ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP

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ABSTRACT

In the past, attitudes toward seeking professional psychological help have been associated with a variety of demographic and experiential variables. This study firstly assessed the utility of a modified version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) as a research instrument in the New Zealand context. Secondly the study investigated the relationship between attitude and a series of classificatory variables. A cross-section of the community was obtained (n = 411) which varied across the variables of age, sex, cultural ties, education level, income level, prior contact with professionals, and how much money prepared to pay for the services. Included in the sample was a reference comparison group of psychological professionals.

Factor analysis of the modified ATSPPH revealed a factor structure different from previous analyses, although similarities were evident. A series of ANOVAs found attitude to be highly predictable along the classificatory variables of age, sex, education level, prior psychological contact (and if so, the outcome of that contact), and how much money prepared to pay. Implications of this study are discussed in terms of future use of the ATSPPH and the attitudinal gap between the general population and psychological professionals.

Interest in the attitudes people hold toward seeking professional psychological help has increased in the last 20 years as indicated by the large body of research concerned with mental illness attitudes (see, for example, Rabkin, 1974). The stigma associated with the "mental illness" label is well documented. For example, the often cited study of Cumming and Cumming (1957) found that people not only fear mental illness, but also try to ignore it. Numerous subsequent studies have concluded that this stigma cuts across social groups and many demographic variables (e.g., age and education). As Nunnally (1961) concluded,

> "old people and young people, highly educated and people with little formal training.....tend to regard the mentally ill as relatively dangerous, dirty, unpredictable, and worthless". (p. 51)

Though attitudes have changed for the better since the 1960s, the stigma still persists. Educational programmes specifically designed to change attitudes have not been very effective, although some sectors of the community may have become better informed (e.g., Ring and Schein, 1970). In a review of close to 100 studies and articles, Rabkin (1974) concluded that the public does not really believe that mental illness is a transient condition. Mental illness is <u>not</u> viewed just like any other illness.

Given this generally negative view of mental illness and the mentally ill, it comes as no surprise that the act of seeking professional psychological help carries a similar stigma. An early study by Phillips (1963) found that those who have sought help are socially rejected to the extent that the helping agency is psychiatrically orientated. That is, an individual consulting a psychiatrist suffers greater rejection than if he or she were consulting a doctor or cleric about an identical problem. It is beyond question that people are usually favourably

disposed towards providing help for mentally ill people (Graves, Krupinski, Stoller, and Harcourt, 1971), but the social consequences of someone utilizing this help require further investigation.

An examination of what is involved in the decision to seek professional psychological help leads to a greater understanding of the problem. Kadushin (1969) pointed out that it was much easier for people to seek professional assistance for specific rather than general or vague difficulties. Emotional problems are often difficult to define - let alone decide what to do about them. Often the symptoms are intangible. Kadushin offers a number of reasons why people do not seek psychological help (p. 274):

(i) cathetic reasons, i.e., the emotional costs involved. Some emotional problems include the denial of the problem by the persons themselves; the social stigma attached to the helping services is enough to prevent their utilization.

(ii) cognitive reasons, e.g., the financial costs appear too great; there is lack of awareness of the services available.

(iii) evaluative reasons, e.g., "I can handle my own problems"; psychological counselling is viewed as unlikely to help since it is considered ineffective.

The above reasons no doubt apply to types of help-seeking behaviour other than psychological. Zeldow and Greenberg (1980), for example drew a comparison between medical and psychological help-seeking. What became apparent was that the help-seeking process was complicated - more complicated than previous research had tended to indicate. This was a view also held by Hagedorn (1977). Factors such as the urgency of the personal problem and the availability of non-professional help (e.g., friends and family) also contribute to the decision to seek

psychological help.

Once the decision has been made, there is then the question of where to seek help. For example, what type of professional or agency should be approached? Different sectors of the community vary in their knowledge of availability of professionals, their image of the helper, and in their ability to initiate and arrange the contact. For example, Schneider, Laury, and Hughes (1980) concluded that potential clients distinguish among groups of professional helpers in terms of assumed personal characteristics. Psychiatrists were perceived as more persistent and understandable than clinical psychologists (p. 591). The latter group were seen as more interested in the client than counselling psychologists. Overall, however, counselling psychologists were preferred more than the other providers (which also included high school counsellor, college counsellor and "advisor"), when dealing with emotional problems. Significantly fewer negative connotations were attributed to this professional group, probably because they were less stigma-arousing than some of the other groups offered (e.g., psychiatrists). As with the decision to seek help, no doubt many other variables are involved in the choice of helper. For example, the type of problem, ease of access, and socio-cultural background (Greenley and Mechanic, 1932: Hummers and DeVolder, 1979; Schneider et. al., 1980).

Significance of Help-Seeking Attitudes

The study of attitudes toward psychological help-seeking is important for a number of reasons. Recent decades have witnessed a growth in the number and variety of mental health care providers. Thus, it will be more common for people to be recipients of psychological services. It seems professional psychological help-givers, along with

other professional groups, are in fact able to create their own market. As Gaylin (1973) pointed out, "if we double the number of psychiatrists in this country (USA), we are guaranteed to double the number of mentally ill, if this is tabulated as the number who are treated for psychiatric illness" (p. 56). With the movement away from inpatient care towards outpatient care (see for example, Barton and Barnett, 1981, for a discussion of this trend) the general community will have more and more contact with those receiving some form of psychological or psychiatric treatment. The climate into which these people are moving should be assessed in some way.

Negative client attitudes to receiving help may be associated with less favourable therapy process and outcome expectancies. Both Cash, Kehr, and Salzbach (1978) and Dadfer and Friedlander (1981) have speculated on this relationship. For example, those with relatively postive attitudes were more optimistic regarding the counsellors helpfulness and expected more favourable counselling outcomes (Cash et. al., 1978, p. 266). Negative attitudes have also been found to be related to severity of psychological problems (Calhoun and Selby, 1974). That is, more disturbed individuals may be less receptive to psychological help. For those who have never experienced professional psychological contact, attitudes may be partly or even wholly based upon misinformation.

