AMERICAN UNIVERSITY OF BEIRUT

PREDICTORS OF ATTITUDES TOWARDS MENTAL HEALTH HELP SEEKING BEHAVIORS AMONG UNIVERSITY STUDENTS IN LEBANON

by
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ABSTRACT
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Attitudes towards help-seeking are defined as one's inclination to seeking help in times of psychological distress or discomfort and can be positive or negative (Fischer & Turner, 1970). Several factors have been shown in the literature to influence one's attitude towards seeking professional psychological help, including symptomatology and levels of distress (Nam et al., 2013). However, in a country like Lebanon, where professional help seeking behavior is a relatively newer practice, many socio-cultural factors may play an even larger part in impacting attitudes towards help seeking behavior.

The present study aimed to investigate the relationship between levels of psychological distress, religiosity, perceived stigma (public and personal), cultural self-construals, westernization and gender on attitudes towards seeking professional psychological help. Participants were recruited from universities across Lebanon through online links on social media. A total of 132 students from more than 14 universities across Lebanon completed the battery of questionnaire. Gender, personal stigma and religiosity were significant predictors of attitudes towards help-seeking whereas public stigma, cultural self-construals, levels of distress and westernization were not significant predictors. The interpretations of the findings, the limitations and future directions of the study were discussed.

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CHAPTER I

INTRODUCTION

In everyday life, individuals are faced with many stressors associated with life transitions. For students, going to university is a transitory stage, during which they are faced with a lot of decisions and new responsibilities. The stress they face and the changes in their life during this period can affect their adjustment levels (Baysden, 2002; Credé, M., & Niehorster, 2012; Greenidge, 2007). One of the adaptive coping strategies that students use is to seek psychological help, which aids in getting the necessary support and assistance to deal with any distress or worries that arise (Rickwood, Thomas & Bradford, 2012). In a study on adolescent help-seeking, the World Health Organization defined help-seeking as (cited from Barker, 2007):

> "Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services – for example, clinic services, counselors, psychologists, medical staff, traditional healers, religious leaders, or youth programmers – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. The "help" provided might consist of a service (eg, a medical consultation, clinical care, medical treatment, or a counseling session), a referral for a service provided elsewhere or for follow-up care or talking to another person informally about the need in question. We emphasize addressing the need in a positive way to distinguish help-seeking behavior from behavior such as association with anti-social peers, or substance use in a group setting, which a young person might define as help-seeking or coping, but which would not be considered positive from a health and well-being perspective."

Help seeking behavior from a mental health professional has been defined in the literature as a process that is initiated with the recognition of symptoms, searching for, and contacting a mental health professional, attending the first session and then completing treatment thereafter (Lin, Inui, Kleinman, and Womack, 1982). Husky (2011) stated that seeking help is conditional on awareness of distress and acknowledging that one cannot resolve his or her psychological distress alone and insinuated that holding positive cognitions and attitudes towards seeking help is influential and important for seeking help for psychological distress. However, seeking professional psychological help is not the easiest decision to make (Baysden, 2002). Most students are reluctant to seek help, and many who do decide to seek help tend to terminate therapy too early (Al-Darmaki, 2003). A study in Lebanon reported that people tend to think their mental health problems will resolve on their own, that they can handle the problem alone, or that the problem isn't severe enough to seek external help (Karam et al., 2019). Additionally, in Lebanon, the number of individuals in the population that actually seek help is relatively small compared to the number of people who need help; a study showed that only about 10% of those who met a 12-month DSM diagnosis sought any type of help (Karam et al., 2006). It is important to state that there are external factors that could also play a role in help-seeking attitudes, such as non-ethical professionals, bad previous experience, and a lack of regulated mental health practices within the country (Kerbage, El-Chammay & Richa, 2016). However, this study aims to look at factors within the individual that can influence attitudes in order to allow for a better understanding of how these can be targeted.

In the past 24 months, Lebanon has been through a lot of difficulties, starting with a revolution at the end of 2019, the covid pandemic that began in 2020 and the Beirut explosion in August 2020, all of which accentuated the economic situation in the country and led to shortage of a lot of necessities (Bizri, Khachfe, Fares & Musharrafieh, 2021). The economic situation has placed financial stress on a lot of families and many students have had to move universities. University students in Lebanon are at especially high-risk for mental health problems due to the extensive exposure to various stressors including the political and financial instability and the covid pandemic (Kassir, El Hayek, Zalzale, Orsolini, & Bizri, 2021). Power cuts and internet problems have also made it difficult for students to keep up with their online studies. The strain of all this can be seen to affect their mental health, with the Lebanese NGO, Embrace, reporting an increase in people calling the National Lifeline in Lebanon (1564) for emotional support and suicide prevention,in the past few months (Embrace, 2021). These vulnerabilities are further compounded by the lack of high-quality mental health services and the presence of some unethical and legally unregulated mental health providers. Therefore, it was very important to look into university students' attitudes towards mental health help seeking.

Help-seeking attitude has been defined in the literature as the evaluation and perception an individual has or the manner and approach one has towards actually seeking help for a mental health problem or during times of psychological distress or discomfort (Fischer & Turner, 1970 Husky, 2011). Due to the effect of several factors, one's attitude can either be positively influenced, leading to more favorable attitudes, or negatively influenced leading to less favorable attitudes (Fischer & Turner, 1970; Mackenzie, Knox, Gekoski, and Macaulay, 2004). Fischer and Turner (1970) further

explain the difference in positive and negative attitudes; one who has more positive attitudes would view help seeking as a beneficial process, being more open and willing to visit a mental health professional (Al-Darmaki, 2003), and have more optimistic expectations about the process. On the other hand, one who has a more negative attitude would be more critical about seeking help, seeing it as a sign of weakness and failure, with no real expectations of actual change or help from the process.

In the Middle East, although many people still fear mental health help seeking and the stigmas accompanied by it and refuse to identify with having a mental health problem (Al-Krenawi, Graham, Al-Bedah, Kadri & Sehwail, 2009), mental health awareness and education has begun gaining momentum. However, despite the advent of more NGOs targeting mental health and providing professional psychological help, and more mental health awareness campaigns taking place in the Middle East and more specifically in Lebanon, psychologists have still suggested that a lack of awareness about mental health help seeking or professional help seeking (both these terms will be used interchangeably in the literature) and the perception of stigma accompanying mental illness and professional help seeking, prevent some individuals from seeking psychological help (Al-Darmaki, 2005; Sayed, 2003; Zalat, Mortada, & El Seifi, 2019). Arguably, these and other socio-cultural factors are impacting help seeking attitudes, causing people to refrain from openly saying that they suffer from a mental health disorder, or admitting to seeing a mental health practitioner, psychiatrist or psychologist (Al-Krenawi, Graham, Dean & Eltaiba, 2004; Möller-Leimkühler , 2002; Nam et al., 2013; Sayed, 2015).

The purpose of this study is to examine the socio-cultural factors that prevail in Lebanese society and their impact on students' help seeking attitude. This research will

be a step forward in helping mental health professionals better understand what socio-cultural aspects of our society affect help seeking and what can be targeted to increase mental health awareness in the region and allow those who need mental health help take the next step in getting treatment. By understanding the attitudes towards help seeking in the student population, counselors, psychologists, and educators can better target student reluctance to seeking help and can raise awareness to allow individuals in need to benefit from their services, keeping in mind the current situation of the country and its detrimental effect on students.

While there have been some studies on the topic, the scarcity of empirical research in the Arab region and specifically in Lebanon has made it difficult to understand the magnitude of the effect of social and cultural factors on help seeking attitudes in the region. After a close examination of the literature, we identified several factors, pertinent to Lebanese society, and worth exploring in relation to attitudes towards professional help seeking behavior. They are: religiosity, perception of stigma, cultural self-construal, westernization, and gender, in addition to symptomatology and levels of distress.

CHAPTER II

PREDICTORS OF HELP-SEEKING ATTITUDES

A. Symptomatology & Levels of Distress

At the core of seeking help for a mental health problem is the presence of psychological distress. When examining attitudes towards mental health help-seeking, the level of distress and the presence of mental health symptoms are important variables to consider. College students in particular experience a need for psychological help due to the many stressors they face during their years there (Al-Darmaki, 2011; Beiter et al., 2015; Nam et al., 2013). Reports and studies conducted on college students in the United States have found an increase in the prevalence rates of mental health disorders among college students, with almost half of them meeting a DSM diagnosis for a mental health disorder (Blanco et al., 2008; Hunt & Eisenberg, 2010). Most of the time, however, due to the lack of tendency to seek help, lack of belief in needing help and not wanting others to worry (Ali et al., 2020; Gulliver, Griffiths, Christensen, 2010; Rickwood, Deanne, Wilson & Ciarrochi, 2005), these symptoms go untreated (Eisenberg, Speer & Hunt, 2012).

Previous research have focused more on the relationship between distress levels and actual help seeking behavior (Kovess-Masfety et al., 2010; Rickwood et al., 2005; Wilson, Rickwood and Deane, 2007) making it difficult to fully understand the impact distress levels have on mental health help-seeking attitudes (Gullivers, Griffith & Christenson, 2010; Rickwood, Deane & Wilson, 2007) given that those who do seek help may or may not have positive attitudes towards help-seeking. Additionally, the

research findings relating levels of distress specifically to attitudes towards help seeking have also been inconsistent. For example, in a meta-analysis by Nam et al. (2013) no significant relationship between distress levels and help seeking attitudes were found. Komiya, Good and Sherrod (2000) found psychological distress to significantly positively affect help seeking attitudes in a population of university students in the US. A significant negative relationship between psychological distress levels and help-seeking attitudes was found in a study on Jamaican immigrants in the US (Yorke, Voisin & Baptiste, 2016) and a study on African American and African community members and students in a Midwestern university in the US (Obasi & Leong, 2009). Based on these findings, cultural minority groups in the US may be struggling with negative attitudes towards mental health help-seeking along with and despite higher distress levels. Most of the studies measured distress levels using a general score index (GSI) of a symptom inventory checklist. A similar measure, the BSI, was used in this study, as it is a good measure of neurotic and somatic symptoms and is representative of the most common mental health problems that students express and experience at the university level.

It is important to point out here that psychological distress manifests itself in different ways (somatic symptoms, anger, restlessness, sadness, insomnia, loneliness, mood changes) and some symptoms may affect one's ability to want to talk to someone (Do et al., 2019; Nam et al., 2013; Pfohl, 2010). One study focused on university students with symptoms of depression and assessed their attitudes, intentions and beliefs towards mental health help seeking (Halgin, Weaver, Edell and Spencer, 1987). They found that university students with current symptoms of depression had more positive attitudes to help seeking, regardless of any previous help-seeking behavior, reporting

that those with depression were more open to seeking help due to the relief that may come after it, regardless of how difficult the actual help-seeking process would be. In a similar study in Australia, university students with eating disorders reported positive attitudes towards help-seeking and that seeking help would be useful (Ali et al., 2020). Eisenberg et al. (2012) conducted a study on students with a mental health problem (anxiety, suicidal ideation and depression). They reported that students who showed untreated symptoms of a mental health problem had more positive attitudes towards help-seeking, and explained that regardless of their untreated symptoms, students could understand the helpfulness of seeking help. On the other hand, results of a meta-analysis of 19 studies analyzing depression and distress, among other variables, as predictors of help seeking attitudes in samples of non-clinical university students, demonstrated that individuals with depression showed significant negative attitudes towards mental health help seeking (Nam et al., 2013). The authors explained this by pointing out how symptoms of depression, which include feelings of helplessness and hopelessness, can interfere with one's general attitude. Similarly, a study conducted on a population of Syrian refugees in Germany found high prevalence of psychological distress levels to be correlated with negative attitudes towards help-seeking (Schlechter et al., 2020). It was mentioned that this could be due to cultural differences between Syrians and Germans and that Syrians were more likely to handle psychological distress by seeking help from family members, on their own or through religion rather than being open to Western psychological help. In the Arab world, and specifically in Lebanon, there have been no studies relating levels of distress and help-seeking attitudes. In Lebanon, looking into distress levels would help mental health professionals better understand the impact on college students help-seeking attitudes,

and help clarify which symptoms per se are more likely to affect their attitude to seeking help from a mental health professional.

B. Religiosity

Religiosity is a universal concept with commonalities across societies, and which has multiple definitions (Rusu & Turliuc, 2011). In simplest terms, it refers to the different activities, practices and rituals one follows due to an organized set of beliefs (Moreno & Cardemil, 2013). Although religion can have a positive role in protecting from mental health disorders, it can also negatively impact people's attitudes towards help seeking (Hackney & Sanders, 2003). Studies conducted on university students of different backgrounds have shown that those who were more religious had less favorable attitudes towards seeking help from a mental health professional (Mendoza et al., 2015) and in some instances would prefer to seek help from a religious figure (Abe-Kim, Gong & Takeuchi 2004; Al-Darmaki, 2003; Kovess-Masfety et al., 2010). This may be because people high in religiosity attribute psychological problems to a higher supernatural being or to spiritual reasons (Moreno & Cardemil, 2013).

Past research on religiosity has looked into different religious orientations. Two orientations of religiosity that have been differentiated in the past by Allport and Ross, and used extensively in research on religiosity, are intrinsic and extrinsic religiosity (Allport & Ross, 1967; Payne, Bergin, Bielema, & Jenkins, 1991). Intrinsic religiosity refers to internal aspects of religion and beliefs, such as morality, discipline, conscientiousness, and their centrality in one's life (Payne et al., 1991). Intrinsic religiosity involves more normative practices and is emotionally meaningful, directed inwards and is a guiding way to follow and live one's life (Allport & Ross, 1967;

Cohen, Hall, Koenig & Meador, 2005). Someone high on intrinsic religiosity would be someone who truly believes and uses religion to guide them in their everyday life, someone who has a more relationship-centered religiosity (Power & McKinney, 2014). Extrinsic religiosity refers to the use of religion and the engaging of religious practices and rituals for more instrumental and utilitarian reasons such as social connectedness and the gaining of social status and protection, with a lesser commitment to religious values (Allport & Ross, 1967; Power & McKinney, 2014). Extrinsic religion offers a sort of solace and security and is used more for one's own comfort and relief, because it helps them feel better, make friends, or fit in (Gorsuch & McPherson, 1989).

This definition has been adopted from the West and has been criticized in the literature as being outdated, non-normative, biased and lacking contemporary utility (Cohen, Hall, Koenig & Meador, 2005; Flere & Lavric, 2008). Therefore, to better reflect the population under study, this study utilized a scale that was based on the definition of the construct of intrinsic religious orientation as it has been validated in a sample of Iraqi students and Lebanese nationals and is newer than the scale devised by Allport and Ross. Harb (2010) reported no significant group differences in religious beliefs between different religions in Lebanon, and so this scale was a better reflection of the population under study than previous scales that measured both intrinsic and extrinsic religiosity. Religion is a complex multifaceted construct and Lebanon is a country with many religions and religious sects. Looking further into religion would require going beyond the scope of this study. This study is interested in investigating the internal aspects of religion and sought to better understand religion as a predictor of help-seeking attitudes, regardless of any social or political pressures.

Moreno and Cardemil (2013) conducted a study on Latino adults to examine religiosity and attitudes towards seeking help from a mental health professional and found that religious individuals had more positive attitudes towards seeking religious help rather than psychological help. Reasons for this varied from being more comfortable talking to a religious figure, trusting them more, feeling more understood due to similar religious beliefs, and simply that religious help was more accessible to them than psychological help. However, some participants had positive attitudes to seeking psychological help if they felt understood or had more severe psychological disorders with a neurological basis (such as schizophrenia, or developmental disorders such as autism).

Highly religious people may be less likely to seek help for a problem and would rather rely on the internal aspects of their religion (Abe-Kim et al. 2004; Payne et al., 1991) for support or guidance. Additionally, it has been reported that those who were more comfortable and familiar seeking help from religious people were less likely to seek help from mental health professionals (Abe-Kim et al., 2004).

Studies, however, have found mixed findings. A study conducted previously by Miller and Eells (1998) on Christian university students found that those who were higher in religiosity were more open to seeking professional help and had more awareness about their mental health, explaining that this could be because they have internalized forgiveness and acceptance as part of their religion, and are therefore more open about their difficulties and finding solutions for their psychological problems. Opposing results were found by McGowan and Midlarsky (2012) who reported that older adults who scored higher on scales of religiosity were less likely to speak to a mental health professional, speculating that this could be because older adults would

prefer to refer to their religion to cope with psychological distress. Rogers-Sirin, Yanar, Yuksekbas, Senturk & Sirin, (2017) also found religiosity to be a negative predictor of help-seeking attitudes in a population of Muslims in Turkey, explaining that many Turks prefer to turn to religious help when going through difficult times. They also pointed out that this was further mediated by family values and independent cultural identities. Using the Harb & Rbeiz religiosity scale, in an unpublished study, Hassan (2015) found that religiosity was a non-significant predictor of help-seeking attitudes in a Lebanese student population at the American University of Beirut. Hassan's study was conducted in an American University setting, whereas university settings outside the American educational culture may demonstrate different findings regarding religiosity.

