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DEVELOPING AN EMIC-ETIC SCALE FOR BARRIERS TO PSYCHOLOGICAL TREATMENT SEEKING

by
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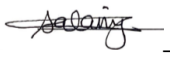
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AN ABSTRACT OF THE THESIS OF

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Within the Arab region, barriers to psychological treatment seeking have been construed and measured by adopting either an etic-based approach (e.g., through the use of instruments that were initially developed in non-Arab cultures) or an emic approach (e.g., anthropological work). However, because these barriers are rooted in a culture's values and belief systems, etic-based instruments may run the risk of construct bias (under-representation) and item bias. Conversely, emic approaches lack quantitative rigor and generalizability. To our knowledge, there is no tool that comprehensively measures all barriers to treatment seeking, within the Arab world and Lebanon specifically. The current study examined the literature in Arab and non -Arab cultures and identified eight major barriers which were used to construct a tool that adequately captures these obstacles in a combined sample of American University of Beirut (AUB) students and a community sample. Results indicated that barriers to psychological treatment seeking may be conceptualized along six factors. These are: I- *Attitudes to Psychotherapy*, II- *Perceived Accessibility Barriers*, III- *Perceived Stigma*, IV- *Mental Health Literacy*, V- *Attitudes to Psychiatric Services*, and VI- *Perceived Need for Help.*

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CHAPTER I

INTRODUCTION

Several reasons, often rooted in socio-cultural elements and belief systems, may prevent individuals from seeking treatment for mental illnesses. Given how these factors are intricately grounded in local practices, attitudes and customs, such as in defining attitudes towards medication or perceived trust in physicians, it follows that it is important for barriers to treatment-seeking to be conceptualized and measured from a perspective that is "local" or emic. A conceptualization and measurement that is grounded in the local cultural ideas and beliefs of groups of people can then be used to make more accurate predictions about why that specific group of people may or may not seek treatment. Consequently, interventions and policies can be customized to the socio-cultural context. In order to develop such an indigenous measure to barriers to treatment seeking in Lebanon, the present paper will first introduce the importance of an emic approach, review the non-Arab and Arab literature on these barriers, and highlight the limitations present in already existing measures that necessitate the development of a new measure.

CHAPTER II

EMIC AND ETIC CONCEPTUALIZATIONS OF TREATMENT-SEEKING BARRIERS

A. Emic and Etic Approaches to Conceptualizing Constructs

Since this paper centers on the development of a psychometric scale, including a full understanding of the construct, the content, and the development of the items, this invokes a broader conversation on the different perspectives that researchers can adopt in such studies. Specifically, the below section discusses the etic (universal) and emic (culturally relevant) approaches to understanding psychological constructs, and how these approaches can be used together to provide a broader understanding of a construct.

Van de Vijver, Chasiostis, and Breugelmans (p. 29, 2011) have stated that mainstream psychology is biased in its focus on Western theory to the marginalization or exclusion of cultural factors and cultural variations of "psychological theorizing" or psychological phenomena. Due to the power differentials in knowledge production within psychological research, the genealogy of these social or psychological notions have generally been produced within a Western framework and methodology and have then been transported to the East without modifying the constructs according to their cultural contexts. Much of the research on barriers to treatment seeking has been conceptualized from this etic approach. According to cultural and cross-cultural researchers, the main tenet of an etic perspective is the universality assumption of the theoretical and methodological underpinnings of a construct. This means that an etic-universalist position assumes that psychological processes and functions are mostly similar across various cultures and

environments (Poortinga, 2016). The difference is only in the behavioral manifestation of these processes which can only be identified and compared by using similar measurement tools across cultures or contexts (Poortinga, 2016). Thus, the etic perspective is most often of a quantitative nature and relies on tools and measurements derived within one context and applied across several cultural or ecological domains (Fontaine; 2011).

In contrast, an emic position to constructs is interested in identifying cultural factors that are heavily assessed through qualitative studies such as ethnographic work and are studied within the specific context in which they occur (Fontaine, 2011). This perspective relies on the assumption of cultural relativism, which means that processes are culturally construed rather than operating identically in different contexts (Fontaine, 2011). While the main aim in an etic-universalist approach is to use quantitative results to make direct cross-cultural comparisons through a nomothetic lens, a relativist perspective aims at gathering evidence for a particular cultural group's functioning from an idiographic lens. Traditionally, the methodology has relied on qualitative studies (a bottom-up approach) and only more recently were these local constructs quantitatively studied through the development of measures and tools that are indigenous to the culture (Lonner, 2011).

Recently, a combined mixed-method approach of both emic and etic constructs was put forward by researchers (Cheung, van de Vijver, & Leong, 2011; Fontaine, 2011; Daouk-Oyry, Zeionoun, Choueri, & van de Vijver, 2016). The approach views these two perspectives as complementary rather than dichotomous and advocates for mixed methods. The emic part of the mixed-methods approach can be seen as important for exploratory work in identifying constructs and generating hypotheses, while the etic component may be in the form of quantitative analysis to develop instruments that reflect the data generated

and gathered (Poortinga, 2011; Karasz, 2011). Additionally, combined emic-etic approaches can be used to better understand how nomological networks – the hypothesized and empirical relationships that the construct has with predictors, outcomes and correlates (Lonner, 2011) – differ across cultures. This approach has been used to understand cross cultural personality constructs and other psychological phenomena (Daouk-Öyry, Zeinoun, Choueiri, & van de Vijver, 2016; Valchev et al., 2014).

Therefore, the purpose of this paper is to investigate barriers to treatment seeking as they are conceptualized within emic (Arab) and etic (cross-cultural) perspectives in order to develop a scale that relies on concepts and conclusions derived from both approaches.

B. Etic and Emic Methodologies in Measurement of Constructs

The discussion of emic and etic perspectives is closely related to the methodologies used to develop tests. That is, test developers choose how to develop tests, based on their explicit (or sometimes implicit) perspectives of whether the construct is culturally unique, or universal, or both. The below section discusses the main three approaches used to develop tests and makes an argument regarding the most fitting method for this study.

The development of new measures for a certain cultural context usually involves one of three methods: adoption, adaptation, or assembly (Table 1).

The adoption perspective, which is the most widely used etic approach, involves the literal translation of tests or measures with the adoption of the test, as is, to the culture's target language through the process of translation. This usually involves the process of forward translation and back translation in order to ensure that the test items have been correctly translated to the target culture, and that they remain faithful to the measure's original linguistic content (van de Vijver, 2015). The strengths of such an approach pertain

to the procedure's relative ease and its usefulness in translating simple items. However, critiques of the adoption technique focused on the straightforward reliance on translation to the exclusion of taking into account certain factors such as the linguistic flow of items, the quality of these translations, and the focus on the measures' linguistic content (van de Vijver; 2015).

Therefore, another method was proposed - the adaptation of tests or measures where the focus is not the linguistic content but the modification of existing measures to make them culturally appropriate. The important aspect in the adaptation process is not only achieving linguistic equivalence but also achieving cultural equivalence. Examples of such changes include changing the currency used in the original test to match the currency used in the target culture or modifying idioms that are difficult to translate or are not relevant to the target culture (van de Vijver; 2015). While this approach does seem to take into consideration the cultural component, it continues to be mostly etic because of the assumption that the construct the test measures is almost identical to that present in the target culture. Therefore, directly and indiscriminately adapting a measure to a new culture, runs the risk of construct of bias (among other types of biases), whereby the entire breadth of the construct in the new culture, may not really be captured by the new instrument. This is particularly true for constructs that are conceptually related to implicit meanings, symbols and traditions within a culture (e.g., values and attitudes). In other words, adoption and adaptation methods are not conducive to identifying emic or indigenous constructs (Cheung, van de Vijver, & Leong, 2011).

When the construct is suspected to be sufficiently different and culturally grounded, in the target culture, neither test development methods are appropriate. In this case, new

items should be developed through a method called *assembly*, which will be used in this study (van de Vijver; 2015). This method is emic in nature because it uses a bottom-up approach that starts from understanding the breadth of the construct in the target culture through the use of methods such as expert panels, qualitative data, and reviews of the literature, and then formulating new items that are particular to the indigenous understanding of the construct (van de Vijver, 2015). The strength of such an approach is its reliance on the cultural context, in order to develop a test which is locally and culturally grounded. Because of this focus on cultural context, the present study adopted an assembly approach to develop a scale to measure treatment barriers.

Table 1
Etic and Emic Approaches to Conceptualizing and Measuring Constructs

Method	Theoretical Approach	Method of Test Development
Adoption	Etic-universalist approach	Translation of test items; linguistic changes
Adaptation	Etic-universalist approach	Translation and modification; linguistic and minor cultural changes
Assembly	Mostly emic-relativist position	Development of new test items through reliance on cultural context.

C. Overview of Etic and Emic Barriers to Treatment Seeking

To review the content of what is meant by "treatment-seeking barriers" as broadly as possible, we conducted a review of the literature of emic (Arab) and non-Arab (etic)

studies published between 1994 and 2019 by searching for English peer-reviewed journals in databases such as PSYCINFO and PsycArticles using keywords such as “help-seeking behavior”, “stigma”, “mental health literacy”, and “service utilization”. We also conducted another review by searching in Arabic databases such as e-Ma3refa, using keywords such as "وصمة عار" and "اتجاه نحو المرض النفسي" and by examining the grey literature such as unpublished theses and articles. Furthermore, we also looked at references of key articles to broaden our search. While this review was not meant to be systematic, it was sufficiently exhaustive for identifying the treatment barriers reported in the literature.

We reviewed the abstracts of approximately 120 articles in English and 10 articles in Arabic, including systematic reviews, theoretical papers, qualitative studies, empirical studies, psychometric studies, and cross-cultural studies, that aimed to explain why adults delay or avoid seeking psychological services. Of these papers, about 92 articles were found to be most relevant (62 can be considered etic, and 30 emic to the Arab region).

Based on our analyses of these articles, we identified eight interrelated treatment barriers that are summarized in Table 2. S*tigma-related* barriers center around discrimination of the treatment seeker and include 1) treatment stigma, 2) public stigma (including associative stigma), 3) internalized stigma (Corrigan, 2004; Clement et al, 2012; Fakhr El-Islam, 2008; Zolezzi et al, 2018). The fourth barrier is *attitudinal barriers,* which subsume personal views on the utility and importance of treatment as well as attitudes towards self-disclosure. Fifth is *mental health literacy,* which emphasizes the effects that knowledge about mental illness has on approaching treatment providers (Jorm, 2000; Doumit et al, 2018). Sixth are *structural barriers,* which involve the practical issues in seeking treatment such as transportation or financial difficulties (Scull et al, 2014, Andrade

et al, 2013). Seventh is *perceived need for help*, which is the extent to which the person believes that they need professional help vis-à-vis their mental status. Finally, *mistrust in treatment providers* centers on beliefs that practitioners are not competent or will breach confidentiality.

In the following section, we comprehensively explain how each of these reviewed constructs act as barriers to treatment seeking, within non-Arab and Arab contexts and elaborate on their nomological networks.

Table 2
Barriers to Psychological Treatment-Seeking Identified in Emic and Etic Literature

Identified Treatment Barrier	Definition	Studies
Treatment Stigma	The stereotyping and discrimination associated with the help-seeking process for a mental illness	Clement et al, 2015
Internalized Stigma	The internalization of stigma against mentally ill people by those suffering from a mental illness	Corrigan, Watson, & Barr, 2016; Corrigan, 2004; Reynders, Kerkhod, Molenberghs, & Audenhove, 2013
Public Stigma	The labeling, discrimination, and social distance associated with others knowledge of a person's mental health and treatment status. It subsumes associative stigma which is the stigma experienced by the patient's family, rather than just the patients themselves.	Vally et al, 2018; Gearing et al, 2012; Gearing et al, 2015; Dardas, Bailey, & Simmons, 2016; Fakhr Al-Islam, 2008
Attitudinal Barriers	Personal views about the utility of treatment	Fischer & Farina, 1995; Fishcer & Turner, 1970; Al-Darmaki, 2003
Mental Health Literacy	Also referred to as knowledge-related barriers, this includes the ability to identify and recognize mental illness, its risk factors, and available sources for treatment	Jorm, 2000; Gorzynski et al, 2017; Ho et al, 2018
Structural Barriers	Practical barriers such as time, cost, and distance	Eisenberg et al, 2007; Clement et al, 2012; Karam et al, 2018

Perceived Need for Help	The degree to which a person believes that they need to seek formal help for their illness/problems	Codony et al, 2009; Eisenberg et al, 2007; Karam et al, 2018
Mistrust in Treatment Providers	An individual's trust in mental health care settings such as confidentiality concerns	Clement et al, 2012; Karam et al, 2018; Rayan & Fawaz, 2017

D. Stigma-Related Barriers

1. Non-Arab Conceptualizations

In the West, several reviews and studies have shown that stigma-related barriers are significantly and negatively related to a person's treatment-seeking behaviors, with small to moderate effect sizes observed in community settings and a more pronounced effect size present in university settings (Clement et al, 2015; Schomerus & Angermeyer, 2008; Corrigan, 2004; Gaddis et al, 2018). Of the extensive types of stigma that are present in the literature, Clement et al (2015)'s systematic review has identified two main stigma-related barriers that have shown a consistent negative but small relationship to mental health treatment-seeking behavior: treatment stigma and internalized stigma. Other stigma-related barriers, such as associative stigma and public stigma, are not consistently construed as treatment-barriers, at least in Western countries. For this reason, they are omitted from the below discussion.

a. Treatment stigma.

Individuals will delay or avoid seeking treatment because they have an explicit awareness of the stigmatizing attitudes and discriminatory behaviors from members of their community as a consequence of their treatment seeking- a phenomenon referred to as "treatment stigma" (Clement et al; 2015). Across cultures, an avoidance of seeking services can be seen as an avoidance of labels associated with people with mental illnesses (Corrigan 2004; Fandi & Naudé, 2019). The avoidance of anticipated prejudice or discrimination, then, regardless of whether the anticipation is rooted in reality or not, influences a person's willingness to initiate treatment seeking and avoid discrimination (Sirey et al, 2001; Reynders et al, 2013).

More specifically, those in need of treatment may avoid services because they fear that accessing mental health services may result in 1) disclosure of confidential information shared in treatment within their communities or employee healthcare program 2) the use of labels such as being crazy (Bilican, 2013), weak (Fandi & Naudé, 2019; Hugo et al, 2003), or violent (Angermeyeter & Dietrich, 2005; Seeman, Tang, Brown. & Ing, 2016), and 3) discrimination in the form of social distance and loss of job status after employers and other community members become aware of a person's mental health or treatment status, what is commonly referred to in the literature as "public stigma" (Subramaniam et al, 2017).

b. Internalized stigma.

The awareness of public stigma, its endorsement, and agreement with commonly held stigmatizing attitudes is called internalized stigma or self-stigma (Corrigan, Watson, & Barr, 2016; Reynders, Kerkhod, Molenberghs, & Audenhove, 2013). Across cultures, several studies have shown that internalized stigma negatively impacts one's attitudes and decisions towards seeking and engaging with mental health care services and ultimately affects future recovery outcomes (Fox, Smith, & Vigt, 2018; Corrigan 2004; Reynders et al, 2013; Oexle et al, 2018; Wade, 2011; Topkaya, 2014). Corrigan (2004) has hypothesized that people avoid accessing mental health services to avoid the feelings of shame and embarrassment that are intrinsic to the experience of internalized stigma. For example, higher levels of self-stigma and shame among Flemish participants, a region with high suicide rates, were negatively associated with having previously received any formal support from mental health services (Reynders et al, 2013). Among Chinese and Filipino individuals, loss of face was seen as related to stigma (Lu et al, 2014; Tuliao et al, 2016), indicating that the expression of stigma may be different cross- culturally.

In terms of the nomological network of internalized stigma and public stigma, several studies have examined their relationship to each other, and with other variables, to further understand how they prevent people from seeking treatment (Vogel et al, 2007, 2013; Fox et al, 2018; Wade et al, 2015). Among American participants, Vogel et al's (2007) study have shown how internalized stigma mediated the relationship between public stigma and avoidance of mental health services, with a full mediation between the two variables observed in another study (Wade et al, 2015). A temporal relationship was later established in a longitudinal study which found that public stigma predicted later internalized stigma scores (Vogel et al, 2013). Internalized stigma also mediated the relationship between anticipation of stigma from friends and family members and access to mental health services, indicating that internalized stigma may be a more *proximal* barrier to accessing services than other forms of stigma (Fox et al; 2018).

2. Arab Conceptualizations

As with the non-Arab literature, studies in Arab countries have shown the existence of stigma as an obstacle to mental health help-seeking behaviors (Doumit et al, 2018; Scull et al, 2013).

a. Public stigma**.**

Stigma research in the Arab region has shown that stigma operates similarly to public stigma elsewhere (Coker et al, 2005; Dardas & Simmons, 2015). The understanding of the construct in Arab societies comes mostly from qualitative studies conducted in the Arab diaspora, Jordan, Kuwait, and Egypt. A common line across these studies, is that society negatively labels people with mental illnesses as "crazy" and shames them. In turn,

this prevents those affected from actively engaging in help-seeking behaviors (Vally et al, 2018; Gearing et al, 2012; Doumit et al, 2018; Gearing et al, 2015; Dardas, Bailey, & Simmons, 2016; Dardas et al, 2017).

b. Associative stigma.

In the Arab world, the family plays an integral bidirectional role in an individual's help-seeking process, by either encouraging or prohibiting help-seeking (Abdul-Al, 2019). As such, the stigma associated with a person's mental health and treatment status have consequences on the family itself rather than just the individual. Despite the scarcity of research on this concept, Fakhr Al-Islam (2008)'s term *associative stigma* illustrates how having a mental illness is stigmatizing not just for the Arab patient but the family as well. In fact, the theoretical literature on stigma in Arab countries has shown that associative stigma acts as a culturally-specific barrier to treatment seeking that needs to be better conceptualized and explored. This is evidenced by one study where 55% of participants thought that stigma affects the families of individuals with mental illness, in addition to the person suffering from a mental illness, (Al-Adl & Balhaj, 2008).

Associative stigma is conceptually similar to the behavioral manifestation of public stigma, whereby people distance themselves from the target person. For example, studies noted that participants reported a decreased willingness to be with hypothetical people with mental illness, as the degree of assumed intimacy between them increased (Coker et al, 2005; Ayazi et al, 2014; Zolezzi et al, 2018). These findings are important to consider alongside Arab culture's general emphasis on traditional family networks, shame, and honor (Kazarian; 2005; Zeinoun et al, 2017; Harb, 2016). Those who espouse honor values fear that they may lose honor and social standing, if they are associated with a family

member that is known to be seeking help for mental illness or psychological problems. By association, seeking treatment may reflect poorly on the family and thus affect their reputation.

c. Internalized stigma**.**

Studies have also shown the existence of internalized stigma as a treatment barrier in Arab societies. However, its nomological network may be different than that of non-Arab countries. Contrary to Western research, a study among Jordanian adolescents found that participants with higher family educational levels had higher levels of internalized stigma. The authors hypothesized that these adolescents may be particularly sensitive to social structure and therefore feel that the stigma affects not just themselves but also their families and social circles (Dardas et al, 2017).

Because the different aspects of stigma are related, several studies have investigated them together in relation to treatment-seeking. Results have yielded mixed evidence across cultures. While Vally et al (2018) found that internalized stigma is a mediator between public stigma and help-seeking attitudes in a sample of female Emirati and non-Emirati residents, Soheilan and Illman's (2009) study with Arab-Americans did not find such a mediating relationship. One reason behind this discrepancy may be related to a different nomological network of internalized stigma, not captured by its initial Western conceptualization.

E. Attitudinal Barriers

1. Non-Arab Conceptualizations

Attitudes towards psychological help-seeking are a person's views towards engaging in mental health services. While there is no formal definition of attitudinal

barriers, some researchers have divided attitudes to either positive or negative (Hammer, Parent, & Spiker; 2018). Across cultures, positive attitudes towards help-seeking behavior include acceptance of the personal usefulness of psychotherapy (Fischer & Farina; 1995) whereas negative attitudes include a reluctance to disclose one's emotional problems to mental health professionals (Wrigley et al; 2007), a desire to solve mental health problems independently (Andrade et al; 2014; Negash et al, 2020), and the concealment of one's mental health or treatment status from others (Tuliao e al, 2016). Nonetheless, because the construct of positive and negative attitudes towards treatment is not well defined, researchers often measure stigma and general attitudes as one score (Fischer & Farina, 1995). This makes the process of disentangling stigma from other attitudinal barriers difficult, and limits the conclusions made about the effects of attitudes on treatment seeking.

The relationship between negative attitudes and reduced treatment seeking use has been clearly shown (Bonabi et al, 2016; ten Have et al, 2000; Motjabai et al, 2010; Andrade et al, 2014; Li, Dorstyn, & Denson, 2014; Seyfi et al, 2013). For example, in Turkey, positive attitudes towards psychological treatment seeking predicted willingness to seek help (Erkan et al 2012). Similarly, the contribution of negative attitudes in predicting reduced help-seeking behavior was greater than that of structural barriers, even in countries with different health care systems (Sareen et al 2007). However, the blurred boundaries of the construct impact the extent to which it shows consistent relationships with outcomes. For example, among Americans, Debate et al (2018) have shown that the relationship between negative attitudes towards help-seeking behaviors among male participants was weak, when controlling for stigma, while other studies have shown that negative attitudes

towards help-seeking were associated with (Rush et al, 2010) and at times predicted by internalized stigma but not public stigma in Turkey(Topkaya, 2014). Furthermore, others have found that positive attitudes indicate a willingness to disclose to family and friends but less so to mental health professionals (Cebi & Demir; 2020), suggesting that attitudes towards seeking help should take into consideration whether formal or informal sources are sought.

2. Arab Conceptualizations

Within the Arab region, attitudinal barriers seem to be centered on negative attitudes of self-disclosure. Among Lebanese participants, 70% thought that mental illness should be kept "secret" by family members (Rayan & Fawaz, 2017). Karam et al's (2018) study found that 16% of participants described hesitancy to self-disclose as a barrier towards help-seeking. However, several studies showed cross-national and gender differences across Arab nations (Al-Darmaki, 2003; Al-Krenawi et al, 2009; Al-Samadi, 1994). For example, Egyptian participants reported significantly less comfort in disclosing interpersonal and emotional concerns to a mental health practitioner, than Kuwaiti, Palestinian, and Arab Israeli participants and more female participants, across all nationalities, had positive views on self-disclosure compared to men (Al-Krenawi et al; 2009). Similarly, a study on Lebanese university students found that those least likely to disclose family issues tended to have negative attitudes towards seeking help (Hassan, 2015).

The perception of self-disclosure as risky rather than beneficial was hypothesized to be linked to the culture of honor in the Arab region. Engaging in help-seeking behaviors,

generally, and self-disclosure, specifically, may be perceived as deviance or non-adherence to cultural and familial norms that emphasize containment and secrecy (Rayan & Fawaz, 2017; Abdullah & Brown, 2011). Thus, self-disclosure might be viewed as leading to familial shame, betrayal of family values and alliances, or reflective of personal weakness (Heath, Vogel, & Darmaki, 2016; Al-Darmaki, 2003; Sayed, 2002).

F. Knowledge-Related Barriers: Mental Health Literacy

1. Non-Arab Conceptualizations

Mental health literacy is defined as the correct identification of different mental disorders, knowledge of their respective risk factors, causes, and available treatments, as well as knowledge of the different professional help currently and locally available for people suffering from a mental illness (Jorm, 2000).

Despite the straight forward definition and apparent ease of measuring this construct through knowledge-related questions, its nomological network is less clear. In fact, the extent to which mental health literacy is prohibitive or conducive to treatment seeking has been mixed across different cultures such as North America and the Western Pacific. Some studies such as Bonabi et al (2016) have found that depression literacy predicts treatment seeking, whereas other studies have found that increased mental health literacy predicts seeking informal services (such as friends and family) but not professional help-seeking (Gorzynski et al, 2017; Ho et al, 2018). Still, others did not find such a relationship at all (Perry et al, 2018).

