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AN EXAMINATION OF ATTITUDES TOWARD HELP-SEEKING AND

ATTRIBUTIONS MADE FOR A PSYCHOLOGICAL PROBLEM BY

AN UNDERGRADUATE ADOLESCENT POPULATION

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Penelope J. Maxwell

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### ABSTRACT.

The aim of the present study was to examine the help-seeking attitudes held by an adolescent undergraduate student population using the modified version of the Attitudes Toward Seeking Professional Psychological Help Scale, (ATSPPH). An investigation was also held into the type of attributions made as to the cause of a psychological problem and the particular help-source chosen to deal with this problem. Four hundred and forty-four hostel resident undergraduate students participated in a three component descriptive study within a quasi-experimental design which included a pre-test pilot study group, a main study matched group and a control group. The results obtained showed that this particular adolescent population held less positive help-seeking attitudes than a wider heterogeneous population. Both females and those subjects who had a prior contact with psychological professionals held more positive pro-help attitudes than either those who had no prior contact and male subjects. Two thirds of the subjects made external (situational) attributions as to the cause of the psychological problem and one-third internal attributions. The majority of subjects from the two attribution groups chose a friend as the preferred help-source to deal with a psychological problem. Help-source significantly discriminated the help-seeking score on the ATSPPH scale with those with less positive attitudes choosing a friend as the preferred help-source whereas those with more pro-help positive attitudes chose a psychologist or psychiatrist. Informal and formal help-sources were defined and the stated preferences of subjects in the present study were evaluated in relation to the mental health resources currently available. Changes that the psychological professionals themselves may need to consider in matching supply to demand were also discussed.

For Jacqueline and Robert James

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## CHAPTER I

### INTRODUCTION.

'Many of the unexplained suicides among students on a university campus are probably committed by young persons who have become aware of a malignant, insidious process that threatens to destroy their minds. Rather than seek psychiatric treatment (for schizophrenia) or confide their feelings of uncontrollable disintegration to their friends, they chose to end their lives'. (Kaplan & Sadock, 1985, p. 214).

This statement highlights the focus of the present study, which is to explore the attitudes and attributions that may affect the process of seeking help from professional psychological services by a late adolescent undergraduate population.

Adolescence is a complex and contradictory stage of development and to deal with the stresses inherent in a time of rapid change, constant adjustment and adaptation are required.

Initially, a special emphasis needs to be laid on the conclusion that adolescence itself is not a handicapping psychiatric condition. (Coleman, 1980). This conclusion has important implications for research for once it is acknowledged that the majority of adolescents cope reasonable well, then attention can be turned to the urgent task of learning more about the minority who are vulnerable and who are likely to find the pressures inherent in the adolescent process too great.

In particular, adolescents from 17 years to the early twenties are a vulnerable group dealing with particular stressors, especially in a current

economy which demands the learning of complex skills if one is to avoid the threat and fear of unemployment.

In a time of 'storm and stress' then, an increase in psychiatric disorder may be expected. Rates of disturbance however, tend to vary depending on the type of population tested. Studies of exclusively urban populations in America, (for example Leslie, 1974) report rates as high as 19% while an investigation in a rural area (Lavik, 1977) found that only 8% of the teenage population manifested psychiatric disturbance.

Overall, estimates of the prevalence of psychiatric disorder vary widely. (Dohrenwend & Dohrenwend, 1982). However within the United States, the President's Commission on Mental Health (1978), concluded that 15% of the population is in need of mental health services at any given time and this estimate may be a suitable guide for New Zealand mental health service requirements.

Regarding the type or nature of psychiatric disorder in the adolescent, it appears that the problems are of a different type, being more severe, more difficult to treat, or following a different course from adults. Graham & Rutter (1977), compared child and adolescent psychiatric problems and came to the following conclusions. Firstly, they noted that depression, anxiety and other emotional disorders become very much more common in adolescence. Secondly, they point to the altered sex ratio in those presenting psychiatric problems. While in childhood disorders are much more likely to be found in boys than girls, during the teenage years the ratio becomes more equal. Thirdly, there are important changes in the incidence of the less common psychiatric problems. For example, schizophrenic and other psychotic conditions, obsessional-compulsive states and suicide attempts are all very rare in childhood, but they become gradually more manifest as reflections of psychiatric disorder in adolescence. Graham & Rutter (1977), also note that among teenagers, severe family discord is less frequently an associated factor of psychological disturbance than it is in childhood.

These conclusions are, in general, supported by research findings. For example, Framrose (1975), reviewed the first seventy admissions to an

adolescent in-patient unit in Scotland and showed that two-thirds were diagnosed as having a developmental crisis and that the most common symptoms of this were anxiety and depression. Other symptoms seen in these patients included phobic states, delinquency, learning difficulties and somatic complaints.

Further researchers, (e.g. Rutter, Graham, Chadwick & Yule, 1976 and Woodmansey, 1969) reported a general increase in the incidence of psychotic disorders in adolescence. The nature of the problems presented reflect the fact that adolescence is a transitional process with disorders coming closer and closer in pattern to those manifested in adulthood.

Of particular concern is the finding that suicide is now the third most common cause of death for the 15-24 year old age group within the following countries; America (Black, 1986) the United Kingdom (Shaffer, 1974) and New Zealand, (New Zealand Official Year Book, 1986-1987, 1987). Cantor (1983) states that those adolescents most at risk from suicide are the middle class, tertiary educational group.

Conger, (1977) reported that the adolescent suicide rate has nearly trebled in the two decades from 1954 to 1974 in America and Coleman (1980) reported the same trend in the United Kingdom against the adult suicide rate which has remained stable or declined in these years.

Statistics differentiate between attempted and successful suicide, and male and female frequency. Black (1986), in a review of rates for several countries (e.g. America and Europe) found that young males outnumber females for successful suicides by at least 2:1, although attempted suicide is far commoner in young females. A study carried out in New South Wales in Australia, found that among all suicide attempts, 14.7% were successful in males between the ages of 10 and 19, while only 2.9% were successful among females of the same age. (Kraus, 1975).

Within New Zealand, attempted suicides for 1980 totalled 2220, with the larger proportion females, (i.e. 1391 as against 829 males). Thus the rate for males per 100,000 of the population 15 years and over is 73.7 whereas for

females it is 121.00. This is a large increase over the figures for the 1955-59 period; i.e. 17.7 males; 25.7 females. (National Health Statistics Centre, 1985). The latest available figures are for the 1985 period for deaths by suicide within New Zealand, (these include those deaths undetermined as to whether they are accidental or purposely inflicted) for the 15-24 year old age group totalled 154; males, 117; females, 37. (National Health Statistics Centre, 1985).

Cantor, (1983) stated that some accidents and homicides may be victim precipitated or thinly disguised suicides and further suggested that a true figure cannot be determined due to the unreliability of statistical data. For example, a family may deny the act and suicide is therefore classified as an accident. A large number of suicides are also assumed to go unreported because of legal, social or religious taboos.

Over the years a variety of studies of undergraduate university populations have been published demonstrating substantial psychological distress for this group. (Mechanic & Greenley 1976; Reifler & Liptzin, 1969; Segal, 1966; Weiss, Segal & Sokol, 1965). However, these studies have used varying measures of distress and describe rather diverse student populations. But the majority of these studies suggest that of even those students suffering relatively higher levels of distress, only a minority seek psychological care, with a significant proportion seeking no formal assistance at all.

The following sections will include a brief summary of literature from the general area of help-seeking. This will be followed by a review of the research on two particularly relevant variables. These are, attitudes to help-seeking and attributions about the causes of psychological problems. A final discussion will centre on the help sources that this particular undergraduate population may use when faced with psychological problems.

## CHAPTER II.

### HELP-SEEKING.

The acceptability and use of professional help for personal problems has increased notably over a twenty-year period. This was found by Veroff, Kulka and Douvan (1981), when replicating an earlier 1957 study in 1976. In 1957 some 14% of the population said they had sought psychological help at some point in their lives; by 1976 this had nearly doubled to 26%. The proportion varied for different subgroups in the population reaching a high of 32% among college graduates.

Other researchers, however, have documented discouragingly low rates of utilization by individuals who are in need of help within the general population. (Fischer & Turner, 1970; Gurin, Veroff & Feld, 1960; Langner & Michael, 1963; Mechanic, 1976; Srole, Langner, Michael, Opler & Rennie, 1962; Wills, 1982).

Research with student populations has suggested that from 14% to 50% of student populations are ignorant of counselling services. (Benedict, Apsler & Morrison, 1977; Kramer, Berger & Miller, 1974) with most estimates of usage around 10% to 25%. (e.g. Benedict et al., 1977; Kirk, 1973; Sharf & Bishop, 1973). In general then, research indicates that the student is unwilling to use the counselling centre as a source of help for personal problems. (Bosmajian & Mattson, 1980; Dreman & Dolev, 1976; Resnick & Gelso, 1971; Snyder, Hill & Derksen, 1972; Strong, Hendel & Bratton, 1971; Tinsley & Harris, 1976).

In attempting to predict and understand utilization patterns, several explanations have been developed within the literature. The term 'help-seeking' has been used in studies of mental health service utilization and defines both those who do seek help for psychological distress and those who do not avail themselves of those services offered by this resource. Psychological constructs which have been useful in exploring variations in

help-seeking and help-acceptance include indebtedness, (Greenberg & Shapiro, 1971), equity, (Castro, 1974; Gross & Latane, 1974) threat to self-esteem, (Fisher & Nadler, 1982) and attribution theory, (Jones & Davis, 1965; Kelley, 1967).

Other researchers have looked at processes such as motivation (Amato & Bradshaw, 1985) and a problem solving approach, (Neal & Heppner, 1986). Amato & Bradshaw (1985) present a taxonomy of five general clusters of motives to avoid help-seeking; i.e. fear and stigma, problem avoidance and denial, helper evaluation, external barriers and independence.

The decision to seek help for psychological distress can also be viewed as a real-life problem solving process. Neal & Heppner (1986), outline an ordered decision making model of help-seeking with certain clusters of concerns becoming more salient at different stages of the help-seeking process. For instance, problem avoidance and denial may initially inhibit help-seeking, followed by concerns about independence, fear and stigma. Then considerations of the availability and suitability of helpers may be relevant as well as external barriers and costs.

Wills (1982) clarified these factors within a conceptual model (Figure 1) which incorporates both motivational and problem clusters.

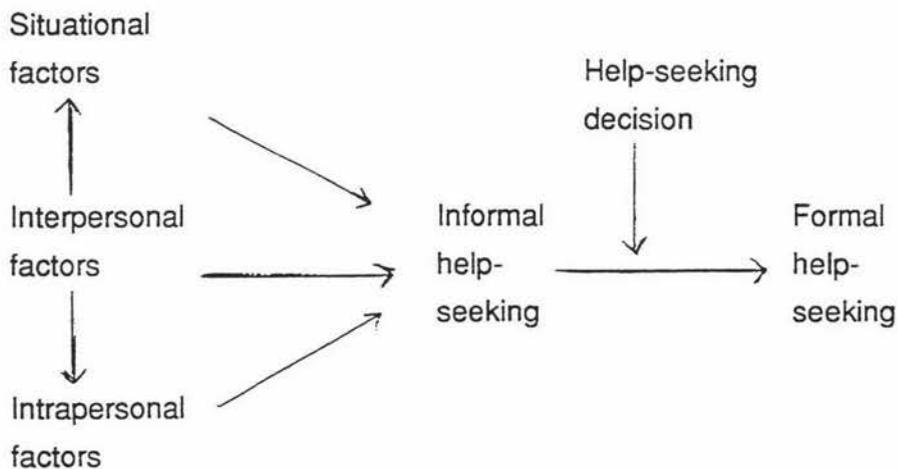


Figure 1. Overview of processes in help-seeking. (Wills, 1982).

This model suggests that problems are seen to develop because of situational, interpersonal, or personality factors, or more probably a complex interaction of all three factors. Subjective distress leads initially to support from informal networks - a process that is only beginning to be clarified in current research. It is posited, that persistence of distress will ultimately lead a person to a crucial decision to seek help from a formal helping agency. The act of making this decision undoubtedly represents a profound turning point in a person's life. (Wills, 1982).

Overbeck (1977), looked at life stress antecedents to applications for help at a mental health centre, and found that stressful life situations evoke disequilibrium and force an adaptive process. He notes that the stress adaptation process is vastly complex and dependent on a multiplicity of interconnected variables; help-seeking is one form of adaptation which may occur when existing support systems are inadequate, depleted or insufficient for restoration of equilibrium.

Gortmaker, Eckenrode & Gore (1982), explored stress and the utilization of health services through a time series using cross-sectional analysis and found that the presence of stress on a given day is associated with an approximate doubling of the probability of a health care contact (i.e. with a neighborhood health centre) on that day. The authors suggest that a more comprehensive analysis of the effects of stress on health service utilization also requires a consideration of other factors known to influence coping responses. For example, the presence or absence of alternative coping resources, whether psychological or social, could interact with the presence of stress to influence utilization of formal health services.

Mechanic (1968), has further illuminated the part played by social customs, traditions and beliefs in the process of help-seeking. Kadushin (1966), also views the help-seeking process as a sociocultural one dependent on both social context and interpersonal influences.

Further research by Olmsted and Smith (1980), suggests the occurrence of a stable pervasive 'cultural belief system' with young people's mental beliefs

shifting gradually towards a closer correspondence with those of adults. Therefore it would appear that the underlying cultural belief system is not only stable over time but 'deep seated' which supercedes the generation gap or youth culture social-structural domains.

However, McKinlay (1972), in reviewing the utilization of health services over two decades, found that an unclear picture emerged as to the precise influence of beliefs - whether positive or negative -in the use of services. He found that most studies had been conducted in situations that had necessitated identifying beliefs and behaviours at the same point in time, or behaviour first and beliefs second. A further problem exists in that work on cognitive dissonance (Rosenstock, 1969) suggests that the decision to utilize or under-utilize some health services may in itself modify beliefs etc.

Hourani and Khlaf (1986), found that higher educational level acted to decrease one's mental health status self-rating, to increase one's awareness of higher level needs and to broaden one's definition of health. Thus high symptom scores were more 'modern' and as such, defined mental health in terms of self-actualization or self-fulfillment. The degree to which these perceptions are determined by sociocultural definitions and the component attitudes toward mental health must be evaluated in order to adequately match the provision of services with the demand and need.

In surveying the health problems, practices and needs of youth, Sternlieb & Munan (1972), noted that nervousness, and anxiety over health were areas of major concern for young adults. Subjects in this survey rated scholastic problems as the most frequent concern, with family problems second, and sex and religious problems third and fourth in ranked frequency. An earlier study by Kirk (1973) had found significant gender differences; i.e. females who used the centre did so for career decisions, tended to come from families of a lower socio-economic status (SES), and were planning to work full time after graduation, whereas males reported greater personal anxiety and a greater frequency of family problems.

Indrisano (1978), found that the amount and intensity of difficulties was inversely related to age. Income was inversely related to difficulties

experienced and an inverse relationship existed between grade point average and level of concern. Study habits and grades were found to be by far the most important level of concern which matches Sternlieb and Munan's (1972) findings. Other high need areas that followed were depression difficulty, choosing a vocation, sleep difficulties, crisis situations and interpersonal skills.

Although medical and psychiatric help-seeking are often studied independently, it is clear that people who seek help often present a mixture of physical complaints and psychological problems which lends further complexity to the area. (Pennebaker & Skelton, 1978; Tessler & Mechanic, 1978).

Over the last decade, a large amount of research has dealt with sorting out the specific variables which will identify those persons who do not seek help. These tend to fall into two broad categories, personal variables and situational variables.

Research has consistently shown that people who seek medical care, dental care and psychological assistance, those who utilize social service facilities and legal facilities, or who join self-help groups tend to be well-educated, white, middle-class and female. (Fischer & Turner, 1970; Gottlieb, 1976; Gourash, 1978; Greenley & Mechanic, 1976; Kadushin 1969; McKinlay, 1972).

Veroff et al., (1981) in their American study, found especially high readiness for help-seeking in people from urban areas, residents of the Pacific American states, Jews, frequent church attenders, divorced men and women, and adults whose fathers were professionals. Continent of origin and cultural commitment are further factors which appear to influence help-seeking behaviour. (Dadfer & Friedlander, 1982; Sanchez & Atkinson, 1983).