The little amount of research conducted in the Middle East makes it difficult to predict if similar results will be found in such a population or not. Moreover, in the Middle East, religion plays a significant role in our everyday lives, and governs one's thoughts, actions and behaviors, leading people to religious help rather than mental health help in times of distress (Gearing et al., 2013). In our region, and more specifically so in Lebanon, there are many different religions and religious sects and so the findings in the literature may not similarly project in Lebanon.

C. The Perception of Stigma

Stigma refers to the negative label that accompanies a word, and the group of people to whom it is referring (Hayward & Bright, 1997). In the case of mental health, stigma is a negative attitude one has towards mental health in general (Mendoza et al.,

2015) and is usually directed towards others and not the self (Masuda, Anderson & Edmonds, 2012).

Several studies measuring stigma as a predictor of attitudes towards mental health help seeking, have found the perception of stigma to be associated with negative attitudes towards help seeking in both general populations (Wrigley, Jackson, Judd & Komiti, 2005) and university students across the US (Eisenberg, Downs, Golberstein & Zivin, 2009). Studies conducted on university students have shown that those who had higher scores on scales of stigma perception endorsed less favorable attitudes towards help-seeking (Masuda et al., 2012; Mendoza et al., 2015).

Many hypotheses as to why the perception of stigma is strongly predictive of negative attitudes have been proposed. Mishra, Lucksted, Gioia, Barnet and Baquet, (2009) propose that negative attitudes towards help seeking are based on fear of being labeled as a mentally ill person. Stigma surrounding mental health leads to negative assumptions about mental health and help-seeking (Corrigan, 2004). These assumptions include being discriminated against, being forced into treatment, thinking that one will not lead a normal life in the presence of psychological distress or a disorder, being labeled as psychologically ill or unstable, or being seen as ‘not normal’, and these tend to cause negative feelings and thoughts towards mental health help seeking (Corrigan, 2004; Mishra et al., 2009). People are inclined to push away from any situation that might attract a label of mental illness to themselves, including visiting a mental health professional (Corrigan, 2004). This is also true in the Arab world which similar to other countries, places a lot of stigma and shame in visiting a mental health professional (Sayed, 2003).

Stigma can come in many forms. Those forms include: *public stigma*, which is a general term for the labels, stereotypes and prejudices about mental health and mental illness held by a community or society public, *personal (or self) stigma*, which is an individual's perception of stereotypes and prejudices, and *perceived public stigma*, which is how an individual perceives the community would react (Corrigan, 2004; Eisenberg et al., 2009; Wang, Peng, Li & Peng, 2015). Wang et al. (2015) reported that stigma significantly predicted attitudes towards help seeking and that, more specifically, both public and personal stigma affected one's attitude towards help-seeking. Eisenberg et al. (2009) conducted a study on university students across the US and found that perceived public stigma and personal stigmas were both associated with negative attitudes towards help seeking. Vogel, Wade and Hackler (2007) found that personal stigma fully mediated the relationship between perceived public stigma and attitudes towards seeking help, and that more-so, personal stigma was a greater indicator of help-seeking attitudes, than was perceived public stigma. Similarly, a study by Jung, von Sternberg and Davis (2017) also found self-stigma to be a significant predictor of help-seeking attitudes on a population of working adults in Texas. In this study, both perceived public and personal stigma will be investigated as predictors of help seeking attitudes in Lebanon.

D. Cultural Identity & Self-Construals

Cultures differ across the world, and have previously been distinguished as being individualistic or collectivistic, with the former placing emphasis on the individual and on independence and the latter on families, societies and on cultural values (Helmes & Gallou, 2014; Triandis & Gelfand, 1998). Cauce et al. (2002) stress

on the importance of culture in societies in relation to help seeking attitudes. In societies and communities in which familial bonds are important, people may be less open to seek help from a mental health professional because their family offers them the support and help needed (Cauce et al., 2002).

Cultural values, along with the norms and beliefs of a culture further influence one's self-construals (Kiuchi, 2006). The research has introduced the concept of cultural self-construals and identities to better capture the influence of culture on an individual. Cultural identity can be defined as the group members' experience, portrayal, and negotiation of dynamic social identifications in specific circumstances (Chen & Lin, 2016). People tend to enact and experience not just one cultural identity at a time, but often numerous cultural identities at the same time as they identify with, or desire to be accepted into, different groups (Chen & Lin, 2016). Markus and Kitayama (1991) further differentiated identities within a culture according to different construals of the self, others, and the interdependence of both. Self-construals have been defined as the meaning individuals give to the self in relation to others (Cross, Hardin & Gercek-Swing, 2011); two identified self-construals are the independent and interdependent, with the former relying more on the self, and the latter emphasizing others relationship to the self, or the connectedness of others to the self (Markus & Kitayama, 1991). In collective societies, individuals tend to relate the self to others and take into consideration the thoughts, emotions, and reactions of others in relation to their experiences (Shea & Yeh, 2008). However, since individuals are integrated into cultures, and cultures define individuals, it can be said that cultures and self-construals are almost one and the same with individualistic cultures endorsing independent self construals and collectivistic cultures endorsing interdependent self-construes (Cross et

al., 2011). Also, Markus & Kitayama (1991) have suggested that individuals have both independent and interdependent self-construals but that one or the other is endorsed through interaction within one's cultural context.

Both cases of independent and interdependent are further differentiated into horizontal and vertical relationships; vertical relationships emphasize hierarchy whereas horizontal relationships emphasize equality (Harb & Smith, 2008; Triandis & Gelfand, 1998). However, it is beyond the scope of this study to examine horizontal versus vertical dimensions since this study is more interested in the cultural aspect of self-construals and relationships that shape one's identity and not the view one has towards equality or hierarchy.

Apart from the country's cultural orientation, the different self-construals one has have been shown to affect attitudes towards help seeking. Although the research has looked into the relationship between self-construal and help seeking attitudes, results have been contradictory, and most studies have explored this relationship in Asian Americans and Asian populations, with one cross-national study comparing them to an American student population (Yamawki, 2010). Shea and Yeh (2008) explain how Asian cultures are more collectivistic, with an emphasis placed on familial bonds, avoidance of emotional openness, lack of self-disclosure to strangers or non-family members, and the protection of their families from shame and dishonor. Yet, studies have shown that having a more interdependent self-construal is usually associated with more favorable attitudes towards mental health help seeking (Hao & Liang, 2007; Shea & Yeh, 2008; Yeh, 2002). Asian American students who had higher relational-interdependent self-construals had more positive attitudes towards help seeking and were more open to seeking help and to forming new relationships with others, such as

mental health professionals, explaining that this could be due to the comfort they have with talking to others and asking for help from others of higher understanding and expertise, and the fact that this study was conducted on Asian Americans living in the US (Shea & Yeh, 2008) A cross-national study comparing Japanese and American student populations showed that having a more independent self-construal predicted more positive attitudes towards help-seeking in both groups (Yamawaki, 2010). This difference can be explained due to the fact that participants in the studies were from different countries, keeping in mind that values differed even within Asian countries. Taking into consideration the strong family ties found in such cultures, some people may find it more difficult to seek help and disclose personal information to a stranger (Shea & Yeh, 2008). These findings have shown that depending on the country and cultural value endorsement (autonomy vs connectedness) of the participants (Yamawaki, 2010) there exists ambiguity in the role of self-construals and professional help seeking attitudes. In some societies, the independent self has been shown to be more open to communicating directly with others, whereas in other societies, the interdependent self is more comfortable with going to others in times of need and are open to expressing emotions, making it easier for them to seek professional help (Cross & Madson, 1997).

In recent years, studies have emerged on Turkish populations. Turkey is a country that is described as bridging between the West and the Middle East, being geographically located close to European countries but having a more Middle Eastern culture within it; therefore, studies in Turkey reflect the influence of both Western and Eastern cultures (Rogers-Sirin, Yanar, Yuksekbas, Senturk & Sirin, 2017) and may give a little insight into the effect of self-construal on help seeking attitudes in a Middle

Eastern country like Lebanon. Yalcin (2016) reported that in a Turkish population of individuals with university degrees, a significant positive relationship was found between independent self construals and help seeking attitudes, whereas a significant negative relationship was found between interdependent self-construals and help seeking attitudes. They explained their finding by relating it to social stigma, explaining that independent people are less affected by stigma than are interdependent individuals. In her study on Turkish university students, Koydemir-Ozden (2010) explored the relation between self-construal and attitudes toward psychotherapy and found an association between higher levels of independent self-construal and more positive attitudes towards help seeking. Contradictory to other findings, she reported a positive relationship between higher interdependence and attitudes towards help seeking, arguing that this could be due to the balance of independent and interdependent self-construal caused by the Westernization of Turkey. She explained that perhaps these two self-construals are not actually opposites or independent of one another but rather have both been integrated within oneself and co-exist in the Turkish culture due to the effect of the West, thus explaining the similar findings with regards to both self-construals and positive help seeking attitudes (2010).

Culture and cultural values are an important part of the Arab world. Arab communities and cultures tend to place importance on the collective rather than the individual, with a focus on religion, patriarchal relations, and family, which play a large role in the individual's growth (Al-Krenawi et al., 2009). A study by Harb and Smith (2008) conducted on an Arab population of Jordanians, Lebanese and Syrians measured the different self-construals found within these populations. They reported that Arabs from Lebanon, Jordan and Syria tended to endorse a more interdependent lifestyle,

explaining how self-construals are affected by one's culture and community, with Arab communities endorsing collectivism more than individualism. Although culture has been shown to affect help seeking behavior, no published research exists that examine the effect of self-construals on attitudes towards help seeking in the Arab world, and studies conducted in the US have shown inconsistent findings with a tendency towards Asian Americans who identify with interdependent self-construals demonstrating more positive attitudes towards help seeking.

Due to the limited number of studies on Middle Eastern communities, no conclusion can be made as to the direct implication of self-construals in a Middle Eastern country, specifically Lebanon. Therefore, this study will aim to identify any significant relationship between cultural self-construals within our culture and mental health help seeking attitudes.

E. Westernization

Although cultural values are an important part of Arab societies, the influence of the west has become more prominent in recent years. Westernization is defined as the acculturation and integration of western technology, media, ideas and research in a non-western population (Stephenson, 2000). Across the years, Middle Eastern countries have adopted various forms of westernization. Westernization has not only affected education and lifestyle but has also been integrated into the different mind-sets and attitudes of the population. Western norms that have been integrated into the Middle East may guide/influence attitudes towards mental health help seeking behaviors.

Studies have examined acculturation as a predictor of help seeking attitudes rather, focusing on populations who live within the western community rather than

societies that have adapted western cultures into theirs. Studies aiming to explore how acculturation may influence attitudes towards mental health help seeking in different ethnic groups has found that the more acculturated a group was, the more positive their attitudes towards seeking help. This was found in Asian American groups (Atkinson & Gin, 1989; Miller, Yang, Hui, Choi & Lim, 2011) and African American students (Obasi & Leong, 2009).

There is very scarce literature conducted on the effect of westernization on mental health help seeking attitudes. To investigate the effects of westernization on mental health help seeking attitudes, one study examined four groups: European Americans, Chinese Americans, Honk Kong Chinese and Mainland Chinese (Chen & Mak, 2008). They based their study on the hypothesis that the more integrated into western norms a group was, the more likely they were to seek help from a mental health professional. They found that with varying degrees of Westernization, the more culturally integrated with Western values the group was, the more favorable their help seeking attitudes. European Americans were more open to seeking help than were Chinese Americans, while Honk Kong Chinese (who are reported to be more westernized than Mainland Chinese) similarly showed more favorable attitudes to seeking help than did Mainland Chinese. Chinese Americans were also shown to have more favorable attitudes than Honk Kong Chinese, supporting the idea that the more westernized a group was, the more positive their help seeking attitudes would be. Middle Eastern immigrants in the United States were found to have a significant positive relationship between levels of acculturation and attitudes towards seeking help, however the author reported that due to the limited research in Middle Eastern

populations there was little insight as to whether this finding can be generalized or not (Tigranyan, 2020).

In the Middle East, an unpublished study by Hassan (2015) showed that the acculturation and integration of western media technology and research has positively predicted help seeking attitudes in a population of Lebanese students attending the American University of Beirut. However, it is unclear whether this finding can be generalized to the university students from different backgrounds. Building on Hassan's study, westernization will be examined in relation to help-seeking attitudes in the different university students in Lebanon.

F. Gender

In different societies across the world, men are expected to be stoic, independent, and successful and to not express much emotion, whereas women are expected to be reliant, dependent, and care-giving, and to show more emotions and affection (Addis & Mahalik, 2003). For these reasons, women have been shown to be more open to help seeking than men (Al-Krenawi et al. 2009). In the Middle East however, women may refrain from getting psychological help because they fear any shame it might bring to them or their families and the effect it may have on the way others think about her and her chances of getting married (Al-Krenawi et al., 2009). This does not mean that men are more likely to seek help; on the contrary, women in Arab countries have been shown to be more open to help-seeking than men, even if they may not actually consider seeking help or if they do not intend to actually seek professional psychological help (Al-Krenawi et al., 2009). In such societies conformity to norms influences both men's and women's decisions and attitudes to seeking help

(Addis & Mahalik, 2003; Al-Krenawi et al., 2009, Yamawaki, 2010). Men tend to associate seeking help with a diminishing of masculinity (Chang, 2007), and it has been reported that Arab males, regardless of education levels, tend to associate psychological problems with self-weakness (Youssef & Deane, 2006).

In different populations, gender has been found to be a significant predictor of seeking mental health professionals (Johnson, 1988; Wrigley et al., 2005, Yamawaki, 2010). Across populations, males tended to have more negative attitudes towards help-seeking (Addis & Mahalik, 2003; Yamawaki, 2010). Men's lack of emotional openness was a main reason behind their negative help-seeking attitudes (Yousaf et al., 2015). Not only did lack of emotional openness lead to negative attitudes (Kaya et al., 2019), but gender-role conflicts and masculine attitudes also added to the negative attitudes men had towards seeking-help. On the other hand, females, and especially female students, have been reported to endorse more positive attitudes towards help seeking than males (Ang, Lim, Tan, & Yau, 2004; Chang, 2007; Do et al., 2019; Leong & Zachar, 1999; Masuda et al. 2012; Mendoza, Masuda & Swartout 2015).

In a study on high school students in Israel, Jewish and Arab females were found to be more likely to seek help than males (Grinstein-Weiss et al., 2005). In a Lebanese university student population, Hassan (2015) found that although gender was not a significant predictor of help-seeking attitudes, females tended to report more positive and favorable attitudes to help-seeking whereas males reported more negative attitudes, congruent with past studies. Matlock-Hetzel (2004) additionally found that female students are more aware of counseling services on campus than are males. In general, the research has shown that females are more open and likely to seek mental health care and to have more positive help-seeking attitudes than are males (Ang et al.,

2004; Bilican, 2013; Johnson, 1988; Mackenzie, Gekoski, & Knox, 2006; Matlock-Hetzel, 2004).

G. Age, Income Level, Previous Help Seeking Behavior, Geographic Location, and Awareness of Help Seeking Resources

While many socio-cultural barriers to help-seeking attitudes have been identified, the literature has also found socio-demographic factors to be associated with help-seeking attitudes.

Studies have found higher income levels to significantly relate to more positive help-seeking attitudes (Karam et al., 2019; Picco et al., 2016). With regards to age, Karam et al., (2019) reported that those who were younger to middle aged have more positive help-seeking attitudes. Attitudes were not assessed using a valid scale but by asking subjective questions about comfort talking to a professional about their problems, likelihood to consult a professional and fear of embarrassment if friends found out they were talking to a professional. Picco et al., (2016) also reported significant positive attitudes in younger adults and discussed the negative relationship between older adults and help-seeking attitudes. Other studies have reported opposing results, finding older adults to generally have more positive help-seeking attitudes (Robb, Haley, Becker, Polivka, and Chwa, 2003), revealing inconsistent age-related differences in help-seeking attitudes.

