MENTAL WELLNESS IN UNITED ARAB EMIRATES FEMALE POST-SECONDARY STUDENTS

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Dedication

I dedicate this thesis to my mother,

Marylynn Theresa Smith,

who assisted me throughout this journey and has provided me with

the advice, support, and guidance to complete this work.

I also dedicate this thesis in memory of my beloved grandmother,

Theresa Bella Schultz,

whose passion for life, devotion, and unwavering love

has inspired me in all areas of my life.

Abstract

The purpose of this thesis was to investigate the prevalence of mental illness in a non-random sample of undergraduate female Emirati students in the United Arab Emirates. In addition, students' views and attitudes towards counselling were solicited. One hundred and twenty-three women completed Golberg and Hillier's (1979) 28-item scaled version of the General Health Questionnaire (GHQ-28). The GHQ-28 revealed a high prevalence of mental illness (51%) among the students surveyed, using a GHQ-28 threshold of eight. Furthermore, students reported they held favourable views towards counselling despite never having sought counselling services. The differences between American/European and Arab views of mental illness are explored as one of several limitations to this study. Recommendations for future research are noted.

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Chapter One: Introduction

Mental health is the basis for the well-being and effective functioning of individuals. The World Health Organization (WHO) states it is the right of every individual to have the opportunity to achieve good mental health and has identified mental health as a global priority (Hanson, Ranson, Oliveira-Cruz, & Mills, 2003). Mental disorders are now recognized as the largest single cause of morbidity causing great suffering for individuals and their families and depriving society of their productivity (WHO, 2002). The World Health Organization (2002) estimates that 25% of individuals develop one or more mental disorders at some point in their lives and mental health problems represent five of the 10 leading causes of disability worldwide. This burden causes great suffering for individuals and their families, has a huge economic cost (WHO, 2003), and individuals who are left untreated are also at risk for many chronic illnesses such as cancer, diabetes and heart disease.

Context of the Study

This thesis examined the mental health status of female students from the United Arab Emirates, a country located in the Persian Gulf region of the Middle East. The Gulf region consists of eight countries that have a coastline on the Persian Gulf and are referred to as the Persian Gulf States. They include Kuwait, Iran, Iraq, Bahrain, Qatar, Oman, Saudi Arabia, and the United Arab Emirates. These countries are part of a larger union of 22 Arab countries whose territory extends from the Atlantic coast of Africa to the Arabian Gulf.

The Eastern Mediterranean region consists mainly of Arabian societies. They are extremely diverse in terms of population, economic wealth, geography and race;

however, they share many similarities. Islam is practiced by 90% of the people, Arabic is spoken by 50% of the people (Hammad, Kysia, Rabah, Hassoun, & Connelly, 1999) and they have a young population with children comprising 45% of the population (Okasha, 2003). They also have a "shared sense of geographic, historical and cultural identity" (Hammad et al., p.v).

The United Arab Emirates is considered one of the rich oil producing countries. It is neighboured by Oman in the east, Iran in the north, and Saudi Arabia in the south. The Emirates include Abu Dhabi (territorially the largest) Ajman, Dubai, Fujairah, Ras al-Khaimah, Sharjah, and Umm al-Qaiwain. The city of Abu Dhabi in Abu Dhabi is the capital. About one-third of the population lives in Abu Dhabi Emirate, which consists of about 80% of the total land area. The Emirates have an estimated population of 4.4 million of which only 15-20% are citizens or Nationals (U.S. Department of State, 2007). A mixture of large and small ethnic groups representing Arabs (40%), Asians (30%), and Westerners (5%) make up the rest of the population (Tadmouri, Al-Marzouqi, Rizvi, & Al-Gazali, 2003). The official language is Arabic and the official religion is Muslim; however, many other languages are spoken and many other religions are practiced (Kraya, 2002).

The United Arab Emirates underwent a profound transformation with the discovery of oil in 1958, turning a traditional society into a wealthy modern one in less than a decade (AlWraikat & Simadi, 2001). Prior to the oil boom there were no roads, no newspapers, and no electricity; life was centred on nomadic desert living (Codrai, 1990). The rapid developments have exposed people to the influence of modern Western culture.

By 2000, 96% of UAE citizens had a car, 98% a phone and 60% a computer (Badrinath et al., 2002).

This surge of prosperity allowed the country to invest in health care and in the past 50 years, child and infant mortality has been reduced, life expectancy increased and hospitals and health care centres have been built (Tadmouri, Al-Marzouqi, Rizvi, & Al-Gazali, 2003). Primary health care services are provided through health centres, maternal and child care centres, school health centres, first aid services and family-medicine training units. Medical services are free to Nationals and include immunization, outpatient treatment and hospitalization. Advances in health care have decreased the prevalence of infectious diseases such as smallpox, trachoma and dysentery (WHO, 2007). In spite of these advances, the Eastern Mediterranean countries have had less success in addressing mental health problems.

Mental Health Issues in the Arab World

In the developed countries, a great deal of information is available on the incidence, prevalence, course and diagnosis of mental illness. Numerous studies and surveys have been conducted and this research has been used to implement sound mental health practices (Kessler, Chiu, Demler, & Walters, 2005; Kessler, Merikangas, Berglund, Eaton, Koretz, & Walters, 2003). In contrast, in the developing countries many authors have indicated that not only is there a lack of resources allocated to mental health issues, but also a lack of systematic research on mental health issues. For instance, Okasha (2003) noted that research on mental health issues in most Arab countries is scattered. He stated, “collaborative, multi-national, cross-sectional and longitudinal studies have not been produced” (p. 39). Likewise, Afifi (2005) found that only 1.2% of

the medical research in the Arab world included mental health issues. Of this percentage, 17.5% were related to mental disorders in children and adolescents, 15.4% were related to substance abuse, 14.8% to anxiety disorders, and 0.7% to mood disorders (Afifi, 2005).

This author undertook an extensive search of the mental health literature in the Gulf Region. This research revealed very few articles that pertained to the prevalence rates of mental health issues compared to the Western world. Only a handful of community-based psychiatric morbidity studies were found (e.g., Ghubash, Hamdi, & Bebbington, 1992; Abou-Saleh, Ghubash, & Daradkeh, 2001; Farhood, Dimassi, & Lehtinen, 2006; Karam et al., 2006) in the Arab world. The remaining articles found in the literature review tended to deal with specific disorders (e.g., Post-partum depression) (Abou-Saleh & Ghubash, 1997; Daradkeh, Ghubash, & Abou-Saleh, 2002; Green, Broom, & Mirabella, 2006) or small populations (e.g., primary care patients and the elderly) (Al-Haddad, Al-Garf, Al-Jowder, & Al-Zurba, 1999; El-Rufaie & Absood, 1993; Ghubash, El-Rufaie, Zoubeidi, Al-Shboul, & Sabri, 2004; Margolis, 2003; Margolis & Reed, 2001).

Purpose of Study

The objective of this thesis was to a) report the prevalence of psychiatric disorders from a non-random sample of female undergraduate students who are citizens of the United Arab Emirates (called Nationals or Emiratis) ; and b) to solicit their views towards counselling. This study's target group was female undergraduate students between the ages of 17-26 who were attending the country's only university for female Emirates in the city of Abu Dhabi (the capital of UAE). The study consisted of two questionnaires

that were administered online to women attending university. The first survey was a mental health survey and was administered in Arabic and English. The self-administered questionnaire focuses on two major areas: The inability to carry out normal functions and the appearance of new and distressing psychological phenomena. The second survey consisted of 14 questions (demographic as well as questions to solicit views on counselling).

It is recognized that cultural limitations will affect the validity and reliability of the results and these issues will be extensively discussed in the thesis. For example, the survey would not have a normative group and many of the questions may not be as culturally sensitive or culturally relevant as they should be. The study is limited to examining female undergraduate students aged 17- 26 from one university, therefore, the results may not be generalizable. In addition, the sample size obtained for this research may not be sufficient to determine construct validity. Furthermore, sound systematic research is necessary in order to address the mental health needs of a population appropriately. This is particularly true in a region where limited research has been undertaken. Despite its limitations, this study is a small step in obtaining information that may be useful in at least two ways: (a) identifying the types and prevalence of mental disorders in this population group, which will add to the body of research in this area of the world; and (b) for the planning and development of mental health services.

Chapter 1 of this thesis provides an overview of the research project. Chapter 2 offers an in-depth literature review pertaining to mental health issues, policies, and stigma. Chapter 3 covers culture and mental health. Chapter 4 outlines prevalence rates of mental illness. Chapter 5 reviews the four areas of psychological distress from the survey.

Chapter 6 describes the methods used to conduct the study. Chapter 7 describes the results of this investigation. Finally, Chapter 8 discusses the implication of the findings, limitations and outlines further research areas.

Chapter Two: Review of Literature

This chapter will provide a general overview of some of the areas that affect mental health. A definition of mental health will be discussed, followed by the importance given to mental health issues, resources available for mental health services and the stigma that surrounds people with mental health problems. The stigma connected with people with mental health problems will also be explored. The chapter will conclude with the impact of globalization on mental health issues.

Mental Health

Mental health is difficult to define because the state of being mentally healthy is open to "too many different interpretations that are rooted in value judgments that may vary across cultures" (Department of Health and Human Services, 1999, p. 5). Although each culture may have its own socially based belief systems and different ways of behaving, this is not necessarily an indication of a mental disorder and cannot be labelled as such. The World Health Organization also states that social, religious or political beliefs cannot be taken as evidence of a mental disorder (World Health Organization, 2001a). These differences in values across countries, cultures, classes, and genders seem to prevent a consensus on a definition of mental health and what constitutes poor mental health (WHO, 2001c). To overcome this difficulty, the World Health Organization provides a positive dimension to the definition of mental health as "a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of

life, work productively and fruitfully, and make a contribution to their communities" (WHO, 2003, p. 7). This positive dimension is consistent with the United States Report of the Surgeon General's (1999) definition of mental health, which described mental health "as a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity" (Department of Health and Human Services, 1999, p. 16).

Awareness and Priority Given to Mental Health Issues

Although psychiatric illnesses account for a major section of the health status of a population, Bland (1998) stated that most public health efforts have focused on dealing with the causes of death that influence mortality statistics. Unfortunately, the leading causes of psychiatric problems differ from the leading causes of death. For instance, major depression ranks high on a worldwide basis as a cause of disability as measured by Disability-Adjusted-Life-Years (DALY). In spite of this, depression does not directly influence mortality statistics and therefore is given low priority compared to physically related deaths (Bland, 1998).

In Canada, the Centre for Addictions and Mental Health (CAMH) (2003) noted that despite the statistics on the prevalence and consequences of poor mental health, it is largely absent from health care reforms and is rarely an integral part of the health care system. This inequity between mental health and physical health care services is unacceptable and discriminatory; increased efforts are needed to provide more equal funding for mental disorders (CAMH, 2003).

Mental Health Policy

The World Health Organization Project Atlas 2001, Mental Health Resources in the World indicated that out of the 185 countries reviewed, covering 99.3% of the world's population, 41% had no mental health policy, 25% no mental health legislation, 28% no mental health budget, 37% no community care facilities, and 70% of the world's population has access to less than one psychiatrist per 100,000 population. In addition, mental health facilities were present in only 87.6% of countries. In 2005, the World Health Organization repeated the study and found only small gains in the provision of mental health care services around the world. They concluded the most recent study by stating that mental disorders continue to be "under recognized, under treated and under prioritized" (Saxena, Sharan, Cumbrera, & Saraceno, 2006, p. 183) and that the resources that the world spends on mental health are "grossly inadequate."

Budget and Financing for Mental Health Issues

When surveying the mental health budget of all countries, the World Health Organization found that 32% of the countries reported not having a specific mental health budget. Of the 89 countries that provided information on the federal mental health budget, 36% spent less than 1% of their total health budget on mental health (Saxena, Sharan, & Saraceno, 2003). In light of the inadequate funding allocated to mental health resources, it is not surprising that in 39% of countries there is less than one psychiatric bed per 10,000 head of population; there also is a shortage of health-care providers in most of the countries. The World Health Organization concluded:

> Mental health resources in the world are highly unsatisfactory. The availability of most resources is poor and their distribution is highly uneven. A substantial

> investment is needed in this area to respond to the existing and projected burden of mental disorders (WHO, 2001, p. 7).

Stigma

Added to the low priority given to mental health throughout the world is the stigma attached to people with mental health difficulties. Studies have found that the social stigma surrounding the term *mental illness* often deters the mentally ill from seeking treatment and that nearly two-thirds of people with diagnosable mental disorders do not seek treatment (e.g., Kessler, Nelson, McKinagle, Edlund, Frank, & Leaf, 1996; Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993). Further, this stigmatization leads to a sense of hopelessness, fear, and embarrassment among the mentally ill. It deprives them of their dignity and interferes with their ability to be productive members of society (Department of Health and Human Services, 1999). According to Health Canada:

> The serious stigma and discrimination attached to mental illnesses are among the most tragic realities facing people with mental illness in Canada. Arising from superstition, lack of knowledge and empathy, old belief systems, and a tendency to fear and exclude people who are perceived as different, stigma and discrimination have existed throughout history. They result in stereotyping, fear and embarrassment, anger and avoidance behaviours. They force people to remain quiet about their mental illnesses, often causing them to avoid seeking health care, avoid following through with recommended treatment, and avoid sharing their concerns with family, friends, co-workers, employers, health service providers and others in the community (2002, p. 4).

It has also been suggested that not only does the public discriminate against people with mental health problems but so do policy makers, insurance companies and labour practices. This is evident in the fact that community-care facilities and treatment for people with mental health problems are severely lacking. Insurance plans often do not cover the cost of treating mental disorders (Saxena, Sharan, & Saraceno, 2003).

Impact of Globalization on Mental Health

The lack of funding and resources, low priority, and the stigma attached to mental health will be further affected by the phenomenon of globalization. Bhurga and Mastrogianni (2004) defined globalization "as a process in which the traditional boundaries separating individuals and societies gradually and increasingly recede" (p. 1). For some, globalization will mean prosperity but for many the rapid social change, the economic insecurity, increases in world conflict, changes to social safety nets, and migration and urbanization will contribute to social and family disintegration that will adversely affect mental health (Bonder, Maclean, McGregor, Oldham, Randriamaro, & Sicchia, 2004). Persaud and Lusane (2000) noted that globalization could increase social inequality and widen the ability to access resources. Bhugra and Mastrogianni (2004) indicated that globalization could marginalize people, resulting in higher rates of unemployment and poverty. Further, Bonder et al. (2004) noted that some of the adverse mental health outcomes associated with rapid change could include increased addictions and an increase in the incidence of depression, anxiety and post-traumatic stress disorder.

Although mental illness accounts for a significant proportion of the disease burden worldwide, many barriers prevent effective intervention. Mental illness continues to have a low priority when it comes to the recognition of its importance and in the

allocation of resources. In spite of advances in the understanding of mental disorders, people with mental disorders experience stigma and discrimination.

The next chapter will discuss the importance of culture in terms of its relationship to mental health. The culture of a society has a direct effect on how mental health or illness is perceived, how it is defined and how mental health services are used.

Chapter Three: Culture and Mental Illness

This chapter will discuss some of the distinct patterns of beliefs and practices of people in the Middle East. Within the context of this culture, the following areas will be discussed: cultural factors, family, gender and education, folk beliefs, traditional healers, religion, the stigma of mental illness, the knowledge of and attitudes towards mental illness and the effect of rapid social change on the society.

