpersonal openness, and confidence in practitioners (Fischer & Turner, 1970), would all have a relationship with acculturation among Asian international students (Zhang & Dixon, 2003).

Demographic variables of age, gender, prior counseling, marital status, children, length of time in the United States, educational level, program of study, religion, country of origin were believed not to have any relationship with attitudes toward seeking psychological help.

The study surveyed 170 Asian international graduate and undergraduate students with the majority representing the nations of China, Korea, Japan, India, Thailand, Taiwan, Malaysia, Indonesia, and a small percentage participating from Singapore, the Philippines, and Nepal (Zhang & Dixon, 2003). The return rate of the mailing was 43%.

The results, through a regression analysis supported Zhang and Dixon’s (2003) first hypothesis by identifying a relationship between acculturation and attitudes toward seeking psychological help. There was no unilateral support for the hypotheses stating that there would be a relationship between acculturation and the four factors of the ATSPPHS. Factor I, recognition of need for psychotherapeutic help, and Factor III, interpersonal openness was found not to have any statistical significance when analyzed with the SL-ASIA-I which represented acculturation as the independent variable (Zhang & Dixon, 2003). However, Factor II, Stigma Tolerance, and Factor IV, Confidence in mental health practitioner indicated a correlation with acculturation. The later hypothesis suggested that there would be no relationship between attitudes toward seeking psychological help and any of the demographic variables. This hypothesis was found true with the exception of Factor IV of the ATSPPHS. Statistical significance was found between confidence in mental health practitioner and the demographic variables (Zhang & Dixon, 2003).

Regarding the reliability and validity of the ATSPPHS Zhang and Gim (2003) mirrored Atkinson and Gim’s (1989) study by only discussing the reliability generated from Fischer and Turner’s (1970) findings resulting from the instrument’s standardization. The psychometrics of the ATSPPHS did not undergo any evaluation to
identify if the scale is valid for measuring attitudes toward seeking psychological help among Asian international students.

**Immigrants from Specific Countries**

Tata and Leong (1994) researched Chinese Americans and the constructs of individualism-collectivism, social-network, orientation, and acculturation as predictors of attitudes toward seeking professional psychological help. Tata and Leong (1994) hypothesized that levels of individualism, social-network orientation, and acculturation would have an effect on Chinese American students’ attitudes toward seeking professional psychological help. Chinese American college students were the sample for this study. The subjects were mailed survey packets and 219 students participated yielding a 42.81% response rate (Tata & Leong, 1994). Individualism-collectivism constructs were measured with the Individualism-Collectivism Scale which pursued the factors of self-reliance with competition, low concern for in-groups, and distance from in-groups (Triandis et al. 1988); social-network orientation was measured by using the Network Orientation Scale which focuses on individuals’ independence-advisability, history, and mistrust (Vaux, 1985); acculturation was measured by the SL-ASIA (Suinn et al. 1987), and attitudes toward seeking professional psychological help were measured by the ATSPPHS (Fischer & Turner, 1970). The study’s results supported the hypothesis that individualism-collectivism values, social-network orientation, and acculturation were all predictors of attitudes toward seeking professional psychological help among Chinese American students (Tata & Leong, 1994). Chinese American students that reported more individualistic characteristics, positive social-network orientation, and higher levels of
acculturation were more favorable to have higher overall scores on the ATSPPHS, than Chinese Americans who did not report.

Addressing reliability and validity of ATSPPHS use in the study indicated a test of internal consistency which yielded a reliability of .80 (Tata & Leong, 1994). This finding was tested against Atkinson & Gim’s (1989) study of Asian-Americans that found no significant difference between the two studies when internal consistency was examined using z scores (Tata & Leong, 1994). As stated earlier, aspects of predictive validity were demonstrated through the variables of individualism-collectivism, social-network orientation, and acculturation being indicators of attitudes toward seeking professional psychological help. However, no process was taken to evaluate the validity of the ATSPPHS for use with a Chinese American sample.

**Intergenerational Populations**

Intergenerational populations are groups that exist within larger populations that have been examined using the ATSPPHS. These groups share many of the cultural values of the population from which they originated as well as the American host society. Second, third, fourth, and fifth generation members of a family would be considered an intergenerational population. The upbringing and understanding from their parents’ or grandparents’ home country and immigrant experience combined with the high probability of American (United States) acculturation warrants this intergenerational category.

Ponterotto et al. (2001) explored Italian and Greek American demographics and acculturation levels that affect attitudes toward counseling. The study also examined preferences for ethnically similar counselors and commitment to Italian and Greek
American culture. Ponterotto et al. (2001) gathered demographic information of sex, age, year of study, family income, prior counseling experience, and if so, the duration of therapy. The data was collected by recruiting volunteers from student organizations and Italian and Greek language classes (Ponterotto et al. 2001). Two hundred and thirty two students from three colleges in New Jersey and New York participated.

Data was collected through the use of several instruments. Demographic information was gathered with use of a personal data form (Ponterotto et al. 2001). Acculturation rating for both Italian and Greek Americans was gathered with a modified version of the Acculturation Rating Scale for Mexican Americans (ARSMA; Cuellar, Harris, & Jasso 1980). Both counselor similarity characteristics and rank ordering of potential help-giving providers were given as different surveys adapted from a previous attitude study of Vietnamese and Anglo-Americans (Atkinson, Ponterotto, & Sanchez, 1984). Finally, attitudes toward seeking counseling were measured by the ATSPPHS (Fischer & Turner, 1970).

The results indicated five correlations ranging from .33 to .46 when computed with ATSPPHS subscales, and a sixth correlation of recognition of need (Factor I) and confidence in professional (Factor IV) was .72 (Ponterotto et al. 2001). When Ponterotto et al. (2001) analyzed the data separately, the ATSPPHS reliability coefficient alphas for Italian Americans were .81 (need), .69 (stigma), .71 (openness), and .79 (confidence), and for the Greeks American .71 (need), .66 (stigma), .53 (openness), and .70 (confidence). The most significant effects were found in recognition of need (Factor I) and confidence in professional (Factor IV) among Italian and Greek American women (Ponterotto et al. 2001).
Although high acculturation had a positive effect on the attitudes of women toward seeking counseling, it had no effect on men. Low acculturation had no effect on either sex (Ponterotto et al. 2001).

Regarding the reliability and validity of the ATSPPHS in the study, attention was turned to the internal consistency of the subscales. Table 1 shows a comparison of subscale reliability between the Fischer and Turner’s (1970) original standardized sample and the Italian and Greek American participants. The Italian American sample reported higher reliability coefficients in all of the ATSPPHS subscales in comparison to Fischer and Turner’s (1970) standardized group and the Greek American samples, with the exception of minimum difference in the stigma tolerance subscale (Factor III) with the standardized group (Ponterotto et al. 2001). The Greek American reliability results were lower than Fisher & Turner’s (1970) original sample, with the exception a .04 difference of Factor I measuring the recognition of need.

Table 1. ATSPPHS Subscale Reliability Coefficients among the Standardized, Italian American, and Greek American Samples

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Descriptor</th>
<th>Standardized</th>
<th>Italian</th>
<th>Greek</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor I</td>
<td>Need</td>
<td>.67</td>
<td>.81</td>
<td>.71</td>
</tr>
<tr>
<td>Factor II</td>
<td>Stigma</td>
<td>.70</td>
<td>.69</td>
<td>.66</td>
</tr>
<tr>
<td>Factor III</td>
<td>Openness</td>
<td>.62</td>
<td>.71</td>
<td>.53</td>
</tr>
<tr>
<td>Factor IV</td>
<td>Confidence</td>
<td>.74</td>
<td>.79</td>
<td>.70</td>
</tr>
</tbody>
</table>

The study revealed that women who scored high levels of acculturation on the revised Acculturation Rating Scale for Mexican Americans (ARSMA; Cuellar et al.
1980), which was referred to as the Acculturation Rating Scale for Italian and Greek Americans had more positive attitudes toward seeking counseling as reported by the ATSPPHS (Ponterotto et al. 2001). Italian American women reported the highest correlation between acculturation and attitudes toward seeking counseling signifying predictive validity. Although the ATSPPHS showed some accuracy with the Italian American sample the same could not be explained for the Greek American sample. The validity of the ATSPPHS with use of the Italian and Greek American sample was neither examined nor discussed.

Liao, Rounds, and Klein (2005) tested Cramer’s (1999) help seeking model and acculturation effect with Asian and Asian American college students. Cramer’s (1999) help seeking model assesses direct and indirect effects of four psychological variables: attitude toward seeking counseling; available social support; distress level, and self-concealment. For purposes of this research Liao et al.’s (2005) study will be classified as research related to Intergenerational populations instead of the category of Immigrants from geographical regions. The rationale for the Intergenerational populations classification is due to Liao et al.’s (2005) use of both Asians and Asian Americans which suggest multiple generations included in the research.

The hypotheses were based on 12 different paths of help seeking models concerning the generalizability of Cramer’s (1999) model. Liao et al. (2005) expected that Cramer’s (1999) model would lead to statistically significant differences when tested between the two groups of Asian and Asian Americans and Whites. The model paths all lead to an individual’s willingness to seek counseling, and utilized a variety of channels which included combinations of the following contextual variables: adherence to Asian
value, attitudes toward counseling, behavioral acculturation, perceived social support, self-concealment, and severity of personal concerns (Liao et al. 2005). The study sample included 202 Asian and Americans and 336 Whites, totaling 538 college student participants. The Asian and Asian American nationalities were comprised of Chinese, Korean, Taiwanese, Filipino, Indian (India), Japanese, Vietnamese, Thai, Cambodian, Iranian, and Singaporean students (Liao et al. 2005). The participants that were recruited from Educational Psychology courses received course credit, and students from other disciplines received a payment of $5.00 (USD). The students that participated completed the following six measures: the ISEL (Cohen, Mermelstein, Kamarack, and Hoberman, 1985) that measured perceived social support; the Self-Concealment Scale (Larson & Chastain, 1990) was used to identify tendencies to conceal personal information; the Personal Problem Inventory (Gim, Atkinson, & Whiteley, 1990) was utilized to measure the severity of personal concerns and the students’ willingness to seek counseling; the SL-ASIA (Suinn et al. 1987) served as the behavioral measure of Asian acculturation in the United States; the Asian Values Scale (Kim, B. S. K., Atkinson, D. R., & Yang, P. H., 1999) measured the adherence to Asian cultural values; and the Attitudes Toward Help Scale (ATHS) was a modified version of Fischer and Turner’s (1970) ATSPPHS, which measured attitudes toward counseling.

The results indicated that Cramer’s (1999) help-seeking model can be generalized to the studied group of Asian and Asian American college students (Liao et al. 2005). Liao et al. (2005) were able to replicate Cramer’s (1999) earlier findings among Whites and demonstrated similar conclusions with Asian and Asian American subjects. However, structural invariance analysis revealed that within model contextual variable
paths differed between Whites and Asian and Asian Americans as expected (Liao et al. 2005).

Focusing on reliability and validity of the ATSPPHS Liao et al. (2005) referred to Fischer and Turner’s (1970) test-retest reliability trials resulting in $\alpha = .86$ for 5 days and $\alpha = .84$ for two months. A reliability analysis produced coefficient alphas for Asian and Asian Americans of $\alpha = .84$ and Whites yielding $\alpha = .87$. These coefficient alphas did share similarities with Fischer and Turner (1970) whole scale score ($\alpha = .83$), Tata and Leong ($\alpha = .80$; 1994), Taylor and Howard-Hamilton ($\alpha = .84$; 1995), Simonsen, Blazina, and Watkins ($\alpha = .89$; 2000), and Williams et al. ($\alpha = .88$; 2001). Although the close proximity of these alphas in relation to one another shows promising reliability through consistencies in mean scores, the psychometrics of Liao et al. (2005) may be altered. The possibility of varying statistical results may be due to the use of a five-point scale (Liao et al. 2005) instead of the original four-point scale that Fischer and Turner (1970) incorporated. Liao et al. (2005) also stated:

Evidence of the measure’s validity has been established for diverse populations… (p. 403)

However, only reliability was mentioned; there was no discussion concerning any forms of validity.

**Eclectic Immigrant Populations**

The eclectic immigrant population is an assortment of immigrants representing countries from around the world. International students attending universities in the United States would be characterized as the eclectic immigrant population. The eclectic
category is not limited by specific country or geographical region, and includes comparison studies of differing nationalities.

Dadfar & Friedlander (1982) studied international students and their demographic and experiential differences that affect attitudes toward seeking professional psychological help. Dadfar & Friedlander (1982) tested for variable differences in continental origin, sex, and educational level, while experiential differences were considered as prior experience with psychological help and time spent in the United States. The participants were mailed the ATSPPHS and a demographic form. One hundred seventy two students participated which yielded a response rate of 58.7% that included international students from 75 countries (Dadfar & Friedlander, 1982). Information concerning age, continent, sex, educational level, time spent in the United States, and prior experience with a professional was collected using the Personal Data Form (Dadfar & Friendlander, 1982), and attitudes toward seeking professional psychological help was measured by the ATSPPHS. The results reported that the demographic components of age, continent, sex, and educational level, and the experiential variables were all predictors of international students’ attitudes toward seeking professional psychological help. Statistical significance was found among international students from countries in the western hemisphere who had received prior professional help. These students from western countries had more positive attitudes toward seeking professional psychological help than those who were from non-western regions and had no prior psychological contact (Dadfar & Friendlander, 1982).

Focusing on reliability and validity of the study, attention was directed to the original standardization of the ATSPPHS. The discussion of reliability also referred to
the ATSPPHS standardization stating the test-retest reliability coefficients over five time
intervals resulting in a range of .73 to .89 (Fischer & Turner, 1970; Dadfar &
Friendlander, 1982). The differential and experiential variables of continent, sex,
education levels, prior professional contact, and years spent in the United States also had
an effect on international students’ mental health seeking attitudes. The strongest
predictors of positive attitudes toward seeking help were continent of origin and previous
experience with a professional, therefore demonstrating characteristics of predictive
validity.

Dadfar & Friendlander (1982) referred to Fischer and Turner’s (1970) “known-
groups validity” that highlighted the ability of the ATSPPHS to discriminate between
those who had prior experience with a mental health professional and those who had not.
Nevertheless, no validation was done to identify the ATSPPHS validity with international
students from a vast number of countries.

