ATTITUDES TOWARDS MENTAL HEALTH AMONG
UNITED STATES INTERNATIONAL UNIVERSITY-
AFRICA STUDENTS

BY

BALRAJ K. BHURJI

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Sciences in Partial Fulfillment of the Requirement for the
Master of Arts in Clinical Psychology

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STUDENT'S DECLARATION

I, the undersigned, declare that this is my original work and has not been submitted to any other institution, or university other than the United States International University – Africa in Nairobi for academic credit.

Signed___________________________    Date___________________

Balraj K. Bhurji (ID 630014)

This thesis has been presented for examination with our approval as the appointed supervisors.

Signed___________________________    Date___________________

Dr. Dana Basnight-Brown

Signed___________________________    Date___________________

Prof Angelina Kioko - Dean, School of Humanities and Social Sciences.

Signed___________________________    Date___________________

Amb (Prof) Ruthie Rono - Deputy Vice Chancellor, Academic and Student Affairs.
Attitudes to Mental Health

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Abstract

Stigma and discrimination are serious problems faced by individuals with mental health problems, and may prevent these individuals from seeking the treatment they need. The present study aimed to examine the attitudes held by USIU-A students towards mental health problems. Data were collected from classes in various courses, at both undergraduate and graduate levels, at the university, including Journalism, International Business Administration, International Relations, and Psychology. Data were collected using the Attitudes towards Mental Health Problems Scale. Data were then analyzed using the Statistical Package for the Social Sciences (SPSS), and results were presented. The analysis revealed that there were no differences in attitudes based on gender, nationality, or major. However, older respondents were found to have more positive attitudes than younger ones. Additionally, Christian respondents showed more negative attitudes than non-Christian ones. The results of the study showed that attitudes to mental health problems are influenced by age and religion, but are not influenced by gender, major, or nationality.

Keywords: Attitudes, mental health, religion, age, gender
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Dedication

This study is dedicated to the many people who suffer from mental health problems and who face stigma and discrimination every day. It is also dedicated to those who stand up for them and dedicate their lives to bettering the standards of mental healthcare everywhere.
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I would like, first and foremost, to thank God for giving me the strength and motivation I needed in order to complete this study. Without His guidance and blessings, I would not have made it this far. I will forever be grateful for the opportunities He has provided me.

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Chapter 1

Background and Introduction

1.1 Introduction

This chapter discusses the background of the study on “Attitudes towards Mental Health Problems among United States International University-Africa Students”. This chapter details the objectives and research questions of the study, as well as the significance and justification for the study. Additionally, this chapter details the hypotheses and assumptions of this study, and also includes definitions of terms used throughout the study.

1.2 Background of the Study

Mental illness has been defined as a range of feelings, thoughts, and behaviors that impede or affect an individual’s interpersonal relationships and their ability to function in the work place, at home, or at school. This definition also encompasses an individual’s level of functioning that is necessary for daily life tasks and the extent to which the individual is hindered from performing them by the mental illness (Overton & Medina, 2008).

Stigma, in the historical sense, was derived from “stigmata”, a Greek word used to describe a mark of disrepute or shame; an identifying characteristic or trait. When used in terms of mental illnesses, stigma is a complex term that involves attitudes, feelings, and behaviors. Stigma has been defined using different theories, including self-stigma, structural stigma, and social identity (Overton & Medina, 2008).

Research studies focused on the impact of stigma associated with mental illnesses have been on the rise in the past decade. This is encouraging, particularly since these studies have played a vital role in the development of anti-stigma campaigns. Research on
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the impact of negative attitudes towards mental illnesses and those suffering from it, is of essence since the stigma associated with mental illness and labelling of those who have been affected by it has been shown to lead to a myriad of adverse effects on individuals such as unemployment, dependence on care givers, and lack of social support (Corrigan & Gelb, 2006).

In addition, studies have shown that individuals who suffer from mental health problems and illnesses are among the most stigmatized, ostracized, labelled, and vulnerable members of society. The stigma that is often associated with mental illness has been shown to negatively affect almost every facet of these individuals’ lives such as renting homes, getting employed, and even seeking access to mental health facilities. The misleading negative connotations that often go hand in hand with mental illnesses have proven to be almost as debilitating as the disease itself, particularly since it may lead to the withdrawal and isolation of the individuals from society (Overton & Medina, 2008).

Although approximately 80% of the world’s population live in low and middle-income countries, only 6% of the research published on mental health issues has been conducted in these countries. In their report, the “Global Burden of Disease and Risk Factors”, Lopez, Mathers, Ezzati, Jamison, and Murray (2006) assessed and compared the burden caused by various health problems in different parts of the world. They found that neuropsychiatric disorders such as major depressive disorder, bipolar disorder, alcohol and substance abuse disorders, epilepsy, dementia, intellectual disability, and anxiety disorders accounted for 9.8% of the total burden of diseases in low and middle-income countries; this number increased to 11.1% when the researchers added in self-inflicted injuries. Additionally, depression is the primary neuropsychiatric disorder causing a burden of disease in low and middle-income countries, and accounts for 3.1% of the total burden of disease (Lopez et al., 2006).
Depressive disorders were found to be the primary cause of “Years Lived with Disability”, which is a measure used to determine the years lost due to time spent in a state of less than full health. Anxiety and schizophrenia were also among the top ten causes of years lived with disability (Vigo, Thornicroft, & Atun, 2016). Psychological and substance use disorders were the sixth leading cause of disability in children and adolescents in 2010, accounting for up to 5.7% of the burden of disease for these groups (Erskine et al., 2015). Additionally, self-inflicted injuries were found to account for over 2% of deaths in low and middle-income countries in Europe and Central Asia, making them the fifth highest cause of death in those countries (Lopez et al., 2006).

According to the Kenya National Commission on Human Rights (KNCHR, 2011), there is deep-seated discrimination and stigma against mental illness and individuals with mental illnesses, and very low awareness on the issues associated with mental health. The mental healthcare sector has been ignored and persons with mental illnesses have been neglected by their families, friends, and the community at large, and are often abandoned in mental health facilities. Additionally, basic mental healthcare services and facilities are inaccessible to a majority of individuals in Kenya, and the steps taken by the government have not been effective in providing the highest possible standard of mental healthcare (KNCHR, 2011).

1.3 Statement of the Problem

Access to health facilities is a basic human right according to the Constitution of Kenya (2010), however, in Kenya mental health facilities are often decrepit and rundown, inaccessible to individuals from low-income families, and are few in number outside Nairobi. This makes it difficult for individuals with mental health problems to access the proper care and treatment, and increases the chances of the development of maladaptive
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coping mechanisms such as substance abuse or turning to traditional healers which may exacerbate the issue since appropriate interventions and treatments are not being utilized. Additionally, the needs of individuals with mental illnesses are often ignored or mismanaged, both medically and psychologically; psychiatric medications are expensive or are abused, and many individuals with these disorders cannot afford to seek psychological help. The stigma associated with mental health issues in Kenya also reduces help-seeking behavior in individuals with mental illnesses, due to the fear that they will be ostracized by their communities.

1.4 Objectives of the Study

The specific objectives of this study are:

1. To determine if attitudes vary among individuals of different age groups.

2. To determine whether there are religious differences in attitudes towards mental health.

3. To determine whether there are differences in attitudes towards mental health between nationalities.

4. To determine if there are differences in attitudes towards mental health among the different majors.

5. To determine whether there are gender differences in attitudes towards mental health.

1.5 Research Questions

The research questions for this study are:

1. Are there age differences in attitudes towards mental illness?
2. Are there religious differences in attitudes towards mental illness?

3. Are there differences in attitudes towards mental illness among people from different nationalities?

4. Are there differences in attitudes towards mental health among different majors?

5. Are there gender differences in attitudes towards mental illness?

1.6 Hypotheses

The hypotheses this study will aim to examine are:

**Null Hypothesis 1:** There are no religious differences in attitudes towards mental health.

**Research Hypothesis 1:** There are religious differences in attitudes towards mental health.

**Null Hypothesis 2:** There are no differences in attitudes towards mental health between nationalities.

**Research Hypothesis 2:** There are differences in attitudes towards mental health between nationalities.

**Null Hypothesis 3:** There are no gender differences in attitudes towards mental health.

**Research Hypothesis 3:** There are gender differences in attitudes towards mental health.

**Null Hypothesis 4:** There are no age differences in attitudes towards mental health.

**Research Hypothesis 4:** There are age differences in attitudes towards mental health.

**Null Hypothesis 5:** There are no differences in attitudes towards mental health among different majors.
Research Hypothesis 5: There are differences in attitudes towards mental health among different majors.

1.7 Justification/Rationale of the Study

Although there is a lot of research that has been conducted on attitudes to mental health, most of this research was conducted in the West; unfortunately, there is a paucity of research conducted in Africa, and especially in Kenya. This research study aims to provide information on the attitudes to mental health in a Kenyan context, and whether these attitudes are similar to those held in Western countries.

1.8 Significance of the Study

This study would be significant in raising community awareness about the negative effects of stigma on the psychological, medical, emotional, and overall wellbeing of individuals with mental illnesses. It may also add on to existing research conducted in Africa and specifically in Kenya.

Additionally, this study may help to increase awareness of the need for increased access to information about mental healthcare, and may lead to increased support for research on mental health. Furthermore, this research aims to emphasize the importance of community based awareness of what mental health problems are and provide accurate information to the society on appropriate evidence based interventions for individuals suffering from mental health problems. This is particularly vital since community support is imperative in the reduction of stigma and discrimination for individuals suffering from mental health problems, and for their families as well.

1.9 Assumptions of the Study

The assumptions of this study are:
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1. That participants will be completely honest while taking part in the study.

2. That the sample will be representative of the target population.

3. That participants are genuinely interested in the study, and are not participating due to external incentives such as extra credit in a course.

4. That a participant’s religion and nationality constitute their culture.

1.10 Limitations

The sample may not be representative of the population in Kenya, and each culture may not be adequately represented in the sample. Due to this, the results of this study may not be generalizable to the population. Language may be another limitation; for some international students whose first language is not English, the questionnaire or the aims of the study itself may not be clear. Additionally, due to the use of cluster sampling in the selection of participants, the results of this study may not be generalizable to the general population.

1.11 Definition of Terms

**Mental health:** refers to the ability of individuals and groups to interact with their environment and each other in a way that promotes optimal development, subjective wellbeing, and utilization of affective, cognitive, and rational skills. Mental health involves realizing one’s potential, influenced by factors such as genetic makeup, family life, gender roles, work opportunities, interpersonal relationships, educational accomplishments, and various socioeconomic and structural elements (Johnston, 2002).

**Mental illness and mental health problems:** refers to a range of emotional, cognitive, and behavioral disorders that interfere with an individual’s functioning in
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various settings such as at home, work, or school, and impact his or her interpersonal relationships (Johnston, 2002).

**Stigma:** a group of negative beliefs and attitudes that influence members of a community to avoid, reject, fear, and discriminate against mentally ill individuals (Centers for Disease Control and Prevention [CDC], Substance Abuse and Mental Health Services Administration [SAMHSA], National Association of County Behavioral Health and Developmental Disability Directors [NACBDDD], National Institute of Mental Health [NHIM], & the Carter Center Mental Health Program [CCMHP], 2012).

**Structural stigma:** negative results of biases against mentally ill individuals inherent in political, social, or legal decisions or institutions (Barke, Nyarko, & Klecha, 2011)

**Self-stigma:** occurs when stigmatized individuals internalize the negative beliefs common in their community and begin to view themselves as unacceptable (Barke et al., 2011).

