The Association Between Perceived Caregiver Mental Health Stigma and Middle Eastern Emerging Adult Help-Seeking Intentions: Moderating Effect of Social Support

by

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ABSTRACT

Mental health stigma is a significant obstacle for those with mental health issues in and from the Middle East, defined as the countries of southwest Asia and North Africa including Afghanistan, Bahrain, Cyprus, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, and Yemen. Such stigma may be passed down generationally; primary caregivers born in the Middle East who immigrate to the United States may pass down their beliefs and opinions of mental health to their children born in the U.S. This study examined the association between perceived primary caregiver mental health stigma and Middle Eastern emerging adults' intention to seek mental help, while also examining the possible moderating effect of peer social support on this association. It was hypothesized that social support would mitigate the proposed negative association between a primary caregiver's mental health self-stigma and their emerging adult child's intention to seek mental health services. Results showed no significant association between perceived primary caregiver mental health stigma and an emerging adult's intention to seek help, and no significant moderating effect of social support. However, findings showed a negative association between emerging adults' mental health self-stigma and their help-seeking intention, as well as a positive association between prior counseling and help-seeking intention. Future implications of this research include bringing awareness to and addressing self-stigma in the Middle Eastern community, as well as providing education and training to those in the mental health field who may work with this population.

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CHAPTER 1

INTRODUCTION

The Middle East is comprised of countries of southwest Asia and North Africa including Afghanistan, Bahrain, Cyprus, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, and Yemen (Mohammadzadeh et al., 2020). In the Middle East, stigma, both toward individuals with mental health concerns and toward help-seeking behaviors, remains a significant barrier for those struggling with their mental health (Gearing et al., 2015). The World Health Organization (WHO) defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (WHO, 2022).

In the Middle East, there is a focus on collectivistic culture over individualistic culture, such that Middle Eastern adolescents might shape their individual personalities to fit their family and familial expectations (Budman et al. 1992). The focus on family or the community is highly regarded over an individual's perspective. Public opinion on mental illnesses is also said to be considered a significant issue with Middle Eastern cultures (Mohammadzadeh et al., 2020). Together, the focus on collectivistic versus individualist perspectives may be an important consideration in understanding how primary caregivers from the Middle East may inadvertently pass down their mental health stigma on to their emerging adult children.

The significance of collectivism and value of family opinion may also be associated with an emerging adult's mental-health help seeking intention. Indeed, a systematic review of 22 studies on perceived barriers on help-seeking in young

individuals found that one of the top facilitators in the help-seeking process for those with mental health issues was encouragement from family and friends (Gulliver et al., 2010). Further, out of 543 college students who reported suicidal ideation, approximately 40% stated they were encouraged by family members to seek help (Downs & Eisenberg, 2012). The role of a primary caregiver and the ideas they hold may affect an emerging adult's intention to seek mental help. This primary caregiver influence may be especially important in Middle Eastern immigrant families, as there may be an intergenerational gap between the views of a primary caregiver born in the Middle East and their emerging adult child born in the United States.

Although primary caregivers are thought to be an influence in an emerging adult's help-seeking process (Wahlin & Deane, 2012), given the importance of social relationships during emerging adulthood (Mawson et al., 2015), peers may also be facilitators in this help-seeking behavior. For example, when transitioning into a college environment, assistance is preferred from peers and friends over instructors or professors (Karabenick & Newman, 2006). Consequently, regarding mental health, support from peers could be a protective factor between negative stigma and help-seeking intentions, especially as a Middle Eastern primary caregiver's view might differ from a U.S.-born emerging adult.

Mental Health and Stigma in the Middle East

The history of mental health and mental health services in the Middle East dates back to the year 705 AD, when one of the first mental health hospitals in the world was built in Baghdad (Murad & Gordon, 2002). There is also evidence of highly regarded Muslim physicians from the Middle East– Al-Razi (d. 925) for instance– who not only

treated psychiatric patients, yet also wrote an encyclopedia for medicine (Pridmore & Pasha, 2004). Another Muslim scholar in psychiatry, Ibn Sina (d. 1037), wrote a 14-volume book on medicine that was used for more than 700 years in the West (Pridmore & Pasha, 2004). While there has been a long-standing history of mental health services, there is also a negative perception associated with mental health in the Middle East. A traditional cultural belief is that mental illnesses are a "punishment from God" or caused by evil spirits (Pridmore & Pasha, 2004).

Despite the notable background and significance of mental health in the Middle East back in history, mental health in the 21st century is not held at the same level of importance (Sewilam et al., 2014). There are still many Middle Eastern countries who fall far behind when it comes to the standard of proper mental health services (Okasha et al., 2012). In fact, Egypt, Palestine, and Qatar are three of the only countries in the Middle East who have reported estimates of mental health expenditure as a percentage of overall health expenditure. Specifically, Egypt reported less than 1%, Palestine reported 2.5%, and Qatar reported 1% of mental health expenditure as this percentage of overall health expenditure (Okasha et al., 2012). Moreover, the importance of mental health services in the Middle East can also be noted by the ratio of psychiatrists to the population. Okasha et al. (2012) states, "It is reported that Iraq, Libya, Morocco, Sudan, Syria, and Yemen have fewer than 0.5 psychiatrists per 100,000 persons" (pp. 52).

Stigma related to mental health in the Middle East is undoubtedly under-represented in research (Al-Darmaki, 2003); however, the minimal research that has been done on this topic has shown that public attitudes are generally rejecting or negative (Al-Krenawi, 2005). Studies show that most Middle Eastern Arab adolescents with mental

health disorders are unwilling to seek out help, because they worry about embarrassing their family (Netemeyer et al., 2015). Moreover, a study in Egypt showed that those with psychiatric disorders are especially stigmatized and are faced with social rejection (Coker, 2005). Consequently, these public opinions and social stigma may result in individuals or families concealing their mental illness, thus delaying, or denying the need for treatment (Saxena et al., 2011).

Goffman (1963) defined stigma as "the situation of the individual who is disqualified from full social acceptance" (pp. 9). Thus, mental health stigma will be defined as this same disqualification felt from people with mental health issues. These stigmas are an unquestionable reality of communities today; they have been around for a long time and unfortunately, they can be inherited by future generations (Malli et al., 2016). Conceptually, negative mental health stigma may be passed down intergenerationally due to the interdependence of family perceptions (Meler, 2017). Moreover, while research has shown that mental health self-stigma affects intention to seek help (Yu et al., 2023), given the significance of collectivism (Budman et al. 1992) and family and community opinion (Mohammadzadeh et al., 2020), it is possible that stigma from the primary caregiver could be more influential on emerging adult's help-seeking intentions, especially for those from the Middle East.