Masuda et al. (2005) researched United States and Japanese college students’
attitudes toward seeking professional psychological help. This comparative study of
cross-cultures investigated nationality, sex, and previous experience of seeking help, and
the relationship those variables have between attitudes toward seeking professional
psychological services. Two hypotheses were created to determine differences among
United States and Japanese students’ attitudes toward seeking professional psychological
help. It was hypothesized that female students would have more positive attitudes than
males, and that individuals who had sought psychological help in the past would have
more favorable attitudes toward seeking professional psychological help regardless of
country of origin (Masuda et al. 2005). Three hundred United States students and 300
Japanese students participated in the study. The combined 600 participants were students recruited from a community college and private university in the United States (Masuda et al. 2005). A survey questionnaire (Masuda et al. 2005) was used to collect demographic information containing the variables of nationality, sex, age, and past experience with seeking professional psychological help. Attitudes toward seeking professional psychological help were assessed with the ATSPPHS (Fischer & Turner, 1970).

The findings resulted in the support of Masuda et al.’s (2005) hypotheses. Both United States and Japanese women reported higher attitudinal scores than men. Individuals who had past experience with professional psychological help scored higher on the ATSPPHS overall scale and in the sub-factor of recognition of need (Factor I). Both sex and past experience were found to be predictors of attitudes toward seeking psychological help (Masuda et al. 2005).

The reliability and validity of the ATSPPHS was not confirmed in this study of United States and Japanese students’ help seeking attitudes. Instead, Masuda et al. (2005) referred to Fisher and Turner’s (1970) original psychometrics reporting the internal consistency reliability estimate of .83, the internal consistency of the four factors ranging from .62 to .74, and test-retest reliability estimates during trials spanning five days to two months. Although the ATSPPHS was originally validated with students from the United States during its development and standardization (Fischer & Turner, 1970), this cross-cultural study did not evaluate the ATSPPHS use among students from Japan. However, Masuda et al. (2005) did recognize the limitation of gathering data with the ATSPPHS in both English and Japanese and concludes:
An additional point of concern is that the questionnaire was developed in two different languages …the verification of its reliability and validity was not conducted. A more extensive study would involve a translation that is tested to ensure its psychological equivalence across the two cultures in addition to the verification regarding reliability and validity … of the ATSPPH. (p. 311)

**Overseas Populations**

Overseas populations are simply sampled groups from countries other than the United States in which the ATSPPHS has been used to conduct research. The studies utilizing the ATSPPHS are therefore collecting data from populations who are living overseas.

Yeh (2002) examined Taiwanese students’ interdependent and independent self-construal, collective self-esteem, and the demographic variables of gender and age as predictors of professional psychological help seeking attitudes. Yeh (2002) expands the focus of attitudes of seeking psychological help to include additional cultural constructs of interdependent self-construal and collective self-esteem. Both interdependence and collectivism are traditional Asian values that were evaluated as predictors of help seeking attitudes. Yeh (2002) hypothesized that Taiwanese students interdependent and independent self-construal scores would predict positive help seeking attitudes; negative collective self-esteem would positively predict help seeking attitudes; females would have more positive attitudes than males; and older students would report more positive attitudes toward seeking psychological help.

The study sampled 594 students attending junior high, high school, and college in Taiwan. Students from various schools in central Taiwan were recruited to participate. Interdependent and independent self-construal was measured by the Self-Construal Scale (Singelis, 1994) which evaluated interdependence and independence. Collective self-
esteem was assessed appraised with use of the Collective Self-Esteem Scale (Luhtanen & Crocker, 1992) which appraises social associations based on sex and varying ethnic and cultural characteristics. Professional psychological help-seeking attitudes were measured using the ATSPPHS (Fischer & Turner, 1970).

The results did not unanimously prove Yeh’s (2002) hypotheses. Interdependent self-construal, independent self-construal, and collective self-esteem were found to be predicators of psychological help-seeking attitudes, but age showed no statistical effect.

The reliability and validity of the ATSPPHS was not validated for use with Taiwanese students in this research. Yeh (2002) recognizes the shortcomings of not validating the ATSPPHS and stated:

...the ...ATSPPHS ...have not been previously validated with Taiwanese populations, thus, conceptual and practical implications generated from these measures are limited. (p. 26)

Similar to Liao et al. (2005), Yeh (2002) also changed the rating scale, instead to a seven point scale potentially varying statistical findings as well.

Al-Darmaki (2003) researched United Arab Emirates students and demographic variables, self-esteem, and depression to identify effects on attitudes toward seeking professional psychological services. Al-Darmaki (2003) examined the demographic variables of age, sex, educational level, and college major, in addition to self-esteem and depression levels. The procedure involved the students filling out the survey packet in a single testing session (Al-Darmaki, 2003). Self-esteem data were measured with the Self-Esteem Scale (SES), symptoms of depression were measured with the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977), and attitudes toward seeking professional psychological help were assessed with the ATSPPHS (Fischer &
Turner, 1970). The purpose of the study was also to explore the validity of the translated ATSPPHS version from English to Arabic, and to compare the factor analysis of the United Arab Emirates student sample with Fischer and Turner’s (1970) original student sample (Al-Darmaki, 2003). The results of the study did not produce a significant difference between sexes and attitudes toward seeking help (Al-Darmaki, 2003). Students who studied in the art associated disciplines had an eigenvalue of $r = -0.22$ in Factor IV of confidence in psychological help providers, and $r = -0.17$ in Factor II of stigma tolerance (Al-Darmaki, 2003). A correlation between education level and the ATSPPHS as the entire scale was $r = 0.21$, Factor II concerning stigma tolerance was $r = 0.22$, and Factor IV of confidence in psychological help providers was $r = 0.17$ (Al-Darmaki, 2003). Although these correlations are significantly associated, their effect sizes are considered weak (Muijs, 2004, p. 145). It is important to mention that statistical findings may be altered due to Al-Darmaki’s (2003) removal of seven ATSPPHS items from the final analysis. Nevertheless, the research indicated that United Arab Emirates University students who had high self-esteem and low levels of depression had more positive attitudes toward seeking professional psychological help than students with low esteem and higher levels of depression (Al-Darmaki, 2003).

Attention was centered on the reliability and validity of ATSPPHS beyond the instrument’s standardization. Al-Darmaki (2003) attempted to establish the translation validity of the ATSPPHS from English to Arabic. The method for testing the validity was for the author to translate the scale from English to Arabic, and reverse the process from Arabic to English to identify any language errors. There were no discrepancies; therefore it was concluded that the translation was valid (Al-Darmaki, 2003).
A factor analysis using the data from the United Arab Emirates students was analyzed against the internal reliability of Fisher and Turner’s (1970) original sample. Al-Darmaki (2003) found that 7 items showed poor correlations below \( r = .20 \) with the scale as a whole. As mentioned earlier, a decision was made (Al-Darmaki, 2003) to remove the following items: A) Factor I (Need), 4, 5, and 24; B) Factor II (Stigma), 20 and 27; and C) Factor III (Openness), 13 and 29. No items were removed from Factor IV representing confidence of mental health provider. The study discussed Fischer and Turner’s (1970) test-retest reliability figures. An estimate of Cronbach’s alpha reliability coefficient using the United Arab Emirates sample of the ATSPPHS whole scale was .78, Factor II (stigma) was .66, Factor III (Openness) was .57, and Factor IV (Confidence) was .70, which was reported as “moderately internally consistent” (Al-Darmaki, 2003, p. 503).

Lastly, the Al-Darmaki (2003) study revealed that self-esteem and depression were predictors for attitudes toward seeking professional psychological help. These indicators demonstrated predictive validity. The factor analysis represented Al-Darmaki’s (2003) efforts to test the validation of the ATSPPHS with United Arab Emirates students, but stated the following limitation:

...comparing these results to previously reported findings from other cultures should be done with caution. ...these findings may suggest that more evidence is needed to establish the reliability and validity of the ATSPPH for the UAE college student population. (p. 506)

**The Need to Assess the Reliability and Validity of the ATSPPHS**

Since the development of the ATSPPHS researchers have widely utilized the scale to measure attitudes toward seeking professional psychological help. The
ATSPPHS has often been used in studies incorporating multiple correlates (e.g. Atkinson & Gim, 1989; Tata & Leong; 1994; Ponterotto et al. 2001). Many researchers have addressed diverse populations such as international students and foreign groups abroad (Dadfar & Friendlander, 1982; Al-Darmaki, 2003). Employing the ATSPPHS to investigate populations that share cultural backgrounds different from the United States presents concerns about the instrument’s utility.

The ATSPPHS was developed nearly 40 years ago using a sample from the Northeastern United States composed entirely of students. It is presumed that the standardized population may have been White middle class Americans, although the ethnicity of the sampled group was not identified. This presents a problem for the accuracy of research on minorities and groups from diverse backgrounds. Several studies have been able to introduce constructs and establish predictive validity with the ATSPPHS (e.g. Tata & Leong, 1994; Dadfar & Friendlander; 1982). An argument for the establishment of concurrent validity with external measures and the ATSPPHS could also be made (Atkinson & Gim, 1989). Nevertheless, the validity of the instrument’s use for measuring immigrants and foreign nationals needs to be addressed. Only Al-Darmki (2003) closely examined the measures of internal consistency to check the appropriateness of the ATSPPHS use with United Arab Emirates students. The majority of researchers rely on Fischer and Turner’s (1970) initial standardization to satisfy reliability and validity in their studies.

As the author, I recognize the need to assess the reliability and validity of the ATSPPHS when utilized among populations that are not representative of Fischer and Turner’s (1970) standardized population. Therefore, the current study is an investigation
of the ATSPPHS reliability and validity among a Jamaican sample residing in the United States.

**Summary**

This chapter critically reviews the literature as it relates to the development and standardization of the ATSPPHS and associated literature pertaining to how the instrument was employed in cross-cultural research. Previous research concerning attitudes toward seeking professional psychological care relied heavily on Fischer and Turner’s (1970) standardization of the ATSPPHS to demonstrate validity within their own studies. Unfortunately, these researchers failed to provide evidence of validity of the ATSPPHS for the populations they studied, thus weakening their conclusions. In contrast, my study examined the reliability and validity of the ATSPPHS with a population of Jamaican Americans.

Chapter three discusses the methods for supporting the use of an estimate of Cronbach’s alpha reliability coefficient, an estimated correlation matrix, and a principal component analysis. These analytical efforts are to understand the internal consistency of the standardization of the ATSPPHS and the potential for those results to be replicated with a Jamaican sample. Furthermore, these steps have been taken to identify if the ATSPPHS is an appropriate measure for assessing Jamaican attitudes toward seeking mental health services.
CHAPTER THREE
RESEARCH METHODS

The purpose of the study is to assess the reliability and validity of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS, Fischer & Turner, 1970) for use among Jamaicans residing in the United States. This chapter will discuss the 1) development and standardization of the ATSPPHS, 2) key concepts related to reliability and validity, 3) and describes the research methods for this study.

Development and Standardization of the ATSPPHS

Subjects

The subjects involved in the development of the ATSPPHS were students from varying educational levels and types of institutions. A total of 882 participants took part in the study: Eight hundred four of the subjects were students attending university, college, community college, a male liberal arts school, or nursing school, while the other 78 participants were high school students (Fischer & Turner, 1970).

Instrumentation

All of the subjects completed a finalized version of the ATSPPHS and at least one of the following instruments. The Marlowe-Crowne Social Desirability Scale (Marlowe & Crowne, 1960) was employed to reveal social desirability correlations with attitude scores. A biographical information form was used to deduce descriptions of personal crisis, to learn how the subjects managed the challenges, and if mental health services were sought (Fischer & Turner, 1970). An abbreviated form of the F Scale (Christie, Havel, & Seidenberg, 1958) was administered to identify authoritarianism and its affect on attitude scores. The Rotter Scale of Interpersonal Trust (Rotter, 1967) was used to
learn if positive attitude scores would correlate with an individual’s trust of professional help. The Rotter Scale of Internal Versus External Locus of Control (Rotter, 1966) was introduced to determine if subjects believed that internal personal beliefs or external forces had significant influences over their lives. Fischer and Turner (1970) believed higher internal locus scores would correlate with positive attitudes toward seeking psychological help. This presumption was based on an individual’s awareness of and belief that control over one’s self could affect personal outcome. In addition, a measure of masculinity-femininity was included to measure differences among sexes with regard to the ATSPPHS factors, constructs, and personality variables.

**Development and Standardization**

Before the ATSPPHS could be standardized, it was imperative to understand what factors affected attitudes toward seeking professional psychological help. To this end, Fischer and Turner (1970) worked with a variety of mental health professionals to develop a pool of attitude statements. Once a battery of attitude statements was formed, the items were judged by a panel comprised of clinical psychologists, counseling psychologists, and psychiatrists to determine the appropriateness of the presented attitudes. The items were rated on their realistic potential as help seeking attitudes, and if the statements were positive or negative attitudes toward seeking psychological services. Only the items considered to be of significant relevance were considered for a preliminary version of the ATSPPHS (Fischer & Turner, 1970).

The preliminary attitude scale was administered to a group of high school and nursing students. Concurrently, participants in the testing sample were also given the Marlowe-Crowne Social desirability Scale (Marlowe & Crowne, 1960), to identify item
correlation with desirable social responses. The use of the social desirability scale indicated that no extreme correlations were found with socially desirable responses. The analysis further revealed that all of the scale’s individual items correlated highly with the overall attitude score (Fischer & Turner, 1970).

A second group of college students was administered the preliminary scale yielding a poor correlation between two items and the overall attitude score. The two items were removed from the instrument resulting in a 29 item final version of the ATSPPHS that is displayed by factor in Table 2 (Fischer & Turner, 1970). Development at this point by Fischer and Turner (1970) was reached through the following methods: professional consultation in creating a battery of attitude statements; an evaluation panel assembled to judge the hypothetical suitability of attitude statements; the testing of attitude items with the use of two sample groups of 97 and 115 student subjects; and the removal of items that did not correlate with total attitude scores. The version of the ATSPPHS that was administered for this study can been seen in Appendix A.