Culture

Mental illness is present in all countries and in spite of the limited research carried out in Middle Eastern countries, the prevalence rate of mental disorders appear to be similar to those of the Western world. However, the way these illnesses are viewed, reacted to, and expressed is different across cultures (Department of Health and Human Services, 1999). Culture is defined as a socially shared system of values, practices, beliefs and attitudes that are transgenerationally transmitted to a community. It is "the sum total of knowledge passed on from generation to generation within any given society" (Castillo, 1997, p. 20) and includes language, forms of expression, religious, political and economic systems and ideas about illness and healing (Castillo, 1997). In mental illness, cultural factors influence behaviour, decision-making, therapy, and the outcome of mental disorders (SGR Mental Health Culture Race and Ethnicity

Supplement, 1999). The standards that define normal and abnormal behaviour are defined by the culture of the people; the beliefs about mental illness are intimately linked with concepts of religion, social values, norms and ideals of human relationships (Health Canada, 2005). Castillo (1997) declared that culture is an inherent part of mental health and mental illness in that it both influences and is an integral part of that state. Cultures view and respond to mental disorders in particular ways. For instance, cultures vary in the meaning given to the illnesses and the way the symptoms are described (Department of Health and Human Services, 1999).

Family

Arab culture often prefers the group over the individual, authoritarian principles over collective ones, social stability over social change, and principles of gender segregation (Hall, 1981). Therefore Arab communities value the collective good over the individual, adhere strictly to social morals and values, and accommodate the expectations of others and social closeness. Okasha (2004) noted that the behaviour of the individual is determined mostly by group needs rather than the needs of the individual, and "the source of control for behaviour is external rather than internal" (p.270).

The preference for group over individual is reflected in the high value placed on families. Individuals are raised to depend on their families for economic, social and emotional support (Al-Krenawi & Graham, 1998). Families expect to be consulted and involved in helping family members solve their problems in times of crisis (Al-Krenawi & Graham, 2000). The general good of families comes before any individual problems and individual problems are viewed as problems of the entire family (Al-Krenawi & Graham, 1996). Therefore, solutions to problems are not created in isolation and

psychiatric interventions with Arab clients need to involve the family, the extended family, the community and traditional healers (Al-Krenawi & Graham, 2000). Okasha (2003) noted that the Arab family contributes a great deal to clinical psychiatry in that it influences "mental development, illness behaviour, illness pattern and illness management" (p. 42).

The reliance on families and the great importance given to them determines culturally accepted ways of dealing with problems. El-Islam (1982) stated that the family decides on the nature of the problem and the solutions to the problem in terms of its cultural beliefs and values (as cited in Mechanic, 1966). Another area where this is evident is in discussing personal and family problems. Self-disclosure of personal problems to a counsellor in the Arab culture is seen as a betrayal of the family and as a sign of weakness in the individual (Al-Darmaki, 2005). Arab clients conceal information that might cause embarrassment (Nasir & Al-Qutob, 2005). Nasser-McMillan and Hakim-Larson (2003) indicated that one of the major barriers to mental health counselling is the reluctance among Arabs to seek counselling outside the family for problems that occur within the family. As a consequence, psychotherapy may be difficult for Arab people because it involves self-disclosure, employs open-ended questions and expects family matters to be divulged. "Talking therapy is done reluctantly because individuals believed it was unrelated to their treatment and because of cultural restrictions against divulging personal information" (Al-Krenawi, Graham, & Kandah, p. 507). Soliman (1993) found that the majority of students at a Kuwait University preferred traditional help-seeking assistance such as their families, friends and religious leaders over counsellors and social workers for all types of problems; in spite of studies

indicating university students hold favourable views and had confidence in professional helpers (Al Darmaki, 2003; Brinson, Saeed, Al Amri, 2005).

Arab societies tend to be dominated by the father and gender differences are very pronounced (Al-Krenawi & Graham, 2000). The father is head of the family and is the final authority in all family matters. Men are responsible for representing the family to the outside community while women play a submissive, dependent role (Al-Haj, 1987). This patriarchal orientation presents difficulties in the area of counselling. Even people who accept that they have a mental health problem and who believe in professional counselling may have difficulty in working with a therapist as a partner and may prefer a more "paternalistic authority figure as a therapist" (Nassar-McMillan & Hakim-Larson, 2003, p. 154). Arab clients tend to expect health professionals to be like teachers, explaining conditions and supplying solutions to their problems with little or no input from them (Al-Krenawi & Graham, 2000). They are more comfortable working with someone in authority who will give them advice and directive helping (Al-Krenawi, 1998) rather than being a part of the decision making process. A study conducted in a mental health clinic in Jordan found that, regardless of gender or education, people preferred to see a family practitioner who would provide them with a concrete solution to their difficulties, such as a prescription or an injection (Al-Krenawi, Graham, & Kandah, 2000).

Gender and Education

Besides cultural beliefs and family values, Sheikh and Furnham (2000) indicated that attitudes towards help-seeking behaviour are influenced by sex and education. They examined the relationship between cultural beliefs and attitudes associated with seeking

professional help among three groups (British Asians, western European, and Pakistanis). They found that men have a less positive attitude towards seeking professional help, as do people with minimal education. Further, many Arab clients may have a cultural and religious restriction when seeing an opposite-sex practitioner. Arab men may find it difficult to accept a female social worker's directions (Al-Krenawi & Graham, 2000). Al-Darmaki (2003) found that confidence in mental health professionals, willingness to seek counselling, and tolerance for stigma is more evident among post-secondary students with high self-esteem and in their senior year at university. He also found that the more advanced students were in their programs, the more confidence they had in believing that they could assist others with counselling therapies. Al-Krenawi and Graham (1999) found that although Arab clients preferred more traditional help-seeking assistance, men appeared to have more choices in the service they accessed. In contrast, women tended to choose seeking help from their families for decisions regarding their problems.

Folk Beliefs

Folk beliefs are another aspect of Arab culture that influences the way the society interprets mental health problems. They also have an effect on help-seeking behaviour. The belief system suggests that unseen forces affect the individual. Mental disorders are often attributed to the influence of these forces. Sheikh and Furnham (2000) found that people with more traditional beliefs in the supernatural causes of mental illness have less interest in professional help, while beliefs in physiological causes result in seeking professional help. They also found that Muslims had the highest score for a belief in supernatural causes, compared to all other religions studied (e.g., Hindus, Christians, Sikhs, and those with no religious affiliation). Their study concluded that although

culture was not a significant predictor of attitudes towards seeking professional help, "cultural causal beliefs about mental distress were significant predictors" (p.332) of where and how they accessed services. This demonstrates the "strength of values and beliefs of the more traditional cultures" (Sheikh & Furnham, p. 332).

Traditional Healers

Traditional healing is the oldest form of structured medicine using holistic and natural methods of treatment. Traditional healers are important figures in the Middle East, as they "share a common world view" with their clients and assists in understanding the problem and the best way of relating to it (Al-Krenawi & Graham, 2000). In traditional healing systems the healer is active and the patient passive. This method engages the dominant figure in the client's family and enlists that person to bring about change in the client (Al-Krenawi & Graham, 2000). Traditional healers highlight an external locus of control (e.g., supernatural powers) for explanation of mental illness and believe "religion, culture and communication are more effective than in the biomedical system" (Al-Krenawi & Graham, 1999, p. 233). Traditional healers may have more success with individuals because they treat the "subjective experience of the patient" (Castillo, 1997, p. 37). That is, they validate the person's experience even when it does not match the diagnosis of the clinician.

Today, traditional healers interact with the modern medical profession in a variety of ways. In some countries they have no interaction with the formal system. In Jordan there is an informal arrangement and in Saudi Arabia they are included as part of the medical staff and their contributions to health care are clearly defined (Okasha, 2003). Although some of the literature indicates that this practice is slowly disappearing and is

more common with older people (Ypinazar & Margolis, 2006), other studies indicate that the practice is still prevalent. Okasha, Seif, El Dawla, and Asaad (1993) found that in Egypt it is estimated that 60% of outpatients at a clinic in Cairo went to a traditional healer before going to a psychiatrist. Similarly, in Jordan 85% of the women attending a mental health clinic consulted traditional healers before and during their psychiatric treatment (Al-Krenawi, Graham, & Kandah, 2000).

Religion

Religion has a predominant place in the area of health and wellness in Arab countries. Culturally rooted religious beliefs and practices have important bearing on the willingness to seek mental health services. Mental health problems may be viewed as spiritual concerns and patients need to renew their commitment to their religion and engage in prescribed religious or spiritual forms of practice (Department Health Human Services, 1999). Ypinazar and Margolis (2006) stated that the "origins, nature, cause, consequences and interventions of health" (p. 774) and illness in the Middle East are strongly influenced by the Islamic faith and traditional culture. Their study found the belief that Allah is in control of their fate prevents them from engaging in preventative health. Brinson and Al-amri (2005) noted that many Islamic people believe that emotional disturbances occur when they stray from the teachings of Islam and they will find peace if they reconnect with their faith. This type of thinking leads people to feel that their problems would subside if they reconnect with the teaching of Islam. They pray to God for guidance with family concerns, personal morality and marital relationships. As a result, counsellors using modern psychological therapy would meet resistance from "clients who are rooted in the teachings of Islam" (Brinson & Al-amri, 2005, p. 498).

A study by Sheikh and Furnhman (2000) indicated that religion is a significant predictor of attitudes towards seeking professional help. They studied 287 adults belonging to three groups (British Asian, western European, and Pakistanis). They found that Muslims have the lowest scores for positive attitudes towards seeking help, whereas people with no religious affiliation had the highest scores. Al-Krenawi, Graham, Dean, and Eltaiba (2004) found that among female undergraduate university students from Jordan, Israel, and the United Arab Emirates, the majority turned to God for help in times of psychological distress. Al-Krenawi, Graham, and Kandah (2000) found that in Jordan all subjects believed in supernatural involvement in their illness and that it was God's will.

Stigma

The admission of a mental illness may have serious consequences, particularly for women. The possibility of being identified as having a mental illness or emotional problems may limit marriage prospects, increase the possibility of divorce or separation, or be used by a husband or his family to obtain a second wife (Al-Krenawi, Graham, Dean, & Eltaiba, 2004). It has been suggested that one of the reasons for the low usage of mental health services among women in the Middle East is the stigma and the consequences of having a mental disorder. A study carried out in Jordan found that men use mental health services far more than women and that women may delay treatment to prevent stigma or to maintain their family's reputation (Al-Krenawi, Graham, & Kandah, 2000). The hospital records in Israel revealed that Arab women use psychiatric services less than Arab men and Arab patients (both men and women) underutilize mental health services in comparison to Jewish patients. Some of the reasons included a lack of

resources in the Arab communities, the influence of cultural as opposed to "professional" services and the attitudes of Arabs to mental health issues (Al-Krenawi, 2002).

In Tunisia, a study was conducted on 115 outpatients who had recently been discharged from hospital. The study concluded that mentally ill women are more stigmatized than men because fewer than 40% of the outpatients were women although the clinic dealt with mental disorders known to be twice as frequent in women than men. A family member made the decision to discontinue for 30.2% of the women compared to 6.5% of the men. The factors that were used to explain these results included: the fear of tarnishing the family's reputation and status, fear of losing marriage prospects or of losing a husband, and of being treated differently within the family. It was also noted that families tolerate mental illness in women as long as they continue to look after the children and household. The authors concluded that stigmatization of mentally ill women is directly linked to their low social status (Ouali, Benzineh, Choukani, Nacef, & Douki, 2007).

Knowledge and Attitudes

In Oman, Al-Adawi, Dorvlo, Al-Ismaily et al. (2002) conducted a study to see whether social factors influence the perception towards people with mental disorders. The researchers looked at the attitudes of medical students, the public and family members of people with mental difficulties. They found that socio-demographic factors such as age or education did not affect attitudes. They also found that that neither the public nor the medical students believed there was a genetic cause for mental illness and that spirits played a part in the illness. Further, they believed that people with mental health problems had unusual characteristics and should be cared for in institutions away from

the community. They suggested that stigma and negative attitudes towards mental illness have much to do with its low priority. Ghubash, Daradkeh, Al-Muzafari, Al-Manssori, and Abou-Saleh (2001) studied socio-cultural changes and the prevalence of psychiatric disorders in a community sample in the United Arab Emirates. Using the Socio-Cultural Change Questionnaire (ScCQ), they found their sample of women to have significantly more liberal and modern attitudes compared to the men in their study. They also found more liberal attitudes among the younger and highly educated participants.

Eapen and Ghubash (2004) studied parental attitudes in the United Arab Emirates about having their children receive mental health assistance. They found that only 38% indicated they would seek help from a mental health professional if they were experiencing problems within the family. The reasons given for this decision was that they did not want to admit to having a problem, they believed there was stigma attached to having a problem, and they questioned the usefulness of the interventions. The parents who were willing to use professional services tended to have more knowledge of mental health issues as well as obtaining higher education than the parents who were not open to using professional services.

Along with the cultural and religious obstacles to accessing mental health services Rahman, Mubbashar, Harrington, and Gater (2000) reported that both the public and health care professionals have misconceptions about mental health. Al-Krenawi (2005) stated that the Arab World shows a lack of awareness of mental health problems. Many people believe that mental difficulties are not real disorders and they are difficult to treat. They see mental health as being different and not part of the primary health care system.

There are two main reasons for the low priority and lack of awareness of mental health issues. The first is the lack of trained and/or foreign-trained professionals in the mental health field to identify and treat mental health problems. Most people in the Middle East access doctors in the primary health care settings for help with mental health problems. These doctors have little experience or knowledge of mental health issues and, as a result, the problems often go undiagnosed and untreated. Not only is there a lack of trained professionals but also those who are practicing are expected to cover all areas of mental health. Rahman, Mubbashar, Harrington, and Gater (2000) noted the consequence of this problem is that it has prevented specialization and "all manifestations of disturbed functioning of mind and brain tend to be dealt with….by a single group of professionals" (p. 540). The heavy reliance on foreign-trained doctors, nurses and other mental health professionals adds to the problems of effective mental health care. Because these professionals are trained in other countries, there may be miscommunication and a lack of understanding of cultural issues (Rahman et al., 2000). Similarly, Al-Krenawi (1999) found that cultural and language difficulties between patients and doctors caused miscommunication and inappropriate treatments. As a result, 50% of patients terminated treatment after two sessions.

Alhamad, Al-Sawaf, Osman, and Ibrahim (2006) studied the knowledge and attitudes of medical doctors and patients on mental health issues in a Saudi hospital. They found that the number of referrals made to psychiatry was very low and these referrals were mainly for patients who were violent, delusional or failed to communicate. Only 38.1% of general practitioners felt that a psychiatrist could be helpful in making a diagnosis and 28.4% would not inform patients of the referral or obtain their consent.

Alhamad et al. (2006) concluded that knowledge and attitudes towards mental health issues were both poor and negative on the part of both doctors and patients. In Abu Dhabi, Saeed and McCall (2006) explored the knowledge of general practitioners regarding anxiety and depression. They found that general practitioners in Abu Dhabi lacked important knowledge that is needed for the recognition and management of anxiety and depression and that many lacked confidence in diagnosing these disorders. Similarly, in a study in Jordan, Nasir and Al-Qutob (2005) found that there was a lack of education on depression among physicians and they had little awareness of diagnosis based on specific criteria.

The second reason for the low priority placed on mental health is the tendency in Arab culture to express psychological problems as physical complaints rather than as emotional ones. El-Islam (1982) reported there is an underestimation of the prevalence of mental disorders because symptoms are explained by cultural beliefs and because of the somatic orientation of both doctors and patients.

Medical doctors often have difficulty recognizing emotional or behavioural problems and ignore the psycho-social aspects of the problem. The fact that somatic symptoms could be of psychic origin is “beyond the imagination of many patients and beyond the knowledge of many medical practitioners” (El-Islam, 1982, p. 11). Even when doctors believe the patient may have a psychological problem they often play a role in concealing this diagnosis and participate with the client in searching for an organic cause.

Social Change

Many authors have indicated that the rapid social change experienced by the Gulf countries must have a serious impact on the mental health of its people. Mohit (1999) noted that the rapid transition from a traditional to a more modern lifestyle would greatly affect "all areas of health and development with mental health being one of the areas most affected" (p. 232). Al-Darmaki (2005) stated that the changes in values, beliefs, and the role expectations of individuals that accompany rapid social change "will affect their psychological health and many may not be able to adjust to these changes" (p. 325). Bebbington, Ghubash and Hamdi (1993) indicated that modernization and social instability "has consequences for the psychological well-being of the inhabitants" (p. 60). Finally, Al-Adawi et al. (2002) stated that beliefs that might have protected people in the past from developing psychiatric problems might be eroded by globalization and acculturation.

