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Magnitude of Perceived Public Stigma on Youths' Attitude Toward  
Seeking Mental Health Treatment; St. Amanuel Mental Specialized  
Hospital, Addis Ababa, Ethiopia

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A Thesis Presented for Partial Fulfillment of Master of Social Work Degree.

November, 2022

Addis Ababa, Ethiopia

## **Acknowledgements**

My sincere gratitude is first and foremost to Almighty God who has helped me in all my endeavors.

I would like to extend my sincere gratitude to my thesis adviser, Dr. Abebe Assefa, for his sincere and helpful criticism from the beginning to the conclusion of this study.

I'm also grateful to St. Amanuel Mental Specialized Hospital for helping me out with crucial support during data collection. My sincere gratitude goes out to the selected respondents and enumerators for their great cooperation throughout data collection and for giving their precious time to help me complete my survey.

My special thanks go to my husband Workineh W/Giorgis, for his unreserved multidimensional assistance and idea sharing. I would also like to sincerely thank my sister Misgana Abera for her unceasing help.

Finally, I want to express my gratitude to my parents, W/ro Alemitu Lera and Ato Abera Ala, for their unwavering support and encouragement in helping me complete this work.

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## **List of Abbreviations and Acronyms**

ATSPPHS-SF: Attitudes Toward Seeking Professional Help Scale: Short Form

CMDs: Common Mental Disorders

CSA: Central Statistics Agency

EES: Etiology and Effects of Stigma

MLT: Modified Labeling Theory

PDD: Perceived Devaluation-Discrimination

SPSS: Statistical Package for Social Sciences

WHO: World Health Organization

YLD: Years Lived with Disability

## Abstract

*Mental health is considered as the vital asset to human health and wellbeing. Stigma toward mental illness is one of the leading reasons individuals with mental illness do not seek treatment for their conditions. This study aimed to study the magnitude of perceived public stigma on youths' attitude toward seeking mental health treatment at St Amanuel Mental Specialized Hospital in Addis Ababa. A Hospital-based cross-sectional study design was conducted and quantitative data were collected by interviewing psychiatric outpatients seeking treatment at the St. Amanuel Mental Specialized Hospital. The dependent variable youth's attitude toward seeking mental health treatment were assessed by attitudes toward seeking professional help scale: short form (ATSPPHS-SF). Perceived public stigma were assessed by using the perceived devaluation-discrimination (PDD) scale. After all necessary data are obtained, entered into and cleaned with SPSS version 22.00. Then univariate, bivariate and multiple linear regression analysis are carried out. The results indicate that, the magnitude of high perceived public stigma was found 55.7% and negative attitude towards mental health treatment was 79.6%. The result of bivariate analyses on this study found, participants' sex, age, marital status, educational level, occupation and public stigma had statistically significant association with youths' attitude toward seeking mental health treatment. Notably, the study depicted that perceived public stigma and ever-married youths' has negatively associated with attitude toward seeking mental health treatment in multiple analyses ( $B=-0.609$ ; 95%CI: -0.328, -0.189 and  $B=-0.235$ ; 95%CI: -3.454, -0.605). That means youths' who have faced public stigma and who have experienced marriage were less likely to be seeking mental health treatment. Regarding the other associated socio-demographic factors, this study found that there were significant positive relationships between youths' attitude toward seeking mental health treatment and secondary education, professionals, and youths with elementary occupation in multiple linear regression ( $B=0.310$ ; 95%CI: 0.256-4.797 and  $B=0.300$ ; 95%CI: 0.720-5.715 and  $B=0.194$ ; 95%CI: 0.218-4.626). Generally, the magnitude of perceived public stigma on youths' attitude toward seeking mental health treatment in the study setting was found high that coupled with association of many independent variables. This needs collaborative effort of all stakeholders and appropriate factor specific interventions.*

**Keywords:** Public stigma, attitude toward seeking mental health treatment, St. Amanuel Mental Specialized Hospital

# CHAPTER ONE

## 1. INTRODUCTION

### 1.1 Background

Mental health is considered as the vital asset to human health and wellbeing. Mental illness can attack anyone at any time in their life across the world of all ages and from all communities. It links with the range of cognitive, emotional and behavioral disorders that interfere with interpersonal relationships as well as functions required for work, at home, and in school (Johnstone, 2001). Types of mental illnesses are many, from these common ones are anxiety disorders, depression, bipolar disorders, eating disorders, personality disorders, post-traumatic stress disorders and psychotic disorders including schizophrenia (WHO, 2017).

The search for mental health treatment can represent an important gain for people in mental suffering. While effective treatment for mental disorders is available, barriers such as stigma against people with mental disorders prevent them from receiving the help they need to get and stay well (WHO, 2001). The stigmatization of individuals with mental health problems is not new. For centuries individuals with mental disorders have long been viewed with fear and suspicion (McDaid, 2006). Stigma toward mental illness is one of the leading reasons individuals with mental illness do not seek treatment for their conditions. It also considered as a barrier to recover from mental illness, even for individuals who receive treatment (Shrivastava *et al*, 2012).

According to societal reaction theory, stigma may lead to labeling and negative societal reaction (Link and Cullen, 1990). As a consequence, stigmatized individuals develop negative attitudes that may include reluctant to professional treatment. Symbolic interaction theory and social comparison theory (Stryker and Statham, 1985) also hypothesize that negative attitudes and unfair

treatment in day-to-day life from a socially stigmatized lead to negative response to their health condition (Rosenberg, 1979). Theories about the construct of stigma associated with mental illness and how it might be deconstructed and defined divided the stigma into three: *self-stigma*, *structural stigma* and *public stigma* (Barnes, 2017).

Self-stigma is an internal evaluation process whereby people judge themselves. This could be a result of messages received from societal norms (Stacy and Sondra, 2008). Structural stigma describes a process that works to deny people with a mental illness their entitlement to things that people who are considered normal take for granted (Johnstone, 2001). According to Goffman (1963) it is an external evaluation of a person that is based on societal norms. Public stigma is the general public's reaction toward people with mental health problems, including a negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness. It can disrupt social relationships and decrease the likelihood that persons with mental illness seek mental health services (Corrigan and Watson, 2007).

Therefore this study aimed to examine attitudes toward seeking mental health treatment from the perspective of public stigma. Because both self and structural stigma arise messages received from general public. So addressing public stigma contributes to eradicating or reducing self and structural stigma. Additionally, the researcher is unable to explore all types of stigma due to resource constraints.

The researcher's experience in a mental health hospital, while patients coming to a mental health hospital for the first time, less interested in seeking professional treatment aroused interest in this topic. The researcher also focused on children, youth, and families as part of social work specialization. That initiated the researcher to study the magnitude of perceived public stigma on

youths' attitude toward seeking mental health treatment in order to better understand the detrimental impact that stigma has. Taking a closer look at public stigma and attitudes towards seeking professional help among a sample of youths' was assisted to identify whether these variables differ or not by socio-demographic and economic factor.

Findings from this study will provide guidance for health care workers, psychologists, social workers and general public to better understand the role of public stigma on attitudes towards seeking professional help. It also helps to develop targeted intervention strategies to reduce mental health stigma and improve attitudes.

## 1.2 Statement of the Problem

About 13% of the global burden of disease is linked with untreated mental disorders (WHO, 2011). In the world, there is a chance to develop mental health disorders for one in four people at some point during their lives. Depressive and anxiety disorders accounted for the majority of the mental disorders diagnosed worldwide and often referred to as common mental disorders (CMDs). In the world more than 450 million people are estimated to be suffering from mental disorders. From these depression is reported to be the largest contributor to the 800,000 deaths due to suicide each year (WHO, 2017). But, a small proportion of these people receive any form of modern treatment, and most untreated cases are found in developing countries (Aradom *et al.*, 2018).

Ethiopia is one of the countries with the highest rates of depression and anxiety in Africa, with a prevalence of 4.7% and 3.4% in the general population. In addition the prevalence of CMDs found to be 11.7% in Addis Ababa and 19.3% in Haromaya (Kebede, et al., 1999). Ethiopia ranks second among African countries in terms of the proportion of total years lived with disability (YLD) attributable to depressive and anxiety disorders (WHO, 2017).

In Ethiopia, less than 10% of persons with severe mental illness had contact with modern psychiatric services. Patients usually choose modern mental health-care services after they have failed to recover and after receiving traditional treatments. A study conducted in Ethiopia showed that less than half of mental illness patients directly contacted a mental hospital, and the median delay between onset of illness and arrival at the psychiatric hospital was 38 weeks (Berhan, 2008).

Besides, in 2001, WHO declared stigma to be the single most important barrier to overcome in the community. In Ethiopia, the study conducted to examine the Magnitude and Associated Factors of Perceived Stigma among Adults with Mental Illness in Jimma town JUSH Hospital, showed the

prevalence of at least one stigma item on the perceived devaluation-discrimination (PDD) scale, was 100% respectively (Hadera *et al*, 2019).

Researchers in Ethiopia as well as other countries' attempts have been made to measure the magnitude of perceived public stigma on youths' attitudes to seek mental health treatment from the perspective of unaffected members of the society and use qualitative method to study. The only reported research in Ethiopia which the researcher found when reviewing different literatures, that quantitatively examine the magnitude of perceived stigma on attitudes to seek mental health treatment in Jimma town and in Mekelle (Hadera *et al.*, 2019; Aradom *et al.*, 2018).

But none of them conducted their study specifically on youths with mental health problems and they did not specifically examine public stigma. Thus, this study examined the magnitude of perceived public stigma on youths' attitudes to seek mental health treatment and investigated another factors associated with youths' attitudes to seek mental health treatments from outpatient youths' sample in Addis Ababa St. Amanuel Mental Specialized Hospital.

### **1.3 Research Questions**

The following research questions guide the study:

1. What is the magnitude of perceived public stigma on youths with mental health problem?
2. What is the magnitude of youths' attitudes to seek mental health treatment?
3. It there a relationship between perceived public stigma and youths' attitudes to seek mental health treatment?
4. Does youths' attitudes to seek mental health treatments differ by socio-demographic and economic factors?

## **1.4 Significance of the Study**

The study will help to make awareness on how public stigma and other factors hinder youths from seeking mental health treatment. In addition, it will provide knowledge and suggestions to micro and macro social work practice such as developing effective approaches towards improving engagement among youths seeking out services. Possible contributions consists of developing mental health knowledge, identifying and addressing treatment misconceptions, and increasing awareness on social sensitivity with youths who may feel discomfort to seek mental health treatment.

This study will also aid further studies and development of interventions that can reduce social exclusion and ridicule and may raise empathy, tolerance, and understanding about mental disorders. The study will increase society's knowledge to reduce stigmatizing attitudes towards youths and may improve help-seeking. Also the study will help to determine what action needs to be taken to address these issues to facilitate youth's attitudes to seek services.

