

Haigazian University

Relationship Between Attitudes Towards Mental Health Problems and Seeking Professional Help Among  
Young to Middle-Aged Adults in Mount Lebanon

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A Thesis submitted to the Faculty of Social and Behavioral Sciences in partial fulfillment of the requirements for the Master of Arts in Psychology – Emphasis: Clinical Psychology at Haigazian University

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Young to Middle-Aged Adults in Mount Lebanon

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*DEDICATION*

*I would like to dedicate this work to my Guardian Aunt, loving parents, supportive friends, Nour, Christine, Sara, Makram, Maan, Maisaa, Layan, Lynn, Rawan, the person who has brightened my life, and to the soul of Nour..*

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## Abstract

This study examined the relationship between attitudes towards mental health problems and seeking professional help through examining the ideologies of 25-55 year old males and females in Mount Lebanon. Also the role of age was examined as a variable that correlates with the attitudes towards seeking professional help. The study was done on 245 adults and the instruments used were the following: Attitudes Towards Seeking Professional Help Scale and Attitudes Towards Mental Health Problems Scale. Results revealed that family and community attitudes towards mental health problems was not correlated to ones' attitudes towards seeking professional help. On the contrary, internal, external, and reflected shame were correlated with ones' attitudes towards seeking professional help. Moreover, no correlation was detected between age and attitudes towards seeking professional help.

## **Relationship Between Attitudes Towards Mental Health Problems and Seeking Professional Help Among Young to Middle-Aged Adults in Mount Lebanon**

Mental health problems refer to different kinds of disorders, such as depression, anxiety, eating disorders, addictive behaviors and others, which affect the patient's thinking, mood and behavior. Moreover, they include symptoms, such as, difficulty in coping with everyday life, feelings of anhedonia, and having the urge to withdraw from the family and people in the surrounding community (Bhundia et al., 2007).

Approximately 30-50% of people are likely to experience a mental health problem at least once in their lifetime, whereas 15-30% of individuals are prone to experience a mental health problem within a particular year (Mackenzie, Gekoski, & Knox, 2006). The World Health Organization estimated that in the year 2014, there were 450 million people in the world suffering from mental health problems of any sort; this constitutes 14% of the global burden of disease. According to Bantman, Gupta, Jiloha, and Kishore (2011), estimates of the year 2020 reveal that neuropsychiatric conditions will elevate to make up 15% of the worldwide diseases. Therefore, it is logical to assume that mental health problems continue to be a health issue that affects the psychological well-being of millions of people globally (Chey, Iranpour, Jackson, Marnane, Patel, Silove, & Steel, 2014).

### **Mental Health problems in the Arab World and Lebanon**

From a narrower perspective, mental health problems continue to be, in the Arab world, an underestimated and an under researched topic. For instance, according to Nasser and Salamoun (2011), few studies on the treatment of mental health problems in the Arab world are available. Furthermore, these studies were limited in their effectiveness since they were conducted in a hospital or in a community setting thus hindering the ability to generalize the results across other settings.

On the other hand, despite the fact that the Arab region has undergone and is still undergoing conflicts and wars, studies examining the effect of war on mental health problems are minimal (Karam, Khalil, Kronfol, Kumar, McInnis, & Suhre, 2008). Furthermore, studies on the underutilization of mental health services among Arab communities were conducted in the United States (Erickson & Timimi, 2001), United Kingdom (Furnham & Hamid, 2012) and Australia (Yousseff & Deane, 2006) rather than in the Arab region. Results from the study conducted in the United States revealed that Arab Americans have their biases and misconceptions towards mental health problems (Erickson & Timimi, 2001). As for the study conducted in the UK, results revealed that Arabs have less positive attitudes towards seeking professional help (Furnham & Hamid, 2012). Similarly, the study conducted on an Arab sample in Australia revealed that 63% of the women had negative attitudes towards seeking professional help due to confidentiality reasons (Yousseff & Deane, 2006). Furthermore, research has revealed that Asian women avoid sharing information related to their mental health problems, even with mental health practitioners in their community (Gilbert et al., 2004).

According to Benedek and Ursano (2008), large-scale national psychiatric studies have been conducted in Western industrialized nations in order to study the prevalence of mental health problems in that region whereas studies in the Arab world have been limited to smaller populations thus reducing the effectiveness of the research. Similarly, according to Dimassi, Fayyad, Kessler, Karam, Mneimneh, and Nasser (2008), published data on the lifetime prevalence of mental health problems in the Arab region does not exist. For instance, research by Akiskal and Judd (2003) revealed that analyses of the research program US National Epidemiological Catchment Area (ECA) database exhibited that bipolar disorders, which are psychiatric disorders, affected 1-5% of the sample which consisted of 18,525 participants. More often than none, the published reports about the prevalence of bipolar disorders originated from the United States rather than from the Arab World (Karam, Khalil, Kronfol, Kumar, McInnis, & Suhre, 2008). As stated by

Yahia (2012), studies conducted in the Arab World address topics about physical abnormalities or about individuals suffering from physical illnesses rather than individuals suffering from mental health problems; this is due to the fact that topics related to mental health problems are considered a taboo within regions in the Arab world. The lack of studies, mentioned above, reveal gaps in research of topics related to mental health problems in our region. Therefore, shedding the light on the importance of improving research and conducting studies about mental health problems, for both the welfare of the individuals suffering from mental health problems and of the society as a whole, is essential (Yahia, 2012).

Moving away from research about mental health problems in the Arab World towards research in Lebanon, the Lebanese Evaluation of the Burden of Ailments and Needs of the Nation (LEBANON) national study was the first study on mental health problems in the Arab World (Nasser & Salamoun, 2011). The study was executed as a part of the World Health Organization (WHO) - World Mental Health (WMH) Survey Initiative in the year 2006. The study consisted of 2,857 non-institutionalized Lebanese participants who were diagnosed according to the Composite International Diagnostic Interview (CIDI 3.0) and the Diagnostic and Statistical Manual (DSM-IV). The findings of the study revealed that seeking professional help was exclusive to 10.9% of the sample and that mental health problems policy or legislation is absent in Lebanon. Moreover, financing for mental health problems is not available in Lebanon (Nasser & Salamoun, 2011). For instance, a national health care system in the country was to be implemented after its formulation in 1987 and mental health problems were to be considered part of that system. However, the war in 1989 has stopped its implementation (Mental Health Atlas, 2005).

Furthermore, the World Health Organization (2006) published an article stating that the prevalence of psychiatric disorders in Lebanon is similar to that in Western Europe. Yet, the number of individuals who are not receiving adequate treatment is higher in Lebanon. Also, a study was conducted by Dr. Elie Karam (2008), head of Institute for Development, Research, Advocacy and Applied Care (IDRAAC) and

head of Department of Psychiatry and Clinical Psychology at the University of Balamand, and his colleagues. The study investigated the lifetime prevalence, treatment, age of onset of mental health problems, and their relationship to war in Lebanon. The two most important findings of the study were that about one-fourth of the sample (25.8%) met criteria for at least one of the DSM-IV disorders at some point in their lives and that only a minority of the population received the needed professional help (Karam et al., 2008). In other words, one in four adults has displayed symptoms of mental health problems. Moreover, a study conducted by El-Jardali and Yehia (2015), which was based on Karam et al's study of 2008, revealed that not only one in four Lebanese adults suffered from mental health problems but also only a minority of those individuals were seeking professional help thus worsening the course of their illness, negatively affecting their family and community and increasing the economic burden in Lebanon due to loss of productivity in the severe cases of mental health problems.

These previously mentioned studies have reached the same conclusion that professional help is not sought by all the individuals who are in need of that help. Furthermore, research has investigated some of the reasons for not seeking professional help when needed; results of the investigations included: negative attitudes towards mental health problems and negative attitudes towards seeking professional help (Falcato, Lauber, Nordt, & Rossier, 2004). Furthermore, another more recent study by Chen, Deng, Fang, Hu, Lan and Liu (2014), revealed that a major variable behind the negative attitudes towards seeking professional help included: shame. Therefore, in correspondence with the stated above about the lack of mental health problems research in Lebanon and the conclusions deduced from other studies conducted, the need for mental health problems research in Lebanon arises. Hence, this study examined the attitudes towards mental health problems and towards seeking professional help in Mount Lebanon.

**Purpose and Rationale of the Study**

The current study assessed the relationship between the attitudes towards mental health problems and the attitudes towards seeking professional help through examining the ideologies of 25-55 year old males and females in Mount Lebanon. As mentioned by Karam et al. (2008), mental health problems research in Lebanon is minimal and, more specifically, research addressing attitudes towards mental health problems and towards seeking professional help has not been conducted yet (Karam et al., 2008). To be more specific, the relationship examined in this study was between each of attitudes towards mental health problems, external shame, internal shame, reflected shame and attitudes towards seeking professional help (all four types of shame will be elaborated on under the background of the study). According to Hamaideh and Mudallal (2009), education, about mental health problems, is necessary for promoting positive attitudes towards these kinds of problems and towards seeking professional help. Similarly, according to Eack, Newhill, and Watson (2012), increased knowledge provided by research about mental health problems impacted the attitudes towards them positively and reduced the feelings of shame associated with seeking professional help. Therefore, this study paved the way for future improvements in the mental health field along with other social improvements such as reducing shame and negative or unfavorable attitudes towards mental health problems and seeking professional help. Furthermore, it provided knowledge for mental health practitioners who are currently working or who are planning to work in Mount Lebanon in the future. In this study, Mount Lebanon specifically included Aley and Chouf.

**Background of the Study**

Based on the ideas discussed, the aim of the current study was to examine the relationship between attitudes towards mental health problems and attitudes towards seeking professional help of adult males

and females in the region of Mount Lebanon. Parallel with research discussed in the proceeding paragraphs, regarding attitudes towards mental health problems and attitudes towards seeking professional help, the current study examined a possible positive relationship between both variables: attitudes towards mental health problems and attitudes towards seeking professional help.

### **Defining Attitudes**

Attitudes, in general, are defined as internal mental constructs which are expressed and communicated by holding certain meanings (Kreitler, 2012). In this study, the adopted definition associated with attitudes is the following: psychological tendencies that are expressed by evaluating a particular entity with some degree of favor or disfavor (Chaiken & Eagly, 1993). To be more specific, attitudes towards mental health problems are defined as: having a favorable or unfavorable stand for individuals suffering from depression, anxiety, and impairment in everyday functioning (Gilbert et al., 2007). Furthermore, attitudes towards seeking professional help is defined as: the favorable or unfavorable perception held towards the action of attending counseling sessions with a psychologist or seeking medical treatment from a psychiatrist rather than turning for help from one's community or one's family or assuming that problems will be resolved by themselves (Fischer & Turner, 1970).

### **Attitudes towards Mental Health Problems and Seeking Professional Help**

As previous research has implied, attitudes are not unlikely to affect behaviors (Bathje & Pryor, 2010). In the context of mental health problems research, a correlation was found between attitudes towards mental health problems and attitudes towards seeking professional help. For instance, individuals with positive or favorable attitudes towards mental health problems are most likely to have a favorable attitude towards seeking professional help (Kaya, 2015). Furthermore, according to Kaya (2015), as age increases, the negative or unfavorable attitudes towards seeking professional help also increase.

According to Mazzer and Rickwood (2014), several factors were correlated with attitudes towards help-seeking behaviors; the major factors were: not recognizing symptoms of mental illness or somatizing their illness (Okasha, 1999), preferences for self-reliance or relying on one's community for help, and shame. In other words, individuals who are less likely to seek professional help are those who have negative views about mental health problems and those who associate shame with seeking professional help (Beall, Chambers, Lindsey, Lucksted, & Pohle, 2012). According to Chen, Deng, Fang, Hu, Lan & Liu (2014), the willingness to seek the professional help was not correlated with the number of problems the individual is experiencing. On the contrary, the willingness to seek professional help was correlated with shame.

#### **The Arab world, Lebanon, and Mount Lebanon**

To top it off, individuals living in collectivistic societies have negative attitudes towards seeking professional help and favorable attitudes towards turning to family members or members in their community (An & McDermott, 2014). Also, attitudes of individuals towards seeking professional help stems from the caregivers' or families' attitudes; in other words, attitudes are shaped by people within the individual's social network (Cohen, Dotson, & Masuda, 2006). Other factors affecting the attitudes towards seeking professional help included: knowledge about mental health services, encouragement and support of the family to seek such services and attitudes towards mental illness (Hom, Joiner, & Stanley, 2015).