1.12 **Abbreviations/Acronyms**

- ADHD: Attention-Deficit Hyperactivity Disorder
- ANOVA: Analysis of Variance
- CDC: Centers for Disease Control and Prevention
- DRC: Democratic Republic of Congo
- DSM-IV: Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition
- DSM-5: Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition
- HIV/AIDS: Human Immunodeficiency Virus/Auto-Immune Deficiency Syndrome
- KNCHR: Kenya National Commission for Human Rights
- NGO: Non-Governmental Organization
1.13 Summary

This chapter has detailed the background and history of stigma against mental illness, the objectives of the study, and the research questions the researcher aims to answer. Additionally, this chapter has included the statement of the problem, the justification of the study, and the significance of the study specifically in Kenya given the paucity of previous research studying the existence of and the effects of stigma against mental illness. The next chapter will focus on the types of stigma and attitudes to mental health across the globe.
Chapter 2

Literature Review

2.1 Introduction

A community’s attitudes and beliefs about mental illness influence how members of that community interact with, support, and provide opportunities for individuals with mental illnesses. These beliefs also affect how people experience and express their own psychological distress and emotional problems, and whether or not they disclose these issues or seek help. It has been reported that 26.2% of American adults have a mental illness at any time, including substance use disorders, mood disorders, and anxiety disorders; suggesting that anyone can have mental health problems (CDC et al., 2012).

Beliefs and attitudes towards mental health problems are influenced by personal knowledge, cultural beliefs about mental illness, familiarity with institutional practices, and interacting with individuals with mental illnesses. When expressed positively, these beliefs result in inclusive and supportive behavior such as willingness to hire a mentally ill individual or be socially intimate with such an individual. When expressed negatively, however, these beliefs can result in exclusion from everyday activities, avoidance, and discrimination and exploitation (CDC et al., 2012).

2.2 Mental Illness and Stigma

The Diagnostic and Statistical Manual of Mental Disorders (DSM 5) defines mental disorders as syndromes characterized by clinically significant disturbances in a person’s emotion regulation, cognition, and behavior, which reflect dysfunctions in the developmental, biological, or psychological processes underlying mental functions. Mental illnesses are usually associated with significant impairment in occupational, social, or functioning in other contexts (American Psychiatric Association [APA], 2013).
Mental health is a topic of concern in both developing and developed regions of the world; for every person, physical, social and mental health are vital components of life that are interdependent and closely interwoven. Mental health disorders account for approximately 12% of the global burden of disease (World Health Organization [WHO], 2001). The multicultural nature of life today requires recognizing the impact of cultural influence on various aspects of mental health; culture may inform attitudes and beliefs about mental health, and may determine the barriers, motivation, and pathways to help. Researchers have continually associated diverse cultural factors such as concerns over prestige, willingness to disclose, and personal dignity, with attitudes to mental health problems (Bener & Ghuloum, 2011).

News media such as television channels and newspapers also play a role in propagating discrimination; studies show that newspapers commonly frame mental health problems in stigmatizing ways. Newspaper articles commonly frame individuals with mental illnesses as dangerous or violent criminals; studies have found that up to 86% of newspaper articles on mental illness focus on violence. Additionally, a majority of articles focus either on medical treatments for mental illnesses, or on negative traits associated with individuals with mental disorders such as unsociability and unpredictability. There are few articles that focus on recovery from mental illness (Corrigan et al., 2004).

The definition of the concept of mental illness or health is difficult due to its largely subjective nature; individuals with mental illnesses are part of society, but are seen differently by society. However, various societies have varying patterns of help seeking behavior, and in some countries traditional healers are involved in the healthcare system, therefore societal reactions to people with mental disorders differs from one society to the other, as a people’s culture is a model for their behavior (Bener & Ghuloum, 2011).
Mental health literacy has been defined as beliefs and knowledge about mental health disorders which help in the prevention, recognition, and management of these disorders. It consists of different aspects such as the ability to identify specific psychological disorders or various forms of psychological distress, and beliefs and knowledge about causes and risk factors, self-help interventions, and professional help available. Additionally, mental health literacy consists of attitudes which enable identification and appropriate help-seeking behavior, and knowledge of how to seek information about mental health (Jorm, 2000). Mental health literacy may derive beliefs and knowledge from other sources such as cultural, personal belief, superstitions, and appropriate education programs. This suggests that culture or ethnicity may influence people’s beliefs or knowledge. Additionally, the extent to which improved mental health facilities are beneficial to patients is influenced by their belief systems, as well as the availability and quality of the services (Bener & Ghuloum, 2011).

Several global reports on the differences in outcomes of mental health problems, such as the International Pilot Study of Schizophrenia, the Study of the Determinants of Outcomes of Severe Mental Disorders and the International Study of Schizophrenia, have found vast differences in the outcomes of mental disorders within and across the different countries. The results of these studies suggested that outcomes for schizophrenia and mental disorders are better in developing, rather than developed countries. The researchers believed that these differences in outcomes are due to higher levels of community cohesiveness and strong family relationships in developing countries (Burns, 2009).

Although the reasons for these differences are somewhat unclear, one of the major explanations involves culturally defined processes. It has been suggested that stigma may be the cause of such results and is the foundation for recovery from mental health problems.
health problems. Therefore, an understanding of the cultural frameworks that facilitate positive outcomes may offer a method of stigma reduction; specifically, whether or not people recognize mental health problems, hold stigma-related beliefs about these conditions, and endorse help seeking behavior is critical, since each represent crucial aspects of culture that may affect the outcome of mental disorders (Pescosolido, Olafsdottir, Martin, & Long, 2008).

Stigma consists of cognitive, behavioral, and emotional aspects; these aspects are stereotypes, prejudice, and discrimination. Stereotypes are information sets known to most members of a given social group; they are an effective way to categorize knowledge about different social groups because they consist of collective views about people or groups. Stereotypes very quickly generate expectations and impressions of individuals who belong to a stereotyped group. People do not inevitably agree with stereotypes they may be aware of; many people may be aware of stereotypical beliefs about a different ethnic group but may not think these beliefs are valid. Prejudiced individuals, however, endorse these negative beliefs, and experience negative emotional reactions as a result (Rusch, Angermeyer, & Corrigan, 2005).

Prejudice is a result of cognitive and emotional responses to stereotypes; a common emotional response is reflexive disgust, which is often accompanied by an overwhelming desire to avoid what is viewed as offensive or unacceptable, or a fear of contamination. After the initial reflex response, a rule-based cognitive process takes over; this process is based on rules that develop from anticipated social interactions. This system allows a person to adjust his/her reflexive and consequent responses; the process can be turned on and off and may result in the initial disgust being replaced by courtesy or pity. Individuals with weak external motivation to control prejudice and strong internal motivation to control it tend to be less biased. If this rule-based process does not occur,
more emotions are formed as a result of prejudice; statements such as “they are dangerous and I’m afraid of them” or “I hate them” are common illustrations of strong emotions toward a targeted group (Overton & Medina, 2008).

### 2.2.1 Types and Theories of Stigma

Goffman (1963) [as cited by Feldman & Crandall, 2007] defined stigma as an attribute that deeply discredits an individual; the individual is viewed as flawed, spoiled, flawed, and generally undesirable. Stigma against mental illness can lead to employment discrimination, strained familial relationships, and general social rejection. The more stigma mentally ill people perceive, the lower their life satisfaction, self-esteem, and social adjustment tends to be. Additionally, experiencing stigma may prevent individuals from seeking help and lead to non-adherence to treatment, reducing the efficacy of therapy (Feldman & Crandall, 2007).

Public stigma has been recognized as a factor that triggers a chain of social, psychological, behavioral, political, and economic events which impact society as a whole, and the stigmatized individual. The stigmatized individuals are thought to possess characteristics which lead to a devaluation of their social identity in a particular context (Crocker, Major & Steele, 1998) [as cited by Mak, Chong & Wong, 2014]. Thus, stigmatization is based on generalized subjective views of a target group of people, rather than on any objective criteria (Conner et al., 2010) [as cited by Mak et al., 2014]. One such stigmatized group is people with mental health problems. Stigma has an effect on the emotional, perceptual, and behavioral responses of the public towards the stigmatized circumstance and its affected persons (Angermeyer & Dietrich, 2006) [as cited by Mak et al., 2014].
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Aside from etiological issues, earlier research in the medical field focused on fundamental issues related to positive outcomes in mental health treatments. Rehospitalization, mortality, symptom reduction, and discussions about the courses of disorders such as schizophrenia dominated the research dialogue in psychology, psychiatry, and mental health services research (Pescosolido et al., 2008). Research conducted by Goffman, in 1963, led to stigma being at the forefront of social science discussions about outcomes of mental disorders. Social scientists tended to place more emphasis on community based issues such as wellbeing, lower quality of life, work and marriage possibilities, low self-esteem, and persistent social stress (Goffman, 1963).

Social identity, a concept first discussed by Goffman (1963), refers to how individuals use social constructs to label or judge someone who is disfavored or different; societies often evaluate individuals to determine whether or not they fit the norm. People who are discriminated against tend to create an imaginary social identity when they are dishonored or disfavored in their communities, and they become outsiders. Because mental illness has historically been viewed as a moral or character flaw, this theory is applicable to individuals with mental illnesses (Overton & Medina, 2008).

Goffman (1963) used the term “spoiled collective identity” to describe stigmatized individuals whose identity was questionable in society’s view. He viewed stigma as a characteristic which socially discredits an individual, leading him/her to be unfairly rejected. Link and Phelan (2001) [as cited by Corrigan, Druss & Perlick, 2014] defined stigma using four components which distinguish it from other social phenomena: stigma is essentially a label of an out-group, the differences labelled are negative, these differences separate “them” from “us”, and this labelling and separation lead to discrimination and loss of social status (Corrigan et al., 2014).
Corrigan (2004) [as cited by Cummings, Lucas & Druss, 2013] postulates that stigma occurs as a result of four socio-cognitive processes; first, individuals infer the existence of a mental illness from cues such as physical appearance, social deficits, and psychiatric symptoms. These cues then elicit stereotypes, defined as beliefs about a certain group of people; stereotypical beliefs about mentally ill persons include the belief that they are responsible for their own illness, they are dangerous, and they are incapable of working or living independently. These stereotypes are then endorsed by individuals who are prejudiced, which results in negative emotional reactions to the stereotyped individual. Prejudice, an affective and cognitive process, leads to the behavioral reaction of discrimination. This discrimination is seen in negative actions such as avoidance of contact with the stereotyped person or group; landlords may not want to rent their property out to these people, and employers may not want to hire them. This is known as public stigma. Stereotyped individuals or groups, however, may internalize these stigmatizing beliefs; this is referred to as self-stigma (Cummings et al., 2013).

Self-stigma refers to the reactions of people belonging to a stigmatized group; these individuals internalize the stigmatizing attitudes and turn these attitudes to themselves. Similar to public stigma, self-stigma consists of stereotyping, prejudice, and discrimination. Individuals agree with the stereotypical beliefs about themselves, which leads to self-prejudice. This self-prejudice causes negative emotional reactions, especially low self-efficacy and low self-esteem. Additionally, due to this self-prejudice, mentally ill individuals may fail to pursue employment or independent living opportunities; they fail to reach these goals due to their self-discriminatory behavior, rather than their mental illness (Rusch et al., 2005).