## **1.5 The scope of the Study**

Much is not known about the magnitude of perceived public stigma on youths' attitudes to seek mental health treatment in Addis Ababa. Therefore, seeking of accuracy and quality has bounded this study to only selected St. Amanuel Mental Specialized Hospital. Also time, money and logistics (resource) constraints has made this study to be limited to the magnitude and the major socio-demographic and economic factors of youth's attitudes to seek mental health treatments from outpatient youths sample in Addis Ababa St. Amanuel Mental Specialized Hospital.

## 1.6 Organization of the Paper

This paper is organized into six chapters. The first chapter deals with introduction part. The second chapter focuses on reviewed literatures. The third chapter deals with methodology including the study design, the study area, sampling procedure, sample size determination, data source and collection instruments, data analysis, the model, and ethical consideration. The fourth chapter illustrates the result. The fifth chapter deals with discussion part. The sixth chapter talks about the conclusion and implications.

## 1.7 Operational Definition

**Mental Illness:** Diagnosed mental health problem by a professionals within St. Amanuel Mental Specialized Hospital Addis Ababa.

**Public Stigma:** It is evaluated by Perceived Devaluation and Discrimination Scale (PDD).

**Youth:** Persons between the ages of 18 and 28 years who are outpatient.

**Outpatient:** A patient who is not hospitalized overnight but who visits St. Amanuel Mental Specialized Hospital for treatment.

**Perceived Devaluation and Discrimination Scale (PDD):** It is a 12-item tool which measured on a 4-point Likert scale with possible scores ranging from 1 to 4 agreement scale (4 = strongly agree, 1 = strongly disagree). A higher scores of perceived devaluation and discrimination is indicated by agreement with six of the items and disagreement with six others. Items 1, 2, 3, 4, 8, and 10 are scored in reverse direction. The cut-off score perceived public stigma was defined as an item mean score of 2.5 and higher on the mean aggregated scale score.

**Attitudes toward Seeking Professional Psychological Help Scale - Short Form (ATSPPHS - SF):** It is a 10-items tool which are rated on a 4-point Likert-type scale (3 = Agree, 0 = Disagree), where items 2, 4, 8, 9, and 10 are reverse scored. Scores are then summed together, with higher scores indicating more positive attitudes toward seeking professional help.

## **1.8 Limitations**

Present findings should be considered in light of salient study limitations. First, this analysis relies on data collected from a sample of youths seeking outpatient in St. Amanuel Mental Specialized Hospital thus findings may not be generalizable to the many youth with untreated mental illness, for whom reasons not to seek professional help may be numerous, including highly stigmatizing of mental illness. However, the presence of these youth in treatment may indicate that these youth and families hold differing ideas about mental illness and psychiatric treatment than others in their community. Second, this study tried to examine only perceived public stigma and did not examine structural stigma and self-stigma, which may have their own impact of stigma finding. The third limitation is the measure used in this study. This measure was adapted from another study, which means that the exact meaning of each item may not have been perfectly preserved as it was modified to fit the youth that it targeted. Finally survey studies have natural limits such as not being able to know if respondents are truthful when answering or the possibility that respondents skew toward more socially appropriate answers.

# CHAPTER TWO

## 2. LITERATURE REVIEW

### 2.1 Introduction

This chapter covers review of the literatures associated with impact of social stigma on youth's attitudes to seek mental health. The literature reviews focus on different terminologies (stigma, social stigma and mental health illness) and factors that influence mental health help seeking attitude or attitudes of seeking treatment, and the impact of public stigma among youths attitudes. Furthermore, this chapter also focused on the relevance and role of theory in youths' attitudes of seeking mental health treatment.

### 2.2 Terminologies

#### 2.2.1 Stigma

Goffman (1963) was one of the first to define the construct of stigma stating that stigma is an attribute or perception that involving deeply negative social evaluation that taints, discredits, or leads someone to reject an individual because of stereotypes associated with mental disorder, ethnicity, drug use, or physical disability. Martin et al. (2007) defined stigma as the presence of negative attitudes, and predispositions to exclude others based on their problems. Corrigan (2004) define stigma characterized by a set of negative perceptions, has been indicated as one of the most relevant inhibitors of the search for therapeutic help. There are many other definitions of stigma and for the purpose of this study Martin et al.'s definition was used. Defining stigma as negative attitudes resulting in exclusion of others based on problems is a clear, yet broad, explanation that best aligns with what the current study is seeking to better examine.

### **2.2.2 Mental Health Stigma**

Link and Phelan (2001) explain that stigma happens when differences among people are distinguished and labeled, when certain labeled persons are seen as different, and when those being labeled suffer discrimination or loss of status. Hence, being labeled with a mental illness, in particular, has been related to stigmatization. Mental health stigma involves the negative perceptions and opinions held by others that the person needing psychological help is socially unacceptable (Corrigan 1998; 2004). The increased negativity associated with mental health problems can complicate the youth's ability to recover from, or be resilient to, a mental health problem. Over all mental health concerns have been found to be stigmatized more than any other health issue (Corrigan, 2004). The stigma associated with mental illness can be divided into three types: self-stigma, structural stigma and public stigma (Barnes, 2017).

Self-stigma is an internal evaluation process whereby people judge themselves. This judgment could be a result of messages received from societal norms, but ultimately it is the individual who is creating the judgment toward himself or herself (Stacy and Sondra, 2008). The second is structural stigma, it depicts the tangible barriers created for people who have mental illness. Structural stigma describes a process that works to deny people with a mental illness their entitlement to things that people who are considered "normal" take for granted (Johnstone, 2001). According to Goffman (1963) it is an external evaluation of a person that is based on societal norms. Public stigma is the general public's negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness (Corrigan and Watson, 2007). Therefore this study was examined public stigma.

### **2.2.3 Public Stigma**

Corrigan and Watson (2007) defined public stigma as the general public's reaction toward people with mental health problems, including a negative belief about those with mental health problems. Specifically, the public responds with fear or anger and actively tries to avoid or refuse help to the stigmatized person. Moses (2009) defined public stigma as a sense of powerlessness related to stereotyping, Prejudiced, discrimination, and other negative behaviors from others with and without mental health problems. This study used Moses' (2009) definition of public stigma as it highlights the youths' perception of external assessment.

### **2.2.4 Attitudes to Seek Professional Mental Health Treatment**

Professional mental health treatment include the assessment, diagnosis, treatment, or counseling in a professional relationship to assist an individual or group in improving mental or emotional illness, symptoms, conditions or disorders (Baylor University, 2015). A large European survey using a conservative estimate of need found half of those needing treatment for mental disorders not getting any medical help for their problem (Alonso et al., 2007). Seeking of professional mental health treatment is generally lower in developing than in developed countries (Wang et al., 2007). Help seeking attitudes differs for different mental disorders: people with substance abuse disorders more frequently fail to seek help than those with anxiety or mood disorders (Wang et al., 2005; Wittchen & Jacobi, 2001). Those seeking help often do so after a considerable delay of many years (Wang et al., 2005).

Research has found that the stigma associated with seeking psychological help is negatively correlated with an attitudes to seek these services (Komiya et al., 2000; Vogel et al., 2005; Vogel

et al., 2007). These negative perceptions create fear of and social distance from mentally ill persons (Corrigan et al., 2001).

### **2.3 Theoretical Review**

Link and Phelan (2001) developed the Modified Labeling Theory (MLT) to focus on the self as constructed by others through day-to-day interaction. MLT hypothesizes that an individual given a mental health label is subject to a negative self-concept if that label and its stereotypes are internalized. This theory is a framework that accounts for the effects of stigma associated with devalued labels such as “mentally ill.” MLT indicates that social expectations and judgments related to labeling can have large negative effects.

MLT suggests that rejection from others based on a mental health label or visible behaviors associated with a mental health problem (public stigma) contribute to both self-protective and self-defeating coping strategies. Self-protective factors are thought to be abilities to engage with others in healthy, proactive ways. On the contrary, self-defeating factors are those that limit one’s ability to engage socially, with examples such as: increasing secrecy, disclosure, and withdrawal; feeling or acting less competent and more unpredictable or harmful; and diminished capacity for independent action (Link, 1987).

Also, Etiology and Effects of Stigma (EES) model suggests socio-demographic characteristics of both the person with the mental health problem and those in a position to accept or reject the person with mental health problems shape attributions and evaluations that reflect the non-affected individual’s beliefs about underlying causes, the nature of the problem, possible outcome, and treatment engagement (Martin et al., 2007). For example, the EES model suggests that those

demographically supposed to be of minority status are more likely to have negative labels attached to them and experience rejection from non-affected individuals. However, Moses (2009) found that Caucasian adolescents reported more personal rejection and self-stigma than minority adolescents.

## **2.4 Magnitude of Perceived Public Stigma on Youth's Attitude to Seek Mental Health Treatment**

Hack and Chow (2001), found that stigma is a primary reason for underuse and lack of treatment adherence among youth with mental health problems. Research in the area of public stigma suggests that more than half of adolescents between the ages of 13 and 17 have stigmatizing attitudes about mental health problems (Corrigan & Watson, 2007). The study which conducted in Pakistan found that 49.09% of the participants had perceived stigma of mental illness (Suntan, 2011). It is higher than what was found in studies done in 16 countries of the world which showed that 13.5% of the overall sample had perceived stigma (22.1% in developing countries and 11.7% in developed ones) (Alonso, 2008). It is also lower than what was found in studies performed in Hong Kong (62.7%) (Wong, 2004), 13 European countries (71.6%) (Brohan, 2011), and Southern Ghana (66.11%) (Barke, 2011).

In Ethiopia, study which conducts to examine the Magnitude and Associated Factors of Perceived Stigma among Adults with Mental Illness in Jimma town JUSH Hospital, shows the prevalence of at least one stigma item on the perceived devaluation-discrimination (PDD) scale, was 100% respectively (Etsedingl *et al*, 2019). This study found prevalence of low perceived stigma of 49.2% (mean PDD scale score < 2.5) and prevalence of high perceived stigma of 50.8% (mean

PDD scale score  $\geq 2.5$ ). The current study was addressed youths perceived public stigma related to participating in an outpatient psychiatric program meant to address mental health problems.

## **2.5 Socio-demographic and Economic Associated Factors**

Demographic variables on attitudes to seek psychological services were identified as the primary influence. These factors included sex (Fischer and Turner, 1970), level of education (Jackson, 2013), marital status (Conner, 2010) and ethnicity (Choi and Miller, 2014). Empirical research examining the relationship between gender and attitudes toward help seeking have noted that women tend to report more positive views than men (Gonzalez, 2005). Similarly, the vast majority of Latina women interviewed believed that services would be helpful, whereas men were more likely to have negative attitudes about the effectiveness of treatment (Bridges, 2012). This difference in help-seeking attitudes may help explain the findings that Latina women are three times more likely to seek mental health providers when compared with Latino men (Vega, 2001).