Client attitudes are of interest to both practitioners and researchers. In terms of research, if attitudes are associated with process and outcome, then a measure of attitudes could be used as a moderator variable or covariate in counselling effectiveness studies. This would result in greater methodological control. Furthermore, by studying help-seeking attitudes, researchers may be able to identify the variables and conditions which promote attitude modification. In terms

of practice, the richness of the therapeutic relationship and its effectiveness may depend not only on the client's attitude towards psychotherapy but also on the therapist's appreciation for and identification with the client's values (Fischer and Turner, 1970). Thus, knowledge of client expectations and attitudes may enable a better match between counselling practices and client needs.

Measurement of Attitudes

While acknowledging their importance, the measurement of "attitudes" per se presents the researcher with considerable difficulties - difficulties which must be addressed if more is to be learned about psychological help-seeking behaviour. One of the major problems concerns the low correlation between expressed attitude and overt behaviour. Rabkin (1974), in a comprehensive analysis of this issue, pointed out that even if attitudes could be accurately measured, factors other than attitude have a significant effect in determing action. For example, various personal factors such as beliefs and motives shape behaviour. Perhaps more importantly, situational variables (e.g., the influence of other people, social expectations, and the variety of alternative actions available in a given set of circumstances) determine behaviour over and above any attitudes held.

Another problem concerns the definition of the concept "attitude". For the purpose of this study, "attitude" is viewed as a relatively stable evaluation which has been formed as the result of two processes:

(i) affectional reactions toward an object, sometimes occurring as a function of relatively enduring personality traits;

(ii) beliefs and knowledge concerning an object.

Despite the pessimism found in the literature concerning the feasibility of and usefulness of measuring attitudes, a number of steps can be taken to enhance its relationship with overt behaviour. Fishbein and Ajzen (1972) have demonstrated that the relationship is strengthened if there is a high degree of specificity in the attitude scale. The example often quoted is that if a researcher wishes to predict whether a target population will participate meaningfully in a campaign to reduce litter, he or she must measure the attitude towards reducing litter, not the general attitude towards protecting the environment. Similarly, if one wishes to predict whether people will use psychological services, and the variables associated with this use, one must measure peoples' attitudes toward help-seeking not their attitudes toward mental health services per se.

It would be a naive researcher who claimed that he or she could accurately predict behaviour on the basis of an attitude scale - no matter how impressive the scale appeared. Attitudes play but one part in determining beliefs, actions, and reactions, but nevertheless an important part. As Kelman (1974) pointed out, "(verbally reported)....attitudes and actions are linked in a continuing reciprocal process, each generating the other in an endless chain" (p. 318). The relationship between attitudes and other aspects of behaviour is sufficiently meaningful to warrant further investigation.

In response to the meagre body of knowledge concerning attitudes toward seeking professional psychological help available at the time, and lack of psychometric instruments to measure this dimension, Fischer and Turner (1970) developed their own scale. In its original form, the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) consisted of 18 negatively stated and 11 positively stated items arranged

in a 4-point Likert format. Individual items were scored 0-3; negative items were scored in reverse. A high score (maximum = 87) indicated a more positive attitude. Factor analysis after orthogonal rotation revealed four components of attitude:

I Recognition of need for psychotherapy help

II Stigma tolerance

III Interpersonal openness

IV Confidence in mental health practitioners

These were claimed to be relatively independent, internally consistent, and relatively free from social desirability response bias. Modest internal reliability coefficients were reported for the subscales with $\underline{r}$ = .83 for the total scale.

Since its development 13 years ago, the ATSPPH has stimulated considerable interest and research, but most studies have continued to use student populations (e.g., Cash, Kehr, and Salzbach, 1978; Sanchez and Atkinson, 1983; Zeldow and Greenberg, 1979). Dadfer and Friedlander (1982) have conjectured, however, that the underlying domains of the scale differ when using different populations. In their study international students attending an American university were sampled, as opposed to Fischer and Turner's indigenous sample. As a result of a principle-axis factor extraction and oblique rotation, three clearly defined factors were identified:

A. Confidence/Appropriateness

B. Stigma/Privacy

C. Coping Alone

These three factors overlap to a reasonable degree with Fischer and Turner's original analysis. Factors I and IV seem to have collapsed into Factor A, Factors II and III combine to produce Factor B, while Factor C

is a mixture of Factors I and III. Dadfer and Friedlander eliminated item II ("A person with a serious emotional disturbance would probably feel most secure in a good mental hospital) from subsequent analyses since it failed to load significantly on any factor.

Response to the ATSPPH as a research instrument has been largely favourable. However, Zeldow and Greenberg (1979), for example, cast doubt on its usefulness in research as a criterion measure for actual help-seeking. Indrisano (1978) also found the scale less reliable than the original standardisation by Fischer and Turner.

In the past, a variety of demographic and experimental variables have been associated with psychological help-seeking attitudes, although not always consistently so. Males and females differ in terms of attitude, as indeed they do in their attitude toward mental illness in general (Cash et. al., 1978; Fischer and Turner, 1970; Greenley and Mechanic, 1976; Indrisano, 1978; Sanchez and Atkinson, 1983; Voit, 1982). Contradicting this finding, Dadfer and Friedlander (1982), Lorion (1974), and Zeldow and Greenberg (1979) failed to discover a sex difference. Related to this has been the interesting discovery that attitudes toward women in general also predict help-seeking attitudes (Zeldow et. al., 1979). They concluded in a subsequent study (1980) that subjects with liberal attitudes toward women would more readily seek psychotherapy and remain in therapy longer than conservatives who, while paying "lip service" to the idea of seeking psychological help, are unlikely to actually consult a therapist (p. 435).

Having actually sought or received psychological help is associated with more positive attitudes. Fischer and Turner (1970) claimed that the ATSPPH is able to differentiate between those who have experienced prior

contact and those who have not. Recent studies seem to have substantiated this claim (Cash et. al., 1978; Kligfeld, 1979) although Zeldow et. al. (1979) found only weak support ($p < .10$). Interesting as this association is, the problem remains as to the cause and effect elements of the association. Do more positive attitudes precede or result from help-seeking? It cannot be assumed that personal contact results in a more positive attitude (possibly to reduce cognitive dissonance) since it is just as plausible that more favourable attitudes are a prerequisite for initiating or receiving help.

Education level has also been consistently correlated with psychological help-seeking attitudes (e.g., Fischer and Cohen, 1972). This association is fairly predictable since those with higher levels of education are more likely to be aware of and positively disposed toward available services - whether they be psychological, medical, or educational. Dadfer et. al. (1982) concluded, however, that education was <u>not</u> uniquely significant in predicting attitudes. Considering that this research team was dealing with a relatively homogeneous sample in terms of education (international students attending a large midwestern university), the results are not surprising.

