**PREDICTORS OF ATTITUDES**

**TOWARDS SEEKING PROFESSIONAL PSYCHOLOGICAL HELP AMONGST UK-BASED FIRST GENERATION GREEK ADULTS**

**by**

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**Abstract**

This study employed quantitative methodology to examine the role of age, gender, years of living in the United Kingdom, past experiences of therapy, acculturation, public stigma and internalised shame in predicting Attitudes Towards Seeking Professional Psychological Help of first generation Greek immigrants (N=120).

The results of the correlational analysis suggested significant correlations between attitudes towards seeking professional psychological help, gender, age, years in the United Kingdom, past experiences of therapy, social stigma and the embarrassment factor of internalised shame. In contrast to the hypothesis and previous studies, acculturation did not correlate significantly with attitudes towards seeking professional psychological help.

Hierarchical regression analysis was further used to present a model of the link between the predictor variables and attitudes towards seeking professional psychological help. The results suggested that past experiences of therapy and social stigma were the main predictors of attitudes towards seeking professional psychological help, with higher levels of social stigma being the most significant predictor. Internalised shame, gender, age and years of living in the United Kingdom did not have a predictive effect in this model.

Implications of the findings to the field of Counselling Psychology are considered. This study appears to be the first to examine the attitudes towards seeking professional psychological help amongst a population of first generation Greek immigrants living in the United Kingdom. The implications of the findings include questioning the utility of a “Western” model of counselling. Considering the possible link between one’s attitudes and their behaviours in relation to seeking help, these findings point out the need for interventions to reduce the social stigma of seeking help of Greek immigrants, which may in turn increase the willingness to seek help for emotional difficulties of this growing immigrant population.

**Keywords:** help-seeking attitudes, acculturation, social stigma, internalised shame, Greek immigrants

*In memory of my grandmother Margarita*

*who passed away*

*a few days prior to the completion of this thesis.*

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**List of Abbreviations Used**

ATSPPH: Attitudes Towards Seeking Professional Psychological Help

ATSPPHS: Attitudes Towards Seeking Professional Psychological Help Scale

SSRPH: Stigma Scale for Receiving Professional Psychological Help

SMAS: Stephenson’s Multigroup Acculturation Scale

ISS: Internalised Shame Scale

**Introduction**

Over recent years Counselling Psychology in Britain has increasingly recognised the importance of considering the socio-cultural context of the individual, and has growingly considered multiculturalism and diversity (Fouad et al, 2005, cited in Moller, 2011). It has been questioned, however, whether its identity was developed based on the values of the dominant culture in the exclusion of the needs of non-majority populations (Moller, 2011). Research points out that only a small percentage of the people who experience mental health problems seek professional psychological help (Williams, Skogstad and Deane, 2001; Mackenzie, Gekoski and Knox, 2006). While some people turn to mental health agencies, some refuse to seek professional psychological support (Kakhnovets, 2011). Considering the effectiveness of psychological treatment, this gap is at the least surprising. Research has further suggested that ethnic minority groups living in the United Kingdom and other Anglophone countries underutilize the mental health services (Bagourdi and Vaisman-Tzachor, 2014). Attitudes Towards Seeking Professional Psychological Help (ATSPPH) have been the centre of attention of many researchers examining cultural differences in seeking therapy (i.e. Shea and Yeh, 2008).

In the last few years many Greeks have moved to various Anglophone countries in search of a better life. According to the Migration Statistic Quarterly report provided by the National Statistics, in the United Kingdom alone, in 2013 the registration of new National Insurance numbers for Greeks has increased by 33% since 2012 (Statistical Bulletin, 27 February, 2014). Such numbers can be a reflection of economic difficulties, or may be linked to other factors, such as pursuing better career opportunities or a career change, educational or training opportunities. Other reasons might include existential motivations, where people make a choice to leave their culture of origin to move to a different one for reasons that might, for example, include exploring foreign cultures in an assessment of their personal identity (Madison, 2006). The growing Greek immigrant group makes first generation Greeks in the United Kingdom potential service users of psychological therapies. Nevertheless, for Greek immigrants, psychological problems appear to stay within the in-group; the family and friends, the support network of the individual and the local communities seem to be important sources of support for Greeks. In addition, the Greek culture has been characterised as family oriented (Evergeti, 2006). However, what happens to the Greek immigrants whose support network is left behind and cannot provide the help needed to meet the current emotional needs of the suffering individual? An alternative option would be seeking professional psychological help for emotional difficulties.

Greek immigrants seem to have low levels of acculturation (Evergeti, 2006) and stigmatisation is associated with mental illness and seeking psychological help (Bagourdi and Vaisman-Tzachor, 2010). A question arises as to what impact these factors have on individuals who have migrated to the United Kingdom. Furthermore, what happens to the individuals who experience long-standing or severe mental health difficulties for which the informal social support network (family and friends) is not sufficient to help the suffering person cope with, or overcome, their difficulties? Does stigma prevent people from seeking professional psychological help even when other available resources are exhausted? Does internalised shame hold individuals from sharing their problems with psychologists who could, potentially, help them overcome them? Ultimately, when people do choose to attend psychological therapy, do shame and stigma in relation to needing help and seeking psychological input enter the room and impact on the therapeutic process? In order for the needs of this immigrant group to be better understood, these factors need to be further explored.

In multicultural environments, such as in the United Kingdom, cross-cultural counselling is a very frequent occurrence (Williams, Skogstad and Deane, 2001). It is worthy of questioning whether a more “Western European” or “Western” model of counselling (Shea and Yeh, 2008) can be sufficient or effective for people who come from different cultural backgrounds.

While western models of therapy focus on the individual, multicultural models of therapy maintain a focus on the individual as part of a culture that influences the person’s behaviours (Segal, Lonner and Berry, 1998). Furthermore, western models do not seem to take into account the process of acculturation which the immigrant individual is faced with (Squire, 2000), or the difficulties that individuals might face due to multilingualism and the associated difficulties that may arise from experiencing the self in more than one languages (Burck, 2004). It is important that the needs of various cultural groups are considered and that an attempt is made to understand the factors that may influence their professional help-seeking attitudes. Given the growing number of first generation Greek immigrants living in the United Kingdom, considering this population’s ATSPPH can help to think about ways to make psychological services more relevant and accessible. This appears to be an area that has not received a great amount of attention in research to date.

This study is concerned with factors related to United Kingdom based first generation Greek immigrants’ attitudes towards seeking professional psychological help. Specifically, age, gender, years of living in the United Kingdom, past experiences of therapy, internalised shame, acculturation and social stigma are explored for their role in predicting attitudes towards seeking help, in an attempt to better understand the attitudes of this minority group. Research has suggested that people’s attitudes towards seeking professional psychological help influence their willingness to seek help; Vogel et al (2007) suggest that people who have more negative attitudes towards seeking counselling will be less willing to seek therapy. Furthermore, an individual’s attitudes influence their behavioural intention and, in turn, their actual behaviour (Fishbein and Ajzen, 1975).

This research adopted a quantitative approach, and Pearson Correlational and Hierarchical Regression analyses are proposed to best test the hypotheses that younger individuals, those who have lived in the United Kingdom for more years, female gender, past experiences of therapy, higher levels of immersion in the British society, lower levels of social stigma and internalised shame will positively predict ATSPPH. The choice of quantitative method was deemed more suited to serve the purpose of the research question. This study’s epistemological position is post-positivism as the researcher shares the view that knowledge is provisional and falsifiable (Magee, 1994) and that the outcomes of research help knowledge advance (Guba and Lincoln, 1994). The proposed study also accepts the pragmatic approach, in the sense that the ultimate choice of methodology was based on technical considerations as opposed to epistemological: the research question led to the choice of methodology (Hammersley, 1996; Hammerlsey, 2010). It also adapts a pragmatic element because the researcher accepts that qualitative and quantitative methodologies can be combined to complement the results of the other (Hammersley, 1996): however, this is not the case for the proposed research.

To sum up, this study looks at possible variables that contribute to the attitudes towards seeking professional psychological help of the first generation Greek immigrants living in the United Kingdom. This study aims to add to the knowledge of which factors contribute to negative attitudes towards seeking professional psychological help as such factors could potentially stop people from seeking professional psychological help when they experience mental health difficulties. Specifically it is concerned with factors related to negative attitudes in the Greek immigrant population living abroad. In doing so, quantitative research is employed, and specifically Correlational and Hierarchical Regression Analyses will be conducted.

In the first part of the study a review of the relevant literature on attitudes towards seeking professional psychological help will be provided. Moving on, an outline of the methodology employed for this study will be drawn. The results will then be analysed in the following section, and their implications will be discussed in regards to their relevance to the field of counselling psychology. This research will eventually conclude with an account of the limitations of the research and some suggestions for future studies, followed by a general conclusion.

**Chapter 1: Literature Review**

**1.1 Attitudes Towards Seeking Professional Psychological Help**

**1.1.1 Defining Attitudes**

Different variations of the definition of attitudes have been offered by various attitude theorists over the years, and they all appear to agree that attitudes involve an evaluation or a judgement: a decision as to whether one is in favour, or not, of a person, an object or an issue (Ajzen, 2005; Maio and Haddock, 2012). Attitude objects can be abstract (e.g. feminism) or concrete (e.g. bicycles), and they can refer to our own self, other people (e.g. an athlete) or social groups etc (Maio and Haddock, 2012).

**1.1.2 A Brief History of Attitudes**

The study of attitudes began in the 1920s and it was mostly associated with the field of social psychology. The idea that attitudes can be quantified and measured originated from the work of Louis Thurstone and Rensis Likert (for example in Thurstone, 1928; Thurstone and Chave, 1929; Likert, 1932, cited in Maio and Haddock, 2012), who focused on the development of measurements of attitudes in the late 1920s – early 1930s. Furthermore, the focus of the early research of attitudes was concerned with their *relation with behaviours*; for example the work of Richard LaPiere in 1934 (cited in Maio and Haddock, 2012).

The study of attitudes was deeply influenced by the events of both World War I and the Cold War, in an effort to understand the bigger social concerns. During the years that followed, research turned to the understanding of the *functions* of people’s attitudes (for example, the work of Daniel Katz in 1960). In the mid-1960s, research into attitudes was concerned with the *social cognition* of attitudes: the work of Icek Ajzen and Martin Fishbein in 1977 and 1980 was focused on the *prediction* of behaviours from the study of attitudes (Ajzen and Fishbein, 1980; Maio and Haddock, 2012). The 1980s marked the beginning of research focusing on the *content* of attitudes and more modern studies focused on the *processes underlying attitude change* (Maio and Haddock, 2007, cited in Maio and Haddock, 2012).

**1.1.3 The Measurement of Attitudes**

As a hypothetical construct that cannot be subject to direct observation, attitudes are inferred from measurable responses. The measurement of attitudes can be achieved by direct assessment, indirect assessment or disguised techniques (Ajzen, 2005). Direct measures were typically self-report questionnaires asking people’s opinions, or using Likert scales, which ask the participants to indicate their degree of agreement with each of the items on a list of belief statements that are relevant to the issue of interest (Maio and Haddock, 2012). One of the main criticisms of the direct measurement of attitudes is concerned with the possibility of the individual responses being representative of their own opinions, an attempt to present themselves in a favourable manner (Paulhus and John, 1998, cited in Maio and Haddock, 2012), or provide socially desirable responses (Ajzen, 2005). Several models have been suggested over the years in an attempt to conceptualise attitudes and their function.

The multicomponent model of attitudes suggests that there are three elements of attitudes, namely Cognitive, Affectionate and Behavioural (CAB). Cognitive refers to the thoughts, attributes and beliefs that people associate to an object (for example one might be in favour of a specific football team, based on their belief that the players are competent and skilled). Affectionate refers to the emotions in relation to the object, while the behavioural component is concerned with past behaviours or experiences in relation to an attitude object (Maio and Haddock, 2012).

It has been suggested that attitudes are important predictors of behaviours; the degree, however, to which they predict behaviours depends on various factors. Generally speaking, the strength and functions of the attitude, the type of the behaviour, and the personality of the individual will determine the strength of the relation between attitude and behaviours (Maio and Haddock, 2012). Some of the models of attitudes will be described in the part that follows.

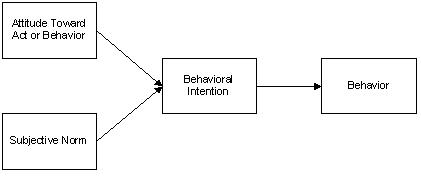
**1.1.4 Do Attitudes Influence Behaviour?**

*Theory of Reasoned Action (by Fishbein and Ajzen, 1975):*

Fishbein and Ajzen suggest that *attitudes towards a behaviour*, combined with *subjective norms*, determine a person’s intention to take a certain action, and it is the intention that determines the behaviour, as shown in Figure 1. They therefore argued that by measuring the attitude of a person, one can understand and predict their behaviour. Furthermore, normative beliefs (referring to a person’s beliefs of whether other important people think that they should perform the behaviour or not, in other words the social pressure to perform or not to) add to the understanding of behaviours (Ajzen and Fishbein, 1980).

**Figure 1: The Theory of Reasoned Action**

**(by Fishbein and Ajzen, 1975, cited in Ajzen and Fishbein, 1980)**



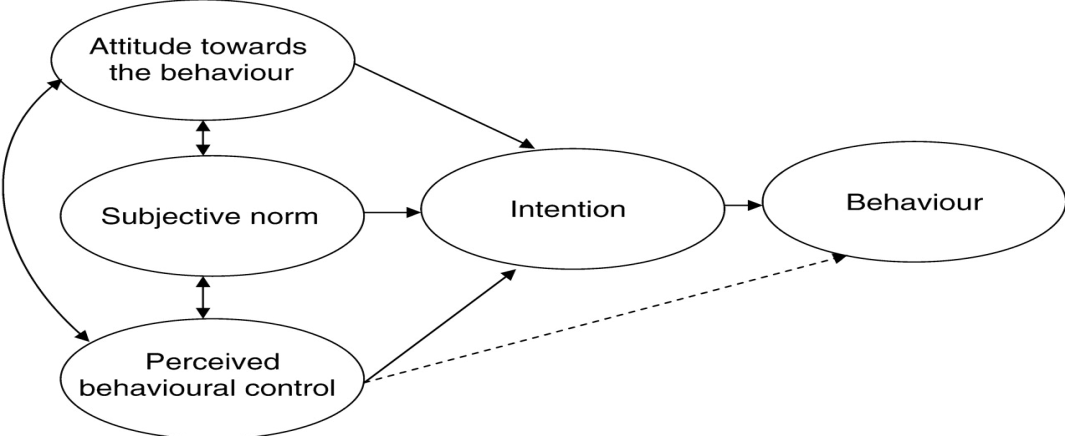
*Theory of Planned Behaviour (by Fishbein and Ajzen, 1975):*

As a continuation of the Theory of Reasoned Action, in their Theory of Planned Behaviour, Fishbein and Ajzen add that it is not only necessary to hold positive attitudes and have positive subjective norms in order to perform behaviour. The Theory of Planned Behaviour adds a third dimension to the model, which suggests that *perceived behavioural control* also plays a part in determining whether or not an individual will proceed with the behaviour (Maio and Haddock, 2012). The later factor refers to the evaluation of the individual as to whether they have the means or ability to perform the behaviour (Ajzen, 2005). In other words the model suggests three dimensions: a personal determinant (attitude), a social determinant (subjective norm) and the perception of self-efficacy (control) or ability to perform the behaviour. All three factors seem to be directly linked to each other, as shown in Figure 2.

Furthermore, the model suggests that perceived behavioural control can also predict behaviours directly (Ajzen, 2005). Both the theory of reasoned action and the theory of planned behaviour imply that there is an indirect effect of attitudes on behaviours, and are based on the assumption that individuals tend to behave in a sensible manner (Ajzen, 2005). Critics of the model questioned the degree to which attitudes and subjective norms are equally important in predicting behaviours; research conducted at later stages suggested that attitudes are normally (but not always) stronger predictors than subjective norms. A second point of criticism is the fact that intentions might not necessarily always predict behaviours (Maio and Haddock, 2012), for example a student who intends to study regularly throughout the academic year. It has been suggested that, despite its usefulness, the Theory of Planned Behaviour does not consider other predictor variables, such as emotion, personal need for satisfaction etc, and that it also fails to explain and predict spontaneous action (Maio and Haddock, 2012).

**Figure 2: The Theory of Planned Behaviour**

**(by Fishbein and Ajzen, 1975, cited in Ajzen, 2005, p. 118)**

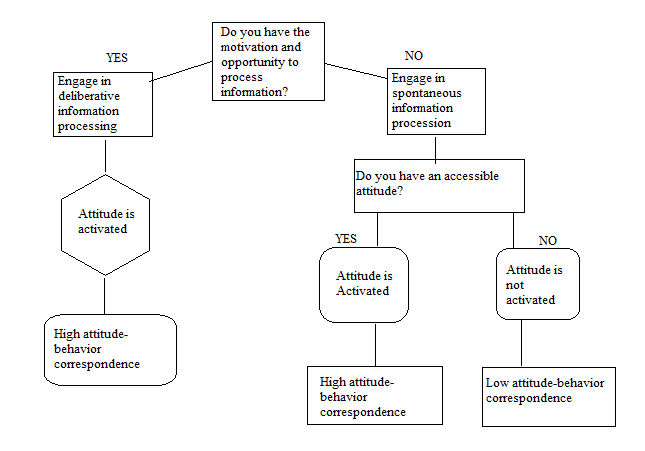


*The Motivation and Opportunity as Determinants of Behaviour (MODE) Model (by Fazio, 1990):*

The MODE model suggests that behaviours can be influenced by attitudes either spontaneously or deliberately. Given the opportunity, and with sufficient motivation, individuals will engage in deliberative information processing, which will activate the attitude, which will in turn predict the behaviour (as shown in Figure 3). When, however, the attitude is not accessible (which might happen in some cases of spontaneous information processing), it will not be activated, and is therefore not likely to be a predictor of behaviours. The MODE model has played an important part in the research on attitudes, because it looks at how attitudes explain both deliberate and spontaneous behaviours (Maio and Haddock, 2012).

**Figure 3: The MODE Model**

**(Fazio 1990, cited in Ajzen, 2005, p. 59)**

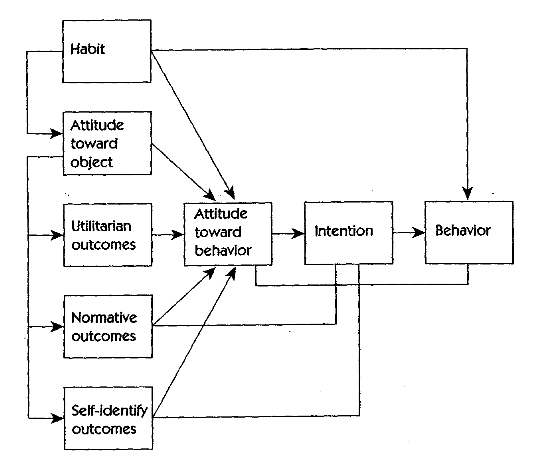
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*The Composite Attitude-Behaviour Model (by Eagly and Chaiken, 1993; 1998)*

A similar, but more complicated model that attempts to explain the link between attitudes and behaviours was introduced by Eagly and Chaiken (1993; 1998, cited in Maio and Haddock, 2012). According to the composite attitude-behaviour model, several factors (as seen in Figure 4, namely habits, attitude toward target, utilitarian outcomes, normative outcomes, self-identity outcomes) can affect intentions, either directly, or indirectly via attitudes toward the behaviour, with the exception of habit, which is believed to directly predict behaviours (Maio and Haddock, 2012). Although there has not been extensive research to test this model, it is nevertheless known amongst attitude researchers as it introduces the idea that habits can predict behaviours (Maio and Haddock, 2012).

**Figure 4: The Composite Attitude-Behaviour Model**

**(by Eagly and Chaiken, 1993, cited in Maio and Haddock, 2012)**



**1.1.5 Attitudes Towards Seeking Professional Psychological Help (ATSPPH)**

All the various models described above seem to agree that there is a link between attitudes and behaviours. For this reason, the study of attitudes has become popular amongst various fields, including psychology. The study of Attitudes Towards Seeking Professional Psychological Help (ATSPPH) has faced increasing popularity by several researchers who have, amongst others, tried to study several factors that predict ATSPPH, in an attempt to understand the underutilization of mental health services (Masuda et al, 2005). Research points out that only a small percentage of the people who experience mental health problems seek psychological help (Williams, Skogstad and Deane, 2001; Mackenzie, Gekoski and Knox, 2005). Help-seeking attitudes have been the centre of attention of many researchers examining cultural differences in seeking counselling (e.g. Shea and Yeh, 2008). Several variables have been considered in relation to attitudes towards seeking professional psychological help, including causal beliefs and perceived service accessibility (Fung and Wong, 2007), gender role conflict (Berger et al, 2005) and cultural mistrust (Townes, Chavez-Korell and Cunningham, 2009).

Research has been conducted to explore the professional help-seeking attitudes of various immigrant populations, and particularly Asian and African immigrants. Nevertheless, European minorities’ ATSPPH have not received the same amount of attention, despite the growing number of European migrants in recent years. Following an extensive search undertaken on one of the biggest psychological databases, Ebsco, it has become apparent that most of the studies concerned with factors relating to Attitudes Towards Seeking Professional Psychological Help (ATSPPH) were conducted in the United States (US), with a relatively low level of research having been carried out in the United Kingdom. This study is specifically interested in the help-seeking attitudes of United Kingdom based Greek immigrants. Firstly, however, a review of the recent changes in the mental health system in Greece will be considered.

**Seeking Professional Psychological Help in Greece**

A number of changes have taken place since Greece entered the European Community in 1981, which included significant changes to the mental health system. Under the EEC Regulation 815/84, the Greek government was asked to review the traditional psychiatric care system (Kolaitis et al, 2010), which was followed by a five year plan that would eventually shift the existing mental health care system to a community-based one (Madianos, Tsiantis and Zacharakis, 1999).

The new national program employed by the Greek Ministry of Health was named “Psychargos” (Loukidou et al, 2013). Psychargos was a program that outlined changes that needed to be made, such as the rehabilitation of long-stay patients and the launch of a new community-based mental health model, different from the model of institutional psychiatry of the past (Madianos, Tsiantis and Zacharakis, 1999). Therefore, the psychiatric reformation that followed led to several major changes to establish services that would provide care and support to mental health patients within their community. Such services included new employment opportunities being made available to mental health patients of psychiatric institutions, the provision of supported living facilities and community mental health centres (Loukidou et al, 2013).

With the implementation of the Psychargos program, five psychiatric hospitals closed down, and the remaining three are expected to close down by the end of 2015 (Loukidou et al, 2013). Following anti-stigma campaigns, local communities appeared to become more comfortable with the idea of inclusion of the people with mental health difficulties. Furthermore, according to a study conducted by Loukidou el al (2013), in which they employed mixed methods of research to systematically evaluate the Psychargos program, other benefits of the move to a community-based mental health system included the employment of more person-centred techniques by staff working with people with mental health issues.

After the economic crisis in Greece, which started in 2009, the Greek National Health System (GNHS) had to undergo several changes that involved several cuts in public healthcare expenditures, in order to cope with the financial difficulties. As a result of these, the healthcare systems have suffered several reductions, such as several healthcare units closing down, cuts in the salaries of healthcare staff, merging different health units, reductions in the number of health professionals, and ultimately significant reduction on the funding for mental health services in 2010 (Simou and Koutsogeorgou, 2014).

In addition, a systematic review of the effects of the economic crisis on health and healthcare conducted by Simou and Koutsogeorgou (2014), has shown a link between the economic difficulties faced by the country and the health and well-being of the Greeks, that included an impact on the mental health. Such examples included an increase in the Greeks that underwent major depression (2.6 times more likely in 2011 compared to 2008). Similarly, the systematic review revealed an increase in the number of suicides (40% increase, as reported by the Greek Ministry of Health in 2011). Several factors might have contributed to this, such as the high levels of unemployment, one of the main difficulties faced by many Greeks following the austerity measures implemented after the financial crisis (the unemployment rates have reached 30-35% in Greece, with youth unemployment reaching 55% in September 2012); other difficulties included reduction of the income or even poverty (Ifanti et al, 2013).

A question arises: what help is accessible to individuals suffering from mental health problems in Greece? It is also worth wondering whether the changes in the healthcare system have had a negative impact on peoples’ ATSPPH and have left them feeling sceptical about seeking professional psychological help for mental health difficulties. Two of the main issues raised in the review conducted by Simou and Koutsogeorgou (2014) were the lack of an appropriate referral system and the lack of coordination between services. In the researcher’s experience, in the cases where people do seek help for mental health problems in Greece, this takes the form of either seeking help directly from a privately practicing psychologist, or being referred to a psychiatrist by their general practitioners. Access to free psychological services is sparse. Seeking help is often done through informal sources of support, such as the family and friends.

**Attitudes Towards Seeking Professional Psychological Help and the Greek Immigrants:**

Similarly to Greeks residing in Greece, Greek immigrants appear to keep psychological problems and distress within the in-group, and Greeks in general seem to rely on families and friends, support networks, the church and the local communities for help with various difficulties (Evergeti, 2006). The Greek culture has been characterised as family oriented (Evergeti, 2006). Furthermore, when Greeks immigrate to different countries, they seem to have low levels of acculturation (Evergeti, 2006); they appear to be mostly maintaining aspects of their culture of origin as opposed to adapting to the values of the host society (Baello and Mori, 2007).

