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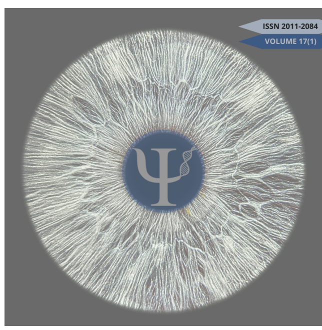

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Design and Validation of the Attitudes Towards Mental Health Helplines Scale (ATMHHS) for the Adult Colombian Population

Diseño y validación de una escala de actitudes hacia líneas telefónicas de salud mental (EALTSM) para adultos colombianos

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Abstract.
The objective of this instrumental study was to design and validate the Attitudes towards Mental Health Helplines Scale for Latin America. A specification table was created to develop the instrument and an evaluation by 7 expert judges from different parts of Latin America was performed. This study had a sample of 503 Colombian participants with a mean age of 29 years. To measure validity and reliability, an exploratory factorial analysis, reliability, and Pearson correlational coefficient analysis were made. The results showed satisfactory charges, levels, and correlations and, after dropping 3 items, 23 items distributed on 3 categories and factors were left: Service's effectiveness, Help reception and accessibility. This evidence, based on content and internal structure, shows elevated levels of reliability and validity. This data suggests that the application of this scale will be informative about the variable measured on Colombian samples, as well as further analysis is pertinent for its complete adaptation to the rest of Latin America.

Resumen.
El objetivo de este estudio instrumental era diseñar y validar la Escala de Actitudes hacia Líneas Telefónicas de Salud Mental (EALTSM). Se diseñó una tabla de especificaciones para la creación del instrumento, que fue evaluada por 7 jueces expertos de distintas partes de Latinoamérica. El estudio se realizó con una muestra de 503 participantes con un promedio de edad de 29 años. Para evaluar su validez y confiabilidad, se empleó un análisis factorial exploratorio, análisis de confiabilidad y coeficientes de correlación de Pearson. Como resultado, se alcanzaron cargas, niveles y correlaciones satisfactorias en una prueba con un total de 23 reactivos distribuidos en 3 categorías: Efectividad del servicio, Recepción de ayuda y Accesibilidad al servicio. Estas evidencias, basadas en el contenido y la estructura interna, denotan altos grados de confiabilidad y validez. Se sugiere su aplicación y en participantes de Colombia, como también más análisis para su completa adaptación a Latinoamérica.

Keywords.
Mental Health Helplines, Mental Health, Attitude, Psychometry, Reliability.
Palabras Clave.
Líneas telefónicas de salud mental, salud mental, actitudes, psicometría, confiabilidad.

1. Introduction

The World Health Organization –WHO– (2004) defines mental health as a state of well-being where the individual has coping capacities, potential to develop his or her own aptitudes, and abilities to learn and work functionally in his or her daily environment. In Colombia, it was recorded in 2018 that some common psychological mood and anxiogenic disorders were not usually recognized by the people who suffered from them or by the health personnel in charge, so that of the 60% of people who resorted to basic health care services and presented depressive and anxious symptoms, only 30% were diagnosed with some psychological disorder and an even lower percentage received the relevant treatment (Palacio, 2018).

In 2019, COVID-19 became a pandemic disease that affected political, economic, and health dynamics and negatively impacted the mental health of people globally (Morillo, 2021). Since the onset of the pandemic, rates of anxiety, depression, and stress have increased worldwide (Salari et al., 2020), indicating that the impact of COVID-19 on mental health is a major challenge for psychologists all around the world (Ministerio de Salud y Protección Social [Minsalud], 2020). The new demand for psychological care is confirmed by pre- and post-pandemic data, revealing increases in mental health deterioration in Colombian adult samples of up to 52% by 2020 (Moya et al., 2021), and global increases in cases of major depressive disorder of 27.6% and anxiety disorders with 25.6% for the same year (Organización Mundial de la Salud [OMS], 2022).

The situation has highlighted the need to innovate the ways in which mental health care is provided, among them, the telephone lines oriented to this type of services, which are defined as telephone contacts aimed at containment and counseling for the management and expression of emotional discomfort that the caller experiences before or during the telephone contact, seeking to prevent the development of major psychological problems in the future (Ministerio de Salud y Protección Social, n.d.); there are more than 40 lines in all departments of Colombia (Colegio Colombiano de Psicólogos, 2020) and in more than 16 Latin American countries (Fondo de las Naciones Unidas para la Infancia, n.d.).

In the context of the pandemic, several countries have employed the service of mental health workers over the telephone to make care more accessible (Nicolini, 2020), such as Colombia, where Minsalud (2020) ordered Health Promoting Entities (EPS for its Spanish acronym) and its health secretariats to inform the Colombian population about the helplines, whose function focuses on informing and guiding about mental health, and to enable them to provide support. As a result of the pandemic, Chile has the Salud Responde [Health Answers] line, with an option dedicated to psychological care and emotional support based on the telemedicine service Hospital Digital [Digital Hospital] (Gobierno de Chile, n.d.; Hospital Digital, n.d.), similar to Mexico, which has lines such as Línea de la Vida [Lifeline] and Unidad de Inteligencia Epidemiológica Sanitaria [Unit of Epidemic and Sanitary Intelligence] (Gobierno de México, n.d.). Perú has La Voz Amiga [The friendly voice] (n.d.), which emerged in 1994 as a psychological service aimed at people who have no one to listen to them. Venezuela has implemented different organizations and initiatives to accompany people who need it free of charge, through direct messages or telephone services (El Pitazo, 2022).

These strategies promote remote mental health and exacerbate the validity of studying the variables that influence its use, usually being a practical and less expensive tool to offer psychiatric treatments (Jesse et al., 2020, as cited in Morillo, 2021). Similarly, studies such as Rickwood et al. (2005) have shown that forms of help-seeking that rely less on engagement in social activity and are more anonymous, such as telephone helplines or virtual means of help, can be effective for young people who wish to avoid direct social contact.

Among these influential aspects in the decision to use or not this psychological service, the following are highlighted: psychological help reception, service effectiveness, and service accessibility. The first category, receipt of psychological help, is understood as the set of predispositions a person has regarding the need to seek psychological services, considering stigmas about mental health and its treatment (Ægisdóttir & Lawrence, 2009; Riveros-Munévar et al., 2015). Stigma is understood as the set of negative perceptions and stereotypes applied to a social group, which usually lead to prejudice and actions of exclusion and rejection (Corrigan & Lam, 2007). Specifically, there is talk of self-stigma for seeking help, which refers to the perception of oneself that affects self-image, self-esteem and self-efficacy when seeking mental health care (Vogel et al., 2006), and perceived public stigma, which is when the person is aware of the stereotypes of the general public regarding receiving psychological care (Link, 1987). This dimension is important since psychological help-seeking behaviors linked to the perception of helplines as a service are usually influenced by the stigma regarding mental health and the psychological treatment that the subject has (Gulliver et al., 2010; Pattyn et al., 2014).