Research about mental health problems, as previously mentioned, in the Arab World is scarce although individuals who are suffering from mental health problems and who are left untreated sum up to around 85% (Betancourt, McBain, Morris, Norton, & Yasamy, 2012). More specifically, research about attitudes towards mental health problems, in the Arab world, was conducted in Jordan and Iraq. In Jordan, a study examining attitudes of 193 nurses towards mental health problems revealed that attitudes were affected by whether or not the nurses have had previous contact with such individuals and whether or not

they have taken courses about mental health problems. In other words, knowledge or previous experiences with individuals suffering mental health problems correlated with positive attitudes towards these problems (Hamaideh & Mudallal, 2009). On the other hand, in Iraq, a research study was conducted on 500 participants in Bagdad. The research examined attitudes towards seeking professional help and results have found that individuals who have stronger family ties hold negative views towards seeking professional help due to the fact that they identify themselves as more resilient whenever their family support is found thus seeking external, professional help becomes a negative attribute (Al-Hasoon, Bradley, Jenkins, & Sadik, 2010).

As literature review indicated, Middle Eastern Arabs suffering from mental health problems avoid seeking professional help due to negative attitudes among Arabs towards seeking professional help (Al-Bedah, Al-Krenawi, Graham, Kadri, & Sehwal, 2008). However, the attitudes towards seeking professional help in Lebanon have not been studied yet. According to Karam et al. (2008), there have been no publications of studies which examine attitudes towards mental health problems and towards seeking professional help in Lebanon.

#### **Age and Attitudes Towards Mental Health Problems**

According to Ewalds-Kvist, Högberg, & Lützén (2013), factors such as age was found to impact ones' attitudes toward persons with mental health problems. Similarly, according to Kaya (2015), age did have an effect on the attitudes towards mental health problems. Research by Dunham & Olson (2008) revealed that attitudes emerge after an extended period of exposure to cultural norms or, in other words, in adulthood. Furthermore, Banaji, Baron, and Dunham (2005) noted that preferences, or notion of likes and dislikes, towards external objects are evident as early as age 10. However, not before adulthood are these preferences developed into attitudes (Banaji, Baron, & Dunham, 2005). Furthermore, according to Agermeyer, Baumeister, Matschinger, Schomerus, & Van der Auwera (2015), as age increases, the negative attitudes towards mental health problems and towards seeking professional help also increases.

In addition, according to Fischer and Sharma (1998), research has shown that people follow similar developmental pathways in information processing and attitude formation across cultures. Therefore, it becomes logical to assume that the case of Lebanon is similar to that described in previous literature concerning the age at which attitudes emerge and how they worsen over the life-span until reaching late adulthood where they become less prone to change (Alwin & Krosnick, 1989). So, the researcher has chosen the age group of participants as young to middle aged adults, between 25 and 55 years of age, due to the fact that this age group is considered to have formed its attitudes, along with the fact that it provides the researcher with different comparative categories in order to conclude if age plays a role in the type of attitudes towards mental health problems or does not.

#### **Shame and Attitudes towards seeking professional help**

Shame is defined as a fear-based state of being accompanied by beliefs of being inferior, weak, not measuring up to the standards and inadequate (Namka, 1997); it is also divided into four subcategories: reflected shame one, reflected shame two, internal shame, and external shame (Gilbert et al., 2007). These subcategories of shame are used and examined in this study. "Reflected shame one" is experienced when an individual fears negative attitudes, of others in the community, towards one's family upon one's seeking professional mental help or one being mentally ill like having depression, difficulty coping with everyday life or anxiety (Gilbert et al., 2007). Furthermore, "reflected shame two" is experienced when one fears negative attitudes, of others in the community, towards one's self when one's relative is suffering from mental illnesses such as depression, anxiety or difficulty coping with everyday life. Moreover, "internal shame" is defined as how one might feel about one's self had he/she been suffering from mental health problems such as depression and anxiety with a difficulty to cope in everyday life (Gilbert et al., 2007). On the other hand, "external shame" involves distressing awareness that others view one's self negatively had one been suffering from depression, difficulty to cope with everyday life or anxiety (Gilbert et al., 2007).

Yi, Wang, Zhang, and Zhou (2014), explored the factors that affect anxiety and depression among individuals suffering from mental illness. The associated factors were found to be: socioeconomic status, family functioning and shame. In other words, individuals living in lower socioeconomic communities, experiencing unhealthy family relationships and having shameful attitudes, are more prone to having higher anxiety and depression levels (Yi, Wang, Zhang, & Zhou, 2014). According to Boyle and Leeming (2004), feelings of shame serve as catalyst for hindering the process of seeking professional help and promote negative attitudes towards them. Also, individuals who have shameful attitudes towards mental health problems tend to have higher feelings of anxiety and depression when seeking professional help (Yi, Wang, Zhang, & Zhou, 2014).

Research conducted in Australia on a sample of 35 Arab women found that 63% of those women had shame and confidentiality as the primary reasons for not seeking professional help (Deane & Youssef, 2008). In other words, Arab clients tend to mistrust mental health professionals and tend to hold shameful attitudes towards seeking professional help (Al-Krenawi & Graham, 2000). From a narrower perspective, a major study addressing shame, in the Arab world, was conducted in Egypt; the study found that individuals living in societies with negative attitudes towards mental health problems will experience shame had they been suffering from such problems or had they been seeking professional help (Ciftci, Corrigan, & Jones, 2012). According to Castro, Cowan and Keene, (2015), when shame is triggered, it is less likely the individual will seek further professional help or treatment. In other words, individuals living in societies with negative attitudes towards mental health problems will lead their members to internalize shame upon seeking professional help (Adongo, Aikins & Tawiah, 2015). This notion is evident in rural regions where seeking professional help is considered an unfavorable, conspicuous act. On the other hand, seeking the help of a family member, a community member, or a religious leader is acceptable (Heflinger, Polaha, Studts, & Williams, 2004).

From these provided examples stemmed the concept of shame-oriented societies or the idea of societies relying on shame to hinder certain behaviors. In other words, behaviors of individuals in these societies are primarily controlled by factors such as shame. According to Nixon (2009), individuals in shame-oriented societies tend to avoid behaviors that would harm the reputation of their families. According to Arneson (2006), shame-oriented societies impose, on their members, certain morals of conduct and behaviors. Individuals living in these societies are expected to strictly abide by these behaviors and are expected to avoid any acts that would bring shame to the community (Arneson, 2006). As described by these studies, shame-oriented societies resemble, to a certain extent, the case of Lebanon, specifically the rural and remote areas, such as Mount Lebanon, where seeking professional help is considered a shameful act. However, since these previous studies were not conducted on the different types of shame, this current study could not do so either. Therefore, the study included the four different types of shame as reflected in the “Attitudes towards Mental Health Problems Scale” and hypothesized on them.

### **Statement of the Problem**

The purpose of this study was to examine the relationship between attitudes towards mental health problems and attitudes towards seeking professional help of young to middle-aged adult males and females in the region of Mount Lebanon.

Previous literature has shown that individuals having positive attitudes towards mental health problems are more likely to have positive attitudes towards seeking professional help (Kaya, 2015). Furthermore, individuals in shame-oriented societies which hold negative attitudes towards mental health problems experienced shame upon seeking professional help (Ciftci, Corrigan, & Jones, 2012). According to Agermeyer, Baumeister, Matschinger, Schomerus, & Van der Auwera (2015), as age increases, the negative attitudes towards mental health problems and towards seeking professional help also increases.

Therefore, and based on the above discussed review of literature, the researcher studied the following hypotheses:

H1:

- a) There is a negative correlation between unfavorable attitudes of one's community towards mental health problems items (*subscale 1 of section 1 of ATMHP Scale*) and favorable attitudes towards seeking professional psychological help (*ATSPH Scale*).
- b) There is a negative correlation between unfavorable attitudes of one's family towards mental health problems (*subscale 2 of section 1 of ATMHP Scale*) and favorable attitudes towards seeking professional psychological help (*ATSPH Scale*).
- c) There is a negative correlation between external shame as instilled by community (*subscale 1 of section 2; ATMHP Scale*) and favorable attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the external shame instilled by the community, the less the favorable attitudes one has towards seeking mental health professionals.
- d) There is a negative correlation between external shame as instilled by family (*subscale 2 of section 2; ATMPH Scale*) and favorable attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the external shame instilled by the family, the less the favorable attitudes one has towards seeking mental health professionals.
- e) There is a negative correlation between internal shame (*section 3 of ATMPH Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the internal shame, the less the favorable attitudes towards seeking mental health professionals.

- f) There is a negative correlation between reflected shame 1 (*section 4 of ATMPH Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the reflected shame 1, the less the favorable attitudes towards seeking mental health professionals.
- g) There is a negative correlation between reflected shame 2 (*section 5 of ATMPH Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the reflected shame 2, the less the favorable attitudes towards seeking mental health professionals.

H2:

Older participants (41-55) will show more unfavorable attitudes regarding seeking professional help (*ATSPH Scale*) than younger participants (25-40).

### **Significance of the Study**

Mental health problems are a growing phenomenon invading our communities nowadays (Chey, Iranpour, Jackson, Marnane, Patel, Silove, & Steel, 2014). Globally, the increasing stressors are expanding thus people are being diagnosed more with mental health problems and are being referred for professional help accordingly. However, previously mentioned research has shown that not all referred individuals are actually receiving the professional help (El-Jardali & Yehia, 2015). These findings have raised various possibilities about the cause of this phenomenon. One of the important possibilities was the preexisting attitudes towards mental health problems. Therefore, in this study, the relationship between attitudes towards mental health problems and attitudes towards seeking professional help among middle-aged males and females in Mount Lebanon was examined. Furthermore, conducting such a study added to the international published research regarding attitudes towards mental health problems.

After working for couple of years in the region of Mount Lebanon and after detecting lack of appropriate research about mental health problems along with an inadequate number of mental health professionals, the significant need to provide the region with a research examining this issue was raised. Specifically speaking, in the region of Aley, two psychotherapists are providing their services along with one neurologist. Similarly, three psychiatrists are providing their services in the region of Chouf without any psychotherapists. These numbers stressed upon the importance of studying the region where mental health professionals and awareness about mental health problems is minimal (Karam et al., 2008). Therefore, this study might become a benchmark for addressing the needs of the region, being the first study conducted on attitudes towards mental health problems and attitudes towards seeking professional help. Moreover, this study provides a pathway for future therapists and professionals who are willing to work in those areas and who are willing to target these regions in maintaining, more or less, a balanced society upon which mental health problems are less stigmatized.

### **Overview of Methodology**

The study employed a quantitative correlation design to examine all the two hypotheses. The 245 participants of the study were targeted from the region of Mount Lebanon, specifically Aley and Chouf. The age range of the participants was between 25 and 55 years of age. The participants were provided with the following questionnaires: Attitudes Towards Mental Health Problems scale and Attitudes Towards Seeking Professional Help Scale. The first scale consisted of different independent subscales without a total score, whereas the second scale comprised of one total score. Both scales were translated to Arabic and then back translated to English.

**Limitations of the proposed study**

As mentioned, this study attempted to explore the relationship between attitudes towards mental illness and attitudes towards seeking mental health professionals among young to middle-aged adults among males and females in Mount Lebanon. In correspondence to that, there were a number of limitations. For instance, since the proposed study targeted Chouf and Aley, it could only be generalized to areas similar to those of Mount Lebanon. However, future studies will confirm that. Furthermore, it only included adults between 25-55 years and therefore, it could not be generalized to younger or to older populations.

**Definition of Key Terms**

**Mental Health Problems:** Disorders, such as depression and anxiety, which make it difficult to cope with everyday life where people can feel tired, not enjoy life, want to hide away and withdraw from family life (Gilbert et al., 2007).

**Attitudes towards mental health problems:** A favorable or unfavorable stand for individuals suffering from depression, anxiety, and impairment in everyday functioning (Gilbert et al., 2007).

**Attitudes towards seeking professional help:** A favorable or unfavorable perception towards the action of attending counseling sessions with a psychologist or seeking medical treatment from a psychiatrist rather than turning for help from one's family or community, or assuming that problems will be resolved by themselves (Fischer & Turner, 1970).

**Shame:** A fear-based state of being accompanied by beliefs of being inferior, weak, not measuring up to the standards and inadequate (Namka, 1997).

**Reflected Shame 1:** The fear of negative attitudes, of others in the community, towards one's family when one is suffering from depression, anxiety or difficulty coping with everyday life (Gilbert et al., 2007).

**Reflected shame 2:** The fear of negative attitudes, of others in the community, towards one's self when one's relative is suffering from depression, anxiety or difficulty coping with everyday life (Gilbert et al., 2007).