Influences of Primary Caregiver Stigma on Emerging Adults

Emerging adulthood is the period of life between adolescence and young adulthood, ranging from 18-25 years old (Arnett, 2015). This period of time can be stressful, as there is more instability at this age (Arnett et al., 2014). Specifically, Arnett et al. (2014) stated that emerging adults "experience a series of love relationships and

frequent job changes before making enduring decisions" (pp. 569). As such, these stressors and instabilities may lead emerging adults to needing mental health services. In fact, according to the Substance Abuse and Mental Health Services Administration, 8.8 million of 18–25-year-olds in the U.S. reported having a mental illness (SAMHSA, 2022). Among that 8.8 million, 42% went untreated for their mental illnesses (SAMHSA, 2022).

An emerging adult's intention to seek mental health services may not be solely dependent on their individual beliefs or perceptions. Indeed, prior research on adolescent influences on help seeking for mental health services has found 90% of young people stated their parents were an influential source in help-seeking behaviors (Wahlin & Deane, 2012). The proposed model of a parent-mediated pathway to services for adolescents (Logan and King, 2001), posits that parents are involved in every step of the adolescent help-seeking process. In the current study, I examine primary caregiver's self-stigma, rather than parent(s) to be more inclusive to diverse caregiving roles in families, and because parents could hold different stigmas toward mental health. Previous research has also utilized the term primary caregivers to understand the association between primary caregiver cultural humility and their children's mental health (e.g., Franco & McElroy-Heltze, 2019). Given the history of mental health stigma in the Middle East (Gearing et al., 2015), primary caregivers from the Middle East who hold such stigma may negatively influence their U.S. born children when it comes to help-seeking intentions; however, help-seeing intentions may also be influenced by one's peers given their stage of development (Mawson et al., 2015).

Perceived Peer Social Support as a Moderating Effect

According to Cutrona and Russel (2017), social support incorporates two concepts: a *safe haven* and a *secure base*. Safe haven support refers to support one receives in times of stress, while the secure base support refers to support of agency in an individual when not in stressful situations. While little is known about the role of peers in a Middle Eastern emerging adult's mental health help-seeking process, and moreover how factors such as parents' national origin and cultural values may influence this help-seeking process, it is well documented that peer support becomes more important as one grows older (Rickwood et al., 2007). Specifically, the role of friends becomes more significant as people go through adolescence, especially in the help-seeking process. For instance, some adolescents go to school counselors specifically asking for help for one of their peers (Rickwood, 2006). Therefore, it is especially important to have a social group that is accepting and encourages help-seeking behaviors (Rickwood & Braithwaite, 1994). If an emerging adult has supportive friends with whom they can talk and rely on when mental health challenges arise, this may normalize seeking professional help despite their primary caregiver's mental health stigma.

CHAPTER 2

PRESENT STUDY

Those from the Middle East face certain barriers when it comes to the stigma of mental health (Al-Krenawi, 2005), yet little is known about how perceptions of a primary caregiver's stigma may be associated with a Middle Eastern emerging adult's intention to seek professional mental health services. Moreover, given the importance of social support for this developmental life-stage (Mawson et al., 2015), there is not much known about the role of peer social support in an emerging adult's mental help seeking intention.

Based on research to suggest there is an influence from caregivers on help-seeking behavior (Logan & King, 2001), it is hypothesized that the stigma from the primary caregiver will be negatively associated with Middle Eastern emerging adults' intention to seek mental help services. Moreover, as friends become more significant in the lives of emerging adults (Mawson et al., 2015), who may contribute more toward the help-seeking process (Rickwood et al., 2007), it is hypothesized that peer support will moderate this association such that if there is greater peer support, the link between caregiver stigma and mental help seeking intention will be weakened.

CHAPTER 3

METHOD

Recruitment and Participants

Participants were emerging adults (N = 90) between the ages of 18 to 25 (M = 22.42, SD = 2.09). Participants were male (n = 25; 26.7%), female (n = 63; 70%), non-binary (n = 2; 2.2%) and transgender man (n = 1; 1.1%). A breakdown of participants' ethnicity can be found in Table 1.

Participants were first recruited through a variety of listservs (university student organizations, undergraduate and graduate courses, AMENA-PSY, and APA Division 17 Listserv) and social media platforms (Facebook and LinkedIn) in June of 2023. There were over 4,500 bots in the dataset, leaving the data unusable. Thus, a new survey with the same exact content was created and posted again within the listservs described above, in addition to different research study recruitment platforms—ResearchMatch, Research Plus Me, and SONA (a platform where ASU students can volunteer to participate in research.) There were 965 total responses to this Qualtrics survey. Upon examining the data, I omitted those who answered "no" to one or more of the screening questions, thus becoming ineligible (n = 18). I also omitted those who did not answer attention check questions correctly (n = 4), and those who were bots (n = 908). Participants were also recruited through Prolific. The same Qualtrics survey was used for this platform, including the screening questionnaires and the attention check questions.

Procedure

Participants of this study must have met the following criteria to be eligible: 1) be between the ages of 18-25, 2) be born in the United States, and 3) have a primary

caregiver born in the Middle East. Interested and eligible participants accessed the survey through Qualtrics. The first page of the survey contained the informed consent, followed by the screening questionnaire to ensure participants met eligibility requirements. Participants who provided valid responses from recruitment through the listservs, ResearchMatch, Research Plus Me, and SONA (n = 35) were able to provide their email address at the end of the survey for a chance to win one of ten $25 Amazon gift cards.

There were 82 total responses from the Prolific platform. I omitted those who answered "no" to one or more of the screening questions, thus becoming ineligible (n = 27), and was left with 55 valid responses. Those who contributed valid responses through Prolific each received a payment of $1.60.

Data collection ended in February of 2024 and included a total sample size of 90 participants.

Measures

Screening Questionnaire. Interested participants first answered three screening questions (1. Are you between the ages of 18-25?; 2. Were you born in the United States?; and 3. Do you have at least one primary caregiver that was born in the Middle East?) These same screening questions were repeated at the end of each survey. Those who answered "no" to one or more of the screening questions were determined to be ineligible.

Demographics. Participants answered demographic questions such as: ethnicity, age, if they currently lived with their primary caregiver, gender identity, religious affiliation, sexual orientation, and if they have ever been to counseling in the past.