The second category of evaluation, service effectiveness, refers to the level of impact and benefits associated with seeking psychological help through a telephone helpline (Jaramillo et al., 2021; Wang & Patten, 2007). It has been found that the intention to seek help may be affected by how much the individual believes that the procedure can help with the problem (Rickwood et al., 2007) and how necessary it is considered to attend the consultation in the first place to deal with the issue (Rickwood et al., 2007; Wilson & Deane, 2012). Measuring the perceived effectiveness of the helpline's

modality will allow a more complete understanding of attitudes in this regard.

Finally, the third category, service accessibility, is presented, which refers to the accessibility of the mental health helplines service based on its operation, logistics, and the knowledge that people have about them (Gulliver et al., 2010). One variable that may affect attitudes toward mental health care is the functioning of the service in question and its understanding, whether with respect to the person's literacy on mental health issues —which includes knowledge about treatments in addition to ways to locate appropriate information and services— (Jorm et al., 1997; Gulliver et al., 2010), costs (Picco et al., 2016; Wilson & Deane, 2012), the types of services available in helpline modalities (Middleton et al., 2016), and common procedures (Rickwood et al., 2007; Wilson & Deane, 2012).

Due to the above, it is considered that this service's use could be influenced by the attitudes people have (Casey et al., 2013). Attitudes are understood as evaluative judgments acquired towards an object, subject or situation, which determine the individual's personal intentions and can influence their behaviors or actions (Martínez, 2008). This attitude is considered multidimensional, composed —according to Briñol et al. (2007)— of three main components: cognitive, which encompasses the thoughts, beliefs, and opinions that the person possesses; affective, which refers to the feelings and emotions towards the attitude object; and conative-behavioral, which groups the intentions, dispositions, and behaviors oriented towards the evaluated construct.

Therefore, the construct that this research will address is *Attitudes towards mental health helplines*, understood as the set of predispositions and value judgments that a subject has towards telephone contact lines intended for the support, advice, and prevention of psychological problems (Briñol et al., 2007; MinSalud, n.d.).

In conclusion, the mental health emergency generated by COVID-19 (Morillo, 2021; Salari et al., 2020) and the importance highlighted by the World Health Organization (2022) of innovating with respect to the modalities of mental health care, making full use of technological means and remote care, it is understood that knowing the attitudes of people regarding mental health care, by means such as helplines, would be vital to achieve a better implementation and promotion of this means in the Latin American population (Ajzen, 1991). Although scales of a similar nature to the one of this study were found in the literature review —such as Riveros-Munévar et al. (2015) or Hammer et al. (2018)— no scales were found to measure attitudes toward mental health helplines, neither in the Colombian context nor globally. Considering this, the general objective of this work is to design and validate a scale of attitudes towards mental health lines for Colombian adult samples to recognize whether users consider the service to be effective in order to make the necessary modifications both at micro level (such as the organizations' helplines) and macro level (nationally); identify whether the subjects are willing to receive help from professionals through the helplines; demonstrate whether MHH are accessible or not for the subjects; and, if the attitude is negative or very negative, be able to mobilize resources to change this. On the other hand, the specific objectives are to identify evidence of validity and reliability that confirm the designed scale is suitable for use.

2. Methodology

2.1 Type of Study

An instrumental study was handled, which according to Montero and León (2005, 2007) and Ato et al. (2013) involves research with the objective of constructing tests and instruments, regarding their design, adaptation, and/or the study of their psychometric properties.

2.2 Participants

A non-probabilistic snowball convenience sampling was chosen (Hernández et al., 2014). The sample consisted of 503 participants between the ages of 18 and 78 years, nationals of Colombia that belong to the general population, with an average age of 29 years and a standard deviation of 13.57, of which 59.6% identified with the female gender, and 40.4% with the male gender. As an exclusion criterion, psychologists and psychology students were not allowed to participate, since this could imply bias in the responses. This size is considered ideal according to the guidelines on factor analysis (Lloret-Segura et al., 2014) where a sample as large as possible, ideally above 500 participants, is proposed. Likewise, the Kaiser-Meyer-Olkin sample adequacy value ($>.8$) approved this sample size.

2.3 Procedure

A literature review was carried out to find theoretical and empirical references to develop a table of specifications, which could estimate an approximate number of items per dimension and propose definitions, as well as creating possible items to be answered using a Likert scale. Although several items per category were proposed, it was decided to make some extra items for each division, considering that with expert judgment, it was possible that several items would be rejected. This led to 47 items.

Since the application of this scale is designed for Latin America, judges from different Latin American countries were sought, including Venezuela (1), Chile (1), Peru (1), Mexico (2) and Colombia (2). They were accessed through the official web pages of universities, which made it possible to obtain clinical psychologists and psychometrists. After sending them an invitation and receiving their willingness for the evaluation, a rubric

was shared with them with the items in terms of their relevance, congruence, use of language and a section for additional observations. The rubric presented the items in their specific category to evaluate their belonging to these categories.

Once the validation of these judges was obtained, a Lawsche analysis modified by Tristán-López (2008) was used to determine the quantitative content validity of both the items and the general test, which guided the modification or elimination of the items.

These were randomly ordered, after which the application was done through the Google Forms platform. It included a brief description of the scale with its rationale, ethical considerations, contact information of those responsible for the project, clarification of the exclusion criteria, acceptance of informed consent, demographic data —age, sex, last level of schooling attained, confirmation of Colombian nationality—, the items with their respective evaluation, and acknowledgements. After collecting 523 responses, those that did not accept consent (7) or confirm Colombian nationality (13) were discounted, resulting in 503 responses.

Following this, by means of JASP v.0 .16.4. (JASP Team, 2022) an Exploratory Factor Analysis was performed based on a Promax oblique rotation with weighted least squares together with the Kaiser-Meyer Olkin analysis and Bartlett's test of sphericity, a reliability analysis with Cronbach's Alpha coefficients, McDonald's Omega, Guttman's Lambda 6 and Guttman's Greatest Lower Bound (GLB) overall and for each factor, and item-item correlation analysis by means of Pearson correlations for each factor, which led to a further refinement of the items.

