Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

BARRIERS TO HELP-SEEKING AS PERCEIVED BY ADOLESCENTS IN EGYPT AND THEIR RELATIONSHIP TO SELF-REPORTED PSYCHOLOGICAL DISTRESS

By

RANA WALID ABDELAAL

A thesis submitted in partial fulfillment of the

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THESIS APPROVAL

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Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

An Abstract of the Thesis of

Rana Walid Abdelaal for the degree of Master of Arts

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Title: BARRIERS TO HELP-SEEKING AS PERCEIVED BY ADOLESCENTS IN EGYPT AND THEIR RELATIONSHIP TO SELF-REPORTED PSYCHOLOGICAL DISTRESS

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Dr. Stavroula Diareme,

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Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

Abstract

This study examined the prevalence of psychological distress among Egyptian adolescents, the attitudes toward seeking professional help, and the associated barriers. The study explored how factors such as the severity of psychological distress, gender, age, socioeconomic status, and geographical region can relate to such barriers. The study design is a quantitative correlational design. Data was collected through a structured online survey (in English and Arabic), including the Kessler Psychological Distress Scale (K-10) and the Barriers to Adolescents Seeking Help Questionnaire (BASH) instruments. A sample of 70 Egyptian adolescents aged between 10 and 21 was recruited using convenience and snowball sampling. Results regarding the prevalence of psychological distress indicated that 77% were likely to have severe difficulties. The three highest-scoring barriers to seeking help were Time Availability, Self-Perception, and Stigma. Moreover, A moderate positive correlation of $r(70) = 0.43$, $p < 0.001$ was found between the severity of psychological distress and barriers to seeking help. Significant differences in perceived barriers were found between genders ($p = 0.02$), different age groups ($p=0.047$), and urban and rural regions ($p<0.001$). As for socioeconomic status(SES), group differences in perceived barriers were insignificant ($p=0.174$). This study's results shed light on understanding the main barriers discouraging Egyptian adolescents from seeking professional help, despite the high prevalence of severe self-reported psychological distress in adolescents in Egypt. Results give rise to useful implementation suggestions, such as nationwide campaigns, school-based interventions, government policies, awareness raising on adolescent mental health and local and online services provision.

Keywords: *Adolescents, Egypt, psychological distress, barriers, professional help*

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Rana Walid Abdelaal

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PROFESSIONAL EXPERIENCE

Junior Student Counselor ***Universities of Canada*** September 2024 -- Present
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- Provided individual counseling to students, addressing personal, academic, and emotional challenges.
- Handled mental health crises, offering immediate support and connecting students with campus resources.
- Coordinated academic accommodations for students with learning difficulties (e.g., extra exam time, note-taking assistance).
- Educated faculty on learning disabilities and supported inclusive teaching practices.
- Planned and led wellness events such as stress-relief workshops and mindfulness sessions to promote student mental well-being.
- Documented counseling sessions and maintained confidential records in compliance with university policies.

Psychologist in Training, ***Campion British International School*** January 2024 -- June 2024
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- Collaborated with the school counselor to discuss specific student cases.
- Organized mental health workshops for students on topics like emotional regulation and stress management.
- Participated in multidisciplinary meetings to review student progress and adjusted intervention plans
- Addressed student behavioral problems and implemented behavior modification using ABA techniques.
- Collaborated with teachers and special education staff to implement strategies that support student's academic and emotional development.
- Participated in learning support (LS) classes to assist students with diverse learning challenges (ADHD-ASD- visual impairments-dyslexia…)
- Conducted individualized, evidence-based interventions for each student in LS.
- Observed screening psychoeducational assessments to identify students' needs and developed tailored intervention plans.

Clinical Psychologist in Training, ***Rakhawy Hospital*** February 2023 — May 2023

- Shadowed in initial interviews with the patients to assess the patient's mental status when admitted and gather background information from the patient if possible or family members.
- Shadowed in department meetings where psychologists and psychiatrists discussed newly

admitted patients, their symptoms, and diagnosis
- Observed follow-up sessions with patients where psychologists and psychiatrists assessed patients improvement and course of treatment
- Observed supervision and peer advice sessions to discuss psychologist difficulties with certain patients and how to go on with the treatment
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ONLINE COURSES/CERTIFICATION

Beck Institute- Cognitive Behavior Therapy Courses

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Student Senate - ***Chairperson Public Opinion*** — January 2021 - September 2021
- Managed 2 social media accounts for AUC Student Senate with daily posts and stories
- Rebranded the student senate logo and created a new brand manual and identity.
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Student Senate - ***Psychology Major Representative*** — September 2020 - September 2021
- Represented psychology students in weekly senate meetings to develop solutions and enhance the university experience.
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PROJECTS

Thesis Project — April 2024 –Present
- *The relationship between perceived mental health difficulties/distress and the barriers (i.e., social, cultural, attitudinal etc.) in seeking help/psychotherapy in adolescents in Egypt*

Applied Behavior Analysis Interventions
- Implemented self-monitoring interventions for three students to enhance on-task behavior, resulting in noticeable improvements.

Clinical Interviews
- *Conducted SCICA interviews with children, their parents, and teachers) and developed a comprehensive case conceptualization of potential diagnosis*

WIATT-3
- Administered, scored, and analyzed the WIATT-3 assessment for a student, providing detailed insight into their academic abilities and needs.

SKILLS
- Fluent in spoken and written English and Arabic
- Microsoft Office (Excel, PowerPoint, Access)
- InDesign
- PHOTOSHOP

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I. INTRODUCTION

Prevalence of Mental Illness

Prevalence of Mental Illness in Adults

Around 970 million people across the world currently live with mental health disorders. Such disorders range widely to include anxiety, depression, bipolar disorder, schizophrenia, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), eating disorders, and more (Dardas et al., 2017). Having any mental health disorder negatively impacts individuals by affecting their lives in all aspects, such as their daily routine, social elements such as friendships and relationships, and professional and overall well-being. This further leads to increased risk to the person's quality of life, affecting their physical health and productivity and, in severe cases, could lead to suicide. However, with such a high existence of mental health disorders globally and their known risks, the percentage of people seeking psychotherapy or professional help remains substantially low, as 30-80 percent of adults do not seek psychotherapy or any means of professional help (Johnson et al., 2020).

Prevalence of Mental Illnesses in Adolescents

Despite such a concerning statistic among adults, the issue is even more pronounced among adolescents. Adolescence, derived from the Latin word "adolescent," meaning "to grow up," includes all individuals between the ages of 10 and 21 years old (Steinberg, 2019). Within this age group, individuals experience lots of new growth and changes as they transition from children to independent adults responsible for their lives (Steinberg, 2019). Hence, the adolescent age group is associated with making sense of the world and numerous changes. Such changes, if they are negatively dealt with or are not met the right way, could lead to individuals developing diverse and countless mental health problems. This is because it is precisely at this

age that individuals may begin to experience high levels of stress, anxiety, and uncertainty as they try to conform to social, cultural, and academic norms and standards (Polanczyk et al., 2015).

According to the World Health Organization (WHO), one in six adolescents experience mental health disorders. This is equivalent to 13.4% of adolescents worldwide and 15% of the global burden of diseases among the adolescent age group (2021). A survey conducted by the National Survey of Children's Health revealed that children and adolescents suffer from high rates of mental disorders such as anxiety, behavioral conduct disorders, ADHD, and depression, among many others. Of the 48 million respondents who took part in the survey, an average of 13.6 million have been diagnosed with one or more mental health disorders (Child and Adolescent Health Measurement Initiative, n.d.). Moreover, the chances of having a mental health diagnosis increased as the adolescent ages increased(Ghandour et al., 2019). One study further indicated that the prevalence of mental disorders is highest among individuals aged 16-24 compared to any other age group (Gulliver et al., 2010).

Specifically, two of the most existing and popular mental disorders among adolescents are anxiety and depression. WHO suggests that an estimated 3.6% of 10–14-year-olds suffer from anxiety disorder, while it is prevalent in 4.6% of 15–19-year-olds. As for depression, it approximately affects 1.4% of adolescents aged 10–14 years and 2.8% of 15–19-year-olds (World Health Organization, 2021). Moreover, 15.9% to 61.9% of adolescents identify with comorbid anxiety and depression, suggesting that both disorders highly correlate with one another, given that they also share similar symptoms affecting mood (Brady & Kendall, 1992).

Help-Seeking in Adolescents

Help-Seeking Behavior in Adolescents

However, despite adolescents' high susceptibility to developing mental disorders, they are often reluctant to seek mental health services. Help-seeking is defined as the behavior of actively getting help from informal (friends and family) or formal (mental health professionals) sources to obtain help during times of distress (Rickwood et al., 2005). This help could be in casual advice, information from others, professional treatment from professional practitioners, and general support (Rickwood et al., 2005).

Srebnik et al. (1996) introduced a model that describes youth help-seeking behaviors and service utilization. He demonstrated three stages in the help-seeking pathway: problem recognition, the decision to help seek, and the help source youth turn to for help. Firstly, concerning problem recognition, the literature findings are contrasting. In one study conducted among 1,687 adolescents presented with a case vignette on depression, less than 25% were able to recognize that the individual in the case had depression (Lam, 2014). On the contrary, in a similar study conducted on 1,002 adolescents, more than 80% were able to identify that the individual in the case vignette had depression (Attygalle et al., 2017). Therefore, it is evident that while some adolescents can indicate mental health problems (either for themselves or others), some are unable to identify the severity of their problems.

As for decisions to seek help, numerous studies have illustrated that adolescents tend to have low intentions for seeking help for their emotional and behavioral difficulties (Hintzpeter et al., 2015; Leach & Rickwood, 2009; Moen & Hall-Lord, 2018). On average, only 10-36% of adolescents with mental disorders seek any form of mental health care, and of this group, only 40% continue with long-term treatment (Hintzpeter et al., 2014; Lu, 2020). Moreover, in a survey study conducted on 1000 high school students and providing them with a depressive

disorder case vignette, only one-third recommended that the individual in the case should seek professional help (Coles et al., 2015). Therefore, it is evident that there are factors (either external or internal factors) that discourage adolescents from seeking professional help for any mental problems they might be facing. Hence, more insight is needed to understand what prevents adolescents from seeking professional help.

Relationship between Psychopathology and Help-seeking

Numerous studies have also indicated that there exists a paradoxical relationship between psychopathology and seeking-help behaviors. The more severe the mental illness is, the less likely it is for adolescents to seek help from anyone, whether it is family, friends, or professionals (Gonzalez et al., 2005; Sawyer et al., 2012; Dardas et al., 2017). One study examined adolescents diagnosed with depression and its effect on their help-seeking behavior (Sawyer et al., 2012). Results suggest that having high and severe depressive symptoms leads to them being 4 times less likely to seek help from anyone as compared to having less severe depressive symptoms. A reason for this could be that one-third of adolescents with severe suicidal ideation, depression, or substance problems demonstrated vital isolative behaviors and beliefs that people should deal with their problems and not seek external help (Gould et al., 2004). Moreover, McLafferty et al. (2022) examined college students help-seeking behavior. They found that reluctance to seek professional help was mainly evident among those who had severe psychological distress compared to individuals who reported moderate to low psychological distress.

Danger of Not Seeking Help

This raises immense concern because mental disorders, left untreated at this stage of development, can result in severe adverse, long-lasting effects (Wilson, 2010). Without proper

treatment, such problems could persist into adulthood, making it much harder to treat and leading to difficulties in numerous aspects of the individual's life, such as personal relationships, social interactions, self-concept, and professional success (Wilson, 2010). Moreover, when such disorders are not treated or get the right help needed, this could result in risk of substance use, self-harm, and suicidal attempts. This raises great importance on the need to understand the discrepancy that exists between the levels of adolescents who have a mental disorder and those who are seeking professional help to be able to have the necessary interventions early on and to provide efficient mental health support.

Barriers To Seeking Help for Adolescents

Extensive research has been conducted to examine the specific barriers that discourage adolescents from seeking professional help. The literature suggests that there exists a numerous and diverse array of barriers. A meta-analysis combined 53 qualitative and quantitative studies conducted on diverse populations across different countries, which include the USA, UK, Australia, Norway, Malaysia, Canada, India, Ireland, and Portugal (Radez et al., 2020). Through analysis of all studies, four main barrier themes were identified. Firstly, 96% of all studies identified that individual problems regarding lack of mental health awareness and perception of psychotherapy are identified as significant barriers. Adolescents had negative attitudes towards mental health, expectations of treatments, and perceptions on how seeking help from professionals would indicate about them for example being a sign of them being weak and letting go of their locus of control. They preferred to try to solve their problems or rely on friends and family for support. Secondly, 92% reported barriers regarding social factors, such as public stigma and image. Across all studies, adolescents anticipated embarrassment and negative attitudes from family, friends, teachers, and general practitioners if they sought help. They feared

being judged or labeled a certain way, and mental illnesses had negative associations. The third theme is perceptions of the therapeutic relationship with professionals (68%), including perceived Confidentiality and the ability to trust an unknown person as a barrier. Moreover, concerns about disclosing personal information to someone they do not know well were widespread. Adolescents fear trusting strangers with their problems as they might inform others, such as family or teachers, of their problems. The final theme is related to systemic and structural barriers, as (58%) of respondents across all studies included obstacles such as financial costs associated with mental health services, logistical barriers, having enough time, and the availability of professional help (Radez et al., 2020).

Similarly, another meta-analysis also examined different quantitative and qualitative studies and found similar results suggesting that the most prevalent barriers perceived by adolescents regarding seeking professional help include many themes regarding societal attitudes on seeking help and being labeled with a mental illness, knowledge of symptoms of mental illness or psychological distress, and available resources for seeking help, having difficulty relying on others, expressing their feelings or trusting a stranger and preferring help from family and friends instead and worry about effect on career (Gulliver et al., 2010). Further research indicates that different demographics such as gender, age, and ethnicity make adolescents perceive barriers to seeking help differently (Leong & Zachar, 1999; Raviv et al., 2000; Tishby et al., 2001.) With regards to gender, adolescent males and females differ in their attitudes toward seeking mental health treatment. Traditional societal expectations for boys/men to be emotionally restrictive, challenging, and have more self-reliant attitudes result in male adolescents learning to discourage emotional vulnerability and promote more negative attitudes toward seeking professional help when needed. Therefore, mental health stigma and lack of

autonomy are two main barriers preventing adolescent males from seeking help much more than adolescent girls (Gonzalez et al., 2005). On the other hand, it is culturally more accepted that girls/women express their emotions and vulnerability; hence, they would have a more positive attitude toward seeking professional help (Blazina & Watkins, 1996; Ortega & Alegria, 2002). One study further indicated that even though male adolescents experienced more psychological problems compared to females, they sought help much less (Cox et al., 2024). This trend has been observed in numerous studies across various populations and settings, with gender differences in help-seeking behavior consistently highlighting that men who adhere to traditional masculinity tend to avoid professional support and do not acknowledge emotional distress. (Mclafferty et al., 2022; Mahalik et al., 2007; Staiger et al., 2020; Wong et al., 2017).

As for age, there is excellent evidence that as adolescents become older, their mental health knowledge increases, resulting in more acceptance of seeking help and fewer stigmatizing attitudes. Swords et al. (2011) found that older adolescents were likelier to seek help than younger adolescents. Moreover, combining both factors of gender and age, it is, therefore, evident that young male adolescents had the worst attitude and acceptance of seeking help for their mental health (Swords et al., 2011). This falls in line with a systematic review conducted by Rickwood et al. (2005), which found that the older adolescent age group had more Knowledge of the resources available and, therefore, did not have high negative attitudes toward help-seeking. Additionally, another research conducted from a large sample of adolescents from countries across the world found that the most common barriers among young adolescents were stigma and lack of mental health knowledge (BMC Psychiatry, 2014). Another study further confirmed these findings as it found that younger adolescents had more difficulties with

recognizing that they have a mental health problem and reaching out compared to older adolescents (Wright et al., 2018).

Concerning socioeconomic status (SES), one study suggests that higher SES results in higher mental health stigma, leading to not seeking professional help. Such stigma results from having a higher social dominance orientation (SDO), which is defined as the belief that certain groups are inherently superior to others, having more power, status, and resources than others (Foster & O'Mealey, 2022). This SDO influences how mental illness is perceived in higher SES as something they can control and that individuals should be able to control their mental health through willpower (Foster & O'Mealey, 2022). On the contrary, most of the existing research found contradicting results suggesting that individuals of lower SES face much more stigma regarding mental illness than individuals of higher SES, causing more and more burdensome barriers when needing to seek help (Pybus et al., 2023 Potts & Henderson, 2020). The individual's education level can explain this higher stigma in lower SES. Higher SES individuals get better education, which could explain being educated well on mental illnesses and the benefits of seeking help, resulting in having less stigmatizing attitudes (McManus et al., 2016). Not only that, but lower SES individuals most likely reside in areas where there are limited mental health resources, which could add even more barriers to seeking help. Therefore, such factors (education standards, limited available access, and societal stigma) all work together immensely to increase the mental health issues within these classes (McManus et al., 2016). The high mental health stigma in lower SES is concerning due to mental illness being more prevalent among these groups compared to those with higher SES (McManus et al., 2016).

Research has also indicated that different ethnicities and cultural attitudes often lead to differences in the barriers concerning seeking professional help from mental health practitioners.

For example, group interest is usually prioritized over individual interest in collectivistic societies. Consequently, people are inclined towards controlling their emotions while cautiously refraining from negatively expressing them (Sue et al., 1976). As a result, individuals tend not to seek help from family members, friends, or even professionals. On the other hand, in individualistic cultures, individuals are encouraged to express their emotions to meet their needs. This means that people in an individualistic society are more likely to express their emotions and seek help from others (Sue et al., 1976). Similarly, it can be concluded that cultural norms about emotional restraint do affect emotional expression and help-seeking behaviors (Sue et al., 1976). More specifically, within the same country or ethnicity, there are differences between attitudes toward seeking professional help between rural and urban residents. Lin et al. (1996) conducted a cross-sectional study and found that residents in urban cities were 3-5 times more likely to seek professional help than rural residents. Rural residents preferred informal help sources, while urban residents were more likely to seek professional help. These findings suggest two possibilities: there needs to be more professional help services or higher perceived barriers and reluctance to seek professional help in rural areas. Similarly, Hoyt et al. (1997) found that rural residents are significantly less likely to seek professional help than urban residents due to more significant concerns about stigma, less availability of services, and different help-seeking patterns. Moreover, Fox et al. (1999) reported that of a sample of 646 rural resident respondents, only 5.8% with a mental disorder sought professional help. Therefore, it is evident that there is a consensus in the literature that barriers to help-seeking are much higher among individuals residing in rural areas compared to urban areas.

Therefore, there is clear evidence that although barriers to seeking professional help exist globally, factors affecting such barriers vary depending on different cultures, ethnicities, or even

geographical regions. Different ethnicities and locations emphasize different barriers, and therefore, the findings of one study could not be representative of all adolescents worldwide. All research mentioned thus far has been conducted on American, European, Asian, and African cultures with no emphasis on the Arab region.

Arab Countries

Prevalence of Mental Illness in Arab Countries

Poor mental health is a critical public health challenge in the Arab region or Middle East. The University of Chicago's Center for Middle Eastern Studies stated that the Middle East constitutes a group of 16 different Arab countries, which include Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates and Yemen (Emberling). Within most of these countries, the recent rise of socio-geo-political problems has also led to an increase in individuals' mental illnesses and psychological distress (Emberling). Moreover, a study found that although major depressive disorder was the 11th factor in the disability-adjusted life years (DALYs) globally, it was the third cause in the Arab region (Ferrari et al., 2013). Likewise, anxiety disorder was estimated to be the fourth cause of DALYs among women and the fifth for men in the Arab region (Ferrari et al., 2013).

Moreover, Saudi Arabia, which is considered one of the current leading Arab countries, is estimated to have two in five individuals with a mental disorder (Aradati et al., 2019). This further highlights the immense prevalence of psychological distress and mental disorders in Arab countries.

There are several reasons why mental illness rates are high for adults and adolescents in the Arab region. Firstly, there is the issue of conflict and instability which the region has been exposed to in recent years which consequently affected it and its people. Such conflicts include

the 2011 revolution in Egypt, the Syrian civil war, and the Palestinian-Iraqi conflict, to name a few (Moussa et al., 2015). According to a research conducted in 2015 titled "Impact of Political Violence on the Mental Health of School Children in Egypt", children attending schools near Tahrir Square, where the revolution primarily took place, showed high rates of depression, PTSD, and anxiety symptoms (Moussa et al., 2015). A later study released in 2020 explains that violent political conflict has had a devastating effect on the physical and mental health of children in the region.