Social change impacts relationships in society. Several authors have identified these relationships that have been particularly affected by modernization and rapid social change. These include relationships within the family (El-Islam, 1982), adolescents and young adults (Mumford & Whitehouse, 1994), women (Al-Krenawi & Graham, 1998), and the older generation (Ghubash, El-Rufaie, Zoubeidi, Al-Shboul, & Sabri, 2004).

Although many negatives accompany rapid social change, Sheikh and Furnham (2000) indicated that with globalization, psychological assistance has become more acceptable and attitudes have become more positive. For instance, Al-Darmaki (2003) studied 350 undergraduate students at the United Arab University regarding their attitudes towards seeking professional help. He found that although negative attitudes

obtained towards a product of Western culture and reliance on traditional methods persisted, there was also more willingness to seek assistance, more confidence in mental health workers and less concern regarding stigma among young adults and the more educated individuals at the UAE University. Al-Darmaki concluded that these results reflect "a trend that may make seeking psychological helping services less stigmatized" (2003, p. 505). Brinson and Al-amri (2005) stated that as the UAE has become more technically advanced, the idea of solving problems in different ways has become acceptable, as have mental health practices. In their study, participants felt that mental health counsellors were perceived favourably and they believed that mental health counselling would be an important occupation in the UAE; many students reported they would see a counsellor for psychological help.

Just as the people of a society have a distinct set of beliefs about what constitutes normal and abnormal behaviour, concepts of cause and effect, and ideas about appropriate treatment, so do health care professionals (Department of Health and Human Services, 1999). Clinicians may hold views that differ from those of the patient, which creates barriers to effective care (Department of Health and Human Services). When these two groups hold different worldviews, intervention is likely to be inadequate and ineffective. Typically, these professionals have been trained in a bio-medical model of mental illness and although they consider social and cultural issues, this is not the focus of their intervention (Castillo, 1997). For instance, psychological interventions are typically based on Western models and these interventions may not be appropriate in other cultures (Al-Krenawi, 2005). Western-trained psychiatrists may not be able to form therapeutic relationships with patients due to lack of knowledge about Islamic culture.

Al-Krenawi (1998) indicated there is a need for trained personal that can provide services adapted to the special cultural characteristics of the Arab population. El-Islam (1982) stated that Western theory must be adapted to local culture before it can be implemented effectively.

Al-Krenawi, Graham, and Kandah (2000) felt it was possible that traditional and religious healing practices could complement modern psychiatric services. This model was used in a project in an Arabian community in Negev, Israel. In this project, Arab social workers were hired as cultural mediators to assist families with various concerns. They found that the cultural mediators provided an important buffer between the modern system, which was seen "as intrusive and threatening, and a traditional system based on kinship relations and other cultural norms" (Al-Krenawi & Graham, 2001, p. 679). Further, it was believed that the professional system had much more success when the doctors identified and collaborated with the tribal members in authority (Al-Krenawi & Graham, 2001).

Therapists' approach to counselling is another important factor. Al-Krenawi, Graham, and Kandah (2000) believed that there would be a greater acceptance and use of "talking therapies" if clinicians used authoritarian and directive behaviour "which corresponds to a society that is authoritarian, hierarchal and patriarchal" (p. 509). Nassar-McMillan and Hakim-Larson (2003) agreed and stated that a benevolent, paternalistic approach can be effective. Also contrary to the Western focus on the individual, clinicians in Arab countries need to recognize the value of family networks in Arab countries and form alliances with them (Mohit, 1999).

In contrast, many traditional beliefs and practices could be stigmatizing to people with mental health problems and that it is necessary to select only the beliefs and values that are consistent with good mental health practice. Rahman, Mubbashar, Harrington, and Gater (2000) declared, "[i]t would be unwise to simply 'import' Western models of interventions to the developing world" (p. 544) and that needs assessments are needed to ensure "appropriate, effective and culturally relevant" (p. 544) treatment. Brinson and Al-amri (2005) believed that counsellor-training programs need to consider the modern models that have been successful in non-Arab countries because they have been successful in producing competent mental health professionals.

As we see, although not the sole determinant of mental health and illness, cultural and social influences play important roles in mental health issues and service use (Department of Health and Human Services, 1999). Vedantam (2005) stated that the wide variation in concepts about the self, coping strategies and styles of communication along with cultural differences create a huge challenge for mental health professionals. Mental disorders are highly complex. Castillo (1997) believed that they needed to be conceptualized more broadly by providing assessments and treatment within the cultural context of the client. The culture of clinicians and services affects diagnosis and treatment; therefore, cultural differences must be recognized to ensure effective treatment (Department of Health and Human Services, 2001). With the focus on a holistic approach to mental well-being, Mohit (1999) suggested that psychiatry needs to be more comprehensive, encompassing the "human being with all the bio-psycho-social, spiritual, historical and even mythological aspects of his/her being" (p. 239).

In spite of the differences between cultures that influence the perception of mental health and illness, many common characteristics occur. In the next section, some of the research on the prevalence of mental illness in the Arab World will be reviewed.

Chapter Four: Mental Health in the Middle East

This chapter will discuss (a) the available literature on mental health issues in the Middle East, (b) recommendations for mental health care in this region and, (c) the prevalence of mental illness in the Arab World.

Challenges in Mental Health Research

Little information is available on the prevalence, incidence, course, diagnosis, and treatment of mental illness in the Eastern Mediterranean region (Abou-Saleh, Ghubash, & Daradkeh, 2001; Okasha, 2003). Of the articles that have been published, a large portion of studies from Arabic-speaking countries have been published only in local journals, therefore, few are available electronically (El-Rufaie, 2005). Further, "valid, reliable and culture relevant Arabic psychiatric research instruments" are almost non-existent (Okasha, 2003, p. 39). The majority of psychiatric screening instruments used in the Arab World were developed in countries outside the Eastern Mediterranean region (El-Rufaie, 2005). Psychiatric screening instruments developed in countries outside the Arab World limits the validity and reliability of the instrument when used in the Arab World.

Two factors lead to many consequences: (a) the lack of valid and reliable standardized instruments developed for the Middle Eastern Region, and (b) the lack of systematic research. First, these factors prevent a wide awareness of mental health issues. Second, the lack of data makes effective policy and program development difficult.

Third, without reliable research on the seriousness of mental health issues, it is difficult to argue for added resources. Thus, this thesis may play a part in rectifying the situation.

Recommendations for Mental Health Services

Although there is a paucity of research conducted in the Arab World, the information that has been accumulated suggests that mental health should be an integral part of the primary health care system (Okasha & Karam, 1998). Further, researchers such as Okasha and Karam (1998) recommend that the Arab countries needed to increase the public awareness of mental health issues, enhance the psychiatric education of mental health professionals, and increase the number of psychiatrists. Other recommended strategies include the development of a mental health act as well as the development of appropriate community prevention and treatment services.

Mohit (1999) noted that mental health in the Middle East is gradually being accepted as a health need and that "there is more awareness in professional academic circles of the holistic nature of man in health and disease" (p. 236). Another development is the World Islamic Mental Health Association, whose objective is to promote mental health in Muslim countries and to carry out research in the cultural psychiatry of the Muslims. They believe that, in order for psychiatry to be effective in the Arab World all aspects of the psychiatric process from diagnosis through treatment and follow-up must be adapted to the Islamic cultural context.

Prevalence of Mental Disorders in the Arab World

To the author's knowledge, only four psychiatric community studies have been carried out in the Middle East on the prevalence of mental disorders (Abou-Saleh, Ghubash, & Darakeh, 2001; Farhood, Dismassi, Lehtinen (2006); Ghubash, Hamdi, &

Bebbington, 1992; Karam Mneimneh, Karam, Fayyad, Nasser, Chatteriji, et Kessler (2006). Karam et al. (2006) studied the prevalence and treatment of mental disorders in Lebanon as part of the World Health Survey Initiative. In total, 2,857 adults were surveyed between 2002 and 2003. The researchers found that 17.0% of the respondents met the criteria for at least one 12-month DSM-IV/CIDI (APA, 2000; WHO, 1994a) disorder, of which 27% were considered serious, 36% moderate, and 37% mild. In their study they found that anxiety disorders were the most prevalent, however mood disorders accounted for the highest number of serious cases. Both anxiety disorders and mood disorders were more prevalent among women (Karam, et al., 2006).

Specifically in the UAE two psychiatric community studies were carried out. The first was conducted by Ghubash, Hamdi, and Bebbington (1992). They assessed psychiatric morbidity among females in the Dubai. They found overall prevalence of disorder to be 23% with higher prevalence found among divorced, widowed, or separated women.

In 2001, Abou-Saleh, Ghubash, and Daradkeh conducted the other psychiatric community study found in the United Arab Emirates. The study examined lifetime prevalence and psychiatric morbidity among a community sample in Al Ain, United Arab Emirates. In this case, 1,394 adults were sampled using a modified version of Composite International Diagnostic Interview (WHO, 1994a) along with other instruments. Overall lifetime prevalence was found to be 8.2%, 11.4% for women and 5.1% for men. The one-week prevalence rate of mental distress was 15.6% (as measured by the Self-Reporting Questionnaire (WHO, 1994b)), and the lifetime prevalence rate of mental distress was 18.9% (as measured by a different screening instrument, not specified). The lifetime

prevalence rate was highest among people with disturbed family relationships, people with a family history of psychiatric disorders and those exposed to chronic difficulties. The authors concluded that the prevalence rates in the UAE were underestimated (Abou-Saleh, Ghubash, & Daradkeh, 2001).

Studies in the Arab countries have consistently concluded that women have higher prevalence rates for psychiatric disorders than men (e.g., Al-Haddad, Al-Garf, Al-Jowder, & Al-Zurba, 1999; Abou-Saleh, Ghubash, & Daradkeh, 2001). Al-Haddad et al. (1999) indicated that this finding is generally accepted. The high prevalence of psychiatric disorders in women is further demonstrated in studies conducted by Daradkeh, Alawan, Al Ma'aitah, and Otoom (2006) and Ghubash, Hamdi, and Bebbington (1992). Daradkeh et al. (2006) found the prevalence rate of psychiatric morbidity among women attending a primary health-care centre in Jordan to be 26.3%. Ghubash, Hamdi, and Bebbington (1992) found psychiatric disorder among women in Dubai up to 23%.

Other studies have assessed prevalence rates in the Eastern Mediterranean region among primary care patients. El-Rufaie, Albar, and Al-Dabal (1988) screened representative samples of primary health-care patients in Saudi Arabia and found the overall psychiatric morbidity in the sample to be 26%. The Saudi Arabia study used the Hospital Anxiety and Depression scale that showed the prevalence of depression to be 17% and prevalence of anxiety 16% (El-Rufaie, Albar, & Al-Dabal, 1988). A similar study conducted in the United Arab Emirates revealed prevalence rates among primary-care patients to be 27.6% (El-Rufaie & Absood, 1993). Using the Clinical Interview Schedule, the UAE study identified the three most common diagnoses as neurotic

depression (55%), mixed anxiety and depressive disorder (13.3%), and anxiety states (11.7%) (El-Rufaie & Absood, 1993).

The above prevalence rates are comparable to those in the Western World. For instance, in Canada, lifetime prevalence was 20% (Health Canada, 2002), and 12 month prevalence in the European Union was 27% (Wittchen & Jaccobi, 2005). In the United States, using the WHO World Mental Health Survey, Kessler et al. (2005) found lifetime prevalence of any disorder to be 46.4%.

In summary, mental illness is common in the Eastern Mediterranean region and prevalence rates have been found to be comparable to the Western World. In the next chapter, the four categories of mental problems measured by the standardized survey will be reviewed, and research on their prevalence will be presented.

Chapter Five: Four Areas of Psychological Distress

The General Health Questionnaire is a screening instrument intended to detect psychiatric disorders in community samples. The scaled version of the GHQ (GHQ-28) was used in this study. The GHQ-28 provides a total score of mental wellness as well as additional profile information with respect to the following four areas of psychological distress : Social Dysfunction, Major depression, Anxiety/insomnia, and Somatic Complaints. To provide insight into each area, this chapter will review the definition of these problems and their prevalence. Emphasis will be placed on the Arab situation.

Social Dysfunction

Social dysfunction is an umbrella term used to describe a variety of emotional problems experienced mainly in social situations. *Social dysfunction* is defined as behaviour inappropriate to the circumstances, such as lack of affective contact,

detachment from social life or a disturbance in participating in social life (Stravnski & Shahar, 1983). Hilton (2004) stated that social dysfunction is a state in which a person experiences considerable dysfunction manifested in daily life with family, school, and friends.

Various psychological models have been created to define *social competence* or *social adjustment*. Stranghellini and Ballerini (2002) have summarized these explanations as follows:

- *Behavioural functionalism*—social competence is the ability to adopt the necessary behaviour in order to satisfy one's needs and goals;
- *Structural functionalists*—use the disability model and indicate that the important aspect in social adjustment is to participate in social life in ways that others expect us to, in other words to perform our social roles according to the rules and expectations that are defined within our social context; and
- *Cognitivism*—is the ability to understand, predict and respond correctly to thoughts, feelings, and behaviours in others, in diverse social contexts.

Arab issues. Poor social functioning is strongly associated with a variety of mental disorders in all cultures. For instance, Ormel et al. (1994) found that psychopathology is consistently associated with increased impairment in functioning; the disorders most affected include major depression, panic disorder and generalized anxiety disorder. Prevalence studies indicate that 7-16% of psychiatric outpatients suffer from social dysfunction either as their main complaint or in conjunction with other mental disorders (Stravynski & Shahar, 1983). Difficulties in functioning and thinking prevent

people from adequately performing their social roles. Therefore their performance as parents, students or workers is compromised.

Major Depression

A mood disorder is a condition in which the person's emotional state is distorted or inappropriate in the circumstances; these emotions are outside the bounds of normal fluctuation from sadness to elation (Department of Health and Human Services, 1999). The *Diagnostic and Statistical Manual of Mental Disorders Four Edition—Text Revision* (DSM-IV TR, 2000) lists the following types of mood disorder: Major Depressive Disorder, Dysthymic Disorder, Bipolar I Disorder, Bipolar II Disorder, and Cyclothymic Disorder.

The predominant mood disorder is major depressive disorder, also known as Unipolar Depression (Department of Health and Human Services, 1999). The DSM-IV-TR (2000) stated that major depressive illness is characterized by having five or more symptoms present during the same two-week period; and (a) the symptoms occurring on a daily basis, (b) the symptoms representing a change from previous functioning, and (c) one of the symptoms being either depressed mood or loss of interest or pleasure. Depressed mood includes feelings of sadness or emptiness, diminished interest and pleasure in most activities, insomnia or hyperssomnia psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness and excessive or inappropriate guilt, which may become delusional.

Depression varies from mild to severe and is most often episodic; however, it can also be recurrent or chronic (World Health Report, 2001). The World Health Organization (2001) noted that 15-20% of those with major depression become

chronically depressed (Department of Health and Human Services, 1999) and 10-15% of previously hospitalized persons with depression commit suicide (Angst, Angst, & Stassen, 1999). Major depressive disorder has the highest mortality rate of any mental disorder and is associated with psychosocial and physical impairments (Angst, Angst, & Stassen, 1999).

The age of onset is fairly evenly spread among the population. It may come on in days or build over years. Over half of people who experience major depression have only one episode. With each successive episode, the patient has a 15% risk that the next episode will be a manic episode, changing their diagnosis to Bipolar Disorder. In the end, approximately 15-20% of those with major depression become chronically depressed (Department of Health and Human Services, 1999).

Epidemiology studies from around the world reveal that prevalence rates of depression range from 0.7% to 24% in Europe (Ayuso-Mateos et al., 2001), and from 2-6% in community samples in the United States (Katon & Schulburg, 1992). Weissman et al. (1996) found lifetime prevalence of depressive disorders to be from as low as 1.5% to as high as 19.0% in the ten countries they studied. Research has revealed depression to be approximately twice as common in women as in men (Abou-Saleh, Ghubash, & Daradkeh, 2001; Bland, 1997; Weissman et al., 1996).