Previous help-seeking behaviors have also been reported to significantly affect help-seeking attitudes (Halgin et al., 1987; Picco et al., 2016). Al-Krenawi, Graham, Dean & Eltaiba (2004) also argued that geographical location can play a role in help seeking attitudes, as professional services are more likely to be found in cities or larger medical facilities. Since most universities in Lebanon are spread out across urban and

rural areas, it was important to keep this in mind when conducting this study. A study on a Jordanian population found socio-demographic factors to have no significant influence on help-seeking attitudes suggesting that lack of awareness of help-seeking resources or cultural and societal factors better explain any significance in help-seeking attitudes (Al-Ali, Alqurneh, Dalky & Al-Omari, 2017). To minimize any possible confounding effects of these variables, age, socioeconomic level, place of residence, previous help seeking behaviors, and awareness of help-seeking resources were controlled for in this study.

CHAPTER III

AIMS AND HYPOTHESES

Research on Middle Eastern attitudes towards help seeking is scarce, as such, little is known about such attitudes in Lebanon. Additionally, there have been no published studies on the effects of multiple socio-cultural variables including self-construals, perceived stigma and westernization, together with levels of distress, as predictors of help-seeking attitudes. The aim of this study was to explore these socio-cultural predictors of attitudes towards help-seeking in university students in Lebanon, with the aim of contributing to the local literature on help-seeking attitudes. Attitudes towards help seeking can lead to one's lack of awareness about his/her mental health and affect his behavior related to mental health help-seeking. Therefore, it is important to assess and understand what factors predict help seeking attitudes, as this will help people better understand the role external societal factors can have on their experiences and attitudes towards help-seeking.

The following hypotheses were examined while controlling for age, socioeconomic level, previous help seeking behaviors, place of residence and awareness of help-seeking resources.

A. Hypotheses

Most studies have found that those high on religiosity had less favorable attitudes towards help-seeking (Abe-Kim, Gong & Takeuchi, 2004; McGowan &

Midlarsky, 2012; Mendoza et al., 2015; Miller & Eels, 1998). Accordingly, the following hypothesis was tested:

Hypothesis 1. Religiosity will be a significant negative predictor of help seeking attitudes.

Research has shown stigma to negatively influence attitudes to help seeking (Eisenberg et al., 2009; Wang et al., 2015; Wrigley et al., 2005). Therefore, the following hypotheses were tested:

Hypothesis 2a. Perceived public stigma will be a significant negative predictor of help-seeking attitudes.

Hypothesis 2b. Personal stigma will be a significant negative predictor of help-seeking attitudes.

Studies have shown westernization to be a predictor of help-seeking attitudes (Miller et al., 2011; Chen & Mak, 2008). Therefore, the following hypothesis was tested:

Hypothesis 3. Westernization will be a significant positive predictor of help-seeking attitudes.

Studies have shown gender to predict help-seeking attitudes, with the research indicating that being female is a positive predictor of help-seeking and being male is a negative predictor of help-seeking attitudes (Ang et al., 2004; Bilican, 2013; Johnson, 2010; Mackenzie, Gekoski, & Knox, 2006; Matlock-Hetzel, 2004). Therefore, the following hypothesis was tested:

Hypothesis 4. Gender will be a significant predictor of help-seeking attitudes.

B. Exploratory Hypotheses

Both symptomatology and psychological distress have been shown in the literature to be a positive predictor of help-seeking attitudes by some (Halgin et al, 1987; Komiya, 2000) and negative predictor by others (Obasi & Leong, 2009; Nam et al., 2013). Because the findings are few and inconclusive, the following hypotheses were tested:

Hypothesis 5a. Psychological distress will be a significant predictor of help-seeking attitudes.

Hypothesis 5b. Levels of depression, anxiety and somatization will differentially affect help seeking attitudes.

Because self-construals have been found to be a significant predictor of help-seeking (Koydemir-Ozden 2010; Shea & Yeh, 2008; Yamawaki 2010), the following hypothesis was tested:

Hypothesis 6. Cultural self-construals will be a significant predictor of help seeking attitudes.

CHAPTER IV

METHODOLOGY

A. Participants

For inclusion in the proposed study, participants had to be enrolled at any university across Lebanon and be at least 18 years old. Tabachnick and Fidell (2013) recommend that the minimum sample size should be calculated according to the formula 50+8m, where m is the number of predictors. This study had 7 predictors, of which one has 2 subscales and another has 3 subscales; therefore, the recruited sample size should exceed 130 participants.

B. Research Design

This was a quantitative non-experimental research study, which used Lime Survey (online survey), which included a demographics form and six scales for data collection. The demographics form consisted of questions related to gender, age, SES, nationality, major, place of residence, year at university, previous help-seeking behavior and awareness of help seeking resources. The battery of questionnaires also included the scales that measured the outcome variable (attitudes towards seeking help) and the predictor variables (symptomatology and levels of distress, religiosity, stigma, self-construals, and westernization). Reliability analyses were conducted to examine the psychometric properties of the scales prior to the use of multiple regression analyses to examine the study's hypotheses. All the instruments were originally in English and were translated to Arabic and backtranslated by professional translators to provide

participants with the option of choosing to fill out the survey in either English or Arabic.

C. Format of the Survey

The questionnaire contained an informed consent form (see Appendix A), for the sample recruited through social media. The form, provided in English and Arabic, informed the potential participants about the study, including its components, risks and benefits associated with it, confidentiality of participant information, their freedom to withdraw from the study and who to call if they have any questions, so as to assist potential participants make an informed decision about whether or not to participate. Participation was totally anonymous and could not be linked to a specific name or email. The informed consent form informed the participants that the study was investigating attitudes of university students in Lebanon towards mental health help-seeking. The informed consent form also included the contact information of the principal investigator and the co-investigator, in case the participants had any questions about the study. The demographics form, and the six scales mentioned above are described in detail next.

D. Scales and Reliability

1. A Questionnaire of Demographics and Other Information

The demographics questionnaire consisted of three sets of items that measure demographic covariates, help-seeking behaviors and access to help-centers (See Appendix B).

a. Demographic Covariates

Seven items measured the demographic covariates gender, age, nationality, his or her family's monthly income, major, year at university, and place of residence (rural or urban).

b. Help-Seeking Behavior.

Three items were used to assess help seeking behaviors. One of the items was used to assess whether participants have ever obtained mental health services in the past. Another item assessed awareness of help-seeking and a third item assessed the type of help (medical help, mental health help, religious help, and help from the family…) that participants would seek were they to experience any symptoms of psychological distress (such as depression or anxiety).

2. Attitudes toward Seeking Professional Psychological Help – Short Form

The Attitudes toward Seeking Professional Psychological Help – Short Form (ATSPPH-SF) (Fishcer & Farina, 1995) was used to measure the outcome variable (attitudes toward help-seeking behavior) (see Appendix C). The ATSPPH-SF is an abbreviated version of the Attitudes toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970). The ATSPPH-SF includes 10 items such as "If I believed I was having a mental breakdown, my first inclination would be to get professional help" and "A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help". The answers were given along a 4-point Likert scale with "1" indicating disagree and "4" indicating agree. The total score of the scale, calculated by summing up the responses on all 10 items, reflects

the participant's overall attitude toward help-seeking behavior. Higher scores indicate positive attitudes to help-seeking behavior and lower scores indicate negative attitudes toward help-seeking behavior. The midpoint score is 25. The validity of the short form was established by significant correlations (.87) with the original scale, indicating that both measured the same construct (Fisher & Farina, 1995). The scale also had high internal consistency .84, high construct validity .87, and high test-retest reliability .80 (Fischer & Farina, 1995). Moreover, Rayan, Baker and Fawaz (2020) found that the Arabic version of this scale had good reliability and validity, with Cronbach alpha of .72, among a Jordanian student sample. In this study, the reliability analysis indicated that this scale had good reliability (Cronbach's α = .77) (see Table 1).

3. Religiosity Scale

The religiosity scale was used to measure the level of religiosity of participants (Rebeiz & Harb, 2010) (see Appendix D). The religiosity scale contains 8 items such as "I believe that God exists", and "My religion influences the way I choose to act in my routine life". The answers are given along a 7-point Likert scale ranging from 1 (strongly agree) to 7 (strongly disagree)[1]. Item number 6 is reverse coded. The total score of the scale is calculated by taking the average of the scores obtained on the 8 items, with lower scores indicating higher religiosity levels (in this study, higher scores (scores higher than 4) indicated higher religiosity levels). This scale has been validated on a sample of Iraqi students (Fischer, Harb, Al-Sarrafe & Nashabe, 2008) and a representative sample of Lebanese nationals (Harb, 2010). The religiosity scale has been

[1]The rating of the religiosity scale, from 1 (strongly disagree) to 7 (strongly agree), was inconsistent with the rating of the original scale. The rating of the original scale was from 1 (strongly agree) to 7 (strongly disagree).

shown to have high internal consistency (α =.93). Cronbach's alpha of the religiosity scale in this study was .93 indicating high reliability (see Table 1).

4. Stigma Scales

Stigma was measured using an adapted scale (see Appendix E). Eisenberg et al., (2009) measured *perceived public stigma* using an adaptation of the Discrimination-Devaluation (D-D) Scale developed by Link and colleagues, which has been used in several previous studies (Link, 1987; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). The D-D scale asks people how much they agree with each 12 statements that ask about stereotypes (discrimination, or the opposite (an accepting view or behavior)). The original D-D scale refers to a "mental patient" or a "former mental patient" or a person "who has been hospitalized for mental illness." Eisenberg et al (2009) adapted the wording to refer instead to "a person who has received mental health treatment" because their objective was to measure perceived stigma regarding a broader concept of mental health treatment. As in the original D-D scale, the answer choices were on a 6-point Likert scale with 5 being *strongly disagree*. and 0 being *strongly agree*. As in the original use of the scale, Eisenberg et al. (2009) constructed an index of perceived stigma by coding each response as 0, 1, 2, 3, 4, or 5 (with higher numbers referring to answers indicating higher perceived stigma) and calculating the average across the 12 items for each individual. The midpoint score for this scale is 2.5. They found a high internal reliability (Cronbach's α = .89) in this adapted scale. The reliability analysis in this study indicated high reliability (Cronbach's α = .86) (see Table 1)

To measure people's own stigmatizing attitudes about mental health treatment or personal stigma, they adapted three items from the perceived stigma scale by replacing

"Most people" with "I". These three items referred, respectively, to a negative attitude ("… would think less of someone …"), an accepting behavior ("…would accept as a close friend …"), and an accepting attitude ("…think someone is just as trustworthy …"). Eisenberg constructed an index of personal stigma by averaging across the three items on a 0 to 5 scale, where higher numbers refer to higher stigma, similar to perceived stigma scale, with a similar average midpoint of 2.5. The internal reliability of this scale was relatively high (Cronbach's $\alpha = .78$). In this study, the reliability analysis showed a high reliability (Cronbach's $\alpha = .83$) (see Table 1). The complete wording of the measures is shown in the appendix.

5. Brief Symptom Inventory

The Brief Symptom Inventory-18 (BSI-18) is a psychological distress assessment instrument, derived from the Brief Symptom Inventory and the Symptom Checklist-90-Revised (SCL-90-R) designed to screen for elevation on depressive, anxious, and somatic symptom dimensions (Derogatis & Lopez, 2000). Previous research has shown support and preference in its use in college and university counseling centers (Hayes, 1997). The BSI-18 is a self-report measure consisting of 18 items that ask the respondents to rate how often they have experienced somatization (SOM), depressive (DEP), and anxiety symptoms (ANX) within the past 7 days on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). Scores can be obtained for the anxiety, depression, and somatization dimensions, in addition to the global severity index (GSI) score. The GSI represents the global or total score, which summarizes the respondent's overall level of psychological distress. The cutoff score of ≥ 54 indicates high psychological distress. Derogatis & Lopez (2001) provided

preliminary support for the validity of the BSI-18 by using the community normative sample. On the basis of the same community of 23 sample, the BSI-18 has shown adequate to good internal consistency (alpha= .74, .84, .79, and .89, for somatization, depression, anxiety, and GSI, respectively; Derogatis & Lopez, 2001) (refer to Appendix F). Moreover, Al-Dweik and Aburuz (2020) found that the Arabic version of this scale had high reliability, Cronbach's alpha = .86, for the GSI. Cronbach's alpha of the BSI in this study was .94, .83, .84, .88, for GSI, depression, anxiety and somatization, respectively, indicating high reliability (see Table 1).

6. Self-Construals Scale

The Sixfold Self-Construal Scale (SSCS; Harb & Smith, 2008) is a 30-item questionnaire designed to measure the personal, relational, and collective dimensions of self-construals (refer to appendix H). Vertical and horizontal dimensions are also included within the scale, however, for the purpose of the current study, the horizontal and vertical scores were not of importance and so were not looked at. The final scale is used to demonstrate the participant's level of connectedness to each of six groups (My family, My friends, Students in my department/faculty, My social grouping, Humanity in general[2], Myself) on five different items. These items include: "I think of myself as connected (linked) to _____" and "I control my behavior to accommodate the wishes (interests) of _____". Responses to the Sixfold Self-Construal Scale are measured on a 5-point Likert type scale (1-to a very small extent; 5-to a very large extent). The midpoint score for the scale is 2.5. Cronbach's alpha coefficients for the scale were

[2] Humanity was included in the questionnaire but was not included in the main analysis of the study as it is a self-construal category unrelated to the purpose of the current study.

above .80 across samples and subcategories, with the exception of reliability coefficients between .64 and .70 for the personal identity category (Harb & Smith, 2008) (see appendix G). For this study, three categories of the scale were utilized: the personal, the relational and the collective. The humanity-bound self-construal was too broad and unrelated to the purpose of this study and therefore was not included in the main analysis of this study. Cronbach's alpha was .87, .86, .84 and .87 for the self-construal scale, personal subscale, relational subscale, and collective subscale respectively in this study indicating high reliability through the scale (see Table 1).

7. Dominant Society Immersion Subscale (DSI) of the Stephenson Multigroup Acculturation Scale (SMAS) (Stephenson, 2000)

The DSI subscale was used to measure Westernization (Appendix H). It is a 15-item subscale designed to assess the level of Westernization. Items are rated on a 4-point Likert scale: false (1), partly false (2), partly true (3), true (4). The total score of the subscale is calculated using the summation score of the 15-items, with higher scores indicating a higher level of Westernization. The cutoff score for this scale is 30. Validity of the DSI factor of the scale was established by Stephenson (2000) by comparing it with the Anglo Orientation Subscale (AOS) of the Acculturation Rating Scale (r= .49) among a sample of diverse ethnic groups in New York City. The DSI subscale was shown to have a good reliability (.75). For this study, the scale was adapted by adding the word "European" next to United States, and French/Spanish next to English language to cover most Western countries that are relevant in Lebanese context. Additionally, item 14 "I feel at home in the United States" was replaced with "If I visited or will ever visit the United States/Europe I will feel at home. An

unpublished study by Hassan (2015) conducted on students in a university in Lebanon, using this scale, found high reliability (α = .85). In this study, Cronbach's alpha for this scale was .89 indicating high reliability (see Table 1).

Table 1

Reliability of the Scales and Subscales: Cronbach's alpha

Scales and Subscales	Cronbach's alpha	N of items
Attitudes toward Seeking Professional Psychological Help- Short Form (ATSPP-SH)	.77	10
Religiosity Scale	.93	8
Stigma Scale		15
Perceived Public Stigma	.86	12
Personal Stigma	.83	3
Brief Symptom Inventory	.94	18
Depression	.83	6
Anxiety	.84	6
Somatization	.88	6
Sixfold Self-Construal Scale	.87	30
Personal Scale	.86	5
Relational Scale	.84	10

Collective Scale	.87	10
Dominant Society Immersion Subscale (DSI) of the Stephenson Multigroup Acculturation Scale (SMAS)	.89	15

E. Pilot Study

After obtaining approval from the IRB, the questionnaires were pilot tested with a convenience sample of 10 students from the American University of Beirut contacted via email, to examine cultural relevance, sensitivity and comprehension of the scales, to record the time it takes to complete the survey and to make sure the questions were clear. Participants were asked to keep their knowledge about the study confidential. The average time needed to complete the questionnaire ranged between 10 to 20 minutes. The participants were asked open-ended questions by the co-investigator and reported that the measures were clear. Therefore, no changes were necessary to any of the measures or procedures.

F. Main Study

1. Procedure and Data Collection

Data collection for the main study started after receiving the Institutional Review Board (IRB)'s approval on May 24th 2021. The recruitment method used to recruit participants for the main study, was computerized and accessible through a Lime Survey link, through non-random convenience sampling. The advertisement, which

included some information about the purpose of the study, information on how to participate and the links to both the English and Arabic survey versions, was circulated across student groups. The advertisement and the link were spread through online links on social media through Facebook and WhatsApp groups of university students by the admins of the groups, to students who attend either AUB or any university across Lebanon. Interested students were asked to click on the link which directed them to the Lime Survey. Participants were presented with an informed consent form. Upon consent, participants were asked to complete the questionnaire. Participants were able to access it at their own comfort and choice of setting.

