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Attitudes towards mental health and seeking mental health services: A perspective of Arabs living in the UK.

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Abstract **4**

Introduction **5**

Mental Illness 5

Stigma and Help seeking 5

Theoretical Background 6

Attitudes towards seeking professional help 7

Shame-Focused Attitudes 8

Implication for research 10

Research Aims 12

Hypotheses 12

Method **13**

Participants 13

Measures 14

Ethical considerations 17

Results **17**

Bivariate Analysis 17

Multi- variate Analysis 21

Discussion **24**

Summary of Findings 24

Limitations of the study 27

Implications of findings 29

Future research 29

Conclusion **30**

References **32**

Appendices **39**

Abstract

This study examined whether or not ethnicity was predictive of attitudes towards seeking mental health services. Participants completed an online questionnaire advertised on social media outlets. Results showed that Arabs showed significantly more shame-focused attitudes towards mental health when compared with their White British counterparts (N = 50). Ethnicity was not found to be a predictive factor for attitudes towards seeking mental health services. However, stigma and shame-focused attitudes towards mental health were predictive of less favorable attitudes to seeking mental health services. Implications are drawn from the results.

Keywords: mental illness; help seeking; shame, stigma; Arabs; UK

Introduction

Mental Illness

Mental illnesses are health conditions that impact a person's emotions, thinking or behaviours (Mental Health Foundation, 2016). This may affect an individuals daily functioning and quality of life. It is reported that 1 in 4 people will experience mental health difficulties in any given year (Time for Change, 2018). It is also common that people who experience mental illness will be conflicted between coping with the symptoms of the mental illness and dealing with the misconceptions of mental illness that are expressed in society (Rüsch, Angermeyer, & Corrigan, 2005).

With this in mind, efforts have been made to reduce the stigma around mental health and encourage people to talk more openly about their experiences. Mental health awareness has grown drastically and policies such as 'Time For Change' launched in 2009, have played a crucial role in promoting positive attitudes towards mental health (Evans-Lacko, Henderson, & Thornicroft, 2013). Other public campaigns such as "World Mental Health Day" have also created a platform for people to share their mental health experiences and spread awareness (World Mental Health Day, 2018).

Despite this, stigma still exists around the issue of mental health therefore, it is important to explore and understand individual differences that may impact attitudes towards this topic and discourage an individual from seeking mental health services.

Stigma and Help seeking

Stigma is the most frequently reported explanation as the explanation for why individuals do not seek help for their mental health problems (Corrigan, 2004). Mental health stigma can be defined as the expression of negative attitudes, "objectifying and dehumanizing" a person who has been labeled as having a ''mental disorder''

(Masuda & Laztman, 2011). Corrigan (2004) proposed two types of stigma, "public stigma" and "self-stigma". Public stigma is the negative stereotypes and prejudice held by society towards a specific group of people. Self-stigma refers to when an individual personally identifies with the group that is not accepted by society and applies stereotypes and prejudices to themselves (Eisenberg et al., 2009).

Research has discovered that public stigma is significantly related to the propensity to display help seeking behaviours (Eisenberg et al., 2009). In support of this, a community based study conducted by Kessler et al., (2001) found 1 in 4 people who expressed a need for help did not seek mental health services due to what others might think.

Theoretical Background

Anderson and Newman (1973) proposed a theoretical framework that suggests two factors that will influence the use of health services: the environment and personal characteristics. Personal characteristics are thought to include predisposing factors that influence whether or not an individual is more inclined to seek out services than others. These characteristics include demographical factors e.g. age, gender, social constructs such as marital status, education, ethnicity and general attitudes and beliefs about support services. These factors are thought to determine an individual's status in the community, the ability to manage the problem and the resources available to cope with the problem (Wacker, Roberto & Piper, 2007).

Drawing from Anderson and Newman (1973) framework, Srebnik, Cauce and Bavader (1996) proposed three pathways to help seeking, "*problem recognition", "the decision to seek help"* and *"the selection of the help provider"*. Srebnik, Cauce and Bavader (1996) argued that context and culture impacts the perceived need for help, which lead to the *problem recognition* pathway. Both of these social constructs may

prevent an individual acknowledging there is a problem due to stigmatizing attitudes or beliefs about the issue that may be endorsed by society. These social constructs may also affect the decision to seek help.

Finally, this model also proposes that whether or not people progress onto the service selection pathway and whom they receive service from (family/friends, mental health services and other collateral service e.g. schools/justice system) is also influenced by context and culture (Cauce et al., 2002). Both theories highlight the process by which social constructs and demographical factors impact the decision to seek help for mental health problems. This emphasizes the importance of exploring these constructs.

Attitudes towards seeking professional help

The term 'attitudes towards seeking professional help' is defined as the propensity to either seek or avoid help from professionals for mental health illnesses (Fischer & Turner, 1970). This has been developed into standardized measures as a way of assessing this concept.

Mental illness has provoked negative responses in various ethnic groups and societies (Hong, 1997). Research has reported a poor relationship between ethnic minorities and the utilization of mental health services (O'Brien, Fahmy & Singh, 2009). It has previously been noted that ethnic minorities are more likely to end their treatment early, become detained under the Mental Health Act and be overrepresented in forensic settings (McGovern & Cope, 1987).

With regards to British research, the majority of findings regarding seeking professional help have been reported from the South Asian population. Sheikh and Furnham (2000) found that ethnicity was not a significant predictive factor for seeking professional help when comparing British Asians, Western Europeans and Pakistanis.

However, sex, education and religion were. Nevertheless, research has shown that Asian and Arab ethnicities were more likely to express more negative attitudes towards seeking professional help when compared to a Western population (Gilbert, Gilbert, & Sanghera, 2004). Similar research has been reported from Arabs in the Middle East (Al-Adawi et al., 2002; Al-Krenawi & Graham, 1999).

Shame-Focused Attitudes

The relationship between the stigmatising attitudes towards mental health and seeking professional help has been significant in various ethnicities. Masuda, Anderson and Edmonds (2012) concluded that stigma was seen to be a major hindrance for the utilization of mental health service among African Americans. Similarly, within Asians, mental illness was strongly associated with the belief that it brings shame to the family (Lauber & Rössler, 2007).

The fear of being stigmatized, shamed and concerns regarding confidentiality have been commonly associated with seeking help from mental health services (Corrigan, 2004). These characteristics have been particularly significant in the Arab community. Studies in Australia have identified inconsistencies in service utilization between ethnic groups when compared with other Australian counterparts (Tobin, 2000). Research has shown that Arabic-speaking people have lower attendance rates for seeking help for psychological problems compared with English-speaking people (Mcdonald & Steel, 1997).

Mental health treatment has been identified as especially stigmatizing among the Arab population and is considered a fundamental barrier to accessing mental health services (Aloud, 2004; Gearing et al., 2014). A study carried out in the United Arab Emirates (UAE) showed that 38% of a sample of 325 parents reported they would utilize mental health services for their children even when they presented with evident

mental health issues (Eapen & Ghubash, 2004).

Similarly, a qualitative study in Kuwait by Scull et al., (2014) found that stigma was the most prominent theme discussed by participants and was central to seeking services. Participants expressed that Arab Kuwaitis tend to hold the belief that an individual must be "crazy" to seek mental health services. Furthermore, Al-Krenawi (2005) found that Arabs with mental illnesses often somatise their symptoms to avoid negative reactions towards their illness from society. Expressing psychological symptoms as physical complaints is believed to be more socially acceptable in the Arab community (Okasha, 1999).

In a qualitative study with Arabic speaking people in Australia, Youseff and Deane (2006) reported that causes for poor mental-health utilization among the Arab communities included: language barriers, concept of mental illness, shame and stigma. With regards to British research, similar findings have been highlighted among Punjabi and South Asian communities (Bhui et al., 2001). Pilkington, Msetfi, and Watson (2011) found that South Asian British Muslims expressed higher levels of shame. This was associated with a less propensity to access help from mental health services.

Shame can be defined as the feeling of humiliation and embarrassment. Abu-Ras 's study in the United States (2003) found that 70% of Arab women reported feelings of shame and 62.7% reported feelings of embarrassment associated with seeking professional help for mental health problems. Furthermore, Arab youths expressed concerns and fear that self-disclosure of mental illness would be perceived as "weak" in their community and bring shame to one's family (Al-Darmaki, 2003; Hijiawi et al., 2013). With regards to gender differences, female Arabs were reluctant to utilise services and engage in treatment out of fear it may impact their marital prospects (Al-

Krenawi et al., 2009). The effect of shame is particularly important for the present study, as research studies have evidenced the negative impact it is on the decision to seek help for psychological problems in the Arab community. Therefore, it is important to explore if the prevalence of shame towards mental health illnesses is just as significant in a UK Arab sample.

Confidentiality has also ben associated with shame-focused attitudes and accessing professional help from mental health services. Gilbert et al. (2004) found that Asian women expressed fears about information regarding their mental health being shared with others including their general practitioner (GP) from their own community. Similarly, 63% of Arabs in Australia expressed that shame and confidentiality are the primary concerns when discussing their mental health with their GP (Youssef & Deane, 2006). In an Arab UK sample, Hamid and Furnham (2013) found that confidentiality concerns were more predictive of seeking professional help than shame-focused attitudes.

Research has largely looked at the attitudes of Arabs in the context of an Arab country. Although this is useful, it is difficult to generalise these findings to Arabs in the UK. It is reported that limited research has been carried out in the UK within the "BAME" communities. This refers to Black, Asians and other ethnic minorities. BAME communities are considered to have an increased risk of poor mental health (Mental Health Foundation, 2016). This reemphasises the need for this issue to be explored further and provide an accurate representation of the attitudes of Arabs in the UK.

Implication for research

It is apparent that the utilizations mental health service among ethnic minorities in the United Kingdom is an issue. Service utilization is a critical step towards

reducing the burden of mental illness. Therefore, considering stigma and shame focused attitudes as obstacles for seeking mental health care in Arab communities in the UK is a priority for services (Dardas & Simmons, 2015).