Arab issues. The World Health Organization projects that by 2020, Major Depression will be the leading cause of disability in developing countries and the second most important contributor to the disease burden worldwide (Murray & Lopez, 1997). As a result of the disability caused by depression, it has a negative impact on the economy because it is the leading cause of absenteeism and loss of productivity (Greenberg,

Stinglin, Finkelstein, & Berndt, 1993). Depression also puts a strain on health care resources. For instance, although only a minority seek professional help to relieve a mood disorder, depressed people are more likely to visit a physician for some other reason (Greenberg et al., 1993). Lack of use of the mental health resources in the Middle East is directly related to the cultural tendency to express emotional problems through physical symptoms. Depression-related visits to physicians thus account for a large portion of health care expenditure.

Community studies in the Arab World indicated prevalence rates of depression ranging from 13-32% across different countries and population groups (El-Akabawi & Fekri, 1983; Ghubash, Hamdi, & Bebbington, 1994; Karam, 1994). Ghubash, Hamdi, and Bebbington (1994) studied urban populations in Dubai, United Arab Emirates and found the prevalence of depression to be 13.7%. El-Rufaie and Absood (1993) screened representative samples of primary health care patients in Al Ain, United Arab Emirates. They found the prevalence of minor psychiatric morbidity to be 26.7%, with depression accounting for 55% of the cases (El-Rufaie & Absood, 1993). Further, Daradkeh, Ghubash, and Abou-Saleh (2002) found that the lifetime prevalence of depressive disorder in Al-Ain, United Arab Emirates, was 2.8% in males and as high as 10.3% in females.

Anxiety

Anxiety disorders are a group of disorders in which the primary symptoms are abnormal, excessive, or inappropriate worry (American Psychological Association, 2000). Anxiety disorders are characterized by the following symptoms: difficulty controlling worry, feeling wound-up or tense, irritability, concentration problems,

significant tension in muscles, and easily becoming fatigued or worn-out (American Psychological Association, 2000). The disorder disturbs a person's mood, behaviour, ability to think clearly and physiological activity (National Institute of Mental Health, 1999). The anxiety is seen as dysfunctional because there is no recognizable stimulus or the stimulus does not warrant such an extreme reaction. The DSM-IV-TR identifies various types of anxiety disorder, which include panic disorder, phobias, post-traumatic stress disorder, obsessive-compulsive disorder and generalized anxiety disorder.

Michael, Zetsche, and Margraf (2007) stated that anxiety is known to develop early in life and in 80-90% of the cases, the disorder appears before the age of 35. The time between 10 and 25 years is high risk for the development of anxiety disorders. Specific and social phobias often start in childhood or adolescence, whereas generalized anxiety disorder, panic disorder and agoraphobia develop in late adolescence and early adulthood.

Countless studies examine the prevalence of anxiety disorders, demonstrating that they are among the most common mental disorders. A recent World Health Organization multinational survey (1997) from 14 countries found a 12-month prevalence rate from 2.4% in China to 18.2% in the United States. Prevalence rates in Lebanon, Mexico and the Ukraine were comparable to Western European countries but rates in the United States were two to three times higher. Michael et al. (2007) reviewed epidemiological studies from the World Health Organization's Mental Health Survey from 14 countries. He reported that anxiety disorders are widespread with lifetime prevalence rates between 13.6% and 28.8% in Western countries. In Canada, the prevalence rates of combined

anxiety disorders is 12%, with 9% of men and 16% of women being affected (National Institute of Mental Health, 2002).

Somers, Goldner, Waraich, and Hui (2006) reviewed the literature on the prevalence and incidence of anxiety disorders in the general population from the years 1980 to 2004. They found that women generally had higher prevalence rates across all anxiety-disorder categories compared with men, but the magnitude of this difference varied. This finding is confirmed by Wittchen, Nelson and Lachner (1998), who studied a random sample of over 3000 participants, aged 14-24, in Germany. They found anxiety disorders to be two to five times more prevalent amongst women (lifetime 20.3%, 12-month 13.8% compared to men's lifetime 8.3%, 12-month 4.7%).

Arab issues. As with depression, anxiety is often expressed through physical complaints. In spite of this, researchers have found anxiety to be prevalent. Prevalence rates of anxiety disorders have been reported to range from 11.7% (El-Rufaie & Absood, 1993) to 16% (El-Rufai, Albar, & Al-Dabal, 1988). Among the studies conducted in these countries, anxiety disorders are ranked as the second most common psychiatric disorder; prevalence rates appear to be higher among the female population (El-Rufai & Absood, 1993; El-Rufaie, Albar, & Al-Dabal, 1988; Ghubash, Hamdi, & Bebbington, 1992).

Somatic Complaints

The *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition Text Revision* (DSM-IV TR, 2000*)* includes a category for somatic symptoms related to psychiatric origins called the somatoform disorders. A person with a somatoform disorder might experience considerable pain without a medical or biological cause or they may

experience constant minor aches and pains without any obvious cause. Somatic symptoms may include hypertension, headaches, abdominal, chest, back or joint pain. Specific somatoform disorders include: (a) somatization disorder, (b) conversion disorder, (c) pain disorder, (d) hypochondriasis, and (e) body dysmorphic disorder. Undifferentiated somatoform is used when there is one or more medically unexplained symptom leading to distress or impairment (American Psychological Association, 2000).

Kirmayer and Young (1998) indicated that somatization is conceptualized in studies in three ways: (a) medically unexplained symptoms, (b) hypochronical worry or somatic preoccupation, or (c) as somatic clinical presentations of affective anxiety or other psychiatric disorder. They noted that these symptoms might be seen as an indication of disease or a medium for expressing social discontent, an indication of intrapsychic conflict or a cultural means of expressing distress (Kirmayer & Young, 1998). Singh (1998) summarized some of the major somatization symptoms. These symptoms include back, chest and abdominal pain, headaches, dizziness, gastrointestinal complaints, abnormal skin sensations, painful menstruation, sleep disturbances, fatigue, irritability, and palpitations. Singh (1998) identified common characteristics of patients with somatoform disorders, which include: (a) exaggerated accounts of their symptoms, (b) minimizing or denying any physiological cause for their symptoms, (c) being convinced they have an organic disease, (d) having trouble expressing emotion. In addition, they tend to be dependent, resist or oppose demands to function at normal expected levels and interpret physical sensations as evidence of a physical illness.

As a result of these varied definitions and criteria, the prevalence of the disorder is difficult to determine. Gureje, Simon, Ustun, and Goldberg (1997) stated, “[w]ith such

diversity in the ways the phenomenon is conceptualized, there is little surprise that research findings have tended to be conflicting" (p. 989). Kirmayer and Young (1998) indicated that the prevalence of somatoform disorders is unclear because of a lack of studies using comparable standardized methodologies. Bass, Peveler, and House (2001) stated that prevalence is often underestimated because psychiatric classifications separate somatoform disorders into groups with low prevalence such as hypochondrias and conversion disorder. The clinical presentation of somatization varies; these complex clinical presentations are further complicated by additional comorbidity with physical illnesses, depression, and anxiety and personality disorders (El-Rufaie, 2005). In spite of the difficulties in determining the prevalence of somatization, the studies that have been conducted demonstrate that the incidence is present in all medical settings and common among all cultural groups.

The prevalence of somatization disorders varies. An estimated prevalence of somatoform disorders in a Dutch study was 16.1% (DeWaal, Arnold, Eekhof, & Van Hemert, 2004). Grabe, Meyer, Hapke, Rumf, Freyberger, and Dilling (2003) found that 1.3% of their sample in Germany met the criteria for somatization disorder. In the United States, prevalence for the most restrictive diagnosis of somatization disorder in community samples was 0.1%. In a Nigerian study, only 1.1% of the sample fulfilled the DSM III-R classification of somatization disorder (Gureke & Obikoya, 1992). Other studies using a broader definition of somatization found higher rates.

Smith, Clarke, Handrinos, Dunsis, and McKenzie (2000) found that the majority of patients suffering from a somatoform disorder were women (76%) and those who had low rates of employment (16%), had a serious physical illness in the past 12 months

(67%), and had another psychiatric illness (28%). Gureje et al. (1997) found that somatization disorder was more frequent in women but in using the less restricted form of the distribution, it was divided equally among men and women. Kirmayer and Robbins (1996) found that lower education and income were not associated with the disorder.

Simon, Gater, Kisely, and Piccinelli (1996) examined individual somatic symptoms (gastrointestinal, neurological, musculoskeletal and automatic and conversion) across all sites in the WHO study. They did not find any clear patterns of association according to geographic or economic development. Gureje et al. (1997) also found only minimal support for the belief that somatization may be related to certain cultures or that it is a mode of expression of psychological problems of less-educated people.

Arab issues. Somatization disorder is found to be prevalent in developing countries (Okasha, 2003). Okasha stated an alarming 70-80% of psychiatry patients in developing countries expressing their emotional illness through physical symptoms. In the United Arab Emirates, a study conducted on a sample of primary health care patients showed that the estimated prevalence of somatization disorder was 12% in the general population and 48% of the total psychiatric patients identified (El-Rufaie, Al-Sabosy, Bener, & Abuzeid, 1999). In Saudi Arabia, Becker, Al-Zaid, and Al-Faris (2002) found that in a cross-sectional study of male and female patients, the prevalence of somatization and depression was comparable to rates in the USA and worldwide.

This chapter reviewed the four subscales of the survey being used in the present study. Definitions and prevalence rates of each disorder were provided. Arab issues were discussed with respect to each disorder. The following chapter presents the method of the study.

Chapter Six: Method

This study is a starting point in assessing (a) the prevalence of psychiatric disorders, and (b) attitudes towards counselling. The surveys were distributed electronically to a non-random sample of female undergraduate students who are citizens of the United Arab Emirates (called Nationals) attending the country's only university for female Nationals in the city of Abu Dhabi (capital of UAE). The target group was between the ages of 17-26.

This chapter will describe the method that was used in conducting this study. It also describes the participants, the standardized questionnaire, the procedure and consent process, and the methods that were used to collect and analyze the data.

Ethics

Ethics approval for this study was obtained from the University of Lethbridge (Lethbridge, Alberta), and from the Zayed University (Abu Dhabi, United Arab Emirates). Once ethics approval from both institutions was obtained, the Curriculum Re-Development Centre (CRDC) at the University of Lethbridge formatted the survey for online availability. Students attending the Zayed University were sent an email directing them to a website that contains the research survey.

Consent. The email inviting participation was sent by the Student Services Department. The weblink first directed students to the online consent form (see Appendix D). Potential participants were all female post-secondary students and able to consent to their participation in the study. The online consent form informed participants that consent to participate in this study was completely voluntary and that they had the right

to withdraw from the study at any time. However, once the participant had completed and submitted the online survey, it would be impossible to retrieve and remove her data.

The consent form included information about the purpose and nature of the study as well as directions for completing the online survey. Specifically, it explained that the researcher is examining mental wellness in post-secondary female students in the United Arab Emirates, and that this type of research is scarce in Arabic countries. It explained some of the benefits of participation such as increasing their knowledge and obtaining a better understanding of mental health issues in this population group. The information gathered could be important for the development of appropriate mental health services (Appendix D).

The consent form provided information on confidentiality and anonymity and explained to participants that no identifiable information (e.g., names) were required or recorded for participation in this study. The participants were also informed that this survey was voluntary and that they could withdraw their participation at any time. However, once they had completed and submitted their survey it would be impossible to remove their data from the analysis. Finally, participants were informed that participation was estimated to take approximately 10 minutes and once the participant had read and accepted the terms they would be required to click on the “agree” button, which would link them to the survey.

Participation in this study neither collected nor required any identifiable information. All data were stored in the CRDC database located at the University of Lethbridge, password protected. The database is under my control and under supervision. The information stored in the database will remain accessible for 10 years. After this

time, if it is deemed the data is no longer valuable, it will be permanently deleted. The participants' information is currently stored on the CRDC database at the University of Lethbridge. The researcher, the researcher's supervisor, and the consulting statistician, along with the individuals from CRDC, had access to the participants' data. However, no identifying features of the survey respondents were in the data file.

Setting

This study takes place in Abu Dhabi, United Arab Emirates. The United Arab Emirates is located in the Persian Gulf Region of the Middle East. For more context, please refer to Chapter 1.

Participants

The participants were selected from a non-random sample of undergraduate female students enrolled at a university in Abu Dhabi, United Arab Emirates. Specifically, 123 female undergraduate students participated in the study. The university is the country's only university for female Nationals. Mean age was 19 with a range of 17-26. The students are all citizens of the Emirates, speak Arabic and typically have English as their second language. Instruction at the university is in English.

Instrument

The study survey consisted of two surveys (Appendix A (GHQ English), B (GHQ Arabic), & C). The first survey consisted of 16 open and closed questions developed by the researcher. The views and attitudes towards counselling are solicited in this section. The second survey is a standardized self-report questionnaire. Completion time was anticipated to be 10 minutes in total. To ensure anonymity for the participants, names and other identifying information were not recorded.

Views and attitudes survey. Demographic and educational information was collected in the first five questions (the participant's age, marital status, and geographical location of residence, level of education, etc.). Two questions pertaining to the participants' career plans were solicited (i.e., Do you plan on working with pay after graduating? What career would you like to have?). Six questions attempted to uncover participants' views and attitudes towards counselling (e.g., Would you be more willing to attend counselling if a friend came with you? Have you ever talked to a counsellor at the university? Do you think counselling should be free of cost?). The remaining three questions measured the participants' opinion of the effectiveness of the General Health Questionnaire on measuring psychological distress as well as their understanding of the survey. For the survey questions, refer to Appendix D.

The General Health Questionnaire. The General Health Questionnaire (GHQ) is a self-administered screening questionnaire designed to detect psychiatric disorders both in the community and among primary care patients (Goldberg, 1989). It identifies an individual's ability to carry out normal healthy functions, and the appearance of new phenomena of a distressing nature (Goldberg & Williams, 1988). The instrument focuses on breaks in normal functioning (detects disorders of less than two weeks' duration) rather than on life-long dysfunction. The questionnaire is easily administered, fairly short, and objective in the sense that does not require the person administering it to make subjective assessments about the respondent (Goldberg & Williams, 1988).

Versions of the GHQ. The questionnaire is available in a variety of forms ranging from 12 to 60 items in length. In the present study, the scaled 28-item version of the GHQ was used. The 28-item GHQ was derived from the original 60-item version by

factor analysis (Goldberg & Hiller, 1979). The advantages of using the 28-item version of the GHQ include the short completion time, additional information being provided by the four subscales, and similar reliability and validity compared with the longer version (El-Rufaie & Daradkeh, 1996; Goldberg, Gater, Sartorius, & Ustun, 1997). In addition, the 28-item version contains four subscales of interest: (a) anxiety and insomnia, (b) somatic symptoms, (c) social dysfunction, and (d) depression. These categories are useful for community samples.

Properties of the GHQ-28 scale. The scaled version of the GHQ (used in this thesis) is intended for studies that require more information than is provided simply by a total score. The four subscales are by no means independent of one another (Goldberg & Hillier, 1979) and the correlation coefficient between the Anxiety Scale and the Total Score (+.90) supports the view that anxiety is a core phenomenon that underlies the common syndrome of psychiatric illness. The three remaining scales allow researchers to measure other dimensions of symptomatology.

Many studies have demonstrated the GHQ-28 to have sound psychometric properties (e.g., Cleary, Goldberg, Kessler, & Nycz, 1982; D'Arcy, 1982; D'Arcy & Siddique, 1984; Goldberg, Rickels, Downing, & Hesbacher, 1976; Huppert, Walters, Day, & Elliott, 1989; Vazquez-Barquero, Williams, Diez-Manrique, Lequerica, & Arenal, 1988). Overall, the factor analysis of the GHQ-28 has been found to be stable across sample groups (Huppert et al., 1989; Vazquez-Barquero et al., 1988). However, Aderibigbe, Riley, Lewin, and Gureje (1996) examined whether the psychopathological subsets of the GHQ-28 obtained by Goldberg and Hillier (1979) could be identified in a different culture or language. Their study concluded that researchers should be cautious

about assuming that the factor scales are stable across cultures; alternative factor scales may need to be considered in non-English samples (Aderibigbe et al., 1996). This finding will be kept in mind when interpreting the data for this thesis.