2. Sample Characteristics and Demographics (see Tables 2 and 3).

The inclusion criteria were to be above 18 and enrolled in any university in Lebanon. A total of 145 students completed the questionnaire. Of those, the data from one student was excluded because they were less than 18 years old and it was stated in the advertisement and informed consent form that participants had to be above 18 years old. The data from 12 students were also excluded because they omitted one or more full scales. The final sample size included 132 participants. The final sample included 41.7% (55) males, 56.8% (75) females, 1.6% (2) other; the mean age of the participants was 22.78 years (SD = 5.04) with a range from 18 to 50 years of age (see table 2). The majority of participants were Lebanese (93.9%), while the remaining participants reported being Palestinian (3%), or other nationalities (3%). Participants were recruited from more than 14 universities across the country (see table 3) with a majority of them registered in the Lebanese University (28.8%) which is a public university. The rest of the participants were registered in private universities. Moreover, most of the

participants were not majoring in psychology (97.2%). Twenty-nine (22%) participants were business majors, 23 (17.4%) were engineering majors, 22 (16.7%) were majoring in social sciences which included psychology, economics, sociology and social workers, followed by 21 (15.9%) science majors which included biology, chemistry, math, physics and computer science and 10 (7.6%) were nursing students. Eight (6.1%) participants also reported majoring in architecture or design (graphic, interior and fashion), 5 (3.8%) were studying arts or languages and 5 (3.8%) were majoring in health sciences and 9 reported studying other majors (6.8%). Furthermore, most of the participants were graduate students (38.6%), followed by senior students (22%), sophomore students (19.7%) and junior students (12.1%). The minority of participants were freshman students (7.6%). In this sample, 71.2% earned a household monthly income in LBP, 25% in USD, and 3.8% other. Details of the amount earned per household are listed in Table 3.

Regarding place of residence, 59.1% (78) participants live in urban areas and 40.9% (54) participants live in rural areas. When asked if they had ever obtained mental health services, 73.5% (97) answered no and 26.5% (35) answered yes. Finally, the majority of participants (90.2%) were aware that were they to experience any mental health problems they can treat them by seeking mental health services.

Table 2

Demographics	N	Min.	Max.	Mean	Std. Dev
Age	132	18	50	22.78	5.04
Valid N (listwise)	132				

Descriptive of the sample characteristics (age)

Table 3

Descriptive of the sample characteristics

		N	%
Gender	Male	55	41.7%
	Female	75	56.8%
	Other	2	1.6%
Nationality	Lebanese	124	93.9%
	Palestinian	4	3.0%
	Other	4	3.0%
University	AUB	27	20.5%
	AUST	2	1.5%
	BAU	6	4.5%
	CNAM	3	2.3%
	LAU	18	13.6%
	LIU	25	18.9%
	LU	38	28.8%
	UOB	2	1.5%

	USEK	2	1.5%
	Other	9	6.8%
Major (Faculty)	Architecture/Design	8	6.1%
	Arts/Languages	5	3.8%
	Business	29	22.0%
	Engineering	23	17.4%
	Health Sciences	5	3.8%
	Nursing	10	7.6%
	Sciences	21	15.9%
	Social Sciences	22	16.7%
	Other	9	6.8%
Year at University	Freshman	10	7.6%
	Sophomore	26	19.7%
	Junior	16	12.1%
	Senior	29	22.0%
	Graduate	51	38.6%
Monthly Income Type	USD	33	25.0%
	LBP	94	71.2%
	Other	5	3.8%
Monthly Income	Less than 1,500,000 LBP	15	11.4%
	1,500,000 LBP - 4,498,500 LBP	30	22.7%
	4,500,000 LBP - 7,498,500 LBP	11	8.3%
	7,500,000 LBP or		

	more	8	6.1%
	Less than $1000	3	2.3%
	$1000- $2,999	10	7.6%
	$3,000- $4,999	6	4.5%
	$5,000 or more	3	2.4%
	Prefer not to say	22	16.7%
	Don't Know	21	15.9%
Place of Residence	Other	4	3.0%
	Urban/City	78	59.1%
	Rural/Village	54	40.9%
Have you ever obtained mental health services (psychiatrists, psychologists, social workers, counselors…)	Yes	35	26.5%
	No	97	73.5%
Are you aware that if you were to experience symptoms of depression, anxiety or any psychological distress, you could treat them by seeking mental health services?	Yes	119	90.2%
	No	13	9.8%
Please select **one** option that you believe would be the most helpful even if you would seek other options	Medical help	18	13.6%
	Mental-health services	50	37.9%
	Religious help	3	2.3%
	Help from family	9	6.8%
	Help from friends or partner	20	15.2%
	Rely on your self	32	24.2%

3. Scale Descriptive

The means and standard deviations of the scales are provided in Table 4. Concerning the outcome variable (attitudes toward help-seeking behavior), on average participants reported positive attitudes toward help seeking behavior (M = 31.92, SD = 4.93). As for the stigma scales, on average participants had low levels of personal stigma (M = 1.08, SD = 1.23) and low to medium levels of public stigma (M = 2.39, SD = 0.85). Concerning religiosity, participants had high levels of religiosity (M = 5.24, SD = 1.35). Concerning symptomatology, participants had low levels of symptoms (M = 20.65, SD = 16.11). Participants had average to high levels of westernization (M = 37.06, SD = 9.63). As for the self-construal scales, the factors of 'family' and 'friends' were combined and averaged to form the 'relational' self-construal variable, the factors 'social grouping' and 'students' were combined and averaged to form the 'collective' self- construal variable, and the factor 'myself' constituted the 'personal' self-construal variable (Harb & Smith, 2008). Participants were most likely to agree with statements concerning the personal self-construal (M = 3.89, SD = .98) followed by statements concerning the relational self-construal (M = 3.73, SD = .68). Participants were least likely to agree with statements concerning the collective self-construal (M = 2.41, SD = .76). This shows that participants were slightly more likely to construe themselves in terms of their personal dyadic relationships and independent traits closely followed by their relationships with family and friends.

Table 4

Scale Descriptive

	N	Minimum	Maximum	Mean	Std. Deviation
Attitudes	132	10.00	40.00	27.89	5.60
Religiosity	132	1.13	7.00	5.24	1.35
Public Stigma	132	0.00	4.58	2.39	.85
Personal Stigma	132	0.00	5.00	1.08	1.23
BSI-18	132	0.00	70.00	20.65	16.11
Personal SC	132	1.00	5.00	3.89	.98
Relational SC	132	1.80	5.00	3.73	.68
Collective SC	132	1.00	5.00	2.41	.76
Westernization	132	18.00	59.00	37.06	9.63
Valid N (Listwise)	132				

CHAPTER V

RESULTS

A. Statistical Analysis

Data analysis was conducted using the Statistical Package for the Social Sciences (SPSS- 28). Preliminary analyses were conducted prior to examining the main analyses. The preliminary analyses involved checking for mis-entered data, missing values analysis, analysis of univariate and multivariate outliers, and the assumptions of normality and homogeneity of variance. Descriptive statistics were run to examine all independent variables. Correlational tests and multiple regression analyses were used to establish the relation among the variables, and among the dependent and independent variables.

1. Missing value analysis.

As stated above, the data from one student was removed because of failure to meet the inclusion age criteria; the data from 12 students were also excluded because they omitted two or more full scales. Missing value analysis was conducted on 132 participants. The analysis of missing values indicated that all variables had less than 5% missing values and missing values were imputed as zero. To test whether the data were missing completely at random Little's MCAR test was run. The results were not significant indicating that the results were missing at random.

2. Outliers in the Solution.

Outliers in the solution are cases that are not well predicted by the regression model and that exert undue bias on the parameters of the regression model. The presence of univariate outliers in the solution was assessed through standardized residuals (z-scores) (Field, 2013). Cases with standardized residuals above the ±3.29 significance level are considered outliers in the solution. An examination of the standardized residuals in the current analysis revealed that there were two univariate outliers on the variable age (case numbers 58 and 66), and one univariate outlier on the variable gender (case number 64). No extreme outliers were found among the dependent and the rest of the independent variables. An inspection of multivariate outliers was done through Mahalanobi's distance using SPSS syntax. One case (case number 66) was found to be a multivariate outlier, $\chi 2\ (13) = 34.53$, $p < .001$. Although this case was both a univariate and multivariate analysis, a scan of the data showed that it was an outlier because the age of the participant was 50, while the mean age of participants was 22.78. This can be an indication of the usual student population in which there are older students but not as common as younger ones. Since it fits the inclusion age criteria and can be informative of the general population, it was not deleted.

3. Normality

Normality was examined for each variable through z-scores of skewness (see Table 5). Variables with skewness of above |3.29| were considered non-normal. The variables of Religiosity, Personal Stigma, BSI, Somatization and Personal SC were skewed (z-skewness values of |4.79|, |5.45|, |3.39|, |5.50| and |5.54| respectively). All

other variables were normally distributed. While these violations may affect the analysis, transformations were not performed as the dependent variable (attitudes) was not skewed and the assumptions for regression analyses were met. Because of the violations of normality, the regression analysis was run using the bootstrapping method because it is a robust method against violations of normality and thus allows generalization of the results from the sample to the general population (Field, 2009).

Table 5

Normality

Variable	Z-Skewness
Attitudes	-2.28
Religiosity	-4.79
Personal Stigma	5.45
Public Stigma	-1.23
BSI	3.39
Depression	2.54
Anxiety	2.63
Somatization	5.50
Relational SC	-2.30
Collective SC	.03
Personal SC	-5.54
Westernization	.92

B. Correlations

Bivariate correlation analysis was run to test the hypotheses and assess for any correlations between the dependent variable (attitudes towards seeking help) and the independent variables.

For the variables that were normally distributed and had confirmatory hypotheses (hypotheses had a specified direction), public stigma, westernization and

gender, a Pearson Correlation (one-tailed) test was conducted to assess the correlation between them and the dependent variable (attitudes towards help seeking). As for the variables with exploratory hypotheses that were normally distributed: relational SC, collective SC, depression and anxiety, a Pearson Correlation (two-tailed) test was conducted to assess the correlation with the dependent variable. For the variables that were not normally distributed, Spearman's Rho was used to assess for any correlations. Spearman's Rho (one-tailed) test was conducted to assess the correlation between religiosity and personal stigma with the dependent variable as they entailed confirmatory hypotheses, while Spearman's Rho (two-tailed) was conducted to assess the correlation between symptomatology, somatization and personal SC with the dependent variable, as they entailed exploratory hypotheses.

The Pearson correlation test revealed that there were non-significant correlations between public stigma and attitudes to help seeking, $r = -.01$, $p = .45$, ns (one-tailed) and between westernization and attitudes towards help seeking $r = .055$, $p = .27$, ns (one-tailed). A significant, positive, small to medium, correlation was found between gender and attitudes towards help-seeking $r = .21$, $p \leq .01$ *(one-tailed)*, indicating that females were more likely to have positive attitudes towards help seeking and thus supporting hypothesis 4. There were no significant correlations between relational SC $r = .02$, $p = .85$, ns *(two-tailed)*, collective SC $r = .13$, $p = .14$, *ns (two-tailed)*, depression $r = -.01$, $p = .95$, ns *(two-tailed)*, anxiety $r = .05$, $p = .59$, ns *(two-tailed)* and attitudes towards help-seeking.

The Spearman's rho correlation test revealed that there was a significant negative, small, correlation between religiosity and attitudes to help seeking $r_s = -.16$, $p = .04$, *(one-tailed)*, indicating that those with higher levels of religiosity were more

likely to have negative attitudes towards help-seeking, supporting hypothesis 1. A significant, negative, small to medium correlation was also found between personal stigma and attitudes to help seeking $r_s = -.26$, $p = .001$ *(one-tailed)*, indicating that participants who had higher levels of personal stigma were more likely to have negative attitudes towards help seeking, supporting hypothesis 2b.

The Spearman's rho correlation test also showed no significant correlations between overall psychological distress and attitudes towards help seeking $r_s = .04$, $p = .68$, ns *(two-tailed)*, between somatization and attitudes towards help seeking $r_s = .06$, $p = .50$, ns *(two-tailed)* and between personal SC and attitudes towards help-seeking $r_s = -.04$, $p = .64$, ns *(two-tailed)*.

C. Main Analyses: Hierarchical Multiple Regression

A multiple regression was conducted to test hypotheses 1 through 6 using the forced entry method. The predictor variables gender, religiosity, public stigma, personal stigma, symptomatology, self-construals and westernization were entered using the forced entry method, to assess their roles as possible predictors of attitudes toward help-seeking behavior, while controlling for age, income amount, previous help and place of residence and awareness of help seeking.

1. Assumptions of Multiple Regression

The assumptions of normality of residuals, multicollinearity, homoscedasticity of the regression slope, and independence of errors were tested. The assumption of normal distribution of the outcome variable was tested by examining z-skewness, and

the histogram which visually resembled a bell curve (refer to graph 1 in the Appendix). The assumption of multicollinearity was tested by looking at the correlation matrix (see Table 6) between the predictor variables and the Variance Inflation Factors (VIF). In this study, all correlations were below .8 and all predictors had a Variance Inflation Factor (VIF) value of less than 10 which indicates an absence of multicollinearity (Field & Miles, 2012). We tested the assumption of linearity by examining P-P plots and scatterplots. No cases were falling below the lines or outside the range of -3 to 3 either on the x-axis or y-axis (Field & Miles, 2012). The assumption of independence of errors was tested by examining the Durbin-Watson value of the model, which was 2.31. Values greater than 1 and less than 3 indicate that the residuals are uncorrelated and cause no concern (Field & Miles, 2012). Finally, the assumption of homoscedasticity was examined through residual plots of standardized predicted values against standardized residuals (refer to graph 2 in the Appendix). The residuals appeared to increase consistently with the distance up the line, indicating that the assumption of homoscedasticity was met (Field & Miles, 2012). Also, Cook's distance was examined to ensure the absence of any outliers or influential cases that may impact the results of the linear multiple regression. No cases had a Cook's distance greater than 1, which indicates the absence of any outliers (Field & Miles, 2012).

Table 6
Correlations Matrix

	1	2	3	4	5	6	7	8	9	10
1.Attitudes towards help seeking	1	-.15*	-.01	-.25**	.04	-.04	.02	.13	-.06	.21*
2. Religiosity		1	-.01	.13	-.04	-.10	.14	.25**	-.22*	.19*
3. Public Stigma			1	.25**	.03	-.17*	-.15	-.08	.01	.04

4. Personal Stigma	1	.11	-.30**	-.28**	.12	-.16	-.04
5. BSI-18		1	-.21*	-.20*	-.05	-.02	.12
6. Personal SC			1	.19*	-.25**	.03	.09
7. Relational SC				1	.40**	.17	-.01
8. Collective SC					1	.28**	.03
9. Westernization						1	.00
10. Gender							1

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

2. Regression Analysis

A multiple regression was conducted to assess the contribution of gender, religiosity, public stigma, personal stigma, symptomatology, self-construal, and westernization in predicting attitudes towards help-seeking, while controlling for the influence of age, socioeconomic level and previous help seeking behaviors, place of residence and awareness of help-seeking resources. As previously mentioned, the regression analysis was run using the bootstrapping method based on 1000 bootstrap samples with 95% confidence intervals and with bias corrected and accelerated. Bootstrapping was used because it is a robust method against violations of normality and thus allows us to generalize the results from our sample to the general population (Field, 2009).

The overall model explained about 32.6% of the variance in the scores of attitudes towards help-seeking (see Table 7). The model of the regression analysis was significant $F(14,117) = 4.03$, $p < .001$, indicating that the regression model was

significantly better than the mean in explaining the variance in the outcome variable. The result of the multiple regression revealed that gender was a significant negative predictor of attitudes towards help-seeking ($\beta = .21$, $p < .01$) (supporting hypothesis 4). Likewise, personal stigma was also shown to be a significant negative predictor of attitudes towards help-seeking ($\beta = -.26$, $p < .05$) (supporting hypothesis 2b) (see Table 8). Religiosity was also shown to be a significant negative predictor of attitudes towards help-seeking ($\beta = -.21$, $p < .05$) (supporting hypothesis 1). Public stigma, psychological distress, westernization and self-construals did not come out as significant predictors of attitudes towards help seeking, and thus hypotheses 2a, 3, 5 and 6 were not supported.