Only one study was found to have examined the ATSPPH of Greek immigrants. This study has been conducted by Bagourdi and Vaisman-Tzachor (2010), who examined the degree of immersion of first and second generation immigrants living in America into the Greek culture, the role of past experience of therapy and the motives of migration, and their relationship with ATSPPH. The results suggested a possible positive (yet not conclusive) impact of previous therapy on ATSPPH, and also that Greek Americans appear to rely on family and friends as opposed to professional sources for help for psychological problems, a finding that was consistent across generations. Overall, the researchers reported that both sets of participants (first and second generation Greeks living in America) appeared to retain elements of their Greek culture, and mildly positive ATSPPH (Bagourdi and Vaisman-Tzachor, 2010). This study, however, did not expand to consider other possible factors that may influence Greek immigrants’ ATSPPH.

As there appears to be a gap in the literature concerned with the ATSPPH of European immigrant populations in general, but also Greek immigrants in specific, this study sets out to explore this further. Specifically, the role of acculturation will be looked at, to examine whether it is an important factor associated with, or influencing the help-seeking attitudes of Greek immigrants living in the United Kingdom. Furthermore, the study that was conducted by Bagourdi and Vaisman-Tzachor (2010) was inconclusive in regards to the role of past therapy on ATSPPH, as there seemed to be a connection between the two variables that was, nonetheless, not confirmed by their research. This study will aim to add to the existing knowledge of the role of past therapy on ATSPPH. In addition, the role of stigma will be considered, as Greeks appear to hold strong stigmatising perceptions in relation to mental illness, and also to seeking psychological help (Bagourdi and Vaisman-Tzachor, 2010). The role of age, gender, and years of living in the United Kingdom will also be added to the model, in order to help gain a fuller picture of what factors contribute to Greek immigrants’ ATSPPH. Finally, a new factor will be introduced in the psychological help-seeking attitude literature in general: the role of shame will be explored for the first time in this study. In order for the psychological services to be more accessible and applicable to people from other cultures, it is crucial to understand the factors that predict ATSPPH. This research starts with a set of research questions and hypotheses that will be discussed in the part that follows.

**1.1.6 Research Question**

This study is concerned with factors related to ATSPPH. Specifically, the research question of the study is: Do various demographic variables (gender, age and years of living in the United Kingdom), past experiences of therapy, internalised shame, acculturation and social stigma towards receiving psychological help predict ATSPPH?

This research question was based on previous research and the past experiences of the therapist. In regards to the gender, the results of a meta-analysis conducted by Nam et al (2010), as well as other studies, such as Soorkia, Snelgar and Swami (2011) suggest that there are significant gender differences on ATSPPH, with women holding more positive attitudes than men. In contrast to the well examined role of gender, age did not appear to have been given equal attention. The results of past studies have been inconsistent, with some suggesting that older individuals and some suggesting that younger individuals will hold more positive ATSPPH (Mackenzie, Gekoski and Knox, 2006). The potential role of years of living in the United Kingdom has not been studied to date, to the knowledge of the researcher. This study aims to explore the role of age and years of living in the United Kingdom on help seeking attitudes of the first generation Greek immigrants.

Furthermore, a set of psychological variables were also introduced: a study that looked at ATSPPH of Greek Americans suggested a possible link between past experiences of therapy and ATSPPH, yet no significant results were reported when other variables were entered into the analysis (Bagourdi and Vaisman-Tzachor, 2010). In regards to internalised shame, following a review of the literature, the researcher has not found any studies examining its role on ATSPPH. Yet seeking help can be a shame inducing experiences; in addition, the idea of being in a room with a professional that can potentially pass judgments can be difficult; also, people sometimes find it difficult to seek help as that would imply failing to achieve their goals, or live up to their ideals (Tangney and Dearing, 2011). Social stigma of seeking psychological help has been linked with negative ATSPPH (Vogel, Wade and Hackler, 2007; Lannin et al, 2007). This may be due to fear of being ostracised or labelled if they seek professional psychological help (Seloilwe and Thupayahale-Tshweneagae, 2007). Finally, acculturation has been found to be a significant predictor of ATSPPH. For Greek immigrants ethnic identity seems to be based on the family and culture (Moskos and Moskos, 2014). Furthermore, according to Bagourdi and Vaisman-Tzachor (2010), difficulties remain within the family: seeking help implies reaching out to the out-group. It is likely that people who are more immersed in the Greek culture will not seek help from professional psychological sources. Following the research question a set of hypotheses were formed and will be listed in the part that follows.

**1.1.7 Hypotheses**

The first sets of hypotheses are concerned with demographic factors and their relation with ATSPPH. The first hypothesis is that:

1. H1: Female UK-based Greek immigrants will hold more positive psychological help seeking attitudes than male.

Secondly, the role of age and years of living in the United Kingdom will be explored, and it is hypothesised that:

1. H2: Younger individuals and those who have lived in the United Kingdom for longer will hold more positive ATSPPH.

According to the results of a study conducted by Bagourdi and Vaisman-Tzachor (2010), past experiences of therapy may be linked to more positive ATSPPH among Greek immigrants. Therefore, this research hypothesises that:

1. H3: Past experiences of therapy will positively predict ATSPPH.

In regards to the psychological variables, this study will explore the role of acculturation, internalised shame and public stigma on ATSPPH with another set of hypotheses. Specifically, the fourth hypothesis is that:

1. H4: Lower levels of immersion in the British culture will negatively predict ATSPPH.

The fifth hypothesis of this study that introduces internalised shame as a new factor that may potentially be linked to negative ATSPPH is that:

1. H5: Participants who score higher on the Internalised Shame Scale will hold more negative ATSPPH.

Ultimately, considering that a consistent finding amongst previous research is that stigma is related to negative attitudes towards seeking psychological help (Vogel et al, 2007; Shea and Yeh, 2008) the final hypothesis of this research is that:

1. H6: Higher scores on the Social Stigma scale will be predictive of more negative ATSPPH, above and beyond the effects of all the other variables.

Following a post-positivistic stance, this study aims to expose several hypotheses to the falsification process; theory advances by eliminating possible alternatives (Coolican, 2009). This research therefore aims to disprove its Null Hypotheses (Fischer, 1971) which are as listed below:

HO: There will not be any statistically significant differences between age groups, or male and female participants’ ATSPPH, or any differences between participants who attended personal therapy and those who did not. Participants who score higher on the social stigma scale and on the internalised shame scale will not hold more negative ATSPPH than participants who score lower. In addition, lower levels of acculturation to British values will not predict ATSPPH. Ultimately, stigma will not predict ATSPPH above and beyond the effects of the remaining variables examined.

**1.2 Gender, Age, Years of Living in the UK and ATSPPH**

Research has consistently shown that women tend to have more positive attitudes towards seeking professional psychological help than men (Soorkia, Snelgar and Swami, 2011), and tend to seek help when experiencing emotional difficulties more often than men (Vogel, Wade and Hackler, 2007). In an American meta-analysis that examined gender differences on ATSPPH, the authors selected 16 studies that examined gender differences using a population of either undergraduate or graduate students (a total of 5,713 participants). Their results suggested that gender is indeed an important predictor of ATSPPH. Specifically, women seem to consistently hold more positive ATSPPH, and are more likely to utilise mental health services (Nam et al, 2010). Despite the lack of studies examining ATSPPH in the United Kingdom (Soorkia, Snelgar and Swami, 2011), the result of the meta-analysis (Nam et al, 2010) were consistent with a British study by Soorkia, Snelgar and Swami (2011), which also confirmed the hypothesis that women held more positive ATSPPH compared to men.

In a study conducted by Mackenzie, Gekoski and Knox (2006), the role of age and gender was examined in relation to help seeking attitudes. In regards to gender, the results have also shown that women seemed to hold more positive attitudes towards seeking professional psychological help, compared to men. Specifically, significant differences were reported in women’s openness to seek psychological input, suggesting that women might be more open to acknowledging psychological difficulties, but also more open to recognising the need to seek help (Mackenzie, Gekoski and Knox, 2006). The implications of the results include that aiming to increase people’s openness to seek psychological input might help improve the general attitudes towards psychological help-seeking attitudes held by men, and potentially reduce the gender differences in seeking help (Mackenzie, Gekoski and Knox, 2006).

Moreover, in the same study, when the researchers examined the role of gender in intending to seek help from a primary care physician, both men and women reported similar levels. Furthermore, while for men education level appeared to be an important factor, for women, it did not seem to influence the results of the impact of gender on ATSPPH. Additionally, Mackenzie, Gekoski and Knox’s (2006) study seems to suggest that prior help-seeking experiences did not influence women’s likelihood of talking to a mental health professional. Nevertheless, despite the consistency of the findings, when looking at gender differences on ATSPPH across different cultures, it appears that the cultural background of the individual is a moderator: there appear to be gender differences in ATSPPH across some cultural groups (e.g. Asian, or Asian American groups), but not others (e.g. Caucasian American). The overall effect size of gender on ATSPPH was reported to range between small and medium, according to Cohen’s criteria, as reported in the meta-analysis (Nam et al, 2010).

These results might help explain the low rates of mental health service utilisation by men (Mackenzie, Gekoski and Knox, 2006). Attempts have been made to explain the reasons behind the gender differences; one of them is linked to a possible gender role conflict. Traditional gender roles assume that men are expected to be strong, competitive, and not express their emotions. Furthermore, public stigma in relation to traditional gender ideation might be linked to the negative ATSPPH held by male members of certain cultures, and might, furthermore, act as a barrier to their willingness to seek help for psychological problems; this seems to be more the case in more “masculine-oriented” cultures (Nam et al, 2010). Additionally, it appears to be more shameful for men of certain cultural backgrounds to disclose personal problems to mental health professionals; this seems to be more the case in cultures which can be described as collectivistic (Nam et al, 2010).

In regards to age and its role on ATSPPH, the results of previous research seem to be inconsistent. The small number of studies that has considered age’s connection to ATSPPH has either concluded that younger individuals hold more positive ATSPPH, or that older individuals have more favourable help-seeking attitudes (Mackenzie, Gekoski and Knox, 2006). Various factors can be linked to this, such as the educational level of the individual, and also the cultural background. There may also be significant differences in the degree of stigma held by various age groups. This study will aim to add to the existing knowledge of the role of age on ATSPPH, and specifically of first generation Greek immigrants. Similarly this study will also examine a possible relationship between years of residing in the United Kingdom and Greek immigrants’ ATSPPH.

In regards to the demographic variables (gender, age and years of living in the UK) and their role on ATSPPH, this study hypothesises that women, younger individuals and those who have lived in the UK for longer will hold more positive ATSPPH.

**1.3 Past Experiences of Therapy and ATSPPH**

Another factor that has not received a large amount of attention in the literature concerned with ATSPPH is past experiences of therapy. In a study conducted by Bagourdi and Vaisman-Tzachor (2010), among other factors, the researchers looked at the possible link between past experiences of therapy and ATSPPH in a population of first and second generation Greek Americans. Their results suggested that there is a possible link between the individuals who have attended therapy in the past and positive ATSPPH, but their data were insufficient: when other variables were added to the model, past experiences of therapy were not significant, limiting the researchers from making confident interpretations about the predictive role of therapy on ATSPPH. This study hypothesises that past experiences of therapy will predict positive help-seeking attitudes amongst first generations Greek immigrants.

It is expected that various factors may contribute to more positive help-seeking attitudes held by those who have had past therapy experiences. Such factors may include the positive outcome of therapy, or may be a reflection of a positive therapeutic experience that perhaps included an empathic therapist, reparation of therapeutic ruptures and a strong therapeutic alliance. Regardless of the therapeutic modality, these factors appear to be linked to positive therapeutic outcomes (Lemma, 2003; Sanders and Wills, 2005), which could in turn help improve people’s ATSPPH.

An alternative explanation, however, could be the need of individuals who have received therapy in the past to achieve cognitive consistency. According to Leon Festinger’s theory of cognitive dissonance, when people hold two or more contradictory beliefs or ideas, they experience distress followed by attempts to achieve cognitive consistency; this may include avoiding information and situations that will expose the person to cognitive inconsistency (Festinger, 1962). It is therefore likely that people who have received psychological help in the past, will avoid expressing negative attitudes towards seeking professional psychological help in an attempt to reach a state of internal cognitive consistency.

Furthermore, another possible reason may be that in the absence of first-hand experience of seeking psychological help, those who have not engaged in therapy in the past will have assumptions or fantasies of what therapy may be like. Such fantasies may also include that they will be seen as mad by other people, or as vulnerable for needing to seek help. In addition, another assumption may be that they will need to disclose information in the presence of another person that may be considered private, and quite often shameful.

**1.4 Internalised Shame and ATSPPH**

**1.4.1 Theories of Shame**

Over the years, various definitions of shame have been suggested. Ferguson and colleagues (Ferguson et al, 1999, cited in Uji et al, 2007, p. 112) defined shame as a *“dejection-based emotion involving feelings of helplessness, incompetence and a desire to escape or avoid contact with others”*. It also implies a sense of exposure of sensitivity or vulnerability, and can therefore be a difficult psychological experience (Uji et al, 2007). Similarly, Elison (2005, p. 6) described shame as *“an affect (ie a basic emotion) evolved by social selection and elicited by perceived devaluation”.* According to Elison (2005), shame has often been confused with guilt, and the various definitions led to a conceptual confusion.

Various developmental theories of shame have been proposed over the years that can be grouped into three theoretical orientations. The first group is the functionalistic theories that are mostly concerned with the adaptive role of shame. One such theorist is Barrett (1995, 1998a, cited in Mills, 2005) who saw shame as having the adaptive quality of ensuring that self-esteem is preserved and that others are accepting of the self. This can be achieved by a constant attempt to learn and maintain social standards. Barrett suggests that shame has three functions, namely behavioural, internal and social regulation (Mills, 2005).

The second group of theorists focus on the cognitive aspect of shame. Helen Block Lewis, for example suggests that shame is connected with the need of the person to attach to other people (Mills, 2005). Lewis (1971; 1981; 1987) argues that shame and guilt, although different, have a common source of internalised aggression, caused by the perception of failure to internalise the admired imago (defined as *“an unconscious idealised mental image of someone, which influences a person’s behaviour”*). Wurmser (1981) argued that shame protects the boundary of privacy and intimacy (Wurmser, 1981, cited in Kaufman, 1993).

Finally, the third group is the object relational or attachment theorists, that focus on the early interactions and attachments with others on the regulation of shame (Mills, 2005). Many theorists embrace the idea that the internalisation of shame has roots in the dynamics of the early interpersonal relationships, and subsequently affected by interaction with others, such as teachers, peers, other adults and intimate partners (Trnka, Balcar and Kuska, 2011). Freud (1933) has attributed the origin of shame to a genital deficiency. Horney (1950) has described shame as “neurotic pride”, arguing that human beings feel ashamed when they believe that their pride is being violated. Around the same time, Erikson (1950) argued that shame is linked to toilet training, and comprises the second of eight stages of the life cycle. Piers and Singer (1953) supported the idea that shame is the result of the tension between the ego and the ego ideal. Lynd (1958) defines the experience of shame as involving the entire self, and deriving from the sense of exposure or inappropriateness, or from a threat to the trust (cited in Kaufman, 1993). Bowlby (1973) despite not focusing directly on the experience of shame, implied a strong link between shame and attachment (cited in Wills, 2005). According to Tomkins and the Affect Theory (1962; 1963; 1982; 1984; 1987a, cited in Kaufman, 1993) the duration, frequency of encounter and intensity increase systematically (affect magnification). They shape, and eventually control the emerging personality: the self is eventually able to reproduce shame (Tomkins, 1987a, cited in Kaufman, 1993). All of the theories seem to agree that the experience of shame occurs when the individual is faced with an inconsistency of how they are, or are seen and how they want to be or be seen.

In regards to the development of shame, different theorists place its onset at different times in a person’s life. According to Lewis (1992, cited in Mills, 2005) shame emerges around the age of two and a half to three years, and is linked to the development of the child’s capacity to compare the self with an internalised cultural standard, goal or rule: shame occurs when the outcome of the global evaluation of the self is negative. Unlike Lewis, Trevarthen (1992, cited in Draghi-Lorenz, Reddy and Costall, 2001) places the emergence of shame around the sixth month of life and suggests that it is linked with the definition of the self in relation to other people. Izard (1978, cited in Draghi-Lorenz, Reddy and Costall, 2001) places the shame experience even earlier, emerging only after two to three months after birth. Despite the variations in time, theorists concerned with the development of emotions appear to agree that shame emerges early and is present before the end of the third year of life (Mills, 2005).

Internal shame is caused by thoughts and feelings that the person holds of their own behaviours, attributes and personality characteristics; in other words it is linked to negative self-evaluation (Gilbert, 2000), as opposed to external shame, which is concerned with a person’s perspective of how others see him/her. There seems to be a correlation between internal and external shame cognitions, meaning that if a person considers that he is inadequate, they will expect that others will also hold a similar view (Gilbert, 2000). The researcher supports a multidimensional approach to shame, that includes both the internalised and the externalised aspects of shame, but one that also takes into account the impact of culture.

**1.4.2 The causes of shame**

Shame is believed to be either internal, or external, depending on whether the source of shame is in the self, or in another person. Despite the common belief that a person needs the presence of another to feel shame, shame can be caused by one’s own self (without the presence of the other), and can therefore be a completely internal experience (Kaufman, 1993): this is referred to as internal shame. This thesis is specifically concerned with shame that is internalised.

Shame has a dual role. Considering the benefits of belonging to a social group, shame serves as an adaptive signal to others as it indicates compliance with social norms; it further serves as a signal to the self (Gilbert and McGuire, 1998, cited in Elison, 2005). It has a positive function in the sense that it motivates self-correction by sending signals to alert of potential misconduct. Similarly, it motivates the correction of behaviours that are not socially acceptable. It is also important for the development of conscience and the identity (Kaufman, 1993). It helps teach norms that are crucial for survival and success in interpersonal relationships (Trnka, Balcar and Kuska, 2011).

Despite its positive role, it can nevertheless be disturbing to the self. Because of its central role in the formation of the identity and conscience, it can lead to self-doubt, poor self-esteem, insecurity etc (Kaufman, 1993). Frequent exposure to shameful experiences might lead to the internalisation of shame: people can develop trait shame which can become part of their identity. Internalisation of shame is a condition in which a person experiences themselves as flawed, or experiences a persistent “badness” that doesn’t seem to change (Trnka, Balcar and Kuska, 2011). Trait shame can take several forms, including developing techniques to hide an aspect of the self that is considered imperfect, or behaving in a manner that increases the chances of receiving shaming messages (Trnka, Balcar and Kuska, 2011).

Shame-prone individuals demonstrate cognitive, emotional and behavioural patterns. Cognitive patterns include, for instance, beliefs such as “something is wrong with me” and obsessive preoccupation with the negatives, as well as subjective reasoning (not involving reality-checking). Emotional patterns refer to a general feeling of badness or emptiness, often accompanied by feelings of guilt. Behavioural patterns are obvious in the appearance of the person, such as blushing, or putting the head down, They are also evident in the interaction with other people; for example a constant strive for perfection, use of sarcastic humour or denial (Harper and Hoopes 1990).

In order to cope with internalised shame, people employ several strategies such as distancing in their relationships with others, blaming other people, rage etc. In more serious cases, people develop behaviours that can be harmful such as substance misuse, changes in eating habits that could lead to eating disorders, self-harming behaviours or attacking others, withdrawal, etc (Trnka, Balcar and Kuska, 2011). It is believed that the experience of shame is universal across cultures (Trnka, Balcar and Kuska, 2011), but different societies impose shame in different ways (Yamawaki, 2007). For example, Benedict (1946, cited in Yamawaki, 2007) described Japan as having a “shame culture”, where the notion of shame is related to being exposed to the public. In that sense, in such cultures, what other people believe or know is a great source of shame. Although this is changing, this may also be the case for the Greek culture, where other people such as family and the community play an important part, and the person is accountable for their actions (Bagourdi and Vaisman-Tzachor, 2010).

**1.4.3 Shame and the Greek culture**

In Greek mythology, Aidos (Ancient Greek: Αἰδώς) was the Greek goddess of shame, modesty and humility. Aidos was relevant to the standards of “arete” (the notion of living up to one’s full potential, and trying to achieve excellence), and also the standards of the society. Homer’s heroes, for example, strive at living up to their ideals (Scott, 1980). Closely related to the idea of aidos is also the idea of “nemesis” (from the Ancient Greek verb νέμειν that means to give what is due) that refers to a punishment that the individual will potentially receive for having carried out an act of aidos (Scott, 1980). The value of aidos was an important value for ancient Greeks, and, to an extent, survived through the years.

Moreover, Boellstorff and Lindquist (2004, cited in Trnka, Balcar and Kuska, 2011) argued that certain culture emotions, including shame, need to be viewed in the cultural context. Scherer and Wallbut (1994, cited in Trnka, Balcar and Kuska, 2011), having compared a number of cross-cultural studies, concluded that the way in which shame is processed and expressed varies amongst different countries, and Creighton (1988) argues that shame is often used both for self and for social control (Yamawaki, 2007). Religion is an example of this. Different religions and Christianity in particular suggests that certain thoughts or behaviours are considered “sins”, and as such should be avoided. The Greek Orthodox Church in specific supports the idea that the person needs to behave in a certain manner in order to avoid the ultimate consequence of going to hell. Non-compliance with the Christian values, or experiencing thoughts that are contradictive even, can lead to people experiencing shame, regardless of the presence of other people. These characteristics of the Greek culture may lead to Greeks holding high levels of shame in relation to going through personal difficulties, suffering from mental health problems or not achieving the standard of life they have envisioned. Shame may in turn be linked to holding negative attitudes to seeking professional psychological help.

**1.4.4 Shame as a Barrier to Seeking Help**

Various reasons seem to prevent people from seeking help for mental health problems. One of them is the shame of needing to seek mental health services. Accessing mental health services would imply exposing the “flawed” sense of self to others (Trnka, Balcar and Kuska, 2011); in that sense mental illness can be seen as a weakness of character. Gilbert and Andrews (1998) argued that avoidance to seek help might be linked to the avoidance of shame itself: this includes avoiding exposing the self to a situation that is likely to provoke shame. Therefore, shame has a role in self-preservation. Moreover, shame can lead to avoidance of shameful situations (Trnka, Balcar and Kuska, 2011). Seeking professional psychological help can be a shame-inducing experience: it implies that the individual has unsuccessfully attempted to resolve their difficulties (Tangney and Dearing, 2011), and can potentially affect people’s attitudes towards seeking professional psychological help, or act as a barrier to seeking professional psychological help.

A further factor is the shame of failing to live up to ideals: such ideals can be imposed on the individual by various sources that include religion, spirituality, familial values and the community, or they may come from the individual. A person may, for example, experience shame following their inability to achieve their career goals, or may also feel shame from not being able to cope with emotional difficulties without the need to resort to professional help (Tangney and Dearing, 2011). Such factors can contribute to a person’s negative ATSPPH.

Ultimately, there is the shame that arises from being in room with a professional, who can potentially pass judgment, and who is therefore a possible source of shame (Tangney and Dearing, 2011). The problem becomes more complicated if the professional is someone senior, or of actual or perceived higher position, or perhaps from a different ethnical or cultural background. Shame can potentially lead to negative help-seeking attitudes, and may hold people back from engaging in psychological therapy. The role of shame, however, in the prediction of ATSPPH has not yet been explored. This research will aim to explore a possible connection between internalised shame and help-seeking attitudes, and hypothesises that higher levels of internalised shame will predict negative ATSPPH.

Vogel, Wade and Hackler (2007) argued that public stigma leads to self-stigma, which in turn can leave the individual experiencing feelings of shame, followed by the employment of avoidance strategies to protect the self from them; thus, internal shame might mediate the effects of stigma, and therefore have an indirect effect on a person’s attitudes towards seeking professional psychological help, and also their intention to seek help where needed. The effects of stigma on ATSPPH will be discussed in the part that follows.

**1.5 Social Stigma and ATSPPH**

**1.5.1 Social Stigma and Mental Illness**

Stigma was defined as a perceived flaw of a personal or physical characteristic that is considered socially unacceptable (Shea and Yeh, 2008). In relation to mental health, the stigma related to the process of seeking help is linked to a view of the individual who seeks the intervention as socially undesirable (Vogel, Wade and Hackler, 2007), dangerous or embarrassing (Pheko et al, 2013) or responsible for their own illness (Corrigan et al, 2005). Previous research suggested that people use negative terminology to describe an individual suffering from a mental health issue (Angermeyer and Dietrich, 2006, cited in Vogel, Wade and Hackler, 2007). Furthermore, a study conducted by Ben-Porath (2002, cited in Vogel, Wade and Hackler, 2007), where participants were offered different scenarios, the people that took part in the study rated those who have sought help for depression as more emotionally unstable and less confident compared to those who did not seek help, and to those who sought help for a back pain. Similar results seem to suggest that it is not simply having a mental illness that is considered stigmatizing, but also seeking psychological input for it (Vogel, Wade and Hackler, 2007; Lannin et al, 2015).

According to Corrigan (2004) stigma is the most frequently mentioned reason in the literature concerned with identifying factors that stop people from seeking treatment from mental health services. It has been suggested that stigma will prevent people from seeking mental health interventions, even when the consequences of not doing so are serious and imply further suffering. The potential harmful consequences of seeking help (i.e. the negative perception of the person who seeks psychological input) seem to outweigh the consequences of not seeking help (Vogel, Wade and Hackler, 2007).