Notably, the literature challenging stigma and shame focused attitudes towards mental illness and the underutilization of mental health services has been heavily researched in Arab communities in the Middle East, Australia and United States (Al-Krenawi, 2002; Yousseff & Deane, 2006; Erikson & Rimimi, 2001). Research has presented findings from both qualitative and quantitative studies, which has provided reliable as well as detailed research findings. However, it is difficult to generalise these findings to UK Arab communities and research exploring whether ethnicity is associated with attitudes towards seeking help from services is scarce.

In addition, it is possible that the outlined factors associated with seeking help from mental health services are dependent on social context. This may be explained through the process of acculturation. This term refers to the process of adopting values, behaviours, knowledge and identity of the dominant ethnicity in society (Hamid & Furnham, 2013). For example, Arabs living in the UK may have adopted values from western society. Furthermore, stigma is embedded in it's social context and so, what is accepted in one society may be considered unacceptable and vulnerable to stigmatization in others (Abdullah & Brown, 2011). Also, mental health services differ across countries and the issue of mental health remains a big taboo in the Middle East. Therefore, it cannot be assumed that Arabs, who are in a different social context e.g. UK, will have the same attitudes as Arabs in the Middle East.

This research will be useful in providing insight into the attitudes of Arabs living in the UK towards mental health and seeking help from services. This enables mental health services to consider individual needs of this ethnic group, the delivery of mental

health services and as result, overcome potential barriers to disengagement from services.

Finally, from a forensic perspective, the literature has identified that the police are commonly the first point of contact for individuals who are experiencing mental health problems (Bradley, 2009). A report by Race for Justice (2008) reported that individuals from ethnic minorities account for 26% of the prison. Similar reports are evident with mental health referrals within ethnic minorities. Therefore, it is possible that understanding the attitudes of Arabs living in the UK towards seeking help from mental health services may allow practitioners to be mindful of strategies for early intervention. In time, this may reduce mental health referrals from police.

Research Aims

1) To compare the stigmatizing attitudes towards mental health between Arabs and White British.

2) To compare shame-focused attitudes towards mental health problems between Arabs and White British individuals.

3) To compare attitudes towards seeking help from mental health services between Arabs and White British individuals.

4) To investigate whether ethnicity is associated with the attitudes towards seek help from mental health services.

Hypotheses

On the basis of previous literature, the proposed hypotheses are the following:

1) Arabs will have more stigmatizing attitudes towards mental health.

2) Arabs will express more shame-focused attitudes towards mental health problems.

3) White British individuals will express more favorable attitudes towards seeking professional help from mental health services.

4) Ethnicity will be a predictive factor of attitudes towards seeking help from mental health services.

Method

Participants

According to G*Power 3.1 calculation, the estimated sample size required for this study was 114. The G*Power also estimated a power of 0.8, a confidence level of 0.05 and a potential effect size of 0.5. Ninety-two female participants aged between 16-25, Arabs *(Mn* = 21.19) White British (*Mn* = 21.66), was obtained for the study. Initially, being born in the UK was part of the criteria; 28.6% of the sample included Arabs born outside of the UK. However, after comparing the responses of UK born Arabs and none UK born Arabs, no differences were identified. For that reason, data from non-UK born participants was included. From the sample 45.7% were Arab and 54.3% were White British. No significant differences were found between the two ethnic groups across the listed demographics.

Table 1. Breakdown of demographics for Arabs and White British

	White British		Arab	
Mean Age	21.19 (21 years)		21.66 (21 years old)	
	N	%	*N*	%
Gender				
• Female	50	100%	42	100%
Born in the UK				
• Yes	50	100%	30	71.4%
• No	0	0%	12	28.6%
Marital Status				
• In a relationship	30	60%	12	28.6%
• Single	20	40%	30	71.4%
Occupation				
• Employed	20	40.0%	16	38.1%

• Unemployed	1	2.0%	2	4.8%
• Student	29	58.0%	24	57.1%
Education				
• Primary School	1	2.0%	0	0
• GCSE or equivalent	6	12.0%	3	7.1%
• A-level or equivalent	13	26.0%	8	19.0%
• Bachelors Degree	17	34.0%	21	50.0%
• Masters Degree	13	26.0%	7	16.7%
• Phd Degree	0	0	3	7.1%
Experienced mental health problems				
• Yes	39	78.0%	30	71.4%
• No	11	22.0%	12	28.6%
Been in contact with mental health services				
• Yes	29	58.0%	14	33.3%
• No	21	42.0%	28	66.7%
Services used:				
• Statuary Services	72	100%	32	76.4%
• Non statuary	0	0	1	2.4%
• Other	0	0	3	7.1%
Known someone close to you who has experienced mental health problems				
• Yes	40	80.0%	34	81.0%
• No	10	20.0%	8	19.0%
Known someone close to you who has been in contact with mental health service				
• Yes	37	74.0%	20	47.6%
• No	13	26.0%	22	52.4%
Services used:				
• Statuary Service	92	82%	32	76.2%
• Non statuary	7	14.0%	2	4.8%
• Other	2	4.0%	2	4.8%

Measures

Stigmatising Attitudes Believability Questionnaire (SABQ)

The SABQ (Masuda et al., 2009) consisted of eight questions to measure level of

stigma towards mental health (see Appendix A). The questionnaire asked participants to rate a variety of statements about an individual with a mental health problem on a 7-point Likert-scale. (e.g."person with a psychological disorder is the one to be blamed for his or her problems"). Scores ranged from 1 (not at all believable) to 7 (completely believable). A high score represented high levels of stigmatizing attitudes. This scale showed acceptable internal consistency with a Cronbach's $\alpha = .742$. As the SABQ was subject to copyright, permission to use the questionnaire was granted by the author.

Attitudes towards Mental Health Problems Scale (ATMHPS)

The ATMHPS (Gilbert et al., 2007) is a 23-item questionnaire assessing shame-focused attitudes towards mental illness (see Appendix B). This reflects how a person, their family and the community may perceive mental health. Participants were asked to rate statements on a 4-point Likert scale, ranging from "Do not agree at all" to "Completely agree". The ATMHPS consisted of four shame-focused subscales; Community/Family attitudes towards mental health problems (CFS), External Shame/Stigma (ES), Family Reflected Shame (FRS) and Reflected Shame from seeking professional help (RS-SP). Questions were adapted to highlight ethnicity in the statement e.g. "I think people from my ethnic community would see me as weak". In addition, four questions were added to reflect professional relationship preference/trust. A high score demonstrated higher levels of shame towards mental health. The dimensions in the scale showed good internal consistency for three out of four subscales with Cronbach's alpha of .89 for CES, .99 for ES and .87 for FRS.

The Inventory of Attitudes towards Seeking Mental Health Services (IASMHS)

The IASMHS (Mackenzie et al., 2004) is a 24-item questionnaire that assesses attitudes towards help-seeking behaviours for mental health illnesses (see Appendix C). Participants were required to score statements relating to help seeking behaviours

on a 4-point Likert-scale ranging from 0 (disagree) to 3 (agree). The questionnaire comprised of three constructs of seeking mental health services; *Psychological openness* (the extent to which a person is open to acknowledging that a psychological problem is present and to seek help), *Help seeking propensity* (an individuals willingness and ability to seek help and *Indifference to stigma* (how an individual would feel if others would find out they were getting professional help (Hyland et al., 2014). A high score is suggestive of negative help-seeking propensity; questions on the *Help Seeking propensity* subscale were reverse scored. The IASMHS displayed acceptable internal consistency for all three subscales with a Cronbach's alpha of .71 for *Psychological Openness*, .79 for *Help-seeking propensity* and .75 for *Indifference to stigma*.

Procedure

This study used a quantitative between-groups design and used an online survey to collect data. This was advertised on social media networks (Twitter, Facebook, Instagram and LinkedIn) (see Appendix D). An inclusion criterion was included; Arab or White British and aged between 16-25) to ensure data was collected from the targeted demographics. A web-link was provided that directed participants to the survey information page (see Appendix E) followed by a consent form (see Appendix F). This highlighted that participation will be anonymous and informed participants of their right to withdraw from the study.

Participants were then directed to answer various demographical questions (e.g. age, gender, ethnicity, education, occupation, employment, history of mental health and contact with mental health services) (see Appendix G). Participants were then asked to complete three questionnaires, the Stigmatizing Attitudes Believability Questionnaire (SABQ) (Masuda et al., 2009) followed by the Attitudes towards

Mental Health Problems Scale (Gilbert et al., 2007) and the Inventory of Attitudes towards Seeking Mental Health Services (IASMHS) (Mackenzie et al., 2004). Participants were directed to the end of the survey and presented with a debrief page (see Appendix H). This also provided a link to Mind for support and further reading about mental health.

Ethical considerations

As part of the study, participants were asked to disclose personal information. To ensure that participants felt comfortable sharing personal information, all information collected was anonymous and kept confidential. Furthermore, to ensure that participants have access to support and mental health information, links to Mind was provided. In addition, participants were provided with a debrief following their completion.

Results

First, a normality test was run to test for normal distribution across the data for all three questionnaires. Shapiro-wilk and visual assessment of histograms was used to assess normality. Values showed to be above 0.05, for the Arabs only, therefore, data were not normally distributed across the White British population. As a result of having a mixed result of normal distribution, non-parametric tests were used as well as bootstrapping for data analysis.

Bivariate Analysis

Stigma towards Mental Health (SABQ)

To investigate Hypothesis 1, A Mann-Whitney test indicated that there was no significant difference between Arabs (*Mdn* = 12) and White British (*Mdn* = 8.5)

participants in their stigmatising attitudes towards mental health $U = 891.0$, $p = .212$, $r = -0.13$.

Table 2. *Means and Standard Deviations on the SABQ scale*

	Arab			White British		
	N	*M*	*SD*	*N*	*M*	*SD*
Total Score	42	11.45	6.38	50	10.3	6.74

Shame-focused Attitudes towards Mental Health Problems (ATMHPS)

To investigate Hypothesis 2, A Mann-Whitney U test was carried out to compare shame-focused attitudes towards mental problems between Arabs and White British. The test indicated that there was a significant difference between Arabs (*Mdn* = 33.5) and White British (*Mdn* = 18.5) participants $U = 678.5$, $p = .004$, $r = -0.30$ with Arabs demonstrating more shame-focused attitudes towards mental health problems.