Table 7
R, R Square, Adjusted R Square

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.571[a]	.326	.245	4.89	.326	4.03	14	117	< .001	2.31

Table 8 *Regression Parameters*

Model	B	SE	Standardized Coefficients β	Sig. (2-tailed)
Gender	2.21	1.05	.22*	.04
Age	.15	.10	.14	.10
SES	-.18	.09	-.17	.05
Place of Residence	1.03	.95	.09	.29
Previous Help	-2.33	1.07	-.18	.06
Awareness of services	-2.82	1.73	-.15	.11
Religiosity	-.87	.36	-.21*	.02
Public stigma	.24	.50	.04	.63
Personal stigma	-1.16	.47	-.26*	.01
BSI	-.00	.03	-.01	.90
Personal SC	-.18	.47	-.03	.69

Relational SC	-.53	.78	-.06	.49
Collective SC	1.71	.73	.23	.06
Westernization	-.04	.06	-.07	.53

*$p < .05$

CHAPTER VI

DISCUSSION

The aim of this study was to explore socio-cultural predictors of attitudes towards help-seeking in a sample of university students who attend universities across Lebanon, while contributing to the local literature on help-seeking attitudes. It was important to do so as there have been no published studies on the effects of multiple socio-cultural variables including self-construals, perceived stigma and westernization on help-seeking attitudes. This is also the first study in the Middle East and, more specifically, in Lebanon, to study the effect of self-construals and the effect of distress levels on help-seeking attitudes. Attitudes towards help seeking can have either positive or detrimental effects on one's mental health awareness and help seeking behaviors. Therefore, assessing and understanding what factors predict help seeking attitudes, can help people better understand the role external societal factors can have on their experiences and attitudes towards help-seeking.

A. Interpretations of the Findings

The results of the study indicated that the predictor variables under study explained a significant proportion of the variance in attitudes towards help-seeking in students enrolled at universities across Lebanon, suggesting that the variables are relevant to the population under study. A significant relationship was established between gender, personal stigma and religiosity and attitudes towards help-seeking. Females had more positive attitudes towards seeking help, which has been supported in the literature, showing women to be more open to seeking help than men (Al-Krenawi

et al., 2009). Across the world, gender has been reported as a significant predictor of seeking mental health professionals (Johnson, 1988; Wrigley et al., 2005, Yamawaki, 2010) with males having more negative attitudes towards help-seeking (Addis & Mahalik, 2003; Yamawaki, 2010), while females, and especially female students, tended to endorse more positive attitudes towards help seeking (Ang, Lim, Tan, & Yau, 2004; Chang, 2007; Do et al., 2019; Leong & Zachar, 1999; Masuda et al. 2012; Mendoza, Masuda & Swartout 2015). Masculinity has been tied to being less emotionally expressive (Kaya et al., 2019) leading to a negative view of help-seeking (Yousaf et al., 2015). Males adherence to gender roles and societal norms, which are characterized by being tough and strong with lack of emotional expressiveness, seems to negatively affect their attitudes towards seeking help (Nam et al., 2010). These norms and gender roles are pertinent in the Arab world, and so males would tend to see help-seeking as a sign of weakness (Lynch, Long & Moorhead, 2018) and something to avoid rather than endorse. The stigma surrounding mental health and help seeking also makes it difficult for men to openly consider help-seeking for mental health or to express any emotional difficulties they may be experiencing (Lynch, Long & Moorhead, 2018; Yousaf et al., 2015) suggesting an interaction effect between gender and stigma which could warrant further research.

The literature has also shown personal stigma to be a negative predictor of help-seeking attitudes (Eisenberg et al., 2009; Wang et al., 2015; Wrigley et al., 2005). The findings of this study confirmed this hypothesis, indicating that those with higher levels of personal stigma tend to have a more negative attitude towards seeking help. Perceived public stigma however was shown to be a non-significant predictor of attitudes towards help-seeking in this study, incongruent with the findings from the literature. Vogel, Wade and Hackler (2007) did however report personal stigma to mediate the relationship between public stigma and attitudes towards help-seeking with personal stigma being a greater predictor. Our findings imply that in this study, personal stigma is a better predictor of help-seeking attitudes than is perceived public stigma. Perceived public stigma measures how the community would react or view others whereas personal stigma refers to an individual's view of themselves and of others. Our results suggest that participants attitudes are not affected by how community members would react were they to seek help as much as they are affected by their own personal views on seeking help for themselves. This finding could also indicate that in Lebanon, stigma is being internalized such that one's own beliefs had a stronger impact on attitudes of help-seeking than other people's beliefs. In a sample of students in AUB, an unpublished study by Hassan (2015) also showed only self-stigma to be a significant predictor while social-stigma was a non-significant predictor. Karam et al. (2019) reported that participants who had considered seeking help were more affected by

personal choices rather than stigma from others were they to find out, further supporting the idea that internalized personal reasons account for negative views towards help-seeking rather than what others would think or react.

Also consistent with our hypotheses, religiosity was found to be a significant negative predictor of attitudes towards help-seeking, indicating that when one had higher levels of religiosity, they were more likely to have negative attitudes towards mental health help seeking. Although this is inconsistent with the findings of Hassan (2015) who found a non-significant relationship between religiosity and attitudes towards help-seeking in a sample of students in one university in Lebanon, it is consistent with the findings in the literature, which have reported religiosity to significantly affect help-seeking attitudes (Mendoza et al., 2015; Rogers-Sirin, Yanar, Yuksekbas, Senturk & Sirin, 2017). They explained that people higher in religiosity tended to feel more comfortable talking to a religious figure or attributing their difficulties to spiritual reasons. Religiosity therefore might be more tied to seeking religious help, with those higher in religiosity preferring to seek help from religious sources and finding more comfort in religion, thus leading to more negative attitudes towards seeking help from a

mental-health professional. Hassan's study was conducted on students in the American University of Beirut only, whereas this study included participants from more than 14 universities across Lebanon, both public and private; therefore, our findings showed a significant relationship between religiosity and help-seeking attitudes when expanding to a larger population.

Inconsistent with our hypotheses, self-construals, psychological distress and westernization all came out as non-significant predictors of attitudes towards help-seeking. The literature showed contradictory findings when examining self-construals and help-seeking attitudes (Cross & Madson, 1997; Koydemir-Ozden, 2010; Yalcin, 2016). In this study, cultural self-construal showed a non-significant relationship with attitudes towards help seeking which was inconsistent with exploratory hypothesis 6. This signifies that the endorsement of specific cultural lifestyles (collective, independent and interdependent), may perhaps not play a significant role on help-seeking attitudes as otherwise speculated. Harb (2010) reported that while the Lebanese youth place the most importance on family relationships, they also tend to place importance on their religious sect. If we were to relate it to the findings from this study, perhaps young adults are influenced by relationships with their family and friends but more so by their internalized religious beliefs when it comes to help-seeking attitudes. Since help-seeking is more of a personal decision and the population under study was significantly influenced by their own personal thoughts and stigma towards help-seeking, then the external relationships they have with others and

their own identity is not as influential on their help-seeking attitudes as is their internalized religiosity and personal stigma.

General levels of psychological distress and more specifically, depression, anxiety and somatization all had non-significant relationships with the dependent variable. Although it is inconsistent with our exploratory hypotheses, the literature has also shown inconsistent findings (Halgin et al, 1987; Komiya, 2000; Obasi & Leong, 2009; Nam et al., 2013) and no studies have assessed the relationship between these variables in Lebanon. Therefore, this finding shows that levels of distress and symptoms play no significant role in one's attitudes towards help-seeking. In their study on a Lebanese population, Karam et al. (2019) measured the relationship between distress levels and help seeking behaviors rather than attitudes. They reported distress levels to impact help seeking behaviors, with more severe symptoms influencing behaviors more strongly. This finding suggests that experiencing symptoms of distress directly impacts the decision to actually seek help rather than the perception and attitude one has towards seeking help. It appears from our findings that having psychological symptoms isn't

necessary to know that seeking help is a good option; and so, whether one had higher levels of psychological distress or not, their attitudes towards seeking help were not affected.

Westernization, although reported in the literature to be a significant predictor of attitudes towards help-seeking (Atkinson & Gin, 1989; Miller, Yang, Hui, Choi & Lim, 2011; Obasi & Leong, 2009), came up as a non-significant predictor of attitudes towards help-seeking in this study. Thus, the finding from Hassan's (2015) study with AUB students, which found westernization to be a positive predictor of attitudes towards mental health help seeking, did not generalize to university students from universities across the country. It can be argued that although seeking help for mental health issues was once seen as more of a western concept, in recent years Arabs have become more accustomed and open to the idea of seeking help from mental health services (Al-Krenawi, Graham, Dean & Eltaiba, 2004), especially so in Lebanon with the rise of stressors and instability across the country (Abi Doumit et al, 2019; Kassir, El Hayek, Zalzale, Orsolini, & Bizri, 2021).

In line with the findings mentioned above, both significant and non-significant, it is worth mentioning that in recent years, several awareness campaigns have been held both by the Ministry of Public Health's (MoPH) National Mental Health Program (NMHP) and by NGOs across the country, working on providing appropriate access to mental health through awareness, advocacy and mental health services, and reducing stigma towards mental health. Stigma however is a complex issue, that entails both implicit and explicit layers, making it difficult and tricky to reduce. While explicit stigma is self-reported with conscious awareness, implicit stigma is more unconscious and outside of one's awareness (Stull, McGrew, Salyers, Ashburn-Nardo, 2013), making it more difficult to identify and target. The MoPH has been working on integrating mental health services into primary health care centers and providing MHgap trainings to health workers in the public sector (MoPH, 2015; El Chammay et al., 2016) and a National Lifeline in Lebanon (1564) for emotional support and suicide prevention, that is free of charge and respects confidentiality, has been established and run by the Lebanese NGO, Embrace. Thus, seeking help for one's mental health is slowly being integrated, accepted and embraced.

Predictors such as westernization and cultural self-construals which may socially seem to affect help-seeking attitudes, statistically showed no significance. This finding helps us better understand that there are not as many differences in help-seeking attitudes amongst students who hold different cultural and identity beliefs (whether more independent or interdependent) and levels of westernization. Western ideas have been integrated within our society, through education, technology and consumerism while also maintaining cultural beliefs and traditions (Al-Krenawi, Graham, Dean &

Eltaiba, 2004; Hallab, 2009), so although psychotherapy began as a western concept, it has become better integrated and embraced within the Lebanese community.

Rather than view each predictor on its own, studies have explained their findings based on the relationship between variables. The complexity of cultures, relationships and public and personal beliefs make our findings all the more relevant when looked at as a socio-cultural model. Although previous findings did find significant differences in help-seeking attitudes when exploring westernization and self-construals, they also reported variables to act as mediating factors. Rogers-Sirin, Yanar, Yuksekbas, Senturk & Sirin, (2017) reported that cultural self-construals mediated the relationship between religiosity and help-seeking attitudes. Koydemir-Ozden (2010) explained that the integration of Western concepts has also reflected on self-construals, creating a balance between the independent and interdependent self-construal's rather than being opposites. Yalcin (2016) tied the findings of their study with the influence exerted by social stigma on the relationship between self-construals and help-seeking attitudes, whereas in this study public stigma was not a significant factor, and could explain why self-construals do not significantly reflect positive or negative help-seeking attitudes.

A socio-cultural assessment study conducted by Harb (2010) showed that the internet and western media had become more mainstream within the Lebanese community and showed multicultural orientations to be interwoven within the Lebanese population. The mainstreaming of westernization in the Lebanese community has made it easier to talk about mental health. With the current situation Lebanon is going through, poor mental health is now the norm and mental health problems no longer carry the public stigma that previously accompanied it.

It can further be explained that the factors that influence help-seeking attitudes are more inherent and internal. In our study, the thoughts and beliefs one has towards him or herself reflected more on their attitudes towards help-seeking than any external factors. Therefore, if we were to look at it as a bigger picture, it can be speculated that religious relationships and religious affiliations better reflect on one's beliefs which implicate why religion plays a significant role on one's attitudes towards help seeking whereas self-construals do not. Studies have reported considerable overlap between religious beliefs and family and social life (Koeing, Zaben & Khalifa, 2012). Religious beliefs, personal stigma, societal norms that have influenced gendered beliefs were more important than the view one has of his relationships whether with the self or others, the levels of western influence and the way the community might react were they to learn that one was seeking mental health help.

B. Implications

The results from this study can assist mental health professionals in better understanding and targeting the factors that affects people's attitudes towards seeking help. It can be important to target beliefs around personal stigma through awareness campaigns across universities or holding focus group discussions with students to provide them with necessary information, workshops, or sessions that can aid in reducing the stigma surrounding mental health. It would also be helpful to include religious figures or religious community members in such sessions to help raise awareness on the importance of help-seeking for mental health problems and explaining that religious help and mental health help-seeking are not mutually exclusive but can both be helpful in reducing psychological distress. Similarly, such group discussions

and awareness sessions can also target different gendered beliefs in an aim to reduce negative attitudes towards seeking help in males. Interventions can be designed to diminish personal stigma and the cultural norms associated with lack of emotional expression in males and while emphasizing the idea that seeking help for a psychological problem is not a situation that men should feel ashamed of. It would also help to begin raising awareness in schools so that by the time students get to universities, their attitudes towards help-seeking will be more positive with a reduction in the stigma tied to seeking help for one's mental health, regardless of what gender they identify as.

C. Limitations and Future Directions

It is important to read the interpretations of this study while keeping in mind its limitations. The main limitation of the current study is the small sample size, mostly due to low response rates. Although there were low levels of missing values, the questionnaire was quite long and so participants may have not agreed to participate because of the time and length of the questionnaire. Power cuts and internet problems were also a problem in the country at the time of data collection and so participants may not have had easy access to the questionnaire as it was all online. These could all have led to the low response rate. Another limitation of this study is that it was conducted using a non-experimental research design, and so only correlational relationships could be inferred between the variables; and causation cannot be implied. The study also included self-reports which may have resulted in participants engaging in social desirability. Participants may have responded in a way that portrays them in a

positive manner rather than their actual beliefs. Participants, for instance, may have wanted to portray themselves as having more positive attitudes towards seeking help and/or having lower stigma levels. With respect to reporting symptoms and distress levels, participants may lack insight into their situation and so relying on information given by the participants may bias the results. A final limitation is that the attitudes scale had good reliability but not high reliability, indicating that the questionnaire may not be capturing all the different attitudes and beliefs about help seeking in our country and culture. It may be important to engage in focus groups and more qualitative research to gain a better understanding of nuances and variance beliefs towards professional mental health help seeking in our culture.

For future studies, additional variables, such as access to mental health resources and cost of mental health services and trust in mental health service providers could be examined to assess their relationship to people's attitudes towards help-seeking. Another recommendation is to develop interventions that target the variables of gender-related concerns and personal stigma (both implicitly and explicitly) and different religious communities in order to improve attitudes and measure the impact of those interventions on students. Interventions could include a series of workshops delivered across schools and universities by mental health professionals and individuals with previous positive help-seeking experiences, with pre and post tests administered to assess results. It would also be interesting to look further into religiosity and how different religions and religious figures may play a role in help-seeking attitudes. Also, it would be important to include participants from the LGBTQ+ population to further assess gender differences and their effects on help seeking attitudes in these populations.

D. Conclusion

The current study contributed to the scarce literature on attitudes towards seeking help from mental health professionals in the Middle East and specifically in Lebanon. It was the first study to examine levels of distress and cultural self-construals in relation to help-seeking attitudes in Lebanon. The findings revealed that gender, religiosity and personal stigma only were significantly predictive of one's attitudes towards help-seeking. Levels of distress, cultural self-construals and westernization were found to be non-significant predictors of attitudes towards help-seeking in the population studied. The findings help highlight what factors to focus on when advocating for mental health and in mental health service provision. Recommendations for future directions were given, as well as recommendations to help reduce personal stigma and target discrepancies in different gender's attitudes towards seeking help and foster more positive help-seeking attitudes within religious communities.

APPENDIX A

ONLINE INFORMED CONSENT

Informed Consent – Social Media Recruitment
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

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Nature and Purpose of the Project: This study is about understanding the predictors of attitudes towards seeking mental health help among students in universities in Lebanon. Several variables have been shown in the literature to predict attitudes towards seeking help from mental health professionals. However, the research in Lebanon in scarce. As such, the current study aims to examine several predictors that affect the attitudes of university students in Lebanon towards mental health help-seeking behaviors.

Explanation of Procedures: To participate in the study, you must be a student at any university in Lebanon and at least 18 years of age or above. It is expected that at least 130 participants will be recruited. Potential participants will see a link with a description of the study on social media.