Structural stigma, an external evaluation of an individual based on societal norms, examines more in-depth how stigma works as a system, and its process through a culture;
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it portrays the real obstacles faced by individuals with mental illnesses. In the United States, individuals with diagnosed mental disorders are prevented from sitting on juries or holding elective offices in a third of the states, and the child custody rights of individuals with mental illnesses are restricted in half of the states; structural stigma refers to a process that denies individuals with mental illnesses their rights to things that “normal” people take for granted. Mentally ill individuals may have difficulty finding their place in society, and in finding supportive and empathetic relationships with others, participatory citizenship, peace of mind, and happiness (Overton & Medina, 2008).

There are several different factors that influence structural stigma, including institutional policies that produce inadvertent consequences for individuals with mental disorders, and governmental or institutional policies that intentionally cause restricted opportunities for individuals with mental disorders. Intentional discrimination by institutions occurs through policies, rules, and procedures of public and private entities in powerful positions that purposefully and consciously restrict opportunities and rights of individuals. Corrigan, Markowitz, and Watson (2004) cited two studies that involved a search of statutes in the US for discriminatory laws against individuals with mental illnesses. The studies used phrases such as mentally ill and mentally incompetent, and aimed to determine whether or not the different American states had passed laws restricting the civil rights of mentally ill individuals in areas including holding elective office, voting, parenting, remaining married, and serving jury duty (Corrigan et al., 2004).

Burton (1990) [as cited by Hemmens, Miller, Burton and Milner, 2002] reported that 16 states restricted mentally ill individuals from holding elective office, 20 restricted parenting, 16 restricted serving jury duty, 19 prevented voting, and 26 restricted mentally ill individuals from remaining married. Similarly, Hemmens et al. reported that while the numbers remained the same for laws restricting voting and holding elective office, 17
states now restricted mentally ill individuals from serving jury duty, and 21 restricted parenting. The only decrease in numbers was seen in the area of remaining married, which went down from 26 states to 21 states (Hemmens et al., 2002).

Additionally, a principle or institutional policy may cause unintentional consequences to stigmatized groups; although public policies that favor cost-effectiveness and good business would not be thought to favor any group in particular, there are unintended consequences of such policies that affect stigmatized individuals. For instance, insurance companies charge higher premiums among African-American communities with higher crime rates, and banks are more reluctant to provide mortgages to African-American buyers. Healthcare sectors generally allocate less money for research and treatment of psychiatric disorders than other medical disorders, and psychiatrists and other mental healthcare professionals choose to go into the private sector, leaving fewer resources and professionals to treat the individuals served by the public healthcare system such as patients with substance abuse disorders and severe mental illnesses. Additionally, disparities in mental health insurance are another example of unintentional structural stigma; employers are not required to provide mental healthcare insurance to their employees, and certain disorders such as substance abuse are not covered (Corrigan et al., 2004).

2.2.2 Mental Illness and Stigma in the Global Context

Only recently have the broader, progressive undercurrents of stigma become visible; longitudinal studies that began in the United States in the 1950s and continued over the next few decades detailed the lack of understanding of mental health problems, negative attitudes about causes of such issues, treatments and outcomes, and a high level of public attitudes that favored the rejection of individuals with mental health problems.
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However, improvements in treatment and an increase in consumer advocacy molded professional perceptions of stigma, and mental health service providers were often credited with decreasing community-based stigma (Pescosolido et al., 2008).

The increase in deinstitutionalization of mental healthcare in high-income countries has led to an increase in community-based care, with more individuals with mental illnesses being provided care at home (Yesufu-Udechuku et al., 2015). Despite this, however, research has shown alarmingly poor outcomes for mental health problems globally; former psychiatric patients in Austria, Hong Kong and Canada have been found living on the margins of society, in appalling conditions, deprived of social life and proper housing. Former patients in Singapore report that stigma has affected their relationships, self-esteem, and employment opportunities, while in Australia and Israel, stigma has caused individuals to avoid seeking help for mental health problems. Additionally, these studies and others conducted in countries like Nigeria, have shown that individuals with mental illnesses are more socially and medically vulnerable than people with tuberculosis, cancer, or coronary heart disease (Pescosolido et al., 2008).

The increasing amount of evidence collected by researchers since the 1990’s has caused advancements in the public’s understanding of the biological links of mental health problems; people have been increasingly exposed to information about genetic and biochemical etiological theories, symptoms of mental illnesses, and to the idea that mental disorders are no different than other medical disorders, and can be treated (Schomerus et al., 2012).

Despite the more positive results regarding types of mental health issues and treatment efficacy, some studies have shown deterioration in attitudes towards mental health problems. Mehta, Kassam, Leese, Butler, and Thornicroft (2009) found that
attitudes towards mental health had become more negative from 1994 to 2003 in England and Scotland. Phelan et al. (2000, as cited by Mehta et al., 2009) found that the American public became more negative in their attitudes during this period, with an increased perception of unpredictability, dangerousness, and instability in mentally ill individuals. Conversely, Madianos et al (1999, as cited by Mehta et al., 2009) found improved attitudes in Athens between the years 1979 and 1994, possibly due to a sustained effort to increase community awareness of mental health (Mehta et al., 2009).

Chou and Mak (1998) conducted a study comparing attitudes among Hong Kong Chinese towards individuals with mental illnesses between 1994 and 1996. They found mixed results, indicating improvements in attitudes towards community care and public knowledge of psychiatric disorders, but showing deterioration in attitudes regarding social distance from mentally ill individuals. Their results also showed that these negative attitudes were strongly associated with lower levels of contact with mentally ill people (Chou & Mak, 1998).

A study conducted by Pescosolido, Medina, Martin and Long (2013) aimed to determine if there exists a pillar of larger cultural attitudes, beliefs and opinions about mental health problems which presents a bigger problem to family, friends, and service providers. The study also aimed to determine whether a lack of knowledge, concerns about treatment, or reluctance to include mentally ill individuals in civil society would interfere with recovery, and if people have different responses to depression and schizophrenia. The researchers analyzed the results of the Stigma in Global Context-Mental Health Study (SGC-MHS) to assess people’s reactions to scenarios of depression and schizophrenia from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) across 16 countries. The study found that across all participant countries, respondents portrayed positive attitudes towards psychiatry, recognized the
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severity of such disorders, acknowledged the efficacy of treatment, and endorsed mental health professionals such as psychologists and counselors. Additionally, most of the countries, with the exception of Bangladesh and the Philippines, did not endorse stigmatizing beliefs about depression and schizophrenia, such as the belief that these disorders are “God’s will” or are due to an individual’s bad character (Pescosolido et al., 2013).

Additionally, the study found that a majority of the respondents reject old etiological ideas about secrecy, individual weakness, and moral failure, and instead accept that the underlying causes of mental illnesses are located in the same areas as other illnesses. However, the study also found that there is a larger pillar of stigma; even in more accepting countries, participants responded negatively to issues dealing mainly with vulnerable groups such as children, intimate settings such as families, or self-harm. In addition, respondents were uneasy about how to interact with mentally ill individuals or feared violent behavior from them; they were also found to be reluctant to see mentally ill individuals in positions of power or authority such as public office or work supervisors. Respondents also expressed concern about issues such as disclosure, embarrassment, secrecy, competence, and intelligence (Pescosolido et al., 2013).

2.2.3 Culture and Stigma

Seeking help for mental illnesses is perceived differently in collectivistic and individualistic cultures; in a collectivistic culture such as among Vietnamese-Americans, individuals are socialized to repress strong emotions, especially negative ones, rather than express them. Additionally, collectivistic cultures place emphasis on family obligations (respecting, helping, and contributing to the family); these individuals may be less likely to seek help for their personal fears, as this may be viewed as putting one’s individual
needs above the family’s needs (Guo et al., 2015). By contrast, in the US, seeking outside help for one’s problems is seen as an acceptable way of dealing with both major and minor issues, and clients are able to maintain their independence from their families while also dealing with their problems (Morris, 2011).

Phillips, Pearson, Li, Xu and Yang (2002) conducted a study in various psychiatric facilities in China, in order to assess the stigma against schizophrenic patients, and to evaluate the factors that mediate the patients’ responses. The results of reports made by the patients’ family members showed that stigma had a moderate to severe impact on their lives, and on the lives of the patients. Schizophrenia is a particular target for stigmatization due to its disruptive behavior, distinctive symptoms, and perceived dangerousness. Etiological beliefs about mental disorders deepen the stigmatization of schizophrenic patients and their families; the Chinese view mental health problems as a punishment for the family’s misconduct or for an ancestor’s bad behavior. In urban areas of China, the most common explanations attributed to schizophrenia are psychosocial factors such as breakdowns in family relationships, while in more rural areas mental disorders are frequently associated with malicious spiritual forces, leading families to seek help from spiritual healers or shamans. Phillips et al., (2002) found that various factors were independently associated with perceived stigma on the patients and their families; if the patient exhibited more positive symptoms, the family lived in an urban area, and the respondent was relatively highly educated, the perceived effect of stigma was higher (Phillips et al., 2002).

A systematic literature review of 36 studies conducted by Parkasepe and Cabassa (2013) aimed to examine methods used to study public stigma in the United States, of mental illnesses and summarize findings based on people’s stigmatizing attitudes, beliefs and attitudes towards individuals with mental health problems. The review found that
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personal contact with people with mental illnesses, individual characteristics, and causal attributions were associated with stigmatizing attitudes, beliefs, and behavior towards treatment for mental illnesses. Individuals with mental illnesses were commonly described as dangerous to themselves or others, while adult respondents were found to view children with Attention Deficit-Hyperactivity Disorder (ADHD) or depression as more dangerous to themselves and others than children with conditions such as asthma. Similarly, child participants also viewed children with depression or ADHD as more dangerous. Adult participants also viewed adults with depression, schizophrenia, alcoholism, or drug dependence as more dangerous than other people, and were more likely to report people with drug addiction or mental illness as dangerous (Parcasepe & Cabassa, 2013).

Similarly, Link et al. (1999) found that many people believe that individuals with mental illnesses such as schizophrenia, depression, or substance use disorders are very likely to exhibit violent behavior. Additionally, they found that people commonly desire social distance from individuals with mental health problems; this is thought to be due to the fear of violent behavior. Respondents in this study reported a stronger desire for social distance from individuals suffering from substance use disorders; these individuals were also viewed as more likely to display violent behavior (Link et al., 1999).

A study conducted by Chen and Mak (2008) aimed to examine the cross-cultural differences in help seeking among Asian-Americans and Asians, and the factors that contribute to seeking help from mental health service providers. There are three general theories to explain the under-utilization of mental health services by Asian-Americans and Asians; cognitive assessment of psychological problems, stigma and shame associated with mental illness, and the conflict between Western psychotherapy process and traditional Asian values. Among individuals of Chinese descent, cultural values may
conflict with the expectations in therapy; Chinese culture values self-restraint rather than emotional expression. Individuals are expected to suppress and control their emotional issues, concern themselves very little over them, or to place little importance to them. Hence the counseling expectation of openly speaking about personal problems may be peculiar to Chinese-American and Chinese clients. Additionally, these individuals may not seek counseling in order to avoid shame and stigma (Chen & Mak, 2008).

A study by Griffiths et al. (2006) compared public attitudes in Australia (an individualistic culture) and Japan (a collectivistic culture); the study aimed to examine the stigma associated with mental disorders such as early schizophrenia, chronic schizophrenia, depression with suicide, and depression. Participants were randomly presented with a vignette depicting one of the aforementioned disorders, and were then asked a series of questions to determine whether they were able to identify the disorder, and to assess their beliefs about prognosis and treatment for the disorder, risk factors, their level of stigma and perceived stigma against the individual depicted, and their level of contact with people similar to those in the vignette. Results showed that Japanese respondents were generally more stigmatizing than Australian respondents; they were more likely to believe that mentally ill individuals suffer from personal weakness, did not have real illnesses, and could snap themselves out of the illness. Australian participants, however, were more likely to view mentally ill individuals as unpredictable, but did not endorse avoiding the individuals (Griffiths et al., 2006).