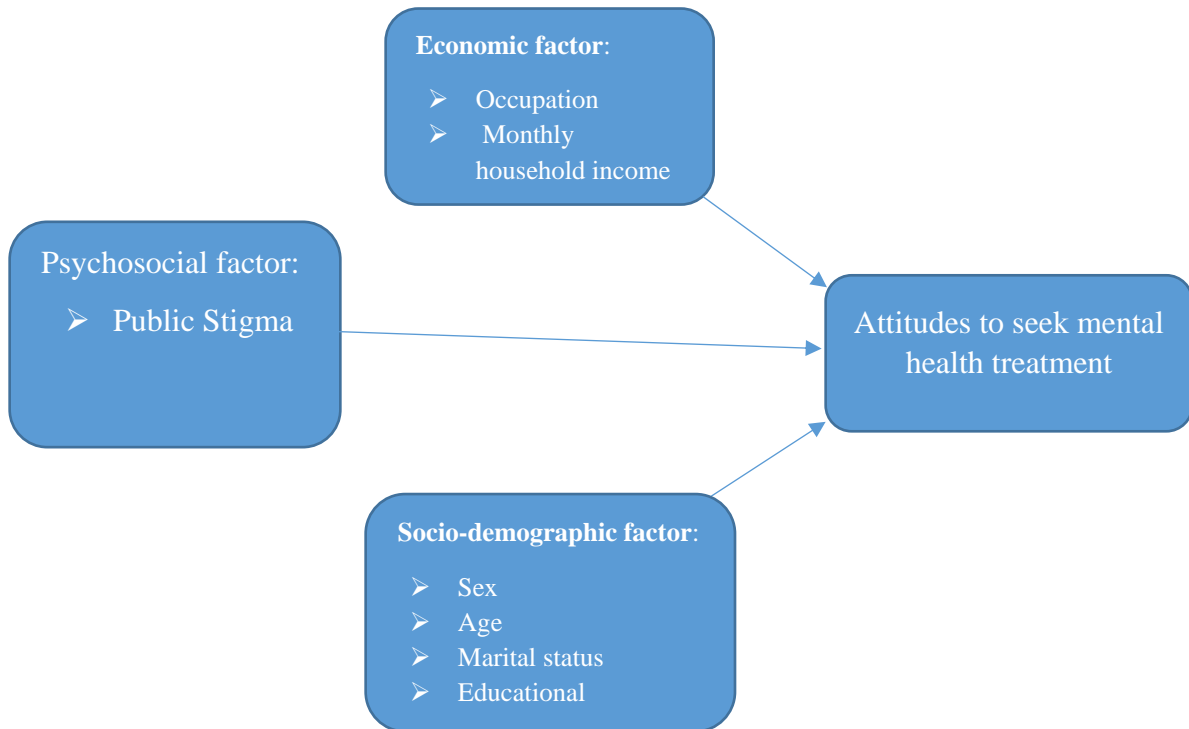
## **2.6 Conceptual Framework**

According to societal reaction theory, psychological factor stigma may lead to labeling and negative societal reaction (Link and Cullen, 1990). As a consequence, stigmatized individuals develop negative attitudes that may include reluctant to professional treatment. Socio-demographic and economic factors, age, education level, and employment status significantly influenced the use of mental health services (Gudmundsdottir, 2010). In addition studies have found that mental health services use differs according to gender; specifically, that women use mental health services more than men (Aromaa, 2011).

Therefore, the aim of this study was to examine the factors that influence youths' attitudes toward seeking mental health treatment at Addis Abeba St. Amanuel Mental Specialized Hospital. Figure

2.1 depicts the conceptual framework for the factors that influence seeking treatment for mental health issues. Thus, the framework displays socio-demographic, economic, and psychological aspects (including public stigma).

**Figure 2.1:** conceptual framework



Source; Adopted by the researcher, 2022.

## 2.7 Summary

The literature review indicates that stigma has an effect on attitudes to seek mental health treatments. Researchers in Ethiopia as well as other countries' attempts have been made to measure the impact of stigma on attitudes to seek mental health treatment from the perspective of unaffected members of society and use qualitative methods to study. The only reported research in Ethiopia, found when reviewing different literatures, which quantitatively examine the impact

of stigma on attitudes to seek mental health treatment in Jimma town and in Mekelle (Etsedingl *et al.*, 2019 and Aradom *et al.*, 2018). But none of them conducted their study specifically on youths with mental health problems and they did not specifically examine social stigma.

Therefore, this study was examined the association of perceived public stigma with attitudes to seek mental health treatment and investigated other factors which associated with youth's attitudes to seek mental health treatments from outpatient youths sampled in Addis Ababa St. Amanuel Mental Specialized Hospital.

# CHAPTER THREE

## 3 RESEARCH METHODS

### 3.1 Research Design

A Hospital-based cross-sectional study was conducted in Addis Ababa St. Amanuel Mental Specialized Hospital. In this study, quantitative data was collected to examine the magnitude of perceived public stigma on youth's attitudes to seek mental health treatment on St. Amanuel Mental Specialized Government Hospital.

### 3.2 Study Area

The study was conducted at St. Amanuel Mental Specialized Hospital which is located in the western part of Addis Ababa in Addis Ketema Sub-city. Addis Ababa is the capital city of Ethiopia and often referred to as "the political capital of Africa" for its historical, diplomatic and political significance for the continent. Addis Ababa is the largest city in the country, with a total population of 3,774,000 (1,992,000 Female Vs 1,782,000 Male) (CSA, 2021). The city is divided into 11 sub-cities and covers 527 square kilometers of area in Ethiopia. The population density was estimated to be near 5,165 individuals per square kilometer (UN World Urbanization Prospects, 2020).

Addis Ababa is located at 9°1'48"N 38°44'24"E. It has an elevation of 2,326 meters above sea level, at the lowest point around Bole International Airport in the southern periphery and it rises to over 3,000 meters above sea level in the Entoto mountains to the north. Addis Ababa has more than 608 health facilities (hospitals, health centers, and private clinics) serving more than three million inhabitants.

St. Amanuel Mental Specialized Hospital is the first and the only mental health-specialized hospital in the city, established in 1938 during the Ethio-Italian war. It is administered under the Federal Ministry of Health and provides treatment services for patients coming with different mental health problems throughout the country. The average number of outpatients per day were 322. The hospital has patient service in the extensive and a total of 361 beds for both women and men inpatient treatment. There are five (5) wards in the hospital namely psychiatric ward (with five case teams), mood ward (with 3 case teams), substance abuse ward, emergency ward, and forensic ward.

### **3.3 Exclusion and Inclusion Criteria**

The total number of outpatients who are on follow-up care for the last 12 months were taken from patient records and then the average number of outpatients per day were calculated. Hence the average number of St. Amanuel Mental Specialized Hospital per day outpatients were 322. From these 10 persons coming to the outpatient clinic aged 18-29 years in each weekday were selected by using a systematic sampling technique to obtain the required numbers of participants. Individuals who are cognitively disabled, had no insight, and unable to speak and hear to give informed consent were excluded from the study.

### **3.4 Sample Size**

To estimate the sample size, the researcher used the prevalence of CMDs in Ethiopia, which was found to be 11.7% in Addis Ababa and 19.3% in Haromaya (Kebede, et al., 1999). Therefore, for this study the sample size was calculated using the prevalence rate of 11.7% to obtain a maximum sample size at 95% certainty,  $\pm 5\%$  error margin and a 5% non-response rate. The sample size (the

eligible number of an outpatient) is calculated using the Cochran's (1977) sample size calculation formula for single population proportion formula,

$$n = \frac{(Z_{\alpha/2})^2}{d^2} [p(1 - p)]$$

Where:  $n$  = sample size,

$Z_{\alpha/2}$  = Critical value at 95% confidence level of certainty (1.96)

$p$  = Life time prevalence of CMD 11.7%, and

$d$  = margin of error between the sample and the population = 5%

$$n = \frac{(Z_{0.05/2})^2}{(0.05)^2} [0.117(1 - 0.117)] = \frac{(1.96)^2}{(0.05)^2} [0.117(1 - 0.117)] = 158.7 + 5\% \text{ non-response rate}$$
$$= 166.6 \approx 167$$

Hence, with these assumptions, the final sample size was 167.

### **3.5 Dependent and Independent Variables of the Study**

The dependent variable for this study is youths' attitudes to seek mental health treatment

The independent variables are:

- I. Psychosocial factor: Public stigma
- II. Socio- demographic: Age, sex, education, marital status and occupation
- III. Economic variables: Monthly household income

### **3.6 Data sources and Measurements**

#### **3.6.1 Data Sources**

Primary and secondary sources of data was used for this study. The primary data was gathered from the outpatient of St. Amanuel Mental Specialized Hospital and the secondary data was

reviewed to strengthen the study. A structured questionnaire was adopted in English and translated into Amharic language by an independent translator and back to English. The validity of language was approved by the advisor. The questionnaire consisted of two parts that assessed outpatient socio-economic demographic and psychosocial factors (perceived public stigma factors).

### **3.6.2 Measurements**

Perceived devaluation-discrimination (PDD) scale used to assess perceived public stigma. The PDD scale is a 12-item tool which measures the extent to which a person believes that most people will devalue or discriminate against someone with a mental health problem. PDD measured on a 4-point Likert scale with possible scores ranging from 1 to 4 on the agreement scale (1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree). A high level of perceived devaluation and discrimination is indicated by agreement with six of the items and disagreement with six others. Items 1, 2, 3, 4, 8, and 10 are scored in reverse direction. The prevalence of high perceived stigma was defined as an item mean score of 2.5 and higher on the mean aggregated scale score. This scale has been widely used across the world including Africa (A. Barke, 2011). Previous work with this measure has shown that the PDD scale has internal consistency of  $\alpha = 0.86$  (Brohan, 2010). In the current study, internal consistency was shown with a Cronbach's  $\alpha = 0.96$ .

Magnitude of youth's attitudes to seek mental health treatment measured by Attitudes toward Seeking Professional Help Scale: Short Form (ATSPHS-SF) which developed by Fischer and Farina (1995). The ATSPHS-SF contains 10 items rated on a 4-point scale (0 = disagree; 3 = agree), with five reverse scored items (items 2, 4, 8, 9, 10 zero = agree and three = disagree). Higher scores indicate a more positive attitude toward seeking psychological help. The total score of the scale ranges from 0 to 30 and cut-off score on the scale is greater than 20 points (Elhai,

2008). Fischer and Farina (1995), provided internal consistency reliability is 0.84. In the current study, internal consistency was shown with a Cronbach's  $\alpha = 0.87$ .

### **3.7 Data Collection Method**

The data was collected by interviewing psychiatric outpatients' about their previous experiences and attitudes on seeking mental health treatment at St. Amanuel Mental Specialized Hospital. Well-trained two psychiatric nurse data collectors were used to collect the data. The investigator make agreement with them to pay 45 Birr for each individual questioner. During data collection one professional with a master's degree in psychiatry was a supervisor and the principal investigator also participated in the supervision. For data collectors and the supervisor one-day training was given by the investigator. The data collection methods, tools, definitions of terms and concepts, how to handle ethical issues, how to fill each part of the questionnaire and how to address problems in the field were discussed with the data collectors.