Vogel, Wade and Hackler (2007) made a distinction between public and self-stigma: the first defined as the perception that people hold of an individual being socially unacceptable. Self-stigma, on the contrary, refers to the perception that the individual has of themselves. Corrigan (2004) argued that in societies where seeking help is perceived as a negative thing, individuals exposed to this idea will often internalise a negative perception of themselves if in need of having to seek help. It was furthermore found that having a diagnosis of a mental illness can lead to poor self-esteem. As a result, people experiencing mental health problems will often seek help from alternative, nonprofessional sources, like family and friends.

**1.5.2 Social Stigma as a Predictor of ATSPPH**

It appears that higher stigma perceptions are linked to negative attitudes towards seeking professional psychological help (Shea and Yeh, 2008). Previous research has shown that negative public stigma perceptions predict negative attitudes towards seeking help (Komiya, Good and Sherrod, 2000). In a study conducted by Vogel, Wade and Hackler (2007), the researchers attempted to examine how perceived public stigma was linked to people’s willingness to seek counselling. Their research has concluded that perceived public stigma predicted self-stigma; self-stigma in turn predicted negative attitudes towards seeking counselling. Despite its limitations, the study by Vogel, Wade and Hackler (2007) has offered a more comprehensive model about the role of stigma on help seeking behaviours. Using Ajzen and Fishbein’s Theory of Reasoned Action as a framework to help understand how people make decisions in relation to help-seeking, the results of this study suggested that a person’s attitudes towards seeking counselling are linked to the perceived public, and also the self-stigma that the person is experiencing (Vogel, Wade and Hackler, 2007). The researchers argued that intentions are directly linked to attitudes. Applied specifically in the study of professional help-seeking attitudes, this finding offered a model that explains how attitudes predict people’s help-seeking willingness, and thus their intention to make a help-seeking decision.

Similarly, Lannin et al (2015) presented a model in which they argued that stigma of mental illness as well as stigma of seeking professional help predict self-stigma, which in turn predicts decreased self-esteem. The way in which the society responds to people who seek, or receive help from professional psychological sources influences public stigma (Bathje and Pryon, 2011). Lannin et al (2015) suggested that societal stigma is eventually internalised and impacts on the self-esteem of the individual. Furthermore, the same authors suggest that stigma relating to seeking professional psychological help predicts people’s intentions to seek help. Understanding the mediating role of self-stigma in predicting attitudes towards seeking help can be of theoretical, but also of practical value, as negative public stigma towards seeking help can be difficult to address, and potential attempts would imply making changes at societal level. Furthermore, understanding the mediating factors can lead to more accessible interventions to help encourage people to consider psychological help for mental health difficulties (Vogel, Wade and Hackler, 2007).

Bathje and Pryor (2011) suggest that intentions are good predictors of behaviours. It is important to further understand the role of stigma in relation to psychological help seeking and its negative impact on people’s attitudes, as it could be a barrier to seeking help even in cases where the severity of the problem has a big impact on someone’s life. Helping different groups make sense of the effects of stigma, and offering ways to address it could lead to an increase in the use of professional psychological services by populations that underutilise them (Vogel, Wade and Hackler, 2007). If a person is afraid of being stigmatised they are likely to avoid seeking professional psychological help, for fear of being ostracised or labelled (Seloilwe and Thupayahale-Tshweneagae, 2007). Interventions can potentially be put in place in order to target specific communities who appear to hold greater stigmatising perceptions, both about mental illness and about seeking help.

Furthermore, understanding, acknowledging, and even addressing the role of stigma can be of benefit in cases when an individual decides to engage in psychological treatment. The stigma associated with mental illness has been found to impact on people’s decision to terminate treatment earlier than necessary (Sirey et al, 2001). By being open to exploring the meaning that stigma has on the help-seeking individual, strategies can be introduced to help the person cope with the negative effects of the internalised stigma. Such strategies can include normalising the occurrence of symptoms, psychoeducation regarding the neurobiological basis of different mental health problems, and also introducing techniques to teach the person to cope with the discrimination and stereotypes (Corrigan and Roa, 2012). Thus, understanding a person’s negative appraisal of themselves for having to seek help, and their concerns in relation to that, could possibly make a difference in the person’s engagement in psychological treatment, and potentially lead to lower drop-out rates and contribute towards better therapeutic outcomes.

**1.5.3 Social Stigma and the Greek Culture**

Among the Greek population, stigma is associated with mental illness; research suggests that the images of the mentally ill are limited to those experiencing hallucinations, are suicidal or those committing homicide (Bagourdi and Vaisman-Tzachor, 2010). Seeking psychological help implies being undesirable or being viewed as “crazy” (Vogel, Wade and Hackler, 2007). Previous research has shown that stigma predicted help seeking behaviours. Shea and Yeh (2008) have found that higher levels of perceived stigma were associated with negative help-seeking attitudes (Shea and Yeh, 2008). To the author’s knowledge, however, there has not been any research conducted examining the role of stigma in psychological help seeking attitudes among Greek populations abroad. This study will attempt to explore the existence of a relationship between social stigma and ATSPPH, with a hypothesis that individuals who hold greater stigmatising perceptions will also hold negative ATSPPH. People who have greater degree of immersion to the British culture may possibly have less stigmatising perceptions about seeking professional psychological help. The role of acculturation will be further discussed in the following section.

**1.6 Acculturation and ATSPPH**

**1.6.1 Defining Acculturation**

The definition of acculturation has changed in recent years. While early sociologists conceptualised acculturation as *“the process of accommodation with eventual (and irreversible) assimilation into the dominant culture group”* (Gordon, 1964, cited in Thomson and Hoddman-Goetz, 2009), in recent years it has been thought of in relation to two separate processes: the maintenance of the culture of origin, and the development of links with the culture to which the individual is exposed to (Thomson and Hoddman-Goetz, 2009). Hence, acculturation has been described by John Berry as the *“the contact between individuals or groups from dissimilar cultural backgrounds, as well as the adaptation (or lack thereof) that takes place as a result of such contact”* (Berry, 1980, cited in Schwartz and Zamboanga, 2008). Berry suggested that individuals’ actions are influenced by their culture and its expectations (Berry, 1992). In some societies, people from various cultural backgrounds live together, resulting in a culturally plural, or diverse, society: this normally happens as a result of immigration. There appears to be a discrepancy between the different groups in regards to size, political, and economical power (Berry, 1997). Berry stresses the importance of a distinction between different cultural groups based on whether the move was voluntarily (e.g. immigrants), or forced (e.g. refugees). There is also a distinction according to the permanence of the process (Berry. 1997). The process of adaptation is believed to be shared by all groups, with varying degrees in the levels of difficulty and the ultimate outcome of acculturation (Berry, 1997).

The field of Cross-Cultural Psychology has shown an increasing interest in enquiring into what happens to people who have been exposed to one cultural context, who later try to re-establish their lives in a different one (Berry, 1997). Following the dominance of social sciences by US scholars, the research of acculturation after World War II has mainly focused on American minorities, mainly of Hispanic and Asian descent (Rudmin, 2009). Redfield, Linton and Herskovits (1936, cited in Berry 1997) defined acculturation as the phenomena occurring when groups of people having certain characteristics come in contact with a different culture, that is described as continuous and first hand. The adaptation of the acculturating person is believed to be influenced by the state of the society of origin (economic and political) as well as the state of the society of settlement (ethnic attitudes and social support): these factors may influence the immigrant group generally, as well as the acculturating individual. Furthermore, the acculturating experience is influenced by personal factors (for example personality, age, gender, coping style), as well as factors that are present during the process of acculturation, such as social support, and acculturation strategy (Berry, 1997).

**1.6.2 Berry’s Acculturation Model**

Acculturating individuals are faced with the issue of deciding how to acculturate. Two major factors influence the decision; the first is concerned with cultural maintenance and the degree to which their original cultural characteristics and ethnic identity are considered worthy of maintenance. Ethnic identity refers to the degree to which a person identifies with a particular ethnic group. The second issue is concerned with contact and participation; the decision of whether to, and if so to what extent, get involved with other or new cultural groups (Berry, 1997). Berry suggested four different acculturation styles that people employ following their exposure to the society of settlement, resulting from the two issues addressed above (Berry, 1997). These strategies are based on the assumptions that the individual has the option to choose how they acculturate and that the dominant society is (a) inclusive and appreciative of cultural diversity, and (b) accommodating of the needs of acculturating individuals and groups (Berry, 1991). The latter involves the acceptance of the dominant society’s basic values, as well as the willingness of the dominant society to adapt national institutions to meet the needs of the acculturating groups (e.g. in education, labour etc).

Assuming that the above pre-conditions are established, Berry suggests that acculturating individuals employ one of the following strategies:

1. Integration is considered the most adaptationally successful strategy, as it involves both maintaining aspects of the culture of origin, while incorporating contact with the culture of the society of settlement (Walsh and McGrath, 2000), adopting a “bicultural” integration style.
2. Assimilation is the strategy in which the acculturating individual moves away from their culture of origin during resettlement in a new country and engages fully with the new or host country.
3. Separation occurs when the acculturating individual maintains their original cultural identity, while avoiding interaction with the new culture they are exposed to.
4. Marginalisation involves the abandonment of the culture of origin, without the intention to learn about the culture of settlement; this strategy is considered the least adaptationally successful (Berry, 1997).

In measuring adaptation, three domains are considered; psychological, socio-cultural and occupational (Walsh and McGrath, 2000). The role of identity is considered central in Berry’s acculturation model. It is furthermore believed that individuals will explore different strategies during the period of their major acculturation, and will eventually settle on one (Kim, 1988, cited in Berry, 1997). Research has shown that people who are more adaptively acculturated are more likely to recognise the need to seek professional psychological help to deal with personal issues, and are believed to be more tolerant to the stigma of seeking help, as well as more open to discussing their difficulties with professional service providers (Kim, 2007).

A point of criticism to Berry’s acculturation model is concerned with the acculturation strategies suggested by Berry: according to Rudmin (2003) there is no concrete evidence to suggest that integration (also known as “biculturalism”) is the most adaptive strategy. Moreover, it has been suggested that there are several types of biculturalism, implying the existence of several subcategories of Berry’s integration strategy (Benet-Martínez and Haritatos, 2005). In addition, the validity of the marginalisation strategy was questioned as there is no theoretical framework to explain how an individual can develop a cultural identity without either the adaptation of aspects of the host culture, or of their culture of origin (Schwartz and Zamboanga, 2008).

Furthermore, Berry’s model was criticised for assuming that the acculturating individual makes a rational decision between four strategies (Rudmin, 2009). Cresswell (2009, cited in Berry, 2009) suggested the idea of intentionality that should be considered in attempting to conceptualise a person’s acculturation: individuals make an active decision as part of their intercultural life. Berry’s response to this criticism was that he had included concepts such as identity, behaviours and motivations in his study of acculturation strategies (Berry, 2009), in an attempt to gain a comprehensive picture of acculturation strategies.

Finally, Berry’s model of acculturation has been criticised for his dual philosophical approach, and specifically the acceptance of both the natural and cultural sciences: Chirkov (2009b) argues that either one or the other ought to be employed. Berry’s reply to this criticism is that a combination of the two advances the knowledge of the processes and the results of acculturation (Berry, 2009). In this respect, Berry’s model fits with the researcher’s epistemological position: this will be further discussed at the methodology section.

**1.6.3 Greek Acculturation**

As part of the wider European migration, as well as a result of Greece’s history of occupations and wars, many Greeks have historically emigrated to the USA, Canada, Australia and Western European countries (Evergeti, 2006). Furthermore, in recent years large numbers of Greeks have emigrated as a result of the economic crisis facing the country, in search of better career opportunities and a better quality of life. Nevertheless, there seems to be very little research conducted that looked at the mental health needs of this immigrant group, both in United Kingdom and in other Anglophone countries.

The studies conducted thus far have been concerned with the means of preservation of the “Greekness” by the Greek Diaspora (referred to the dispersion of a population from their country of origin to different geographic areas). A narrative study conducted by Evergeti (2006) suggests that acculturating Greek immigrant families often go through serious psychological difficulties (Evergeti, 2006). She further argues that the family unit seems to play a central role in providing support; this is often translated into offering financial and emotional support, an example of which is caring for elderly parents, which is seen as a moral obligation (Evergeti, 2006).

The family and its extended kinships appear to be the most important social bonds among the Greek immigrants. However, because of the central role of the family, the needs of the individual are often sacrificed and emphasis is instead placed on the needs of the wider familial unit (Tsemberis and Orfanos, 2002, cited in Evergeti, 2006). Several means have been employed by Greek immigrants residing abroad, to ensure the maintenance of their “Greekness”. Moskos and Moskos (2014) report Greek orthodox churches, “Greek towns”, a Greek newspaper and Greek satellite in different parts of America. These examples in the United Kingdom include Greek restaurants, community centres, kafeneia (cafes where traditionally mainly men would go to, mostly of older age) and the London Greek Radio. Other means include Greek festivals, satellite television, the internet, Greek schools, the Greek language, honouring traditions, performing ethnic rituals and celebrations, and attending church services. Evergeti (2006) suggests that these help maintain contact with family and friends residing in the homeland.

As with other places where many Greek immigrants reside, in several parts of the Britain the church seems to play a central role in the formation of a community. Evergeti (2006) suggests that the family and the community appear to contribute significantly to the reformulation of an ethnic identity and culture: similarly Moskos and Moskos (2014) suggest that for Greek immigrants, ethnic identity is based on family and culture. Bagourdi and Vaisman-Tzachor (2010) argue that difficulties often remain within the family. As with other ethnic minorities, the formation of an ethnic identity appears to be constantly shaped through the interactions between the culture of the home-country and the host-country (Evergeti, 2006) and is evolving as the acculturating individual attempts to adapt to the new reality.

Bagourdi and Vaisman-Tzachor (2010) questioned whether it is the negative stigma that holds immigrants back from seeking psychological help, or if psychological therapy is so strange to some cultures that it is not even considered as a possibility. Some minority groups tend not to reveal issues related to their psychological well-being with people from the “out-group” but instead prefer to share them with friends and families, often from the same ethnic or cultural group (Bagourdi and Vaisman-Tzachor, 2010). The research conducted to date agrees that the more immersed a person is to the host country the more positive their ATSPPH will be (Baello and Morri, 2007). Thus, the current research hypothesises that acculturation will predict positive ATSSPH.

It has been suggested that two socio-economic variables influence the mental health of immigrants: the first is concerned with contextual factors, and the second with the prior experiences of the immigrant. Contextual factors include the attitudes of the host country in regards to immigration and the degree of similarity or difference of the culture of origin with the host culture. Prior experience refers to the personal experiences of the person and the reasons for immigration (Bagourdi and Vaisman-Tzachor, 2010). In recent years, many Greeks left their country in a desperate attempt to pursue a better quality of life, and increase the likelihood of finding a job. Furthermore, while some countries and governments are more open to immigration, others are not. These factors can possibly impact on Greek immigrants’ acculturating experiences, and may also influence the degree to which they immerse into the British culture or maintain links with their culture of origin. The role of acculturation and the remaining factors that were introduced in this section in relation to ATSPPH will be explored further. In doing so, this study employs quantitative methodology.

**Chapter 2: Methodology**

The methodology chapter will start with an introduction to some research paradigms and a justification of the choice to employ quantitative methodology. Details of the specific research design will then be offered. Following that, there will be a section concerned with the participants of the study, and specifically the inclusion criteria, the sample size and the demographic characteristics of the sample will be considered. Moving on, instrumentation and the procedure for data collection will be discussed, followed by some ethical considerations that were taken into account in the process of planning and conducting this research.

**2.1 Research Paradigms and Design Framework**

*Reflections upon Research Paradigms for Counselling Psychology practice and research*

Since the 20th century, there has been an on-going debate between the supporters of qualitative and quantitative research (Bryman, 1988; Hammersley, 2012). Thomas Kuhn (Babbie, 1998) introduced the term “paradigm”. A paradigm has been defined as a conceptual and philosophical framework for understanding and studying the world (Ponterotto, 2005). Based on different epistemological assumptions, each paradigm offers a proposition of how social life can be better understood (Bryman, 1988); this in turn leads to certain choices of tools and methods employed to carry out research (Ponterotto, 2005). The number of paradigms in social research seems to vary across researchers; some of the main ones are described below.

*The quantitative paradigm*

Positivism was introduced by Auguste Comte (Miller, 1999). Based on philosophical realism (Ponterotto, 2005), Comte’s view was that society could be studied scientifically; objectivity could be reached if knowledge was based on observations (Babbie, 1998). The use of quantitative research can serve as a means to testing hypotheses about the existence of relationships between attributes, such as attitudes, by employing methods from the natural sciences (Bryman, 1988). If direct evidence is not available, quantitative research suggests the use of indirect indicators (Gorard, 2010), for example looking at occupation, household income and number of houses possessed to measure wealth; a sum of indicators is used in this way to form a measure (Bartholomew, 2010). A point of criticism to this approach was concerned with the fact that positivism does not recognise scientific theories unless they are directly observable (Bryman, 1988). Another main principle of positivism is that science is deductive; a general theory leads to specific observations. Hypotheses are formed, suggesting possible causal relationships between entities, and these are then subject to empirical testing in order to determine whether it can be confirmed or not (Bryman, 1988; Robson, 2011).

Over the years, the idea of the existence of a reality (Guba and Lincoln, 1994) independent of the human factor was challenged by many (Hammersley, 2012). One of the main criticisms of the positivistic approach is that it does not take into consideration the impact that the researcher and their perspective have on the phenomenon being studied (Robson, 2011). It rules out the subjective experience of the researcher (Bryman, 1988). Supporters of the post-positivistic approach argue that the researcher comes with their past experiences and values that can influence the thing being observed. Post-positivists suggest acknowledging the impact of such effects: by default, observation is selective: the researcher chooses an interest, a problem or an object to study, and makes their own interpretations of what they observe in the light of theories (Magee, 1994). According to this approach, the researcher’s impact contributes to a perception of reality that is probabilistic and imperfect (Robson, 2011).

Following the same deductive approach as positivists, post-positivists suggest that each theory is subject to testing through data collection. According to them, however, theory can never be correct. Nevertheless, the best available evidence guides our knowledge, tells us something that we do not know as yet, and is subject to being falsifiable and rejected under the light of new evidence (Magee, 1994). Despite their differences, both positivists and post-positivists employ quantitative methods of investigation (Robson, 2011); this has often been criticised as it does not directly take into account the role of the researcher. The following paragraphs will discuss some of the points of criticism of the quantitative approaches, and briefly introduce alternative paradigms.

*The qualitative paradigm*

Alternative approaches to positivism suggest a more interpretative approach to research (Hammersley, 2012). Qualitative is a very heterogeneous field (Hammersley, 2012), but is based on the idea that there are several subjective views and that “objective reality” does not exist (Babbie,1998). One of the main epistemological positions in qualitative research for instance, is phenomenology, which is based on the work of philosophers such as Kant and Hegel (Pascal, 2010). One of its main arguments is that people’s experiences should be the basis for understanding social reality and therefore the role of the social scientist is to understand the process of how an individual interprets their experience (Bryman, 1988) and this can be achieved by “bracketing” their own subjectivity; bracketing refers to an attempt to ground the understanding of social phenomena in people’s experiences of them (Pascal, 2010). One of the main criticisms of Phenomenology is whether reduction is indeed possible (Bryman, 1988). Martin Heiddeger argued that the researcher’s experiences cannot be bracketed and should therefore be reflected upon; this served as a basis for the development of hermeneutics (Heidegger, 1996, cited in Pascal, 2010).

Another paradigm guiding psychological theory and research is the Constructivist, which places its focus on the lived experiences of the individual, as they make sense of it, and from their own point of view. Reality is therefore a construction of the individual and the meaning that they place to it (Ponterotto, 2005). In regards to research, the researcher forms research questions based on their personal interests (Banister et al, 2002) and engages in a dialectical interchange with the participants: through this, the researcher can unfold the meaning that the person places to their experiences (Guba and Lincoln, 1994). This method of enquiring has been criticised for its trustworthiness and for the possibility of misapprehensions (Guba and Lincoln, 1994).

*Rationale for Chosen Research Paradigm and Framework*

One of the main points of criticism to the positivistic approach is whether the indirect measurement of phenomena studies indeed *real* phenomena (Bartholomew, 2010). Karl Popper introduced the idea that knowledge is theoretical and provisional (Magee, 1994). Knowledge advances by testing whether a theory is false. Any findings are true in the sense that they explain a phenomenon in a way that is more precise than any other alternative ways. Hence, supporters of the postpositivistic approach argue that we can only get closer to the truth (Magee, 1994) and reality can only be approximately understood (Guba and Lincoln, 1994).

The post-positivistic approach further supports that research is falsifiable (Magee, 1994). Karl Popper suggested a Hypothetico-Deductive method, which starts with several hypotheses. The incorrect hypotheses will be rejected, which should lead to new attempts to form new hypotheses and subject them to the falsification process. Popper suggests that after multiple unsuccessful attempts to falsify a hypothesis, it can be accepted that it resists falsification (Giotelli and Ellison, 2004) and is true in the sense that it is more helpful than its alternatives (Magee, 1994). Along with positivism, post-positivism served as a basis for the development of quantitative research. At an epistemological level, this research adopts a post-positivistic approach. Null Hypotheses (HO) were formed to suggest the non-existence of any relationship between the variables being studied; Alternative Hypotheses (HA) suggest significant relationships (Fisher, 1971; Gotelli and Ellison, 2004). Specifically, Null Hypotheses were included to ensure that there are no patterns between the several Independent Variables (IV: gender, age, years of living in the UK, past experiences of therapy, stigma, shame and acculturation) and the Dependant Variable (DV: attitudes towards seeking professional psychological help) of this study.

Furthermore, according to the post-positivistic approach, the outcomes of a study help knowledge advance (Guba and Lincoln, 1994). The proposed research is concerned with various factors that predict ATSPPH. An interpretative way of looking at this would be to invite a small number of people to discuss their attitudes towards help-seeking; a Heideggerian phenomenologist would argue that the researcher has their own ATSPPH, which needs to be acknowledged and reflected (Heidegger, 1996, cited in Pascal, 2010). A Social Constructionist would perhaps aim to reconstruct the meaning that the person gives to their experiences and explain it through the process of interaction (Guba and Lincoln, 1994). Any possible attempt to study attitudes qualitatively would imply looking at the way in which the people being studied make sense of it (Bryman, 1988). However, the results of such research would perhaps be limiting in the sense that they cannot be generalizable: quantitative research, on the other hand, is based on the selection of random samples that are deemed representative of the population of interest, which would make the results more reliable and solid (Bryman, 1988).

There has been a debate about whether the distinction between quantitative and qualitative is a technical one or an epistemological one. The latter position suggests that the research question should determine which of the two methods is more suitable to answer it (Bryman, 1988) and that the two approaches can work in a complementary manner (Hammersley, 1996). This attitude towards social research has been described as pragmatic (Hammersley, 2010). Hammerlsey argued that the view that different paradigms explain different quantitative and qualitative work is not valid either on a methodological or a philosophical level (Hammersley, 1996). This study adopts a pragmatic element because the researcher accepts that qualitative and quantitative methodologies can be combined to complement the results of the other (Hammersley, 1996): having accepted their complementary roles, for the purposes of this study, only quantitative methodology is employed. This study also accepts the pragmatic approach in the sense that the ultimate choice of methodology was based on technical considerations as opposed to epistemological: the research question, which focuses on the predictive capacities of age and years living in the UK, gender, past therapy experiences, social stigma, internalised shame and acculturation on ATSPPH, led to the choice of methodology (Hammersley, 1996; 2010).

Finally, positivism and post-positivism’s aim is to explain various phenomena in order to allow for predictions and control over them (Guba and Lincoln, 1994). The research question of the study is concerned with looking at the relationship between demographic factors, internalised shame, social stigma and acculturation with ATSPPH. As the aim of the research is not to understand (in which case an IPA methodology would be more suitable) and/or reconstruct people’s views (Social Constructionism) on various phenomena (Guba and Lincoln, 1994) but to predict, quantitative research appears more suitable.

**2.2 Research Design**

The overall research design of this study is explanatory; the focus of the research is to explain which factors could be related to ATSPPH. The specific research design proposed is a Correlational design. The design of this research is a within participant design: the study will aim to discover how several predictor variables relate to the outcome variable using only one group of participants (first generation Greek-British adults).

This study has seven predictor variables:

1. Gender (a categorical variable with two levels: male and female)
2. Age (a categorical variable with four levels: 18-24, 25-34, 35-44, 45+)
3. Years of Living in the UK (a categorical variable with two levels: 1-5, 6+)
4. Past Experiences of Therapy
5. Acculturation
6. Social Stigma
7. Internalised Shame

This study’s outcome variable is:

1. Attitudes Towards Seeking Professional Psychological Help (ATSPPH)

**2.3 Participants and Recruitment**

*Inclusion-Exclusion Criteria*

The participant selection criteria were guided by the research question and included (a) being Greek, (b) first generation immigrant, (c) living in the UK, (d) of age 18 and over. In an attempt to recruit a representative sample in order for the results to be generalizable to the population of interest, an effort was made to recruit participants who represent different age groups (all 18 years or older), living in different parts of the United Kingdom and both participants with and without past experiences of psychological help.