Chen and Mak (2008) compared attitudes towards help seeking by sampling four groups: Chinese Americans, who encompass both Eastern and Western values; European Americans, who are influenced by Anglo-Saxon practices; Hong Kong Chinese, who are relatively westernized, and Mainland Chinese, who are deeply rooted in traditional Chinese culture. Generally, the results showed that exposure to Western influences
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increased the likelihood that an individual would seek treatment, whereas traditional Asian cultural beliefs lead to less help-seeking behavior (Chen & Mak, 2008).

There were consistent and significant disparities in attitudes in social distance and personal stigmatizing beliefs between Australia and Japan; in most cases, Australian respondents showed less negative stigmatizing attitudes than Japanese ones. The differences in results may be due to varying importance placed on individualism and conformity in the two countries; the deviation of mentally ill individuals from the norm may be a cause of stigmatization as conformity is more valued in Japan. Additionally, these differing attitudes may be a result of the varying service provision in the two countries; while Australia focuses on de-institutionalization and provision of rehabilitation and community services, the Japanese system focuses more on long-term institutionalization. Another factor that may contribute to the differences in attitudes is the greater availability of stigma reduction and public health education in Australia over the previous 10 years. One common factor between the two countries was that respondents in both more commonly stated that other people held stigmatizing beliefs about mentally ill individuals (Griffiths et al., 2006).

Kurihara, Kato, Sakamoto, Reverger, and Kitamura (2000) compared attitudes towards individuals with mental illnesses of lay persons from Tokyo, a metropolitan center in a developed nation, and Bali, a developing society. In Tokyo, the capital of Japan, the main religions are Buddhism and Shintoism, while the Balinese are largely devout Hindus. Samples from both countries consisted of office workers who had not been enrolled in Psychology or Medical courses. Results showed that the Balinese portray a more positive attitude to individuals with histories of psychiatric treatment than the Japanese. Balinese respondents were less likely than Japanese respondents to see schizophrenics as abnormal, and thought themselves more likely to develop schizophrenia
later. Balinese respondents were also less uncomfortable about schizophrenic individuals, and were more optimistic about the individual’s likelihood of readjusting to society and recovering. Additionally, Balinese respondents considered the individuals more capable of making judgments and less dangerous, indicating that the Balinese have a more positive attitude towards schizophrenic patients. The results revealed that the Balinese estimate lower likelihoods of developing depression themselves, were less optimistic about recovery, and saw depressed patients as more dangerous. The Balinese more commonly thought patients with OCD are unable to tell right from wrong, and more dangerous. The results imply that the Balinese express more negative attitudes to OCD and depression compared to their responses to schizophrenia (Kurihara et al., 2000).

Results reported by Parcasepe and Cabassa (2013) also showed that participants’ perceptions of level of dangerousness varied according to the disorder; adults with substance use disorders (SUDs) were the most likely to be reported as dangerous to themselves or others. Adults with alcoholism and schizophrenia were also thought to be dangerous to themselves and others, and were thought of as more dangerous than depressed adults. Additionally, both adults and children with depression were seen as a danger to themselves, with a majority of adult respondents seeing depressed children as dangerous to themselves. Perceptions of level of dangerousness were linked to causal attributions of mental disorders; genetic or neurochemical causes increased the likelihood that a schizophrenic individual would be viewed as a danger to themselves and others, and depressed people as dangers to themselves (Parcasepe & Cabassa, 2013).

The public attitudes of the Balinese towards schizophrenic patients may be attributed to the fact that these patients have better outcomes in developing countries rather than in developed countries. Additionally, Balinese people are in more frequent contact with these patients due to the few services available. Public attitudes may also be
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influenced by people’s cognition of a mental disorder; the Balinese believe that diseases are caused by an interaction they refer to as sekala, the physical component, and niskala, an abstract and invisible aspect which can only be removed by traditional healers. Psychotic disorders are thought to be caused by niskala mechanisms such as black magic or the supernatural; this reference to external factors, rather than referring to internal issues such as family problems or genetics, may be one of the causes of the more positive attitude expressed in Bali. The negative attitudes expressed towards people with OCD and depression may be due to the low level of contact with such individuals, since the two disorders have a lower prevalence (Kurihara et al., 2000).

The World Health Organization (WHO) estimates that up to 450 million people suffer from mental health problems, and approximately 80% of these individuals live in Low and Middle Income Countries. Of the people in LAMIC living with severe mental disorders, four out of five do not receive the necessary healthcare services. Among the Indian population, the estimated prevalence of mental illnesses is 5.8%, and despite efforts to cope with such disorders, mental health problems are still hidden burdens due to discrimination and stigma. A study conducted by Venkatesh, Andrews, Mayya, Singh, and Parsekar (2015) aimed to evaluate the relation between mental health issues and stigma.

The study, conducted in Karnataka, India, focused on studying participants’ responses on four scales: Authoritarianism, which refers to the perception that mentally ill people are inferior and require coercion and supervision, implying oppressive or authoritative behavior towards subordinates; Benevolence, a sympathetic and humanistic perception of mentally ill individuals, with a high score corresponding to a malevolent and less humanistic attitude towards the mentally ill; Community mental health ideology, which refers to the community’s integration of mentally ill people and acceptance of
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mental health services; and SR refers to the perception of mentally ill individuals as threats to society that should be avoided (Venkatesh et al., 2015).

A majority of the respondents did not know the names of mental disorders, and stated that they would identify an individual with a mental illness by his attitude and behavior. A large proportion of the participants did not believe that mental disorders have any genetic inheritability. The results of the study revealed that female participants exhibited higher stigma on all four scales. Additionally, respondents with a lower level of education (primary school) showed higher stigma levels on all the scales, and the general results showed high levels of stigma in all the scales (Venkatesh et al., 2015).

Another study by Bener and Ghuloum (2011) assessed the cultural differences in knowledge, attitudes and behaviors of the population of Qatar towards mental health problems. The study was conducted among Arab Qatari residents and Arab expatriates in primary healthcare facilities (Bener & Ghuloum, 2011).

The results of the study showed that a significantly larger proportion of Qatari respondents believed that mental illnesses are a punishment from God, and that mentally ill people as mentally retarded. A larger proportion of non-Qataris knew that mental health problems can be treated with psychotherapy, and that mentally ill individuals can live in the community. Additionally, more Qatari participants attributed mental illnesses to possession by malevolent spirits and believed that psychiatric medications will lead to addiction, while more non-Qataris believed that brain disease and substance abuse could lead to mental disorders. Most non-Qataris reported preferring psychiatric treatment for emotional issues, while a majority of the Qatari respondents preferred turning to a traditional healer. Non-Qatari respondents expressed more positive attitudes towards living near or having conversations with mentally ill people, and were better able
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to identify common mental health issues such as depression, schizophrenia, autism, anxiety, and psychosis. Qatari respondents reported learning what they knew about mental health issues from friends and family, whereas non-Qataris learned mainly from the media (Bener & Ghuloum, 2011).

Similarly, a study conducted by Al-Adawi et al. (2003) examined the attitudes to mental illness in Oman. The study found that family members of mentally ill patients exhibit negative attitudes towards individuals with mental illnesses, and believe that these individuals are unable to tell right from wrong and are unable to form relationships. Additionally, both members of the public and medical students share similar etiological beliefs; both groups favor the role of supernatural factors rather than genetic predisposition. The results of the study corroborated the theory that culture and societal influences affect attitudes to mental health problems, and further found that level of education did not seem to influence attitudes in the participants (Al-Adawi, et al., 2003).

2.2.4 Attitudes to Mental Illness in the African Context

Organizations such as the WHO have documented the burden of mental health problems in terms of unemployment, overwhelmed health systems, deaths due to mental illnesses, and limited productivity. Approximately 30% of the global population develop mental illnesses annually, and up to 60% of them do not receive treatment; additionally, up to 75% of the global burden of mental illness occurs in Low and Middle Income Countries. In such countries, mental health is one of the lowest priorities, due to few health facilities and systems that focus on infectious diseases such as HIV, tuberculosis, and malaria (Monteiro, Ndiaye, Blanas & Ba, 2014).

In many non-Western countries, mental healthcare is generally limited to institutional services in urban areas where resources are limited. Areas in conflict,
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specifically, often have few mental health professionals despite the urgent need for them. In order to address the lack of resources, it is important to first evaluate the community’s concept and perception of mental health problems, and how members of the community define mental illness (Ventevogel, Jordans, Reis & Jong, 2013).

Mental health problems are considered a silent epidemic in most parts of Africa. Due to systemic and structural barriers such as insufficient numbers of mental health professionals, inadequate healthcare infrastructure, and lack of access to care, mental health problems have been characterized as burdensome and neglected issues which affect all sectors of the population in Africa. Prioritizing mental healthcare has proved difficult due to limited funding, lack of resources, and ineffective mental health policies. Most policy makers, funders, and governments have traditionally focused on communicable diseases such as tuberculosis, malaria, and HIV/AIDS (Group, Lancet Global Mental Health [LGMH], 2007) [as cited by Monteiro, 2015]. Due to discrimination and stigma, many people with mental illnesses do not seek help. Additionally, a large sector of the population in African countries is vulnerable to mental health problems due to psychosocial and socioeconomic stressors such as migration, conflict, war, poverty, and disasters (Okasha, 2002) [as cited by Monterio, 2015].

Monteiro et al. (2014) conducted a study in Senegal in order to determine the attitudes and knowledge of mental health issues among healthcare workers. Participants gave various explanations for the etiology and presentation of mental disorders; mental illnesses were described as any serious psychiatric condition such as schizophrenia, but participants additionally defined mental illness as any condition where an individual does not fit the societal rules and norms of his or her community or isolates him or herself from family. Participants described mentally ill individuals as those who cut themselves off from their families or those who eat trash and live in the street. Participants generally
described anxiety as an individual being withdrawn and agitated, and defined psychosis by an individual’s inability to take care of oneself and inappropriate behavior, such as taking off one’s clothes. Additionally, the participants reported that an individual’s demeanor, movements, and thought processes, can be used to identify mental illnesses; one participant responded that always appearing happy and laughing is abnormal behavior (Monteiro et al., 2014).

Ventevogel et al., (2013) conducted a study in four African settings in order to assess the local concepts of mental illnesses. The researchers collected data from Burundi, the Democratic Republic of Congo (DRC), and South Sudan. All settings were rural, had no formal mental health facilities or professionals, and were between 50 kilometers and over 100 kilometers away from formal mental healthcare facilities (Ventevogel et al., 2013).

The study was conducted using interviews and focus group discussions. The researchers identified what they referred to as local syndromes; symptoms that members of a community claim to suffer and for which the culture provides causes, diagnoses, treatments, and prevention methods. The results showed similarities among the four communities; each community described local syndromes referring to severe behavioral disturbances such as chaotic behavior, including walking around naked, interpersonal violence, and unintelligible speech. Additionally, the four communities have local syndromes describing overwhelming feelings of sadness and social isolation, similar to anxiety disorders, mood disorders, and complicated grief. The local syndromes characterized by violence and severe behavioral disturbances were found to be similar to psychotic disorders, including mania (Ventevogel et al., 2013).
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The psychiatrists interviewed by Monteiro et al. (2014) believed that two main factors influence community attitudes towards mental illness; one is that community or cultural interpretations of psychiatric symptoms lean more towards external causes such as evil spirits and witchcraft. The second factor is the belief that psychiatry is a discipline forced on Africa by Western cultures, and that many people attempt to reaffirm their cultural roots by using traditional methods to treat social and psychological issues (Monteiro et al., 2014).