### **3.8 Data Quality Control**

A pre-test was conduct to check the suitability and simplicity of the questionnaire in Yekatit 12 Hospital on five mental health outpatients'. That was helped to identify potential problems in the proposed procedures, such as administration of data collection tools, and to check the performance of the data collectors. Hence, the finding from pre-test shows the tool is suitable and simple to conduct the main survey and the data collectors are well understand the concept on the tool. Regular supervision and monitoring as well as supporting data collectors by the supervisor and principal investigator was made daily. Each completed questionnaire was edited and the necessary feedback was offered to interviewers the following morning to correct if any error happened. The

collected data was properly reviewed and checked for completeness and consistency by the supervisor and principal investigator daily.

### **3.9 Data Processing and Analysis**

After all necessary data were obtained, the data was checked for completeness, edited and cleaned. The data entry was carried out with SPSS version 22.00. Data was explored to detect inconsistencies, outliers, and missing values. Numeric variables were summarized as mean, standard deviation, minimum and maximum and categorical variables as frequency tables and bar graphs. Furthermore, bivariate analysis was used to identify potential candidate variables for multiple linear regression. For bivariate analysis the researcher used independent t-test, one way ANOVA and Pearson correlation. Then, further analysis was carried out using multiple linear regression to check the association between dependent and independent variables. The result reported as being statistically significant whenever the p-value is less than 0.05.

Multiple linear regressions model was used to test the association between perceived public stigma and youths' attitudes to seek mental health treatment and socio-demographic and economic variables. To evaluate model fit: R-squared, the overall F-test, the Root Mean Square Error and Durbin-Watson was tested in the multiple linear regression analysis. Hence, the result shows that this model is well fitted for this study (Appendix 3).

### **3.10 Rationale to Choose Linear Regressions Model**

According to Gujarati (2004), linear, logit and probit are approaches to develop a probability model for binary response variables. The linear probability model measures the conditional probability of the event Y occurring given X, it must necessarily lie between 0 and 1. Linear

regression models apply when the response variable can be assumed to be a continuous variable or to be normally distributed. Both logit and probit models are quite similar, except that the logistic distribution has slightly fatter tails. They are unlike linear regression, their response variables can be categorical.

The dependent variable for this study is ATSPHS-SF, it is a continuous variable and it has a normal distribution. Therefore by considering the above probability assumptions a linear probability model was used to satisfy this study.

### **3.11 Ethical Consideration**

An official letter was given from School of Social Work of Addis Ababa University to the concerned officials of the St. Amanuel Mental Specialized Hospital to request permission for conducting the research. The study was undertaken after getting ethical approval from St. Amanuel Mental Specialized Hospital Institutional Review Board (IRB). Moreover, before continuing data collection, data collectors got the informed consent of the respondents of the study. Therefore, each respondent was informed about the objective of the study and a written consent was secured from them. Participants had the right to refrain from answering some questions or withdraw from the study process at any time.

To keep the respondents anonymous, their names were not recorded and efforts were made to maintain the privacy and confidentiality of the information provided by the study participants. Considering the COVID-19 pandemic, COVID-19 protocols were kept during data collection.

## CHAPTER FOUR

### 4. RESULTS

#### 4.1 Background Characteristics of the Sample

In a Hospital-based cross-sectional study which was conducted in Addis Ababa St. Amanuel Mental Specialized Hospital, a total of 167 participants were fully participated in the study that made a response rate of 100%. Before examining the magnitude of perceived public stigma on youths' attitudes to seek mental health treatment, the socio-demographic characteristics of the sample are presented in this section.

**Table 4.1:** Background characteristics of the respondents

Characteristics	Categories	Number	Percent
Sex	Male	78	46.7
	Female	89	53.3
Marital Status	Never Married	112	67.1
	Ever Married	55	32.9
Educational Level	Primary Education	35	21
	Secondary Education	91	54.5
	College Education	41	24.6
	Professionals	29	17.4
Occupation	Service and Sales	12	7.2
	Agricultural and Craft Works	18	10.8
	Elementary Occupations	20	12
	Student	59	35.3
	Unemployed	29	17.4
Region	Amhara	28	16.8
	Oromiya	45	26.9
	SNNP	23	13.8
	Addis Ababa	44	26.3
	Harari, Somali and Dire Dawa	27	16.2

Source: Field survey, 2022

Of the total 167 surveyed outpatients, 89 participants were female (53.3%) and 78 were male (46.7%). The marital status of majority participants was found to be never married 112 (67.1%) and ever married were 55 (32.9%). Ninety-one (54.5%) of the participants were completed secondary education. The respective percentages of primary and college are 21.5 and 24.6%. Regarding occupational status, 59 (35.3%) of the participants were students and 29 (17.4%) were professionals and unemployed. Region wise, the largest proportion 45 (26.9%) of the participants were from Oromia, followed by Addis Ababa 44 (26.3%) (Table 4.1).

Overall the data indicates that the majority of respondents are female. They are also never married and their current educational level is completed secondary education and currently student.

**Table 4.2:** Continuous demographic and economic variables

Variables	Mean	S.deviation	Min	Max
Age	21.7	3.2	18	28
Household Income	4349.7	3191.8	1000	15000

Source: Field survey, 2022

The mean monthly household income and standard deviation were (4349.7 Ethiopian birr  $\pm$ 3191.8) with minimum and maximum values of 1000 and 15,000 Ethiopian birr, respectively. The mean age and standard deviation of the participants were 21.7 years ( $\pm$ 3.2 years) with minimum and maximum age 18 and 28, respectively (Table 4.2).

## 4.2 Descriptive Statistics

### 4.2.1 Descriptive Statistics for Attitudes toward Seeking Professional Help

Attitudes toward Seeking Professional Help Scale: Short Form (ATSPHS-SF) items requiring reverse-scoring were coded as such. There was no substantial skewness ( $>1.0$ ) or kurtosis ( $>1.0$ ) in the distribution of ATSPHS-SF scores. Table 4.2 lists the means, standard deviations, minimum and maximum score of items.

The total score of ATSPHS-SF ranged from 7 to 26 and the mean was less than 20 ( $M = 16.1$ ,  $SD = 4.1$ ). That was indicating the overall attitude was negative. Participants were in greatest

agreement on the item “A person should work out his or her own problems; getting psychological counseling would be a last resort” having the highest score ( $M = 1.8, SD = 1$ ) and with the item “Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me” having the lowest score ( $M = 1, SD = 1.1$ ) on reverse scoring.

**Table 4.3: Attitudes towards Seeking Professional Help Scale: Short Form (ATSPHS-SF)**

Items	Mean	S. deviation	Min	Max
Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	1	1.1	0	3
If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	1.3	1	0	3
There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	1.3	0.9	0	3
Personal and emotional troubles, like many things, tend to work out by themselves.	1.3	1	0	3
I would want to get psychological help if I were worried or upset for a long period time.	1.4	1	0	3
A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.	1.4	1	0	3
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	1.6	1	0	3
I might want to have psychological counseling in the future.	1.6	1	0	3
The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	1.7	0.9	0	3
A person should work out his or her own problems; getting psychological counseling would be a last resort.	1.8	1	0	3
*Total score	16.1	4.1	7	26

Source: Field survey, 2022

#### 4.2.2 Descriptive Statistics for Public Stigma

Perceived Devaluation-Discrimination (PDD) Scale items requiring reverse-scoring were coded as such. There was no substantial skewness or kurtosis in the distribution of PDD scores. Table 4.4 shows the means, standard deviations, minimum and maximum score of items.

**Table 4.4: Perceived Devaluation-Discrimination (PDD) Scale**

Items	Mean	S. deviation	Min	Max
Most people in my community would treat a person who has been hospitalized for mental illness just as they would treat anyone.	2.1	0.9	1	4
Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job.	2.2	0.9	1	4
Most people would accept a person who once had a serious mental illness as a close friend.	2.3	0.9	1	4
Most people believe that a person who has been hospitalized for serious mental illness is just as trustworthy as the average citizen.	2.3	0.9	1	4
Most people would accept a person who has made a full recovery from serious mental illness as a teacher of young children in a public school.	2.3	0.9	1	4
Most people believe that a person who has been in a psychiatric hospital is just as intelligent as the average person.	2.4	0.9	1	4
Most young women would be reluctant to date a man who has been hospitalized for a serious mental illness.	2.5	1	1	4
Most people think less of a person who has been in a psychiatric hospital.	2.6	1	1	4
Most employers will pass over the application of a person who has been hospitalized for mental illness in favor of another applicant.	2.6	1	1	4
Most people think that a person who has been hospitalized for serious mental illness is dangerous and unpredictable.	2.6	1	1	4
Most people believe that entering a psychiatric hospital is a sign of personal failure.	2.7	1	1	4
Most people will not hire a person who has been hospitalized for serious mental illness to take care of their children, even if he or she had been well for some time.	2.9	0.9	1	4
*Total score	32.3	9.6	12	48

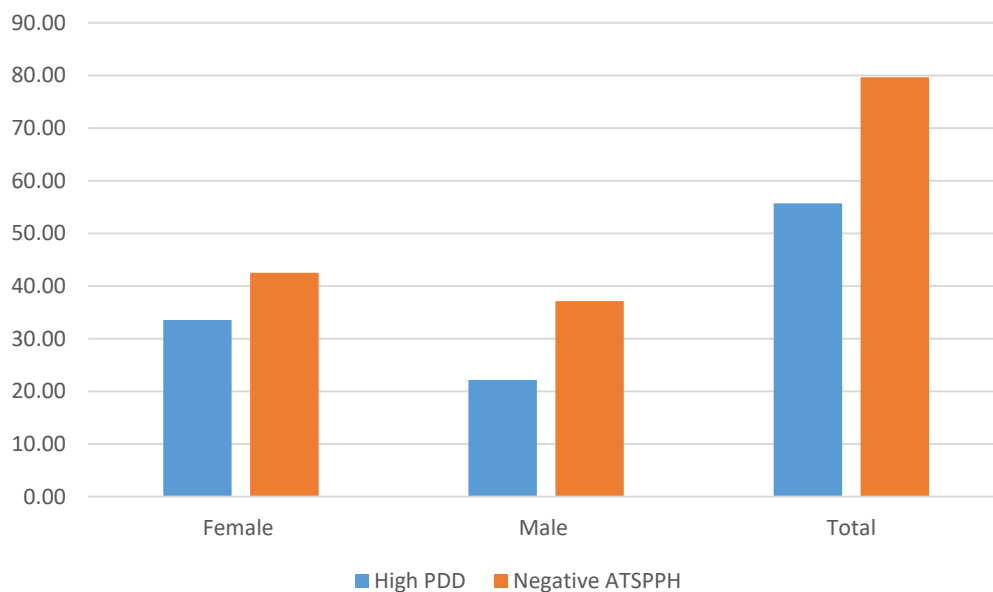
Source: Field survey, 2022

The total score of PDD ranged from 12 to 48 ( $M=32.3$  and  $SD=9.6$ ). That was indicating the overall attitude was negative. Participants were in greatest agreement on the item “Most people will not hire a person who has been hospitalized for serious mental illness to take care of their children, even if he or she had been well for some time” having the highest score ( $M = 2.9$ ,  $SD = 0.9$ ) and with the item “Most people in my community would treat a person who has been hospitalized for mental illness just as they would treat anyone” having the lowest score ( $M = 2.1$ ,  $SD = 0.9$ ) on reverse scoring (Table 4.4).