More specifically, Arabs (*Mdn* = 13) demonstrated significantly higher scores on Subscale 1 (Community/Family attitudes towards mental health problems) $U = 682.0$, $p = .004$, $r = -0.30$ compared with White British (*Mdn* = 8) participants. This suggests that Arabs expressed more shame-focused attitudes associated with their ethnic community/ family. Furthermore, compared with White British participants (*Mdn* = 6), Arabs (*Mdn* = 2) showed significantly higher scores on Subscale 3 (Family reflected shame) $U = 595.0$, $p = .000$, $r = -0.37$. This suggests that Arabs expressed more shame-focused attitudes concerned with the impact of having mental health problems on one's family.

Table 3. *Means and Standard Deviations for the ATMHPS Scale*

	Arab			White British		
	N	*M*	*SD*	*N*	*M*	*SD*
Subscale 1 Community/ Family Attitudes towards Mental Health	42	13.10	5.83	50	9.32	6.19
Subscale 2 External Shame/ Stigma	42	8.71	5.22	50	7.08	5.92
Subscale 3 Family Reflected Shame	42	6.17	4.15	50	3.28	4.10
Subscale 4 Reflected Shame from Seeking Professional Help	42	5.55	2.51	50	5.10	2.37
Total Score	42	32.50	14.63	50	24.78	15.76

Attitudes towards Seeking Help from Mental Health Services (IASMHS)

To investigate Hypothesis 3, A Mann-Whitney test indicated that there was no overall significant difference between Arabs (*Mdn* = 32.5) and White British (*Mdn* = 31.5) participants in their attitudes towards seeking mental health services $U = 959.0$, $p = .475$, $r = -0.07$.

With regards to the subscale concerned with psychological openness, there was a significant difference between Arabs (*Mdn* = 9.5) and White British (*Mdn* = 7) participants $U = 761.5$, $p = .023$, $r = -0.24$. White British participants presented as more open to acknowledging a mental health problem and the importance of seeking

help from professionals than Arabs. Results did not demonstrate any significant differences between the two ethnicities on the remaining subscales; *Help seeking propensity* and *Indifference to stigma.*

Table 4. *Means and Standard Deviations for the IASMHS scale*

	Arab			White British		
	N	*M*	*SD*	*N*	*M*	*SD*
Subscale 1 Psychological Openness	42	10.31	4.20	50	8.36	4.44
Subscale 2 Help-seeking Propensity	42	13.36	4.79	50	14.08	4.94
Subscale 3 Indifference to Stigma	42	8.60	4.30	50	9.14	5.10
Total Score	42	32.26	6.67	50	31.58	7.82

Exploration of Ethnicity as a predictive factor for shame-focused attitudes towards mental health

Due to the significant Arabs expressing significantly more shame-focused attitudes in comparison to White British, a linear regression using bootstrapping was carried out to explore ethnicity as a predictive factor for shame-focused attitudes towards mental health (ATMHPS). The results of the linear regression indicated that the model explained 7.7% of the variance and was predictive of shame-focused attitudes towards mental health ($F(1,91) = 7.5$, $p = .007$). Ethnicity showed a negative relationship (B -8.74, $p = .006$) with shame-focused attitudes.

Table 5. *Simple Linear Regression for Ethnicity as a predictive variable for Attitudes towards Mental Health Problems (ATMPHS)*

Variable	β	SE	*p*	R2	Adjusted R2
				.077	.067
Ethnicity	-8.74	3.22	.010		

Multi- variate Analysis

To investigate Hypothesis 4, a Multiple Linear Regression using bootstrapping was carried out to investigate ethnicity as a predictive variable of help-seeking propensity. To further explore the data set, demographical factors, stigma towards mental health and shame-focused attitudes towards mental health were also included in the analysis as potential predictive variables.

The results from the analysis indicated that the model explained 32.8% of the variance and showed two significant predictor variables for attitudes towards seeking mental health services ($F(10,81) = 3.10$, $p < .000$). Ethnicity was not found to be a significant predictor of attitudes towards seeking mental health services (B 2.24, $p = .203$). Therefore, not supporting Hypothesis 4.

Stigmatising attitudes towards mental health (B .35, $p = .003$) was a significant predictive factor, demonstrating a positive relationship. As stigma towards mental health illness increases, negatives attitudes towards seeking mental health services increased by .35. Attitudes towards mental health problems (ATMHPS) were also found to be a significant predictor of attitudes towards seeking services (B .14, $p = .005$). This demonstrated a positive relationship, as shame-focused attitudes towards mental health increased by one standard deviation, negative attitudes towards seeking services increased by .14.

Table 6. *Bootstrapped Multiple Linear Regression for Ethnicity as a predictive variable for seeking mental health services (IASMHS)*

Variable	β	SE	*p*	R2	Adjusted R2
				.328	.245
Ethnicity	2.24	1.72	.203		
Shame-focused attitudes towards mental health (ATMHPS)	.14	.05	.005		
Stigma (SABQ)	.35	.12	.003		

Significant predictive variables for subscales on the Inventory of Attitudes towards Seeking Mental Health Services

Subscale 1: Psychological Openness

Looking at the subscales of IASMH, the multiple linear regression analysis showed that the model explained 30.5% of the variance and showed stigma towards mental health illnesses as predictive of psychological openness ($F(10,81) = 3.56$, $p < .001$). This demonstrated a positive relationship (B .19 $p = .008$), as stigma towards mental health increased, scores for psychological openness also increased showing less favourable attitudes towards mental illness.

Table 7. *Bootstrapped Multiple Linear Regression for predictive variables for Psychological Openness.*

Variable	β	SE	*p*	R2	Adjusted R2
				.305	.220
Stigma (SABQ)	.19	.07	.008		

Subscale 2: Help- seeking propensity

The multiple linear regression model explained 27.45% of the variance and was predictive of Help seeking propensity (F(10,81) = 3.06 p= .002). The following were significant predictors of help seeking propensity, Stigma (SABQ) (B .17, p = .040), Shame-focused attitudes towards mental health illnesses (ATMHPS) (B -.10 p = .002), Age (B .51 p = .029) and Occupation (B 1.16, p = .046).

Table 8. *Bootstrapped Multiple Linear Regression for predictive variables for Help-seeking Propensity.*

Variable	β	SE	*p*	R2	Adjusted R2
				.274	.184
Age	.51	.23	.029		
Stigma (SABQ)	.17	0.78	.040		
Shame-focused attitudes towards mental health (ATMHPS)	-.10	.03	.002		
Occupation	1.16	.57	.046		

Subscale 3: Indifference to stigma

Other various demographical factors and attitudes explained 45.3% of the variance and was predictive of indifference to stigma (F(10,81) = 6.704 p< .000). The following showed a significant predictive relationship towards indifference to stigma; shame-focused attitudes towards mental health problems (ATMHPS) (B .17, P = .001), Ethnicity (B 2.34, p = .027) and Education (B -1.16, p = .023). Personal experience of mental health problems (B -2.61, p = .029) and previous contact with services (B -.2.20, p = 0.28) demonstrated a negative relationship.

Table 9. *Bootstrapped Multiple Linear Regression for predictive variables for Indifference to Stigma.*

Variable	β	SE	*p*	R2	Adjusted R2
				.453	.385
Shame-focused attitudes towards mental health (ATMHP)	.17	.032	.001		
Ethnicity	2.34	1.04	.027		
Education	-1.16	.50	.023		
Personal experience of mental health problems	-2.61	1.08	.029		
Previous contact with mental health services	-2.20	1.00	.028		

Discussion

Summary of Findings

Hypothesis 1

Contrary to previous findings, Hypothesis 1 was not supported and Arabs did not demonstrate more stigmatizing attitudes towards mental health in comparison to White British participants. Mental health stigma has been consistently reported in the literature within Arab communities (Scull et al., 2014). However, the majority of conclusions have been drawn from research carried out in the Middle East. Although findings do not support the hypothesis, the outcome has highlighted the potential

impact of social context. This supports Srebnik, Cauce and Bavader (1996) theory that suggests social context impacts the decision to seek help.

It is likely that Arabs living in the UK have become acculturated with western society, and developed an understanding of mental health through mental health awareness campaigns. This may explain why Arabs did not differ to White British individuals in their stigma towards mental health. The impact of social context can be explored further in future research.

Hypothesis 2

When compared with White British participants, Arabs expressed more shame-focused attitudes towards mental health problems. Thus, supporting hypothesis 2. More specifically, Arabs expressed more shame-focused attitudes towards how family and their community perceive mental health problems (Subscale 1) as well as how mental illness reflects on a family's status and reputation in their community (Subscale 2).

Although Arabs living in the UK may have adopted western attitudes regarding mental health, it appears that negative perceptions of mental health illnesses are still ingrained within the Arab community. Due to Arabs expressing significantly more shame towards mental health, ethnicity was explored as predictive factor for shame-focused attitudes towards mental health. This relationship appeared to be significant and influenced more expressed shame towards mental health problems. This suggests that ethnicity shapes attitudes towards mental health problems.

Hypothesis 3

Overall, Arabs and White British participants did not differ in their attitudes towards seeking help from mental health services. Therefore, not supporting hypothesis 3. However, differences on Subscale 1 (psychological openness) were

identified. Arabs were less open to acknowledging the presence of mental health problems and less likely to seek help from services. This is consistent with previous findings.

Hypothesis 4

Hypothesis 4 was not supported and ethnicity was not predictive of attitudes towards seeking help from mental health services. Contrary to, Hamid and Furham's (2013) findings, shame-focused attitudes towards mental health problems showed to be predictive of attitudes towards seeking help. Stigma towards mental health was also a predictive factor. Both demonstrated a negative relationship and influenced less favourable attitudes towards seeking mental health services. As ethnicity is associated with shame-focused attitudes, it is possible that ethnicity indirectly impacts attitudes towards seeking help from services. This relationship should be explored further in future research.