Another factor that has proven to also drive high mental illness rates among adolescents in the Arab world is economic challenges including high unemployment rates. According to the Arab Development Portal, in 2014, the rate of unemployment among the youth in the region reached 30 replaced, and this percentage was double that of the global average at the time. As a result, adolescents end up experiencing feelings of hopelessness, stress, as well as anxiety about their future opportunities in the labor market (Ahmed Rashad, 2017).

Barriers to Seeking Help for Adults in Arab Countries

Within the Middle East, different barriers hinder Arab adults from seeking professional help. Three main barriers include cultural context, community and systems, and clinical engagement process (Elshamy et al., 2023). Cultural context obstacles entailed stigma as well as beliefs and values, such as opting for traditional healers, who practice psychological healing or therapy based on traditional or cultural beliefs, practices, and methods rather than conventional Western psychological approaches. As for stigma, it was divided into three diverse features: public stigma, structural stigma, and self-stigma (Voldby et al., 2022).

On the one hand, public stigma highlights the labeling and social shame as well as the distress of humiliation of one's family and bias that is associated with mental illness (Voldby et

al., 2022). Secondly, structural stigma constitutes the inequalities within the societal structure of not having sufficient mental health coverage or very few accessible psychological facilities. Lastly, self-stigma is when individuals, due to being labeled, start to feel inferior and rejected by others due to the disorder they are diagnosed with (Voldby et al., 2022). Barriers relating to community and systems discussed barriers related to having available and accessible mental health services (Elshamy et al., 2023).

Aside from such existing barriers mentioned above that discourage Arabs from seeking professional help, some also associate psychological distress/mental illnesses as sometimes associated with signs of being possessed by an evil spirit or being a victim of the evil eye of others. Therefore, choosing to resort to traditional religious customs and individuals is more prevalent in the Middle East than seeking professional help with their mental illnesses (Elshamy et al., 2023).

One study further identifies 16 qualitative studies examining adults' mental health-seeking behaviors, specifically in the Middle East (Elshamy et al., 2023). Such meta-analysis generated six themes that constitute the significant barriers to seeking professional help under psychological distress. Some of such themes include similar to what mentioned above, having negative attitudes and stigmas regarding seeking professional help, economic and structural barriers that prevent them from having access to mental healthcare facilities, religious beliefs preventing them from seeking help and seeking alternative sources of help from family members and traditional healers (Elshamy et al., 2023). Therefore, it is evident that there seems to be a consensus in the research regarding what are the main barriers within the Middle East that discourage Arab adults from seeking professional help when needed for their mental illnesses.

Barriers to Seeking Help for Adolescents in Arab Countries

As for focusing specifically on barriers for adolescents in the Middle East, minimal research exists. Of the minimal research, a study conducted by Omari et al. (2022) examined the facilitators and barriers to mental health help-seeking behaviors among adolescents in Oman. Four hundred twenty-four adolescents completed five self-reported questionnaires addressing their perception and attitude toward psychotherapy. One hundred thirty-nine suggested that they feared getting diagnosed as they didn't want to be stigmatized specifically by friends and social groups, as this would lead to them being alienated (Al Omari et al., 2022). Moreover, other adolescents feared that they would lose their family's support and approval if they were labeled as having a mental health issue since many highlighted that parents' lack of mental health literacy and acceptance would discourage them from getting mental health healthcare advice from professionals (Al Omari et al., 2022).

Another study aimed to examine what Jordanian adolescents diagnosed with depression help-seeking intentions were and whether depression severity and stigma, as well as the interaction between both factors, affected Jordanian adolescents' willingness to seek help (Dardas et al., 2017). Through working with the Jordanian Ministry of Education, a nationwide school-based survey was distributed among 2,349 adolescents aged between 12-17 years old. The results indicated that 25% of the participants would only seek professional help after acknowledging the need to do so. Moreover, a paradoxical relationship was evident in this study, as the majority of this 25% had higher average depression scores (Dardas et al., 2017). However, of those adolescents who took part in the study, 57% stated they would most likely seek help from family members, 46% from school counselors, 43% from psychiatrists, 39% from religious individuals in their community, and 28% from general health practitioners (Dardas et al., 2017).

Barriers to Seeking Help in Egypt

Barriers to Seeking Help for Adolescents in Egypt

Regarding Egypt, research focusing specifically on adolescents and their patterns of seeking professional help is limited. One large-scale study of mental health administered a survey on 14,640 Egyptians aged 18-29 in five different governorates. The researchers found that 16.93% of respondents had a mental disorder of which 6.43% had anxiety disorders, and 4.75% had multiple disorders, 4.72% (Ghanem et al., 2009). Therefore, there is clear evidence suggesting that the prevalence of psychological distress is very evident in the Egyptian population.

Another by Baklola et al. (2023) attempted to examine mental health literacy among Egyptian undergraduate students and whether it is related to attitude toward seeking professional help. An online survey was distributed on social media and accomplished a sample of 1740 students (Baklola et al., 2023). The study utilized the Mental Health Literacy Scale (MHLS) and the General Help-Seeking Behavior Questionnaire (GHSPQ). Results indicate that all respondents scored low on their Mental health literacy scale, indicating that most are not well-educated and informed on mental illnesses (Baklola et al., 2023). However, there is no relation between the two scales, as low scores on the MHLS scale did not relate to having low scores on the GHSPQ.

Moreover, having parents educated above secondary level, as well as having a previous family history of mental illness, were more likely to seek professional help (Baklola et al., 2024). A similar study was conducted on a much larger sample size of 3240 undergraduate students in 21 different Egyptian universities utilizing an online survey with two questionnaires: the Arabic General Health Questionnaire (AGHQ-28) to examine the psychological well-being of

adolescents and the Barriers to Access to Care Evaluation (BACE- 30) to examine possible barriers preventing them from seeking help (Bakola et al., 2024). Results of the study indicate that 64% of respondents had high levels of psychological distress, and 90.3% needed to seek professional help yet chose not to do so. Moreover, examining the specific barriers to seeking professional help, the most common were wanting to solve the problem alone, Being unsure where to go to get professional care, Dislike talking about my feelings, emotions, or thoughts, and, having no one who could help me get professional care among many other (Baklola et al., 2024). Moreover, it was evident that students from rural backgrounds were less likely to seek professional help than students from urban family backgrounds. Lastly, it was also evident that respondents aged 20 and higher and with a positive family history of mental disorders were also more likely to seek professional help (Baklola et al., 2024).

Measuring Adolescent Psychological Distress

Numerous instruments exist that measure individuals' psychological distress. Some are generic to include all individuals, while others are more specific and use language that only works for adolescents. A well-known instrument that focuses specifically on adolescents and younger individuals includes the Child Depression Inventory (CDI), which is an instrument that includes 27 items and asses adolescents ages 7-17 on the severity of having depressive symptoms and possible diagnosis of depression (Penze & Zeman, 2002). However, even though it is excellent, it only focuses on depressive symptoms and disregards any other form of psychological distress. A similar issue is examined when it comes to instruments that focus only on Anxiety, such as the State-Trait Anxiety Inventory for Children (STAIC) (Speilberger et al., 1973). This instrument is designed to measure two different aspects of Anxiety in adolescents and children, which are state anxiety (short-term relating to a specific situation) and trait anxiety (a long-term and general form of Anxiety) (Speilberger et al., 1973). Although also very

beneficial, it only focuses on Anxiety and does not consider any other form of psychological distress.

Other instruments that combine psychological distress, such as both Anxiety and Depression, include the Revised Children's Anxiety and Depression Scale (RCADS), which is a 47-item instrument designed to diagnose adolescents with Depression or Anxiety and consists of five subscales that examine issues such as generalized Anxiety, separation anxiety, social phobia, and panic, as well as depressive symptoms (Chorpita et al., 2000). Although the RCADS is very beneficial due to how comprehensive it is, it is mainly used for diagnostic purposes and not to assess the general psychological distress of adolescents (Chorpita et al., 2000). Similarly, the Youth-Self Report (YSR) is another very well-known and verified instrument that assesses adolescents' psychological distress; however, it consists of 112 items and, therefore, is also very comprehensive and time-consuming for adolescents to fill out accurately (Ebesutani et al., 2011).

Realizing the drawbacks of having such protracted and comprehensive instruments, researchers have attempted to create shortened and compressed versions of long instruments. For example, the Dass-42 and its shortened version, the Dass-21, are both designed to measure and quantify the negative states of Depression, Anxiety, and Stress, understand the degree of these core symptoms in the individual, and assess the severity (Szabo & Lovibond, 2022). Much shorter instruments also include the Kessler Psychological Distress Scale (K-10), which is a mental health screener instrument for psychological distress, specifically Depression and Anxiety, and constitutes only ten items. There is also a shorter version, the Kessler Psychological Distress Scale (K-6), which only includes six items (Kessler et al., 2002). However, with the concise nature of the screener, it cannot fully validate the result of the instrument on which it is based. Therefore, this suggests the K10 scale compared to the K6 as it provides greater detail and

validity of the results (Kessler et al., 2002). Therefore, it is also evident that there is a limit to how short an instrument can become before it loses its validity and what it is supposed to measure.

Measuring Adolescents' Barriers to Seeking Help

Researchers utilize various methods to measure barriers affecting adolescents' help-seeking behavior adequately. The methods include both qualitative and quantitative measures. The qualitative arm comprises conducting semi-structured interviews or focus groups with adolescents to thoroughly understand what deters them from pursuing assistance.

There are many instruments and questionnaires available for quantitative measures. Some studies create their surveys to cater to exactly what they wish to explore, while others utilize validated and sound instruments.

While some studies create surveys to ask specific questions they wish to explore, others use more sound and valid instruments. One well-known and widely used instrument is the Barriers to Access to Care Evaluation (BACE) scale (Clement et al., 2012). It comprehensively measures the barriers to seeking mental health care among both adults and adolescents who have never sought professional help or who have had previous experience but have stopped going. Another instrument is the General Help-Seeking Questionnaire (GHSQ), which assesses two critical aspects of help-seeking: the individual's present intentions to seek help and previous professional help-seeking experiences (Tillman & Sell, 2013). Unlike the BACE, the GHSQ focuses on individual intentions and behaviors rather than attitudes. Therefore, this measure does not allow for understanding the underlying barriers in specific groups but focuses on the individual(Tillman & Sell, 2013). Moreover, it does not necessarily focus on professional help but examines both formal and informal sources of help. Another utilized scale is the Mental Help Seeking Attitudes Scale (MHSAS), with 65 items to measure individuals' general assessment

(negative vs. positive) of their inclination to seek assistance from a professional psychological expert when faced with a mental health issue (Hammer et al., 2018). This is a comprehensive and long instrument that can affect respondents' accurate scoring, especially adolescents, and can hinder the results of the study as the participant moves deeper into the survey. The Attitudes Toward Seeking Professional Psychological Help (ATSPPH-SF) is another tool used to measure participants' attitudes toward seeking professional help. It includes ten items (Hammer et al., 2018). This scale is considered narrow and not as comprehensive as the other scales, which can provide insufficient results for actual attitudes. Lastly, the Barriers to Adolescents Seeking Help scale (BASH) assesses adolescents' attitudes to help-seeking rather than intentions and includes 37 items assessing 13 barrier categories regarding seeking help (Kuhl et al., 1997). This proves that there should be a sufficient number of items to examine different barriers and not bore the young participants, as adolescents are quick to be bored and require short content to grasp their full attention.

Important of the Study/ Study Aim

This study aims to add to the existing literature that focuses on adolescents in Egypt and examines the factors that discourage them from seeking professional help and going to psychotherapy. This population as a whole has not been previously studied for its perceptions of seeking professional help despite the significant mental health challenges present there. Existing research on this topic conducted in Egypt has focused mainly on undergraduate students aged 17 and above, therefore only representing some older adolescents accurately. Hence, this study will investigate the reasons for Egyptian adolescents aged 10-21 do not seek help from professional mental health practitioners. The study will explore different factors, such as stigma, awareness, and cultural attitudes toward mental health services, among many others. The study will also

attempt to examine the relationship between psychological distress and perceived barriers considering the paradoxical relationship reported in the literature. It will also examine different demographic characteristics, such as age, gender, SES, and region on adolescents' perceived barriers to seeking professional help.

Moreover, the study seeks to inform mental health practitioners and back the development of effective strategies and plans to further elevate mental health support for Egyptian adolescents by providing a comprehensive understanding of these factors. Hence, this guided the following research questions: What are the primary barriers that prevent adolescents in Egypt from seeking professional help, and to what extent do psychological distress, gender, age, geographical region, and economic standards relate to these barriers?

Hypothesis

Hypothesis 1

Null Hypothesis (H_0): There is no significant relationship between scores for psychological distress and scores in perceived barriers to seeking professional help.

Alternative Hypothesis (H_1): There is a significant positive relationship between scores for psychological distress and scores for perceived barriers to seeking professional help – the higher the psychological distress, the higher the perceived barriers to seeking help.

Hypothesis 2

Null Hypothesis (H_0): There is no significant difference between adolescent males and females in their perception of barriers to seeking professional help in Egypt.

Alternative Hypothesis (H_1): Adolescent males will have higher scores in perceived barriers to seeking help compared to adolescent females in Egypt.

Hypothesis 3

Null Hypothesis (H_0): There is no significant difference between early adolescents and late adolescents in their perception of barriers to seeking professional help in Egypt.

Alternative Hypothesis (H_1): Young adolescents will have higher scores in perceived barriers in seeking help compared to older adolescents in Egypt.

Hypothesis 4

Null Hypothesis (H_0): There is no significant difference between urban and rural residents in their perception of barriers to seeking professional help in Egypt.

Alternative Hypothesis (H_1): Rural residents will have higher scores in perceived barriers in seeking help compared to urban residents in Egypt.

Hypothesis 5

Null Hypothesis (H_0): There is no significant difference between low SES and high SES respondents in their perception of barriers to seeking professional help in Egypt.

Alternative Hypothesis (H_1): Lower SES respondents will have higher scores in perceived barriers to seeking professional help compared to higher SES respondents in Egypt.

II. Methodology

Study Design

The study employed a quantitative design by conducting a structured online survey of a diverse sample of Egyptian adolescents. It is a descriptive and correlational study that aims to examine the main barriers that discourage adolescents from seeking professional help for mental health problems and the relationship between different factors such as psychological distress, gender, age, region, and socioeconomic status, on the perceived barriers of help-seeking in Egypt.

Participants

The study initially included 83 participants; however, 13 were excluded due to prior experience with mental health services, leaving a final sample of 70 participants. Respondents' chosen language to fill out the form included n=51 (72.85%) in English and n=19 (27.14%) in Arabic. Respondents' genders were n=44 (62.86%) females and n=26 (37.14%) males. Regarding their age distribution, 25 respondents were aged between 18-21 years old (35.71%), 22 respondents were aged between 14-17 years old (31.43%), and 23 respondents were aged between 10-13 years old (32.85%). As for regions, 36 respondents were from Cairo (51.43%), 19 were from Alexandria (27.14%), eight were from Upper Egypt (11.43%), and seven were from Delta (10%). In regards to Income levels, 25 respondents lived in a household that earned more than 70,000 EGP (35.71%), 22 respondents lived in a household that earned between 50,000-70,000 EGP 22 (31.43%), 18 respondents lived in a household that earned between 30,000-50,000 EGP 18 (25.71%), five respondents lived in a household that earned between 10,000-30,000 EGP (7.14%). Efforts were made to reach a diverse population sample by targeting different ages during adolescent years, different regions, and various socioeconomic backgrounds within Egypt.

Recruitment of respondents was conducted using convenience sampling. A link to the survey was shared across various social media platforms, including Facebook and WhatsApp, targeting parents or adolescents with a non-threatening invitation titled "Survey on Attitudes Toward Help-Seeking and Psychological Characteristics and Difficulties of Teenagers." Additionally, snowball sampling was utilized, as participants or adolescents who agreed to participate in the study were encouraged to share the survey with others they knew who might be willing to participate. Lastly, to achieve representation from rural regions, market researchers assisted in providing contact numbers, which allowed the survey to be distributed via WhatsApp in such areas.

The participants included in the study were selective to include specific characteristics. The inclusion criteria included Egyptian adolescents (male, female, or other) aged 10 to 21. Additionally, they must have had no prior experience with therapy, as the purpose is to understand what is stopping them from seeking help for the first time. The exclusion criteria for participation were citizenship, as individuals who were not Egyptian citizens (even if they live in Egypt) were not included in the sample and who fall outside the age range of an adolescent (10-21 years).

Material

The instruments used in this study included the Kessler Psychological Distress Scale K-10 (English and Arabic versions) and the Barriers to Adolescents Seeking Help Questionnaire (BASH) (English and Arabic versions) (See Appendix A and B).

Kessler Psychological Distress Scale K-10

Developed by Professors Ron Kessler and Dan Mroczek the Kessler Psychological Distress Scale (K-10) is a short, self-administered questionnaire. It is constructed to measure

general psychological distress specifically regarding anxiety and depression (Kessler et al., 2002). It comprises ten items, and each question is rated on a Likert scale ranging from 1 (none of the time) to 5 (all of the time). Statements focus on aspects such as nervousness, agitation, and mood, among other symptoms of anxiety and depression. Scoring of the K-10 is calculated by summing the answers with a score of 10 indicating minimum psychological distress and a score of 50 indicating severe distress. Hence, this scale allowed for measuring and understanding the prevalence and severity of psychological distress among the respondents. As for the Arabic version, a translated and validated version of the K-10 already exists in Arabic (Easton et al., 2017).

Psychometric properties of the English K-10 were evaluated, and results indicate good validity and reliability. Concerning construct validity, it is evident that the K-10 has a Cronbach's alpha of 0.84 and an omega total of 0.88, indicating excellent construct validity (Lins et al., 2021). The criterion validity of the K10 as a tool for predicting severe mental illness is very good to excellent, ranging from 0.76 to 0.85. Similarly, it provides strong internal consistency reliability with a Cronbach's alpha of 0.93 (Kessler et al., 2002). As for the psychometric properties of the Arabic version K-10, results indicate it has strong reliability, with Cronbach's equal to 0.88 (Easton et al., 2017). Moreover, it also has strong convergent validity. These findings suggest that the translated items measure the same overall construct of psychological distress as the original English version.

Barriers to Adolescents Seeking Help Questionnaire (BASH)

This instrument is a 37-item questionnaire based on prior created to measure what are the most significant barriers that discourage adolescents from seeking professional help (Kuhl et al., 1997). Like the K-10, respondents would have to rate each question on a Likert scale ranging

from 1 (Strongly disagree) to 5 (Strongly agree). Items in the BASH questionnaire include hypothetical questions regarding attitudes toward psychotherapy that address different themes and barriers, which include Affordability, Alienation, Confidentiality, Family as sufficient to help, Knowledge of resources, Locus of control, Perception of Therapist, Self-awareness, Self-perception, Stigma, Time availability, and Usefulness of therapy (Kuhl et al., 1997).

Moreover, the instrument has good validity, test-retest and internal reliability, and adequate validity in the tested population. Validity was tested by looking at the connections between the BASH and variables relating to help-seeking behavior (Kuhl et al., 1997). Adolescents with previous and current history of treatment had low BASH scores, while adolescents who have never sought professional help had high BASH scores. This suggests the overall validity of the test and identifies the barriers to seeking professional help. Reliability was assessed through test-retest reliability on 65 adolescents with a time interval of 2 weeks between each test. This indicated a Cronbach alpha of 0.91, indicating high reliability (Kuhl et al., 1997). Different from the K-10, the BASH questionnaire has yet to be officially translated into Arabic; therefore, a translation of the BASH questionnaire into Arabic was conducted in this study.