Perceived Primary Caregiver's Mental Health Stigma. Middle Eastern emerging adults' perceptions of their primary caregiver's mental health stigma was measured using an adapted version of The Perceptions of Stigmatization by Others for Seeking Help Scale (PSOSH; Vogel, Wade, & Ascheman, 2009). As I am interested in emerging adults' perception of their primary caregiver's self-stigma of help-seeking behavior, the instructions were adapted by replacing "the people you interact with" to "your primary caregiver." The PSOSH is a 5-item measure designed to measure the perception of stigma associated with seeking professional psychological help in an individual's social group (Vogel, Wade, & Ascheman, 2009). As I am interested in emerging adults' perception of their primary caregiver's self-stigma of help-seeking behavior, the instructions were adapted by replacing "the people you interact with" to "your primary caregiver."

Responses were rated on a 5-point scale ranging from 1 (*Not at all*) to 5 (*A great deal*). Participants were asked, for instance, to rate the degree to which their primary caregiver would "react negatively to you" if they sought counseling services for an issue. In the current study, higher sum scores indicated greater perceived primary caregiver stigma. The internal consistency in this current study was .91, indicating that these items measured the same construct of perceived primary caregiver mental health stigma.

Emerging Adult Mental Health Self-Stigma. Emerging adult self-stigma was measured using the Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006), and was used as a control variable. I controlled for self-stigma of seeking help because it is important to note to what degree primary caregiver stigma relates to an emerging adult's help seeking intention, despite their own self-stigma toward mental health.

The SSOSH is a 10-item measure designed to measure how a person's self-esteem might be impacted if they sought help from a mental health professional (Vogel et al., 2006). Responses were rated on a 5-point scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*), and items 2, 4, 5, 7, and 9 were reversed scored. Higher sum scores indicated greater self-stigma of seeking help for mental health issues. The internal consistency of this measure was .91 in the original study (Vogel et al., 2006), and .86 in the present study. Factor structure was also measured, and results indicated that this measure has adequate reliability in that it is measuring this single construct (Vogel et al., 2006).

Intention to Seek Mental Help. Middle Eastern emerging adults' intention to seek mental health services was measured using the Mental Help Seeking Intention Scale (MHSIS; Hammer & Spiker, 2018). This three-item measure asked participants their intention to seek out professional help if they had a mental health issue. Sample items included "If I had a mental health concern, I would intend to seek help from a mental health professional" and "If I had a mental health concern, I would plan to seek help from a mental health professional."

Responses of intention were reported using a 6-point Likert scale ranging from 1 (*extremely unlikely*) to 7 (*extremely likely*). The average of the three scores was taken by adding each individual score of the three items and dividing by three. The overall mean should be a number within the range of 1 and 7. A higher score indicated greater intention to seek help. The internal consistency of the present study .97. Support was also found for convergent validity through positive associations between intention and attitudes toward mental health help-seeking behavior (Hammer & Spiker, 2018).

Perceived Peer Support. Perceived support from peers or friends was measured using the Perceived Social Support from Friends scale (PSS-Fr) (Procidano & Heller, 1983). This 20-item measure assessed the perceived social support that one receives from friends. For the purpose of this study, I changed the responses of these statements to a 5-point Likert scale ranging from 1 (*Strongly disagree*) to 5 (*Strongly agree*). Items 2, 6, 7, 15, 18, and 20 were reverse scored. Sample items included "My friends give me the moral support I need" and "My friends are sensitive to my personal needs." In the original measure from Procidano and Heller (1983), responses to these statements include "Yes," "No," and "Don't know." Mean scores were calculated for this measure, and higher mean scores indicated a higher degree of perceived social support from friends. The internal reliability of this scale was .90 in the present study.

Control Variables

Controlling for certain variables is important in research to ensure that those specific variables are not influencing your dependent variable in any way. This can enhance the internal validity within studies by limiting the amount of influence from any other variables other than your independent variable(s).

Age was included as a control variable as older individuals tend to have more favorable help-seeking attitudes toward mental health than younger individuals, according to a study looking at underutilization of mental health services and influences of mental health help-seeking attitudes (Mackenzie et al., 2006). Lastly, I controlled for self-stigma of seeking help, prior counseling, and living with the primary caregiver. A previous study from Lannin and colleagues (2015) have shown associations between prior counseling and help-seeking intentions.

Data Analytic Plan

First, data were examined for skewness, kurtosis and missingness. Next, bivariate correlations were used to determine any associations among the demographic variables and the proposed variables of interest. Then, a hierarchical multiple regression analysis was used to investigate 1) the association between the perceived primary caregiver's mental health stigma on the Middle Eastern emerging adult's intention to seek mental help, and 2) the possible moderating effect of peer support on this association.

For the hierarchical multiple regression, in Step 1, I entered the control variables, which were age, self-stigma of seeking help, and prior counseling. Gender was not associated with intention to seek mental help (r = -.090, p = .408), so it was not included in the model. In Step 2, I entered the primary caregiver's perception of the mental health variable and the peer support variable to test for the possible main effects of the emerging adult's view of their primary caregiver's perception of mental health on the emerging adult's intention to seek mental health services. In Step 3, I entered the interaction term between primary caregiver's perception of mental health and peer support, to examine if a high level of peer support weakens the association between the primary caregiver's perception of mental health and the emerging adult's intention to seek mental help.

CHAPTER 4

RESULTS

Missing data was examined using Little's (1988) Missing Completely at Random (MCAR). Results indicated that the data were missing completely at random, $\chi 2(39) = 20.13$, $p = .995$. Assumptions of the multiple hierarchical regression showed that skewness levels ranged from -.37 to 1.29, while kurtosis levels fell between -.94 and .81, both falling between the range of -2 and +2, which means data are normally distributed. Cook's distance values were all less than 1.00, which indicated that there are no outliers in the sample. Multicollinearity was assessed by examining VIF and tolerance values. All VIF scores were under 10 and all tolerance scores were above 0.1, indicating no issue with multicollinearity. The predictor variables were standardized before running the models.

Univariate and Bivariate Correlations

Descriptive statistics and correlations are shown in Table 2. The average value of perceived primary caregiver mental health stigma was surprisingly low at a 9.24, with a maximum possible score of 25 (highest amount of mental health stigma) and a minimum possible score of 5 (lowest amount of mental health stigma). Mental health self-stigma was reported at an average of 23.07 on a scale of 10 to 41, which reflects that participants' self-stigma in this study was toward the lower end of this range. The average score of the sample for help-seeking intentions was reported at a 4.64, with a value of 1 being low help-seeking intentions and a maximum score of 7 being the highest help-seeking intention. The average score for perceived peer social support was 3.62 on a

scale of 2.05 to 4.80, with 4.80 being the highest level of perceived peer support. This indicates that participants viewed their peer support in the higher range.