Demographical factors were also explored as potential predictive factors of attitudes towards seeking help from services. Significant relationships were demonstrated on the subscales. Stigma towards mental health showed a negative relationship with Subscale 1, *Psychological Openness*. This suggested that the more stigmatising attitudes an individual had, the less likely they would be open to acknowledging that a psychological problem is present and to seek help. Age and occupation were both associated with *Help-seeking propensity* (Subscale 2), which refers to less willingness to seek help from services.

Finally, lack of personal experience of mental health problems and previous contact with services were associated with *Indifference to Stigma* (Subscale 3). This refers to negative feelings about others finding out they were getting professional help. This may suggest that previous experience with services, either positive or

negative may shape an individual's perception of mental health services and their illness. As shame towards mental health is held strongly in the Arab community, it is possible that this plays an active role in eliciting fear of others finding they are getting help for mental health problems from services.

However, as these factors were not the primary focus of the study, it would be useful to explore them in more detail in future research.

Limitations of the study

It is important to consider the results alongside the limitations. Prior to starting the study, a sample size of 114 participants was calculated using G* Power 3.1, however only 92 participants were obtained. A difficulty during data collection for the study was recruiting Arab participants. It appeared that the dominant demographic within social platforms was White British. This put the study at a disadvantage and created challenges in accessing an Arab population. It is possible that with a longer timescale and further knowledge regarding Arab specific social platforms, this may have allowed opportunity in accessing more Arab participants. Furthermore, a larger sample size may have shown more significant results. Future considerations should be made for accessing resources with a wider Arab population.

A further explanation for challenges in reaching Arab research participants is the negative attitudes and feelings that surround the topic of mental health. Based on previous findings and due to the sensitivity of the topic, this may have deterred Arab participants from taking part in the study.

Furthermore, the study did not assess length of residency in the UK and therefore assumes that Arabs in the sample are accustom to western society. Due to the process of acculturation, it would be valuable for future research to specify this in order to assess the impact of social context on attitudes towards mental health and

seeking help from services. Furthermore, as the sample was all female, findings cannot be generalised and gender differences analysed. Female participants were more forthcoming with regards to completing the survey. Only 19 male participants were obtained. Due to the unequal male to female ratio, data from male participants could not be sufficiently analysed. Therefore, males were excluded from the sample.

The study solely relied on a quantitative method to collect data. Although this provided reliable and internally valid data (Coolican, 2004), it limited the opportunity for participants to elaborate and give detail regarding their attitudes towards mental health and seeking professional help from services. It would have been useful to gather qualitative data as well as quantitative to form a well-rounded understanding of participant's attitudes towards the issue. Previous research has favored either quantitative or qualitative and not considered the use of both methodologies collectively. This can be considered for future research to identify themes of barriers for seeking help from mental health services in UK Arabs.

Also, previous findings highlighted that concerns regarding confidentiality was a predictive factor for seeking help from mental health services (Youssef & Deane, 2006; Hamid & Furnham, 2013). This factor was not sufficiently assessed in this study. The ATMHPS and IASMHS questionnaires included sub questions that related to ethnic preferences of professionals, expressing mental health concerns to a professional and trusting professionals with information regarding mental state. It may have been more useful to assess confidentiality as a separate construct. This would have allowed for the relationship between confidentiality and seeking professional help from mental health services to be explored.

Implications of findings

Although not all hypotheses were supported, findings are valuable and have given insight into attitudes towards mental health within the Arab community. Research in the Middle East has identified a high prevalence of shame in Arab communities regarding mental health (Al-Darmaki, 2003), this evidently transpires across Arabs living in the UK. This finding has provided insight into the obstacles that prevent the Arab community from seeking mental health services as well as potential resistance professionals may be faced with when engaging individuals from the Arab community in treatment. It is therefore a priority for organisations to educate mental health professionals about the attitudes expressed by Arabs.

From this, mental health professionals are able to make considerations and address individual needs and concerns of the Arab community. This is imperative in improving the delivery of services therefore, providing positive experiences and overcoming barriers to disengagement and service underutilisation. In addition, as Arabs are more forthcoming to seek help for physical as opposed to mental illness, the findings can help medical professionals e.g. GP's to be more aware and take the opportunity to check-in with patients regarding mental wellbeing.

Finally, creating a positive experience with mental health services for ethnic minorities may encourage individuals to seek help from services before crisis point. Such preventative strategies may reduce mental health referrals from police services due to offending behaviour and risk to self/and or others.

Future research

Future research should consider the use of a mixed method approach by combining the use of qualitative and quantitative methods for data collection. This provides a comprehensive and in-depth understanding of factors that may explain the

resistance to seeking help from services in the Arab community. This method may also be useful in identifying factors that may have not previously been considered.

Furthermore, due to the majority being born in the UK, an assumption is made that participants have become accustom to western attitudes, values and behaviours. However, future research should specify length of time spent in the UK and how this may influence attitudes towards mental health and seeking help.

With the recent increase of Arab asylum seekers entering the UK from the Middle East, it is likely that they will experience a sense of divide between their countries attitudes, values, behaviours and what is accepted in western society. Mental health services differ across countries and there is reported underutilization of mental health services among Arab communities (Yousseff & Deane, 2006; Al-Krenawi, 2002). Due to war and political conflicts in the Middle East, there is likely to be a high prevalence of mental health problems among Arab asylum seekers. Therefore, it is important to focus on this population. Furthermore, if shame-focused attitudes towards mental health are still significantly ingrained in young Arabs living in the UK, it is likely that Arabs who have recently resided to the UK, who are not familiar with western society, will have the same attitudes if not hold stronger views. Therefore, they are likely to be more resistant towards mental health services.

Finally, research has often focused on exploring factors that prevent the utilisation of mental health services. However, future research should consider factors that may encourage Arabs to seek help. This may have useful implications for mental health services and more beneficial to meeting the needs of Arabs in the UK.

Conclusion

Based on the literature and findings from the present study, it is clear that there is resistance from the Arab community to acknowledge mental illnesses and seek help

from mental health services. Therefore, it is imperative that research explores further into this issue, in order to meet the needs of ethnic minorities and improve the delivery of mental health services.

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Appendices

Appendix A

Stigmatizing Attitudes Believability Questionnaire

Imagine that the following thoughts occurred to you right now.

How valid or believable would each be? Please use the following scale. For each question, please circle a number 1 through 7.

Scale

1 2 3 4 5 6 7

Not believable Completely Believable

1) Those with mental health problems are dangerous to others.

1 2 3 4 5 6 7

2) A person with a mental health problem is unpredictable.

1 2 3 4 5 6 7

3) Those with mental health problems are hard to talk to.

1 2 3 4 5 6 7

4) I feel that I am different from those with mental health problems.

1 2 3 4 5 6 7

5) A person with a mental health problem is the one to be blamed for his or her problems.

1 2 3 4 5 6 7

6) A person with a mental health problem cannot pull himself/herself together in order to appropriately function in society.

1 2 3 4 5 6 7

7) Those with a mental health problem will not improve even if they are treated.

1 2 3 4 5 6 7

8) Those with mental health problems will never recover.

1 2 3 4 5 6 7

Appendix B

Attitudes Towards Mental Health Problems Scale

Below are a series of statements about how you, your community and your family may think about mental health problems **(e.g., loss of appetite, suicidal thoughts, depression, anxiety, hearing voices that are not physically present).** Read each statement carefully and circle the number that best describes how much you agree with each statement.

0 = Do not agree at all

1 = Agree a little

2 = Mostly agree

3 = Completely Agree

For this first set of questions please think about how people from your ethnic community and family view mental health problems

1) People from my ethnic community see mental health problems as something to keep secret.

0 1 2 3

2) People from my ethnic community see mental health problems as a personal weakness.

0 1 2 3

3) People from my ethnic community would tend to look down on somebody with mental health problems.

0 1 2 3

4) People from my ethnic community would want to keep their distance from someone with mental health problems.

0 1 2 3

5) My family see mental health problems as something to keep secret.

0 1 2 3

6) My family see mental health problems as personal weakness.

0 1 2 3

7) My family would tend to look down on someone with mental health problems.

0 1 2 3

8) My family would want to keep their distance from someone with mental health problems.

0 1 2 3

For the next set of question please think about how *you* might feel if you suffered from mental health problems causing you a difficulty to cope in everyday life.

9) I think people from my ethnic community would look down on me.

0 1 2 3

10) I think people from my ethnic community would see me as weak.

0 1 2 3

11) I think people from my ethnic community would not understand/ accept me.

0 1 2 3

12) I think my family would look down on me.

0 1 2 3

13) I think my family would see me as weak.

0 1 2 3

14) I think my family would see me as not measuring up to their standards.

0 1 2 3

For the next set of questions we would like you to think about how you might feel if *you* suffered from mental health problems causing difficulty to cope in everyday life. Consider how worried or concerned you would be on the impact on your family and other relationships.

15) My family would be blamed for my problems.

0 1 2 3

16) My family would lose status in the community.

0 1 2 3

17) I would worry that I would be letting my family's honour down.

0 1 2 3

18) I would worry that my mental health problems could damage my family's reputation.

0 1 2 3

19) I would worry that disclosing my mental health problem would hinder my marital prospects.

0 1 2 3

For the next set of question please think about how *you* might feel if you visited a mental health professional about mental health problems you are experiencing.

20) It would be relatively easy for me to trust a professional with my mental health problems.

0 1 2 3

21) I would feel more comfortable seeking help for mental problems from a professional who is of the same ethnicity as me.

0 1 2 3

22) My family would not approve of me speaking to a professional about my mental health.

0 1 2 3

23) I would feel more comfortable talking to a professional about my medical symptoms than mental health symptoms.

0 1 2 3

Appendix C

Inventory of Attitudes Towards Seeking Mental Health Services

Please read the following statements and rate using the scale below the degree to which you agree or disagree with them.

0 = Disagreement

1= Probable disagreement

2= Probable agreement

3= Agreement

1. There are certain problems, which should not be discussed outside of one's immediate family.

0 1 2 3

2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for mental health problems.

0 1 2 3

3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from mental health problems.

0 1 2 3

4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

0 1 2 3

5. If good friends asked my advice about a mental health problem, I might recommend that they see a professional.

0 1 2 3

6. Having been mentally ill carries with it a burden of shame.

0 1 2 3

7. It is probably best not to know everything about oneself.

0 1 2 3

8. If I were experiencing a serious mental health problem at this point in my life, I would be confident that I could find relief in therapy.