With regard to gender differences, it has been found that females express more positive attitudes towards mental health needs than males, (De Paulo, 1982; Fischer & Turner, 1970; Indrisano, 1978) and are more likely to seek assistance. (Anderson & Anderson, 1972; Parcel, Nader & Myer, 1977;

Phillips & Segal, 1969; Sanchez & Atkinson, 1983). However an anomaly exists, for Amato and Bradshaw, (1985) found that females are more likely to report problem avoidance and denial than males.

A further important determinant of help-seeking behaviour is whether one also had prior contact with psychological professionals. (Dadfer & Friedlander, 1982; Fischer & Cohen, 1972; Fischer & Turner, 1970; Surgenor, 1985; Utz, 1983). It would appear that having been a client will foster more positive attitudes toward help-seeking, counselors and counseling.

Veroff et al. (1981), has offered three interpretations for the subgroups who are especially likely to seek professional help; they have experienced consistent social stress in their lives; they have a well developed psychological orientation, and they have reference group support for choosing professional help as a means of coping with stress.

An interesting study was done in 1967 by Cooke & Kiesler who were able to determine differences in personality 'abnormality' from counselled and non-counselled students. All incoming students routinely received the MMPI, (Minnesota Multiphasic Personality Inventory) and later comparisons indicated that counselled students had significantly higher total MMPI and neurotic tetrad mean scores than non-clients. Armstrong (1969) found no difference on levels of anxiety between two groups of subjects, but Indrisano (1978) found that A-State and A-Trait scores (State and Trait Anxiety Scores) were slightly higher for respondents who had not sought help versus respondents who had sought help. Perhaps the decision to seek professional help allows for an escalation in anxiety, which subsides once contact has been made with a psychological professional.

Other researchers however, are pessimistic about discriminating help-seekers by personality variables. (Berdie & Stein, 1966; Minge & Bowman, 1967). In comparing the characteristics of students who use and do not use university counselling facilities, a large number of researchers have found that in general, student's do not differ in terms of abilities, interests, family background or personality characteristics. (Berdie & Stein, 1966; Cooke & Kiesler, 1967; Minge & Bowman, 1967; Tessler & Schwartz, 1972). However

Campbell (1965) did find two significant differences; counselled students were more likely to be first-born children and to have been some-what more unhappy while growing up. The finding that help-seekers are more likely to be first-borns has not been replicated since that time, although research has indicated that there are more first-borns within the total university population. This is clearly a confounding factor in interpreting Campbell's research.

Recent research has suggested that personality variables may not be useful categories to measure behaviour. (Fancher & Gutkin, 1971). Currently, behaviour is seen in the main as situationally specific rather than an enduring intrapsychic individual trait over time. The reliability and validity of personality measures such as the MMPI is also a current area of concern. (Heller, Price, Reinharz, Riger, Wandersman & D'Aunno, 1984). Until this area is clarified then, it would seem reasonable to be cautious about interpreting research findings which deal with personality differences between the two help-seeking groups.

There are also other individual differences that have been found to predict help-seeking. These include sex-role ideology, (Wallston, 1976) self-esteem, (Tessler & Schwartz, 1972) achievement orientation, (Tessler & Schwartz, 1972) and non-verbal sensitivity, (De Paulo & Fisher, 1980).

Studies based on the concept of locus of control for reinforcement of behaviour (Rotter, 1966) have indicated that those with an external locus of control are less likely to seek therapy for personal problems. (Rubio & Lubin, 1986; Utz, 1983).

Research which has used clients actually receiving assistance at university counselling centres at the time of study has found that the students who were receiving help in a Reading and Study Skills Centre tended to have less academic potential than other students. (Berdie & Stein, 1966). They reported that the counselled females tended to have fewer social skills, were less social and had less social contacts. This finding was replicated by Bosmajian & Mattson, (1980). Gross, Fisher, Nadler, Stiglitz and Craig, (1979) also noted the relevance of self-acceptance scores for users of

counselling services. However, Stringham, (1969) found that those who did seek counselling were more verbally competent, and less in need of counselling than non-seekers. She did not however, expand on this point when reporting her longitudinal study. Research findings also indicate that denial and difficulty in identifying problems by a distressed person may further confound help-seeking behaviour. (Golan, 1969; Moore, Boling & Brown, 1963; Snyder & Kahne, 1969).

Attitudinal correlates of psychiatric help seeking include readiness to acknowledge one's need for help, interpersonal openness, and desire for feedback about oneself. (e.g. Fischer & Turner, 1970; Greenley & Mechanic, 1976). Utz (1983), found that attitude was a discriminatory variable for those who were vocationally indecisive; i.e. both help-seeking groups were indecisive, but those with more positive attitudes did seek help.

The perception of a possible help-source further influences help-seeking behaviour; i.e. the resource may be seen as incompetent, unavailable or unable to help for several reasons. (Bosmajian & Mattson, 1980); Mechanic, 1976; Utz, 1983).

In order to explore the assumption that differences in help-seeking are related to the severity or type of psychological distress, Greenley and Mechanic (1976) did a cross-sectional study and found that when psychological distress becomes particularly high, or when symptoms become bizarre and frightening, students are more likely to come directly or to be referred to psychological services. Also data from inpatient populations support the hypothesis that social selectivity is less when behaviour is bizarre, violent or otherwise frightening. (Mechanic, 1968).

However, Amato and Saunders, (1985) looked at instances of help-seeking among university students and found that several concerns were considered by students prior to help-seeking. They were concerned with the degree of seriousness of the problem and its potential threat to self-esteem, whether the helper was a friend or stranger, whether the helper was a professional or non-professional and the extent to which reciprocity could be maintained with the helper. With regard to these findings it was of interest that those

episodes that were perceived as being the most stigmatizing, embarrassing and intimate were also those that were seen as being the most serious and difficult to solve and were also the least likely to be taken to a professional for assistance with. Although this finding may appear to be counter intuitive, it is consistent with some clinically based research. (Calhoun & Selby, 1974; Calhoun, Dawes & Lewis, 1972).

Bosmajian and Mattson (1980), also found that perceived severity of help-seeker pathology was a significant discriminatory variable. Amato and Saunders (1985), suggest that the reason why a severely distressed person may not seek help is that high-need assistance is often more embarrassing, stigmatizing and difficult to ask for than low-need assistance and hence is more likely to make the receiving of assistance a less pleasant experience.

Although these research findings relating to the more extremely psychologically distressed would seem contradictory; (i.e. those individuals with problems that are more embarrassing and stigmatizing will not seek help whereas those individuals who have bizarre or frightening symptoms will seek help) an attempted explanation may be possible. Bizarre, uncontrollable or acting-out behaviour would come to the attention of others, who may negotiate to enable the individual to approach the mental health services. Whereas a problem that is embarrassing or particularly sensitive for the individual, may present only as internalized phenomena which is not apparent to others, therefore a help-seeking decision would rest entirely with that particular individual. However, the previous evidence presented would suggest that the seeking out of a psychological professional is not the only option that would be considered. For instance suicide may be considered as an alternative.

Situational variables are presented as a category within help-seeking, but it is clear that these cannot be considered in isolation as they will interact with both individual characteristics and interpersonal variables.

External constraints such as monetary cost, time factors and transportation difficulties may inhibit help-seeking behaviour. (Acosta, 1980). Veroff et al. (1981), found that the cost of care did not inhibit the use of

professional help in 1976 whereas there was a clear relationship between income and use of professional help in 1957. For student adolescent populations, the cost of care would not be relevant, as most universities provide counselling services either free or for a nominal fee for undergraduate students.

Alternate sources of help apart from professional services are of importance. (Bosmajian & Mattson, 1980; Gross et al., 1979; Snyder, Hill & Derkson, 1972). Gurin, et al., (1960) in their large study of 1,460 normal stable adults found that only a few of those who wish help actually select a mental health resource. Non-professional personal resources within the individual's social network were the preferred resource to deal with psychological difficulties.

To summarize, it would appear that the higher educated, white, female, more psychologically orientated person and those who have had a previous contact with mental health services, are more 'ready' to seek help for psychological problems from psychological professionals. This may indicate that mental health services attract a pre-selected population who already hold most off the values and orientations of the mental health professionals themselves.

It appears that much of the research on help-seeking is confounded by the fact that the non-help-seeking group are treated as a quantifiable whole. Yet it is reasonable to assume that there are individual differences among persons in this group and that these differences are important. Current research studies have tended to ignore these differences and there is clearly a need to develop adequate research paradigms and techniques in order to detect them. In the following chapters research on two variables which could contribute to the development of a more adequate conceptualization of help-seeking behaviour will be discussed. These are, attitudes to help-seeking and attributions about the causes of psychological problems.

### CHAPTER III.

#### ATTITUDES.

Professional use and definition of the term attitude range widely, from the operationally bound to the metaphorical, yet there appears to be one common characteristic: Attitude entails a predisposition to respond to social objects which, in interaction with situational and other dispositional variables, guides and directs the overt behaviour of the individual. (Cardno, 1955). Attitudes reflect either positive or negative stands and through them the individual is either for or against various situations and ideas which will influence behaviour. (Sherif & Sherif, 1969).

A common view of attitudes is that they have three components; cognitive, affective and behavioral. However, there is still disagreement about whether such a breakdown is either necessary or useful. (Oskamp, 1977) Attitudes are learned - that much is agreed upon by all authorities. However the processes of attitude formation, and the factors which are most important in the development of attitudes, are still subjects of dispute. (Oskamp, 1977).

There are a variety of factors which can operate in the acquisition of attitudes. The most fundamental factor in attitude formation is direct personal experience, either in salient incidents or in repeated exposure over time. (Zajonc, 1968). Parental influence is very great in forming the child's early attitudes. (McGuire, 1969). Group determinants are schools, peer groups, conformity pressures in general, (Pettigrew, 1971) and reference groups (Coleman, 1980) become more important as the child grows older.

Finally, the mass media not only provide much of our information, but also help to form our attitudes by highlighting particular events and interpreting the nature of reality to us. (Lang & Lang, 1959). However there is a paradox. Nunnally (1961) notes that the ideas about mental health portrayed in the mass media are less 'correct' in comparison to expert

opinion than are the beliefs of the public at large. Perhaps then, the public is able to discriminate between 'valid' information and unrealistic portrayals.

There are many learning processes by which attitude formation may occur; classical conditioning, (Weiss, 1968; Zanna, Kiesler & Pilkonis, 1970) stimulus generalization, (Bem, 1970), instrumental conditioning, (Weiss, 1968), and selective learning, (Weiss, 1968) all processes which rely on the effects of reinforcement. Imitation or modelling of attitudes, on the other hand, often occurs without any reinforcement nor any explicit instruction. (Bandura, 1965; Berkowitz, 1972).

Since the 1940's, research on attitudes toward mental illness held by the public, by mental health professionals and by psychiatric patients and their families has been substantial. Simply, prior research has shown that the label 'mental illness' has negative connotations which, when attached to an individual, results in rejection of and for that person. More specific evidence has indicated that the public has been less quick to label odd or deviant behaviour as mental illness than those employed in the mental health field. (Weiss, 1985). However, once this label is assigned by the community or professionals, societal response is characteristically negative and rejecting. The label of mental illness usually leads to stigma with irreversibly diminished standing in the community, a circumstance which exacerbates whatever problems of adjustment were present. (Rabkin, 1972).

Sarbin and Mancuso (1970), critically analyzed published reports on the public's attitudes toward mental illness. They note that the central objective of the mental health movement has been to influence the general public to regard mental illness with the same non-rejecting valuations as somatic illness. However, the conclusion drawn is that the public tends to declare negative (rejecting) valuations on persons diagnosed as mentally ill. That result is echoed in Nunnally's (1961) statement; i.e. psychologically orientated professionals seek to say that the 'man in the street' is callous, inhumane and unliberal and resorts to defense mechanisms such as denial.

Levine (1972) has suggested that attitudes toward mental illness reflect the wider social-political structure of a country and are part of a person's

general orientation to social issues, rather than a narrow function of his or her concept of mental illness. For example, in a community climate characterized by an authoritarian structure, one would then expect to find authoritarian and socially restrictive attitudes toward the mentally ill.

This issue was explored by Rabkin (1974), who, in her review of public attitudes toward mental illness, noted that these attitudes include several components, some of which are a function of relatively enduring personality traits such as authoritarianism while others are related to more accessible dimensions such as educational exposure. Mental health campaigns are apt to influence only those attitudinal components associated with information level, such as beliefs about psychiatric etiologies, and have little effect on those attitudes associated with underlying personality characteristics.

Barten and Bellak (1972), in noting that attitudes are important in investigations in the mental health field, emphasized how public attitudes largely determine public policy which then affects the quality and efficacy of any programs directed at change within the wider community. In order to initiate and sustain a humanistic and tolerant approach toward the mentally distressed, Mangum and Mitchell (1973), claim that mental health attitudes must be enlightened and shared by both key professional and citizen groups who are drawn from and reflect the attitudes held by the wider public.

The study of attitude change and whether this occurs through time and exposure or by deliberate experimental procedures has been a rich area of study and concern. (Cook & Flay, 1978; Eagly & Himmelfarb, 1978). As attitudes include beliefs, values, feelings and overt behaviour any observed change in one may not necessarily imply or involve a corresponding change in another attitudinal component. (Cook & Flay, 1978).

Green, Walkey, Taylor and McCormick (1987), in investigating the mental health attitudes of New Zealand university students found that this type of population had continued to maintain negative stereotypes of the mentally ill over time. They suggest that this is due to an 'entrenchment of traditional attitudes' which is highly resistant to change. This substantiates Nunnally's (1961) and Olmsted & Durham's (1976) earlier findings, that traditional

attitudes are firmly anchored in a cultural belief system. These attitudes are effectively transmitted from one generation to the next and are not very susceptible to modification by 'external' forces, such as educational or promotional campaigns by experts.

Nunnally's (1961), survey of public attitudes towards mental health professionals and treatment shows that although the public holds moderately high favorable attitudes towards psychologists, psychiatrists and other 'mental' specialists, it holds much more favorable attitudes toward 'physical' treatment specialists such as physicians and nurses. While the public makes a clear distinction between doctor and psychiatrist, it does not make connotative distinctions among the sub-professions in the mental health field (e.g. psychiatry, psychoanalysis, clinical psychologist, experimental psychologist). Evidently they attribute a common meaning to all professional titles prefixed by the morpheme 'psych-' which also connotes some of the characteristics of the mentally ill.

Nunnally's results also indicate that what is 'wrong' with public attitudes is not so much a degrading of the mental health professionals as a degrading and distrust of treatment methods and institutions. When this finding is coupled with the fact that treatment methods and institutions are presently not as effective as one would like, (Szasz, 1961), the inevitable conclusion is that public attitudes are not really so irrational after all.

With regard to help-seeking, Parish and Kappes (1979), supported Phillips (1963), finding that people's attitudes are generally very negative toward anyone who seeks psychological services. They found that undergraduates negatively evaluated anyone seeking counselling.

Lehtinen and Vaisanen (1978), found that subjects who were assessed as being in need of psychological help, displayed more negative attitudes towards mental illness than those who were mentally healthy. Calhoun and colleagues (Calhoun et al., 1972; Calhoun & Selby, 1974) determined that individuals with more severe psychological disturbances, whether self-perceived, role played, or psychometrically assessed, maintained a more negative set toward professional assistance; (i.e. had the most negative help-

seeking attitudes). Because of this negative attitude, Rust and Davie (1961), suggest that individuals are likely to discount their level of distress, and conclude that their problems are not serious enough for professional help.

It has been reported that attitudes have a significant positive influence on the perceived expertise of counsellors. This includes perceptions of trustworthiness, regard, empathy, genuineness, and general helpfulness, on a subjects' expected willingness to return for a second interview and on their expectancies of improvement across a variety of personal problems. (Cash, Kehr & Salzbach, 1978).

Gender related issues are an important variable in research on attitudes to mental health. For example males are rejected more strongly by the wider public than are females when exhibiting pathological behaviour. (Phillips, 1969). For girls in this society, a stronger interpersonal orientation is expected, and the capacity for intimacy and dependency are not only acceptable but highly valued. There is little doubt that the processes of socialization all tend in this direction. For boys however, the stress is placed on skills, achievement and self-sufficiency. (Coleman, 1974; Douvan & Adelson 1966).

Gender has been found to be consistently related to help-seeking, with females having more favorable attitudes than males. (De Paulo, 1982). Female undergraduates who had prior contact with psychological professionals were reported to have more favorable attitudes, (including greater recognition of need, stigma tolerance, interpersonal openness and confidence in mental health professionals) than those individuals who had no such prior contact. (Cash, et al., 1978). There were no significant differences between the two types of contact groups for the male subject population.