2. Arab Conceptualizations

The conceptualization of literacy in the Arab region is similar to that of other countries and refers to the extent to which one has accurate information about mental illnesses. In Arab societies, much of the understanding of knowledge about mental illness and how it impacts treatment seeking comes from qualitative studies, which have captured indigenous/traditional understandings of mental illness. Gregg (2005), in anthropological investigations of rural areas around the Arab region, described a "folk theory of mental illness", which focuses on the attribution of a person's symptomatology to punishment from God, to "ain"/evil eye by others or to djinns who "possess" the patient as explanations behind several psychological or emotional problems (Bragazzi & Del Puente, 2012; Blom & Hoffer, 2012; Gregg, 2005; Fakhr El-Islam, 2008; Lim, Hoek, and Blom, 2015). Quantitative studies have also observed how a significant number of the Arab population, such as Omani and Kuwaiti participants, and, more recently, Qatari, non-Qatari residents, and Lebanese students, believed in spirits and possession behind mental illnesses (Al-Adawi, 20002; Al-Krenawi et al, 2005; Bener & Ghuloum, 2010; Rayan & Fawaz, 2017). This adoption of a traditional understanding rather than the biopsychosocial approach precludes the use of Western psychological services as a possible treatment. While there have been major shifts towards adopting the biopsychosocial model, the scarcity of research limits the generalizability to populations beyond the Gulf area (Al-Darmaki, Thomas, & Yaaqeib; 2016).

In contrast to the mixed evidence that relate mental health literacy to treatment seeking in non-Arab contexts, there is evidence that knowledge of mental illness predicts treatment seeking in Arab cultures, at least within existing studies. Karam et al (2018)

showed that up to 75% of a Lebanese sample did not seek treatment for their mental illness because they thought "*the problem would get better on its own*".

G. Structural Barriers: Time, Cost, Distance, and Availability

1. Non-Arab Conceptualizations

Several studies have centered on accessibility, also known as structural barriers to treatment, such as lack of time (Eisenberg et al, 2007; Clement et al, 2012; Lu et al, 2014), financial cost (Givens& Tija, 2002; Lu et al, 2014), or transportation difficulties (Lu et al, 2014). Studies have consistently found that such factors are unique predictors of mental health treatment-seeking (Andrade et al, 2014; Gulliver, Griffiths, & Christenson, 2010; Jennings et al, 2017; Fox et al, 2001; Bonabi et al, 2016). These barriers, however, differ by location so that location is more important in rural areas (Bonabi et al, 2016; Gulliver, Griffiths, & Christenson, 2010) while financial considerations are greater in countries where the mental health care system is not covered by public funding. For example, participants from the United States who do not have universal healthcare, were more likely to report financial cost as a barrier to treatment seeking compared to Canadian and Dutch participants who have free public health care (Sareen et al, 2007).

2. Arab Conceptualizations

Structural barriers in the Arab region are similar to those reported in non-Arab literature and include financial cost and transportation difficulties (Karam et al, 2018). Also consistent with the literature, the extent to which structural factors act as barriers to treatment, differs across settings. In Lebanon, for example, there is a reliance on out-of-pocket expenditures for covering psychiatric or psychotherapeutic treatment, and fewer

available resources within rural areas (Yehia, Nahas, & Saleh, 2014). About 21% of Lebanese participants declared financial cost, transportation and inconvenience as major barriers behind not seeking treatment (Karam et al, 2018). Furthermore, 65% reported not having enough time to seek counseling (Rayan & Fawaz, 2017). In contrast, no such barriers were reported in a qualitative study with Kuwaiti participants which offers its citizens free treatment under the government's health care system (Scull, Khullar, Al-Awadhi, & Ernheim, 2014).

H. Perceived Need for Help

1. Non-Arab Conceptualizations

Lack of perceived need refers to the subjective reporting of disinterest in seeing a mental health professional despite meeting diagnostic criteria for a mental disorder or reporting intrapersonal or interpersonal problems. This construct has not been as extensively researched as other barriers.

Studies which have addressed the issue, however, have found denial of symptoms as a primary or major barrier to treatment seeking (Bilican, 2013; Negash et al, 2020). Still, the relationship between perceived need and treatment seeking may not be straightforward, and other variables may moderate or mediate the relationship. First, perceived need for treatment seems to depend on the type and severity of the disorder (Codony et al, 2009; Eisenberg et al, 2007). For example, at least in North America, 60% of participants with panic disorder stated a need to seek psychological help, but only 11% of those with substance use did (Edlund et al, 2006; MacKenzie et al, 2005). Second, low perceived need

is in itself predicted by negative beliefs about treatment and subjective social norms such as stigma (van Voorhees et al, 2006).

2. Arab Conceptualizations

Among the limited studies on this topic, the construct of perceived need is similar to that of non-Arab conceptualizations, but it appears to be related to the perceived severity of one's difficulties. Karam et al (2018) found that around 13.5% of Lebanese who met diagnostic criteria did not seek help because they did not perceive the problem as severe enough to engage in help-seeking behaviors.

I. Mistrust in Treatment Providers

1. Non-Arab Conceptualizations

In the United Kingdom (UK), Clement et al's (2012) study has found that 60% of participants reported confidentiality concerns for not seeking treatment. Dissatisfaction with mental health services is another provider-related variable that has been negatively associated with mental health service use. Expressions of dissatisfaction included having had previous negative experiences with the mental health treatment system, reporting being unhappy with currently available services (Clement et al, 2012), and finding mental health practitioners to have a "bad reputation" in Pakistan (Husain, 2019).

2. Arab Conceptualizations

Only two identified studies have particularly addressed this concern (Karam et al, 2018; Rayan & Fawaz, 2017). Karam et al (2018) found that 12% reported dissatisfaction

with previously accessed services as a main reason behind not seeking treatment. Surprisingly, up to 65% of Lebanese participants in Rayan & Fawaz's (2017) study stated that they do not find mental health professionals' competence to be adequate. These findings are important to consider alongside the reality of mental health professionals in Lebanon. According to El-Khoury et al (2020), there are around 1346 mental health professionals in Lebanon, with 23 professionals for every 100,000 people in Lebanon, a low number in comparison with other countries. While there are more psychologists than psychiatrists (El-Khoury et al, 2020), these services are mostly centered in Beirut, and are either provided in hospitals, private practice, or by non-governmental organizations (NGOs). Thus, perceptions towards mental health providers must take into account the landscape of the profession in the country, as the presence and access to services may affect participants' responses on the degree to which they are satisfied or are confident in professionals.

CHAPTER III

PSYCHOMETRIC MEASURES OF TREATMENT-SEEKING BARRIERS

As aforementioned, in order to develop an indigenous psychometric measure of treatment-seeking barriers, we must not only review the conceptualizations of the construct, but also critically review available instruments that measure the construct(s). In our comprehensive search, we identified several English scales and 9 Arabic scales that measure one or more of the eight treatment-seeking barriers. With the exception of two scales, all of the Arabic scales were developed using an etic-approach, whereby they were translated from scales originally developed in English. Table 4 summarizes psychometric information about the 9 Arabic scales and their original English source, when applicable.

Table 3

Psychometric Properties of the English Scales and Their Corresponding Etic and Emic Arabic Scales

	English Etic Scales				Arabic Scales						
Construct	Etic Measure	Author (Date)	Number of Items	Subscales	Author (Date)	Sample	Method of Development	Replication of Original Factor Structure	Cronbach's Alpha of Total Scale	Subscales	Number of Items
Treatment Stigma	-	-	-	-	-	-	-	-	-	-	-
Internalized Stigma	Self Stigma of Depression Scale (SSDS)	Barney et al (2010)	16	Shame, Self-Blame, Social Inadequacy, Help-seeking Inhibition	Darraj et al (2017)	120 adolescents from KSA	Etic – (translation, backtranslation, pilot study)	Partial	0.84	Shame, Self-blame, Social inadequacy, Help-seeking inhibition	16
	Internalized Stigma of Mental Illness (ISMI)	Boyed et al (2003)	22	Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal, Stigma Resistance	Zisman-Illani et al (2013)	194 Arab parents of children with mental illness	Etic – (translation, backtranslation, minor modification of items)	Partial	0.76	Discrimination, Social withdrawal and alienation, Stereotype endorsement	12
					Kira et al (2015)	330 Arab American mental health	Etic - (translation, backtranslation, focus	No	0.94	Generalized internalized stigma, Positive (moderate) stigma	28

						patients from Lebanon, Yemen, and Iraq	groups)			resistance, Diminished self-efficacy, Tough stigma resistance, Mild stigma resistance	
	Self-Stigma of Seeking Psychological Help (SSOPH)	Vogel et al (2006)	10	-	Vally et al (2018)	114 female undergraduate psychology and education students in the UAE	Etic (translation, backtranslation, item revision)	None reported	0.81	N/A	10
Public Stigma	-	-	-	-	-	-	-	-	-		
Attitudinal Barriers	Attitudes towards Seeking Professional Psychological Help (ATSPPH)	Fischer & Turner (1970)	29	Recognition of Need for Psychological Help, Stigma Tolerance, Interpersonal Openness, and Confidence in Mental Health Professionals	Al-Krenawi et al, 2004	282 females from Jordan and UAE (Al-Krenawi et al, 2004)	Etic-Adaptation (no information reported)	None reported	0.84	None reported	30

				Al-Krenawi et al, 2009	716 Egyptians, Palestinians, and Arabs in occupied Palestine	Etic-Adaptation (translation and addition of 1 question related to prayer)	Not reported	0.85	Recognition of need for support, Threat of stigmatization as a result of treatment, Interpersonal openness, Confidence in treatment providers	30
				Al-Darmaki (2003)	350 college students from a UAE university	Etic-Adoption (translation, back-translation)	Partial	0.78	Confidence in treatment providers, Stigma tolerance, Interpersonal Openness	22
				Leach et al (2009)	420 Egyptian college students	Etic- Adoption (based on Al-Darmaki's 2003 translation)	No	0.7	4 subscales, only 1 consistent with the original ATPHS (Confidence in treatment providers) No other information reported.	29
ATSPPH-Short Form	Fischer & Farina (1995)	10	Unspecified	Leach et al (2009)	420 Egyptian college students	Etic – Adoption (no information reported)	No	0.35	N/A	10

	-	-		-	Arar, Al-Masnad & Al-Taham (2015)	70 non-mentally ill and 113 individuals with mental illness in Qatar	Emic – Assembly (item development by authors and revision by a panel of professionals)	N/A	0.84	3 subscales: Negative, Neutral, and Positive Attitudes to Psychotherapy	19
Mental Health Literacy	-	-	-	-	Al-Krenawi et al (2009)	716 Egyptians, Kuwaitis, Palestinians, and Arabs in occupied Palestine	Emic – Assembly (no other information reported)	Not reported	0.60	Belief in traditional/supernatural etiologies, Belief in the biomedical reasons	11
Structural Barriers	-	-	-	-	-	-	-	-	-	-	-
Perceived Need for Help	-	-	-	-	-	-	-	-	-	-	-
Mistrust in Providers	*Confidence in Mental Health Practitioners* subscale from the ATSPHH	Fischer & Turner (1970)	9	N/A	Al-Darmaki (2003)	350 college students from a UAE university	Etic – Adoption (translation, back-translation)	Yes	0.7	Confidence in Mental Health Practitioners	9

A. Stigma-Related Measures to Treatment Seeking

For a review of all *English* stigma-related measures since 2004, the reader is referred to Fox et al's (2017) review. In Arabic, we identified *four* scales, which can be used as measures of stigma-related barriers. Among these four sigma measures, none were developed indigenously for the Arab culture, and none were specifically made to construe stigma as a barrier to treatment-seeking. Instead, all were developed by translating or adapting Western stigma measures and were intended to measure *internalized* stigma in specific clinical populations.

1. Arabic Self-Stigma of Depression Scale *(SSDS; Darraj, Mahfouz, Al Sanosi, Badedi & Sabai, 2017).*

This is a 16-item scale that measures self-stigma among patients with depression, using four subcomponents of self-stigma on a five-point scale. Originally *assembled* in English using focus groups and content analysis (Barney, Griffiths, Christenson & Jorm, 2010) the scale was *adapted* into Classical Arabic using two independent forward and backtranslations, followed by comparison of versions and consensus, and piloting for comprehension. Then, the scale was tested on a sample of 120 adolescents in the Jazan City of Kingdom of Saudi Arabia (KSA) to produce validity and reliability evidence where the scale had good internal reliability of 0.84. Its internal structure revealed 4 obtained similar to the original scale - Shame, Self-Blame, Social Inadequacy, and Help-Seeking Inhibition. All had adequate internal reliability that ranged between 0.70 and 0.77.

However, the scale runs several limitations. The use of translation and backtranslation alone means that the scale only covers the construct as intended in the

original Western culture, and therefore the test is prone to construct bias in the target culture. In addition, using an adolescent sample with depression from a KSA city, to produce psychometric properties, may not be generalizable to adults or other Arab populations. Finally, the use of Classical Arabic may require a certain level of Arabic education to understand it, in addition to being rather difficult to understand similarly across all Arab contexts. (Banter, Rusch, & Brondino, 2008; Darraj et al, 2017; Daouk-Öyry, Zeinoun, Choueiri, & van de Vijver, 2017)

2. Arabic Internalized Stigma of Mental Illness (ISMI; Zisman et al, 2013; Kira et al, 2015).

The ISMI is a 29-item 4-point Likert scale, composed of 5 subcomponents assembled through focus groups with people with mental illness followed by content analysis (Boyd, Ritsher, Otilingam, & Granjales, 2003). Two studies have adapted the original English ISMI scale into Arabic.

Zisman-Illani et al (2013) *adapted* the original ISMI scale into Arabic through translation and backtranslation, in addition to adding, removing and modifying items to fit the context. They tested it on a population of 194 Arab parents of children with mental illness and found partial replication of the original factor structure. Instead of five components, they found three factors pertaining to Discrimination Experience, Social Withdrawal and Alienation, and Stereotype Endorsement. The latter two had poor internal reliability of 0.65 and 0.61 (Zisman-Illani et al; 2013).

The differences in the emergent factor structures may be due to sampling biases. Adapting the scale to Arab parents of children with mental illness when the original scale was tested on American participants experiencing mental illness limits the degree to which

one can compare the studies' results. The target population and culture in Zisman-Illani's (2013) study may have different characteristics and experience a different set of challenges than the original culture. As such, this may have resulted in inadequate coverage of the internalized stigma construct, leading to the scale's poor psychometric properties.

More recently, Kira et al (2015) produced another Arabic version of the ISMI by conducting translation and back-translation, two focus groups of bilingual mental health professionals and patients, and content analysis. The scale was tested on 330 Arab-American immigrants and was also found to have a different internal factor structure than the original scale. The subscales that emerged, *General Stigma, Diminished Self-efficacy, Positive Stigma Resistance, Mild Stigma Resistance, and Tough/Violent Stigma Resistance* subscales, had internal consistency measures of .96, .72, .88, .66, and .68, respectively (Kira et al, 2015).

Again, the different factor structure obtained in the Arab sample, suggests that the Arabic scale may actually be measuring something different than what it intended. For example, Kira et al's (2015) Arabic ISMI produced three new subscales pertaining to variations of Stigma Resistance - positively coping with one's mental health condition and rejecting stigma - while the original version had only one such factor, which was also poor psychometrically. It follows that the Arabic ISMI seems to be over representing stigma resistance, and under-representing internalized stigma,originally intended by the scale.

3. Arabic Self-Stigma of Seeking Psychological Help (SSOPH; Vally et al, 2018)

The Self-Stigma of Seeking Psychological Help (SSOPH) is a 10-item unidimensional scale that was assembled through developing items based on Corrigan's

(2004) definition of self-stigma. The initial 28 items were subjected to feedback from college students and counselors to assess for clarity, readability, and the items' content validity. Afterwards, the items were reduced using item-total correlations, resulting in 10 items that form a unidimensional structure (Vogel, Wade, & Haake, 2006). The final scale had excellent internal reliability of 0.91.

The scale was recently *adopted* to Arabic (Vally et al, 2018) through translation and backtranslation by two separate groups of translation students. A third student group reviewed and edited the discrepancies present across the two translations. The scale was then completed by 114 female undergraduate psychology and education students from the UAE. An internal consistency measure of .81 was obtained.

While there is no information on whether the scale has shown a similar unidimensional structure as its English counterpart, the scale has shown less positive internal consistency measures than the original scale, indicating that there may be aspects to self-stigma within the UAE population that were not addressed within the etic scale.

B. Measures of Attitudinal Barriers

There are five Arabic scales that measure attitudes towards treatment-seeking, with only one having been conceptualized and developed using indigenous methods. Of the remaining scales, two were translations and the other two were adaptations.

1.Arabic Attitudes towards Seeking Professional Psychological Help (ATSPPH; Al-Darmaki, 2003; Al-Krenawi et al, 2004; Leach et al, 2009; Al-Krenawi et al, 2009).

The original English ATSPPH is a 29-item scale developed in order to measure four aspects of attitudes associated with seeking professional help (Fischer & Turner, 1970). Al-Krenawi et al's 2004 and subsequent 2009 studies adapted the scale through translating, back-translating the items, and adding one question related to prayer, totaling 30 items. The tool was tested, across two studies, on 282 female participants from Jordan and UAE (Al-Krenawi et al, 2004) and later on 717 Egyptians, Kuwaitis, Palestinians, and Arabs living in occupied Palestine (Al-Krenawi et al, 2009). The scale had good overall internal consistency of 0.84 and 0.85 across both studies. However, Al Krenawi did not conduct any factor analysis or other methods of assessing validity, and therefore there is no way of knowing whether the scale is valid for use among an Arab population.

In contrast, Al-Darmaki (2003) and Leach et al (2009) conducted a factor analysis, but did not replicate the same factor structure present in the original ATSPPH. Al-Darmaki (2003), after *adopting* the scale through translation and back-translation and administering it to 350 UAE participants, found only 22 items and three factors instead of four - *Confidence in Mental Health Providers, Stigma Tolerance, and Interpersonal Openness.* They all had poor internal consistency that ranged between 0.57 and 0.70. Only the first subscale was consistent with the original ATSPPH developed in 1970. Leach et al (2009) administered the ATSPPH to 420 Egyptian college students using Al-Darmaki's (2003) translation, and again, with the exception of the *Confidence in Mental Health Providers* subscale, failed to replicate the same structure.

Similar to the limitations of other measures presented here, these Arabic scales did not replicate the original construct structure. They also neither used a methodology or analysis that provides other evidence of validity, nor one that unravels indigenous aspects

of the constructs, thus suggesting possible construct bias. Additionally, the Arabic scales retained some of the problems of the original English scale, whereby they failed to discriminate between attitudes and stigma, further weakening the scales' construct validity.

2. Arabic Attitudes towards Seeking Professional Psychological Help-Short Form (ATSPPH-SF; Leach et al, 2009)

This is a unidimensional 10-item 4-point Likert-type scale that was translated into Arabic from the original shortened English scale of ATSPHH (Fischer & Farina, 1995). Leach et al (2009) administered the Arabic translation of the scale to 420 Egyptian college students in order to assess whether the one-factor structure will be similar to that of the original English scale. Despite finding a similar one factor solution, the scale had an unacceptable internal consistency measure of 0.35. Therefore, it is very possible that the scale shows major item-level bias, whereby the original items did not go together as expected.

3. Attitude Scale for Psychotherapy (Arar, Al-Masnad & Al-Tahami, 2015)

This is the only indigenous scale for attitudes towards psychotherapy that we could identify. It was constructed in Arabic by the authors of the study by first reviewing the literature on attitudes towards seeking psychological help and then developing 30 items on the importance, benefits, and attitudes towards psychotherapy. These items were then reviewed by a panel of mental health professionals for clarity and content. Afterwards, the scale was completed in Qatar by 77 participants with no history of mental illness and 113 participants with a mental illness. The scale had 3 factors related to positive, neutral, and

negative attitudes towards psychotherapy. The final scale was composed of 19 items, with an overall internal consistency measure of 0.84.

While the scale seems to be a unique example in indigenous development of scales, and has a good internal consistency, it runs several limitations. First, the scale development phase remains vague on what exactly these attitudes are, especially since the scale is not available. There is, as of yet, no evidence on the subscales' internal consistency measures and no evidence of validity for the scale as a whole. Furthermore, it remains unclear whether any indigenous attitudes towards psychotherapy were found, as the authors offer no description on the items themselves.

C. Measures of Mental Health Literacy

Al-Krenawi et al (2009) indigenously constructed an 11-item Arab scale meant to measure knowledge of mental illness among Arabs. However, the authors do not report any information on how the scale was assembled, casting doubt on the extent to which this scale truly captures the construct as intended. The developed measure had an overall internal consistency measure of 0.60, and its first factor (belief in supernatural reasons behind mental illnesses) and second factor (belief in the biomedical health system) had poor internal consistency measures of 0.67 and 0.58, respectively.

D. Measures of Perceived Need, Structural barriers, and Provider-Related Barriers

There are no scale-based measures for any of these barriers, whether globally or in the Arab region. Researchers typically measure perceived need by comparing whether

participants report a need to see a mental health professional against scores on a screening tool for mental illnesses. Participants who report a lack of need despite meeting cut-off scores for any mental illness are designated as having low perceived need. In terms of structural barriers, researchers typically incorporate questions into scales that address all identified barriers to treatment seeking but rarely do they analyze such questions in isolation. As for (lack of) confidence in treatment providers, an exception is the ATSPPH which measures *Confidence in Mental Health Providers* as a subscale, with an internal consistency of 0.74 (Fischer & Turner, 1970). Interestingly, the two Arabic versions of the ATSPPH found that this is the only subscale from the original scale that replicated in the Arab samples (Al-Darmaki, 2003; Leach et al, 2009).

CHAPTER IV

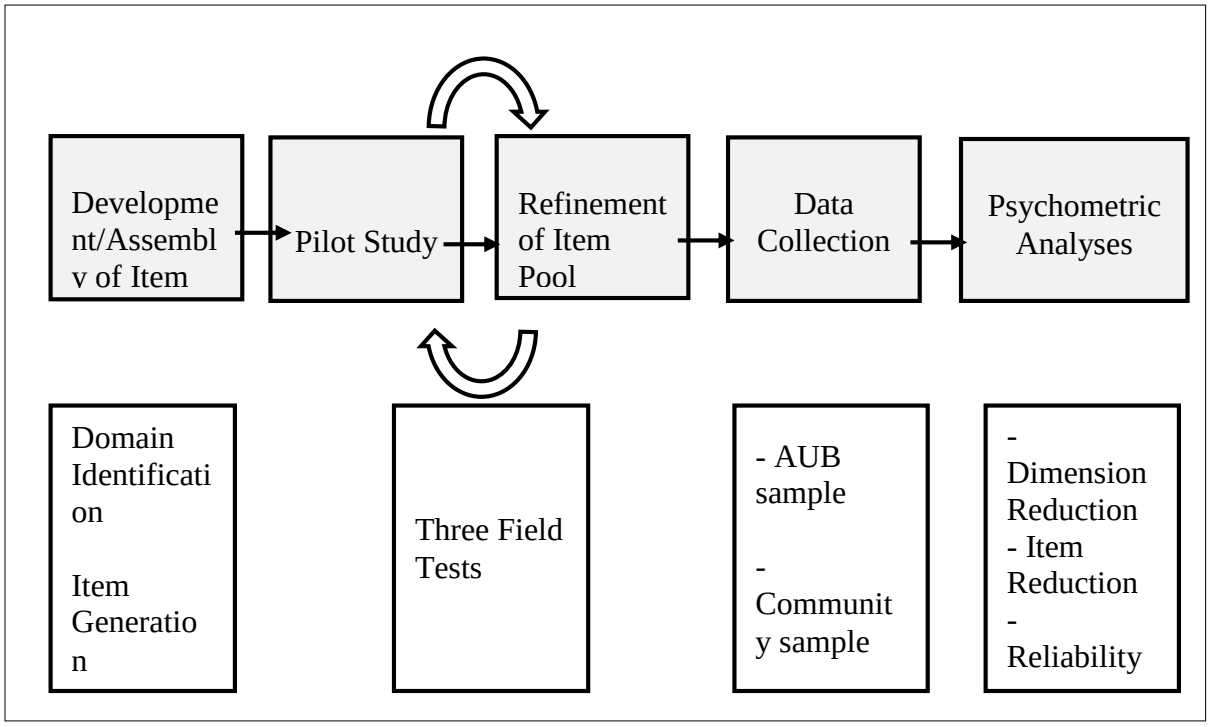
METHODS

A. Research Design

The study was composed of four stages: 1) Development/Assembly of Item Pool 2) Pilot Study and Refinement of Item Pool 3) Data Collection and 4) Psychometric analyses. The test development /assembly phase, described in details below, is the phase in which the constructs of interest (barriers to treatment seeking) were clearly defined alongside the population of interest (who the test applies to). Afterwards, the stage involved the development or assembly of the items themselves to form measure of barriers to treatment seeking. This process entailed writing the items, over several instances and revisions, in a manner congruent with the apriori defined constructs and population of interest. In other words, the items written were matched with the defined construct specifications. These items were written in accordance with not only Boateng et al's (2018) article on best practices but also the International Test Commission guidelines (ITC; 2018), and the *Standards for Educational and Psychological Testing* (American Educational Research Association et al., 2017). The second and third stages were co-dependent. Based on the feedback from participants on the pilot study, the scale instructions and items were modified. Responses from the pilot stage were not included in the final analyses but were used in order to refine the item pool. Afterwards, we analyzed the data through psychometric analyses which involved identifying the number of factors the scale is composed of, reducing the number of scale items, as well as establishing the scale's initial reliability and validity evidence.