Emerging adults' mental health self-stigma was negatively correlated with their help-seeking intention (r = -.55). Additionally, as expected, there was a positive correlation between past counseling and intention to seek mental help (r = .34). Lastly, as expected, there was a positive association between age and help-seeking intention (r = .24).

Main Analyses

The results of the multiple regression analysis are shown in Table 3. In Step 1, all control variables (currently living with your primary caregiver, past counseling, self-stigma, and age) were added to the model to see if any of the control variables were associated with the outcome variable of intention to seek mental help. In model 1, past counseling was positively associated with intention to seek help (r = .25), such that if participants had prior counseling experience, they were more likely to seek out mental help. Self-stigma was negatively correlated with help-seeking intention (r = -.46), such that the greater the self-stigma, the less likely Middle Eastern emerging adults were to seek mental help. In this model, age and living with one's primary caregiver were not associated with intentions to seek mental help.

In Step 2, I added the standardized predictor variables to the 2nd model, which included perceived primary caregiver mental health stigma and peer social support. The predictor variables accounted for 38% (R^2 = .38) of the variability in help-seeking intention. In model 2, unexpected to my hypotheses, primary caregiver mental health stigma was not associated with intentions to seek help (r = -.09), and peer social support

was not associated with intentions to seek help (r = .02). Additionally, age was not associated with intentions to seek help (r = .07), and neither was living with your primary caregiver (r = .17). Prior counseling was positively associated with intentions to seek help (r = .25), and self-stigma was negatively correlated with intentions to seek help (r = -.46).

In Step 3, I added the interaction term between primary caregiver stigma and peer social support. In model 3, all variables accounted for 38% (R^2 = .38) of the variability in intention to seek mental help. Prior counseling was positively associated with intentions to seek help (r = .24), and self-stigma was negatively correlated with intentions to seek help (r = -.46). Contrary to my hypothesis, peer social support did not moderate primary caregiver mental health stigma (r = -.03)

CHAPTER 5

DISCUSSION

Mental health stigma in the Middle East is a significant hurdle for individuals who suffer from mental health concerns (Gearing et al., 2015). Due to the interdependence of family perceptions in this culture (Meler, 2017), it could be argued that caregivers born in Middle Eastern countries may pass this stigma down to their U.S. born children. Despite the small amount of research on mental health in Middle Eastern countries, studies have shown that the rates of mental disorders in Arab countries are comparable to rates in Western countries (Kessler et al., 2009), and only a small amount of those in Arab countries ever seek help professionally (Karam et al., 2008). More specifically, little is known about the extent to which a Middle Eastern emerging adult's primary caregiver's mental health stigma may influence their intention to seek out mental health services, as well as how peer social support may also influence help-seeking intention despite caregiver stigma.

Based on previous research that suggests the correlation between caregivers' mental health views and help-seeking behavior (Logan & King, 2001), and how friends become more significant in the lives of emerging adults (Mawson et al., 2015), I hypothesized that primary caregiver mental health stigma would be negatively associated with help-seeking intentions, and peer social support would moderate this proposed negative association. These hypotheses were tested in this present study including 90 Middle Eastern emerging adults. The results, limitations, and future directions are presented below.

Main Findings

Findings from the present study suggested that prior counseling was positively correlated with intentions to seek mental help. These findings coincide with previous research in undergraduate students (mostly European Americans) showing positive associations between prior counseling and help-seeking intentions (Lannin et al., 2015). Additionally, self-stigma was negatively associated with help-seeking intentions, such that the higher mental health self-stigma someone has, the less likely they are to seek out mental help. This is consistent with former research in Middle Eastern populations that has found negative correlations between the attitude and intention of help-seeking behaviors and self-stigma around help-seeking (Topkaya, 2014).

Contrary to my hypotheses, results indicated that primary caregiver mental health stigma was not associated with a Middle Eastern emerging adult's intention to seek mental help. While previous research has suggested that about 90% of young people view their parents as an influential source in help-seeking behaviors (Wahlin & Deane, 2012), these findings may not be generalizable to the age range of emerging adults. It is possible that emerging adults who are between the ages of 18-25 may already have formed their own sense of identity and beliefs, regardless of how they were raised and influenced by their primary caregivers. In fact, according to Arnett (2000) and Erikson (1968), a fundamental developmental task in adolescence through emerging adulthood is growing and cultivating a sense of identity. Further, at this stage of life, it is necessary for emerging adults to "individualize" their life and their identities (Schwartz et al., 2005, pp. 203). Thus, Middle Eastern emerging adults may have their own views and identity concerning mental health, as demonstrated by the significant association between self-stigma in emerging adults and their intention to seek mental help. Moreover, another

potential reason for these findings and the low average scores on primary caregiver mental health stigma may be that participants may have felt reluctant to rate their primary caregiver's mental health stigma as negative, which in their eyes may have felt like putting their caregiver in a negative light. This may be explained due to the Middle East's collectivistic culture, including core tenets of family cohesion and loyalty (Nassar-McMillan & Hakim-Larson, 2003).

Furthermore, peer support did not moderate the association between primary caregiver stigma and emerging adult help-seeking intention. Interestingly, there was no correlation between peer social support and mental health self-stigma, nor peer social support and intention to seek help. These findings were surprising considering research that has shown that friendships become more prominent and influential than caregivers as one gets older (Rickwood et al., 2007). Perhaps, however, emerging adults may not disclose information about their mental health to their peers. In fact, research done on multiethnic emerging adults in the UK has shown that to protect themselves from stigma and labeling, these individuals have trouble deciding whether to disclose their mental health struggles (Rüsch et al., 2014). Further, in a study on emerging adults looking at stigma and disclosure of mental health problems, findings showed that keeping their mental health problems a secret prevented them from experiencing rejection, lowered self-esteem, and stigma (Prizeman & Weinstein, 2024). For the current study, it may be important to consider specifically how much of the support from peers is related to their disclosure about their mental health. As the measure on social support from peers in the present study only asked about support broadly rather than with regards to mental health,

results may have been different if the measure asked specifically about disclosure and support around conversations of mental health and well-being.

Limitations

The present study contributes to the advancement of literature on emerging adults and their mental health help-seeking intention with the focus on the Middle Eastern population, a population which is very underrepresented in research. Despite the strengths of this work, there are still limitations to this study. The first limitation is the fact that this study is cross-sectional, meaning that causal claims cannot be deduced from this study as it is a mere snapshot at one timepoint in these Middle Eastern emerging adults' lives. If a longitudinal study were to be implemented, primary caregiver influence could be tracked over time from childhood to emerging adulthood, presenting possible evidence for how parent influence on mental health might be stronger or weaker as one gets older.