### 4.3 Magnitude of Public Stigma and Youths’ Attitudes to Seek Treatment

The magnitude of perceived public stigma on youths with mental health problem were measured by perceived devaluation-discrimination (PDD) scale. As shown in figure 4.1 the magnitude of high PDD scale (the mean values revealed that  $\geq 2.5$  points) was 55.7%. Also sex disaggregated prevalence were 33.5% for female and 22.2% for male.

Figure 4.2: Magnitude of public stigma and youths’ attitudes to seek treatment by sex



Source: Field survey, 2022

Besides the magnitude of youths' attitudes to seek mental health treatment measured by attitudes towards seeking professional help scale: short form (ATSPHS-SF), the above figure 4.1 presents the prevalence of negative attitude towards mental health treatment ( $< 2.0\%$  mean values of ATSPHS) was 79.6%. Females' negative attitude was 42.5% and males 37.1%.

#### **4.4 Inferential Statistics**

To understand the relationship between perceived public stigma and youths' attitudes to seek mental health treatment, bivariate and multivariate analysis are carried out. Apart from public stigma, socio-demographic and economic variables are also statistically analyzed. For bivariate analysis the researcher used independent t-test, one way ANOVA and Pearson correlation. For those statistically significant variables at the time of bivariate analysis, a multivariate linear regression model were carried out. The categorical and continuous variables included and analyzed in bivariate statistical test are summarized in Table 4.5 and Table 4.6. In addition, multivariate linear regressions results are summarized in table 4.7.

##### **4.4.1 Bivariate Analysis**

The results of independent t-test and one way ANOVA-test indicated that there were significant differences in sex, marital status, education level and occupation related to youths' attitudes to seek mental health treatment. The study showed that females mean value were found higher than the male counterpart ( $M = 17.07$ ,  $SD = 4.39$ ), and the overall respondents sex has significant differences related to youths' attitudes to seek mental health treatment ( $t = -3.46$ ,  $P = 0.001$ ) (Table, 4.5).

Regarding respondents' current living regions, Oromiya and Addis Ababa have higher mean values ( $M= 16.38$ ,  $SD= 4.57$  and  $M=16.09$ ,  $SD= 3.34$ ), than the rest of respondents' regions. But there were no significant differences on attitudes to seek mental health treatment ( $F=1.113$ ,  $P=0.344$ ) (Table, 4.5).

As can be shown in table 4.5, occupation has a significant difference with youths' attitudes to seek mental health treatment ( $F=4.65$ ,  $P=0.001$ ). While the higher mean value is for professional occupation and the lower for elementary occupations ( $M= 19.1$ ,  $SD= 3.69$  and  $M= 14.85$ ,  $SD= 4.07$ ), respectively.

Table 4.5: Bivariate comparison of the ATSPH-SF scores by socio-demographic characteristics

Characteristics	Number	Mean	Std. Deviation	t	F	df	P-value
<b>Sex</b>				-3.46		1	0.001*
Male	78	14.95	3.35				
Female	89	17.07	4.39				
<b>Marital Status</b>				4.31		1	0.000*
Never Married	112	16.98	3.67				
Ever Married	55	14.24	4.25				
<b>Educational Level</b>					14.06	2	0.000*
Primary Education	35	13.63	2.95				
Secondary Education	91	16.04	4.11				
College Education	41	18.24	3.07				
<b>Occupation</b>					4.65	5	0.001*
Professionals	29	19.1	3.69				
Service and Sales	12	14.67	4.62				
Agricultural and Craft Works	18	15.89	5.06				
Elementary Occupations	20	14.85	4.07				
Student	59	15.41	3.41				
Unemployed	29	15.97	3.59				
<b>Region</b>					1.13	4	0.344
Amhara	28	14.68	4.41				
Oromiya	45	16.38	4.57				
SNNP	23	16.3	4.76				
Addis Ababa	44	16.09	3.21				
Harari, Somali and Dire Dawa	27	16.81	3.34				

Source: Field survey, 2022

**NB:** M= mean; SD= standard deviation; t= independent sample t-test; F= ANOVA-test; df= degree of freedom and \* indicate the level of significance at 5%.

Table 4.6 shows that perceived public stigma and age correlated to help-seeking attitude. Of these, age were positively correlated to youths' attitudes to seek mental health treatment. In addition, perceived public stigma was negatively related to help-seeking attitude. Therefore, as they age increases, they have good attitudes toward seeking professional psychological treatment. Additionally, those who have experienced public stigma are less likely to seek out professional psychological help.

Table 4.6: Bivariate comparison of the ATSPHS-SF scores by continuous variables

Variables	Mean	Std. Deviation	Min	Max	Correlation coefficient	P-value
Age	21.7	3.2	18	28	0.211	0.006
Household Income	4349.7	3191.8	1000	15000	-0.021	0.792
PDD	32.3	9.6	12	48	-0.675	0.000

Source: Field survey, 2022

#### 4.4.2 Multiple Analysis and Interpretation

Table 4.7 presents the comparison of youths' attitudes to seek mental health treatment by dummy socio-demographic and continuous variables. The results of multiple linear regression indicated that there were significant relationship in marital status, education level, occupation and perceived public stigma related to seeking professional psychological help. Marital status and perceived public stigma was negatively related with youths' attitudes to seek mental health treatment.

The result revealed that those who were ever married has negative attitude towards seeking professional psychological help (B=-0.235; 95%CI: -3.454, -0.605) as compared to never married. Which means people who have ever married are less likely seek professional psychological help than those never married. In addition, participants who were completed secondary education has positive relation to seeking professional psychological help (B=0.310; 95%CI: 0.256, 4.797) and they are more likely seeking professional psychological help than who were completed primary education. Professional and elementary occupation type were found positive significant factor that related to seeking professional psychological help as compared to student (B= 0.300; 95%CI: 0.720, 5.715 and B= 0.194; 95%CI: 0.218, 4.626), respectively. Also, those who experiencing public stigma has negative attitude towards seeking professional psychological help (B=-0.609; 95%CI: -0.328, -0.189) (Table 4.7). Therefore, as bivariate analysis, also in multiple analysis, those who have experienced public stigma are less likely to seek out professional psychological help.

As can be shown in table 4.7, participants who were currently living in any region and sex of respondents has no statistical significant relation to seeking professional psychological help.

**Table 4.7: Multiple Analysis**

Variables	Youths' attitudes to seek mental health treatment		
	Coefficient (B)	95%CI	P-value
<b>Sex</b>			
Male	1.00	-	-
Female	0.045	(-0.704, 1.441)	0.499
<b>Marital Status</b>			
Never Married	1.00	-	-
Ever Married	-0.235	(-3.454, -0.605)	0.006*
<b>Educational Level</b>			
Primary	0.215	(-0.646- 4.930)	0.131
Secondary	0.310	(0.256- 4 .797)	0.029*
College	1.00	-	-
<b>Occupation</b>			
Students	1.00	-	-
Unemployed	0.098	(-0.564-2.668)	0.200
Professionals	0.300	(0.720- 5.715)	0.012*
Service and Market Sales Workers	0.048	(-1.512- 3.036)	0.509
Agricultural and Craft Works	0.116	(-0.760-3.791)	0.190
Elementary Occupations	0.194	(0.218- 4.626)	0.031*
<b>Region</b>			
Addis Ababa	1.00	-	-
Amhara	-0.011	(-1.859-1.628)	0.896
Oromiya	-0.015	(-1.466-1.201)	0.844
SNNP	0.018	(-1.559-1.991)	0.811
Harari, Somali and Dire Dawa	0.054	(-0.950- 2.149)	0.446
<b>Age</b>	0.076	(-0.148- 0.343)	0.433
<b>HH Monthly Income</b>	-0.105	(000- 000)	0.112
<b>Public Stigma</b>	-0.609	(-0.328- (-0.189))	0.000*

Source: field survey, 2022

**NB:** \* indicate the level of significance at 5%.

## CHAPTER FIVE

### 5. DISCUSSION

#### 5.1 Magnitude of Public Stigma and Youths' Attitudes to Seek Treatment

In this study, the highest magnitude of perceived public stigma was 55.7%. This finding is higher than the study which conducted in Pakistan found that 49.09% of the participants had perceived stigma of mental illness (Suntan, 2011). Also it is higher than what was found in a study performed at Jimma University Specialized Hospital (JUSH) which found to be 50.8% of the participants had perceived public stigma of mental illness (Hadera *et al*, 2019). It is also lower when compared with the study carried out at Amanuel Mental Specialized Hospital on perceived stigma and associated factors among people with schizophrenia that constituted for 83.5% (Berhanu and Berihun, 2014).

This variation may be due to study year (time change) and people with different mental health problem perception on stigma level. Also, the variation could be due to the differences in sample size, the population surveyed in the setting, method of data collection, and ant-stigma interventions program.

Thus, on this study the overall magnitude of negative attitude towards mental health treatment was found to be 79.6%. The total score of ATSPHS-SF mean value was less than 20 ( $M = 14.5$ ,  $SD = 3.2$ ) indicating that overall attitude was negative. This finding is in line with previous study which has found in a study conducted in China that found the total score of ATSPHS-SF mean value was less than 20 ( $M = 18.13$ ,  $SD = 5.63$ ) indicating a negative attitude (Pan Chen, 2020).

#### 5.2 Associated Factors in Bivariate and Multiple Analysis

This study aimed at determining the role of public stigma and socio-demographic and economic factors associated with psychological help-seeking in predicting attitudes toward psychological help-seeking. Therefore, bivariate statistical test and multiple linear regression models were carried out to examine the relationship of public stigma and socio-demographic and economic factors with youths' attitudes to seek mental health treatment.

### 5.2.1 Association with Public Stigma

Notably, the study depicted that perceived public stigma has statistically significant association with help-seeking attitude in bivariate and multiple analysis at one percent level of significance. On the other hand, this perceived public stigma negatively associated with the psychological help seeking attitude. The result of the study indicates that individuals who were faced high public stigma have more negative attitude towards help-seeking. Similarly, (Hack and Chow, 2001), found that stigma is a primary reason for underuse and lack of treatment adherence among youth with mental health problems.

Also, this result is consistent with previous research findings. For instance, the study conducted to understand gender, self-stigma, and public stigma in predicting attitudes toward psychological help-seeking (Topkaya, 2014) showed that, there was a significant negative correlation between attitudes toward psychological help-seeking and the public stigma. Additionally, study conducted in China showed public stigma were negatively significantly associated with value and need in seeking professional help (Pan Chen, 2020). Contrary to this study, findings that examined the relationship between attitudes toward the treatment of mental disorders and both the self-stigma and public stigma associated with psychological help-seeking demonstrated that no significant relation was observed between public stigma and psychological help-seeking (Conner, 2008).