**Internal Shame:** How one might feel about one's self had he/she been suffering from mental health problems such as depression and anxiety with a difficulty to cope in everyday life (Gilbert et al., 2007).

**External Shame:** The distressing awareness that others view one's self negatively had one been suffering from depression, difficulty to cope with everyday life or anxiety (Gilbert et al., 2007).

## Chapter 2

### Review of Literature

The aim of this current study was to assess the relationship between the attitudes towards mental health problems and the attitudes towards seeking professional help among 25-55 year old participants in the region of Mount Lebanon. The purpose of this chapter is to review important literature studies that contribute to the context of the examined hypotheses.

#### Reasons for not seeking Professional Psychological Help

According to Kohn, Levav, Saraseno, and Saxena (2004), there is a noticeable gap in seeking professional psychological help among different communities. In other words, only a minority of individuals who meet diagnostic criteria for mental health problems seek professional help. A research study conducted on 646 participants suffering from anxiety or depression has shown that only approximately 18% to 34% of these individuals sought professional help. According to Gekoski, Knox, & Mackenzie (2007), negative attitudes related to mental health problems correlate with negative attitudes towards seeking professional help and contribute to the underutilization of professional help. On the other hand, according to Jackson, Judd, Komiti, and Wrigley (2009), positive attitudes towards mental health problems correlated with positive attitudes towards seeking professional help. In other words, the more the favorable attitudes towards mental health problems, the more likely the individual seeks professional help.

Research in Switzerland, on a sample of 594 Swiss participants, has investigated some of the reasons for not seeking professional help when needed. Numerous reasons have been imputed, some of which included: lack of knowledge about mental health problems (poor mental health literacy) and negative attitudes towards them, the belief that the mental health problem will be resolved by itself, and the desire to seek family's or community's help rather than external one (Kohn et al., 2004). In a more recent study, it was shown that the ability to recognize symptoms of mental distress is not common among the public.

More specifically, in that study, which was conducted on 2,031 participants in Australia, it was concluded that only 39% of the participants could recognize symptoms of depression and 27% could recognize those of schizophrenia (Jorm, 2011). Similarly, a study in the United States conducted on 346 participants revealed that the public was reasonably familiar with mood disorders, such as depression, but not with somatic ones (Kamimura et al., 2014).

In addition to recognizing symptoms of the disorders, understanding the causes of such disorders was found to be an essential component due to its ability to influence help-seeking behaviors. For instance, a study in Malaysia revealed that beliefs that mental health problems are caused by supernatural factors correlated with greater usage of traditional healers rather than seeking professional help (Jorm, 2011). Furthermore, beliefs about self-help interventions were studied in the United Kingdom and in Australia. Results from the study identified self-help interventions, such as seeking the help of the family and the community, as the top contributor for not seeking professional help (Jorm, 2011).

According to McClure (2010), individuals who do not seek professional help are more likely to be part of societies or families who hold negative attitudes towards mental health problems and who label or fear individuals who discuss such problems with mental health professionals. In a study done in Germany, it was revealed that discussing physical abnormalities among family members was more favorable than discussing mental health problems. Moreover, other studies showed that mental health professionals were less rated than General Practitioners in developed countries. As for developing countries, traditional sources of help such as witchcraft and herbalists were preferred over mental health professionals (Jorm, 2011).

In conclusion, shameful attitudes towards mental health problems, preference for self-reliance, and poor mental health knowledge or literacy were predictors for negative attitudes towards seeking professional help. On the other hand, facilitators for seeking professional help included: positive attitudes towards

mental health problems and mental health professionals, knowledge or awareness about mental health and family or community support for seeking professional help (Christensen, Griffiths, & Gulliver, 2010).

### **The Arab world, Lebanon, and Mount Lebanon**

Literature review on mental illness in the Arab world has shown that only three countries (Lebanon, Kuwait and Bahrain) had more than 30 psychiatric beds per 100,000 populations in the year 2007, while Sudan and Somalia had less than 5 psychiatric beds per 100,000 populations. In addition, Qatar, Bahrain and Kuwait have the largest number of psychiatrists, while other countries such as: Iraq, Libya, Morocco, Somalia, Sudan, Syria and Yemen have less than 0.5 psychiatrists for every 100,000 populations. Some improvement has occurred in the last decade, but the mental health human resources and the attention devoted to mental health issues are still insufficient (Okasha, 2012).

According to Al-Krenawi, Dean, Eltaiba, and Graham (2004), few studies have been executed in the Arab world which target topics related to mental health problems and seeking professional help. From these few studies, one study revealed that Arab clients underuse professional help and mistrust mental health professionals due to the negative attitudes of Arabs towards mental health problems (Al-Krenawi & Graham, 2000). Also, previous studies have shown that family or community support towards seeking professional help is an essential factor which influences attitudes towards mental health problems and towards seeking professional help of individuals (Chiriboga, Herrera, Jang, Schonfeld, & Tyson, 2011). For instance, a study conducted by Deane, Rickwood, and Wilson (2007) revealed that holding favorable attitudes towards seeking professional help among individuals is triggered by the social norms of their community. In other words, families or societies which encourage help-seeking behaviors are more likely to trigger positive attitudes towards seeking professional help among their members. Similarly, the local beliefs, or the beliefs of the culture, influence the access to mental health services. In other words, beliefs or attitudes of the surrounding

society influence whether or not the individual seeks professional help (Abdullah & Brown, 2011). Furthermore, families who support individuals for seeking professional help, trigger positive attitudes towards mental health problems and towards seeking professional help in the members. Similarly, research by Cohen, Dotson, & Masuda (2006) revealed that families shape the attitudes of individuals within their network. However, in certain cultures where family dynamics are closely-knitted, seeking external help and not turning to one's family or community is considered an unfavorable act.

More often than none, the negative attribute associated with seeking professional help is evident in collectivistic societies such as the Arab world. According to Al-Krenawi & Graham (2000), Arab societies are characterized as: male dominance, patriarchy, prioritizing the family and emphasizing collectivism over individualism. In other words, Arab societies are considered community-oriented ones which value the family and the community over the individuals.

These previously mentioned studies conclude that attitudes towards mental health problems and towards seeking professional help are shaped by the individual's family or environment. To be more specific, individuals living in societies where mental health problems are labeled and stigmatized are more likely to hold unfavorable attitudes towards mental health problems and seeking professional help (Al-Krenawi & Graham, 2000). The effects of the unfavorable attitudes towards mental health problems in Arab societies were found to be: damage for one's reputation or one's family reputation, increasing the likelihood of separation or divorce, lack of seeking of professional help and social exclusion (Al-Krenawi & Graham, 2000).

Furthermore, research by Al-Krenawi & Graham (2000) has shown that Arabs tend to hold positive attitudes towards interventions which stem from the context of the family, community or tribal background. On the contrary, they tend to have negative attitudes towards seeking professional help or reaching out to external sources of aid. A study executed in Qatar examined knowledge, practice and attitudes towards mental health problems among the Qatari population (Bener and Ghuloum, 2011). The results revealed that

individuals had negative cultural beliefs towards mental health problems. More specifically, they believed that mentally ill people were possessed by the devil and that traditional healers could help in the healing process. Moreover, individuals expressed fear and preference for not talking to other individuals suffering from mental health problems.

Another study conducted by Al-Bedah, Al-Krenawi, Graham, Kadri, and Sehwal (2008) in the Arab world encompassed 617 participants from Egypt, Kuwait, and Palestine. The aim of the study was to examine attitudes towards mental health problems and towards seeking professional help among Arab clients. Results of the study emphasized positive attitudes towards resorting to traditional healing methods and seeking out the family's or the community's support. In addition to family or community values being an influential factor in shaping the attitudes of its members towards mental health problems and seeking professional help. Furthermore, factors which hindered the process of seeking professional help included: reluctance for self-disclosure and expressing emotions, in addition to negative attitudes of the family or the community towards mental health problems and seeking professional help.

Moving away from the Arab world towards Lebanon, attitudes towards seeking professional help have not been studied yet. According to Karam et al. (2008), there have been no publications of studies which examine attitudes towards mental health problems and towards seeking professional help in Lebanon.

In specific areas of Lebanon, there exist community-oriented societies which hold strong ties among their members and closely-knitted family dynamics. Some of these societies include the region of Mount Lebanon, specifically Aley and Chouf, which are the regions targeted in this study. According to Boshoff, Dirwaye, Hugo, Traut, and Stein (2003), individuals living in collectivistic, community-oriented societies and rural areas are less likely to seek professional help. The fact that Aley and Chouf are community-oriented societies and lack many of the essential mental health facilities that, for instance, Beirut, the

capital of Lebanon has, gave the author more rationale to conduct her research. The hope is that future researchers will expand on this study and target different regions and maybe include more representative samples of the whole country. The few studies examining other kinds of attitudes in that region, Mount Lebanon, were exclusive to the following topics: attitudes of elementary teachers, in four private schools in Mount Lebanon, towards the inclusion of children with Autism Spectrum Disorders in regular classrooms (Al-Rayess, 2014) and the leadership attitudes of principles in thirteen Catholic schools in Mount Lebanon (Younes, 2011). Therefore, the focus of this study was to examine the attitudes of young to middle aged adults towards mental health problems and towards seeking professional help in the rural areas of Lebanon, specifically: Mount Lebanon.

#### **Relationship between Attitudes towards Mental Health Problems and Seeking Professional Help**

As previously mentioned, research has shown that attitudes exhibit an effect on attitude-related behaviors. For instance, attitudes towards mental health problems influence the process of seeking mental health professionals. According to Hackler, Vogel, and Wade (2007), attitudes towards mental health problems influenced the help-seeking attitudes and consequently, the help-seeking behaviors. In other words, attitudes towards mental health problems influenced the attitudes towards seeking professional help and whether or not an individual actually sought help. Moreover, individuals who hold negative attitudes towards mental health problems are more likely to experience feelings of shame and low self-esteem, and /or feelings of being left out, such as exclusion and social distance. These different feelings, whether they reflect an internal or an external state of emotion, hinder the process of seeking professional help (Crowe & Averett, 2015). The different feelings of shame will be discussed more thoroughly in the proceeding paragraphs.

**Shame and Attitudes towards seeking professional help**

According to Boyle & Leeming (2004), feelings of shame serve as catalyst for hindering the process of seeking professional help and promote negative attitudes towards mental health problems. Furthermore, according to Castro, Cotting, Hoge, Koffman, McGurk, and Messer (2004), a study was executed on 6210 participants in the U.S. army who were suffering from PTSD, major depression, and generalized anxiety. The results of this study revealed that only 23% to 40% sought the needed professional help and those percentages were ones of the individuals who reported more positive attitudes towards mental health problems. On the other hand, the participants who have not sought professional help were those who reported negative attitudes towards mental health problems and seeking professional help, in addition to beliefs about possible stigma and shame associated with seeking professional help. Therefore, the study concluded that stigma and shame were among the primary reported factors which hinder the process of seeking professional help among individuals who have met the criteria for mental health problems such as PTSD, major depression, and generalized anxiety (Boyle et al., 2004).

Similarly, an article discussing the reasons behind not seeking professional help among the individuals who are suffering from mental health problems, explained that the primary factors which hinder the process of seeking professional help are: stigma associated with mental health problems and shame (Corrigan, 2004). Moreover, according to Heinze, Jackson, Johnson, Jones, Lin, and Wood (2014), a study conducted on a clinical group suffering from mental illness revealed that these individuals experience high levels of shame due to their mental health problems thus reducing their acceptance towards seeking professional help.

As previously mentioned, there is a lack of research conducted on attitudes towards seeking professional help in the Arab world. Furthermore, in the context of the Arab world, seeking professional help or psychotherapy is perceived as a sign of weakness or an act that brings shame to one's family or community

(Sayed, 2003). More often than none, research originated from Arab communities living in the United States rather than in Arab countries (Erickson & Timimi, 2001). One of these studies encompassed semi-structured interviews conducted face-to-face on a sample of 35 Arab women living in the United States. Results of the study revealed that 63% of those women had shame and confidentiality as the primary reasons for not seeking professional help (Deane & Youssef, 2008). In a more recent study, a study showed that 70% of Arab women living in the United States reported feelings of shame when discussing the attitudes towards seeking mental health professionals (Furnham & Hamid, 2012). Another major study addressing shame, in the Arab world, was conducted in Behman Hospital in Cairo, Egypt on 46 participants suffering from mental health problems, as diagnosed by psychiatric doctors in the hospital. Participants were qualitatively studied via interviews and results found that individuals living in societies with negative attitudes towards mental health problems will experience shame had they been suffering from mental health problems or had they been seeking professional help (Ciftci, Corrigan, & Jones, 2012).