According to Sousa and Rojjanasrirat (2010), seven steps must be followed to translate, adapt, and validate instruments or scales for cross-cultural research. However, a simplified version of the instrument's translation process was conducted for this research. Firstly, a certified English-to-Arabic translator was recruited to translate the original instruments into Arabic. The translator has over 20 years of experience translating English to Arabic and earned a master’s degree from the University of Plymouth in the UK back in 2013. Secondly, the translated BASH questionnaire was pilot-tested on a sample of four individuals. These four individuals were chosen based on whether they met the inclusion criteria of the target sample so they could

accurately represent adolescents who will be reading the instruments in the survey and ensure they are from different age ranges. They were asked to rate each item on a dichotomous scale, clear or unclear. Participants who rated any statements as unclear were then asked to suggest how to make them more transparent.). The translator reviewed it again if 20% of participants rated any statement unclear. Items that were rated as unclear included Participant 1 (2,12,22,24,37), Participant 2 (2,3,22,24,26), Participant 3 (2,3,37), and Participant 4 (3,12,24,26). Most participants were concerned about not understanding the meaning of a word or believing the statement was phrased weirdly. Hence, all items stated were translated again more straightforwardly and clearly.

Procedure

The study participants were asked to fill out an online survey using Google Forms. The survey was estimated to take approximately 15 minutes, including eight sections, and required the parents and adolescents to complete it. The first section of the survey asked respondents to choose the language they preferred to fill out the survey in, either English or Arabic. The second section is a screening question regarding adolescents needing to gain previous help-seeking experience. Failing to meet this criterion automatically ended the survey since they had been to therapy before. If this criterion is met, the survey will direct parent respondents to the third section, the parental consent form, with a detailed overview of the study, potential benefits, and risks associated with their adolescents participating in the research. The fourth section was the last section for the parents, which included a question regarding the household income per month.

Following this, the remaining sections were for the adolescents to fill out themselves. The fifth section included the consent form for the adolescent to agree to. They were informed that they could end the survey at any time if they wished to do so and included a clear articulation of

the research goal, risks and benefits, mental health services if needed, and the researcher's contact information. The sixth section included demographic questions that gathered the necessary background information regarding the participants' age, gender, education level, and geographical region where they resided within Egypt. The seventh and eighth sections included the K-10 and the BASH questionnaires. In both instruments, respondents had to rate each statement in the questionnaire on a scale of 1-5 with how much they agreed with the statements. They could not leave any questions unanswered before they moved to the following sections.

Lastly, the last section of the survey was the debriefing statement, thanking participants for their contribution to the study and restating facts already mentioned in the consent form regarding the purpose of the research, highlighting the confidentiality and anonymity of their responses, and where they can seek help if they experienced any distress while filling in the survey.

Data Analysis

The study results were analyzed using the statistical online software JASP for data analysis. Since neither questionnaire had previously been used in an Egyptian sample, psychometric testing was conducted within this new context. The normal distribution for each item in the questionnaires was checked to ensure that central tendency and distribution were appropriate. Moreover, psychometric tests were conducted to test the internal reliability of the two questionnaires used in the Egyptian sample.

After such initial analysis, a summary of the K-10 scores was generated to understand the overall well-being of adolescents in Egypt and how common mental illness is. As for the BASH, a summary of the results was computed to demonstrate the scores of different barriers and which were the most common among adolescents in Egypt. This gave some initial insight into Egypt's most prevalent barriers to adolescents. Results included measures of central tendency to

understand the data distribution. Following such an initial summary of the data, descriptive statistics such as frequencies and percentages were calculated to present the demographic characteristics of participants and ensure the sample was representative of the population.

After conducting descriptive statistics, inferential statistics such as correlation, t-tests, and ANOVA were applied to examine the relationships between variables (psychological distress, age, gender, and geographical region) and the perceived barriers to seeking professional help. Concerning psychological distress and its relationship to barriers to seeking professional help, correlation analysis was conducted to quantify the relationship between the study's variables and the direction of the relationship (positively or negatively correlated). As for gender, since all respondents either responded as male or female, t-tests were conducted to see the differences between the two genders in the scores of the BASH questionnaire. All of the subscales in the questionnaire. As for age, region, and SES, ANOVA tests were run with the general scores of the BASH questionnaire and then with each of its subscales. Statistical significance for all tests was set at $p < 0.05$. Additionally, multiple regression analysis was performed to assess the combined effect of psychological distress, gender, age, SES, and geographical region on the scores of the BASH questionnaire to examine their combined effect on the adolescent's barriers to help-seeking.

III. Results

Normality/ Central Tendency

K-10 Questionnaire - Central Tendency

The scores in the two versions of the questionnaire (Arabic and English) were combined to measure the questionnaire's overall normality within the Egyptian population. The normality and central tendency results indicate that the K-10 scale is reliable for assessing psychological distress in the Egyptian population. Normality was tested by evaluating each item's skewness, kurtosis, and distribution plots. Regarding the skewness, the normality assumption is supported as all raw values ranged between -0.27 and 0.21. Kurtosis's normality assumption was also supported for each item, as the raw values ranged between -0.98 and 0.60. Distribution plots also visually indicated that each item corresponded to a roughly symmetric bell-shaped curve (see Figure 1, Appendix C). Therefore, overall normality is assumed for the K-10 scale within an Egyptian population.

BASH Questionnaire - Central Tendency

Normality and central tendency checks were conducted for the BASH questionnaire as it was the first time it was used in an Egyptian population (in English), as well as a translated Arabic version of the questionnaire was developed and used for the first time in the Egyptian population by this study. Normality was tested by assessing each subscale's skewness, kurtosis, and distribution plots. Regarding the skewness, the normality assumption is supported as each subscale value ranged between -0.04 and 0.13. As for Kurtosis, the normality assumption was also supported for each subscale as the raw values ranged between -0.24 and 0.06, except for the perception scale, which indicated a kurtosis value of -1.16. Distribution plots also visually indicated that each item corresponded to a roughly symmetric bell-shaped curve (see Figure 2,

Appendix C). Therefore, overall normality is assumed for the BASH scale in an Egyptian population.

Internal Reliability

An internal reliability test was conducted to determine whether both scales had consistent scores within their items or subscales. Regarding the K-10 questionnaire, Cronbach's alpha was calculated for each item in the scale to measure the overall internal reliability of the scale. The K-10 scale demonstrates good internal reliability ($\alpha = 0.89$). As for the BASH questionnaire, Cronbach's alpha was calculated using each subscale to measure the overall internal reliability of the scale. The BASH questionnaire demonstrates really good internal reliability ($\alpha = 0.90$). These results suggest that the items in the K-10 and BASH questionnaires consistently measure the same construct regarding adolescents' current psychological distress and barriers to seeking professional help, respectively.

Descriptive Statistics

K-10 Scores

Respondents' mean score and standard deviation were M=34.97 and SD=6.9, with raw scores ranging between 18 and 46. Moreover, 4.29% of respondents were likely to be well, 11.43% were likely to have a mild disorder, 7.14% were likely to have a moderate disorder, and 77% were likely to have a severe disorder. This indicates that the majority of adolescents in Egypt are severely experiencing psychological distress.

BASH Scores

The overall mean score and standard deviation were M=131.01 and SD=23.78, and raw scores ranged between 76 and 172. More specifically, the BASH questionnaire subscale scores,

listed in descending order based on their means, reveal that the three highest mean scores regarding barriers to seeking professional help included Time Availability (M = 3.94, SD = 1.09), Self-perception (M = 3.89, SD = 0.89) and Stigma (M =3.83, SD 0.72). The remaining eleven BASH subscales mean scores in descending order were as follows: Peer as Sufficient to Help (M =3.74, SD =1.02), Alienation (M = 3.73, SD = 0.96), Self-awareness (M = 3.66, SD = 1.09), Perception of the Therapist (M = 3.67, SD = 0.69), Affordability (M = 3.66, SD = 1.20), Self-sufficiency (M = 3.65, SD = 0.87), Confidentiality (M =3.57, SD =1.02), Family as Sufficient to Help (M =3.37, SD =0.90), Usefulness of Therapy (M =2.86, SD =0.68), and Knowledge of Resources (M = 2.56, SD =1.21).

Inferential Statistics

Correlation Between K-10 and BASH Score

To examine the relationship between levels of psychological distress and perceived barriers to seeking professional help by Egyptian adolescents, a one-tailed positive Pearson correlation was conducted between the K-10 scale and the BASH questionnaire scale. The correlation results indicate a significant correlation of $r(70) = 0.43$, $p < 0.001$. This suggests a moderate positive relationship between scores of the two questionnaires, meaning that as scores on the K-10 scale increase (indicating higher psychological distress), scores on the BASH scale also increase (indicating more perceived barriers to seeking professional help). Moreover, an estimated 18.4% of the variance in the BASH scale is explained by the scores in the K-10 scale. This indicates that higher K-10 scores would also rise on the BASH scale.

Gender Scores

A one-tailed independent sample t-test was conducted to examine the gender differences between adolescent males and females in terms of their perceived barriers to seeking

professional help. The independent samples t-test examined the alternative hypothesis of 'Men scores>Women scores' and revealed a statistically significant difference between males (M=143.81; and SD = 23.66) and females (M=127.52; and SD= 30.74) in their scores on barriers to seeking professional help, t(68) =-2.16, p = 0.02.

Supplementary analysis was also conducted using independent one-tailed sample t-tests to examine gender differences for the 14 subscales in the BASH questionnaire to identify precisely where group differences lay. One-tailed independent samples t-test of the alternative hypothesis of 'Men scores>Women scores' revealed a statistically significant difference in five out of the fourteen BASH subscales as follows: Usefulness of Therapy: Males (M = 4.09, SD = 0.71) scored significantly higher than females (M = 3.05, SD = 0.69), t(68) =−3.30, p=0.002; Locus of Control: Males (M = 4.09, SD = 0.72) scored significantly higher than females (M = 3.60, SD = 0.86), t(68)=−2.46,p=0.017; Self-Sufficiency: Males (M = 4.00, SD = 0.70) scored significantly higher than females (M = 3.50, SD = 0.91), t (68) =−2.54, p=0.013; Self-Awareness: Males (M = 4.00, SD = 0.83) scored significantly higher than females (M = 3.46, SD = 1.19), t(68)=−2.06,p=0.04; Stigma: Males (M = 3.99, SD = 0.77) scored significantly higher than females (M = 3.13, SD = 0.58), t(68)= −1.73, p=0.032. No other subscales had significant differences in the scores of the two genders as indicated in Table 1 (See Appendix D). In general, though, females scored lower than males in all subscales. Therefore, it is evident that male adolescents perceive overall more significant barriers to seeking professional help compared to female adolescents.

Age Score

A one-way ANOVA was conducted to test the different adolescent age groups (10-13 years old, 14-17 years old, and 18- 21 years old) on the overall barriers to seeking professional

help in Egypt. Results indicate a significant difference between different age groups on their perceived barriers F(2,67)=3.31,p=0.042. Post-hoc multiple comparisons analysis using Bonferroni correction was conducted to test where these differences lay in the group. The mean scores of each age group were 10-13 years (M=138.57., SD=19.64), 14-17 years (M=134.46, SD=24.63), and 18-21 years (M=121.36, SD=26.53) were compared to one another. Post Hoc ANOVA results indicate a significant difference between age groups 10-13 years old and '18-21 years old' on their perceived barriers F(2,67)= -2.42, p= 0.047. No other group comparisons indicated significant differences.

Separate one-way ANOVA was conducted to examine differences between the age groups on each of the 14 different subscales of the BASH questionnaire. Results indicate a statistically significant difference between age groups in the following BASH subscales: Stigma subscale F (2,67) = 3.70, p= 0.003 having the 18–21 years old group (M = 3.27, SD = 0.75) scored lower than the 10–13 years group (M = 3.82, SD =0.62) and the 14–17 years group (M = 3.57, SD = 0.72); Locus of Control: F (2,67) =4.88, p=0.010 with the 18–21 years group (M =3.36, SD = 0.98) scored lower than the 10–13 years group (M = 4.04, SD= 0.64) and the 14–17 years group (M = 3.92, SD = 0.73); Knowledge of Resources F(2,67)= 5.88, p=0.004 with the 18–21 years old group (M = 3.39, SD = 1.20) scored lower than the 10–13 years group (M = 4.28, SD = 0.89) and the 14–17 years group (M = 4.14, SD = 0.99); Self-awareness: F (2,67)= 3.95, p= 0.024 with t he 18-21 years old group (M = 3.15, SD = 1.08) scored lower than the 10–13 years group (M = 3.90, SD = 1.02) and the 14–17 years group (M = 3.91, SD = 1.05); Self-Perception: F (2,67)= 5.88, p= 0.004 with the 18-21 years old group (M = 3.41, SD =0.95) scored lower than the 10–13 years group (M = 4.20, SD = 0.65) and the 14–17 years group (M = 4.00, SD = 0.90); Usefuleness of Therapy F (2,67)= 5.02, p= 0.009 with the 18-21 years old

group (M = 3.39, SD =1.19) scored lower than the 10–13 years group (M = 4.28, SD = 0.89) and the 14–17 years group (M = 4.13, SD = 0.99); Self-Sufficiency F (2,67)= 4.50, p= 0.015 with the 18-21 years old group (M = 3.24, SD =0.82) scored lower than the 10–13 years group (M = 3.91, SD = 0.76) and the 14–17 years group (M = 3.80, SD = 0.91); Confidentiality F (2,67)= 4.26, p= 0.018 with the 18-21 years old group (M = 3..11, SD =1.01) scored lower than the 10–13 years group (M = 3.92, SD = 0.85) and the 14–17 years group (M = 3.66, SD = 1,07) No other subscales had significant differences in the scores of the different age groups as indicated in Table 2 (See Appendix D) . Hence, results indicate that the age group 10-13 perceive overall higher barriers to seeking professional help compared to the other age groups, and more specifically in the subscales: Stigma, Locus of Control, Knowledge of Resources, Self-Awareness, Confidentiality, Self-Perception, Usefuleness of Therapy and Self-Sufficiency.

Region Scores

A one-way ANOVA was conducted to test the different regions of residence (Cairo, Alexandria, Delta, and Upper Egypt) on the overall barriers to adolescents seeking help in Egypt. Results indicate a significant difference between the different regions $F(3,66) = 8.49$, $p<0.001$. Post-hoc multiple comparisons analysis using Bonferroni correction was conducted to test where these differences lay in the group. The mean scores of each region; Cairo (M=123.944, SD=23.750), Alexandria (M=124.895, SD=23.459), Delta (M=158.857, SD=8.726), Upper Egypt (M=153, SD=8.2110) were compared to one another. Results indicate significant differences between the Cairo group and the Delta group p=0.001, the Cairo group and Upper Egypt group p=0.006, the Alexandria group and Delta group p=0.004, and the Alexandria group and Upper Egypt p=0.017. No other group comparisons were significant, such as Cairo and Alexandria or Delta and Upper Egypt. These findings illustrate that adolescents in Delta and

Upper Egypt perceive much higher barriers to seeking professional help than adolescents residing in Cairo and Alexandria.

Further, one-way ANOVA was conducted between the different regions and each of the 14 subscales in the BASH questionnaire. Results indicate a significant difference between the different regions in all of the subscales as follows; Stigma $F(3,66)= 6.28$, $p<0.001$ with mean scores in Cairo ($M=3.33$, $SD=0.71$)and Alexandria ($M=3.50$, $SD=0.72$) lower compared to Delta ($M=4.21$, $SD=0.28$) and Upper Egypt ($M=4.18$, $SD=0.24$); Affordability $F(3,66)= 10.17$, $p<0.001$ with mean scores in Cairo ($M=2.13$, $SD=0.99$) and Alexandria ($M=2.71$, $SD=1.38$)lower compared to Delta ($M=4.03$, $SD=0.17$) and Upper Egypt ($M=3.95$, $SD=0.21$); Knowledge of Resources $F(3,66)= 25.30$, $p<0.001$ with mean scores in Cairo ($M=1.972$, $SD=0.85$) and Alexandria ($M=2.37$, $SD=0.90$) are lower compared to Delta ($M=4.43$, $SD=0.79$) and Upper Egypt ($M=4.00$, $SD=0.76$); Perception of Therapist $F(3,66)= 12.00$, $p<0.001$ with mean scores in Cairo ($M=3.36$, $SD=0.50$)and Alexandria ($M=3.68$, $SD=0.61$) are lower compared to Delta ($M=4.36$, $SD=0.80$) and Upper Egypt ($M=4.44$, $SD=0.50$); Alienation $F(3,66)= 5.01$, $p=0.003$ with mean scores in Cairo ($M=3.52$, $SD=0.95$)and Alexandria ($M=3.51$, $SD=0.95$) are lower compared to Delta ($M=4.62$, $SD=0.36$) and Upper Egypt ($M=4.42$, $SD=0.73$); Confidentiality $F(3,66)= 5.03$, $p=0.003$ with mean scores in Cairo ($M=3.39$, $SD=1.01$)and Alexandria ($M=3.26$, $SD=1.02$) are lower compared to Delta ($M=4.50$, $SD=0.58$) and Upper Egypt ($M=4.31$, $SD=0.53$); Locus of Control $F(3,66)= 5.50$, $p=0.002$ with mean scores in Cairo ($M=3.60$, $SD=0.83$) and Alexandria ($M=3.56$, $SD=0.87$) are lower compared to Delta ($M=4.57$, $SD=0.32$) and Upper Egypt ($M=4.42$, $SD=0.30$); Self-awareness $F(3,66)=4.01$, $p=0.011$ with mean scores in Cairo ($M=3.39$, $SD=1.04$)and Alexandria ($M=3.53$, $SD=1.18$) are lower compared to Delta ($M=4.43$, $SD=0.84$) and Upper Egypt ($M=4.50$, $SD=0.66$); Self-

perception F(3,66)= 9.06, p<0.001 with mean scores in Cairo (M=3.63, SD=0.87) and Alexandria (M=3.66, SD=0.77) are lower compared to Delta (M=4.71, SD=0.57) and Upper Egypt (M=4.88, SD=0.23); Self-suffiniciency F(3,66)= 11.68, p<0.001 with mean scores in Cairo (M=3.41, SD=0.73) and Alexandria (M=3.36, SD=0.84) are lower compared to Delta (M=4.60, SD=0.35) and Upper Egypt (M=4.65, SD=0.55); Family sufficent to help F(3,66)= 6.28, p<0.001 with mean scores in Upper Egypt (M=2.86, SD=1.12) being the lowest then Cairo (M=3.25, SD=0.84) and Alexandria (M=3.32, SD=1.01) are lower compared to Delta (M=4.71, SD=0.49); Time Availibility F(3,66)= 5.48, p=0.002, with scores in Cairo (M=3.69, SD=1.06**)** and Alexandria (M=3.68, SD=1.16) are lower compared to Delta (M=4.86, SD=0.38) and Upper Egypt (M=4.86, SD=0.35); Usefulness of Therapy F(3,66)= 5.91, p=0.001 with mean scores in Cairo (M=3.56, SD=0.87) and Alexandria (M=3.42, SD=1.22) are lower compared to Delta (M=4.86, SD=0.38) and Upper Egypt (M=4.37, SD=0.52). Hence, it is evident that there are significant differences in perceived barriers to seeking help among adolescents living in different regions in Egypt, with Delta and Upper Egypt reporting higher overall barriers and all the subscales compared to Cairo and Alexandria. These findings are summarized in Table 3 (See Appendix D).

Income Level Scores

A one-way ANOVA was conducted to examine differences in overall barriers to seeking professional help among adolescents from different household income levels (10,000–30,000 EGP, 30,000–50,000 EGP, 50,000 –70,000 EGP, and more than 70,000). Due to having a small number of respondents in the 10,000-30,000 EGP group, it was combined with the 30,000-50,000 EGP group for a more accurate analysis of group differences. Results indicated no statistically significant differences between income groups, F(2,67) =1.62, p=0.174. This

suggests that no significant differences between groups were found and that all household income level groups had somewhat similar overall results in barriers to seeking help.

Separate one-way ANOVA was conducted to examine differences between the different household income level groups on each of the 14 different subscales of the BASH questionnaire. Results indicate a statistically significant difference between the different household income levels in the subscales; Affordability $F(2,67)= 20.87$, $p<0.001$, with the 10,000–50,000 EGP group (M=4.28, SD=0.79) scoring higher than the 50,000-70,000 EGP group (M=4.04, SD=0.72) and more than 70,000 EGP (M=2.61, SD=1.27); Confidentiality $F(2,67)= 3.64$, $p=0.032$ with the 10,000–50,000 EGP group (M=4.02, SD=0.99) scoring higher than the 50,000-70,000 EGP group (M=3.30, SD=1.11) and more than 70,000 EGP (M=3.40, SD=0.85); Knowledge or Resources $F(2,67)= 11.61$, $p<0.001$, with the 10,000–50,000 EGP group (M=3.26, SD=1.25) scoring higher than the 50,000-70,000 EGP group (M=2.68, SD=1.09) and more than 70,000 EGP (M=1.80, SD=0.82). No other subscales had significant differences in the scores of the different household income levels as indicated in Table 4 (see Appendix D). Hence, these findings suggest that adolescents from lower-income households perceive greater barriers, particularly in affordability, confidentiality, and knowledge of resources, compared to their higher-income counterparts, highlighting the socioeconomic disparities in access to professional help.