Methodological issues are of prime importance for any discussion of attitudes. Many attitudes possess intangibles as their referents and these intangibles are often highly theoretical abstract constructs which cannot be operationally defined. Because of this difficulty in obtaining an adequate definition of the referent, some attitude scales can be unsatisfactory with regard to their functional characteristics. (Shaw & Wright, 1967).

It is also clear that our conception of attitude is implicit in the techniques of attitude measurement. The most frequently used methods of measuring attitude (e.g. Guttman, 1944; Likert, 1932; Thurstone, 1929, 1931) require subjects to indicate their agreement or disagreement with a set of statements about the attitude object. Generally, these statements attribute to the object, characteristics that are positively or negatively evaluated and rarely neutral. This would suggest then that these scales only measure the positivity and negativity of the affective reaction of attitudes.

Therefore, an inferential leap is made on the assumption that the evaluations of the persons involved in scale construction correspond to those of the individuals whose attitudes are being measured. Allport (1935) phrased the situation perhaps more clearly; that is, how does one know that attitudes exist at all? Only by necessary inference.

Methodological problems with regard to attitude are of particular relevance in using adolescent populations. First there is the problem of being able to get close enough to the young person's subjective personal world so as to circumvent the possibility that responses to a questionnaire will simply reflect what he or she considers to be socially acceptable answers. Another problem which cannot be ignored concerns the developmental nature of the adolescent. This is not a static but a dynamic period in the life cycle; the young person is growing and changing throughout this stage and the design of any research project needs to take this fact into account and to evaluate conclusions drawn in the light of it.

The problem of validation is important in attitudinal scales, particularly predictive validity (with regard to future behaviour). A well known formula for the analysis of any form of behaviour is  $B = f(P.E.)$ . (Lewin, 1936). In words; behaviour is a function of the interaction between P (all the person's inner determinants, such as temperament, attitudes or character traits) and E (all the environmental factors, as perceived by the individual). When one has full knowledge of all but one part of the formula, one should be able to predict the variable that is not known.

This model is simplistic and open to criticism on a number of counts. First of all, B (behaviour) has a complex relationship with its inner determinants because of the influence of environmental factors (which may be differently perceived by different individuals). Therefore one cannot use it as a measure or index of such inner determinants. One cannot accurately infer attitudes from behaviour unless one has full knowledge of the effects of environmental determinants also. Furthermore, one cannot expect a direct predictor of overt behaviour merely from inferences about one inner determinant based on scores on an attitude scale. Behaviour is subject to many variables and behaviour may be a compromise, a resultant of the interaction of multiple forces.

In all types of research limits are imposed by measurement techniques. Any knowledge gained in research is constrained by the types and form of questions asked. Whole features of a problem may go unexamined simply because no questions were asked about them, while other features may receive excessive attention. These points seem to be particularly relevant in evaluating the literature on attitudes. For example, constraints on the depth of response, such as limiting response options to precoded categories, affect what and how much can be reported. Without such constraints, a person might list for example, an unwieldy number of people as members of her or her social network when asked for non-professional help-resources. Clearly only a compromise can be achieved. The investigator must impose a framework that organizes information and prompts the respondent for important and relevant information.

Rabkin (1974), states that because attitudes and behavioral influences are multidimensional, any investigations into this area requires a multivariate research design. Within this research area, not only do several factors usually operate simultaneously, but their interactions are often as powerful as their separate effects. 'Simple calculations of percentage of agree and disagree responses to various attitude measures hardly do justice to the task at hand, and in fact may produce misleading and dubious results'. (Rabkin, 1974, p. 29).

The literature reviewed in this section would appear to suggest that the wider public, which includes the late adolescent population, hold not only negative attitudes toward the mentally ill, but less positive attitudes toward the psychological professions as well. This bias may help to explain not only why an individual who seeks a professional resource to deal with a psychological problem is devalued, but also some of the difficulties that a potential help-seeker would have in dealing with this decision. An individual in need of help, who mirrors the entrenched negative attitudes of the wider society, would seem to be placed in an unenviable position.

In summary the research on attitudes to mental health and help-seeking suggests that negative attitudes towards both are still quite widespread in Western culture. Some useful indicators as to the characteristics of individuals and groups who hold these attitudes can also be extrapolated from the literature. However, as much of this research is the result of a compromise between research necessity and the theoretical and methodological problems reviewed above, the whole domain remains somewhat nebulous and difficult to measure and quantify. A closely related field of study that is concerned with the way people make judgments and attributions about events may provide an additional perspective for the present study. Selected literature from this domain will be reviewed in the following section.

## CHAPTER IV.

### ATTRIBUTIONS.

Attribution theories were conceptualized by Heider (1958), Jones and Davis (1965), and Kelley (1967), and these have provided a frame of reference to understand how people make judgments about the causes of events. Causes of events generally are perceived as located either as internal (dispositional, i.e. relate to the individual) or external (situational, i.e. relate to the environment) attributions. According to these theories, attributions are based on information from two sources; relevant expectations that individuals bring to a situation and information contributed by the particular conditions of the interaction.

Rotter (1966), also articulated a one-dimensional internal-external classification for the causality of events. Rotter labeled this dimension, locus of control, which is not to be confused with attribution theory as formulated by the above theorists which is primarily concerned with person-perception, or inferences about the intentions and dispositions of others or oneself. Therefore, the terms that will be used within this discussion, i.e. external and internal, relate to causal attribution only, not locus of control.

Attribution theory further stipulates that there are three kinds of information (i.e. distinctiveness, consistency and consensus) that, when present in varying degrees, facilitates one causal attribution over another. (Kelley, 1967). An internal attribution results when behaviour is characterized by low distinctiveness, low consensus and high consistency, whereas an external attribution is made when behaviour reflects high distinctiveness, high consensus and high consistency.

Kelley's (1967), attribution formulation is also relevant to help-seeking. Tessler and Schwartz (1972), examined the effects of consensus information of help-seeking behaviour. In line with the causal attribution theory, they

reasoned that, other things being equal, if consensus is high (i.e. many people need help on a similar task) the need for help should be attributed externally and if consensus is low (i.e. few people need help on a similar task) it should be attributed internally. The results of their study supported this analysis. However, Nadler and Porat (1978), when using the same attribution manipulation, found that it affected help-seeking only when individuals remained anonymous. When identifiable, all subjects refrained from seeking help regardless of the consensus information.

These attributional inferences may be quite retrospective, summarize a number of experiences, take place below a level of immediate awareness, and be intimately tied with self-esteem and self-concept. (Weiner, 1979). The process of the interpretation of facts (of the cognitive construction of reality) necessitates inference, which can take the form of the attribution of motives and characteristics. Perspectives are determined by prior individual learning experience, beliefs, motives and self-interests which may be a function of one's particular role within the wider society. Many human acts are determined more by situations than dispositions and by the limited number of alternatives available to the actor. A central assumption of attribution theory, is that the search for understanding is the (or a) basic 'spring of action'. (Weiner, 1979).

Mechanic (1979), suggests that although many factors may contribute to personal suffering, the perception and expression of that pain is molded by meanings people learn to assign to inner feeling states and the extent to which they focus on them and monitor them. In predicting psychological distress in 1977 on the basis of 1961 measures, Mechanic tentatively supported the conclusion that factors that focus the child's attention on internal states and that teach a pattern of monitoring contribute to a distress symptom in adult life.

For example, respondents with distress syndromes were more likely to come from families in which the mother had been more upset and symptomatic, the child had more physical symptoms, and attention had been directed to such symptoms by keeping the child home from school. (Mechanic, 1979). Moreover, the data did not support the hypothesis that

adulthood distress syndromes form simply from a continuous pattern of illness from childhood to young adulthood. Although learned internal monitoring appears to be an important aspect of psychological distress, whether or not such distress actually develops depends on many other factors as well, such as the degree of psychological and bodily dysfunction, adverse life experiences and influences that reinforce a focus on internal feeling states. (Mechanic, 1980).

Heider's (1958), balance theory of attribution states that people with a positive view about their achievement capabilities tend to view success as a function of internal, personal characteristics and failure as a function of external, situational factors. In contrast, individuals with a negative view of their achievement capabilities tend to view success as being more externally caused and failure as more internally caused. Markus (1977), also notes that the development of a positive or negative view about one's social skills can be based on repeated observations of one's own patterns of social behaviour over time, which yields a fairly stable framework for making inferences about the causes of social interactions.

However, this does not allow one to make judgments about the accuracy of the causal attributions held by any one individual. If there was an initial erroneous perception of the cause of one's difficulties, any stability factor would then suggest that the original attribution would hold over time which would perhaps lead to a distortion of reality.

Weiner, Russell and Lerman (1978), suggest that there is a relation between attributions and emotions. They found that the affects of depression, apathy and resignation were reported primarily by those who gave internal and stable attributions for failure (lack of ability, lack of typical effort, and personality deficit). This suggests that only attributions conveying that events will not change in the future, would beget feelings of helplessness, giving up and depression.

Attribution theory, as developed by Jones and Davis (1965), and Kelley (1967), suggests that the potential for threat to self-esteem inherent in an act of seeking help is directly related to whether the person attributes

responsibility for his or her failure and hence for his/her need for help to him or herself. Attributions of personal responsibility for failure is most likely to occur in the absence of external justifications for failure.

This self-attribution for failure is experienced as reflecting personal inadequacies. Therefore the act of seeking help with these conditions has the symbolic significance of affirming that one is indeed possessed with the inadequacies implied by one's poor performance. Central attributes are functionally linked with many aspects of one's self-concept such as social adjustment and mental health, (Tessler & Schwartz, 1972) while peripheral attributes are loosely tied to other aspects of the self, (Miller, 1961) which are less threatening.

Therefore an attribution of failure to external causes or a down grading of the centrality of the implicated attributes would reduce the symbolic threat inherent in seeking help. Tessler and Schwartz (1972), however put forward the caution that for those strongly motivated to achieve on their own, efforts to persuade them that seeking help does not constitute an admission of failure may be in order.

Regarding how those already in treatment see their problems, Calhoun et al., (1972), found that only a small minority of adult outpatients at a university psychology clinic saw their problem as due to external causes, with the majority indicating that their problem was internal therefore making a dispositional, internal attribution. Veroff et al., (1981), notes that therapists often train their clients to see problems in personal adjustment terms perhaps fostering internal attributions which suggests that clients can in fact learn to label their problem as internally caused. Mechanic (1979), found that the reporting of psychological distress by young adults is a learned pattern of illness behaviour involving a focus on internal feeling states, careful monitoring of body sensations, and a high level of self awareness.

Attribution theory has been used in the investigation of the perceived causes of psychological problems, (House, 1981), and the planning of treatment for behavioral disorders, (de Charms, 1968; Deci, 1975; Goldfried,

1971). It has also been used by professionals to discriminate help-seekers from those who do not, and to increase the probability of help-seeking for psychological problems. (Tessler & Schwartz, 1972).

As noted above, attribution theory has provided a framework for investigating the perceived causes of psychological problems. Prior research has demonstrated that problems perceived as caused by internal factors are defined by both patient and non-patient populations as more severe and of longer duration than problems perceived as caused by external factors. (Calhoun, Peirce & Dawes, 1973; Calhoun, Peirce, Walters & Dawes, 1974; Calhoun, Johnson & Boardman, 1975). However, House (1981), found that higher external attribution ratings were associated with higher ratings of perceived severity which suggests that those seeking help may also perceive their problems as partly caused by external factors. House explained these contradictory findings by stating that is the higher attribution score, whether internal or external, which will explain the ratings of problem severity. However, the strong emphasis in the literature on internal attributions and severity may be partially an artifact of the particular measuring instruments used within the investigations. The reported findings also suggest that attribution theory may account for only a small portion of the variance of causal attributions for psychological difficulties and that supplementation by other concepts may be necessary.

This review of the literature on attribution would seem to indicate that attributions about the causes of one's difficulties are due to personal inferences or assumptions made by the individual. Attributions, whether internal or external, can affect one's mental health and possibly the perseveration of some of life's difficulties. Research has indicated that those who are already clients within the mental health care system tend to hold internal attributions about the causes of psychological problems, yet it has been suggested that a more functional approach could be one that involves external attributions or a combination of the two types which would allow for a more realistic perception of reality.

It has been indicated in this discussion that mental health professionals may influence the type of attribution held by the individual. An

investigation of those help-sources which are available to the distressed late adolescent undergraduate population could be useful in clarifying this issue. This will be discussed in the following section with the main focus on professional psychological services.

## CHAPTER V.

### HELP-SOURCE.

Help resources will be described as help-source; i.e. the range of helpers, either within a formal mental health service or informally within a community, available for an individual who is experiencing psychological difficulties.

With regard to the utilization of health services, McKinlay (1972), suggests that there is a need for a number of hypotheses-generating, small-scale exploratory studies in an inductive vein to tease out the various variables that are relevant to this area of concern. McKinlay also made a recommendation for survey studies to be explicitly concerned with the investigation of the utilization behaviour of identifiable groups in relation to particular services.

This suggestion has been supported by Wolinsky (1978), who assessed the effects of predisposing, enabling and illness-morbidity characteristics on health service utilization; by using standardized regression coefficients he found that these characteristics are substantially unrelated to health service utilization. He suggests that various alternative paradigms need to be explored before a causal model can be introduced and verified. Measures need to be taken of attitudes, values and delivery system characteristics as they may be statistically interactive with those predisposing, enabling and illness morbidity factors.

It would be valuable to know whether, and to what extent, certain client definitions and typifications of agencies are specific to certain types of organization and delivery, or specific to a certain area of activity regardless of organizational type. However, before looking at formal mental health services, informal help-sources within the adolescent's social network are of importance and need to be explored.

### INFORMAL HELP-SOURCES.

Within this area an initial look at an individual's ability to provide personal resources to a psychological problem would seem to be in order. For example, in looking at social-psychological processes in informal help-seeking, De Paulo (1982), noted that individuals seemed to hesitate to seek help when they felt that they should be able to succeed on their own.

However, Veroff and colleagues (1981), in repeating a study carried out 20 years earlier found that the proportion of responses to self-help alternatives for dealing with psychological problems declined from 44% to 34%. They suggested that those respondents who checked the self-help option either possessed great personal resources or had powerful denial patterns. These authors also noted that any distress about work was likely to stimulate thoughts of self-help. Alternatively, if there was a clear option to leave the situation which had induced the distress, people would often take that option thus side-stepping professional help.

It is also reasonable to assume that those individuals who do choose to help themselves may have been members of a social milieu so supportive that they felt able to manage with the personal and informal resources available to them. Therefore, it now seems appropriate to investigate those informal help-sources within the social environment which are available to an individual in distress.

A substantial body of research links the presence of supportive interpersonal relationships with successful resolution of stressful experiences and with overall psychological well-being, (for reviews see Cobb, 1976; Heller, 1979; Kahn & Antonucci, 1980; Mechanic, 1976; Silver & Wortman, 1980). In fact the absence of social ties has been linked to mortality. (Berkman & Syme, 1979; Durkheim, 1957).

Heller (1979), notes however, that there is no clear evidence that social support does actually reduce distress. Also Veroff et al. (1981), in reinterpreting research that linked social support to reduced distress, found that those people whose distress could be easily managed are also people

who readily enlisted social support. Thus those who receive social support may be better at coping.

A number of researchers have tried to tease out those aspects within supportive relationships which may be responsible for a decrease in an individual's distress. Veroff and colleagues (1981), found that the dominant mode for coping in American society was talking to someone about troubles and concerns. However, 'talking' is a broad term and various attempts have been made to clarify specific components within a verbal helping social interaction. For example Cobb (1976), has identified emotional support, such as feeling loved and cared for, and esteem support as important contributions to a sense of worth. Kahn and Antonucci, (1980) classify support as affect (similar to Cobb's definition of emotional support), aid (which may be advice, information, or direct intervention in problem solving) and affirmation, (contribution to the individual's sense that he or she is interpreting events correctly).

Dunkel-Schetter and Wortman (1981) identified two important components within social interaction. These are ventilation; i.e. the opportunity to express feelings fully, and validation, which is similar to Kahn and Antonucci's (1980), affirmation. Definitions of social support by Caplan (1974), and Caplan and Killilea (1976), also include validation and feedback as components. These authors also see need fulfillment and reciprocity as important aspects of social support.