Another limitation to this study is its small sample size. Given that only 90 participants' results were used in the study, this may make the data generalizable to the general Middle Eastern population. As this population is difficult to reach, their voices may not be heard or shared in research, thus the importance of replicating this study and conducting more research on this topic within this population.

Further limitations include the primary caregiver mental health stigma scale, as this measure looked at caregiver stigma through the emerging adult's perspective, not the caregiver's. The perceived stigma from the emerging adult may have skewed results and again brings forward the possibility that family loyalty and respect may be prominent factors in Middle Eastern cultures. Future research might ask caregivers about their

mental health stigma directly. Additionally, given that there were no significant predictors in this study within the emerging adult age range, future research might look at if the association between primary caregiver mental health stigma and intention to seek help exists in younger children.

Clinical, Teaching, and Advocacy Implications

While results of this present study did not show any significant predictors, mental health stigma remains a significant issue in Middle Eastern cultures (Al-Krenawi, 2005). Although the average score for self-stigma and help-seeking intention in this population in the middle range, it would still be pertinent to address stigma in this population and how it contributes to the likelihood of seeking help. These results bring to the forefront the importance of educating this population on mental health and well-being, as well as bringing awareness to stigma around mental health (Sewilam et al., 2015). It is essential that universities provide seminars and educational workshops for this population specifically outlining the prevalence of self-stigma within this community and that individuals are not alone in feeling this. Campus or community support groups may be helpful in facilitating thoughtful discussions on these topics.

Counselor training centers can also use this research to bring to light the importance of discussing culture in therapy sessions, specifically with those who belong to more marginalized communities. It is imperative that counselors or psychologists in training also be taught that forming a safe and trusting relationship with clients of this population might take some time, as they may be holding onto shame, distrust, fear, and confusion (Boghosian, 2011). A nonjudgmental attitude, cultural competence, flexibility, and understanding the nuances and complexities of Middle Eastern cultures has been

shown to be essential in therapists working with those of Middle Eastern descent (Boghosian, 2011). Thus, it would be important to bring these competencies in when training future counselors or psychologists to assist in making the therapeutic process more enticing and valuable to Middle Eastern emerging adults. Given the present study found that attending counseling in the past was associated with help-seeking intention, once Middle Eastern emerging adults have had this past counseling experience, they may be more likely to seek services in the future. Results from this study highlight the importance of training and educating counseling and psychology professionals on cultural competency and the specifics in working with this population.

REFERENCES

Al-Darmaki, F. R. (2003). Attitudes towards seeking professional psychological help: What really counts for United Arab Emirates University students? *Social Behavior and Personality: An International Journal, 31*(5), 497–508. https://doi.org/10.2224/sbp.2003.31.5.497

Al-Krenawi A. (2005). Mental health practice in Arab countries. *Current Opinion in Psychiatry*, *18*(5), 560–564. https://doi.org/10.1097/01.yco.0000179498.46182.8b

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55*(5), 469–480. https://doi.org/10.1037/0003-066X.55.5.469

Arnett, J. J. (2015). Emerging adulthood: *The winding road from the late teens through the twenties* (2nd ed.). New York, NY: Oxford University Press

Arnett, J. J., Žukauskienė, R., & Sugimura, K. (2014). The new life stage of emerging adulthood at ages 18-29 years: implications for mental health. *The lancet. Psychiatry*, *1*(7), 569–576. https://doi.org/10.1016/S2215-0366(14)00080-7

Atkin, A.L., Ahn, L.H. Profiles of Racial Socialization Messages from Mothers and Fathers and The Colorblind and Anti-Black Attitudes of Asian American Adolescents. *J Youth Adolescence* 51, 1048–1061 (2022). https://doi.org/10.1007/s10964-022-01597-2

Boghosian, Sara, "Counseling and Psychotherapy with Clients of Middle Eastern Descent: A Qualitative Inquiry" (2011). All Graduate Theses and Dissertations. 898. https://digitalcommons.usu.edu/etd/898

Budman, C. L., Lipson, J. G., & Meleis, A. I. (1992). The cultural consultant in mental health care: The case of an Arab adolescent. *American Journal of Orthopsychiatry, 62*(3), 359–370. https://doi.org/10.1037/h0079347

Coker E. M. (2005). Selfhood and social distance: toward a cultural understanding of psychiatric stigma in Egypt. *Social Science & Medicine (1982)*, *61*(5), 920–930. https://doi.org/10.1016/j.socscimed.2005.01.009

Cutrona, C. E., & Russell, D. W. (2017). Autonomy promotion, responsiveness, and emotion regulation promote effective social support in times of stress. *Current Opinion in Psychology*, *13*, 126–130. https://doi.org/10.1016/j.copsyc.2016.07.002

Downs, M. F., & Eisenberg, D. (2012). Help seeking and treatment use among suicidal college students. *Journal of American College Health 60*(2), 104–114. https://doi.org/10.1080/07448481.2011.619611

Erikson, E. H. (1994). *Identity: Youth and crisis*. WW Norton & company.

Franco, M., & McElroy-Heltzel, S. (2019). Let me choose: Primary caregiver cultural humility, racial identity, and mental health for multiracial people. *Journal of Counseling Psychology, 66*(3), 269-279. https://doi.org/10.1037/cou0000317

Gearing, R. E., MacKenzie, M. J., Ibrahim, R. W., Brewer, K. B., Batayneh, J. S., & Schwalbe, C. S. (2015). Stigma and mental health treatment of adolescents with depression in Jordan. *Community mental health journal*, *51*(1), 111–117. https://doi.org/10.1007/s10597-014-9756-1

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity. New York: Simon and Schuster.*

Gordon, H., & Murad, I. (2005). Psychiatry and the Palestinian population. *The Israel Journal of Psychiatry and Related Sciences*, *42*(2), 73–80. https://doi.org/10.1383/psyt.4.2.73.59109

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

Hammer, J. H., & Spiker, D. A. (2018). Dimensionality, Reliability, and Predictive Evidence of Validity for Three Help Seeking Intention Instruments: ISCI, GHSQ, and MHSIS. *Journal of Counseling Psychology, 65*, 394-401. https://doi.org/10.1037/cou0000256

Karabenick, S. A., & Newman, R. S. (Eds.). (2006). *Help seeking in academic setting: goals, groups, and contexts.* Lawrence Erlbaum Associates Publishers.