**Reliability based on Fischer and Turner’s Research**

Fischer and Turner (1970) used the two testing groups of 212 participants as the standardization sample. The estimate of Cronbach’s alpha reliability coefficient for the ATSPPHS was .86 (Fischer & Turner, 1970). A subsequent application of the ATSPPHS of 406 participants resulted in an estimate of .83 (Fischer & Turner, 1970). Table 3 establishes test-retest reliability through five time intervals as reported by Fischer and Turner (1970). Each group was administered the ATSPPHS at the beginning and end of each time interval. Fischer and Turner (1970, p. 81) suggested that the estimates of Cronbach’s alpha reliability coefficient indicated “moderately good consistency.” Only
the six week test-retest sample was found to be lower than .80. The test-retest estimate of reliability remained stable in all other time intervals (Fischer & Turner, 1970).

Table 2.  *ATSPPHS* Items by Factors

| Factor I: Recognition of the need for psychotherapeutic help (Need) |
|---|---|
| 4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist. |
| 5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem. |
| 6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. |
| 9. Emotional difficulties, like many things, tend to work out by themselves. |
| 18. I would want to get psychiatric attention if I was worried or upset for a long period of time. |
| 24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help. |
| 25. At some future time I might want to have psychological counseling. |
| 26. A person should work out his own problems; getting psychological counseling would be a last resort. |

| Factor II: Stigma tolerance (Stigma) |
|---|---|
| 3. I would feel uneasy going to a psychiatrist because of what some people would think. |
| 14. Having been a psychiatric patient is a blot on a person’s life. |
| 20. Having been mentally ill carries with it a burden of shame. |
| 27. Had I received treatment in a mental hospital, I would not feel that it ought to be “covered up.” |
| 28. If I thought I needed psychiatric help, I would get it no matter who knew about it. |
Table 2. ATSPPHS Items by Factors (continued)

<table>
<thead>
<tr>
<th>Factor III: Interpersonal openness (Openness)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.</td>
</tr>
<tr>
<td>10. There are certain problems which should not be discussed outside of one’s immediate family.</td>
</tr>
<tr>
<td>13. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns.</td>
</tr>
<tr>
<td>17. I resent a person–professionally trained or not–who wants to know about my personal difficulties.</td>
</tr>
<tr>
<td>21. There are experiences in my life I would not discuss with anyone.</td>
</tr>
<tr>
<td>22. It is probably best not to know <em>everything</em> about oneself.</td>
</tr>
<tr>
<td>29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor IV: Confidence in mental health practitioner (Confidence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Although there are clinics for people with mental troubles, I would not have much faith in them.</td>
</tr>
<tr>
<td>2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.</td>
</tr>
<tr>
<td>8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.</td>
</tr>
<tr>
<td>11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.</td>
</tr>
<tr>
<td>12. If I believe I was having a mental breakdown, my first inclination would be to get professional attention.</td>
</tr>
<tr>
<td>15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.</td>
</tr>
<tr>
<td>16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.</td>
</tr>
<tr>
<td>19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.</td>
</tr>
<tr>
<td>23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.</td>
</tr>
</tbody>
</table>
Table 3. ATSPPHS Test-Retest Reliability Time Intervals

<table>
<thead>
<tr>
<th>Testing Intervals</th>
<th>Student Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( r )</td>
</tr>
<tr>
<td>5 days</td>
<td>.86</td>
</tr>
<tr>
<td>2 weeks</td>
<td>.89</td>
</tr>
<tr>
<td>4 weeks</td>
<td>.82</td>
</tr>
<tr>
<td>6 weeks</td>
<td>.73</td>
</tr>
<tr>
<td>2 months</td>
<td>.84</td>
</tr>
</tbody>
</table>

Source: Fischer & Turner, 1970

Validity based on Fischer and Turner’s Research

In order to determine validity for existing groups, Fischer and Turner (1970) had college and nursing students complete the Biographical Information Questionnaire along with the ATSPPHS. The instrument’s authors wanted to identify the “known-groups” (Fischer & Turner, 1970, p. 83) of those who self-identified as having a psychological problem and determine if those individuals had sought mental health attention.

Within the sample of 531 students, 47 reported getting attention for personal issues. The group reporting utilization of mental health services was found to have notably positively skewed responses toward seeking help for mental health issues (Fischer & Turner, 1970). This was the case for both males and females. Fischer and Turner (1970) reported the means for males through the following groups: high school males = 49.1; coed college males = 56.1; and male liberal arts college students = 58.2; (t = 3.30, \( p < .0001 \), df = 231). Females had a greater difference through their reported
means for female groups who sought help and those who did not: high school females = 57.6; coed college females = 63.2; and nursing students = 56.5; (t = 4.73, p < .0001, df = 296). Since the attitudes toward seeking psychological services were sharply higher for subjects who never sought attention for mental issues, a median test was conducted to further examine this difference. A chi-square of 20.09 (df = 1, p < .0001) was reported, demonstrating the ability of the ATSPPHS to differentiate between the attitudes of those who had sought psychological help and groups that had not (Fischer & Turner, 1970).

Fischer and Turner (1970) conducted factor analyses of the ATSPPHS using the responses of 424 college and nursing students. The responses were intercorrelated to identify the highest correlation. Themes began to emerge from the correlation matrix that determined the major factors of attitudes toward seeking psychological help. Based on the factor analysis of the final version of the ATSPPHS with 29 items, four areas stood out as having an effect on attitudes. These subscales are shown in Table 2: A) Factor I – Recognition of need for psychotherapeutic help, B) Factor II – Stigma tolerance, C) Factor III – Interpersonal openness, and D) Factor IV – Confidence in the mental health practitioner (Fischer & Turner, 1970). The sub-scores for each of these constructs were combined to create a single attitudinal score reflecting a willingness to seek mental health services (Fischer & Turner, 1970; Fischer & Cohen, 1972).

This first factor analysis was conducted on the responses of 249 females and 175 males. Fischer and Turner (1970, p. 84) described this as, “a large sample, with adequate representation.” Concerned with differences between gender attitudes and the scale’s validity, two more analyses with a second group of 180 females and a third of 201 males...
were conducted. These subsequent analyses produced the same four factors as the first analyses.

Overall, according to Fischer and Turner (1970) the ATSPPHS subscales were found to have low intercorrelations, reflecting independence among the four attitude factors. The subscale estimates were found to be moderately reliable, however the estimate of reliability for the total instrument were found to be “moderately good” at \( r = .83 \) (Fischer & Turner, 1970, p. 81). The estimates of reliability for the ATSPPHS subscale are displayed in Table 4 along with the number of items by factor.

**Table 4. ATSPPHS Subscale Reliability**

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Descriptor</th>
<th>Number of Items</th>
<th>( r )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor I</td>
<td>Need</td>
<td>8</td>
<td>.67</td>
</tr>
<tr>
<td>Factor II</td>
<td>Stigma</td>
<td>5</td>
<td>.70</td>
</tr>
<tr>
<td>Factor III</td>
<td>Openness</td>
<td>7</td>
<td>.62</td>
</tr>
<tr>
<td>Factor IV</td>
<td>Confidence</td>
<td>9</td>
<td>.74</td>
</tr>
</tbody>
</table>

**Elements of Measurement**

The two most important elements in psychological measurement are reliability and validity. Researchers strive to design instruments that measure concepts through operationalization of the variables of interest to the investigator. When an instrument displays satisfactory accuracy and consistency, it therefore is considered valid and reliable (Nardi, 2006, p. 58). According to Wilkinson and the Task Force on Statistical
Inference (1999), the importance of reporting psychometric properties is to contribute to the field of current knowledge and facilitation of future work.

**Reliability in Measurement**

Reliability in measurement refers to the consistency of results. An instrument with high reliability represents stability in the measure. Granello (2007) suggests that psychometric properties including reliability should be discussed in studies. Estimates of reliability can be verified through the methods of test-retest, parallel forms, split-half, and interrater reliability (Nardi, 2006, p. 60).

*Test-retest.* This form of reliability is a repeated measure that monitors instrument consistency. A scale can be tested and followed with a series of retests days, weeks, or months later. If the retest score results correlate with the original test, high reliability is found.

The ATSPPHS underwent a series of test-retest measures to indicate instrument reliability over time. As displayed earlier, Table 3 presents the five time intervals of 1) five days, 2) two weeks, 3) four weeks, 4) six weeks, and 5) two months, in addition to the original estimate of reliability. The ATSPPHS was found to have good test-retest reliability with estimates for all but one time interval greater than $r = .80$ (Fischer & Turner, 1970). The fourth interval of six weeks can be considered satisfactory at $r = .73$. Overall, the test-retest estimate of reliability maintained stability over time, despite the dropping in the estimate of reliability during the six week testing period (Fischer & Turner, 1970).

*Parallel form.* This technique determines reliability that examines the consistency of measured constructs (Nardi, 2006, p. 62). This can be achieved by
measuring similar sets of factors concurrently or by using two versions of the same scale. The method of comparing related items is interitem reliability. Nardi (2006, p. 62) describes interitem reliability as a process to identify items that belong together to make an instrument.

Nardi (2006, p. 62) suggests reliability increases when more items are used to examine a construct. Fischer and Turner (1970) potentially increased the interitem reliability of the ATSPPHS by introducing multiple items to represent all four factors: 1) Need = eight, 2) Stigma = five, 3) Openness = seven, and 4) Confidence = nine. Table 4 shows the ATSPPHS attitude domains and which items are related to the individual factors. However, twenty five years later, Fischer and Farina (1995) redesigned the ATSPPHS into a single score short form. The original 29 item ATSPPHS was shortened to 10 items with some of the attitude statements being refined (Fischer & Farina, 1995).

**Split-half.** This form of reliability is a common method of detecting instrument stability. Generally, a sample can be split in two or divided into sets and then the groups’ responses or scores can be analyzed. The analysis is a statistical comparison of within group differences. To measure internal reliability, Cronbach’s alpha is commonly estimated (Nardi, 2006, p. 63). During the examination of psychometrics of the ATSPPHS, Fischer and Turner (1970) used Tryon’s (1957) method. The estimate of internal reliability was .86, with a reliability estimate of .83 (Fischer & Turner, 1970). Both estimates of reliability are considered good since they approach 1.0, which represents perfect reliability (Light, Willett, & Singer, 1990; Nardi, 2006, p. 63).

**Interrater reliability.** This form of measurement accuracy is referred to use in qualitative research. Qualitative methods employ the use of observation, interviews, and
open-ended written responses during data collection. To achieve interrater reliability there must be conformity among those who will be analyzing the collected data. Nardi (2006, p. 63) also refers to an agreement among data sorting techniques as intercoder reliability. This can be reinforced by external audits that evaluate the findings of the study and the interpretation methods used to generate the data driven conclusions (Creswell, 1997, p. 203).

Although the ATSPPHS was designed for use as a quantitative instrument, there were qualitative methods that contributed to the scale’s development. Subjects completed the three item Biographical Information questionnaire which asked respondents to briefly explain “personal crisis” and if they sought mental health attention (Fischer & Turner, 1970, p. 81). Fischer and Turner’s (1970) psychometric methodology did not discuss coder agreement, therefore interrater reliability of the Biographical Information questionnaire responses is unknown.

Fischer and Turner (1970) took steps to establish the reliability and validity of the ATSPPHS. Instrument precision was evaluated during the scale’s development and standardization. The ATSPPHS represents a pioneering effort to measure attitudes toward seeking professional psychological help. The psychometric properties regarding the accuracy and consistency of the ATSPPHS were necessary to inform researchers planning to conduct future studies with this attitude scale (Wilkinson & the Task Force on Statistical Inference, 1999).
Validity in Measurement

Validity in psychological measurement concerns the accuracy of what the researcher or instrument is attempting to measure. Social science researchers generally recognize face, content, construct, and criterion validity in measurement.

*Face validity.* This refers to the subject’s ability to generally understand a measure’s constructs regardless of the participants’ knowledge base. Nardi (2006, p. 59) refers to this as the “face value” of an instrument. Researchers in search of face value need only to present a measure to any individual, and if the instrument constructs are generally recognizable, then face validity is achieved.

Before the final version of the ATSPPHS was established, 97 students were given the scale. The first sentence of the directions that accompanied the ATSPPHS stated, “Below are a number of statements pertaining to psychology and mental health issues” (Fischer & Turner, 1970, p. 81). This first administering of the ATSPPHS to students may have served as a test of face validity. This was not stated by Fischer and Turner (1970), however the written directions clearly provided the students with a basic understanding of what was to be expected on the instrument. This expectation may have addressed face validity for the students completing a trial of the ATSPPHS.

*Content validity.* This differs from face validity with regards to who will identify the measure’s constructs. In content validity, experts in the field, rather than casual bystanders make the determination of validity. Granello (2007) urges researchers developing new instruments to employ panels of professionals in the field and conduct pilot studies to validate a measure’s content. Content validity is usually determined by
consensus of evaluating researchers to insure that the item contents encompass the 
breadth of the variables being studied (Nardi, 2006, p. 59).

Fischer and Turner (1970) satisfied content validity by assembling a panel of 
mental health professionals within the disciplines of counseling psychology, clinical 
psychology, and psychiatry. The panel served as judges rating the appropriateness of the 
attitude statements and whether they belonged on the ATSPPHS. The attitudes were also 
determined to be positive or negative statements (Fischer & Turner, 1970).

**Construct validity.** This form of validity centers attention on developing items 
that measure constructs derived from abstract concepts, such as attitudes. Constructs are 
conceptual ideas that tend to be multifaceted and for which there may be multiple 
approaches to measure their attributes (Nardi, 2006, p. 59). The accuracy of construct 
validity is determined through statistical analysis. Construct validity is based on 
numerical results, which can then be correlated with related variables for future research 
(Nardi, 2006, p. 59).

Following the development of the ATSPPHS, Calhoun, Dawes, and Lewis (1972, 
p. 153) conducted research investigating the correlation between attitudes toward seeking 
help and the “locus of causal attribution of the problem.” Fischer and Cohen (1972) 
studied the relationship between attitudes toward seeking professional psychological help 
and social class, education level, religion, and academic major. These studies helped to 
support the construct validity of ATSPPHS.

More recently, Liao, Rounds, and Klein (2005) examined correlates among 
attitudes of Asians toward seeking help and self-concealment, perceived social support, 
severity of personal concerns, willingness to seek counseling, behavioral acculturation,
and adherence to Asian values. In one study of the risks of self-disclosure, Vogel and Wester (2003) correlated attitudes toward seeking professional psychological help with self-disclosure, anticipated risk, and anticipated utility. In a second study, the same correlations were explored with the addition of intent, self-concealment, perceived social support, and psychological distress (Vogal & Wester, 2003). This recent research provides further understanding of construct validity for the ATSPPHS.