2.4 Ethical Considerations

Following the general provisions of Ley 1090 of 2006 (Congreso de la Republica de Colombia), when participating in the validation of the test, the confidentiality of the information given by the participants was assured by means of an informed consent in which the data obtained were processed anonymously and for research purposes. Likewise, in accordance with Resolución 8430 (Ministerio de Salud, 1993), this study is considered a risk-free investigation, given that no intervention or modification of the psychological variables —in this case the attitudes of the study participants— was carried out.

3. Results

Through a literature review, more information about the Psychological Help Reception dimension was found, compared with the Service Effectiveness and Service Accessibility; therefore, these categories were assigned percentages of 38.46%, 30.77% y 30.77% respectively. Regarding attitudes, White et al. (2018) found in a systematic review that most articles about health seeking and attitudes towards psychological services tend to cover these constructs as intentions and behaviors, as well as from the tendencies and beliefs people have on the topic, which is why the conative-behavioral and cognitive dimensions were assigned a percentage of 38.46%, while the affect dimension will work with a percentage of 23.08%.

Because of the lack of instruments to measure this construct, similar scales were investigated to determine the number of items to be used. For example, one scale designed and validated by Riveros-Munévar et al. (2015) about attitudes towards professional psychologist's labor had 28 items. The IASPHPP —Attitudes towards Seeking Professional Help for Psychological Problems— scale had 24 items (Mackenzie et al., 2004). Likewise, in the MHSAS —Mental Help Seeking Attitudes Scale— there were three similar dimensions: public stigma to help-seeking, self-stigma about help seeking, and anticipated risks and benefits, which employed 23 items total (Hammer et al., 2018). Therefore, for the following scale it was decided to work with 26 items.

Following this, 7 judges evaluated the items through a form. Although items 3 and 5 got a score of .57 on the content validity index, in the congruence area and the category 'cognitive attitudes towards help reception' got the same score in terms of sufficiency, it was decided to keep those items and that category, considering the judges' qualitative assessment and how close those scores were to the cut-off point score.

With the pertinent software, the Kaiser-Meyer Olkin test was performed, with results between .72 y .96, and a general MSA of .92, which justifies that the sample size is big enough to be subjected to an Exploratory Factor Analysis (Méndez & Rondón, 2012). Regarding Bartlett's sphericity test, this showed an appropriate significative correlation matrix, since their significance level is lower than .05 —$<$.001— (Méndez & Rondón, 2012). Knowing this, the following is the Exploratory Factor Analysis with the corresponding loadings for each factor.

The EFA loaded 3 factors. Factor 1 (11 items), Factor 2 (8 items) and Factor 3 (4 items). Items 5, 11 and 15 were discarded since they loaded in more than one factor.

Following this, general reliability was calculated with McDonald's ω —.91—, Cronbach's α de Cronbach —.89—, Guttman's $\lambda 6$ —.93—, and the Greatest Lower Bound [GBL] —.96—. These data represent appropriate reliability coefficients, since they surpass the required minimum of .7 (Ovideo & Campo-Arias, 2005). Next, the reliability of those coefficients was analyzed by factor and by each item's contribution to their respective factors, as evidenced by Tables 2, 3 y 4.

On Tables 2, 3, and 4, its shown that the removal of any of the present items would be counterproductive for the test's reliability. These data contribute to the internal structure evidence of validity, which sustain keeping the items and factors in the final version of the scale.

Table 1

Correlation Matrix of the Factor Analysis

	Factor 1	Factor 2	Factor 3	Uniqueness
V25	.95			.12
V23	.92			.18
V24	.88			.25
V26	.87			.20
V19	.87			.30
V21	.86			.26
V20	.85			.22
V9	.76			.33
V7	.73			.47
V12	.66			.40
V13	.59			.35
V2		.65		.48
V4		.64		.58
V3		.59		.62
V18		.58		.64
V1		.56		.63
V8		.50		.69
V22		.50		.71
V17		.41		.76
V14			.80	.41
V16			.65	.39
V10			.64	.43
V6			.52	.48

Note. The rotation was promax.

Table 2

Reliability Coefficient of Factor 1 and Hypothetical Coefficients after Item Removal

Item/Factor	McDonald's ω	Cronbach's α	Guttman's $\lambda 6$	GLB	Item-total Correlation
Factor 1	.95	.95	.96	.97	
Item			If item is removed		
V25	.95	.95	.95	.96	.88
V24	.95	.95	.95	.97	.80
V19	.95	.95	.95	.969	.76
V20	.95	.95	.95	.966	.84
V26	.95	.95	.95	.965	.85
V21	.95	.95	.95	.967	.81
V9	.95	.95	.95	.967	.76

Table 3

Reliability Coefficient of Factor 2 and Hypothetical Coefficients after Item Removal

Item/Factor	McDonald's ω	Cronbach's α	Guttman's $\lambda 6$	GLB	Item-total Correlation
Factor 2	.79	.789	.784	.832	—
Item			If Item is removed		
V14	.75	.75	.67	.75	.58
V16	.73	.72	.64	.73	.64
V10	.73	.73	.66	.73	.61
V6	.75	.75	.68	.75	.56

Table 4

Reliability Coefficient of Factor 3 and Hypothetical Coefficients after Item Removal

Item/Factor	McDonald's ω	Cronbach's α	Guttman's $\lambda 6$	GLB	Item-total Correlation
Factor 3	.95	.95	.96	.97	
Item			If Item is removed		
V7	.95	.95	.95	.970	.70
V12	.95	.95	.95	.968	.71
V13	.95	.95	.95	.97	.70

Finally, Pearson's correlations were carried out between the variables of every factor. All correlations were positive and significant, with a P value lower to .05 —$p < .001$— (Goss-Sampson & Meneses, 2019), indicating a high internal consistency between each dimension's variables.

The English translated version of the scale can be seen on Appendix A and scoring interpretation norms (created through grouping by quintiles) on Appendix B. The original Spanish versions of both the scale (Appendix C) and the norms (Appendix D) are also available.

4. Discussion

The present research had the objective of designing and validating the Attitudes Towards Mental Health Helplines Scale, with dimensions of service effectiveness, help reception and Accessibility of Service, built around the theorical and empirical reviews performed.