Other variables of significance include religion (Fischer and Cohen, 1972), strength of commitment and identity with a particular cultural group (Sanchez and Atkinson, 1983) and locus of control (Calhoun, Peirce, Walters, and Dawes, 1974).

There are virtually no New Zealand studies using the ATSPPH or any other scale. Although a few authors (notably Blizard, 1969, and Maxwell, 1972) have investigated attitudes toward mental illness, none have specifically focused upon seeking professional psychological help. Given this lack of research, there were a number of aims which this study

sought to achieve. Firstly, the study assessed the utility of a modified version of the ATSPPH as a research instrument with a non-student sample in the New Zealand context. This was achieved in part by conducting a factor analysis, since it was hypothesised that the underlying structure of the attitude scale would differ across populations and continents. Secondly, the study investigated the relationship between attitude and various demographic and experimental variables - most of which had been associated with attitude in previous research (e.g., age, sex, education level, cultural identity, and prior contact with professionals). In addition, a series of exploratory classificatory variables (e.g., outcome of prior contact, how much an individual would be willing to pay for the service) were investigated in an attempt to further isolate the determinants of help-seeking attitudes.

METHOD

Development of the Attitude Scale

A number of changes were made to the original ATSPPH scale. The major modification involved changing terminology to fit the New Zealand context. "Psychological counselling" was used instead of "psychotherapy" while "psychologist/counsellor" replaced the variety of helper titles used by Fischer and Turner such as "psychiatrist" and "counsellor". Amendments to the ATSPPH were also made by Sanchez and Atkinson (1983) for similar reasons.

At the same time, an attempt was made to move away from the medical model which is more applicable to psychiatry as opposed to the focus of this investigation - psychological counselling. To this end, "clinic" was changed to "agency" and "treatment/advice" was referred to as "help/assistance". The term "mental hospital" was eliminated completely.

Other minor modifications included the following:

(i) the format of "Probably Agree, Agree, Disagree, Probably Disagree" was dropped in favour of "Strongly Agree etc." This more standard Likert terminology was adopted in order that participants could record strongly held attitudes.

(ii) in line with APA guidelines, the scale was made genderless by the use of plural pronouns.

Five new statements were included. These statements represented psychological counselling as a vehicle for promoting personal growth, a form of relationship enhancement and education (e.g., Item 12 : Psychological counselling can lead to positive growth for all, not just people with personal or emotional problems). Although there are divergent views concerning the purpose and objectives of psychotherapy, this often overlooked educative dimension merited specific attention. These five items (items number 7, 12, 20, 25, 29) were dispersed randomly throughout the scale: three were positively stated and two negatively. (See Appendix A for an indication of positive and negative phrasing of statements).

The amended format was then pilot-tested (n = 42) to assess the clarity and structure of items. Further amendments were subsequently made:

(i) Despite the specific instructions at the beginning of the questionnaire emphasising the personal nature of the response, many respondents were confused as to whether they were responding on behalf of society in general or as individuals. To minimize this confusion, most items were personalised by adding phrases such as "In my opinion...."

(ii) A number of items were changed or grammatically restructured to improve clarity. For example,

"Had I received treatment in a mental hospital, I would

not feel that it ought to be covered up"

became....."If I had received help from a counselling agency, I would want it covered up" (Note that this has now become a negatively stated item)

In the past the ATSPPH has almost exclusively been used with tertiary student populations and the question of readability was unlikely to have arisen before. The original ATSPPH had a relatively high reading difficulty and might have presented difficulties for those with limited reading skill. The amendments outlined above, designed in part to simplify the terminology, did not appreciably lower the readability. As a conservative estimate, the amended scale had a reading age suitable for the average 13 year old using the Noun Frequency Method (Elley, 1975).

The attitude scale was incorporated as Part I of a two-part questionnaire; Part II requested information concerning the various demographic and experiential variables described earlier in the Introduction to the report (age, sex, education level, cultural identity, prior contact, outcome of prior contact, and how much an individual would be willing to pay for the service). A full copy of the questionnaire can be found in Appendix B. Participants were then asked to state any difficulties encountered in completing the scale. This entire process took about 15 minutes to complete.

Subjects and Procedure

Random selection was not practicable because of time and resource limitations. Therefore a degree of representativeness was attempted by approaching various available groups in the community which would ensure a reasonable cross-section. Groups of subjects were selected on the basis of their availability, willingness to participate, and the need to gain

a cross-section of the urban community. A significant number of subjects were tested at their place of employment. These included policemen, firemen, clerical workers, apprentice mechanics, cleaners, technicians, and Lincoln College lecturers. The next largest source of subjects came from educational and vocational groups. For example, Polytechnic courses (young unemployed, nursing studies, community health studies for women), WEA courses (predominantly retired people), and a PTA meeting. A third type of subject included voluntary organisatins such as Rotaract and Centrepoint, the former being young people (20s), the latter consisting of women of mixed age and background. Finally, a cross-section of people were sampled from a medical centre waiting room. Subjects for a reference comparison group were also tested : an inservice course at Teachers' College for Guidance Counsellors and related professionals, and a local Psychological Society annual general meeting (n = 43). The latter subgroup included a substantial number of currently practising clinical psychologists. The sample size on which subsequent analyses were based totalled 411. Table 1 shows the breakdown by age and sex groups, including the reference comparison group.

TABLE 1

Sample Size of Subjects Classified in Terms of Age and Sex*

		AGE		
		< 25 years	25-50 years	> 50 years
SEX	Male	n = 58	100	25
	Female	66	108	45

*Nine respondents failed to supply age and therefore have been omitted from this table.

Participants were informed that they were taking part in an anonymous survey, the purpose of which was to assess attitudes that people have towards psychology and counselling. All subjects were informed of the voluntary nature of the questionnaire. Two groups declined participation because the research would have interfered with work routines, while 2% of individuals chose not to participate. After completing the questionnaire, subjects were invited to discuss any aspect of the research with the author. Seven percent failed to complete the questionnaire correctly, either by failing to answer sections, or in some cases, ignoring whole pages. These respondents were omitted from the study.