Criterion validity. This form of validity establishes accuracy of constructs that are difficult to measure. To verify criterion validity, an instrument can be tested in comparison to other criteria. If scores of outside criteria are in agreement with the measure being investigated, concurrent validity is present. This validity coefficient is only evident when there is a correlation between an instrument and a measureable behavior (Carmines & Zellar, 1979).

Concurrent validity. This form of validity identifies items that concurrently correlate with external criteria. An example of this would be the development of a new instrument. Researchers would test the new measure with an existing instrument with the same population based on similar theoretical constructs in order to identify concurrent validity. Nardi (2006, p. 59) recognizes that reputable predictive validity findings give researchers confidence in pursuing future studies on related construct measurements.

Atkinson and Gim (1989) reported a concurrent correlation between the acculturation levels measured by the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA; Suinn, Rickard-Figueroa, Lew, & Vigil, 1987) and attitudes toward seeking psychological help as measured by the ATSPPHS. Within the study it was hypothesized and found that high acculturation levels correlate with positive attitudes toward seeking

Tata and Leong (1994) found the constructs of individualism-collectivism, social network orientation, and acculturation as indicators of attitudes toward seeking professional psychological help. Tata and Leong (1994) measured the following: individualism-collectivism with the Individualism-Collectivism Scale (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988); social-network orientation was measured by the Network Orientation Scale (Vaux, 1985); acculturation was measured by the SL-ASIA (Suinn et al. 1987); and attitudes toward seeking professional psychological help were measured by the ATSPPHS. All of the variables were reported to be predictors of attitudes toward seeking professional psychological help among Chinese American students (Tata & Leong, 1994). The constructs of individualism-collectivism, social network orientation, and acculturation showed forms of predictive validity when used with the ATSPPHS.

The Biographical Information questionnaire was administered concurrently with the ATSPPHS to student participants to examine known-group validity (Fischer & Turner, 1970). This test of criterion validity indicated a positive attitude toward seeking help among subjects that had previously received help or were currently in a therapeutic relationship. Responses of receiving help on the Biographical Information questionnaire correlated highly with the positive attitude scores toward seeking professional psychological help on the ATSPPHS (Fischer & Turner, 1970). Therefore, criterion
validity was established between previously receiving mental health attention and positive attitudes toward seeking help.

**Research Questions**

This research is a study of the reliability and validity of the ATSPPHS. The instrument was completed by Jamaican Americans to examine the appropriateness of using the ATSPPHS with that Caribbean population. The study sought to understand if the psychometric properties of reliability and validity found by Fischer and Turner (1970) can also be found based on the responses from a sample of Jamaicans. These questions guided the research:

1. Does the ATSPPHS demonstrate reliability when utilized with Jamaicans residing in the United States?
2. Does the ATSPPHS demonstrate validity when measuring Jamaican attitudes toward seeking mental health services?

**Description of Instrumentation**

*Attitudes Toward Seeking Professional Psychological Help Scale*

The ATSPPHS was developed and standardized by Fischer and Turner (1970). Following the instrument’s development, Fischer and Cohen (1972) examined the ATSPPHS demographic correlates with the variables of social class, educational level, religion, and college major. Twenty five years after the instrument’s design Fischer and Farina (1995) created a 10-item short form with grammatical changes and additions that was highly correlated with the original instrument ($r = .87$).

The ATSPPHS was designed to measure attitudes toward seeking professional psychological help. The attitudes are divided into four factors: a) recognition of personal
need for professional help, b) tolerance of stigma associated with psychological help, c) interpersonal openness, and d) confidence in mental health professional (Fischer & Turner, 1970). These factors are intended to differentiate between those who would and would not seek professional mental health services (Fischer & Turner, 1970; Fischer & Farina, 1995).

Fischer and Turner’s (1970) design of the ATSPPHS totaling 29 items, 11 which are positively written and 18 negatively written, thus requiring reverse scoring for purposes of the analysis (Fischer & Farina, 1995). All 29 item responses are recorded using a four-point Likert-type scale: 0 = Strongly disagree, 1 = Disagree, 2 = Agree, and Strongly agree = 3 (Fischer & Turner, 1970; Fisher & Farina, 1995).

**Demographic Information Form**

I created a demographic information sheet as the last component that finalizes the survey packet. This form collects demographic information relating to age, sex, socio-economic status, education level, length of time in the United States, and the previous utilization of mental health services. See Appendix B for a copy of this form.

**Participants**

The participants in this study are first generation Jamaicans who have migrated to the United States. Malcarne, Chavira, Fernandez, and Kiu (2006) describe first generation as members from one country who have migrated to a new host country. For the purpose of this research participants would have to be born in Jamaica, but currently reside in the United States in order to qualify for this study. The 2000 Census reported that 736,513 Jamaican Americans lived in the United States (U.S. Census Bureau, 2007). The Census Bureau figures are likely to be conservative due to survey response rate and
illegal immigration, which could raise the numbers of Jamaicans living in the U.S. to 800,000 to 1,000,000. The majority of Jamaican Americans reside in the New England region, New York, Southern Florida, and Washington, D.C. metropolitan area (U.S. Census Bureau, 2007). These demographics were reflective of the sample.

The majority of participants were based on the East Coast of the United States, but the study also included participants from other regions of the country. The participants are members of two different Jamaican cultural and civic organizations. Executive board members from both organizations agreed to participate in this research, by providing the list of their memberships. One organization’s membership is entirely comprised of Jamaicans, with the majority being first generation immigrants. The other association’s membership is open to the Caribbean as a whole with the majority of their members representing first generation immigrants from Jamaica. All participants are volunteers, 18 years of age or older, and represent both sexes.

**Data Collection Procedures**

I collected data using a purposeful sample. The decision to survey first generation Jamaicans living predominately on the United States East Coast is due to the large number residing in this region (Census Bureau, 2007). Keppel and Wickens (2004, p. 10) refer to this approach as a nonstatistical generalization based on knowledge of the research area.

Data collection procedures began following the approval of the Institutional Review Board that oversees the use of human subjects in research pertaining to the University of New Mexico (IRB; see Appendix C). Three hundred and thirty seven questionnaires were mailed to members of two Jamaican national organizations in the
United States. One hundred and five questionnaires were returned. Eleven did not meet the study’s criteria of first generation Jamaicans living in the United States and were withheld from the final analysis. A total of 94 participants qualified and were included in the study’s analysis, which yielded a response rate of 27.9 percent.

The questionnaires were coded for both organizations in order to avoid collecting duplicate data. The first mailing was sent to the membership of both groups in attempt to contact 337 potential participants. The packets of the first mailing consisted of an informed consent and welcome letter (see Appendix D), the ATSPPHS, the demographic questionnaire, and a self addressed return envelope. After a two week period, a second mailing was sent as a reminder to those who had not yet completed and returned the surveys. The second mailing contained a reminder letter (see Appendix E) concerning the study and again included the ATSPPHS, demographic form, and a self addressed return envelope. Following an additional two weeks, a third mailing was sent as a final reminder to those who had not participated and “thank you” correspondence (see appendix H) to those who participated in the study. Both participants and those who did not take part in the research were welcomed to contact the researcher for a summary of the study’s findings.

The data collection procedures began with an informed consent and welcome letter explaining who I am and the purpose of the research being conducted. The letter also stated informed consent for the participants. The last page of the questionnaire (Demographic Information form) instructed the participants to return the completed forms with the self-address and prepared envelopes. These steps were repeated for the second mailing.
Management of Missing Data

Not all of the participants fully completed the questionnaire. Seventy-seven percent of the respondents (n = 73) completed the ATSPPHS in its entirety. Twenty-two percent (n = 21) of the participants did not respond to at least one item on the ATSPPHS. One participant did not respond to three items and one other did not complete five. See Appendix G for the participant response report. The majority of respondents that did not fully complete the ATSPPHS left one item blank. Missing data on the ATSPPHS were replaced by using the variable mean for items one through 29. See Appendix H for values used to replace missing data.

I handled the missing data for the demographic information differently. The section of the questionnaire that asks for demographic information (items 30-40) was completed by the vast majority of the respondents (89.4%), while ten participants (10.6%) did not fully complete the demographic section. The majority of participants that did not completely fill out the questionnaire left one item blank. Missing data for the following items were not replaced: Age; number of years in the United States; previous use of mental health services; and access to services.

Data Analysis

Raw data were obtained from the ATSPPHS that was completed by a sample of 94 Jamaicans residing in the United States. See Appendix I for data code book. I created an Excel file that contains the responses to the items on the ATSPPHS (Items 1-29) and the demographic information (Items 30-40) for each participant. I examined the data for entry errors and did not find any. Missing values on the ATSPPHS were replaced by the mean. I imported the Excel file into SPSS version 16.0 (SPSS Inc., 2008) for analysis.
I calculated descriptive statistics for the demographic variables. I estimated Cronbach’s alpha reliability coefficients for the entire scale of 29 items and also for the four sub-scales (e.g. Factor I: Recognition of need for psychotherapeutic help) to examine the internal consistency of the instrument. I estimated the correlations between the overall ATSPPHS, the four factors, and the demographic variables.

I further conducted analysis of the data using principal components analysis to determine if the factors that emerge based on the responses from this sample are similar to or different from the factors that emerged from the original study by Fischer and Turner (1970). The use of principal components analysis also helped me access the construct validity of the ATSPPHS and its factors when tested on a sample of first generation Jamaicans living in the United States.
CHAPTER FOUR

RESULTS OF THE DATA ANALYSIS

The purpose of this study is to investigate the reliability and validity of Fischer and Turner’s (1970) Attitudes Toward Seeking Professional Psychological Help Scale with a Jamaican sample residing in the United States. The statistical analyses conducted are: (1) Descriptive statistics of the scores and demographic variables, (2) the estimate of Cronbach’s alpha reliability coefficient estimate for the overall ATSPPHS, and the four attitudinal factors, (3) the estimated correlation matrix for the ATSPPHS, the four ATSPPHS factors, and demographic variables, and (4) principal components analysis to examine the structure of the factors and validity.

Demographic Profile of Scores

The ATSPPHS employs a Likert-type scale ranging from 0 to 3, which creates the possibility for potential total score to range from 0 to 87. There is considerable variation in the participants’ scores with a minimum score of 21 to the maximum score of 77 (range = 56). There are the possible ranges in scores for the four sub-scales: Factor I (Recognition of need for psychotherapeutic help) with eight items, 0 to 24; Factor II (Stigma tolerance) with five items, 0 to 15; Factor III (Interpersonal tolerance) with seven items, 0 to 21; and Factor IV (Confidence in mental health practitioner) with nine items, 0 to 27. The only factor with an observed range equal to the possible range was Factor II. The descriptive statistics for the overall ATSPPHS and its attitudinal factor scores are displayed in Table 5.
Table 5. Participants’ ATSPPHS Overall and Factor Scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Maximum</th>
<th>Minimum</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPHS (Overall Score)</td>
<td>94</td>
<td>54.83</td>
<td>11.07</td>
<td>77</td>
<td>21</td>
<td>56</td>
</tr>
<tr>
<td>Factor I (Need)</td>
<td>94</td>
<td>14.15</td>
<td>3.49</td>
<td>22</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Factor II (Stigma)</td>
<td>94</td>
<td>8.89</td>
<td>3.06</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Factor III (Openness)</td>
<td>94</td>
<td>13.07</td>
<td>3.74</td>
<td>21</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Factor IV (Confidence)</td>
<td>94</td>
<td>18.71</td>
<td>3.67</td>
<td>27</td>
<td>10</td>
<td>17</td>
</tr>
</tbody>
</table>

Demographic Profile of Sample

The 94 participants in the analysis were born in Jamaica and are now living in the United States. Thirty-nine males (41.5%) and 55 females (58.5%) participated in this study. The mean age of the participants is 56.66 years and the mean length of time living in the United States is 32.92 years. There is a notable amount of variation in terms of age and length of time living in the United States (see Table 6).

Table 6. Participants’ Age and Number of Years in the United States

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Maximum</th>
<th>Minimum</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>91</td>
<td>56.66</td>
<td>14.51</td>
<td>88</td>
<td>20</td>
<td>68</td>
</tr>
<tr>
<td>Years in the United States</td>
<td>93</td>
<td>32.92</td>
<td>13.17</td>
<td>70</td>
<td>6</td>
<td>64</td>
</tr>
</tbody>
</table>
Social and Economic Profile

Demographic information concerning social and economic status was gathered to demonstrate a wide range of participation from the Jamaican American community.

Table 7 displays the occupational categories (U.S. Department of Labor, 2009) that the participants reported. Healthcare practitioner and technical occupations (20.2%), retired (16%), education, training, and library occupations (11.7%), and management

Table 7. Participants’ Occupations

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare Practitioner and Technical</td>
<td>19</td>
<td>20.2</td>
</tr>
<tr>
<td>Retired</td>
<td>15</td>
<td>16.0</td>
</tr>
<tr>
<td>Education, Training, and Library</td>
<td>11</td>
<td>11.7</td>
</tr>
<tr>
<td>Management</td>
<td>10</td>
<td>10.6</td>
</tr>
<tr>
<td>Business and Financial Operations</td>
<td>7</td>
<td>7.4</td>
</tr>
<tr>
<td>Office and Administrative Support</td>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td>Personal Care and Service</td>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td>Protective Service</td>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td>Architecture and Engineering</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Building and Grounds Cleaning and Maintenance</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Installation, Maintenance, and Repair</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Legal</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Student</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Arts, Design, Entertainment, Sports, and Media</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Community and Social Services</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Computer and Mathematical Science</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Life, Physical, and Social Science</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Production</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Sales and Related</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Not reported</td>
<td>7</td>
<td>7.4</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The occupational categories are determined and used by the U.S. Department of Labor (2009). The classification of retired, student, and not reported were added for the purposes of this study.
occupations (10.6%) represent the majority of respondents (58.5%). There is a wide range of education levels, from eight participants with no more than a high school diploma to 15 participants with terminal degrees. The majority of participants earned their highest level of education in the United States (85.1%), while the remainder were educated in Jamaica (11.7%), and other countries (3.2%). As can be seen in Table 8, a notable 91.5 percent of the respondents reported obtaining at least some college education. The category of university, college, or technical school graduate had the highest numbers of responses (n = 26), followed by earned masters or juris doctorate (n = 21), and earned doctorate (n = 15).