The first factor, service effectiveness —11 items–, measures the perception of how effective, satisfactory, and beneficial the psychological service is (Jaramillo et al., 2021; Wang and Patten, 2007). The second factor, help reception —8 items—, evaluates the tendency towards turning to a psychological service considering the presence or absence of beliefs and social stigma (Ægisdóttir & Lawrence, 2009; Riveros-Munévar et al., 2015). The third dimension, service accessibility —4 ítems—, assesses the knowledge the person has about the availability, operation, and logistics of the helpline (Gulliver et al., 2010).

The factors matched these dimensions that were proposed based on the theory, comprising the attitudes according to their cognitive, affective, and behavioral dimensions (Briñol et al., 2007). However, for the measuring it was preferred to employ a model that included univalent attitudes from very negative to very positive (De Liever et al., 2007), considering in the middle point one level of neutrality.

Content-based validity was proven by making a solid table of specifications, and later by counting with the approval of seven external judges. There was also evidence based on internal structure validity found on the EFA and its high levels of variance explained, on the significative item-item and item-total correlations and on the reliability indexes of Cronbach's alpha, McDonald's omega, Guttman's Lambda 6, and the GLB, showing overall satisfactory results and with every item contributing individually to the reliability as seen through the hypothetical removal of all items. Therefore, it is concluded that the Spanish version of the scale counts with high levels of internal consistency and a good capacity to measure its intended purpose, so there is enough evidence to confirm the validity and reliability of the ATMHHS, recognizing that it is fit for use on the Colombian population. It is important to highlight that this study represents a first step to achieve (content) validity for other Latin American countries, given the approval of judges from several parts of South America.

Regarding limitations, it is advised that this scale is used on representative samples of all ages, including minors. Furthermore, since the applications were done virtually, in different environments and through the snowball method, there was no control of external variables that could have impacted participant's answers.

It is important to recognize the Spanish version of the scale has been designed and validated for Colombian samples, reason to suggest its use on this population to develop future research that could allow a better comprehension on the attitudes towards this type of helpline, favoring them and improving the kind of service they provide. It would also be interesting to develop comparative studies between people who have already used helplines and people who never have, to test if there are differences on attitudes based on experience. It us also worth noting that the English version of the scale, although translated properly, has not been validated, which is why it would be ideal to verify its psychometrical proprieties.

This scale will be useful to recognize the attitudes that people have towards MHH, which will allow to carry out objective evaluations over the likelihood that people will turn to this type of psychological service or not, as well as an objective measure that could aid intervention programs oriented to improve said attitudes. The access to mental health services is heavily important, and this scale facilitates an assessment of perception on helplines that can provide it.

Finally, it is recommended to carry out studies about the psychometric properties of this instrument on different Latin American contexts, to guarantee the invari-

ance in other populations keeping in mind transcultural parameters.

5. Conclusion

This study focused on the construction and analysis of the metric quality of an instrument that measures attitudes towards mental health helplines. The data allows to affirm that a 23-item scale with three dimensions —perception of service effectiveness, help reception, and accessibility to the service— has been built, which is a scale that evaluates with reliability and validity (given adequate evidence of content and internal structure validity) the construct it claims to study. Scoring interpretation norms have been provided, which guarantee the possibility of using and scoring this instrument in an objective manner.

References

Ægisdóttir, S., & Lawrence, H. G. (2009). Beliefs About Psychological Services (BAPS): development and psychometric properties. *Counselling Psychology Quarterly*, *22*(2), 197–219. https://doi.org/10.1080/09515070903157347

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior & Human Decision Processes*, *50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020-T

Ato, M., López-García, J. J., & Benavente, A. (2013). Un sistema de clasificación de los diseños de investigación en psicología. *Anales de Psicología/ Annals of Psychology*, *29*(3), 1038–1059.

Briñol, P., Falces, C., & Becerra, A. (2007). Actitudes. In J. Morales, C. Huici, M. Moya, & E. Gaviria (Eds.), *Psicología Social* (pp. 457–490). McGraw-Hill.

Casey, L. M., Joy, A., & Clough, B. A. (2013). The impact of information on attitudes toward e-mental health services. *Cyberpsychology, behavior and social networking*, *16*(8), 593–598. https://doi.org/10.1089/cyber.2012.0515

Colegio Colombiano de Psicólogos. (2020). *Directorio de Líneas de ayuda en salud mental - Colombia* [PDF File]. http://www.bienestar.unal.edu.co/fileadmin/user_upload/universidadsaludable/saludmental/biblioteca_virtual/materialdeconsulta/directorio_colombia_salud.pdf

Congreso de la Republica de Colombia. (2006, September 6). Ley 1090 de 2006. *Por la cual se reglamenta el ejercicio de la profesión de Psicología, se dicta el Código Deontológico y Bioético y otras disposiciones.* D.O. No. 46383. https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=66205

Corrigan, P. W., & Lam, C. (2007). Challenging the structural discrimination of psychiatric disabilities: Lessons learned from the American disability community. *Rehabilitation Education*, *21*(1), 53–58.

De Liver, Y., Pligt, J., & Wigboldus, D. (2007). Positive and negative associations underlying ambivalent attitudes. *Journal of Experimental Social Psychology*, *43*(2), 319–326. https://doi.org/10.1016/j.jesp.2006.02.012

El Pitazo. (2022, January 4). *Conoce las instituciones que ofrecen atención psicológica gratuita.* https://elpitazo.net/salud/conoce-las-instituciones-que-ofrecen-atencion-psicologica-gratuita/amp/

Fondo de las Naciones Unidas para la Infancia. (n.d.). Guía por países: Encuentra servicios de apoyo de salud mental para los adolescentes. https://www.unicef.org/lac/Ayuda-SaludMental

Gobierno de México. (n.d.). *Salud mental.* Salud mental - Coronavirus. https://coronavirus.gob.mx/salud-mental/

Gobierno de Chile. (n.d.). *Ayuda de Profesionales.* Gob.cl. https://www.gob.cl/saludablemente/ayudaprofesionales/

Goss-Sampson, M. A., & Meneses, J. (2019). *Análisis estadístico con JASP: Una guía para estudiantes.* Universitat Oberta de Catalunya.

Gulliver, A., Griffiths, K., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*, 113. https://doi.org/10.1186/1471-244X-10-113

Hammer, J. H., Parent, M. C., & Spiker, D. A. (2018). Mental Help Seeking Attitudes Scale (MHSAS): Development, reliability, validity, and comparison with the ATSPPH-SF and IASMHS-PO. *Journal of Counseling Psychology*, *65*(1), 74. https://doi.org/10.1037/cou0000248

Hernández, R., Fernández-Collado, C., & Baptista, P. (2014). *Metodología de la investigación* (4 Ed.). McGraw-Hill.