The decision to include a wide inclusion of criteria in regards to age and years of living in the United Kingdom was based on an attempt to recruit a sample that was representative of the Greek immigrant population in the United Kimgdom. Various reasons have historically contributed to the immigration of Greeks to other counties; for example the dictatorship and civil war in 1936-1941 and 1946-1949 respectively, and the military regime or “Junta” in 1967-1974 (Bagourdi and Vaisman-Tzachor, 2010). More recent immigration might have been partly (yet not exclusively) due to of economic crisis faced by the country (discussed in more detail in section 1.1.5), or due to other factors such as education or existential motives. The decision to include a category 6+ years of living in the United Kingdom was due to an effort to examine a possible relationship between participants who moved to the United Kingdom more recently, and those who have had a chance to settle in following more years of residence. This study attempted to capture Greek immigrants that represent different categories of what forms the modern first generation Greek immigrant group, younger and older adults who have lived in the United Kingdom for various numbers of years, thus the decision to include wide age and years of living in the United Kingdom criteria.

In addition, the inclusion of people who have had experiences of therapy as well as those who did not was based on an attempt to examine the role of past experiences of therapy, as a predictor variable of ATSPPH. The role of past therapy on ATSPPH does not appear to have been examined extensively in the past, and it seems unclear whether it has a predictive role on ATSPPH. The decision to include past therapy as a variable was ultimately due to the possible implications of what such a significant relationship would have for Counselling Psychologists working in the development of services aiming to promote psychological services (this will be further discussed in the discussion chapter).

*Sampling Framework and Generalisability*

The participants were recruited through opportunistic, self-selected and through snowball sampling (Coolican, 2009). The participants recruited through opportunistic sampling were handed a hard copy of the “call for participants” invitation, following which, if they decided to take part, were given a hard copy of the questionnaire pack (which will be discussed further at a later part of this chapter). These participants were friends and acquaintances of the researcher.

The self-selected sampling recruitment took place online:

a) Through various Facebook groups for Greek people living in different cities within the United Kingdom. The participants were initially invited to take part by reading a posted “call for participants” invitation (see Appendix 1).

b) By adding a recruitment posting on the “Greek London” website, which consisted of a shorter version of the “call for participants” invitation and a link to direct participants to the online questionnaire.

Both sets of participants were also encouraged to forward the research details to other people they know who may meet the recruitment criteria.

In regards to the generalizability of the results, this research strived to recruit participants that were representative of the population of interest. Diversity of the sample was, to a certain degree achieved by ensuring that participants were recruited from different parts of the United Kingdom and of different age groups.

*Power Analysis to determine Sample Size*

Power Analysis was conducted using a program called G\*Power (Faul et al, 2007) to determine the required sample size that would give an estimated medium effect size. The aim was for a power estimate of =0.3: in order to reach that level with the estimated effect size, a number of N=63 of participants is required for a Hierarchical (Linear) Regression Analysis with 7 predictor variables (for Power Analysis results, see Appendix 12).

*Demographic Characteristics of Sample:*

120 individuals took part in this study: 46 of them are men, while the remaining 74 are women (as shown in table 1).

**Table 1: Frequencies - Gender**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Frequency | Percent |
|  | Male | 46 | 38.3 |
|  | Female | 74 | 61.7 |
|  | Total | 120 | 100.0 |

In regards to the ages of the participants of this research, (as shown in table 2), 12 (10%) of them were aged 18-24, 62 (the majority, a percentage of approximately 52%) were aged 25-34; 23 participants were between 35-44 years of age (19%), and the remaining 23 participants were aged 45 and above (a percentage of 19%).

**Table 2: Frequencies - Age**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| 18-24 | 12 | 10.0 |
| 25-34 | 62 | 51.7 |
| 35-44 | 23 | 19.2 |
| 45+ | 23 | 19.2 |
| Total | 120 | 100.0 |

Out of the 120 participants, 61% (73 participants) have been living in the UK for 1-5 years, while the remaining 39% (47 participants) have been living in the UK for more than 6 years (table 3). As explained at an earlier part of this chapter (see “Inclusion-Exclusion Criteria”), the decision to include participants from a different age groups was based on an attempt to capture a sample that was deemed as representable of the Greek immigrant population in the United Kingdom as possible. Following the descriptive statistics, however, it became obvious that the majority of the sample (51.7%) were aged 25-34. This diversity in regards to age might have affected the data and findings, and has been considered as a possible limitation of this study; this will be discussed further in the general discussion and limitation sections.

**Table 3: Frequencies – Years of living in the United Kingdom**

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| 1-5 | 73 | 60.8 |
| 6+ | 47 | 39.2 |
| Total | 120 | 100.0 |

In regards to past experiences of therapy, as shown on table 4, out of the 120 participants, 40 (33%) reported having past experiences of psychological therapy, and 80 (67%) reported not having any.

**Table 4: Frequencies – Past Experiences of Therapy**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Frequency | Percent |
|  | Yes | 40 | 33.3 |
|  | No | 80 | 66.7 |
|  | Total | 120 | 100.0 |

Table 5 (chi square table: gender\*therapy) shows that out of the 74 women who took part in this study, 31 had past therapy experiences (42%); while only 9 out of the 46 men (20%) had past experiences of therapy, suggesting that a significantly higher percentage of women than men in the sample had past experiences of therapy (χ2=3.36, df=1, p=0.01 – for chi-square table, see Appendix 6).

**Table 5: Gender \* Therapy**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | Therapy | | Total |
| No | Yes |
| Gender | Female | 43 | 31 | 74 |
| Male | 37 | 9 | 46 |
| Total | | 80 | 40 | 120 |

**2.4 Instrumentation**

The data collection instruments used in this study are described below (and also included in the Appendices):

*Attitudes Towards Seeking Professional Psychological Help*

The Attitude Towards Seeking Professional Psychological Help Scale (ATSPPHS) by Fischer and Turner (1970) was used to measure ATSSPH. This scale includes four subscales (Fischer and Turner, 1970) namely:

* 1. Recognition of need for help
  2. Stigma tolerance
  3. Confidence in Mental Health Practitioners
  4. Interpersonal Openness

Despite the fact that the ATSPPH scale was initially introduced in 1970 (Fischer and Turner, 1970), it is nevertheless the most widely used measure of attitudes towards seeking help to date (for example Soorkia, Snelgar and Swami, 2011). In a meta-analysis conducted by Mackenzie et al (2014) where they examined changes in ATSPPH over time, the authors have reported that ATSPPH scale by Fischer and Turner (1970) is the most commonly used self-report measure of help-seeking attitudes in the literature, which has proven reliability and validity. This scale has been used in student samples, clinical populations, various immigrant groups, etc (ten Have et al, 2010, cited in Mackenzie et al, 2014). This scale has not been used on first generation Greek immigrants living in the United Kingdom in the past, but its short version has been used with first and second generation Greek American immigrants (see study by Bagourdi and Vaismaz-Tzachor, 2010), and the complete version has been subject to reliability analysis (described below).

Fischer and Turner reported that the scale has moderately high internal reliability .85 within the entire scale, and the internal consistency of the subscales ranged between .62 and .74 (Fischer and Turner, 1970). All the subscales in the current study generated reliability estimates similar to the ones reported by Fischer and Turner (1970), and specifically the Cronbach Alphas were: .81 for the recognition of need for psychological help, .56 for stigma tolerance, .60 for interpersonal openness, and .74 for confidence in mental health practitioners. The total scale reliability estimate was .88, comparable to Fischer and Turner (1970) reliability report of .85.

The scale consists of 29 items and the responses are rated on a four-point Likert scale (where 0=Strongly Disagree and 3=Strongly Agree): the higher the score one achieves, the more positive their ATSPPH will be (Shea and Yeh, 2008). An example of the questions of the scale is: “The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts” (see Appendix 4, Section 1).

*Social Stigma*

Social stigma was measured using the Social Stigma Scale for Receiving Psychological Help (SSRPH: by Komiya, Good and Sherrod, 2000). It consists of five questions and is scored using a four-point Likert scale (where 1=Strongly Disagree and 4=Strongly Agree); higher scores refer to greater levels of perceived social stigma. The scale’s internal consistency ranged from .73 to .76 in different studies (Komiya, Good and Sherrod, 2000). For the present sample, the scale appeared to have good internal consistency with Cronbach Alpha of α=.89, suggested high internal reliability. An example of the questions of the scale states: “Seeing a psychologist for emotional or interpersonal problems carries social stigma” (see Appendix 4, Section 2).

*Acculturation*

Stephenson Multigroup Acculturation Scale (SMAS by Stephenson, 2000). This scale has been adapted for the purposes of this study as follows; “United States” was replaced with “England”; “American” was replaced with “English”. Stephenson Multigroup Acculturation Scale consists of 32 items and is scored using a four-point Likert Scale (ranging from 1=False to 4=True). A question example of the scale is: “I feel comfortable speaking my own language” (see Appendix 4, Section 3). SMAS has two subscales: “Dominant-Society Immersion”, consisting of 15 questions, and “Ethnic Society Immersion”, formed by the remaining 17 questions (Stephenson, 2000).According to Stephenson (2000) the Coefficient alphas for the entire scale were .86, and .94 and .75 for the ethnic society immersion and dominant society immersion subscales respectively. In the present study, however, both the subscales yielded low reliability, with Cronbach’s α=-.49 and α=.28 respectively: this will be discussed further in the limitations section.

*Shame*

Choosing measurements for shame depends on whether the focus is on state or trait shame: state referring to a transitory affect, while trait concerned with the internalisation of shame (Trnka, Balcar and Kuska, 2011). Various scenario-based measures of shame were introduced, an example of which is the Test of Self Conscious Affect (TOSCA-3) by Tangney and colleagues (2000), where participants are asked to read several positive or negative scenarios, which were drawn from personal experiences of shame, and then rate multiple responses (Trnka, Balcar and Kuska, 2011). Scenario-based measurements of shame have been criticised for measuring peoples’ responses to the scenario as opposed to the shame that they experience in their daily life (Trnka, Balcar and Kuska, 2011).

Internalised Shame Scale (ISS: by Cook, 1988) was chosen to measure shame. Various measures of shame were considered: from the options available two appeared to be more suitable, and the ISS was eventually chosen as it appeared to be more sensitive to people’s experiences of shame and seemed more suitable to measure internalised shame (Harper, 2011). It consists of 35 items scored using a five-point Likert scale (0=Never, 4=Almost Always). The reliability coefficient for the sample was α=.95 (Cook, 1988). This study also confirmed high reliability of the scale α=.96. The participants are asked to respond to questions, such as “Compared to other people I feel like I somehow never measure up” (see Appendix 4, Section 4).

*Demographics*

A demographic questionnaire (see Appendix 4, Section 5) was created by the researcher to include:

* 1. Age (18-24, 25-34, 35-44, 45+)
  2. Gender (Male, Female)
  3. Years of living in the UK (1-5, 6+)
  4. Personal experiences of psychological therapy (Yes, No)

**2.5 Procedure of Data Collection**

*Context and Location of Study*

The data were collected from first generation Greek-British adults (age 18+) living in the UK. The recruitment was through self-selected, opportunistic and snowball sampling. The data collection took place online; contact was made with the Greek community. Furthermore, participants were recruited by giveaways of hard copies of the questionnaires (for details see Section 2.3).

*Order Effects*

The participants were asked to complete batteries of the questionnaires and scales mentioned above. It is argued that the order of the questions can potentially lead to bias of the responses in a battery (Siminski, 2008). The possible effects of the order in which the participants received the questionnaires were considered in the design of the questionnaire and action was taken to reduce the possibility of an order effect on the outcome variable (ATSSPH). The order of the questionnaires will be discussed in the following part.

*Completion of the Questionnaire*

An invitation to take part in the study was sent out either electronically or by posting. The invitation (see “Call for Participants” - see Appendix 1) briefly explained the context in which the study was taking place (i.e. as part of the requirements of a Professional Doctorate in Counselling Psychology) and the selection criteria. The participants were then directed to either a web link to the questionnaire (created through the use of [www.surveymonkey.com](http://www.surveymonkey.com)), or were handed hard copy packets of the questionnaire.

In both means of participant recruitment (i.e. online or hard copy), the participants were initially presented with an Information Sheet (see Appendix 2) that included brief information about the research. They were informed that the expected duration for the completion of the questionnaire was estimated between 15-25 minutes, and further informed of their rights to confidentiality, anonymity and withdrawal from the study. Following that, the participants were directed to read a consent form and either sign (if hard-copy version) or select the consent option (online version).

Prior to commencing the completion of the questionnaire, the participants were directed to the question *“Are you a first generation Greek immigrant (i.e. born in Greece and migrated to the UK)?”* and were offered the options:

1. No – In this case participants were thanked for their time and informed that this study is limited to first generation Greek immigrants.
2. Yes – In which case participants were directed to proceed to the questionnaire.

This aimed to ensure that only Greek UK-based immigrant participants were recruited.

Following that, the participants were presented with the questionnaires/scales in the order that follows:

1. Attitudes Towards Seeking Professional Psychological Help Scale (Fischer and Turner, 1970)
2. Social Scale for Receiving Psychological Help (Komiya, Good and Sherrod, 2000)
3. Stephenson’s Multigroup Acculturation Scale (Stephenson, 2000)
4. Internalised Shame Scale (Cook, 1988)
5. Demographic Questionnaire

After the completion of the questionnaire, the participants were directed to a Debriefing Form (see Appendix 5). This offered them their unique number which aimed to help identify and remove their questionnaire from the study should they wish to withdraw. Further information about the research was offered, and the participants were also provided with the number of the Samaritans Emotional Support Line to contact should they feel distressed following the completion of the questionnaire. Finally, the participants were thanked and they were provided with the researcher’s email to contact for further information, or to withdraw if they wished to.

**2.6 Ethical Considerations**

The proposed research was planned to comply with the University of East London’s requirements and was subject to Ethical Approval. The main issues taken into account and planned for include, following the guidelines of Punch (2006), and also in accordance to the British Psychological Society Code of Ethics and Conduct (British Psychological Society, 2009), are:

-The researcher aimed to gain **informed consent** by providing information to the participants regarding the research and the researcher prior to directing the participants to the questionnaire.

-The participation was on a **voluntary** basis; the participants were informed prior to the study.

-Prior to commencing the completion of the questionnaire, the participants were directed to an **information** form explaining their rights as participants and were directed to either continue, stating this way that they have read, understood and agree to participate, or were otherwise offered the option to **withdraw**.

-**Anonymity** was ensured as the participants were not asked to state their name at any case, in order to protect their identity. The participants that chose to take part were offered a unique code after the completion of the questionnaire, which aimed to help identify them anonymously should they wish to withdraw; the email of the researcher was provided for this reason. Anonymity was also ensured by storing the hard copies of the **consent forms** separately from the questionnaires.

-**Confidentiality** was maintained by ensuring that the questionnaires were stored safely. The data were stored securely (online using security passwords; hard copies kept in locked cupboards) and will be destroyed appropriately after the completion of the research.

-The possibility of **result publication** was considered in the planning of this study and, in line with the British Psychological Society code of ethics and conduct, all the participants were informed that *“the data will be retained for up to three years in case there is a possibility of publishing the findings”* in the Information Sheet that they were given (see Appendix 2) prior to the beginning of the questionnaire completion process.

-In regards to **risk and harm** issues, this study was planned in a way to ensure that the participants are not hurt or stressed in any way while completing the questionnaires. However, in the unlikely event that the study caused distress to participants, they were provided with the details of an emotional support line (i.e. the Samaritans).

**Chapter 3: Results and Analysis**

In order to answer the research hypotheses concerned with how the various predictor variables relate to attitudes towards seeking professional psychological help (ATSPPH), Correlational Analyses and Hierarchical Regression Analyses were conducted. In preparation for these, however, and because of the size of the Internalised Shame Scale, Factor Analysis was carried out. The results and analysis chapter will begin with an explanation of how the researcher dealt with missing data, and how the remaining data were eventually prepared for analysis before moving on to the main analyses.

**3.1 Managing Missing Data**

The online questionnaire was set up in a way that ensured that the participants could not proceed to the next part of the questionnaire if they missed out any questions; therefore there were no missing data for the online version of the questionnaire. When collecting the results from the online questionnaire, however, it was observed that some participants have started filling in the questionnaire but did not fully complete it. Where questionnaires were incomplete, those participants’ responses were omitted from the analysis (Allison, 2009). In regards to the hard copy, on a couple of occasions where participants failed to provide an answer to a question, substitute scores were calculated for that specific question based on the person’s average rating for the remaining questions in that specific section of the questionnaire. These participants were then included in the analysis.

**3.2 Data Preparation and Analysis**

**3.2.1 Reverse Scoring, Total Scores**

The data gathered from the questionnaires was entered into the IBM SPSS Statistics software for analysis. ATSPPH has twenty nine items and the participants were asked to rate each item using a 4-point Likert scale, where 0=Strongly Disagree, and 3-Strongly Agree. Eleven of the scale items were worded positively, and the remaining eighteen negatively: the latter were reverse scored, and an average score was obtained for each individual by summing all the individual item scores and then dividing them by twenty nine. In addition, the average score for each of the four subscales was calculated for each participant following the same procedure. High scores on the scale suggest a positive attitude towards seeking professional psychological help (Ang, Lim and Tan, 2004).

Similarly, Social Stigma for Receiving Psychological Help Scale (SSRPH) comprises of five items, all of which are worded negatively. Higher scores therefore indicate a greater perception of social stigma in regards to receiving psychological help. The participants were asked to use a 4-point Likert scale to select their responses, where 1=Strongly Disagree and 4=Strongly Agree, providing total scores that ranged between 5-20; the average score for the scale was calculated for each participant and entered into the analyses that were carried out.

The third item on the battery of questionnaires was Stephenson’s Multigroup Acculturation Scale (SMAS) which consists of two sub-scales: 15 of the questions form the subscale “Dominant-Society Immersion”, while the remaining 17 questions form the subscale “Ethnic Society Immersion” (Stephenson, 2000). Individual average scores were obtained for each of the two subscales by adding the scores of each answer and dividing them by 15 or 17 respectively. Reverse scoring was not required for this scale. Higher scores on either of the subscale suggest higher levels of immersion on either the dominant or the ethnic society.

For the Internalised Shame Scale all the results were added to calculate the total score for each participant and then divided by 35 to obtain the average scores, higher scores indicating higher levels of internalised shame (Cook, 1998).

**3.2.2 Descriptive Statistics**

Descriptive statistics were employed. Table 6 shows the maximum and minimum scores, as well as the means and standard deviation for each of the scales used. The mean score for ATSPPH was 1.79 (with scores ranging between .41 and 2.69), for SSRPH was 2.16 (with a range of scores between 1.00 and 4.00), for the Ethnic Society Immersion subscale of the SMAS was 3.01 (scores varying between 2.18 and 3.71), for the Dominant Society Immersion 3.07 (range of scores varied between 2.07 and 3.72), and for the ISS 1.06 (with scores ranging between a minimum of .11 and a maximum of 3.14). For the social stigma scale, the results of the descriptive statistics suggested a wide range of answers when looking at the minimum and maximum sores of participants.

**Table 6: Descriptive Statistics (Means, Maximum and Minimum Scores)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | N | Minimum | Maximum | Mean | Std. Deviation |
| Attitudes | 120 | .41 | 2.69 | 1.79 | .43 |
| Stigma | 120 | 1.00 | 4.00 | 2.16 | .77 |
| Acculturation  (Ethnic Society Immersion) | 120 | 2.18 | 3.71 | 3.01 | .29 |
| Acculturation (Dominant Society Immersion) | 120 | 2.07 | 3.73 | 3.07 | .29 |
| Internalised Shame | 120 | .11 | 3.14 | 1.06 | .72 |

In regards to the differences between male and female participants’ ATSPPH scores, descriptive statistics revealed that female participants have more positive ATSPPH (mean score=1.8) compared to men (mean score=1.68).

**Table 7: Descriptive Statistics (Gender Differences on ATSPPH)**

|  |  |  |  |
| --- | --- | --- | --- |
| Gender | Mean | N | Std. Deviation |
| Female | 1.85 | 74 | .39 |
| Male | 1.68 | 46 | .46 |
| Total | 1.79 | 120 | .42 |

**3.2.3 Online Vs Hard Copy**

Twenty-five participants completed the hard copy version, and the remaining ninety-five completed the online version of the questionnaire. To check whether there were differences in the means of the people who completed the online and the people who completed the hard copy versions of the questionnaire, five t-tests were conducted, which did not show any statistically significant differences in any of the questionnaires used, as shown on table 8. We can therefore assume that the variances between the scores of the two groups are equal, and that there are no differences in the scores of any of the scales between participants who completed the questionnaire online, and those who filled in the hard copy version.

**Table 8: T-Test: Online Vs Hard Copy**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Online/Hard Copy | N | Mean | Std. D. | T | df | Sig. |
| Attitudes Towards Seeking Help | Hard Copy  Online | 25  95 | 1.83  1.78 | .30  .46 | .38  .48 | 56.74 | .70  .63 |
| Stigma | Hard Copy  Online | 25  95 | 1.95  2.22 | .76  .76 | -1.56  -1.56 | 37.45 | .12  .13 |
| Acculturation (ethnic society immersion) | Hard Copy  Online | 25  95 | 3.09  2.99 | .28  .29 | 1.42  1.44 | 38.05 | .16  .16 |
| Acculturation (dominant society immersion) | Hard Copy  Online | 25  95 | 3.10  3.07 | .31  .29 | .39  .38 | 36.11 | .70  .70 |
| Internalised Shame | Hard Copy  Online | 25  95 | .93  1.10 | .52  .76 | -1.05  -1.29 | 53.30 | .30  .20 |

The part that follows will discuss the analysis conducted to test whether the hypotheses of this study were confirmed.

**3.3 Factor Analysis**

Factor analysis was conducted in order to explore the factorial validity of the questions of the Internalised Shame Scale, which comprises of 35 items (Cook, 1998). Factor analysis looks at patterns of correlations between variables (Field, 2009); specifically, the aim was to explore if the different questions of Internalised Shame Scale (ISS) relate to one specific idea, forming therefore one factor that can in turn correlate with (and possibly predict) other variables. A principal component analysis was carried out on the 35 items of the ISS, with Varimax orthogonal rotation (Field, 2009). An analysis was firstly run to look at the eigenvalues of each of the components of the data. As shown on table 9, six factors were extracted that were thought to contribute significantly to the variation as they had eigenvalues higher that Kaiser’s criterion of 1 (Field, 2009). All six factors combined explained 68% of the variance (see table 10).

Even though six factors were originally extracted, the decision of which of them to retain for the purposes of this study, was based on two considerations. Firstly, Guadagnoli and Velicer’s guideline (1988, cited in Field, 2009) was taken into account. They suggest that only factors that have four or more variables loading above 0.6 are considered reliable (regardless of the sample size). Out of the six factors that were originally extracted in the Factor Analysis of the ISS, only the first three met the above criteria with at least four loading higher than 0.6 (when rounded up to the nearest whole number, with one decimal place), as shown on table 9.