Figure 1

Methodology Stages



1. Development/Assembly of Item Pool

This stage entailed several successive steps, organized under domain identification and item generation (ITC, 2018; Standards for Educational and Psychological Testing, 207; Boateng et al, 2018).

a. Domain Identification**.**

The aim of this stage was to accurately define what we mean by barriers to treatment seeking. To do that, we had to make several apriori decisions. Besides the already discussed barriers, we needed to strictly define what mental health treatment services the scale measures. For example, should the scale target all mental health services such as psychiatric, psychological, or social work services? Or should the scale be defined according to access to one service over another? Other decisions pertain to how to define the reasons behind participants seeking of mental health services: Since there are several barriers to treatment, would patients respond in a biased way if the term *mental disorder* was explicitly mentioned? Finally, in order to specify the population of interest, we had to decide whether participants would be of the general population or people who have previously sought treatment.

i. Psychiatric vs Psychological Services.

First, we decided that the scale will deal with barriers towards psychotherapy in specific, and not towards general mental health services that might include psychiatric services. The rationale behind this decision is three fold. First, psychiatric and psychotherapy consultations differ fundamentally as disciplines (medical versus not), in the logistics of the sessions (e.g., frequency, length, cost), and other factors. Lumping them together would erase important nuances in people's perceptions and barriers towards seeking treatment in one or the other. Second, the two services seem to predict different behaviors, therefore warranting different measures. For example, Modradveisi et al (2014) found that preference for psychotherapy in a randomized control trial predicted dropout from antidepressant treatment, but preference for antidepressants did not predict dropout from the psychotherapy condition, indicating that preferences for psychotherapy may have

better predictive value than preferences for other services. Finally, another reason for focusing on barriers towards one treatment modality is that current literature on barriers has not been clear in whether they are measuring preferences towards therapists or psychiatrists. For example, Bener & Ghuloum (2010) reported that 80% of participants would visit a psychiatrist for emotional problems, but no similar question was posed for visiting a psychologist. Therefore, no data exists on this type of help-seeking preference. Similarly, Al-Ali et al (2017) asked questions regarding seeking help from "mental health professionals", but did not define what is meant by this term. Therefore, it is unclear whether the measured help-seeking attitudes are towards psychologists or psychiatrists.

ii. Mental Disorder vs Psychological Difficulties**.**

Second, the scale would be used by anyone who is experiencing a problem that could be addressed in psychotherapy rather than only a mental disorder. The rationale was based on methodological considerations because participants, due to stigma and other factors, may not recognize any of their current difficulties as a mental illness. The term "mental illness" was avoided, as much as possible, so that participants do not feel alienated by the items' phrasings in order to prevent resistance or denial of experiencing any difficulties from acting as a confounding variable to participants' responses. In other words, the second domain was defined in an inclusive manner so that the main concern was *any* sort of problem that may prompt individuals to seek treatment (such as academic, work-related, or relationship difficulties). What mattered was participants' understanding of the issue rather than a firm diagnostic label. Therefore, the term "psychological difficulties", defined in the scale's instructions, was consistently used in all the items, in order to reflect

both a diagnosable mental illness or more general life difficulties such as relationship, academic, or work difficulties.

iii.Participants With or Without Treatment History**.**

Finally, we decided that the scale items would be relevant to anyone completing the survey -whether they have sought any type of psychological treatment in the past or not. Therefore, the items, as much as possible, did not assume that a person has a mental illness or that they have sought treatment before.

a. Item Generation**.**

The aim of this stage was to write the items of our scale. To do that, we followed a series of steps and decisions, based on the domains that we previously defined.

i. Language and Cultural Considerations

We decided that the scale will be written in both English and Arabic, using a simultaneous decentered approach, whereby items were written in both languages from scratch without the use of translation (Iliescu, 2017). A decentered approach means that test items were not translated but were formulated in a way appropriate to the target culture. This method dealt not only with the items themselves but the message they're trying to convey, thereby making sure the items were culturally appropriate in both targeted languages (Iliescu, 2017). The purpose was to retain the meaning of each item rather than maintain a literal translation, thereby minimizing linguistic nonequivalence.

Items were first written in simple, clear Arabic while avoiding words that are very formal or colloquial. Some refer to this as a "middle" language because it lies midway on the continuum between formal Modern Standard Arabic and vernacular dialects. Following

the construction and review of the items in Arabic, SJ also wrote them in English without using translation. That is, the intended meaning of the item was written in simple English.

In line with general guidelines on item construction (ITC, 2018; Boateng et al, 2018), we also avoided double-barreled items, double negatives, and idioms. For example, the literal translation of stigma in Arabic is an idiom ("mark of shame"/ "وصمة عار"). Therefore, we did not depend on literal translation so as to avoid the use of idioms. Finally, items were written in the present tense.

iii. Writing Items for the Eight Components.

Second, we wrote several items for each cluster, targeting different aspects of each cluster. These items were reviewed and edited over several meetings between the authors, from early August to late October 2019, before being field-tested. For example, we wrote 8 items for the cluster *Treatment Stigma* which targeted aspects such as distancing oneself from a person in mental health treatment and expecting to be negatively labeled or discriminated against by others, if one goes to treatment. The cluster *Social Stigma* contained 3 items, which addressed social distance due to the awareness of one's mental illness as well as treatment seeking as related to Western culture. We wrote 9 items for the cluster *Self-Stigma* which targeted aspects such as shame, associative stigma, and perceived loss of dignity. The *Mental Health Literacy* cluster was composed of 10 items which addressed objective knowledge on mental illness, medications, and treatment, as well as perceived etiology of mental illness. We wrote 6 items for the *Perceived Need* cluster which targeted participants' perception of illness levels and various treatment needs (e.g. need for psychotherapy vs medication). We wrote 14 items for *Attitudinal Barriers* which addressed attitudes of self-reliance, hesitancy to seek treatment or to self-disclose, as well

as general openness to treatment. The *Mistrust in Treatment Providers* cluster was composed of 8 items that tackled concerns about confidentiality and concerns about the treatment providers' characteristics. Finally, the *Accessibility Barriers* cluster was composed of 5 items which were about financial reasons for not seeking treatment and issues related to transportation or time.

These items underwent several revisions and changes. To illustrate the types of edits, initially, the items targeting financial barriers were written as: "*My insurance doesn't cover psychotherapy sessions*" and "*I cannot afford the fees of therapy sessions*". After revision, however, these items were changed to "I would see a psychotherapist if I could afford the fees/if my insurance covered the sessions" in order to more accurately reflect that financial reasons actively act as barriers to treatment seeking.

B. Measures

Besides our developed emic scale, the below measures were added. To screen for anxiety and depression and in order to compare participants' perceived need for help to objective levels of distress, the Patient Health Questionnaire-9 and the Generalized Anxiety Disorder-7 scales were administered. Additionally, we added etic scales of barriers to treatment seeking in order to assess for the convergent validity of our JZ scale. Further explanation into why each scale was added is found under the description of each scale.

1. Socio Demographic and Occupational Questions.

Socio-demographic information included gender, age, current family status, number of children, nationality, and country of residence. Educational, occupational, and

socioeconomic information included level of education completed, level of education completed by mother and father, number of family members living with the participant, number of bedrooms in the house, whether participants are currently students, family income per month, and job status (Appendices E & F).

2. Utilization and familiarity with mental health care services.

We asked participants whether they or any family member have ever accessed, in the past two years, a mental health service by inquiring about different professionals and treatment modalities they may have accessed and whether they have taken any psychiatric medications (Appendices E & F).

***3. Patient Health Questionnaire-9 (PHQ-9*).**

The PHQ-9 is a 9-item self-administered measure of depressive symptoms, developed based on the DSM-IV criteria for Major Depressive Disorder (Kroenke, Spitzer, & Williams, 2001). Each item is scored on a scale from 0 (*not at all*) to 3 (*nearly every day*). The scale is scored by summing the ratings into a total score that can range from 0 to 27, with higher scores indicating more severe depressive symptoms.

The scale was initially validated on a sample of 6,000 American patients, and showed excellent internal consistency and test-retest reliability (Kroenke, Spitzer, and Williams, 2001). An Arabic version of the PHQ-9 was developed and tested on 186 Lebanese adult outpatient psychiatric participants, and found to have high internal consistency $\alpha = .88$. When using cut-off scores of 10, which indicate the presence of moderate levels of depression, the scale correctly identified depressive symptoms in

patients with any mental illness with a 77% sensitivity (Sawaya, Atoui, Hamadeh, Zeinoun , & Nahas, 2016). In this study, the scale had similarly good internal consistency (α= .898), among those who completed it in full (*n* = 491).

4. Generalized Anxiety Disorder-7 (GAD-7).

The GAD-7 is a 7-item self-report scale measure designed to screen and assess for the severity of Generalized Anxiety Disorder, based on the DSM-IV criteria. Each item is scored on a scale from 0 *(not at all)* to 3 *(nearly every day)*. The scale is scored by summing all the ratings, to produce a total score ranging from 0 to 21, with higher scores indicating more anxiety symptoms.

The scale was initially validated on a sample of 2740 adult American patients where the scale showed excellent internal consistency of 0.92 and good test-retest reliability. Higher GAD-7 scores were associated with greater functional impairment, with cut-off scores of 10 being indicative of moderate anxiety levels (Spitzer, Kroenke, Williams, & Löwe, 2006).

An Arabic version of the GAD-7 was developed and tested on 186 Lebanese adult outpatient psychiatric participants, and found to have high internal consistency (α = .95) (Sawaya, Atoui, Hamadeh, Zeinoun, & Nahas, 2016). It has a sensitivity of detecting 57% of those with true anxiety (cut-off = 10) among outpatient psychiatric samples in Lebanon (Sawaya et al, 2016). In this study (*n* = 487) the scale had excellent internal consistency (α = .928).

5. Stigma Scale for Receiving Psychological Help (SSRPH).

Because of a need to assess whether public stigma as conceptualized in etic methods of development is sufficiently capable of capture the experience of public stigma in our sample, we added the Stigma Scale for Receiving Psychological Help, the only measure of public stigma that we could identify. The Stigma Scale for Seeking Psychological Help (SSRPH) is a 5-item unidimensional scale that measures perceived public stigma towards seeking psychological help, on a scale ranging from 0 (*strongly disagree)* to 3 *(strongly agree).* An example item is: "*People will see a person in a less favorable way if they come to know that he/she has seen a psychologist*." (Komiya, Good, & Sherrod, 2000). The scale is scored by summing ratings across items, with higher scores indicating greater levels of perception of stigma associated with seeking psychological help.

The original English scale (Komiya, Good, & Sherrod, 2000) and a recently translated Greek version (Efstathiou, Kouvaraki, Ploubidis, & Kalantzi-Azizi, 2019) have both shown adequate internal consistency measures ranging between 0.69 to 0.72. Because there was no available version of the scale in Arabic and we needed a measure of public stigma to assess the convergent validity of our JZ scale, the co-investigator (SJ) used guided translation to translate the five items. Guided translation is the process in which items are translated into the targeted language while keeping in mind each item's intent (Iliescu et al, 2017). In other words, the translation to Arabic is guided by the item's message and content and not literal translation. In line with this method, all items were reviewed by a native speaker of Arabic with a psychology background and extensive experience in translating psychological scales. This approach does not require any blinded procedures or independent translators because it relies on understanding the content to translate the items. The review process resulted in

minor grammatical and linguistic edits (Appendices M & N). The items were also subjected to feedback from participants in the pilot study to further assess for clarity and understandability.

In the current study, among participants who completed this scale (n=427), it had adequate internal consistency (α = .717).

6. Self-Stigma of Seeking Psychological Help (SSOSPH).

In order to measure internalized stigma, the Self-Stigma of Seeking Psychological Help was included. The scale was chosen, because unlike other scales, it does not contain any assumptions on participants' access to services.

The SSOSPH is a 10 item scale that measures the experience of internalized stigma or self-stigma, on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The scale has a unidimensional factor structure, and is scored by summing the scores on all items. Higher scores indicate a perception that seeking psychological treatment would negatively impact one's self-regard and self-esteem (i.e., greater internalized stigma). An example item is "*I would feel inadequate if I went to a psychotherapist for psychological help*".

The scale was initially developed and validated on a sample of 583 American college students, and has showed moderate to excellent internal consistency and test retest reliability measures of 0.91 and 0.72, respectively (Vogel et al, 2006). The scale has been translated to Arabic and tested on a sample of 114 female college students from the United Arab Emirates (UAE), where it showed good internal consistency measure of 0.81 (Vally et al, 2018)

Similarly, when used in this study, the Arabic SSOPH, provided by Vally et al (2018) showed adequate internal consistency (α = .788), among those who completed it in full (n = 424).

7. Attitudes Towards Seeking Professional Psychological Help (ATSPPH).

In order to assess for attitudinal barriers as conceptualized in etic methods of development, the Attitudes towards Seeking Professional Psychological Help scale was added because it is the most commonly used measure of attitudinal barriers.

The ATSPPH scale is a 29-item scale that measures a person's attitudes towards help-seeking behavior, on a 4-point Likert scale ranging from 0 *(strongly disagree)* to 3 *(strongly agree).* It is composed of 4 factors: 1) *Recognition of need for psychological help,* 2) *Stigma tolerance,* 3) *Interpersonal openness, and* 4) *Confidence in mental health practitioners*. A total score ranging between 0 and 87 is computed by summing items which are positively stated (i.e., indicating favorable views towards psychological help-seeking). Of the 29 items, 18 were reverse coded. An example item in the Interpersonal Openness factor is: "*There are experiences in my life I would not discuss with anyone*".

The scale was originally developed and validated in 1970 on a sample of 960 American high school and college students, showing adequate to good internal consistency (α = 0.83) for the total scales, and the four subscales (α = 0.64 to 0.74) (Fischer & Turner; 1970).The scale has been translated to Arabic in several studies, and used on Egyptian, Palestinian and Emirati samples. It showed internal consistencies ranging from 0.7 (Leach et al, 2009) to 0.85(Al Krenawi et al 2009) to 0.78 (Al-Darmaki, 2003).

While Al-Darmaki's translation of the ATSPPH did not have the highest internal consistency compared to other translated versions, it had significant information on the scale's reliability and validity evidence, which were useful for comparison with our newly constructed scale. Al-Darmaki (2003)'s Arabic adaptation resulted in 22 rather than 29 items, with 3 factors instead of 4. These are: 1) *Confidence in treatment providers* 2) *Stigma tolerance* and 3) *Interpersonal Openness.*

We used the Arabic translation provided by Al-Darmaki (2003), on a Likert scale ranging from 0*(strongly disagree)* to 4*(strongly agree).* The English and Arabic scales had the same number of items. For our study (n = 446), Cronbach's alpha was .666 for *Confidence in Mental Health Providers,* .809 for *Stigma Tolerance,* and .738 for *Interpersonal Openness*. The *Total* scale had good internal reliability (α = .876), which is higher than that found in other Arabic speaking samples (Al-Darmaki, 2003; Al-Krenawi et al, 2004, 2009; Leach et al, 2009).

8. Marlowe-Crowne Social Desirability Scale - Short Form (MCSDS - SF).

Because concepts such as stigma and attitudinal barriers may be influenced by social desirability bias, the brief MCSDS was included. It is a 13-item measure that assesses social desirability bias, using a Yes or No response format (Crowne & Marlowe, 1960; Reynolds, 1982). Examples of such items include: "*There have been occasions when I took advantage of someone*" and "*I never resent being asked to return a favor*", with the assumption that people who endorse such items are denying behaviors that are undesirable yet quite common, and thus attempting to "fake good". The scale is scored by summing the

number of socially desirable items endorsed, with higher scores indicating more social desirability tendencies (Appendices G & H).

The reliabilities of the scale's short form have been adequate across samples, ranging between 0.74 (Zook & Sipps, 1985) to 0.76 (Reynolds, 1982). Its Arabic translation, however, has shown minimally adequate reliability ($\alpha = 0.64$) in Iraqi and other Arab samples (Alqudah, 2013; Daouk-Oyry, Zeinoun, Sahakian, Van De Vijver, in progress). In this study, among participants who completed the scale ($n = 438$) Cronbach's alpha was again barely adequate, at $\alpha = .666$. Table 6 summarizes all the tools, and how they were mapped unto the constructs of interest.

Table 4

Etic and Emic Measures of Barriers to Psychological Treatment Seeking

Construct of Interest	Etic Measure	Author	Date	Emic Measure
1. Treatment Stigma	-	-	-	8 items
2. Public Stigma	Stigma Scale for Receiving Psychological Help (SSRPH)	Komiya et al	2000	3 items
3. Internalized Stigma	Self-Stigma of Seeking Psychological Help	Vogel et al	2006	10 items
4. Mental Health Literacy	-	-	-	12 items
5. Perceived	-	-	-	GAD/PHQ

	Need for Help				score vis-à-vis reported need/ 6 items
6.	Attitudinal Barriers	Attitudes towards Seeking Professional Psychological Help (ATSPPH)	Fischer & Turner	1970	14 items
7.	Confidence in Mental Health Providers	*Confidence in Mental Health Practitioners* subscale from the Attitudes Towards Seeking Professional Psychological Help	Fischer & Turner	1970	8 items
8.	Structural Barriers	-	-	-	5 items

C. Procedures

We placed all instruments online on LimeSurvey. Participants could access the survey online, provide informed consent (Appendices A & B), and choose to complete the survey in either English or Arabic. No incentives were provided for participation. The study (including the pilot) obtained approval by the AUB Institutional Review Board.

D. Sampling

We calculated the sample size for the main study based on the requirements of the main statistical analyses planned. To conduct exploratory factor analysis for a new scale, approximately ten participants are needed per item (Tabachnick & Fidell, 2007). The scale's initial item pool included 66 items. Therefore, we needed the final sample size to be at least 660 participants. Our inclusion criteria were: being above 18 years old, residing in

any Arab country, and having Internet access to complete the survey. In order to achieve this, we approached the entire AUB student community and a large community population.

Student participants were approached by sending an invitation script email (Appendices S) to the entire AUB student body, to 5000 emails, with reminders once a week for three weeks (Appendix S). Following IRB approval, the email invitation was approved by the Dean of Student Affairs. Afterwards, the emails were acquired by the LimeSurvey IT team and anonymously sent by the co-investigator (SJ) to the student body. This technique enabled 181 students in total to click on the survey link.

To recruit community participants, we created a page on Facebook called "Psychological Treatment Seeking on Lebanon", where we posted advertisements for the survey in English and Arabic (Appendices T & U). The advertisements were boosted over 3 weeks. The targeted demographics were Lebanese nationals above 18 years old. We also used snow-ball sampling, where we shared the advertisement on various social media pages and told acquaintances to share it. These methods resulted in 972 participants from the community sample accessing the survey link.

E. Participants

Using the above recruitment methods, from late January to early March 2020 (before the outbreak of COVID-19 in Lebanon and the further devaluation of the Lebanese lira), we obtained a sample of *N*=1,153. After removing cases with missing data, the sample was reduced to *N*=535 (103 AUB students and 432 community participants).

F. Statistical Analyses

Data was analyzed using SPSS v25. For data obtained from the pilot study, we examined means and standard deviations of items, and reviewed qualitative comments. For the analysis of the main sample, we first conducted missing value analysis, and data cleaning. Second, we ran summary statistics on the sample's demographic, occupational, and socioeconomic characteristics as well as the sample's access to mental health services. Third, to examine for any demographic differences between the AUB and the community sample, and between those that completed the survey in English or Arabic, we conducted independent T-test and chi-square analyses on demographic variables and access to mental health services. Fourth, we ran summary statistics and reliability analyses on our etic measures related to barriers (ATSPPH, SSRPH, SSOSH), the mental health scales that were used as proxy for perceived need (PHQ-9, GAD-7), and the social desirability scale MCSDS.

For our main analysis, we conducted rotated and unrotated Principal Components Analysis (PCA) on the developed scale to examine its factor structure and to choose the one that best fit the data. In order to reduce the number of items in the scale, we conducted item-total correlations to remove those with low correlations. To further reduce items, we correlated the MCSDS total score with the scale items to remove items in which participants responded to in socially desirable ways. Internal reliability for the resulting factors was established through Cronbach's alpha for 1) the entire sample 2) residents of Lebanon and 3) those who completed the survey in English and 4) those who completed the survey in Arabic.

Preliminary evidence for convergent validity was established through bivariate correlations between the scores of the emic factors, and the scores of the etic scales (SSOSH, SSRPH, ATSPPH total score, and *Confidence in Mental Health Providers* subscale of the ATSPPH).

CHAPTER V

RESULTS

A. Pilot Study

Because pilot studies are an integral phase in test-development, it is discussed in detail. The purpose of the pilot study was to assess for an overall impression of the survey (such as item clarity and participant pattern responses), pose direct questions related to items from our developed scale, and solicit comments on the clarity of the Arabic translation of the Self-Stigma for Receiving Psychological Help (SSRPH).

1. Sampling

Using snowball sampling, author SJ approached potential participants using the inclusion criteria that they are above 18 years old, residing in Lebanon (in order to be accessible for focus groups), and with online access to the study. All participants gave informed consent. Participants (n = 40) consisted of 23 women and 17 men, with an average age of 36.61 (SD = 15.06). With the exception of 4 participants who were Syrian, all participants were Lebanese nationals.

18 participants took the survey in English and 22 in Arabic.

2. Procedure

The pilot study consisted of three consecutive field tests of the test, using focus groups of 3-5 participants led by SJ. All participants took the survey in their language of choice and were asked open-ended and closed-ended questions.

In the first field-test, participants were asked open-ended questions about their overall impression of the survey (e.g*., So, what do you think of this questionnaire? What comments/thoughts do you have about the items and instructions?),* and closed-ended questions on whether it was long or short, and whether they felt engaged enough to complete the survey or not. Participants were also asked whether the Arabic items of the Stigma Scale for Receiving Psychological Help (SSRPH) were clear and understandable**.** Then, specific questions about the new scale (items and instructions) were posed in the form of cognitive interviewing (Peterson, Peterson, & Powell; 2017). For example, participants were orally asked whether they understood the difference between a psychotherapist and a psychiatrist, and whether they felt any of the questions assumed participants have psychological difficulties. All participant comments were documented verbatim by SJ, discussed with author PZ, and relevant changes were made to items and instructions. This process was repeated twice (second and third field-test), until participants had no further comments to make.

3. Analysis and Results

Based on participants' responses, we edited items and instructions in the respective English and Arabic items. Appendix V lists original items, comments, and edited items that were eventually used in the study. In addition to these qualitative results, we also conducted summary statistics for item means and standard deviations. None of the items had a consistent mean across field tests, above 4.5 or below 0.5, or a standard deviation below 0.3. It is worth noting that due to the small number of people in each focus group, summary

statistics are not reliable across the field tests. Results of the pilot study were not included in the main analysis.

B. Results

1. Missing Value Analysis

Because our analysis involved a newly constructed scale, it was important that all data-points of the new scale were complete. Therefore, we removed all cases that had any missing data on the newly constructed scale. This reduced the sample size from N=1,153 to N=535.

Next, we examined the proportion of missing data for each of the remaining scales. If a participant had *more* than 20% of the ratings missing on a given scale, then we removed the participant's responses on that scale from further analysis. If *less* than 20% of the values were missing on a scale, we imputed the missing values. By using the cut-off of less than 20% missing values, we found 3, 9, 10, and 26 empty cells, across the PHQ-9, GAD-7, SSOSH, and ATSPPH, respectively. We did not impute any values from the SSRPH, a 5-item scale, as any empty cell would have exceeded our 20% cut-off.