Hospital Digital. (n.d.). *Hospital Digital - Ministerio de Salud.* Ministerio de Salud. https://www.hospitaldigital.gob.cl/

Jaramillo, J. L., Villavicencio, C. E., & Peña, G. (2021). Análisis de la efectividad terapéutica en los servicios públicos de atención psicológica. *Scienti-Americana*, *8*(1), 17–30. https://doi.org/https://revistacientifica.uamericana.edu.py/index.php/scientiamericana/article/view/543

JASP Team. (2022). JASP (Version 0.16.4) [Computer software]. The JASP Team. https://static.jasp-stats.org/JASP-0.16.4-64bit.msi

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "mental health literacy": A survey of the public's abil-

ity to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical journal of Australia*, *166*(4), 182–186. https://doi.org/10.5694/j.1326-5377.1997.tb140071.x

La Voz Amiga. (n.d.). *Te escuchamos cuando más lo necesitas.* https://www.lavozamigaperu.org

Link, B. G. (1987). Understanding Labeling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection. *American Sociological Review*, *52*(1), 96. https://doi.org/10.2307/2095395

Lloret-Segura, S., Ferreres-Traver, A., Hernández-Baeza, A., & TomásMarco, I. (2014). Exploratory Item Factor Analysis: A practical guide revised and up-dated. *Annals of Psychology*, *30*(3), 1151–1169. https://doi.org/10.6018/analesps.30.3.199361

Mackenzie, C. S., Knox, V. J., Gekoski, W. L., & Macaulay, H. L. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. *Journal of Applied Social Psychology*, *34*, 2410–2433. https://doi.org/10.1111/j.1559-1816.2004.tb01984.x

Martínez, O. J. (2008). Actitudes hacia la matemática. *Sapiens. Revista Universitaria de Investigación*, *9*(1), 237–256.

Méndez, C. M., & Rondón, M. A. (2012). Introducción al análisis factorial exploratorio. *Revista Colombiana de Psiquiatría*, *41*(1), 197–207. http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0034-74502012000100014&lng=en&tlng=es.

Middleton, A., Pirkis, J., Chondros, P., Bassilios, B., & Gunn, J. (2016). The health service use of frequent users of telephone helplines in a cohort of general practice attendees with depressive symptoms. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(5), 663–674. https://doi.org/10.1007/s10488-015-0680-7

Ministerio de Salud. (1993, October 4). Resolución No. 8430. Ministerio de Salud. *Por la cual se establecen las normas científicas, técnicas y administrativas para la investigación en salud.* https://www.minsalud.gov.co/sites/rid/lists/bibliotecadigital/ride/de/dij/resolucion-8430-de-1993.pdf

Ministerio de Salud y Protección Social. (n.d.). *Atención telefónica en salud mental: Pautas generales para su implementación y funcionamiento en el contexto de la pandemia por COVID19* [PDF File]. https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/lineamiento-implementacion-lineas-orientacion-salud-mental.pdf

Ministerio de Salud y Protección Social. (2020). *Salud mental, uno de los principales retos de la pandemia.* Boletín de Prensa No. 237. https://www.minsalud.gov.co/Paginas/Salud-mental-uno-de-los-principales-retos-de-la-pandemia.aspx

Montero, I., & León, O. G. (2005). Sistema de clasificación del método en los informes de investigación en Psicología. *International Journal of clinical and health psychology*, *5*(1), 115–127.

Montero, I., & León, O. G. (2007). A guide for naming research studies in Psychology. *International Journal of clinical and Health psychology*, *7*(3), 847–862.

Morillo, C. (2021). *Afectación en la salud mental de la población española por la crisis del covid-19 y el aislamiento social.* Universidad Pontificia Comillas. https://repositorio.comillas.edu/xmlui/bitstream/handle/11531/50906/tfg%20-%20morillo%20cury%2C%20claudia%20.pdf?sequence=1&isAllowed=y

Moya, A., Vargas, J., Cabra, M., Farfán, A., & Romero, O. (2021). *¿Cómo se relaciona la pandemia del COVID-19 con la salud mental de los colombianos? Resumen de políticas según la iniciativa Respuestas Efectivas contra el COVID-19 (RECOVR)?.* Departamento Nacional de Planeación. https://colaboracion.dnp.gov.co/CDT/Sinergia/Documentos/Notas_politica_publica_SALUD%20MENTAL_22_04_21_V7.pdf

Nicolini, H. (2020). Depresión y ansiedad en los tiempos de la pandemia de COVID-19. *Cirugía y cirujanos*, *88*(5), 542–547. https://doi.org/10.24875/CIRU.M20000067

Organización Mundial de la Salud. (2004). *Promoción de la salud mental. Conceptos, evidencia, práctica emergente. Informe compendiado: Un informe de la Organización Mundial de la Salud. Departamento de Salud Mental y Abuso de Sustancias Psicoactivas en colaboración con la Fundación Victorian para la Promoción de la Salud de la Universidad Melbourne.* Organización Mundial de la Salud. https://apps.who.int/iris/handle/10665/78545

Organización Mundial de la Salud. (2022). *Salud mental y COVID-19: datos iniciales sobre las repercusiones de la pandemia: resumen científico.* Organización Mundial de la Salud. https://apps.who.int/iris/bitstream/handle/10665/354393/WHO-2019-nCoV-Sci-Brief-Mental-health-2022.1-spa.pdf?sequence=1&isAllowed=y

Oviedo, H. C., & Campo-Arias, A. (2005). Aproximación al uso del coeficiente alfa de Cronbach. *Revista Colombiana de Psiquiatría*, *34*(4), 572–580. http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0034-74502005000400009&lng=en&tlng=es.