Kapungwe et al. (2010) conducted a study in Zambia to explore the existence of stigma against mental health problems, the causes of stigma, and possible ways of reducing stigma. The study aimed to explore systemic discrimination and stigma as well as individual behavior and attitudes, by studying the perceptions and attitudes of particular population groups such as policy makers, general and mental healthcare service providers, recipients of psychiatric services, academics, teachers, police officers, and traditional healers (Kapungwe et al., 2010).

The results showed that stigma towards mental illness and mentally ill individuals is very common in Zambia, with most respondents, including psychiatric nurses, commenting that mentally ill people are embarrassments to their communities, feared, stigmatized, seen as stupid and as the laughing stock of the society, and are labelled in entirely negative terms. The mental healthcare professionals and recipients of psychiatric services who were interviewed reported that mentally ill individuals are stigmatized wherever they go, lose their jobs, and are even attacked while members of their communities watch. Additionally, this stigma extends to anything associated with mental health problems; family members of mentally ill patients are also stigmatized and rejected by their communities due to the assumption that the entire family is mad (Kapungwe et al., 2010). The results also showed that structural stigma is widespread among
government officials and policy makers; this was evident in the limited funding available for mental healthcare. The mental health law also views mentally ill individuals as unworthy and dangerous, hence providing no protection for the rights of mentally ill members of the society (Kapungwe et al., 2010).

Crabb et al. (2012) conducted a study in Malawi in order to explore the stigma and attitudes towards mental illness in the country. Data were collected through a cross-sectional survey over a period of two weeks, during which patients and their care-givers in the waiting rooms of psychiatry, epilepsy, surgical and general medical outpatient clinics were asked to complete a questionnaire. Participants most commonly attributed mental illness to drug and alcohol abuse, brain disease, possession by spirits, and psychological trauma. There were no significant differences in stigmatizing attitudes by gender, level of education, or whether the participant was a care-giver or patient. Participants from lower-income backgrounds were more likely to associate mental illnesses with trauma or shock than participants from higher socioeconomic backgrounds. Additionally, patients in general health clinics were less likely to want to marry an individual with mental illness than participants in the epilepsy and psychiatry clinics. Older participants more commonly considered mentally ill individuals to be a nuisance, while younger respondents more commonly attributed mental illness with drug and alcohol use, and as a punishment from God. Only approximately 25% of the respondents believed that mental health issues can be treated outside an institution, although very few respondents reported that they would be ashamed if a relative or friend had a mental illness. On the other hand, very few respondents stated that they would be comfortable with increased intimacy with an individual who had experienced mental health problems; less than 50% were willing to share a room with a mentally ill individual, while only one
in five respondents reported that they would consider marrying such an individual (Crabb et al., 2012).

Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, and Kola (2005) conducted a study in South-Western Nigeria in order to explore the knowledge of and attitudes towards mental illness. A majority of the respondents believed that drug and alcohol use could lead to mental health issues, with the second-most common perceived cause being possession by evil spirits. Over 9% of respondents believed that mental illness was a punishment from God, showing that a large number endorsed spiritual etiologies of mental illness. Respondents generally referred to mentally ill individuals as dangerous, a public nuisance, or mentally retarded, and a majority preferred not to interact socially with mentally ill individuals. There were no significant differences based on gender, age, or socioeconomic status (Gureje et al., 2005).

Barke, Nyarko, and Klecha (2011) collected data in Southern Ghana to determine the public’s attitudes towards individuals with mental illnesses and psychiatric patients’ perceptions of stigma and discrimination against them. A majority of participants did not believe that mental health problems are illnesses like any other, and thought that mental illnesses are a result of a lack of self-discipline and willpower. Participants also believed that individuals with mental illnesses should be avoided, and that such individuals should be isolated from society. Generally, respondents believed individuals with mental illnesses deserve sympathy, that they shouldn’t be denied their fundamental rights, and that mentally ill people have been ridiculed for too long. Among the psychiatric patients, perceived stigma was very high; a majority believed that the opinions of mentally ill individuals are not taken seriously, and that they are seen as untrustworthy and unintelligent (Barke et al., 2011).
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As evidenced by the aforementioned studies, stigma towards mental illness is very common in African countries. In many societies, mental health issues are thought to be a result of evil spirits or defects within families, leading to the isolation of individuals with mental illnesses. Additionally, many communities believe that mentally ill individuals are responsible for their disorders, especially when the problem is associated with drug and alcohol abuse. Because of these negative attitudes, mentally ill individuals do not get the understanding and empathy usually given to sick individuals in traditional African communities. Negative attitudes towards individuals with mental illnesses have been associated with the belief that such individuals are unable to care for themselves, are less competent, and are unpredictable and dangerous; these beliefs lead to increased discrimination against mentally ill individuals despite increased knowledge in recognizing, diagnosing, and managing mental health problems by healthcare providers.

Ndetei, Khasakhala, Mutiso, and Mbwayo (2011) conducted a study in Kenya aimed at exploring the knowledge and attitudes towards mental health problems in hospital staff in general healthcare facilities. The study was a cross-sectional survey done in various healthcare facilities and economic settings. The researchers interviewed medical personnel using a detailed structured questionnaire used to assess how general doctors manage psychological issues (Ndetei et al., 2011).

With regard to treatment options, respondents commonly stated that mental illnesses can be managed by non-psychiatric doctors, and approximately a third of respondents stated that mental illnesses can be managed by the patient’s family. Approximately 2.6% of the respondents believed that mental health issues are best managed by traditional witchdoctors. Younger nurses and doctors tended to stigmatize depressed patients more than older respondents, as did nursing and medical students (Ndetei et al., 2011).
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The large number of undiagnosed cases due to a lack of adequately trained professionals, and the widespread stigma and discrimination towards individuals with mental health issues, show a need for greater integration of mental healthcare into primary healthcare and an increase in mental health awareness training for healthcare providers and members of the community in order to greatly improve the quality of services provided to patients, and ultimately to improve their quality of life.

2.2.5 Mental Illness and Help-Seeking Behavior (HSB) among University Students

In the United States, mental illnesses account for more years lost due to disability among adolescents and young adults than any other conditions. Early mental health problems are major predictors of educational achievements, productivity and employment, interpersonal relationships, and mortality (Eisenberg, Hunt & Speer, 2012).

Mental illnesses are a common issue among younger individuals between the ages of 16 and 24 years (Gulliver, Griffiths & Christensen, 2010). Three out of every 10 students report difficulties in functioning due to feelings of depression. Additionally, up to 6% of university students had had suicidal ideations and 1% attempted suicide in the previous year. Individuals with mental illnesses often find relief through treatment; psychotherapy, which includes investigating feelings, thoughts, and behaviors, is one of the treatment options available. Combined with pharmacological interventions, psychotherapy is an effective treatment for mental illnesses; however, several university students do not seek help for mental health issues because they feel their symptoms are typical of the stresses of university, and because they are afraid others will judge them for seeking help (Vidourek et al., 2014).
Eisenberg et al. (2012) found that among university students aged between 19-25 years who had experienced mental health problems in the past year, only 18% sought help, compared to 21% of non-university students of the same ages. Specifically, the proportion of students with mood disorders who sought help was 34%, those with anxiety disorders was 16%, and those with alcohol or substance abuse disorders was only 5% (Eisenberg et al., 2012).

Without treatment, students with mental illnesses risk lower grade point averages, unemployment, and dropping out of school. In order to help make students more comfortable in seeking professional treatment when they have mental health issues, it is important to understand the barriers to help-seeking, and the benefits students gain from treatment; to achieve this, the Health Belief Model (HBM) is used to study factors associated with health behavior (Vidourek et al., 2014). The Health Belief Model (HBM) explains help-seeking and perceived need using an individualistic approach; the model suggests that interventions to change students’ attitudes, knowledge, and beliefs about mental health issues will increase their use of mental healthcare services (Eisenberg et al., 2012).

Barriers to help seeking reduce the probability that an individual will seek treatment for a mental illness; these barriers include perceived stigma towards mental illness, lack of knowledge about mental health services, lack of accessibility of mental health services, unwillingness to express emotions, and concern about the competence of the mental health professional. Additionally, issues about trust and confidentiality, and a difficulty in identifying the signs of mental health problems may also be barriers to help-seeking (Gulliver et al., 2010).
Attitudes towards mental health issues may be influenced by characteristics of the perceiver, such as ethnic group, gender, and experiences with friends or family members with mental disorders. Vidourek et al. (2014) found that the most common perceived benefits of treatment were reduced stress, improved mental health, and resolving one’s issues, while the lowest benefits perceived were improved sleep, increased energy, and increased social support. Results revealed that males perceived fewer benefits of treatment than females, and that white students and students with a family member with a mental illness perceived greater benefits of treatment. Additionally, it was found that older students perceived a significantly smaller number of barriers to help seeking, non-white students perceived fewer barriers than did white students, and students who had never received mental health treatment perceived fewer barriers than those who had received treatment. There were no significant gender differences (Vidourek et al., 2014).

A similar study by Eisenberg, Golberstein & Gollust (2007) found that students with already-diagnosed mental health problems were more likely to perceive benefits of help-seeking, while those who had never used mental health services were less likely to perceive benefits of mental health treatment. Additionally, international, non-white students were less likely to perceive any benefits of seeking help, while female students were more likely to seek help than males. The likelihood of seeking help was also lower for students who came from low-income families, those who were younger than 26 years old, and those who were married (Eisenberg et al., 2007).

Students with a friend or family member with a mental illness perceived higher benefits of treatment, while those without a friend or family member with a disorder were more likely to have stigma-related attitudes. Furthermore, adults with experience of mental illness through family or friends were less likely to endorse negative attitudes towards individuals with mental health issues. It has also been found that having family
members or friends who have received treatment is associated with more positive help seeking behavior; these attitudes may be influenced by contact with such individuals, as experience with people with mental illnesses is associated with a more positive attitude towards them. Thus, it may be important to increase students’ exposure to mental health problems and to educate them on mental health in order to reduce stigma (Vidourek et al., 2014).

2.3 Summary

The stigma and discrimination suffered by individuals with mental illnesses have far-reaching and long-lasting effects; not only does stigma prevent these individuals from seeking help in many cases, but also affects their quality of life and that of their families. Because culture and tradition have a significant influence on attitudes to mental illness, it is important to explore the various cultural beliefs that are associated with the negative attitudes towards mentally ill individuals, and look for ways in which to increase awareness and knowledge of mental illnesses, treatment, and outcomes in order to improve the quality of services offered to individuals with mental illnesses.

The next chapter provides details on how the researcher conducted this study, by detailing the research design, study population, data collection and analysis techniques, sampling technique, and ethical considerations that were taken into account while conducting the study.
Chapter 3

Research Methodology

3.1 Introduction

The current study explored the attitudes of students at USIU-A toward mental health, and has contributed to the scarce literature on attitudes toward mental health in Kenya. Additionally, this chapter has provided details on the methodology the researcher utilized when conducting the study. It provides details on the research design, the sampling technique, the population, and data collection and analysis techniques that were used. This section has also addressed any ethical concerns that may have arisen, and how the study adhered to the ethical guidelines set by the American Psychological Association.