Layout and method of scoring. The GHQ-28 contains four 7-item sub-scales, which were reviewed extensively in the previous chapter. These include: social dysfunction, depression, anxiety and insomnia, and somatic symptoms (Goldberg & Hillier, 1979). Each item on the GHQ-28 asks about the recent experience of a particular symptom, and half of the items are presented positively (agreement indicates absence of symptoms). For example, "Have you recently felt capable of making decisions about things?" Half are presented negatively (agreement indicates presence of symptoms), e.g., "Have you recently found at times you couldn't do anything because your nerves were too bad?" The scaled version of the GHQ has been developed on the basis of the results of the principal components analysis. The four sub-scales, each containing seven items, are as follows:

- A—somatic symptoms (items 1-7)
- B—anxiety/insomnia (items 8-14)
- C—social dysfunction (items 15-21)
- D—severe depression (items 22-28)

The four-point response scale may be scored in two ways. It can be scored as a multiple-response scale or a Likert scale and have weights assigned to each position. The alternative method is the binary scoring response scale (i.e., 0-0-1-1) for the detection of the presence or absence of distress (Goldberg & Hiller, 1979). Goldberg recommended the binary method of scoring for simplicity, finding little advantage to the Likert scoring

methods, with correlations between the two scoring methods between 0.92 and 0.94 (Banks, 1983). This thesis used the binary method of scoring.

Cultural influences on the GHQ. The General Health Questionnaire has been translated into at least 38 languages and has been studied in a variety of cultural settings (Gibbons, de Arevalo, & Monico, 2004). The GHQ has been applicable in developing countries compared to developed countries with few problems in preserving the integrity of the scale when translating the GHQ into other languages (Goldberg et al., 1997). Further, Goldberg et al. found validity coefficients from 10 translated versions to be nearly as high as in the original language (English); thus, it supports Goldberg's hypothesis that a common language of psychological distress exists between cultures. To avoid any language barriers, the online questionnaire was set up to have both the English and Arabic versions of the questionnaire (Appendix A & B). The Arabic version is discussed next.

Arabic version. The Arabic version of the GHQ has been found to be a valid screening instrument in an Arab community in the UAE with an overall sensitivity and specificity of 0.83 (Ghubash, Daradkeh, El-Rufaie, & Abou- Saleh, 2001). Validation of the Arabic versions of the 30- and 12-item General Health Questionnaires have been performed and have found a sensitivity of 0.83 for both. The specificity was found to be 0.83 for the GHQ-30 and 0.80 for the GHQ-12. Both versions of the GHQ were found to have a strong concurrent validity (El-Rufaie & Daradkeh, 1996). The total discriminatory powers of the GHQ-30 and the GHQ-12 were approximately 93% and 86% respectively.

Language and culture. The GHQ has been translated into a wide variety of languages and appears to perform well in a variety of cultural settings (Gibbons, de

Arevalo, & Monico, 2004). The sensitivity of the non-English studies was higher than that for the English studies (78% compared with 74%), although the difference is not significant. This would indicate that linguistic factors make a rather small contribution to the identification of minor psychiatric illness (Goldberg & Hillier, 1979).

Reliability. ***Split-half reliability.*** The split-half reliability of the GHQ-60 was computed on the 853 completed questionnaires that were used in all the other studies, and was shown to be 0.95. Internal consistency in the reliability of the shorter versions ranged from +0.82 to +0.93 using the Likert scoring method. The split-half reliability for the GHQ-28, with Likert scoring, was 0.78 (Goldberg, 1972). Banks et al. (1980) found internal consistency with the GHQ scoring method to be 0.90, 0.82 and 0.87 for the GHQ-60, GHQ-30, and GHQ-12. The r-values correspond to the versions in the order cited.

Test-retest reliability. Test-retest reliability was reported to be +0.90 for the GHQ-28 (Robinson & Price, 1982) and 0.85 for the GHQ-30 (DePaulo & Folstein, 1978). Samples drawn from the general population have reported lower coefficients. Layton (1986) administered the GHQ-60 to 186 school-leavers and 101 men facing redundancy some 11 months apart. Test-retest reliability correlations were +0.58 and +0.51 respectively.

Validity. ***Criterion validity.*** Many studies have estimated a correlation coefficient between the GHQ and standardized psychiatric assessment as part of a validity study aimed at measuring how well the GHQ measures the severity of psychiatric disturbance. Results from 22 studies show a median correlation between the GHQ and the criterion interview to be +0.70. The GHQ-28 has been found to have a correlation coefficient of

+0.76 with the Clinical Interview Schedule (Goldberg & Hiller, 1979), and +0.67 and +0.83 with the Present State Examination (Banks, 1983; Rabins & Brook, 1981).

Validity of the GHQ-28. Twelve studies have reported the data on the validity of this version. The results from two studies show the sensitivity of the instrument to range from 44% (Mann et al., 1984) to 100% (Banks, 1983). Values for the specificity of the GHQ-28 range from 74% (Medina-Mora, Padilla, Campillo-Serrano, Mas, Ezban, Caraveo, & Corona, 1983) to 93% (Rabins & Brooks, 1981).

Socio-demographic characteristics. Goldberg et al. (1976 found that the function of the GHQ was more accurate with men than women, and with whites than blacks; however, the differences were not statistically significant. Further, they noted that age and social class did not have an effect on misclassification. Williams et al. (1987) found the sensitivity for 31 studies giving data for both sexes to be 76%.

Obtaining the survey. The process of obtaining permission to use the General Health Questionnaire-28 involved the researcher becoming a registered user of nferNelson test (National Foundation of Educational Research) (GL Assessment, 2005) by completing the customer registration form. Once the researcher was registered, it was necessary for the researcher to apply for permission to use the scale. Once the researcher had obtained permission to use the scale, she was given a license to use the scale for the intended research. An electronic copy of the scale in its original form (UK English) was sent. To obtain the Arabic version, the researcher contacted the Mapi Research Trust (Mapi Research Institute, 2004). Both the English and Arabic versions were received by the researcher via email.

Procedure

Once ethical approval of this study was obtained, students were invited to participate in the survey by an email sent by the Campus Announcement coordinator at the Zayed University in the UAE. If they were interested in the study, they were provided with a link to access the informed-consent form. Once this form was read and agreed to, the students clicked on an icon to gain access to the questionnaires via the World Wide Web. The participants completed the survey online in a location of their choosing.

Data Analysis

The quantitative data collected by the research was analyzed using the Predictive Analytics Software 18 (PASW) for Windows. Descriptive statistics were tabulated with respect to frequencies and percentages describing the characteristics of the sample among the following variables: age, marital status, place of residence and level of education. The PASW scores (including overall score, total score, and subscale scores: anxiety and insomnia, somatic complaints, social dysfunction, and severe depression) were evaluated in terms of mean, standard deviation, range and distribution. Finally, the frequency and percentage of risk scores were analyzed to determine the percentage of poor functioning among this population group.

Scoring of the GHQ. The binary scoring method was used in scoring the GHQ; for the purpose of this study, a cut-off score of 8 was used to define “cases” and “non cases” for presenting symptoms of psychiatric morbidity. Goldberg and Hillier (1979) recommended the cutting score of 5 for the 28-item version; this cut-off point applies to both clinical and nonclinical settings. This means that with binary method scores of 5 or higher, persons are regarded as demonstrating symptoms of “caseness” for psychiatric

morbidity (Goldberg & Hillier, 1979, as cited in Lim & Chew, 1991). For this thesis, the authors felt that using the normal cut-off point would lead to very high numbers of GHQ cases and consequently too high an estimate of psychiatric morbidity among this population. In addition, due to the limited research on the prevalence rates of mental wellness in this region, and the American-based norms of the instrument, cultural differences may reflect higher levels of psychiatric symptoms. Goldberg, Oldehinkel, and Ormel (1998) indicated that the mean score found in an exploratory study will provide a guide to the best threshold and Willmott, Boardman, Henshaw and Jones (2004) stated that the median score is the optimal threshold in settings where the sensitivity and specificity are unknown. By increasing the cut-off point for the present study, the author of this thesis hoped to account for some of the cultural variations. However, even with the higher cut-off point, the numbers reported needed to be interpreted with caution. The author recognized that this was an exploratory study; a more thorough examination of the data will be discussed in the following chapter.

A point biserial correlation was applied to examine the relationship between marital status, coded as currently married and not married, and a total score. A Kendall Tau b correlation was applied to examine the strength of the relationship between respondents' age coded as an ordinal variable, ranging from a value of 1, 17 years or younger to a value of 8, 24 years or older. A Kendall tau b correlation was also applied to examine the strength of the relationship between respondents' year of program.

A chi-square test was conducted to evaluate whether different age groups have a different pattern of mental wellness. A chi-square test was also conducted to evaluate

whether individuals who are married have a different pattern of mental wellness than those who are not married.

The qualitative data collected was thoroughly studied for themes and trends. Each open-ended response was reviewed and coded twice to ensure accuracy of coding. Key words and phrases (e.g., when I feel sad) were used to develop thematic groupings. The frequency with which a particular theme occurred was also tabulated.

The results gained through analysis of the data are presented in Chapter 7. Demographic information as well as prevalence rates of mental illness will be reported.

Chapter Seven: Results

The first section of this chapter will provide an overview of the purpose of the study and then present the demographic characteristics of the sample. The major section of this chapter will report the prevalence rate of presenting symptoms of mental illness determined by the questionnaire used, followed by the participants' responses to the questions on their views and attitudes towards counselling.

This study investigated the prevalence of mental illness in a convenience sample of post-secondary students attending university in the United Arab Emirates. The survey used a mental health survey, the General Health Questionnaire item-28, which examines functioning in two main areas: (a) the ability to carry out usual healthy activities, and (b) the recent development of subjective symptoms of psychological distress (Goldberg & William, 1988). In addition, students' views and attitudes towards counselling were solicited.

A Kendall Tau b correlation was applied to examine the strength of the relationship between respondents age (M= 19, SD= 1.7) and the GHQ total score (*M* =

9.1, *SD* = 6.3). An extremely weak negative non-significant correlation was obtained, τ, = -0.69, *p* = .303 (2-tailed), indicating that age is not significantly associated with GHQ total scores or vice versa. A chi-square test was conducted to evaluate whether different age groups have a different pattern of mental wellness. A non-significant chi-square statistic was obtained, χ^2 (7, N=123) = 4.7, *p* = .696).

In all, 84.6% of the participants reported being single, while 4.9% were engaged and 10.6% were married. A chi-square test was also conducted to evaluate whether individuals who are married have a different pattern of mental wellness than those who are not married. A non-significant chi-square statistic was obtained, χ^2 (1, N = 123) = .363, *p* = .547. A point biserial correlation was applied to examine the relationship between marital status, coded as currently married (n = 13) and not married (n = 110), and a total score. The mean total score and standard deviation for the not married group was 9 and 6.36 respectively, whilst for the married group it was 9.5 and 6.2. A weak non-significant positive correlation was obtained, (*r* = .027, p = .773 [2-tailed]), indicating that the total score on the GHQ is not associated with marital status. Indeed less than 1% of the variability in GHQ total score is predicted by knowing a respondent's marital status, or vice versa.

Of the total of 123 participants, 22.8% reported being in the first year of their program, 25.2% were in the second year, 27.6% were in their third year, and 24.4% were in their fourth year of study. A Kendall tau b correlation was applied to examine the strength of the relationship between respondents' year of program (*M* = 2.5, *SD* = 1.1) and GHQ total score (*M* = 9.1, *SD* = 6.3). An extremely weak negative non-significant

correlation was obtained, $\tau = -0.58$, $p = .403$ (2-tailed), indicating that year in program is not significantly associated with GHQ total scores or vice versa.

Location

All of the participants resided in the United Arab Emirates. The majority of the participants reported living in the country's capital Abu Dhabi n = 51 (41.9%) or in a nearby city Dubai n = 39 (31.7%). The remaining participants lived in more rural areas including Sharjah (12.2%), Ajman (4.1%), Baniyas (3.3%), Umm Al Qwain (2.4%), Al Fugiera (1.6%), and Al Shahama (.8%).

Education and Career

The majority of the participants indicated that their mother had an education level of either less than high school (38.2%) or a high school diploma (24.4%). Eighteen percent of participants (18.7%) indicated that their mother had a bachelor's degree. The participants' reported their father's education level as follows: less than high school diploma (31.7%), bachelor's degree (23.6%), certificate or higher diploma (12.2%), and high school diploma (10.6%).

A Kendall tau b correlation was applied to examine the strength of the relationship between respondents' mother's education level ($M = 2.4$, $SD = 1.6$) and GHQ total score ($M = 9.1$, $SD = 6.3$). An extremely weak negative non-significant correlation was obtained, $\tau = 0.03$, $p = .676$ (2-tailed), indicating that mother's education level is not significantly associated with GHQ total scores or vise-a versa. There were five missing values for mother's education that were not replaced.

A Kendall tau b correlation was applied to examine the strength of the relationship between respondents' father's education level ($M = 3.2$, $SD = 2.1$) and GHQ

total score (M = 9.1, SD= 6.3). An extremely weak negative non-significant correlation was obtained, τ = 037, p = .591 (2-tailed), indicating that father's education level is not significantly associated with GHQ total scores or vise-a versa. There were six missing values for father's education that were not replaced.

An overwhelming majority of the participants (84%) indicated that they would like a career after graduation. The participants responded with a wide variety of careers, although a constant theme was a career in education, business and management, or socially related fields. Other responses included "a career that I enjoy," "[earn] a good salary," and "[a career that] doesn't conflict with my cultural values and religious beliefs."

Scores from the GHQ

Scoring procedure. A total of 123 participants completed the survey. Out of a possible 123, 112 participants had no more than two questions unanswered. The standard procedure for all versions of the General Health Questionnaire is to count omitted items as low scores (GL Assessment Online, 2009). For the present study, all omitted items were scored zero.

Using a threshold cut-off score of 8 (8 or more symptoms) to detect the likelihood of participants experiencing psychological distress, 63 (51.2%) of the 123 participants produced scores of 8 or above on the General Health Questionnaire-28 (M = 9.1, SD = 6.3). This indicated that 51% of the self-selected sample (63 participants) presented with symptomology of a psychological disorder. Forty-nine percent (60 participants) obtained scores less than eight, which indicated that they did not meet the criteria for a psychological disorder.

The possible range on the General Health Questionnaire-28 was 0- 28. The obtained range was 0- 27 with a median score of eight. The overall scores on the General Health Questionnaire were moderately positively skewed. See Figure 1 for Histogram of GHQ scores.