To impute missing values, we ensured that data was missing completely at random (MCAR). Little's MCAR test was not significant for the PHQ-9: $\chi 2(N=492)= 16.114$, p= .884, the GAD-7: $\chi 2(N= 487)=37.408$, p=.110, the ATSPPH: $\chi 2(N=450)=246.255$, p=.705, and the SSOSH: $\chi 2(N=429)=38.786$, p=.991. Missing values were imputed using Expectation-Maximization (Tabachnick & Fidel, 2013).

2. Participants' Demographic Characteristics

The total sample (N=535), consisted of both AUB students (n = 103) and participants from the community (n = 432) with the majority being female (67%), and single (61.5%). Participants had a mean age of 31.7 (*SD*=12.30) and most of the participants (91.6%) were residents of Lebanon, with 88% of the entire sample having a Lebanese nationality. The remaining demographic characteristics are presented in Table 7.

Several significant differences emerged between the AUB and the community samples. For example, there were significant differences with regards to age $t(533)= -6.9$, $p<0.01$, where participants in the AUB sample were significantly younger (M=24.46, SD=5.613) than participants in the community sample (M= 33.43, SD=12.82). The differences across age were large d= 0.89. Chi-square analyses also revealed differences across marital status ($X^2(N=535)= 36.20$, $p<.01$), whereby the AUB sample were more likely than the community sample to be single.

We also found differences between those who chose to complete the survey in English versus those who completed it in Arabic. Participants who completed the survey in English *(*N=279) were significantly younger (M=25.90, SD=7.490) compared to the 256 participants who completed the survey in Arabic (M=38.03, SD=13.361), $d=1.11$. The age differences across the two samples were large. Chi-squared analyses also revealed differences along marital status (X^2 ($N=533)$=118.063, $p<0.01$), whereby those who completed the survey in English were more likely to single. There were also significant differences in nationality X^2 ($N=522)$=12.930, $p=0.02$ and residence status X^2 ($N=525)$=13.613, $p=0.01$. Those who completed the survey in Arabic were more likely to be a resident in an Arab country whereas survey users in English were more likely to be

residents in a non-Arab country. Finally, those who completed the survey in Arabic were more likely to be non-Lebanese Arab nationals compared to those who completed the survey in English who were more likely to be non-Arab nationals.

Table 5
Demographic Characteristics

Variable	N	%	Range	Mean	SD
Gender					
Female	358	67%	-	-	-
Male	176	33%			
Age	-	-	18-69	31.70	12.30
Current marital status					
Single	328	61.5%	-	-	-
Married	179	33.6%	-	-	-
Divorced/Separated	13	2.4%	-	-	-
Widowed	3	0.6%	-	-	-
In a domestic partnership	10	1.9%	-	-	-
Number of Children	-	-	0-7	0.87	1.29
Nationality					
Lebanese	463	88.7%			
Non-Lebanese Arab	40	7.7%	-	-	-
Non-Arab	19	3.6%	-	-	-
			-	-	-
Residency					
Lebanese	480	91.4%	-	-	-
Non-Lebanese Arab	20	3.8%	-	-	-
Non-Arab resident[d]	25	4.8%	-	-	-

Note. a Other Arab nationalities include (in alphabetical order): Algeria, Egypt, Iraq, Jordan, Kingdom of Saudi Arabia (KSA), Morocco, Palestine, Qatar, and Syria. *b* Non-Arab nationalities include: Armenia, Aruba, Australia, Brazil, Canada, France, Ghana, Lesotho, Nigeria, Turkmenistan, United Kingdom (UK), United States of America (USA), and Venezuela. *c* Non-Lebanese Arab residents include: Algeria, Egypt, Iraq, Jordan, Kingdom of Saudi Arabia (KSA) Kuwait, Oman, Palestine, Syria, and United Arab Emirates (UAE). *d* Non-Arab residents include: Angola, Australia, Belgium, Canada, France, Mozambique, Netherlands, Poland, Sweden, Switzerland, United Kingdom (UK), United States of America (USA), and Venezuela.

3. Participants' Educational, Occupational and Socioeconomic Characteristics

As listed in Table 8, the majority of the sample had a least a Bachelor's degree (70%), with 52% currently in university. About 33% reported that their mother and father had at least a Bachelor's degree. In terms of occupation, half of the participants were either employees in the private sector or were students.

In terms of socioeconomic status (SES), participants' family income was diverse, with around 31% of family income reported to be above $3,000 per month. It is notable that 11.7% preferred not to disclose their family income. Additionally, participants lived with an average of 3.6 people in the home including themselves (*SD = 0.07)* and 40% of them lived in a house with two bedrooms or less ($M = 2.76$, $SD = 0.4$).

There were some significant differences between AUB students and the community sample. The AUB sample reported higher levels of completed education (X^2 (N=534)=17.603, p=.007), and family income per month (X^2 (N=532)=24.387, p=.001) than the community sample.

There were also differences between those who completed the survey in English versus Arabic. Those that completed the scale in English had higher levels of completed education (X^2 (*N=534)*=53.039, p<0.01), and current reported family income (X^2 (*N=532)*=110.887, p<0.01), than those who chose Arabic.

Table 6
Educational, Occupational, and Socioeconomic Characteristics

Variable	N	%
Level of education completed		
Less than Grade 12/Baccalaureate II	18	3.4%

Variable	N	%
Grade 12/Baccalaureate II	72	13.5%
Vocational degree/Skills-based training	20	3.7%
Some college, no degree	64	12%
Bachelor's degree	211	39.5%
Master's degree	132	24.7%
Doctorate	17	3.2%
Mother's educational level		
Less than Grade 12/Baccalaureate II	188	35.6%
Grade 12/Baccalaureate II	94	17.8%
Vocational degree/Skills-based training	38	7.2%
Some college, no degree	59	11.2%
Bachelor's degree	107	20.3%
Master's degree	30	5.7%
Doctorate	12	2.3%
Father's educational level		
Less than Grade 12/Baccalaureate II	191	36.2%
Grade 12/Baccalaureate II	80	15.2%
Vocational degree/Skills-based training	51	9.7%
Some college, no degree	34	6.4%
Bachelor's degree	101	19.1%
Master's degree	41	7.8%
Doctorate	30	5.7%
Currently a Student		
Yes	270	52.7%
Freshman	5	1.9%
Sophomore	25	9.4%
Junior	42	15.8%
Senior	63	23.8%
Graduate level	130	49.1%
No	242	47.3%
Number of Family Members		
Living alone	71	14.1%
≤ 5 family members	375	74.3%
> 5 family members	59	11.7%
Number of bedrooms		
≤ 2 bedrooms	209	40%
> 2 bedrooms	313	60%

Variable	N	%
Family income, per month		
Less than $499	29	5.5%
$500 to $999	70	13.2%
$1,000 to $1,999	112	21.1%
$2,000 to $2,999	87	16.4%
$3,000 to $3.999	50	9.4%
$4.000 to $4,999	35	6.6%
Over $5,000	87	16.4%
Preferred not to answer	62	11.7%
Job Status[a]		
Public Sector	49	7.2%
Private Sector	140	20.6%
NGO Employee	44	6.5%
Business Owner/Freelancer	63	9.3%
Unemployed	72	10.6%
House Caretaker	28	4.1%
Retired	13	1.9%
Student	270	39.8%
Number of Job Statuses Endorsed		
1 Job category endorsed	487	91.5%
2 Job categories endorsed	45	8.5%

Note. a These are not exclusive categories as participants could endorse more than one category.

4. Participants' Access to Mental Health Services.

Table 9 contains a description of participants' familiarity and utilization of various mental health services. Out of the 525 participants who responded to the following sets of questions, almost 37% of participants (n= 194) had sought services from either a medical doctor, a non-medical professional, or had consulted both. Conversely, 63% of participants did not consult anyone. Of participants who sought a medical professional only, 44.2% (n=23) consulted a psychiatrist. Among those who consulted a non-medical professional only, an equal number of participants consulted a university/school counselor (n=29) and a clinical psychologist (n=29),

In terms of treatment, 17% of participants reported taking psychotropic medication during the past two years, with almost half of them obtaining a prescription by a psychiatrist (52.2%). Interestingly, 10% of participants did not have a prescription for the psychiatric medications they were taking.

Across the AUB and community samples, there were no significant differences in the samples' reported access to medical professionals, X^2 (*N=527)*=.675, *p=.411,* or non-medical mental health professionals: X^2(*N=530)*=3.179, *p*=.075. There were also no significant differences on whether participants take psychiatric medication or not, across the AUB and community samples X^2 (*N*=528) = .178, *p*=.673.

However, there were significant differences between those completed the survey in either English or Arabic. Participants who completed the survey in English were more likely to have sought a medical professional (X^2 (*N=527)*=8.892, *p*=0.003) or a non-medical professional (X^2 (*N=530)*= 9.821, *p=.002) c*ompared to those who completed the survey in Arabic.

Table 7
Access to and Familiarity with Mental Health Services

Variable	N	%	Range	Mean	Standard Deviation
Consultation with Medical Professional Only	53	10.1%	-	-	-
Family Doctor	18	34.6%	-	-	-
Neurologist	4	7.7%	-	-	-
Psychiatrist	23	44.2%	-	-	-
Other	7	13.5%	-	-	-
Consultation with Non-Medical Professional Only	73	13.90%	-	-	-
University or School	29	39.7%	-	-	-

Counselor					
Clinical Psychologist	29	39.7%	-	-	-
Life Coach	3	4.1	-	-	-
Alternative Professional	6	8.2	-	-	-
Other	6	8.2	-	-	-
Consultation with Both Medical and Non-Medical Professional	68	12.95%	-	-	-
No Consultations	331	63.05%	-	-	-
Number of Visits to Medical Professional	-	-	0-48	5.88	8.42
Number of Visits to Non-Medical Professional	-	-	1-50	11.41	15.20
Taking Psychiatric Medications					
Yes	90	17%	-	-	-
No	438	83%	-	-	-
Prescription for Medication by					
Family Doctor	16	17.8%	-	-	-
Neurologist	14	15.6%	-	-	-
Psychiatrist	47	52.2%	-	-	-
No Prescription	9	10.0%	-	-	-
Other[a]	4	4.4%	-	-	-
Medications in Past 2 Years					
SSRIs[b]	37	28.68%	-	-	-
SNRIs[c]	10	7.75%	-	-	-
MAOIs[d]	0	0%	-	-	-
TCAs[e]	5	3.94%	-	-	-
Atypical Antidepressants[f]	7	5.51%	-	-	-
Anxiolytics[g]	19	14.96%	-	-	-
Mood stabilizers[h]	7	5.52%	-	-	-
Antipsychotics[i]	27	21.26%	-	-	-
Other[j]	15	11.81%			
Family Members' Access to Mental Health Professional					

Non-Psychiatrist Medical Doctor	36	6.1%	-	-	-
Psychiatrist	70	11.9%	-	-	-
Psychologist	98	16.7%	-	-	-
Life Coach	11	1.9%	-	-	-
Alternative Professional	18	3.1%	-	-	-
None	264	45.1%	-	-	-
Not Sure	89	15.2%	-	-	-

Note. a Other includes medical doctors such as hematologist and cardiologist. *b* SSRIs include: Escitalopram, Citalopram, Luvoxamine, Fluoxetine, Paroxetine, Sertraline. *c* SNRIs include: Duloxetine, Venlafaxine. *d* MAOIs include: Phenelzine. *e* TCAs include: Amitriptyline, Clomipramine, and Imipramine. *f* Atypical Antidepressants include: Agomelatine, Bupropion, Mirtazapine, and Vortioxetine. *g* Anxiolytics include: Bromazepam, Chlordiazepoxide, Clonazepam, Diazepam, Eszopiclone, Flupentixol-melitracen, Lorazepam, and Oxazepam. *h* Mood stabilizers include: Carbamazepine, Lamotrigine, Lithium, and Valproic Acid. *i* Antipsychotics include: Chlorpromazine, Clozapine, Haloperidol, Olanzapine, Paliperidone, Quetiapine, and Ziprasidone. *j* Other includes medications that cannot be classified into any of the above categories. *k* Alternative professional refers to priests, sheikhs, and alternative healers. *l* Other refers to friends.

5. Summary Statistics of Measures

Social desirability was high, with about 8/13 socially desirable items endorsed on average (*SD*= 2.68), indicating that many participants endorsed items that were "fake good". In terms of mental health, about 34% and 35% of participants scored above the cutoff of 10 for depression (PHQ-10) and anxiety (GAD-7) respectively, indicating that slightly more than one third of participants screened positive for depression and anxiety. In terms of scores on the etic scales related to barriers, there was a lot of variability across participants' answers. Participants had low scores on the measure of public stigma but relatively higher scores on the measure of self-stigma. Interestingly, participants showed positive attitudes towards seeking professional help.

Table 8
Summary Statistics of Measures

Scale	Subscale	Mean	SD	Range	Score Interpretation	Alpha
Marlowe Crowne Social Desirability Scale (MCSDS)	-	7.85	2.68	0-13	High score indicates socially desirability.	.665
Patient Healthy Questionnaire-9 (PHQ-9)	-	8.93	6.71	0-27	Cut-off of 10 indicates moderate depression	.899
Generalized Anxiety Disorder-7 (GAD-7)	-	9.04	6.65	0-21	Cut-off of 10 indicates moderate anxiety	.928
Stigma Scale for Receiving Psychological Help (SSRPH)	-	5.51	2.54	0-15	Higher score indicates more public stigma.	.718
Self-stigma of Seeking Help (SSOSH)	-	18.46	5.05	0-50	Higher score indicates more internalized stigma.	.808
Attitudes towards Seeking Professional Psychological Help (ATSPPH)		60.012	11.51	0- 88	Higher score indicates more positive attitudes to treatment seeking.	.885
	Confidence in Mental Health Providers	24.52	4.43		-	.702
	Stigma Tolerance	25.68	5.47		-	.811

	Interpersonal Openness	9.78	3.42	-	.738

6. Emic Measure: The JZ Scale

i. **Determining Number of Factors to Extract**

As a first step, we examined the means and standard deviations of all items. No items had extreme values, and therefore no item was removed at this step. Next, to estimate the number of possible factors that best fit the data, we applied unrotated Principal Component Analysis (PCA) on the 66 items and examined the scree plot and the number of residual correlations.

The scree plot revealed 16 factors with an eigen value above 1. However, there was a significant drop in eigenvalues after the 5^{th} factor, suggesting that about 5 factors are a good fit for the data. Next, we examined the residual correlations as an additional estimation of the number of factors to extract. According to Fidel and Tabachnick (2012), more factors should be extracted when a "good proportion" of the residual correlations remains greater than 0.05 (absolute value). When we extracted 3 factors, 36% of residuals are greater than 0.05, which means that more than 3 factors should be extracted in order to reduce the number of residual correlations. When 4 and 5 factors were extracted, there were 32% and 27% of residual correlations, respectively, greater than 0.05 again suggesting that they could possibly still be reduced. When 5, 6, 7 and 8 factors were extracted, there was a 2 percent decrease in the residual correlations, at each level of extraction (ie, there were 25%, 23%, and 21% of residuals, respectively, above 0.05). This suggested that the residual

correlations could not be reduced any further, and that the appropriate number of factors to extract was likely between 5 and 8, inclusive.

ii. Determining Rotations

To choose between orthogonal rotation where factors do not correlate with each other, and oblique rotations where factors are allowed to correlate, we considered both conceptual and psychometric criteria. Conceptually, barriers to treatment seeking are related to each other to the extent that they were difficult to differentiate in the literature (e.g., stigma versus attitudes towards treatment). Psychometrically, we examined correlations between factors and found that several factors were above .32, suggesting that the factors are correlated enough to warrant oblique rotations (Tabashnick & Fidell, 2013). Therefore, we examined the solutions of 5, 6, 7, and 8- principal component solutions, with oblimin rotation, to find the most meaningful solution.

The 8-factor and the 7-factor solutions contained factors that were too heterogenous and undefined, combining items from several conceptual clusters without an identifiable unified theme. Therefore, these two factor solutions did not seem meaningful. Next, we examined the 5-factor and 6-factor solutions and found that they are very similar, but with one main difference. In the five-factor solution, the emergent factors were I) *Attitudes towards Psychotherapy* II) *Positive Attitudes and Ambivalence,* III) *Perceived Stigma,* IV) *Mental Health Literacy,* and V) *Attitudes to Psychiatric Services.* The 6-factor solution yielded similar factors, except that factor II (*Positive Attitudes and Ambivalence)* split into two separate and more meaningful factors – *Perceived Accessibility Barriers* and *Perceived Need for Help.* Because these two factors seemed theoretically distinct from each other, the

6-factor solution, described below in more details, was seen as conceptually and psychometrically superior. These 6 factors accounted for 42.03% of the total variance.

7. The 6-Factor Solution

The authors reviewed and discussed the items that were loading on the same factor to uncover the underlying themes. Some items were double loading (i.e., they loaded on two factors simultaneously). In instances such as these, we examined the item conceptually and decided under what factor they are best considered to be under. Based on these reflections, we identified the 6 factors as being: I) *Attitudes towards Psychotherapy,* II) *Perceived Accessibility Barriers,* III) *Perceived Stigma,* IV) *Mental Health Literacy,* V) *Attitudes to Psychiatric Services,* and VI) *Perceived Need for Help.*

i. Attitudes towards Psychotherapy**.**

The factor described attitudes such as not being open to discussing problems with psychotherapists, attitudes of self-sufficiency and believing in the ineffectiveness of therapy versus more positive attitudes such as being able to commit to therapy and willingness to visit a psychotherapist if the need arises. Most of the items present in this factor were from the *Attitudinal Barriers* cluster, so we named the factor *Attitudes towards Psychotherapy.*

ii. Perceived Accessibility Barriers.

The second factor described barriers such as issues with transportation, financial reasons, and not being encouraged by others to seek therapy. It clearly reflected perceived practical barriers that prevent people from seeking psychotherapy. The entire *Accessibility Barriers* cluster loaded onto this factor so it was named *Perceived Accessibility Barriers*.

iii. Perceived Stigma

The third factor comprised entirely of items that depict treatment stigma and internalized stigma. Items reflecting treatment stigma included worries over one's career and relationships being negatively affected due to one's treatment status. Items reflecting internalized stigma included worries that one's family reputation will be affected or ruined as well as feeling embarrassed or crazy over seeking therapy. Therefore, this factor was named *Perceived Stigma*.

iv. Mental Health Literacy.

The fourth factor was comprised of items that reflect basic knowledge about mental health and illness. This includes items that inquire over the definition of bipolar disorder and schizophrenia, the definitions of psychiatrist vs psychotherapist, as well as a general inquiry into whether treatments exist for mental disorders. Because the items reflect general knowledge about psychological difficulties such as definition, treatment, and treatment providers, this factor was named *Mental Health Literacy.*

v. Attitudes Towards Psychiatric Services.

This factor described attitudes towards psychiatric medications in specific, and psychiatric services in general. It described attitudes such as preferring to give children medication, having a personal preference for medications, and visiting a psychiatrist first if psychological difficulties arise versus less favorable attitudes such as believing that medications are addictive. Therefore, this factor was named *Attitudes toward Psychiatric Services.*

vi. Perceived Need for Help**.**

This factor captures the degree to which participants believe they need help from either a psychotherapist or a psychiatrist, regardless of their actual mental health. It includes statements that assess a person's need for seeking services or not, as well as a subjective evaluation of whether they have any psychological difficulties or not. This factor mostly combined items from the *Perceived Need for Help* cluster; therefore, we named this factor *Perceived Need for Help*.

8. Item Reduction

Having established that the data best fit into a 6-factor solution, we wanted to further reduce the items, so that the scale would be more user-friendly in future studies.

First, we removed 5 items that did not adequately load on any of the 6-factors obtained (i.e., had loadings below 0.3). Afterwards, a total score was computed for each factor, and each item was correlated with the total factor score (item-subtotal correlations). Items that correlated above .40 with the subscale score were retained, whereas those items which correlated below .40 were removed as they do not adequately represent the factor being measured. While some authors recommend using a cut-off of .30 (Boateng et al, 2018), we decided to use a higher cut-off in order to be able to remove more items, as few correlations were found below .30. Using this method, 3 items were removed, resulting in 58 remaining items.

As a final measure of item reduction, we examined whether any of the items were excessively associated with social desirability, as measured by the MCSDS. Previous research had found that social desirability bias may play a role in participants' reporting of

barriers to treatment seeking (Henderson, Evans-Lacko, Flach, & Thornicroft, 2012). The total MCSDS score was positively correlated with only some of the scale items, and no correlations were above .240. Therefore, no items were removed using this method. Table 10 contains the final scale solution, with loadings for each factor, presented in decreasing order.

Table 9
Six-Factor Solution

Item Code	Item	Attitudes towards Psychotherapy	Perceived Accessibility	Perceived Stigma	Mental Health Literacy	Attitudes towards Psychiatric Services	Perceived Need for Help
AT5	I don't see a psychotherapist because I don't like to talk about my feelings.	0.736					
AT6	I don't like to talk about family matters to a stranger such as a psychotherapist.	0.724					
MIS2	If I need help, I don't believe that a psychotherapist will be able to help me.	0.703					
AT3	I prefer not to see a psychotherapist so that I don't open up on issues that I prefer to forget.	0.700					
AT4	I feel afraid to see a psychotherapist.	0.694					
SS7	My dignity prevents me from seeing a psychotherapist.	0.608					

AT12	Seeing a psychotherapist would not be effective for my psychological difficulties.	0.570
AT2	Seeing a psychotherapist means I am not strong enough to solve things myself.	0.510
AT10	I don't encourage others to see a psychotherapist	0.476
AT1	A person has to solve their own psychological difficulties, without the help of a psychotherapist.	0.450
AT11	I believe that yoga and exercise are better than seeing a psychotherapist.	0.411
MHL7	Psychological difficulties solve themselves.	0.392
MIS7	I don't trust the ability of the psychotherapists around me.	0.340
MIS8	I don't trust that the psychotherapist will keep my informational confidential.	0.327
MIS6	I believe that many psychotherapists are genuinely good people.	-0.305
PN4	If I had psychological difficulties, I would visit a	-0.424

	psychotherapist first.				
AT14	I can commit to weekly therapy sessions with a psychotherapist.	-0.404			
AT7	I would feel relieved to talk to a psychotherapist about my psychological difficulties.	-0.603			
ACC3	I would see a psychotherapist, if it was nearby.		0.758		
ACC5	I would see a psychotherapist, if I had time.		0.713		
ACC2	I would see a psychotherapist, if my insurance covered the sessions.		0.641		
ACC1	I would see a psychotherapist, if I could afford the fees.		0.634		
AT13	I would see a psychotherapist, if there was someone to encourage me.		0.474		
SS2	If I see a psychotherapist, I would feel humiliated in front of others.			0.729	
TS4	If I see a psychotherapist, people I know will look at my positively (e.g. I am			0.445	

	responsible and mature)	
TS8	I don’t have a problem if some of my friends, relatives, or co-workers know I see a psychotherapist.	0.411
SS10	If I see a psychotherapist, I would like to keep it private.	0.408
SS9	If I see a psychotherapist, I would feel like a weak person.	0.384
SS6	If I see a psychotherapist, I will stop respecting myself.	-0.436
SS1	If I see a psychotherapist, I would feel embarrassed	-0.478
SS8	If I see a psychotherapist, I would feel crazy	-0.449
TS5	If I see a psychotherapist, I worry that my career will be negatively affected.	-0.609
TS6	If I see a psychotherapist, I worry that my relationships will be negatively affected.	-0.613
TS2	If I see a psychotherapist, people will say I’m not normal.	-0.645
TS7	If I see a psychotherapist, some of my friends, relatives, or co-workers might distance themselves	-0.691

	from me.		
TS3	If I see a psychotherapist, I worry what my family will say about me.	-0.695	
SS5	If I see a psychotherapist, people will stop respecting me.	-0.821	
SS3	If I see a psychotherapist, my family would feel humiliated.	-0.821	
SS4	If I see a psychotherapist, my family's reputation will be affected.	-0.825	
MIS3	There are no treatments for psychological difficulties.		0.416
SoS1	It's not part of our culture to see a psychotherapist.		-0.306
MHL5	Schizophrenia and bipolar disorder are biological, heritable disorders		-0.507
MHL9	A psychotherapist helps people with mental disorders, through weekly sessions, that aim to understand their feelings and how to better handle them.		-0.528
MHL8	A psychiatrist is a medical doctor who treats mental disorders by prescribing and managing medication.		-0.571

MHL11	Bipolar disorder is marked by periods of high energy (mania) and periods of low energy (depression)	-0.637	
MHL12	A person who hears voices or sees images of things that don't exist may be diagnosed with schizophrenia.	-0.677	
MIS4	I prefer to take medications for psychological difficulties.		0.635
PN3	If I had psychological difficulties, I would visit a psychiatrist first.		0.633
MHL2	Giving medication to children is acceptable, if they have psychological difficulties.		0.446
TS1	If I meet someone new who is seeing a psychotherapist, I prefer not to get close to them.		0.390
MHL1	Medications for psychological difficulties are addictive.		-0.370
AT9	I don't encourage others to see a psychiatrist.		-0.446
MIS1	If I need help, I don't believe that a psychiatrist will be able to help me.		-0.506

PN5	I don’t think my current psychological difficulties are severe enough for me to see a psychotherapist.	0.772
PN6	I would not visit a psychotherapist because I don’t have any psychological difficulties.	0.725
PN1	I have not thought about seeing a psychotherapist before now.	0.502
AT8	I thought about starting therapy a lot, but I either postponed or changed my mind.	-0.515
PN2	I feel a great need to see a psychotherapist.	-0.785

9. Scoring

We calculated total scores by summing (and reverse-coding when appropriate), scores for each factor so that higher scores indicate more barriers. We reverse- scored 4 items from the first factor, 5 items from factor 2, 3 items from factor 3, 6 items from factor 4, 3 items from factor 5, and 2 items from factor 6. Total scores for each scale indicate the presence of *more* barriers to treatment seeking (i.e., negative attitudes towards psychotherapy and psychiatric services, more accessibility barriers, higher stigma, lack of mental health literacy, and lack of perceived need for help).