This above review of social interaction has indicated that there are important processes within helping social interactions which may be of benefit to an individual in distress. It would seem appropriate now to specify those informal help-sources who may have those respective skills.

It has been found that college students, when experiencing some type of problem, consulted friends first, parents second, with professional help agents decreasing in terms of frequency of contact. (Amato & Bradshaw, 1985; Cowen, 1982; Snyder et al., 1972). De Paulo (1978), also reported that many respondents preferred seeking help from close friends as opposed to others, and clinical research indicates that people usually take their problems

to friends and family members before going to professionals. (Mechanic, 1976).

With regard to adolescence, friends, companions and peers are generally considered to play an especially important role in the development of the young person. Coleman (1980), gives a number of reasons for this, firstly, in the process of disengagement from parents and from the family setting, an emotional gap is left. To fill this gap, in the majority of cases, a young person will turn for support to their peer group. A second reason, is that common experience creates bonds between people. Thus the adolescents reliance on friends and peers is strengthened by the fact that conflicts, anxieties and difficulties can be shared with others and often thereby resolved as a result of mutual sympathy and understanding.

A third reason is the vulnerability experienced by many during this stage of their lives, where individuals are lacking in self-confidence, uncertain of their own capabilities, and are required to adjust to major changes. Since it is precisely at this point in time that young people feel least able to turn to their parents, (Coleman, 1980), it is hardly surprising to find peers occupying a position of central importance.

Amato and Saunders (1985), reported that certain subjects in a study preferred seeking help from strangers (as opposed to friends). This may be related to the fact that many people find it easier to self-disclose to strangers than to friends. (Derlega & Chaikin, 1977). Yet Shapiro (1980) found that help-seeking is more frequent between friends than strangers. Perhaps friends are relatively unaffected by temporary imbalances in their relationship since they have continuing exchanges and their past histories are generally equitable. (Weinstein, De Vaughn & Wiley, 1969).

Studies of student housing complexes have found that next-door neighbors are chosen most often as friends and that friendship choices decline rapidly with increasing distance. (Moos & Mitchell, 1982). Also, social network density was associated with more support being available from peers for students dealing with the stress of exams. (Hirsch, 1980).

A study by Brown (1978) suggested that there is a relationship between negative views concerning help-seeking and personal and social resources. Drawing from a longitudinal survey of adults, Brown focused on differences between persons who sought help from informal or formal support systems in response to troublesome life changes and those who handled problems without seeking assistance. Persons who did not seek help were classified into two groups; the self-reliant, who thought they could manage without help and the reluctant non-seekers who felt no effective help was available. Reluctant non-seekers reported the lowest self-esteem and least effective coping repertoire, had comparatively unreliable informal networks and strong reservations about discussing their problems with others. Moos and Mitchell (1982), suggests that the failure of such individuals to maintain network ties probably results in a lack of network support during times of crisis and this confirms their negative view of help-seeking.

Mechanic and Greenley (1976), found that those students who were distressed either had fewer close friends, or else had identified with introspective students and joined them in the discussion of the problem. This may lend support to the thesis that there are 'psychological cultures' within a community that may increase the propensity of persons to focus on intrapsychic states; this could either heighten psychological distress or the inclination to report it. That notion is consistent with Kadushin's (1966), concept of the social circle and the 'friends and supporters of psychotherapy'.

Informal help may also be a significant factor in explaining why, in studies of psychotherapy outcome, there is a surprising amount of improvement in control groups. (Luborsky, Singer & Luborsky, 1975; Strupp & Hadley, 1979). Also studies of 'spontaneous remission' show a notable rate of improvement of psychological distress in untreated samples. (Lambert, 1976).

Antonucci and Depner (1982), identified the number of satisfying interpersonal relationships as a strong predictor of psychological well-being, and increased social support was associated with higher levels of both life

satisfaction and happiness. Although this relationship was true for both males and females, the finding was stronger for females than males.

Hess (1979), has noted that whereas social networks for males seem to be large and diffuse, the networks of females are smaller and more intense. Other research reports that males are inclined to be autonomous and not to admit to vulnerability. (Veroff et al., 1981). Research has also shown that males tend to rely on one key relationship, usually their relationship with their sexual partner, as the source of confiding and as the nexus of the fuller range of social relationships. (Komarovsky, 1974).

One cannot say however that friendship is more or less important for one or other of the sexes. What is clear from the research is that females express more anxiety about this relationship. (Coleman, 1974; Douvan & Adelson, 1966). It could be suggested that the differing socialization process, as well as the high value which is placed on intimacy and dependency for females (Gilligan 1982), are explanations for this discrepancy between males and females.

Other studies indicate that the quality and quantity of available support varies considerably across individuals. (Amato & Saunders, 1985; Heller, Price, Reinharz, Riger, Wandersman & D'Aunno, 1984). There is also literature that suggests that there is considerable variation in dispositional needs for social support. (Antonovsky, 1979; Green, 1975; Hinkle, 1974). Further, even if social relationships are a major source of an individual's personal gratification, it does not necessarily follow that a particular individual will adopt a coping style that emphasizes a reliance on interpersonal resources. For example Heller, (1979) reports that social support may be an integral part of the individual's coping style or it may be completely incompatible with long-term mechanisms of coping by defenses such as denial.

Finally, circumstances dictate whether social support would be a reasonable or an efficient means of addressing certain problems. Dunkel-Schetter and Wortman (1981) observe that some circumstances (e.g. terminal illness or bizarre behaviour) are likely to frighten off potential supporters

because they may feel vulnerable to the same fate and/or incapable of solving the problem.

In summarizing this section, it would appear that physical proximity is an important factor in providing a social network for the resident university student. Gender differences for relating with others are apparent with females having more intensity in their social relationships with males more distant and autonomous. Talking would seem to be more than just a verbalization of concerns and the components which were outlined would appear to be amplified in a proportion of students; i.e. the more 'psychologically minded'. However, an individual's coping style for psychological difficulties may not include the choice to tap into informal help-sources, or the problem may itself be of significant magnitude to preclude the attention of others, therefore a further option that is available to the adolescent undergraduate needs to be explored.

#### FORMAL HELP-SOURCES.

Greenley and Mechanic (1976), report that attention needs to be given to younger undergraduate students at University and to the problems of psycho-social adjustment that they face, as this group has been found to be the most vulnerable within the larger student population. The main professional formal help-sources available for adolescent undergraduate students are counselling services and these will be the central focus for this discussion.

Counselling centres within university settings are designed specifically to encourage young people, often hesitant or skeptical, to make use of adult resources. In order to do this, these services are usually situated in an acceptable place away from an institutional framework. They may stay open at weekends and evenings, and perhaps most important, they do not require the young person to have an appointment in order to be seen by the counsellor.

Carney, Savitz and Weiskott (1979), found that students were most likely to participate within a university counselling service if workshops assisted

them in career planning, negotiating the university system, and coping with financial and academic concerns. Professional assistance was less likely to be sought for personal-social concerns however as this was seen as a sign of weakness, especially for males. Overall, those most receptive to counseling services tended to be younger and undergraduate, to have lower grade point averages, and to live in a residence hall.

Greenley and Mechanic (1976), in looking at the role of social selection in seeking help for psychological problems, found that female university students were over-represented in all formal health care agencies. They state that the sex differences cannot be explained in terms of other socio-demographic characteristics, attitudes or levels of distress, despite the fact that women report higher levels of distress than men.

It may be that women find it more acceptable to assume dependent relationships required by helping relationships and that they have less of a cultural need to appear stoical. (Greenley & Mechanic, 1976). As noted previously, the socialization of women may encourage a pattern of values and behaviour consistent with accepting dependency more readily, and sex differences in the expression of feelings and complaints are apparent at an early age. (Gilligan, 1982; Mechanic, 1964).

Gelso and Karl (1974), in exploring student perceptions of counsellors and other help-givers found that undergraduates were more likely to discuss difficult relations with family, problems in getting along with friends, uncomfortable feelings and emotions, and problems in sexual adjustment with psychiatrists rather than with counsellors. However, they point out that there is a problem with the generic term, 'counsellor' as counsellors and counselling psychologists are labels or titles that are used interchangeably.

Gelso and Karl (1974) note that there is a need to inform the public that counselling services incorporate counselling psychologists or clinical psychologists in order to increase the likelihood that students will seek help for personal problems from these centers. This may be of concern for the professionals only however, for at this stage, further research is needed in order to establish just what adolescent perceptions of these services are.

For example, whether counselling centres, psychologists and psychiatrists are perceived as different from each other by potential clients.

The issue of how the attitudes and attributions of the professionals themselves affect the help-seeker both before and after they have contacted a therapist is important. The literature suggests that those who have had prior contact with psychological professionals will not only have more positive mental health attitudes but will be less reluctant to attend psychological services. Further exploration of this area is clearly indicated.

With regard to client expectations for counselling, Tinsley and Harris (1976), found the strongest expectations of student respondents in their study were to see an experienced, genuine, expert and accepting counsellor they could trust. Expectancies that the counsellor would be understanding and directive were somewhat lower.

Calhoun and colleagues (1974), focused on the possible social rejection of a help-seeker by others as a consequence of their efforts to seek assistance and found that less rejection occurred and less mental illness was attributed to help-seeking when the problem was described as externally caused than when it was internally caused. This finding was valid for a working class population. However, it may not be valid for the more 'psychologically minded' middle and upper class persons, who tend to see internally caused problems as those which are the most appropriate for professional help-seeking. (Fancher & Gutkin, 1971; Sarbin & Mancuso, 1970).

Cash, Kehr and Salzbach (1978), make the point that counsellors might usefully examine the predictive potential of clients help-seeking attitudes not only in relation to premature termination of treatment, but also as indicators of potential sources of resistance and of perceptual distortions of counsellor behaviour. Other studies (Baekeland & Lundwall, 1975; Duehn & Proctor, 1977; Duckro, Beal & George, 1979; Rosen & Wish, 1980) report that the behaviours, treatment approaches and attitudes of some therapists may be critical variables for explaining high drop-out rates.

Wills (1978), in reviewing the literature with regard to the perception of clients by psychological professionals, found an overall positive bias towards internal attributions. That is, a personalistic tendency to attribute behaviour to personality characteristics thereby minimizing the contribution of situational factors. Research findings suggest that clients who blame others for their difficulties are not expected to be helped by counselling, whereas acceptance of responsibility seems to be related to continuation in treatment and more favorable outcomes. (Pierce & Schauble, 1970). Therefore a client who accepts responsibility is seen as more committed to change than one who denies responsibility. Virtually every theory of individual counselling postulates that change occurs within the person and psychological health seems to be equated with acceptance of responsibility for maladaptive behaviour. Schwartz, Friedlander & Tedeschi (1986), report wide support for this statement in the literature.

Attribution theory may provide an explanation for this finding. Theorists have long been aware (Heider, 1958; Jones & Davis, 1965) that not all inferences concern causes. Indeed the most important attribution made about a client's problem by a helper seems to be a locus attribution rather than a causal one. (Bateson, O'Quin & Pych, 1982). At the most general level, the counselor's locus attribution involves a dichotomous choice - dispositional versus situational. For a given problem, the helper's most basic attribution is to decide whether the problem lies within the client (a dispositional attribution) or with the client's physical and social environment (a situational attribution). There is also a third possibility, that the problem is collective; i.e. the client reacting to a particularly difficult situation (an interactional attribution) however this type of attribution is made rarely by professionals in practice. (Bateson et al., 1982).

It is also relevant to assess the tendency for a dispositional bias to creep into logical inference actor-observer differences. It is argued that while each person tends to see their own behaviour as the result of situational (external) factors, observers who view this same behaviour are more likely to attribute it to dispositional (internal) factors. (Jones, 1976). Perhaps psychological professionals are not immune to committing this fundamental attribution error (Ross, 1977), with regard to a client's behaviour.

Client attributions themselves also seem to be biased, tending toward a dispositional inference. (Calhoun et al., 1972). This raises a number of questions that deserve attention. Do clients really perceive their problems dispositionally, or do they say they do because that is the response they think the helper wants to hear; or does this bias exist because our language emphasizes personalistic descriptions of problems? Could the very term 'problem' evoke dispositional attributions? If so, a dispositional bias may exist at a far more fundamental level than so far suspected. (Laing, 1967; Langer & Abelson, 1974; Rosenham, 1975). Rather than a bias on the part of trained helpers, it may pervade our entire way of thinking about people in need in our culture. (Bateson et al., 1982).

This short review on the formal help-sources available to adolescent undergraduates suggests that female students form the larger proportion of a student clientele at university counselling services. It also suggests that those who have had prior contact with psychological services will readily avail themselves of formal services. The reason that these two groups are more likely to utilise formal help-sources may be related to the attitudes and attributions held by the professionals who tend to make dispositional/internal attributions when working within the mental health services.

To summarize, it would appear that both informal and formal help-sources are utilized by this specific population, but with some preferences indicated by particular sub-groups within this population; i.e. females and those who have had prior contact with professionals show a preference for help-seeking from formal help-sources. It was suggested that there may be a relationship between the attributions made by professionals for psychological problems and the types of clients prepared to utilize their services. This hypothesized relationship cannot be established, however, until the attitudes and attributions held by potential help-seekers are clearly identified and confirmed by more definitive research.

## CHAPTER VI.

### THE PRESENT STUDY.

The main purpose of the present study is to examine attitudes and attributions and their relationship to help sources available for dealing with psychological problems for a late adolescent population, specifically first-year undergraduate students. It is also proposed to examine the reliability and validity of two questionnaires which have been used and modified within help-seeking research for a number of years.

These are respectively, an instrument in the form of a questionnaire which investigates the interpersonal and attitudinal processes inherent in seeking assistance for psychological difficulties; and secondly, an instrument looking at the type of causal attribution made for psychological problems and the type of helper from which help will be sought.

#### 1. Attitude Measure.

A questionnaire has been developed and standardized as a research instrument by Fischer and Turner, (1970) and is known as the 'Attitudes Toward Seeking Professional Psychological Help' Scale, (ATSPPH). It originally consisted of 29 Likert-type items presented in a 4-point, agree-disagree response format and scored 0-3, (reverse keyed for negative items). The theoretical scored range was 0-87, with high scores indicative of a global pro-help attitude.

Fischer and Turner, (1970) reported that four factors were contained within the global attitude for their American sample:

Factor 1 - Recognition of personal need for professional help;

Factor 2 - Tolerance of stigma associated with psychiatric help;

Factor 3 - Interpersonal Openness;

#### Factor 4 - Confidence in mental health professionals.

Dadfer and Friedlander (1982), as a result of a principle-axis factor extraction and oblique rotation, identified three defined factors which overlapped with the original four; i.e. Confidence/Appropriateness; Stigma/Privacy and Coping Alone. They suggest that their use of a non-American sample; i.e. international students from 75 countries, may reflect different underlying ethnic domains which could account for this difference.

Although the sample populations used for this instrument have tended to be student populations, (Cash et al., 1978; Dadfer & Friedlander, 1982; Fischer & Cohen, 1972; Fischer & Turner, 1970; Indrisano, 1978; Kligfeld, 1979; Zeldow & Greenberg, 1979), Calhoun et al. (1972), used the ATSPPH scale with adult outpatients of whom 41% were non-students. Surgenor (1985) modified the original Fischer and Turner (1970) inventory to quantify the instrument as a valid measure for populations other than students and to assess its utility within a New Zealand context. These modifications were respectively;

- terminology; i.e. helper titles were changed to fit New Zealand terminology; e.g. psychological counselling was used instead of psychotherapy;
- Likert-format altered from the original; i.e. Probably Agree, Agree, Disagree, Probably Disagree to Strongly Agree, Agree, Disagree, Strongly Disagree. This was adopted in order that answers could reflect strongly held attitudes;
- gender. Plural pronouns were used to make the scale genderless;
- readability. As the original ATSPPH had fairly high reading difficulty, amendments were made to simplify the terminology. The Noun Frequency Method, (Elley, 1975) was used to make a level of readability suitable for the average 13 year-old;

- items. Five new statements were included representing psychological counselling within an educative dimension. Appendix A-1 outlines these particular questions which were included in the questionnaire. Four other items, (Appendix A-2) were deleted due to non-loading for Factor 1 significance.(Surgenor, 1985).

This resulted in a final 31-item scale with an internal consistency of .91. Item-total correlations for the scale ranged from .39 to .76 with a mean of .53. (Surgenor, 1985). Factor analysis revealed a factor structure different from those reported from earlier studies (e.g. Dadfer & Friedlander, 1982; Fischer & Turner, 1970). Surgenor found that principle factor extraction with orthogonal rotation resulted in 5 factors with eigenvalues greater than one, but a clearer picture was provided by the original unrotated structure with some evidence of item clustering in line with Fischer and Turner's (1970) original analyses.