3.2 Research Design

This study employed the survey technique, a form of quantitative research. This design was utilized because this study aimed to explore the various attitudes to mental health. Additionally, the use of a qualitative design allowed the researcher to explore participants’ own experiences and beliefs.

3.3 Study Population

Participants were selected from students taking various courses at the United States International University-Africa, a university based in Nairobi, the capital city of the Republic of Kenya. The university offers various courses including, but not limited to, International Business Administration, International Relations, Psychology, and Pharmacy.
3.4 Sample Size

The sample consisted of 250 students selected from undergraduate, graduate, and doctoral classes from various programs at the university including the following: Psychology, International Relations, and International Business Administration. This sample size was selected in order to be as representative as possible of the study population, and in order to provide a clear picture of the differences between programs of study.

3.5 Sampling Technique

This study utilized a cluster sampling technique in which classes of students were selected randomly from a list of the classes being offered that semester. This technique was employed in order to ensure that participants were selected from as many courses as possible.

3.6 Data Collection Instruments

This study employed the use of two questionnaires; a short biographical one and the Attitudes toward Mental Health Problems questionnaire. The biographical questionnaire helped provide information on the participant’s age, gender, country of origin, program of study, and level of study (See appendix B).

Gilbert, Bhundia, McEwan, Irons, and Sanghera (2007) developed the Attitudes towards Mental Health Problems scale in order to explore the aspects of shame associated with mental health issues among women of Asian descent. These aspects include family attitudes, community attitudes, and self-stigma. The scale explores aspects of reflected shame, which refers to how other individuals (friends or family members) may cause shame to someone, or how an individual may cause shame to others (relatives or friends).
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Additionally, the scale explores external shame, which refers to an individual’s perception of how others view him or her (Gilbert et al., 2007).

The Attitudes towards Mental Health Problems questionnaire (See appendix C) is a 35-item scale where each item is rated on a Likert scale of 0-3, where 0=do not agree at all, 1=agree a little, 2=mostly agree, and 3=completely agree. The items are categorized into three groups of statements; the first deals with community beliefs and attitudes towards individuals with mental health problems, the second deals with external shame, the third contains statements referring to how one would see him/herself if they had mental health problems (internal shame), and the last two groups of statements deal with reflected shame; how one’s family would be treated if they had mental health problems, and how one feels they would be treated if a family member had a mental health problem (Gilbert et al., 2007).

3.7 Data Collection Procedure

Data for this research study was collected from 250 students in various classes at the United States International University-Africa. The researcher utilized cluster sampling in order to identify which classes participants would be selected from. Data was collected using a short biographical information questionnaire (See Appendix B), as well as the Attitudes towards Mental Health Problems Scale questionnaire (See Appendix C) which was used to assess participants’ attitudes to mental illness.

Before handing out the questionnaires the researcher informed the participants about what the study entailed, and answered any questions the participants had. The participants were handed a consent form, the contents of which the researcher explained to the participants regarding the significance of the study and how it would be carried out (See appendix A). The consent form also stated that participation was voluntary, and that
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participants were free to withdraw from the research at any point should they wish to do so. Additionally, participants were assured that all information would be completely anonymous and would be kept confidential.

All participants who consented to participation were then handed the biographical questionnaire and the Attitudes towards Mental Health Problems Scale (See appendices B and C). The questionnaire took approximately 15-20 minutes to complete, and during this time the researcher was available to answer any questions and make any clarifications needed. Once participants had completed their responses, they were debriefed in order to address any anxiety or misconceptions about the purpose of the research and the information collected.

3.8 Data Analysis

Once data were collected, the total scores for each section in the questionnaires were added up to get the total score for each participant. The results were first entered into a Microsoft Excel spreadsheet and processed before being copied into a data sheet in the Statistical Package for the Social Sciences (SPSS). Average scores and standard deviations were calculated per program of study, level of study, gender, and country of origin. This was done in order to assess any differences in scores for the different categories. Additionally, one-way ANOVAs were conducted in order to find differences in average scores on the basis of nationality, religion, age, and major; in the event of any significant differences, post-hoc T-tests were conducted in order to determine where these differences lay. Independent sample T-tests were also conducted to determine if there were any significant differences in average scores between male and female respondents.
3.9 Ethical Considerations

This research was conducted in a way that upheld all the ethical guidelines set by the American Psychological Association. All participants were informed that their participation in the study was completely voluntary, and that they could withdraw participation at any point during the study. The researcher also provided participants with the following information:

1. What the research was about, the purpose of the research, and the approximate time it would take to complete the questionnaires.
2. Information about any foreseeable factors that may influence the participant’s decision to participate, if any existed, such as any possibility that the participant may be harmed in any way during the study.
3. Information on the benefits and significance of the study and future implications of the research.
4. Participants were assured that all information collected was anonymous and would remain confidential.
5. Participants were also provided with information on who they could contact if they needed more information on the study or further information on their rights as participants.

Debriefing: the researcher provided verbal debriefing to the participants after they had completed the forms. They were also provided with a debrief form which provided them with information on why the research was being conducted (See appendix D). The form also encouraged participants to seek counseling services at the USIU-A counseling center if they experienced any emotional distress after the study.
Additionally, the researcher provided contact information that the participants needed should they want to follow up on the results of the study.

3.10 Summary

This chapter detailed the research design that was utilized, the study sample, sampling technique, and ethical considerations that were taken into account while conducting the study. Additionally, it discussed the data collection procedure, data collection tools that would be used, and the statistical analysis conducted once the data collection stage was complete.
Chapter 4

Results and Findings

4.1 Introduction

This chapter outlines the results of the data analysis conducted. Data were collected and analyzed in order to answer the research questions posed in Chapter 1 of this thesis. The main goal of this study was to evaluate the attitudes students of the United States International University-Africa held towards mental health problems, and to identify any differences in attitudes on the basis of gender, religion, and program of study.

4.2 General Information

The classes selected for this study consisted of a total of 280 students, all of whom were approached for participation. Of these 280, 250 students consented for participation. A total of 211 questionnaires were correctly completed, creating a response rate of 84.4%. The sample consisted of 149 females and 52 males between the ages of 17-59 years (M=24.04, SD=6.84). For ease of statistical analysis, the participants were categorized into four age groups (See Figure 4.1); 17-20, 21-22, 23-27, and 28-60. A total of 15 nationalities were represented in the sample (Table 4.1), with Kenya being the most represented country (86.7%). Ten religions were represented in the sample, with a majority (72%) identifying as Christian (Table 4.2). In cases where an individual listed more than one nationality or religion, the response was coded as “mixed”. The sample consisted of students in ten programs of study, with International Relations being the most represented (31.8%) and Business Administration being the least represented (0.5%). Participants were selected from undergraduate, graduate, and doctoral classes, with undergraduate classes being the most represented (72%). Due to the small number of
doctoral students, Master’s and Doctoral classes were combined into the “Graduate” category.

**Table 4.1: Nationality**

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>America</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Botswana</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Burundi</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Chad</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>India</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Kenya</td>
<td>183</td>
<td>86.7</td>
</tr>
<tr>
<td>Mexico</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Mixed</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>Nigeria</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Rwanda</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>South Sudan</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Tanzania</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>Uganda</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Ukraine</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Zambia</td>
<td>2</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Because the numbers of respondents from other countries were small, the scores of Kenyan respondents were compared with the scores of respondents of all other represented nationalities.
Figure 4.1: Age Groups

For ease of statistical analysis, the scores of Christian respondents were compared with the average scores of respondents of other religions (“Christian” vs. “Other”).

Table 4.2: Religion

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>152</td>
<td>72</td>
</tr>
<tr>
<td>Hindu</td>
<td>7</td>
<td>3.3</td>
</tr>
<tr>
<td>Islam</td>
<td>33</td>
<td>15.6</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Mixed</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>None</td>
<td>14</td>
<td>6.6</td>
</tr>
<tr>
<td>Rastafari</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Sikh</td>
<td>2</td>
<td>0.9</td>
</tr>
</tbody>
</table>
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Table 4.3: Major

<table>
<thead>
<tr>
<th>Program</th>
<th>School</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Administration</td>
<td>Business</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Business Information Technology</td>
<td>Business</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>SHSS</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Human Resource Management</td>
<td>SHSS</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>International Business Administration</td>
<td>Business</td>
<td>55</td>
<td>26.1</td>
</tr>
<tr>
<td>International Relations</td>
<td>SHSS</td>
<td>67</td>
<td>31.8</td>
</tr>
<tr>
<td>Information Systems Technology</td>
<td>Science</td>
<td>6</td>
<td>2.8</td>
</tr>
<tr>
<td>Journalism</td>
<td>SHSS</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Science</td>
<td>32</td>
<td>15.2</td>
</tr>
<tr>
<td>Psychology</td>
<td>SHSS</td>
<td>39</td>
<td>18.5</td>
</tr>
</tbody>
</table>

For ease of statistical analysis, the different programs were grouped according to the school (School of Business, School of Humanities and Social Sciences, and School of Science) (Table 4.3), and the scores of respondents in the four most-represented majors (IBA, IR, Psychology, and Pharmacy) were compared.

4.3 USIU-A Students’ Attitudes to Mental Health Problems

The researcher wanted to examine the attitudes held by USIU-A students towards mental health problems. In order to do this, the researcher conducted a frequency analysis of respondents’ total scores on each of the five scales on the Attitudes towards Mental Health Problems Scale questionnaire (Appendix C). The questionnaire consists of 35 items separated into five sections; attitudes towards mental health problems, external shame/stigma awareness, internal shame, reflected shame 1, and reflected shame 2.
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The first section, which contained eight items, required participants to think about how their communities and families viewed mental health problems. Scores were associated with the respondent’s attitude; the higher the score, the more negative his/her attitude. The average score on this section was 9.12 (SD=5.94). The second section of the questionnaire contained 10 items requiring respondents to think about how they might feel, if they themselves suffered from mental health problems. The average score was 11.84 (SD=8.01). Section three consisted of five items requiring participants to think about how they might feel about themselves if they suffered from mental health problems; the mean score was 6.47 (SD=5.21). Section four consisted of seven items; participants were required to think about how they felt their families would be affected if they themselves suffered from mental health issues. The mean score on section four was 9.56 (SD=5.73). The final section of the questionnaire contains five items and refers to how participants might feel if one of their close relatives suffered from mental health issues. The average score on this section was 5.32 (SD=5.26).