10. Reliability

We calculated internal reliability for each of the factors, using the full sample. As noted in Table 12, Factor 1, *Attitudes towards Psychotherapy,* was composed of 18 items and had a good reliability of .889. Factor 2, *Perceived Accessibility Barriers,* composed of 5 items and had adequate reliability of .791. Factor 3, *Perceived Social Stigma,* contained 16 items and had excellent reliability of .902. The *Mental Health Literacy* factor, the fourth factor, was composed of 7 items, and had barely adequate reliability of .668. Factor 5, *Attitudes towards Psychiatric Services,* had weak reliability of .614 and was composed of 7 items. The final factor, *Perceived Need for Help,* had adequate reliability of .751.

The reliability analyses were then repeated across three subsamples - participants who were residents of Lebanon (*n*=480), participants who completed the survey in English (*n=279),* and participants who completed the survey in Arabic (*n=256).*

Table 10
Reliability Coefficients for the Different Subsamples

	I Attitudes towards Psychotherapy	II Perceived Accessibility Barriers	III Perceived Stigma	IV Mental Health Literacy	V Attitudes towards Psychiatric Services	VI Perceived Need for Help
Total Sample (*N*=535)	.889	.791	.902	.668	.618	.751
Residents of Lebanon (*n*=480)	.890	.788	.903	.666	.613	.744
Survey Users in English (*n*=279)	.868	.810	.898	.687	.616	.722
Survey Users in Arabic (*n*=256)	.913	.742	.911	.633	.565	.777

11. Convergent Validity

Evidence of convergent validity was established through bivariate correlations with the total scores of the available stigma-related and attitude-related etic scales: SSOSH, SSRPH, and ATSPPH, as well as the *Confidence in Mental Health Providers* subscale of

the ATSPPH. The below table contains the bivariate correlations for the etic instruments with the subscales from the JZ emic scale.

Most of our factors, with the exception of two, showed small and non-significant correlations with all the etic scales. In contrast, Factor I *Attitudes Towards Psychotherapy,* was negatively and strongly correlated with the ATSPPH total score (r = -.810, p <0.05) and Confidence in Mental Health Providers subscale (r= -.629, p<0.05). This is expected because high scores on Factor 1 indicate negative attitudes towards psychotherapy, whereas the opposite is true in ATSPPH scale. Factor I *Attitudes Towards Psychotherapy* was also positively and strongly correlated with the Self-Stigma scale (r=.699, p<0.05). Factor II, the *Perceived Stigma* subscale, was weakly correlated with the SSRPH, a measure of social stigma, (r= .340 , p<0.01), moderately correlated with SSOSH, a measure of internalized stigma (r=.530, p<0.01), and moderately correlated with the ATSPPH total score (r=-.568, p<0.01) and the Confidence in Mental Health Providers subscale.(r=-.455, p<0.01). Finally, Factor V, the *Attitudes towards Psychiatric Services* subscale, was positively but weakly correlated with the ATPSPPH (r=.296, p<0.01).

Table 11
Correlations of the SSOSH, SSRPH, ATSSPH, and ATSPPH-Confidence with the JZ Subscales

	1	2	3	4	5	6	7	8	9	10
1. I Attitudes towards Psychotherapy	1									
2. II Perceived Accessibility	.201**									
3. III Perceived Stigma	.549**	.030								
4. IV Mental Health Literacy	.334**	.235**	.163**							
5. V Attitudes towards *Psychiatric Services*	-.204**	.080	-.145**	0.055						
6. VI Perceived Need for Help	.230**	.443**	.093**	.240**	.115**					

7. Attitudes towards Seeking Professional Psychological Help- Confidence in Mental Health Providers	-.629*	-.100**	-.455**	-.327**	.343**	-.218**			
8.Attitudes towards Seeking Professional Psychological Help-Total	-.810*	-.125**	-.568**	-.358**	.296**	.255**	.840**		
9. Stigma Scale for Receiving Psychological Help-Total	.269*	-.010	.340**	0.095	-.093*	.037	-.346**	-.480**	
10. Self-Stigma of Seeking Help-Total	.699*	.170**	.530**	.266**	-.056	.184**	-.543**	-.688**	.445**

** Correlation is significant at the 0.01 level *Correlation is significant at the 0.05 level

CHAPTER VI

DISCUSSION

The main aim of the study was to develop a scale to measure barriers to psychological treatment seeking in Lebanon. Given that delays to treatment seeking can range between 6 to 28 years for different mental disorders in the Lebanese adult population (Karam et al, 2008), significant barriers to treatment seeking must exist within the community at large. These barriers are particularly important to understand, especially since the current situation in Lebanon (COVID-19, economic situation, and the repercussions of the August 4 explosion) might increase people's psychological need to access mental health resources. Our study found that barriers to treatment seeking can be conceptualized along six dimensions or factors. These are attitudes to psychotherapy and psychiatric services, perceived accessibility barriers, perceived stigma, mental health literacy and perceived need for help. This is the first study, to our knowledge, which comprehensively addresses the barriers, discussed in Arab and non-Arab conceptualizations, within the Arab world and Lebanon specifically and constructs a scale that measures these barriers.

A. Attitudes Towards Psychotherapy and Psychiatric Services.

Consistent with previous literature, our study showed that attitudinal barriers are indeed present in our sample (Bonabi et al, 2016; Al-Darmaki, 2003; Al-Krenawi et al, 2009). However, and unlike what could have been known using previous scales, these attitudes depended on whether the treatment modality was psychotherapy or psychiatric

consultation. That is, because previous scales lumped both services into "mental health services", they produced an artificial construct and score that measured general mental health services. However, in our study, by producing different items for psychotherapy and psychiatric services, we were able to discover this nuance and show clearly the presence of two attitudinal subscales rather than one. Future studies on treatment barriers on help-seeking attitudes and behaviors should consider measuring attitudes towards psychotherapy apart from attitudes towards psychiatric services, at least in Lebanon.

While some researchers found it challenging to disentangle attitudes from stigma (Debate et al, 2018; Rush et al, 2010; Fischer & Turner, 1970), our study was able to conceptually and psychometrically discriminate between attitudes and stigma. The emergence of separate scales for these two constructs in our study indicates that they may indeed be different, and deserve separate attention. However, when present measures such as the ATSPPH conflate stigma and general attitudes into one scale and score, the effect of each construct on treatment seeking is erased. One example from the ATSPPH is: *"Having been mentally ill carries with it a burden of shame"*. Though present as an attitudinal item in general, with one of the highest factor loadings on the ATSPPH, the item's actually also taps on the emotional component of internalized stigma. This is an example of how stigma and attitudes were merged together in the ATSPPH, unlike in our scale. It seems, then, that this measure did not adequately define its construct of interest and so was unable to discriminate between them. In contrast, we had operationally predefined our constructs of interest based on specified categories in the literature and so we were able to unravel the minute differences between attitudes and stigma, through the presence of two distinct attitudinal and one stigma subscale.

Our *Attitudes to Psychotherapy* subscale consistently had good to excellent internal consistency (ranging between .868 to .913). The scale also had good convergent validity, through having a large correlation with the ATSPPH scale, indicating that the attitudes towards psychotherapy were properly conceptualized. At the level of the items themselves, the subscale illustrated that attitudinal barriers may be multi-faceted and combine different attitudes towards psychotherapy. These include hesitancy to self-disclose not just one's personal feelings but also family matters, a desire to solve problems independently, a general mistrust in psychotherapists or weariness with the utility of psychotherapy, as well as one's preference to either commit to therapy or resort to alternative self-help forms. The convergence of these items unto one subscale is important to highlight because, to our knowledge, these attitudes, up until now, have not been reflected in and have not previously loaded unto a single factor before.

Furthermore, the emergence of the *Attitudes to Psychiatric Services* subscale came as a surprise, especially considering the scales' focus on psychological services, and the subscales' containing of various items across different clusters. For instance, items on medications under the mental health literacy cluster, as well as items pertaining to trust in psychiatrists, in specific, seemed to convene together under one factor. What this reveals about participants' responses to these items is particularly enlightening, highlighting that even items on medications, which were intended as objective measures of knowledge, were perceived by participants as reflective of a general attitude towards psychiatric services. The subscale also correlated moderately with our etic subscales, further illustrating that the subscale may be measuring a unique component of barriers to treatment seeking. One reason behind this conclusion is that the subscale's focus on medication is not inherent in

the etic scales. For example, while the ATSPPH does mention "psychiatric help", items on medication are not explicitly mentioned or captured. Therefore, our scale may provide a unique contribution into an emic understanding of attitudes towards psychiatric services. In other words, the moderate correlation may emphasize that the subscale is measuring a construct not described in the etic scales.

B. Perceived Accessibility Barriers

A new finding in the literature, which to our knowledge is neither present in Arab nor non-Arab measures, is the emergence of perceived accessibility barriers as a factor on its own. The importance of these findings is the confirmation of the presence of systemic factors that may prevent people from seeking treatment (Karam et al, 2018), despite the emphasis on individual barriers within the literature (Sareen et al, 2007). While the subscale may express participants' *perception* of these accessibility barriers, these barriers mirror the reality present in Lebanon. In fact, psychotherapy sessions in Lebanon are not covered by public institutions nor most private insurance companies (Yehia, Nahas, & Salah, 2016); thus, most patients in psychotherapy rely on out-of-pocket financing, which, given the duration and cost of treatment, may be financially burdensome for many. Another important aspect of this subscale is the item "*I would see a psychotherapist if there was someone to encourage me".* While it may seem counterintuitive at first, the item further highlights the non-individual factors which play a role in the decision-making process of seeking psychological treatment, as it emphasizes how the person's direct surroundings or ecology are part of the systemic environment, playing a non-negligible role in getting people to treatment.

Another interesting perspective to the role of accessibility barriers in seeking treatment can be gleamed from participants' behaviors in accessing these services. Across the AUB and community samples, there were no significant differences in participants' access to medical or nonmedical mental health services. This is of particular importance because the samples differ in the services made available to them. Whereas AUB offers its students and faculty members free counseling, with up to 8 sessions covered by the university's insurance program at the medical center, the community sample presumably does have not such availability of services. However, despite these differences in availability, the reported behaviors of seeking help from mental health professionals were still the same. The absence of any discrepancy, then, may indicate that personal-level barriers such as attitudes and stigma, may play a much more important role than structural barriers of accessibility (e.g., treatment cost) in driving people towards treatment.

C. Perceived Stigma

In contrast to the etic scales on stigma (SSRPH and SSOPH) which had only adequate measures of internal consistency, the JZ subscale, *Perceived Stigma*, has shown good to excellent internal consistency. This indicates that our subscale captured the experience of perceived stigma within Lebanese populations better than the etic scales have. One reason behind this conclusion is the presence of high factor loadings for items which were written based on the emic literature. In fact, the highest factor loadings on the stigma subscale pertained to items related to notions of *family* humiliation and embarrassment if one seeks treatment. These ideas were theoretically framed by Fakhr Al-Islam (2008) who coined the term "associative stigma". The emphasis in these items was not just on individual feelings of shame and embarrassment but the repercussions of one's

mental illness and treatment status onto the family as well. These ideas were repeatedly identified in the emic literature as important stigma-related barriers to treatment. For example, Youssef & Deane (2006)'s qualitative study showed that family dishonor is one feared repercussion of seeking treatment. Our scale, then, illustrated quantitatively that associative stigma is not only present in Arab, particularly Lebanese, societies, but also highlighted that they may be even more relevant than other aspects of stigma. The robust presence of these items in the scale may partially explain why previous attempts at adopting or adapting stigma scales to Arabic resulted in partial replications and relatively low measures of reliability (Vally et al, 2018; Kira et al, 2015; Zisman-Illani et al, 2013). As such, another contribution of the scale is its illustration of how emic concepts enhanced the psychometric properties of the subscale and resulted in a measure of perceived stigma which comprehensively captured the different types of stigma involved in treatment seeking.

The subscale's focus on the role of the family then emphasizes the presence of a culture of honor which exists in Lebanese culture, and which was explicitly presented in Youssef & Deane's (2006) study, even among the diaspora. Participants may avoid seeking treatment because they are afraid of how their mental illness may reflect on their family members, who in turn, might see their access to services as reflecting lower social standing. As such, the concept of associative stigma and its link to a culture of honor are both indigenous ways of being in the Lebanese society. Their unraveling in the subscale, explicitly and implicitly, then, provide an added understanding into how the local values affects one's perceptions and fears towards accessing care.

D. Mental Health Literacy

While the etic literature seemed to be inconsistent with how mental health literacy predicts treatment seeking (Bonabi et al, 2016; Gorzynski et al, 2017; Ho et al, 2018; Perry et al, 2018), the emergence of this subscale indicates that within the Lebanese population, at least, mental health literacy does have a considerable role to play. However, our subscale has shown only adequate measures of internal consistency across the different subsamples, which may be attributed to the item development phase. The first reason behind the relatively low internal consistency measures may be the difficulty of the items. That is, we may have overestimated the levels of mental health literacy present in our sample. For example, in the pilot study, when presented with the item "*Schizophrenia and bipolar disorder are biological, heritable disorders*", some participants were unfamiliar with the terms *bipolar disorder* and *schizophrenia*. As such, they were unable to answer whether these disorders are heritable or not, because they were unfamiliar with the terminology. Indeed, across the three different pilot versions, this item had a mean level ranging between 3.36 to 2.00, with participants mostly responding with either "unsure" or "disagree". This is also true of other statements regarding mental health literacy such as "*Psychological difficulties solve themselves*". This leads us to conclude that participant's mental health literacy levels may be poorer than we had anticipated. Therefore, we subsequently added two items, which we presumed are easier, and which targeted the definitions of *bipolar disorder* and *schizophrenia* separately. However, even with these changes, the internal reliability of the subscale were only adequate. This may mean that the items were of varying levels of difficulty, and did not correlate sufficiently to produce a better internal consistency. Another related reason behind the only adequate measures of internal

consistency may be due to the items not being homogenous with each other. For example, the items focused on knowledge about schizophrenia and bipolar disorder, and knowledge about the profession of psychotherapy and psychiatry. These domains of knowledge may not have been sufficiently associated to produce one unified mental health literacy component. However, given the absence of systematic research on mental health literacy in Lebanon, the subscale still provides a good blueprint for future studies by highlighting that understanding the community's knowledge in identifying mental disorders and treatment providers is highly needed.

E. Perceived Need for Help

Given that low perceived need for treatment was identified as the greatest barrier to seeking treatment in Lebanon (Karam et al, 2018) and across cultures (Andrade et al, 2013; Codony et al, 2009; Bonabi et al, 2016), it is not surprising that *perceived need for help* emerged as a factor on its own. Our results in this regard are similar to the etic framework, where, for example, Bonabi et al (2016) have shown that perceived need *independently* predicted service use, irrespective of mental health literacy, stigma, and positive attitudes to help-seeking. Future analyses could focus on subsamples the screened positively on the GAD-9 and PHQ-7, to better understand whether individuals with actual symptoms, differ in their conceptualization of barriers than the general sample.

F. Strengths and Limitations

One of the key strengths of this study is the use of both English and Arabic, which allowed us to sample as many participants from the community as possible, thereby

reflecting the diversity present within the community. The use of "middle Arabic" to write our items is particularly important as the items were accessible and understood by participants who completed the scale in Arabic, irrespective of dialect and educational background. Another strength is the comprehensiveness of the scale, which took into consideration all the barriers that have been identified in both the emic and the etic literature. As such, the scale may be said to include barriers which are important to the Lebanese community, specifically. These included items pertaining to associative stigma and the role of the family as well as the effect of honor on preventing participants from seeking treatment. It also highlighted the role of accessibility barriers and perceived need for help on seeking psychological services. With regards to stigma, the *Perceived Stigma* subscale may be the first measure which has psychometrically included items which measured treatment stigma in an Arab study.

On the other hand, there are a number of limitations to this study. At the item level of our scale, a small number of items assumed that participants had psychological difficulties, which may have affected participants' responses. One such item is: "*Seeing a psychotherapist would not be effective for my psychological difficulties*." However, some of these assumptions were necessary in order to look at participants' level of perceived need for help. These items will need to be revised for future studies. In addition, we could not assess the convergent validity of our *Mental Health Literacy* subscale as we did not include an etic measure in the survey. Furthermore, three of our six subscales had only adequate reliabilities, indicating that some of the items could have been improved upon to make them more items homogenous with each other. These are specifically related to *Attitudes to Psychiatric Services, Perceived Need for Help,* and *Mental Health Literacy* subscale.

Finally, a number of events have taken place since data collection was completed, all of which can be seen as stressors in the community: COVID-19, the devaluation of the Lebanese lira, and the August 4 explosion. As such, participants' rates of anxiety or depression in the current study may underestimate the rates of anxiety currently present in the community. Therefore, these measures should be interpreted bearing in mind the context of the study.

G. Future Directions

As the scale is currently composed of 58 items, a recommendation for future research is to make the scale more user-friendly by making it shorter. In addition, more evidence of reliability and validity needs to be established for the scale. Specifically, test-retest reliability needs to be addressed before using the scale to measure changes across help-seeking attitudes and behaviors in intervention studies. Further evidence of validity also needs to be established by looking at whether the scale can discriminate between people who have already accessed mental health services and those who haven't (i.e., known-groups evidence of validity). Another opportunity would include looking at whether the scale also discriminates between people who were experiencing distress, as indicated by having high scores on either the PHQ-9 or the GAD-7. In other words, based on participants' PHQ-9 and GAD-7 scores, researchers could compare between participants who have sought or not sought treatment, thereby establishing further evidence of validity for the scale. Other possibilities also include looking at the differential attitudes to psychotherapy and psychiatric services within the community, to assess people's attitudes.

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APPENDIX A: ENGLISH INFORMED CONSENT

American University of Beirut

P.O. Box 11-0236; Riad El Solh, 1107 2020; Beirut, Lebanon

CONSENT TO SERVE AS A PARTICIPANT IN A RESEARCH PROJECT

Research Project: Developing an Emic Etic Scale on Barriers to Psychological Treatment Seeking

Principal Investigator: Pia Zeinoun, Ph.D., LCPC.
Assistant Professor of Psychology, Department of Psychology,
pz05@aub.edu.lb
01-350000 Ext. 4360

Student Investigator: Salam Jabbour, M.A Candidate
Graduate student in Clinical Psychology, Department of Psychology
smj19@mail.aub.edu

Nature and Purpose of the Project:

Several barriers to mental health treatment seeking have been identified. These include barriers such as stigma, knowledge about mental illness, individuals' perceived need for treatment, and practical barriers such as the financial cost of treatment. However, few of the studies have systematically tackled these barriers in the Arab world. The aim of this study is to construct a scale that comprehensively identifies barriers to psychological help-seeking behaviors in Arab countries.

Explanation of Procedures:

The recruitment strategy approved by IRB is to approach participants online. There are approximately 800 participants who will be recruited in this study, aged above 18, and residing in any Arab country.

To participate, first, you must read this consent form and consider if you would like to participate in this study. If you provide informed consent to participate in this study, you will then be asked to fill a 25-minute survey that asks questions about your demographics, your mental health, and potential reasons behind not seeking previous treatment.

Your participation in this study is **completely voluntary**. You are **not** required to answer questions that you prefer not to answer. Also, you may withdraw your consent to participate, and exit the survey at any point without any explanation and without any penalty. The principal investigator and research investigator might disregard your answers

if the results show that you have not abided by the instructions given to you or if you do not fit within the participant characteristics that are relevant to this study, without **any penalties.**

Your name will **not be asked**. The results of your participation are completely **anonymous, and confidential**. Only the research investigators (Dr. Zeinoun and Ms. Jabbour) have access to the anonymous data. Any data reported in future publications will be in aggregate format and not particular to any individuals.

Your participation incurs **no costs and there are no monetary incentives**. There are **no risks.** Whether you participate or not, will not impact your relationship with AUB now or in the future. There are also **no direct benefits** associated with participation in this study. However, the potential benefit is that you will participate in a study that will enhance our understanding of barriers to psychological help-seeking behaviors in the Arab world.

If you have any questions about your rights as a research participant, or to report a research related injury, you may call: **Institutional Review Board (IRB) at the American University of Beirut 01-350000 Ext. 5445**

If you have any other concerns or questions, you may contact the principal investigator Dr. Pia Zeinoun on pz05@aub.edu.lb

By clicking "I agree" or "Next" you agree to participate in this research project.

APPENDIX B: ARABIC INFORMED CONSENT

دراسة عن العلاج للصحة النفسية في العالم العربي

البحث: بناء قياس للعوامل التي تعيق طلب المساعدة للصحة النفسية

الباحث الرئيسي: الدكتورة بيا زينون
أستاذة مساعدة في الجامعة الأمريكية في بيروت، قسم علم النفس
pz05@aub.edu.lb
961-1350000+ الرقم الداخلي 4360

المساعد الباحث: الآنسة سلام جبور
طالبة ماجستر في قسم علم النفس في الجامعة الأمريكية في بيروت
smj19@mail.aub.edu

يهدف هذا البحث إلى تطوير فهمنا العلمي للعوامل التي تعيق طلب العلاج والمساعدة للصحة النفسية في العالم العربي، ومن ثم بناء اختبار لقياس هذه العوامل. هناك العديد من الدراسات المماثلة، لكن لم يتم أي منها في بلد عربي لاستكشاف هذه العوامل بطريقة شاملة.
لقد تم اختياركم أثناء جهودنا في البحث عن مشاركين في الدراسة عبر الانترنت، بعد الموافقة من لجنة المراجعات في الجامعة الأميريكية في بيروت. سيتضمن هذا البحث مشاركين فوق ال 18سنة ، و مقيمين في أي دولة عربية.
نوّد أن نأخذ بضع دقائق من وقتكم لنشرح لك سبب دعوتنا لكم للمشاركة في هذا البحث وما سيحصل بالمعلومات الّتي ستزودننا بها.

يتكوّن الإستبيان من أسئلة حول معلومات ديموغرافية، الصحة النفسية، والعوامل التي قد منعتكم من طلب المساعدة سابقاً. سيستغرق الاستبيان حوالي ٢٥ دقيقة من وقتكم

مشاركتكم في هذه الّدراسة اختيارّية وطوعية.
يمكنكم رفض المشاركة أو التوقف عنها في أي لحظة من غير محاسبة أو خسائر. كما يمكنكم عدم الإجابة عن الأسئلة التي لا ترغبون بالإجابة عنها. لا توجد أي تأثيرات سلبية أو تعويضات مالية. إنما قد تتجاهل الباحثة الرئيسية ومساعدة الباحث إجاباتكم إذا ظهرت النتائج أنكم لم تلتزمون بالتعليمات المقدمة أو إذا لم تتناسب مع خصائص المشاركة ذات الصلة بهذه الدراسة، دون أي عواقب.
لن يُطلب منكم إعطاء أي معلومات عن هويتكم، ولا يمكن التعرف عليكم من خلال أجوبتكم. إن علاقتكم الحالية أو المستقبلية مع الجامعة الأمريكية في بيروت لن تتأثر بقراركم بالمشاركة أو عدم المشاركة.