Taking these previously mentioned studies into consideration, stems the concept of shame-oriented society or the idea of societies relying on shame to hinder certain behaviors. In other words, shame-oriented societies are based on the notion of triggering shame among individuals in order to hinder any behaviors which are not community-oriented or which hold unfavorable attitudes among community members (Baello & Mori, 2007). According to Ciftci, Corrigan, & Jones (2012), family ties are closely-knitted and reputation is highly valuable in shame-oriented societies thus leading individuals to avoid seeking professional help since that would bring shame to their families (Adongo, Aikins & Tawiah, 2015). Furthermore, according to Castro, Cowan & Keene (2015), individuals suffering from mental health problems and living in shame-oriented societies are, most probably, going to anticipate that their families would view them as less worthy.

A study conducted by Hampton and Sharp (2014) studied the effects of culture or community on shame-focused attitudes towards seeking mental health professionals. Asian and American participants were involved in the study. The results revealed that American participants had the lowest shame-focused attitudes, while the Asian participants had the highest (Hampton & Sharp, 2014). According to Becher, Shannon, Simmelink, and Wieling (2015), individuals living in refugee camps in Ethiopia, Burma and Somalia hold unfavourable attitudes towards seeking mental health professionals due to their need to avoid shame. From these previous examples, it became evident that community-oriented and collectivistic societies hold more shameful and unfavourable attitudes towards mental health problems and towards seeking professional help. In other words, such societies inflict shame on their members had they been suffering from mental health problems or seeking professional help.

A study conducted by Gilbert et al. (2007) on 186 participants (89 Asians and 97 non-Asians) revealed that the main concern of Asians stemmed from their community and family attitudes. Furthermore, these participants scored higher on negative beliefs on how their communities and families view mental health problems (external shame). In addition, they reported that their primary concerns were: secrecy and confidentiality. On the contrary, there was no difference in the results concerning internal shame. In other words, Asians and non-Asians reported same levels of internal shame. However, with respect to reflected shame 1, Asian students reported significantly higher concerns about bringing shame to their family as a result of having mental health problems than non-Asian students. As for reflected shame 2, there were no significant differences among the two samples. As a conclusion from this study, results have shown that reflected shame one was the major factor contributing to negative attitudes towards mental health problems among the Asian sample. In addition, the Asians are as prone to internal shame as the non-Asians.

Furthermore, according to Kim, Jorgensen, and Thibodeau (2011), external shame, or shame triggered by the society, paves the way for two other factors which are: social anxiety (internalizing the negative beliefs thus becoming anxious when being around people in the society) and fear of negative evaluation (FNE) (feeling unworthy and acting to counteract these feelings or avoiding them). Both factors represent the negative impact of society on individuals with mental illness or individuals seeking mental health services (Yoon, 2015).

As described by these studies, shame-oriented societies resemble, to a certain extent, the case of Lebanon, specifically in the rural and remote areas, such as Mount Lebanon, where seeking professional help is considered a shameful act.

#### **Age and Attitudes Towards Mental Health Problems**

According to Banaji, Baron, & Dunham (2005) preferences, or notion of likes and dislikes, towards external objects are evident as early as age 10. However, not before adulthood are these preferences developed into attitudes. Similarly, according to Alwin and Krosnick (1989), during early adulthood the individuals initiate their active participation, or the process of experiencing and learning in the adult world, thus forming attitudes. These attitudes are triggered by the socialization process of the individual or the process of inheriting the psychological tendencies upon which one evaluates the degree of favour or disfavour towards a particular entity. During later stages of life, the “socialization period” passes and the individuals’ attitudes become more fixed and less prone to change. In other words, the change in attitudes is more likely to occur during early adulthood and remain constant during later stages of life. Furthermore, research has shown that knowledge and experience are more likely to influence changes in the attitudes during early adulthood. However, the attitudes are less likely to be influenced or altered during later stages of life or at older ages (Alwin & Krosnick, 1989).

Studies examining the correlation between age and attitudes have revealed that there exists a shared perception that negative attitudes are, more often than none, common among older-aged individuals. According to Czaja and Sharit (1998), a sample of 384 participants were studied, ages ranging between 25 and 70 years of age, in order to test their attitudes towards the usage of computers. Results have shown that age had influenced attitudes. In other words, the higher the age, the more the unfavorable attitudes towards using computers.

Based on these previously mentioned studies about the correlation between older age and negative attitudes along with the less likelihood of altering attitudes during late adulthood, it becomes logical to assume that as age increases, negative attitudes towards mental health problems and seeking professional help also increase and they become less prone for improvement. Similarly, research has been conducted on factors affecting attitudes towards mental illness. For instance, among those studies was one by Ewalds-Kvist, Högberg, & Lützén (2013) which revealed that as the age of the individuals increased, the unfavourable attitudes towards mental health problems and towards seeking professional help also increased. Similarly, according to Agermeyer, Baumeister, Matschinger, Schomerus, & Van der Auwera (2015), as age increases, the negative attitudes towards mental illness and towards seeking mental health professionals also increases.

According to Fischer and Sharma (1998), research has shown that people follow similar developmental pathways in information processing and attitude formation across cultures. Therefore, it becomes logical to assume that the case of Lebanon is similar to that described in previous literature concerning the age at which attitudes emerge and how as age increases, over the life-span, the negative attitudes towards mental health problems and seeking professional help also increases.

In light of the above discussed literature, the following hypotheses were examined:

H1:

- a) There is a negative correlation between unfavorable attitudes of one's community towards mental health problems items (*subscale 1 of section 1 of ATMHP Scale*) and favorable attitudes towards seeking professional psychological help (*ATSPH Scale*).
- b) There is a negative correlation between unfavorable attitudes of one's family towards mental health problems (*subscale 2 of section 1 of ATMHP Scale*) and favorable attitudes towards seeking professional psychological help (*ATSPH Scale*).
- c) There is a negative correlation between external shame as instilled by community (*subscale 1 of section 2; ATMHP Scale*) and favorable attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the external shame instilled by the community, the less the favorable attitudes one has towards seeking mental health professionals.
- d) There is a negative correlation between external shame as instilled by family (*subscale 2 of section 2; ATMHP Scale*) and favorable attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the external shame instilled by the family, the less the favorable attitudes one has towards seeking mental health professionals.
- e) There is a negative correlation between internal shame (*section 3 of ATMHP Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the internal shame, the less the favorable attitudes towards seeking mental health professionals.
- f) There is a negative correlation between reflected shame 1 (*section 4 of ATMHP Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the reflected shame 1, the less the favorable attitudes towards seeking mental health professionals.

- g) There is a negative correlation between reflected shame 2 (*section 5 of ATMPH Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the reflected shame 2, the less the favorable attitudes towards seeking mental health professionals.

H2:

Older participants (41-55) will show more unfavorable attitudes regarding seeking professional help (*ATSPH Scale*) than younger participants (25-40).

## **Chapter 3**

### **Method**

#### **General Perspective**

This study is a quantitative correlational one that examined the relationship between attitudes towards mental health problems and the attitudes towards seeking mental health professionals of adult males and females in Mount Lebanon. Moreover, the study examined the relationship of attitudes towards mental health problems, external shame, internal shame, reflected shame, and age with the attitudes towards seeking professional help.

#### **Population**

This study aimed to explore the relationship between attitudes towards mental health problems and the attitudes towards seeking professional help in the population of young to middle-aged adults (25-55 years old) males (37%) and females (63%) residing in the region of Mount Lebanon, specifically Aley (46%) and Chouf (34%). Eighty-one percent of the population were born and raised in the region and 13% have lived in Mount Lebanon for more than 10 years. Out of 245 surveys distributed, 48 were missing data on the area of residency. Therefore, a total of 197 questionnaires were used for the analysis of the relationship between the area of residency and the attitudes towards mental health problems and seeking professional help.

#### **Participants**

The sample of this study was a convenient and purposeful one that consisted of a total of 245 individuals, specifically 154 females and 89 males, between the ages of 25-55, who were all residing in Mount Lebanon. Furthermore, the participants were divided into two groups: group 1 (ages 25-40) and group 2 (ages 41-55). Research by Dunham and Olson (2008) revealed that attitudes emerge after an extended pe-

riod of exposure to cultural norms or, in other words, in adulthood. Furthermore, Banaji, Baron, and Dunham (2005) noted that preferences, or notion of likes and dislikes, towards external objects are evident as early as age 10. However, not before adulthood are these preferences developed into attitudes. Therefore, the participants were chosen as adults. The average age group of the sample ranged between 25 and 30 years of age; more specifically the age was 27.5 years. The 245 questionnaires included missing data on age in 51 questionnaires. Therefore, a total of 194 surveys were used for the analysis of the correlation between age and attitudes towards mental health problems in addition to seeking professional help.

As for the marital status of the participants, 45% were married, 27% were single, 2% were divorced and the rest were divided between widowed (2%) and separated (0.8%). Furthermore, 23% of the participants have not provided responses to this question.

In addition, the participants were asked about whether or not they have children. A total of 101 participants (41%) responded positively, 84 participants (34%) responded negatively, and 60 participants (24%) did not provide a response. More often than none, the majority of the responds (71%) ranged between having 2 to 3 children.

Inquiries about the participants' educational level came as such: 33% were holding a bachelor's degree, 20% had a high school degree, 12 % were graduate degree holders, and 11% did not have any degree. Moreover, 20% of the participants have not responded to this piece of information.

Furthermore, according to Agermeyer, Baumeister, Matschinger, Schomerus, & Van der Auwera (2015), as age increases, the negative attitudes towards mental health problems and towards seeking professional help also increases. In other words, this group of participants was chosen since they are neither too young, and hence have formed their attitudes, nor too old thereby increasing the probability of having negative attitudes towards mental health problems (Agermeyer, Baumeister, Matschinger, Schomerus, & Van der Auwera, 2015).

The sample also consisted of individuals who were born and raised in Aley and Chouf region. In other words, the sample consisted of residents who were raised upon the standards and the ideologies of the people in that region. Moreover, the sample consisted of, mostly, the Muslim Druze sect (88.2%), who happen to be the most dominant sect residing in that area, in addition to other Muslim sects (6.5%), Christians (1.6%), and seculars (9%) who were minorities in the sample. Furthermore, this study targeted Chouf and Aley, which are considered collectivistic societies, since they have never undergone any sort of research about mental health problems. In other words, the regions are under researched and they lack tested and scientific knowledge about mental health problems. Consequently, the sample of participants is purposeful and convenient. The convenient method in approaching the participants is discussed in the procedure.

## **Materials**

In this study the materials used were a questionnaire consisting of a consent form originally written in Arabic (see Appendix A), a demographics sheet also originally written in Arabic (see Appendix B) and the two scales which were translated to the Arabic language (see Appendix C). The two scales are: *Attitudes Towards Mental Health Problems (ATMHP)* and *Attitudes Towards Seeking Professional Help Scale (ATSPHS)*. The original scales, written in the English language, are included in Appendix D. Also, the back translations are included in Appendix E.

### *Attitudes Towards Mental Health Problems Scale*

Attitudes towards Mental Health Problems is a scale developed by Bhundia, Gilbert, Irons, McEwan, Mitra, & Sanghera in the year 2007. According to Gilbert et al. (2007), the development of the scale stemmed from their interest in examining adult's thoughts and feelings about mental health problems. Therefore, the scale was developed to contain 35 items which target the relationship between various aspects of shame with mental health problems. Furthermore, previous research by Gilbert et al. (2004) on

Asian women revealed that the shame concerns towards mental illness were related to: community attitudes, family attitudes, and self-attitudes. Hence, these findings paved the way for the notion of internal shame, external shame and that of reflected shame. Therefore, the scale was divided into five sections. The first section contained two sub-sections, the first sub-section included questions one till four which tapped a person's perception of how their community sees mental health problems. The second sub-section contained questions five till eight and it tapped a person's perception of how their family perceives mental health problems. Furthermore, the second section also contained two sub-sections and it related to external shame. The first sub-section included statements nine till thirteen and it tapped a person's perception of how their community would see them if they had mental health problems. The second sub-section included statements fourteen till eighteen which target a person's perception of how their family would see them had they been mentally ill. The third section included statements nineteen till twenty-three and it tapped internal shame and the negative self-evaluation of having a mental health problem. Moreover, the fourth section included statements twenty-four till thirty and it focused on reflected shame (shame) and beliefs about how one's family would be seen if one had a mental health problem (reflected shame 1). The fifth section included questions thirty-one till thirty-five and it examined the fears of reflected shame on self, associated with a relative having mental health problems (reflected shame 2). These thirty-five items were scored on a 4-point Likert scale where zero represented "do not agree at all", one represented "agree a little", two represented "mostly agree", and three represented "completely agree".