As a research participant, you will be asked to read this informed consent form and consider carefully your participation. If you decided to participate (by clicking the yes button), the link will take you to the survey. You will then be asked to respond to a questionnaire written in English or Arabic depending on your preference. The questions asked will help in the field of research investigating attitudes towards help-seeking behaviors of students in Lebanon. You are only urged to read the questions carefully, and to answer in a truthful and honest manner. Please do not agonize over your answers. There are no right or wrong answers, and first impressions are usually fine. Just think about what best reflects your own opinions or feelings.

Please understand that your participation is voluntary and that you have the right to discontinue your participation anytime without any justification or penalty. Your name and contact information will **not be asked** and **it can be assured that there are no identifiers. Anonymity is secured and hence no one could link a certain response to**

a particular participant. Additionally, refusal to participate will not affect in any way your relationship with AUB or with the organizations involved in sharing information about the opportunity to participate in the study. Clicking "yes" indicates that you have read and understood the consent form and agreed to participate in the study.

Only the project director and the co-investigator will have access to the data. **Data sets (i.e. soft copies) that are present on the computer will be protected via a secure password** for a period of seven years after which the data will be **permanently deleted**. It is expected that your participation in this survey will last about 20 minutes.

Potential Discomfort and Risks: There are no more than minimal risks (similar to those encountered in routine physical and psychological exams) associated with participation in this survey. We are aware that some of the questions might be personal and sensitive and might make you feel uncomfortable. In case this happens, you are kindly asked to inform the co-investigator collecting the data. Additionally, we have provided you with a list of names and phone numbers of mental health centers and professionals in Lebanon that provide minimal or no charges for their services in this consent form and at the end of the survey.

Benefits: There are no direct benefits associated with participation in this study. The potential benefit is that your participation will contribute to the research concerned with understanding attitudes of young students in Lebanon to help-seeking behaviors.

Costs/Reimbursements: Your participation in this survey incurs no costs.

Alternatives to Participation: Should you decide not to give consent to participate in this survey, no alternative procedures will be offered. You may, however, contact the project director or co-investigator to learn more about the study conducted.

Termination of Participation: Should you decide to give consent to participate in this survey, the project director might disregard your answers if the results show that you have not abided by the instructions given at the top of each set of questions, have filled in more than one survey, have intentionally lied on the survey, or have filled in the survey in a random manner. You may also choose to terminate your participation at any point by exiting the survey.

Confidentiality: The results of your participation will be kept fully confidential. This means that only the project director and co-investigator will have access to the data, which will be anonymous, as no identifying information would be linked to the data you provided. Only information that cannot be traced to you will be used in reports published or presented by the director or investigator. Raw data on the computer **will be protected via a secure password** for a period of 7 years following the termination of the study. After the 7 years have elapsed, the raw data will be **permanently** deleted.

Withdrawal from the Project: Your participation in this survey is completely voluntary. You may withdraw your consent to participate in this research at any point

without any explanation and without any penalty. You're free to stop answering this survey at any point in time without any explanation.

Who to Call if You Have Any Questions: This project has been reviewed and approved for the period indicated by the American University of Beirut (AUB) Institutional Review Board for the Protection of Human Participants in Research and Research Related Activities. If you have any questions about your rights as a research participant, or to report a research related injury, you may call: IRB, AUB: 01-350000 Ext. 5445 or 5455

If you have any concerns or questions about the conduct of this research project, you may contact:
-Fatimah Al-Jamil: fa25@aub.edu.lb, 01-350000 Ext. 4372
-Khadijah Mokbel: kmm21@mail.aub.edu, 71-361840

Help-seeking options: One of the questionnaires, the brief symptom inventory (BSI) evaluates psychological distress. If you screen positive on most BSI items, the research team recommends you contact a health care professional referred to below and the referral sheet provided at the end of the questionnaire.

If you have any concerns or wish to seek help, you may contact or visit:

-AUB counseling center: 01350000 ext 3196 or counselingcenter@aub.edu.lb

or counseling center at your university if available

-The Community Mental Health Center at Rafic Hariri University Hospital, 81-314932.

-Embrace: hotline 1564 or mental health center 81003870

-IDRAAC, 76100576 or 01583583

-Blue Mission, psychological support hotline: 78665062

Participant's Consent: By clicking the yes button, you agree that you have had the time to read and understand the information contained in this document, and to consider your participation in this research study. You also provide consent to participate in this research study. The purpose, procedures to be used, as well as, the potential risks and benefits of your participation have been explained to you in detail. You can refuse to participate or withdraw your participation in this study at any time without penalty.

I agree to participate in this study YES NO

APPENDIX B

ADVERTISEMENT OF THE STUDY

This notice is for an AUB-IRB Approved Research Study

It is not an Official Message from AUB

We would like to invite you to participate in a study on different predictors that may affect the attitudes of university students in Lebanon towards seeking help from mental health professionals.

You are eligible to participate in the study if you are:

1. A student at any university in Lebanon
2. 18 years of age or above

The study aims at examining and understanding the predictors of attitudes towards seeking mental health help among students in universities in Lebanon.

What will you be asked to do?

You will be asked to fill out a questionnaire about different predictors of attitudes towards seeking mental health help.

Completion of the study is expected to take no longer than 20-30 minutes of your time. If you are interested in participating in the study, you can access the study via the link below that will direct you to an online version of the survey.

Please note that to ensure your privacy and confidentiality, you will not be asked to provide any personal information.

For questions and further information, please contact the principle investigator Dr. Fatimah El Jamil at the American University of Beirut at 01-350000 Ext. 4372 or the co-investigator Khadijah Mokbel at 71-361840.

To access the survey please click here:

(https://survey.aub.edu.lb/index.php/629132/lang- en)

APPENDIX C

INSTRUMENTS

DEMOGRAPHICS QUESTIONNAIRE

1. Gender: □ Male □ Female □ Other □ Prefer not to answer
2. Age in years: _____
3. Nationality: _____

- Do you belong to a culture that you deem to be different from the Lebanese culture?

  YES NO

4. University: _____
5. Major: _____
6. Year at University

   □ Freshman □ Sophomore □ Junior □ Senior □ Graduate

7. a. Household (Family) Monthly Income: □ LBP □ USD □ Other

   b. Household (Family) Monthly Income. Please use the scale provided:

   ___Less than $1,000 (Less than 1,500,000 LBP)

   ___$1,000-2,999 (1,500,000 – 4,498,500 LBP)

   ___$3,000-4,999 (4,500,000 – 7,498,500 LBP)

   ___$5,000-$6,999 (7,500,000 – 10,498,500 LBP)

   ___$7,000- 8,999 (10,500,000 – 13,498,500 LBP)

   ___$9,000 or more (13,500,000 LBP or more)

   ___Prefer not to say

   ___Don’t know

8. Place of residence: RURAL URBAN

9. Have you ever obtained mental health services (psychiatrists, psychologists, social workers, counselors…)

YES NO

10. Are you aware that if you were to experience symptoms of depression, anxiety or any psychological distress, you could treat them by seeking mental health services?

YES NO

- Please select **one** option that you believe would be the most helpful even if you would seek other options:

Medical help

Mental-health services

Religious help

Help from family

Help from friends or partner

Rely on your self

ATTITUDES TOWARDS SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE – SHORT FORM

(Fischer & Farina, 1995)[3]

Instructions: Please read the following statements and rate them using the scale provided. Place your ratings to the left of each statement by recording the number that most accurately reflects your agreement or disagreement for the following items. There are no "wrong" answers, just rate the statements as you honestly feel or believe. It is important that you answer every item.

Disagree Agree

1 2 3 4

____ 1. If I believed I was having a mental breakdown, my first inclination would be to get professional help.

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

____ 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

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

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

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

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

---

[3] Items 2, 4, 8, 9 and 10 were reverse coded.

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

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

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

RELIGIOSITY SCALE

(Rebeiz & Harb, 2010)[4]

Instructions: For the following set of questions, please select the answer that best describes your religious views.

Strongly Disagree	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

I believe that God exists.	1	2	3	4	5	6	7
Prayer to God is one of my usual practices.	1	2	3	4	5	6	7
Religion gives me a great amount of security in life.	1	2	3	4	5	6	7
I consider myself a religious person.	1	2	3	4	5	6	7
My religion influences the way I choose to act in my routine life.	1	2	3	4	5	6	7
I feel there are many more important things in life than religion.	1	2	3	4	5	6	7
I am interested in religion.	1	2	3	4	5	6	7
Religious considerations influence my every day affairs.	1	2	3	4	5	6	7

[4] Item six was reverse coded.

STIGMA SCALE

Stigma items in the questionnaire (From Eisenberg et al., 2009)

Perceived Public Stigma

Please indicate whether you agree or disagree with the following statements.

Answer choices for each item are: 0 = *strongly agree*, 1 = *agree*, 2 = *somewhat agree*, 3 = *somewhat disagree*, 4 = *disagree*, 5 = *strongly disagree*.

1. Most people would willingly accept someone who has received mental health treatment as a close friend.
2. Most people believe that a person who has received mental health treatment is just as intelligent as the average person.
3. Most people believe that someone who has received mental health treatment is just as trustworthy as the average person.
4. Most people would accept someone who has fully recovered from a mental illness as a teacher of young children in a public school.
5. Most people feel that receiving mental health treatment is a sign of personal failure.*
6. Most people would not hire someone who has received mental health treatment to take care of their children, even if he or she had been well for some time.*
7. Most people think less of a person who has received mental health treatment.*
8. Most employers will hire someone who has received mental health treatment if he or she is qualified for the job.
9. Most employers will pass over the application of someone who has received mental health treatment in favor of another applicant.*
10. Most people in my community would treat someone who has received mental health treatment just as they would treat anyone.
11. Most young adults would be reluctant to date someone who has been hospitalized for a serious mental disorder.*
12. Once they know a person has received mental health treatment, most people will take that person's opinions less seriously.*

Personal Stigma

Please indicate whether you agree or disagree with the following statements.

1. I would willingly accept someone who has received mental health treatment as a close friend.
2. I would think less of a person who has received mental health treatment.*
3. I believe that someone who has received mental health treatment is just as trustworthy as the average person.

Items were adapted from the Discrimination-Devaluation scale developed by Bruce Link and colleagues, as described in the methods section. Items with a '*' are reverse-scored—i.e., "Strongly agree" corresponds to 5 points instead of 0 points, and so on.

BRIEF SYMPTOM INVENTORY

(Derogatis, 2001)

Instructions: The BSI 18 test consists of problems people sometimes have. Please read each one carefully and choose the number of the response that best describes how much that problem has distressed you during the past 7 days including today. Choose only one number for each problem. Do not skip any items.

To calculate your score, add up your response numbers. If you screen positive (scored between 3-4 on most items or a total score ≥ 54), the research team recommends you contact a health care professional, some of which are referred to in the consent form and a list that will be provided at the end of the questionnaire. It is important to note that the BSI-18 is a screening tool for evaluating the possible presence of a particular mental health related problem and not an official diagnosis method. Please refer to a health care professional for further support.

Please use the following ratings:

Not at all	A little bit	Moderately	Quite a bit	Extremely
0	1	2	3	4

In the past 7 days, how much were you distressed by:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Faintness or dizziness	0	1	2	3	4
2. Feeling no interest in things.	0	1	2	3	4
3. Nervousness or shakiness inside.	0	1	2	3	4
4. Pains in heart or chest.	0	1	2	3	4
5. Feeling lonely	0	1	2	3	4
6. Feeling tensed or keyed up.	0	1	2	3	4
7. Nausea or upset stomach.	0	1	2	3	4
8. Feeling blue.	0	1	2	3	4
9. Suddenly scared for no reason.	0	1	2	3	4
10. Trouble getting your breath.	0	1	2	3	4
11. Feelings of worthlessness.	0	1	2	3	4
12. Spells of terror or panic.	0	1	2	3	4

13. Numbness or tingling in parts of your body.	0	1	2	3	4
14. Feeling hopeless about the future.	0	1	2	3	4
15. Feeling so restless you couldn't sit still	0	1	2	3	4
16. Feeling weak in parts of your body.	0	1	2	3	4
17. Thoughts of ending your life.	0	1	2	3	4
18. Feeling fearful	0	1	2	3	4

To calculate your score, add up your response numbers. If you screen positive (scored between 3-4 on most items or a total score ≥ 54), the research team recommends you contact a health care professional, some of which are referred to in the consent form and a list that will be provided at the end of the questionnaire. It is important to note that the BSI-18 is a screening tool for evaluating the possible presence of a particular mental health related problem and not an official diagnosis method. Please refer to a health care professional for further support.

Sixfold Self-Construal Scale

Instructions: Below, you will find a series of questions that revolve around your perception of yourself. Each question is followed by a set of **6** possible categories: family, friends, social groupings, school/department peers, humanity in general, and personal self. Social groupings could be any of the following: *political group/party, Governmental institution, or religious affiliation*.

Make sure to read each question carefully. Thank you.

Scale use: You are asked to mark, from a low of 1 to a high of 5 the **frequency/magnitude** that most reflects your response to each question. Please respond to each question **AND** to each item within that question.

1	2	3	4	5
To a very small extent	To a small extent	To a moderate extent	To a large extent	To a very large extent

1)- I think of myself as connected (linked) to :

My family	1	2	3	4	5
My friends	1	2	3	4	5
Students in my department/faculty	1	2	3	4	5
My social grouping	1	2	3	4	5
Humanity in general	1	2	3	4	5
Myself (I am a unique person separate from others)	1	2	3	4	5

2)- I control my behaviour to accommodate the wishes (interests) of:

My family	1	2	3	4	5
My friends	1	2	3	4	5
Students in my department/faculty	1	2	3	4	5
My social grouping	1	2	3	4	5
Humanity in general	1	2	3	4	5
Myself (I act as an independent person)	1	2	3	4	5

3)- I am affected by events that concern(relate) to:

My family	1	2	3	4	5
My friends	1	2	3	4	5
Students in my department/faculty	1	2	3	4	5
My social grouping	1	2	3	4	5
Humanity in general	1	2	3	4	5
Myself (I act as an independent person)	1	2	3	4	5

4)- I am aware of the needs, desires and goals of:

My family	1	2	3	4	5
My friends	1	2	3	4	5
Students in my department/faculty	1	2	3	4	5
My social grouping	1	2	3	4	5
Humanity in general	1	2	3	4	5
Myself (I act as an independent person)	1	2	3	4	5

5)- I feel I have a strong relationship with:

My family	1	2	3	4	5
My friends	1	2	3	4	5
Students in my department/faculty	1	2	3	4	5
My social grouping	1	2	3	4	5
Humanity in general	1	2	3	4	5
Myself (I am an independent person)	1	2	3	4	5

DOMINANT SOCIETY IMMERSION SUBSCALE (DSI) OF THE STEPHENSON MULTIGROUP ACCULTURATION SCALE (SMAS)

(Stephenson, 2000)[5].

Below are a number of statements that evaluate changes that occur when people interact with others of different cultures or ethnic groups. The West refers to America, Australia, Canada and Western Europe (Britain, France, Germany, Spain, Italy and Portugal).

Select the answer that best matches your response to each statement.

	False	Partly False	Partly True	True
1. I attend social functions with people from western countries.	1	2	3	4
2. I have many acquaintances from western countries.	1	2	3	4
3. I speak English or French at home.	1	2	3	4
4. I know how to prepare western foods.	1	2	3	4
5. I am familiar with important people in western history.	1	2	3	4
6. I think in English or French.	1	2	3	4
7. I speak English or French with my family.	1	2	3	4
8. I feel totally comfortable with western people.	1	2	3	4
9. I understand one of these languages: English or French, but I'm not fluent in any of those languages.	1	2	3	4
10. I am informed about current	1	2	3	4

[5]Item nine was reverse coded.

affairs in the West.				
11. I like to eat western foods.	1	2	3	4
12. I regularly read western-based newspapers.	1	2	3	4
13. I feel comfortable speaking English or French.	1	2	3	4
14. If I visited or will ever visit a western country, I would feel at home.	1	2	3	4
15. I feel accepted by western people.	1	2	3	4

_____

APPENDIX D

ONLINE INFORMED CONSENT IN ARABIC

موافقة مسبقة - البريد الإلكتروني ووسائل التواصل الاجتماعي
المشاركة
الجامعة الأمريكية في بيروت
ص.ب ب 11-0236، رياض الصلح، 1107 2020، بيروت ، لبنان
الموافقة على العمل كمشارك في مشروع بحثي

الباحث الرئيسي: فاطمة الجميل، دكتوراه، أستاذ مساعد في علم النفس
قسم علم النفس، الجامعة الأمريكية في بيروت
هاتف: 01/350000 مقسم 4372

الباحث المساعد: خديجة مقبل، طالبة دراسات عليا في علم النفس العيادي، قسم علم النفس، الجامعة الأميركية في بيروت kmm21@aub.edu.lb

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طبيعة المشروع والغرض منه:

تهدف هذه الدراسة إلى فهم تنبؤات المواقف تجاه طلب المساعدة في مجال الصحة النفسية بين طلاب الجامعات في لبنان. تم عرض العديد من المتغيرات في الأدبيات للتنبؤ بالمواقف تجاه طلب المساعدة من المتخصصين في الصحة العقلية. ومع ذلك، فإن الأبحاث في لبنان نادرة. على هذا النحو، تهدف الدراسة الحالية إلى فحص العديد من المؤشرات التي تؤثر على مواقف طلاب الجامعات في لبنان تجاه سلوكيات طلب المساعدة في مجال الصحة النفسية.