Karam, E. G., Mneimneh, Z. N., Dimassi, H., Fayyad, J. A., Karam, A. N., Nasser, S. C., Chatterji, S., & Kessler, R. C. (2008). Lifetime prevalence of mental disorders in Lebanon: first onset, treatment, and exposure to war. *PLoS medicine*, *5*(4), e61. https://doi.org/10.1371/journal.pmed.0050061

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., … Wang, P. S. (2009). The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. *Epidemiologia e Psichiatria Sociale*, *18*(1), 23–33. doi:10.1017/S1121189X00001421

Lannin, D. G., Vogel, D. L., Brenner, R. E., & Tucker, J. R. (2015). Predicting Self-Esteem and Intentions to Seek Counseling: The Internalized Stigma Model Ψ. *The Counseling Psychologist, 43*(1), 64–93. https://doi.org/10.1177/0011000014541550

Le, T. P., Bradshaw, B. T., Wang, M. Q., & Boekeloo, B. O. (2022). Discomfort in LGBT community and psychological well-being for LGBT Asian Americans: The moderating role of racial/ethnic identity importance. *Asian American Journal of Psychology, 13*(2), 149-157. https://doi.org/10.1037/aap0000231

Little, R. J. A. (1988). A test of missing completely at random for multivariate data with missing values. *Journal of the American Statistical Association, 83*(404), 1198–1202.

Logan, D. E., & King, C. A. (2001). Parental facilitation of adolescent mental health service utilization: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 8*(3), 319–333. https://doi.org/10.1093/clipsy.8.3.319

Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: the influence of help-seeking attitudes. *Aging & Mental Health*, *10*(6), 574–582. https://doi.org/10.1080/13607860600641200

Malli, M. A., Forrester-Jones, R., & Murphy, G. (2016). Stigma in youth with Tourette's syndrome: a systematic review and synthesis. *European Child & Adolescent Psychiatry*, *25*(2), 127–139. https://doi.org/10.1007/s00787-015-0761-x

Mawson, E., Best, D., Beckwith, M. *et al.* Social identity, social networks and recovery capital in emerging adulthood: A pilot study. *Subst Abuse Treat Prev Policy* 10, 45 (2015). https://doi.org/10.1186/s13011-015-0041-2

Meler, T. (2017). The Palestinian family in Israel: Simultaneous trends. *Marriage & Family Review, 53*(8), 781–810. https://doi.org/10.1080/01494929.2017.1359810

Mental Illness and Substance Use in Young Adults. SAMHSA. (2022, September 22). Retrieved January 15, 2023, from https://www.samhsa.gov/young-adults

Mohammadzadeh, M., Awang, H., & Mirzaei, F. (2020). Mental health stigma among middle eastern adolescents: A Protocol for a systematic review. *Journal of Psychiatric and Mental Health Nursing*, *27*(6), 829–837. https://doi.org/10.1111/jpm.12627

Nassar-McMillan, S. C., & Hakim-Larson, J. (2003). Counseling considerations among Arab Americans. *Journal of Counseling & Development, 81*(2), 150–159. https://doi.org/10.1002/j.1556-6678.2003.tb00236.x

Netemeyer, R., Burton, S., Delaney, B., & Hijjawi, G. (2015). The Legal High: Factors Affecting Young Consumers' Risk Perceptions and Abuse of Prescription Drugs. *Journal of Public Policy & Marketing, 34*(1), 103–118. https://doi.org/10.1509/jppm.14.073

Okasha, A., Karam, E., & Okasha, T. (2012). Mental health services in the Arab world. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, *11*(1), 52–54. https://doi.org/10.1016/j.wpsyc.2012.01.008

Pridmore, S. and Pasha, M.I. (2004), Psychiatry and Islam. *Australasian Psychiatry, 12*: 380-385. https://doi.org/10.1111/j.1440-1665.2004.02131.x

Prizeman, K., McCabe, C., & Weinstein, N. (2024). Stigma and its impact on disclosure and mental health secrecy in young people with clinical depression symptoms: A qualitative analysis. *PloS one*, *19*(1), e0296221. https://doi.org/10.1371/journal.pone.0296221

Procidano, M. E., & Heller, K. (1983). Measures of perceived social support from friends and from family: Three validation studies. *American Journal of Community Psychology, 11*(1), 1–24. https://doi.org/10.1007/BF00898416

Rickwood, D. J., & Braithwaite, V. A. (1994). Social-psychological factors affecting help-seeking for emotional problems. *Social Science & Medicine (1982)*, *39*(4), 563–572. https://doi.org/10.1016/0277-9536(94)90099-x

Rickwood, D.J., Deane, F.P. & Wilson, C.J. (2007), When and how do young people seek professional help for mental health problems?. *Medical Journal of Australia, 187*: S35-S39. https://doi.org/10.5694/j.1326-5377.2007.tb01334.x

Rickwood, D.J. Seeing the school counsellor: why or why not [poster]? Proceedings of the Joint Conference of the Australian Psychological Society and the New Zealand Psychological Society. 2006; Sep 26–30; Auckland. Melbourne: Australian Psychological Society, 2006.

Rüsch, N., Brohan, E., Gabbidon, J., Thornicroft, G., & Clement, S. (2014). Stigma and disclosing one's mental illness to family and friends. *Social Psychiatry and Psychiatric Epidemiology*, *49*, 1157-1160. https://doi.org/10.1007/s00127-014-0871-7

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet (London, England)*, *370*(9590), 878–889. https://doi.org/10.1016/S0140-6736(07)61239-2

Schwartz, Seth J., et al. "Identity and Agency in Emerging Adulthood: Two Developmental Routes in the Individualization Process." *Youth & Society*, vol. 37, no. 2, 2005, pp. 201–29, https://doi.org/10.1177/0044118X05275965.