RESULTS

Factor Analysis

In view of the equivocal nature of the factor analyses of the scale discussed earlier, the present analysis was conducted without theoretical preconceptions concerning the number or nature of factors to be found. The aim was to use whatever revealed information of interest. Eysenck (1967) argued that methods of statistical analysis, and particularly questions of rotation, are dependent on one's views of the aims of factor analysis and the nature of the factors. In this exploratory study, the most parsimonious solution was adopted in explaining the factor structure of the scale.

Preliminary analyses were conducted separately for each sex, but since the patterns were essentially similar, pooled samples were used thereafter. Principal factor extraction with orthogonal rotation (the normal varimax solution) resulted in five factors with Eigen values greater than one; these five factors accounted for 78.6% of the common variance. Table 2 sets out the results of both the unrotated and rotated solutions. Note that the principal factor solution resulted in three factors with Eigen value greater than one, accounting for 76.5% of the common variance.

TABLE 2

Factor Loadings for 35 Attitude Scale Variables - Unrotated and Rotated

Factor Loadings

	Principle Factors			h^2	Rotated (Varimax)					h^2
	I	II	III		I	II	III	IV	V	
ITEM 1.	.43	-.00	-.03	.19	.22	.18	.08	.13	.36	.23
2.	.48	-.13	.17	.28	.15	.28	.11	.31	.39	.36
3.	.42	.31	.25	.34	.05	.09	.55	.18	.15	.39
4.	.57	-.03	-.32	.43	.32	.54	.02	.07	.22	.45
5.	.53	-.36	-.04	.41	.40	.27	-.01	.20	.33	.38
6.	.61	-.02	-.17	.40	.32	.32	.16	.17	.30	.35
7.	.24	-.02	-.19	.09	.16	.04	.08	.03	-.08	.04
8.	.45	.08	.27	.28	.22	-.01	.22	.12	.57	.44
9.	.63	-.01	.06	.40	.42	.12	.23	.23	.34	.41
10.	.53	-.03	-.12	.30	.26	.26	.13	.13	.25	.23
11.	.48	.24	-.09	.30	.12	.46	.24	.02	.15	.31
12.	.63	-.25	-.15	.48	.71	.17	.04	.14	.07	.56
13.	-.05	-.31	.43	.28	-.02	-.03	.06	.28	-.02	.08
14.	.45	-.12	.30	.31	.20	.10	.16	.53	.10	.37
15.	.25	.19	-.30	.19	.03	.26	.07	.06	.05	.08
16.	.54	.28	.02	.37	.26	.37	.53	.08	.01	.49
17.	.56	-.09	.13	.34	.19	.20	.18	.50	.13	.38
18.	.41	-.31	.29	.35	.22	.03	.02	.55	.17	.38
19.	.49	.19	-.02	.28	.28	.21	.22	.04	.13	.19
20.	.62	-.15	-.03	.41	.66	.12	.18	.12	.11	.51
21.	.63	-.23	.07	.45	.56	.17	.10	.26	.22	.47
22.	.77	.02	-.10	.60	.45	.43	.22	.23	.29	.57
23.	.36	.49	.13	.39	.05	.09	.62	.00	.06	.40
24.	.39	.21	.08	.20	.06	.25	.15	.10	.20	.14
25.	.56	-.15	-.07	.34	.54	.23	.14	.12	.09	.39
26.	.16	.21	.01	.07	.06	.07	.09	.02	-.02	.02
27.	.67	-.18	.12	.50	.50	.17	.15	.41	.16	.50
28.	.47	.06	-.18	.26	.16	.49	.12	.20	.03	.32
29.	.44	.09	-.30	.29	.20	.53	.07	.04	-.03	.33
30.	.56	-.25	.04	.38	.45	.24	.07	.39	.02	.42
31.	.59	.01	-.13	.37	.30	.40	.19	.26	.11	.37
32.	.38	.42	.13	.34	.11	.13	.60	.00	.04	.39
33.	.38	-.11	-.14	.18	.42	.10	.04	.03	.03	.19
34.	.41	.22	.35	.34	.19	.04	.47	.22	.14	.33
35.	.34	.25	.18	.21	-.01	.03	.29	.17	.28	.19
EIGENVALUES	8.50	1.56	1.25		3.65	2.36	2.21	1.90	1.50	

The orthogonal rotation produced a solution which was somewhat ambiguous. Factor I, which was most similar to Dadfer and Friedlander's (1982) Factor I, appeared to refer to two things : one's trust and faith in the profession, and the degree to which psychological treatment is seen as an appropriate means for solving problems. However, the similarity between Factor I and previous analyses was limited. Some of the items with the highest loading on this factor were those which were incorporated into the scale for the first time. For example,

Item 12 : Psychological counselling can lead to positive growth for all, not just people with personal or emotional problems. (Factor loading = .71)

Item 20 : Counselling can assist all people to develop self-esteem and strength within themselves. (Factor loading = .66)

The inclusion of these items changed the nature of Factor I from previous studies.

Factor II incorporated only some of the items from Dadfer et al.'s "Coping Alone" factor and was consequently unclear. Many items loading significantly on this dimension also load highly on others, e.g., items 4, 22, and 31. The clearest pattern of loadings occurred with Factor III. This factor was concerned with the social stigma associated with seeking professional psychological help. For example,

Item 23 : In my opinion, having been diagnosed emotionally or psychiatrically ill carried with it a burden of shame. (Factor loading = .62)

Item 32 : If I had received help from a counselling agency, I would want it covered up. (Factor loading = .60)

Factors IV and V consisted of a small number of items and were of an equivocal nature, and therefore were largely ignored. A further oblique

rotation (following Dadfer and Friedlander, 1982) did not in any way improve the interpretability of the factor analysis. Many items still loaded on more than one factor making intrepretation extremely difficult.

Both orthogonal and oblique rotations therefore produced results which were not clearly interpretable. The clearest picture was provided by the original unrotated structure, even though there was some evidence of item clustering in line with previous analyses (e.g., Factor III). All but four items (numbers 7, 13, 15 and 26) loaded significantly on Factor I (.30 or higher). Therefore, a single general factor solution was adopted. Factor I was defined as general attitude toward seeking professional psychological counselling. Summing individual item scores on this large 31 item scale yielded a score for this attitude.