في حال كنت تريد أي معلومات أو توضيحات إضافية، يمكنكم التواصل مع الدكتورة بيا زينون والآنسة سلام جبور من خلال البريدين الإلكترونيين pz05@aub.edu.lb و smj19@mail.aub.edu. في حال وجود ملاحظات حول أخلاقيات الدراسة، يمكنكم التواصل مع لجنة المراجعات في الجامعة الأميريكية في بيروت على البريد الإلكتروني irb@aub.edu.lb أو من خلال الهاتف على 961 1 350000 (رقم داخلي: ٥٤٤٥).

الدكتورة بيا زينون
أستاذة مساعدة، الجامعة الأميريكية في بيروت، لبنان

التوقيع أو (الضغط على *"التالي"*) يؤكد أنكم فوق ال ١٨ سنة ، مقيمون في أي دولة عربية ، و تودّون المشاركة في الدراسة.

APPENDIX C: ENGLISH JZ SCALE

Instructions: There are several types of mental health professionals.
A psychiatrist is a medical doctor who prescribes and manages medication for psychological difficulties.
A psychotherapist treats psychological difficulties by discussing with the person their thoughts, emotions, and behaviors, on a regular basis and cannot prescribe medication.
Psychological difficulties may be related to a mental illness or may be relationship, emotional, work or academic difficulties that a person is experiencing. Below are statements related to seeking help for any psychological problem. Please rate the extent to which each statement reflects your attitudes. There are no right or wrong answers.

		Strongly Disagree	Disagree	Neutral /Unsure	Agree	Strongly Agree
TS_1	If I meet someone who is seeing a psychotherapist, I prefer not to get close to them	1	2	3	4	5
TS_2	If I see a psychotherapist, people will say I'm not normal	1	2	3	4	5
TS_3	If I see a psychotherapist, I worry what my family will say about me	1	2	3	4	5
TS_4	If I see a psychotherapist, people I know will look at me positively (e.g. I am responsible and mature)	1	2	3	4	5
TS_5	If I see a psychotherapist, I worry that my career will be negatively affected	1	2	3	4	5
TS_6	If I see a psychotherapist, I worry that my relationships with be negatively affected	1	2	3	4	5
TS_7	If I see a psychotherapist, some of my friends, relatives, or co-workers might distance themselves from me	1	2	3	4	5
TS_8	I don't have a problem if some of my friends-relatives, or co-workers know I see a psychotherapist	1	2	3	4	5
SoS_1	It's not part of our culture to see a psychotherapist	1	2	3	4	5
SoS_2	Our society has become more	1	2	3	4	5

	accepting the idea of seeing a psychotherapist					
SoS_3	I prefer that only people close to me know about my psychological difficulties	1	2	3	4	5
SS_1	If I see a psychotherapist, I would feel embarrassed	1	2	3	4	5
SS_2	If I see a psychotherapist, I would feel humiliated in front of others	1	2	3	4	5
SS_3	If I see a psychotherapist, my family would feel humiliated	1	2	3	4	5
SS_4	If I see a psychotherapist, my family's reputation will be affected	1	2	3	4	5
SS_5	If I see a psychotherapist, people will stop respecting me	1	2	3	4	5
SS_6	If I see a psychotherapist, I will stop respecting myself	1	2	3	4	5
SS_7	My dignity prevents me from seeing a psychotherapist	1	2	3	4	5
SS_8	If I see a psychotherapist, I would feel crazy	1	2	3	4	5
SS_9	If I see a psychotherapist, I would feel like a weak person	1	2	3	4	5
SS_10	If I see a psychotherapist, I would like to keep it private	1	2	3	4	5
MHL_1	Medications for psychological difficulties are addictive	1	2	3	4	5
MHL_2	Giving medication to children is acceptable, if they have psychological difficulties	1	2	3	4	5
MHL_3	Most people who try or commit suicide have psychological difficulties	1	2	3	4	5
MHL_4	Most psychological difficulties are due to one big childhood trauma	1	2	3	4	5
MHL_5	Schizophrenia and bipolar disorder are biological, heritable disorders	1	2	3	4	5
MHL_6	Prayer is as good as any professional treatment	1	2	3	4	5
MHL_7	Psychological difficulties solve themselves	1	2	3	4	5

MHL_8	A psychiatrist is a medical doctor who treats mental disorders by prescribing and managing medication	1	2	3	4	5
MHL_9	A psychotherapist helps people with mental disorders, through weekly sessions, that aim to understand their feelings and how to better handle them	1	2	3	4	5
MHL_10	Most psychological difficulties are due to a chemical imbalance in the brain	1	2	3	4	5
MHL_11	Bipolar disorder is marked by periods of high energy (mania) and periods of low energy (depression)	1	2	3	4	5
MHL_12	A person who hears voices or sees images of things that don't exist may be diagnosed with schizophrenia	1	2	3	4	5
PN_1	I have not thought about seeing a psychotherapist before now	1	2	3	4	5
PN_2	I feel a great need to see a psychotherapist	1	2	3	4	5
PN_3	If I had psychological difficulties, I would visit a psychiatrist first	1	2	3	4	5
PN_4	If I had psychological difficulties, I would visit a psychotherapist first	1	2	3	4	5
PN_5	I don't think my current psychological difficulties are severe enough for me to see a psychotherapist	1	2	3	4	5
PN_6	I would not visit a psychotherapist because I don't have any psychological difficulties	1	2	3	4	5
AT_1	A person has to solve their own psychological difficulties, without the help of a psychotherapist	1	2	3	4	5
AT_2	Seeing a psychotherapist means I am not strong enough to solve things myself	1	2	3	4	5

AT_3	I prefer not to see a psychotherapist so that I don't open up on issues that I prefer to forget	1	2	3	4	5
AT_4	I feel afraid to see a psychotherapist	1	2	3	4	5
AT_5	I don't see a psychotherapist because I don't like to talk about my feelings	1	2	3	4	5
AT_6	I don't like to talk about family matters to a stranger such as a psychotherapist	1	2	3	4	5
AT_7	I would feel relieved to talk to a psychotherapist about my psychological difficulties	1	2	3	4	5
AT_8	I thought about starting therapy a lot, but I either postponed or changed my mind	1	2	3	4	5
AT_9	I don't encourage others to see a psychiatrist	1	2	3	4	5
AT_10	I don't encourage others to see a psychotherapist	1	2	3	4	5
AT_11	I believe that yoga and exercise are better than seeing a psychotherapist	1	2	3	4	5
AT_12	Seeing a psychotherapist would not be effective for my psychological difficulties	1	2	3	4	5
AT_13	I would see a psychotherapist, if there was someone to encourage me	1	2	3	4	5
AT_14	I can commit to weekly therapy sessions with a psychotherapist	1	2	3	4	5
MIS_1	If I need help, I don't believe that a psychiatrist will be able to help me	1	2	3	4	5
MIS_2	If I need help, I don't believe that a psychotherapist will be able to help me	1	2	3	4	5
MIS_3	There are no treatments for psychological difficulties	1	2	3	4	5
MIS_4	I prefer to take medication for psychological difficulties	1	2	3	4	5
MIS_5	I believe that many psychotherapists do it for the	1	2	3	4	5

	money, and not their patients' wellbeing					
MIS_6	I believe that many psychotherapists are genuinely good people	1	2	3	4	5
MIS_7	I don't trust the competence of the psychotherapists around me	1	2	3	4	5
MIS_8	I don't trust that the psychotherapist will keep my information confidential	1	2	3	4	5
ACC_1	I would see a psychotherapist, if I could afford the fees	1	2	3	4	5
ACC_2	I would see a psychotherapist if my insurance covered the sessions	1	2	3	4	5
ACC_3	I would see a psychotherapist, if it was nearby	1	2	3	4	5
ACC_4	I would not see a therapist if I had to commute/drive a lot	1	2	3	4	5
ACC_5	I would see a psychotherapist, if I had time	1	2	3	4	5

APPENDIX D: ARABIC JZ SCALE

الإرشادات:
هنالك العديد من الأخصائيين في مجال الصحة النفسية.
الطبيب النفسي هو طبيب يصف ويتابع الأدوية للمشاكل النفسية.
المعالج النفسي يعالج المشاكل النفسية من خلال مناقشة أفكار، عواطف، وتصرفات المرء بطريقة منتظمة ولا يستطيع وصف الدواء.
الصعوبات النفسية قد تكون متعلقة بمرض نفسي أو قد تكون مشاكل تتعلّق بالعلاقات، العواطف، العمل، أو الدراسة. إن الجمل أدناه، المكتوبة في العامية، تدور حول طلب المساعدة من أجل أي صعوبة نفسية. الرجاء حدد لأي درجة تعبّر هذه الجمل عن مواقفك. ليس هناك إجابات خاطئة أو صحيحة.

		أعارض بشدة	أعارض	حيادي/لست متأكد	أوافق	أوافق بشدة
TS_1	إذا تعرّفت على شخص جديد عم يشوف معالج نفسي، بفضل ما إتقرب منو	1	2	3	4	5
TS_2	إذا بشوف معالج نفسي، رح يقولوا العالم إني مش طبيعي	1	2	3	4	5
TS_3	إذا بشوف معالج نفسي، بعتل همّ شو رح تحكي عني عيلتي	1	2	3	4	5
TS_4	إذا بشوف معالج نفسي، رح تنظرلي الناس لي بعرفها بطريقة إيجابية (مثلاً، إني شخص مسؤول وناضج)	1	2	3	4	5
TS_5	إذا بشوف معالج نفسي، بعتل همّ يتأثر عملي بطريقة سلبية	1	2	3	4	5
TS_6	إذا بشوف معالج نفسي، بعتل همّ تتأثر علاقاتي بطريقة سلبية	1	2	3	4	5
TS_7	إذا بشوف معالج نفسي، رح يبعدو عني بعض من رفقائي، أقربائي، أو زملائي بالعمل	1	2	3	4	5
TS_8	ما عندي مشكلة إذا حدا بيعرف إني بشوف معالج نفسي	1	2	3	4	5
SoS_1	مش من عادات مجتمعنا إنو شخص يشوف معالج نفسي	1	2	3	4	5
SoS_2	مجتمعنا صار يتقبل أكثر فكرة رؤية المعالج النفسي	1	2	3	4	5

SoS_3	بفضّل بس الأشخاص القراب مني يعرفو عن صعوباتي النفسية	1	2	3	4	5
SS_1	بستحي شوف معالج نفسي	1	2	3	4	5
SS_2	إذا بشوف معالج نفسي، بتجرّص قدام العالم	1	2	3	4	5
SS_3	إذا بشوف معالج نفسي، بتتجرّص عايلتي	1	2	3	4	5
SS_4	إذا بشوف معالج نفسي، بتنأذى سمعة عيلتي	1	2	3	4	5
SS_5	إذا بشوف معالج نفسي، بتبطّل الناس تحترمني	1	2	3	4	5
SS_6	إذا بشوف معالج نفسي، ببطّل إحترم حالي	1	2	3	4	5
SS_7	عزّة نفسي بتمنعني شوف معالج نفسي	1	2	3	4	5
SS_8	إذا بشوف معالج نفسي، بحس حالي مجنون	1	2	3	4	5
SS_9	إذا بشوف معالج نفسي، بحس حالي شخص ضعيف	1	2	3	4	5
SS_10	إذا بشوف معالج نفسي، بفضّل يكون الموضوع سرّي	1	2	3	4	5
MHL_1	الأدوية لي بتعالج الصعوبات النفسية بتأدّي للإدمان	1	2	3	4	5
MHL_2	إعطاء الأدوية للأولاد مقبول، إذا كان عندن صعوبات نفسية	1	2	3	4	5
MHL_3	معظم الأشخاص لي بتحاول تنتحر أو بتنتحر عندا صعوبات نفسية	1	2	3	4	5
MHL_4	معظم الصعوبات النفسية هي نتيجة صدمة كبيرة صارت بالطفولة	1	2	3	4	5
MHL_5	الفصام وإضطراب ثنائي القطب يمكن ينتجو عن عوامل بيوليجية وراثية	1	2	3	4	5
MHL_6	الصلاة بتفيد قد ما المعالج المختص بفيد	1	2	3	4	5
MHL_7	الصعوبات النفسية بتنحل لحالها	1	2	3	4	5
MHL_8	الطبيب النفسي هوّي طبيب متخصص لمعالجة الأمراض النفسية من خلال وصف ومتابعة الدواء	1	2	3	4	5
MHL_9	المعالج النفسي بساعد المريض النفسي من خلال الحكي بجلسات أسبوعية، ليفهم مشاعره، ويتعامل مع مشاكله بشكل أفضل	1	2	3	4	5
MHL_10	معظم الصعوبات النفسية نتيجة إختلال التوازن الكيميائي في الدماغ	1	2	3	4	5

MHL_11	الشخص لي بكون عندو اضطراب ثنائي القطب بكون عندو فترات فيا طاقة عالية و حيوية وفترات اكتئاب بكون ما عندو طاقة و حماس.	1	2	3	4	5
MHL_12	الشخص لي بيسمع أو بيشوف إشيا مش موجودة يمكن يتشخّص بمرض الفصام.	1	2	3	4	5
PN_1	ما فكرت قبل هلأ إني شوف معالج نفسي	1	2	3	4	5
PN_2	بشعر إني بحاجة شديدة لشوف معالج نفسي	1	2	3	4	5
PN_3	لو كان عندي صعوبات نفسية، كنت زرت طبيب نفسي أولاً	1	2	3	4	5
PN_4	لو كان عندي صعوبات نفسية، كنت زرت معالج نفسي أولاً	1	2	3	4	5
PN_5	ما بفتكر إنو صعوباتي النفسية بتستدعي إنو شوف معالج نفسي	1	2	3	4	5
PN_6	ما بزور معالج نفسي لأنو ما عندي ولا أي صعوبة نفسية	1	2	3	4	5
AT_1	الواحد لازم يحل صعوباته النفسية لحاله، بلا مساعدة معالج نفسي	1	2	3	4	5
AT_2	إذا بشوف معالج نفسي يعني أنا مش قوي كفاية لحل الإشيا لحالي	1	2	3	4	5
AT_3	بفضّل ما شوف معالج نفسي مشان ما إفتح مواضيع بفضل إنساها	1	2	3	4	5
AT_4	بخاف شوف معالج نفسي	1	2	3	4	5
AT_5	ما بشوف معالج نفسي لأنو ما بحب احكي عن مشاعري	1	2	3	4	5
AT_6	ما بحب احكي عن أمور عائلية لشخص غريب مثل المعالج النفسي	1	2	3	4	5
AT_7	بحس بإرتياح إذا بحكي مع معالج نفسي عن صعوباتي النفسية	1	2	3	4	5
AT_8	فكرت كثير بلّش جلسات علاج نفسية، بس أجّلتها أو غيرت رأيي	1	2	3	4	5
AT_9	ما بشّجع حدا يشوف طبيب نفسي	1	2	3	4	5
AT_10	ما بشجّع حدا يشوف معالج نفسي	1	2	3	4	5
AT_11	بعتقد إنو اليوغا والرياضة أفضل من إنو شوف معالج نفسي	1	2	3	4	5
AT_12	مش حتساعدني زيارة معالج نفسي مع صعوباتي النفسية	1	2	3	4	5
AT_13	كنت بشوف معالج نفسي لو في حدا يشجعني	1	2	3	4	5
AT_14	أنا فيّ إلتزم بجلسات أسبوعيّة مع	1	2	3	4	5

	معالج نفسي					
MIS_1	ما بعتقد إنّو طبيب نفسي في يساعدني	1	2	3	4	5
MIS_2	ما بعتقد إنو معالج نفسي في يساعدني	1	2	3	4	5
MIS_3	ما في ولا علاج للصعوبات النفسية	1	2	3	4	5
MIS_4	بفضّل إنّي آخد دواء للصعوبات النفسية	1	2	3	4	5
MIS_5	بعتقد كثير من المعالجين النفسيّة بيشتغلوا للمصاري، مش كرمال صحّة مرضاهن	1	2	3	4	5
MIS_6	بعتقد إنو عنجد المعالجين أشخاص مناح	1	2	3	4	5
MIS_7	ما عندي ثقة بكفاءة المعالجين النفسيّة اللي حواليي	1	2	3	4	5
MIS_8	ما عندي ثقة إنو المعالج النفسي رح يحفظ أسراري	1	2	3	4	5
ACC_1	كنت بشوف معالج نفسي لو بقدر إدفع جلسات العلاج	1	2	3	4	5
ACC_2	كنت بشوف معالج نفسي لو الضمان/التأمين الصحي بغطّي جلسات علاج	1	2	3	4	5
ACC_3	كنت بشوف معالج نفسي لو كانت عيادتو قريبة منّي	1	2	3	4	5
ACC_4	ما بشوف معالج نفسي إذا لازم إتنقّل كثير على الطريق	1	2	3	4	5
ACC_5	كنت بشوف معالج نفسي لو كان عندي وقت	1	2	3	4	5

APPENDIX E: ENGLISH DEMOGRAPHICS AND ACCESS TO MENTAL HEALTH SERVICES

1. Gender: (*drop down menu)*
    a. Male
    b. Female
    c. Other
2. Age: (*drop down menu from 18 to 100*)
3. Current marital status
    a. Single
    b. Married
    c. Divorced/separated
    d. Widowed
    e. In a domestic partnership/Cohabitation
4. Number of children *(drop down menu 0 to 10)*
5. How many family members (e.g., mother, father, sibling, offspring, grandparent) live at home with you, almost always? Please count yourself. (*drop down menu from 1 to 30)*
6. Number of bedrooms in the house in which the above people live, <u>including yourself</u>.
   (drop down menu from 0 to 20)
7. Level of education <u>completed</u>: *(drop down menu)*
    a. Less than Grade 12 or Baccalaureate II
    b. Grade 12 or Baccalaureate II
    c. Vocational degree or skills-based training
    d. Some college, no degree
    e. Bachelor's degree (e.g. BA, BS, DEA)
    f. Master's degree (e.g. MA, MS, Med, DESS)

g. Doctorate (e.g. MD, PhD, EdD)

8. Are you <u>currently</u> a student at <u>any</u> university?

    a. Yes

        i. Name of university _____

            1. Current level of university education:

                a. Freshman

                b. Sophomore

                c. Junior

                d. Senior

                e. Graduate level student

    b. No

9. **<u>Current</u>** estimated **<u>family</u>** income, **<u>per month</u>**: (*drop down menu*)

    a. Less than 499$

    b. 500$ - 999$

    c. 1000$ to $1,999

    d. $2,000 to $2,999

    e. $3,000 to $3,999

    f. $4,000 to $4,999

    g. Over $5,000

    h. Prefer not to answer

10. What is the highest level of education completed by your **<u>mother</u>**? (*drop down menu*)

    a. Less than Grade 12 or Baccalaureate II

b. Grade 12 or Baccalaureate II

c. Vocational degree or skills-based training

d. Some college, no degree

e. Bachelor's degree (e.g. BA, BS, DEA)

f. Master's degree (e.g. MA, MS, Med, DESS)

g. Doctorate (e.g. MD, PhD, EdD)

11. What is the highest level of education completed by your **father?** (*drop down menu*)

    a. Less than Grade 12 or Baccalaureate II

    b. Grade 12 or Baccalaureate II

    c. Vocational degree or skills-based training

    d. Some college, no degree

    e. Bachelor's degree (e.g. BA, BS, DEA)

    f. Master's degree (e.g. MA, MS, Med, DESS)

    g. Doctorate (e.g. MD, PhD, EdD)

12. Which one of the below, best describes where you work? (participants can choose more than one option)

    a. Public sector (e.g., government, army, public school)

    b. Private sector (e.g., bank, private school)

    c. Non-Governmental Organization

    d. Business owner or freelancer

    e. I don't work (I'm looking for work)

    f. I don't work (I'm a house caretaker)

g. I don't work (I'm retired)

h. I don't work (I'm a student)

i. Other: _____

13. In what country are you currently residing? *(drop down menu of all countries)*

14. What is your primary nationality (*drop down menu of all countries*)

Access to Mental Health Services

Instructions:

The below questions ask about the extent to which you have consulted with professionals who are trained to help others with their emotional issues, academic problems, life stress, etc. To consult means to call or see someone officially for their services.

A psychiatrist is a medical doctor who prescribes and manages medication for psychological difficulties.

A psychotherapist is a non-medical professional who treats psychological difficulties by discussing with the person their thoughts, emotions, and behaviors, on a regular basis and cannot prescribe medication.

Please read the questions carefully.

Medical

15. During the past two years, have you ever consulted a *medical* professional for any psychological, emotional or academic/work problem you are experiencing (e.g., feeling worried, feeling sad, physical symptoms that have no medical explanation

such as tension, insomnia, pounding heart, or fatigue?) ***[Online skip rules: If no, skip to question 17, then skip to 21]***

a. Yes

b. No (If not, survey will skip to Q 17)

16. If yes, *what type of medical professional* did you consult? *(drop down menu)*

    a. Family doctor (e.g., generalist)

    b. Neurologist

    c. Psychiatrist

    d. Other _____

17. Have you ever taken any *medication* for any psychological, emotional or academic/work problem that *you* are experiencing (e.g., feeling worried, sad, not focusing, having physical symptoms that have no medical explanation such as tension, pounding heart)? (if Yes, move to question 19. If No, skip to 22)

    a. Yes (If yes, survey will continue to Q 18, 19)

    b. No (If no, survey will go to Q21)

18. What type of medical professional wrote your prescription?

    a. Family doctor (e.g., generalist)

    b. Neurologist

    c. Psychiatrist

    d. Other _____

    e. I do not have a prescription

19. Check the box for the following <u>medications you have taken</u>, during the past two years, whether with or without a prescription? *(drop down menu of common psychotropic medications)*

- Anafranil (Clomipramine)
- Ativan (Lorazepam)
- Brintellix (Vortioxetine)
- Camcolit, Manicarb (Lithium)
- Cipralex, Lexapro (Escitalopram)
- Cipram (Citalopram)
- Cymbalta (Duloxetine)
- Depakine (Valproic Acid)
- Haldol (Haloperidol)
- Inductal (Eszopiclone)
- Invega (Paliperidone)
- Largactil (Chlorpromazine)
- Leponex (Clozapine)
- Lexotanil (Bromazepam)
- Lamictal (Lamotrigine)
- Librium or Librax (Chlordiazepoxide)
- Luvox (Fluvoxamine)
- Nardil (Phenelzine)
- Prozac, Fluxone (Fluoxetine)
- Rivotril (Clonazepam)
- Remeron (Mirtazapine)
- Risperdal (Risperidone)
- Stilnox (Zolpidem)
- Serax (Oxazepam)
- Seroquel (Quetiapine)
- Seroxat, Paxil, Paxera (Paroxetine)
- Tegretol (Carbamazepine)
- Tofranil (Imipramine)
- Topamax (Topiramate)
- Triptizol (Amitriptyline)
- Valdoxan (Agomelatine)
- Venlax, Efexor (Venlafaxine)
- Wellbutrin (Bupropion)
- Valium (Diazepam)
- Xalipro or Abilify (Aripriprazole)
- Xanax (Alprazolam)
- Zeldox (Ziprasidone)
- Zoloft, Pristiq (Sertraline)

- Zyprexa (Olanzapine)
- Other: _____

20. During the past two years, approximately how many times did you visit any medical doctor for any psychological, emotional or academic/work problem that you are experiencing (e.g., feeling worried, feeling sad, physical symptoms that have no medical explanation such as tension, insomnia, pounding heart, or fatigue)?

(drop down menu of zero to 50)

Non-medical

21. During the past two years, have you ever consulted a *non-medical* professional (e.g., a psychologist or counselor) for any psychological, emotional or academic/work problem you are experiencing (e.g., feeling worried, feeling sad, physical symptoms that have no medical explanation such as tension, insomnia, pounding heart, or fatigue?*)*

a. Yes (If yes, survey will go to Q22)
b. No (If no, survey will go to Q24))

22. If yes, what kind of non-medical professional did you consult?

a. University or school counselor
b. Clinical psychologist/ psychotherapist in private clinic
c. Life coach
d. Alternative professional (priest, sheikh, or traditional healer)
e. Other: _____

23. During the past two years, how many times did you visit all of the above, non-medical professionals? *(drop down menu from 0 to 50)*

Access by family member

24. During the past two years, did your children or close family member consult with any of the below professionals for any psychological, emotional or academic/work problem? (open choice)

a. Yes, they consulted a medical doctor who is NOT a psychiatrist

b. Yes, they consulted a psychiatrist medical doctor.

c. Yes, they consulted a non-medical professional like a psychologist.

d. Yes, they consulted a life coach.

e. Yes, they consulted a priest, sheikh, or traditional healer

f. No, they did not consult anyone.

g. I don't know.