Multiple Linear Regression Analysis on Barrier to Seeking Help

Multiple linear regression was conducted to examine the effects of all the factors: age, gender, income level, region, and K-10 scores on overall barriers to seeking professional help. The overall model was statistically significant, $F(5,64)=11.709$, $p<.001$with an $R2=0.478$, indicating that the predictors explained 47.8% of the variance in barriers to seeking help.

Moreover, the adjusted R2 equaled 0.437, which suggests that the model's results could apply beyond this sample.

Regarding specific predictors, gender had an unstandardized coefficient of s B=9.076, SE=4.674, and the standardized coefficient was β=0.178, t(64)=1.942, p=0.057. This result suggests that barriers to seeking professional help are marginally affected by gender, specifically that male adolescents report having higher perceived barriers compared to females. However, the p-value is slightly above the conventional $p<0.05$ threshold, suggesting only marginal significance. As for region, the unstandardized coefficient was B=8.789, SE=2.536, and the standardized coefficient was β=0.364, t(64)=3.465, $p<0.001$. This indicates that region is a significant predictor of barriers to seeking help, with adolescents from certain regions experiencing greater perceived barriers than others. Thirdly, regarding age, the unstandardized coefficient was B=−9.943, SE=2.767, and the standardized coefficient was β=−0.334, t(64)=−3.594 $p<0.001$. This suggests that older adolescents report fewer barriers to seeking professional help than younger adolescents, with a statistically significant negative effect. Fourthly, Psychological distress scores in the K-10 have an unstandardized B=1.333, SE=0.328, and the standardized coefficient was β=0.385, t(64)=4.063, $p<0.001$. This indicates that higher scores in the K-10 indicate higher psychological distress, which is associated with higher perceived barriers to seeking help, with a significant positive effect. Lastly, income level had an unstandardized coefficient for income level B=1.185, SE=3.094; the standardized coefficient was β=0.040, t(64)=0.383, (p=0.703). This suggests that income levels do not strongly predict barriers to seeking help among Egyptian adolescents.

Hence, this regression analysis suggests that psychological distress, region, and age were the most significant predictors of barriers to seeking help. More specifically, psychological

distress and region had positive effects, meaning higher psychological distress, and certain regions (Delta and Upper Egypt) were associated with higher perceived barriers. Age had a negative effect, as higher age groups had lower perceived barriers. As for gender, it was somewhat significant but of lesser effect. Lastly, income level was not a significant predictor in this model.

IV. Discussion

Summary of Findings

This study aimed to examine what are the most common barriers that prevent Egyptian adolescents aged 10-21 from seeking professional help when under psychological distress. Overall, the findings of this study found that 77% of Egyptian adolescents suffered from severe psychological distress yet did not seek professional help from mental health practitioners. Overall findings of the BASH questionnaire further suggest that Egyptian adolescents perceive many personal, cultural, and structural barriers that discourage them from seeking help. The three most common barriers included time availability, self-perception, and stigma.

Moreover, the study examined the relationship between psychological distress and different demographic characteristics, such as gender, age, SES, and region, on adolescents' perceived barriers to seeking professional help. A one-tailed Pearson correlation was conducted to investigate the relationship between psychological distress and perceived barriers. Results indicated a moderate positive correlation between the K-10 scores (a measure of psychological distress) and the total BASH score. This indicates that the more severe psychological distress adolescents face results in an increase in the perceived barriers to seeking help. Moreover, a one-tailed independent samples t-test was conducted to examine the gender differences in their perceived barriers. Male adolescents reported significantly more significant overall perceived barriers to seeking help than female adolescents. Specifically, they scored much higher in the Usefulness of Therapy, Locus of Control, Self-Sufficiency, Self-Awareness, and Stigma subscales.

Additionally, a series of one-way ANOVA tests were conducted to examine how different ages, SESs, and regions differed in their perceived barriers to seeking help. Younger adolescents in the age group 10-14 years old perceived significantly higher barriers to seeking

help compared to older adolescents, specifically in the subscales: Stigma, Locus of Control, Knowledge of Resources, Self-Awareness, Confidentiality, Self-Perception, Usefulness of Therapy, and Self-Sufficiency. As for SES, there were no significant differences between overall perceived barriers between different income levels of households. However, a more specific analysis of subscales indicated that adolescents from lower-income earning households with 10,000–50,000 EGP scored significantly higher than the 50,000-70,000 EGP group in Affordability Confidentiality and Knowledge or Resources. Lastly, for regions, individuals in rural regions (Delta and Upper Egypt) scored significantly higher barriers to perceived barriers compared to urban regions (Cairo and Alexandria) in all 14 subscales of the BASH questionnaire.

Correlation Between K-10 and BASH Scores

The alternative hypothesis is confirmed as a statistically significant positive relationship was observed between the scores for psychological distress and the perceived barriers to seeking help. Beyond being supported by the results in this study – this is also an expected finding based on the literature, given that adolescents generally demonstrated low intention toward help-seeking and that the more severe their psychological distress is, the less likely they are to seek help. Indeed, Hintzpeter et al. (2014) found that as few as 10% of adolescents suffering from mental disorders seek help. Moreover, Sawyer et al. (2012) and McLafferty et al. (2022) demonstrated that having high and severe depressive symptoms leads to them being 4 times less likely to seek help from anyone as compared to having less severe depressive symptoms. Hence, the findings of this study align with the existing literature. However, it is important to consider that this is the first study in Egypt and the Arab region to examine such a relationship. Therefore,

it is important to understand this relationship within the study's cultural context and where it was conducted.

While there is a consensus in the literature that there is a positive relationship between these two factors, psychological distress and barriers to seeking help, examining it from an Egyptian context, the findings of this study could be understood due to two different possibilities. Similar to the literature conducted internationally, this could be because adolescents suffering from severe distress would isolate themselves, feel hopeless, and believe that others either cannot help with their problems or that seeking external support is not worthwhile. Hence, this leads to them developing barriers that discourage them from seeking help as they believe it will be ineffective and that no one can help them. While this might be true, it is equally important to consider the context in which this study was conducted and how it could affect adolescents' perceived barriers. In Egypt and just like other Arab countries, the cultural perception of seeking professional help from mental health practitioners is negatively looked down upon (Endrawes et al., 2007). This cultural stigma could contribute to adolescents perceiving high barriers to help-seeking, not necessarily due to feelings of hopelessness, as suggested by some studies, but rather because of the cultural norms that discourage seeking external help (Endrawes et al., 2007). Therefore, even though adolescents who scored higher in having psychological distress also scored higher in their perceived barriers, this could be due to the cultural context in Egypt and not necessarily connected to their level of distress.

It is also essential to consider the interplay of these two factors together. The findings do not necessarily have to be entirely one or the other, but both factors working together affect the overall perception of barriers to seeking professional help.

Gender

The results reject the null hypothesis as statistically significant differences between males and females were observed in the data. Specifically, males reported higher barriers to seeking help in the Usefulness of Therapy, Locus of Control, Self-Sufficiency, Stigma, and Self-Awareness subscales. This is consistent with Gonzalez et al. (2005), who identified mental health stigma and lack of autonomy as significant barriers preventing adolescent males from seeking help more so than adolescent females. This trend has been observed in numerous studies across various populations, with gender differences in help-seeking behavior consistently highlighting that men tend to seek help less frequently and do not acknowledge emotional distress (Mahalik et al., 2007; McCafferty et al., 2022; Staiger et al., 2020; and Wong et al., 2017). Hence, it is evident that gender norms contribute to shaping help-seeking behaviors.

While the results of this study provide similar results to the existing literature, it could also be considered not just gender norms but also cultural context and expectations and how they play a factor. The study conducted by Sue et al. (1976) clearly illustrated how cultural norms surrounding gender can affect help-seeking behavior. Within the context of Egypt and Arab countries, it is necessary to assess how societal norms, traditions, and cultures both shape and define masculinity and femininity. In Arab countries and cultures, there is a great emphasis and highlight put on masculinity being connected to physical and emotional strength (El-Said & El-Said, 2012). Hence, this leads to males connecting seeking help as a challenge to their masculinity and the fear of being judged or looked down on them. This is even more evident from the findings of this study, as males perceived higher barriers, specifically in subscales such as locus of control and self-sufficiency. These subscales revolve around the notion of being tough and self-reliant. This gives insight into how Egyptian adolescent males view seeking help for

psychological distress as a sign of weakness, which goes against traditional Arab notions and views on masculinity.

Additionally, given the collective nature of Egyptian culture, it can be assumed that individuals strongly value their social image among the community and care about preserving family honor (Elsaid & Elsaid, 2012). Seeking therapy or admitting experiencing mental health challenges can be perceived as bringing shame to one's family, strengthening men's hesitance towards help-seeking behaviors.

Hence, it is evident that help-seeking behavior is affected by gender norms, as indicated in international studies and Arab ones, too (Bakalola et al., 2023; Elsaid & Elsaid, 2012; Mahalik et al., 2007; McCafferty et al., 2022; Staiger et al., 2020; and Wong et al., 2017) however, recognizing the cultural context of masculinity in the Arab world adds a layer of complexity to the barriers. Hence, mental health practitioners need to be culturally sensitive when promoting mental health and help-seeking among male adolescents.

Age

The null hypothesis is rejected because the data indicated differences between age groups and the prevalence of barriers to help-seeking on the BASH scale. The data confirms the alternative hypothesis because the oldest group of adolescents (18-21) reported the lowest barriers to seeking help. In contrast, younger adolescents reported higher barriers with not only stigma and locus of control but also six other subscales of the BASH scale. It is important to note that this confirms the findings found in the literature, as studies have indicated that older individuals perceive lower barriers to help-seeking behavior than younger individuals (Swords et al., 2011; Rickwood et al., 2005; Wright et al., 2018). This agreement between the data and literature review not only lends credibility to the findings of this study through triangulation of

data, but it indicates that Egyptian adolescents are likely – at least concerning the effects of age – to display similar characteristics to international peers about help-seeking in cases of psychological stress. Furthermore, like the findings in earlier studies, age-related barriers in this study were closely linked to factors such as lack of knowledge, limited recognition of the problem, and less autonomy in younger adolescents (Swords et al.,2011). Specifically, the present study identified significant age-related differences in barriers such as stigma, knowledge of resources, confidentiality, self-perception, and locus of control. —all of which further support the patterns seen in the literature.

In addition, it is essential to consider how Egypt's cultural context might have influenced such results. As mentioned previously, mental health stigma is still high in Egypt, which might lead to younger adolescents conforming more to parental and societal expectations about mental health difficulties and help-seeking. Younger adolescents, especially the youngest age group, might not be able to make their own decisions and would internalize negative beliefs and views on mental health and seeking help. However, as adolescents become older, they become more independant and start to seek and research on information on their own, breaking out of familial expectations and societal pressure. By doing so they are able to understand for themselves the importance of seeking help.

Such results provide great insight for mental health practitioners, not only on the importance of educating younger adolescents on the benefits and importance of seeking help and reducing the stigma regarding mental health at a young age but also on the importance of educating parents on recognizing when their children are struggling and the importance of seeking external professional help.

Region

With regards to region, the alternative hypothesis is confirmed, and the null is rejected by the data, as the scores of adolescents living in rural regions such as Delta and Upper Egypt reflected more perceived barriers to seeking professional psychological help compared to adolescents in urban cities such as Cairo and Alexandria.

Stigma, Affordability, and Knowledge of Resources are the three subscales that exhibited the most significant differences between regions. Stigma is most likely associated with sociocultural factors such as cultural beliefs being more rooted in rural areas where there is less exposure to progressive attitudes towards mental health problems (Endrawes et al., 2007). The social isolation and the small community's pressure for conformity can often make adolescents feel self-conscious, uncomfortable, and embarrassed about sharing or admitting that they need support out of fear of exposure within their communities (Endrawes et al., 2007). On the other hand, when it comes to urban areas, adolescents may relevantly look at mental health difficulties from a slightly more modern lens. Nevertheless, even in urban areas, stigma can still exist, especially if the cultural values are conservative by nature. Affordability and knowledge of available resources are more likely related to structural barriers linked to economic disparities between urban and rural areas, which include family-level income and broader infrastructure such as education and adequately trained medical staff (Okasha et al., 2022). Given the significant differences in education, culture, beliefs, norms, etc., discussed in the literature, it is reasonable to assume that the rural region is more affected than the urban one by such barriers to seeking help. A study conducted in Egypt found that mental health facilities are not distributed proportionately between urban and rural areas, as they are significantly more present in urban ones (Elnemais, 2017). Moreover, a key aspect to consider from this study is that it focuses

mainly on comparing rural and urban rather than differences between specific regional urban cultures. For instance, Cairo and Alexandria are Egypt's most significant urban centers, so it would be helpful to explore whether smaller cities like Mansoura or Aswan show similar barriers to help-seeking or are more similar to rural areas.

A previous study conducted by Okasha et al. (2022) found that individuals residing in rural Egyptian regions were more likely to seek help from traditional religious healers than professional mental health practitioners. While this could be true in explaining the results of this study, especially with the high score in the subscale lack of knowledge of resources, the BASH instrument used in this study does not directly consider the preference of seeking help from a traditional healer as a subscale in the instrument due to it being an international scale. Hence, it should have been considered in the scope of this study. However, further research is needed to examine this aspect further.

Income level

Despite some significant limitations regarding the diversity of respondents regarding socioeconomic status (SES), the results regarding household income still provided important insights into the findings of this study. In this case, the null hypothesis was confirmed as there were almost no statistically significant differences between low SES and high SES respondents in their perception of barriers to seeking professional help in Egypt. In the literature, it was evident that contradicting views existed regarding the relationship between SES and barriers to seeking help. Some studies suggested that individuals of lower SES face much more stigma regarding mental illness than individuals of higher SES, leading to more perceived barriers when needing to seek help (McManus et al., 2016; Potts & Henderson, 2020; Pybus et al., 2023). On the other hand, other studies suggested that higher SES results in higher social dominance

orientation (SDO) and that individuals should be able to control their mental health through willpower and hence higher perceived barriers compared to lower SES (Foster & O'Mealey, 2022). Even though there were no statistical differences between SES levels, it remains to be seen whether the theory of SDO is necessarily applicable within the Egyptian context.

The follow-up one-way ANOVA of BASH subscales results did find statistically significant differences concerning affordability, confidentiality, and knowledge of resources, where adolescents from lower SES scored higher perceived barriers than high SES adolescents. While it is clear that income levels influence affordability, factors like confidentiality and knowledge of resources may be affected by other indirect issues, such as differences in education and infrastructure. For example, adolescents living in rural areas of Egypt may have limited access to quality schools and mental health services due to uneven infrastructure. This could lead to misunderstanding on how mental health support services function in Egpyt, affecting their beliefs on confidentiality, and that their problems might be shared with others in the community. Moreover, the lack of professionally trained professionals makes it harder for adolescents to know what resources are available. This might be the case even if their household income is similar to that of an urban adolescent. Therefore, while income does play a role in the BASH results, these findings are likely influenced by other factors, with affordability being the main exception, as it is directly tied to socioeconomic status (SES).

K10 Scores

One important element of the findings was the disparity between the observed percentage of Egyptian adolescents exhibiting psychological stress (77%) and the results in previous relevant research, namely Ghanem et al.'s study (2009). That study did not focus purely on adolescents. However, it did have a much larger sample of Egyptian adolescents and adults. It

found far lower rates of 16.93% of prevalence of psychological disorders than is indicated by the present study's results. Other studies from the literature, such as Bakola et al. (2024), found that 64% of Egyptian respondents exhibited psychological distress, which is closer to the 77% found in the present study.

This considerable disparity between results raises essential questions of validity, including those in the present study, because it is unclear to what extent Egyptian adolescents are experiencing psychological stress in terms of multiple agreeing data points. However, these results could be explained by considering the events taking place in the Arab region mentioned earlier such as political conflict and instability as well as economic challenges and high unemployment rates, coupled with adolescent's exposure to a wide diverse array of content on social media, this could justify the prevalence of high psychological distress among adolescents in Egypt (Ahmed Rashad, 2017 and Moussa et al., 2015).. In the recent year in particular, the escalation in the Palestinian-Israeli conflict and its raw documentation on social media has further propelled deterioration in terms of mental health among adolescents not only in the region but around the world. It is proven that virtual exposure to violence is a significant risk factor for the development of psychopathology in young people (Wagner et al., 2020).

Aside from that other contributing factors would explain the high percentage of respondents in this study reporting severe psychological stress. One major likely factor is self-selection bias, whereby respondents were motivated to respond to this study because they were experiencing psychological stress and barriers to seeking help. While careful efforts were made to ensure inclusivity in the language (the scales were presented in both English and Arabic) and limitations in reaching traditionally difficult-to-reach populations, such as poorer respondents in rural areas, no data was gathered regarding respondents' previous experiences with mental health

services. Future studies should remember that self-selection could affect results regarding the prevalence of psychological stress. However, even if the pool of respondents exhibited self-selection bias, that does not invalidate the findings regarding hypothesis testing or overall barriers to seeking help, as these were meant to focus on individuals experiencing psychological stress. Indeed, self-selection bias may have positively contributed to more people with psychological distress completing the questionnaire because the topic was of interest to them.

Another potential contributing factor to the high prevalence of respondents reporting psychological stress is related to the time required to complete the survey. This study utilized a somewhat comprehensive survey that took 15 minutes to complete and needed both parents and adolescents to complete the forms. Hence, individuals who were not invested for some reason in completing the survey likely did not take the time to participate; similar to self-selection, only individuals who had a reason, such as personal experience with psychological stress or mental illness, may have decided to complete the survey. Future studies could address this self-selection problem by partnering with schools and universities to ask their students to take the survey as extra credit for a specific course to gather more responses and reach more diverse participants.

Comparative Discussion of BASH Results

BASH results were gathered and analyzed based on the specific demographic factors tested within this study's hypotheses: gender, age, SES, and region. While each of the hypotheses tested BASH results against these factors separately, a descriptive analysis was also conducted that identified the most common barriers to adolescents seeking help in Egypt. Based on this comparative analysis of BASH subscale scores, the three highest mean barriers to Egyptian adolescents seeking help for psychological stress are Time Availability, Self-Perception, and Stigma. These findings stand in pretty stark comparison with the literature.

Stigma was an expected finding, given that Radez et al. (2020) identified that 92% of studies in their meta-study reported the social factor of public stigma as a primary barrier to seeking professional help for psychological stress. Structural/logistical barriers, however, were only found to be a prominent barrier in 58% of the studies examined, and self-perception was not identified as any of the four main barriers to adolescents seeking professional help. While Gulliver et al. (2020) did find that self-perception was part of a main barrier because of the negative attitudes most adolescents have towards mental health care, it was not explicitly identified because it was only included as part of broader negative perceptions regarding seeking treatment for or admitting to having, mental health problems. While these meta-studies did mention logistical factors such as access and knowledge of healthcare options as potential barriers, lack of availability of time was not explicitly identified in any of the literature as a barrier to help-seeking behavior.

This is the most noteworthy of all the findings presented in this discussion because of how much it stands out relative to the literature. On an inferential basis, there is considerable pressure on many Egyptian adolescents to participate in sports and after-school activities and to take academic lessons outside of school. This could be the specific source of time limitations, though a targeted study is needed to understand this fully. However, it could also be that adolescents reporting that lack of time availability is a barrier that prevents them from seeking help is a subconscious deflection of responsibility for the problem; the literature (Lam, 2014) (Attygalle et al., 2017) consistently identified that adolescents were generally aware when they had a problem but did not often seek help – it could be that this answer from respondents was a sub-conscious way of avoiding the issue rather than acknowledging it. Again, this is purely conjecture and warrants future study.