Items 7, 13, 15, and 26 were dropped from the scale and all other subsequent analyses. Interestingly, item 13 (item 11 on the original ATSPPH) had also been eliminated by Dadfer et. al. (1982) for the same reason. Consideration should be given to removing this item in any future studies using the ATSPPH.

Reliability

As an index of internal consistency of this 31 item scale, Coefficient Alpha was calculated. The coefficient of .91 obtained was higher than has previously been reported by Kligfeld (1979) and other measures of reliability by Fischer and Turner (1970) which ranged from .83 to .86. This can be accounted for by the heterogeneity of the sample obtained, and the fact that the scale was marginally longer in length.

Predicting Attitudes

A series of exploratory analyses of variance (ANOVAs), and in one

case, analysis of covariance (ANCOVA), were conducted using various premutations of the classificatory variables (age, sex, education level, prior counselling contact, outcome of contact, and how much prepared to pay for the service). The variables of "cultural ties" and "length of time in New Zealand" were dropped since the sample sizes of cultural minorities (n = 24) and recent immigrants (n = 10) were too small to warrant further investigation. Sample sizes in many other analyses fluctuated due to the type of analysis conducted or, in some instances, due to missing data. When significant main effects were found, a posteriori contrasts were conducted. Scheffé comparisons ($\alpha = .05$) were used because of their conservative nature, simplicity, and applicability to groups of unequal size (Hays, 1963). Table 3 presents all significant main effects and interactions for the different analyses conducted. Fuller ANOVA and ANCOVA summary tables are reported in Appendix B (Tables A-F). Results which were not significant have not been presented in Table 3.

TABLE 3

Significant Main Effects and Interactions

	Classificatory Variable	F Ratio	Level of Significance
Analysis 1	Age	$F = 12.24$	$p < .001$
	Sex	$F = 13.84$	$p < .001$
	Education	$F = 12.45$	$p < .001$
Analysis 2	Age	$F = 9.0$	$p < .001$
	Sex	$F = 9.92$	$p < .01$
	Prior Contact ("Help")	$F = 92.11$	$p < .001$
	Age x Sex	$F = 3.97$	$p < .05$
Analysis 3	Outcome (of prior contact)	$F = 10.39$	$p < .001$
Analysis 4	Sex	$F = 13.61$	$p < .001$
	Fee	$F = 3.69$	$p < .01$
Analysis 5	Group (Guidance Counsellors/ Psychologists vs General Population)	$F = 49.06$	$p < .001$
Analysis 6	Fee	$F = 3.63$	$p < .01$

Where a classificatory variable has been included in a number of analyses (e.g., sex and age), the analysis with the largest sample size is discussed since this was considered the most stable result.

A highly significant main effect for sex was found in all analyses except Analysis 3, which is discussed later. Females (M=57.76) had more positive attitudes to seeking psychological counselling than males (M=53.22). Age was also highly significant in predicing attitudes. A posteriori comparisons showed younger people's (< 25 years) attitudes to be significantly less positive (M=51.52) than either the 25-50 years age group (M=57.2) or those over 50 years of age (M=57.7). The Age x Sex interaction was significant ($p < .05$) in Analysis 2 but not in Analysis 1 which employed a slightly smaller sample size (n=402 as opposed to n=407). Most of this interaction can be accounted for by males who hold relatively negative attitudes that become more positive with advancing age. Female attitudes, although changing in the same direction with increasing age, do not show such a dramatic improvement since they are relatively positive to begin with. This pattern is clearly seen in Table 4 below.

TABLE 4

Mean Attitude Score Classified According to Age and Sex

		SEX	
		Male	Female
AGE	< 25 yrs	47.43	55.23
	25-50 yrs	55.82	59.38
	> 50 yrs	56.48	57.58

However the failure of Analysis 1 to replicate this finding indicates the tentative nature of the interaction. In addition, female performance indicates a degree of uncertainty. Attitude scores actually decrease

slightly for the over 50 years age group. Therefore, little importance can be attributed to the Age x Sex interaction at this stage.

Level of formal education was categorised as follows;

(i) at least some university study

(ii) University Entrance

(iii) those holding formal qualifications below University Entrance (e.g., School Certificate passes) or no qualifications at all.

Scheffé contrasts revealed that those with some university experience held significantly more positive attitudes (M=59.95) than either of the other two levels of education (M_{UE}=53.72; $M_{SC \text{ or less}}$= 53.68). No significant difference was obtained between these lower levels.

A significant main effect was found for the classificatory variable of prior contact with a professional counsellor/psychologist. Those who reported having sought or received such help had significantly more positive attitudes (M=64.18) than those who had not (M=52.41). It was interesting to note that in the small sample of subjects (28%) who had experienced prior contact with counsellors or psychologists there was no difference in attitude between the sexes (M_m=63.36; M_f=64.61).

For those reporting previous contact, the outcome of that contact was also highly significant. As is the typical pattern in most outcome research, a significant number recorded a positive outcome (68%), a smaller number of neutral outcome ("neither positive nor negative, 29%) while a few felt worse (3%). Scheffé multiple comparisons revealed that those reporting a positive outcome held significantly more positive attitudes (M=66.45) than either of the other two outcome categories ($M_{neutral}$=60.52; $M_{negative}$=48.75). Although not statistically significant, a large difference between these latter two categories was observed. The conservative nature of Scheffé contrasts and the small sample size of those reporting a negative

outcome (n=4) probably resulted in the difference not being statistically significant.

Two other main effects were evident. First, the reference comparison groups (consisting primarily of guidance counsellors, psychologists and related helping professionals) were more receptive to the idea of seeking professional psychological help (M=66.58) than the general population sampled (M=54.37). A closer analysis within the reference groups revealed that the guidance counsellors held slightly, though not significantly, more positive attitudes (M=69.24) than the Psychological Society group (M=64.05). Secondly, a main effect was found for how much money subjects were prepared to pay for each one hour counselling session. A covariance analysis with income as the covariate (Analysis 6) determined that this classificatory variable was virtually independent of gross annual income (r=.10). A posteriori comparisons found that those who were not prepared to pay anything, who expected the service free, held significantly less positive attitudes (M=52.14) than those who would consider paying between $1 - $20 (M=56.3) or over $20 per hour (M=58.97). Eight percent of respondents recorded "I don't know" or "It depends..." and these responses were omitted from the statistical analyses.