Palacio, C. A. (2018). Situación de salud mental en Colombia. *International Journal of Psycholog-*

ical Research, *11*(2), 6–9. https://doi.org/10.21500/20112084.3712

Pattyn, E., Verhaeghe, M., Sercu, C., & Bracke, P. (2014). Public stigma and self-stigma: Differential association with attitudes toward formal and informal help seeking. *Psychiatric Services*, *65*(2), 232–238. https://doi.org/10.1176/appi.ps.201200561

Picco, L., Abdin, E., Chong, S., Pang, S., Shafie, S., Chua, B. Y., Vaingakar, J. A., Ong, L. P., Tay, J., & Subramaniam, M. (2016). Attitudes toward seeking professional psychological help: Factor structure and socio-demographic predictors. *Front. Psychol*, *7*(547). https://doi.org/10.3389/fpsyg.2016.00547

Rickwood, D., Deane, F., Wilson, C., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health*, *4*(3), 218–251. https://doi.org/10.5172/jamh.4.3.218

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems? *Medical journal of Australia*, *187*(S7), 35–39. https://doi.org/10.5694/j.1326-5377.2007.tb01334.x

Riveros-Munévar, F., Bohórquez-Borda, D., López-Castillo, S., & Sepúlveda-Rodríguez, E. (2015). Diseño y validación de un instrumento para medir las actitudes frente a la labor profesional del psicólogo. *Revista Iberoamericana De Psicología*, *8*(2), 55–65. https://doi.org/10.33881/2027-1786.rip.8205

Salari, N., Hosseinian-Far, A., Jalali, R., Vaisi-Raygani, A., Rasoulpoor, S., & Mohammadi, M. (2020). Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: a systematic review and meta-analysis. *Global Health*, *16*, 57. https://doi.org/10.1186/s12992-020-00589-w

Tristán-López, A. (2008). Modificación al modelo de lawshe para el dictamen cuantitativo de la validez de contenido de un instrumento objetivo. *Avances en Medición Instituto de Evaluación e Ingeniería Avanzada*, *1*(6), 37–48. https://www.humanas.unal.edu.co/lab_psicometria/application/files/9716/0463/3548/VOL_6._Articulo4_Indice_de_validez_de_contenido_37-48.pdf

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*(3), 325–337. https://doi.org/10.1037/0022-0167.53.3.325

Wang, J., & Patten, S. B. (2007). Perceived effectiveness of mental health care provided by primary-care physicians and mental health specialists. *Psychosomatics*, *48*(2), 123–127. https://doi.org/10.1176/appi.psy.48.2.123

Watkins, M. W. (2018). Exploratory Factor Analysis: A Guide to Best Practice. *Journal of Black Psychology*, *44*(3), 219–246. https://doi.org/10.1177/0095798418771807

White, M. M., Clough, B. A., & Casey, L. M. (2018). What do help-seeking measures assess? Building a conceptualization framework for help-seeking intentions through a systematic review of measure content. *Clinical psychology review*, *59*, 61–77. https://doi.org/10.1016/j.cpr.2017.11.001

Wilson, C. J., & Deane, F. P. (2012). Brief report: Need for autonomy and other perceived barriers relating to adolescents' intentions to seek professional mental health care. *Journal of Adolescence*, *35*(1), 233–237. https://doi.org/10.1016/j.adolescence.2010.06.011

Appendix A

Attitudes Towards Mental Health Helplines Scale

Name: ________________ Age: ________________ Sex: ________________

Below, you will find a series of statements related to Mental Health Helplines (MHH). Please read and answer each statement taking into account the following scale from 1 to 6, 1 "completely disagree (CD)", 2 "disagree (D)", 3 "partially disagree (PD)", 4 "partially agree (PA)", 5 "agree (A)", 6 "completely agree (CA)". Answer each item keeping in mind that there are no right or wrong answers, and consider how you feel, think, and act when faced with mental health helplines. In case you do not have personal experience with MHH, answer based on your knowledge and beliefs.

	CD	D	PD	PA	A	CA
	1	2	3	4	5	6
1. MHH only work for those who do not have other people to confide their problems to						
2. It is embarrassing to have to contact an MHH						
3. MHH provide a barely personalized service						
4. I feel indifferent to the benefits that MHH may have						
5. MHH are as effective as traditional psychological services						
6. I would look for information about MHH for my own use in the future						
7. If I had an emotional crisis I would try to resolve it by myself or with the help of the people around me, instead of contacting an MHH						
8. In case of needing psychological support, I would contact a MHH, without feeling bad about myself						
9. I am satisfied with the information available on the operation of MHH						
10. If I need an alternative to solve my problems, I would call an MHH						
11. The help provided by MHH workers is useful						
12. There is enough information about how to access a MHH						
13. The MHH have a correct follow up of all the cases						
14. The MHH have restricted time slots						
15. If I contacted an MHH, I would prevent other people from finding it out						
16. I would look for information about MHH to guide people who need psychological help						
17. I would recommend attending a MHH to properly resolve any psychological difficulties						
18. I would contact a MHH if I consider I could not deal with a situation on my own						
19. Contacting a MHH could generate rejection from my acquaintances						
20. If I perceive that someone close to me is feeling emotional distress, I would tell them that they can access MHH						
21. I would be relieved to see third parties contacting MHH						
22. I would consider going to an MHH if I were having an emotional crisis						
23. I would feel comfortable going to a MHH						

Appendix B

Scoring Norms

The items of the Attitudes toward mental health helplines scale are scored considering that the scores for each response correspond to:

- Completely Disagree (1)
- Disagree (2)
- Partially Disagree (3)
- Partially Agree (4)
- Agree (5)
- Strongly Agree (6)

Except for items 1, 2, 3, 4, 8, 11, 15, 17, 18 and 22, because these were scored inversely, that is, the lower value is equivalent to Strongly Agree (1) and the higher value is equivalent to Strongly Disagree (6).

This way, the score is summed up taking into account each factor of the test or the test in general. Thus, the minimum score of the test at the general level for the male gender was 47 and the maximum 127, while for the female gender the minimum was 46 and the maximum 133. The scores obtained should be placed in the following table, to locate the score of each person depending on their gender.

Attitude	Total test		Service effectiveness		Help reception		Service accessibility	
	1	2	1	2	1	2	1	2
Very negative	46–79	47–72	11–37	11–33	14–28	8–26	4–7	4–7
Negative	80–90	73–85	38–47	34–43	29–32	27–30	8–10	8–10
Neutral	91–100	86–9	48–54	44–49	33–36	31–33	11–12	11–12
Positive	101–111	95–103	55–59	50–55	37–40	34–38	13–14	13–15
Very positive	112–133	104–127	60–66	56–66	41–48	39–48	15–23	16–24

Note. 1 Feminine, 2 Masculine.

Interpretation of general attitudes towards MHH:

To obtain the overall test score, each subject's value of all test items is considered. According to the result and the location in the rating table, the person has:

Very negative attitude: indicates that the individual considers this means of care to be obsolete and not at all useful. This is a person who would not recommend the services of the MHH to his/her acquaintances and who would resort to any other means to solve any type of psychological distress.

Negative attitude: Indicates that the person considers that this means of care does not meet his or her expectations regarding the availability and attention of the service, based on the stigmatization that he or she may have towards someone or what her or she could receive in case of going to MHH.