### 5.2.2 Association with Socio-demographic Factors

Regarding the associated demographic factors, this study found participants' sex had statistically significant association in bivariate analysis. These results were consistent with the previous study (Topkaya, 2014). Elsewhere in the globe, sex of participants reported as associated factors with help-seeking attitudes (Conner KQ, 2010). Interestingly, in multiple analysis of this study, sex of respondents has no statistically significant association. Similarly, Louisa Picco (2016), in multivariate analysis found there was no gender differences in relation to attitude towards seeking psychological help.

Contrary to these findings, studies have shown sex was significantly associated with seeking professional help for emotional problems in multiple analysis (Pan Chen, 2020). Also, another

empirical research that examined the relationship between gender and attitudes toward help seeking has noted that women tend to report more positive views than men (Gonzalez, 2005). Similarly, the vast majority of Latina women interviewed believed that services would be helpful, whereas men were more likely to have negative attitudes about the effectiveness of treatment (Bridges, 2012). Given these inconsistencies, there is a need to further explore for male attitude to seeking psychological help in general.

Marital status has been shown to be a significant predictor of ATSPHS in both bivariate and multiple analysis. In this study, outpatients who are ever married have negative relation towards youths' attitudes to seek mental health treatment, as compared to the never married ones. Consistent to this, other studies have found that those who were never married were more likely open to seeking professional help (Picco, 2016).

From associated factors, participants who completed secondary education were more likely willing to seeking psychological help. Similar to this, other study found lower education was associated with less attitudes to seeking psychological professional help (Picco, 2016). This suggests that, the respondents who completed higher education viewed psychological help-seeking more favorably, which can be understood as they have greater knowledge of psychological help-seeking options and the associated benefits of such treatments.

Participants who engaged in professional and elementary occupation were more likely willing to psychological help-seeking as compared to students. Consistent to this, other study also showed that employed individuals are more likely willing to psychological help seeking (Pan Chen, 2020). Employed participants (professional and elementary occupation workers) have more opportunities for communication and interaction with others in their work setting, this might solve problems more effectively and have a greater sense of self-worth. Thus, they are more open to seek mental health professionals when encountering psychological problems. In addition, having a source of income also provides financial support to facilitate help-seeking actions.

In bivariate analysis, participants in this study had an increasingly negative attitude toward youths' attitudes to seek mental health treatment with increasing age. While a person's age is increasing, he/she might incline to seek help from family or friends rather than professionals (Picco, 2016). Consistent to this study, other study depicted that an increasingly negative attitude

towards seeking professional psychological help increasing along with age (Pan Chen, 2020). The recent research has shown that age related differences in help-seeking attitudes are inconsistent (Picco, 2016). Contrary to this, other studies have shown that when age is increasing, attitude towards seeking help is also increasing (Robb et al., 2003). Given these inconsistencies, there is a need to further explore the impact of age on help-seeking attitudes in general.

# CHAPTER SIX

## 6. CONCLUSION AND IMPLICATIONS

### 6.1 Conclusion

This study investigated the magnitude of perceived public stigma on youths' attitudes to seek mental health treatment and examined other factors associated with youth's attitudes to seek mental health treatments from outpatient youths sampled in Addis Ababa St. Amanuel Mental Specialized Hospital. For successful completion of this study, a community based cross sectional study was conducted on 167 outpatients. The study assessed, the magnitude of perceived public stigma by using perceived devaluation-discrimination (PDD) scale measurement. That was revealed 55.7% of the total 167 outpatients participated in the survey. Also the magnitude of youths' attitudes to seek mental health treatment were measured by attitudes toward seeking professional help Scale: short form (ATSPHS-SF). That revealed negative attitude towards mental health treatment was found to be 79.6% of the total 167 outpatients participating in the survey. In addition, this study investigated if there is difference regarding youths' attitudes to seek mental health treatments by socio-demographic and economic factors.

Notably, the study depicted that perceived public stigma has statistically significant negative relation with youths' attitudes to seek mental health treatments in bivariate and multivariate analysis at one percent level of significance. This indicates that individuals who were faced with high public stigma have a more negative attitude towards help-seeking.

Also, the results of bivariate (independent t-test, one way ANOVA-test and Person correlation) indicated that there were significant differences in sex, age, marital status, education level and occupation related to youths' attitudes to seek mental health treatment. In multivariate linear regression, outpatients that were complete secondary education and engaged in professional and elementary occupation have positive relation with youths' attitudes to seek mental health treatment. However, the result reveals that participants who were married or separated had a negative relation with attitudes to seek mental health treatment. Generally, the magnitude of perceived public stigma on youths' attitudes to seek mental health treatment in the study setting was found high that coupled with association explanatory variables.

## 6.2 Implications

The findings of this study have a number of implications for social work practice, for future research and for policy makers or planners.

### I. For social work practice

Present finding indicates youth outpatients' perceived public stigma subsequently led to negative attitudes toward mental health treatment. Therefore, it might be helpful for social work practitioners' to focus on public stigma when working with youth with mental health problems to reduce barriers to seeking mental health treatment. In addition, there is a need to strengthen education and training of mental health professionals to promote greater confidence between those who seek treatment and the providers. This study also has important implications in terms of service planning and increasing utilization.

### II. For Future Research

This study indicated apart from perceived public stigma, various socio-demographic variables are correlates related to youths' attitudes to seek mental health treatment including age, sex, marital status, education and occupation. Therefore this study contributes to the literature on attitudes to seek mental health treatment as the significant interaction of perceived public stigma in explaining the variation in help-seeking attitudes.

Future studies could continue to include other measures of stigma in order to know the role of help-seeking attitudes. Also, future studies could focus on repeating the results of this study to verify that the findings are generalizable across different samples. In addition, researchers could conduct a longitudinal study that tracks individuals' psychological distress levels, public stigma and attitudes toward seeking help over time.

To expand on the findings presented in this paper, future studies could look to apply other multiple regression models to determine the amount of association accounted for by public stigma with regard to their influence on participant's attitudes toward seeking psychological services.

### III. For policy makers or planners

Government programs focused on mental health education and awareness of the community should be expanded to close the gap between different among socio-demographic characteristics of the people. Outreach programs, like public-wide discussions about public stigma, could also challenge the stigmatizing beliefs around mental health help-seeking among youths. In addition, based on the current findings, it is important to consider methods to promote better help-seeking attitudes in the general public by eliminating public stigma associated with mental health problems and educating the public about the importance of mental health treatment. The focus of these efforts should be centered on youths. Emphasis should be placed on the use of social media channels to spread relevant information to increase mental health literacy.

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## APPENDIX

### 1. Reliability

**Reliability Statistics**

Cronbach's Alpha	N of Items
.961	12

**Reliability Statistics**

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.874	.874	10

### 2. Skewness and Kurtosis

**Statistics**

		RPPD	RATSPPH
N	Valid	167	167
	Missing	0	0
Skewness		-.017	.013
Std. Error of Skewness		.188	.188
Kurtosis		-.727	-.555
Std. Error of Kurtosis		.374	.374

### 3. Model Summary

**Model Summary<sup>b</sup>**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.725 <sup>a</sup>	.526	.475	2.949	1.962

**ANOVA<sup>a</sup>**

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1445.433	16	90.340	10.387	.000 <sup>b</sup>
	Residual	1304.555	150	8.697		
	Total	2749.988	166			

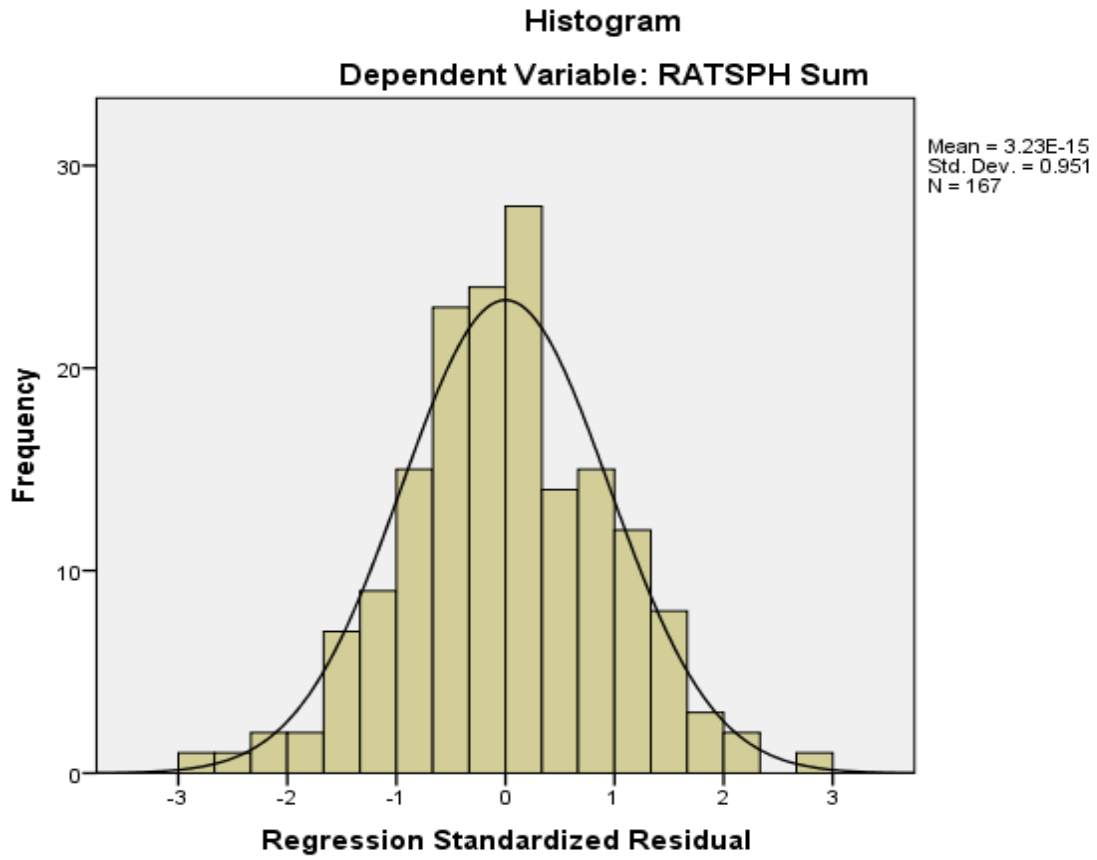
#### 4. Multivariate Linear Regression

**Coefficients<sup>a</sup>**

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
1 (Constant)	20.209	3.170		6.376	.000	13.947	26.472
Primary Education	2.142	1.411	.215	1.518	.131	-.646	4.930
Secondary Education	2.526	1.149	.310	2.198	.029	.256	4.797
M_Status_new=Married & Separated	-2.030	.721	-.235	-2.816	.006	-3.454	-.605
Occupation_new=Professionals	3.218	1.264	.300	2.545	.012	.720	5.715
Occupation_new=Service & Sales	.762	1.151	.048	.662	.509	-1.512	3.036
Occupation_new=Agriculture & Craft Worker	1.516	1.152	.116	1.316	.190	-.760	3.791
Occupation_new=Elementary Occupation	2.422	1.115	.194	2.172	.031	.218	4.626
Occupation_new=Unemployed	1.052	.818	.098	1.286	.200	-.564	2.668
Region_new=Amhara	-.115	.882	-.011	-.131	.896	-1.859	1.628
Region_new=Oromiya	-.133	.675	-.015	-.197	.844	-1.466	1.201
Region_new=SNNP	.216	.898	.018	.240	.811	-1.559	1.991
Region_new=Harari, Somali & Dire Dawa	.599	.784	.054	.765	.446	-.950	2.149
Sex_new=Female	.368	.543	.045	.678	.499	-.704	1.441
Age	.098	.124	.076	.786	.433	-.148	.343
HH monthly income	.000	.000	-.105	-1.599	.112	.000	.000
RPPD Sum	-.258	.035	-.609	-7.357	.000	-.328	-.189