0 1 2 3

9. People should work out their own problems; getting professional help should be a

last resort.

0 1 2 3

10. If I were to experience mental health problems, I could get professional help if I wanted to.

0 1 2 3

11. Important people in my life would think less of me if they were to find out that I was experiencing mental health problems.

0 1 2 3

12. Mental health problems, like many things, tend to work out by themselves.

0 1 2 3

13. It would be relatively easy for me to find the time to see a professional for mental health problems.

0 1 2 3

14. There are experiences in my life I would not discuss with anyone.

0 1 2 3

15. I would want to get professional help if I were worried or upset for a long period of time.

0 1 2 3

16. I would be uncomfortable seeking professional help for mental health problems because people in my social or business circles might find out about it.

0 1 2 3

17. Having been diagnosed with a mental health problem is a blot on a person's life.

0 1 2 3

18. There is something admirable in the attitudes of people who are willing to cope with their conflicts and fears without resorting to professional help.

0 1 2 3

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

0 1 2 3

20. I would feel uneasy going to a professional because of what some people would think.

0 1 2 3

21. People with strong characters can get over mental health problems by themselves and would have little need for professional help.

0 1 2 3

22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

0 1 2 3

23. Had I received treatment for mental health problems, I would not feel that it ought to be ‘covered up’.

0 1 2 3

24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with mental health problems.

0 1 2 3

Appendix D

Research Advert- (to be posted on Twitter, Facebook, LinkedIn and Callforparticipants)

Exploring Ethnic Attitudes Towards Mental Health

How do we think about mental health? And does this influence our decision to get help for our mental health problems?

I am a doctorate student at the University of Nottingham and would like to invite you to be part of this purposeful research study.

As part of my research, I am looking to develop an understanding of the attitudes of specific ethic groups about mental health and seeking help in this area.

If you are between the ages of 16-25 and identify as either White British or Arab born in the UK, I will be grateful if you could click the link below to read more about the study and take part in a short questionnaire.

(Insert link here)

Appendix E

Information Page

Researcher: Arwa Sultan (arwa.sultan@nottingham.ac.uk)

Supervisor: Dr Shihning Chou- (Shihning.chou@nottingham.ac.uk)

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Title: Attitudes towards mental health and help-seeking behaviours: A perspective of Arabs living in the UK.

General Information

Thank you for your interest in this questionnaire/online survey. You have been invited to participate as you are aged 16-25 years old and identify as either white British or an Arab born in the UK. Please read through this information before agreeing to participate by ticking the 'yes' box below. If you have any questions, please contact the researcher, Arwa Sultan at the email address above.

We are exploring the attitudes of Arabs born in the UK towards mental health and seeking professional help for mental health problems. This research may help inform mental health services of ethnic differences and how to improve therapeutic engagement.

You will be given three questionnaires to complete. It should take you about **15-20** minutes to complete with a total of 68 questions. No background knowledge is required. Data will be anonymous and accessed by individuals involved in this study. This would be Arwa Sultan who is leading the research and Dr Shihning Chou who is supervising the study.

How will your data be used?

Your answers will be completely anonymous and will be kept confidential. Your participation in this study is entirely voluntary. You can withdraw at any point during the questionnaire for any reason, before submitting your answers by clicking the Exit button/closing the browser. The data will only be uploaded on completion of the questionnaire by clicking the SUBMIT button.

Your data will be stored in a password-protected file and may be used in academic publications. Your IP address will not be stored. All questions must be answered in order to proceed through the survey.

Who will have access to your data?

The University of Nottingham is the data controller for the purposes of the Data Protection. Your data may be shared with the supervisor of this project.

We believe there are no known risks associated with this research study; however, as mental health maybe a personal and sensitive topic for some, further information and support can be found on https://www.mind.org.uk. As with any online related activity the risk of a breach is always possible. We will do everything possible to ensure your

answers in this study will remain anonymous. We will minimize any risks by storing data in password-protected programmes and erasing data once the study is completed. The results of the study may be published in scientific journals and presented at scientific conferences. The data will be reported anonymously, with any identifying information removed.

If you have any questions about this project, you may contact the Lead Researcher Arwa Sultan or if you have any concerns about any aspect of this study please contact the Research Supervisor: Dr Shihning Chou. If you remain unhappy and wish to complain formally, you should then contact the FMHS Research Ethics Committee Administrator, c/o The University of Nottingham, Faculty PVC Office, B Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH. E-mail: FMHS-ResearchEthics@nottingham.ac.uk

This study has been reviewed and given a favourable opinion by the University of Nottingham, Faculty of Medicine & Health Sciences Research Ethics Committee.

I have read and understood the above information, I confirm that I am 16 years old or older and by clicking the NEXT button, I will be taken to the consent page. This will indicate my willingness to voluntarily take part in the study.

NEXT – To be taken to consent page

EXIT -- I do not want to take part

Thank you for participating!

Appendix F

Consent Form

Title: Attitudes towards mental health and seeking mental health services: A perspective of Arabs living in the UK.

Researcher: Arwa Sultan

Supervisor: Dr Shihning Chou

School of Medicine

Address:

B Floor - YANG Fujia Building

Jubilee Campus

Wollaton Road

Nottingham

NG8 1BB

Ethics ref no:

Please, tick each box to continue:

- o I confirm that I have read and understood the information on the previous page
- o I am 16 years old and/or older
- o I understand that my participation is voluntary and I can end the study at any time and withdraw my data by clicking the EXIT button .
- o I understand that my answers will be anonymous.
- o I understand the overall anonymized data from this study may be used in the future for research (with research ethics approval) and teaching purposes.

NEXT – to be taken to the consent page.

Appendix G

Demographic Questions

Please answer the following questions:

1) What is your gender?

- Female
- Male

2) What is your age?

_____

3) What is your ethnicity?

- White British
- Arab

4) Where you born in the UK?

Yes

No

5) What is your marital status?

- Single
- In a relationship
- Married
- Divorced
- Widowed

5) What is your highest (or current) level of education?

- No formal education
- Primary School
- GCSE's or equivalent

- A-level or equivalent
- Bachelor's degree
- Masters degree
- PhD degree

7) What is your occupation?

- Employed (Full time)
- Employed (Part time)
- Unemployed
- Student
- Homemaker

8) Have you experienced mental health problems (e.g. loss of appetite, suicidal thoughts, depression, anxiety, hearing voices that are not physically present)?

- No
- Yes (if yes please answer question 10)

9) Has anyone close to you experienced mental health problems (e.g. loss of appetite, suicidal thoughts, depression, anxiety, hearing voices that are not physically present)?

- No
- Yes (if yes please answer question 11)
-

10) Have you been in contact with services for mental health needs?

- No
- Yes (if yes please answer question 12)

11) Has anyone close to you been in contact with services for mental health needs?

- No

- Yes (if yes please answer question 13)

12) What types of service(s) were used (please select all that applies)?

- GP
- A&E
- Walk-in clinic
- School counseling
- Community / outpatient Child and Adolescent Mental Health Service
- Hospital care under Child and Adolescent Mental Health Service
- Hospital care under Adult Psychiatric Service
- Non-statutory or voluntary organisation in the community
- Religious support group
- Police referral
- Youth Offending Services referral
- Other (please specify: _____)

13) What types of service(s) were used (please select all that applies)?

- GP
- A&E
- Walk-in clinic
- School counseling
- Community / outpatient Child and Adolescent Mental Health Service
- Hospital care under Child and Adolescent Mental Health Service
- Hospital care under Adult Psychiatric Service
- Non-statutory or voluntary organisation in the community
- Religious support group
- Police referral
- Youth Offending Services referral
- Other (please specify: _____)

Appendix H

Debrief

Thank you for your participation!

By completing the surveys in this study, you have contributed to this research by providing an in-depth understanding to how people from different ethnicities may perceive mental health and asking for help from professionals.

Also, identifying stigmatising attitudes specific to an ethnicities is useful as it provides mental health services with a better understanding of why an individual may refuse help and how services better accommodate for and be mindful of individual needs.

Please be aware that your data will be kept anonymous, confidential and the data will only be accessed by the researchers.

To read more about mental health, visit https://www.mind.org.uk

If you have any further questions regarding your participation in the study, please contact:

Research: Arwa Sultan arwa.sultan@nottingham.ac.uk

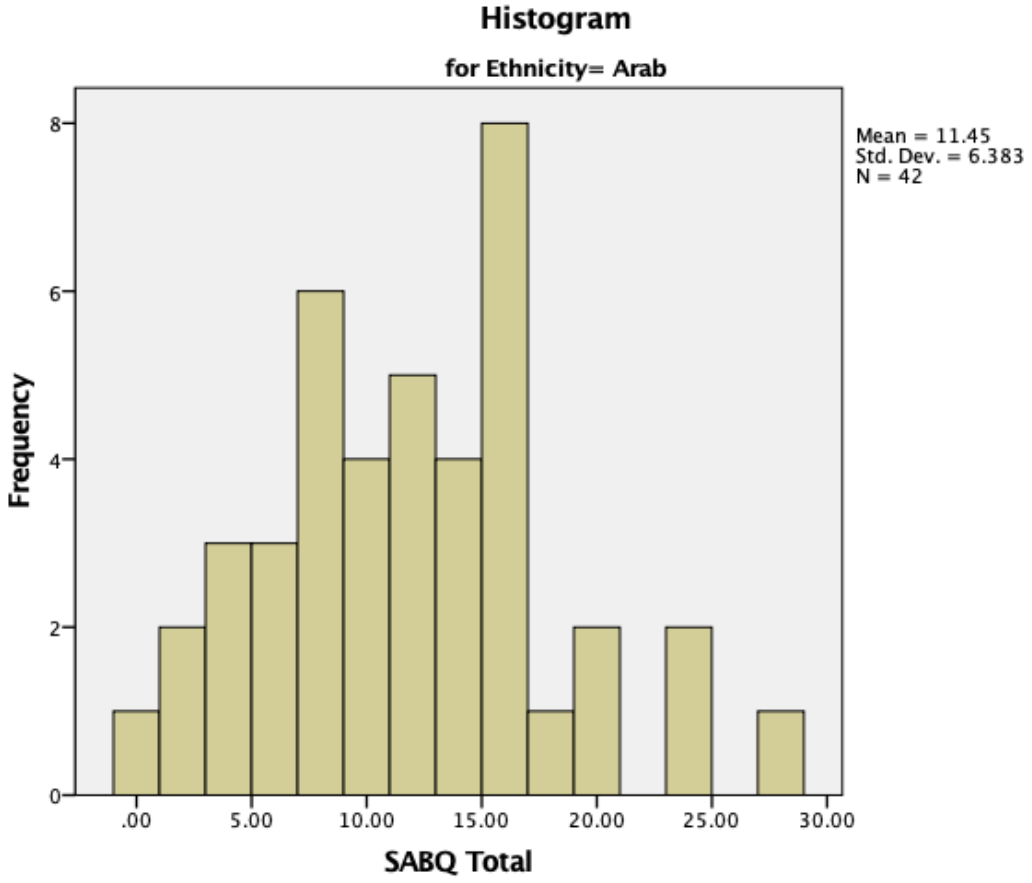
Supervisor: Dr Shihning Chou Shihning.chou@nottingham.ac.uk