Both Patois and English are spoken regularly in Jamaica. However, the participants in this study reported that English (75.5%) is their mostly commonly spoken dialect in the United States. Patois (9.6%) and the combination of both Patois and English (14.9%) were also reported as dialects that were spoken regularly.

Annual income was the final piece of social and economic data that were collected. The income brackets were divided into intervals of $20,000 (USD). The income categories with the highest number of respondents were the following: 22.3 percent of the participants earn $40,001 - $60,000; 17 percent earn $60,001 - $80,000, and 17 percent earn above $100,001.
Table 8. Social and Economic Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level of education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 9th grade education</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Some high school</td>
<td>4</td>
<td>4.3</td>
</tr>
<tr>
<td>High school graduate</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Some college</td>
<td>13</td>
<td>13.8</td>
</tr>
<tr>
<td>University, college, or technical school</td>
<td>26</td>
<td>27.7</td>
</tr>
<tr>
<td>Some graduate school beyond undergraduate</td>
<td>10</td>
<td>10.6</td>
</tr>
<tr>
<td>Earned Masters degree or J.D.</td>
<td>21</td>
<td>22.3</td>
</tr>
<tr>
<td>Earned Doctorate (e.g. Ph.D., Ed.D., DrPH, MD)</td>
<td>15</td>
<td>16.0</td>
</tr>
<tr>
<td>Not reported</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.00</td>
</tr>
<tr>
<td>Where highest level of education was earned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Great Britain</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Jamaica</td>
<td>11</td>
<td>11.7</td>
</tr>
<tr>
<td>United States</td>
<td>80</td>
<td>85.1</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.00</td>
</tr>
<tr>
<td>Language dialect most commonly spoke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patios</td>
<td>9</td>
<td>9.6</td>
</tr>
<tr>
<td>English</td>
<td>71</td>
<td>75.5</td>
</tr>
<tr>
<td>Both Patios and English</td>
<td>13</td>
<td>13.8</td>
</tr>
<tr>
<td>Other dialect</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.00</td>
</tr>
<tr>
<td>Annual income $USD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below $20,000</td>
<td>8</td>
<td>8.5</td>
</tr>
<tr>
<td>$20,001 - $40,000</td>
<td>12</td>
<td>12.8</td>
</tr>
<tr>
<td>$40,001 - $60,000</td>
<td>21</td>
<td>22.3</td>
</tr>
<tr>
<td>$60,001 - $80,000</td>
<td>16</td>
<td>17.0</td>
</tr>
<tr>
<td>$80,001 - $100,000</td>
<td>12</td>
<td>12.8</td>
</tr>
<tr>
<td>Above $100,001</td>
<td>16</td>
<td>17.0</td>
</tr>
<tr>
<td>Not reported</td>
<td>9</td>
<td>9.6</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.00</td>
</tr>
</tbody>
</table>
Mental Health Demographics

The demographic items asked for information on previous use of mental health services and potential access to services. Responses were heavily skewed toward those who had never received mental health services, 77 of 94 participants (81.9%). Of those who had received help, 13.8% (n = 13) received services in the United States. Three respondents reported seeking help in Jamaica only, while three also reported receiving services both in the United States and Jamaica.

When asked if they have access to mental health services if suffering from an emotional issue or personal problem, nearly half of the participants (n = 46) reported that they do, both inside and outside of the Jamaican community. Thirty-six percent reported “yes” to having access to services outside of the Jamaican community. Thirteen percent of participants reported that they did not have access to mental health services. See Table 9 for complete responses to items related to previous use of and access to mental health services.
Table 9. Previous Use of and Access to Mental Health Services

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous use of mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>77</td>
<td>81.9</td>
</tr>
<tr>
<td>Yes, in Jamaica</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Yes, in the United States</td>
<td>13</td>
<td>13.8</td>
</tr>
<tr>
<td>Yes, in both the United States and Jamaica</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Not reported</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.00</td>
</tr>
<tr>
<td>Access to services if needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>12.8</td>
</tr>
<tr>
<td>Yes, in the Jamaican community only</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Yes, outside of the Jamaican community</td>
<td>34</td>
<td>36.2</td>
</tr>
<tr>
<td>Yes, both in and outside of the Jamaican community</td>
<td>46</td>
<td>48.9</td>
</tr>
<tr>
<td>Not report</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Reliability of the Attitudes Toward Seeking Psychological Professional Help Scale (ATSPPHS)

In order to determine the internal consistency of the ATSPPHS when tested with a Jamaican American sample, I obtained an estimate of Cronbach’s alpha of reliability coefficient estimate and compared it to Fischer and Turner’s (1970) original findings. I examined an estimated correlation matrix of the relationships between the ATSPPHS, the attitudinal factors, and demographic variables.

Estimate of Cronbach’s Alpha Reliability Coefficient

The estimate of Cronbach’s alpha reliability coefficient for the ATSPPHS with a Jamaican American sample was $\alpha = .87$ (n = 94). This estimated reliability coefficient is very strong according to Carmines and Zeller’s (1979) general assessment of widely used instruments. This finding is consistent with Fischer and Turner’s (1970) reliability.
estimate of .86 based on the standardized sample of 212 participants. Fischer and Turner (1970) later computed a reliability estimate of .83 on a larger sample (n = 406), and refer to this as the “whole scale estimate” (1970, p. 84).

The estimates of Cronbach’s alpha reliability coefficients for the ATSPPHS subscales in this study were: Factor I (Recognition of need for psychotherapeutic help) $\alpha = .61$; Factor II (Stigma tolerance) $\alpha = .72$; Factor III (Interpersonal openness) $\alpha = .77$; and Factor IV (Confidence in mental health practitioner) $\alpha = .72$. As we can see in Table 10, estimates .61 for Factor I are lower than the estimate provided by Fischer and Turner (1970). The larger Factor III estimate of Cronbach’s alpha reliability coefficient of the Jamaican sample also differed from Fisher and Turner’s (1970) standardized sample.

Table 10. Comparison of Estimates of Cronbach’s Alpha Reliability Coefficients for the ATSPPHS based on Fischer and Turner (1970) and Palmer (2009)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>406</td>
<td>94</td>
</tr>
<tr>
<td>ATSPPHS (whole scale)</td>
<td>.83</td>
<td>.87</td>
</tr>
<tr>
<td>Factor I (Need)</td>
<td>.67</td>
<td>.61</td>
</tr>
<tr>
<td>Factor II (Stigma)</td>
<td>.70</td>
<td>.72</td>
</tr>
<tr>
<td>Factor III (Openness)</td>
<td>.62</td>
<td>.77</td>
</tr>
<tr>
<td>Factor IV (Confidence)</td>
<td>.74</td>
<td>.72</td>
</tr>
</tbody>
</table>
**Estimated Correlation Matrix (Pearson Correlation)**

The estimated Pearson correlation matrix for the ATSPPHS overall scale, attitudinal sub-factors, and scores for Jamaican American sample revealed a number of notable results. Table 11 displays the estimated correlation matrix for the ATSPPHS and its factors that were significant at the $p = < .001$ level or greater.

The estimated Pearson correlation reveals that the ATSPPHS in its entirety is statistically significantly associated with the four attitudinal factors (Factor I, $r = .744$, $p < .001$; Factor II, $r = .705$, $p < .001$; Factor III, $r = .870$, $p < .001$; Factor IV, $r = .832$, $p < .001$). In addition to the ATSPPHS whole scale estimated correlations, all four factors are statistically significantly associated with one another, but the magnitude of these statistical correlations fall in the moderate range.

**Table 11. Estimated Correlation Matrix of ATSPPHS and Attitudinal Factors (Pearson Correlation)**

<table>
<thead>
<tr>
<th></th>
<th>ATSPPHS (Whole Scale)</th>
<th>Factor I (Need)</th>
<th>Factor II (Stigma)</th>
<th>Factor III (Openness)</th>
<th>Factor IV (Confidence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPHS (Whole Scale)</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor I (Need)</td>
<td>.744**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor II (Stigma)</td>
<td>.705**</td>
<td>.304**</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor III (Openness)</td>
<td>.870**</td>
<td>.543**</td>
<td>.526**</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Factor IV (Confidence)</td>
<td>.832**</td>
<td>.483**</td>
<td>.465**</td>
<td>.647**</td>
<td>1.000</td>
</tr>
</tbody>
</table>

** $p = < .001$ level of significance
* $p = < .05$ level of significance
The estimated Spearman correlation matrix was also used to examine relationships between demographic variables. Previous use of services and the overall score on the ATSPPHS ($r = .354, p < .001$) are statistically significantly associated. Factors I (Need, $r = .448, p < .001$), Factor III (Openness, $r = .260, p < .05$), and Factor IV (Confidence, $r = .283, p < .001$) were found to have statistically significantly positive associations with previous use of mental health services (see Table 12).

Occupations that consisted of least 10 percent of the respondents (healthcare practitioner and technical, 20.2%; retired, 16.0%; education, training, and library, 11.7%; and management, 10.6%) were analyzed to learn if a relationship existed among participants’ professions, the ATSPPHS, and its factors scores. The only statistically significantly association among occupations was between the education, training, and library professions and Factor I (Need, $r = .224, p < .05$). The only other demographic characteristic that presented a positive relationship was language which is statistically significantly associated with Factor III (Openness, $r = .242, p < .05$).
Table 12. *Estimated Correlation Matrix of ATSPPHS, Attitudinal Factors, and Selected Demographic Variables (Spearman Correlation)*

<table>
<thead>
<tr>
<th>ATSPPHS (Whole Scale)</th>
<th>Factor I (Need)</th>
<th>Factor II (Stigma)</th>
<th>Factor III (Openness)</th>
<th>Factor IV (Confidence)</th>
<th>Received (Services)</th>
<th>Occupation (Education)</th>
<th>Language (Most Spoken)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPHS (Whole Scale)</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor I (Need)</td>
<td>.765**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor II (Stigma)</td>
<td>.657**</td>
<td>.296**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor III (Openness)</td>
<td>.848**</td>
<td>.544**</td>
<td>.512**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor IV (Confidence)</td>
<td>.812**</td>
<td>.483**</td>
<td>.442**</td>
<td>.617**</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received (Services)</td>
<td>.354**</td>
<td>.448**</td>
<td>.098</td>
<td>.260*</td>
<td>.283**</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Occupation (Education)</td>
<td>.107</td>
<td>.224*</td>
<td>-.034</td>
<td>.023</td>
<td>.053</td>
<td>-.183</td>
<td>1.000</td>
</tr>
<tr>
<td>Language (Most Spoken)</td>
<td>.150</td>
<td>.054</td>
<td>.055</td>
<td>.242*</td>
<td>.183</td>
<td>.038</td>
<td>-.106</td>
</tr>
</tbody>
</table>

Coding for demographic variables:
- Received Services: 0 = No, have never received services, 1 = Yes, previously received services
- Occupation / Education: 0 = All other occupations, 1 = Education occupations
- Language most spoken: 0 = Patois, 1 = English or both English and Patois

*p = < .05 level of significance  ** p = < .001 level of significance*
Validity of the Attitudes Toward Seeking Psychological Professional Help Scale (ATSPPHS)

Principal component analysis was used to examine the relationship between the items and underlying constructs or factors. The analysis was completed by using both Varimax rotation and no rotation. The results of the analysis without rotation are displayed in Table 13. Column 1 indicates that among the Jamaican American population, only one factor is apparent. Sixteen of the 29 items supported factor loadings modestly weighed at .500 and above. No other factors were presented, differing sharply from Fischer and Turner’s (1970) factor analysis producing four independent factors.

Within the one major component found among Jamaican American scores the 16 strongest factor loadings represented all four attitudinal factors used by Fischer and Turner (1970). Of those 16 items, 14 were reversed scored. Only four items out the 18 negative written items were not loaded at above .500.
Table 13. Principal Component Matrix for the Un-Rotated Solution