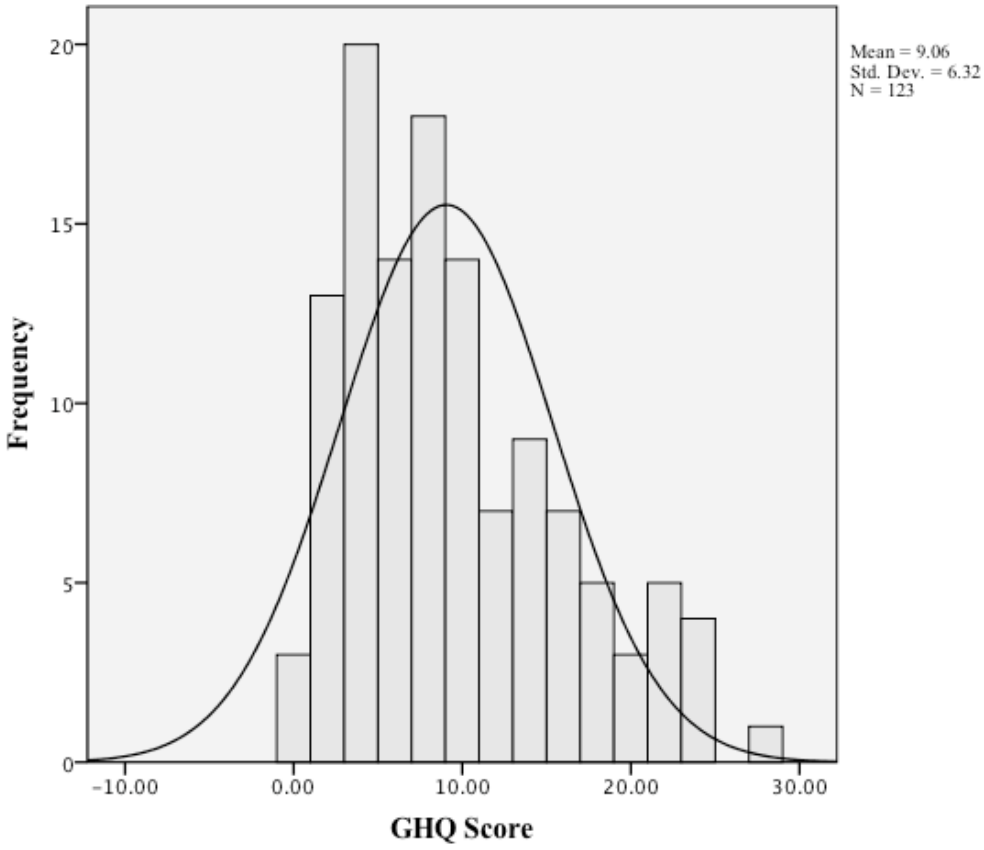

Figure 1. Histogram of GHQ Scores.

Subscales. The GHQ-28 subscales represent dimensions of symptomatology and are not intended for distinct diagnoses. The subscales simply allow for additional profile information regarding the symptoms of psychological distress experienced. There are no thresholds or cut-off scores for individual sub-scales (Goldberg, 1978), however for the purpose of this research, a threshold of 5 (5 or more symptoms) will be used to determine

specific and significant problems in each subscale. Of the 123 participants, 30.9% (38 participants) showed significant problems in anxiety, 17.9% (22 participants) in social dysfunction, 14.6% (18 participants) in somatic complaints, and 8.9% (11 participants) in severe depression. It must be noted that the percentages of participants scoring in each category is not independent of one another. Ten participants (8%) scored above the cut off range in all four categories, 21 (17%) participants scored above cut off range in three categories, and 36 (29%) participants scored above the cut off range in two categories. A Kendall tau b correlation was applied to examine the strength of the relationship between sub-scale scores. In an attempt to compensate for the volume of correlation tests being conducted the cut off value for significance was reduced from .05 to .01. A significant positive correlation was obtained between the anxiety scores and somatic complaints scores, $\tau = .510$, $p = < .001$ (2-tailed) as well as depression scores, $\tau = .420$, $p = < .001$ (2-tailed). In other words, of the 44 participants who scored above the cut off range for anxiety, 27 (61%) also scored above the cut off range for somatic complaints, and 17 (39%) for depression. A significant positive correlation was also obtained between somatic complaints scores and depression scores, $\tau = .413$, $p = <.001$ (2-tailed). In other words, of the 36 participants who scored above the cut off range for somatic complaints, 15 (42%) also scored above the cut off range for depression. A significant positive correlation was found between social dysfunction and somatic complaints, $\tau = .180$, p=<.01. See Table 1 for the correlation between GHQ subscales.

Table 1

Correlations between GHQ Subscales

Measure	Depression	Somatic	Social Dysfunction
Anxiety	0.420**	0.510**	0.214**
Depression		0.413**	0.303**
Somatic			0.180*

Note. p<.01*, p<.001 **

Summary. The first research question of this thesis was to report the prevalence rates of mental illness among a self-selected sample of female Emirati undergraduate students. In summary, over half the selected sample (51%) presented with a high degree of psychological distress. The percentage of distress in the specific subscales were as follows: anxiety (31%), social dysfunction (18%), somatic complaints (15%), and depression (9%).

Views and Attitudes towards Counselling

Six questions at the end of the survey solicited the participants' views and attitudes towards counselling. The response rate for each question varied. For the question "Have you ever talked to the ZU counsellor in her office?" 123 participants responded. Twenty-two percent (22.8%) responded, "Yes," while 77.2% said they never talked to the ZU counsellor.

For the question "Have you ever talked to a counsellor who did not work for ZU," 123 participants responded. Thirteen percent responded, "Yes," while 87% said they had never talked to a counsellor who did not work for ZU.

For the question "Would you be more willing to attend counselling if a friend came with you?", 122 participants answered this question. Forty-one percent (41%) (50 participants) of the participants reported that they would be willing to attend counselling if a friend came with them to the session; the majority of participants (59%) (72 participants) responded that they would *not* be more inclined to attend counselling with a friend.

One hundred and twenty-three (123) participants answered the question "Do you think counselling should be free of cost (no cost)?" The majority of the participants (77.2%) (95 participants) reported counselling should not be free of cost. A small portion of participants (22.8%) (28 participants) felt that counselling should be free.

Eighty-seven participants answered the question "List five reasons why you or someone you know might see a counsellor." The responses to this question were examined for apparent themes and six main categories emerged: (a) academic support, (b) stress, (c) psychological distress (e.g., depression, anxiety, etc.), (d) help with problem solving and receiving advice, (e) family problems, and (f) acceptance and support. It is worthy to note that participants may have recorded a response in more than one category. Each six of these themes will be briefly reviewed next.

Academic support. Seeing a counsellor for educational assistance or support was a common themed response from the participants, with a total of 21.8% (19 participants) responding that this would be a reason to see a counsellor. Responses included "suffering [form] from a low GPA," "academic problems," "repeating the course," "when they don't know what to choose as a concentration in their studies," "have difficulties learning," and

"sometimes girls face some problems in their study at ZU, like some of them had a fail in a course because of [a] medical issue."

Psychological distress. Forty percent (40.2%) reported that psychological distress (e.g., "any kind of emotional disturbance," "psychological diseases (eating disorders, phobias, etc.)," "rape, divorce, personality disorder," "obsession with something (e.g., games, internet)," and "depression") would be a reason to see a counsellor. While 18.4% indicated family problems (e.g., "family issues," "neglect from family," and childhood history"), 13.9% reported stress as a reason to see a counsellor.

Problem solving. The majority of participants (67.8%) (59 participants) indicated that they or someone they know would see a counsellor if they needed help in problem solving and/or needed advice. Participants included "help to manage what you'r[e] struggling with," "need advice," "have problems," "if they have problems and they want somebody to help them," "they might be confused between two things," and "they might need some advice on how to react to some problem."

Stress. Seeing a counsellor to deal with stress was a common themed response. Twelve percent (12.6%) (11 participants) indicated that stress management would be a reason to seek counselling services.

Acceptance and support. Acceptance and support from the counsellor along with unconditional positive regard were viewed as good reasons to see a counsellor by 26.4% of the participants. The participants reported that a "counsellor will understand their problems better than anyone," would be a "good listener," "open-minded," "listen without judging," and would be more inclined to "keep secrets."

One hundred and eighteen (118) participants answered the question, “Do you think counselling was an effective way of helping people with their problems?” An overwhelming majority of participants (95.8%) (113 participants) felt that counselling is an effective way of helping people with their problems. The participants who responded “Yes” indicated that “a counsellor can help [yo]u think effectively and find solutions because he sees the problem in a different way,” “counselling in an excellent most wonderful thing that a person can do for a person, because that counsellor might save a person’s life,” and “for some people, all they need to overcome their problems is somebody that listens and that’s what a counsellor does.”

A small percentage of participants (4.2%) (5 participants) said counselling is not effective. Participants who responded “No” indicated, “A counsellor is just a stranger who gets paid for listening to you although he or she is not really interested. If you’re facing some problems you just need a FRIEND.” Further, a handful of participants (6) indicated that they would not see a counsellor and/or did not know why or have any reasons to see a counsellor (e.g., “Why would someone?” “I do not believe in counselling.” “I have never hear[d] that there is a counsellor in ZU. So I don’t know what the counsellor do[es].” “I do not know.”

For the next question, 120 participants answered, “Do you think this survey is a good way to find out how your mental wellness is?” Over 48 percent (48.3%) (58 participants) of the participants felt that this survey was a good way to find out about their mental wellness. Forty-six percent (46.7%) indicated that the survey was “somewhat” a good measure, and 5% felt that this survey was “not at all” a good measure of their mental wellness.

Summary. The second research question was to solicit the participants' views and attitudes towards counselling. In summary, the majority of participants held favourable views about the counselling process and the counsellor, and felt that counselling was an effective means of assisting individuals with their problems. Despite an overwhelming majority of participants indicating that counselling is an effective means of assisting people with their problems (i.e., problem-solving, stress management, advice, and support); few of the participants had ever sought any type of counselling services either at the university or outside the university.

The implications of the results will be explored in Chapter 8. The limitations of the study and areas for future research will also be examined.

Chapter Eight: Discussion

Nature of the Study

This thesis had two purposes. The first was to determine the prevalence of psychiatric disorders in a non-random sample of female post-secondary students attending a university in the United Arab Emirates as measured by the General Health Questionnaire-item 28 (Goldberg & Hillier, 1979). The second purpose was to report the participants' views and attitudes towards counselling.

To the author's knowledge, this research was the first empirical study in the UAE that attempted to uncover the prevalence rates of mental illness among young adult Emirati females. Thus, it is exciting to explore the results in this chapter, but it is necessary to note that interpretation of the results should be made cautiously since it is an exploratory study. Further, research of this nature is new to this region so the reliability and validity of the results need to be ascertained by replicated studies. Since the

instrument was based on American and European norms, as previously noted in Chapter 6, any assumptions about the meaning of the results need to be made cautiously. Additional limitations will be listed later in the chapter. Despite these limitations, the results provide a basis for future research.

This chapter will summarize the demographic results followed by the prevalence rates of mental illness as defined by the measures used in the sample. Thereafter, the chapter will discuss the descriptive findings of the study related to the students' views of counselling. Finally, an examination of the limitations of the study will be presented along with a series of recommendations for future research.

Discussion of the Results

Demographic information. The 123 survey participants, between the ages of 17-26, were attending undergraduate university in their home country. They were Emiratis, natives to the United Arab Emirates (UAE).

GHQ results. Fifty-one percent of the participants met the criteria for having psychological distress, based on a self-report measure they completed. Anxiety, followed by social dysfunction and somatic complaints along with depression characterized the sample, with anxiety having the most reported symptoms (31%).

Interpretation of the prevalence rate. The prevalence rates reported in this study (51%) appear slightly higher compared to some of the previous international studies findings that used the General Health Questionnaire 28. For instance, Ardekani, Kakooei, Ayattollah, Choobineh, and Seragi (2008) evaluated 1,195 shift-work hospital nurses in Shiraz, Iran, and reported that 45% presented with psychological distress symptoms. In their study, they found that more women experienced psychological

distress as compared to men. Another study in England reported that 44% of the 273 of women they studied in the early stages of pregnancy presented with psychological distress (Swallow, Lindow, Masson, & Hay, 2003).

Noorbala, Yazdi, Yasamy, and Mohammad (2004) studied over 35,000 people in Iran and reported 26% of women and 15% of men were likely to experience psychiatric problems (this finding was based on a cut-off score of six which is lower than the cut-off used in this study). This Iranian study found depression and anxiety symptoms to be more prevalent than somatization and social dysfunction symptoms. In Lebanon, Farhood, Dimassi, and Lehtinen (2006) used the GHQ 28 to assess general psychiatric morbidity in a civilian population in Lebanon. They found the mean total score to be 10.46 (which is higher than the mean score of 9 found in the present study). The overall prevalence of psychiatric morbidity among the women sampled was 36.6% as measure by the Harvard Trauma Questionnaire (HTQ), which corresponds with the DSM III. The authors noted that the total score of the GHQ was found to be highly correlated with PTSD symptoms ($r = .73$). In another study using the GHQ, Al-Haddad, Al-Garf, Al-Jowder, and Al-Zurba (1999) assessed the prevalence of psychiatric morbidity in primary care setting in Bahrain. They found the prevalence of psychiatric morbidity, as measured by the GHQ, in their sample to be 45% (cut off of 5 or higher) and 27% (cut off score of 9 or higher).

All of these studies used the General Health Questionnaire-28. Thus, these research studies revealed that the participants in the previous cited GHQ studies had lower prevalence rates of psychological distress compared to this study of Emirati undergraduate students.

Anxiety. In the present study, anxiety symptoms were found to be very prevalent among the female undergraduate students. Of the 123 participants surveyed, 38 (31%) presented with significant problems in the anxiety subscale (using a cut off score of 5). Questions in this subscale included: lost much sleep over worry?, felt constantly under strain?, had difficulty in staying asleep once you are off? Similar to this study's findings, countless other studies from around the world have found anxiety symptoms to be the most prevailing and anxiety disorders to be among the most common mental disorders (World Health Organization, 1997). Studies have also indicated that women generally present with higher prevalence rates across anxiety disorders compared to men (Somers, Goldner, Waraich & Hui, 2006).

Views about counselling. In general, the Emirati undergraduate students in this study held favourable views on counselling. In fact, an overwhelming majority of students indicated they believe counselling is, and can be an effective way of helping people with their problems.

These findings from the Emirati students about their views on counselling are consistent with other UAE research related to perceptions of counsellors. For example, Brinson and Al-amri (2005) measured perceptions of the importance of counselling from 141 undergraduate post-secondary students in the UAE. In their study, the students perceived mental health counselling as an important occupation in the UAE society. Further, Al-Krewani, Graham, Dean, and Eltaiba (2004) reported that attitudes towards help-seeking behaviour among Arab women are positively influenced by educational attainment. Specifically, the more educated the person was, the more favourable their attitudes are towards mental health services. Further, in the United Arab Emirates, Al-

Darmaki (2003) discovered that students who are in their senior years at university tend to be more confident in receiving psychological help services and attach less stigma with accessing psychological help compared to students in their first or second year of university.

In this thesis, the sample of educated Emirati women revealed positive views towards counselling. This finding is consistent with previous research that indicates women in the UAE in general tend to have more favourable views towards counselling compared to UAE men (Al-Damarki, 2003) and that educational attainment is positively correlated with favourable views towards counselling within an UAE sample (Al-Krewani, Graham, Dean, & Eltaiba, 2004).

Despite the participants in this thesis indicating favourable attitudes towards counselling, the majority of participants indicated they had never spoken to their university counsellor (77%), nor have they talked to a counsellor outside of the university (87%). This lack of use of mental health services among UAE university students was also reported by Al-Darmaki (2003). Based on his preliminary observations of university students in the UAE, Al-Darmaki reported that most of the students who would benefit from counselling services never used these services. Thus, the UAE students in his study, much like the student participants in this thesis, support counselling yet do not identify a need to access the services of a counsellor.

Explanation of the Results

In an attempt to understand why the prevalence rates reported in this thesis were higher than in previous international studies that used the General Health Questionnaire-28, the effect of a variety of social and cultural stressors will be examined. First, the

reason for selecting the GHQ will be briefly reviewed. Second, the causative factors (i.e., insufficient resources, stressors influencing poor coping mechanisms, and the impact of globalization, e.g., conflicting values) will be thoroughly examined as potential contributors to the high incidence of mental illness reported by the UAE students in this study. Third, the issue of seeking help when experiencing a mental disorder will be explored within the students' social context. This discussion will include: (a) the stigma associated with having a mental illness, and (b) the role Islamic teachings play in seeking assistance for mental health problems.

The General Health Questionnaire-item 28 was chosen for this study because it is designed to identify non-psychotic psychological distress in communities. It was also selected because the GHQ has been translated into many different languages and the Arabic General Health Questionnaire (AGHQ) has been proven to be valid in the Arab culture, specifically in the United Arab Emirates (Ghubash, Daradkeh, El-Rufaie, & Abou-Saleh, 2001). In fact, Goldberg, et al. (1997) found that there was no tendency for the GHQ to work less efficiently in developing countries to determine prevalence rates of mental illness. Furthermore, gender, age, and educational level are shown to have no significant effect on the validity of the GHQ. Overall, the GHQ 28 has shown impressive versatility and acceptable psychometric properties and is a viable and ideal instrument for testing the mental wellness of this population in the UAE.