As for the scoring, Gilbert et al's (2007) study revealed that the ATMHPS was designed to be used as a series of sub-scales with face validity rather than to be factor analyzed. Hence, the most appropriate statistic for the scale is the Cronbach's alpha for each sub-scale. The first sub-scale of the first section, attitudes towards mental health problems: community, scored a reliability coefficient of 0.5. The second sub-scale of the first section, towards mental health problems: family, scored a Cronbach's alpha of 0.6.

Also, the first sub-scale of the second section, external shame/stigma awareness: community, scored 0.8. Similarly, the second sub-scale of the second section, external shame: family, scored 0.8. The third section, internal shame, also scored 0.8. On the other hand, the fourth section, or reflected shame was found to have a reliability coefficient of 0.9. Finally, the fifth section or self-reflected shame was found to have a cronbach alpha of 0.8. Moreover, another research has found that all of the sub-scales had good Cronbach's alphas ranging between 0.85 and 0.97 (Gilbert et al. (2007) which are considered very strong reliability coefficients.

#### *Attitudes toward Seeking Professional Help Scale*

Attitudes toward Seeking Professional Help Scale (ATSPH) is a widely used measure of mental health treatment attitudes in adults. The scale was first established by Fischer and Turner in the 1970. The scale consisted of 18 negative statements and 11 positive statements arranged in a 4-point format, zero representing "disagree", one representing "Partly disagree", two representing "partly agree", and three representing "agree". However, the scale has undergone several changes in its form until it became a 10-item unidimensional scale which measures attitudes toward seeking professional psychological help (Fischer & Farina, 1995). This 10-item version has been translated to Arabic in order to be used, along with the Attitudes towards Mental Health Problems scale, in this current study.

Various studies were conducted to test the reliability and validity of Attitudes Towards Seeking Professional Help scale. For instance, Anderson, Elhai, and Schweinle (2008) proved that the scale presents adequate internal consistency of 0.81. Another study testing the reliability and the validity was conducted by Palmer (2009) on a Jamaican sample. The study's estimate of Cronbach's alpha reliability coefficient was  $\alpha = .87$  which is considered as a very strong reliability coefficient (Carmines & Zeller, 1979). In com-

parison to that of Palmer (2009), the reliability coefficient of Fischer and Turner, in their original population of study which consisted of a 212 participants, was less with a Cronbach's alpha of .86. As opposed to the reliability, the validity of the scale was not established with the Jamaican sample thus highlighting the importance of mental health professionals to the individuals who underutilize mental health services (Palmer, 2009). Although The Attitudes Towards Seeking Professional Help Scale has been widely used, there is no coherent study which examined the reliability and the validity of the scale's Chinese version (ATSPHS-C). In the Arab world, a study conducted in the United Arab Emirates examined the attitudes towards seeking mental health professionals of college students across the UAE by using the Attitudes Towards Seeking Professional Help scale (Al-Darmaki, 2011). The internal reliability estimates for the entire scale, as measured by coefficient alpha, ranged from 0.83 to 0.73. As for the four sub-scales, the estimates ranged from 0.74 to 0.62 and from 0.76 to 0.53 (Fischer & Turner, 1970).

The scoring format used for this discussed scale is sum. The score is obtained by reversely scoring the items numbered 2, 4, 8, 9, and 10 then these items are added up in order to get a sum. Furthermore, the scores are interpreted as such: the higher the obtained, the more the positive attitudes towards seeking mental health professionals.

In this study both scales were translated into an Arabic version, by a certified translation company, in order to rule out any inconsistencies and misunderstandings of the questions by the residents of Mount Lebanon. Also, the scales were back translated by a certified translator in order to insure the validity of the questions asked in English. Furthermore, a pilot study has been executed on 58 adult participants. The Cronbach's alpha of the Arabic version of the Attitudes Towards Seeking Professional Help scale was 0.75, whereas the Attitudes Towards Mental Health Problems Scale consisted of seven sub-sections with the Cronbach's alphas: 0.73, 0.80, 0.90, 0.90, 0.87, 0.88 and 0.91 respectively.

### **Research Design**

The research design of this study is an empirical correlational one that examines the relationship between the attitudes towards mental health problems and towards seeking professional help of adult males and females in Mount Lebanon.

### **Procedure**

In this study, the scales discussed above were combined in one paper questionnaire which was distributed and collected as hard copies rather than electronic formats. The front page of the survey included the consent form and the second page included demographical information such as: age, gender, educational background, religion, area of residence, years of residency in Mount Lebanon, marital status, and number of kids. Furthermore, as mentioned, the participants were a purposeful sample where the individuals were residing in Mount Lebanon. Due to the fact that the study was conducted on individuals residing in that region, then living in Mount Lebanon was considered a criteria and a controlled variable at the same time. Moreover, the participants were chosen conveniently as the research team had approached them in person. Questionnaires were distributed evenly between Aley and Chouf. In other words, 150 questionnaires were distributed in Chouf, of which 83 were completed, and 150 questionnaires in Aley, of which 114 were completed. Moreover, 48 questionnaires had non-specified regions, and overall 245 questionnaires were collected.

In the region of Aley, the Municipality had volunteered to aid in distributing the questionnaires and had provided the researcher with the chance to explain about the research to the participants. Furthermore, in the region of Chouf, the surveys were distributed by members of the municipality of Kfarhim, in the region of lower Chouf, the municipality of Baakline, in the middle Chouf region, and the municipality of Baadarane in the higher Chouf region. Moreover, the researcher was given the chance to explain to the members about the research in order to ensure the proper selection process of participants.

Although the research addressed attitudes towards mental health problems and towards seeking professional help, neither psychological nor mental illness topics were discussed before or during the process of collecting the surveys. Furthermore, participation was voluntary and the information collected was confidential. In other words, no names or means to identify participants were used and the researcher was the only person allowed to access the data.

### **Data Analysis**

After collecting the data and tracking the responses, the statistical tool SPSS was used to produce the statistical results. Pearson Correlation Coefficient “ $r$ ” was used to test if there was a significant correlation between attitudes towards mental health problems and attitudes towards seeking professional help among adult males and females in Mount Lebanon.

## **Chapter 4**

### **Results**

This chapter reveals the findings of the hypotheses that were tested. Testing for reliability was conducted. Correlations were computed in order to test whether or not seeking professional help is related to external shame, internal shame, attitudes towards mental health problems, reflected shame 1, reflected shame 2, and age.

#### **Reliability Testing**

To determine the internal consistency of the scales used, Cronbach's alpha was calculated. The previously calculated reliability coefficients, from other studies, are displayed in the table below along with the ones calculated in this current study (see below table 1). It should be noted that the Cronbach's alpha scores of the Attitudes Towards Mental Health Problems Scale (Family and Community) were higher in the current study than in previous studies.

**Table 1**

*Cronbach's alpha for the Attitudes Toward Seeking Professional Help Scale, Attitudes Towards Mental Health Problems, External Shame, Internal Shame, Reflected Shame 1, and Reflected Shame 2*

	Cronbach's alpha from Previous Studies	Cronbach's alpha from Current Study
ATMHP (sub-section1)	.50	.73
ATMHP (sub-section 2)	.60	.80
External Shame (sub-section 1)	.80	.90
External Shame (sub-section 2)	.80	.90
Internal Shame	.80	.87
Reflected Shame 1	.90	.88
Reflected Shame 2	.80	.91
ATSPH	.87	.75

## Hypothesis Testing

The following hypotheses were tested:

- a) There is a negative correlation between unfavorable attitudes of one's community towards mental health problems items (*subscale 1 of section 1 of ATMHP Scale*) and favorable attitudes towards seeking professional psychological help (*ATSPH Scale*).
- b) There is a negative correlation between unfavorable attitudes of one's family towards mental health problems (*subscale 2 of section 1 of ATMHP Scale*) and favorable attitudes towards seeking professional psychological help (*ATSPH Scale*).

- c) There is a negative correlation between external shame as instilled by community (*subscale 1 of section 2; ATMHP Scale*) and favorable attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the external shame instilled by the community, the less the favorable attitudes one has towards seeking mental health professionals.
- d) There is a negative correlation between external shame as instilled by family (*subscale 2 of section 2; ATMPH Scale*) and favorable attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the external shame instilled by the family, the less the favorable attitudes one has towards seeking mental health professionals.
- e) There is a negative correlation between internal shame (*section 3 of ATMPH Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the internal shame, the less the favorable attitudes towards seeking mental health professionals.
- f) There is a negative correlation between reflected shame 1 (*section 4 of ATMPH Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the reflected shame 1, the less the favorable attitudes towards seeking mental health professionals.
- g) There is a negative correlation between reflected shame 2 (*section 5 of ATMPH Scale*) and attitudes towards seeking mental health professionals (*ATSPH Scale*). In other words, the higher the reflected shame 2, the less the favorable attitudes towards seeking mental health professionals.

H2:

Older participants (41-55) will show more unfavorable attitudes regarding seeking professional help (*ATSPH Scale*) than younger participants (25-40).

To check these predictions, a correlation analysis was done. They are all presented in table 2.

**Table 2**

*Correlation Coefficients for Attitudes Towards Mental Health Problems (ATMHP) and Attitudes Toward Seeking Professional Help (ATSPH)*

		ATMHP (section 1)	ATMHP (section 2)	External Shame (section 1)	External Shame (section 2)	Internal Shame	Reflected Shame 1	Reflected Shame 2
ATSPH	Pearson Cor- relation	-.066	-.116	-.140*	-.136*	-.178**	-.145*	-.133*
	Sig. (2-tailed)	.317	.080	.033	.040	.006	.028	.042
	N	233	231	234	231	233	230	233

Hypothesis 1 a was not confirmed ( $r = -0.066$ ,  $p > .01$ ).

Hypothesis 1 b was not confirmed ( $r = -0.116$ ,  $p > .01$ ).

Hypothesis 1 c was confirmed ( $r = -0.14$ ,  $p < .01$ ).

Hypothesis 1 d was confirmed ( $r = -0.136$ ,  $p < .01$ ).

Hypothesis 1 e was confirmed ( $r = -0.178$ ,  $p < .01$ ).

Hypothesis 1 f was confirmed ( $r = -0.145$ ,  $p < .01$ ).

Hypothesis 1 g was confirmed ( $r = -0.133$ ,  $p < .01$ ).

Another hypothesis was tested. Hypothesis 2 suggested that older participants between 41-55 years will show more unfavorable attitudes regarding seeking professional help (ATSPH Scale) than younger participants, between 25-40 years. The participants were divided into two categories for comparison; Group 1 consisted of participants from 25 years of age until 40 years and group 2 consisted of participants from 41 years of age until 55 years. To check hypothesis 2 an independent t-test was performed (see table 4). No

significant difference was found between both age groups regarding seeking professional help ( $t = -0.139$  at  $p = 0.89$ ) and hence hypothesis 2 was not confirmed.

**Table 3***Descriptive Statistics*

	25-40 years				41-55 years			
	N	Mean	Std. De- viation	Std. Error Mean	N	Mean	Std. De- viation	Std. Error Mean
ATMHP (sub-section1)	114	6.9035	2.84704	.26665	76	6.6447	3.07117	.35229
ATMHP (sub-section 2)	114	3.9825	2.83462	.26549	74	4.5405	3.15876	.36720
External Shame (sub-section 1)	115	8.2522	4.22367	.39386	76	8.1184	4.14397	.47535
External Shame (sub-section 2)	114	3.6228	3.30564	.30960	75	4.5333	3.88807	.44896
Internal Shame	112	6.2768	3.92316	.37070	77	5.6104	3.50246	.39914
Reflected Shame 1	113	7.8142	4.97413	.46793	75	6.2800	4.68049	.54046
Reflected Shame 2	114	4.1140	4.25256	.39829	75	4.3600	3.99202	.46096
ATSPH	108	17.638	17.6390	.64227	78	18.9359	6.17355	.69902

**Table 4***Difference between younger and older participants regards Seeking Professional Help*

t-test for Equality of Means							
	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Community	-1.321	237	.188	-.51498	.38995	-1.28319	.25323
Family	.260	235	.795	.11312	.43440	-.74270	.96893
External Shame Community	-.466	238	.642	-.25612	.55006	-1.33973	.82749
External Shame Family	1.245	234	.214	.63563	.51063	-.37039	1.64166
Internal Shame	-1.064	236	.289	-.56606	.53211	-1.61435	.48223
Reflected Shame 1	.967	233	.334	.66651	.68895	-.69085	2.02388
Reflected Shame2	1.333	236	.184	.76333	.57263	-.36479	1.89145
ATSPH	-.139	233	.890	-.12344	.88995	-1.87682	1.62994

### Further Analysis

Since no significant results were noted between the 2 age groups, further analysis was conducted to see if gender played a role. The following significant results were found (see table 6). A marginal significant difference was found between males and females in which males exhibited higher levels of external shame 2 ( $t=-1.726$  at  $p= 0.086$ ); also a significant difference was found between both genders in which males exhibited higher levels of reflected shame 1 ( $t= 2.120$  at  $p= 0.035$ ).