APPENDIX F: ARABIC DEMOGRAPHICS AND ACCESS TO MENTAL HEALTH SERVICES

1. الجنس :
   a. ذكر
   b. أنثى
   c. آخر

2. العمر:
3. الوضع الاجتماعي:
   a. أعزب/ة
   b. متزوج/ة
   c. مطلق/ة أو منفصل/ة
   d. أرمل/ة
   e. في علاقة مساكنة
4. عدد الأولاد

5. ما عدد أفراد العائلة الساكنين في البيت معك تقريبا دائماً، بمن فيهم أنت (مثلاً، الأم، الأب، ابن أو ابنة، أخ أو أخت أو جد/ة)؟
6. ما عدد غرف النوم للساكنين في البيت أعلاه، بمن فيهم أنت؟
7. المستوى التعليمي المُنجز:
   a. أقل من الصف الثاني عشر أو شهادة البكالوريا
   b. الصف الثاني عشر أو شهادة البكالوريا
   c. شهادة مهنية أو تدريب قائم على اكتساب مهارات
   d. بعض التعليم في الجامعة، دون الحصول على شهادة جامعية
   e. شهادة جامعية (e.g. BA, BS, DEA)
   f. شهادة ماجستير(e.g. MA, MS, Med, DESS)
   g. شهادة دكتوراه (e.g. MD, PhD, EdD)

8. هل أنت حالياً تلميذ في أي جامعة ؟
   a. نعم
      i. اسم الجامعة: _____
      1. مستوى التعليم:

   a. طالب/ة في السنة الأولى (Freshman)
   b. طالب/ة في السنة الثانية (Sophomore)
   c. طالب/ة في السنة الثالثة (Junior)
   d. طالب/ة في السنة الأخيرة (Senior)
   e. طالب/ة في الدراسات العليا

   b. كلا

9. تقدير حالي لدخل العائلة، في الشهر:
   a. أقل من 499$
   b. بين ال 500$ وال999$
   c. بين ال1000$ وال 1999$
   d. بين ال2,000$ وال 2,999$
   e. بين ال3,000$ وال3,999$
   f. بين ال4,000$ وال4,999$
   g. فوق ال5,000$
   h. أفضل عدم الإجابة

10. ما هو أعلى مستوى تعليمي أكملته **الوالدة:**
   a. أقل من الصف الثاني عشر أو شهادة البكالوريا
   b. الصف الثاني عشر أو شهادة البكالوريا
   c. شهادة مهنية أو تدريب قائم على اكتساب مهارات
   d. بعض التعليم في الجامعة، دون الحصول على شهادة جامعية
   e. شهادة جامعية (e.g. BA,BS, DEA)
   f. شهادة ماجستير(e.g. MA, MS, Med, DESS)
   g. شهادة دكتوراه (e.g. MD, PhD, EdD)

11. ما هو أعلى مستوى تعليمي أكمله ***الوالد***:

a. أقل من الصف الثاني عشر أو شهادة البكالوريا
b. الصف الثاني عشر أو شهادة البكالوريا
c. شهادة مهنية أو تدريب قائم على اكتساب مهارات
d. بعض التعليم في الجامعة، دون الحصول على شهادة جامعية
e. شهادة جامعية (e.g. BA,BS, DEA)
f. شهادة ماجستير(e.g. MA, MS, Med, DESS)
g. شهادة دكتوراه (e.g. MD, PhD, EdD)

12. حدد طبيعة عملك الحالي:
a. في القطاع العام (مثلاً، في الدولة، الجيش، أو مدرسة رسمية)
b. في القطاع الخاص (مثلاً، في بنك أو مدرسة خاصة)
c. في منظمات غير حكومية
d. صاحب عمل أو عامل مستقل
e. لا أعمل. إنني أبحث عن عمل.
f. لا أعمل، إنني ربة منزل
g. لا أعمل، إنني متقاعد/ة
h. لا أعمل، إنني طالب/ة
i. غيره، حدد: ----------

13. في أي دولة أنت مقيم حالياً؟
14. ما هي جنسيتك الأساسية؟

Access to Mental Health Services

تهدف الأسئلة أدناه إلى الاستفهام حول مدى استشارتك المختصين الممرنين على مساعدة من يعانون من مشاكل عاطفية، أو مشاكل دراسية، أو من ضغوطات الحياة. تعني الاستشارة أن تتصل أو تذهب إلى عيادة متخصصة بصفة رسمية بهدف الحصول على خدماتهم.
الطبيب النفسي هو طبيب يصف ويتابع الأدوية للمشاكل النفسية.
المعالج النفسي هو مختص غير طبي يعالج المشاكل النفسية من خلال مناقشة أفكار، عواطف، وتصرفات المرء بأسلوب مدروس/ممنهج ولا يستطيع وصف الدواء.

الرجاء قراءة الأسئلة بتمعن.

Medical

15. خلال السنتين الماضيتين، هل قمت بزيارة أي طبيب من أجل أي مشكلة نفسية (مثلاً القلق، أو الشعور بالحزن أو عدم التركيز أو عوارض جسدية ليس لها تفسير طبي كالتوتر الزائد، الأرق، خفقان القلب بسرعة أو التعب)؟
a. نعم
b. كلا (if not skip to Q18)

16. ما هو إختصاص الطبيب الذي استشرته؟
a. طبيب الأسرة (طبيب عام)
b. طبيب عصبي
c. طبيب للأعصاب/الأمراض العقلية
d. غيره، حدد: ----------

17. خلال السنتين الماضيتين، هل وُصف لك *دواء* من أجل أي مشكلة نفسية، عاطفية، أو مشاكل تتعلق بالدراسة أو العمل تمرُّ بها (مثلاً، الشعور بالقلق أو الحزن، عدم التركيز، أو الشعور بعوارض جسدية ليس لها تفسير طبي كالتوتر الزائد، الأرق، خفقان القلب بسرعة أو التعب؟)
   a. نعم (continue to q19)
   b. كلا (continue to q22)
18. ما هو اختصاص الطبيب الذي وصف لك الدواء؟
   a. طبيب الأسرة (طبيب عام)
   b. طبيب عصبي
   c. طبيب للأعصاب/الأمراض العقلية
   d. غيره، حدد: ----------
   e. لم يكن عندي وصفة طبية
19. ضع علامة في المربع إن أخذت أي من الأدوية التالية، خلال السنتين الماضيتين، سواء مع أو دون وصفة طبية.
20. خلال السنتين الماضيتين، كم مرة قمت بزيارة طبيبك لأي من المشاكل أعلاه كمشكلة نفسية، عاطفية، أو مشاكل تتعلق بالدراسة أو العمل تمرُّ بها (مثلاً، الشعور بالقلق أو الحزن، عدم التركيز، أو الشعور بعوارض جسدية ليس لها تفسير طبي كالتوتر الزائد، الأرق، خفقان القلب بسرعة أو التعب) ؟

Non-medical

21. خلال السنتين الماضيتين، هل قمت باستشارة أخصّائي غير طبي (معالج أو مرشد نفسي) من أجل أي مشكلة نفسية، عاطفية، أو مشاكل تتعلق بالدراسة/العمل (مثلاً القلق، أو الشعور بالحزن أو لعوارض جسدية ليس لها تفسير طبي كالتوتر الزائد، الأرق، خفقان القلب بسرعة أو التعب)؟
   a. نعم (if yes, go to Q23)
   b. كلا (if no, go to Q25)
   c. آخر، حدد: ---------

22. ما هو اختصاص الأخصائى الغير طبي الذي استشرته:
   a. مرشد في الجامعة أو المدرسة
   b. معالج نفسي في عيادة خاصة
   c. مدرب حياة
   d. أخصائي بديل (مثلاً شيخ، كاهن، أو معالج تقليدي)
   e. آخر، حدد: ----------

23. خلال السنتين الماضيتين، كم عدد المرات التي زرت فيها كلاً من الأخصائيين الغير أطباء من الذين وردوا سابقاً؟
24. خلال السنتين الماضيتين، هل استشار أولادك أو أي فرد مقرب من العائلة أي من الأخصائيين النفسيين من أجل أي مشكلة نفسية، عاطفية، أو مشكلة تتعلق بالدراسة أو العمل؟
   a. نعم، لقد استشاروا طبيب ليس مختصاً بالأمراض العقلية.
   b. نعم، لقد استشاروا طبيب للأمراض العقلية.
   c. نعم، لقد استشاروا أخصائي ليس طبيباً كمعالج نفسي
   d. نعم، لقد استشاروا مدرب حياة
   e. نعم، لقد استشاروا بمعالج بديل (مثلاً شيخ، كاهن، أو معالج تقليدي)
   f. كلا، لم يقوموا باستشارة أحد
   g. لا أعرف

APPENDIX G: MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE (MCSDS)

Instructions:

Listed below are a number of statements concerning personal attitudes and traits. Select whether the statement is true or false as it pertains to you personally. There is no right or wrong answer.

		True	False
MCSDS1	It is sometimes hard for me to go on with my work if I am not encouraged.	True	False
MCSDS2	I sometimes feel resentful when I don't get my way.	True	False
MCSDS3	On a few occasions, I have given up doing something because I thought too little of my ability.	True	False
MCSDS4	There have been times when I felt like rebelling against people in authority even though I knew they were right.	True	False
MCSDS5	No matter who I'm talking to, I'm always a good listener.	True	False
MCSD6	There have been occasions when I took advantage of someone.	True	False
MCSDS7	I'm always willing to admit it when I make a mistake.	True	False
MCSDS8	I sometimes try to get even rather than forgive and forget.	True	False
MCSDS9	I am always courteous, even to people who are disagreeable.	True	False
MCSDS10	I have never been irked when people expressed ideas very different from my own.	True	False
MCSDS11	There have been times when I was quite jealous of the good fortune of others.	True	False
MCSDS12	I am sometimes irritated by people who ask favors of me.	True	False
MCSDS13	I have never deliberately said something that hurt someone's feelings.	True	False

APPENDIX H: ARABIC MARLOWE-CROWN SOCIAL DESIRABILITY SCALE (MCSDS)

Daouk-Oyry, Zeinoun, P., Sahakian, T, Van de vijver, F (in progress). A brief measure of Arab personality indicators: Psychometric properties from 10 Arab countries

الإرشادات:

فيما يلي مجموعة من العبارات التي يمكن أن تصف سلوكك و لصفات التي تتحلى بها.
الرجاء قراءة كل منها و تحديد ما إذا تعتقد بانها تنطبق عليك أم لا.

		صح	خطأ
1	من الصعب عليّ أحيانا أن أكمل عملي إن لم أكن مشجعًا على ذلك		
2	أشعر أحيانا بالاستياء عندما لا تجري الأمور على طريقتي الخاصة أو وفقًا لرغباتي		
3	في بعض الأحيان قد تخليت عن فعل شيء ما لأنني استخففت بقدراتي		
4	هناك أوقات شعرت فيها بالتمرد على مَن هم في السلطة رغم أنني كنت أعرف أنهم على حق		
5	أنا دائمًا مستمعٌ جيدٌ بغضّ النظر الى من اتحدث		
6	هناك أوقات قد استغلّيت فيها شخص ما		
7	أنا دائما على استعداد للاعتراف بخطأ إن ارتكبته		
8	أحاول أحيانًا الانتقام، بدلا من الغفران والنسيان		
9	أنا دائمًا مهذب حتى مع مَن هم مزعجون		
10	لا انزعج أبدًا عندما يُعرب الناس عن أفكار مختلفة جدًا عن أفكاري		
11	هناك أوقات غِرت فيها من حسن حظ الآخرين		
12	أنزعج أحيانًا من الناس الذين يطلبون مني الخدمات		
13	لم أعمد قط على قول شيئٍ قد يجرح مشاعر شخص ما		

APPENDIX I: PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Instructions:
Over the last 2 weeks, how often have you experienced any of the following?

		Not at all	Several days	Over half the days	Nearly every day
PHQ1	Little interest or pleasure in doing things	0	1	2	3
PHQ2	Feeling down, depressed, or hopeless	0	1	2	3
PHQ3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
PHQ4	Feeling tired or having little energy	0	1	2	3
PHQ5	Poor appetite or overeating	0	1	2	3
PHQ6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
PHQ7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
PHQ8	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
PHQ9	Thoughts that you would better off be dead, or of hurting yourself	0	1	2	3

APPENDIX J: ARABIC TRANSLATION OF PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

الإرشادات:

خلال الأسبوعين الأخرين، ما هي الوتيرة التي اختبرت فيها ما يلي؟

		أبداً	عدة الأيام	أكثر من نصف الأيام	تقريباً كل يوم
PHQ1	فقدان المتعة والفرح في تأدية كافة الأمور	0	1	2	3
PHQ2	الشعور بالحزن، أو الاكتئاب، أو اليأس	0	1	2	3
PHQ3	اضطرابات في النوم (عدم القدرة على النوم، نوم متقطع أو نوم زائد)	0	1	2	3
PHQ4	الشعور بالتعب أو بقلة الطاقة	0	1	2	3
PHQ5	ضعف في الشهية أو الإفراط في تناول الطعام	0	1	2	3
PHQ6	الشعور بالسوء حيال نفسك – أو أنك فاشل أو أنك قمت بخذل نفسك أو أسرتك	0	1	2	3
PHQ7	صعوبة في التركيز على الأمور، مثل قراءة الجريدة أو مشاهدة التلفاز.	0	1	2	3
PHQ8	التحرك أو التكلم بغاية البطء بحيث قد يلاحظ على ذلك الآخرون. أو عكس ذلك، أن تكون بغاية التململ أو التهيج بحيث أنك تتحرك بكثير أكثر من العادة.	0	1	2	3
PHQ9	أفكار حول أنك ستكون أفضل حالاً لو كنت ميتاً أو أن تؤذي نفسك بطريقة ما.	0	1	2	3

APPENDIX K: GENERALIZED ANXIETY DISORDER-7 (GAD-7)

Instructions:
Over the last 2 weeks, how often have you experienced any of the following?

		Not at all	Several days	Over half the days	Nearly every day
GAD1	Feeling nervous, anxious, or on edge	0	1	2	3
GAD2	Not being able to stop or control worrying	0	1	2	3
GAD3	Worrying too much about different things	0	1	2	3
GAD4	Trouble relaxing	0	1	2	3
GAD5	Being so restless that it's hard to sit still	0	1	2	3
GAD6	Being easily annoyed or irritable	0	1	2	3
GAD7	Feeling afraid as if something awful might happen	0	1	2	3

GAD8 If you experienced any of the above problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

a. Not difficult at all
b. Somewhat difficult
c. Very difficult
d. Extremely difficult

APPENDIX L: ARABIC TRANSLATION OF GENERALIZED ANXIETY DISORDER-7 (GAD-7)

الإرشادات:

خلال الأسبوعين الماضيين، ما هي الوتيرة التي اختبرت فيها ما يلي؟

		أبداً	عدة أيام	أكثر من نصف الأيام	تقريباً كل يوم
GAD1	الشعور بالتوتر، القلق، أو العصبية	0	1	2	3
GAD2	عدم القدرة على التوقف عن القلق أو السيطرة عليه	0	1	2	3
GAD3	القلق الشديد حول أمور عديدة	0	1	2	3
GAD4	صعوبة في الاسترخاء	0	1	2	3
GAD5	الشعور بالتململ لدرجة أنه من الصعب الجلوس بهدوء	0	1	2	3
GAD6	من السهل أن تنزعج أو تغضب	0	1	2	3
GAD7	الشعور بالخوف وكأن شيئاً مريعاً قد يحصل	0	1	2	3

GAD8

إن مررت بأي من المشاكل أعلاه، حدد إلى أي مدى أدت هذه المشاكل إلى صعوبة في القيام بعملك، أو الاهتمام بالأمور المنزلية، أو الانسجام مع الآخرين؟

a. لا صعوبات أبداً
b. صعوبات بسيطة
c. صعوبات كثيرة
d. صعوبات شديدة

APPENDIX M: SELF-STIGMA FOR RECEIVING PSYCHOLOGICAL HELP (SSRPH)

Instructions:

Below are some attitudes that some people have. For each question, please mark the extent to which you agree with the statement. There is no right or wrong answer.

		Strongly disagree	Disagree	Agree	Strongly agree
SSRPH1	Seeing a psychologist for emotional or interpersonal problems carries social stigma.	0	1	2	3
SSRPH2	It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.	0	1	2	3
SSRPH3	People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.	0	1	2	3
SSRPH4	It is advisable for a person to hide from people that fact that he/she has seen a psychologist.	0	1	2	3
SSRPH5	People tend to like less those who are receiving professional psychological help.	0	1	2	3

APPENDIX N: ARABIC TRANSLATION OF SELF-STIGMA FOR RECEIVING PSYCHOLOGICAL HELP (SSRPH)

الإرشادات:
الأدناه هي بعض العبارات عن مواقف قد يتبناها البعض. الرجاء اختيار درجة موافقتك أو معارضتك مع كل جملة. ليس هناك إجابات صحيحة أو خاطئة.

		أعارض بشدة	أعارض	أوافق	أوافق بشدة
SSRPH1	تحمل رؤية معالج نفسي بسبب مشاكل عاطفية أو في العلاقات الشخصية وصمة عار اجتماعية.	0	1	2	3
SSRPH2	تدل رؤية معالج نفسي بسبب مشاكل عاطفية أو في العلاقات الشخصية على فشل شخصي.	0	1	2	3
SSRPH3	سينظر الناس إلى شخص بطريقة أقل إيجابية إن عرفوا أنه يذهب إلى معالج نفسي.	0	1	2	3
SSRPH4	من المفضل أن يخبئ المرء من الناس مسألة ذهابه إلى معالج نفسي.	0	1	2	3
SSRPH5	يميل الناس إلى ملاطفة الشخص بصورة أقل إن علموا بأنه يذهب لمعالج نفسي.	0	1	2	3

APPENDIX O: SELF-STIGMA OF SEEKING PSYCHOLOGICAL HELP (SSOSPH)

Instructions:

The below questions ask about your attitudes towards seeking help with a psychologist/psychotherapist (*i.e. a non-medical professional who helps people with their psychological, emotional or work/academic issues through talking and interaction called psychotherapy, or "counseling" or "psychoanalysis").* Please mark the extent to which you agree with each statement. There is no right or wrong answer.

		Strongly disagree	Disagree	Neutral/Not sure	Agree	Strongly agree
SSOSH1	I would feel inadequate if I went to a psychotherapist for psychological help.	1	2	3	4	5
SSOSH2	My self-confidence would NOT be threatened if I sought professional help from a psychotherapist.	1	2	3	4	5
SSOSH3	Seeking psychological help would make me feel less intelligent.	1	2	3	4	5
SSOSH4	My self-esteem would increase if I talked to a psychotherapist.	1	2	3	4	5
SSOSH5	My view of myself would not change just	1	2	3	4	5

	because I made the choice to see a psychotherapist					
SSOSH6	It would make me feel inferior to ask a psychotherapist for help	1	2	3	4	5
SSOSH7	I would feel okay about myself if I made the choice to seek professional help from a psychotherapist.	1	2	3	4	5
SSOSH8	If I went to a psychotherapist, I would be less satisfied with myself.	1	2	3	4	5
SSOSH9	My self-confidence would remain the same if I sought help for a problem I could not solve by myself.	1	2	3	4	5
SSOSH10	I would feel worse about myself if I could not solve my own problems.	1	2	3	4	5

APPENDIX P: ARABIC TRANSLATION OF SELF-STIGMA OF SEEKING PSYCHOLOGICAL HELP (SSOSPH)

الإرشادات:
إن الأسئلة التالية تتمحور حول وجهة نظرك تجاه طلب المساعدة من أخصائي كالمعالج النفسي، أي أخصائي ليس طبيباً يساعد في مشاكل الشخص النفسية، العاطفية، أو مشاكل تتعلق بالدراسة أو العمل من خلال التكلم والتفاعل وجهاً لوجه، ما يسمى علاج نفسي أو إرشاد نفسي أو"تحليل نفسي". الرجاء حدد لأي درجة توافق مع كل عبارة. ليس هناك جواب خطأ أو صح

		أعارض بشدة	أعارض	حيادي/لست متأكداً	أوافق	أوافق بشدة
SSOSH1	سأشعر بعدم الاكتفاء بنفسي/بالدونية إن ذهبت لمعالج/ة نفسي/ة من أجل مشاكل نفسية	1	2	3	4	5
SSOSH2	لن تتهدد ثقتي بنفسي لن تكون مهددة إن طلبت المساعدة لصحتي النفسية من معالج نفسي.	1	2	3	4	5
SSOSH3	سأشعر إني أقل ذكاء إن طلبت المساعدة للصحية النفسية/ة.	1	2	3	4	5
SSOSH4	ستزداد ثقتي بنفسي ستزداد إن تكلمت مع معالج/ة نفسي.	1	2	3	4	5
SSOSH5	لن تتغير نظرتي لنفسي لن تتغير فقط لأنني أخذت قرار رؤية معالج/ة نفسي لمساعدتي.	1	2	3		5
SSOSH6	سأشعر بالنقص إذا طلبت المساعدة من معالج/ة نفسي/ة.		2	3	4	5
SSOSH7	سأشعر بخير إن اتخذت قرار طلب مساعدة نفسية.	1	2	3	4	5
SSOSH8	إن ذهبت لمعالج/ة نفسي/ة فـإنني سأشعر بأقل رضى أقل عن نفسي.	1	2	3	4	5
SSOSH9	ستبقى ثقتي بنفسي ستبقى كما هي إن استعنت بالمساعدة من أجل مشكلة لم أستطع حلها.	1	2	3	4	5
SSOSH10	سأشعر بالسوء تجاه نفسي إن لم أستطع حل مشاكلي لوحدي.	1	2	3	4	

APPENDIX Q: ATTITUDES TOWARDS SEEKING PROFESSIONAL PSYCHOLOGICAL HELP (ATSPPH)

Instructions:

Below are some attitudes that some people have. Please mark the extent to which you agree with the statement. There is no right or wrong answer.

		Strongly disagree	Disagree	Neutral/Not Sure	Agree	Strongly agree
ATSPPH1	Although there are clinics for people with mental troubles, I would not have much faith in them.	0	1	2	3	4
ATSPPH2	If a good friend asked my advice about a mental problem, I might recommend that they see a psychiatrist.	0	1	2	3	4
ATSPPH3	I would feel uneasy going to a psychiatrist because of what some people would think.	0	1	2	3	4
ATSPPH6	Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	0	1	2	3	4
ATSPPH7	I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	0	1	2	3	4
ATSPPH8	I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.	0	1	2	3	4
ATSPPH9	Emotional difficulties, like many things, tend to work out by themselves.	0	1	2	3	4
ATSPPH10	There are certain problems that should not be discussed outside of one's immediate family.	0	1	2	3	4
ATSPPH11	A person with a serious emotional disturbance would probably feel more secure in a good mental hospital.	0	1	2	3	4
ATSPPH12	If I believed I was having a mental breakdown, my first	0	1	2	3	4

	inclination would be to get professional attention.					
ATSPPH14	Having been a psychiatric patient is a negative mark on a person's life.	0	1	2	3	4
ATSPPH15	I would rather be advised by a close friend than by a psychologist, even for an emotional problem.	0	1	2	3	4
ATSPPH16	A person with an emotional problem is not likely to solve it alone; they are likely to solve it with professional help.	0	1	2	3	4
ATSPPH17	I resent a person – professionally trained or not – who wants to know about my personal difficulties.	0	1	2	3	4
ATSPPH18	I would want to get psychiatric help if I was worried or upset for a long period of time.	0	1	2	3	4
ATSPPH19	The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	0	1	2	3	4
ATSPPH21	There are experiences in my life I would not discuss with anyone.	0	1	2	3	4
ATSPPH22	It is probably best not to know *everything* about oneself.	0	1	2	3	4
ATSPPH23	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3	4
ATSPPH25	At some future time I might want to have psychological counseling	0	1	2	3	4
ATSPPH26	A person should work out their own problems, and getting psychological counseling would be a last resort.	0	1	2	3	4
ATSPPH28	If I thought I need psychiatric help, I would get it no matter who knew about it.	0	1	2	3	4

APPENDIX R: ARABIC TRANSLATION OF ATTITUDES TOWARDS SEEKING PROFESSIONAL PSYCHOLOGICAL HELP (ATSPPH)

الإرشادات:
إن العبارات أدناه عن بعض وجهات النظر لبعض الأشخاص. الرجاء حدد لأي درجة توافق مع كل عبارة. ليس هناك جواب خطأ أو صحيح.