a. Dependent Variable: RATSPH Sum

## 5. Histogram



## 6. Correlations

**Correlations**

		RATSPH Sum	RPPD Sum	Sex new	Region	Occupation	Marital status	Educational Level
RATSPH Sum	Pearson Correlation	1	-.675**	.260**	.114	-.232**	-.318**	.382**
	Sig. (2-tailed)		.000	.001	.142	.003	.000	.000
	N	167	167	167	167	167	167	167
RPPD Sum	Pearson Correlation	-.675**	1	-.380**	-.167*	.266**	.316**	-.622**
	Sig. (2-tailed)	.000		.000	.031	.001	.000	.000
	N	167	167	167	167	167	167	167
Sex new	Pearson Correlation	.260**	-.380**	1	.041	-.129	-.110	.299**
	Sig. (2-tailed)	.001	.000		.603	.097	.157	.000
	N	167	167	167	167	167	167	167
Region	Pearson Correlation	.114	-.167*	.041	1	-.110	-.225**	.373**
	Sig. (2-tailed)	.142	.031	.603		.158	.003	.000
	N	167	167	167	167	167	167	167
Occupation	Pearson Correlation	-.232**	.266**	-.129	-.110	1	-.199**	-.347**
	Sig. (2-tailed)	.003	.001	.097	.158		.010	.000
	N	167	167	167	167	167	167	167
Marital status	Pearson Correlation	-.318**	.316**	-.110	-.225**	-.199**	1	-.208**
	Sig. (2-tailed)	.000	.000	.157	.003	.010		.007
	N	167	167	167	167	167	167	167
Educational Level	Pearson Correlation	.382**	-.622**	.299**	.373**	-.347**	-.208**	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.007	
	N	167	167	167	167	167	167	167

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

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

## Questionnaire

### I, ENGLISH VERSION OF QUESTIONNAIRE

#### **Informed Consent to Participate in a Research Study**

My name is ----- and I am conducting a study as part of the requirements for the Preparation of **Thesis for Degree of Master of Art in Social Work** which I am attending at Addis Ababa University. The purpose of this letter is to invite you to be a participant in my study and to provide you with the information that you need to consider in deciding whether or not to participate.

This study aims to examine Impact of Public Stigma on Youths' Attitudes to Seek Mental Health Treatment. Once you have finished listen to this information, and if you are willing to take part in the study, you will be interviewed to complete the questionnaire, this should take between 25 and 30 minutes. At the beginning of the questionnaire, you will be interviewed for some socio-demographic and economic information (age, gender, occupation etc.) and proceed to stigma related questions.

The study has been planned in a way which ensures that you are not put at risk in any way. The questionnaire also ensures that no discomfort or distress is caused during or after participation. Regardless of how you provide your answers to the questionnaire, your data will be treated with the utmost confidentiality throughout the study.

If you complete the interview your data will be wholly anonymous – your identity cannot be revealed. You will, however, have a unique code assigned to you and you can withdraw from the study should you subsequently wish to do so. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

The interview will be stored safely on a password-protected private computer and any hard copies of questionnaires will be stored in locked filing cabinets and fired after the data entry process completion. You are not obliged to take part in this study and should not feel coerced.

Please feel free to ask me any questions. If you are happy to continue we can proceed. If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor:

Lamirot Abera

School of Social Work, College of Social Science, Addis Ababa University

Email address: [lamirotabera@gmail.com](mailto:lamirotabera@gmail.com)

Phone No\_ +251913906717

Thank you in anticipation.

**Section 1: Identification Information**

Participant's ID: \_\_\_\_\_

Researcher's Name: Lamiroto Abera

Name and signature of data collector

Date of interview \_\_\_\_\_

Checked by supervisor name and signature \_\_\_\_\_

Checked by investigator Lamiroto Abera , signature and date \_\_\_\_\_

Questionnaire number \_\_\_\_\_

## Section 2: Socio-Economic and Demographic Characteristics

No	Description	Codes/values
1	Sex	0=male 1=female
2	Age	-----
3.	Marital status	1= never married      2= married 3=separated            4= divorced 5=widowed              6= co-habiting
4.	Can you read and write?	1= Yes    0= No
5.	What is the highest level of education completed?	1= less than primary 2=Primary education 3=Secondary education 4=college education
6.	The main occupation	1= Legislators, Senior Officials and Managers 2= Professionals 3= Technician and Associate Professionals 4= Clerks 5= Service Workers and Shop and Market Sales Workers 6= Skilled Agricultural and Fisher Work 7= Craft and Related Trade Works 8= Plant And Machine Operators and Assemblers 9= Elementary Occupations 10= Student 11= unemployed 12= Other (Specify)
7.	Monthly income of household	_____
8.	Place of origins (region)	1= Affar 2= Tgiray 3= Amhara 4= Oromiya 5= Somali 6= Benshangul-Gumuz 7= SNNP 8= Sidama 9= Gambela 10= Harari 11= Addis Ababa 12= Dire Dawa

### Section 3: Perceived Devaluation-Discrimination (PDD) Scale

Please rate your previous experiences and attitudes on seeking mental health treatment by agreement with the following statements on a scale from 1 to 4, where “1” means you strongly disagree, “2” means you disagree, “3” means you agree, and “4” means you strongly agree. So please listen each statement carefully, then choice the number that best expresses your feeling.

	1	2	3	4
1. Most people would accept a person who once had a serious mental illness as a close friend.				
2. Most people believe that a person who has been in a psychiatric hospital is just as intelligent as the average person.				
3. Most people believe that a person who has been hospitalized for serious mental illness is just as trustworthy as the average citizen.				
4. Most people would accept a person who has made a full recovery from serious mental illness as a teacher of young children in a public school.				
5. Most people believe that entering a psychiatric hospital is a sign of personal failure.				
6. Most people will not hire a person who has been hospitalized for serious mental illness to take care of their children, even if he or she had been well for some time.				
7. Most people think less of a person who has been in a psychiatric hospital.				
8. Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job.				
9. Most employers will pass over the application of a person who has been hospitalized for mental illness in favor of another applicant.				
10. Most people in my community would treat a person who has been hospitalized for mental illness just as they would treat anyone.				
11. Most young women would be reluctant to date a man who has been hospitalized for a serious mental illness.				
12. Most people think that a person who has been hospitalized for serious mental illness is dangerous and unpredictable.				

## Section 4: Attitudes Toward Seeking Professional Help Scale: Short

### Form (ATSPHS-SF) Scale

Please listen each statement carefully and respond to each item by indicating your previous experiences and attitudes on seeking mental health treatment agreement, partial agreement, partial disagreement, or disagreement. There are no “wrong” answers. Please respond using the following rating scale: 0 = Disagree; 1= Partly Disagree; 2 = Partly Agree; 3= Agree

	0	1	2	3
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.				
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.				
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.				
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.				
5. I would want to get psychological help if I were worried or upset for a long period time.				
6. I might want to have psychological counseling in the future.				
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.				
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.				
9. A person should work out his or her own problems; getting psychological counseling would be a last resort.				
10. Personal and emotional troubles, like many things, tend to work out by themselves.				

# መጠይቅ

## II. የአማርኛ ትርጉም መጠይቅ

### በጥናታዊ ምርምር ለመሳተፍ የቀረበ በመረጃ የተደገፈ የስምምነት ውል

ስሜ----- ይባላል። በአዲስ አበባ ዩኒቨርሲቲ ሁለተኛ ዲግሪ የሶሻል ዎርክ ተማሪ ስሆን ይህ የማካሂደው ጥናት ለመመረቂያ ጽሁፍ ዝግጅት የሚያገለግል ነው። ስለሆነም በእኔ ጥናት ተሳታፊ እንዲሆኑ እየጋበዘኩኝ ይህን ደብዳቤ የማነብልዎት በፈቀደኝነት እንዲሳተፉ ለመግለጽ ነው።

የዚህ ጥናት ዓላማ ወጣቶች የአዕምሮ ህመም ህክምና ለማግኘት ባላቸው ፍላጎት ዙሪያ የሚኖረውን የህብረተሰቡ ጥሩ ያልሆነ አመለካከት ለመፈተሽ ነው። አሁን የማነብልዎትን ካዳመጡ በኋላ በጥናቱ ለመሳተፍ ፈቃደኛ ከሆኑ ከ25 እስከ 30 ደቂቃ ቃለ መጠይቅ አደርግልዎታለሁ። በቃለ መጠይቁ መግቢያ አካባቢ የሚጠየቁት ማህበራዊ፣ ኢኮኖሚያዊና ስነ-ህዝባዊ መረጃዎች ለምሳሌ ዕድሜ፣ ፆታ፣ ሥራ የመሳሰሉትንና በመቀጠል ደግሞ ህብረተሰቡ ለአዕምሮ ህመም ያለውን መልካም ያልሆነ አመለካከትን በተመለከተ ይሆናል።

በጥናቱ በሚሳተፉበት ወቅትም ሆነ ከዛ በኋላ ጥናት በምንም ዓይነት ሁኔታ የእርስዎን ደህንነት አደጋ ላይ በማይጥል መልኩ የታቀደ ሲሆን መጠይቁም ደግሞ ምቹትዎንና ስሜትዎን የማይረብሽ ነው። ጥናቱ ተጀምሮ እስኪያል ድረስ የሰጡት መረጃ ምስጢራዊነቱ የተጠበቀ ነው። ቃለ መጠይቁን ሙሉ በሙሉ ካጠናቀቁ ስምዎም ሆነ ማንነትዎ ለማንም አካል ግልጽ አይደረግም።

ምንም እንኳን ለእርስዎ ብቻ የተሰጠ መለያ ኮድ ቢኖርም ቃለ መጠይቁን ማቋረጥ በሚፈልጉበት ጊዜ ምንም ዓይነት ምክንያት ማቅረብ ሳይጠበቅብዎ ማቋረጥ ይችላሉ።