**Table 9: Factor Analysis - Rotated Component Matrix**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Component | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 |
| s1 | .8 |  |  |  |  |  |
| s2 | .8 |  |  |  |  |  |
| s8 | .7 |  |  |  |  |  |
| s14 | .7 |  |  |  |  |  |
| s5 | .7 |  |  |  |  |  |
| s3 | .7 |  |  |  |  |  |
| s4 | .7 |  |  |  |  |  |
| s7 | .7 |  |  |  |  |  |
| s25 | .6 |  |  |  |  |  |
| s26 | .6 |  |  |  |  |  |
| s6 | .6 |  |  |  |  |  |
| s9 | .6 |  |  |  |  |  |
| s13 | .5 | .7 |  |  |  |  |
| s19 |  | .6 |  |  |  |  |
| s16 |  | .6 |  |  |  |  |
| s11 |  | .6 |  |  |  |  |
| s15 |  | .6 |  |  |  |  |
| s17 |  | .6 |  |  |  |  |
| s20 |  | .6 |  |  |  |  |
| s18 |  | .5 |  |  |  |  |
| s35 |  |  | .8 |  |  |  |
| s32 |  |  | .7 |  |  |  |
| s31 |  |  | .7 |  |  |  |
| s30 |  |  | .6 |  |  |  |
| s12 |  | .5 | .5 |  |  |  |
| s34 |  |  |  | .8 |  |  |
| s29 |  |  |  | .8 |  |  |
| s28 |  |  |  | .7 |  |  |
| s10 |  |  |  |  | .7 |  |
| s21 |  |  |  |  | .6 |  |
| s22 |  |  |  |  | .5 |  |
| s23 |  |  |  |  | .5 |  |
| s33 |  |  |  |  |  | .9 |
| s24 |  |  |  |  |  |  |
| s27 |  |  |  |  |  |  |

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

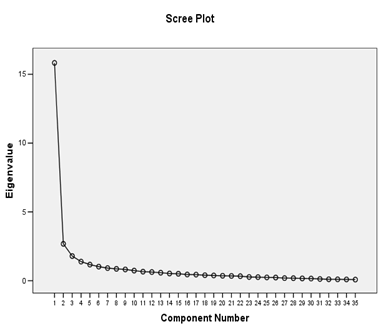
**Table 10: Factor Analysis – Total Variance Explained**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Component | Initial Eigenvalues | | | Extraction Sums of Squared Loadings | | | Rotation Sums of Squared Loadings | | |
| Total | % of Variance | Cumulative % | Total | % of Variance | Cumulative % | Total | % of Variance | Cumulative % |
| 1 | 15.826 | 45.216 | 45.216 | 15.826 | 45.216 | 45.216 | 7.202 | 20.576 | 20.576 |
| 2 | 2.678 | 7.650 | 52.867 | 2.678 | 7.650 | 52.867 | 5.236 | 14.961 | 35.537 |
| 3 | 1.792 | 5.120 | 57.987 | 1.792 | 5.120 | 57.987 | 3.683 | 10.522 | 46.059 |
| 4 | 1.388 | 3.966 | 61.953 | 1.388 | 3.966 | 61.953 | 3.098 | 8.851 | 54.911 |
| 5 | 1.170 | 3.343 | 65.297 | 1.170 | 3.343 | 65.297 | 3.042 | 8.691 | 63.602 |
| 6 | 1.023 | 2.922 | 68.219 | 1.023 | 2.922 | 68.219 | 1.616 | 4.617 | 68.219 |
| 7 | .915 | 2.615 | 70.834 |  |  |  |  |  |  |
| 8 | .861 | 2.459 | 73.293 |  |  |  |  |  |  |
| 9 | .818 | 2.336 | 75.629 |  |  |  |  |  |  |
| 10 | .733 | 2.093 | 77.722 |  |  |  |  |  |  |
| 11 | .657 | 1.877 | 79.599 |  |  |  |  |  |  |
| 12 | .629 | 1.797 | 81.396 |  |  |  |  |  |  |
| 13 | .581 | 1.659 | 83.055 |  |  |  |  |  |  |
| 14 | .523 | 1.494 | 84.549 |  |  |  |  |  |  |
| 15 | .504 | 1.439 | 85.989 |  |  |  |  |  |  |
| 16 | .451 | 1.290 | 87.279 |  |  |  |  |  |  |
| 17 | .441 | 1.261 | 88.540 |  |  |  |  |  |  |
| 18 | .399 | 1.140 | 89.679 |  |  |  |  |  |  |
| 19 | .380 | 1.086 | 90.765 |  |  |  |  |  |  |
| 20 | .358 | 1.024 | 91.789 |  |  |  |  |  |  |
| 21 | .347 | .991 | 92.779 |  |  |  |  |  |  |
| 22 | .329 | .940 | 93.720 |  |  |  |  |  |  |
| 23 | .269 | .769 | 94.489 |  |  |  |  |  |  |
| 24 | .260 | .741 | 95.230 |  |  |  |  |  |  |
| 25 | .237 | .678 | 95.908 |  |  |  |  |  |  |
| 26 | .230 | .657 | 96.566 |  |  |  |  |  |  |
| 27 | .191 | .544 | 97.110 |  |  |  |  |  |  |
| 28 | .184 | .527 | 97.637 |  |  |  |  |  |  |
| 29 | .167 | .478 | 98.115 |  |  |  |  |  |  |
| 30 | .158 | .450 | 98.565 |  |  |  |  |  |  |
| 31 | .124 | .356 | 98.921 |  |  |  |  |  |  |
| 32 | .105 | .300 | 99.220 |  |  |  |  |  |  |
| 33 | .100 | .285 | 99.505 |  |  |  |  |  |  |
| 34 | .092 | .264 | 99.769 |  |  |  |  |  |  |
| 35 | .081 | .231 | 100.000 |  |  |  |  |  |  |

Extraction Method: Principal Component Analysis.

Furthermore, a second criterion that was considered in the process of deciding which factors to retain was Cattell’s technique, which suggests that a scree-plot needs to be used in order to determine which factors to extract; Cattell suggested retaining only the factors that fall left of the inflexion point of the curve (Field, 2009). Therefore, for the purposes of this study, Cattell’s technique was employed, which also confirmed that the first three factors meet the criteria: those were therefore eventually retained in the final analysis (as shown on figure 5). Furthermore, the decision of which factors to include in further statistical analyses was based on theoretical reasons (Dancey and Reidy, 2002), and eventually the first three factors were retained.

**Figure 5: Factor Analysis – Scree Plot**



To sum up, the Rotated Component Matrix table (table 9) shows how the items loaded on each factor after rotation. The items that loaded highly on more than one factor (items s12 and s13) were removed on the basis that they did not load clearly on either of the factors. The remaining items that clustered under the same factor were eventually combined into a component, and were named accordingly based on what they had in common (Dancey and Reidy, 2002). Thus, the first three factors that were eventually retained for the analysis were given names that were thought to best express the content of the questions that clustered on the factor (for details of which items clustered on the same factor, refer to Appendix 7):

Factor 1: Low Self-Esteem/Shame

Factor 2: Inner Emptiness

Factor 3: Embarrassment

The reliability analyses for each of the three factors reported Cronbach Alpha as follows: α=.94 for Low Self-Esteem/Shame, α=.89 for Inner Emptiness and α=.80 for Embarrassment.

**3.4 Correlational Analysis**

Following the factor analysis, correlational analysis was carried out to (a) explore the relationship between the demographic variables and ATSPPH, (b) to explore the relationship between the psychological variables and ATSPPH, (c) to look for correlations between the demographic variables and each of the four subscales of the ATSPPH scale, and (d) to explore possible correlations between the psychological variables and each of the subscales of the ATSPPH scale. For all the correlational analyses conducted and described below, the results quoted are based on a one-tail probability.

**3.4.1 Demographic Variables and ATSPPH**

Firstly, the demographic variables (namely age, gender, years living in the UK and past experiences of therapy) were examined in relation to the total score of the ATSPPH scale. According to the outcomes of the correlation analysis (the results of which are shown on table 11), there seemed to be a negative relationship between gender and ATSPPH (Pearson correlation coefficient: r=-.202 and p<.05), suggesting a relationship between female gender and more positive attitudes. Furthermore, a significant negative relationship was noted between age and ATSPPH, with a Spearman correlation coefficient of ρ=-.234, and p<.01. In addition, a negative relationship between years of living in the UK and ATSPPH (r=-.176 and p<.05) was observed, suggesting that more positive ATSPPH were held by people who have lived in the UK for fewer years. Moreover, a positive relationship between past experiences of therapy and ATSPPH (r=.415 and p<.01) was observed, suggesting that individuals with past experiences of therapy scored higher on the ATSPPH scale.

Age was furthermore positively related to gender (r=-.209 and p<.05) and years of living in the UK (r=.649 and p=<.01), and gender was further positively related to years living in the UK (r=.175 and p<.05), and also negatively related to past experiences of therapy (r=-.230 and p<.05).

**3.4.2 Psychological Variables and ATSPPH**

The relationship between the psychological variables (social stigma, acculturation and internalised shame) was explored at a second phase. The results of the correlational analysis (as seen in table 11) demonstrated a significant negative relationship between social stigma and ATSPPH, with a Pearson Correlation Coefficient r=-.543 and p<.01, suggesting that deeper stigmatising perceptions were related with more negative ATSPPH. Moreover, the Embarrassment factor of internalised shame appeared to be significantly negatively correlated to ATSPPH (r=-.181 and p<.05), implying that people who scored higher on the embarrassment factor had more negative ATSPPH. There did not appear to be any significant relationships between any of the subscales of acculturation and ATSPPH, or between low self-esteem/shame and inner emptiness (ISS factors) with ATSPPH. These results were contrary to Hypotheses 4 (H4) that suggested that lower levels of immersion to the British culture will negatively predict ATSPPH, and Hypothesis 5 (H5) that participants who score higher on ISS will hold more negative ATSPPH.

At a second stage, each of the four subscales of the ATSPPH scale was examined separately with each of the independent variables.

**Table 11: Correlational Analysis**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Pearson Correl. | Age | Gender | Years in the UK | Past Therapy | Social Stigma | Accultu-ration:  Ethnic Society Immers. | Accultu-ration: Dom. Society Immers. | Low Self-Esteem/Shame | Inner Empt. | Embarassment | AttitudeTowards Seeking Help | ATSPPH Subscale:  Recogn. of Need of Psych. Help | ATSPPH Subscale Stigma Toler. | ATSPPH Subscale: Interpers.Open. | ATSPPH Subscale:  Conf. in Mental Health Pract. |
| Age | - |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Gender | .209  (\*) | - |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Years in UK | .649  (\*\*) | .175  (\*) | - |  |  |  |  |  |  |  |  |  |  |  |  |
| Past Therapy | -.136 | -.230  (\*\*) | -.060 | - |  |  |  |  |  |  |  |  |  |  |  |
| Social Stigma | .380  (\*\*) | .128 | .281  (\*\*) | -.230  (\*\*) | - |  |  |  |  |  |  |  |  |  |  |
| Accult,: Ethnic Society Immers. | -.009 | .017 | -.029 | .023 | -.212  (\*) | - |  |  |  |  |  |  |  |  |  |
| Accult.:  Dominant Society  Immers. | .068 | -.044 | .077 | .116 | .032 | .525  (\*\*) | - |  |  |  |  |  |  |  |  |
| Low Self-Esteem/  Shame | .041 | -.181  (\*) | -.057 | .158  (\*) | .116 | -.329  (\*\*) | -.132 | - |  |  |  |  |  |  |  |
| Inner Emptiness | .068 | -.088 | -.007 | .062 | .153  (\*) | -.383  (\*\*) | -.210  (\*) | .787  (\*\*) | - |  |  |  |  |  |  |
| Embarrassment | .278  (\*\*) | -.060 | .165  (\*) | .017 | .321  (\*\*) | -.302  (\*\*) | -.237  (\*\*) | .586  (\*\*) | .581  (\*\*) | - |  |  |  |  |  |
| Attitudes Towards Seeking Help | \*\*\*  -.234  (\*\*) | -.202  (\*) | -.176  (\*) | .415  (\*\*) | -.543  (\*\*) | .061 | .058 | -.011 | -.070 | -.181  (\*) | - |  |  |  |  |
| ATSPPH Subscale:  Rec. of need of Psy. Help | \*\*\*  -.165  (\*) | -.279  (\*\*) | -.086 | .442  (\*\*) | -.323  (\*\*) | -.048 | .055 | .127 | .147 | -.017 | .843  (\*\*) | - |  |  |  |
| ATSPPH Subscale:  Stigma Tolerance | \*\*\*  -.232  (\*\*) | -.027 | -.256  (\*\*) | .109 | -.548  (\*\*) | .089 | -.140 | -.227  (\*\*) | -.246  (\*\*) | -.277  (\*\*) | .613  (\*\*) | .309  (\*\*) | - |  |  |
| ATSPPH Subscale: Interpers. Openness | \*\*\*  -.230  (\*\*) | -.083 | -.179  (\*) | .276  (\*\*) | -.552  (\*\*) | .137 | .117 | -.086 | -.216  (\*\*) | -.213  (\*\*) | .823  (\*\*) | .519  (\*\*) | .492  (\*\*) | - |  |
| ATSPPH Subscale:  Conf. in MH Pract. | \*\*\*  -.236  (\*\*) | -.191  (\*) | -.109 | .415  (\*\*) | -.419  (\*\*) | .063 | .099 | .039 | -.036 | -.157  (\*) | .902  (\*\*) | .715  (\*\*) | .399  (\*\*) | .687  (\*\*) | - |

\* Correlation is significant at the 0.05 level (1-tailed). N=120

\*\*Correlation is significant at the 0.01 level (1-tailed).

\*\*\* Spearman Correlation

**3.4.3 Demographic Variables and ATSPPH subscales**

The various demographic variables included in the study were entered into the correlational analysis with each of the subscales of the ATSPPHS and the results were as follows:

*Recognition of Need for Help*

In regards to the recognition of need for help, age was statistically correlated (ρ=-.165 and p<.05) with the recognition of need for help subscale. Furthermore, female gender was also significantly correlated with higher scores on the recognition of need for help subscale (r=-.279 and p<.01), and so were past experiences of therapy (r=.442 and p<.01).

*Stigma Tolerance*

In regards to stigma tolerance, age appeared to be significantly correlated, with ρ=-.232 and p<.01. Similarly, significant correlations were observed between stigma tolerance and years of living in the UK (r=-.256 and p<.01).

*Interpersonal Openness*

Age and years of living in the UK were further negatively correlated with interpersonal openness (with ρ=-.230 and p<.01 and r=-.179 and p<.05 respectively). In addition, past therapy was positively related to interpersonal openness (r=.276 and p<.01), suggesting that people who have had experiences of therapy scored higher on the interpersonal openness subscale.

*Confidence in Mental Health Practitioners*

Older individuals appeared to have less confidence in mental health practitioners (ρ=-.236 and p<.01). In addition, the results of the correlational analysis suggested that female gender was linked to more confidence in mental health practitioners (r=-.191 and p<.01). Ultimately, past experiences of therapy were significantly positively correlated to increased confidence in mental health practitioners (r=.415 and p<.01).

**3.4.4 Psychological variables and ATSPPH subscales**

Following the examination of possible correlations between the demographic variables and the subscales of ATSPPHS, correlations with the psychological variables were also considered, as described below:

*Recognition of Need for Help*

Firstly, the subscale “Recognition of Need for Help” was considered in relation to Social Stigma, the two subscales of Acculturation, and the three factors extracted after the Factor Analysis of the Internalised Shame Scale (namely Low Self-Esteem/Shame, Inner Emptiness, Embarrassment). The results of the correlational analysis (as shown on table 11) suggest a statistically significant negative relationship between the Recognition of Need of Help subscale and Social Stigma (r=-.323 and p<.01).

Moreover, several correlations were observed between the predictor variables. Specifically, Social Stigma was negatively related to the Ethnic Society Immersion subscale of Acculturation (with a Pearson Correlation Coefficient of r=-.212 and p<.05), and positively related to the factors Inner Emptiness (r=.153 and p<.05) and Embarrassment (r=.321 and p<.01) of Internalised Shame. Equally, Ethnic Society Immersion appeared to be highly negatively related to all three factors of Internalised Shame (with Pearson Correlational Coefficients of r=-.329 for Low Self-Esteem/Shame, r=-.383 for Inner Emptiness, and r=-.302 for Embarrassment, and p<.01 respectively). Dominant Society Immersion also negatively correlated with Inner Emptiness (r=-.210 and p<.05) and Embarrassment (r=-.237 and p<.05).

*Stigma Tolerance*

The second subscale that was considered was the Stigma Tolerance subscale of the ATSPPH scale, which was also examined in relation to the predictor variables. The results suggested, as expected, a relationship between Stigma Tolerance and Social Stigma (r=-548 and p<.01), and also a negative relationships between Stigma Tolerance and all three of the ISS Factors (Low Self-Esteem/Shame: r=-.227 and p<.05, Inner Emptiness: r=-.246 and p<.05, Embarrassment: r=-.277 and p=.01).

*Interpersonal Openness*

The next subscale considered when examining the results of the correlation analysis (see table 11) was ‘Interpersonal Openness’, which was examined in relation to all the psychological predictor variables. According to the results of the correlational analysis, Interpersonal Openness was significantly negatively related to Social Stigma (r=-.552 and p<.01), and the Internalised Shame factors of Inner Emptiness and Embarrassment (with r=-.216 and p<.01, and r=-.213 and p<.05 respectively).

*Confidence in Mental Health Practitioners*

Finally, the last of the subscales of ATSPPH, namely ‘Confidence in Mental Health Practitioners’, correlated negatively with Social Stigma (r=-.419 and p<.01) and the factor Embarrassment of the Internalised Shame Scale (with r=-.157 and p<.05).

In summary, the results of the correlational analyses suggest that there is a relationship between gender, age and years of living in the UK, past experiences of therapy, as well as social stigma and the embarrassment factor of internalised shame with participants’ general ATSPPH.

More specifically, when looking at the correlations of each predictor variable with each of the four subscales of the ATSPPH, a number of statistically significant correlations were observed: recognition of need for help was correlated with age, gender, past therapy and stigma. Stigma tolerance was significantly correlated with age, years of living in the UK, social stigma, and all three of the internalised shame factors. Furthermore, interpersonal openness was correlated with age, years in the UK, past therapy, social stigma, inner emptiness and embarrassment. Finally, confidence in mental health professionals was correlated with age, gender, past therapy, social stigma and embarrassment.

These results, however, do not give an indication if the variables of interest predict ATSPPH. In order to (a) further explore the role of each of the statistically significantly correlated predictor on ATSPPH, as well as (b) what happens when the significantly related predictor variables are considered simultaneously, hierarchical regression analyses were conducted, the results of which will be outlined in the part that follows.

**3.5 Hierarchical Regression Analysis**

The aim of conducting a regression analysis was to examine whether the hypothesised predictors (namely Social Stigma, the Embarrassment factor of Internalised Shame, age, years of living in the UK, past experiences of therapy and gender), that were previously found to correlate significantly with either ATSPPH or its subscales, account for significant variation in ATSPPH (Dancey and Reidy, 2002). Additionally regression analysis aimed to identify which of the variables predicts ATSPPH better than the others (Field, 2009). Several assumptions need to be met in order to be able to draw conclusions, and were considered prior to the regression analysis (Dancey and Reidy, 2002). These assumptions are discussed below:

1. Before commencing a multiple regression, **all predictor variables need to be continuous or categorical**, while the outcome variable must be quantitative, unbounded and continuous (Field, 2009). The outcome variable that was used for the purposes of this study (ATSSPH and its subscales) met this assumption. Similarly, all the predictor variables that were used for the purposes of this research were either continuous (Social Stigma, Acculturation and its subscales, the three factors of the Internalised Shame Scale) or categorical with two categories (Gender, Therapy, Years living in the UK), apart from Age which is a categorical variable with four levels. In order to enter age into the regression analysis, a set of **dummy variables** were created to represent the different age groups, using 0 and 1 (Field, 2009). Four dummy variables were therefore created, one for each of the age groups (18-24, 25-34, 35-44 and 45+).
2. **The number of participants needs to be sufficient**: as a general rule it is suggested that a minimum of 15 participants are used for each variable entering the regression analysis in order for the results to be generalizable (Dancey and Reidy, 2002). For this purpose Power Analysis was conducted (details of which are mentioned in the Methodology Section) which estimated 100 number of participants required for a medium effect size. The final number of participants was 120. This assumption has therefore been met.
3. For the results to be generalizable it is assumed that a **linear relationship** exists between the predictors and the outcome variable (Dancey and Reidy, 2002; Field, 2009).
4. Additionally, to achieve the best possible outcome the predictor variables need to correlate highly with the outcome variable, but not to correlate very highly between each other (Dancey and Reidy, 2002) as this would make it difficult to assess how a variable individually predicts the outcome variable; however, low levels of collinearity do not affect the regression analysis significantly (Field, 2009). To control for **multicollinearity** a correlation analysis specifically for all the predictor variables was run. The correlation matrix (see table 12) was subsequently scanned through to look for correlations: even though some correlations between predictors existed, the results suggest that none of the predictor variables correlated very highly (at a level above .80 or .90) with another predictor variables (Field, 2009). This outcome suggests that this assumption is also met (this will be further discussed at a later section).

**Table 12: Correlational Analysis - Multicollinearity Assumption Check**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | Age | Gender | Years In  UK | Past  Therapy | Social Stigma | Accult.  Ethnic Soc. Immer. | Accult. Dom. Soc. Immer. | Low Self-Esteem/Shame | Inner Emptiness | Embarrass-ment |
| Age | Cor. | - |  |  |  |  |  |  |  |  |  |
| Gender | Cor. | \*\*\*  .214(\*\*) | - |  |  |  |  |  |  |  |  |
| Years In UK | Cor. | \*\*\*  .650(\*\*) | .175(\*) | - |  |  |  |  |  |  |  |
| Past Therapy | Cor. | \*\*\*  -.133 | -.230(\*\*) | -.060 | - |  |  |  |  |  |  |
| Social Stigma | Cor. | \*\*\*  .349(\*\*) | .128 | .281(\*\*) | -.230(\*\*) | - |  |  |  |  |  |
| Accult.:  Ethnic Society Im. | Cor. | \*\*\*  -.023 | .017 | -.029 | .023 | -.212(\*) | - |  |  |  |  |
| Accult.  Dominant  Society Im. | Cor. | \*\*\*  .100 | -.044 | .077 | .116 | .032 | .525(\*\*) | - |  |  |  |
| Low Self-Esteem/  Shame | Cor. | \*\*\*  .041 | -.181(\*) | -.057 | .158(\*) | .116 | -.329(\*\*) | -.132 | - |  |  |
| Inner Emptiness | Cor. | \*\*\*  .083 | -.088 | -.007 | .062 | .153(\*) | -.383(\*\*) | -.210(\*) | .787(\*\*) | - |  |
| Embarrassment | Cor. | \*\*\*  .232(\*\*) | -.060 | .165(\*) | .017 | .321(\*\*) | -.302(\*\*) | -.237(\*\*) | .586(\*\*) | .581(\*\*) | - |

\* Correlation is significant at the 0.05 level (1-tailed). N=120

\*\*Correlation is significant at the 0.01 level (1-tailed).

\*\*\* Spearman Correlation

**3.5.1 Hierarchical Regression Analysis: Outcome Variable ATSPPH**

Hierarchical Regression Analysis was performed to assess the effects of Gender, Age (as converted into four sets of dichotomous variables using dummy variable coding), Past Experiences of Therapy, Social Stigma and the Embarrassment factor of Internalised Shame on Attitudes Towards Seeking Professional Psychological Help. The choice of hierarchical regression was deemed better to assess the validity of the psychological predictors independent of the influence of demographic predictors (Field, 2009).

To test the first three hypotheses of the study (H1, H2 and H3), all of the correlated demographic variables (gender, past therapy and age -dummy variable 25-34 and dummy variable 45+) were entered into the first step of the analysis, and ATSPPH was entered as an outcome variable. Dummy variable age 45+ was subsequently removed as it did not add to the variance of attitudes accounted for by the model in a significant way. The results of this, as seen on table 13, showed that the multiple correlation squared was R2=.23; this model (gender, age and past experiences of therapy), therefore, explained 23% of the attitude variance.

**Table 13: Hierarchical Regression Analysis – Model Summary**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
| 1 | .47(a) | .23 | .20 | .38 |
| 2 | .63(b) | .40 | .37 | .34 |

a Predictors: (Constant), Therapy, Age25to34, Gender

b Predictors: (Constant), Therapy, Age25to34, Gender, Embarrassment, Social Stigma

On inspection of the results of the multiple regression coefficients, Hypothesis 1 (H1) that female participants will hold more positive psychological help seeking attitudes than men was not confirmed. Hypothesis 2 (H2) suggested that younger individuals and those who have lived in the United Kingdom for longer will hold more positive ATSPPH. Contrary to the hypothesis, living in the United Kingdom for longer was not a significant predictor of positive ATSPPH. In regards to age, it appears to be a significant predictor in the first step of the analysis, yet not in the second step, when other factors were added.

The results suggest, however, that past experience of therapy appeared to be a significant predictor of attitudes towards seeking professional psychological help (with β=.38, t=4.47 and p<.001), confirming the third hypothesis (H3) of this study that past experiences of therapy predict more positive scores on the ATSPPH scale.

**Table 14: Hierarchical Regression Analysis – Coefficients**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Sig. | Part/Semi-Partial Correlation | Semi-Partial Correlation  Squared |
| B | Std. Error | Beta |
| 1 | (Constant) | 1.62 | .07 |  |  |  |  |  |
|  | Age25to34 | .17 | .07 | .20 | 2.47 | .015 | .22 | .05 |
|  | Gender | -.09 | .07 | -1.0 | -1.14 | .255 | -.11 | .01 |
|  | Therapy | .34 | .08 | .38 | 4.47 | .000(\*) | .34 | .12 |
| 2 | (Constant) | 2.22 | .12 |  |  |  |  |  |
|  | Age25to34 | .07 | .07 | .09 | 1.10 | .274 | .10 | .01 |
|  | Gender | -.06 | .07 | -.07 | -.98 | .336 | -.09 | .01 |
|  | Therapy | .26 | .08 | .29 | 3.80 | .000(\*) | .34 | .12 |
|  | Social Stigma | -.24 | .05 | -.43 | -5.36 | .000(\*) | -.45 | .20 |
|  | Embarrassment | -.01 | .04 | -.03 | -.34 | .737 | -.03 | .00 |

\* p<0.001

**Table 15: Hierarchical Regression Analysis – ANOVA**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Model | | Sum of Squares | | Df | Mean Square | F | Sig. |
| 1 | Regression | 4.920 | 3 | | 1.640 | 11.210 | .000(\*) a |
|  | Residual | 16.971 | 116 | | .146 |  |  |
|  | Total | 21.892 | 119 | |  |  |  |
| 2 | Regression | 8.674 | 4 | | 1.737 | 15.000 | .000(\*) b |
|  | Residual | 13.204 | 114 | | .116 |  |  |
|  | Total | 21.892 | 119 | |  |  |  |

a Predictors: (Constant), Therapy, Age25to34, Gender

b Predictors: (Constant), Therapy, Age25to34, Gender, Embarrassment, Social Stigma

c Dependent Variable: Attitudes towards Seeking Help

\* p<0.001

On the second step of the Hierarchical Regression Analysis, Stigma and Embarrassment (ISS factor) were entered into the analysis. As shown on table 13, the multiple correlation squared was R2=.40, and the new model explained 40% of the attitude variance accounted for by Gender, Age, Past Experiences of Therapy, Embarrassment and Social Stigma. The regression coefficients show that social stigma was a statistically significant predictor of ATSPPH, with β=-.43 and p<.001 (as shown on table 14), suggesting that higher levels of stigma predict negative ATSPPH, confirming Hypothesis 6 (H6) of this study. As shown on table 13, the second model explained 40% of the ATSPPH variance.