	العبارة	أعارض بشدة	أعارض	حيادي / لست متأكداً	أوافق	موافق بشدة
ATSPPH1	بالرغم من وجود عيادات أو مراكز للأشخاص الذين يعانون من مشكلات نفسية إلا أنني لا أثق بها	0	1	2	3	4
ATSPPH2	إذا ما سألني صديق عزيز عن نصيحة بخصوص مشكلة انفعالية (نفسية) فإنني سوف أنصحه برؤية أخصائي نفسي	0	1	2	3	4
ATSPPH3	أشعر بعدم الراحة لذهابي إلى أخصائي نفسي وذلك بسبب نظرة الناس السلبية للعلاج النفسي	0	1	2	3	4
ATSPPH6	أخذاً بالاعتبار الوقت والتكاليف الذي يتطلبه العلاج النفسي فإنني أشك في قيمته لشخص مثلي	0	1	2	3	4
ATSPPH7	إنني على استعداد لمصارحة مختص بمسائلي الشخصية إذ ما اعتقدت بأن ذلك سوف يساعدني أو يساعد أفراد أسرتي	0	1	2	3	4
ATSPPH8	أفضل العيش مع مشكلتي على أن أضع نفسي تحت رحمة العلاج النفسي	0	1	2	3	4
ATSPPH9	الصعوبات الانفعالية مثل معظم الأشياء لديها الميل إلى الحل من جراء ذاتها	0	1	2	3	4
ATSPPH10	هناك مشكلات معينة يجب أن لا تناقش خارج نطاق الأسرة	0	1	2	3	4
ATSPPH11	الشخص الذي يعاني من اضطراب انفعالي حاد من الممكن أن يشعر بالأمان أكثر في مستشفى أمراض نفسية	0	1	2	3	4
ATSPPH12	إذا ما اعتقدت بأن لدى انهيار عصبي فإن أول ما أفكر به هو الحصول على رعاية أو اهتمام	0	1	2	3	4

	من شخص متخصص					
ATSPPH14	رؤية أخصائي نفسي يعتبر عار في حياة الشخص	0	1	2	3	4
ATSPPH15	أفضّل الحصول على نصيحة من صديق قريب على أن أحصل عليها من أخصائي نفسي حتى ولو كانت لمشكلة نفسية	0	1	2	3	4
ATSPPH16	ليس من السهل على الفرد أن يحل مشكلته النفسية بنفسه وإنما يحلها بمساعدة شخص مختص	0	1	2	3	4
ATSPPH17	إنني لا أحب الشخص – مختص كان أم لا – الذي يريد أن يعرف عن مشكلاتي الشخصية	0	1	2	3	4
ATSPPH18	سوف أرغب في الحصول على علاج نفسي إذا كنت قلق أو متضايق لمدة طويلة	0	1	2	3	4
ATSPPH19	أعتبر فكرة الحديث مع أخصائي نفسي عن المشكلات أسلوب ضعيف للتخلص من الصراعات النفسية	0	1	2	3	4
ATSPPH21	هناك خبرات أو تجارب في حياتي لا أريد أن أناقشها مع أحد	0	1	2	3	4
ATSPPH22	من الأفضل عدم معرفة كل شئ عن ذات الفرد	0	1	2	3	4
ATSPPH23	فيما لو تعرضت لصدمة انفعالية حادة في فترة ما من حياتي فإنني على ثقة من الحصول على راحة نفسية بالعلاج النفسي	0	1	2	3	4
ATSPPH25	في وقت ما مستقبلا ربما أرغب في الحصول على إرشاد نفسي	0	1	2	3	4
ATSPPH26	يجب على الشخص أن يحل مشكلاته بنفسه ويعتبر الحصول على إرشاد نفسي آخر الحلول	0	1	2	3	4
ATSPPH28	إذا شعرت بالرغبة في الحصول على مساعدة نفسية فإنني سوف أحصل عليها بالرغم من معرفة الآخرين	0	1	2	3	4

APPENDIX S: EMAIL INVITATION & REMINDER TO PARTICIPATE IN THE STUDY

Invitation to Participate in a Research Study
This notice is for an AUB-IRB Approved Research Study, conducted by Dr. Pia Zeinoun
It is not an Official Message from AUB

Dear student,

I am inviting you to participate in a study about barriers to psychological treatment seeking. Do you ever wonder, why some people who need help, do not actually seek treatment? People may have minor relationship or emotional issues, or serious mental illness, but the rate of getting help is still low. We are conducting a study to understand what prevents people from seeking treatment, and construct a scale that measures that.

To participate, you will need to complete a **25-minute online survey**, with questions about your demographic information, your mental health, and potential reasons behind not seeking treatment. The survey is anonymous and confidential.

You are eligible for this study if you are above 18, and **currently residing in an Arab country. To know more and decide whether you would like to participate, please read the consent form on the below link:**

studysurvey.limequery.com

If you have any questions, you may contact the principal investigator, Dr. Pia Zeinoun, or the student investigator, Salam Jabbour, on the below information.
Thank you.

Dr. Pia Zeinoun, Assistant Professor of Psychology
Department of Psychology, American University of Beirut
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APPENDIX T ENGLISH FACEBOOK AD

Why don’t people go to therapy?!

Share your thoughts with us by filling out this questionnaire!

You can access the study in English through the following link [insert link]

APPENDIX U: FACEBOOK AD IN ARABIC

ليش العالم ما بتروح عند معالج نفسي؟ شاركنا برأيك!

الاطلاع على الدراسة للدكتورة بيا زينون في الجامعة الأمريكية في بيروت من خلال هذا الرابط: [insert link] المشاركة اختيارية.

APPENDIX V: PILOT RESULTS: ITEM WORDING, MEAN, STANDARD DEVIATIONS, AND PARTICIPANT COMMENTS

Item Code	Item Version 1	M (*SD*) (*n*=26)	Comments	Changed Items Version 2	M (*SD*) (*n*=7)	Comments	Changed Items Version 3	M (*SD*) (*n*=7)
TS1	I prefer not to be close to someone who is seeing a psychotherapist. / **أفضّل ما إتقرّب من شخص بشوف معالج نفسي.**	2.44 (*1.58)*	Answer would be different depending on whether participants newly meet the person seeking therapy or not.	If I meet someone who is seeing a psychotherapist, I prefer not to get close to them./ **إذا تعرفت على شخص جديد عم يشوف معالج نفسي، أفضل ما إتقرّب منو**	2.29 *(1.38)*			2.14*(1.46)*
TS2	If I see a psychotherapist, people will say that I'm not normal. / **إذا بشوف معالج نفسي، رح يقولوا العالم إني مش طبيعي**	1.88 *(1.13)*			2.43 *(0.98)*			2.71 *(1.38)*
TS3	If I see a psychotherapi	1.76 *(1.12)*	It’s not an issue of		2.57 (*1.40)*			2.17 *(1.47)*

	st, I worry what my family will say about me. / إذا بشوف معالج نفسي، بعتل همّ شو رح تحكي عني عايلتي		what people will say but participants thought it better to keep the matter private. There is no item which reflects that sentiment		
TS4	If I see a psychotherapist, people I know will look at me positively (e.g. I am responsible and mature). / ذا بشوف معالج نفسي، رح تنظرلي الناس لي بعرفها بطريقة إيجابية (مثلاً، إني شخص مسؤول وناضج)	3.28 (*0.89)*		3.57 *(0.79)*	3.43 *(0.54)*
TS5	If I see a	2.12		2.29 *(1.25)*	1.86 *(0.38)*

	psychotherapist, I worry that my career will be negatively affected. / إذا بشوف معالج نفسي، بعتل همّ عملي يتأثر بطريقة سلبية	*(1.24)*		
TS6	If I see a psychotherapist, I worry that my relationships will be negatively affected./ إذا بشوف معالج نفسي، بعتل همّ تتأثر علاقاتي بطريقة سلبية	2.00 *(1.12)*	2.29 *(1.25)*	1.57 *(0.54)*

TS7	If I see a psychotherapist, some of my friends, relatives, or co-workers might distance themselves from me. / إذا بشوف معالج نفسي، بعض من رفقائي، أقربائي، أو زملائي بالعمل رح يبعدو عني	2.12 *(1.05)*			2.43 *(0.98)*	2.43 *(0.98)*
TS8	I don't have a problem if others know I see a psychotherapist. / ما عندي مشكلة إذا حدا بيعرف إني بزور معالج نفسي	3.84 *(1.06)*	Others is not clear. Participants stated it depended on the person.	I don’t have a problem if some of my friends, relatives, or co-workers know I see a psychotherapist. / ما عندي مشكلة إذا بعض من رفقائي، أقربائي، أو زملائي بالعمل بيعرفوا إني بزور	3.83 *(0.41)*	3.71*(1.25)*

		معالج نفسي		
SoS1	It's not part of our culture to see a psychotherapist./ مش من عادات مجتمعنا إنو شخص يشوف معالج نفسي	3.24 *(1.48)*	3.57 *(0.79)*	4.29*(0.76)*
SoS2	Our society has become more accepting of the idea of seeing a psychotherapist. / **مجتمعنا صار يتقبل أكثر فكرة رؤية المعالج النفسي**	3.60 *(1.22)*	1.57 (0.54)	3.86 *(0.90)*
SoS3	I prefer that only people close to me know about	3.72 *(1.17)*	1.86 *(1.07)*	4.00 *(1.00)*

	my psychological difficulties. / **أفضّل بس الأشخاص القراب مني يعرفو عن صعوباتي النفسيية**			
SS1	If I see a psychotherapist, I would feel embarrassed. / **أستحي إنو شوف معالج نفسي**	1.48 *(0.59)*	2.86(*1.22)*	2.00 *(1.00)*
SS2	If I see a psychotherapist, I would feel humiliated in front of others. / **إذا بشوف معالج نفسي، بتجرّص قدام الآخرين**	1.52 *(0.77)*	2.43*(1.27)*	1.57 *(0.79)*
SS3	If I see a psychotherapi	1.44 *(0.65)*	2.43 (*1.13)*	1.71 *(0.49)*

	st, my family would feel humiliated. **إذا بشوف معالج / نفسي، بتتجرص عايلتي**			
SS4	If I see a psychotherapist, my family's reputation will be affected. / إذا بشوف معالج نفسي، سمعة عايلتي بتتأثر	1.68 *(0.852)*	1.57 *(0.54)*	1.71*(0.49)*
SS5	If I see a psychotherapist, people will stop respecting me. / **إذا بشوف معالج نفسي، الناس بتبطل تحترمني**	1.80 *(1.00)*	1.57 *(0.54)*	1.86(0.69)
SS6	If I see a psychotherapist, I will stop	1.20 *(0.40)*	1.43 (*0.54)*	1.29 *(0.49)*

	respecting myself. / إذا **بشوف معالج نفسي، ببطّل إحترم تفسي**			
SS7	My dignity prevents me from seeing a psychotherapist./ **عزّة نفسي بتمنعني شوف معالج نفسي**	1.48 *(1.04)*	1.86 (*0.69)*	1.57 (*0.78)*
SS8	If I see a psychotherapist, I would feel crazy. / إذا بشوف معالج نفسي، بحس حالي مجنون	1.28 *(0.68)*	3.57 (0.54)	1.29 *(0.49)*
SS9	If I see a psychotherapist, I would feel like a weak person. / **إذا بشوف معالج نفسي، بحس حالي**	1.64 *(1.00)*	2.29 *(0.49)*	1.71 *(1.11)*

	شخص ضعيف				
SS10			If I was seeing a psychotherapist, I would like to keep it private./ إذا بشوف معالج نفسي، بفضّل الموضوع يكون خاص/خصوصي*	3.43 *(0.79)*	3.71 *(0.95)*
MHL1	Medications for psychological difficulties are addictive./ لأدوية لي بتعالج الصعوبات النفسية بتأدّي للإدمان	2.60 *(1.00)*		4.00 *(1.00)*	3.57 (*1.40)*
MHL2	Giving medication to children is acceptable, if they have a problem. / إعطاء الأدوية	3.36 *(1.22)*		3.43 *(0.98)*	3.14 *(1.22)*

	للأولاد مقبول، إذا كان عندن مشكلة			
MHL3	Most people who try or commit suicide have psychological difficulties. معظم الأشخاص / لي بتحاول تنتحر أو بتنتحر عندا صعوبات نفسية	3.92 *(1.28)*	3.43 *(0.79)*	4.00 *(0.82)*
MHL4	Most psychological difficulties are due to one big childhood trauma./ معظم الصعوبات النفسية نتيجة صدمة وحدة كبيرة بالطفولة	3.28 *(1.24)*	3.00 *(1.00)*	3.14 (*1.35)*

MHL5	Schizophrenia and bipolar disorder are biological, heritable disorders./ الفصام وإضطراب ثنائي القطب هنّي أمراض بيوليجية، وراثية	3.36 *(1.08)*	Participants responding in Arabic didn't know what schizophrenia and bipolar disorder are.	2.00 *(0.82)*	3.29 *(0.76)*
MHL6	Prayer is as good as any professional treatment. / الصلاة هو بنفس فعالية علاج عند متخصص	3.20 *(1.38)*		4.14 *(0.69)*	3.57 *(1.27)*
MHL7	Psychological difficulties solve themselves. / الصعوبات النفسية بتنحل لحالها	2.08 *(0.75)*		4.29 *(0.49)*	2.00 *(1.00)*
MHL8	A psychiatrist is a medical doctor who	3.96 *(0.98)*		2.86 (*0.69)*	3.43 *(1.51)*

	treat mental disorders by prescribing and managing medication./ الطبيب النفسي هوّي طبيب متخصص لمعالجة الأمراض النفسية من خلال وصف ومتابعة الدواء			
MHL9	A psychotherapist helps people with mental disorders, through weekly sessions, that aim to understand their feelings and how to better handle them. / لمعالج النفسي بساعد المريض النفسي من خلال الحكي	4.08 *(0.91)*	3.86 *(0.69)*	4.14 *(0.69)*

	بجلسات أسبوعية، ليفهم مشاعره، ويتعامل مع مشاكله بشكل أفضل				
MHL10	Most psychological difficulties are due to a chemical imbalance in the brain. / عظم الصعوبات النفسية هي نتيجة إختلال التوازن الكيميائي في الدماغ	3.04 *(0.73)*		4.00 *(0.58)*	3.14 *(0.90)*
MHL11			Bipolar disorder is marked by periods of high energy (mania) and periods of low energy (depression). / يتميز الاضطراب الثنائي القطب	2.71 *(1.25)*	3.43 *(0.54)*

			بفترات الطاقة العالية وفترات الطاقة المنخفضة *(الاكتئاب)		
MHL12			A person who sees images/hears voices of things that don't exist may be diagnosed with schizophrenia. / الشخص الذي يسمع أصواتًا/يرى صوراً لأشياء غير موجودة قد يتم تشخيصه بمرض الفصام*	3.29 *(1.11)*	4.14*(0.69)*
PN1	I have not thought about seeing a psychotherapist before now. / ما فكرت قبل هلأ إني	2.72 *(1.08)*		3.29 *(0.95)*	3.14 *(0.90)*

	شوف معالج نفسي			
PN2	I feel a great need to see a psychotherapist. / شعر إني بحاجة شديدة لشوف معالج نفسي	2.64 (*1.08)*	3.86 *(1.07)*	3.43 (*0.54)*
PN3	If I had psychological difficulties, I would visit a psychiatrist first. لو كان عندي صعوبات نفسية، كنت زرت طبيب نفسي أولاً	3.36 *(1.04)*	3.00 *(1.00)*	3.43 *(0.54)*
PN4	If I had psychological difficulties, I would visit a psychotherapist first. / لو كان عندي صعوبات نفسية، كنت زرت معالج نفسي أولاً	3.72 *(0.84)*	2.57 *(1.13)*	2.00 *(1.16)*

PN5	I don't think my current psychological difficulties are severe enough for me to see a psychotherapist. / ما بفتكر إنو صعوباتي النفسية الحالية خطيرة لدرجة إنو شوف معالج نفسي	3.76 *(1.05)*	2.29 *(0.95)*	3.71 *(1.11)*
PN6	I would not visit a psychotherapist because I don't have any psychological difficulties. ما بزور معالج نفسي لأنو ما عندي ولا أي صعوبة نفسية	3.28 *(1.06)*	2.86*(1.46)*	2.86 *(1.57)*
AT1	A person has to solve their own psychological	2.40 *(0.91)*	2.57*(0.79)*	3.86 *(1.07)*

	difficulties, without the help of a psychotherapist./ الشخص لازم يحل صعوباتوالنفسية لحاله، بلا مساعدة معالج نفسي			
AT2	Seeing a psychotherapist means I am not strong enough to solve things myself. / إذا بشوف معالج نفسي يعني أنا مش قوي كفاية لحل الإشيا لحالي	2.08 *(1.12)*	2.43 *(1.13)*	2.29 *(1.38)*
AT3	I prefer not to see a psychotherapist so that I don't open up on issue that I prefer to forget./ أفضل	2.04 *(1.02)*	2.43 *(1.13)*	2.57 *(1.27)*

	ما شوف معالج نفسي مشان ما إفتح مواضيع بفضل إنسيها				
AT4	I feel afraid to see a psychotherapist. / بخاف شوف معالج نفسي	1.76 *(0.83)*		4.00 *(0.58)*	1.71 *(0.76)*
AT5	I don't see a psychotherapist because I don't like to talk about my feelings. ما بشوف معالج نفسي لأنو ما بحب إحكي عن مشاعري	2.36 *(1.25)*		3.00 *(1.16)*	2.43 *(1.51)*
AT6	I don't like to talk about family matters to a stranger. / ما بحب إحكي عن أمور عائلية لشخص غريب	2.68 *(1.245)*	I don't like to talk about family matters to a stranger such as a psychotherapist. /	2.00*(1.00)*	1.57 *(0.54)*

AT7	I would feel relieved to talk to a psychotherapist about my psychological difficulties./ بحس بإرتياح إذا بحكي مع معالج نفسي عن صعوباتي النفسية	3.80 *(0.816)*	2.29(*0.49)*	1.86 *(1.07)*
AT8	I thought about starting therapy a lot, but I either postponed or changed my mind./ فكرت كثير بلّش جلسات علاج مع معالج نفسي، بس أجّلتها أو غيرت رأيي	2.36 *(1.11)*	2.14*(0.69)*	1.57 *(0.54)*
AT9	I don't encourage others to see a psychiatrist./ ما بشّجع حدا	1.60 (*0.76)*	3.29 *(0.76)*	2.14 *(1.07)*

	يشوف طبيب نفسي			
AT10	I don't encourage others to see a psychotherapist /. ما بشجّع حدا يشوف معالج نفسي	1.40 *(0.50)*	3.57*(0.98)*	3.86 *(1.35)*
AT11	I believe that yoga and exercise are better than seeing a psychotherapist/ بعتقد إنو اليوغا والرياضة أفضل من إنو شوف معالج نفسي	2.44 *(0.92)*	2.29*(0.95)*	3.00 *(1.63)*
AT12	Seeing a psychotherapist would not be effective for my psychological difficulties. /	2.00 *(0.82)*	2.43*(0.98)*	1.86*(1.07)*

	زيارة معالج نفسي مش رح يكون فعّال لصعوباتي النفسية					
AT13	I would see a psychotherapist, if there was someone to encourage me./ كنت بشوف معالج نفسي لو في حدا يشجعني	2.52 *(1.16)*			1.86 *(0.38)*	3.43 *(1.40)*
AT14	I can commit to weekly therapy sessions with a psychotherapist./ / أنا فييّ إلتزم بجلسات أسبوعيّة مع معالج نفسي	3.28 *(0.89)*			2.29 *(0.76)*	3.29 *(1.60)*
MIS1	I don't believe that a psychiatrist will be able to help me. / ما بعتقد إنّو	2.16 *(1.03)*	This statement assumed they have psychological	If I need help, I don't think that a psychiatrist will be able to help me. / ما	2.71*(0.76)*	2.57 *(1.134)*

	طبيب نفسي في يساعدني		difficulties	بعتقد إنو طبيب نفسي فس يساعدني، لو كنت بحاجة للمساعدة			
MIS2	I don't believe that a psychotherapist will be able to help me./ ما بعتقد إنو معالج نفسي في يساعدني	2.08 *(0.95)*	This statement assumed they have psychological difficulties	If I need help, I don't believe that a psychotherapist will be able to help me. / لو كنت بحاجة للمساعدة، ما بعتقد إنو معالج نفسي في يساعدني	3.86*(0.69)*		2.00*(0.577)*
MIS3	There are no treatments for psychological difficulties. / ما في ولا علاج لصعوباتي النفسية	1.68 *(0.80)*	In Arabic, the item assumed that the person has psychological difficulties	There are no treatments for psychological difficulties./ ما في ولا علاج لالصعوبات النفسية	2.57*(0.54)*		2.14 (1.069)
MIS4	I prefer to take medication for psychological difficulties. / بفضّل إنّي آخد	2.52 *(1.33)*	In Arabic, the item assumed that the person has psychological	I prefer to take medication for psychological difficulties./ بفضّل إنّي آخد دواء لالصعوبات النفسية	2.57 *(0.79)*		2.17 *(1.33)*

	دواء لصعوباتي النفسية		difficulties			
MIS5	I believe that many psychotherapists do it for the money, and not their patients' wellbeing. / بعتقد كثير من المعالجين النفسيّة بيشتغلوا للمصاري، مش كرمال صحّة مرضاهن	2.52 *(1.08)*			3.57 *(1.13)*	2.43 (*0.98)*
MIS6	I believe that many psychotherapists are genuinely good people. بعتقد إنو المعالجين النفسيين عنجد أشخاص مناح	(3.96; *0.61*)			3.86*(0.90)*	4.43*(0.79)*
MIS7	I don't trust the	2.40 *(0.76)*	Competence is a difficult	I don't trust the ability of	2.57 *(0.54)*	2.43*(0.98)*

	competence of the psychotherapist around me. / **ما عندي ثقة بكفاءة المعالجين النفسيّة اللي حواليي**		word	the psychotherapist around me				
MIS8	I don't trust that the psychotherapist will keep my information confidential./ **ما عندي ثقة إنو المعالج النفسي رح يحتفظ بالمعلومات عنّي**	2.24 *(0.88)*			2.57 *(0.79)*			2.29*(0.95)*
ACC1	I would see a psychotherapist, if I could afford the fees. / **كنت بشوف معالج نفسي لو بقدر إتكلّف جلسات العلاج**	2.88 *(1.09)*			3.57 (*1.13)*	In Arabic, "law be2dar etkallaf" was seen as too formal	كنت بشوف معالج نفسي لو بقدر إدفع جلسات العلاج	3.28 *(1.38)*

ACC2	I would see a psychotherapist if my insurance covered the sessions./ **كنت بشوف معالج نفسي لو الضمان/التأمين الصحي بغطّي جلسات علاج**	3.24 *(1.052)*			3.86 *(0.90)*			3.29 (1.38)
ACC3	I would see a psychotherapist, if it was nearby./ **كنت بشوف معالج نفسي لو كان قريب منّي**	2.64 *(1.08)*			3.43*(0.98)*	In Arabic, the equivalent of the word "nearby/arib" was understood as seeing a' relative	كنت بشوف معالج نفسي لو كانت عيادتو قريبة منّي	2.86 (*1.35)*
ACC4	I would not see a therapist if I had to commute a	2.16 *(0.90)*	Commute is a difficult word.	I would not see a therapist if I had to commute/drive a lot	3.71*(0.76)*			3.00 *(1.41)*

	lot./ ما بشوف معالج نفسي إذا لازم إتنقّل كثير على الطريق			
ACC5	I would see a psychotherapist, if I had time./ كنت بشوف معالج نفسي لو كان عندي وقت	2.48 *(1.16)*	3.29*(1.11)*	2.86 *(1.46)*