Fifty-one percent of the students in this convenience sample met the criteria of being in a state of psychological distress. As noted earlier, these rates seem high in comparison to some of the cited studies using the same measure. Therefore, it is appropriate to explore some of the factors that may be influencing the high prevalence of

mental health problems in this self-selected sample. The factors to be discussed include: (a) the lack of allocated mental health services in the region (insufficient resources), and (b) the stressors that influence poor coping mechanisms among this population group. The stressors that are discussed include the stress that occurs when attending post-secondary education and the stress that may arise with globalization (changes in values, beliefs, and role expectations that may in turn affect their psychological health). These factors are examined next.

Insufficient resources. The lack of mental health resources in this region may contribute to the high incidence of mental health problems found in this study. In 2007, the Arabian Business Bulletin stated that psychiatric care and the level of resources available for mental health were almost non-existent. In this bulletin, the author stated that the UAE is vastly under-served in psychology with a severe shortage of certified mental health practitioners (Arabian Business Bulletin, 2007). The literature indicates that mental health problems can be minimized by a combination of "well targeted treatment programs" (WHO, 2003). When resources are not readily accessible or available and when stigma and lack of awareness of mental health issues are present, individuals experiencing mild psychological distress may develop more serious problems. This may contribute to the prevalence of mental health difficulties.

Stressors influencing poor coping mechanisms. The high percentage of UAE students in this study presenting with symptoms of psychological distress may have been affected by a number of life stressors. These stressors may influence the individual's ability to cope, thus presenting increased symptoms of psychological distress. The two

main stressors that will be explored are the stress of being a university student and the effect of globalization on young women in the UAE.

Attending university. Attending post-secondary education is a stressful experience for most students. Stallman (2008) stated that university students have an overwhelming amount of pressure and stress, many students are presenting with psychological distress including depression and anxiety, and many are not seeking counselling. In addition to the academic demands placed on university students, they often face other stressors that contribute to the development of mental health problems. For example, in his study of Australian students, Stallman (2008) found that many more students experienced high levels of distress compared with the general population, and few of the students had sought treatment for their distress.

Other studies that indicated high level of stress among university students include one by the Royal College of Psychiatrists (2003), which reviewed the prevalence and causes of mental health problems in higher education in the UK. Based on an extensive literature review, the report concluded that there was a rise in university students presenting with symptoms of mental disorders. For instance, using the Hospital Anxiety and Depression Scale (HAD), Webb et al. (1996) found that 12% of males and 15% of female students presented with high levels of depression in their sample of 3000 students from 10 universities in the UK. They also reported 17% of males and 25% of female students had scores suggesting moderate to severe levels of anxiety. Likewise, studies conducted at universities in Kuwait (Soliman, 1993) and in the United States (Heppner, Kivlighan, Good, Roehlke, Hills, & Ashby, 1994) indicated that university students were

likely to experience psychological problems during their university years and may have benefited from professional counselling help.

University students aspire to choose a career and enter the workforce, which provokes stress. Entry into the workforce seems to be more complex for women than for men in Middle Eastern countries, given gender discrimination and stereotyping (Yaqub, 1998). Muslim women in the Middle East may have difficulty achieving their career goals because of religion and gender discrimination in the workplace and the community. This may be further complicated when their career choices do not align with their parents' views. Young Muslim women from the Middle East may face a disproportionate amount of pressure from the family, which is often related to the family worrying how their daughter's career aspirations will be perceived in the wider community (Yaqub, 1998).

In order understand why this study revealed higher rates of mental illness, research is needed to validate these assumptions. Suggestions for future research are elaborated upon later in this chapter.

Globalization. Another stressor that the students in this study may have been exposed to is globalization. Globalization is "the process in which the traditional boundaries separating individuals and societies gradually and increasingly recede" (Bhurga & Mastrogianni, 2004, p. 1). Due to development of the oil reserves in the United Arab Emirates, the country has undergone profound change. The oil industry has vastly increased the wealth of the region and this wealth has allowed for rapid modernization (Badrinath, Al-Shboul, Zoubeidi, Gargoum, Ghubash, & El-Rufaie, 2002). Consumerism linked with modernization tends to raise the expectations and aspirations of

individuals (Bhugra & Mastroginanni, 2004). This rapid social change often taxes individuals' coping mechanisms, their social response to distress and their help-seeking behaviour (Kirmayer, 2001). The following sections will speculate that this change experienced by Muslim women in the UAE could be stressful, leading to poor mental health.

Identify confusion. The rapid social change experienced by the citizens of United Arab Emirates has exposed Emirati women to an influx of Western influences. This exposure comes from a variety of sources (e.g., the internet, media, tourism, and the many foreign workers that live in the country) and introduces Emirati women to new ways of thinking and behaving. For example, Emiriti women attending university are exposed to the Western cultures emphasis on career aspirations. However their local community and their families may expect them to assume familial duties and obligations. Another example is in marriage, where traditionally their parents decide on who they should marry as compared to Western cultures where they are free to choose a partner. Traditional values also come in conflict with western cultures in the area of religion. Whereas the traditional culture values religious devotion, global cultures are secular and religious issues are ignored in favor of consumerism and leisure activities (Arnett, 2002). Relatedly, young Emirati women may experience conflict in values is in the Western emphasis on assertion of autonomy from parents as opposed to the fulfillment of responsibility to them.

As a result of adolescents and young adults being exposed to different cultures, creating one's own cultural identity has become more complex. For example, people may need to make choices between incorporating the beliefs and practices of their traditional

culture or choosing those of the other culture (Arnett, 2000). This decision process appears relevant for young Emirati women, who face the task of integrating diverse values, cultural beliefs and behaviours presented to them by multiple agents of socialization (e.g., media and internet) and where these socialization agents are often at odds with their original culture.

Arnett (2002) stated that globalization and the rapid social change that comes with it increase the proportion of young people in non-western countries who experience a state of identity confusion rather than successfully forming an identity. Growing up with a lack of cultural certainty, lack of clear guidelines as to how to live and how to behave lead to a sense of alienation. This may result in young adults believing they do not fit in any culture (Arnett, 2002). The task of forming a coherent cultural identity in a multicultural environment presents challenges that can be extremely stressful and difficult to overcome. Arnett (2002) indicated that identity confusion in young people may be reflected in problems such as depression, suicide and substance abuse.

Although most people successfully adapt to change, for others, it is more difficult. Berry (1997) stated that when there is a great discrepancy between the beliefs and behaviours of the cultures one is exposed to, the greater the psychological and social problems. This situation is true for the United Arab Emirates where there is a great difference in local values regarding religion, family responsibilities, community cohesion, authority of fathers and gender differences as compared to Western cultures which are mainly secular, value independence and autonomy, and believe in gender equality. Jensen (2003) indicated that there are also benefits from exposure to new cultures, but the factors that influences a positive or negative outcome are varied and

complex. He indicated that research needs to focus on the gains and losses that occur when a person forms a multicultural identity rather than an identity based on one's cultural tradition. Future research, such as the work by Barrell and McBride (2008) will encourage a deeper understanding of the role of globalization and how it impacts the formation of the development of a coherent cultural identity of young women residing in the UAE.

In summary, this section began by comparing the results from this thesis with other international samples. It was found that the prevalence rates of psychological distress among the sample of female undergraduate university students were higher than other samples that used the same measure. To help explain the high prevalence rate, social and cultural stressors were explored. The next section examines the effect of having a mental illness on help-seeking behaviour.

Impact of Having a Mental Illness on Help-seeking Behaviour

The women in this study indicated they approve of counselling. Yet, the majority reported they do not access counselling services. This section explores the barriers that may be present for Emirati women when they consider seeking treatment for psychological distress. The barriers to be discussed include the stigma against mental health, the role of traditional Islamic faith healings in mental health treatment.

Stigma of mental health. Mental illness is often misunderstood and portrayed negatively in communities and cultures across the world. Douki, Zineb, and Halbried (2007) described how, in Arab communities in the Middle East, mentally ill women appear to be more stigmatized, have less access to care and suffer from a worse social outcome than in other countries. Although stigma does not cause mental illness, its

presence may prevent Emirati women from accessing needed mental health services. In other words, stigma against mental illness forces people to remain silent about their mental illnesses. This often causes them to avoid seeking health treatment (Health Canada, 2002).

Perhaps Emeriti women are hesitant to seek treatment because the admission that they have a mental illness may have serious consequences for them. For example, it may limit marriage prospects or increase the possibility of divorce or separation. Concerns about stigmatization may result in seeking treatment by reporting somatic symptoms instead (Budman, Lipson, & Meleis, 1992; Fenta, Hyman, & Noh, 2004). Furthermore, a study conducted by Al-Darmaki (2003) in the United Arab Emirates suggested that the lack of access to psychological care, fear of talking about emotions or reluctance to self-disclose to a stranger, perception of mental health stigma, and fear of treatment, were realistic reasons people would avoid seeking help for psychological distress (Al-Darmaki, 2003).

The next barrier to explore is how religion may influence the type of treatment individuals seek. Religion is a particularly important topic because it often influences the understanding of mental illness and may influence the decisions a person makes regarding treatment.

Traditional Islamic teaching. The role of religion in Islamic societies appears to have consequences for young women dealing with symptoms of mental illness. Traditional Islamic teachings explain mental illness in a variety of ways. Al-Krenawi and Graham (1999) described how mental illness could be perceived as having a defective relationship with Allah, being a punishment from God or the imponderable result of

God's will (Al-Krenawi & Graham, 1999). If one believes mental illness is a punishment from God for some wrongdoing, then taking a passive attitude towards dealing with afflictions would make sense. Instead of seeking professional assistance for symptoms of mental illness, these guilt-ridden individuals may instead attempt to deal with the symptoms through prayer, consulting with their religious leaders or ignoring the symptoms (Al-Krenawi & Graham, 1999).

In summary, fifty-one percent of the female undergraduate students surveyed in this study presented with a high degree of psychological distress. An overwhelming majority of these participants (96%) believe counselling to be an effective means of assisting people with their problems in spite of never utilizing these services for themselves. The role of traditional Islamic teaching and the stigma attached to mental illness in the Arab World were discussed as possible motives to why counselling services are not being utilized. Follow-up research will be essential to further understand why some Emiratis do not seek counselling when experiencing psychological distress. Before additional areas of research are noted, the limitations of the study will be presented.

Limitations

This investigation has a number of limitations and the interpretation of the data reported in the discussion chapter should be made within the context of these limitations. The first is the survey in this thesis that has norms based on American and European definitions of psychopathology. This may not accurately reflect what is considered mental illness among the Arab population. Further, for the purpose of this thesis, the author is in no way attempting to render any kind of diagnosis of mental illness. The data obtained in this thesis was an attempt to measure psychological distress among a selected

group of female Emirati students. The subscale scores are intended to provide additional information of the specific areas of psychological distress experienced.

Finally, there is a paucity of research on the prevalence rates of mental health in the Arab region compared to the Western World. Few articles address the prevalence rate of mental illness among female Emiratis and none, to the author's knowledge, address the mental health of post-secondary female Emiratis. Therefore, it is unknown whether the prevalence rates reported in this thesis are typical for this population group.

The second limitation is that the additional survey questions were not piloted and may not accurately reflect the views and attitudes of Emirati women towards counselling services. The questions were in English (e.g., "Do you think counselling is an effective way of helping people with their problems?") and may have been misinterpreted by some participants. Some participants may have had difficulty communicating their responses in written English. Likewise, the author of this study may have misinterpreted the participants' responses.

The third limitation is the targeted sample for this study not being a representative sample of the general population. The self-selected sample was taken from a population of female university students aged approximately 17-26. The author acknowledges that this sample does not reflect the prevalence of mental illness in the general population of this region and does not reflect the situation of Emirati women in general.

Despite these limitations, this exploratory study was still a useful investment of time and effort. The study allowed the researcher to gain valuable skills in conducting research. Further, it is hoped the results of this study will provide a stepping-stone for further research and some insight into the mental health of Emirati women.

Suggestions for Future Research

This exploratory study is one of the very few that have been conducted to understand UAE women's views on counselling and discovering the frequency of self-reported mental illness. The results from this thesis provide preliminary findings to guide future research. Recommendations for future research include:

- Replicated studies with more Emiratis would enhance the validity of this preliminary study as well as establish the prevalence of mental illness among this population group;
- Studies of Emiratis with different socio-economic backgrounds.
- Additional research on the use of mental health services would be useful as well as the benefits of accessing mental health services; and
- Additional revelations concerning current views and attitudes towards counselling are recommended.

Each of these recommendations is elaborated upon below.

Further estimates of the prevalence of mental illness. The author of this study acknowledges that more research in this area needs to be completed in order to have a basic understanding of mental wellness in the UAE and among the specific targeted population group of this study. Studies are required that examine the prevalence of mental illness across different settings within the UAE (e.g., academic, career, and household) and population groups (e.g., adolescents, young adults, and older adults).

The need for additional systematic research is two-fold. First, research provides the information that determines the mental health needs of a specific group. Second, research provides awareness of mental health issues in this region at this time. This

awareness initiates the development and implementation of mental health resources and services.

Knowledge and the integration of cultural values. In developing mental health services and resources it is important to consider the social, psychological, and economic variables that affect emotional health in the region. Research needs to be based on the values and beliefs of the Arab culture so that it is relevant. It was challenging to find counselling materials that pertained to educating a Western counsellor unfamiliar with Islamic beliefs, customs, and traditions. Counsellors have an ethical obligation to develop culturally sensitive material and treatment practices, yet few of these resources exist. The literature reviewed in this thesis will be useful, but more voices from the Arab students need to be collected and analyzed so treatment and the development of counselling programs is as free of Western influence as possible.

Encouraging collaboration and communication between mental health professionals, researchers, and Muslim religious leaders may facilitate proper referrals and improve access to culturally appropriate mental health services. Religious leaders could play an important role in decreasing stigmatization and the misconceptions associated with mental illness in Muslim society. Further, incorporating Islamic beliefs and practices such as prayer, the importance of the Hadith and the Qur'an, and the communal emphasis in Muslim culture may facilitate therapy (Hamdan, 2007). In addition, religious leaders and health professionals from Emirati culture should be consulted in the design of future research studies in the UAE.

Utilization of mental health services and outcomes of accessing mental health resources. There is a paucity of literature related to the utilization of mental health

services among young female adults in Arab countries. Such studies are pertinent for improving mental health care and also for the implementation of intervention and prevention programs. A Study of interest may include the correlation between parental education and willingness to see a counsellor. Further, longitudinal studies assessing outcomes of mental health treatment would be of considerable value in understanding best practices for treating Emiratis with mental health problems. Specifically, studies that measure the psychological symptoms experienced prior to treatment and once again after treatment. This would determine if mental health treatment improved their overall functioning.

Awareness of mental health issues. Finally, additional research in understanding mental wellness and illness in the Emirati culture would allow for increased activism in mental health issues. Activism is essential because it increases awareness of mental health problems. At the first mental health conference in Dubai (2009), Khaled Ibrahim stated, "Mental health issues require more awareness because factors such as social pressure prevent people from coming forward with their problems and this leads to further deterioration in their condition" (Dubai Health Authority, 2009).

Personal Reflection of the Research Experience

My interest in the field of mental health started long before I began the process of writing this thesis. My initial interest came when I was working with children who were experiencing emotional, social and behavioural difficulties. I became aware that mental health did not involve chronic illness nor did being mentally ill always coincide with the overt presentation of physical symptoms. The more I learned about mental health, the more intrigued I was by the consequences of the disease and the way mental health is

intertwined with all aspects of one's life. In particular, in my experience as an educator, I have observed that many children who have difficulties learning are also at risk for developing mental health problems. Therefore I have become aware of how important early intervention and prevention programs are in terms of preventing the development of problems in these children.