Neutral attitude: Indicates that the individual considers that this means of care is neither good nor bad, and therefore does not have marked cognitive, emotional, or cognitive-behavioral attitudes that form a value judgment.

Positive attitude: Indicates that the individual considers this means of care to be viable and sufficiently useful to provide psychological help. This is an individual who would moderately recommend the MHH service and who would turn to this medium as a source of help in case of any type of psychological distress.

Very positive attitude: Indicates that the individual considers this means of care to be very useful and appropriate when in need of psychological help. This is an individual who would actively recommend the services of the MHH to his or her acquaintances and who, would turn to this medium as a source of help in case of any type of psychological distress.

Interpretation of attitudes toward service effectiveness:

To obtain the score of attitudes towards the service effectiveness, it is necessary to add the scores of the items corresponding to this factor. According to the result obtained and the scale table, the person has:

Very negative attitude: the individual considers the service useless because it does not produce the expected effect, so he/she feels dissatisfied with its operation.

Negative attitude: The individual considers that this means of care is ineffective, its impact is little, and feels dissatisfied with its operation.

Neutral attitude: The individual considers this means of attention to be moderately effective and his levels of satisfaction are ambivalent, recognizing some of its benefits.

Positive attitude: The subject is sufficiently satisfied with the care provided by MHHs, as he/she recognizes several benefits and considers them relevant.

Very positive attitude: This is an individual who considers MHH to be highly effective, feels completely satisfied, and recognizes benefits of great value.

Interpretation of attitudes towards help reception:

To obtain the score of attitudes toward receiving help, the values of the items corresponding to this factor are added together. According to the result obtained and the scoring table, the person has:

Very negative attitude: indicates that the individual would not consider going to an MHH at all if he/she had any kind of psychological distress, considering stigmas about receiving help.

Negative attitude: Indicates that the subject would avoid attending an MHH if he/she presented psychological distress, considering stigmas about receiving help.

Neutral attitude: Indicates that the individual does not have a marked inclination to attend or not to attend the service based on stigmas about receiving help.

Positive attitude: Indicates that the individual would consider going to an MHH if he/she had some type of psychological distress, seeing it as a viable means to solve it.

Very positive attitude: Indicates that the subject would go to a MHH without hesitation if he/she felt any kind of psychological distress, considering it a very viable means to solve it.

Interpretation of attitudes toward service accessibility:

To obtain the score of attitudes toward service accessibility, the values of the items corresponding to this factor are added together. According to the result obtained and the scale table, the person has:

Very negative attitude: Indicates that the individual considers that the line schedules, their operation. and logistics are completely inaccessible.

Negative attitude: Indicates that the individual feels and thinks that the effort to find logistical information —timetables, procedures, etc.— of the MHH is considerable, making the service inaccessible.

Neutral attitude: Indicates that the individual does not have a strong position on the availability, operation, and logistics of the MHH.

Positive attitude: Indicates that the individual considers that the logistical information regarding the MHHs —schedules, procedures, etc.— is accessible and that the service is available, and that he/she could recommend it to his/her acquaintances.

Very positive attitude: Indicates that the individual considers that the logistical information concerning MHH —timetables, procedures, etc.— is very easily accessible and that the service has high availability, and therefore considers it highly recommendable to his or her acquaintances.

Appendix C

Escala de Actitudes hacia las líneas telefónicas de salud mental

Nombre: ______________ Edad: ______________ Sexo: ______________

A continuación, encontrará una serie de afirmaciones relacionadas a las Líneas Telefónicas de Salud Mental (LTSM). Por favor lea y conteste cada afirmación teniendo en cuenta la siguiente escala del 1 al 6, 1 "completamente en desacuerdo (CD)", 2 "en desacuerdo (D)", 3 "parcialmente en desacuerdo (PD)", 4 "parcialmente de acuerdo (PA)", 5 "de acuerdo (A)", 6 "completamente de acuerdo (CA)". Responda cada ítem teniendo en cuenta que no hay respuestas correctas o incorrectas, y tenga en cuenta cómo se siente, piensa y actúa ante las líneas telefónicas de salud mental. En caso de no tener experiencia personal con las LTSM, responda con base a sus conocimientos y creencias.

	CD 1	D 2	PD 3	PA 4	A 5	CA 6
1. Las LTSM sólo sirven para quienes no tienen otras personas en quien confiar sus problemas.						
2. Es vergonzoso tener que acudir a una LTSM.						
3. Las LTSM proveen un servicio poco personalizado.						
4. Siento indiferencia por los beneficios que puedan tener las LTSM.						
5. Las LTSM son tan efectivas como los servicios psicológicos tradicionales.						
6. Buscaría información acerca de las LTSM para mi propio uso en el futuro.						
7. Si tuviera una crisis emocional intentaría resolverla por mí mismo o con ayuda de las personas que me rodean, en vez de acudir a una LTSM.						
8. En caso de necesitar apoyo psicológico, acudiría a una LTSM, sin sentirme mal conmigo mismo.						
9. Me siento satisfecho con la información disponible sobre el funcionamiento de las LTSM.						
10. Si necesito una alternativa para solucionar mis problemas, entonces llamaría a una LTSM.						
11. La ayuda que proveen los trabajadores de una LTSM es útil.						
12. Existe bastante información sobre cómo acceder a las LTSM.						
13. Las LTSM cuentan con un correcto seguimiento de todos los casos.						
14. Las LTSM cuentan con franjas de horario restringidas.						
15. Si acudiera a una LTSM, evitaría que otras personas se enteraran.						
16. Buscaría información acerca de las LTSM para orientar a personas que necesiten auxilio psicológico.						
17. Recomendaría asistir a una LTSM para solucionar apropiadamente alguna dificultad psicológica.						
18. Acudiría a una LTSM si considerara que no puedo lidiar con una situación por mi cuenta.						
19. Acudir a una LTSM podría generar rechazo por parte de mis conocidos.						
20. Si percibiera que alguien cercano siente malestar emocional, le comentaría que puede acceder a las LTSM.						
21. Me sentiría aliviado de ver a terceros que acuden a las LTSM.						
22. Consideraría acudir a una LTSM si tuviera una crisis emocional.						
23. Me sentiría cómodo/a al acudir a una LTSM.						