Moreover, the standardized regression coefficients suggest that social stigma (β=-.43, t=-5.36 and p<.001) is a stronger predictor of ATSPPH than past therapy (β=.29, t=-3.80 and p<.001), as hypothesised (H6). This finding was also confirmed by the semi-partial correlations, as shown on table 14, which were also carried out to assess the unique variance accounted for by each of the predictor variables (Field, 2009). According to the results of the regression analysis, of the 40% of the variance accounted for in total, social stigma accounts for 20%, past experiences of therapy for 12%, and age and gender for 1% respectively; the remaining 6% is shared variance.

To further explore that the multicollinearity assumption was met by the suggested model, a collinearity diagnostic test was completed (details shown on table 16) that confirmed that this study met the multicollinearity assumption. Specifically, according to Menard (1955, cited in Field, 2009), if the tolerance values are higher than 0.1, collinearity is not an issue: this was the case for all tolerance values for the predictor variables used in the proposed regression model. Similarly, this study does not meet Myers’ (1990, cited in Field, 2009) collinearity criterion, which suggests that VIF values need to be greater than 10 to indicate a collinearity issue.

**Table 16: Hierarchical Regression Analysis – Multicollinearity Test**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Collinearity Statistics | |
| Tolerance | VIF |
| 1 | (Constant) |  |  |
|  | Age25to34 | .99 | 1.01 |
|  | Gender | .94 | 1.06 |
|  | Therapy | .94 | 1.06 |
| 2 | (Constant) |  |  |
|  | Age25to34 | .88 | 1.14 |
|  | Gender | .93 | 1.08 |
|  | Therapy | .90 | 1.11 |
|  | Stigma | .81 | 1.24 |
|  | Embarrassment | .84 | 1.20 |

**3.5.2 Hierarchical Regression Analyses: Outcome Variables ATTSPPH Subscales**

*Recognition of Need for Psychological Help*

In regards to the subscale ‘recognition of need for psychological help’, gender and therapy were entered into the regression model at the first step, and social stigma was added at the second. The demographic factors (gender and therapy) explained 23% of the variance, with R2=.23, and the addition of social stigma at the second step added only 4% (R2=.27) to the variance of attitudes explained by the model. Past therapy appears to be the most significant predictor in this model, with β=3.53 and p<0.001 (for regression analysis tables, see Appendix 8).

*Stigma Tolerance*

The second subscale examined was ‘stigma tolerance’. In this hierarchical model, age (45+ dummy variable) and years in the UK were entered into the first step, while social stigma and the three factors of internalised shame (low self-esteem, inner emptiness and embarrassment) were added in the second step; all of these factors were significantly correlated with stigma tolerance (as shown after carrying out the correlation analysis earlier on). The results of the hierarchical regression analysis showed that the demographic factors (age and years in the UK) only accounted for 8.5% of the variance (R2=.085). When social stigma, and the three factors of internalised shame were added into the second step of the analysis, the model explained 34% of the variance of stigma tolerance. The only variable, however, that was independently a significant predictor of stigma tolerance was social stigma (β=-.495 and p<0.001), suggesting that higher degrees of social stigma negatively predict people’s ability to tolerate stigma (for regression analysis tables, see Appendix 9).

*Interpersonal Openness*

The third subscale that was considered was ‘interpersonal openness’. The factors that were significantly correlated with this outcome variable were age (and specifically the age groups 25-34 and 45+), years of living in the UK, therapy (all of which were entered into the first step of the hierarchical regression analysis) and social stigma, inner emptiness and embarrassment (entered into the second step of the analysis). The results suggested that age, years in the UK and therapy combined accounted for approximately 17% of the variance (R2=.167), while the addition of social stigma, inner emptiness and embarrassment brought the total variance to approximately 37% (R2=.369). On closer examination of the beta scores, past experiences of therapy and social stigma appear to be significant predictors independently (with β=.162 and p<.05 for therapy, and β=-.475 and p<0.001 for stigma): social stigma predicted inner openness above and beyond the effects of the other variables (for regression analysis results, see Appendix 10).

*Confidence in Mental Health Practitioners*

Lastly, the subscale ‘confidence in mental health practitioners’ was entered into a hierarchical regression model as an outcome variable, with the following predictors: for the first step, age (dummy variable 45+ which was significantly correlated), gender and past experiences of therapy were entered. In the second step, social stigma and embarrassment were added. The results (see Appendix 11), suggested that past experiences of therapy and social stigma were the most significant predictors (therapy: β=.325, p<0.001, social stigma: β=-.304, p=0.001), with therapy being marginally more significant. The first step of the hierarchical regression analysis explained 20% of the variance (R2=.203), while the addition of social stigma and embarrassment added 9% to the model (R2=.293).

In summary, the results of the subsequent hierarchical regression analyses (with outcome variables each of the four of the subscales of ATSPPH), as well as of the main hierarchical regression analysis (with the total scores of ATSPPH as the outcome variable), consistently suggested that past therapy and stigma were significant predictors of ATSPPH and its subscales.

**Chapter 4: Discussion**

**4.1 Summary of results**

The purpose of this study was to explore the help-seeking attitudes of Greek immigrants living in the UK by examining the power of several demographic factors (gender, age, years living in the UK and past experiences of therapy), as well as social stigma, acculturation and internalised shame, to predict attitudes towards seeking professional psychological help.

In summary, the hypotheses of this research were partly confirmed by the results. Contrary to the hypothesis (H4) of this study, acculturation was not found to be correlated with ATSPPH. Furthermore, the embarrassment factor of internalised shame was correlated with, yet not a predictor of, ATSPPH (H5). As hypothesised, past experiences of therapy (H3) and social stigma (H6) were significant predictors of ATSPPH. These results will be further discussed in the part that follows. The discussion chapter will also provide a reflection of the originality of this study as well as a consideration of its contribution to the field of Counselling Psychology. Some of the limitations of the study will then be discussed, and the chapter will conclude with some suggestions for future studies.

For the purposes of this study, Correlational Analysis and Hierarchical Regression Analyses were conducted. The results of the Correlational Analysis will be discussed first, followed by a discussion of the results of the Hierarchical Regression Analysis.

**4.1.1 Correlation Analysis: Demographic Variables**

The initial focus of the correlational analysis was to examine the role of the several demographic variables in relation to ATSPPH. The results suggested that female participants, those with past experiences of therapy, those who have lived in the United Kingdom for fewer years, and the participants of younger age held more positive attitudes towards seeking professional psychological help.

*Gender and ATSPPH*

One of the hypotheses (H1) of this study was that the female Greek immigrants living in the United Kingdom will hold more positive psychological health-seeking attitudes than male, which was confirmed by the results. This is a consistent finding amongst several previous studies that have examined the role of gender in relation to attitudes towards seeking help in different populations, and a meta-analysis conducted in 2010 that concluded that gender has an important effect on ATSPPH (Nam et al, 2010). According to a study by Vogel, Wade and Hackler (2007), this finding may be linked to the hypothesis that men internalise public stigma more, compared to women; however, the results of the present research did not suggest a significant relationship between gender and social stigma.

In addition, the results suggested that women appeared to have more positive attitudes on the “recognition of need of psychological help”, and on the “confidence in mental health practitioners” subscales. The results that women are more able to recognise when they need psychological input were consistent with previous studies (for example, Ang, Lim and Tan, 2004; Mackenzie, Gekoski and Knox, 2006).

*Age and ATSPPH*

In regards to the relationship between age and ATSPPH, the results suggested that older age was associated with negative ATSPPH. Furthermore, it was observed that older individuals also scored higher on the social stigma scale, and embarrassment (ISS factor), suggesting higher levels of internalised shame. Upon closer examination (a correlation analysis conducted where each age group dummy variable was examined with the total scores of ATSPPH), it was observed that two of the age groups used for the purposes of this study were significantly correlated with ATSPPH: specifically, individuals aged between twenty-five and thirty-four appeared to have more favourable help-seeking attitudes, and also scored less on social stigma and internalised shame. The participants aged forty-five and above, on the other hand, had significantly negative attitudes towards seeking professional psychological help, higher social stigma scores and higher levels of internalised shame. These results suggest that older first generation Greek immigrants hold more negative attitudes towards seeking professional psychological help compared to younger individuals.

Even though a large body of research on attitudes towards seeking professional psychological help has consistently looked at the relationship between gender and help-seeking attitudes, age differences have not received equal amount of attention (Mackenzie, Gekoski and Knox, 2006). Moreover, there seems to be a discrepancy between the results of the small number of studies that have looked into the role of age on ATSPPH, with some suggesting that older adults have more negative attitudes, while others suggesting that more favourable attitudes are held by older individuals (Mackenzie, Gekoski and Knox, 2006). Various factors could be linked to the results of the existing study (suggesting that older first generation Greek immigrants tend to have more negative attitudes), such as the influence of stigma and shame. A closer examination on the level of the subscales suggested that older individuals have less stigma tolerance, less confidence in mental health professionals and have less interpersonal openness. It is possible that older individuals have learned, over time, to resolve their difficulties without resorting to psychologists for help, in contrary to younger people who may be more open to receiving a professional opinion.

Another possible explanation for these findings may be linked to the degree of education of younger Greek adults in comparison to older generations. It is likely that younger adults would have received a better education in regards to mental illness and have a better understanding of the aetiology of it, as well as the prognosis. Furthermore, in more recent years mental illness is considered less of a taboo, and seeking therapy is not considered as stigmatising as it used to be in the past (Bagourdi and Vaisman-Tzachor, 2010). Nonetheless, despite the significant correlation between age and ATSPPH, the results of the hierarchical regression analysis (discussed in the following section), did not show a predictive effect of age on psychological help-seeking attitudes.

Nevertheless, caution is taken in the interpretation of the results in regards to the role of age on ATSPPH due to the diversity of the ages of the people who have taken part. As discussed in the methodology section, 51.7% of the participants of the sample were aged 25-34, meaning that the other categories were underrepresented. The decision to include all the categories in the analysis of the results, despite the discrepancy in the number of people in each age group, was to test the role of age on ATSPPH further, as this is an area that appears to be under-studied. The results that younger participants had more favourable ATSPPH might be due to various reasons: this will be further discussed in the limitation section.

*Years in the United Kingdom and ATSPPH*

Perhaps not surprising, age has been found to be correlated with years of living in the United Kingdom in this study. The results of the current study suggest that the participants who lived in the United Kingdom for fewer years have more positive attitudes towards seeking professional psychological help. A closer examination of the results at the level of the subscales showed that this relationship was only significant for the stigma tolerance aspect of the attitudes towards seeking professional psychological help; the results suggested a correlation between the first generation Greek immigrants who have moved to the United Kingdom more recently and higher levels of tolerance to stigma. This finding may be because during the first few years after moving to a new country, people generally tend to be positive and optimistic about the future, and perhaps more open to trying things that could potentially be helpful, despite of the stigma attached to it.

This might, in turn, be explained by the fact that some of the newest immigrants may not necessarily have a strong support network in place when they first move to the United Kingdom. Evergeti (2006) suggests that family, friends, the church and the community are important sources of emotional (and also financial) support for Greek immigrants. Where such a strong support network is not yet in place to meet the emotional needs of the new immigrant individual, other sources of support may be considered instead, for example seeking help from professionals, including psychologists. The need for emotional support could also explain why Greek immigrants who have lived in the United Kingdom for fewer years are more willing to tolerate the stigma in relation to receiving psychological help.

*Therapy and ATSPPH*

Another important finding of this study was the significantly higher percentage of female participants who reported having had past experiences of therapy, compared to male participants. Overall, one third of the participants reported having had past experiences of therapy. It is possible, however, that this finding can be a result of the recruitment process itself, and specifically the way in which the majority of the participants were invited to take part in the study (via the internet): this way of recruiting might have attracted more participants who had past experiences of therapy.

Although caution is exercised in making interpretations due to possible limitations of the recruitment process, this number is, nevertheless, consistent with a previous study conducted by Bagourdi and Vaisman-Tzachor (2010), in which they examined the relation of different factors and Greek Americans’ ATSPPH. Their results suggested a possible relation between past experiences of therapy and ATSPPH, but the authors reported that their data were not sufficient to confidently suggest that previous therapy influences positive ATSPPH (Bagourdi and Vaisman-Tzachor, 2010). The relationship between past experiences of therapy and ATSPPH will be further discussed at a later part of this chapter.

**4.1.2 Correlation Analysis: Psychological Variables**

The second set of correlational analyses looked at the different psychological variables introduced in this study (namely social stigma, acculturation and internalised shame) and their relationships to the dependent variable (attitudes towards professional help-seeking) and its subscales (recognition of need of help, stigma tolerance, interpersonal openness and confidence in mental health practitioners), as well their relationships with each other.

*Social Stigma and ATSPPH*

The results suggested that, in general, people who scored higher on the social stigma and internalised shame scales also scored less favourably on the attitudes towards seeking help scale. Higher levels of social stigma for receiving psychological help were related to lower scores on the total ATSPPHS, but also on all of its four subscales, suggesting that there is a relationship between stigma for receiving psychological help and people’s ability to recognise that they need help, their ability to tolerate stigma, their interpersonal openness and their confidence in mental health practitioners. The role of social stigma for receiving psychological help on ATSPPH will be discussed later in this chapter in relation to its predictive role in ATSPPH.

*Internalised Shame and ATSPPH*

In examining the relationship between internalised shame and ATSPPH, it was decided to factor analyse the Internalised Shame Scale (ISS): this decision was guided by the need to further investigate whether several items, grouped together, could help understand the first generation Greek immigrant’s professional psychological help-seeking attitudes. In other words, to examine which aspects of internalised shame could yield information about what makes people have negative attitudes towards help seeking. The factor analysis has shown that six major factors were extracted for the Internalised Shame Scale; three met Guadagnoli and Velicer’s, as well as Catell’s criteria (Field, 2009), and they were eventually named low self-esteem/shame, inner emptiness and embarrassment. The relationship between these three factors and ATSPPH will be discussed in the part that follows.

One important finding was that the different factors of internalised shame were related to three of the four ATSPPH subscales, generally suggesting that higher levels of internalised shame are linked to a reduced ability to tolerate stigma, reduced interpersonal openness and lower degrees of confidence in mental health professionals. Various factors might have contributed to this finding. Shame is linked with a view of the self as flawed (Trnka, Balcar and Kuska, 2011), and despite its beneficial role, it can lead to self-destructive patterns of behaviour that people employ to cope with it, which include distancing themselves from social relationships, and having a negative attitude towards seeking professional psychological help. This can escalate to more harmful behaviours such as self-harming and substance misuse (Trnka, Balcar and Kuska, 2011). Seeking help for emotional problems is, therefore, quite essential, and where this need cannot be satisfied by the support network of the individual, professional help can be crucial. Despite it being a universal phenomenon, the experience of shame (Yamawaki, 2007), as well as the way in which it is processed and expressed, varies amongst different societies (Scherer and Wallbut, 1994, cited in Trnka, Balcar and Kuska, 2011). Because of this, it seems important that further exploration of shame’s relation to ATSPPH takes place in general, but also for specific immigrant groups.

The results of the regression analysis of this study did not report a significantly important effect between internalised shame (and the three factors specifically) and ATSPPH, but this finding might have been linked to the fact that most of the participants of this study scored fairly low on the Internalised Shame Scale, so the range of the results might have therefore not been wide enough to allow significant predictions; further issues with the Internalised Shame Scale will be discussed in the limitation section.

*Acculturation and ATSPPH*

Contrary to the hypothesis, higher levels of immersion to the British society were not correlated with more positive attitudes towards seeking professional psychological help. This result was puzzling given the previous research that suggested that there is a significant relation between acculturation and ATSPPH (for example Baello and Mori, 2007; Hamid Simmonds and Bowles, 2009). Specifically, previous studies have described acculturation levels as a significant factor explaining the variation in help-seeking attitudes among immigrant populations (Bagourdi and Vaisman-Tzachor, 2010). A possible explanation for this discrepancy could be the use of Stephenson’s Multigroup Acculturation Scale (Stephenson, 2000) that consists of two subscales, one measuring the levels of immersion in the dominant society, and one in the ethnic society.

According to Berry’s acculturation model, however, people who leave their culture of origin to settle in a new society employ one of four strategies depending on the level of immersion in the society of settlement: these strategies are integration (where both cultures are integrated and elements of both are maintained), assimilation (where the individual immerses into the culture of settlement), separation (where the acculturating person maintains elements of their culture of origin), and marginalisation, in which the individual abandons the values of their ethnic society but at the same time does not adapt aspects of the society of settlement (Berry, 1997). Stephenson’s acculturation scale, however, examines either end of the continuum (i.e. the degree to which the person immerses into the society of settlement, or into the society of origin) but is not concerned with the specific strategies that people employ.

By looking at the mean scores of the two respective subscales of Stephenson’s Multigroup Acculturation scale, it becomes clear that the participants of this sample scored similarly on both of the scales (with the mean scores for each of the subscales being almost equal), scoring considerably high on both of the subscales of the SMAS, suggesting an acculturation strategy that resembles what Berry would describe as “integration”.

Another possible explanation for these results is that the scale assesses the behavioural aspect of acculturation, for example the language(s) spoken, the choice of food etc, as opposed to the values (Kim, 2007). Nevertheless, this result is consistent with research that studied the relationship between acculturation and ATSPPH among a sample of Greek Americans: that study also did not report a significant relationship between the levels of acculturation and ATSPPH (Bagourdi and Vaisman-Tzachor, 2010).

In summary, the factors that were significantly related with ATSPPH were age, gender, year of living in the United Kingdom, past experiences of therapy, social stigma and the embarrassment factor of internalised shame. These predictor variables were entered into the hierarchical regression analysis, the results of which will be discussed in the part that follows.

**4.1.3 Hierarchical Regression Analysis**

The third part of the analysis involved carrying out a hierarchical multiple regression analysis to test the hypotheses, with a view to bringing more clarity to the attitudes towards seeking professional psychological help of the first-generation Greek immigrants living in the United Kingdom. In the first step of the hierarchical regression analysis, the roles of age, gender and past experiences of therapy were examined.

Despite the results of the bivariate correlational analysis suggesting that age (and specifically the age group 25-34) and gender were significantly related to the attitudes towards seeking professional psychological help of the first generation immigrant sample, the multiple hierarchical regression model did not confirm a predictive effect of these factors on ATSPPH. This outcome suggests that female gender and younger age are not significant predictors of attitudes towards seeking professional psychological help of our sample, as hypothesised (H1 and H2), when other variables are considered at the same time.

In regards to gender being a predictor for ATSPPH, this finding is contradictory to findings of previous studies that have shown that gender is a significant predictor, as confirmed by a meta-analysis conducted by Nam and colleagues (Name et al, 2010). The findings of the same meta-analysis, however, revealed that the person’s cultural background had a moderating effect on gender differences in regards to ATSPPH, with “non-Western” ethnicity groups reporting greater gender differences on ATSPPH scores (Nam et al, 2010). In most recent years, in the Greek culture, the gender roles have shifted from the more traditional model of the past, a phenomenon mainly observed in the bigger cities and in younger generations (Bagourdi and Vaisman-Tzachor, 2010), which may be a possible explanation for the non-statistically significant gender influence on ATSPPH as explained by the results of the study.

In regards to age, as described above, results of previous studies have not been consistent about the predictive qualities of age on ATSPPH. Due to the lack of sufficient evidence to suggest the predictive role of age on ATSPPH, and as there has not been any previous studies examining the role of age on ATSPPH in Greek immigrants specifically, to the researcher’s knowledge, this study is limited in simply reporting the results of the regression analysis, which suggested that age is not a significant predictor of ATSPPH when other variables are considered at the same time, and caution is taken in making any interpretations. Nevertheless, age and gender were included in the final regression model because a combination of the factors age, gender and past experiences of therapy accounted for 22% of the variance of the attitudes towards seeking professional psychological help in the regression model.

Furthermore, the results suggested that therapy was a significant predictor of attitudes towards seeking professional psychological help. This result confirmed the hypothesis (H3) that past experiences of therapy will positively predict ATSPPH amongst first generation Greek immigrants living in the UK. This outcome is consistent with the findings from Bagourdi and Vaisman-Tzachor (2010) which suggested a possible relationship between previous experiences of therapy and ATSPPH in a sample of Greek American immigrants, and also with the findings of a study conducted by Kim (2007), which showed that previous counselling experiences were significant predictors of ATSPPH. Past experiences of therapy, especially in cases in which the therapeutic outcomes were positive, appear to improve people’s understanding of what therapy is and possibly reduce the levels of stigma attached to it (the fear perhaps of being seen as someone weak because of needing to seek help for emotional difficulties). Another possible explanation for this finding is that having had past experiences of therapy and having seen the benefits of the results is likely to positively influence peoples’ attitudes towards psychological help-seeking for emotional difficulties. Moreover, individuals who have not had past experiences of therapy may hold assumptions and have fantasies about therapy that may not necessarily be accurate and may be contributing to negative ATSPPH.

An alternative explanation can be the attempt of the individual who has engaged in therapy in the past to achieve attitude-behaviour consistency and avoid cognitive dissonance (Festinger, 1962). In accordance to this theory, people who have engaged in therapy, despite their possible negative beliefs or ideas about therapy, will still report having positive attitudes towards seeking professional psychological help. Nevertheless, assuming that this finding is accurate, it is possible that interaction with people who have experiences of therapy might increase one’s awareness and understanding of what it is, reduce the stigma attached and also the possible shame that the individual may be experiencing.

Further exploration of the reasons why people who have had experiences of therapy hold more positive attitudes would be helpful in understanding how this impacts on people’s attitudes. Due to the limitations of this study, this has not been explored more in depth; qualitative research would be useful in helping psychologists understand this better. It would also be interesting to explore possible similarities or differences between different ethnic groups and the impact that past therapy has on their ATSPPH, as this would potentially enhance our understanding of the variables associated with the lower numbers of immigrant populations accessing psychological services.

Finally, considering the significance of the variance on ATSPPH accounted for by past experiences of therapy within the first generation Greek immigrant group of this study, it seems important that this factor is further explored to understand the reasons why Greek immigrants who have not had experiences of therapy in the past hold more negative attitudes compared to those who have. By advancing our understanding of the reasons linked to less positive attitudes, interventions can be put in place to improve them, in the hope that more positive attitudes will eventually lead to increased willingness to seek psychological help for emotional problems when needed, for example in cases of long-enduring problems that do not improve with time, or in cases where the support network of the individual is not available or sufficient to help them get through their difficulties.

In the second step of the hierarchical multiple regression, the embarrassment factor of the internalised shame scale and social stigma were entered into the model to assess whether their addition can help better understand the variance in attitudes towards seeking professional psychological help. Contrary to the hypothesis (H5) that higher levels of internalised shame will negatively predict ATSPPH, the results did not show any significant impact on the help-seeking attitudes of the sample when they were entered into the regression. As this was the first study, to the researcher’s knowledge, that examined the role of shame on ATSPPH, and considering the high correlation of the Factors of the Internalised shame that were entered into the correlation analysis with ATSPPH and its subscales, the role of shame on ATSPPH needs to be further explored. This result may be due to methodological limitations that are concerned with the choice of questionnaire. This study is limited in that it has not looked at possible mediation effects: studies examining the role of shame as a possible mediator, for example, might help increase our understanding of what causes negative help-seeking attitudes.

The second step of the regression, in which social stigma for receiving psychological help was included, added to the amount of variance explained by the proposed regression model by approximately 18%, bringing the total to about 40%. Social stigma for receiving psychological help was a significant predictor of help-seeking attitudes in this study. This finding is consistent with previous research that showed the negative impact of social stigma to attitudes towards seeking psychological help (Vogel, Wade and Hackler, 2007; Shea and Yeh, 2008).

In addition, the results suggested that stigma is a stronger predictor of ATSPPH compared to therapy and have further supported the hypothesis (H6) that greater social stigma perceptions will negatively predict ATSPPH above and beyond the effects of all the other predictors (namely age, gender, past experiences of therapy, acculturation and internalised shame). Stigma is associated with the perception that the person who seeks help for emotional difficulties is socially undesirable (Shea and Yeh, 2008). Different reasons may be linked to peoples’ stigma, including peoples’ understanding of the aetiology of the mental health problems (Komiya, Good and Sherrod, 2000), or issues related to the belief that the person is unable to cope with their difficulties and requires the input of a professional.

According to Vogel, Wade and Hackler, (2007), people who have more negative attitudes towards seeking counselling will be less willing to seek counselling. Considering the importance of stigma in predicting the attitudes towards seeking professional psychological help of the first generation Greek immigrants of this study’s sample (and also other immigrant samples), it is crucial that interventions are put in place with a view to increasing awareness in regards to mental health issues and reducing the negative perceptions held by people about those who seek psychological input for mental health issues. This will be discussed in more detail at a later section.