**Table 5**

#### *Descriptive Statistics*

	Male				Female			
	N	Mean	Std. Deviation	Std. Error Mean	n	Mean	Std. Deviation	Std. Error Mean
ATMHP (sub-section1)	89	6.6517	2.91197	.30867	150	7.1667	2.91586	.23808
ATMHP (sub-section 2)	89	4.7753	2.94939	.31264	148	4.6622	3.39979	.27946
External Shame (sub-section 1)	89	8.2472	3.92336	.41588	151	8.5033	4.22512	.34384
External Shame (sub-section 2)	89	4.9213	3.63138	.38493	147	4.2857	3.90118	.32176
Internal Shame	88	6.2273	3.71616	.39614	150	6.7933	4.09992	.33476
Reflected Shame 1	87	8.4368	4.49211	.48161	148	7.7703	5.42368	.44582
Reflected Shame 2	88	5.2500	3.99784	.42617	150	4.4867	4.41282	.36031
ATSPH	89	17.4382	6.12921	.64969	146	17.5616	6.89725	.57082

**Table 6**

*Difference between males and females regarding Mental Health Attitudes and Seeking Professional Help*

t-test for Equality of Means							
	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Community	.595	188	.553	.25877	.43516	-.59964	1.11719
Family	-1.260	186	.209	-.55808	.44278	-1.43161	.31544
External Shame Community	.216	189	.829	.13375	.61973	-1.08873	1.35624
External Shame- Family	-1.726	187	.086	-.91053	.52745	-1.95104	.12999
Internal Shame	1.198	187	.232	.66640	.55631	-.43106	1.76385
Reflected Shame1	2.120	186	.035	1.53416	.72376	.10633	2.96199
Reflected Shame2	-.399	187	.691	-.24596	.61723	-1.46358	.97165
ATSPH	-1.349	184	.179	-1.29701	.96134	-3.19368	.59967

## Chapter 5

### Discussion

The aim of the current study was to examine the relationship between attitudes towards mental health problems and the attitudes towards seeking mental health professionals. The research studied the relationship of attitudes towards mental health problems, external shame, internal shame, reflected shame, and age with the attitudes towards seeking professional help.

This research revealed that hypotheses 1(a) and 1(b) were not confirmed. In other words, there was no significant correlation between attitudes of one's community towards mental health problems items (*subscale 1 of section 1 of ATMHP Scale*) and attitudes towards seeking professional help (*ATSPH Scale*). Moreover, there was no significant correlation between attitudes of one's family towards mental health problems (*subscale 2 of section 1 of ATMHP Scale*) and attitudes towards seeking professional help (*ATSPH Scale*). Research by Furnham and Sheikh (2000) explored whether or not the surrounding culture influenced ones' attitudes associated with seeking professional help. The research sample consisted of: British Asian, Pakistanis, and Western Europeans who completed the Orientations to Seeking Professional Help (Fischer and Turner 1970), the Mental Distress Explanatory Model Questionnaire (Eisenbruch 1990), and a demographic data sheet. The results of the study revealed that positive attitudes toward seeking professional help for psychological distress were similar for British Asians, Westerners and Pakistanis. In other words, the surrounding culture or, community, was not a significant predictor of a positive attitude towards seeking professional help (Furnham & Sheikh, 2000). However, the community's cultural explanation of the causes of mental health problems was a significant predictor of whether or not one will seek professional help (Furnham & Sheikh, 2000). Similarly, research by Van der Ham et al. (2011) was executed in order to examine attitudes towards mental health and seeking professional help. The study was done on 200 adults between 18 years and older in Hue city at central Vietnam using a semi-structured questionnaire which included both open and

closed questions. The first part of the questionnaire involved demographic data about the participants, including age, gender, marital status, occupation, education level, ethnicity and religion. Moreover, the questions addressed awareness and knowledge of respondents about mental illness, its symptoms, causes and treatment. The results of the study revealed that the cultural meanings of illness are related to whether or not people are motivated to seek treatment; however, the attitudes of the community towards seeking professional help is not related to seeking professional help. For instance, the Vietnamese population recognized overt abnormal behavior, such as: strange behavior, talking or laughing alone, improper dressing and abnormal eating behavior, as mental illness. Furthermore, abnormal facial expressions and avoiding contact or isolation were referred to sad or to unhappy individuals (Van der Ham et al., 2011). Responses about the causes of mental illness included: stress, thinking too much, emotional shock, family and marital conflicts along with genetic or congenital conditions and brain disturbance. Results from this study revealed that positive attitudes were expressed towards individuals with genetic or congenital conditions and brain disturbances. On the other hand, respondents showed more negative attitudes towards individuals with emotional or psychological disturbances. Moreover, the participants revealed preferences for family and community support rather than seeking professional help. In addition to the mentioned research, a study by Picco et al. (2016), was done on the impact of the community on the perceptions towards mental illness and on the attitudes towards seeking professional help on 3006 participants from Singapore, ranging between 18-65 years of age. The participants ought to be residents of Singapore who completed face to face interviews done by the research team. The interview included questions from the Attitudes Towards Seeking Professional Help Scale (ATSPH). Results from this study revealed that there exists a relationship between the cultural causal attributions to mental health problems and the attitudes towards seeking professional help. Furthermore, according to Picco et al. (2016), research has consistently shown that family influences the attitudes towards seeking professional help; specifically, the causal attributions that the family gives to the mental

health problem. In other words, the causal attributions to mental health problems provided by one's family influences ones' attitudes towards seeking professional help. Therefore, one explanation to the results of hypotheses 1 (a) and 1 (b) in this current study is that the cultural meaning associated with mental health problems should have been a variable to be examined in order to detect the relationship between the attitudes towards mental health problems and the attitudes towards seeking professional help.

Results from this study confirmed hypothesis 1 (c) which suggested that there is a negative correlation between external shame as instilled by community (subscale 1 of section 2; ATMHP Scale) and favorable attitudes towards seeking professional help (ATSPH Scale). As previously mentioned external shame triggers a negative impact on the individuals with mental illness or individuals seeking mental health services (Yoon, 2015). Furthermore, a study by Ryan, Saporito, and Teachman (2013) revealed that external shame triggered by the community is a significant barrier to seeking professional help.

This current study also confirmed hypothesis 1 (d) which suggested that there is a negative correlation between external shame as instilled by family (*subscale 2 of section 2; ATMPH Scale*) and favorable attitudes towards seeking professional help (*ATSPH Scale*). As previously mentioned, according to Ciftci, Corrigan, & Jones (2012), family ties are closely-knitted and reputation is highly valuable in shame-oriented societies thus leading individuals to avoid seeking professional help since that would bring shame to their families (Adongo, Aikins & Tawiah, 2015).

Moreover, according to Jimenez et al. (2013), Asian societies, place great importance on bringing honor to one's family. Therefore, a great deal of shame has been attached to mental health problems which are perceived as a threat to the harmony of the family. In other words, having a family member with mental health problems brings shame to one's family thus triggering negative attitudes towards seeking professional help.

Hypothesis 1 (e) was confirmed by this current study and it suggested that there is a negative correlation between internal shame (*section 3 of ATMPH Scale*) and favorable attitudes towards seeking professional help (*ATSPH Scale*). As previously mentioned, the reasons behind not seeking professional help among the individuals who are suffering from mental health problems are: stigma associated with mental health problems and shame (Corrigan, 2004). According to Jimenez et al. (2013), the perceived stigma attributed to mental health problems is a contributor to the internal shame an individual might feel. Also, the more the stigma associated with mental health problems, the higher the negative attitudes towards seeking professional help.

This current study confirmed hypotheses 1 (f) and 1 (g) which are that there is a negative correlation between reflected shame 1 (*section 4 of ATMPH Scale*) and favorable attitudes towards seeking professional help (*ATSPH Scale*); moreover, there is a negative correlation between reflected shame 2 (*section 5 of ATMPH Scale*) and favorable attitudes towards seeking professional help (*ATSPH Scale*). As previous research has shown, reflected shame 1 and reflected shame 2 are significant predictors of whether or not an individual will seek professional help (Gilbert et al., 2007). In other words, the higher the reflected shame (1 and 2), the more likely the individual will have negative attitudes towards seeking professional help thus reducing the likelihood of seeking help.

Hypothesis 2 stated that older participants (41-55) will show more unfavorable attitudes regarding seeking professional help (*ATSPH Scale*) than younger participants (25-40). However, this current study did not confirm this hypothesis. On the contrary, the results have shown that there was no relationship between age and the attitudes towards seeking professional help. According to Mackenzie et al. (2006), age differences in seeking professional help remain unclear and reveal contradictory evidences. Therefore, this might be an explanation to the lack of validation of hypothesis 2. Another possible explanation could be that the

current study categorized the age groups into two groups and hence used a t-test to compare the means. Results could have been different if a correlational hypothesis was examined.

### **Further Discussions**

As previously mentioned, a marginal significant difference was found between males and females in which males exhibited higher levels of external shame 2 and reflected shame 1.

According to Pandalangat (2011), the socialization process, within the family, plays a vital role in triggering shame in men which also affect men's help seeking behaviors. For instance, in closely-knitted families the males have to fulfill certain roles which place the males in positions of strength thus seeing a counselor might be perceived as a sign of weakness and, therefore, may evoke shameful emotions. According to Gilbert and Procter (2006), males are more prone to feelings of external shame because they are more concerned about how others might perceive them. This is due to the fact that in male-dominating societies, the gender roles are strictly defined by the community thus seeking professional help, which is not considered a 'manly act', triggers feelings of shame. Furthermore, as a previous study by Gilbert and Sanghera (2006) has shown that males, more than females, are concerned with how their family members view them when they suffer from mental health problems (external shame 2) and with the effects of their mental health problems on the families (reflected shame 1). A study was executed by Galhardo, Matos, and Pinto-Gouveia (2011) revealed that women exhibit lower levels of shame and higher levels of depressive and anxiety symptoms, when seeking professional help than the male counterparts. In other words, females are more prone to experience the symptoms of shame, such as anxiety and depression; whereas, the males are more prone to experience shame itself.

**Clinical Implications**

This study could help the clinicians, of that region, in addressing mental health issues in a culturally sensitive manner. Based on the results of this study, the specific variables external shame, internal shame, and reflected shame should be focused on by a therapist or any mental health professional, rather than the attitudes of one's family and community, towards seeking professional help. Moreover, clinicians should be aware of the fact that since external and reflected shame are both higher among the males, this indicates that males are more concerned about how others, in their community, view them. In other words, mental health practitioners should focus on the fear of negative evaluation which concerns males more than females.

**Limitations of This Study**

Several factors have contributed to the strength of this study. It is among the few studies in the Arab World which tap the attitudes towards mental health problems and seeking professional help. Moreover, no studies have been published in Mount Lebanon, more specifically Aley and Chouf, which address attitudes towards mental health problems and seeking professional help. However, as is the case with most of the studies, in this current study there were some limitations and drawbacks. For instance, this study could probably be generalized to similar areas as Mount Lebanon; however future studies have to confirm that. Moreover, the study could not be generalized to other age groups since the age of the participants was limited to adults. In other words, had the age range, in this study, included younger participants then there would have been greater room for comparison among young participants' attitudes towards seeking professional help and older participants' attitudes towards seeking professional help.

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## Appendix A

## طلب موافقة

يطلب منك أن تشارك في دراسة بحثية، وهي أطروحة دراسات عليا، تجريها نور حمزة برعاية الدكتورة حنين الحوت من قسم علم النفس في جامعة هايكازيان. مشاركتك في هذه الدراسة طوعية تمامًا. ويرجى قراءة المعلومات الواردة أدناه قبل اتخاذ قرار المشاركة أو عدم المشاركة.