<table>
<thead>
<tr>
<th>Items</th>
<th>Components</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1 RS</td>
<td>.485</td>
<td>-.099</td>
<td>.210</td>
<td>.204</td>
<td>-.401</td>
<td>-.290</td>
<td>.085</td>
<td>.082</td>
<td>.274</td>
<td></td>
</tr>
<tr>
<td>Item 2</td>
<td>.298</td>
<td>.106</td>
<td>.115</td>
<td>-.125</td>
<td>.289</td>
<td>.447</td>
<td>.137</td>
<td>.597</td>
<td>-.096</td>
<td></td>
</tr>
<tr>
<td>Item 3 RS</td>
<td>.586</td>
<td>-.269</td>
<td>.005</td>
<td>-.077</td>
<td>.072</td>
<td>-.282</td>
<td>.268</td>
<td>-.031</td>
<td>.344</td>
<td></td>
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<tr>
<td>Item 4 RS</td>
<td>.474</td>
<td>-.181</td>
<td>-.171</td>
<td>.131</td>
<td>-.431</td>
<td>.285</td>
<td>.438</td>
<td>.064</td>
<td>-.112</td>
<td></td>
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<tr>
<td>Item 5</td>
<td>.128</td>
<td>.752</td>
<td>-.084</td>
<td>-.141</td>
<td>.056</td>
<td>-.309</td>
<td>.203</td>
<td>-.128</td>
<td>.003</td>
<td></td>
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<tr>
<td>Item 6 RS</td>
<td>.578</td>
<td>-.079</td>
<td>.104</td>
<td>.418</td>
<td>-.059</td>
<td>-.024</td>
<td>.348</td>
<td>.114</td>
<td>.101</td>
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<tr>
<td>Item 7</td>
<td>.388</td>
<td>.434</td>
<td>.049</td>
<td>.075</td>
<td>-.172</td>
<td>-.206</td>
<td>-.172</td>
<td>.568</td>
<td>.011</td>
<td></td>
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<tr>
<td>Item 8 RS</td>
<td>.710</td>
<td>.067</td>
<td>.095</td>
<td>.221</td>
<td>.120</td>
<td>-.163</td>
<td>.050</td>
<td>.172</td>
<td>-.203</td>
<td></td>
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<tr>
<td>Item 9 RS</td>
<td>.267</td>
<td>-.007</td>
<td>-.546</td>
<td>.456</td>
<td>.170</td>
<td>.292</td>
<td>-.130</td>
<td>-.032</td>
<td>.008</td>
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<tr>
<td>Item 10 RS</td>
<td>.649</td>
<td>.155</td>
<td>-.324</td>
<td>-.168</td>
<td>-.349</td>
<td>.234</td>
<td>.133</td>
<td>.056</td>
<td>-.083</td>
<td></td>
</tr>
<tr>
<td>Item 11</td>
<td>.105</td>
<td>-.076</td>
<td>.500</td>
<td>.266</td>
<td>.366</td>
<td>.258</td>
<td>.378</td>
<td>-.020</td>
<td>.097</td>
<td></td>
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<tr>
<td>Item 12</td>
<td>.623</td>
<td>.059</td>
<td>.237</td>
<td>.151</td>
<td>.236</td>
<td>-.101</td>
<td>.009</td>
<td>-.177</td>
<td>-.347</td>
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</tr>
<tr>
<td>Item 13 RS</td>
<td>.549</td>
<td>-.121</td>
<td>-.109</td>
<td>.128</td>
<td>.110</td>
<td>.011</td>
<td>-.135</td>
<td>-.083</td>
<td>.142</td>
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<td>Item 14 RS</td>
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<td>-.260</td>
<td>-.065</td>
<td>-.114</td>
<td>.097</td>
<td>.059</td>
<td>-.143</td>
<td>-.006</td>
<td>.523</td>
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<td>Item 15 RS</td>
<td>.621</td>
<td>-.189</td>
<td>.100</td>
<td>.164</td>
<td>.060</td>
<td>.095</td>
<td>-.235</td>
<td>-.013</td>
<td>-.229</td>
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</tr>
<tr>
<td>Item 16</td>
<td>.366</td>
<td>.281</td>
<td>.229</td>
<td>-.092</td>
<td>.102</td>
<td>.613</td>
<td>-.230</td>
<td>-.178</td>
<td>.153</td>
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</tr>
<tr>
<td>Item 17 RS</td>
<td>.643</td>
<td>.073</td>
<td>-.219</td>
<td>.005</td>
<td>.031</td>
<td>.061</td>
<td>-.354</td>
<td>.051</td>
<td>.299</td>
<td></td>
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<tr>
<td>Item 18</td>
<td>.294</td>
<td>.596</td>
<td>.219</td>
<td>-.031</td>
<td>.113</td>
<td>.075</td>
<td>-.017</td>
<td>-.089</td>
<td>.232</td>
<td></td>
</tr>
<tr>
<td>Item 19 RS</td>
<td>.615</td>
<td>.279</td>
<td>.205</td>
<td>.248</td>
<td>-.149</td>
<td>-.112</td>
<td>-.257</td>
<td>-.169</td>
<td>.010</td>
<td></td>
</tr>
<tr>
<td>Item 20 RS</td>
<td>.603</td>
<td>-.501</td>
<td>-.072</td>
<td>-.305</td>
<td>.129</td>
<td>-.193</td>
<td>.078</td>
<td>-.041</td>
<td>.015</td>
<td></td>
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<tr>
<td>Item 21 RS</td>
<td>.631</td>
<td>.038</td>
<td>-.019</td>
<td>-.430</td>
<td>-.072</td>
<td>.141</td>
<td>.093</td>
<td>.025</td>
<td>-.075</td>
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<tr>
<td>Item 22 RS</td>
<td>.616</td>
<td>-.051</td>
<td>-.162</td>
<td>-.359</td>
<td>-.252</td>
<td>-.112</td>
<td>-.245</td>
<td>.160</td>
<td>-.217</td>
<td></td>
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<tr>
<td>Item 23</td>
<td>.535</td>
<td>.167</td>
<td>.398</td>
<td>-.157</td>
<td>-.183</td>
<td>.024</td>
<td>.045</td>
<td>-.432</td>
<td>-.135</td>
<td></td>
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<td>.061</td>
<td>-.243</td>
<td>-.162</td>
<td>-.090</td>
<td>.144</td>
<td>.229</td>
<td>-.264</td>
<td>-.090</td>
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<td>.461</td>
<td>-.310</td>
<td>-.049</td>
<td>.391</td>
<td>-.262</td>
<td>.268</td>
<td>.089</td>
<td>.085</td>
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</tr>
<tr>
<td>Item 26 RS</td>
<td>.428</td>
<td>.075</td>
<td>-.628</td>
<td>.239</td>
<td>.232</td>
<td>-.074</td>
<td>.037</td>
<td>-.213</td>
<td>-.129</td>
<td></td>
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<td>.128</td>
<td>-.624</td>
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<td>-.049</td>
<td>.054</td>
<td>.034</td>
<td>-.011</td>
<td></td>
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<tr>
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<td>-.239</td>
<td>-.077</td>
<td>.057</td>
<td>.455</td>
<td>-.180</td>
<td>-.138</td>
<td>.031</td>
<td>-.182</td>
<td></td>
</tr>
<tr>
<td>Item 29 RS</td>
<td>.567</td>
<td>-.139</td>
<td>.435</td>
<td>.145</td>
<td>.003</td>
<td>-.167</td>
<td>-.162</td>
<td>.075</td>
<td>-.158</td>
<td></td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis
Nine Components Extracted
CHAPTER FIVE

DISCUSSION

This study focused on the reliability and validity of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) use among Jamaican Americans. This discussion presents the assessment of reliability and validity to test the research hypotheses and answer the research questions that guided this dissertation.

Research Hypotheses

1. The ATSPPHS reliability based on the standardized population will not be comparable to reliability generated from a Jamaican sample.

2. The ATSPPHS in its original form will not demonstrate validity for measuring Jamaican attitudes toward seeking mental health services.

Research Questions and Explanation of Findings

Reliability of the ATSPPHS among Jamaican Americans

1. Does the ATSPPHS demonstrate reliability when utilized with Jamaicans residing in the United States?

In this study, reliability was tested through the use of an estimate of Cronbach’s alpha reliability coefficient and an estimated Pearson correlation matrix. The reliability coefficient of the Jamaican sample was $\alpha = .87$, which shows good comparison with Fischer and Turner’s (1970) standardized population yield of $\alpha = .83$. Both the Jamaican American ($\alpha = .87$) sample and Fischer and Turner’s (1970) standardized population ($\alpha = .83$) are considered very strong alphas (Carmines and Zellar, 1979, p. 51). The internal reliability was also found to be consistent with other researchers’ findings. Table 13 highlights comparisons of the reliability coefficient alphas among the ATSPPHS.
standardized population, the current study, and from previous studies that utilized the ATSPPHS that met the criteria that I set forth to review literature of diverse samples (immigrants from geographical regions, immigrants from specific countries, intergenerational populations, eclectic immigrant populations, and oversees populations).

The Jamaican sample not only produced a strong alpha, but also remained consistent with Fischer and Turner’s (1970) findings. These consistent results have been found across repeated measurements with previous studies of diverse samples (Tata & Leong, 1994; Ponterotto et al. 2001; and Zhang & Dixon, 2003) as seen in Table 14. This trial of testing the ATSPPHS with a Jamaican sample has demonstrated reliability due to the yield of consistent results with Fischer and Turner’s (1970) standardized population. According to the calculation of the estimate of Cronbach’s alpha reliability coefficient, the first hypothesis concerning the whole scale reliability of the ATSPPHS based on the standardized population will not be comparable to reliability generated from a Jamaican sample was rejected. However, a closer examination of the hypothesis was proven within the subscale of Factor III (Interpersonal Openness). Fischer and Turner’s (1970) standardized population produced a reliability coefficient of $\alpha = .62$ where the Jamaican sample resulted in $\alpha = .77$. The attitudes scale’s Factor III (Interpersonal Openness) scores were not reliable.
Table 14. *Comparison of ATSPPHS and Factors Reliability Coefficients of Previous and Current Studies*

<table>
<thead>
<tr>
<th>Instrument and Subscales</th>
<th>Samples of Previous Studies</th>
<th>Current Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tata &amp; Leong (1994)</td>
<td>Jamaican American</td>
</tr>
<tr>
<td></td>
<td>Ponterotto et al. (2001)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Palmer (2009)</td>
<td></td>
</tr>
<tr>
<td>ATSPPHS (Whole scale)</td>
<td>.83</td>
<td>.87</td>
</tr>
<tr>
<td>Factor I (Need)</td>
<td>.67</td>
<td>.61</td>
</tr>
<tr>
<td>Factor II (Stigma)</td>
<td>.70</td>
<td>.72</td>
</tr>
<tr>
<td>Factor III (Openness)</td>
<td>.62</td>
<td>.77</td>
</tr>
<tr>
<td>Factor IV (Confidence)</td>
<td>.74</td>
<td>.72</td>
</tr>
</tbody>
</table>

n/r = Not reported in study
The estimated Pearson correlation matrix revealed that all four attitudinal factors are statistically significantly associated with the ATSPPHS whole scale (see Table 11). When the factors are compared to each other they are also found to be statistically significantly associated with all sub-scales. Even though the factors had positive associations, the correlations are considered moderately statistically significant with each other (Muijs, 2004, p. 145). This finding is comparable to Fischer and Turner’s (1970) findings of low inter-correlation between factors. The findings of moderate positive associations among factors further support reliability of the ATSPPHS. The Jamaican American sample factor correlations were similar to Fischer and Turner’s (1970) inter-correlation findings. The sub-scales demonstrated consistency, yet the factors were independent of each other. The positive estimated correlations between the ATSPPHS whole scale and the scores for the four factors suggest that the hypothesis stating that the ATSPPHS would not be reliable for Jamaican Americans was rejected.

**Validity of the ATSPPHS among Jamaican Americans**

2. Does the ATSPPHS demonstrate validity when measuring Jamaican attitudes toward seeking mental health services?

Validity of the ATSPPHS among Jamaican Americans was analyzed with an estimated Spearman correlation matrix and principal component analysis. The estimated Spearman correlation matrix was employed to measure and display the categorical variables of the demographics. All demographic variables were analyzed and there were three relationships found with the ATSPPHS and its factors: Previous use of mental health services; occupations; and language use (see Table 12).
A statistically significantly association was found between previous use of mental health services and the ATSPPHS whole scale ($r = .354, p < .001$). Factor I (Need, $r = .448, p < .001$), Factor III (Openness, $r = .260, p < .05$), and Factor IV (Confidence, $r = .283, p < .001$) were also found to be statistically significantly associated among previous use of services. These relationships indicate criterion related validity (Carmines and Zeller, 1979, p. 17; Jaeger, 1993, p. 80). More specifically, higher scores on the ATSPPHS whole scale, Factor I (Need), Factor III (Openness), and Factor IV (Confidence) are associated with previous use of mental health services. The ATSPPHS demonstrated attributes of predictive validity because its ability to predict more positive attitudes toward seeking mental health services, therefore potentially becoming a predictor of help seeking behavior.

Fischer and Turner (1970) reported similar findings in their comparison of groups who had prior professional psychological help, and groups who had no contact. According to Fischer and Turner (1970) both groups of males and females who had experienced prior professional psychological help scored higher on the ATSPPHS. The Jamaican scores further reinforced the ability of the ATSPPHS to predict more positive attitudes. Concerning predictive validity, the second hypothesis stating that the ATSPPHS will not demonstrate validity among a Jamaican sample was rejected. Previous use of mental health services displayed the most relationships (total scores of ATSPPHS, Factors I, III, and IV) out of all the demographics. Factor II (Stigma) was the only subscale that did not present an association among the Jamaican American sample of those who previously utilized mental health services.
Participants that are employed in the education, training, and library occupations were found to be statistically significantly associated with the ATSPPHS subscale of Factor I (Need, \( r = .224, p < .05 \)). Therefore, the potential for predictive validity was recognized within this relationship. Those who scored higher on Factor I, representing items relating to the recognition of the need for psychological help were associated with occupations in the fields of education. By example, the relationship between education occupations and Factor I (Need) share characteristics of criterion-related validity evidence (Ary, Jacobs, Razavieh, and Sorensen, 2006, p. 246). However, the consistency of this finding is not confirmable at this point, since no literature has investigated this dimension of statistical relationships while researching help seeking attitudes. The majority of research examining attitudes toward seeking mental health services has focused on student attitudes, so previous researchers did not recognize a need to examine the influences of professional occupational backgrounds. My research vastly differs from previous studies due to the wide variance of participants within the sample. In the case of educational occupations demographics, the relationship with Factor I (Need) became noteworthy. Evidence of instrument validity is present, but with the lack of theoretical research construct validity along with other forms of validation, is not conclusive. Therefore the hypothesis concerning the lack of validity of the ATSPPHS is not rejected.

The final identifiable correlation between the total scores of the ATSPPHS and its four factors was in language usage. Respondents of the Jamaican sample who regularly spoke English or both English and Patois were found to be statistically significantly associated with Factor III (Openness, \( r = .242, p < .05 \)). Similar to the correlation found among occupation, language use was correlated at the \( p < .05 \) level. This finding
indicates that those participants who spoke English regularly consistently scored higher on Factor III items that refer to interpersonal openness. The predictive validity of this relationship suggests that those who have a command of the English language are able to and have a greater willingness to seek mental health services. Being able to have greater interpersonal openness with a mental health professional increases positive attitudes toward seeking help.

Differences in language usages are not typically researched. Non-English speaking populations overseas have been examined, and in those cases translations of the ATSPPHS were made (Kuwait, Al-Rowaie, 2001; Taiwan, Yeh, 2002). Of course, it is possible that participant’s individual acculturation levels may have affected language dialect usage. Jamaica’s official language is English, however Patois is commonly spoken in all aspects of daily life and is identified as a language within Jamaican culture. In United States society, individuals who are more acculturated would have better opportunities of receiving help if needed. This would result in more positive attitudes toward seeking mental health services. Comparable to occupation, language dialect use lacks the body of research needed to confirm construct validity, but shares characteristics of predictive validity (Jaeger, 1993, p. 80). The second hypothesis concerning validity based the relationship between language use and Factor III (Interpersonal openness) shows characteristics of validity. However, it was not rejected due to the lack of theoretical research to support validity evidence.