Surgenor (1985), suggests that the heterogeneity of the sample affected the attitudinal components, (i.e. need, stigma, interpersonal and confidence) and the use of a more homogeneous population may result in the re-emergence of the factors reported by Fischer and Turner, (1970).

## 2. Attributions.

A questionnaire developed by Calhoun, Peirce, Walters and Dawes (1974), drawn in part from Phillips (1963), was modified for this study. The initial questionnaire developed by Calhoun et al., was essentially a booklet which contained a brief description of an adult male currently seeking help for a 'personal problem' and a response sheet. This response sheet followed the general format used by Phillips and indicated that the individual was currently seeking help from one of three helpers; a friend, a mental health centre or a clinical psychologist. The respondents chose the one they felt was the most appropriate. An associated paragraph included a description of whether the respondent attributed the help-seeker's problem to internal causes (feelings, personality traits) or to external causes (e.g. job situation). (See Appendix A-3).

A modification was made to this questionnaire for the pilot study, in that the paragraph now dealt with a 'personal problem' for a student within a student hostel. For the help source only mental health centre was changed to Student Counselling Service which is the type of community mental health centre available to students on campus. The causal attribution variable was modified to include the academic situation rather than a job situation and the sex of the student was 'genderized'; i.e. male subjects received a male student description, females likewise. (See Appendix A-4).

In order to make the psychological problem more valid for a student population, further modifications were made for the main study. The description of the student now contained some difficulties; i.e. was missing some lectures and meals, is having problems sleeping and is not his or her usual self. The external influences, which were offered as explanations for the student's difficulties, were also changed to more general and less leading items.

Within the help-source selection, three new categories were added; self-help, parent and medical doctor to see if there was a wider range of help resources being utilised by this population than had been indicated in the literature. Psychologist was paired with psychiatrist as feedback from the pilot study indicated a greater familiarity with the term psychiatrist rather than a clinical psychologist.

#### OBJECTIVES AND HYPOTHESES.

Evidence from the literature reviewed up to this point suggests the existence of a number of relationships. In essence, help-seeking attitudes held by a late adolescent population would seem to be 'negative'; i.e. less pro-help than in the wider population, (e.g. Surgenor, 1985). Females would seem to have more favorable attitudes toward psychological services than males, (e.g. De Paulo, 1982). There also seems to be a difference between those individuals who have had prior contact with professional psychological services and those with no such contact, (e.g. Dadfer & Friedlander, 1982).

With regard to attributions, it would appear that there may be moderating variables between attitudes and the decision to seek professional psychological services. To this end, internal/external causal attributions have been introduced as a moderator variable. It has been suggested that those who perceive their problems as the result of internal causes may seek mental health professionals, whereas those who perceive their problems as external to themselves may use less 'stigmatized' services such as a mental health centre or approach a personally trusted and close friend to share their problems with.

It is important to establish whether those who have negative help-seeking attitudes for seeking professional help will also make an external causal attribution for psychological problems as this may further effect their decision to use a particular help-source. This is of concern, for isolation of the factors that may be linked to the non-use of the current health services by a large percentage of the population for psychological difficulties is needed before one can provide and present services in a manner acceptable to the public.

In addition, the study provided the opportunity to test a major research instrument which had been modified for a heterogeneous population within a New Zealand context. The following hypotheses were investigated:

HYPOTHESIS I: It is predicted that those who have had no prior contact with professional psychological services will hold more negative attitudes toward psychological professionals.

HYPOTHESIS II: It is expected that females will have a higher mean pro-help global attitude score than males.

HYPOTHESIS III: The global attitude score will discriminate between the type of helper sought for dealing with a psychological problem.

HYPOTHESIS IV: It is predicted that those subjects who have had no prior contact with psychological professionals will make external attributions about

psychological problems as against those subjects who had prior contact, who will make internal attributions.

HYPOTHESIS V: It is expected that females will attribute psychological problems to internal causes, whereas males will make external attributions.

HYPOTHESIS VI: The type of attribution held will discriminate between the help-sources chosen to deal with a psychological problem.

HYPOTHESIS VII: There will be an interactive relationship between help-seeking attitudes and attribution type.

## CHAPTER VII.

### METHOD.

#### DESIGN.

The present study used descriptive questionnaire survey methods with closed response formats aimed at collecting statistical data. Matched groups were used in a quasi-experimental method, i.e. pre and post testing was carried out, with the further addition of a control group.

#### SUBJECTS AND SAMPLING.

The total sample consisted of 444 first year undergraduate students drawn from the Halls of Residence within the Massey University Campus. There were 181 males and 258 females in the sample ranging in age from 17 to 25 years with a mean age of 18.5 years. Subjects for the pilot study were drawn from 3 hostel residences during 1986 while those participating in the main study were drawn from 18 hostel residences during June and July in 1987.

A total of 112 students were approached directly to participate in the pilot study; 87 of these returned a correctly completed questionnaire resulting in a 77% response rate. For the main study, 625 questionnaires were distributed indirectly to students; of these, 281 were returned (45%). From this group 150 subjects were asked if they would also fill in a matched post-measure questionnaire on a voluntary basis; 72 subjects (48%) returned completed post-test measures.

A further 150 subjects, who did not participate in the main study, were asked to complete a control post-test measure. The response rate for this group was 50.7%, (76 subjects).

Questionnaires were distributed to an equal number of males and females in the main study. Differential response rates resulted in a preponderance of females in the final sample.

The number of subjects and the sex distribution within each phase of the study are presented in Table 1.

TABLE 1. TOTAL NUMBER AND SEX OF SUBJECTS WITHIN EACH PHASE.

PHASE	TYPE	N	MALES	%	FEMALES	%	MISSING	%
1	Pilot	87	39	44.8	48	55.2	-	-
2	Main	281	114	40.6	167	59.4	-	-
3	Control	76	28	36.8	43	56.6	5	6.6
TOTAL		444	181	40.7	258	58.1	5	1.1

For the total sample there were 258 females (58.1%), 181 males (40.7%) and 5 missing cases on this variable. Out of a total of 87 subjects in the pilot study, 48 were female (55.2%) and 39 male (44.8%). The percentage of females was highest in the main study; 167 (59.4%) compared with 114 (40.6%) males. Distribution by sex for the control group was females 43 (56.6%) and males, 28 (36.8%) with 5 subjects failing to report gender (6.6%).

Subjects came from a wide range of degree/diploma type courses. Of the total subjects, 32 (7.2%) were Diploma students within the agricultural and horticultural field. Combined technical science, veterinary science and pure science degrees accounted for 43.7% of the sample, (194 subjects). There were 140 Bachelor of Business Studies students, (31.5%), and the final group were 61 Bachelor of Arts students (13.7%). A total of 16 subjects did not define their degree type, (3.8%).

The hostel population is a selected group at Massey University; i.e. priority for placement is given to the degree type specific to that university (Veterinary Science) and some other degrees which are available at only a small number of universities in New Zealand: (i.e. Diploma in Horticulture and Agriculture, and Food Technology). When these groups have been catered for, the remaining places are filled using a ballot system. Therefore,

this hostel placement selection process is reflected in the particular percentages for the diploma/degree types.

## MATERIALS.

Two measuring instruments were used, one questionnaire investigating attitudes and one other questionnaire exploring attributions.

### Attitude Measure.

#### 1. Attitudes towards seeking professional psychological help (ATSPPH) inventory.

A 31-item modified ATSPPH questionnaire was used which had 13 positively stated and 18 negatively stated items which were arranged in a 4-point Likert-type format, presented in an agree-disagree response format. High scores represented more positive attitudes toward receiving help, (range 0-93). (Appendix A-3).

A further true-false item was placed at the end of the help-seeking inventory; i.e. 'On at least one occasion during my life I sought and received professional help for a personal problem'. This item was used to sort subjects into categories of those who had an earlier contact with mental health professionals and those who had not. A separate additional item dealt with demographic data measures for sex, age and degree format of subject. The total questionnaire is presented in Appendix B-1.

### Attribution Measure.

#### 2. Locus of causal attribution for a psychological problem questionnaire.

A paragraph which described behaviours indicative of psychological stress was introduced, from which the respondent was required to answer two specific questions. One asked respondents to indicate the causal locus of the

psychological problem, the other offered a six-option choice for the preferred help source to deal with the psychological problem.

The subjects were asked to make a dichotomous choice for the causal locus item; i.e. an internal or external problem. The help-source option ranged from self-help, friend, parent, medical doctor, student counselling service to psychologist/psychiatrist with one choice required from the respondent. A final choice item asked whether subjects had prior contact with mental health professionals or not. Demographic variables for sex, age and degree format were also measured.

### PROCEDURE.

A three-phase study was set up to draw on two first-year undergraduate populations. The pilot study, (Phase 1) included the modified ATSPPH scale and the causal-locus questionnaire. Phase 2, the main study, consisted of two parts; the administration of the modified causal-locus questionnaire, and a further administration of the ATSPPH scale to a small randomly selected population from within this group. Phase 3 consisted of the completion of the ATSPPH scale by a control group of first-year hostel students. Thus, a post-measure using the ATSPPH scale was available from two groups, a matched sample and a control sample.

#### Data Collection Sequence.

Data was collected from two different first-year student populations. The pilot study drew on a 1986 student population in September of that year. The main study and control group were drawn from the 1987 hostel first-year student intake during the months of June and July.

#### Phase 1: Pilot Study.

The purpose of the pilot study was to:

- (1) Test the clarity and suitability of the items contained in the causal-locus questionnaire:

- (2) Test the modified version of the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale.

This phase was also used as a pre-measure for the main study, and to establish whether any cohort differences existed between the yearly intake of students.

A small hostel student population; i.e. 200 hostel students, were approached and those that accepted, received both the ATSPPH and causal-locus questionnaire accompanied by an explanatory letter. (Appendix B-2).

The comments received, both verbally and written with regard to the causal-locus questionnaire, resulted in further modifications. For example, most students did not know what a clinical psychologist was, so the term 'clinical' was dropped and psychologist incorporated with psychiatrist. The range of options for the help-source was also expanded. Further, small modifications were made to the instructions and response format to more clearly define the options and the respective questions.

#### Phase 2: Main Study.

The subjects were selected from the main university hostel student population. Selection depended on size and location of hostels; i.e. the larger hostels in the main clusters were used to allow the outlying smaller hostels to remain relatively naive so a post-measure could be administered later.

The subjects received the causal-locus questionnaire with an accompanying letter. (Appendix B-3). This differed from the other letters as it asked them to record a number, which had been randomly allocated to each form. This number would be called on if they were selected for the matched ATSPPH post-measure group. The questionnaires had been individually numbered from 1 to 625, then further randomly sorted. Questionnaires were also distributed by gender type; i.e. females received a description of a female student and vice versa for males.

Students from the preselected hostels received the questionnaire and letter indirectly; i.e. they were placed under each individual's door. The supervisory staff within the hostels received the completed questionnaires anonymously and these were later collected by the researcher. A time limit of 10 days was set for the return of the questionnaire and only these were used for data collection.

Two weeks later a further questionnaire (ATSPPH) was given directly; i.e. randomly selected subjects from the main study population were approached and asked if they would participate in completing the help-seeking scale. Only those who had remembered to retain their previous random number were included. They also received an accompanying letter. (Appendix B-4).

### Phase 3: Control Group.

The remaining hostel student population was approached directly to ask if they would complete the ATSPPH questionnaire. The purpose of this was two-fold; firstly, to act as a control group for the matched main study group, and secondly, to test the modified questionnaire against a different population than the pre-measure group. Those who agreed to participate received both the ATSPPH scale and an explanatory letter. (Appendix B-2).

### ETHICAL ISSUES.

An assumption was made that this particular age group of first-year university students (mainly 17 and 18 year-olds), may be vulnerable and/or sensitive to mental health issues. Both the Universities Hostel's Department and the Student Counseling Service were approached and permission was gained to commence this type of study.

Confidentiality was of particular importance in this study, not only to reassure subjects that their individual rights on a sensitive issue would be preserved and to facilitate a true reflection of their attitudes of the area under study, but also to assure those who may have had prior contact with psychological services, that this issue would be treated with strict confidentiality.

All subjects within Phase 1, (pilot study), Phase 2 (main study), and Phase 3, (control group) were approached to volunteer to participate and given the opportunity to decline in accordance with the principle of informed consent. The main study population were randomly allocated numbers, which left the researcher blind as to the respondents identity and responses. A further coding system as used to retain anonymity; i.e. a further set of numbers were allocated arbitrarily to all completed questionnaires from each phase for the final data collection. In addition, to further maintain confidentiality, the participating hostels are not specifically identified.

CHAPTER VIII.

RESULTS.

The data from the three groups was analyzed on all dimensions using t-tests for the independent groups, (See Appendix C-1, C-2, C-3 for summary tables). As no significant differences were found on any of these dimensions, it was considered legitimate to treat the groups as homogeneous and to collapse data into a single data pool.

For help-seeking attitudes, 235 subjects from three groups completed the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) questionnaire. The total global attitude mean score was 53.54 with a standard deviation of 11.0.

This sample was then broken into two groups based on contact criteria, i.e. those who had engaged in prior contact with a psychological professional and those who had not. Fewer subjects (43) had prior contact, while 192 subjects had no prior contact with psychological professionals.

TABLE 2.

Mean help-seeking global attitude score and factor sub-scale scores on the ATSPPH for 235 subjects with and without prior contact.

SCORES	CONTACT		NO CONTACT		T	P
	M	S.D.	M	S.D.		
Global Attitude	57.6087	10.671	52.6302	10.904	2.71	.007
Factor 1						
Need	14.6512	3.709	12.7604	3.505	3.16	.002
Factor 2						
Stigma	10.1163	2.206	9.5000	2.721	1.39	N.S.
Factor 3,						
Inter-personal	8.6047	2.470	8.1250	2.586	1.11	N.S.
Factor 4						
Confidence	24.2326	4.487	22.2448	4.821	2.47	.014

Table 2 reveals that the contact group had a higher mean global score on the ATSPPH (57.61, SD 10.67) than the no-contact group (52.63, SD 10.90). This difference was significant, ( $t = 2.7$ ,  $df = 233$ ,  $p < .01$ ). Only two factor sub-scales reached significance. These were Factor 1 (NEED),  $t = 3.16$ ,  $df = 233$ ,  $p < .002$ ; and Factor 4 (CONFIDENCE),  $t = 2.47$ ,  $df = 233$ ,  $p < .02$ .

A further analysis compared male and female scores on the ATSPPH. The mean global score for females (54.85, SD 11.54) was higher than the score for males (51.68, SD 10.0). This difference was significant, ( $t = -2.14$ ,  $df = 228$ ,  $p < .05$ ). Only one ATSPPH sub-scale showed a significant difference between the scores of male and female subjects. This was Factor 1 (NEED),  $t = -2.46$ ,  $df = 228$ ,  $p < .02$ . (For summary table see Appendix C-4).

The female and male subject sample were sorted into contact criteria; i.e. those who had previous contact with a professional and those who had not. These results are shown in Table 3.

TABLE 3.

Male and female subject numbers within the contact categories.

SUBJECTS	N	CONTACT	NO-CONTACT
Males	90	13	77
Females	140	29	111

Table 3 reveals there was a smaller group of males, 90, of whom 13 had prior contact while 77 had not. For females there were 140 subjects, with 29 having prior contact and 111 no contact. A t-test revealed no significant results for males for the contact categories. However for females, there was a significant difference between the contact groups. Results for female subjects are shown in Table 4.

TABLE 4.

Mean help-seeking attitude and factor scores on the ATSPPH for female subjects with and without prior professional contact.

ATTITUDE SCORES	CONTACT		NO-CONTACT		T	P
	M	S.D.	M	S.D.		
Global						
Attitude	59.1379	11.575	53.7297	11.310	2.28	.024
Factor 1						
Need	15.2414	3.934	13.1532	3.598	2.73	.007
Factor 2						
Stigma	10.3793	2.352	9.7297	2.601	1.22	N.S.
Factor 3 Inter-						
personal	9.0000	2.752	8.3243	2.650	1.21	N.S.
Factor 4						
Confidence	24.5172	4.525	22.5225	4.936	1.97	.051

Table 4 shows that females with prior professional contact had a higher mean global ATSPPH score (59.14, SD 11.58) than those with no prior contact (53.73, SD 11.31). This result was significant ( $t = 2.28$ ,  $df = 138$ ,  $p < .02$ ). Two factor sub-scale scores also reached significance. These were Factor 1 (NEED)  $t = 2.73$ ,  $df = 138$ ,  $p < .007$ ; and Factor 4 (CONFIDENCE)  $t = 1.97$ ,  $df = 138$ ,  $p < .05$ . Scores for Factor 2 and Factor 3 did not reach significance.