ይህ ቃለ መጠይቅ የይለፍ ቃል (ፓስዎርድ) ባለው የግል ኮምፒዩተር ውስጥ በጥንቃቄ የሚቀመጥና መረጃ የተሞላባቸው ቅጾችም ቁልፍ ባለው ሳጥን ውስጥ የሚቆዩ ይሆናል። መረጃ ወደ ኮምፒዩተር የማስገባት ስራ ከተጠናቀቀ በኋላ መረጃ የተሞላባቸው ቅጾች በእሳት ይቃጠላሉ።

በዚህ ጥናት ለመሳተፍ ፈቃደኛ እስካልሆኑ ድረስ በፍጹም አይገደዱም። ማንኛውም ዓይነት ጥያቄ ካለ በነጻነት መጠየቅ ይችላሉ። ቃለ መጠይቁን ለመጀመር ፈቃደኛ ከሆነ ጥያቄዎችን አቀርብልዎታለሁ። በተጨማሪ ስለጥናቱ ግልጽ ያልሆኑ ነገሮች ካሉ ደግሞ ከዚህ በታች ባለው አድራሻ የጥናቱን ተቆጣጣሪ ማግኘት ይችላሉ።

ላምሮት አበራ

የሶሻል ዎርክ ትምህርት ክፍል፣ በማህበራዊ ሳይንስ ኮሌጅ አዲስ አበባ ዩኒቨርሲቲ

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አመሰግናለሁ

## ክፍል 1: የመለያ መረጃ

የተሳታፊው መለያ: \_\_\_\_\_

የተመራማሪ ስም: ላምሮት አበራ

የመረጃ ሰብሳቢ ስምና ፊርማ \_\_\_\_\_

ቃለ መጠይቁ የተደረገበት ቀን: \_\_\_\_\_

የተቆጣጣሪ ስምና ፊርማ: \_\_\_\_\_

ተመራማሪ ላምሮት አበራ፣ ፊርማና ቀን: \_\_\_\_\_

መጠይቅ ቁጥር: \_\_\_\_\_

**ክፍል 2: ማህበረ-ኢኮኖሚያዊና ስነ-ህዝባዊ ባህሪያት**

ቁጥር	መግለጫ	ኮዶች
1	ፆታ	1= ወንድ 0= ሴት
2	ዕድሜ	-----
3.	የጋብቻ ሁኔታ	1= አግብተው የማያውቁ 2= ያገቡ 3= የተለያዩ 4= የተፋቱ 5= የሞተበት/የሞተባት 6= እንደባልና ሚስት አብረው የሚኖሩ
4.	ማንበብና መጻፍ ይችላሉ?	1= አዎን 0= የለም
5.	ያጠናቀቁት ከፍተኛ ክፍል ስንት ነው?	1= ከአንደኛ ደረጃ በታች 2= አንደኛ ደረጃ ትምህርት 3= ሁለተኛ ደረጃ ትምህርት 4= የኮሌጅ ትምህርት
6.	ዋና ስራዎ ምንድን ነው	1= ዋና ስራ አስፈጻሚዎች 2= ፕሮፌሽናሎች 3= ቴክኒሻያኖችና ተባባሪ ፕሮፌሽናሎች 4= የጽህፈትና ተመሳሳይ ሠራተኞች 5= አገልግሎትና ሽያጭ ሠራተኞች 6= የግብርና፣ ደንና አሳ ሀብት ዕውቀት ያላቸው ሰራተኞች 7= የዕደጥበብና ተመሳሳይ ንግድ ሠራተኞች 8= ማምረቻ መሳሪያዎች አፕራተሮችና ገጣጣሚዎች 9= ዝቅተኛ የስራ ዓይነቶች 10= ተማሪ 11= ምንም ዓይነት ስራ የሌለው 12= ሌላ ይገለጽ
7.	የቤተሰቡ ወራዊ ገቢ	_____
8.	የትውልድ አካባቢ/ክልል	1= አፋር 2= ትግራይ 3= አማራ 4= ኦሮሚያ 5= ሶማሌ 6= ቤኒሻንጉል ጉሙዝ 7= ደ/ብ/ብ/ሀ 8= ሰላማ 9= ጋምቤላ 10= ሐረሪ 11= አዲስ አበባ 12= ድሬዳዋ

ክፍል 3፡ አምነው የተቀበሉት/የተገነዘቡት/የታወቀ ዝቅ የማድረግ የአድሎ ደረጃ

እባክዎ ቀጥሎ ባሉት ሀሳቦች የእርስዎን የመስማማት ደረጃ ከ1 እስከ 4 ባሉት ደረጃዎች በመለካት ይግለፁ። እነሱም 1፣ በጣም አልስማማም 2፣ አልስማማም 3፣ እስማማለሁ 4፣ በጣም እስማማለሁ ናቸው። ስለዚህም እባክዎ ሀሳቦቹን በጥንቃቄ አዳምጠው ስሜትዎን በይበልጥ የሚገልጸውን ቁጥር ይምረጡ።

	1	2	3	4
1. አብዛኛው ሰው በአንድ ወቅት ከባድ የአዕምሮ ታማሚ የነበረውን ሰው የቅርብ ጓደኛ አድርጎ መቀበል ይችላል				
2. አብዛኛው ሰው በአንድ ወቅት የአዕምሮ ህክምና ሆስፒታል ውስጥ ሲታከም የነበረውን ሰው እንደማንኛውም ጤናማ ሰው ማሰብ ይችላል ብሎ ያምናል				
3. አብዛኛው ሰው በአንድ ወቅት በከባድ የአዕምሮ ህመም ምክንያት ሆስፒታል ውስጥ ሲታከም የነበረውን ሰው እንደማንኛውም ጤናማ ዜጋ እምነት ሊጣልበት ይችላል ብሎ ያምናል				
4. አብዛኛው ሰው ከከባድ አዕምሮ ህመም ሙሉ በሙሉ ያገለገመውን ሰው በመንግስት ትምህርት ቤት የልጆች መምህር አድርጎ መቀበል ይችላል				
5. አብዛኛው ሰው የአዕምሮ ህክምና ሆስፒታል መግባትን የውድቀት ምልክት አድርጎ ይወስዳል/ያምናል				
6. አብዛኛው ሰው በአንድ ወቅት በከባድ የአዕምሮ ህመም ምክንያት ሆስፒታል ውስጥ ሲታከም የነበረውን ሰው ምንም እንኳን ጤናማ ሆኖ ቢታይም የልጆቹ ተንከባካቢ አድርጎ አይቀጥርም				
7. አብዛኛው ሰው በአንድ ወቅት የአዕምሮ ህክምና ሆስፒታል ውስጥ ሲታከም ለነበረውን ሰው ዝቅተኛ የሆነ አመለካከት አለው				
8. ለስራው ብቁ እስከሆነ ድረስ አብዛኛው ቀጣሪ በአንድ ወቅት የአዕምሮ ህክምና ሆስፒታል ውስጥ ሲታከም የነበረን ሰው ይቀጥራል				
9. አብዛኞቹ ቀጣሪዎች በአንድ ወቅት በአዕምሮ ህመም ምክንያት ሆስፒታል ውስጥ ሲታከም የነበረን ሰው ማመልከቻ ትተው የሌላውን ይቀበላሉ				
10. አብዛኛው ሰው እኔ በምኖርበት ማህበረሰብ ውስጥ በአንድ ወቅት በከባድ የአዕምሮ ህመም ምክንያት ሆስፒታል ውስጥ ሲታከም የነበረውን ሰው እንደማንኛውም ጤናማ ሰው ያየዋል/ይቀበሉዋል				
11. አብዛኛው ወጣት ሴት በአንድ ወቅት በከባድ የአዕምሮ ህመም ምክንያት ሆስፒታል ውስጥ ሲታከም ከነበረውን ወንድ ጋር የፍቅር ግንኙነት ለመመስረት ፈቃደኛ አይደለም				
12. አብዛኛው ሰው በአንድ ወቅት የአዕምሮ ህክምና ሆስፒታል ውስጥ ሲታከም የነበረው ሰው አደገኛና ተለዋዋጭ ባህሪ አለው ብሎ ያስባል				

**ክፍል 4: ሙያዊ ድጋፍን የመፈለግ አመለካከት ደረጃ፡ አጭር ቅጽ**

እባክዎ እያንዳንዱን ሀሳብ በጥንቃቄ አዳምጠው ለእያንዳንዱ ጥያቄ መልስ ሲሰጡ መስማማትዎን፣ በከፊል መስማማትዎን፣ በከፊል አለመስማማትዎን፣ ወይም አለመስማማትዎን ይግለጹ። ምንም ዓይነት ስህተት የሆነ መልስ የለውም። እባክዎ የሚከተሉትን የመለኪያ ደረጃዎችን በመጠቀም ይመልሱ፡ 0፣ አልስማማም 1፣ በከፊል አልስማማም 2፣ በከፊል እስማማለሁ 3፣ እስማማለሁ

	0	1	2	3
1. የአዕምሮ መታወክ ችግር አለብኝ ብዬ ባምን ኖሮ የመጀመሪያ ዘንባሌዬ የሚሆን የነበረው ሙያዊ ድጋፍ ማግኘት ነበረ				
2. ከስሜት/መንፈስ መረበሽ ለመውጣት ከስነ-አዕምሮ ባለሙያ ጋር ስለችግሮች ማውራቱ ጥሩ መንገድ/መፍትሔ ነው ብዬ አላስብም				
3. አሁን ላይ ከባድ የመንፈስ/ስሜት መቃወስ እያስተናገድኩ ቢሆን ኖሮ በስነ-ልቦና ህክምና ፋታ እንደማገኝ እርግጠኛ ነኝ				
4. ያለተደጋጋሚ የሙያ ድጋፍ ስጋቶቼንና ችግሮቼን ብቻውን ለመጋፈጥ ወይም ለመፍታት የሚጥር ሰው ይገርማል				
5. ለረጅም ጊዜ ተጨንቄ ወይም ተረብሼ ቢሆን ኖሮ ስነ-ልቦናዊ ድጋፍ ለማግኘት እፈልግ ነበረ				
6. ወደፊት ስነ-ልቦናዊ ምክር የሚያስፈልገኝ ይመስለኛል				
7. የስሜት/መንፈስ መረበሽ ችግር ያለበት ሰው ችግሩን ብቻውን መፍታት አይችልም፤ ችግሩን መፍታት የሚችለው በሙያዊ ድጋፍ ነው				
8. በስነ-ልቦናዊ ህክምና የዋለው ጊዜና ወጪ ሲታሰብ ለኔ ዓይነቱ ሰው ያለው ዋጋ/ጠቀሜታ አጠራጣሪ ነው				
9. አንድ ሰው የራሱን ችግር ራሱ መፍታት አለበት፤ ስነ-ልቦናዊ ምክር መጨረሻ ላይ መሆን አለበት				
10. የግልና የመንፈስ መረበሽ ችግሮች እንደ ሌሎች ነገሮች በራሳቸው መፈታት አለባቸው				