In pursuit of answering the research question concerning the ATSPPHS validity, principal component analysis was employed to identify construct validity. Using principal component analysis, I calculated and found nine extractions. On further
analysis it was clear that only one factor emerged as a sub-scale for measuring attitudes toward seeking mental health services based on the scores of the Jamaican American sample. This conclusion was reached by identifying items with a loading of .500 and greater. Principal component analysis assists researchers in recognizing themes that emerge from the data, and if those factors can be supported by theoretical concepts.

During Fischer and Turner’s (1970) original development of the ATSPPHS four factors were found and identified as: Factor I, Recognition of need for psychotherapeutic help; Factor II, Stigma tolerance; Factor III, Interpersonal openness; and Factor IV, Confidence in mental health practitioner. The Jamaican sample differs from Fischer and Turner’s (1970) findings, with the emergence of only a single attitudinal factor. This finding based on the Jamaican American scores raises questions about construct validity.

Fischer and Farina (1995) saw the need to modernize and shorten the ATSPPHS. Nineteen items were removed and of the remaining 10, six received grammatical changes or were otherwise modified. The shortened version of the ATSPPHS has a closer resemblance to stronger item loadings based on the Jamaican American scores. The hypothesis suggesting that the ATSPPHS will not demonstrate validity for measuring Jamaican attitudes toward seeking mental health services was not rejected. This conclusion is based on the emergence of only one attitudinal factor among the responses of the Jamaican American sample. In addition, within the one emerged sub-scale 13 of the 29 items failed to reach a factor loading of .500.

**Unexpected Outcomes from the Analyses**

Following the data analysis there were several outcomes which were found to be surprising. The first unexpected outcome was the strength of the estimated Cronbach’s
alpha reliability coefficient (α = .87). I initially did not believe that the sample of Jamaicans would have similar means as compared with Fischer & Turner’s (1970) standardized population. When looking closely into the demographics, the reasons for similarities between the two groups becomes apparent. Although the Jamaican sample was not entirely students as were Fischer and Turner’s population, this Caribbean group has experienced a great deal of American (United States) culture. The mean age of the Jamaican American sample was 57 years. The reliability of the ATSPPHS among the Jamaican sample was also a surprise due to the wide variance of age (SD = 14.51), as compared to the high school and college aged participants in Fischer and Turner’s standardized group. This comparability between the standardized group (Fischer & Turner, 1970) and the Jamaican American sample may be explainable though the mean length of time residing in the United States.

The mean number of years residing in the United States was 33. With more years in the United States, the participants’ exposure to United States infrastructure rose. This included level of education in the United States, time in the United States workforce, common use of English, and ability to earn an increased income. A mean age of 33 years living in the United States indicates that acculturation potentially contributed a large role in the Jamaican American sample’s attitudinal scores.

The second unexpected outcome of the analyses was during the ATSPPHS validity investigation. All demographic variables were examined to identify existing relationships with the ATSPPHS whole scale and its four factors. In previous studies, it was found that student respondents who had psychology and related majors scored higher on the ATSPPHS, and therefore have more positive attitudes seeking toward mental
health services (e.g. Fischer & Cohen, 1972; Al-Rowaie, 2001). From previous findings in the literature, I believed that scores from the Jamaican sample employed in healthcare practitioner and technical occupations (health care occupations) and the education, training, and library occupations (education occupations) would be statistically associated with the ATSPPHS. This was not the case. As seen in Table 12, the only association was found between education occupations and the ATSPPHS subscale of Factor I (Need, $r = .224, p < .05$). This finding was surprising considering that the field of psychology relates directly to both the health care and education occupations, which are helping professions.
Table 15. *Estimated Correlation Matrix of ATSPPHS, Attitudinal Factors, and Selected Occupation Demographic Variables (Spearman Correlation)*

<table>
<thead>
<tr>
<th></th>
<th>ATSPPHS (Whole Scale)</th>
<th>Factor I (Need)</th>
<th>Factor II (Stigma)</th>
<th>Factor III (Openness)</th>
<th>Factor IV (Confidence)</th>
<th>Occupation (Health Care)</th>
<th>Occupation (Education)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPHS (Whole Scale)</td>
<td>1.000</td>
<td>Coding for demographic variables:</td>
<td></td>
<td></td>
<td>Occupation / Health Care 0 = All other occupations 1 = Health care occupations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor I (Need)</td>
<td>.765**</td>
<td>1.000</td>
<td></td>
<td></td>
<td>Occupation / Education 0 = All other occupations 1 = Education occupations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor II (Stigma)</td>
<td>.657**</td>
<td>.296**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor III (Openness)</td>
<td>.848**</td>
<td>.544**</td>
<td>.512**</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor IV (Confidence)</td>
<td>.812**</td>
<td>.483**</td>
<td>.442**</td>
<td>.617**</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation (Health Care)</td>
<td>.025</td>
<td>-.151</td>
<td>.008</td>
<td>.115</td>
<td>.170</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Occupation (Education)</td>
<td>.107</td>
<td>.224*</td>
<td>-.034</td>
<td>.023</td>
<td>.053</td>
<td>-.183</td>
<td>1.000</td>
</tr>
</tbody>
</table>

* * p = < .05 level of significance  ** p = < .001 level of significance
Lessons Learned from Collecting Data from a Jamaican Population

There were lessons learned from collecting data from a Jamaican population. Historically, collecting data from people of color has been challenging. People from Afro-Caribbean heritage can be mistrusting of those who are considered potential “informers.” In general, mistrust among much of Africa and the Caribbean is well warranted stemming from years of colonization, economic and political oppression, and racism.

First and foremost, trust must be established within the community from which one is seeking data. This initial contact and trust was made possible through a dialog I established and maintained with members of the executive boards of the two cultural and civic organizations with Jamaican membership. I was able to make a presentation to one of the organizations during a monthly membership meeting and meet with an executive officer of the other association to propose my potential research. Being able to establish personal contact with the officers and some of the members of the organizations allowed me to explain the purpose of my research and its potential benefits to the community, further establishing my creditability.

Early in the data collection, it became apparent that many of the addresses provided by the Jamaican organizations were not the current residence of all members. Many members relocated without updating their information with either organization. While managing the mailing, I updated both organizations mailing lists and provided the officers with updated listings, making note of members who had not provided current addresses. This will assist these organizations with communicating with the membership and lower cost from lost postage.
Lessons learned from conducting a mailing with a population that has migrated to the United States is the potential for those who have not established themselves through social networks, education, and employment to move more often than those who have resided longer. Both mailing listings had 403 members, 66 (16.3%) of which were returned mail due to incorrect addresses and the lack of current addressees. A portion of these may be due to more recent migrates that have not yet established within the community. Another reason could be due to the length of time between mailing listing updates by both organizations.

Limitations

The study did not include cognitive interviewing of participants to determine the extent to which the items “capture” these constructs as understood by Jamaicans Americans. A qualitative section in this research could have been represented in individual and group formats. The use of focus groups may have potentially broadened awareness of Jamaican Americans comprehension and attitudes of the items in the ATSPPHS.

Implications for Mental Health Practitioners

Implications for those serving members of the Afro-Caribbean communities are promising. Jamaicans, like other minorities and people of color, have traditionally underutilized mental health services. Clinicians trying to serve this population have referred to countless multicultural and cross-cultural literature to gain a better understanding of how to counsel these populations. My study indicates that a mental health care professional needs to gain a better understanding of Jamaican attitudes toward seeking mental health services to understand some of the barriers to receiving help from a
western ideology. This understanding of attitudes toward seeking help must come before any effort to theorize about strategies for providing services.

In fact, if counselors in training are taught the fundamental of attitudes toward seeking mental health services, there would be greater opportunity to deliver services to populations that historically underutilize counseling and other forms of therapeutic care. Multicultural counseling texts and other training media need to incorporate cognates of attitudes toward seeking help. Indeed, entire texts need to be dedicated to the topic of this instrumental topic.

The examination of the reliability and validity of the ATSPPHS among Jamaican Americans is the first step to this complex understanding. The ATSPPHS demonstrated strong reliability with the Jamaican American sample and was comparable to Fischer and Turner’s (1970) standardized population. The ATSPPHS did display some characteristics of validity, but was not entirely convincing. For this reason research on confirming the appropriateness of the ATSPPHS with Jamaican and other Afro-Caribbean populations needs to continue from this study’s examination of reliability and validity.

**Future Research**

Future research needs to continue to increase contributions to the overall understanding of attitudes toward seeking mental health services. Without an understanding of the attitudes that motivate or prevent one from seeking services, it is difficult to provide appropriate services to those in need. The people of Jamaica, as well as other Afro-Caribbean cultures, have been ignored by mental health researchers in the United States and around the world. However, these populations have migrated in large
number to the United States in recent decades, reinforcing the need for continued understanding. My study revealed that many of the demographic variables tested did not have a theoretical foundation to support claims of validity, so a need to study further correlations is recommended. Fischer and Farina (1995) found this true nearly 15 years earlier and summarized:

The need for studies that go beyond the examination of simple correlates of the attitude with other measures or demographic variables was emphasized. (p. 368)

Further research also needs to focus on the economic influences on culture and attitudes toward seeking mental health services. In the United States, therapy is not provided without cost to the client in need; therefore economic status will have an effect on one’s attitudes toward seeking help. This potential factor could influence cultural views of mental health care. Palmer (2009) is aware of the United States cultural influences on the Caribbean and states:

The more globalized the world becomes the blurrier become the cultural boundaries of the nation states. The proximity of the small Caribbean states to the Unites States means that they must struggle to maintain their cultural identity against the constant assault of U.S. culture. (p. 152)

Summary

The ATSPPHS has been continuously utilized to measure attitudes toward seeking mental health services since its inception in 1970. In the decades following the ATSPPHS development and standardization, the measure has been utilized with samples that share similar demographic characteristics, that is, white middle class students within the United States (Fischer & Cohen, 1972; Fischer & Farina, 1995). During the 1980’s through present day, mental health practitioners and researchers began to focus on
samples considered as diverse populations. These groups have been people of color, immigrants to the United States, and samples from developing countries.

Much of this research focusing on diverse populations has not taken into account the reliability and validity of the ATSPPHS when measuring one’s attitudes toward seeking mental health services. This is especially important when considering the difference among Fischer and Turner’s (1970) standardized population in comparison to the diverse samples being researched.

Therefore, the recent cross-cultural use of the ATSPPHS creates a necessity to examine reliability and validity. The need for validation of the ATSPPHS stems from a responsibility to, and respect for, the political, social, regional, cultural, and economic differences not shared by the attitude scale’s original standardized population. Although the ATSPPHS in this study demonstrated promising reliability, the validity was not globally convincing. This warrants future research to contribute to clinicians’ understanding of attitudes toward seeking mental health services and how to appropriately and effectively serve Jamaicans and other populations from Afro-Caribbean cultures.
APPENDICES

APPENDIX A  ATTITUDES TOWARD SEEKING PROFESSIONAL
PSYCHOLOGICAL HELP SCALE (ATSPPHS) ................................................................. 94

APPENDIX B  DEMOGRAPHIC INFORMATION FORM ........................................... 97

APPENDIX C  INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL....................... 99

APPENDIX D  INFORMED CONSENT AND WELCOME LETTER
(MAILING 1) ............................................................................................................. 102

APPENDIX E  REMINDER TO PARTICIPATE LETTER (MAILING 2) ................. 104

APPENDIX F  THANK YOU LETTER (MAILING 3) ................................................. 106

APPENDIX G  PARTICIPANT RESPONSE REPORT .............................................. 108

APPENDIX H  REPLACED VALUES OF MISSING DATA ..................................... 110

APPENDIX I  DATA STRUCTURE CODE BOOK .................................................. 112
APPENDIX A

ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE (ATSPPHS)
### Attitudes Toward Seeking Professional Psychological Help Scale

**Directions:** Please circle the number that best expresses your level of agreement.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Although there are clinics for people with mental troubles, I would not have much faith in them.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>I would feel uneasy going to a psychiatrist because of what some people would think.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>Emotional difficulties, like many things, tend to work out by themselves.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>There are certain problems which should not be discussed outside of one’s immediate family.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
<td>A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12.</td>
<td>If I believed I was having a mental breakdown, my first inclination would be to get professional attention.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>Having been a psychiatric patient is a blot on a person’s life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Please continue to next page.  
Page 1 of 3
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. I resent a person—professionally trained or not—who wants to know about my personal difficulties.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. I would want to get psychiatric attention if I was worried or upset for a long period of time.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Having been mentally ill carries with it a burden of shame.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. There are experiences in my life I would not discuss with anyone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. It is probably best not to know <em>everything</em> about oneself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears <em>without</em> resorting to professional help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. At some future time I might want to have psychological counseling.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. A person should work out his own problems; getting psychological counseling would be a last resort.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Had I received treatment in a mental hospital, I would not feel that it ought to be “covered up.”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. If I thought I needed psychiatric help, I would get it no matter who knew about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
APPENDIX B

DEMOGRAPHIC INFORMATION FORM
Demographic Information Form

**Directions:** Please respond to the following items.

30. Age: ________

31. Sex: □ Male  □ Female

32. Number of years lived in the United States: ________

33. Country of Birth: ________________

34. Occupation: ______________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 35. Have you ever received mental health services?                      | □ Yes, in the United States  
|                                                                         | □ Yes, in Jamaica  
|                                                                         | □ Yes, both in the U.S. and Jamaica  
|                                                                         | □ No                                                                 |
| 36. If suffering from an emotional issue or personal problem would you | □ Yes, outside of the Jamaican community  
| have access to mental health services?                                  | □ Yes, in the Jamaican community only  
|                                                                         | □ Yes, both in & outside of the Jamaican community  
|                                                                         | □ No                                                                 |
| 37. What is your highest level of earned education?                     | □ Less than 9th grade education  
|                                                                         | □ Some high school  
|                                                                         | □ High school graduate  
|                                                                         | □ Some college  
|                                                                         | □ University, college, or technical school graduate  
|                                                                         | □ Some graduate school beyond undergraduate  
|                                                                         | □ Earned Masters degree or J.D.  
|                                                                         | □ Earned Doctorate (e.g. Ph.D., Ed.D., DrPH, MD)                        |
| 38. Where was your highest level of education earned?                   | □ Jamaica  □ United States  
|                                                                         | □ other country ____________________ (Please Specify)                    |
| 39. What language dialect do you most commonly speak?                  | □ Patois  □ English  
|                                                                         | □ other dialect ____________________ (Please Specify)                    |
| 40. What is your annual income ($USD)?                                 | □ Below $20,000  □ $60,001 – $80,000  
|                                                                         | □ $20,001 – $40,000  □ $80,001 – $100,000  
|                                                                         | □ $40,001 – $60,000  □ Above $100,000  |

*Please return survey with self-addressed envelope*

**Thank you for your participation**
APPENDIX C

INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL
04-Feb-2009

Responsible Faculty: Deborah Rifenbary
Investigator: Geoffrey J. Palmer
Dept/College: Individual Family Comm Educ IFCE

SUBJECT: IRB Approval of Research - Modification
Protocol #: 06-600
Project Title: An Examination of Reliability and Validity of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSSPPHS) among Jamaican Americans.
Type of Review: Expedited Review
Approval Date: 26-Jan-2009
Expiration Date: 25-Jan-2010

The Main Campus Institutional Review Board has reviewed and approved the above referenced protocol. It has been approved based on the review of the following:

IRB Application received 1/9/09
Reminder and Thank You Letters

Consent Decision:
Waived the requirement to obtain a signed consent form.