A further analysis of ATSPPH scores was conducted with the sample broken down according to type of help source selected. Initial data processing indicated that three of the six help-source types were given extremely low response rates. These were, SELF-HELP, PARENT and MEDICAL DOCTOR. It was considered that inclusion of these responses would dilute the data and possibly obscure major trends and they were consequently excluded from the statistical analysis. Responses given to help sources, FRIEND, STUDENT COUNSELLOR and PSYCHOLOGIST/

PSYCHIATRIST accounted for 96.1% of total responses. Only these responses were included in the statistical analysis.

Subjects were grouped according to whether they had prior contact with a professional help-source or no prior contact. The results of this analysis are presented in Table 5.

TABLE 5.

Mean Global Attitude score for subjects with and without prior professional contact by help-source.

HELP-SOURCE	CONTACT		NO-CONTACT	
	N	M	N	M
friend	13	54.77	79	52.13
Student Counseling Service	10	61.10	33	57.47
Psychologist/ Psychiatrist	4	62.50	9	53.78

Table 5 indicates that for both contact groups, the lowest mean score was given to help-source FRIEND ( i.e. contact 54.77, no-contact, 52.13). For the no-contact group the highest mean score was given to STUDENT COUNSELING SERVICE (57.47). The contact group gave the highest mean score to the PSYCHOLOGIST/PSYCHIATRIST help-source (62.50) with mean scores for the contact group for this help-source considerably lower (53.78).

A more rigorous test was carried out on the above data. A 2 x 3 analysis of variance, (CONTACT X HELP-SOURCE X GLOBAL ATTITUDE) revealed a significant main effect for global attitude ( $F(3,148) = 4.210, p < .01$ ). The help-source variable also reached significance ( $F(2,148) = 4.151, p < .02$ ) indicating a relationship between preferred help-source and score on the attitude questionnaire. (For summary table see Appendix C-5). There was no significant effect for contact indicating that attitude scores were not

related to subject's prior experience with professional help-sources. The interaction between help-source and contact did not reach significance.

Analysis of variance was carried out for each of the four factors of the global attitude score. Significant results were obtained for only two subscales. These were Factor 1 (NEED) and Factor 4 (CONFIDENCE). A 2 x 3 analysis of variance, (CONTACT X HELP-SOURCE X NEED) revealed a significant main effect for Factor 1 (NEED) ( $F(3,147) = 4.798, p < .003$ ). The help-source variable also reached significance, ( $F(1,148) = 3.814, p < .05$ ) indicating a relationship between preferred help-source and the need subscale score. There was also a significant effect for contact ( $F(1,147) = 4.938, p < .05$ ) which indicates that need subscale scores were related to subject's prior experience with professional help-sources. (For summary tables see Appendix C-6). The interaction between help-source and contact did not reach significance.

A 2 x 3 analysis of variance, (CONTACT X HELP-SOURCE X CONFIDENCE) revealed a significant main effect for Factor 4 (CONFIDENCE), ( $F(3,147) = 4.345, p < .006$ ). The help-source variable also reached significance ( $F(2,147) = 4.919, p < .01$ ), indicating a relationship between preferred help-source and confidence score on the attitude questionnaire. (For Summary table see Appendix C-7). There was no significant effect for contact indicating that confidence subscale scores were not related to subject's prior experience with professional help-sources. The interaction between help-source and contact did not reach significance.

The type of causal attribution was dependent on the selection of either an internal or external attribution for the psychological problem. The total subject sample completing this measure numbered 363. Of these 248 indicated external attributions, 79 chose internal attributions.

Each attribution type was then broken into contact criteria; i.e. those who had engaged in prior contact with psychological professionals and those who had not. A smaller number of the subjects had prior contact; 52, than no contact; 363. A chi-square analysis revealed no significant difference between the two groups. (For Summary table see Appendix C-8).

To test if there was any difference between the male and female subjects within the type of attribution, a chi-square analysis was carried out. A Yates correction revealed no significant difference for male and female subjects, (For Summary table see Appendix C-9).

To determine whether there was any differences between attribution type and preferred help-source for psychological problems, a further chi-square analysis was carried out. The results indicated a significant difference between type of attribution and help source;  $\chi^2 (2, n = 327) = 39.55326, p < .0001$ , (Table 6).

TABLE 6.

Numbers of subjects within each help-source classified by attribution type.

ATTRIBUTION TYPE	CLASSIFICATION CATEGORY.			TOTAL	%
	FRIEND	COUNSELING	PSYCHO/PSYCHI		
Internal	37	20	14	71	21.7
External	180	73	3	256	78.3
TOTAL	217	93	17	327	
%	66.4	28.4	5.2	100	

Table 6 reveals that the majority of subjects, 256, (78.3%) chose external attributions, whereas only 71 subjects (21.7%) made internal causal attributions. Friend was the main help-source chosen for both attribution types; i.e. internal 37, external, 180. For the student counseling help-source 93 subjects (28.4%) indicated a preference for this option. Twenty of these had made internal attributions and 73 external attributions. For the psychologist/psychiatrist help-source, a total of 17 subjects (5.2%) chose this option with internal attributions accounting for the largest proportion, 14, as against 3 subjects who made external attributions.

To test if there was any interaction between the help-seeking global attitude score and attribution type, a one-way analysis of variance was carried out on subjects from the pilot study and the matched main study group. There were no significant results. (For Summary table see Appendix C-10).

A two-way analysis of variance was carried out including the contact categories with attribution type and the global attitude score. There was a significant main effect;  $F(2,153) = 3.643, p < .03$ , (See Appendix C-11). The contact categories significantly discriminated the global attitude scores,  $F(1,153) = 4.123, p < .05$ . (For Summary table see Appendix C-11).

A further two-way analysis of variance for help-source by attribution type and global attitude score did reach a significant level for main effects;  $F(3,147) = 3.977, p < .01$ . Global attitude score significantly discriminated help-source;  $F(2,147) = 4.312, p < .02$ . (For Summary table see Appendix C-12).

As a modified version of the ATSPPH questionnaire had been used with an undergraduate population, further analysis were carried out on the data that was obtained in order to look at its internal consistency and reliability in comparison with Surgenor's (1985) results. (See Appendix C-13). Table C-13 shows that for the under 25 year old populations, there was only a small difference between the two means, i.e. 53.54 (Present Study) and 51.52, (Surgenor, 1985).

As an index of internal consistency of the modified 31-item scale, Coefficient Alpha was calculated. The coefficient of .8931 was obtained for the 235 questionnaires. An item analysis was also carried out and means, standard deviations and the Pearson correlation coefficients are outlined in Appendix C-14 for the separate items within the questionnaire. Item total correlations for the scale ranged from .30 to .63, with a mean of .49.

## CHAPTER IX.

### DISCUSSION.

#### ATTITUDES.

The initial data analysis indicated that there was no difference between the two year groups of student populations for the global attitude score obtained for the ATSPPH questionnaire. The total global attitude score indicated that a significant proportion of respondents held negative attitudes toward seeking professional help for psychological problems. This not only indicates that there were no apparent cohort differences, but also tends to support the literature which suggests that late adolescent student populations hold mainly 'negative' attitudes toward seeking help from psychological professionals. Research indicates that this finding has remained stable over a twenty-five year time span. (Fischer & Turner, 1970; Nunnally, 1961; Surgenor, 1985). The overall global attitude score for the present study reflects closely the score obtained for the late adolescent population in Surgenor's (1985) research.

It was predicted that those subjects who had prior contact with psychological professionals would have a higher global help-seeking attitude than those who had no prior contact. The results indicate that there is a significant difference between for the two contact type groups on this variable. Conrad and Maul (1981), note that if the differences are statistically significant, they are unlikely to have occurred by chance alone, and can, therefore be attributed to the relevant variable under investigation. That is, that the contact variable will discriminate the score obtained on the ATSPPH questionnaire. This result clearly supports previous research findings. (Fischer & Turner, 1970; Surgenor, 1985). Findings from the present study confirm those from previous studies which report that having been a client will foster more positive attitudes toward any future help-seeking from a psychological professional source. (Dadfer & Friedlander, 1982; Fischer & Cohen, 1972; Utz, 1983).

The mean scores for two sub-scales (ie. recognition of personal need for professional help and confidence in mental health professionals) were also significantly higher in the present study than were scores for the two other sub-scales on the ATSPPH. This shows that the group who have had prior contact with psychological professionals are not only more able to recognise a need for mental health services, but also have a greater confidence in mental health professionals.

Gender differences were predicted for the global attitude score. Females were expected to have more positive pro-help attitudes than males and the results confirmed this expectation. Within the total global attitude score, Factor 1, (Need) was also significantly higher for female subjects which suggests that females have a greater ability to recognise the type of psychological distress which is appropriate for professional help. This further verifies findings from the literature. That is, females have been consistently found to hold more positive attitudes towards help-seeking than males, (e.g. De Paulo, 1982; Fischer & Turner, 1970; Greenley & Mechanic, 1976; Gourash, 1978; Surgoner, 1985).

The scores for female subjects from the two contact groups showed that females with prior professional contact had significantly higher ATSPPH scores than those females who had no contact. This difference did not occur for the male subject group. Also significant were the Factor 1 sub-scale (Need) and Factor 4, (Confidence). Therefore, those females who had prior professional contact held more pro-help attitudes with a greater recognition of need for and confidence in mental health professionals than those females who had no prior contact.

These results suggest that the social values and the societal socialization process which encourages emotional sensitivity and a strong interpersonal orientation in females, leads to an awareness or insight into psychological distress which may be an important explanation for gender differences. Both Gilligan (1982), and Mechanic (1982), indicated that young females are not only more dependant than males, but that they will more readily accept a dependent role in relationships. The issue of whether prior contact with a psychological professional fosters an acceptance of or willingness to seek out

further dependent therapeutic relationships has been raised in earlier literature. (Mechanic & Greenley, 1976). This issue is currently unresolved.

There are four factors in the help-seeking attitude scale, need, stigma, interpersonal openness and confidence. Two of these factors (Need and Confidence) significantly discriminated for gender and contact differences but this is not the case for the stigma and interpersonal openness factors. Therefore the two latter factors would appear to be less important components within an encompassing help-seeking attitude.

However, it is important to interpret this result with caution and to note Fischer and Turner's (1970), claim that the factors should be interpreted with reference to the overall scale, rather than used as a separate measure. It is also relevant that three out of the four sub-scales (i.e. Factor 1, Need, Factor 2, Stigma and Factor 3, Interpersonal Openness) contain relatively few items. The largest number of items within the ATSPPH questionnaire dealt with Factor 4, confidence in mental health professionals.

This may reflect some bias in the questionnaire. The respondent may be guided in a certain direction to provide data relevant to the results desired by the researcher. As Conrad and Maul (1981), note, questionnaires can create as well as measure attitudes. This 'funneling' effect (Oppenheim, 1979) could reflect the concern of psychological professionals with their own credibility, rather than be a true reflection of the relevant components within a help-seeking attitude.

There is also a potential subject response bias with regard to closed-response forms. The condensation and compression of acceptable answers 'forces' the respondent to choose between fixed alternatives. (Oppenheim, 1979). This rigidity results, not only in a loss of spontaneity and richness, but also in the exclusion of further information that may be relevant or interactive with attitudes toward help-seeking.

The present study also investigated the hypothesis that a higher pro-help attitude score would increase the likelihood of subjects seeking professional help. A significant result was obtained which indicates that the attitude

score will discriminate selection between the different help-sources. Results indicate that those students with the most 'negative' attitudes, (i.e. less pro-help ATSPPH scores) are likely to choose a friend to deal with psychological problems, whereas those with the most positive pro-help attitudes will choose professional psychological services.

Scores obtained for the Factor 1 sub-scale (Need) of the attitude scale were significant in discriminating type of help-source and also in establishing whether a respondent had had prior contact with psychological professionals or not. One other sub-scale, Factor 4 (Confidence), significantly discriminated between the types of help-source. That is, those with less confidence of or need for professional help will chose a friend. Whereas those who are more 'psychologically minded'; (i.e. have greater confidence and recognition of need for psychological professional help), will choose professional help. The data describes only a possible relationship between attitudinal variables and utilization of mental health services but does not establish a causal link.

These results tend to support research (Mechanic & Greenley, 1976; Kadushin, 1966; Sarbin & Mancuso, 1970) which suggests that a recognition of need for professional services is related to a personality dimension of 'psychological mindedness'. This type of subject will have stronger pro-help attitudes and will more readily choose professional help-source for psychological problems. These positive attitudes will also be reflected in higher scores on confidence ratings of and for professional services.

An item analysis of the internal consistency and reliability of the ATSPPH questionnaire, tends to reflect past analyses of this scale, (e.g. Dadfer & Friedlander, 1982; Fischer & Turner, 1970; Kligfeld, 1979; Surgenor, 1985). Within the present study, the correlation coefficient of .89 was higher than that recorded by Fischer and Turner (1970), which ranged from .83 to .86. However, the result from the present study is lower than that reported by Surgenor (1985), who obtained the coefficient of .91. This difference is reflected in the scores obtained for the item correlations in the present study, slightly lower in range and total score than the item scores obtained by Surgenor, (1985). This difference may be a function of the

homogeneous population who responded to the questionnaire within the present study as against the wider heterogeneous population used by Surgenor, (1985).

It is important to consider whether written statements of attitude-elicited from attitude scales will correlate with behaviour. That is, will the responses reported by subjects in this study predict actual help-seeking behaviour. The literature suggests that this is unlikely. Fishbein and Ajzen (1975), in a survey of the literature on attitudes, make it clear that traditional measures of attitudes are only appropriate as independent variables when one is concerned with the variety of behaviours which interact or may result from these attitudes. These authors conclude that studies of predictors of specific acts should focus on behavioral intentions to perform such acts, and that traditional attitude measures should be reserved for designs which include all the relevant behavioral components.

Rabkin (1974), followed the previous authors point through and found attitudinal variables seldom present singly. A multitude of variables may interact with specific behaviour with regard to actual help-seeking, and these interactions often account for more of the variances than their separate effects. This would discount studies which deal with any single variable.

#### ATTRIBUTIONS.

In the present study over two thirds of the undergraduate population sampled made an external attribution as to the cause of the presented psychological problem. This emphasis on external attribution supports general trends in the literature (e.g. Calhoun, et al., 1975; House, 1981; Tessler & Schwartz, 1972) with regard to Kelley's (1967), attribution theory; (i.e. that three kinds of information, distinctiveness, consistency and consensus, which when present in varying degrees, will dictate the type of causal attribution made about events). Therefore the subjects within the present study may have perceived the student's problem to be of high distinctiveness, high consensus and high consistency, that is, many students react in this manner to periods of academic stress. These results are relevant to research which

confirms that if many people need help for a similar problem, the need for help will be attributed externally. (Tessler & Schwartz, 1972).

Students in the present study were asked to make judgments about a third person statement. However, the external attributional bias found within the present study may also reflect the respondents' preferred explanation for themselves when experiencing any psychological difficulties. Hare-Mustin and Garvine (1974), indicates that respondents will project themselves into subjective third-person questions. Jones (1976), correspondent inference model of actor-observer differences suggests that a fundamental attribution error (Ross, 1977), will occur when explanations are needed about the cause of one's own behaviour. The emphasis on external attributions suggests that a situational/external bias was made by the majority of respondents indicating an actor's perspective for the problem.

It was predicted that there would be a significant difference between type of attribution made and help-source selected. The results from the present study indicated a significant difference between each type of causal attribution and preferred help-source. The largest number of subjects in both the internal and external attribution groups classified friend as the most acceptable choice for dealing with psychological problems. As the numbers proportionally decreased, so the least psychological service (Student Counselling Service) was first approached then the most psychologically orientated professions, (i.e. psychologist/psychiatrist).