Appendix D

Normas de calificación

Los ítems de la escala Actitudes hacia las líneas telefónicas de salud mental se califican teniendo en cuenta que las puntuaciones de cada respuesta corresponden a:

- Completamente en desacuerdo (1)
- En desacuerdo (2)
- Parcialmente en desacuerdo (3)
- Parcialmente de acuerdo (4)
- De acuerdo (5)
- Completamente en acuerdo (6)

Se exceptúan los reactivos 1, 2, 3, 4, 8, 11, 15, 17, 18 y 22, debido a que estos fueron calificados de forma inversa, es decir, que el menor valor equivale a Completamente en acuerdo (1) y el mayor a Completamente en desacuerdo (6).

De esta manera, el puntaje se suma teniendo en cuenta cada factor de la prueba o la prueba en general. Así, el puntaje mínimo de la prueba a nivel general para el género masculino es de 47 y el máximo de 127, mientras que para el género femenino el mínimo fue 46 y el máximo de 133. Los puntajes obtenidos se deben ubicar en la siguiente tabla, indicando la puntuación de cada persona dependiendo de su género.

Actitud	**Prueba total**		**Efectividad del servicio**		**Recepción de ayuda**		**Accesibilidad del servicio**	
	1	**2**	**1**	**2**	**1**	**2**	**1**	**2**
Muy negativa	46–79	47–72	11–37	11–33	14–28	8–26	4–7	4–7
Negativa	80–90	73–85	38–47	34–43	29–32	27–30	8–10	8–10
Neutra	91–100	86–9	48–54	44–49	33–36	31–33	11–12	11–12
Positiva	101–111	95–103	55–59	50–55	37–40	34–38	13–14	13–15
Muy positiva	112–133	104–127	60–66	56–66	41–48	39–48	15–23	16–24

Note. 1 Femenino, 2 Masculino.

Interpretación de actitudes generales hacia las LTSM:

Para obtener la calificación de la prueba en general se tiene en cuenta el valor de cada sujeto de todos los ítems de la prueba. Según el resultado y la ubicación en la tabla de baremación, la persona tiene:

Actitud muy negativa: Indica que el individuo considera que este medio de atención es obsoleto y para nada útil. Es una persona que no recomendaría los servicios de las LTSM a sus conocidos y que, de tener algún tipo de malestar psicológico, recurriría a cualquier otro medio para solucionarlo.

Actitud negativa: Indica que la persona considera que este medio de atención no cumple con sus expectativas respecto a la disponibilidad y atención del servicio, basado en la estigmatización que puede tener hacia alguien o recibir en caso de acudir a LTSM.

Actitud neutra: Indica que el individuo considera que este medio de atención no es ni bueno ni malo, por lo que no tiene actitudes cognitivas, emotivas, ni conativo-conductuales marcadas que formen un juicio de valor.

Actitud positiva: Indica que el individuo considera que este medio de atención es viable y lo suficientemente útil para proveer auxilio psicológico. Es un individuo que recomendaría moderadamente el servicio de las LTSM y que, de tener algún malestar psicológico, acudiría a este medio como fuente de ayuda.

Actitud muy positiva: Indica que el individuo considera que este medio de atención es muy útil y adecuado al necesitar auxilio psicológico. Es un individuo que recomendaría activamente los servicios de las LTSM a sus conocidos y que, de tener algún tipo de malestar psicológico, recurriría a este medio como fuente de ayuda.

Interpretación de actitudes hacia la efectividad del servicio:

Para obtener la puntuación de las actitudes hacia la efectividad del servicio, es necesario sumar las puntuaciones de los ítems que corresponden a este factor. Según el resultado obtenido y la tabla de baremación, la persona tiene:

Actitud muy negativa: El individuo considera que el servicio es inútil debido a que no produce el efecto esperado, por lo que se siente totalmente insatisfecho con su funcionamiento.

Actitud negativa: El individuo considera que este medio de atención es inefectivo, su impacto es poco y se siente insatisfecho con su funcionamiento.

Actitud neutra: Es un individuo que considera que este medio de atención es medianamente efectivo y sus niveles de satisfacción son ambivalentes, reconociendo algunos de sus beneficios.

Actitud positiva: El sujeto se encuentra suficientemente satisfecho con la atención que ofrecen las LTSM, ya que reconoce varios beneficios y los considera pertinentes.

Actitud muy positiva: Es un individuo que considera que las LTSM son altamente efectivas, se siente totalmente satisfecho y reconoce beneficios de gran valor.

Interpretación de actitudes hacia la recepción de ayuda:

Para obtener la puntuación de las actitudes hacia la recepción de ayuda, se suman los valores de los ítems correspondientes a este factor. Según el resultado obtenido y la tabla de baremación, la persona tiene:

Actitud muy negativa: Indica que el individuo no consideraría en lo absoluto acudir a una LTSM de tener algún tipo de malestar psicológico, considerando estigmas sobre la recepción de ayuda.

Actitud negativa: Indica que el sujeto evitaría asistir a una LTSM de presentar malestar psicológico, considerando estigmas sobre la recepción de ayuda.

Actitud neutra: Indica que el individuo no tiene una inclinación marcada hacia asistir o no al servicio con base en estigmas sobre la recepción de ayuda.

Actitud positiva: Indica que el individuo consideraría acudir a una LTSM de tener algún tipo de malestar psicológico, viéndola como un medio viable para solucionarlo.

Actitud muy positiva: Indica que el sujeto acudiría a una LTSM sin dudarlo al momento de sentir algún tipo de malestar psicológico, al considerarla un medio muy viable para solucionarlo.

Interpretación de actitudes hacia la accesibilidad al servicio:

Para obtener la puntuación de las actitudes hacia la accesibilidad al servicio, se suman los valores de los ítems correspondientes a este factor. Según el resultado obtenido y la tabla de baremación, la persona tiene:

Actitud muy negativa: Indica que el individuo considera que los horarios de las líneas, su funcionamiento y logística son completamente inaccesibles.

Actitud negativa: Indica que el individuo siente y piensa que el esfuerzo para encontrar información logística —horarios, procedimientos, etc.— de las LTSM es considerable, por lo que el servicio es poco accesible.

Actitud neutra: Indica que el individuo no posee una postura contundente respecto a la disponibilidad, funcionamiento y logística de las LTSM.

Actitud positiva: Indica que el individuo considera que la información logística referente a las LTSM —horarios, procedimientos, etc.— es accesible y que el servicio tiene disponibilidad, por lo que podría recomendarla a sus conocidos.

Actitud muy positiva: Indica que el individuo considera que la información logística referente a las LTSM —horarios, procedimientos, etc.— es de muy fácil acceso, y que el servicio tiene alta disponibilidad, por lo que la considera altamente recomendable hacia sus conocidos.