When consent is required, it is the responsibility of the Principal Investigator (PI) to ensure that ethical and legal informed consent has been obtained from all research participants. A date stamped original of the approved consent form(s) is attached, and copies should be used for consenting participants during the above noted approval period.

As the principal investigator of this study, you assume the following responsibilities:

Renewal: Unless granted exemption, your protocol must be re-approved each year in order to continue the research. You must submit a Progress Report no later than 30 days prior to the expiration date noted above.

Adverse Events: Any adverse events or reactions must be reported to the IRB immediately.

Modifications: Any changes to the protocol, such as procedures, consent/assent forms, addition of subjects, or study design must be submitted to the IRB for review and approval.
Completion: When the study is concluded and all data has been de-identified (with no link to identifiers), submit a Final Report Form to close your study.

Please reference the protocol number and study title in all documents and correspondence related to this protocol.

Sincerely,

J. Scott Tonigan, PhD
Chair
Main Campus IRB

* Under the provisions of Title 45, Code of Federal Regulations (45CFR46), the Main Campus IRB has determined that this proposal provides adequate safeguards for protecting the rights and welfare of the subjects involved in the study and is in compliance with IRB Regulations (45CFR46).
APPENDIX D

INFORMED CONSENT AND WELCOME LETTER (MAILING 1)
Dear Friends,

My name is Geoffrey J. Palmer and I am a doctoral student pursuing a degree in Counselor Education at the University of New Mexico. Before graduating I must complete my final research project. This dissertation is a study of an instrument’s ability to measure Jamaican attitudes toward seeking mental health services.

The instrument that I am testing was developed in 1970 for use with people from the United States. Since the instrument was not designed for use among Jamaicans, my goal is to identify whether it is an appropriate measure of Jamaican help seeking attitudes.

Implications of this research may indicate that a new instrument specifically for measuring Jamaican help seeking attitudes may need to be developed. This may assist those providing mental health services to Jamaicans, to better understand the needs of Jamaican Americans in the United States.

I invite you to participate in this study concerning Jamaican attitudes toward seeking mental health services. I plan to use the data for my dissertation and future research in summary form.

Individual responses will be kept strictly confidential. If you would like more information about the study, the research findings, or additional surveys please feel free to contact me.

Thank you for your participation,

Geoffrey J. Palmer

Geoffrey J. Palmer
Doctoral Candidate
APPENDIX E

REMINDER TO PARTICIPATE LETTER (MAILING 2)
Dear Friends,

A couple weeks ago I sent an invitation to participate in my research study concerning Jamaican attitudes toward seeking mental health services. If you would like to participate, but have not had an opportunity to return the survey you can still be a part of the study. **If you have already returned the survey thank you for supporting my study.**

This research project is part of my educational requirement before graduating. I am testing an instrument that was developed in 1970 for use with people from the United States. Since the instrument was not designed for use among Jamaicans, my goal is to identify whether it is an appropriate measure of Jamaican help seeking attitudes.

Implications of this research may indicate that a new instrument specifically for measuring Jamaican help seeking attitudes may need to be developed. This may assist those providing mental health services to Jamaicans, to better understand the needs of Jamaican Americans in the United States.

I invite you to participate in this study concerning Jamaican attitudes toward seeking mental health services. I plan to use the data for my dissertation and future research in summary form.

Individual responses will be kept strictly confidential. If you would like more information about the study, the research findings, or additional surveys please feel free to contact me.

Thank you for your participation,

Geoffrey J. Palmer
Doctoral Candidate
APPENDIX F

THANK YOU LETTER (MAILING 3)
Dear Friends,

_I want to thank those who_ participated in my study concerning _Jamaican attitudes toward seeking mental health services_. I am now in the process of analyzing the data that I have collected with your help.

_Regardless if you participated or not_, information concerning the results of my study can be made available by contacting me. Once again, thank you for your interest and support.

Sincerely,

_Geoffrey J. Palmer_

Geoffrey J. Palmer  
Doctoral Candidate
APPENDIX G

PARTICIPANT RESPONSE REPORT
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Participant response report on the ATSPPHS (Items 1 through 29)
APPENDIX H

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Replaced values of missing data on the ATSPHS (Items 1 through 29)
APPENDIX I

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<td>ATSPPHS1</td>
<td>Item 1 on the ATSPPHS – Although there are clinics for people with mental troubles, I would not have much faith in them. (Factor IV, Confidence in mental health practitioner)</td>
<td>0 = Strongly Disagree &lt;br&gt; 1 = Disagree &lt;br&gt; 2 = Agree &lt;br&gt; 3 = Strongly Agree</td>
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<td>ATSPPHS2</td>
<td>Item 2 on the ATSPPHS – If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist. (Factor IV, Confidence in mental health practitioner)</td>
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<td>ATSPPHS3</td>
<td>Item 3 on the ATSPPHS – I would feel uneasy going to a psychiatrist because of what some people would think. (Factor II, Stigma tolerance)</td>
<td>0 = Strongly Disagree &lt;br&gt; 1 = Disagree &lt;br&gt; 2 = Agree &lt;br&gt; 3 = Strongly Agree</td>
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<td>ATSPPHS4</td>
<td>Item 4 on the ATSPPHS – A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist. (Factor I, Recognition of need for psychotherapeutic help)</td>
<td>0 = Strongly Disagree &lt;br&gt; 1 = Disagree &lt;br&gt; 2 = Agree &lt;br&gt; 3 = Strongly Agree</td>
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<td>ATSPPHS5</td>
<td>Item 5 on the ATSPPHS – There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem. (Factor I, Recognition of need for psychotherapeutic help)</td>
<td>0 = Strongly Disagree 1 = Disagree 2 = Agree 3 = Strongly Agree</td>
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<td>ATSPPHS6</td>
<td>Item 6 on the ATSPPHS – Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. (Factor I, Recognition of need for psychotherapeutic help)</td>
<td>0 = Strongly Disagree 1 = Disagree 2 = Agree 3 = Strongly Agree</td>
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<td>ATSPPHS7</td>
<td>Item 7 on the ATSPPHS – I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family. (Factor III, Interpersonal Openness)</td>
<td>0 = Strongly Disagree 1 = Disagree 2 = Agree 3 = Strongly Agree</td>
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<td>ATSPPHS8</td>
<td>Item 8 on the ATSPPHS – I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment. (Factor IV, Confidence in mental health practitioner)</td>
<td>0 = Strongly Disagree 1 = Disagree 2 = Agree 3 = Strongly Agree</td>
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<td>Item 9 on the ATSPPHS – Emotional difficulties, like many things, tend to work out by themselves. (Factor I, Recognition of need for psychotherapeutic help)</td>
<td>0 = Strongly Disagree 1 = Disagree 2 = Agree 3 = Strongly Agree</td>
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| K      | ATSPPHS10     | Item 10 on the ATSPPHS – There are certain problems which should not be discussed outside of one’s immediate family. (Factor III, Interpersonal Openness) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree  |
| L      | ATSPPHS11     | Item 11 on the ATSPPHS – A person with a serious emotional disturbance would probably feel most secure in a good mental hospital. (Factor IV, Confidence in mental health practitioner) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree  |
| M      | ATSPPHS12     | Item 12 on the ATSPPHS – If I believed I was having a mental breakdown, my first inclination would be to get professional attention. (Factor IV, Confidence in mental health practitioner) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree  |
| N      | ATSPPHS13     | Item 13 on the ATSPPHS – Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns. (Factor III, Interpersonal Openness) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree  |
| O      | ATSPPHS14     | Item 14 on the ATSPPHS – Having been a psychiatric patient is a blot on a person’s life. (Factor II, Stigma tolerance) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree  |
| P      | ATSPPHS15     | Item 15 on the ATSPPHS – I would rather be advised by a close friend than by a psychologist, even for an emotional problem. (Factor IV, Confidence in mental health practitioner) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree  |
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| Q      | ATSPPHS16     | Item 16 on the ATSPPHS – A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help. (Factor IV, Confidence in mental health practitioner) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| R      | ATSPPHS17     | Item 17 on the ATSPPHS – I resent a person—professionally trained or not—who wants to know about my personal difficulties. (Factor III, Interpersonal Openness)                                                  | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| S      | ATSPPHS18     | Item 18 on the ATSPPHS – I would want to get psychiatric attention if I was worried or upset for a long period of time. (Factor I, Recognition of need for psychotherapeutic help)                                                        | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| T      | ATSPPHS19     | Item 19 on the ATSPPHS – The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. (Factor IV, Confidence in mental health practitioner)                                  | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| U      | ATSPPHS20     | Item 20 on the ATSPPHS – Having been mentally ill carries with it a burden of shame. (Factor II, Stigma tolerance)                                                                                                     | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| V      | ATSPPHS21     | Item 21 on the ATSPPHS – There are experiences in my life I would not discuss with anyone. (Factor III, Interpersonal Openness)                                                                                       | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
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| W      | ATSPPHS22     | Item 22 on the ATSPPHS – It is probably best not to know *everything* about oneself. (Factor III, Interpersonal Openness) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| X      | ATSPPHS23     | Item 23 on the ATSPPHS – If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy. (Factor IV, Confidence in mental health practitioner) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| Y      | ATSPPHS24     | Item 24 on the ATSPPHS – There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help. (Factor I, Recognition of need for psychotherapeutic help) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| Z      | ATSPPHS25     | Item 25 on the ATSPPHS – At some future time I might want to have psychological counseling. (Factor I, Recognition of need for psychotherapeutic help) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| AA     | ATSPPHS26     | Item 26 on the ATSPPHS – A person should work out his own problems; getting psychological counseling would be a last resort. (Factor I, Recognition of need for psychotherapeutic help) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
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| AB     | ATSPPHS27     | Item 27 on the ATSPPHS – Had I received treatment in a mental hospital, I would not feel that it ought to be “covered up.” (Factor II, Stigma tolerance) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| AC     | ATSPPHS28     | Item 28 on the ATSPPHS – If I thought I needed psychiatric help, I would get it no matter who knew about it. (Factor II, Stigma tolerance) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| AD     | ATSPPHS29     | Item 29 on the ATSPPIIS – It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen. (Factor III, Interpersonal Openness) | 0 = Strongly Disagree  
1 = Disagree  
2 = Agree  
3 = Strongly Agree |
| AE     | DEMO30        | Age                  | Years of Age |
| AF     | DEMO31        | Sex                  | 0 = Female  
1 = Male |
<p>| AG     | DEMO32        | Number of years lived in the United States | Years in the United States |
| AH     | DEMO33        | Country of Birth     | Country of origin (Jamaica) |</p>
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</table>
| AI     | DEMO34        | Occupation            | 1 = Architecture and Engineering Occupations  
2 = Arts, Design, Entertainment, Sports, and Media Occupations  
3 = Building and Grounds Cleaning and Maintenance Occupations  
4 = Business and Financial Operations Occupations  
5 = Community and Social Services Occupations  
6 = Computer and Mathematical Science Occupations  
7 = Education, Training, and Library Occupations  
8 = Food Preparation and Serving Related Occupations  
9 = Healthcare Practitioner and Technical Occupations  
10 = Installation, Maintenance, and Repair Occupations  
11 = Legal Occupations  
12 = Life, Physical, and Social Science Occupations  
13 = Management Occupations  
14 = Office and Administrative Support Occupations  
15 = Personal Care and Service Occupations  
16 = Production Occupations  
17 = Protective Service Occupations  
18 = Retired  
19 = Student  
20 = not reported  
21 = Sales and Related Occupations |
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| AJ     | DEMO35        | Have you ever received mental health services? | 0 = No  
1 = Yes, in Jamaica  
2 = Yes, in the United States  
3 = Yes, both in the U.S. and Jamaica  
4 = not reported |
| AK     | DEMO36        | If suffering from an emotional issue or personal problem would you have access to mental health services? | 0 = No  
1 = Yes, in the Jamaican community only  
2 = Yes, outside of the Jamaican community  
3 = Yes, both in & outside of the Jamaican community  
4 = not reported |
| AL     | DEMO37        | What is your highest level of earned education? | 1 = Less than 9th grade education  
2 = Some high school  
3 = High school graduate  
4 = Some college  
5 = University, college, or technical school graduate  
6 = Some graduate school beyond undergraduate  
7 = Earned Masters degree or J.D.  
8 = Earned Doctorate (e.g. Ph.D., Ed.D., DrPH, MD)  
9 = not reported |
| AM     | DEMO38        | Where was your highest level of education earned? | 1 = Jamaica  
2 = United States  
3 = other country  
4 = not reported |
| AN     | DEMO39        | What language dialect do you most commonly speak? | 1 = Patios  
2 = English  
3 = other dialect  
4 = not reported |
| AO     | DEMO40        | What is your annual income ($USD)? | 1 = Below $20,000  
2 = $20,001 – $40,000  
3 = $40,001 – $60,000  
4 = $60,001 – $80,000  
5 = $80,001 – $100,000  
6 = Above $100,001  
7 = not reported |

Data structure code book for the ATSPPHS (Items 1 through 29) and the Demographic Information Form (Items 30 through 40)
REFERENCES