Practical Implications and Interventions

The findings presented in this study provide significant insights that could inform Egyptian mental health practitioners and psychologists about what services and interventions are needed to help reduce barriers to seeking help in Egypt and encourage more adolescents to seek professional help. Overall, given the high rates of psychological distress and barriers to seeking help, as illustrated in the scores of both instruments, more nationwide campaigns targeting Egyptian adolescents are needed to raise awareness of the benefits of seeking help and the effectiveness of talking to a professional mental health practitioner. Moreover, since stigma was one of the highest three subscale scores, this further indicates the need for campaigns that aim at reducing the stereotypes and breaking the cultural beliefs and labels placed on having a mental disorder or seeking help from mental health practitioners. More specifically, having more well-known influential men speak up more about their mental health and the benefits they experienced from seeking help would help reduce the cultural aspects regarding masculinity that discourage males from seeking external help or expressing signs of emotional distress.

Secondly, school-based interventions could help reach adolescents from a young age and work on de-stigmatizing mental health through holding sessions that entail identifying signs of psychological distress, learning the importance and benefits of seeking help, and creating a safe environment where students could discuss their emotions and where to seek support during emotional distress whether internally with a school counselor or externally. Not only that but ensuring that all schools have a counselor within the system is needed as hundreds of schools, specifically public schools, do not consider the importance of school counselors. A governmental policy should implement a new law to enforce all schools across Egypt to have a counselor that ensures the well-being of students. This could allow students to see the importance and benefits of mental health practitioners.

Moreover, specific interventions targeting adolescents residing in rural regions or from low SES classes, which face not only cultural and personal barriers but also structural barriers such as affordability, lack of available time, or lack of knowledge of resources, are also needed. One existing online platform called O7 Therapy is an Egyptian mental health platform that provides different services, including affordable online therapy sessions and free chat-based anonymous support (both in Arabic and English). Such a platform must be promoted more in rural regions and among low SES classes, highlighting its usefulness and benefits. Considering that it is a free service, online, completely confidential, and anonymous, this would eliminate many perceived barriers and allow adolescents to believe that seeking help is a lot more accessible and safe for them to do so. Hence, raising more awareness on such a platform and informing adolescents that such services exist in Egypt is important.

Limitations

This study presents some limitations to consider. The most significant limitation is regarding the sample size of the respondents who participated in this study. The sample only included 70 participants; a relatively low number compared to the overall Egyptian population of adolescents. It does not represent Egyptian adolescents and hence does not provide generalizable results. Compared to other studies in the literature conducted explicitly in Egypt that included sample sizes in the 1000s, this study has a much smaller number of participants. Hence, it does not accurately represent the adolescent population in Egypt. This limitation might result from a methodological drawback of having the survey shorter and requiring both the parent and adolescent to fill out different survey sections. This might have discouraged participants from participating in the study as it included different steps and the approval of a parent.

Moreover, the unequal representation of different demographic groups, specifically SES and geographical regions, is also a limitation of this study. For example, regarding geographical areas, urban cities like Cairo and Alexandria had a much higher number of respondents compared to rural regions (Delta and Upper Egypt), each with less than ten respondents. This unequal representation of different groups might have affected the study's overall results, as comparisons between these groups are not accurate. A reason for this imbalance in groups might be snowball sampling, even though snowballing allowed participating individuals to spread the survey to others who might have needed help to reach otherwise. However, snowballing also likely contributed to limitations in the diversity of participants. The root of this issue is that snowballing tends to occur within social groups. Hence, people living in the same geographical region and those with a certain income level are likely to share the survey with people who also fall into that category. Hence, the small, potentially biased sample limits the study's external validity, making it difficult to generalize the findings to the broader adolescent population in Egypt or other cultural contexts in the Arab world.

Another limitation is regarding the self-selection bias, as most respondents were most likely participating in the survey as it was a topic of interest to them since they experienced either psychological distress or faced barriers to seeking help. This bias resulted in an inaccurate and overrepresentation of the prevalence of psychological distress among Egyptian adolescents. Not only that, but it is important to consider self-report bias as well in the study, as participants may provide inaccurate or socially desirable responses, which could distort the findings and affect the overall validity of the results.

Moreover, concerning the translation of the BASH questionnaire, this study utilized a shortened version of Sousa and Rojjanasrirat’s (2010), seven steps to translating a scale. Due to

time constraints and the scope of this study, recruiting two translators and having back-and-forth translation was hard to achieve. This raises some concerns about the validity of the translation of the survey.

Recommendations for Future Research

Such limitations to this study give rise to recommendations that would help improve future research. Firstly, future researchers need to attempt to generate a much larger sample size and ensure that the sample generated is diverse and equally represents all different demographic groups (genders, ages, SES, and regions). Also, a more concise survey should be considered to increase the number of participants. This will encourage more adolescents to participate in the study as it won't take so much of their time or feel too demanding. Another way would be to provide an incentive, such as a small monetary voucher, which might be a great way to encourage more participants to participate in the study.

As for ensuring an equal representation of different demographic groups, not utilizing convenience sampling and snowball sampling and relying more on randomized sampling or stratified sampling might help improve the representation of various demographic groups as it could be more equal. Also, partnering with schools, universities, or mental health organizations could help access a more representative sample as they would share the survey with diverse adolescents and students. This would reduce the limitation of self-selection bias and its effect on the overall scores of the study. This will lead to a more representative sample, which could enhance the generalizability of the findings.

Regarding the translation of the BASH questionnaire, future studies should attempt to follow the full steps to effectively translate the questionnaire to ensure more accurate results. Moreover, put more emphasis on translating the specific items that were initially rated unclear in this study (++++ mention which items were these, here).

Lastly, based on the recommended intervention regarding school-based interventions a final recommendation would suggest future studies to implement a study that measures perceived barriers pre-and post-implementation of the intervention to truly measure if it is effective among Egyptian Adolescents.

V. Conclusion

This study is a pioneering study aimed at understanding what are the barriers that prevent Egyptian adolescents aged 10-21 from seeking professional help when facing psychological distress. Examining a range of personal, cultural, and structural barriers generates valuable insight into the most prominent barriers that prevent Egyptian adolescents from seeking help. Moreover, since this is the first study of its kind to be conducted in Egypt, it explored different aspects such as psychological distress, gender, age, region, and socioeconomic status (SES) and how they influence adolescents' barriers to seeking help. This ensures that an overview of the situation in Egypt is understood holistically and from a broad perspective. However, more in-depth studies examining each of these demographic groups individually and making more in-depth comparisons to one another are still needed to generate a much better understanding of these demographics and their unique barriers to seeking help. This will further allow for more specific and targeted interventions.

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VII. Appendices

Appendix A : English Survey

Section 1

Psychotherapy Experience

Have you ever received treatment or counseling from a mental health practitioner, such as a psychotherapist, psychologist, psychiatrist, counselor, or therapist, for any mental health concerns or issues?

Yes (end survey here)

No (continue survey)

Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

Section 2 (Parental Consent Form)

Purpose of the Research:

The purpose of this research is to understand what prevents adolescents in Egypt from seeking professional mental health services such as (psychiatrists, psychologists, and counselors…) and examine if there is a relationship between adolescent characteristics such as psychological distress, gender, age, socioeconomic status, and geographical region on their mental health-seeking behavior.

What You Will Do in This Research:

If you decide to allow your son/daughter to participate, they will complete one online survey. Some of the questions will be about their opinions regarding mental health services in Egypt, and others will focus on their mental health and feelings of distress.

Duration and Time Required:

The survey will take approximately 15-20 minutes to complete.

Risks:

Some of the questions may cause them discomfort; therefore, if they feel uncomfortable or distressed at any point, they are free to end the survey.

Also, if you feel your child is uncomfortable or distressed by any part of the survey, please consider seeking support by contacting any of the following mental health resources in Egypt:

Egyptian Mental Health Hotline: +20220816831

Behman Hospital: +20 2 28166610

Online Mental Health Support Platforms: Shezlong, O7 therapy

Such resources are available in Egypt and can provide your child with professional support if they are experiencing any psychological distress and need to talk with a professional mental health practitioner.

Benefits:

There are no benefits from your child's participation in this study. However, their participation will contribute to a better understanding of mental health-seeking behaviors among Egyptian adolescents, which can help improve mental health services.

Confidentiality:

Your child's responses are confidential as the research will only collect demographic questions regarding age, gender, no personal questions will be asked keeping your childs identity unknown. Moreover, their records and data will be kept confidential through coded responses.

Participation and Withdrawal:

Your child's participation is entirely voluntary; they can end the survey and withdraw anytime. Please ensure in the case that you have more than one adolescent that, only one takes part in the survey. Moreover, if your child chooses to withdraw at any point during the survey, their responses will not be used in the study.

To Contact the Researcher:

If you have questions or concerns about this research at any time, please contact

- Researcher: Rana Abdelaal
- Phone: +30 694 3413316
- Email: R.abdelaal@acg.edu

You may also contact the faculty member supervising this work:

- Supervisor: Dr. S. Diareme, Ph.D., Clinical Psychologist, Part-time Faculty,

- Phone: +30 210 600 9800
- Email: sdiareme.acg.edu
- Address: The American College in Greece, DEREE - School of Graduate and

Professional Education, 6 Gravias Street, 15342, Athens, Greece,

I have read and understood the information provided to me. I have had all my questions answered satisfactorily, and I voluntarily agree for my daughter/son to participate in this study.

Signature _____

Section 3

What is your household's (parents') current income level per month?

Less than 10,000EGP

10,000-30,000EGP

30,000-50,000EGP

50,000-70,000EGP

More than 70,000EGP

Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

Section 4 (Adolescent Consent Form)

Purpose of the Research:

The purpose of this research is to understand what prevents adolescents in Egypt from seeking professional mental health services such as (psychiatrists, psychologists, and counselors…) and examine if there is a relationship between adolescent characteristics such as psychological distress, gender, age, socioeconomic status, and geographical region on their mental health-seeking behavior.

What You Will Do in This Research:

If you decide to participate, you will complete an online survey. Some questions will be about your opinions regarding mental health services in Egypt. Others will focus on your mental health and feelings of distress.

Duration and Time Required:

The survey will take approximately 15-20 minutes to complete.

Risks:

Some of the questions may cause you some discomfort; therefore, if you feel uncomfortable or distressed at any point, you are free to end the survey.

Also, if you feel you are uncomfortable or distressed by any part of the survey, please consider seeking support by contacting any of the following mental health resources in Egypt:

Egyptian Mental Health Hotline: +20220816831

Behman Hospital: +20 2 28166610

Online Mental Health Support Platforms: Shezlong, O7 therapy

Such resources are available in Egypt and can provide you with professional support if you are experiencing any psychological distress and need to talk with a professional mental health practitioner.

Benefits:

There are no benefits from your participation in this study. However, your participation will contribute to a better understanding of mental health-seeking behaviors among Egyptian adolescents, which can help improve mental health services.

Confidentiality:

Your responses will be kept confidential as results are reported and described in summary altogether and not specific to anyone. Moreover, responses are confidential as the research will only collect demographic questions regarding age, gender, no personal questions will be asked keeping your identity unknown.

Participation and Withdrawal:

Your participation is voluntary, and you can end the survey and withdraw anytime. If you choose to withdraw, your responses will not be used in the study.

To Contact the Researcher:

If you have questions or concerns about this research at any time, please contact

Researcher: Rana Abdelaal

Phone: +30 694 3413316

Email: R.abdelaal@acg.edu

You may also contact the faculty member supervising this work:

Supervisor: Dr. S. Diareme, Ph.D., Clinical Psychologist, Part-time Faculty,

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Address: The American College in Greece, DEREE - School of Graduate and Professional Education, 6 Gravias Street, 15342, Athens, Greece,

I have read and understood the information provided to me. I have had all my questions answered satisfactorily, and I voluntarily agree to participate in this study.

Signature _____

Section 5 (Demographics)

Age:

- 10-13 years old
- 14-17 years old
- 18-21 years old

Gender:

- Male
- Female
- Other
- Prefer not to say

Region:

- Cairo
- Alexandria
- Delta
- Upper Egypt
- Other

Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

Section 6 (Kessler Psychological Distress Scale K-10 (Likert 1-5))

- About how often did you feel tired out for no good reason?
- About how often did you feel nervous?
- How often did you feel so nervous that nothing could calm you down?
- About how often did you feel hopeless?
- About how often did you feel restless or fidgety?
- About how often did you feel so restless you could not sit still?
- About how often did you feel depressed?
- About how often did you feel that everything was an effort?
- How often did you feel so sad that nothing could cheer you up?
- About how often did you feel worthless?

Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

Section 7 (Barriers to Adolescents Seeking Help Questionnaire (Likert 1-5))

If I had a problem I would solve it by myself

I think I should work out my own problems

Adults really can't understand the problems that kids have

If I had a problem, my family would help me more than a therapist

If I had a problem, my friends could help me more than a therapist

From what I know, most people get help from therapy

I would never want my friends to know that I was seeing a therapist

If I had a problem, my parents would think that speaking to a therapist was a good idea

I cannot imagine having a problem so serious I would go for help

I know people who have been helped by therapy

Even if I had a problem, I'd be too embarrassed to talk to a therapist about it

Even if I wanted to, I wouldn't have time to see a therapist

Therapists are more helpful to adults than to teenagers

I know where I could find a therapist if I needed one

People don't need therapists to help them with their problems

My friends would think I was crazy if I saw a therapist

If I ever talked to a therapist about personal things, I'm sure my family would hear about it

Therapists really can't understand teenager's problems today

The idea of going to a therapist is pretty scary to me

Going to a therapist means you don't have the strength to handle the problem yourself

If I went to a therapist, it would make me feel like I was crazy

I have had problems in the past which really upset me

My problems will go away by themselves

Therapy can often help teenagers with problems

I'd never want my family to know I was seeing a therapist

No matter what I do it will not change the problems I have

A therapist might make me do or say something that I don't want to

I could not afford to see a therapist even if I wanted to

I think that therapists really want to help people

My parents have said they really don't believe in therapy

If I ever went to a therapist, my parents would be pretty upset

I think therapy can be harmful

If I saw a therapist my family would think I was weak

If I went to see a therapist, I might find out I was crazy

If I had a problem and told a therapist, he would not keep it secret

My family thinks that anyone who goes to a therapist is crazy

People who see therapists are crazy

Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

Section 8 (Debriefing Statement)

Thank you for participating in this study to understand the barriers preventing adolescents in Egypt from seeking professional mental health services. Your input will help us understand what might stop adolescents from seeking professional help.

This research study aims to identify why Egyptian adolescents aged 10-21 do not seek help from professional mental health practitioners. It attempts to examine the relationship between psychological distress and different demographic characteristics such as age, gender, SES, and region on the perceived barriers to seeking professional help. Through analysis of the data collected, this study aims to provide insights that can help mental health professionals understand the problem and, therefore, develop effective strategies to support adolescents in accessing the care they need.

We understand that some questions may have been sensitive or challenging to answer. If you experienced any discomfort or distress while completing the survey, we encourage you to seek support from the following mental health resources in Egypt:

- Egyptian Mental Health Hotline: +20220816831
- Behman Hospital: +20 2 28166610
- Online Mental Health Support Platforms: Shezlong, O7 therapy

Such resources are available in Egypt and can provide you with professional support if you are experiencing any psychological distress and need to talk with a professional mental health practitioner As a reminder, your responses are confidential and will be used solely for this research. The information you provide will be kept secure and will be reported in a way that ensures your anonymity.

If you have questions or concerns about this research at any time, please contact

Barriers to Help-Seeking and Psychological Distress in Egyptian Adolescents

- Researcher: Rana Abdelaal
- Phone: +30 694 3413316
- Email: R.abdelaal@acg.edu

You may also contact the faculty member supervising this work:

- Supervisor: Dr. S. Diareme, Ph.D., Clinical Psychologist, Part-time Faculty,
- Phone: +30 210 600 9800
- Email: sdiareme.acg.edu
- Address: The American College in Greece, DEREE - School of Graduate and Professional Education, 6 Gravias Street, 15342, Athens, Greece,

Thank you again for your valuable contribution to this vital research.

Appendix B: Arabic Survey

تجربة العلاج النفسي

هل سبق لك أن تلقيت علاجا أو استشارة من ممارس متخصص بالصحة العقلية، مثل المعالج النفسي أو الطبيب النفسي أو المستشار النفسي أو الأخصائي النفسي بخصوص أي مخاوف أو مشاكل تتعلق بالصحة العقلية؟

أ. نعم (قم بإنهاء الاستبيان هنا)

ب. لا (تابع الرد على الاستبيان)

<u>نموذج موافقة الوالدين</u>

:الغرض من البحث

الغرض من هذا البحث هو فهم الحواجز التي تمنع المراهقين في مصر من البحث عن العلاج النفسي وفهم تأثير الضيق النفسي والعمر والجنس على تلك الحواجز.

ما الذي ستقوم به في هذا البحث

إذا قررت السماح لابنك/ابنتك بالمشاركة، فسيقومون باستكمال استبيان واحد وستكون بعض الأسئلة حول تجاربهم وتصوراتهم فيما يتعلق بالعلاج النفسي في حين ستركز أسئلة أخرى علىصحتهم العقلية وشعورهم بالضيق.

:المدة والوقت المطلوبان

سيستغرق الاستبيان حوالي 15-20 دقيقة لإكماله.

المخاطر

قد تسبب بعض الأسئلة عدم الراحة أو الإحراج لهم، ومع ذلك، إذا شعروا بعدم الارتياح في أي وقت، فإن لهم مطلق الحرية في التوقف عن استكمال الاستبيان.

وإذا شعرت أن ابنك غير مرتاح أو منزعج من أي من الأسئلة، فيرجى التفكير في طلب الدعم من موارد الصحة النفسية والعقلية التالية في مصر:

- الخط الساخن المصري للصحة العقلية: +20220816831
- مستشفى بهمان: +20 2 28166610
- منصات دعم الصحة العقلية عبر الإنترنت: Shezlong، Therapy O7

يمكن أن توفر هذه الموارد الدعم والمساعدة السرية إذا كانوا يعانون من ضائقة عاطفية نفسية أو يحتاجون إلى التحدث إلى شخص ما حول صحتهم العقلية.

الفوائد:

لا توجد فوائد مباشرة ومع ذلك ستساهم مشاركتهم في تكوين فهم أفضل لحواجز الصحة انفسية والعقلية بين المراهقين المصريين، مما يمكن أن يساعد في تحسين خدمات الصحة العقلية ودعمها.

السرية:

سيتم الحفاظ على سرية ردود أبنائكم على الاستبيان ولن يمكن الوصول إلى بياناتهم وهويتهم إلا للباحث القائم بالدراسة الحالية. سيتم الحفاظ على سرية السجلات والبيانات من خلال الاستجابات المشفرة والتخزين الآمن. عندما يتم الإبلاغ عن نتائج البحث، سيتم تلخيص مجموع الردود معا بشكل عام وليس بشكل فردي محدد بشخص معين.

المشاركة والانسحاب:

مشاركة أبنائكم في الاستبيان تطوعية تماما، ويمكنهم الانسحاب في أي وقت. وإذا اختاروا الانسحاب فلن يتم استخدام ردودهم في الدراسة.

التواصل مع الباحث:

إذا كانت لديك أسئلة أو مخاوف بشأن هذا البحث في أي وقت، فيرجى الاتصال:

- الباحثة: رنا عبدالعال
- رقم الهاتف: +302106009800
- البريد الإلكتروني R.abdelaal@acg.edu

يمكنك أيضا الاتصال بعضو هيئة التدريس المشرف على هذه الدراسة:

- المشرف: د. س. دياريم طبيب نفسي سريري، أستاذة جامعية بدوام جزئي
- رقم الهاتف: +30 210 600 9800
- البريد الإلكتروني sdiareme.acg.edu
- العنوان: الكلية الأمريكية في اليونان، DEREE -كلية الدراسات العليا والدراسات المهنيه، 6 شارع غرافياس، 15342، أثينا، اليونان

لقد قرأت وفهمت المعلومات المقدمة لي ولقد حصلت على أجابات مرضية على جميع أسئلتي وأوافق طواعية على مشاركة ابنتي/ابني في هذه الدراسة.

__التوقيع _____ التاريخ _____

***ما هو مستوى الدخل الحالي لأسرتك شهريا؟**

- 10,000-30,000جنيه مصري
- 30,000-50,000جنيه مصري
- 50,000-70,000جنيه مصري
- أكثر من 70,000 جنيه مصري

نموذج موافقة المراهقين

الغرض من البحث:

الغرض من هذا البحث هو فهم الحواجز التي تمنع المراهقين في مصر من البحث عن العلاج النفسي وفهم تأثير الضيق النفسي والعمر والجنس على تلك الحواجز.