To reiterate, the results of this study suggested that positive attitudes towards seeking professional psychological help were significantly related to younger age, female gender, fewer years of living in the United Kingdom and past experiences of therapy, as well as lower levels of social stigma for receiving psychological help and lower levels of the embarrassment factor of the Internalised Shame Scale. When entered into the regression analysis, however, only past experiences of therapy and lower degrees of social stigma were significant predictors of attitudes towards seeking professional psychological help. Nevertheless, a combination of therapy with social stigma helps provide a good understanding of the participants’ attitudes towards professional help-seeking. Stigma was the most significant of the predictors of the help-seeking attitudes of the first generation Greek immigrants living in the United Kingdom that formed the sample of this study.

According to the Theory of Reasoned Action (Fishbein and Ajzen, 1975, cited in Ajzen and Fishbein, 1980) and various other theories that try to conceptualise what leads individuals to behave in a certain manner, attitudes towards the behaviour itself, combined with other factors (that vary depending on the model, and that include the personality of the person, normative beliefs etc) can predict the behaviour that the person would employ. While some models argue for a direct prediction (for example, the Composite Attitude-Behaviour Model by Eagly and Chaiken, 1998), others hypothesise a more indirect effect of attitudes on behaviours; these models suggest that attitudes influence the person’s behavioural intention, which in turn leads to the behaviour (for example, the Theories of Reasoned Action and Planned Behaviour respectively, by Fishbein and Ajzen, 1975). Despite the differences, all the models agree that attitudes towards something will contribute to the behaviour employed. Subsequently, more positive attitudes towards seeking professional psychological help may be linked to an increased likelihood that an individual will seek help for psychological matters if they needed to.

A study conducted by Vogel, Wade and Hackler (2007) suggested that psychological help-seeking attitudes, as influenced by other factors such as stigma, predicted willingness to seek counselling in a sample of American students. The current research did not extend to examine a possible link between attitudes towards seeking professional psychological help and willingness in the population of Greek immigrants living in the United Kingdom; such a mediation model would potentially add to the existing knowledge of the relationship between help-seeking attitudes and willingness to seek psychological help among this population. Nevertheless, it is the first study that examined the psychological help-seeking attitudes of Greek immigrant populations in the United Kingdom, and one of the very few studies that has examined the attitudes of Greek people living in other multi-cultural environments in general.

A qualitative study conducted by Evergeti (2006) showed that the Greek immigrant populations seem to keep psychological problems and distress within the in-group and appear to rely on families and friends, support network, the church and the local communities for emotional support. A question remains, however, as to what happens to the individuals who are not part of the community, or who have moved to the United Kingdom or elsewhere for various reasons that include economical ones, who have not got a strong family or friend network. Furthermore, what happens to the individuals suffering from persistent mental health problems that cannot be resolved with the support of the family, friends, the church or the community?

**4.1.4 Reflective practice**

This research idea originated from my personal experience of seeking professional psychological help. My own negative attitude towards it when I was told that I had to attend psychological therapy in order to meet the requirements of the professional doctorate in counselling psychology have made me reflect on what may be causing it. Even though I could rationalise the importance of seeking professional psychological help, I have noticed that quite often I would be secretive about it. I wondered what was causing this rather negative attitude at the beginning of the course, and soon realised that shame and stigma were two very important factors. I wondered whether other people who come from a similar culture as mine shared such thoughts, and I realised that in my experiences as a trainee counselling psychologist I have not come across any Greek clients, despite the growing number that has recently moved to the United Kingdom, and the fairly large population of Greeks that pre-existed. This has made me question whether the role of culture is considered in the design of psychological services, and whether the needs of my cultural group are taken into account in order to increase the likelihood that individuals who need to access psychological services have positive attitudes and are willing to do so.

**4.2 Originality of the Study**

The body of research conducted to date that examines factors related to help seeking attitudes has mainly focused on various demographic, cultural and psychological characteristics and their relation to help-seeking attitudes. However, the majority of the research about immigrants’ ATSPPH has focused on Asian and Afro-Caribbean populations. Differences between European cultures in help seeking attitudes failed to be considered. At the same time the growing number of people from European countries immigrating to the United Kingdom has increased significantly in the last ten years, according to the Migration Statistic Quarterly report provided by the National Statistics (Statistical Bulletin, 27 November, 2014). According to the same report, the number of EU citizens that immigrated to the United Kingdom in the year ending June 2014 was doubled (32000 in year ending June 2014, compared to 18000 in the previous year), a statistically significant increase (Statistical Bulletin, 27 November, 2014).

This research is one of the few to have studied ATSPPH, not only of Greek immigrant populations, but also of European minorities living in Anglophone countries in general. For the purposes of this study, theory related to ATSPPH, developed through research from mainly Asian and Afro-Caribbean populations living in Anglophone Western countries was applied to a European sample (Greek immigrants) with a view to expanding the understanding of the factors linked to seeking psychological help and enhancing insights of which factors are more associated with negative ATSSPH amongst this population.

Furthermore, only a small percentage of people who suffer from mental health problems end up seeking professional psychological help (Ang, Lim and Tan, 2004) for emotional difficulties. This gap in the research calls for a need for studies to take place to further examine immigrants’ ATSPPH, and specifically, to further study and understand the factors that influence European immigrant groups’ ATSPPH. Considering the close relationship of attitudes and behaviours (Ajzen, 2005), it is very likely that help-seeking attitudes will influence, or even predict, a person’s willingness to seek professional psychological help.

This research has achieved what it set out to do to the extent that it has provided an initial model of understanding the professional psychological help-seeking attitudes of the first generation Greek immigrants residing in the United Kingdom. The originality of this study lies in the fact that a new set of variables were examined in combination to deepen the understanding on the factors that contribute to people having negative attitudes towards seeking professional psychological help. Specifically, this research’s original and substantial contribution to knowledge was found in the combination of demographic and psychological factors, namely social stigma, internalised shame, acculturation, past experiences of therapy, gender and age, and their relationship with ATSPPH. Furthermore, this is the first study to have examined the attitudes of Greek immigrants in the United Kingdom.

An extensive search undertaken on one of the biggest psychological databases, Ebsco, has produced many articles related to ATPPSH and the various factors explained above (i.e. social stigma, age, gender, past experiences of therapy). Although most of these factors have been established (to varying degrees) to predict ATSPPH in the literature, they have not been studied together and therefore there has not been a linking research, as proposed in this study, to date and to the researcher’s knowledge. In addition, internalised shame was further added to the model to explore its role in understanding ATSPPH. Ultimately, this research attempted to test the validity of the aforementioned factors as predictors of ATSPPH.

To sum up, this research confirms the findings of past studies that have pointed out the predictive role of social stigma and past experiences of therapy on ATSPPH. Furthermore, the significant correlation of internalised shame with ATSPPH that was found in this study advances the existing empirical literature of the factors affecting people’s help-seeking attitudes, and possibly the intentions to seek help when needed, although this study has not extended to examine this. The implications of the findings of the study, as well as its relevance to the field of Counselling Psychology will be discussed in the part that follows.

**4.3 Implication of the Findings of the Study and Relevance to Counselling Psychology**

The findings of the current study contribute to the existing body of research in that they add to the knowledge of Greek immigrants in the United Kingdom and their ATSPPH. Moreover, the findings of the study make a contribution to the literature concerned with the factors related to the attitudes towards seeking professional psychological help. This research is relevant to the area of psychology concerned with cross-cultural issues (cross-cultural psychology). In places such as the United Kingdom, cross-cultural counselling is a very common form of psychological therapy (Williams and Justice, 2007). It is expected that studying ATSPPH in countries where people from various ethnic minorities reside will inform our understanding of counselling psychology and question the utility of a more “Western European” or “Western”, as described in literature, model of counselling (Shea and Yeh, 2008).

It is possible that by introducing a more appropriate model or approach of counselling, the ATSSPH of people who share certain cultural characteristics could improve, resulting in an increase on the number of people who seek psychological help for mental health problems. Making psychological services accessible and relevant to specific cultures as well as understanding cultural factors related to the problems faced by potential clients’ attitudes to counselling are crucial. The practical implications of the results include providing the right form of psychological services and understanding to clients from different cultural backgrounds.

The results of this study suggested that women are more positive in their attitudes towards seeking professional psychological help in comparison to men, and specifically they appear to have more confidence in mental health professionals and also to be more able to recognise the need to seek psychological help when needed. Aiming to increase people's confidence in mental health practitioners might potentially help improve their attitudes and possibly their willingness to seek help. Such interventions can help reduce the gender differences. Furthermore, understanding the factors that contribute to women’s ability to recognise the need for psychological help can help us understand the barriers that men face, and can potentially help us improve their help seeking attitudes. For example, a study by Levant et al (1998, cited in Berger et al, 2005) suggested that it is likely that men will possibly respond better to therapy that is focused more on thinking, such as CBT, instead of feeling. Also, changing the description of the service provided could attract a higher number of men who seek professional psychological help (Robertson and Fitzerald, 1992, cited in Berger et al, 2005).

In addition, psychoeducation can help people understand more about mental health, its causes and its symptoms. For example, there is evidence to suggest that when the symptoms that the person was experiencing were explained to them, they were then normalised, which may in turn lead to a reduction of self-stigma (Vogel, Wade and Hackler, 2007) and possibly shame related to seeking help. One way to achieve this would be introducing mental health education in school and educational curricula.

Moreover, in order for Counselling Psychologists to be able to respond to the needs of a growing Greek immigrant population living in the United Kingdom, it is important to consider the acculturation style of the individuals they are working with, and the difficulties that the person may be facing as part of their acculturation process. Additionally, further exploration of the culture of the individual can give an insight into the degree to which the person’s family and community are an important part of their identity. This can lead to the development of interventions that are respectful of, and more relevant to, the person’s culture. As Counselling Psychologists, it is important to explore different cultural styles of coping that may involve the social network of the individual (Papadaki, Bagourdi and Papadopoulos, 2001, cited in Bagourdi and Vaisman-Tzachor, 2010). Welts (1982 in Bagourdi and Vaisman-Tzachor, 2010) suggested that in order to encourage the participation of Greek Americans in psychological therapy, the therapist ought to understand the role of the family and the degree to which they are significant to the individual. In practical terms, this can take the form of teaching coping strategies in which the family and people from the close environment are involved (Shea et al, 2008).

Research conducted by Vogel, Wade and Hackler (2007) suggested that exposure to public stigma can lead to the internalisation of stigma. One way for Counselling Psychologists to help improve this is through prevention. The results of the current research suggest that past experiences of therapy predict more positive ATSPPH. Interventions such as promoting campaigns in which people who had received therapy in the past (and who also come from the Greek immigrant group) share their experiences with others in an attempt to reduce the stigma related to it can be helpful. Public workshops based in local communities (such as the several Greek communities in the United Kingdom), but also the provision of web-based information and the use of other media (such as the Greek newspapers, or radio) to talk about mental health can help people understand more about mental illness and reduce the stigma attached.

Furthermore, research suggests that the stigma linked to mental illness has been associated with early termination of treatment (Sirey et al, 2001, cited in Vogel, Wade and Hackler, 2007). With respect to clinical practice, counselling psychologists working with Greek immigrants who hold strong stigmatising perceptions in regards to receiving psychological help should aim to help them learn how to manage and cope with the negative effects of stigma (Vogel, Wade and Hackler, 2007). Such interventions could, for instance, include teaching CBT techniques to challenge relevant thoughts or beliefs in relation to seeking help for mental health issues, and also for having a mental illness (such beliefs could take the form, for example, of “I am mad” or “others will think I am mad”).

In regards to shame, research suggests that shame in relation to personal difficulties is reduced when the person has information that suggests that their mental health difficulties are not a sign of personal incompetence, that the problems are reversible and also that treatment can help improve their symptoms (Vogel, Wade and Hackler, 2007). Counselling psychologists have an important role to play in promoting the message that experiencing mental health difficulties is a common occurrence that can happen at any time to anyone, and as such is not something shameful. Furthermore, Dearing and Tangney (2011) suggest various techniques that therapists can use to help clients manage their shame: as with any other issue, it is crucial to develop a supportive and empathic therapeutic relationship that would allow the clients to open up about their experiences of shame in relation to their mental health issues. It is also important to help them identify shame in a way that the client *“experiences dignity in the telling”* and does not feel overwhelmed by it. In addition, teaching clients techniques to regulate their experiences of shame in relation to mental health difficulties can be beneficial; such techniques can include self-soothing and self-acceptance, as suggested by acceptance and commitment therapy (Hayes, Strosahl and Wilson, 1999, cited in Dearing and Tangney, 2011). Other techniques include “exploring the exceptions” to challenge beliefs related to mental health problems, an example of which can be “I am a failure”, used in Cognitive Behavioural Therapy tools (Dearing and Tangney, 2011).

It is important for the therapist to be able to monitor and explore their own perceptions of mental illness, and also their own feelings of stigma and shame that can be evoked in the therapy room (Dearing and Tangney, 2011): personal therapy and supervision, for example can offer place for reflection. In order for Counselling Psychologists to be able to teach their clients or the general population about mental health and seeking help, they need to first consider their own attitudes towards seeking professional psychological help (Nordt et al, 2006). Furthermore it is crucial for mental health practitioners to have sufficient knowledge in regards to mental health in order to increase peoples’ confidence in them: insufficient knowledge could also lead to not providing the best possible care by, for example, excluding the family (Dixon et al, 1995, cited in McFarlane et al, 2003).

In summary, Counselling Psychologists have an important role to play in identifying the factors related to immigrant populations’ attitudes towards seeking professional psychological help. The knowledge that gender differences exist in regards to ATSPPH, and that past experiences of therapy predict more positive ATSPPH, can be helpful in planning interventions that aim to inform people and help improve their psychological help-seeking attitudes. Furthermore, several interventions can help reduce the levels of social stigma and internalised shame in relation to experiencing mental health difficulties, and also to seeking professional psychological help for them.

**4.4 Limitations of the Study**

Several limitations of this study might have hindered the results, and must therefore not be overlooked. These limitations will be discussed in the section that follows.

**4.4.1 Sample, Recruitment, Role of the Researcher**

This study is limited in the fact that the participants self-selected. It is likely that the participants who chose to take part in a study that is concerned with ATSPPH are participants who are interested in the topic for personal reasons. This might be due to personal, present or past mental health difficulties; this may also explain the high number of participants (40 out of the 120 sample) who reported having had past experiences of therapy. It is likely that those who had past experiences of therapy chose to take part in this study because of their pre-existing positive attitudes towards seeking professional psychological help. This further raises the question of the generalizability of the results of this study.

In addition, a limitation of this research is concerned with the underrepresentation of men. The number of men who took part in this study was 46, as opposed to the number of women which was 74. Also 62 of the participants (the vast majority) were aged 25-34; although this is a limitation as the other categories were underrepresented, it is also possible that it reflects the demographics of the existing Greek immigrant population living in the United Kingdom, as formed by the recent economic changes. Moreover, in regards to the age of the participants and the variations in how many years they have resided in the United Kingdom, there may be significant differences in that this “Greek immigrant” category includes people who have migrated at different points, possibly following different historical and economical changes, who will therefore be diverse in regards to their subjective experiences of acculturation, especially considering that acculturation styles are influenced by the degree to which the host country is open and welcoming (Berry, 1991). However, removal of certain age groups from the analysis would have affected the data and findings in the sense that it would have not captured a sample that is representative of the first generation Greek immigrant population residing in the United Kingdom as it would have excluded other participants of older ages. The decision to include age in the analysis, despite the discrepancies in the numbers of the participants in each age group, was guided by the wish to explore the relationship of age with ATSPPH, as this seems to be an under-researched variable in the study of ATSPPH.

Additionally, another issue that needs to be considered with caution is the fact that the participants of the study were invited to take part, based on their country of origin; it is worthy of questioning whether their answers to the questionnaires were biased due to the fact that they were invited to answer as members, or representatives, of the immigrant Greek category (Potter and Hepburn, 2005) to start with. The problem might be what Hammersley describes as a desire of the participants to provide a good presentation of themselves (Hammersley, 2012), or representation of the category based on which they were chosen to take part in the research.

Another limitation is concerned with the recruitment process. The participants were mostly recruited online (apart from a small number who completed the hard copy of the questionnaire). Although an effort was made to, among others, also recruit participants who were not as highly immersed into the society of origin (and are therefore not necessarily involved with the Greek community), this might have not been achieved at the end, which may explain the results in regards to the relationship of acculturation and ATSPPH.

An additional issue is concerned with sampling. One of the main problems faced by qualitative research is that the interviewer often imposes their own agenda on the interviewee (Popper and Hepburn, 2005). Similarly, in quantitative research, participants might try to read the motives and intentions of the researcher and respond accordingly (Hammersley, 2010). It is acknowledged by the researcher that inviting Greek immigrants to take part in a study that measures several factors in relation to their ATSPPH will be similar to imposing the researcher’s agenda on them, running a risk to receive an edited version back. This gets further complicated by the fact that the researcher is of Greek origin.

Ultimately, the circumstances in which the participants potentially completed the questionnaire could have affected their answers. The researcher is aware that online questionnaires could be filled in at peoples’ conveniences (for example during their break), which might affect the validity of the results (Hammersley, 2010). This however is a fact that can only be reflected upon.

**4.4.2 Conceptual and Methodological Limitations**

Further limitations of the research are concerned with conceptual issues. The concept of stigma, for example, has at least two dimensions that ought to be separated; one being the social or public aspect and the other one the self-aspect of stigma (Vogel et al, 2007). An attempt was made to examine the social aspect of stigma, and the internalised aspect of shame. Despite the two variables being conceptually similar, they refer to different things and the measures used in this study helped explore and differentiate between them. The results of this study, in addition, have not demonstrated statistically significant correlations between the two variables.

In regards to the methodology, one of the limitations of this study is concerned with the use of Stephenson’s Multigroup Acculturation Scale. As discussed earlier (section 4.1.2, acculturation), this scale does not examine the specific strategies that the acculturating individuals who took part in this study employ and how this might impact on their ATSSPH. Furthermore, it does not explain whether it is the loss of the traditional Greek cultural values, or the acquisition of the British cultural values that is linked with more negative ATSPPH.

In addition, the use of the Internalised Shame Scale is a limitation of this study (by Cook, 1988). This scale is dated and there has since been a new improved version of the scale that, unfortunately, the researcher was unaware of at the time of planning this research. The newest version includes two subscales: a “shame” subscale and a “self-esteem” subscale (Nathanson, 1996) and contains fewer items than the original version used in this study. It is possible that the results of this study did not show a significant predictive impact of shame on ATSPPH due to the choice of measure of shame used.

**4.4.3 Result Limitations**

The regression model suggested in this study offers correlational results but does not explain the causal process; it does not explain *how* the combination of factors causes changes on the attitudes towards seeking help (Hammersley, 2012), which would perhaps be better understood by the use of qualitative research as a complementary methodology (Hammerlsey, 1996). Nevertheless, this study seems to advance the existing knowledge on how gender, age, years of living in the UK, previous therapy experiences and social stigma affect the help-seeking attitudes of the first generation Greek immigrants living in the United Kingdom in a way which appears to be more informative than its alternatives (Magee, 1994); this research is therefore, in a post-positivistic sense, useful in offering an initial understanding of the Greek immigrants ATSPPH.

Finally, the results of this study are limiting in the sense that they will not explain *how* and *in what way* the predictors of the study impact on peoples’ ATSPPH. The use of a Causal Model, such as Path Analysis as an extension of Multiple Regression Analysis might have helped check for mediation effects; perhaps this would have provided a clearer understanding on the role of internalised shame on ATSPPH. Such a model could potentially add to the current knowledge on ATSPPH of the Greek immigrants (and immigrants in general) in a different way than previous research. A similar result could have also possibly been achieved by the complementary use of qualitative research. Following a pragmatic stance, this seems to be a good example of how qualitative research can be used to advance the results of quantitative research (Bryman, 1988; Hammersley, 1996).

To reiterate, this research is limited in the fact that it talks about variables that influence help-seeking ATSPPH; it does not, however, examine the link between attitudes and people’s willingness to seek help. It furthermore does not explain causality. If this research was to be done again, the researcher would possibly consider different measures of internalised shame and acculturation. In the part that follows some recommendations will be made for future research.

**4.5 Recommendations for Future Research**

Based on the results of this study, some recommendations are made for future studies. In regards to the role of age on ATSPPH, the results of this research suggested that older individuals generally scored lower on ATSPPH; age did not, however, appear to be a significant predictor of ATSPPH on its own. Considering the small amount of research that has examined the role of age on ATSPPH, it would be important for it to be explored further. A meta-analysis of the age differences in help-seeking attitudes can help bring the existing knowledge of the role of age differences on ATSPPH together and examine whether other (for example cultural) factors moderate the age differences on people’s ATSPPH.

In regards to the research on Greek immigrants’ attitudes, but also of the attitudes of other European immigrant minorities residing in the United Kingdom and other multi-cultural environments, there seems to be a gap in the research. Considering the large number of people who have migrated from their countries of origin in recent years in search of a better quality of life following the economic crisis that many European counties were faced with, the number of people that may be in need of psychological services has increased, making it important to understand their attitudes, both for reasons of planning, and also for delivering appropriate interventions that are respectful of the individual’s needs.

Furthermore, another limitation of this study and other similar ones is concerned with the fact that they do not explain causality: they do not explain the way in which past experiences of therapy and social stigma, internalised shame and acculturation impact on peoples’ ATSPPH. Therefore, future research is recommended to examine meditation: specifically, the role of shame on ATSPPH may be worthy of exploring further, as it is possible that it has a meditative effect on help-seeking attitudes.

Moreover, qualitative research can be employed to add to the knowledge of the results of quantitative research in regards to attitudes towards seeking professional psychological help. Qualitative and quantitative methodologies can be combined to complement the results of the other (Hammersley, 1996); this can either be achieved by the use of qualitative research to explore, for instance, *how* stigma affects peoples’ attitudes towards help-seeking, or to extend the findings of quantitative research. Qualitative studies can be conducted to understand how stigma in relation to seeking professional psychological help arises, and how it is represented and maintained in the cognitive system of the individual.

Qualitative research can also be used to identify other factors that may impact on peoples’ willingness to seek help in different immigrant groups, and the Greeks specifically. Moreover, complementary qualitative research may explain *how* past experiences of therapy shape peoples’ attitudes; for example, what they have experienced that was positive and what they have learned that other people might also benefit from knowing. This combination of approaches can give us a more comprehensive understanding of ATSPPH, and guide future campaigns aiming to promote mental health services. It is therefore crucial that the choice of methodology for future research on ATSPPH is research question led (Hammersley, 1996, Hammerlsey, 2010).

Another recommendation for future studies is to plan and deliver campaigns that aim to reduce the public stigma in regards to seeking psychological help for mental health difficulties. This can include presentations and informational leaflets delivered in various Greek community centres, presentations at the Greek radio station, or articles on the Greek newspapers. It would also be useful to explore whether targeted interventions change people’s ATSPPH; this can be achieved by administrating the Attitude Towards Seeking Professional Psychological Help Scale (Fischer and Turner, 1970) at two points in time, prior to and following an intervention. Such future interventions can include a program to increase the knowledge about different disorders or mental health issues, aiming to decrease the stigma related to seeking psychological help and to experiencing mental health difficulties (Takamura et al, 2008).

Ultimately, future research can help further explore the role of acculturation on Greek immigrants’ residing in the United Kingdom ATSPPH. It would be interesting to explore the role of the motives for migration and people’s experiences of the attitudes of the host country and how these may impact on their acculturation style. It would also be helpful to further explore how peoples’ acculturation style impacts on their help seeking behaviours. In addition, it would be further useful to understand the difficulties that Greek immigrants are facing during the process of acculturation, and how it may vary depending on the duration of their residence in the United Kingdom, the support network available to them and the degree to which they are involved with the Greek community.

In summary, this study adds to the literature that is concerned with factors related to Greek immigrants’ attitudes towards seeking professional psychological help. Despite its important contribution, however, it has limitations that are mainly concerned with causality and that prevent a deeper understanding of the reasons that influence Greeks’ ATSPPH, that can help guide the planning of appropriate interventions to encourage more Greek immigrants to access psychological services when needed, and to also help psychologists working with Greek immigrants adapt their approach to the specific needs of this client group. Further research can help advance our insight into Greek immigrant’s ATSPPH.

**Summary and Conclusion**

This study employed quantitative research methodology to test whether gender, age, years of living in the United Kingdom, past experiences of therapy, internalised shame, acculturation and social stigma predict attitudes towards seeking professional psychological help (ATSPPH) among a population of 120 first generation Greek immigrants. The findings confirmed the hypotheses that past experiences of therapy and social stigma are significant predictors of ATSPPH. Contrary to the hypotheses, acculturation was not found to be correlated with ATSPPH, and aspects of internalised shame were linked, yet not significant predictors of ATSPPH.

The study of attitudes has been the focus of several psychologists, mainly for their relationship with behaviours. Different models suggest that attitudes towards something will either directly or indirectly influence the behaviour that the person will employ (e.g. Ajzen and Fishbein, 1980). It is believed that the study of attitudes towards seeking professional psychological help will increase our understanding of what causes the low percentage of people suffering from mental health illness from seeking professional psychological help (Mackenzie et al, 2006). This study’s original and distinctive contribution lies in the fact that it studies the professional help-seeking attitudes of Greek immigrants living in the United Kingdom for the first time. It also added to the existing knowledge of factors that are related to negative ATSPPH by studying the role of internalised shame. The use of a combination of demographic variables (gender, age, years of living in the United Kingdom and past experiences of therapy) along with psychological variables (acculturation, social stigma and internalised shame) has also contributed to our understanding of the role of each variable in predicting ATSPPH.