One therefore could suggest that the social support system which includes friends is of prime importance for this type of student population. This contention is well supported in the literature. (Amato & Bradshaw, 1985; Cowen, 1982; Mechanic, 1976; Rust & Davie, 1961; Snyder et al., 1972). Veroff et al. (1981), found that young people as well as the more educated person, are much more orientated toward using informal help than older people, with both these groups having more complex and larger support systems. The results from the present study would seem to lend further credence to this evidence.

The present study also examined a prediction that there would be an interactive relationship between global help-seeking attitude score and attribution type. The results obtained did not support this hypothesis.

In completing this section a word of caution is needed. In the present investigation, respondents completed a closed-response format with regard to a hypothetical individual. Although present findings offer a descriptive analyses about possible relationships, the generalization of present findings would require the generation of more specific experimental evidence with further cross-validation in actual social settings.

#### HELP-SOURCE.

The majority of subjects from both the external attribution group and the internal attribution group in the present study chose a friend as the preferred help-source for dealing with a psychological problem. Approximately one quarter of each of these groups chose the student counselling service option. Very few from the external attribution group, only two, chose the psychologist/psychiatrist option, whereas for the internal attribution group, a larger proportion of respondents chose this particular help-source. Although this difference was significant the result should be viewed with caution as the numbers within this subject sub-set are small. This is likely to confound any conclusions. However, it would seem that the results from the present study indicate that help-source is a moderating variable of some importance. This may also reflect the particular degree or type of help-seeking attitude held by an individual.

It is important to keep in mind that both the attitude inventory and the attribution questionnaire used a restricted closed-response format. This type of format results in instruments which have the chief function of dividing people into a number of broad groups, and as such, are techniques for placing people in relation to one another, in relative but not absolute terms. (Oppenheim, 1979). Along with this relativity is an implicit assumption of a simple causal relationship between a multi-dimensional conception of attitude towards a social object and specific behaviour towards that objective,

irrespective of the situation. This is a false and oversimplified viewpoint. (Thomas, 1971).

With this caution noted, the present study may have generated further questions (a need outlined by McKinlay (1972) relevant to the current and future utilization of psychological professional services. Delivery system characteristics may be statistically interactive with both the individuals attitudes, attributions plus other predisposing and enabling factors.

Of particular interest to the present study is the contact variable. Those who had prior contact with a psychological professional and also high pro-help attitude scores indicated a preference for future professional services. It is not possible to ascertain whether those individuals already had high pro-help attitudes when the initial contact was made with the professional services, or whether they already had a more internalized attribution mode. Rosenstock (1969), notes that the actual decision to seek professional help may create cognitive dissonance, and thereby modify either attitudes or attributions, thus confounding the issue further.

Subsequent treatment may also have consolidated these tendencies, which would allow for subsequent positive help-seeking attitudes toward further contact with professional psychological help. If one takes the view that prior contact is both a necessary and sufficient condition to influence positive help-seeking attitudes toward professional help, then further investigation of the relationship is clearly warranted.

Levine and Levine (1970), developed the thesis that mental health theories (which are reflected in treatment of the individual) will reflect the political and social milieus present at a particular point in time. These may either emphasize external determinants of behaviour (such as was apparent in the 1960's, 1970's) or internal, intrapsychic phenomena which may be seen by society as responsible for an individual's difficulties. Heller et al. (1984), notes this ebb and flow of external and internal causal phenomena over time and predicts an ascendance of internal/individual causal phenomena for the difficult decade of the 1980's.

The late adolescent undergraduate student population in this study indicated a strong preference for a friend as a help-source to deal with psychological problems. This supports research which suggests that people will tend to manage stressful problems with the support and help of others. (Cowen, 1982; Snyder et al., 1972; Veroff et al., 1981). But as Veroff and colleagues (1981) note, 'most people don't need to be told this. It may be mostly the experts who find this eye opening information'. (Pg. 12).

It would appear from the literature that attitudes have emotional connotations, (Oppenheim, 1979) with the ingrained view that psychological professionals have 'positive' attitudes towards mental illness whereas the public's attitudes are seen as 'callous'. (Nunnally, 1961). The late adolescent population also seem to have 'negative' attitudes towards mental illness and help-seeking, which has been further described as the 'arrogance of youth'. (Surgenor, 1985).

The Joint Commission on Mental Illness and Health (1961), has suggested that the psychiatric profession has tried diligently to make society accept their 'positive' views by consistently drawing attention to the public's antipathy and indifference. The Commission notes this problem and puts forward the notion that it may be time to turn the whole problem around and let 'the man in the street' get a serious hearing. That is, to turn the issue around and see it from the other side. The findings presented, both from the present study and past research findings would suggest that this viewpoint may still be a valid option for today.

Perhaps instead of labelling others with emotive statements, one could investigate the late adolescent undergraduate population's perception of the mental health services. Could 'negative' attitudes to these services be positive indicators of trust in themselves and their peers? If so, an important role for psychological professionals could be to act as educators, providing those friends and lay leaders who are sought in times of psychological distress with the necessary skills and resources.

Friedson (1960), introduced and defined the term 'lay referral structure' which signifies a collection of associates consulted by an individual who is

seeking help in the community. This network of potential consultants could therefore be identified and used not only to provide effective support but as Green (1970), has suggested, develop and provide positive norms of preventative mental health behaviour. Kadushin (1966), has shown how social networks can also both speed an individual to appropriate psychotherapeutic resources and also provide the anticipatory guidance which is a prerequisite for acceptance and retention by professional practitioners.

In the face of matching resources to need, the mental health establishment has proposed two changes in facilities. First, the use of paraprofessionals and health professionals who would train non-specialist groups, who, in turn would deliver care directly. (Veroff et al., 1981). Second, the initiation of the community health care movement implies that persons have the ability to manage ordinary problems on their own, since mental health clinics are to serve mainly as a support in crisis management. Perhaps the present study had indicated that the 'public' in fact already have the desire to handle psychological problems within the community, and it may be only the professionals who are belated in realising the value of this perspective.

A further paradox exists in that the professional bodies within the mental health services tend to hold internal attributions about the locus of psychological difficulties. (Bateson et al., 1982). This attributional dispositional bias may be contradictory to a clinician's aim which is to help the client to achieve a more balanced view of difficulties and to educate the individual about the relevant aspects of the environment, the self and their relationships (Strong, 1970), which suggests a mix of both internal and external factors.

Gross and colleagues (1979), describe two methods to use in reaching target populations, (a) using multiple techniques, and (b) tailoring appeals to the personality and demographic characteristics of potential aid recipients. Morrison and Teta (1980), demonstrated that if students are persuaded to change their reported beliefs about mental illness in an anti-medical model direction through demythologizing, those same persons also will report a decreased fear of mental illness or of 'going crazy'.

Tessler and Schwartz (1972), presented a format for use with individuals needing help. They suggest that they be given options for attributing the need for help to external factors. Calhoun and colleagues (1974), followed this notion through and found that for working-class males, behaviour-change approaches that emphasize the environmental causation of problems may lead to less rejection for help-seeking than approaches that emphasize intrapsychic causation of psychological problems.

Therefore it would seem valid to use what one has, and an undergraduate population, of whom a large percentage make external attributions for psychological problems may benefit from a shift in professional attributions from a dispositional bias toward a situational one. As Surgenor (1985) notes: 'Psychological service providers should pay particular attention to their public image and client attitude. By doing this they can learn to tailor services to client needs and wants, rather than tailor clients to existing services'. (P. 33).

#### SUMMARY.

The overall global attitude help-seeking score obtained for this adolescent undergraduate population was lower than the positive attitudes held by a heterogeneous population as described in earlier research. Those students who had prior contact with mental health professionals scored a more positive pro-help attitude. Also females held more positive pro-help attitudes than males. Components within the overall attitude score which were significant for the contact variable indicated that the prior contact group had a greater recognition of need for professional help when distressed, and as one would expect, greater confidence in professionals. The score obtained on the recognition of need sub-scale was a significant discriminator for gender differences, perhaps indicating that females have a greater awareness or perception of emotional subjective phenomena.

The largest proportion of the student sample made external attributions about the cause for the presented psychological problem. There were no significant differences between the type of attribution and the contact

variable or between the attribution type and gender. Although there was no significant interaction between attributions and help-seeking attitude the results indicated that perception of help-source may be a moderating variable of importance. Both attribution type and help-seeking attitude score separately discriminated the help-source which would be used for a psychological problem.

Of importance to the specific subject population are friends, to whom the majority of subjects indicated they would turn when help-seeking for a psychological problem. External causal attributions indicated that problems are perceived to have been caused by situational stress or constraints. One could therefore conjecture that a fellow student who is also a friend is likely to be seen as the most empathic person to deal with a common student concern. It would appear that psychological professionals tend to hold alternate attributions about psychological problems (i.e. internal/dispositional attributions which emphasize that the individuals themselves are not only the cause but also responsible for psychological difficulties). Whether that professional internal/situational emphasis has been perceived by an adolescent undergraduate population resulting in negative help-seeking attitudes is a question that can only be answered by further definitive research.

### CONCLUSION.

Attitudes and attributions are abstract concepts, as well as intrapsychic phenomena which are difficult to objectively define and quantify. In the main, surveys have been the main method used to investigate internal states and phenomena which are very difficult to research by any other means than by self-report. This type of descriptive research does not address cause and effect relationships but can alert researchers to relationships that exist between phenomena and other variables.

The resulting discussions may range from the metaphorical to the definitive. In this type of research, one engages in deductive reasoning, that is by making an inference from general statements to the particular. Whether any conclusions reached can be considered valid, depends on the correctness of the presented premises and the legitimacy of any basic

assumptions made. Therefore quantitative and qualitative experimental research is needed, in both the laboratory and the clinical settings in order to allow for inductive reasoning; (i.e. the inference of the general from particular instances).

Therefore at this stage, subtle connotations drawn from a descriptive study can only suggest that, for a late adolescent undergraduate population, help-source is a critical variable within the process of help-seeking. Research has shown that this group is vulnerable. For some adolescents who do not reach the appropriate professional resources when the need is great there can be disastrous results, that is, suicide.

The answer may lie in several directions, even perhaps within those questionnaire's which were not returned, for non-response is not a random process. (Oppenheim, 1979). Or it may lie within the domain of the psychological services themselves, for although professional attitudes and attributions may be intangible, their effects can be far reaching. Perhaps then, it is time to make the implicit, explicit.

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APPENDIX A.Supplement to Present Study Section.

1. New statements incorporated into the modified ATSPPH ATSPPH questionnaire by Surgenor, (1985).
2. Deleted items from Fischer & Turner's (1970) ATSPPH questionnaire and Surgenor's (1985) modified version.
3. Original attribution questionnaire by Calhoun et al., (1974).
4. Pilot study attribution/help-source questionnaire.
5. Final attribution/help-source questionnaire.

New Statements incorporated into the modified form of the  
ATSPPH questionnaire by Surgenor. (1985).

Question

Number.

11. Psychological counseling can lead to positive growth for all, not just people with personal or emotional problems.
17. Counseling can assist all people to develop self-esteem and strength within themselves.
22. Psychological counseling is another form of teaching, a way of learning about one's abilities and potentials.
25. In my opinion, no one needs the help of a psychologist/ counselor to develop ordinary personal and interpersonal skills.
29. Psychological counseling focuses just as much on preventing stress and problems in the community as on helping people overcome their problems.

2. Deleted items from the original ATSPPH questionnaire, (Fischer & Turner, 1970) and the modified ATSPPH questionnaire, (Surgenor, 1985).

Items.

Psychological counselors tend to see only people with problems.

I believe that a person with a serious emotional disturbance would probably feel more secure in a good psychiatric hospital.

A good solution, in my opinion, for avoiding personal worries and concerns, is keeping your mind on a job.

I believe that it is probably best not to know everything about oneself.

3. Original attribution questionnaire by Calhoun et al. (1974).

Here is a description of a man. Imagine that he is a person living in your neighborhood. He has a good enough job and is fairly well satisfied with it. He is married and has two children. He has some personal problems and has been going to a (friend, mental health centre, clinical psychologist) regularly about these problems. The \_\_\_\_\_ believes these problems were probably caused by

internal influences (for example, the mind, his personality traits, etc.). The \_\_\_\_\_ also believes that the problems will best be solved by discussion of the man's feelings, thoughts, and emotions.

external influences (for example, his job situation, the way his family behaves, etc.). The \_\_\_\_\_ also believes that the problems will best be solved by specific suggestions aimed at producing specific changes in the man's behaviour.

4. Pilot study attribution/help-source questionnaire.

PLEASE READ THE FOLLOWING PARAGRAPH CAREFULLY.

FILL IN THE FIRST SPACE WITH EITHER FRIEND, STUDENT COUNSELING SERVICE OR CLINICAL PSYCHOLOGIST, AND THE SECOND SPACE WITH EITHER INTERNAL OR EXTERNAL INFLUENCES.

Here is a description of a student. Imagine that she is a person living in your student hostel. She is doing reasonably well with her studies and is fairly well satisfied with her progress. She has some personal problems and has been going to a (friend, Student Counseling Service, or Clinical Psychologist) regularly about these problems.

The \_\_\_\_\_ believes these problems were probably caused by \_\_\_\_\_.

INTERNAL INFLUENCES, (for example, the mind, her personality traits, etc.). These problems would best be solved by discussion of the student's feelings, thoughts and emotions.

OR

EXTERNAL INFLUENCES, (for example, her academic situation, the way her friends or fellow students behave etc.). These problems would best be solved by specific suggestions aimed at producing specific changes in the student's behaviour.

Thank you for your time and cooperation in filling out this questionnaire.

P.J. MAXWELL  
GRADUATE STUDENT.

5. Final attribution/help-source questionnaire.

NUMBER .....

AGE .....

DEGREE .....

PLEASE READ THE FOLLOWING PARAGRAPH CAREFULLY

Here is a description of a student. Imagine that she is a person living in your student hostel. She appears to be having difficulties; i.e. missing some lectures and meals, is having problems sleeping and overall seems not to be her usual self.

Q. WOULD YOU SAY THIS STUDENT IS HAVING PROBLEMS WITH;

Tick One of the following that applies.

Internal influences (for example, the mind, her personality traits etc.).

OR

External influences (for example, her academic situation, community living or personal relationships etc.).

Q. WOULD YOU RECOMMEND THAT THIS STUDENT DEAL WITH IT THEMSELVES OR APPROACH ANOTHER RESOURCE AS OUTLINED BELOW.

Tick One of the following that applies.

self-help  
friend  
parent  
medical doctor  
student counseling service  
psychologist/psychiatrist.

Q. ON AT LEAST ONE OCCASION DURING MY LIFE I SOUGHT AND RECEIVED PROFESSIONAL HELP FOR A PERSONAL PROBLEM.

Tick One of the following that applies.

true  
false

APPENDIX B.Supplement to Method Section.

1. Final ATSPPH questionnaire.
2. Letter sent to both pre-measure and post-measure groups with ATSPPH questionnaire.
3. Letter sent to main study group with attribution/help-source questionnaire.
4. Letter to matched main study group with ATSPPH questionnaire.

1. ATSPPH (Attitudes Toward Seeking Professional Psychological Help) Questionnaire.

BELOW ARE A NUMBER OF STATEMENTS RELATING TO PSYCHOLOGY AND MENTAL HEALTH ISSUES. READ EACH STATEMENT CAREFULLY AND INDICATE THE EXTENT TO WHICH YOU STRONGLY DISAGREE (SD), DISAGREE (D), AGREE (A) OR STRONGLY AGREE (SA). PLEASE EXPRESS YOUR HONEST OPINION IN RATING THE STATEMENTS. THERE ARE NO WRONG ANSWERS, AND THE ONLY RIGHT ONES ARE WHATEVER YOU HONESTLY FEEL OR BELIEVE. PLEASE INDICATE YOUR ANSWER BY CIRCLING THE APPROPRIATE RESPONSE. IT IS IMPORTANT THAT YOU ANSWER EVERY ITEM.

INFORMATION GIVEN BY YOU IN THIS QUESTIONNAIRE SHOULD BE COMPLETELY ANONYMOUS. PLEASE DO NOT WRITE YOUR NAME ON THIS FORM.