الدراسة المقترحة سوف تكون مفيدة في تقييم العلاقة بين المواقف تجاه المرض النفسي والمواقف تجاه اللجوء إلى أخصائيي الصحة العقلية، وذلك من خلال دراسة أيديولوجيات الذكور والإناث من 25 إلى 55 عامًا في جبل لبنان. هذه الدراسة تمهد الطريق لإدخال تحسينات في المستقبل على مجال الصحة النفسية، جنبًا إلى جنب مع التحسينات الاجتماعية الأخرى، مثل الحد من وصمة العار، والمواقف السلبية تجاه الصحة النفسية، والعاملين في مجال الصحة النفسية.

## إجراءات:

للمشاركة في هذه الدراسة، سوف يطلب منك تعبئة استمارة الخصائص الديمغرافية مع استمارتين إضافيتين.

## المخاطر المحتملة والمضايقات:

لن تكون هناك مخاطر محتملة عند المشاركة في البحث. لكن قد يكون هناك بعض الانزعاج النفسي عند الإجابة على بعض الأسئلة.

## السرية:

إن أي معلومات يتم الحصول عليها في هذه الدراسة سرية. وعلاوة على ذلك، لن يتم طلب أسماء المشاركين في البحث.

## المشاركة أو الانسحاب:

يمكنك اختيار المشاركة أو عدم المشاركة في هذه الدراسة دون عواقب من أي نوع كانت.

## تحديد هوية المحققين:

إذا كان لديك أي أسئلة بخصوص الدراسة من فضلك لا تتردد في طرحها. لمزيد من المعلومات يرجى الاتصال على: الرقم 670044/70

Appendix B

الخصائص الديمغرافية

\*ضع دائرة حول الإجابة الصحيحة، أو اكتب ما يجب:

1-السن:

أ 25-30 -

ب 31-35 -

ج 36-40 -

د 41-45 -

هـ 46-50 -

و 51-55 -

2-الجنس: ذكر / أنثى

3-الديانة \_\_\_\_\_:

4-الوضع العائلي:

أ - أعزب

ب - متزوج

ج - مطلق

د - منفصل

هـ - أرمل

5- لديك أطفال: لا / نعم تحديد العدد \_\_\_\_\_

6- درجة التعليم:

أ - لا شهادة

ب - الشهادة الثانوية العامة

ج - البكالوريوس

د - درجة الماجستير

هـ - دكتوراه

و - شهادة أخرى: \_\_\_\_\_

7- مكان الإقامة:

أ - الشوف

ب - عاليه

ج - مكان آخر: \_\_\_\_\_

8- سنوات الإقامة في جبل لبنان:

أ - أقل من سنة

ب 1-5 -سنوات

ج 5-10 -سنوات

د - أكثر من 10 سنوات

هـ - كل حياتي

## Appendix C

## مواقف من طلب مساعدة مهنية

## تعليمات

اقرأ كل عبارة بعناية، وأثر إلى درجة موافقتك، وفقاً للمقياس أدناه، يرجى أن يكون ردك صريحاً:

(٠) = لا أوافق (١) = لا أوافق جزئياً (٢) = أوافق جزئياً (٣) = أوافق

١. \_\_\_\_\_ إذا اعتقدت أنني أعاني من انهيار عصبي، سيكون خيارى الأول هو طلب المساعدة من اختصاصى علم نفس.
٢. \_\_\_\_\_ فكرة الحديث عن مشاكل مع طبيب نفسي تبدو لي وسيلة ضعيفة للتخلص من المشاكل أو النزاعات العاطفية.
٣. \_\_\_\_\_ إذا كنت أعاني من أزمة عاطفية خطيرة في هذه المرحلة من حياتي، أكون واثقاً أنني سأجد الإغاثة في العلاج النفسي.
٤. \_\_\_\_\_ هناك شيء مثير للإعجاب في موقف الشخص الذي هو على استعداد للتعامل مع نزاعاته ومخاوفه دون اللجوء إلى مساعدة مهنية.
٥. \_\_\_\_\_ ود أن أحصل على مساعدة نفسية إذا كنت أشعر بالقلق أو بالانزعاج لفترة طويلة.
٦. \_\_\_\_\_ أود أن أحصل على الإرشاد النفسي في المستقبل.
٧. \_\_\_\_\_ إن الشخص الذي يعاني من مشكلة عاطفية من المرجح أنه لن يستطيع أن يحلها بمفرده؛ لكنه سيتمكن من حلها بمساعدة مهنية.
٨. \_\_\_\_\_ بالنظر إلى وقت العلاج النفسي وتكاليفه، إن قيمته وفعاليتيه مشكوك بها لشخص مثلي.
٩. \_\_\_\_\_ على الإنسان أن يحل مشاكله الخاصة بنفسه، ويكون الحصول على الإرشاد النفسي هو الملاذ الأخير.
١٠. \_\_\_\_\_ المشاكل الشخصية والعاطفية، مثل أشياء كثيرة، تميل إلى الحل من تلقاء ذاتها.

## مواقف من مشاكل الصحة العقلية

نحن مهتمون بأفكار الناس ومشاعرهم حول مشاكل الصحة العقلية. وكما تعلمون، يعاني بعض الناس من مشاكل في صحتهم العقلية كالاكتئاب والقلق. وهذا ما يصعب عليهم التكيف في الحياة اليومية. ويشعر المكتوبون بالتعب، ولا يستمتعون بالحياة، وقد ينسحبون من الحياة العائلية.

تجدون أدناه سلسلة من البيانات حول كيفية تفكيركم وتفكير مجتمعكم وعائلتكم إزاء هذه المشاكل. إقرأ كل بيان بدقة، وضع دائرة حول الرقم الذي يحدد بشكل أفضل مقدار موافقتك عليه.

(٠) = لا أوافق (١) = لا أوافق جزئياً (٢) = أوافق جزئياً (٣) = أوافق

## مواقف من مشاكل الصحة العقلية

بالنسبة للمجموعة الأولى من الأسئلة، يرجى التفكير فيها من منظور مجتمعك وعائلتك إلى مشاكل الصحة العقلية مثل الاكتئاب والقلق، مع صعوبة في التكيف في الحياة اليومية.

١. ينظر مجتمعي إلى مشاكل الصحة العقلية على أنها شيء يجب المحافظة على سريةه
٢. ينظر مجتمعي إلى مشاكل الصحة العقلية على أنها ضعف شخصي
٣. يميل مجتمعي إلى التقليل من قيمة الشخص الذي يعاني من مشاكل الصحة العقلية
٤. يرغب مجتمعي بالابتعاد عن شخص لديه مشاكل في الصحة العقلية
٥. تنظر عائلتي إلى مشاكل الصحة العقلية على أنها شيء يجب المحافظة على سريةه
٦. تنظر عائلتي إلى مشاكل الصحة العقلية على أنها ضعف شخصي
٧. تميل عائلتي إلى التقليل من قيمة الشخص الذي يعاني من مشاكل الصحة العقلية
٨. ترغب عائلتي بالابتعاد عن شخص لديه مشاكل في الصحة العقلية

## العار الخارجي /وصمة عار

بالنسبة للمجموعة التالية من الأسئلة، يرجى التفكير في شعورك، إذا كنت تعاني من مشاكل في الصحة العقلية مثل الاكتئاب والقلق، مع صعوبة في التكيف في الحياة اليومية.

- |         |   |
|---------|---|
| • ١ ٢ ٣ | ٩. أعتقد أن مجتمعي سينظر إليّ باحتقار           |
| • ١ ٢ ٣ | ١٠. أعتقد أن مجتمعي سينظر إليّ أنني أدنى مستوى  |
| • ١ ٢ ٣ | ١١. أعتقد أن مجتمعي سيراني غير مؤهل             |
| • ١ ٢ ٣ | ١٢. أعتقد أن مجتمعي سيراني ضعيفاً               |
| • ١ ٢ ٣ | ١٣. أعتقد أن مجتمعي سيراني لا أرقى إلى مقاييسه  |
| • ١ ٢ ٣ | ١٤. أعتقد أن عائلتي ستتظر إليّ باحتقار          |
| • ١ ٢ ٣ | ١٥. أعتقد أن عائلتي ستتظر إليّ أنني أدنى مستوى  |
| • ١ ٢ ٣ | ١٦. أعتقد أن عائلتي ستراني غير مؤهل             |
| • ١ ٢ ٣ | ١٧. أعتقد أن عائلتي ستراني ضعيفاً               |
| • ١ ٢ ٣ | ١٨. أعتقد أن عائلتي ستراني لا أرقى إلى مقاييسها |

## العار الداخلي

بالنسبة للمجموعة الثانية من الأسئلة، يرجى التفكير في شعورك، إذا كنت تعاني من مشاكل في الصحة العقلية مثل الاكتئاب والقلق، مع صعوبة في التكيف في الحياة اليومية.

- |         |                                       |
|---------|---------------------------------------|
| • ١ ٢ ٣ | ١٩. قد أرى نفسي أدنى مستوى من الآخرين |
| • ١ ٢ ٣ | ٢٠. قد أرى نفسي غير مؤهل              |
| • ١ ٢ ٣ | ٢١. قد ألوم نفسي على مشاكلي           |
| • ١ ٢ ٣ | ٢٢. قد أرى نفسي شخصاً ضعيفاً          |
| • ١ ٢ ٣ | ٢٣. قد أرى نفسي شخصاً فاشلاً          |

## العار المنعكس ١

بالنسبة للمجموعة التالية من الأسئلة، يرجى التفكير في شعورك، إذا كنت تعاني من مشاكل في الصحة العقلية مثل الاكتئاب والقلق، مع صعوبة في التكيف في الحياة اليومية. هذه المرة، ففكر في مقدار قلقك، أو مدى اهتمامك، في تأثير ذلك على عائلتك.

٢٤. قد تُرى عائلتي أنها أدنى مستوى من الآخرين . ٠ ١ ٢ ٣
٢٥. قد تُرى عائلتي أنها غير مؤهلة . ٠ ١ ٢ ٣
٢٦. قد تُلام عائلتي على مشاكلي . ٠ ١ ٢ ٣
٢٧. قد تخسر عائلتي مكانتها في المجتمع . ٠ ١ ٢ ٣
٢٨. قد أقلق على مدى تأثير ذلك على عائلتي . ٠ ١ ٢ ٣
٢٩. قد أقلق على أنه يمكن أن أخذل شرف عائلتي . ٠ ١ ٢ ٣
٣٠. قد أقلق على أن مشاكل صحتي العقلية قد توذي سمعة عائلتي . ٠ ١ ٢ ٣

### العار المنعكس ٢

بالنسبة للمجموعة التالية من الأسئلة، يرجى التفكير في شعورك، إذا كان أحد أقربائك يعاني من مشاكل في الصحة العقلية مثل الاكتئاب والقلق، مع صعوبة في التكيف في الحياة اليومية. هذه المرة، ففكر في مقدار قلقك، أو مدى اهتمامك، في تأثير ذلك عليك.

٣١. قد أقلق بأن ينظر إليّ الآخرون باحتقار . ٠ ١ ٢ ٣
٣٢. قد أقلق بأن الآخرين قد لا يرغبون بالارتباط بي . ٠ ١ ٢ ٣
٣٣. قد أقلق بأن سمعتي وكرامتي قد تتأذى من ذلك . ٠ ١ ٢ ٣
٣٤. قد أقلق بأنه إذا عُرف هذا الأمر فإنني قد أخسر مكانتي في المجتمع . ٠ ١ ٢ ٣
٣٥. قد أقلق بأن الآخرين قد يظنون أنني أنا أيضًا لدي مشاكل في الصحة العقلية . ٠ ١ ٢ ٣

## Appendix D

**Attitudes Toward Seeking Professional Help**Your sex:  Male  FemaleYour race/ethnicity:  African American Asian/Asian American White/European American Latino/a Arab/Middle Eastern Other: Please specify \_\_\_\_\_**Instructions**

Read each statement carefully and indicate your degree of agreement using the scale below.

In responding, please be completely candid.

0 = Disagree

1 = Partly disagree

2 = Partly agree

3 = Agree

\_\_\_\_\_ 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

\_\_\_\_\_ 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

\_\_\_\_\_ 3. 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.

\_\_\_\_\_ 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

\_\_\_\_\_ 5. I would want to get psychological help if I were worried or upset for a long period of time.

\_\_\_\_\_ 6. I might want to have psychological counseling in the future.

\_\_\_\_\_ 7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

\_\_\_\_\_ 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

\_\_\_\_\_ 9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

\_\_\_\_\_ 10. Personal and emotional troubles, like many things, tend to work out by themselves.