The final question in Part II of the questionnaire gave respondents the opportunity to comment upon any difficulties encountered in completing the scale. Sixty-seven percent made no comment and 2% said either that they enjoyed participating in the research or that the questionnaire itself was well designed. The problems mentioned by the 31% who did make objections included the lack of a neutral category in the Likert scale, lack of contact with the psychological profession, and problems with specific items. Interestingly, items singled out for criticism most frequently were those which were subsequently dropped from the scale.

DISCUSSION

This study, while raising a number of interesting questions concerning psychological help-seeking attitudes, largely confirms the findings of similar North American studies discussed in the introduction.

The sex difference in attitude can be interpreted in several ways. The dependent position often assumed to be required of a client in a helping relationship could be seen as more acceptable to women than men. Furthermore, most forms of counselling require the expression of feelings which is also more acceptable behaviour for women. These findings are consistent with Lilliston, Brown, and Schliebe (1982) who concluded that males prefer the adoption of an intellectual solution to personal problems (e.g., reading to learn more about the problem) as opposed to a religious or spiritual solution (e.g., increased church attendance, prayer, or seeking an emotional religious experience). Perhaps the sex difference can be accounted for by the higher percentage of females who actually seek help. In this study, 21% of males versus 34% of females reported prior counselling contact. Is this because women experience more distress, and therefore have greater psychological need, or is there greater female awareness of the services and openness to use them?

The classificatory variable of prior contact raises some of the most interesting questions. The figure of 28% reporting prior contact is comparatively high in relation to other studies. Cash et. al. (1978) reported 14%, Dadfer et. al. (1982) 22%, while Fischer and Turner (1970) a low 9%. Is it a feature of the 1980s (as suggested by Dadfer et. al.) that more people require psychological services or that the helping services are seen as a more acceptable and viable alternative solution to personal problems? Perhaps the increasing number and variety of professional helpers are in fact creating their own market, as suggested

by Gaylin (1973). Interestingly, 74% of the reference comparison group (guidance counsellors, psychologists, etc) reported prior counselling contact. This compares equally with the 74% of psychotherapists reported by Henry (1977) who had undergone therapy. The prior contact with professionals may have subsequently stimulated these individuals to become professionally involved in the field. Alternatively, aspects of their training (e.g., T-groups, encounter groups) may have perhaps highlighted problems in their own lives which they wished to work on in therapy. Both hypotheses are equally plausible and deserve further investigation.

The finding that positive outcome of contact with a psychologist/ counsellor is associated with attitude lends support to the hypothesis that the perceived quality of the counselling experience has an effect on attitude. However, the suggestion of Cash et al (1978) that the perceived quality of the experience may be predisposed by the client's already existing attitudinal set should not be discounted. Ideally future research should continue to address this issue of cause and effect.

The discovery that young people (< 25 years) harbour relatively negative attitudes could be interpreted in terms of the "arrogance of youth". For one thing, younger people are less likely to have experienced particular emotional crises or problems leading them to consider the option of seeking professional help. Younger people are also less trusting of establishment representatives (such as professionals and social welfare agencies) and less conforming (Coleman, 1980). There is some comfort in the knowledge that age brings with it a more sympathetic disposition in terms of attitude score on the ATSPPH. However, in some sense, the above finding is interesting. A large body of literature (for example, see Rabkin, 1974) indicates that the older the individual, the more unsympathectic intolerant, rejecting, and distant are his or her attitudes about the mentally

ill in general. Clearly attitudes toward the mentally ill must be seen as different from attitudes toward seeking professional help.

The classificatory variable of how much money respondents are prepared to pay for counselling has in the past been relatively neglected by researchers. A recent study by Corens (1978) however indicated the potential importance of this financial variable for psychotherapy expectations and attitudes;

> "When respondents read about a psychotherapist who fee matched the highest affordable psychotherapy fee payable, they had greater attributions of professional competence to the psychotherapist and higher expectations of behavioural change than when respondents read about a psychotherapist whose fee was either higher or lower than the highest affordable psychotherapy fee payable".
>
> (p.40258)

The highly significant difference in terms of attitude between paying nothing and paying something is, on the surface, easily interpretable. How highly <u>any</u> goods or services are valued (in part a function of attitude) will be associated with how much money will be exchanged in order to obtain them. Just over 20% of respondents reported that they would expect counselling free. While it could be concluded that these people do not value the psychological services very highly, it could also be suggesting something about expectations. That is, the relatively high percentage of those expecting counselling free can in part be attributed to the advanced social welfare services freely available in New Zealand. As Maxwell (1972) also found, the government is seen as primarily being responsible for spending money on and supporting mental health services. There is the expectation that professional psychological services should be an integral part of the system, much like medical services. Indeed many respondents expressed this opinion. What emerged from this data was that, on average,

people are prepared to pay considerably less money per session ($10-$14) than current charges for individual psychotherapy in Christchurch (on average, approximately $35 per session). Of course, there is a difference between how much people are "prepared" to pay and how much people "expect" to pay. The former response was requested, but no doubt some will have interpreted the question in terms of expectations. This whole area requires further investigation.

The significant difference in attitude scores obtained between the general population sampled and the reference group is expected in light of past research concerned with therapists' attitudes toward mental illness (Rabkin, 1977). Professional psychological helpers are usually better informed about counselling process, counselling outcome, and the cause of emotional problems, when compared to the general population. All these variables are likely to be associated with attitude. The significant difference in attitude scores obtained between these two groups enhances the validity of the scale. However differences within the reference group itself raises some interesting questions. The guidance counsellors sampled included many who had only recently entered the field, but they generally scored higher (M=69.24) than the more professional group represented at the Psychological Society Annual General Meeting (M=64.05). Perhaps the latter group has become familiar enough with the services provided and the processes involved within these services to know that as Schneider et al (1980) put it, "counselling can hurt as well as help".

In the modified form adopted in this study, the ATSPPH scale proved useful for the study of attitudes of the general population. However, the components of attitude (e.g., recognition of need, interpersonal openness, confidence etc) originally identified by Fischer and Turner (1970) were not evident in this sample. Factor analysis using a more homogeneous

population than the present one may well result in the re-emergence of factors reported in past literature. What does seem to be evident from this study is that the factor structure of the scale is not stable across populations, even allowing for the modifications made to the instrument. It is recommended that the format of the scale, incorporating all the modifications outlined earlier should be maintained, at least in New Zealand studies. Future researchers using the scale should, at the same time, be sensitive to the nature of the sample being tested.