Sewilam, A. M., Watson, A. M., Kassem, A. M., Clifton, S., McDonald, M. C., Lipski, R., Deshpande, S., Mansour, H., & Nimgaonkar, V. L. (2015). Suggested avenues to reduce the stigma of mental illness in the Middle East. *The International Journal of Social Psychiatry*, *61*(2), 111–120. https://doi.org/10.1177/0020764014537234

Topkaya, N. (2014). Gender, self-stigma, and public stigma in predicting attitudes toward psychological help-seeking. *Kuram ve Uygulamada Eğitim Bilimleri, 14*(2), 480–487. DOI:10.12738/estp.2014.2.1799

Vogel, D. L., Wade, N. G., & Ascheman, P. L. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counseling Psychology, 56*(2), 301–308. https://doi.org/10.1037/a0014903

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

Wahlin, T., & Deane, F. Discrepancies between parent- and adolescent-perceived problem severity and influences on help seeking from mental health services. *Australian & New Zealand Journal of Psychiatry*. 2012;46(6):553-560. doi:10.1177/0004867412441929

World Health Organization. (2022, June 17). Mental health: Strengthening our response. World Health Organization. Retrieved February 5, 2023, from https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Yousaf, O., Popat, A., & Hunter, M. S. (2015). An investigation of masculinity attitudes, gender, and attitudes toward psychological help-seeking. *Psychology of Men & Masculinity, 16*(2), 234–237. https://doi.org/10.1037/a0036241

Yu, B. C. L., Chio, F. H. N., Chan, K. K. Y., Mak, W. W. S., Zhang, G., Vogel, D., & Lai, M. H. C. (2023). Associations between public and self-stigma of help-seeking with help-seeking attitudes and intention: A meta-analytic structural equation modeling approach. *Journal of Counseling Psychology, 70*(1), 90–102. https://doi.org/10.1037/cou0000637

APPENDIX A

TABLE 1

Table 1

Demographic Details of the Sample

Ethnicity	***n* (%)**
Afghan	3 (3.3%)
Bahraini	—
Cypriot	2 (2.2%)
Egyptian	4 (4.4%)
Iranian	16 (17.8%)
Iraqi	7 (7.8%)
Israeli	8 (8.9%)
Jordanian	7 (7.8%)
Kuwaiti	—
Lebanese	18 (20%)
Omani	0 (0%)
Palestinian	13 (14.4%)
Qatari	—
Saudi Arabian	1 (1.1%)
Syrian	4 (4.4%)
Turkish	8 (8.9%)
Emirati	—
Yemeni	3 (3.3%)
Multiethnic	10 (11.1%)
Other	6 (6.7%)
Age	
18	4 (4.4%)
19	6 (6.7%)
20	7 (7.78%)
21	11 (12.2%)
22	17 (18.9%)
23	14 (15.6%)
24	8 (8.9%)
25	23 (25.6%)
Primary Caregiver	
Biological mother	72 (80%)
Biological father	16 (17.8%)
Grandfather	—
Aunt	—
Uncle	—
Stepmother	—
Stepfather	—
Adoptive mother	—
Adoptive father	—
Other	2 (2.2%)

Gender Identity	
Male	24 (26.7%)
Female	63 (70%)
Non-binary	2 (2.2%)
Transgender man	1 (1.1%)
Transgender woman	—
Not listed	—
Prefer not to say	—

APPENDIX B

TABLE 2

Table 2

Descriptive Statistics and Correlations among Study Variables

	1	2	3	4	5	6	7
1. Age	—						
2. Living with PC	-.07	—					
3. Past Counseling	.17	-.21*	—				
4. PC Stigma	-.14	.15	-.08	—			
5. Self-stigma	-.29**	.004	-.23*	.06	—		
6. Peer Social Support	.09	-.26*	.05	-.18	-.19	—	
7. Help-Seeking Intention	.24*	.10	.34**	-.12	-.54**	.09	—
M	22.44			9.24	23.07	3.62	4.64
SD	2.10			4.97	7.18	0.61	1.80

Note. PC = Primary Caregiver

*$p < .05$, **$p < .01$

APPENDIX C

TABLE 3

Table 3

Moderating Effect of Peer Social Support on the Association between PC Stigma and Help-Seeking Intention

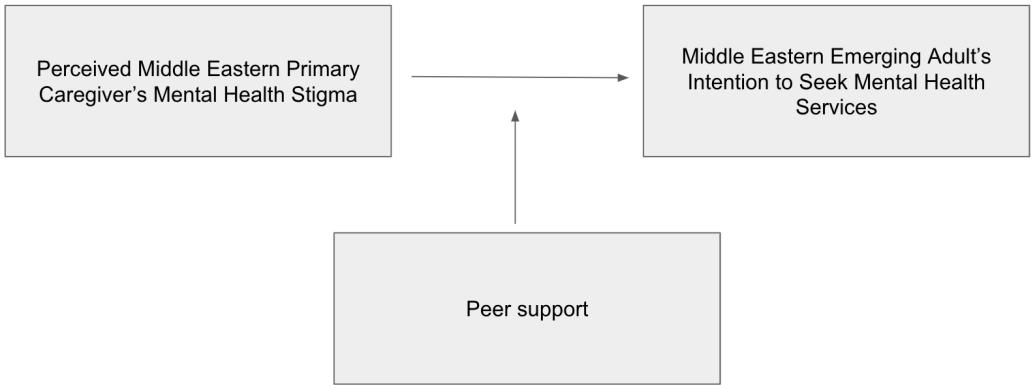
Variable	β	SE	*p*	R^2	$\triangle R^2$
Step 1				.37	.37
Age	.08	.08	.38		
Living with PC	.15	.33	.09		
Past Counseling	.25	.33	.008*		
Self-Stigma	-.46	.17	<.001**		
Step 2				.38	.009
Age	.07	.08	.46		
Living with PC	.17	.34	.07		
Past Counseling	.25	.33	.009*		
Self-Stigma	-.46	.17	<.001**		
PC Stigma	-.09	.16	.31		
Peer Social Support	.02	.17	.86		
Step 3				.38	.001
Age	.07	.08	.47		
Living with PC	.17	.34	.07		
Past Counseling	.24	.34	.01*		
Self-Stigma	-.46	.17	<.001**		
PC Stigma	-.10	.16	.30		
Peer Social Support	.03	.18	.80		
PC Stigma*Peer Social Support	-.03	.14	.79		

Note. *$p < .05$, **$p < .01$
PC = Primary Caregiver

APPENDIX D

FIGURE 1

Figure 1. ***Conceptual Model***



APPENDIX E

SCREENING QUESTIONNAIRE

1. Are you between the ages of 18-25? Y/N
2. Were you born in the U.S.? Y/N
3. Do you have a primary caregiver that was born in the Middle East? (Afghanistan, Bahrain, Cyprus, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, and Yemen) Y/N

*If participants indicate "No" for any of the above questions, they are ineligible to participate.