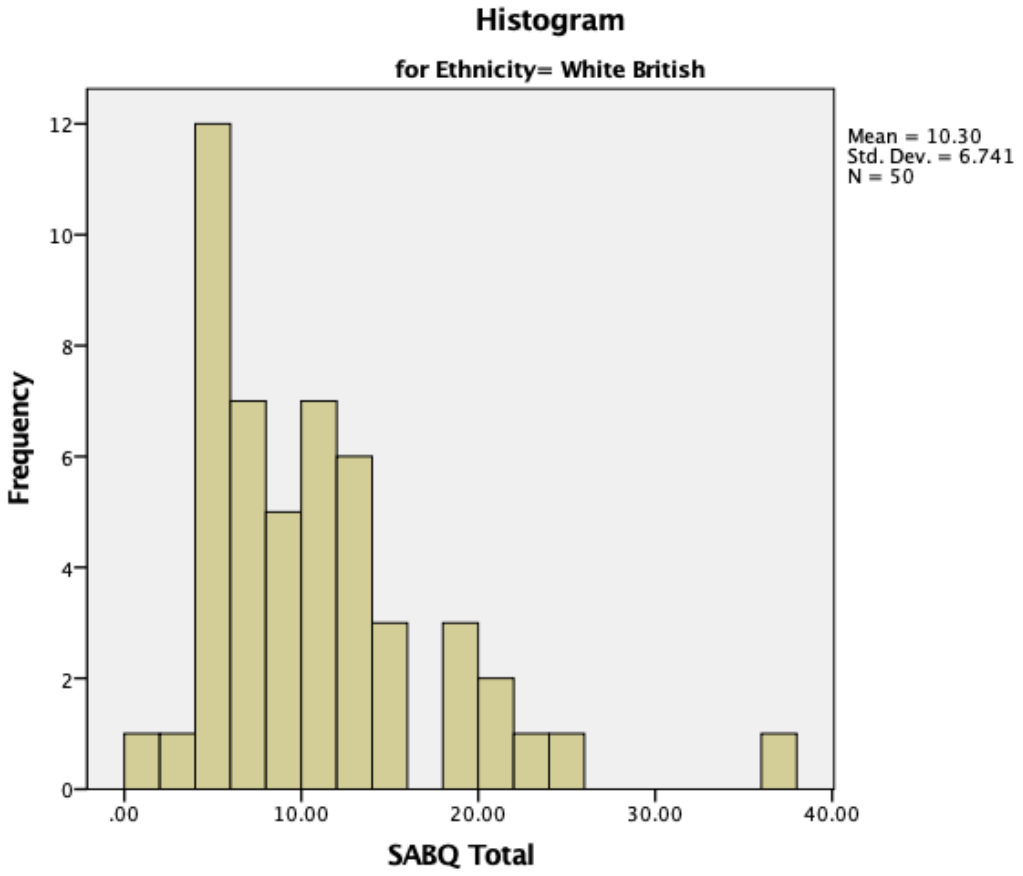
Appendix I

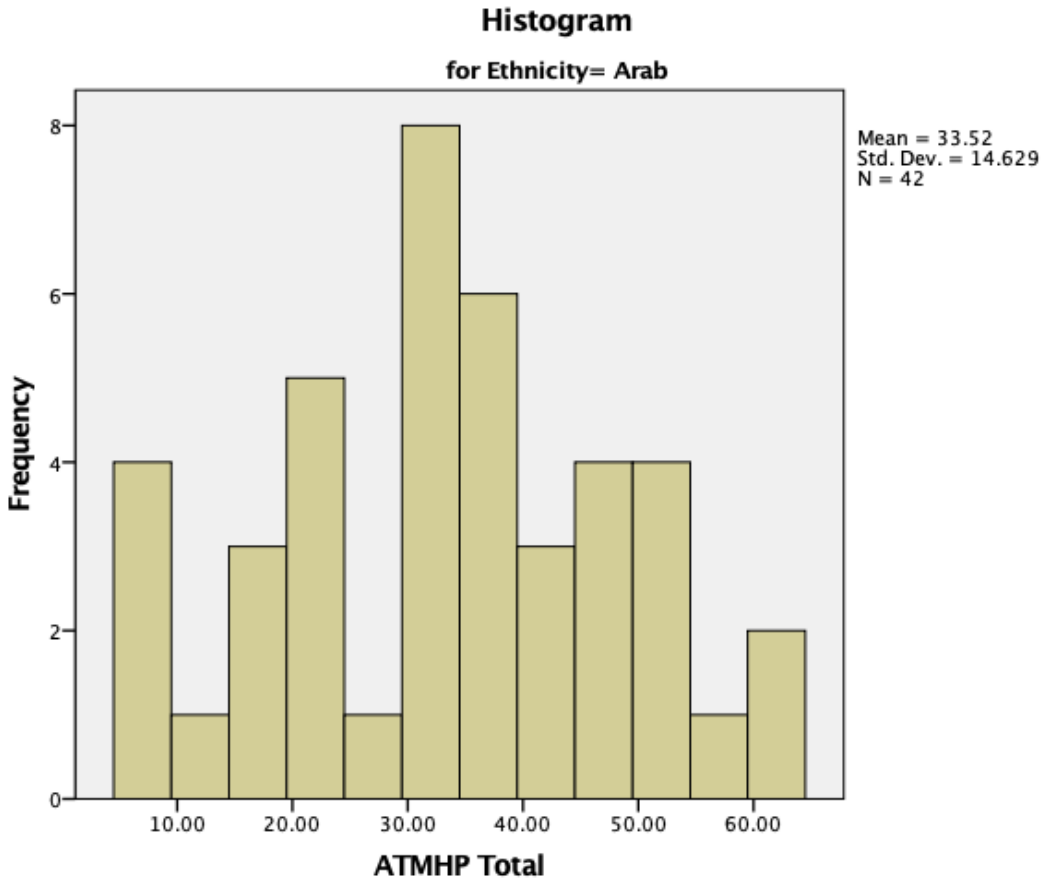
SPSS Output of normality tests and histograms