Attitude surveys have limited value in terms of their results. However they can be extremely useful in exploring an area and illuminating future research questions. This research paper does not point to the need for general education programmes designed to change attitudes; the effectiveness of such programmes have been shown in the past to be limited. In this study, attitudes toward seeking professional psychological help were slightly positive (Grand mean = 55.65, maximum possible score = 93). Rather, the investigation points to two things.

First, it identifies the attitudes held by specific groups and isolates some of the contributing factors. Some sectors of the community hold negative views, in particular, young males. Secondly it identifies a gap between the public and the helping professionals themselves. Not only did the public not hold the positive attitudes that the psychological professional subscribed to, but what rapidly became evident was the general lack of awareness among the population sampled of the qualifications and roles of psychologists/counsellors. Questions often asked of the researcher included, for example, "What is the difference between a psychiatrist and and psychologist/counsellor?" and "What are the steps and processes involved in actually seeking such help, once the decision has been made?" Professional psychological groups must continuously be aware of client and

nonclient concerns about, and attitudes toward, seeking psychological help, as well as the profile of the professional groups and other consumer issues. One step that can be taken to this end is for counsellors/psychologists to give clients more prior information about themselves and their services (for example of this practice, see Manthei, 1982). The information brochure distributed recently by the Canterbury Branch of the New Zealand Psychological Society addressing some of these questions is a practical step leading to greater awareness among the public - and ultimately more enlightened attitudes. However, if such information brochures are to be distributed again in the future, it is hoped that greater care is taken. "Psychologist" was spelt three different ways on one page, while three out of the four case-studies presented were females, once again reinforcing the stereotype of help-seeking being the domain of females.

There are a number of pressing issues in the New Zealand context concerning psychological help-seeking attitudes. In a country with such a large Polynesian population, in what way does cultural and ethnic identity effect attitudes? Do ethnic minorities view psychologists/counsellors in an entirely different light? Other studies could also investigate the attitudes of groups such as medical practitioners, lawyers, and other service occupations likely to come into contact with those using professional psychological resources. Of particular interest would also be the attitudes held by specific groups of clients. It would not be a lengthy nor costly business to obtain client attitudes, for example, during the initial interview.

While certainly focusing on the attitudes of the public and recognising the importance of this area, the location of attention in the immediate future should be with the psychological professionals

themselves. It is acknowledged that the public could become more aware of the psychological services and their role, however it is even more critical that psychological professionals become more aware of the public's stance. Psychological service providers should pay particular attention to their public image and client attitudes. By doing this they can learn to tailor services to client needs and wants, rather than tailor clients to existing services. It is in the interest of the psychologist/counsellor and, in particular, in the interest of the client, that such moves are made. Otherwise the psychological professionals are in danger of catering only for the well-educated, enlightened, and articulate among those who could benefit from psychological counselling - a trend which is perhaps already apparent in terms of attitude as this study has demonstrated.

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Appendix A.

ATTITUDES TO PSYCHOLOGY AND COUNSELLING

University of Canterbury

Education Department

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.

		Strongly Agree	Agree	Disagree	Strongly 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 about a personal or emotional problem, I might recommend that they see a psychologist/counsellor.	SA	A	D	SD
-	3. I would feel uneasy going to a psychologist/counsellor because of what some people would think about me.	SA	A	D	SD
-	4. People with a strong character can get over personal or emotional conflicts by themselves, and would have little need of a psychologist, counsellor, in my opinion.	SA	A	D	SD
+	5. There are times when I have felt completely lost and would have welcomed professional help for a personal or emotional problem.	SA	A	D	SD
-	6. Considering the time and expense involved in psychological counselling, it would have doubtful value for a person like me.	SA	A	D	SD
-	7. Psychological counsellors tend to see only people with problems.	SA	A	D	SD
+	8. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	SA	A	D	SD
-	9. I would rather live with certain personal or emotional conflicts than go through the ordeal of getting psychological counselling.	SA	A	D	SD
-	10. I believe that emotional difficulties, like many things, tend to work out by themselves.	SA	A	D	SD

		Strongly Agree	Agree	Disagree	Strongly Disagree
-	11. There are certain personal or emotional problems which should not be discussed outside of one's immediate family, in my opinion.	SA	A	D	SD
+	12. Psychological counselling can lead to positive growth for all, not just people with personal or emotional problems.	SA	A	D	SD
+	13. I believe that a person with a serious emotional disturbance would probably feel most secure in a good psychiatric hospital.	SA	A	D	SD
+	14. If I believed I was having a personal or emotional breakdown, my first inclination would be to get professional help.	SA	A	D	SD
-	15. A good solution, in my opinion, for avoiding personal worries and concerns, is keeping your mind on a job.	SA	A	D	SD
-	16. I believe that having received psychological counselling is a blot on a person's life.	SA	A	D	SD
-	17. I would rather be assisted by a close friend than by a psychologist/ counsellor, even for an emotional problem.	SA	A	D	SD
+	18. 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
-	19. I resent a person - professionally trained or not - who wants to know about my personal or emotional difficulties.	SA	A	D	SD
+	20. Counselling can assist all people to develop self-esteem and strength within themselves.	SA	A	D	SD
+	21. I would want to get psychological attention if I was worried or upset for a long period of time.	SA	A	D	SD
-	22. The idea of talking about problems with a psychologist/counsellor strikes me as a poor way to get rid of emotional or personal conflicts.	SA	A	D	SD

P.T.O.

		Strongly Agree	Agree	Disagree	Strongly Disagree
-	23. In my opinion, having been diagnosed emotionally or psychiatrically ill carries with it a burden of shame.	SA	A	D	SD
-	24. There are experiences in my life I would not discuss with anyone.	SA	A	D	SD
+	25. Psychological counselling is another form of teaching, a way of learning about one's abilities and potentials.	SA	A	D	SD
-	26. I believe that it is probably best not to know <u>everything</u> about oneself.	SA	A	D	SD
+	27. 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 counselling.	SA	A	D	SD
-	28. 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
-	29. In my opinion, no one needs the help of a psychologist/counsellor to develop ordinary personal and interpersonal skills.	SA	A	D	SD
+	30. At some future time I might want to have psychological counselling.	SA	A	D	SD
-	31. In my opinion, people should work out their own problems; getting psychological counselling would be a last resort.	SA	A	D	SD
-	32. If I had received help from a counselling agency, I would want it 'covered up'.	SA	A	D	SD
+	33. Psychological counselling focuses just as much on preventing stress and problems in the community as on helping overcome their problems.	SA	A	D	SD
+	34. If I thought I needed professional psychological help, I would get it no matter who knew about it.	SA	A	D	SD

	Strongly Agree	Agree	Disagree	Strongly Disagree
35. 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

PLEASE ANSWER THE FOLLOWING:

(1) Age _____ years

(2) Sex ☐ Male ☐ Female

(3) Which of the following formal educational qualifications do you have?