APPENDIX F

DEMOGRAPHICS QUESTIONNAIRE

1. How old are you? ____ Years
2. To which gender identity do you most identify?
    a. Male
    b. Female
    c. Non-binary
    d. Transgender man
    e. Transgender woman
    f. Not listed (please specify): _____
    g. Prefer not to say
3. What is your present religion, if any? _____
    a. Christian
    b. Jewish
    c. Muslim
    d. Hindu
    e. Buddhist
    f. Atheist
    g. Agnostic
    h. Other (please specify:) ____
    i. Don't know
    j. Prefer not to say
4. Religious beliefs influence all my dealings in life (RCI-10; Worthington et al., 2003)
    a. Not at all true of me

b. Somewhat true of me

c. Moderately true of me

d. Mostly true of me

e. Totally true of me

5. What is your ethnicity?

a. Afghan

b. Bahraini

c. Cypriot

d. Egyptian

e. Iranian

f. Iraqi

g. Israeli

h. Jordanian

i. Kuwaiti

j. Lebanese

k. Omani

l. Palestinian

m. Qatari

n. Saudi Arabian

o. Syrian

p. Turkish

q. Emirati

r. Yemeni

s. Multiethnic (please describe): _____

t. Other (please specify): _____

6. What is your sexual orientation?

    a. Heterosexual

    b. Bisexual

    c. Queer

    d. Lesbian

    e. Gay

    f. Asexual

    g. Pansexual

    h. Uncertain

    i. Other (please specify): _____

    j. Prefer not to respond

7. Indicate primary caregiver (i.e., the person who had the most influence raising you) below:

    a. Biological mother

    b. Biological father

    c. Grandmother

    d. Grandfather

    e. Aunt

    f. Uncle

    g. Stepmother

    h. Stepfather

i. Adoptive mother

j. Adoptive father

k. Other (please specify): _____

8. What is your zip code? _____

9. Do you currently live with your primary caregiver(s) Y/N

10. Have you ever been to counseling in the past? Y/N

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APPENDIX G

ADAPTED VERSION OF THE PERCEPTIONS OF STIGMATIZATION BY OTHERS FOR SEEKING HELP SCALE (PSOSH; VOGEL, WADE, & ASCHEMAN, 2009)

INSTRUCTIONS: Imagine you had an emotional or personal issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that **your primary caregiver** would _____.

1 = Not at all 2 = A little 3 = Some 4 =A lot 5 = A great deal

1. React negatively to you

2. Think bad things of you

3. See you as seriously disturbed

4. Think of you in a less favorable way

5. Think you posed a risk to others

Scoring: Sum of items 1-5. Higher scores indicate greater primary caregiver stigma.

APPENDIX H

SELF-STIGMA OF SEEKING HELP SCALE (SSOSH; VOGEL ET AL., 2006)

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior if I asked a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Scoring: Sum of items 1-10. Items 2, 4, 5, 7, and 9 are reverse scored. Higher scores indicate greater self-stigma from seeking help for mental health issues.

APPENDIX I

MENTAL HELP SEEKING INTENTION SCALE (MHSIS; HAMMER & SPIKE, 2018)

INSTRUCTIONS: For the purposes of this survey, "mental health professionals" include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, "mental health concerns" include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression). Please mark the box that best represents your opinion.

1. If I had a mental health concern, I would intend to seek help from a mental health professional.

1 (extremely unlikely) 2 3 4 5 6 7 (extremely likely)

2. If I had a mental health concern, I would try to seek help from a mental health professional.

1 (definitely false) 2 3 4 5 6 7 (definitely true)

3. If I had a mental health concern, I would plan to seek help from a mental health professional.

1 (strongly disagree) 2 3 4 5 6 7 (strongly agree)

Scoring: The MHSIS contains three items which produce a single mean score. To calculate the mean score, add the scores for all three items then divide by three. The resulting mean score should range from a minimum of 1 to a maximum of 7.

APPENDIX J

ADAPTED VERSION OF THE PERCEIVED SOCIAL SUPPORT FROM FRIENDS SCALE (PSS-FR; PROCIDANO & HELLER, 1983)

Directions: The statements which follow refer to the feelings and experiences which occur to most people at one time or another in their relationships with friends. For each statement, please use the 5-point scale to indicate the choice that best represents your opinion.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. My friends give me the moral support I need.

2. Most other people are closer to their friends than I am.

3. My friends enjoy hearing about what I think.

4. Certain friends come to me when they have problems or need advice.

5. I rely on my friends for emotional support.

6. If I felt that one or more of my friends were upset with me, I'd just keep it to myself.

7. I feel that I'm on the fringe in my circle of friends.

8. There is a friend I could go to if I were just feeling down, without feeling funny about it later.

9. My friends and I are very open about what we think about things.

10. My friends are sensitive to my personal needs.

11. My friends come to me for emotional support.

12. My friends are good at helping me solve problems.

13. I have a deep sharing relationship with a number of friends.

14. My friends get good ideas about how to do things or make things from me.

15. When I confide in friends, it makes me feel uncomfortable.

16. My friends seek me out for companionship.

17. I think that my friends feel that I'm good at helping them solve problems.

18. I don't have a relationship with a friend that is as intimate as other people's relationships with friends.

19. I've recently gotten a good idea about how to do something from a friend.

20. I wish my friends were much different.

Scoring: Mean score of items 1-20. Items 2, 6, 7, 15, 18, and 20 are reverse scored. Higher mean scores indicate a higher degree of perceived social support from friends.

APPENDIX K

ASU IRB APPROVAL

APPROVAL: EXPEDITED REVIEW

Ha Rim Ahn

CISA: Counseling and Counseling Psychology

-

LydiaAhn@asu.

edu Dear Ha

Rim Ahn:

On 4/17/2023 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	The Association Between Perceived Caregiver Mental Health Stigma and Middle Eastern Emerging Adult Help-Seeking Intentions: Moderating Effect of Social Support
Investigator:	Ha Rim Ahn
IRB ID:	STUDY00017882
Category of review:	
Funding:	Name: ASU: Graduate and Professional Student Association (GPSA)
Grant Title:	
Grant ID:	
Documents Reviewed:	• Consent Form_Saka_PrimaryCaregiverStigma&Help-SeekingIntentions_2023.pdf, Category: Consent Form; • JumpStart Thesis Funding2023.pdf, Category: Sponsor Attachment; • Recruitment_Methods_Email_11-04-2023.pdf, Category: Recruitment Materials; • Recruitment_Methods_Flyer_13-04-2023.pdf, Category: Recruitment Materials; • Saka_ FINAL IRB Social Behavioral Protocol_final 03.03.2023 (2).docx, Category: IRB Protocol; • Supporting Documents 11-04-2013_PrimaryCaregiverStigma&Help-SeekingIntentions (1).pdf, Category: Measures

	(Survey questions/Interview questions /interview guides/focus group questions);

The IRB approved the protocol effective 4/17/2023. Continuing Review is not required for this study.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Selin
Saka
Selin
Saka Ha
Rim
Ahn

Ashley Randall
Kimberly
Updegraff