الإجراءات المتبعة:

للمشاركة في الدراسة، يجب أن تكون طالبًا في أي جامعة في لبنان ولا يقل عمرك عن 18 عامًا أو أكثر. من المتوقع أن يتم تجنيد ما لا يقل عن 130 مشاركًا. سيرى المشاركون المحتملون رابطًا يحتوي على وصف للدراسة على وسائل التواصل الاجتماعي.
بصفتك مشاركًا في البحث، سيُطلب منك قراءة نموذج الموافقة المستنيرة والتفكير مليًا في مشاركتك. إذا قررت المشاركة (بالنقر فوق الزر "نعم")، فسيأخذك الرابط إلى الاستبيان. سيُطلب منك بعد ذلك الرد على استبيان مكتوب باللغة الإنجليزية أو العربية حسب تفضيلاتك. ستساعد الأسئلة المطروحة في مجال البحث الذي يدرس المواقف تجاه سلوكيات طلب المساعدة للطلاب في لبنان. نشجعك فقط لقراءة الأسئلة بعناية والإجابة عليها بصدق وصراحة.

نتمنى عليك عدم الشعور بالألم تجاه إجاباتك إذ ما من إجابات صحيحة أو خاطئة والانطباعات الأولية عادة ما تكون جيدة. فكر فقط في أفضل ما يعكس آراءك ومشاعرك الخاصة
يرجى تفهم أن مشاركتك طوعية ويمكنك التوقف عن المشاركة في أي وقت من دون أي تبرير أو بند جزائي. **لن يطلب منك** اسمك ومعلومات عن الاتصال بك، ويمكن التأكد **من عدم وجود**

المعرفات. يتم التأكد من إخفاء الهوية، وبالتالي لا يمكن لأحد ربط إجابة معينة بمشارك معين. بالإضافة إلى ذلك، إن رفضك المشاركة لن يؤثر بأي حال من الأحوال على علاقتك مع الجامعة الأمريكية في بيروت أو مع المنظمات المعنية في مجال تبادل المعلومات حول فرصة المشاركة في هذه الدراسة. يشير اختيار خيار " نعم " الوارد في نهاية استمارة الموافقة إلى أنك قرأت وفهمت استمارة الموافقة ووافقت على المشاركة في الدراسة.

فقط مدير المشروع والباحث المشارك سيكون لديهما الحق بالوصول إلى البيانات. **ستتم حماية مجموعات البيانات (أي النسخ الإلكترونية) الموجودة على الكمبيوتر عبر كلمة مرور آمنة** لمدة سبع سنوات يتم بعدها **حذف البيانات نهائياً**.
من المتوقع أن تحتاج مشاركتك في هذا الاستطلاع الى حوالي 20 دقيقة.

المتاعب والمخاطر المحتملة:

لا يوجد أكثر من الحد الأدنى من المخاطر (مثل تلك التي تمت مواجهتها في الاختبارات الجسدية والنفسية الروتينية) المرتبطة بالمشاركة في هذا الاستطلاع. نحن ندرك أن بعض الأسئلة قد تكون شخصية وحساسة وقد تجعلك تشعر بعدم الارتياح. في حالة حدوث ذلك، يُطلب منك التفضل بإبلاغ المحقق المشارك الذي يجمع البيانات. بالإضافة إلى ذلك، قدمنا لك قائمة بأسماء وأرقام هواتف مراكز الصحة العقلية والمتخصصين في لبنان الذين يقدمون رسومًا قليلة أو معدومة مقابل خدماتهم في نموذج الموافقة هذا وفي نهاية الاستبيان

الفوائد:

لا توجد فوائد مباشرة مرتبطة بالمشاركة في هذه الدراسة. الفائدة المحتملة هي أن ستساهم مشاركتك في البحث المعني وبالتالي فهم مواقف الطلاب الشباب في لبنان فيما يتعلق بسلوكيات المساعدة. من خلال مشاركتك، ستحصل على نقطة مئوية إضافية واحدة في صفك النهائي في مقرر علم النفس التمهيدي.

التكاليف / التعويضات:

لا تتحمل مشاركتك في هذا الاستطلاع أية تكاليف.
إنهاء المشاركة: إذا قررت الموافقة على المشاركة في هذا الاستطلاع، فقد يتجاهل مدير المشروع إجاباتك إذا أظهرت النتائج أنك لم تلتزم بالتوجيهات الواردة في أعلى كل مجموعة من الأسئلة أو إذا كنت قد ملأت أكثر من استطلاع واحد، أو كذبت عمدًا على الاستبيان ، أو قمت بملء الاستطلاع بطريقة عشوائية. يمكنك أيضًا اختيار إنهاء مشاركتك في أي وقت عن طريق الخروج من الاستطلاع.
السرية: ستبقى نتائج مشاركتك سرية بشكل تام. وهذا يعني أن مدير المشروع والباحث المشارك فقط من بإمكانهما الوصول إلى البيانات، والتي ستكون مجهولة المصدر، حيث لن يتم ربط أي معلومات تعريف بالبيانات التي قدمتها. ستستخدم فقط المعلومات التي لن تساعد بتتبعك، سيتم استخدامها في التقارير المنشورة أو المقدمة من قبل المدير أو الباحث. **سيتم حماية البيانات الأولية**

الموجودة على جهاز الكمبيوتر عبر كلمة مرور آمنة لمدة 7 سنوات بعد انتهاء الدراسة. على ان يتم حذف البيانات الخام نهائياً بعد انتهاء هذه الفترة.
الانسحاب من المشروع: مشاركتك في هذا الاستطلاع هي طوعية تماماً. يمكنك سحب موافقتك على المشاركة في هذا البحث في أي وقت دون أي تفسير ودون أي عقوبة. لك مطلق الحرية في التوقف عن الإجابة على هذا الاستطلاع في أي وقت دون أي تفسير.

بمن عليك الاتصال في حال كان لديك أية أسئلة؟: يشير ختم الموافقة على نموذج الموافقة هذا إلى أن هذا المشروع قد تمت مراجعته والموافقة عليه للفترة المشار إليها من قبل مجلس المراجعة المؤسساتية في الجامعة الأمريكية في بيروت لحماية المشاركين في الأبحاث والأنشطة المتعلقة بالبحوث. إذا كان لديك أية أسئلة حول حقوقك كمشارك في البحث، أو للإبلاغ عن إصابة متعلقة بالبحث، يمكنك الاتصال بـمجلس المراجعة المؤسساتية في الجامعة الاميركية في بيروت على الرقم 01/350000 مقسم 5445 أو 5455

إذا كانت لديك أية مخاوف أو أسئلة حول إجراء هذا المشروع البحثي، فيمكنك الاتصال بـ:
-فاطمة الجميل: fa25@aub.edu.lb ، 01-350000 Ext. 4372
-خديجة مقبل: kmm21@mail.aub.edu ، 71-361840

خيارات طلب المساعدة:

أحد الاستبيانات، جرد الأعراض المختصر (BSI) يقيم الضائقة النفسية. إذا كانت النتيجة إيجابية بالنسبة لمعظم عناصر BSI، يوصي فريق البحث بالاتصال بأخصائي الرعاية الصحية المشار إليه أدناه وورقة الإحالة المتوفرة في نهاية الاستبيان.
إذا كانت لديك أية مخاوف أو ترغب في طلب المساعدة، فيمكنك الاتصال أو زيارة:
- مركز الاستشارات في الجامعة الأميركية في بيروت:
counselingcenter@aub.edu.lb أو01350000 ext 3196
أو مركز الاستشارة في جامعتك إذا كان متاحًا
- مركز الصحة النفسية المجتمعية بمستشفى رفيق الحريري الجامعي: 81-314932.
- إمبرايس: الخط الساخن 1564 أو مركز للصحة النفسية 81003870
- إدراك: 76100576 أو 01583583
- مركز بلو ميشن: الخط الساخن للدعم النفسي 78665062
موافقة المشارك:

بالنقر على الزر "نعم"، فإنك توافق على أنك أخذت الوقت الكافي لقراءة وفهم المعلومات الواردة في هذا المستند، ولأخذ مشاركتك في هذه الدراسة البحثية بعين الاعتبار. كما وتعني موافقتك على المشاركة في دراسة البحث هذه. لقد شرح الغرض والإجراءات التي سيتم استخدامها، بالإضافة إلى المخاطر والفوائد المحتملة لمشاركتك بالتفصيل. يمكنك رفض المشاركة أو سحب مشاركتك في هذه الدراسة في أي وقت دون عقوبة.
أوافق على المشاركة في هذه الدراسة
نعم لا

APPENDIX E

ADVERTISEMENT OF THE STUDY IN ARABIC

هذا الإشعار لدراسة بحثية موافق عليها من قبل مجلس المراجعة المؤسسية للعلوم الاجتماعية والسلوكية في الجامعة الأميركية في بيروت
ليست رسالة رسمية من الجامعة الأميركية في بيروت

نود أن ندعوك للمشاركة في دراسة حول عوامل تنبؤيه مختلفة قد تؤثر على مواقف طلاب الجامعات في لبنان تجاه طلب المساعدة من المتخصصين في الصحة النفسية
أنت مؤهل للمشاركة في الدراسة إذا كنت:
1. طالب في أي جامعة في لبنان

2. عمرك 18 سنة وما فوق

تهدف الدراسة إلى فحص وفهم تنبؤات المواقف تجاه طلب المساعدة في مجال الصحة النفسية بين طلاب الجامعات في لبنان

ماذا سيطلب منك أن تفعل؟
سيُطلب منك ملء استبيان حول العوامل التنبؤيه المختلفة بالمواقف تجاه طلب المساعدة في مجال الصحة النفسية.
من المتوقع ألا يستغرق إكمال الدراسة أكثر من 20-30 دقيقة من وقتك. إذا كنت مهتمًا بالمشاركة في الدراسة، فيمكنك الوصول إلى الدراسة عبر الرابط أدناه الذي سوف يرشدك إلى نسخة الاستطلاع الإلكترونية
يرجى ملاحظة أنه لضمان خصوصيتك وسريتك، لن يُطلب منك تقديم أي معلومات شخصية.
للأسئلة ومزيد من المعلومات، يرجى الاتصال بالباحثة الرئيسية الدكتورة فاطمة الجميل في الجامعة الأمريكية في بيروت على 01350000 تحويلة 4372 أو المحققة المشاركة خديجة مقبل على 71361840

للوصول إلى الاستبيان يرجى الضغط هنا:
(https://survey.aub.edu.lb/index.php/629132/lang- ar)

APPENDIX F: INSTRUMENTS IN ARABIC

إستبيان للتركيبة السكانية

1. الجنس: □ ذكر □ أنثى □ أخر □ افضل عدم الإجابة
2. العمر بالسنوات_____
3. الجنسية_____

- هل تنتمي لثقافة تعتبرها مختلفة عن الثقافة اللبنانية؟

نعم / لا

4. الجامعة_____
5. التخصص_____
6. السنة الجامعية

□سنة أولى □ سنة ثانية □ سنة ثالثة □ سنة أخيرة □ دراسات عليا

7a.الدخل الشهري للأسرة: □ ليرة لبنانية □ دولار أمريكي □ آخر

7b. الدخل الشهري للأسرة. يرجى استخدام المقياس المقدم:

___أقل من $ 1,000 أوL.L.1,500,000

_____ 1000 دولار- 2,999 دولار (1,500,000 L.L - 4,498,500 L.L)

_____ 3000 دولار- 4,999 دولار (L.L4,500,000 - L.L - 7,498,500)

_____ 5000دولار- 6,999 دولار (L.L 7,500,000 - L.L 10,498,500)

_____ 7000 دولار – 8,999 دولار (L.L 10,500,000 - L.L 13,498,500)

_____ 9000 دولار أو أكثر(L.L 13,500,000) او أكثر)

___أفضل عدم التصريح

___لا أعرف

8. مكان الإقامة : مدينة قرية

9. هل سبق لك أن حصلت على خدمات الصحة النفسية (الأطباء النفسيين، علماء النفس، الأختصاصيين الاجتماعيين، المستشارين)

نعم / لا

10. هل تدرك أنه إذا كنت تعاني من أعراض الاكتئاب أو القلق أو أي اضطراب نفسي، فيمكنك معالجتها عن طريق البحث عن خدمات الصحة النفسية؟

نعم / لا

-يرجى تحديد خيار واحد تعتقد أنه سيكون الأكثر فائدة حتى إذا كنت تبحث عن خيارات أخرى:

مساعدة طبية

خدمات الصحة النفسية

مساعدة دينية

المساعدة من الأسرة

المساعدة من الأصدقاء أو الشريك

تعتمد على نفسك

المواقف تجاه طلب المساعدة النفسية المهنية - نموذج قصير

Fischer & Farina, (1995)

التوجيهات: يرجى قراءة البيانات التالية وتقييمها باستخدام المقياس المقدم. ضع تقييماتك على يمين كل عبارة من خلال تسجيل الرقم الذي يعكس بدقة موافقتك أو عدم موافقتك على العناصر التالية. لا توجد إجابات "خاطئة"، فقط قيّم العبارات كما تشعر بصدق أو تؤمن. من المهم أن تجيب على كل عنصر.

لا أوافق أوافق

1 2 3 4

1------- إذا كنت أعتقد أنني أعاني من انهيار عقلي، فإن أول ما أفكر فيه هو الحصول على مساعدة مهنية.

2------- إن فكرة الحديث عن المشاكل مع طبيب نفسي تبدو لي كطريقة فقيرة للتخلص من الصراعات العاطفية.

3------- إذا كنت أعاني من أزمة عاطفية خطيرة في هذه المرحلة من حياتي، فسأكون واثقاً من أنني سأجد راحة في العلاج النفسي.

4------- هناك شيء مثير للإعجاب في موقف الشخص الذي يرغب في التعامل مع نزاعاته ومخاوفه دون اللجوء إلى المساعدة.

5------- أودّ الحصول على مساعدة نفسية إذا كنت قلقاً أو منزعجاً لفترة طويلة من الزمن.

6------- قد أرغب في الحصول على إرشاد نفسي في المستقبل.

7------ من غير المحتمل أن يقوم الشخص الذي يعاني من مشكلة عاطفية بحلها بمفرده؛ من المرجح أن يحلها بمساعدة مهنية.

8------- بالنظر إلى الوقت والنفقات التي ينطوي عليها العلاج النفسي، سيكون لها قيمة مشكوك فيها لشخص مثلي.

9------ يجب على الشخص حل مشاكله الخاصة؛ الحصول على الإرشاد النفسي سيكون الملاذ الأخير.
10------- تحل المشاكل الشخصية والعاطفية، مثل أشياء كثيرة، من تلقاء نفسها

مقياس التدين
(Rebeiz & Harb , 2010)[6]

التوجيهات: بالنسبة لمجموعة الأسئلة التالية، يرجى تحديد الإجابة التي تصف آرائك الدينية بشكل أفضل.

لا أوافق أبداً	لا أوافق	لا أوافق الى حد ما	محايد	أوافق الى حد ما	أوافق	اوافق بشدة
1	2	3	4	5	6	7

أعتقد أن الله موجود.	1	2	3	4	5	6	7
الصلاة إلى الله هي إحدى ممارساتي المعتادة.	1	2	3	4	5	6	7
الدين يعطيني قدراً كبيراً من الأمان في الحياة.	1	2	3	4	5	6	7
أعتبر نفسي شخصية دينية.	1	2	3	4	5	6	7
يؤثر ديني على الطريقة التي أتصرف بها في حياتي	1	2	3	4	5	6	7
أشعر أن هناك أشياء أكثر أهمية في الحياة من الدين.	1	2	3	4	5	6	7
أنا مهتم بالدين.	1	2	3	4	5	6	7
الإعتبارات الدينية تؤثر على شأني اليومي.	1	2	3	4	5	6	7

مقياس السمة
عناصر وصمة العار في الاستبيان
(From Eisenberg et al., 2009)

[6] تم ترميز البند السادس بشكل معاكس

وصمة العار العامة المتصورة

يرجى توضيح ما إذا كنت توافق أو لا توافق على العبارات التالية.