ما الذي ستقوم به في هذا البحث:

إذا قررت المشاركة، فستكمل استبيانا واحدا. ستكون بعض الأسئلة حول تجاربك وتصوراتك فيما يتعلق بالعلاج النفسي في حين ستركز أسئلة أخرى على صحتك العقلية وشعورك بالضيق.

المدة والوقت المطلوبان:

سيستغرق الاستبيان حوالي 15-20 دقيقة لإكماله.

المخاطر:

قد تسبب لك بعض الأسئلة عدم الراحة أو الإحراج ، ومع ذلك، إذا شعرت بعدم الارتياح في أي وقت، فإن لك مطلق الحرية في التوقف عن استكمال الاستبيان.

وإذا شعرت أنك غير مرتاح أو منزعج من أي من الأسئلة، فيرجى التفكير في طلب الدعم من موارد الصحة النفسية والعقلية التالية في مصر:

- الخط الساخن المصري للصحة العقلية: 20220816831
- مستشفى بهمان: +20 2 28166610
- منصات دعم الصحة العقلية عبر الإنترنت: Shezlong، Therapy O7

يمكن أن توفر هذه الموارد الدعم والمساعدة السرية إذا كنت تعاني من ضائقة عاطفية نفسية أو تحتاج إلى التحدث إلى شخص ما حول صحتك العقلية.

الفوائد:

لا توجد فوائد مباشرة ومع ذلك ستساهم مشاركتك في تكوين فهم أفضل لحواجز الصحة النفسية والعقلية عند المراهقين المصريين، مما يمكن أن يساعد في تحسين خدمات الصحة العقلية ودعمها.

السرية:

سيتم الحفاظ على سرية ردودك على الاستبيان ولن يمكن الوصول إلى بياناتك وهويتك إلا للباحث القائم بالدراسة الحالية. سيتم الحفاظ على سرية السجلات والبيانات من خلال الاستجابات المشفرة والتخزين الآمن. عندما يتم الإبلاغ عن نتائج البحث، سيتم تلخيص مجموع الردود معا بشكل عام وليس بشكل فردي محدد بشخص معين.

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مشاركتك في الاستبيان تطوعية تماما، ويمكنك الانسحاب في أي وقت. وإذا اخترت الانسحاب فلن يتم استخدام ردودك في الدراسة.

التواصل مع الباحث:

إذا كانت لديك أسئلة أو مخاوف بشأن هذا البحث في أي وقت، فيرجى الاتصال:

الباحثة: رنا عبدالعال

رقم الهاتف: +302106009800

البريد الإلكتروني R.abdelaal@acg.edu

يمكنك أيضا الاتصال بعضو هيئة التدريس المشرف على هذه الدراسة:

المشرف: د. س. دياريم طبيب نفسي سريري، أستاذة جامعية بدوام جزئي

رقم الهاتف: +30 210 600 9800

البريد الإلكتروني sdiareme.acg.edu

العنوان: الكلية الأمريكية في اليونان، DEREE - كلية الدراسات العليا والدراسات المهنية، 6 شارع غرافيكس، 15342، أثينا، اليونان

لقد قرأت وفهمت المعلومات المقدمة لي ولقد حصلت على أجابات مرضية على جميع أسئلتي وأوافق طواعية على المشاركة في هذه الدراسة.

__التوقيع _____ التاريخ _____

التركيبة السكانية

العمر:

- من 10-**13** سنة
- من **14**-17 سنة
- من **18**-**21** سنة

الجنس:

- ذكر
- أنثى
- أخرى

المنطقة

- القاهرة
- الإسكندرية
- الدلتا
- صعيد مصر
- أخرى

مقياس الضيق النفسي

Kessler Psychological Distress Scale K-10 (Likert 1-5)

1. كم مرة شعرت بالتعب بدون سبب وجيه؟
2. كم مرة شعرت بالتوتر؟
3. كم مرة شعرت بالتوتر لدرجة أنه لا شيء يمكن أن يهدئك؟
4. كم مرة شعرت باليأس؟
5. كم مرة شعرت بعدم الراحة أو العصبية؟
6. كم مرة شعرت بعدم الراحة لدرجة أنك لم تستطع الجلوس هادئاً بلا تململ؟
7. كم مرة شعرت بالاكتئاب؟
8. كم مرة شعرت أن كل شيء يحملك جهدا؟
9. كم مرة شعرت بالحزن لدرجة أنه لا شيء يمكن أن يبهجك؟
10. كم مرة شعرت بأنه لا قيمة لك؟

الحواجز التي تمنع المراهقين من طلب المساعدة استبيان(Likert 1-5)

1. إذا كانت لدي مشكلة، فسأحلها بنفسي
2. أعتقد أنني يجب أن أحل مشاكلي الخاصة
3. لا يستطيع البالغون حقا فهم المشاكل التي يعاني منها الأطفال
4. إذا واجهت مشكلة، فإن عائلتي ستساعدني أكثر من المعالج النفسي
5. إذا واجهت مشكلة، يمكن لأصدقائي مساعدتي أكثر من المعالج النفسي
6. حسب معلوماتي، فإن معظم الناس يحصلون على المساعدة من العلاج النفسي
7. لا أريد أبدا أن يعرف أصدقائي أنني كنت أتردد على معالج نفسي
8. إذا واجهت مشكلة، فسيعتقد والداي أن التحدث إلى معالج نسي فكرة جيدة
9. لا أستطيع أن أتخيل وجود مشكلة خطيرة لدرجة إحتياجي لطلب المساعدة
10. أعرف أشخاصا ساعدهم العلاج النفسي
11. حتى لو كانت لدي مشكلة، سأكون محرجا جدا من التحدث إلى معالج نفسي عن الموضوع
12. وحتى لو أردت ذلك، لن يكون لدي وقت للتردد على المعالج النفسي
13. المعالجون النفسيون أكثر فائدة للبالغين من المراهقين
14. أعرف أين يمكنني العثور على معالج نفسي إذا احتجت إليه
15. لا يحتاج الناس إلى معالجين نفسيين لمساعدتهم في مشاكلهم
16. سيظن أصدقائي أنني مجنون إذا ذهبت لمعالج نفسي
17. إذا تحدثت إلى معالج نفسي عن أشياء شخصية، فأنا متأكد من أنها ستصل الى عائلتي
18. لا يستطيع المعالجون النفسيون حقا فهم مشاكل المراهقين اليوم
19. فكرة الذهاب إلى المعالج النفسي مخيفة جدا بالنسبة لي
20. الذهاب إلى المعالج النفسي يعني أنه ليس لديك القوة على التعامل مع المشكلة بنفسك
21. إذا ذهبت إلى معالج نفسي، فإن ذلك سيجعلني أشعر بأنني مجنون
22. لقد واجهت مشاكل في الماضي مما كان مزعجا حقا

23. ستختفي مشاكلي من تلقاء نفسها

24. يمكن أن يساعد العلاج في كثير من الأحيان المراهقين الذين يعانون من مشاكل

25. لا أريد أبدا أن تعرف عائلتي إذا ذهبت لمعالج نفسي

26. بغض النظر عما سألن يفعله فلن يغير المشاكل التي أوجهها

27. قد يجعلني المعالج النفسي أفعل أو أقول شيئا لا أريده

28. لا أستطيع تحمل تكاليف الذهاب للمعالج النفسي، حتى لو أردت ذلك

29. أعتقد أن المعالجين النفسيين يريدون حقا مساعدة الناس

30. قال والداي إنهما حقا لا يؤمنان بالعلاج النفسي

31. إذا ذهبت إلى معالج نفسي فسيكون والداي مستائين جدا

32. أعتقد أن العلاج النفسي قد يكون ضارا

33. لو ذهبت لمعالج نفسي ستعتقد عائلتي أنني ضعيف

34. إذا ذهبت لرؤية معالج نفسي فقد أكتشف أنني مجنونا

35. إذا واجهت مشكلة وأخبرت المعالج انفسي فلن يحافظ على سريتها

36. تعتقد عائلتي أن أي شخص يذهب إلى معالج نفسي فهو مجنون

37. الأشخاص الذين يترددون على المعالجين النفسيين مجانين

شكرا لبيان استخلاص المعلومات

نشكرك على مشاركتك في هذه الدراسة لفهم الحواجز التي تمنع المراهقين في مصر من البحث عن العلاج النفسي. ستساعدنا مدخلاتك على فهم ما قد يمنع المراهقين من طلب المساعدة المهنية.

تهدف هذه الدراسة البحثية إلى تحديد أسباب عدم طلب المراهقين المصريين الذين تتراوح أعمارهم بين 10 و21 عامًا المساعدة من ممارسي الصحة النفسية المحترفين. يحاول فحص العلاقة بين الضائقة النفسية والخصائص الديموغرافية المختلفة مثل العمر والجنس والحالة الاجتماعية والاقتصادية والمنطقة حول العوائق المتصورة التي تحول دون طلب المساعدة المهنية. من خلال تحليل البيانات التي تم جمعها، تهدف هذه الدراسة إلى تقديم رؤى يمكن أن تساعد المتخصصين في الصحة العقلية .على فهم المشكلة، وبالتالي تطوير استراتيجيات فعالة لدعم المراهقين في الوصول إلى الرعاية التي يحتاجون إليها

نحن نتفهم أن بعض الأسئلة ربما كانت حساسة أو صعبة الإجابة عليها. إذا شعرت بأي إزعاج أو ضيق أثناء إكمال الاستبيان، فنحن نشجعك على طلب الدعم من موارد الصحة العقلية التالية في مصر:

- الخط الساخن المصري للصحة العقلية: 20220816831
- مستشفى بهمان: +20 2 28166610
- منصات دعم الصحة العقلية عبر الإنترنت: Shezlong، Therapy O7

يمكن أن توفر هذه الموارد الدعم والمساعدة السرية إذا كنت تعاني من ضائقة عاطفية نفسية أو تحتاج إلى التحدث إلى شخص ما حول صحتك العقلية

:التواصل مع الباحث

إذا كانت لديك أسئلة أو مخاوف بشأن هذا البحث في أي وقت، فيرجى الاتصال:

- الباحثة: رنا عبدالعال
- رقم الهاتف: +302106009800
- البريد الإلكتروني R.abdelaal@acg.ed

يمكنك أيضا الاتصال بعضو هيئة التدريس المشرف على هذه الدراسة:

- المشرف: د. س. دياريم طبيب نفسي سريري، أستاذة جامعية بدوام جزئي
- رقم الهاتف: +30 210 600 9800
- البريد الإلكتروني sdiareme.acg.edu

شكرك مرة أخرى على مساهمتك القيمة في هذا البحث الحيوي

Appendix C: List of Figures

Figure 1

Distribution Plots for K-10 items 1-10

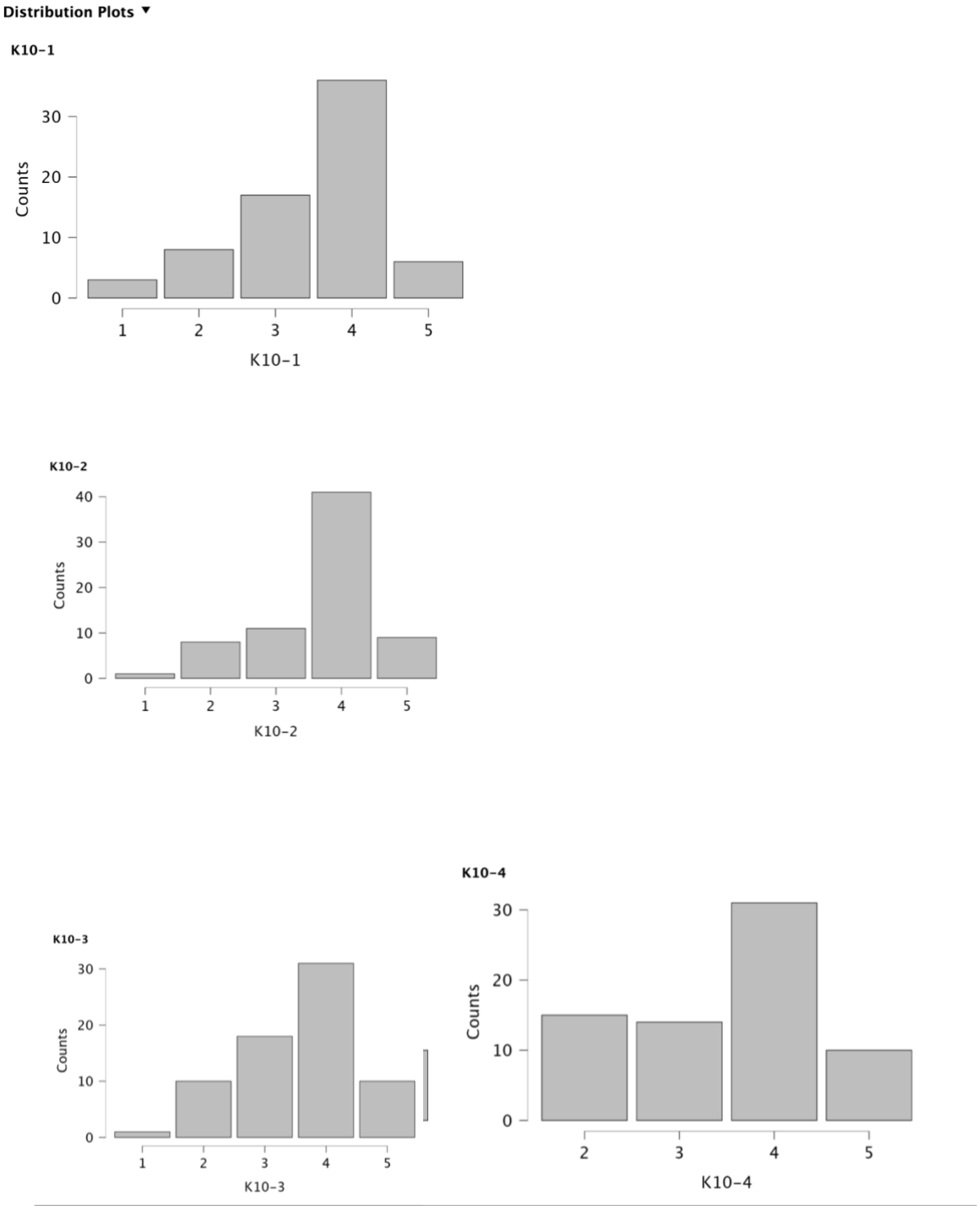
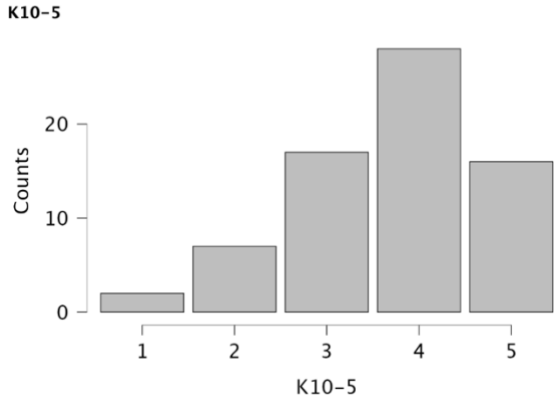
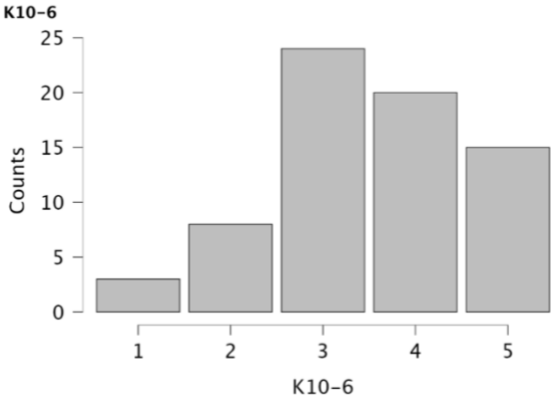


Figure 1

Distribution Plots for K-10 items 1-10(continued)





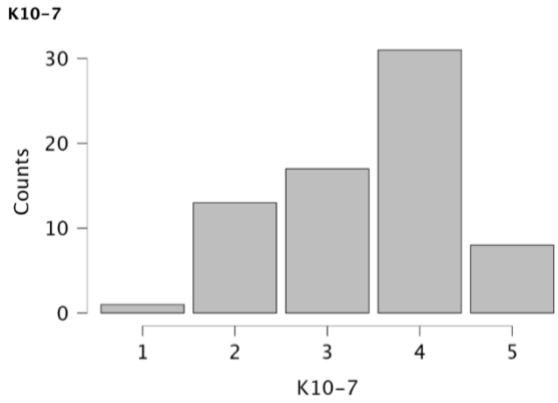
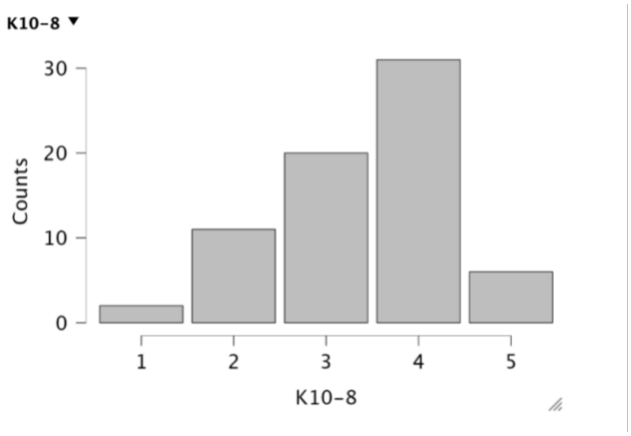
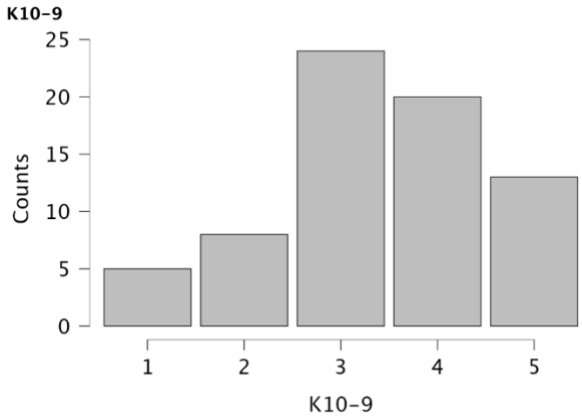


Figure 1

Distribution Plots for K-10 items 1-10 (continued)