### **Scoring**

Reverse score items 2, 4, 8, 9, and 10, then add up the ratings to get a sum. Higher scores indicate more positive attitudes towards seeking professional help. Calculate a mean for males, for females, and for each of the ethnic groups to examine group differences. Discuss any observed similarities and/or differences between the groups with the class.

### **ATTITUDES TOWARDS MENTAL HEALTH PROBLEMS**

We are interested in people's thoughts and feelings about mental health problems. As you may know, some people suffer from mental health problems such as depression and anxiety. These can make it difficult to cope with everyday life. Depressed people can feel tired, not enjoy life, want to hide away and may withdraw from family life. Below are a series of statements about how you, your community and your family may think about such problems. Read each statement carefully and circle the number that best describes how much you agree with each statement.

Please use the following scale:

0 = Do not agree at all;      1 = Agree a little;      2 = Mostly agree;      3 = Completely Agree

### **Attitudes Towards Mental Health Problems**

We are interested in people's ideas concerning mental health problems. As it is known, some people suffer from mental health problems like depression and anxiety which makes it difficult for them to cope with everyday life. Depressed people may feel fatigue and lack of enjoyment of life and they may have the desire to hide. Moreover, they may retreat from family life. Below you will find a series of statements about how you, your community and your families may think about such problems. Carefully, read every statement and circle the number which mostly determines your degree of agreement with each statement.

0= Do not agree at all;      1= Agree a little;      2= Mostly agree;      3= Completely agree

**Attitudes Towards Mental Health Problems**

Concerning the first group of questions, please think about how your community and family might consider the mental health problems like depression and anxiety with a difficulty to cope with everyday life.

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1 | My community considers mental health problems as something secretive. | 0 | 1 | 2 | 3 |
| 2 | My community considers mental health problems as weakness.            | 0 | 1 | 2 | 3 |
| 3 | My community may devalue of a person with mental health problems.     | 0 | 1 | 2 | 3 |
| 4 | My community may isolate a person with mental health problems.        | 0 | 1 | 2 | 3 |
| 5 | My family considers mental health problems as something secretive.    | 0 | 1 | 2 | 3 |
| 6 | My family considers mental health problems as weakness.               | 0 | 1 | 2 | 3 |
| 7 | My family may devalue of a person with mental health problems.        | 0 | 1 | 2 | 3 |
| 8 | My family may isolate a person with menta health problems.            | 0 | 1 | 2 | 3 |

**External Shame/ Stigma Awareness**

Concerning the following group of questions, please think of your personal feeling if you suffered from mental health problems like depression and anxiety with a difficulty to cope with everyday life.

- |    |  |   |   |   |   |
|----|--|---|---|---|---|
| 9  | I think my community will look down at me with contempt. | 0 | 1 | 2 | 3 |
| 10 | I think my community will consider me inferior.          | 0 | 1 | 2 | 3 |
| 11 | I think my community will consider me inadequate.        | 0 | 1 | 2 | 3 |
| 12 | I think my community will consider me fragile.           | 0 | 1 | 2 | 3 |
| 13 | I think my community will consider me unqualified.       | 0 | 1 | 2 | 3 |
| 14 | I think my family will look down at me with contempt.    | 0 | 1 | 2 | 3 |

- |    |   |   |   |   |   |
|----|---|---|---|---|---|
| 15 | I think my family will consider me inferior.    | 0 | 1 | 2 | 3 |
| 16 | I think my family will consider me inadequate.  | 0 | 1 | 2 | 3 |
| 17 | I think my family will consider me fragile.     | 0 | 1 | 2 | 3 |
| 18 | I think my family will consider me unqualified. | 0 | 1 | 2 | 3 |

**Internal Shame**

Concerning the following group of questions, please think of your personal feeling if you suffered from mental health problems like depression and anxiety with a difficulty to cope with everyday life.

- |    |  |   |   |   |   |
|----|--|---|---|---|---|
| 19 | I may consider myself inferior.        | 0 | 1 | 2 | 3 |
| 20 | I may consider myself inadequate.      | 0 | 1 | 2 | 3 |
| 21 | I may blame myself for my problems.    | 0 | 1 | 2 | 3 |
| 22 | I may consider myself a weak person.   | 0 | 1 | 2 | 3 |
| 23 | I may consider myself as unsuccessful. | 0 | 1 | 2 | 3 |

**Reflected Shame 1**

Concerning the following group of questions, please think of your personal feeling if you suffered from mental health problems like depression and anxiety with difficulty to cope with everyday life. This time think about your concerns and worries towards the impact of this on your family.

- |    |   |   |   |   |   |
|----|---|---|---|---|---|
| 24 | Your family may be considered inferior.     | 0 | 1 | 2 | 3 |
| 25 | My family may be considered inadequate.     | 0 | 1 | 2 | 3 |
| 26 | My family may be blamed for my problems.    | 0 | 1 | 2 | 3 |
| 27 | My family may lose their status in society. | 0 | 1 | 2 | 3 |
| 28 | I may worry about the impact on my family.  | 0 | 1 | 2 | 3 |

- 29 I may worry about humiliating my family's honor. 0 1 2 3
- 30 I may worry that my mental health problem would hurt the reputation of my family. 0 1 2 3

**Reflected Shame 2**

Concerning the following group of questions, please think of your personal feeling if one intimate relative suffers from mental health problems like depression and anxiety with difficulty to cope with everyday life.

This time think about your concerns and worries towards the impact of this on yourself.

- 31 I may worry that others will look at me with contempt. 0 1 2 3
- 32 I may worry that others will isolate. 0 1 2 3
- 33 I may worry that my reputation and honor will be hurt. 0 1 2 3
- 34 I may worry that if someone knows about it, I will lose my social status. 0 1 2 3
- 35 I may worry that others will think that I also suffer from mental health problems. 0 1 2 3

## Appendix E

**Attitudes Towards Seeking Professional Help****Instructions**

Carefully, read every expression and indicate the degree of your agreement according to the numbers below; please be explicit with your answers.

0= Disagree            1= Partly disagree            2= Partly agree            3= Agree

- \_\_\_\_\_ 1        If I believed that I am suffering from a mental breakdown, the first thing I would tend to do is to get professional care.
- \_\_\_\_\_ 2        The idea of discussing problems with a psychologist seems to me as a very weak way to get over the emotional problems.
- \_\_\_\_\_ 3        If I was suffering from a dangerous emotional problem in this current period of my life, I will be sure that I will find the cure in psychotherapy.
- \_\_\_\_\_ 4        There is something attractive in the attitude of the person who is ready to deal with his/her struggles and worries without referring to professional help.
- \_\_\_\_\_ 5        I would like to get a psychological help if I felt anxious or bothered for a long period of time.
- \_\_\_\_\_ 6        I would like to get psychological counseling in the future.
- \_\_\_\_\_ 7        A person with emotional problems is not likely to solve it alone. He/She can solve it through professional help.
- \_\_\_\_\_ 8        According to someone like me, the time and cost of psychotherapy is doubted.
- \_\_\_\_\_ 9        One must solve his/her personal problems; considering psychological guidance should be the last choice.
- \_\_\_\_\_ 10        Personal and emotional problems, like many other things, tend to be resolved on their own.

**Points**

Reverse result items 2, 4, 8, 9, 10, then add the ratings to get the total. Higher scores indicate more positive attitudes towards seeking professional help. Calculate a mean for males, for females, and for every group of the ethnic groups in order to study their differences. Discuss, with the class, the similarities and /or differences between the groups.

### Attitudes Towards Mental Health Problems

We are interested in people's ideas concerning mental health problems. As it is known, some people suffer from mental health problems like depression and anxiety which makes it difficult for them to cope with everyday life. Depressed people may feel fatigue and lack of enjoyment of life and they may have the desire to hide. Moreover, they may retreat from family life. Below you will find a series of statements about how you, your community and your families may think about such problems. Carefully, read every statement and circle the number which mostly determines your degree of agreement with each statement.

0= Do not agree at all;      1= Agree a little;      2= Mostly agree;      3= Completely agree

### Attitudes Towards Mental Health Problems

Concerning the first group of questions, please think about how your community and family might consider the mental health problems like depression and anxiety with a difficulty to cope with everyday life.

- |   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1 | My community considers mental health problems as something confidential.         | 0 | 1 | 2 | 3 |
| 2 | My community considers mental health problems as personal weakness.              | 0 | 1 | 2 | 3 |
| 3 | My community may minimize the value of a person with mental health problems.     | 0 | 1 | 2 | 3 |
| 4 | My community may desire to keep space from a person with mental health problems. | 0 | 1 | 2 | 3 |
| 5 | My family considers mental health problems as something confidential.            | 0 | 1 | 2 | 3 |
| 6 | My family considers mental health problems as personal weakness.                 | 0 | 1 | 2 | 3 |
| 7 | My family may minimize the value of a person with mental health problems.        | 0 | 1 | 2 | 3 |
| 8 | My family may desire to keep space from a person with mental health problems.    | 0 | 1 | 2 | 3 |

**External Shame/ Stigma Awareness**

Concerning the following group of questions, please think of your personal feeling if you suffered from mental health problems like depression and anxiety with a difficulty to cope with everyday life.

- |    |  |   |   |   |   |
|----|--|---|---|---|---|
| 9  | I think my community will look down at me with contempt.                 | 0 | 1 | 2 | 3 |
| 10 | I think my community will consider me inferior.                          | 0 | 1 | 2 | 3 |
| 11 | I think my community will consider me inadequate.                        | 0 | 1 | 2 | 3 |
| 12 | I think my community will consider me weak.                              | 0 | 1 | 2 | 3 |
| 13 | I think my community will consider me not qualified for their standards. | 0 | 1 | 2 | 3 |
| 14 | I think my family will look down at me with contempt.                    | 0 | 1 | 2 | 3 |
| 15 | I think my family will consider me inferior.                             | 0 | 1 | 2 | 3 |
| 16 | I think my family will consider me inadequate.                           | 0 | 1 | 2 | 3 |
| 17 | I think my family will consider me weak.                                 | 0 | 1 | 2 | 3 |
| 18 | I think my family will consider me not qualified for their standards.    | 0 | 1 | 2 | 3 |

**Internal Shame**

Concerning the following group of questions, please think of your personal feeling if you suffered from mental health problems like depression and anxiety with a difficulty to cope with everyday life.

- |    |  |   |   |   |   |
|----|--|---|---|---|---|
| 19 | I may consider myself inferior.        | 0 | 1 | 2 | 3 |
| 20 | I may consider myself inadequate.      | 0 | 1 | 2 | 3 |
| 21 | I may blame myself for my problems.    | 0 | 1 | 2 | 3 |
| 22 | I may consider myself a weak person.   | 0 | 1 | 2 | 3 |
| 23 | I may consider myself as unsuccessful. | 0 | 1 | 2 | 3 |

**Reflected Shame 1**

Concerning the following group of questions, please think of your personal feeling if you suffered from mental health problems like depression and anxiety with difficulty to cope with everyday life. This time think about your concerns and worries towards the impact of this on your family.

- |    |   |   |   |   |   |
|----|---|---|---|---|---|
| 24 | Your family may be considered inferior.   | 0 | 1 | 2 | 3 |
| 25 | My family may be considered inadequate.   | 0 | 1 | 2 | 3 |
| 26 | My family may be blamed for my problems.  | 0 | 1 | 2 | 3 |
| 27 | My family may lose their status in society.                                       | 0 | 1 | 2 | 3 |
| 28 | I may worry about the impact on my family.  | 0 | 1 | 2 | 3 |
| 29 | I may worry about humiliating my family's honor.                                  | 0 | 1 | 2 | 3 |
| 30 | I may worry that my mental health problem would hurt the reputation of my family. | 0 | 1 | 2 | 3 |

**Reflected Shame 2**

Concerning the following group of questions, please think of your personal feeling if one intimate relative suffers from mental health problems like depression and anxiety with difficulty to cope with everyday life. This time think about your concerns and worries towards the impact of this on yourself.

- |    |  |   |   |   |   |
|----|--|---|---|---|---|
| 31 | I may worry that others will look at me with contempt.                             | 0 | 1 | 2 | 3 |
| 32 | I may worry that others will not desire any link with me.                          | 0 | 1 | 2 | 3 |
| 33 | I may worry that my reputation and dignity will be hurt.                           | 0 | 1 | 2 | 3 |
| 34 | I may worry that if someone knows about it, I will lose my social status.          | 0 | 1 | 2 | 3 |
| 35 | I may worry that others will think that I also suffer from mental health problems. | 0 | 1 | 2 | 3 |