Another reason I was interested in this topic was the fact that the population I was studying was both similar to myself, yet very different. The young women in my study were of similar age, they were attending university, and were facing decisions about career choice, marriage and family. Although many experiences were the same, the women in the study faced these challenges in a different cultural context from my own.

Besides the above interests, I was also extremely fortunate to gain an understanding of Arab culture through this thesis. I have learned a great deal about belief, customs, religion, and traditions that I had not previously known. This knowledge has given me a much broader perspective on the complexity of mental health issues and challenged me in viewing mental health and wellness in a different way.

Reflecting on this journey, I have to admit it was more challenging than I expected. Throughout the project, I have found myself preoccupied with other academic interests and exploring other career paths. At times, it was difficult to understand or rationalize this endeavour without fully understanding other areas of my life. The outcomes of this project led to so many questions that the more I revealed, the more questions I had and the more answers I needed. The process has allowed me to rediscover other areas of interest, and renew the passion I once had in assisting individuals with mental health problems.

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Appendix A: General Health Questionnaire (English Version)

THE GENERAL HEALTH QUESTIONNAIRE
(GHQ-28)
David Goldberg

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, *over the past few weeks.* Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently

Al	**been feeling perfectly well and in good health?**	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2	**been feeling in need of a good tonic?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A3	**been feeling run down and out of sorts?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A4	**felt that you are ill?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A5	**been getting any pains in your head?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A6	**been getting a feeling of tightness or pressure in your head?**	Not at all	No more than usual	Rather more than usual	Much more than usual
A7	**been having hot or cold spells?**	Not at all	No more than usual	Rather more than usual	Much more than usual

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B1	**lost much sleep over worry?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B2	**had dIfficulty in staying asleep once you are off?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B3	**felt constantly under strain?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B4	**been getting edgy and bad-tempered?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B5	**been getting scared or panicky for no good reason?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B6	**found everything getting on top of you?**	Not at all	No more than usual	Rather more than usual	Much more than usual
B7	**been feeling nervous and strung-up All the time?**	Not at all	No more than usual	Rather more than usual	Much more than usual

Have you recently

C1	**been managing to keep yourself busy and occupied?**	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2	**been taking longer over the things you do?**	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3	**felt on the whole you were doing things well?**	Better than usual	About the same	Less well than usual	Much less well
C4	**been satisfied with the way you've carried out your task?**	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5	**felt that you are playing a useful part in things?**	More so than usual	Same as usual	Less useful than usual	Much less useful
C6	**felt capable of making decisions about things?**	More so than usual	Same as usual	Less so thanusual	Much less capable
C7	**been able to enjoy your normal day-to-day activities?**	More so than usual	Same as usual	Less so than usual	Much less than usual
D1	**been thinking of yourself as a worthless person?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D2	**felt that life is entirely hopeless?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D3	**felt that life isn't worth living?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D4	**thought of the possibility that you might make away with yourself?**	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5	**found at times you couldn't do anything because your nerves were too bad?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D6	**found yourself wishing you were dead and away from it all?**	Not at all	No more than usual	Rather more than usual	Much more than usual
D7	**found that the idea of taking your own life kept coming into your mind?**	Definitely not	I don't think so	Has crossed my mind	Definitely has

A	B	C	D	Total

Appendix B: General Health Questionnaire (Arabic Version)

استبيان الصحة العامة

GHQ-28

المرجو قراءة هذا الاستبيان بدقة

نريد التعرف هل سبق لك أن تعرضت لحالة غير جيدة وكذلك التعرف على حالتك الصحية ***خلال الأسابيع القليلة الماضية***. المرجو منك أن تجيب على **جميع** الأسئلة وذلك من خلال وضع خط تحت الإجابة التي تعبر على احساساتك خلال الأسبوع الماضي. تذكّر بأننا نريد التعرف على شكاواك الحالية والحديثة وليس التي تعرضت لها في الماضي. يجب الإجابة على **جميع** الأسئلة.

نشكرك على مساهمتك.

أ1	هل شعرت مؤخرا بأنك معافى وبصحة جيدة؟	أحسن من المعتاد	كالمعتاد	أقل من المعتاد	أقل بكثير جدا من المعتاد
أ2	هل أحسست مؤخرا بأنك في حاجة لبعض المنشطات؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
أ3	هل شعرت مؤخرا بأنك منهكا و ليس بحالة جيدة؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
أ4	هل أحسست مؤخرا بأنك مريض؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
أ5	هل شعرت مؤخرا بصداع في الرأس؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
أ6	هل شعرت مؤخرا بالضيق أو بالضغط في الرأس؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
أ7	هل تعرضت مؤخرا لفترات باردة أو حارة؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد

ب1	هل أصبح نومك قليلا نتيجة القلق؟	لا لم يحدث ذلك	ليس بأكثر من المعتاد	أكثر من المعتاد	صار نومي أقل بكثير من المعتاد
ب2	هل أحسست مؤخرا بأن لديك مشكل في	لا أبدا من المعتاد	ليس بأكثر المعتاد	أكثر من المعتاد	أكثر بكثير البقاء نائما؟

ب3 هل شعرت مؤخرا تحت توترات متواصلة؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
ب4 هل أصبحت مؤخرا سريع الغضب و سيئ المزاج؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
ب5 هل عانيت مؤخرا من الخوف والهلع بدون أسباب معقولة؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
ب6 هل وجدت مؤخرا بأن كل شيء يصير عبئا ثقيلا عليك؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
ب7 هل شعرت مؤخرا بالتوتر والعصبية في كل الأوقات؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد

اقلب الورقة من فضلك

ت1 هل حاولت مؤخرا أن تشغل وقتك وتملأ فراغك؟	أكثر من المعتاد	كالمعتاد	أقل من المعتاد	أقل بكثير جدا من المعتاد
ت2 هل استغرقت مؤخرا وقتا طويلا بخصوص الأعمال التي كنت تقوم بها؟	أسرع من المعتاد	كالمعتاد	أطول من المعتاد	أطول بكثير من المعتاد
ت3 هل أحسست مؤخرا بأنك عموما تؤدي أعمالك بصورة حسنة؟	أحسن من المعتاد	كالمعتاد	أقل من المعتاد	أقل بكثير جدا من المعتاد
ت4 مؤخرا هل كنت راضيا على الطريقة التي أديت بها أعمالك؟	أحسن من المعتاد	كالمعتاد	أقل من المعتاد	أقل بكثير جدا من المعتاد
ت5 هل أحسست مؤخرا بأن لك دورا مفيدا في الأمور حولك؟	أكثر من المعتاد	كالمعتاد	أقل من المعتاد	أقل بكثير جدا التي تجري من المعتاد
ت6 هل أحسست مؤخرا بأنك قادر على اتخاذ القرارات؟	أكثر من المعتاد	كالمعتاد	أقل من المعتاد	أقل بكثير جدا من المعتاد
ت7 هل كنت قادرا على الاستمتاع بأنشطتك اليومية؟	أكثر من المعتاد	كالمعتاد	أقل من المعتاد	أقل بكثير جدا من المعتاد

ث1 هل أحسست مؤخرا بأنك شخص لا قيمة له؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
ث2 هل شعرت مؤخرا بأنه لا أمل في الحياة بتاتا؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
ث3 هل شعرت مؤخرا بأن الحياة لا تستحق العيش؟	لا أبدا	ليس بأكثر من المعتاد	أكثر من المعتاد	أكثر بكثير من المعتاد
ث4 هل فكرت مؤخرا بإمكانية التخلص من نفسك؟	لا قطعا	لا أعتقد ذلك	لقد راودتني الفكرة	بالتأكيد
ث5 هل كنت مؤخرا في بعض الأوقات لا تستطيع عمل	لا أبدا	ليس بأكثر	أكثر من	أكثر بكثير

أي شيء نتيجة أعصابك المتوترة؟		من المعتاد	المعتاد	من المعتاد
ث6 هل راودتك مؤخرا أمنية الموت والتخلص كليا؟	لا أبدا من المعتاد	ليس بأكثر المعتاد	أكثر من من المعتاد	أكثر بكثير من هذه الحياة
ث7 هل اعتقدت مؤخرا بأن فكرة الانتحار قد راودتك مرات عديدة؟	لا قطعا	لا أعتقد ذلك	لقد راودتني الفكرة	بالتأكيد

أ ☐ ☐ ☐ ☐ ☐ نوع:

Appendix C: Consent Form

Hello.

I am a graduate student in counselling psychology from Canada at the University of Lethbridge. I am excited to write to you today. I have heard many wonderful things about your beautiful country from Dr. Dawn McBride, a former psychology professor at Zayed University. She is now my supervisor for this study.

This email is to invite you to participate in my student research! It is an online survey that will take about 10 minutes of your time. Before I tell you more, you must know that I will never ask your name. I do not need to know who you are – ever! Also, no one will know if you did or did not participate in the survey.

The topic of the survey is WELLNESS in post secondary students. The survey consists of 28 questions on mental wellness. Once you have completed the survey, you will be able to access your mental wellness score.

If you would like to participate or know more about the study, please click on this WEBLINK and it will take you to the consent form and the survey.

University of Lethbridge
Faculty of Education

PARTICIPANT (ADULT) CONSENT FORM

TITLE OF STUDY:
MENTAL WELLNESS IN POST SECONDARY STUDENTS IN AN ARAB CULTURE.

Hi. Thank you for coming to this webpage that will tell you about my survey.

WHO IS THE SURVEY FOR? This survey is only open to students at Zayed University.

WHAT IS THE SURVEY ABOUT? Mental health wellness in female post secondary Nationals.

WHY IS THIS IMPORTANT? This research will be a starting point to understanding the rate and type of mental health problems in university students. The information collected may be useful to those who believe that counselling services are important for UAE post secondary students.

WHAT ARE THE BENEFITS? Knowledge about yourself!! You will be able to access your mental wellness scores from the survey.

DO I HAVE TO SHARE MY NAME? NO! You will never be asked to reveal your name or anything about your family. Never. The information from the survey will be coded numerically.

WHAT WILL I HAVE TO DO? Complete an online survey on mental wellness. The online survey will take approximately 10 minutes to complete.

CAN I STOP THE SURVEY? You can stop the survey at anytime without explanation. However, once you have submitted the survey (clicked on the SUBMIT button) it would be impossible to locate and remove your data. Remember that your name is NEVER required.

WHO IS CONDUCTING THE STUDY? Megan Smith. I am a graduate student in the counselling psychology program in the Faculty of Education at the University of Lethbridge.

DO I KNOW THE RESEARCHERS? The supervisor of this project is Dawn McBride and you may have a relationship with her. To avoid this potential relationship from influencing your decision to participate we have distributed the survey via email and you will NEVER be asked to give your name.

Dr. Dawn will NEVER know if you participated or if you did not participate in the survey.

WHAT WILL HAPPEN TO THE RESULTS FROM THE SURVEY? The results from the survey will be used in a thesis. The results of this research may also be used in comparison for future studies and may be published or used for conference purposes. Again, we do NOT need your name.

ARE THERE RISKS TO PARTICIPATING? Some of the questions may provoke some discomforts to you. You can contact the University Counsellor (suhair.awadalla@zu.ac.ae) or your faculty advisor, or by e-mail (mrazek@uleth.ca).

WHO ELSE CAN I TALK TO ABOUT THE STUDY? In addition to being able to contact the researcher and supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Chair of the Faculty of Education Human Subjects Research Committee at the University of Lethbridge (dial as is: 011-403-329-2425).

WHAT NOW? If you agree to the conditions above- you can click on the CONTINUE button to link to the web-page. All answers to the questions will be either in the form of clicking an option (left mouse button) or typing in information. Completing the questionnaire should take you about 10 minutes. Make sure you reply to all questions before submitting the questionnaire.

I PROMISE: The on-line questionnaire does not contain any questions to identify you as a respondent. There is NO hidden information being collected about remote computer name, browser type, or user identification.

REMEMBER: Your linking to the survey will mean that you have agreed to participate in this study. You can also discontinue your participation at any time.

HOW DO I CONTACT YOU? You may contact me if you have further questions by telephone 011- 306- 692-5651 (DIAL AS IS) or by email: megan.smith6@uleth.ca. This study is being conducted under the supervision of Dawn McBride. You may contact my supervisor at 011-403- 317-2877 (DIAL AS IS) or by email dawn.mcbride@uleth.ca.

Go to the survey link here:

Appendix D: Views and Attitudes Survey

1. How old were you on January 1, 2007? (*Mark one box*)

☐ 17	☐ 21
☐ 18	☐ 22
☐ 19	☐ 23
☐ 20	☐ 24-26

2. What is your marital status? (*Mark one box*)

☐ Single	☐ Married
☐ Engaged	☐ Divorced
☐ Widowed	

3. What level or year of your program are you in?

☐ first year	☐ third year
☐ second year	☐ fourth year

4. What is the highest educational level completed by your parents? (*mark one box in each column*)

	Mother	Father
Less than high school diploma	☐	☐
High school diploma	☐	☐
Certificate, Diploma, Higher Diploma	☐	☐
Bachelor's Degree	☐	☐
Master's Degree	☐	☐
Medical or Dental Degree	☐	☐
Law Degree	☐	☐
Doctorate (Ph.D or Ed.D.)	☐	☐
Other (specify)		

5. Where do you live? (*please select one answer*)

☐ Abu Dhabi	☐ Dubai
☐ Sharjah	☐ Baniyas
☐ Ras Al Khaima	☐ Al Shahama
☐ Ajman	☐ Al Fugiera
☐ Umm Al Qwain	☐ Other

6. Do you plan on working full time with pay after graduating?

☐ Yes	☐ No

7. Ideally, what career would you like to have?

A counsellor can be defined as a professionally trained person that talks with people and their families about emotional or physical needs, and finds them support services.

8. Have you ever talked to the ZU counsellor in her office?

☐ Yes ☐ No

9. Have you ever talked to a counsellor who did not work for ZU?

☐ Yes ☐ No

10. List 5 reasons why you or anyone might see a counsellor?

11. Would you be more willing to attend counselling if a friend came with you?

☐ Yes ☐ No

12. Do you think counselling should be free (no cost)?

☐ Yes ☐ No

13. Do you think counselling is an effective way of helping people with their problems?

☐ Yes ☐ No

Why or why not?

14. Do you think this survey is a good way to find out how your mentally wellness is?

- ☐ not at all
- ☐ Somewhat
- ☐ Yes for the most part
- ☐ Yes, Definitely

Explain.

15. How well do you think this survey did in measuring:

if you are depressed?
- ☐ Poor
- ☐ Okay
- ☐ Good
- ☐ Excellent

If you have physical complaints?
- ☐ Poor
- ☐ Okay
- ☐ Good
- ☐ Excellent

if you are anxious?
- ☐ Poor
- ☐ Okay
- ☐ Good
- ☐ Excellent

16. Did you have any problems understanding the questions in the General Health Questionnaire?

- ☐ Yes, I had a lot of problems understanding (more than 7 questions)
- ☐ Some trouble understanding (4-7 questions)
- ☐ A little trouble understanding (2-3 questions)
- ☐ No, I did not have trouble understanding (1 or no questions)

Appendix E: Ethics Approval

The University of Lethbridge

MEMORANDUM

TO: Megan Smith
FROM: Rick Mrazek
Date: November 1, 2007

RE: Human Subject Research Application:
"Mental Wellness in United Arab Emirates Post Secondary Students"

The Faculty of Education Human Subject Committee has **approved** your HSR application. However, the committee has identified a number of grammatical corrections, typographical corrections, and additions which should be made to your letter of introduction, consent form, and English on-line survey form prior to the administration of the survey instrument. Please refer to the attached document regarding specific details of the required corrections and additions. This approval adheres to the tri-university council guidelines, published on the website www.nserc.ca/programs/ethics/english/index.htm.

Good luck with your research.

per

Rick Mrazek, Ph.D.
Chair Human Subject Committee
Faculty of Education

Cc: Graduate Studies
Dawn McBride
Doug Orr

Attachment