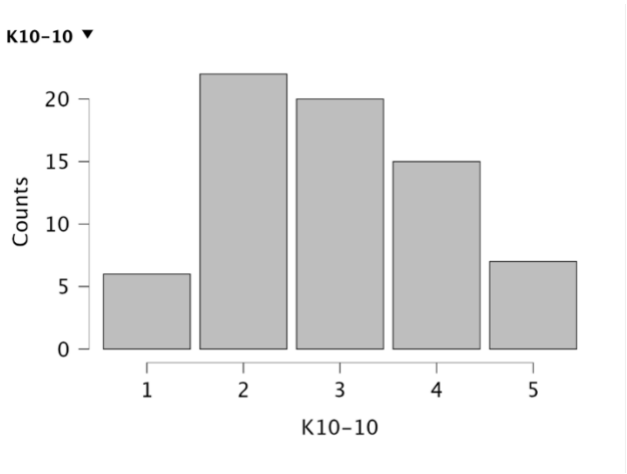


Figure 2

Distribution Plots for BASH items 1-37

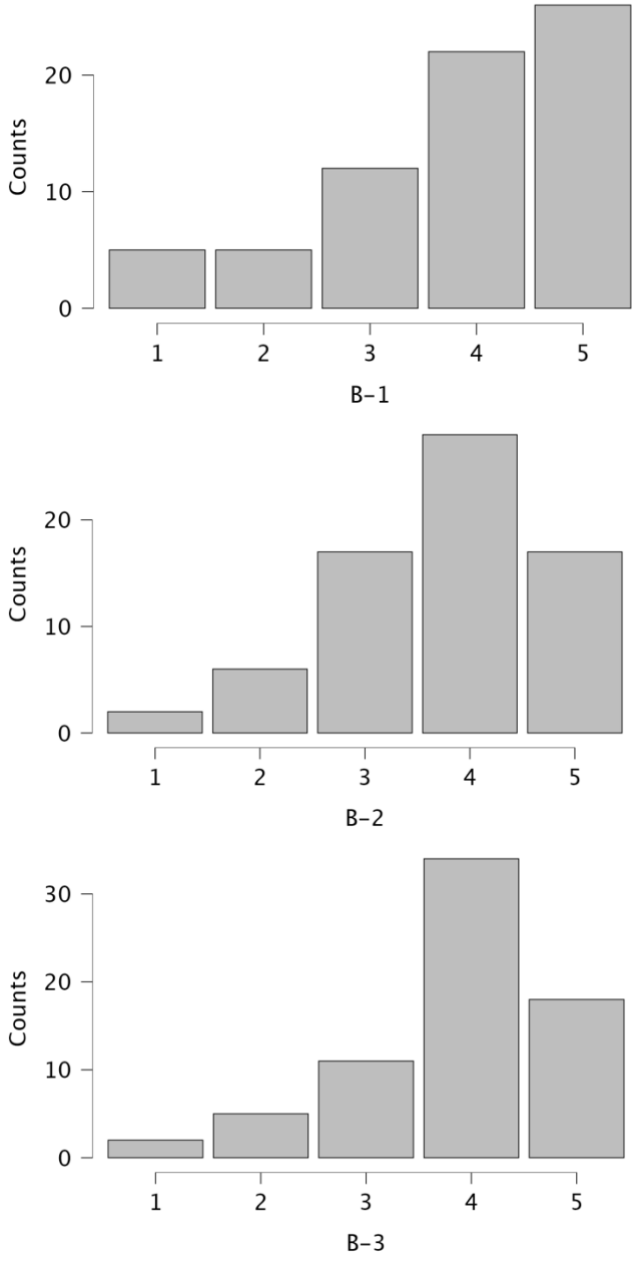
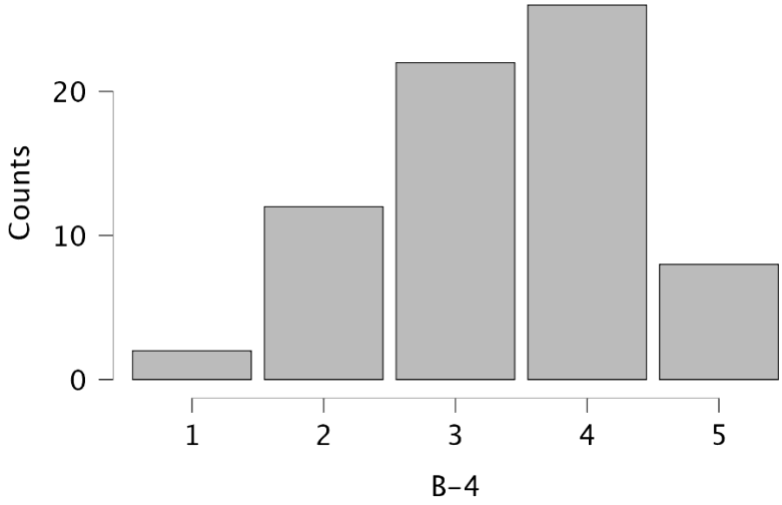
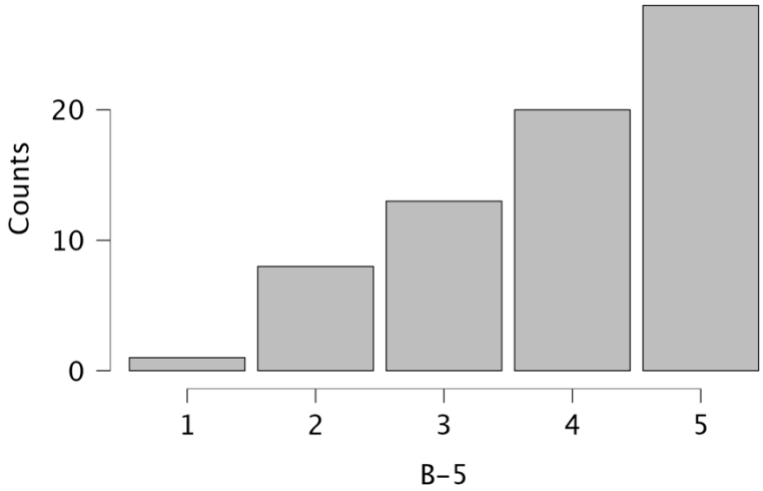


Figure 2

Distribution Plots for BASH items 1-37 (continued)





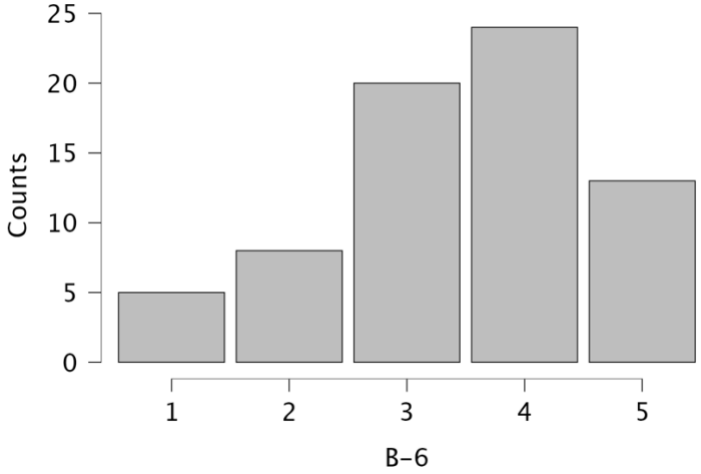


Figure 2

Distribution Plots for BASH items 1-37 (continued)

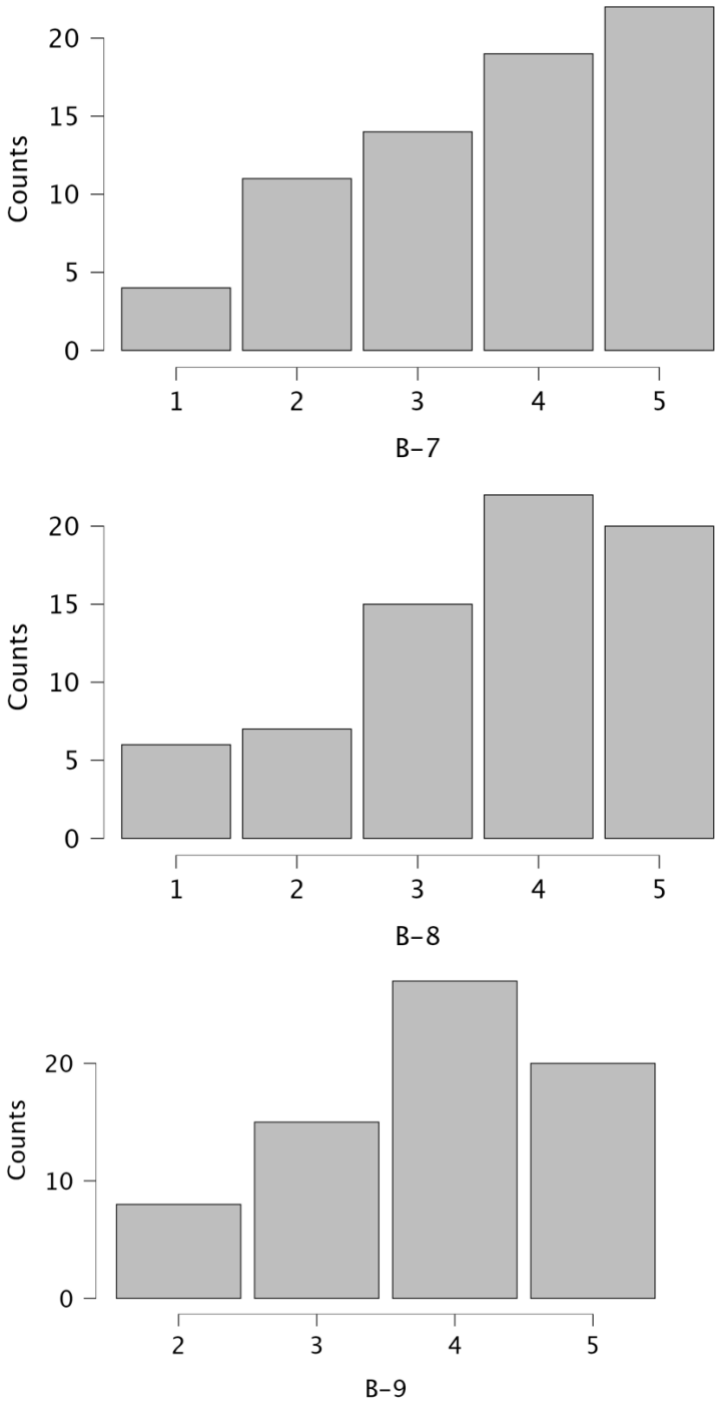


Figure 2

Distribution Plots for BASH items 1-37 (continued)

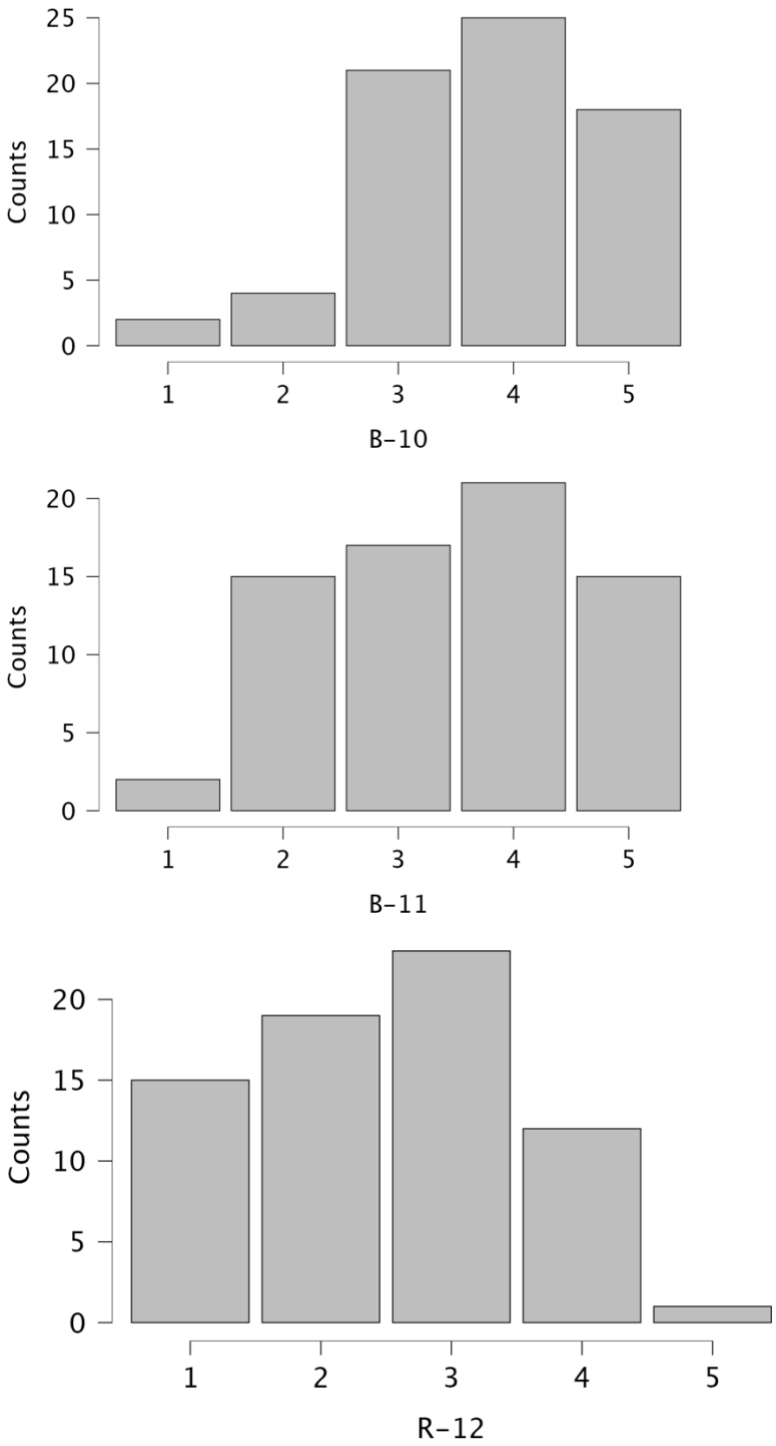


Figure 2

Distribution Plots for BASH items 1-37 (continued)

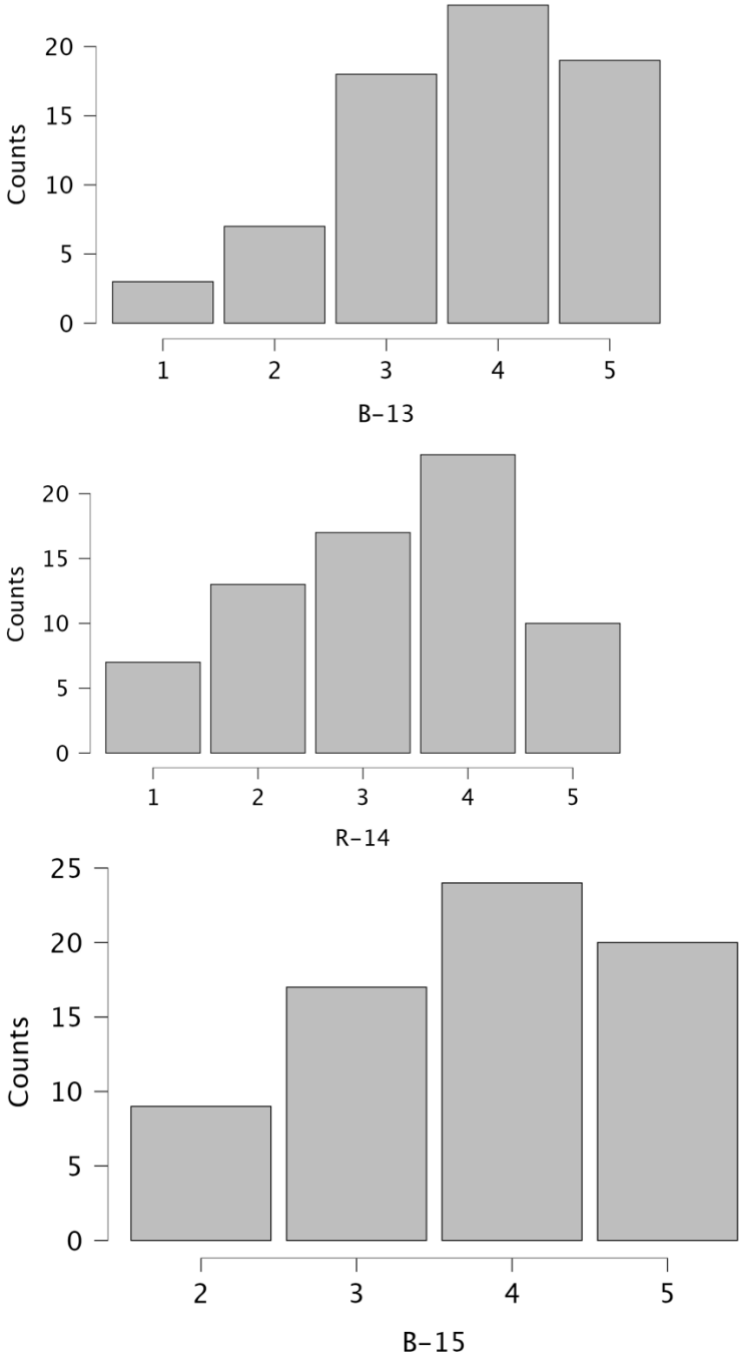


Figure 2

Distribution Plots for BASH items 1-37 (continued)

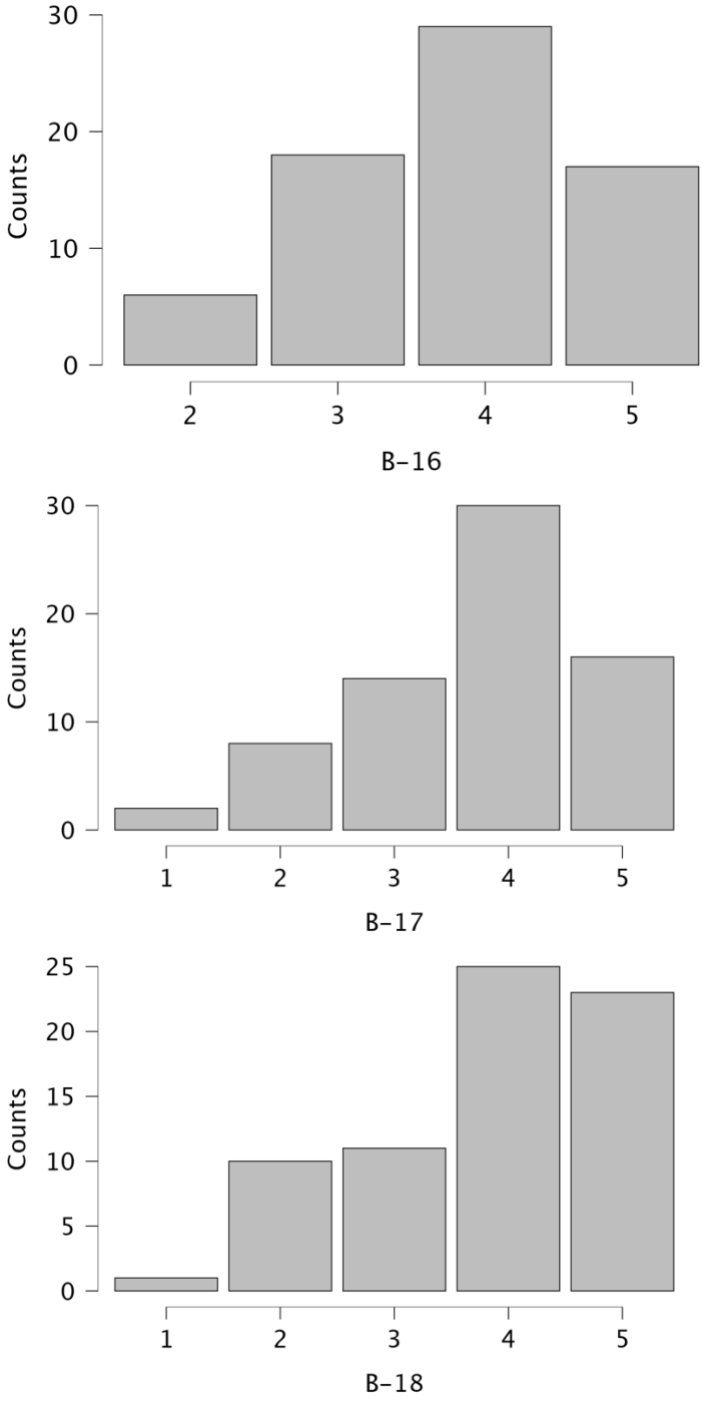


Figure 2

Distribution Plots for BASH items 1-37 (continued)