Post-positivism and pragmatism informed the research and guided the choice of methodology employed. The researcher adopts a pragmatic stance as the ultimate choice of quantitative methodology was research question, as opposed to epistemology, driven (Hammerlsey, 2010). They also adopt the post-positivistic way of explaining how knowledge progresses via the falsification process (Magee, 1994). The choice of quantitative methodology was for two main reasons: firstly, the aim of the research is to *predict* how several factors affect ATSPPH as opposed to explain, and secondly because quantitative research allows tentative generalizability of the results (Bryman, 1988).

At the first step of the analysis, Correlational Analysis was conducted to examine both correlations between the predictor variables, and also correlations of each of the predictor variable with the outcome variable. The results confirmed that the multicollinearity assumption was met, and suggested the women who took part in this study had more positive help-seeking attitudes in comparison to the men of the sample, and specifically that they were more able to recognise the need to seek psychological help, but also had more confidence in mental health practitioners. Gender, however, did not individually predict attitudes towards seeking professional psychological help.

In regards to age, Greek immigrants who were aged twenty five to thirty-four seemed to hold more positive ATSPPH, while those participants who were forty-five years or older appeared to have more negative ATSPPH compared to the remaining age groups. Furthermore, the results suggested that those participants who moved to the United Kingdom more recently had more favourable ATSPPH. This finding may be due to the higher levels of stigma held by older individuals. The more positive attitudes of younger individuals can be linked to higher levels of education in regards to mental illness. Furthermore, people who have lived in the United Kingdom for fewer years held more positive help-seeking attitudes, possibly due to the fact that their informal support network is not available to offer emotional support. The relationship, however, was not statistically significant.

At a later phase in the analysis, Hierarchical Regression Analyses was conducted. When gender, age and past experiences of therapy were entered into the first step of the hierarchical regression analysis, past experiences of therapy appeared to be a significant predictor of ATSPPH. In addition, gender, age and past therapy experiences combined accounted for 23% of the variance of ATSPPH as explained by the regression model. At the second step of the hierarchical regression analysis, the embarrassment factor of the internalised shame scale that was previously found to be correlated with ATSPPH, as well as social stigma, were entered into the regression model. Embarrassment did not add to the variance of ATSPPH explained by the model. Social stigma appeared to be a significant predictor, adding to the variance of ATSPPH explained by the overall model and bringing it to 40%. Social stigma further appeared to be the most significant of all the predictors used in this study.

In regards to the predictive effect of past experiences of therapy on ATSPPH, this finding can be interpreted in several ways. One possible explanation is that people who had received therapy in the past will have reduced levels of stigma attached to it. It could also be that their answers were linked to the fact that having had past experiences of therapy, they strived for attitude-behaviour consistency. Another reason may be that they have had first-hand experience of the benefits of psychological therapy. As far as social stigma is concerned, the findings can be explained in regards to people’s ideas in terms of the aetiology of mental illness or about the ability of the suffering individual to cope with their difficulties.

Several practical implications of the findings were considered. Counselling psychologists have a dual responsibility both to inform people about mental health and promote mental health services, and also to identify, manage and work with issues related to acculturation, shame and stigma that enter the therapeutic room when clients engage in psychological therapy. Promoting campaigns that include getting mental health service users to share their experiences of past therapy and public workshops targeting specific communities can help reduce the stigma in relation to seeking help and to having a mental health difficulty. Furthermore, interventions that aim to reduce shame include talking about the frequency of mental illness and the treatments available, and perhaps introducing mental health education into school or educational curricula.

Moreover, when Greek immigrants engage in psychological therapy, psychoeducation can help reduce the degree of stigma that the individual might have internalised. Techniques such as challenging the thoughts and beliefs in relation to having mental health difficulties and seeking help can improve peoples’ attitudes. Furthermore, Counselling Psychologists need to be able to identify shame in relation to mental health in the therapy room, offer clients a safe space to process it and learn how to effectively regulate it. Offering the appropriate form of psychological services to clients who come from different cultures can help engage them in therapy and could potentially increase the likelihood of positive therapeutic outcomes.

Despite the limitations of this study, it was nevertheless one of the few to have studied the attitudes towards seeking professional psychological help of Greek immigrants. Research needs to take place to further explore what stops immigrant populations in general from seeking help for mental health problems, and Greek immigrants in particular. Research that employs qualitative methodology can complement the results of quantitative research and help gain a more in-depth understanding of why people do not seek help when faced with long-lasting or severe mental health difficulties: future research can focus on causality. It may also be helpful if the attitudes of Greek immigrants are measured before and after targeted campaigns and interventions that aim to increase mental health awareness and reduce the social stigma in relation to mental health and help-seeking.

Finally, as Counselling Psychologists we also need to monitor our own perception of mental illness, and our own attitudes towards seeking help in order to be able to understand what stops clients from seeking professional psychological help for emotional difficulties. It may also be worth considering the impact of our own culture and experiences on our understanding of mental health and on our help-seeking attitudes, as they may potentially help us get closer to grasping what stops people from seeking professional psychological help. It is also worth monitoring our own thoughts and feeling in relation to seeking help and, where necessary, challenging them, as they may potentially get in the way of seeking professional help (either in the form of personal therapy, peer support or supervision) when we are faced with personal or professional difficulties, but can also potentially impact on the therapeutic relationship with our clients.

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**Appendices**

**Appendix 1: Call for Participants**

**CALL FOR PARTICIPANTS**

**Are you a first generation Greek immigrant living in the UK or do you know someone who is?** I am currently conducting research for my Doctorate in Counselling Psychology on attitudes towards seeking professional psychological help.

I would be very grateful if you would spare 15-20 minutes of your time to participate in my study or forward the details to anyone who meets the requirements (ie first generation UK-based Greek immigrant) and may be willing to take part.

This study is planned in a way that ensures that your identity will remain completely anonymous and that all of the information that you provide will be kept strictly confidential.

To take part in this study, click the following link:

**https://www.surveymonkey.com/s/YYZC3N5**

Thank you very much for your time.

Best wishes,

Yiota Kyriakou

**Appendix 2: Information Sheet**

[](http://www.uel.ac.uk/) **UNIVERSITY OF EAST LONDON**

School of Psychology, Stratford Campus

Water Lane, London E15 4LZ

The Principal Investigator: Panayiota Kyriakou

u0842304@uel.ac.uk

**Consent to Participate in a Research Study**

My name is Panayiota Kyriakou and I am conducting a study as part of the requirements of a Professional Doctorate in Counselling Psychology degree which I am undertaking at the University of East London. The purpose of this letter is to invite you to be a participant in my study and to provide you with the information that you need to consider in deciding whether or not to participate.

**Project Title**

Predictors of Attitudes Towards Seeking Professional Psychological Help Amongst First Generation UK-Based Greek Adults.

**Project Description**

This research aims to examine possible factors related to psychological help-seeking attitudes among first generation Greek immigrants living in the United Kingdom. Once you have finished reading this information sheet, and if you are willing to take part in the study, you will be asked to complete a consent form. You will then be asked to complete a questionnaire (which will be either available online or as a hard copy) – this should take between 15 and 25 minutes. At the end of the questionnaire, you will be asked for some demographic information (age, gender, etc).

The research has been planned in a way which ensures that you are not put at risk in any way. The questionnaire also ensures that no discomfort or distress is caused during or after participation. In the unlikely event that you feel distressed following the completion of the questionnaire, the details of an emotional support line (Samaritans) will be provided at the end.

**Confidentiality of the Data**

Regardless of how you provide your answers to the questionnaire, your data will be treated with the utmost confidentiality throughout the study.

If you complete the questionnaire online your data will be wholly anonymous – your identity cannot be revealed. You will, however, have a unique code assigned to you and you can use this to withdraw from the study should you subsequently wish to do so. My email will be provided at the end for this purpose.

If you complete a hard copy of the questionnaire and a consent form at the same time then there is a possibility that you will not be fully anonymous. However, by keeping these documents separately as much as possible I will endeavour to ensure your anonymity.

The data collected from the questionnaires will be stored safely on a password-protected private computer and any hard copies of questionnaires will be stored in locked filing cabinets. Once the study has been completed, the questionnaires will be shredded. The data-file will be retained for up to three years in case there is a possibility of publishing the findings.

**Location**

The current study will mostly be carried out online; however, hard copies will be available if you either have no computer access or are unable to complete the online version.

**Disclaimer**

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form or click the consent option for the online version prior to your participation. If you have any questions or concerns about how the study has been conducted, please contact the study’s supervisor:

Dr James Walsh

School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email address: j.j.walsh@uel.ac.uk

Or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn

School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: [m.finn@uel.ac.uk](mailto:m.finn@uel.ac.uk))

Thank you in anticipation.

Yours sincerely,

Panayiota Kyriakou

**Appendix 3: Consent Form**

**Consent to participate in a research study**

Predictors of Attitudes Towards Seeking Professional Psychological Help Amongst UK-based Greek Adults

I have read the information sheet relating to the above research study and have been given a copy to keep/been able to copy it for future reference. The nature and purposes of the research have been made clear to me, and I have been given the opportunity to ask questions about this information should I need to do so. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study before the data are analysed without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw thereafter, the researcher reserves the right to use my anonymous data in the write-up of the study (if this has already been commenced) and in any further analysis that may be conducted by the researcher.

Participant’s Name (BLOCK CAPITALS): ………………………………………

Participant’s Signature: …………………………………………………………...

Researcher’s Name (BLOCK CAPITALS) : PANAYIOTA KYRIAKOU

Researcher’s Signature: P. Kyriakou

Date: ……………………..…….

**Appendix 4: Questionnaire**

**Questionnaire**

Are you a first generation Greek immigrant (ie born in Greece and migrated to the UK)?

**YES –** Please proceed to Section 1

**NO –** Thank you for your time, however this study’s focus is on first generation

Greek immigrants.

**SECTION 1**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Strongly Disagree** | **Disagree** | **Agree** | **Strongly Agree** |
| 1. Although there are clinics for people with mental troubles, I would not have much faith in them. | 0 | 1 | 2 | 3 |
| 1. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist. | 0 | 1 | 2 | 3 |
| 1. I would feel uneasy going to a psychiatrist because of what some people would think. | 0 | 1 | 2 | 3 |
| 1. A person with a strong character can get over mental conflicts by themselves, and would have little need of a psychiatrist. | 0 | 1 | 2 | 3 |
| 1. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem. | 0 | 1 | 2 | 3 |
| 1. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. | 0 | 1 | 2 | 3 |
| 1. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family. | 0 | 1 | 2 | 3 |
| 1. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment. | 0 | 1 | 2 | 3 |
| 1. Emotional difficulties, like many things, tend to work out by themselves. | 0 | 1 | 2 | 3 |
| 1. There are certain problems which should not be discussed outside of one’s immediate family. | 0 | 1 | 2 | 3 |
| 1. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital. | 0 | 1 | 2 | 3 |
| 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention. | 0 | 1 | 2 | 3 |
| 1. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns. | 0 | 1 | 2 | 3 |
| 1. Having been a psychiatric patient is a blot on a person’s life. | 0 | 1 | 2 | 3 |
| 1. I would rather be advised by a close friend than by a psychologist, even for an emotional problem. | 0 | 1 | 2 | 3 |
| 1. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help. | 0 | 1 | 2 | 3 |
|  | **Strongly Disagree** | **Disagree** | **Agree** | **Strongly Agree** |
| 1. I resent a person -professionally trained or not- who wants to know about my personal difficulties. | 0 | 1 | 2 | 3 |
| 1. I would want to get psychiatric attention if I was worried or upset for a long period of time. | 0 | 1 | 2 | 3 |
| 1. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. | 0 | 1 | 2 | 3 |
| 1. Having been mentally ill carries with it a burden of shame. | 0 | 1 | 2 | 3 |
| 1. There are experiences in my life I would not discuss with anyone. | 0 | 1 | 2 | 3 |
| 1. It is probably best not to know everything about oneself. | 0 | 1 | 2 | 3 |
| 1. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy. | 0 | 1 | 2 | 3 |
| 1. There is something admirable in the attitude of a person who is willing to cope with their conflicts and fears without resorting to professional help. | 0 | 1 | 2 | 3 |
| 1. At some future time I might want to have psychological counselling. | 0 | 1 | 2 | 3 |
| 1. A person should work out their own problems; getting psychological counselling would be a last resort. | 0 | 1 | 2 | 3 |
| 1. Had I received treatment in a mental hospital, I would not feel that it ought to be “covered up”. | 0 | 1 | 2 | 3 |
| 1. If I thought I needed psychiatric help, I would get it no matter who knew about it. | 0 | 1 | 2 | 3 |
| 1. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen. | 0 | 1 | 2 | 3 |

**SECTION 2**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Strongly Disagree** | **Disagree** | **Agree** | **Strongly Agree** |
| 1. Seeing a psychologist for emotional or interpersonal problems carries social stigma. | 1 | 2 | 3 | 4 |
| 1. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems. | 1 | 2 | 3 | 4 |
| 1. People will see a person in a less favourable way if they come to know that he/she has seen a psychologist. | 1 | 2 | 3 | 4 |
| 1. It is advisable for a person to hide from people that he/she has seen a psychologist. | 1 | 2 | 3 | 4 |
| 1. People tend to like less those who are receiving professional psychological help. | 1 | 2 | 3 | 4 |

**SECTION 3**

**Directions:** Below are a number of statements that evaluate changes that occur when people interact with others of different cultures or ethnic groups. For questions that refer to "COUNTRY OF ORIGIN" or "NATIVE COUNTRY," please refer to the country from which you originally came. For questions referring to "NATIVE LANGUAGE," please refer to the language spoken where you originally came from. Circle the answer that best matches your response to each statement.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **False** | **Party False** | **Partly True** | **True** |
| 1. I understand English, but I'm not fluent in English. | 1 | 2 | 3 | 4 |
| 1. I am informed about current affairs in the United Kingdom. | 1 | 2 | 3 | 4 |
| 1. I speak my native language with my friends and acquaintances from my country of origin. | 1 | 2 | 3 | 4 |
| 1. I have never learned to speak the language of my native country. | 1 | 2 | 3 | 4 |
| 1. I feel totally comfortable with British people. | 1 | 2 | 3 | 4 |
| 1. I eat traditional foods from my native culture. | 1 | 2 | 3 | 4 |
| 1. I have many British acquaintances. | 1 | 2 | 3 | 4 |
| 1. I feel comfortable speaking my native language. | 1 | 2 | 3 | 4 |
| 1. I am informed about current affairs in my native country. | 1 | 2 | 3 | 4 |
| 1. I know how to read and write in my native language. | 1 | 2 | 3 | 4 |
| 1. I feel at home in the United Kingdom. | 1 | 2 | 3 | 4 |
| 1. I attend social functions with people from my native country. | 1 | 2 | 3 | 4 |
| 1. I feel accepted by British people. | 1 | 2 | 3 | 4 |
| 1. I speak my native language at home. | 1 | 2 | 3 | 4 |
| 1. I regularly read magazines of my ethnic group. | 1 | 2 | 3 | 4 |
| 1. I know how to speak my native language. | 1 | 2 | 3 | 4 |
| 1. I know how to prepare British foods. | 1 | 2 | 3 | 4 |
| 1. I am familiar with the history of my native country. | 1 | 2 | 3 | 4 |
| 1. I regularly read a British newspaper. | 1 | 2 | 3 | 4 |
| 1. I like to listen to music of my ethnic group. | 1 | 2 | 3 | 4 |
| 1. I like to speak my native language. | 1 | 2 | 3 | 4 |
| 1. I feel comfortable speaking English. | 1 | 2 | 3 | 4 |
| 1. I speak English at home. | 1 | 2 | 3 | 4 |
|  | **False** | **Party False** | **Partly True** | **True** |
| 1. I speak my native language with my spouse or partner. | 1 | 2 | 3 | 4 |
| 1. When I pray, I use my native language. | 1 | 2 | 3 | 4 |
| 1. I attend social functions with British people. | 1 | 2 | 3 | 4 |
| 1. I think in my native language. | 1 | 2 | 3 | 4 |
| 1. I stay in close contact with family members and relatives in my native country. | 1 | 2 | 3 | 4 |
| 1. I am familiar with important people in British history. | 1 | 2 | 3 | 4 |
| 1. I think in English. | 1 | 2 | 3 | 4 |
| 1. I speak English with my spouse or partner. | 1 | 2 | 3 | 4 |
| 1. I like to eat British foods. | 1 | 2 | 3 | 4 |

**SECTION 4**

**Directions:** Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. These are all statements of feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings or experiences. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and mark the number that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Do not omit any item. Use the scale below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Never** | **Seldom** | **Sometimes** | **Frequently** | **Almost Always** |
| 1. I feel like I am never quite good enough. | 0 | 1 | 2 | 3 | 4 |
| 1. I feel somehow left out. | 0 | 1 | 2 | 3 | 4 |
| 1. I think that people look down on me. | 0 | 1 | 2 | 3 | 4 |
| 1. Compared to other people I feel like I somehow never measure up. | 0 | 1 | 2 | 3 | 4 |
| 1. I scold myself and put myself down | 0 | 1 | 2 | 3 | 4 |
| 1. I feel insecure about others’ opinions of me. | 0 | 1 | 2 | 3 | 4 |
| 1. I see myself as being very small and insignificant. | 0 | 1 | 2 | 3 | 4 |
| 1. I feel intensely inadequate and full of self-doubt. | 0 | 1 | 2 | 3 | 4 |
| 1. I feel as if I am somehow defective as a person, like there is something basically wrong with me. | 0 | 1 | 2 | 3 | 4 |
|  | **Never** | **Seldom** | **Sometimes** | **Frequently** | **Almost Always** |
| 1. I have an overpowering fear that my faults will be revealed in front of others. | 0 | 1 | 2 | 3 | 4 |
| 1. I have this painful gap within me that I have not been able to fill. | 0 | 1 | 2 | 3 | 4 |
| 1. There are different parts of me that I try to keep secret from others. | 0 | 1 | 2 | 3 | 4 |
| 1. I feel empty and unfulfilled. | 0 | 1 | 2 | 3 | 4 |
| 1. When I compare myself to others I am just not as important. | 0 | 1 | 2 | 3 | 4 |
| 1. My loneliness is more like emptiness. | 0 | 1 | 2 | 3 | 4 |
| 1. I always feel like there is something missing. | 0 | 1 | 2 | 3 | 4 |
| 1. I really do not know who I am. | 0 | 1 | 2 | 3 | 4 |
| 1. I replay painful events over and over in my mind until I feel overwhelmed. | 0 | 1 | 2 | 3 | 4 |
| 1. At times I feel like I will break into a thousand pieces. | 0 | 1 | 2 | 3 | 4 |
| 1. I feel as if I have lost control over my body functions and my feelings. | 0 | 1 | 2 | 3 | 4 |
| 1. Sometimes I feel no bigger than a pea. | 0 | 1 | 2 | 3 | 4 |
| 1. At times I feel so exposed that I wish the earth would open up and swallow me. | 0 | 1 | 2 | 3 | 4 |
| 1. I become confused when my guilt is overwhelming because I am not sure why I feel guilty. | 0 | 1 | 2 | 3 | 4 |
| 1. I seem always to be either watching myself or watching others watch me. | 0 | 1 | 2 | 3 | 4 |
| 1. I see myself striving for perfection only to continually fall short. | 0 | 1 | 2 | 3 | 4 |
| 1. I think others are able to see my defects. | 0 | 1 | 2 | 3 | 4 |
| 1. When bad things happen to me I feel like I deserve it. | 0 | 1 | 2 | 3 | 4 |
| 1. Watching other people feels dangerous for me, like I might be punished for that. | 0 | 1 | 2 | 3 | 4 |
| 1. I can’t stand to have anyone look directly at me. | 0 | 1 | 2 | 3 | 4 |
| 1. It is difficult for me to accept a compliment. | 0 | 1 | 2 | 3 | 4 |
| 1. I could beat myself over the head with a club when I make a mistake. | 0 | 1 | 2 | 3 | 4 |
| 1. When I feel embarrassed, I wish I could go back in time and avoid that event. | 0 | 1 | 2 | 3 | 4 |
| 1. Suffering degradation and distress seems to fascinate and excite me. | 0 | 1 | 2 | 3 | 4 |
| 1. I feel dirty and messy like no one should ever touch me or they’ll be dirty too. | 0 | 1 | 2 | 3 | 4 |
| 1. I would like to shrink away when I make a mistake. | 0 | 1 | 2 | 3 | 4 |

**SECTION 5**

Please circle as appropriate:

Age:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **18-24** | **25-34** | **35-44** | **45-54** | **55-64** | **65+** |

Gender :

|  |  |
| --- | --- |
| **MALE** | **FEMALE** |

Years of living in the UK:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1-5** | **6-10** | **11-15** | **16-20** | **20+** |

Do you have any personal experiences of psychological therapy?

|  |  |
| --- | --- |
| **YES** | **NO** |

**Appendix 5: Debriefing Sheet**

**Debriefing for a study on Attitudes Towards Seeking Professional Psychological Help**

Your unique participant number (you will need this if you want to withdraw your results at a later date) is: \_\_\_\_\_

I would like to thank you for taking the time to complete the questionnaire. This study is concerned with the Attitudes Towards Seeking Professional Psychological Help (ATSPPH) of first generation Greek immigrants living in the UK. Previous studies have found that ethnic minorities underutilise the mental health services.

The aim of this research is to examine the role of shame, social stigma, acculturation and gender as predictors of Attitudes Towards Seeking Professional Psychological Help. It is hypothesised that higher degrees of shame and public stigma, lower acculturation levels and male gender will negatively predict ATSPPH.

This research has been planned in a way that ensures that no distress is caused during or after your participation. If, however, you have found the experience distressing you may call the **Samaritans Emotional Support Line on 08457909090**.

We would like to ensure you that the data will remain anonymous and will be destroyed after the completion of the research. If you would like more information about the study or wish to withdraw from the study, please contact u0842304@uel.ac.uk.

Thank you for your participation.

**Appendix 6: Chi-square Test results (gender\*therapy)**

**Chi-Square Tests**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Value | df | Asymp. Sig. (2-sided) | Exact Sig. (2-sided) | Exact Sig. (1-sided) |
| Pearson Chi-Square | 6.363(b) | 1 | .012 |  |  |
| Continuity Correction(a) | 5.398 | 1 | .020 |  |  |
| Likelihood Ratio | 6.655 | 1 | .010 |  |  |
| Fisher's Exact Test |  |  |  | .016 | .009 |
| Linear-by-Linear Association | 6.310 | 1 | .012 |  |  |
| N of Valid Cases | 120 |  |  |  |  |

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 15.33.

**Appendix 7: Factor Analysis – Items Forming Each Factor**

**FACTOR ANALYSIS**

**FACTOR 1 (12 items): Low self-esteem/shame**

1. I feel like I am never quite good enough.

2. I see myself striving for perfection only to continually fall short.

3. I think others are able to see my defects.

4. Compared to other people I feel like I somehow never measure up.

5. I scold myself and put myself down

6. I feel insecure about others’ opinions of me.

7. I see myself as being very small and insignificant.

8. I feel intensely inadequate and full of self-doubt.

9. I feel as if I am somehow defective as a person, like there is something basically wrong with me.

14. When I compare myself to others I am just not as important.

25. I see myself striving for perfection only to continually fall short.

26. I think others are able to see my defects.

**FACTOR 2 (7 items): Inner Emptiness**

11. I have this painful gap within me that I have not been able to fill.

15. My loneliness is more like emptiness.

16. I always feel like there is something missing.

17. I really do not know who I am.

18. I replay painful events over and over in my mind until I feel overwhelmed.

19. At times I feel like I will break into a thousand pieces.

20. I feel as if I have lost control over my body functions and my feelings.

**FACTOR 3 (4 items): Embarrassment**

30. It is difficult for me to accept a compliment.

31. I could beat myself over the head with a club when I make a mistake.

32. I would like to shrink away when I make a mistake.

35. When I feel embarrassed, I wish I could go back in time and avoid that event.

**Appendix 8: Hierarchical Regression Analysis**

**(Outcome variable: Subscale Recognition of Need of Psychological Help)**

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**Appendix 9: Hierarchical Regression Analysis**

**(Outcome variable: Subscale Stigma Tolerance)**

**Model Summary**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate |
| 1 | .291(a) | .085 | .069 | .52536 |
| 2 | .588(b) | .346 | .311 | .45191 |

a Predictors: (Constant), YearsInUK, Age45plus

b Predictors: (Constant), YearsInUK, Age45plus, Factor 1, Stigma, Factor 3, Factor 2

****

****

**Appendix 10: Hierarchical Regression Analysis**

**(Outcome variable: Subscale Interpersonal Openness)**

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**Appendix 11: Hierarchical Regression Analysis**

**(Outcome variable: Subscale Recognition of Need of Psychological Help)**

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**Appendix 12: Power Analysis (G\*Power) Results Summary**

**Exact -** Linear multiple regression: Random model

**Options:** Exact distribution

**Analysis:** A priori: Compute required sample size

**Input:** Tail(s) = One

H1 ρ² = 0.3

H0 ρ² = 0

α err prob = 0.05

Power (1-β err prob) = 0.95

Number of predictors = 7

**Output:** Lower critical R² = 0.2172972

Upper critical R² = 0.2172972

Total sample size = 63

Actual power = 0.9512916