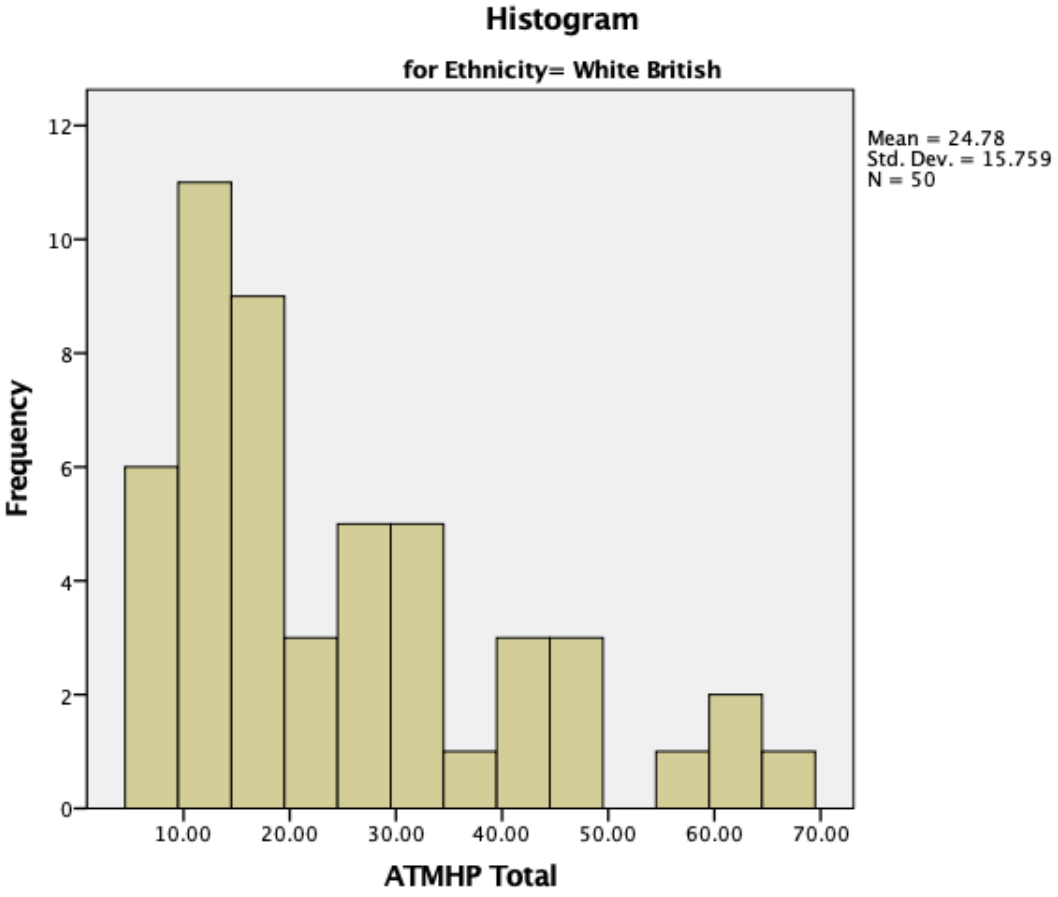
Shapiro-Wilk

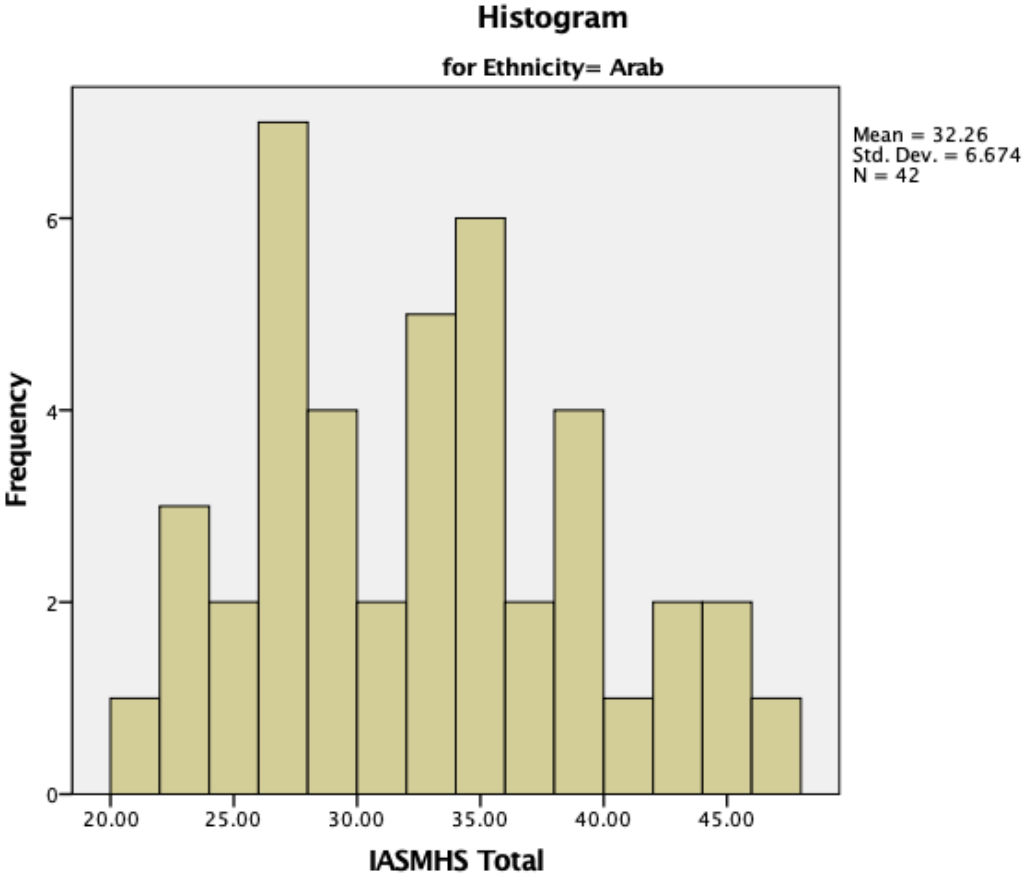
Measures	Ethnicity	Statistic	*df*	*Sig*
IASMHS	Arab	.968	42	.282
	White British	.953	51	.044
SABQ	Arab	.974	42	.438
	White British	.868	51	.000
ATMHPS	Arab	.978	42	.576
	White British	.889	51	.000

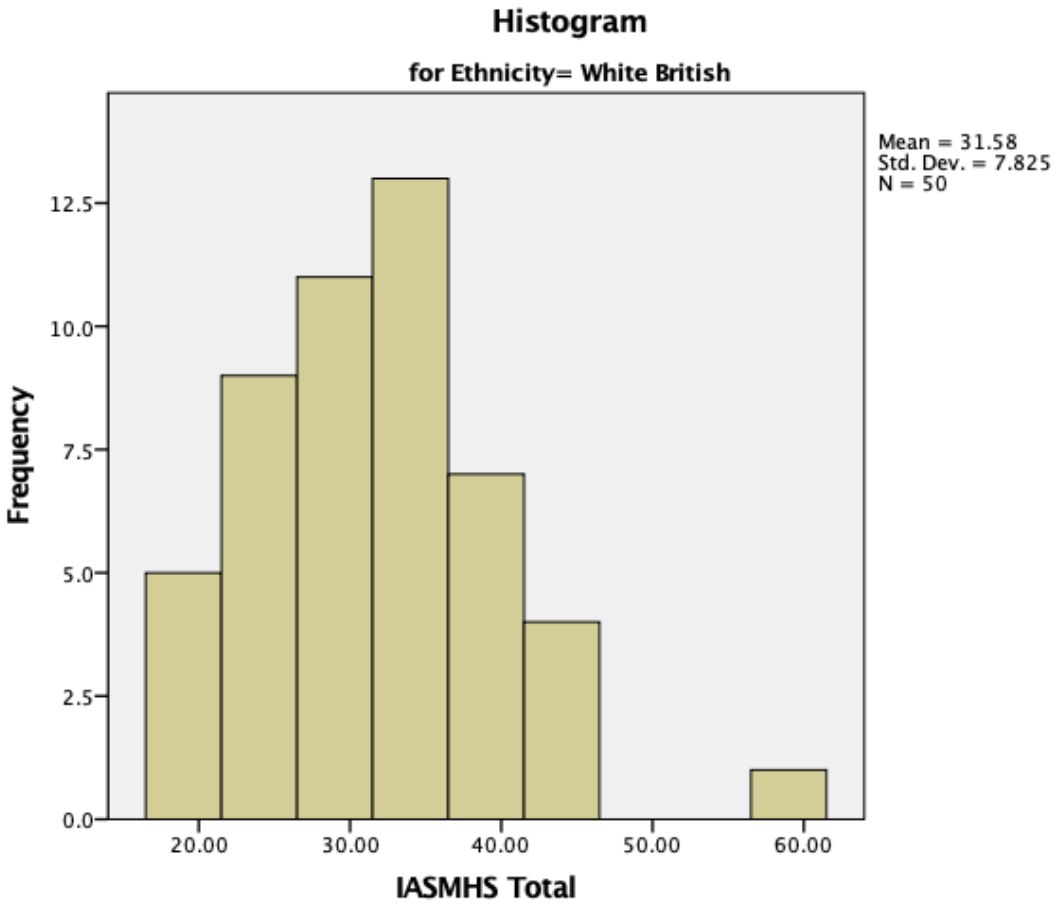



Histogram
for Ethnicity= White British
Mean = 10.30
Std. Dev. = 6.741
N = 50
Frequency
SABQ Total
0
2
4
6
8
10
12
.00
10.00
20.00
30.00
40.00


Histogram
for Ethnicity= Arab
Mean = 33.52
Std. Dev. = 14.629
N = 42
Frequency
ATMHP Total
0
2
4
6
8
10.00
20.00
30.00
40.00
50.00
60.00


Histogram
for Ethnicity= White British
Mean = 24.78
Std. Dev. = 15.759
N = 50
Frequency
ATMHP Total
0
2
4
6
8
10
12
10.00
20.00
30.00
40.00
50.00
60.00
70.00


Histogram
for Ethnicity= Arab
Mean = 32.26
Std. Dev. = 6.674
N = 42
Frequency
IASMHS Total
0
2
4
6
20.00
25.00
30.00
35.00
40.00
45.00


Histogram
for Ethnicity= White British
Mean = 31.58
Std. Dev. = 7.825
N = 50
Frequency
12.5
10.0
7.5
5.0
2.5
0.0
20.00
30.00
40.00
50.00
60.00
IASMHS Total

Appendix J

SPSS Output for Mann-Whitney U test comparing Arab and White British participants response's' on the SABQ Scale

Ranks

	Ethnicity	N	Mean Rank	Sum of Ranks
SABQ Total	Arab	42	50.29	2112.00
	White British	50	43.32	2166.00
	Total	92		

Test Statistics[a]

	SABQ Total
Mann-Whitney U	891.000
Wilcoxon W	2166.000
Z	-1.249
Asymp. Sig. (2-tailed)	.212

a. Grouping Variable: Ethnicity

Appendix K

SPSS Output for Mann-Whitney U test comparing Arab and White British participants response's' on the ATMHP Scale

Ranks

	Ethnicity	N	Mean Rank	Sum of Ranks
ATMHP Total	Arab	42	55.35	2324.50
	White British	50	39.07	1953.50
	Total	92		
ATMHP Subscale 1	Arab	42	55.26	2321.00
	White British	50	39.14	1957.00
	Total	92		
ATMHP Subscale 2	Arab	42	51.18	2149.50
	White British	50	42.57	2128.50
	Total	92		
ATMHP Subscale 3	Arab	42	57.33	2408.00
	White British	50	37.40	1870.00
	Total	92		
ATMHP Subscale 4	Arab	42	50.62	2126.00
	White British	50	43.04	2152.00
	Total	92		

Test Statistics[a]

	ATMHP Total	ATMHP Subscale 1	ATMHP Subscale 2	ATMHP Subscale 3	ATMHP Subscale 4
Mann-Whitney U	678.500	682.000	853.500	595.000	877.000
Wilcoxon W	1953.500	1957.000	2128.500	1870.000	2152.000
Z	-2.913	-2.890	-1.545	-3.590	-1.369
Asymp. Sig. (2-tailed)	.004	.004	.122	.000	.171

a. Grouping Variable: Ethnicity

Appendix L

SPSS Output for Mann-Whitney U test comparing Arab and White British participants response's' on the IASMHS Scale

Ranks

	Ethnicity	N	Mean Rank	Sum of Ranks
IASMHS Total	Arab	42	48.67	2044.00
	White British	50	44.68	2234.00
	Total	92		
IASMHS Subscale 1	Arab	42	53.37	2241.50
	White British	50	40.73	2036.50
	Total	92		
IASMHS Subscale 2	Arab	42	43.37	1821.50
	White British	50	49.13	2456.50
	Total	92		
IASMHS Subscale 3	Arab	42	46.02	1933.00
	White British	50	46.90	2345.00
	Total	92		

Test Statistics[a]

	IASMHS Total	IASMHS Subscale 1	IASMHS Subscale 2	IASMHS Subscale 3
Mann-Whitney U	959.000	761.500	918.500	1030.000
Wilcoxon W	2234.000	2036.500	1821.500	1933.000
Z	-.714	-2.270	-1.034	-.157
Asymp. Sig. (2-tailed)	.475	.023	.301	.875

a. Grouping Variable: Ethnicity

Appendix M

SPSS Output for Simple Linear Regression using bootstrapping to explore ethnicity as a predictor of Attitudes towards mental health services.