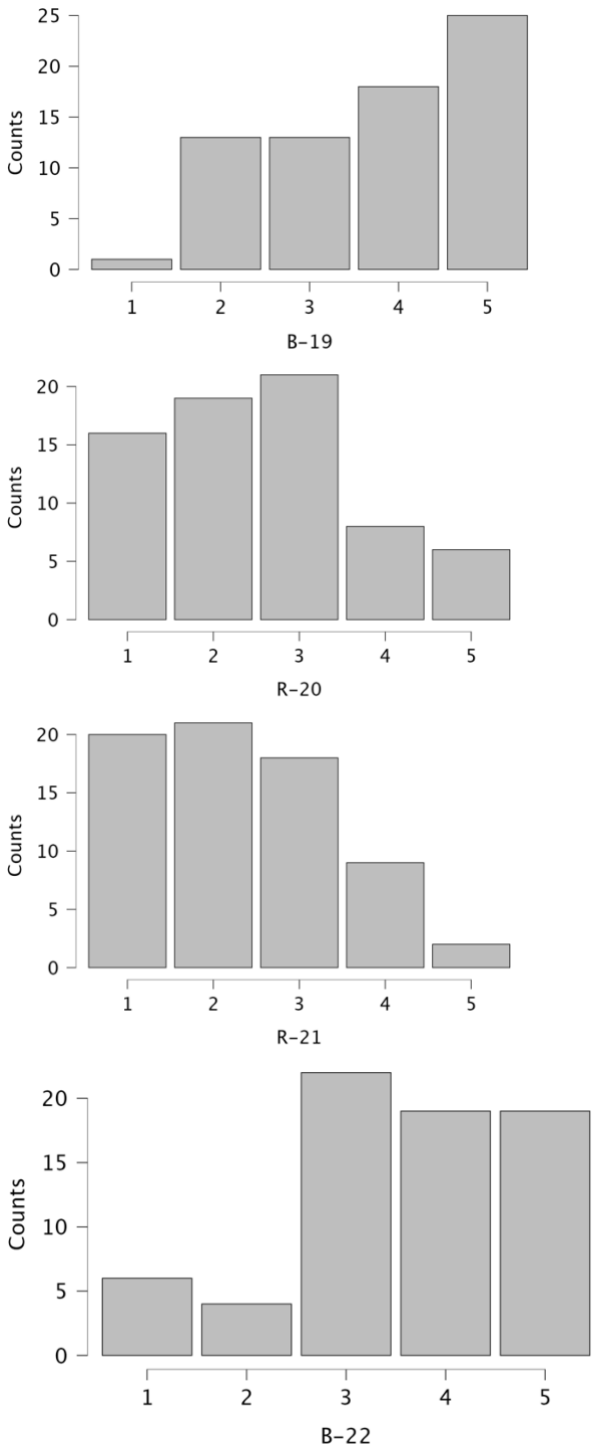
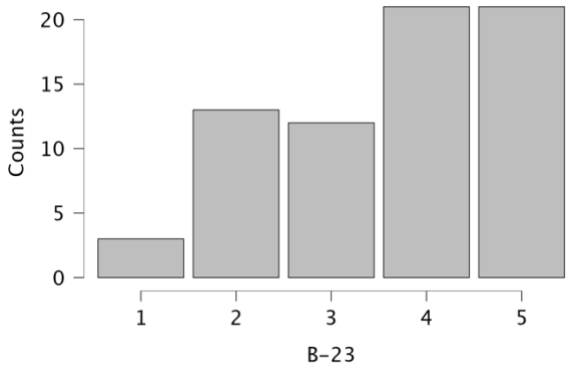
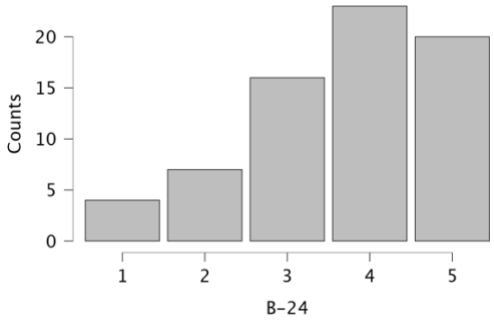
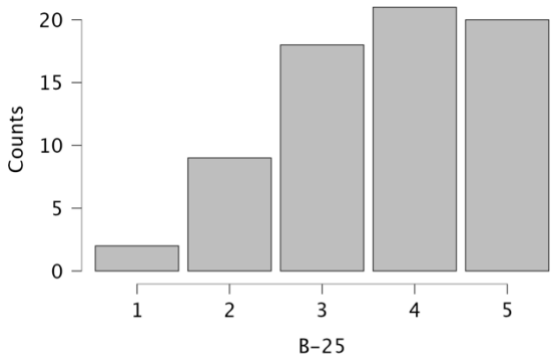


Figure 2

Distribution Plots for BASH items 1-37 (continued)







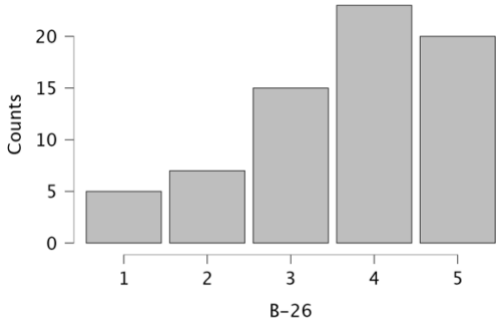


Figure 2

Distribution Plots for BASH items 1-37 (continued)

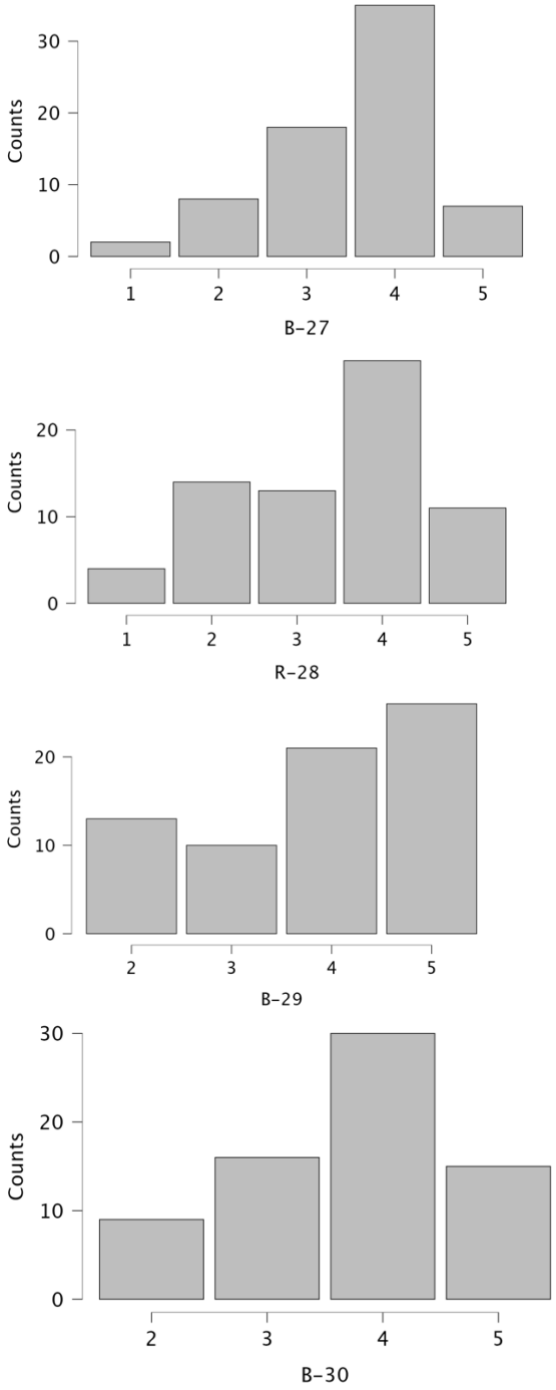


Figure 2

Distribution Plots for BASH items 1-37 (continued)

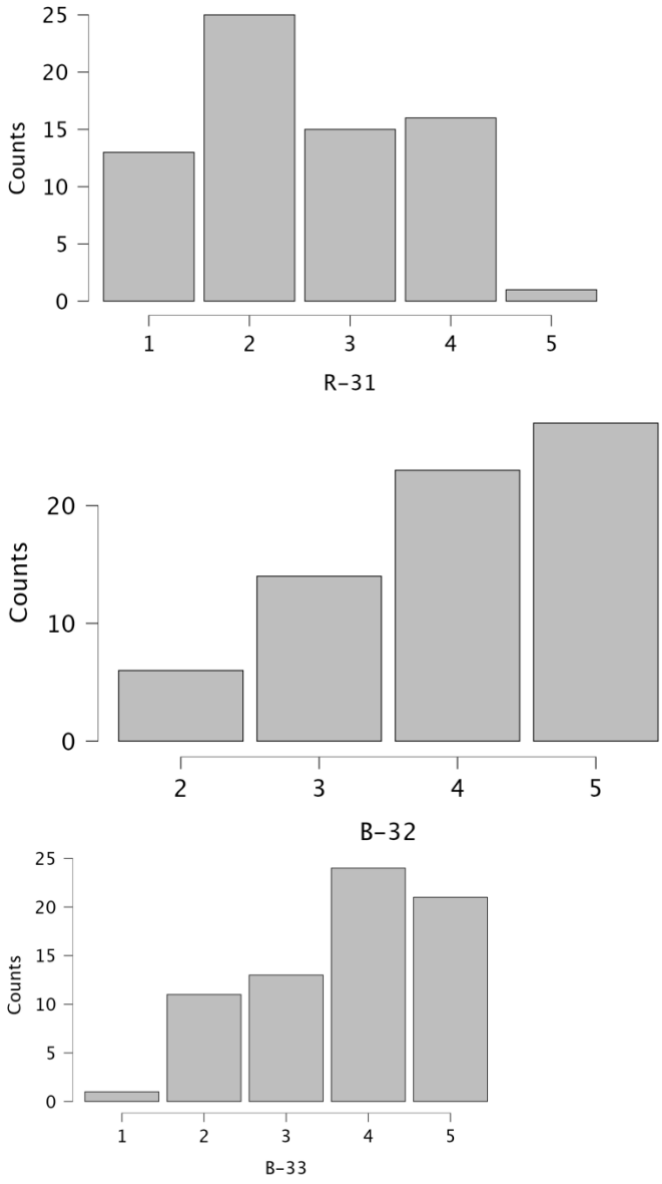


Figure 2

Distribution Plots for BASH items 1-37 (continued)

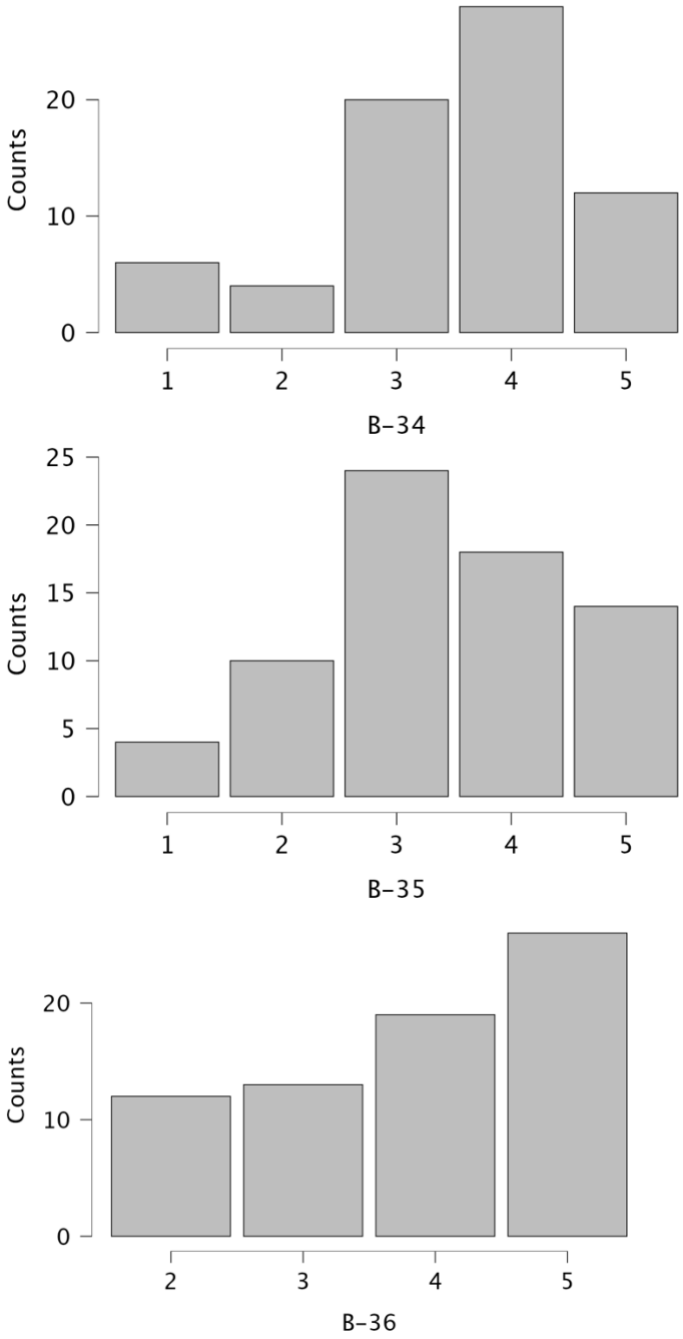
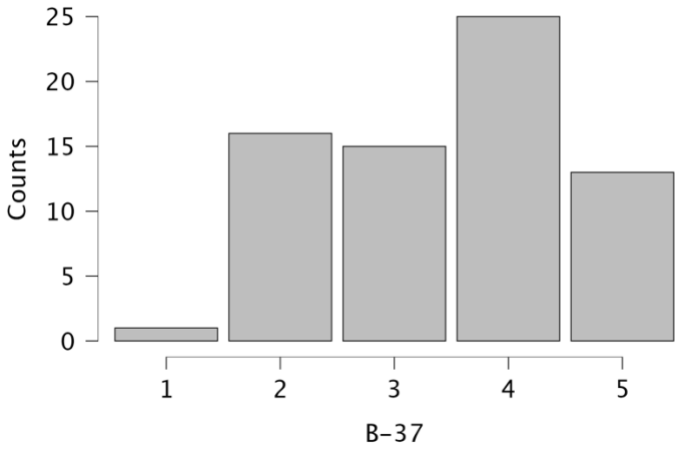


Figure 2

Distribution Plots for BASH items 1-37 (continued)



Appendix D: List of Tables

Table 1

Gender-Based Differences in BASH Subscale Scores: Results of Independent Samples t-Test

BASH Subscale	Gender	Means	SDs	t-values	P values
Usefulness of Therapy	Males	4.09	0.71	-3.30	0.002
	Females	3.05	0.69		
Time Availability	Males	4.15	0.83	-1.25	0.22
	Females	3.82	1.21		
Stigma	Males	3.99	0.77	-1.73	0.032
	Females	3.13	0.58		
Knowledge of Resources	Males	2.65	1.29	-0.51	0.611
	Females	2.50	1.17		
Locus of Control	Males	4.09	0.72	−2.46	0.017
	Females	3.60	0.86		
Peer as Sufficient	Males	3.85	1.01	-0.65	0.518
	Females	3.68	1.03		
Alienation	Males	3.89	0.90	-1.04	0.300
	Females	3.64	0.99		
Self Awareness	Males	4.00	0.83	-2.06	0.043
	Females	3.46	1.19		
Perception of Therapist	Males	3.58	0.73	0.89	0.379
	Females	3.73	0.66		
Affordibility	Males	3.54	1.33	0.63	0.530
	Females	3.73	1.13		
Self-sufficieny	Males	4.00	0.70	-2.54	0.013
	Females	3.50	0.91		
Confidentiality	Males	3.75	0.93	-1.13	0.264
	Females	3.47	1.07		
Family as suffiecient	Males	3.39	1.10	-0.09	0.933

	Females	3.36	0.94		
Usefuleness of Therapy	Males	4.09	0.71	3.30	0.002
	Females	3.05	0.69		

Note: N=70, n(male)=26 , n(female) =44

Table 2

Comparison of BASH Subscale Scores Across Age Groups Using One-Way ANOVA

Age Groups	10–13		14-17		18-21		F (2,67)	P value
BASH Subscale	M	SD	M	SD	M	SD		
Stigma	3.82	0.62	3.57	0.72	3.27	0.75	3.70	0.030
Affordability	3.96	1.11	3.46	1.37	3.56	1.12	1.11	0.335
Knowledge of resources	4.28	0.89	4.14	0.99	3.39	1.20	5.88	0.004
Perception of Therapist	3.72	0.72	3.75	0.77	3.54	0.56	0.60	0.551
Alienation	3.96	0.82	3.86	0.88	3.66	0.98	2.89	0.062
Confidentiality	3.92	0.85	3.66	1.07	3.11	1.01	4.26	0.018
Locus of Control	4.04	0.64	3.92	0.73	3.36	0.98	4.88	0.010
Self-awareness	3.90	1.02	3.91	1.05	3.15	1.08	3.95	0.024
Self-perception	4.20	0.65	4.00	0.90	3.41	0.95	5.88	0.004
Self-sufficiency	3.91	0.76	3.80	0.91	3.24	0.82	4.50	0.015
Family sufficient help	3.48	0.77	3.59	1.14	3.04	1.02	1.99	0.145
Time Availability	3.08	0.77	2.82	0.70	2.69	0.55	2.02	0.141
Usefulness of therapy	4.28	0.89	4.14	0.99	3.39	1.19	5.02	0.009
Peer as sufficient	3.96	0.94	3.82	0.96	3.44	1.12	1.72	0.187

Note: N=70, n(10-13)=23 , n(14-17) =22, n(18-21) =25

10-13= 10-13 year olds, 14-17=14-17 year olds, 18-21=18-21 year olds

Table 3

Comparison of BASH Subscale Scores Across Regions Using One-Way ANOVA

Region	Cairo		Alexandria		Delta		Upper Egypt		F (3,66)	P value
BASH Subscale	M	SD	M	SD	M	SD	M	SD		
Stigma	3.33	0.71	3.50	0.72	4.21	0.28	4.18	0.24	6.28	<0.001
Affordability	2.12	0.99	2.71	1.38	4.02	1.00	3.95	0.91	10.17	<0.001
Knowledge of resources	1.97	0.85	2.37	0.90	4.43	0.79	4.00	0.76	25.30	<0.001
Perception of Therapist	3.36	0.50	3.68	0.61	4.36	0.80	4.44	0.50	12.01	0.003
Alienation	3.52	0.95	3.51	0.95	4.62	0.36	4.42	0.73	5.01	0.003
Confidentiality	3.39	1.01	3.26	1.02	4.50	0.58	4.31	0.53	5.03	0.003
Locus of Control	3.60	0.83	3.56	0.87	4.57	0.32	4.42	0.30	5.50	0.002
Self-awareness	3.39	1.04	3.53	1.18	4.43	0.84	4.50	0.66	4.01	0.011
Self-perception	3.63	0.87	3.66	0.77	4.71	0.57	4.88	0.23	9.06	<0.001
Self-sufficiency	3.41	0.73	3.36	0.84	4.60	0.35	4.65	0.55	11.68	<0.001
Family sufficient help	3.25	0.84	3.32	1.01	4.7§	0.49	2.86	1.12	6.28	<0.001
Time Availability	3.69	1.06	3.68	1.16	4.86	0.38	4.86	0.35	5.48	0.002
Usefulness of therapy	3.56	0.87	3.42	1.22	4.86	0.38	4.37	0.52	5.91	0.001
Peer as sufficient	3.43	0.71	3.67	1.08	3.22	0.97	3.30	0.95	1.73	0.187

Note: N=70, n(Cairo)=66 , n(Alexandria) =19, n(Delta) =7, n(Upper Egypt) = 8

Table 4

Comparison of BASH Subscale Scores Across Income Levels Using One-Way ANOVA

Income levels	30-50		50-70		>70		F (2,67)	P value
Bash Subscales	M	SD	M	SD	M	SD		
Stigma	3.80	0.69	3.56	0.76	3.34	0.68	2.58	0.083
Affordability	4.28	0.79	4.05	0.72	2.61	1.27	20.87	<0.001
Knowledge of resources	3.26	1.25	2.68	1.09	1.80	0.82	11.610	<0.001
Perception of Therapist	3.85	0.79	3.77	0.59	3.42	0.61	2.82	0.066
Alienation	3.81	1.06	3.77	0.88	3.61	0.97	0.28	0.755
Confidentiality	4.02	0.99	3.30	1.11	3.40	0.85	3.64	0.032
Locus of Control	3.97	0.80	3.85	0.90	3.55	0.79	1.67	0.195
Self-awareness	3.94	0.91	3.55	1.33	3.50	1.02	1.11	0.334
Self-perception	4.13	0.96	3.98	0.78	3.58	0.87	2.55	0.086
Self-sufficiency	3,96	0.94	3.68	0.88	3.35	0.70	3.09	0.052
Family sufficient help	3.48	1.16	3.36	0.95	3.28	0.89	0.23	0.792
Time Availability	4.30	1.02	3.86	0.94	3.68	1.22	2.12	0.128
Usefulness of therapy	2.77	0.69	2.94	0.65	2,86	0.73	0.35	0.708
Peer as sufficient	4.09	0.90	3.64	1.22	3.52	0.87	2.10	0.130

Note: N=70, n(10,000-50,000)=23 , n(50,000-70,000) =22, n(more than 70,000) =25

30-50= 30,000-50,000 EGP, 50-70= 50,000-70,000 EGP, >70= more than 70,000