4.4 Age and Attitudes towards Mental Health Problems

In order to determine the existence of any age differences in average scores, the researcher conducted a one-way ANOVA. The results are shown in the table below (Table 4.4).
Table 4.4: Age and Attitudes towards Mental Health Problems

<table>
<thead>
<tr>
<th>Section</th>
<th>Mean Score</th>
<th>SD</th>
<th>F(3,207)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes towards Mental Health</td>
<td>9.12</td>
<td>5.94</td>
<td>3.49</td>
<td>0.017*</td>
</tr>
<tr>
<td>External Shame</td>
<td>11.84</td>
<td>8.00</td>
<td>2.75</td>
<td>0.044*</td>
</tr>
<tr>
<td>Internal Shame</td>
<td>6.47</td>
<td>5.21</td>
<td>0.23</td>
<td>0.873</td>
</tr>
<tr>
<td>Reflected Shame 1</td>
<td>9.56</td>
<td>5.73</td>
<td>1.09</td>
<td>0.356</td>
</tr>
<tr>
<td>Reflected Shame 2</td>
<td>5.32</td>
<td>5.26</td>
<td>1.06</td>
<td>0.367</td>
</tr>
</tbody>
</table>

Note: * indicates a significant value

The results of the one-way ANOVA revealed significant age differences in average scores in both the “Attitudes towards Mental Health Problems” and “External Shame” sections of the questionnaire. High scores in section one indicate a greater awareness of the stigma towards mental health problems in one’s community, while section two examines the level of self-stigma one would exhibit if one suffered from mental health problems. Follow-up independent samples T-tests were conducted in order to find out where the differences in average scores for these two sections lay. The results of the T-tests on section one (Attitudes to mental health problems) revealed that there was a significant difference in average scores between age group one (17-20) and age group three (23-27); t (118) = -2.03, p=0.04. There was also a significant difference in scores found between age group one and four (28-60); t (93) = -2.71, p=0.008, and a significant difference between age group two (21-22) and four; t (89) = -2.49, p=0.015. Respondents aged 23-60 scored higher on average than those aged 17-22, suggesting that older...
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participants were more aware of the stigma against mental illness among members of their communities.

The follow-up T-tests on section two (External shame) revealed a significant difference in scores between age groups one and two; \( t(118) = -2.12, p=0.036 \), and between age groups one and four; \( t(93)=-2.59, p=0.011 \). Similar to the results on section one, older respondents scored higher on section two, implying that they would be more likely to display self-stigma if they suffered from mental health problems.

4.5 Gender and Attitudes to Mental Health

The researcher wanted to determine whether there were any gender differences in attitudes towards mental health problems. In order to do so, an independent samples t-test was conducted. The results of the analysis did not reveal any significant differences.

4.6 Nationality and Attitudes to Mental Health

The study aimed to determine if any differences existed in attitudes to mental health based on respondents’ nationalities. Because “Kenyan” was the majority (86.7%), all other nationalities were grouped together in order to allow for comparison. To determine if there were any differences in scores based on nationality, an independent samples T-test was conducted. The results of this test revealed no significant differences between nationalities in average scores.

4.7 Religion and Attitudes to Mental Health

One of the research objectives was to determine the existence of any religious differences in attitudes towards mental health problems. Because each religion was not equally represented in the sample i.e. some religions had only one or two participants, the religions were grouped as "Christian” and “Other” in order to make a statistical
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comparison. In order to determine whether any differences exist, the researcher carried out an independent samples t-test. The results of the test revealed no significant differences in scores on attitudes, external shame, internal shame, or reflected shame 1. However, the results showed a difference on section five (reflected shame 2); \( t(209)=3.621, p=0.000 \). Christian respondents had a higher average score (\( M=6.11, \) \( SD=5.44 \)) than other religions (\( M=3.27, \) \( SD=4.12 \)), suggesting that Christian respondents were more likely to believe their families would be discriminated against if they were suffering from mental health problems.

4.8 Major and Attitudes towards Mental Health

The researcher wanted to determine if any differences existed in average scores of respondents taking different majors. The most represented courses were selected (IBA, IR, Psychology, and Pharmacy), and the average scores compared. This was done by conducting a one-way ANOVA of the results. The results of the ANOVA showed no significant differences in average scores among the different majors.

4.9 Summary

This chapter detailed the statistical tests utilized in data analysis, and provided details on the results revealed by the analysis. Additionally, it provided details on the various significant findings revealed by the statistical analysis.
Chapter 5

Summary, Discussion, Conclusions, and Recommendations

5.1 Introduction

This chapter provides a summary of the results of the statistical analysis of data, and any significant findings. Additionally, this chapter discusses the purpose of the study, a summary of the methodology utilized, and major findings based on the research questions. This chapter also includes the researcher’s conclusions, and recommendations for improvement and further research.

5.2 Summary of the Study Results

The purpose of this study was to examine the attitudes held by USIU-A students towards mental health problems, and to determine whether any relationship existed between these attitudes and respondents’ cultural background (represented by religion and nationality), gender, age, and major. Statistical analysis was carried out in order to determine the existence of any differences in average scores based on participants’ religion, age, gender, major, and nationality.

The study found significant age differences in average scores on sections one and two of the questionnaire; older respondents scored higher than younger ones on both sections, suggesting that older participants are more aware of the stigma associated with mental health problems in their communities, and that they would be more likely to self-stigmatize if they suffered from mental health problems.

The results of the study also revealed significant differences in average scores between Christian respondents and non-Christian respondents on section five of the questionnaire (Reflected shame 2). Christian respondents scored higher on this section,
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suggesting that they were more likely to believe their families would be discriminated against if they themselves suffered from mental illnesses.

Additionally, the results of this study revealed no significant differences in average scores between participants from different countries and those taking different courses. There were also no gender differences in the average scores on the questionnaire; this suggests that attitudes towards mental health do not differ on the basis of nationality, gender, or major.

The results of this study showed that USIU-A students generally do not have negative attitudes towards mental health problems; the frequency analysis of respondents’ scores on the questionnaire showed that, on average, respondents’ scores were not extremely high.

5.3 Discussion of Results

5.3.1 Attitudes and Age

Studies have shown that older adults tend to underutilize mental health care services. Hatfield [1999, cited in Robb et al., 2003] found that although older adults make up approximately 12.7% of the American population, only 2% utilize private mental healthcare services, while 4-7% utilize community facilities. It has been found that some of the barriers to help-seeking include lack of accessibility, insurance coverage, and negative attitudes held by professionals about working with the elderly. Another barrier to help-seeking is the attitudes held towards mental health and mental healthcare; research suggests that a lack of knowledge about mental health care and stigma and negative attitudes towards mental illness may deter individuals with mental health problems from seeking treatment (Robb et al., 2003).
Birren and Renner [1979, cited in Robb et al., 2003] suggested that older adults view help-seeking as a sign of personal weakness, while Lebowitz and Niederehe [1992, cited in Robb et al., 2003] found that mental illness stigma is strong among older adults who believe that mental illnesses are a result of spiritual deficiency or personal failures (Robb et al., 2003). Additionally, Stuber, Rocha, Christian, and Link (2014) conducted a study to evaluate the attitudes towards mentally ill individuals held by mental health professionals. Their findings revealed that older mental health professionals viewed schizophrenic and depressed patients as incompetent, as compared to younger professionals (Stuber et al., 2014).

Contrary to the results of the aforementioned studies, the present study found that the attitudes of older participants were more positive than those of younger participants. However, older respondents were found to be more likely to display self-stigma if they suffered from mental health problems.

### 5.3.2 Attitudes and Gender

Gonzalez, Alegria, and Prihoda (2005) found differences in attitudes towards mental health problems and help-seeking behavior based on gender; females had more positive attitudes towards treatment than males. Similarly, Chambers et al. (2010) found that female nurses were less likely to believe that mentally ill individuals are a threat to society; they are more likely to be compassionate and sympathetic towards mentally ill patients than male nurses (Chambers et al., 2010).

Similarly, Leong and Zachar (1999) found that, among a sample of college students, female students had more positive attitudes to mental health than male students did. Females were also more likely to endorse the need for help-seeking and display greater interpersonal openness and confidence in mental health professionals (Leong &
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Zachar, 1999). Additionally, Kabir et al. (2004) found that, although female participants were more sympathetic towards mentally ill individuals, they also tended to be more fearful and avoided the mentally ill. The present study, however, found no significant gender differences in attitudes towards mental health problems.

5.3.3 Attitudes and Nationality

In their study on nurses’ attitudes towards mental illness, Chambers et al. (2010) found that their attitudes differed according to their country of origin; nurses in Lithuania generally had negative attitudes towards mental illness, while nurses in Portugal generally held the most positive attitudes. Additionally, it was found that nurses in Finland, Italy, and Ireland had similar attitudes, although Finnish nurses had slightly more negative attitudes. Mehta et al. (2009) found that participants from England and Scotland generally showed positive attitudes towards mental health problems. The present study did not find any significant differences in attitudes towards mental health problems between Kenyan respondents and respondents from other countries.

5.3.4 Attitudes and Religion

Beliefs that people hold about the causes of mental illness may influence their attitudes and behaviors towards mentally ill individuals. These behaviors, if negative, may reduce the likelihood of mentally ill individuals seeking treatment, and therefore lead to a poor prognosis. Srinivasan and Thara (2000) conducted a study in Chennai, India, where a majority of the population is Hindu, to evaluate the beliefs about causes of schizophrenia. They found that 12% of their participants attributed the development of schizophrenia to supernatural causes, such as demons. Similarly, in a study of mainly Muslim participants in Southwest Nigeria, Adebowale and Ogunlesi [1998, as cited by Kabir et al., 2004] found that the most reported causal factor for schizophrenia was
supernatural causes. Kabir et al. (2004) conducted a similar study in Northern Nigeria, using participants who were mainly Muslim (90%) and Christian (10%), to evaluate the beliefs and attitudes towards mentally ill people. They found that supernatural causes were the third leading factor believed to cause mental illness, and that a majority of participants held negative beliefs about mentally ill people (Kabir et al., 2004).

The present study found significant differences in attitudes towards mental health between religions; Christian respondents generally held more negative attitudes towards mental illness than non-Christian respondents. Additionally, Christian respondents were more likely to believe that their families would be discriminated against if they, themselves, suffered from mental illnesses.

5.3.5 Attitudes and Major

The quality of care provided by mental health professionals and medical personnel is largely influenced by the attitudes and beliefs these professionals hold about mental illness. As such, many researchers have focused on the attitudes of mental health professionals and psychology/psychiatry students towards mentally ill patients. A study by Fan [1999, as cited by Chung, Chen & Liu, 2001] found that Chinese university students were more likely to view mentally ill patients as incapable of taking care of themselves, and were more likely to advocate for social distance from mentally ill patients than Western university students. Conversely, Eker [1985, as cited by Chung et al., 2001] found that there were no significant differences in attitudes of undergraduate psychology students and experienced clinicians (Chung et al., 2001).

Similarly, Ucok et al. (2004) conducted a study in Turkey to evaluate the attitudes held by psychiatrists towards mentally ill patients. The study revealed that psychiatrists, similar to the general population in the area, held negative attitudes towards patients with
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schizophrenia. The present study, however, found no significant difference in attitudes towards mental health problems between students taking different majors.

5.4 Conclusions

The results of this study enabled the researcher to draw several conclusions about attitudes towards mental health problems among USIU-A students, based on the statistical analysis conducted.

5.4.1 Attitudes and Age

Based on the data analysis, it can be concluded that attitudes towards mental health problems change as one gets older; older participants held more positive attitudes to mental illness than younger ones did. Additionally, older respondents were more likely to display self-stigma if they suffered from mental health problems.

5.4.2 Attitudes and Gender

The data analysis showed no significant gender differences in attitudes to mental health problems. It can therefore be concluded, based on the data, that gender has no effect on attitudes to mental illnesses.

5.4.3 Attitudes and Nationality

The data analysis revealed no significant differences in attitudes towards mental health problems based on respondent’s nationalities. Therefore, based on the results, it can be concluded that attitudes to mental health do not differ based on one’s nationality.

5.4.4 Attitudes and Religion

The results showed significant differences in attitudes between Christian and non-Christian respondents; Christian respondents had more negative attitudes overall, as compared to non-Christians. Additionally, Christian respondents were more likely to
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believe that their families would be discriminated against if they, themselves, suffered from mental illness. Thus, it can be concluded that Christians show more stigmatizing attitudes towards mental health problems than non-Christians.