☐ No formal educational qualifications

☐ School Certificate (one subject or more)

☐ University Entrance

☐ Some credit towards a university degree/diploma

☐ University degree/diploma

(4) Estimate your (if single) or your family's income to the nearest thousand dollars per year.

$ _____

(5) Please identify your cultural ties. For example, if you consider yourself a Vietnames, write "Vietnamese". If you consider yourself a European, write "European".

_____

(6) How long have you lived in New Zealand?

_____ years

(7) Have you ever received help from a professional counsellor/psychologist for any personal or emotional troubles you have experienced?

☐ Yes ☐ No

a) If yes, where did you receive this professional help from?

_____

b) What was the overall result of that counselling for you?

☐ Positive ☐ Neither positive nor negative ☐ Negative

(8) If you decided to seek professional counselling, how much would you be prepared to pay for each one-hour session?

☐ Nothing - I would expect it free
☐ $0 - $10
☐ $11 - $15
☐ $16 - $20
☐ $21 - $25
☐ $26 - $30
☐ Over $30

(9) Write in the space below any difficulties you had in understanding or filling out this questionnaire.

****

Please make sure you have answered all the questions you can.

Thank you for your participation.

Appendix B.

ANOVA AND ANCOVA SUMMARY TABLES

TABLE A

ANALYSIS OF VARIANCE OF TOTAL ATTITUDE SCALE SCORES CLASSIFIED ACCORDING TO AGE, SEX, AND EDUCATION LEVEL - ANALYSIS 1

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif. of F
Main Effects	7875.425	5	1575.085	14.120	-0.000
Age	2730.911	2	1365.456	12.240	0.000
Sex	1543.340	1	1543.340	13.385	0.000
Education	2777.808	2	1388.904	12.451	0.000
2-Way Interactions	1142.544	8	142.818	1.280	0.252
Age Sex	536.312	2	268.156	2.404	0.092
Age Education	568.065	4	142.016	1.273	0.280
Sex Education	393.282	2	196.641	1.763	0.173
3-Way Interactions	266.734	3	88.911	0.797	0.496
Age Sex Education	266.734	3	88.911	0.797	0.496
Explained	9284.703	16	580.294	5.202	-0.000
Residual	42948.242	385	111.554		
Total	52232.945	401	130.257		

TABLE B

ANALYSIS OF VARIANCE OF TOTAL ATTITUDE SCALE SCORES CLASSIFIED ACCORDING TO AGE, SEX, AND PRIOR CONTACT EXPERIENCE ('HELP') - ANALYSIS 2

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif. of F
Main Effects	13977.022	4	3494.256	36.625	0.000
Age	1717.725	2	858.863	9.002	0.000
Sex	945.998	1	945.998	9.916	0.002
Help	8788.087	1	8788.087	92.113	0.000
2-Way Interactions	1298.339	5	259.668	2.722	0.020
Age Sex	758.225	2	379.113	3.974	0.020
Age Help	563.822	2	281.911	2.955	0.053
Sex Help	54.957	1	54.957	0.576	0.448
3-Way Interactions	192.555	2	96.277	1.009	0.365
Age Sex Help	192.555	2	96.277	14.739	0.365
Explained	15467.916	11	1406.174	14.739	0.000
Residual	37685.274	395	95.406		
Total	53153.189	406	130.919		

TABLE C

ANALYSIS OF VARIANCE OF TOTAL ATTITUDE SCALE SCORE CLASSIFIED ACCORDING TO SEX AND OUTCOME OF COUNSELLING - ANALYSIS 3

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif. of F
Main Effects	1812.082	3	604.027	7.060	0.000
Sex	15.326	1	15.326	0.179	0.673
Out	1776.960	2	888.480	10.385	0.000
2-Way Interactions	185.804	2	92.902	1.086	0.341
Sex Out	185.804	2	92.902	1.086	0.341
Explained	1997.886	5	399.577	4.671	0.001
Residual	9325.157	109	85.552		
Total	11323.043	114	99.325		

TABLE D

ANALYSIS OF VARIANCE OF TOTAL ATTITUDE SCALE CLASSIFIED ACCORDING TO SEX AND FEE - ANALYSIS 4

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif. of F
Main Effects	4507.724	7	643.961	5.316	0.000
Sex	1648.110	1	1648.110	13.605	0.000
Fee	2680.412	6	446.735	3.688	0.001
2-Way Interactions	770.011	6	128.335	1.059	0.387
Sex Fee	770.011	6	128.335	1.059	0.387
Explained	5277.735	13	405.980	3.351	0.000
Residual	44094.445	364	121.139		
Total	49372.180	377	130.961		

TABLE E

ANALYSIS OF VARIANCE OF TOTAL ATTITUDE SCALE CLASSIFIED ACCORDING TO GROUP (REFERENCE GROUPS VERSUS OTHERS) - ANALYSIS 5

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif. of F
Main Effects	5741.640	1	5741.640	49.064	-0.000
GP	5741.640	1	5741.640	49.064	-0.000
Explained	5741.640	1	5741.640	49.064	-0.000
Residual	47862.204	409	117.023		
Total	53603.844	410	130.741		

TABLE F

ANALYSIS OF COVARIANCE OF TOTAL ATTITUDE SCALE SCORE WITH INCOME CLASSIFIED ACCORDING TO FEE - ANALYSIS 6

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif. of F
Covariates	489.946	1	489.946	3.761	0.053
Y	489.946	1	489.946	3.761	0.053
Main Effects	2834.583	6	472.430	3.626	0.002
Fee	2834.583	6	472.430	3.626	0.002
Explained	3324.529	7	474.933	3.645	0.001
Residual	43124.061	331	130.284		
Total	46448.590	338	137.422		