ملاحظة: خيارات الإجابة لكل عنصر هي: 0 = موافق بشدة، 1 = موافق، 2 = موافق إلى حد ما، 3 = غير موافق إلى حد ما، 4 = غير موافق ، 5 = لا أوافق بشدة.

1. يتقبل معظم الناس عن طيب خاطر شخصاً، تلقى علاجاً نفسياً، ليكون لهم كصديق مقرب.
2. يعتقد معظم الناس أن الشخص الذي تلقى علاج الصحة النفسية هو بنفس ذكاء الشخص العادي.
3. يعتقد معظم الناس أن الشخص الذي تلقى علاج الصحة النفسية هو جدير بالثقة مثل الشخص العادي.
4. سيتقبل معظم الناس شخصاً شفي تماماً من مرض نفسي للعمل كمدرس للأطفال الصغار في مدرسة عامة.
5. يشعر معظم الناس بأن تلقي العلاج النفسي علامة على الفشل الشخصي.
6. لن يقم معظم الأشخاص بتوظيف شخص، تلقى علاجاً نفسياً، لرعاية أطفالهم، حتى لو كان / كانت بصحة جيدة لبعض الوقت* .
7. ينظر معظم الناس نظرة دونية للشخص الذي تلقى العلاج النفسي* .
8. سيقوم معظم أصحاب العمل بتوظيف شخص تلقى علاج نفسي إذا كان مؤهلاً للوظيفة.
9. سيهمل معظم أصحاب العمل طلب شخص تلقى علاجاً نفسياً لصالح مقدم طلب آخر* .
10. يعامل معظم الناس في مجتمعي شخصاً تلقى علاجًا نفسياً كما يعامل أي شخص.
11. يتردد معظم الشباب في مواعدة شخص دخل المستشفى بسبب اضطراب نفسي خطير* .
12. بمجرد أن يعرفوا أن شخصاً ما تلقى علاجاً نفسياً، سيأخذ معظم الناس آراء ذلك الشخص على محمل الجد* .

وصمة العار الشخصية

يرجى توضيح ما إذا كنت توافق أو لا توافق على العبارات التالية.

ملاحظة: خيارات الإجابة لكل عنصر هي: 0 = موافق بشدة، 1 = موافق، 2 = موافق إلى حد ما، 3 = غير موافق إلى حد ما، 4 = غير موافق ، 5 = لا أوافق بشدة.

1. أوافق وبملأ إرادتي على أن يكون لدي صديق مقرب تلقى علاج للامراض النفسية.
2. أعتقد أنني سأنظر بدونية للشخص الذي تلقى علاج نفسي
3. أعتقد أن الشخص الذي تلقى علاج الصحة النفسية هو جدير بالثقة مثل الشخص العادي

.

تم تعديل العناصر من مقياس التمييز - التبخيس الذي طوره بروس لينك وزملاؤه، كما هو موضح في قسم الأساليب. العناصر التي تحمل علامة "*" لها نتائج عكسية، أي أن "موافق بشدة" تتوافق مع 5 نقاط بدلاً من (صفر) نقاط، وهكذا لتحقيق التوازن بين التأثيرات المحتملة لترتيب الأسئلة،

سيتم اختيار المشاركين بشكل عشوائي بحيث يكون لديهم فرصة بنسبة 50 في المائة للسؤال عن عناصر السمة المحسوسة قبل عناصر السمة الشخصية، وفرصة بنسبة 50 في المئة للعكس.

جرد الأعراض المختصر
(Derogatis, 2001)

التوجيهات: يتكون إختبار BSI 18 من مشاكل يعاني منها الناس في بعض الأحيان. يرجى قراءة كل واحد بعناية واختيار رقم الجواب الذي يصف على أفضل وجه الى أي مدى أزعجتك المشكلة في خلال الأيام السبعة الماضية بما في ذلك اليوم. إختر رقم واحد فقط لكل مشكلة. لا تتخط أي عنصر.
لحساب النتيجة، قم بإضافة أرقام الرد الخاصة بك. إذا كانت النتيجة إيجابية (سجلت بين 3-4 على معظم العناصر أو النتيجة الإجمالية ≥ 54)، فإن فريق البحث يوصيك بالاتصال بأخصائي الرعاية الصحية، والذي نوصي إليه في نموذج الموافقة والقائمة التي سيتم توفيرها في نهاية الاستبيان. من المهم ملاحظة أن BSI-18 هي أداة فحص لتقييم الوجود المحتمل لمشكلة ذات صحة النفسية معينة وليست طريقة تشخيص رسمية. يرجى الرجوع إلى أخصائي الرعاية الصحية لمزيد من الدعم.

يرجى استخدام التقييمات التالية:

على الاطلاق	قليلاً	باعتدال	الى حد ما	الى اقصى حد
صفر	1	2	3	4

في الأيام السبعة الماضية، بما في ذلك اليوم ، كم مرة أصبت ب:

	على الاطلاق	قليلاً	باعتدال	الى حد ما	الى اقصى حد
الإغماء أو الدوخة	صفر	1	2	3	4
الشعور بعدم الاهتمام بالأشياء	صفر	1	2	3	4
العصبية أو الاهتزاز في الداخل	صفر	1	2	3	4
آلام في القلب أو الصدر	صفر	1	2	3	4
الشعور بالوحدة	صفر	1	2	3	4
الشعور بالتوتر أو الضغط	صفر	1	2	3	4

غثيان أو اضطراب في المعدة	صفر	1	2	3	4
الشعور بالكآبة	صفر	1	2	3	4
الخوف فجأة بدون سبب	صفر	1	2	3	4
صعوبة في التنفس	صفر	1	2	3	4
الشعور بعدم القيمة	صفر	1	2	3	4
نوبات الرعب أو الذعر	صفر	1	2	3	4
خدر أو وخز في أجزاء من جسدك	صفر	1	2	3	4
الشعور باليأس بشأن المستقبل	صفر	1	2	3	4
الشعور بعدم الراحة بحيث لا يمكنك الوقوف مكتوف الايدي	صفر	1	2	3	4
الشعور بالضعف في أجزاء الجسم	صفر	1	2	3	4
التفكير في إنهاء حياتك	صفر	1	2	3	4
الشعور بالخوف	صفر	1	2	3	4

إذا كانت النتيجة إيجابية (درجات بين 3-4) في معظم العناصر، فإن فريق البحث يوصيك بالاتصال بأخصائي الرعاية الصحية، والذي نوصي إليه في نموذج الموافقة والقائمة التي سيتم توفيرها في نهاية الاستبيان.

لحساب النتيجة ،قم بإضافة أرقام الرد الخاصة بك. إذا كانت النتيجة إيجابية (سجلت بين 3-4 على معظم العناصر أو النتيجة الإجمالية ≥ 54)، فإن فريق البحث يوصيك بالاتصال بأخصائي الرعاية الصحية، والذي نوصي إليه في نموذج الموافقة والقائمة التي سيتم توفيرها في نهاية الاستبيان. من المهم ملاحظة أن BSI-18 هي أداة فحص لتقييم الوجود المحتمل لمشكلة ذات صحة النفسية معينة وليست طريقة تشخيص رسمية. يرجى الرجوع إلى أخصائي الرعاية الصحية لمزيد من الدعم.

مقياس الستة أضعاف للتفسير الذاتي

التوجيهات: ستجد أدناه سلسلة من الأسئلة التي تدور حول إدراكك لنفسك. يتبع كل سؤال مجموعة من 6 فئات محتملة: الأسرة والأصدقاء والمجموعات الاجتماعية وأصدقاء المدرسة / الصف والإنسانية بشكل عام والذات الشخصية. المجموعات الاجتماعية هي: مجموعة / حزب سياسي أو مؤسسة حكومية أو انتماء ديني.
تأكد من قراءة كل سؤال بعناية. شكرا لك.

استخدام المقياس: يُطلب منك تحديد التردد/المقدار الذي يعكس إجابتك على كل سؤال من مستوى منخفض من 1 إلى مرتفع 5. يرجى الرد على كل سؤال وعلى كل عنصر ضمن هذا السؤال.
إلى حد صغير جدا إلى حد صغير إلى حد معتدل إلى حد كبير إلى حد كبير جدا

1	2	3	4	5	
1) أرى نفسي مرتبط :					
بعائلتي	1	2	3	4	5
بأصدقائي	1	2	3	4	5
بالطلاب في جامعتي / صفي	1	2	3	4	5
بمجموعتي الاجتماعية	1	2	3	4	5
بالانسانية بشكل عام	1	2	3	4	5
بنفسي(انا شخص وحيد منفصل عن الآخرين)	1	2	3	4	5
2) أتحكم في سلوكي لاستيعاب رغبات (الاهتمامات)					
عائلتي	1	2	3	4	5
أصدقائي	1	2	3	4	5
الطلاب في جامعتي / صفي	1	2	3	4	5
مجموعتي الاجتماعية	1	2	3	4	5
الانسانية بشكل عام	1	2	3	4	5
نفسي (انا شخص وحيد منفصل عن الآخرين)	1	2	3	4	5
3) أتأثر بالأحداث التي تتعلق (تتعلق) ب:					
عائلتي	1	2	3	4	5
أصدقائي	1	2	3	4	5
الطلاب في جامعتي / صفي	1	2	3	4	5
مجموعتي الاجتماعية	1	2	3	4	5
الانسانية بشكل عام	1	2	3	4	5
نفسي (انا شخص وحيد منفصل عن الآخرين)	1	2	3	4	5
4) أنا على علم باحتياجات ورغبات وأهداف:					
عائلتي	1	2	3	4	5
أصدقائي	1	2	3	4	5
الطلاب في جامعتي / صفي	1	2	3	4	5
مجموعتي الاجتماعية	1	2	3	4	5
الانسانية بشكل عام	1	2	3	4	5
نفسي (انا شخص وحيد منفصل عن الآخرين)	1	2	3	4	5
5) أشعر أن لدي علاقة قوية مع:					
عائلتي	1	2	3	4	5

أصدقائي	1	2	3	4	5
الطلاب في جامعتي / صفي	1	2	3	4	5
مجموعتي الاجتماعية	1	2	3	4	5
الانسانية بشكل عام	1	2	3	4	5
نفسي (انا شخص وحيد منفصل عن الآخرين)	1	2	3	4	5

من مقياس التثقف متعدد المجموعات مقياس فرعي للغمر في المجتمع المسيطر لستيفنسون.

(Stephenson, 2000)[7]

فيما يلي عدد من العبارات التي تقيِّم التغييرات التي تحدث عندما يتفاعل الأشخاص مع أشخاص آخرين من ثقافات أو مجموعات عرقية مختلفة. نقصد بالغرب هنا أمريكا وأستراليا وكندا وأوروبا الغربية (بريطانيا وفرنسا وألمانيا وإسبانيا وإيطاليا والبرتغال).

حدد الإجابة التي تتناسب بشكل أفضل مع ردك على كل عبارة.

	خطأ	جزئياً خطأ	جزئياً صحيح	صحيح
أحضر المناسبات الاجتماعية مع أشخاص من الدول الغربية.	1	2	3	4
لدي العديد من المعارف من الدول الغربية.	1	2	3	4
أتحدث اللغة الإنجليزية أو الفرنسية في المنزل.	1	2	3	4
أعرف كيفية تحضير الأطعمة الغربية.	1	2	3	4
لدي اطلاع على أشخاص مهمين في التاريخ الغربي.	1	2	3	4
أفكر باللغة الإنجليزية أو الفرنسية.	1	2	3	4
أتحدث اللغة الإنجليزية أو الفرنسية مع عائلتي.	1	2	3	4
أشعر بالراحة التامة مع الغرب.	1	2	3	4
أفهم إحدى هذه اللغات: الإنجليزية أو الفرنسية ، لكني لا أتقن أيًا من هذه اللغات.	1	2	3	4
أنا على اطلاع بالشؤون الجارية في الغرب.	1	2	3	4
أحب أكل الأطعمة الغربية.	1	2	3	4
أقرأ بانتظام الصحف الغربية.	1	2	3	4
أشعر بالراحة في التحدث باللغة الإنجليزية أو الفرنسية.	1	2	3	4
إذا زرت دولة غربية أو كنت سأزورها في أي وقت، فسأشعر أنني في بلدي.	1	2	3	4
أشعر أنني مقبول من قبل الشعب الغربي.	1	2	3	4

[7] تم ترميز البند بشكل معاكس

APPENDIX G

FIGURES

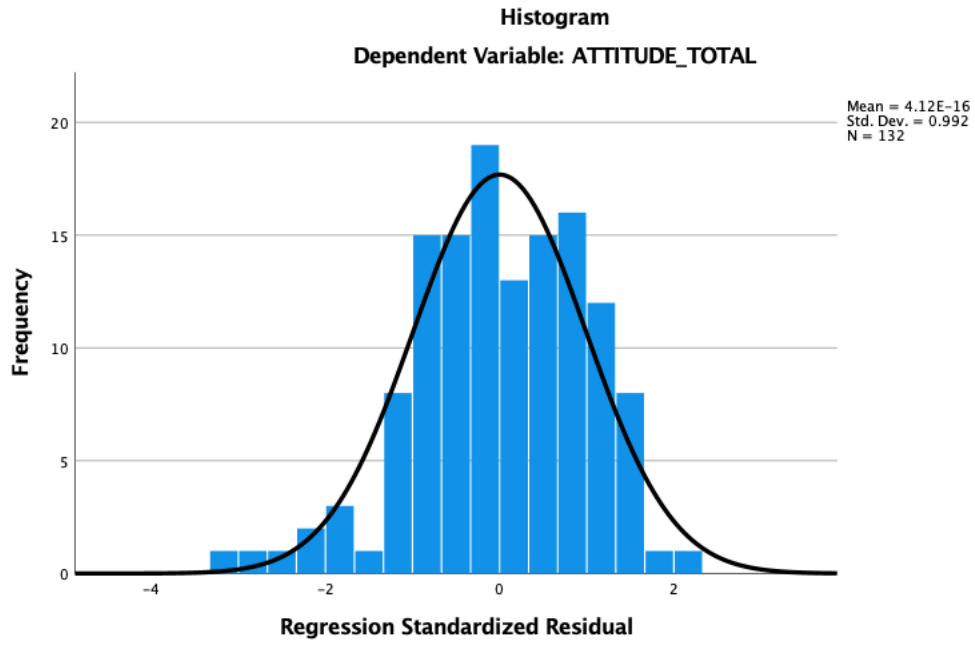

Figure 1: Historgram of Standardized Residuals

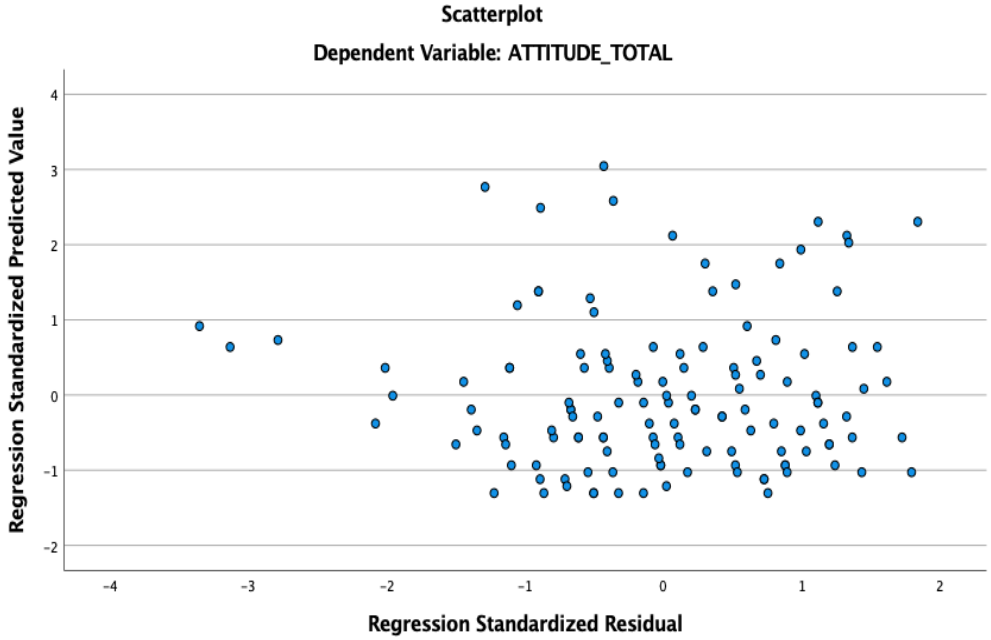

Figure 2: Scatterplot

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