5.4.5 Attitudes and Major

The results did not reveal any significant differences in attitudes between students of different majors. It can therefore be concluded that one’s major has no effect on their attitudes to mental health problems.

5.5 Recommendations

5.5.1 Recommendations for Improvement

While conducting this study, the researcher noted several limitations in sampling and data collection.

It was noted that not all programs were represented in the sample, and that the sample was not representative of the entire population of USIU-A students. Additionally, because doctoral classes are much smaller than graduate or undergraduate classes, it is difficult to get a comparable sample. It is therefore recommended that a larger sample be taken, and that all the programs and levels of study be represented in the sample.

Another limitation to this study is the sampling technique used. Although cluster sampling was used, this limited the data analysis in terms of comparing the results of participants according to different criteria such as religion, nationality, age, and major. Due to this, the analysis conducted was done using the most-represented categories, and the results of the study may not be representative of the study population. Additionally, the results may not be generalizable to the general population.
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The researcher also found that it was difficult to collect data from certain classes because the lecturers refused to let students fill out the questionnaires during the lesson. This lead to difficulties in retrieving the questionnaires, and negatively affected the response rate. It is recommended that lecturers be sensitized to these difficulties and asked to be more understanding of the research process.

Additionally, although the study aimed to determine if there were any differences in attitudes among students at different levels of study, the lowest level of education was an undergraduate class. The results may have been different if the sample included participants with only a high-school education, or participants who had already completed their doctorates. The researcher recommends adding these participant variables to the sample.

5.5.2 Suggestions for Further Research

During the data collection process, a number of participants suggested adding questions regarding specific psychological disorders such as depression and schizophrenia to the questionnaire in order to assess more in-depth the attitudes towards such disorders. It is therefore recommended that in future studies these additions be made to the questionnaire. Additionally, it is recommended that future studies utilize questionnaires that address specific beliefs and perceptions of people suffering from mental health problems, such as beliefs about the individuals’ ability to provide for themselves.

One of the objectives of this study was to identify differences in attitudes based on level of education. Although no significant differences were found between the levels of study, it is important to evaluate differences among other levels of education i.e. non-university students or those who have only a high school education. This modification
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may help researchers identify the various attitudes towards mental health problems held by individuals with varying education levels. Additionally, it is important to consider participants’ socioeconomic status as a factor in their attitudes towards mental health.

The researcher also recommends that future studies attempt to identify and reduce research biases such as social desirability bias, where respondents answer questions in a way that they think will lead to them being more liked. Another bias that should be dealt with is habituation, where respondents provide the same answers to different questions with similar wording. The researcher found habituation to be a challenge in this study, as the questions in the different sections of the questionnaire were similarly worded, leading several respondents to assume the questions had been repeated.

It is recommended that future studies allow for more time to explain to respondents the purpose of the study and the definitions of terms such as “community” in order to obtain the most accurate responses possible and to avoid confusion among the respondents. It is also recommended that a more in-depth tool be used to measure attitudes towards mental health, in order to allow for more detailed and accurate answers. Including focus groups may improve the accuracy of the research, and may allow for a more detailed exploration of the various attitudes towards mental health problems held by USIU-A students, and Kenyans in general.

5.6 Summary

This chapter has detailed the summary of results found through analysis of data collected. It has also detailed the various conclusions drawn from the results of the data analysis. Additionally, this chapter contains the limitations of the present study, and recommendations for any future research.
References


CDC, SAMHSA, NACBHDDD, NHIM, & CCMHP. (2012). *Attitudes toward mental illness: results from the behavioral risk factor surveillance system.* Atlanta, GA: Author.
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Attitudes to Mental Health


Attitudes to Mental Health


Attitudes to Mental Health


Attitudes to Mental Health


Attitudes to Mental Health


World Psychiatric Association [WPA] (2002). WPA programme to reduce stigma and discrimination because of schizophrenia. Author.

APPENDIX A: CONSENT FOR RESEARCH FORM

Dear Participant,

My name is Balraj Bhurji and I am a graduate student in the Clinical Psychology Program at the United States International University - Africa located in Nairobi, Kenya. For me to meet my graduation requirements, I am required to conduct and complete a research study. I am hereby inviting you to participate in this research study by completing some questionnaires.

The information provided below explains what my research will be and what procedures will be used to collect data for it. It will also highlight what your role as a participant will be and attempt to answer all questions that you may have about it.

**Title of the research:** Attitudes to mental health among students at the United States International University-Africa.

You will be asked to complete two questionnaires that are important for the study. The first questionnaire is a short biographical questionnaire that will provide information such as your age, gender and country of origin. The second questionnaire is known as the Attitudes towards Mental Health Problems Scale. You will be asked to fill these questionnaires as honestly as possible and to answer all questions provided. Both questionnaires will not require more than 30 minutes to complete. All participation will be voluntary and you are free to stop participation at any time should you feel the need to.

All information provided will be done so anonymously, to ensure this, you are not required to fill in your name for any of the questionnaires.

I believe that there are no risks to this research, however if participation causes any psychological distress, feel free to consult the researcher who will arrange for a
Attitudes to Mental Health

counselling session on site. In addition, if a participant feels that participation is causing any undue stress, they are free to stop participation in the research at any point.

This research is significant in that it will help provide information on the prevailing attitudes and beliefs regarding mental health problems. It will also provide information on community beliefs regarding mental health, and may help provide information that can be used to create target-specific interventions in order to raise awareness of mental health problems and treatment options.

For individuals who wish to participate but are having difficulty understanding the language of instruction, the researcher will be available to offer any assistance possible.

Please feel free to contact the researcher, Balraj Bhurji, either personally or through her email address balraj.bhurji@gmail.com if you have any questions or concerns.

Your participation in this research project will be greatly appreciated.

Regards

Balraj Bhurji

**My Consent to Participate:**

By signing below, I confirm my questions have been answered I consent to participate in this study.

_________________________________  __________
Signature of Participant  Today’s Date

_________________________________  __________
Principal Researcher  Today’s Date
APPENDIX B: BIOGRAPHICAL INFORMATION

Please complete the following form:

Age: ________  Nationality:___________  Religion:__________

Gender:  

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

Please state your major: ________________________________

Level of study (Please tick appropriate box):

<table>
<thead>
<tr>
<th>Undergraduate</th>
<th>Graduate</th>
<th>Doctorate</th>
</tr>
</thead>
</table>

For undergraduate (Please tick appropriate box):

<table>
<thead>
<tr>
<th>Freshman</th>
<th>Sophomore</th>
<th>Junior</th>
<th>Senior</th>
</tr>
</thead>
</table>

For Graduate and Doctorate, please state year of study: ________________
APPENDIX C: ATTITUDES TOWARDS MENTAL HEALTH PROBLEMS

SCALE

We are interested in people's thoughts and feelings about mental health problems. As you may know, some people suffer from mental health problems such as depression and anxiety. These can make it difficult to cope with everyday life. Depressed people can feel tired, not enjoy life, want to hide away and may withdraw from family life. Below are a series of statements about how you, your community and your family may think about such problems. Read each statement carefully and circle the number that best describes how much you agree with each statement.

Please use the following scale:

0 = Do not agree at all; 1 = Agree a little; 2 = Mostly agree; 3 = Completely Agree

Attitudes towards Mental Health Problems

For this first set of questions please think about how your community and family view mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

1. My community sees mental health problems as something to keep secret

   My community sees mental health problems as something to keep secret
   0 1 2 3

2. My community sees mental health problems as a personal weakness

   My community sees mental health problems as a personal weakness
   0 1 2 3

   My community would tend to look
   0 1 2 3
### Attitudes to Mental Health

3. down on somebody with mental health problems
   
   My community would want to keep their distance from someone with mental health problems

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

5. My family see mental health problems as personal weakness

6. My family would tend to look down on somebody with mental health problems

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

### External Shame/Stigma Awareness

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

8. I think my community would look down on me
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>I think my community would see me as inferior</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I think my community would see me as inadequate</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I think my community would see me as weak</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I think my community would see me as not measuring up to their standards</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>I think my family would look down on me</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I think my family would see me as inferior</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I think my family would see me as inadequate</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I think my family would see me as weak</td>
<td></td>
</tr>
</tbody>
</table>
Attitudes to Mental Health

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

Internal Shame

For the next set of questions please think about how you might feel about yourself if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

19. I would see myself as inferior

20. I would see myself as inadequate

21. I would blame myself for my problems

22. I would see myself as a weak person

23. I would see myself as a failure

Reflected Shame 1
For the next set of questions we would like you to think about how you might feel if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life. This time consider how worried or concerned you would be on the impact on your family.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>My family would be seen as inferior</td>
<td>0   1   2   3</td>
</tr>
<tr>
<td>My family would be seen as inadequate</td>
<td>0   1   2   3</td>
</tr>
<tr>
<td>My family would be blamed for my problems</td>
<td>0   1   2   3</td>
</tr>
<tr>
<td>My family would lose status in the community</td>
<td>0   1   2   3</td>
</tr>
<tr>
<td>I would worry about the effect on my family</td>
<td>0   1   2   3</td>
</tr>
<tr>
<td>I would worry that I would be letting my family's honor down</td>
<td>0   1   2   3</td>
</tr>
<tr>
<td>I would worry that my mental health problems could</td>
<td>0   1   2   3</td>
</tr>
</tbody>
</table>
Attitudes to Mental Health

damage my family's reputation

Reflected Shame 2

For the next set of questions we would like you to think about how you might feel if one of your close relatives suffers from mental health problems such as depression and anxiety with a difficulty to cope in everyday life. This time consider how worried or concerned you would be on the impact on you.

31. I would worry that others will look down on me 0 1 2 3

32. I would worry that others would not wish to associate with me 0 1 2 3

33. I would worry that my own reputation and honour might be harmed 0 1 2 3

34. I would worry that if this were known I would lose status the community 0 1 2 3

35. I would worry that others might think I might also have a mental health problem 0 1 2 3
APPENDIX D: DEBRIEF FORM

Thank you for participating in this research study. The purpose of this study is to gain an understanding of the attitudes towards mental health problems in USIU-A. Your participation will help researchers gain more insight into the various beliefs and attitudes, and the differences in attitudes among participants.

In the event that you experience any distressful reactions or concerns regarding the questions presented to you in this study, feel free to seek support through counseling at the USIU-A counseling center.

If you have any questions regarding the research, you may contact the researcher at the following number 0721273190 or through the following e-mail address balraj.bhurji@gmail.com Once again, thank you for your participation.

Regards,

Balraj K. Bhurji

Tel: 0721273190

E-mail: balraj.bhurji@gmail.com
APPENDIX E: LETTER OF AUTHORIZATION

USIU-A Institutional Review Board (IRB)

15th November 2016
USIU-A/IRB/16/S19
Balraj K. Bhurji,
MA in Clinical Psychology,
Email: balraj.bhurji@gmail.com

IRB-RESEARCH APPROVAL

The USIU-A IRB has reviewed and granted ethical approval for the research proposal titled 'Attitudes towards Mental Health Among Usiu-A Students.' The approval is for six months from the date of IRB. Please submit a completed copy of the study to the IRB office, soft copy is acceptable.

You are advised to follow the approved methodology and report to the IRB any serious, unexpected and related adverse events and potential unanticipated problems involving risks to subjects or others.

Should you or study participants have any queries regarding IRB’s consideration of this project, please contact irb@usiuan.ac.ke.

Prof. Damary Sikateh,
Chair | IRB | USIU-Africa,
cwattson@usiuan.ac.ke
Office 20.3606 112.

CC: Research Office