AGE:           SEX:

ACADEMIC DEGREE ENROLLED IN:

MAJOR:

	STRONGLY		STRONGLY	
	AGREE		DISAGREE	
1. Although there are agencies for people with personal or emotional troubles, I would not have much faith in them.	SA	A	D	SD
2. If good friends asked my advice a personal or emotional problem, I might recommend that they see a psychologist/counselor.	SA	A	D	SD
3. I would feel uneasy going to a psychologist/counselor because of what some people would think about me.	SA	A	D	SD



	STRONGLY AGREE	DISAGREE	STRONGLY	
	SA	A	D	SD
<u>not</u> be discussed outside of one's immediate family, in my opinion.				
11. Psychological counseling can lead to positive growth for all, not just people with personal nor emotional problems.	SA	A	D	SD
12. If I believed I was having a personal or emotional breakdown, my first inclination would be to get professional help.	SA	A	D	SD
13. I believe that having received psychological counseling is a blot on a person's life.	SA	A	D	SD
14. I would rather be assisted by a close friend than by a psychologist/ counselor, even for an emotional problem.	SA	A	D	SD
15. People with an emotional or personal problem, in my opinion, are not likely to solve it by themselves; they <u>are</u> likely to solve it with professional help.	SA	A	D	SD
16. I resent a person - professionally trained or not - who wants to know about my personal or emotional difficulties.	SA	A	D	SD

	STRONGLY AGREE		STRONGLY DISAGREE	
17. Counseling can assist all people to develop self-esteem and strength within themselves.	SA	A	D	SD
18. I would want to get psychological attention if I was worried or upset for a long period of time.	SA	A	D	SD
19. The idea of talking about problems with a psychologist/counselor strikes me as a poor way to get rid of emotional or personal conflicts.	SA	A	D	SD
20. In my opinion, having been diagnosed emotionally or psychiatrically ill carries with it a burden of shame.	SA	A	D	SD
21. There are experiences in my life I would not discuss with anyone.	SA	A	D	SD
22. Psychological counseling is another form of teaching, a way of learning about one's abilities and potentials.	SA	A	D	SD
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 psychological counseling.	SA	A	D	SD

	STRONGLY AGREE	A	D	STRONGLY DISAGREE
24. I think that there is something admirable in the attitude of people who are willing to cope with their conflicts and fears <u>without</u> resorting to professional help.	SA	A	D	SD
25. In my opinion, no one needs the help of a psychologist/counselor to develop ordinary personal and interpersonal skills.	SA	A	D	SD
26. At some future time I might want to have psychological counselling.	SA	A	D	SD
27. In my opinion, people should work out their own problems; getting psychological counselling would be a last resort.	SA	A	D	SD
28. If I had received help from a counselling agency, I would want it 'covered' up.	SA	A	D	SD
29. Psychological counselling focuses just as much on preventing stress and problems in the community as on helping people overcome their problems.	SA	A	D	SD
30. If I thought I needed professional psychological help, I would get it no matter who knew about it.	SA	A	D	SD

STRONGLY                      STRONGLY  
AGREE      DISAGREE

31. I believe that it is difficult to talk about personal affairs with highly educated people such as doctors, counsellors, clergymen, and psychologists.

SA                      A                      D                      SD

32. On at least one occasion during my life I sought and received professional help for a personal problem.

TRUE/FALSE.

2. Letter sent to both pre-measure and post-measure groups with ATSPPH questionnaire.

MASSEY UNIVERSITY

DEPARTMENT OF PSYCHOLOGY.

Dear Student,

You are invited to participate in a research project run jointly for the Hostel's Department and the psychology Department at Massey University.

In essence, you will be required to fill out a questionnaire which would take approximately fifteen minutes to complete.

Complete confidentiality is assured as questionnaire responses will be completely anonymous.

The success of the research will depend on a large number of hostel students taking part, so that the information that is obtained is representative off the hostel student population.

The research is designed to enhance future conditions within the University Hostels and your participation is appreciated.

When you have completed this questionnaire, would you place it under your Hostel Supervisor's door as soon as possible please.

Thank you for your co-operation.

P.J. MAXWELL

GRADUATE STUDENT.

3. Letter sent to the Main study group with the attribution/  
help-source questionnaire.

MASSEY UNIVERSITY

DEPARTMENT OF PSYCHOLOGY.

Dear Student,

You are invited to participate in a research project run jointly for the Hostel's Department and the Psychology Department at Massey University.

In essence, you would be required to fill out a questionnaire which would take approximately ten minutes to complete.

Complete confidentiality is assured as questionnaire responses will be completely anonymous. Please note however, that the questionnaire is numbered. Would you record that number in a private place, perhaps on the back of your drivers licence, and should you be asked to fill in a follow-up questionnaire then it would be possible to match data from this random population. That way confidentiality will be preserved as it will allow questionnaires to be matched - not people, thus assuring you of complete anonymity.

The success of the research will depend on a large number of hostel students taking part, so that the information that is obtained is representative of the hostel student population.

The research is designed to enhance future conditions within the University Hostel and your participation would be appreciated.

When you have completed this questionnaire could you please place it under your Hostel Supervisor's door as soon as possible.

Thank you for your cooperation.

P.J. MAXWELL

GRADUATE STUDENT.

4. Letter to matched main study group with the ATSPPH questionnaire.

MASSEY UNIVERSITY.

DEPARTMENT OF PSYCHOLOGY.

Dear Student,

You are invited to once again participate in a research project run jointly for the Hostel's Department and the Psychology Department at Massey University.

In essence you will be required to fill out the following questionnaire which will take approximately fifteen minutes to complete. As we wish to correlate this data with the previous questionnaire which was handed to you earlier, could YOU PLEASE PLACE YOUR CONFIDENTIAL NUMBER FROM THE EARLIER FORM ON THE TOP RIGHT HAND CORNER OF THIS QUESTIONNAIRE. This will allow the various questionnaires to be matched - not people, thus assuring you of complete anonymity.

Your participated is appreciated, and I thank you for the time and effort that has been involved. When you have completed this questionnaire, would you place it under your Hostel Supervisor's door as soon as possible please.

Thank you for your co-operation.

P. J. MAXWELL  
GRADUATE STUDENT.

APPENDIX C.SUPPLEMENT TO RESULTS SECTION.

### DATA PROCESSING.

Subject responses were transferred to data coding forms and the data was analyzed using the 'Statistical Package for the Social Sciences'.

### SEPARATE VS. POOLED VARIANCE ESTIMATES.

In all cases where the F value was not significant at the  $p < .05$  level, a pooled variance estimate was used and reported whereas a separate variance was used on those cases where the F value of the distribution was significant at the  $p < .05$  level.

## APPENDIX C-1,

TABLE C-1.

T-test comparing the pilot study and matched main study group across total global attitude score and factor sub-scales.

GROUP	N	M	S.D.	T	P
<u>Global Attitude</u>					
Pilot study	87	53.2184	10.934		
Matched Group	72	54.7361	11.738	-0.84	N.S.
<u>Factor 1, Need</u>					
Pilot study	87	12.9540	3.095		
Matched study	72	13.5278	3.982	-1.02	N.S.
<u>Factor 2, Stigma</u>					
Pilot study	87	9.5517	2.752		
Matched group	72	10.1389	2.585	-1.38	N.S.
<u>Factor 3, Interpersonal</u>					
Pilot study	87	8.3333	2.577		
Matched group	72	8.3611	2.629	-0.07	N.S.
<u>Factor 4, Confidence</u>					
Pilot study	87	22.3793	4.821		
Matched group	72	22.7083	4.831	-0.43	N.S.

## APPENDIX C-2.

TABLE C-2.

T-test comparing pilot study and control group across global attitude and factor sub-scale.

GROUP	N	M	S.D.	T	P
<u>Global Attitude</u>					
Pilot study	87	53.2184	10.934		
Control group	76	52.7763	10.420	0.26	N.S.
<u>Factor 1, Need</u>					
Pilot study	87	12.9540	3.095		
Control group	76	12.8816	3.798	0.13	N.S.
<u>Factor 2, Stigma</u>					
Pilot study	87	9.5517	2.752		
Control group	76	9.1842	2.507	0.89	N.S.
<u>Factor 3, Interpersonal</u>					
Pilot study	87	8.3333	2.577		
Control group	76	7.9342	2.505	1.00	N.S.
<u>Factor 4, Confidence</u>					
Pilot study	87	22.3793	4.821		
Control group	76	22.7763	4.846	-0.52	N.S.

APPENDIX C-3.TABLE C-3.

T-test comparing matched main study group and control group for global attitude and factor sub-scales.

GROUP	N	M	S.D.	T	P
<u>Global Attitude</u>					
Matched group	72	54.7361	11.738		
Control group	76	52.7763	10.420	1.08	N.S.
<u>Factor 1, Need</u>					
Matched group	72	13.5278	3.982		
Control group	76	12.8816	3.798	1.01	N.S.
<u>Factor 2, Stigma</u>					
Matched group	72	10.1389	2.585		
Control group	76	9.1842	2.507	2.28	N.S.
<u>Factor 3, Interpersonal</u>					
Matched group	72	8.3611	2.629		
Control group	76	7.9342	2.505	1.01	N.S.
<u>Factor 4, Confidence</u>					
Matched group	72	22.7083	4.831		
Control group	76	22.7763	4.846	-0.09	N.S.

APPENDIX C-4.TABLE C-4.

T-test comparing males and females for global attitude and factor scores for the ATSPPH questionnaire.

GROUP	N	M	S.D.	T	P
<u>Global Attitude</u>					
Males	90	51.6778	10.005		
Females	140	54.8500	11.535	-2.14	0.033
<u>Factor 1, Need</u>					
Males	90	12.3889	3.341		
Females	140	13.5857	3.753	-2.46	0.015
<u>Factor 2, Stigma</u>					
Males	90	9.2667	2.743		
Females	140	9.8643	2.556	-1.68	N.S.
<u>Factor 3, Interpersonal</u>					
Males	90	7.8889	2.329		
Females	140	8.4643	2.675	-1.67	N.S.
<u>Factor 4, Confidence</u>					
Males	90	22.1333	4.705		
Females	140	22.9357	4.905	-1.23	N.S.

APPENDIX C-5.TABLE C-5.

Summary ANOVA table for global attitude score by contact criteria  
and help-source.

SOURCE	SS	DF	MS	F	P
Main Effects	1342.172	3	447.391	4.210	0.007
A (Contact)	310.162	1	310.162	2.919	0.090
B (Help-source)	882.151	2	441.076	4.151	0.018
A X B	82.162	2	41.081	0.387	0.680
Explained	1424.334	5	284.867	2.681	0.024
Residual	15088.558	142	106.257		
Total	16512.892	147	112.333		

## APPENDIX C-6.

TABLE C-6.

Summary ANOVA table for Factor 1, (NEED) for contact criteria  
by help-source.

SOURCE	SS	DF	MS	F	P
Main Effects	153.194	3	51.065	4.798	0.003
A (Contact)	52.548	1	52.158	4.938	0.028
B (Help-source)	81.176	2	40.588	3.814	0.024
A X B	3.462	2	1.732	0.163	0.850
Explained	156.659	5	31.332	2.944	0.015
Residual	1511.200	142	10.642		
Total	1667.858	147	11.34		

TABLE C-6A.

Factor 1, (NEED) mean scores for subjects by contact criteria  
and help-source.

HELP-SOURCE	CONTACT		NO-CONTACT	
	N	M	N	M
Friend	13	14.08	79	12.56
Counselling	10	15.50	33	14.24
Psychologist/ Psychiatrist.	4	16.00	9	13.44

## APPENDIX C-7.

TABLE C-7.

Summary ANOVA table for Factor 4, (CONFIDENCE) by contact criteria and help-source.

SOURCE	SS	DF	MS	F	P
Main Effects	258.030	3	86.010	4.345	0.006
A (Contact)	38.736	1	38.736	1.957	0.164
B (Help-source)	194.737	2	97.368	4.919	0.009
A X B	29.421	2	14.710	0.743	0.477
Explained	287.450	5	57.490	2.905	0.016
Residual	2810.658	142	19.793		
Total	3098.108	147	21.076		

TABLE C-7A.

Factor 4, (CONFIDENCE) mean scores for contact criteria by help-source.

HELP-SOURCE	CONTACT		NO-CONTACT	
	N	M	N	M
Friend	13	22.92	79	21.75
Counseling	10	25.00	33	24.48
Psychologist/ Psychiatrist	4	26.50	9	22.22

APPENDIX C-8TABLE C-8.

Chi-square contingency table for attribution type by contact criteria.

ATTRIBUTION	CLASSIFICATION CATEGORY		TOTAL	%
	CONTACT	NO-CONTACT		
Internal	15	64	79	21.8
External	37	247	248	78.2
TOTAL	52	311	363	
%	14.3	85.7	100	

$\chi^2 (1, N = 363) = 1.33579$ , difference is not significant.

## APPENDIX C-9.

TABLE C-9.

Chi-square contingency table for attribution type by male and female subjects.

ATTRIBUTION	CLASSIFICATION CATEGORY			%
	MALE	FEMALE	TOTAL	
Internal	37	42	79	21.8
External	112	172	284	78.2
TOTAL	149	214	363	
%	41.0	59.0	100.0	

$\chi^2 (1, N = 363) = 1.39823$ , difference is not significant.

APPENDIX C-10.TABLE C-10.ANOVA table for global attitude score by attribution type.

SOURCE	SS	DF	MS	F	P
Main Effects	345.600	1	345.600	3.074	0.082
Residual	17086.842	152	112.413		
Total	17432.442	153	113.938		

APPENDIX C-11.TABLE C-11.

ANOVA table for global attitude score by attribution type  
and contact criteria.

SOURCE	SS	DF	MS	F	P
Main Effects	796.068	2	398.034	3.643	0.029
A (Attribution)	292.055	1	292.055	2.673	0.104
B (Contact)	450.468	1	450.468	4.123	0.044
A X B	247.368	1	247.368	2.264	0.135
Explained	1043.436	3	347.812	3.183	0.026
Residual	16389.005	150	109.260		
Total	17432.422	153	113.938		

APPENDIX C-12.TABLE C-12.

ANOVA table for global attitude score by attribution type and help-source.

SOURCE	SS	DF	MS	F	P
Main Effects	1262.903	3	420.968	3.977	0.009
A (Attribution)	230.893	1	230.893	2.181	0.142
B (Source)	912.891	2	456.446	4.312	0.015
A X B	218.179	2	109.089	1.031	0.359
Explained	1481.082	5	296.216	2.798	0.019
Residual	15031.810	142	105.858		
Total	16512.892	147	112.333		

## APPENDIX C-13.

TABLE C-13.

Means and standard deviations for the present study and  
Surgenor's (1985) sample.

CATEGORY	PRESENT STUDY			SURGENOR (1985)		
	N	M	S.D.	N	M	S.D.
<u>Age</u>						
25years	235	53.54	11.0	126	51.52	11.0
<u>Sex</u>						
Male	90	51.68	10.0	187	53.22	11.60
Female	140	54.85	11.54	224	57.67	10.92
<u>Prior Contact</u>						
Yes	43	57.60	0.67	115	64.13	9.97
No	192	52.63	10.90	296	52.35	10.22

## APPENDIX C-14.

TABLE C-14.

Means, standard deviations and Pearson correlation  
Coefficients for the ATSPPH questionnaire items and total  
score.

ITEMS	MEAN	STD. DEV.	COR. COEF.	P
Help 1	1.915	.621	.4948	.01
Help 2	1.549	.705	.4816	.01
Help 3	1.766	.812	.4059	.05
Help 4	1.855	.835	.4786	.01
Help 5	1.464	.848	.4237	.02
Help 6	1.740	.720	.5777	.001
Help 7	2.043	.697	.5363	.01
Help 8	1.843	.749	.5490	.01
Help 9	1.502	.803	.5427	.01
Help 10	1.540	.916	.5044	.01
Help 11	1.962	.629	.4990	.01
Help 12	1.374	.845	.5657	.001
Help 13	2.379	.645	.4912	.01
Help 14	1.064	.673	.5097	.01
Help 15	1.336	.711	.4306	.02
Help 16	1.864	.715	.4578	.01
Help 17	1.996	.559	.5154	.01
Help 18	1.821	.675	.5298	.01
Help 19	2.140	.648	.6377	.001
Help 20	2.026	.852	.4136	.02
Help 21	1.136	.851	.4795	.01
Help 22	2.009	.523	.4869	.01
Help 23	1.638	.680	.5986	.001
Help 24	1.557	.698	.4200	.02
Help 25	1.774	.701	.4753	.01

Continued over page.

Help 26	1.732	.680	.5414	.01
Help 27	1.434	.789	.5272	.01
Help 28	1.540	.741	.4268	.02
Help 29	2.009	.531	.3040	.1
Help 30	1.902	.736	.5113	.01
Help 31	1.630	.797	.4415	.02

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SCORE	53.540	11.009
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