Model Summary[b]

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	.497[a]	.247	.164	14.43766	.247	2.983	9	82	.004	2.138

a. Predictors: (Constant), Age, Ethnicity, Personal experienc of mental health problems , SABQ Total, Occupation, Born in th United Kingdom, Relationship, Have you been in contact with services for mental health needs?, Education

b. Dependent Variable: ATMHP Total

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	5595.623	9	621.736	2.983	.004[b]
	Residual	17092.583	82	208.446		
	Total	22688.207	91			

a. Dependent Variable: ATMHP Total

b. Predictors: (Constant), Age, Ethnicity, Personal experienc of mental health problems , SABQ Total, Occupation, Born in th United Kingdom, Relationship, Have you been in contact with services for mental health needs?, Education

Bootstrap for Coefficients

Model		B	Bootstrap[a] Bias	Std. Error	Sig. (2-tailed)	95% Confidence Interval Lower	Upper
1	(Constant)	32.587	.344	18.535	.077	-4.614	68.163
	Ethnicity	-10.662	.215	3.453	.005	-17.108	-3.269
	Born in the United Kingdom	-2.241	.075	5.250	.651	-12.159	8.421
	Relationship	-1.504	-.005	3.161	.622	-7.681	4.970
	Education	-2.928	.209	2.176	.182	-7.064	1.544
	Occupation	-2.757	.047	2.029	.186	-6.694	1.220
	Personal experience of mental health problems	-1.982	-.261	4.060	.603	-10.522	6.314
	Have you been in contact with services for mental health needs?	4.837	-.075	3.869	.210	-2.641	12.611
	SABQ Total	.542	-.009	.257	.038	-.039	.994
	Age	.457	-.048	.968	.630	-1.479	2.314

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Appendix N

SPSS Output for the Multiple Linear Regression using bootstrapping to explore ethnicity as a predictor of seeking mental health services.

Model Summary[b]

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	.573[a]	.328	.245	6.33431	.328	3.955	10	81	.000	1.888

a. Predictors: (Constant), Age, ATMHP Total, Personal experienc of mental health problems , Born in th United Kingdom, SABQ Total, Relationship, Occupation, Ethnicity, Have you been in contact with services for mental health needs?, Education
b. Dependent Variable: IASMHS Total

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1586.912	10	158.691	3.955	.000[b]
	Residual	3250.001	81	40.123		
	Total	4836.913	91			

a. Dependent Variable: IASMHS Total
b. Predictors: (Constant), Age, ATMHP Total, Personal experienc of mental health problems , Born in th United Kingdom, SABQ Total, Relationship, Occupation, Ethnicity, Have you been in contact with services for mental health needs?, Education

Bootstrap for Coefficients

Model		B	Bootstrap[a] Bias	Std. Error	Sig. (2-tailed)	95% Confidence Interval Lower	Upper
1	(Constant)	18.134	-.119	7.124	.011	4.508	32.066
	Ethnicity	2.242	.013	1.715	.203	-1.204	5.591
	Born in th United Kingdom	2.528	-.008	2.356	.265	-1.985	7.284
	Relationship	-1.647	-.171	1.648	.314	-5.079	1.409
	Education	-1.369	.049	.992	.176	-3.212	.705
	Occupation	.259	.011	.875	.782	-1.484	1.909
	Personal experience of mental health problems	-1.875	-.126	1.824	.305	-5.646	1.709
	Have you been in contact with services for mental health needs?	-3.251	-.009	1.746	.068	-6.596	.321
	SABQ Total	.354	-.004	.117	.003	.112	.563
	ATMHP Total	.141	-.001	.049	.005	.048	.241
	Age	.559	.005	.381	.148	-.191	1.315

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Appendix O

SPSS Output for the Multiple Linear Regression using bootstrapping to explore predictive variables for IASMHS Subscale 1: Psychological Openness.

Model Summary[b]

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	.553[a]	.305	.220	3.90418	.305	3.560	10	81	.001	1.962

a. Predictors: (Constant), Age, ATMHP Total, Personal experienc of mental health problems , Born in th United Kingdom, SABQ Total, Relationship, Occupation, Ethnicity, Have you been in contact with services for mental health needs?, Education
b. Dependent Variable: IASMHS Subscale 1

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	542.596	10	54.260	3.560	.001[b]
	Residual	1234.654	81	15.243		
	Total	1777.250	91			

a. Dependent Variable: IASMHS Subscale 1
b. Predictors: (Constant), Age, ATMHP Total, Personal experienc of mental health problems , Born in th United Kingdom, SABQ Total, Relationship, Occupation, Ethnicity, Have you been in contact with services for mental health needs?, Education

Bootstrap for Coefficients

Model		Bootstrap[a]					
		B	Bias	Std. Error	Sig. (2-tailed)	95% Confidence Interval	
						Lower	Upper
1	(Constant)	11.870	.267	4.531	.011	3.324	20.965
	Ethnicity	-.267	-.061	1.189	.810	-2.672	2.015

	Born in the United Kingdom	1.882	-.016	1.457	.187	-1.206	4.604
	Relationship	-.509	.037	.927	.569	-2.346	1.280
	Education	-.480	.021	.609	.436	-1.694	.720
	Occupation	-.651	-.006	.486	.192	-1.577	.298
	Personal experience of mental health problems	-.683	-.005	1.050	.519	-2.707	1.336
	Have you been in contact with services for mental health needs?	-1.325	.045	1.092	.245	-3.455	.806
	SABQ Total	.187	-.006	.071	.008	.030	.315
	ATMHP Total	.064	-.003	.035	.071	-.006	.134
	Age	-.138	-.009	.252	.595	-.644	.342

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Appendix P

SPSS Output for the Multiple Linear Regression using bootstrapping to explore predictive variables for IASMHS Subscale 2: Help-seeking Propensity.

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.523[a]	.274	.184	4.38702	.274	3.057	10	81	.002

Model	Durbin-Watson
1	2.062

a. Predictors: (Constant), Age, ATMHP Total, Personal experienc of mental health problems , Born in th United Kingdom, SABQ Total, Relationship, Occupation, Ethnicity, Have you been in contact with services for mental health needs?, Education

b. Dependent Variable: IASMHS Subscale 2

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	588.330	10	58.833	3.057	.002[b]
	Residual	1558.920	81	19.246		
	Total	2147.250	91			

a. Dependent Variable: IASMHS Subscale 2

b. Predictors: (Constant), Age, ATMHP Total, Personal experienc of mental health problems , Born in th United Kingdom, SABQ Total, Relationship, Occupation, Ethnicity, Have you been in contact with services for mental health needs?, Education

Bootstrap for Coefficients

Model		B	Bootstrap[a] Bias	Std. Error	Sig. (2-tailed)	95% Confidence Interval Lower	Upper
1	(Constant)	.395	.026	4.486	.930	-8.891	9.434
	Ethnicity	.166	.001	1.329	.902	-2.393	2.651
	Born in th United Kingdom	1.310	-.049	1.601	.387	-2.050	4.329
	Relationship	.533	-.032	1.151	.654	-1.816	2.832
	Education	.267	.029	.587	.645	-.885	1.353
	Occupation	1.155	-.023	.571	.046	.004	2.265
	Personal experienc of mental health problems	1.417	-.008	1.156	.232	-.919	3.739
	Have you been in contact with services for mental health needs?	.273	.013	1.149	.819	-1.975	2.590
	SABQ Total	.171	.006	.078	.040	.009	.322
	ATMHP Total	-.095	-.001	.029	.002	-.154	-.039
	Age	.507	-.006	.228	.029	.082	.973

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

Appendix Q

SPSS Output for the Multiple Linear Regression using bootstrapping to explore predictive variables for IASMHS Subscale 3: Indifference to Stigma.

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
1	.673[a]	.453	.385	3.70931	.453	6.704	10	81	.000	2.269

a. Predictors: (Constant), Age, ATMHP Total, Personal experienc of mental health problems , Born in th United Kingdom, SABQ Total, Relationship, Occupation, Ethnicity, Have you been in contact with services for mental health needs?, Education

b. Dependent Variable: IASMHS Subscale 3

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	922.434	10	92.243	6.704	.000[b]
	Residual	1114.479	81	13.759		
	Total	2036.913	91			

a. Dependent Variable: IASMHS Subscale 3

b. Predictors: (Constant), Age, ATMHP Total, Personal experienc of mental health problems , Born in th United Kingdom, SABQ Total, Relationship, Occupation, Ethnicity, Have you been in contact with services for mental health needs?, Education

Bootstrap for Coefficients

Model		Bootstrap[a]					
		B	Bias	Std. Error	Sig. (2-tailed)	95% Confidence Interval	
						Lower	Upper
1	(Constant)	5.870	.052	4.810	.219	-3.801	15.375
	Ethnicity	2.343	-.068	1.037	.027	.109	4.228
	Born in the United Kingdom	-.664	-.063	1.374	.619	-3.504	1.962
	Relationship	-1.671	.017	.948	.083	-3.461	.388

	Education	-1.156	.004	.502	.023	-2.166	-.165
	Occupation	-.245	.017	.569	.679	-1.300	.929
	Personal experience of mental health problems	-2.609	-.091	1.082	.029	-4.760	-.554
	Have you been in contact with services for mental health needs?	-2.198	-.029	.999	.028	-4.251	-.270
	SABQ Total	-.003	-.005	.070	.978	-.152	.116
	ATMHP Total	.172	-.002	.032	.001	.104	.232
	Age	.190	.005	.238	.447	-.266	.646

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples