

INVESTIGATING INTENTIONS TO SEEK PSYCHOLOGICAL HELP FROM
PROFESSIONALS IN KÖKLÜK VILLAGE, ORDU: A MIXED METHOD
STUDY

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SEMANUR GÜNEŞ ÇAKMAK

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METHOD STUDY**

submitted by **SEMANUR GÜNEŞ ÇAKMAK** in partial fulfillment of the requirements for the degree of **Master of Science in Psychology, the Graduate School of Social Sciences of Middle East Technical University** by,

Prof. Dr. Yaşar KONDAKÇI
Dean
Graduate School of Social Sciences

Prof. Dr.Sibel KAZAK BERUMENT
Head of Department
Psychology

Assoc. Prof. Dr.Deniz CANEL ÇINARBAŞ
Supervisor
Psychology

Examining Committee Members:

Prof. Dr.Özlem BOZO ÖZEN(Head of the Examining Committee)
Middle East Technical University
Psychology

Assoc. Prof. Dr.Deniz CANEL ÇINARBAŞ(Supervisor)
Middle East Technical University
Psychology

Assist. Prof. Dr.Yağmur AR KARCI
TED University
Psychology

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last Name: SEMANUR GÜNEŞ ÇAKMAK

Signature:

ABSTRACT

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GÜNEŞ ÇAKMAK, Semanur

M.S.,The Department of Psychology

Supervisor: Assoc. Prof. Dr. Deniz CANEL ÇINARBAŞ

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The purpose of the current thesis was to investigate whether having psychological problems, attitude, stigma towards seeking psychological help and demographic variables predict intention to seek professional psychological help. A mixed-method design was employed to achieve this aim, and a quantitative and qualitative studies were performed, respectively. In the quantitative study, data were collected from 117 citizens of Köklük village, Ordu. Multiple linear regression and mediation analysis were used to understand the relationship between the variables of the study. The results showed that attitude toward seeking psychological help and the age of the participants significantly predicted the intention to seek professional psychological help. According to results of the mediation analysis, only stigma significantly mediated the relationship between having psychological problems and intention to seek psychological help. In the qualitative study, semi-structured interviews were conducted with 10 participants who had relatively higher mental health problems yet lower intention to seek psychological help scores in the quantitative study. Obtained data was analyzed by using thematic analysis. In total, 3 super-ordinate themes emerged which

were psychological problems, psychological help, and coping strategies. Findings obtained from two studies were discussed in line with the relevant literature.

Keywords: Psychological Help, Intention, Stigma, Attitude

ÖZ

ORDU İLİNİN KÖKLÜK MAHALLESİNDE PROFESYONEL PSİKOLOJİK YARDIM ALMA NİYETİNİN İNCELENMESİ: BİR KARMA YÖNTEM ARAŞTIRMASI

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Bu tezin amacı, psikolojik sorunlara sahip olmanın, psikolojik yardım aramaya yönelik tutumun, damgalamanın ve demografik değişkenlerin profesyonel psikolojik yardım arama niyetini yordayıp yordamadığını incelemektir. Bu amaca ulaşmak için karma yöntem tasarımı kullanılmış ve sırasıyla nicel ve nitel çalışma yapılmıştır. Nitel çalışmada Ordu'nun Köklük Köyünde yaşayan 117 kişiden veri toplanmıştır. Araştırmanın değişkenleri arasındaki ilişkiyi anlamak için çoklu doğrusal regresyon ve aracı değişken analizleri yapılmıştır. Sonuçlar psikolojik yardım almaya karşı tutumun ve yaşın profesyonel psikolojik yardım alma niyetini anlamlı şekilde yordadığını göstermiştir. Aracı değişken analizleri sonucunda ise sosyal damgalamanın psikolojik probleme sahip olma ile psikolojik yardım arama niyeti arasındaki ilişkiye aracılık ettiği görülmüştür. Nitel kısımda, ilk çalışmaya katılan 117 katılımcı içinde görece daha yüksek psikolojik probleme sahip olan ancak psikolojik yardım arama niyeti düşük olan 10 katılımcı ile yarı yapılandırılmış görüşmeler yapılmıştır. Elde edilen veriler tematik analiz kullanılarak analiz edilmiştir. Toplamda, psikolojik sorunlar, psikolojik yardım ve başa çıkma stratejileri olmak üzere 3 ana tema ortaya

çıkmiştir. İki çalışmadan elde edilen bulgular, ilgili literatür doğrultusunda tartışılmıştır.

Anahtar Kelimeler: Psikolojik Yardım, Niyet, Damgalama, Tutum

To Freedom and Love

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CHAPTER 1

INTRODUCTION

Mental illness is a health condition that brings along difficulties in maintaining daily life as well as changes in the individual's thoughts, feelings and behaviors. DSM-5 (American Psychiatric Association, 2013) gives a broader definition:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual as described above (p.20).

The number of people with mental problems constitutes a significant proportion in the society. According to American Psychiatric Association, 19 % of the U.S. adults have a mental disorder, 4.1 % have a serious mental disorder, and 8.5 % experience a substance use disorder (APA, 2013). There is no recent study about the mental health profile of Turkish society. However, in 2019, with the cooperation of Ministry of Health, General Directorate of Health Services and Hacettepe University announced that they started preparatory studies of "Mental Health Profile of Turkey-2 Survey, but they did not provide information about when the study will be completed. According to Mental Health Profile of Turkey, one of the biggest epidemiological studies conducted in Turkey, the prevalence of mental disorders in the population over the age of 18 is 17.2 %. Yet, the rate of people who sought treatment was 4.7% (Erol et al., 1998). According to the results of another study conducted in 2004, revealed that the percentage of the people who required mental health care but did not seek

professional treatment was estimated to be 60 % in Turkey (Kohn et al., 2004). These rates show that there is a gap between the number of people who have psychological problems and who seek psychological treatments. This gap reveals that there may be some underlying mechanisms in terms of decision making processes in help seeking behavior. In addition, there should be some obstacles that affect the behavior of seeking help. These barriers include normalization of the condition, failure to notice the problem, fear of stigmatization (Winter et al., 2016), mistrust toward professionals (Corry & Leavey, 2017), negative thoughts, and limited knowledge about treatment (Sun et al., 2016). In a comprehensive study which was conducted with 3500 people to identify barriers to psychological help in Pakistan; lack of faith in psychological treatment, prior personal experience, religious fatalism, not paying attention to mental disorders, social defame, personal shame, bad reputation of mental health practitioners, prohibition by family, and fear of treatment were found to be obstacles that prevent psychological help seeking (Husain, 2020). On the other hand, it is important to eliminate the gap between prevalence of mental illness and help seeking tendency because untreated mental health problems may have serious consequences. According to the World Health Organization's Mental Health Action Plan 2013-2020, people who have mental disorders are subject to higher proportions of mortality and disability. People with major depression and schizophrenia have a 40% to 60% increased risk of premature death compared to the general population (WHO, 2013, p.7). Therefore, it is extremely important to understand the factors that prevent people from seeking help for mental illnesses.

The aim of the current thesis was to investigate factors related to the intention of seeking psychological help. The effects of attitudes and stigma toward seeking psychological help, having psychological problems, age, gender, education level, and previous psychological help history on the intention to seek psychological help were examined.

1.1. Help Seeking Intention and Behavior

When people encounter problems that they cannot overcome, they may seek professional and non professional resources and supports in order to get rid of those problems. This behavior is called help seeking (Arslantaş et al., 2011). Studies about this topic mainly focused on predictors of help seeking, such as, intention, attitude and stigma toward mental health problems. In addition, problems and situations in which people need help and these people's preferences in terms of help seeking from professionals have been frequently studied. The intention to seek psychological help is defined as the individual's request for seeking help from a mental health professional regarding various psychological problems. People who experience relational, traumatic, affective and behavioral problems may need psychological help and support (Topkaya, 2012).

Looking at help seeking through the framework of behavior models will facilitate understanding this behavior. Many models have been developed to explain human behaviors and behavior change (Morris et al., 2012). Among these models, frequently used ones were Health Belief Model, Transtheoretical Model and Theory of Planned Behavior.

According to Health Belief Model (HBM) (Rosenstock, 1966), illness threat and treatment expectations affect the health-related behaviors. Perceptions about risk of contracting an illness (perceived susceptibility) and severity of illness (perceived severity) constitute illness threat part in this model. The second part, which is treatment expectations, contains perceived benefits and barriers in terms of seeking and receiving treatment and cues to action that affect actual behavior change (Morris et al., 2012). In order to take an action in health related conditions, one must feel at risk, think that the possible consequences of the present condition or behavior are serious, and believe that changing the behavior will prevent or reduce these negative consequences and harm. Moreover, the cost of this behavioral change must be acceptable, and barriers that may hinder

behaviors must be overcome. Self efficacy, which was later added to the model, affects the individual's determination to demonstrate and maintain new behavior. Some triggers may be needed to ensure that actual behavior is demonstrated. These triggers can be related to the person themselves, and may be internal or externally sourced. The type and effect of these triggers may vary depending on the perceived severity of the illness and susceptibility or vulnerability of the individual. For example, if a person thinks that the problem is not serious and he or she is not at risk, this person needs stronger triggers to change his or her behavior to become healthier. If a person feels at risk and takes the problem more seriously, then there is no need for strong triggers to demonstrate new behavior (Nispet & Gick, 2008).

Based on this model, it can be said that in order for a person to seek psychological help, the person should see himself or herself at risk against this psychological problem. Also, the person should think that the problems will disappear or harm will decrease with psychological treatment and that he or will face serious consequences without any help. Furthermore, one should have the power to receive psychological help and there should be no obstacles to get this help. If there are any obstacles, the person should believe that they can be eliminated. The belief that the person can maintain the new situation after receiving psychological help will also affect the process of getting help. In addition, if the person does not think that the treatment will work, he or she will not want to receive this treatment. This shows that the expectations about the treatment will affect receiving psychological help.

One of the studies that was conducted with student-athletes who had receive psychological help supported the Health Belief Model. Participants of this study stated that when they encountered a problem affecting their daily lives, they realized the benefits of getting help from a professional who has knowledge and experience in the field and the coping strategies taught by the professional. Although there were barriers such as beliefs about needlessness of psychological help and uncertainty about forming a relationship with a mental health

professional, realization of necessity of help and the support of the athletic trainer in terms of help seeking facilitated this process (Bird et al., 2020). In another study conducted with 243 participants in Australia, Langley and colleagues (2018) investigated whether the Health Belief Model explained psychological help seeking behavior in anxiety disorders. The variables of the model explained 51% of the variance in intention to seek psychological help. The strongest predictor of the intention to seek psychological help was perceived benefits. The most prominent barriers were participants thinking that they could not afford psychological help and that they had to solve problems themselves rather than explaining their psychological problems to a professional helper (Langley et al., 2018). In addition, O'Connor et al. (2014) conducted a study with 180 volunteers aged between 17 and 25 and found that help-seeking behavior was predicted by personality trait of extraversion, perceived benefits, perceived barriers, and social support. Moreover, perceived benefits were stronger predictors than barriers in terms of help seeking process.

Transtheoretical Model (TTM) (Prochaska, 1979), which is also known as Stages of Change Model, is another model that explained health-related behavior change. It was named Transtheoretical, because the model took into account many theories and models related to behavior change and psychotherapy. This model, which was originally created for smoking cessation, has been applied to many areas especially in the treatment of addiction. According to this model, behavioral change is a continuous process consisting of six stages rather than a single event. These stages are pre-contemplation, contemplation, preparation, action, maintenance and termination. At the pre-contemplation stage, which is pre-contemplation stage, the person is not aware that there is a problem and has no desire to change the problematic behavior. In contemplation stage, awareness of the problem starts and the person starts to think seriously about behavior change. In the third stage, the person has an intention to take an action. In the fourth stage, the person changes his behavior, experiences or environment in order to cope with the problem. In the fifth stage, the person works to prevent relapses and to reinforce the achievements. At the last stage, the person has

changed his or her behavior one hundred percent and never returns to the old unhealthy behavior (Procaska et al., 2015, p.98). However, this model has been criticized for ignoring the environmental, economic, and cultural factors that have the potential to affect a person's behavioral change (Morris et al., 2012).

In addition to these stages, this model involves ten processes in the progress of these stages. Consciousness raising, dramatic relief, and environmental reevaluation are seen in the transition from the first to the second stage. As the person's knowledge about the problem increases, he or she begins to experience and show feelings about the problem and solutions, evaluates the possible impact of these problems on the environment. Self-reevaluation can be seen between contemplation and preparation stage. This process involves realization and assessment of the importance of the behavior change in terms of the person's feelings, thoughts and identity. Self-liberation is the fifth process and can be seen in transition from preparation to action stage and involves person's beliefs about the ability to change and commitment to act. Counter conditioning, stimulus control, reinforcement management, and helping relationship are situated in between action and maintenance stages. In these processes, the person replaces problem behavior with alternatives, avoids stimuli that will cause the problem behavior, forms a rewarding system for the desired behavior and establishes healthy relationships with trust, acceptance, openness and social support. Social liberation process, which is located between the last two steps, means developing other alternative behaviors that are accepted and can be applied in the society in which the person lives (Procaska et al., 2015, p.98). Treating problematic behaviors using TTM can provide a more holistic and scientific perspective, combining theory and practice. The process of change is based on both theoretical principles and experimental studies. TTM also adopted an integrative position toward counseling and psychotherapy (Petrocelli, 2002).

TTM can also be applied to psychological help-seeking behavior. In the first stage, the person does not think that he or she has a problem and does not seek help. In the second stage, the person realizes the psychological problem and

starts to think about what to do to eliminate this problem. In the third step, the person is ready to receive psychological help. In the action stage, the person receives psychological help and tries to show behaviors that will solve the problem according to the psychological help. In the fifth step, the person tries to maintain the gains from the psychological help and to prevent relapses. In the last step, the person does not return to his or her unhealthy behavior. The person is aware of the benefits of psychological help and knows that if there is a problem again, he or she should get psychological help.

A study, which was conducted with hospitalized coronary heart disease (CHD) patients in China, showed the use of Transtheoretical Model in psychological help (Li et al., 2020). The possible effect of a TTM-based intervention to cope with depression was investigated, because depression is a major risk factor for patients with CHD. Participants were divided into two groups. While the treatment of CHD as applied to the control group, the intervention group received a 3-session intervention based on the transtheoretical model in addition to the normal treatment. TTM was found to have positive effects. There was an increase in the level of knowledge, healthy behavior, and perceived benefits of and decrease in perceived barriers in the intervention group compared to those in the control group. In another study which was conducted with 136 people who gamble regularly, the help seeking behaviors were examined using the constructs and perspective of TTM. Participants were interviewed at the 6th and 12th months after the first interview. In these interviews, the participants were asked whether they received any help during this time and the researchers assessed whether TTM constructs predicted the behavior of receiving help. It was found that perceived severity of the problem, social liberation, helping relationship, and counter conditioning processes of change predicted the behavior of getting help in these participants (Kowatch & Hodgins, 2015).

The last and most frequently cited model in behavior studies is Theory of Planned Behavior (TPB), previously known as Theory of Reasoned Action (TRA). TPB is an improved version of TRA. According to TPB, motivational

factors are important in shaping behavior and the strongest predictor of behavior is the intention for that behavior. The constructs of attitude, social norms, perceived behavioral control (perception of barriers), and the intention to understand and predict behavior form the basis of the model (Ajzen & Madden, 1986). According to TPB, intention is one of the main predictors of behavior and the readiness of a person to achieve that behavior. Intention has three main indicators. Attitude toward a behavior is the first indicator, which includes a person's evaluation and opinion about that behavior. The second indicator is the subjective norm, which is related to perceived social pressure about the performance of that behavior. The last predictor of the intention is behavioral control, which includes perceived facilitators of and obstacles against performing the behavior (Ajzen, 1991). TPB has been frequently used in behavioral research, especially in studies regarding psychological help seeking (Mak & Davis, 2014; Smith et al., 2008; Topkaya, 2012) and was also the focus of the present study.

According to the TPB, a person's attitudes toward a behavior, such as seeking mental health services, subjective beliefs about what others think about this behavior, and the degree to which there are perceived barriers all influence the person's intention to seek mental health services. For this reason, examining the intention to seek psychological help is important in terms of affecting the process of getting psychological help. If an individual has positive attitudes toward getting psychological help, this person will intend to seek psychological help more so than a person who has negative attitudes. If the person does not worry that he or she will be subjected to negative reactions or labeling in the community due to getting psychological help, this person may also have a high intention to get help. Finally, if the person thinks that he or she has sufficient funds to get and sustain the psychological help, and if the person's perceived control in this matter is high, the probability of getting help may be higher for this person (Morris et al., 2012).

Findings supported TPB's position regarding psychological help seeking behavior and researchers generally showed positive effects of attitudes on the intention to seek psychological help (Bohon et al., 2016; Hess & Tracey, 2013; Lin et al., 2017; Mesidor & Sly, 2014; Smith et al., 2008). Zorilla and colleagues (2019), for instance, conducted a study with 430 people between the ages of 18 and 24 living in California and examined the predictors of intention to seek psychological help using TPB. One third of the participants were found to show symptoms of depression, and two thirds of them had a family member or friends with depression. Perceived behavioral control, perceived barriers, mental health literacy, positive subjective norms variables, especially attitudes toward seeking psychological help were predictors of the intention to seek psychological help (Zorilla et al., 2019). The same results were obtained in a similar and older study by Mo and Mak (2009). This study was conducted with Chinese people and the researchers found that constructs of the TPB predicted the intention to seek psychological help and subjective norm was correlated with attitudes and perceived control in the process of seeking psychological help. In another study, Mak and Davis examined the effect of subjective norm and proposed a new model that emphasized the subjective norm component of traditional TPB (Mak & Davis, 2014).

In summary, human behavior is a complex process that includes many steps and dimensions. Psychological help seeking behavior is also a complex behavior with many components. Many models have been developed in order to explain human behavior and behavior change. The most widely researched and applied models are Health Belief Model, Transtheoretical Model, and Theory of Planned Behavior. There are several studies where psychological help seeking behavior is investigated in the context of these models.

The subject of the present study was to understand the mechanisms underlying psychological help seeking behavior. Studies in this area mostly focused on intention not behavior, and the only theory that associated behavioral intention and behavior was TPB. TPB was also used in studies on intention to seek

psychological help frequently. For this reason, the present study focused on intention to seek help and concepts of TPB, such as attitude, intention, and subjective norm played a guiding role in the development phase of this study. However, the Theory of Planned Behavior was not tested, only some of its variables were used in this study.

1.2. Attitudes toward Seeking Psychological Help

Studies on behavioral intention and psychological help have frequently emphasized effects of attitudes on behavior. Before examining attitudes toward seeking psychological help, it would be appropriate to draw a general framework about attitudes. The concept of attitude, which is frequently encountered in the social psychology literature, has been defined many times since the 1800's (Sakallı-Uğurlu, 2018). One of the oldest definitions of attitude was made by Gordon Allport (1935, p.798) was: "a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related." In his highly quoted article, Allport mentioned the history of attitudes and categories of attitudes as positive and negative. This polarity in attitudes has been a part of several other definitions of attitudes (Bogardus, 1931; Sherif et al., 1965; Eagly & Chaiken, 1993; Fishbein & Ajzen, 1975). Attitude is not a behavior, but a preparation of a behavior and tendency of a response to an attitude object (Oskamp & Schultz, 2005, p.8). It can also be defined as positive or negative emotional, intellectual, and behavioral tendencies related to an object as a result of learning (Sakallı-Uğurlu, 2018, p.23). According to function-structure model, which is one of the models examining the predictors of attitudes, past experiences, beliefs, and feelings about an object affect attitudes toward that object under the moderating effect of motivation (Maio & Olson, 2000). Attitude provides a general assessment of an attitude object (Bohner & Wanke, 2002). Moreover, it simplifies interaction between person and environment because of its effects on decision process (Maio et al., 2004).

Attitudes form as a result of learning and experience. New attitudes can be learned and changes can be made in existing attitudes throughout life. The person's own experience, family, school, and society are important factors in formation of attitudes (Oskamp, 2005). Also, because attitude is a learning process, classical conditioning, operant conditioning and modeling can create new attitudes or change the existing attitude (Sakallı-Uğurlu, 2018, p.27).

Researchers mentioned three components of attitudes: Cognitive, affective and behavioral (Katz & Stotland, 1959; Rosenberg et al., 1960). Sakallı-Uğurlu (2018, p.29) discussed these components in detail. The cognitive component includes ideas, beliefs, positive or negative evaluations about a particular object. If one believes that a behavior is appropriate for him or her, then it is valid for him or her regardless of scientific validity of that behavior. This belief determines the person's attitude toward that object. When people are asked verbally about the attitude object, information about the cognitive component of an attitude can be obtained. The affective component involves positive and negative feelings toward the attitude object. This component can be understood from verbal expressions of feelings or body language. Behavioral component, which is the last one, includes the action tendency of the person toward the object. This component reveals the possibility of an attitude to turn into a behavior. Someone who has positive feelings and thoughts about an object is likely to behave in relation to that object. This dimension can be understood from a person's statements about intentions and tendencies related to a behavior. The relationship of these components with each other has been the subject of many studies and several theories have been put forward on this subject (Oskamp & Schultz, 2004, p. 10). The oldest view regarding the structure of attitudes is the three-componential viewpoint, including cognitive, affective, and behavioral components. Oskamp and Schultz (2005) stated that this model is an old model dating back to Plato. Accordingly, the three dimensions of attitude are interrelated with each other, and they cannot be evaluated independently. According to a newer perspective (Fishbein & Ajzen, 1975), however, these three dimensions are independent, and they constitute separate entities, and they do

not have to be related. This model includes beliefs, attitudes and behavioral intention dimensions. These are used in place of the cognitive affective and behavioral dimensions in the previous model, respectively.

Another theoretical perspective is the latent process viewpoint (DeFleur & Westie, 1963). According to this approach, attitude is a latent process that helps to explain or mediate the relationship between the event that stimulates the person and the person's response to this event. In the face of an observable event, the person's cognitive, affective and behavioral processes are activated. These processes constitute the person's attitude toward that event. Even though the processes mentioned in the attitude cannot be observed, the person's attitude toward the event can be understood from his cognitive, affective and behavioral responses to the attitude object. Although all these models have their differences, each model is in agreement with the three building blocks of attitude. Attitude toward getting psychological help is also based on the cognitive, affective, and behavioral components of attitudes.

Attitude toward seeking psychological help is defined as a tendency to seek help from mental health professionals when needed (Fischer & Farina, 1995). It includes all of the cognitive, affective and behavioral tendencies toward getting help from professional psychological resources if the individual sees mental health in danger (Kushner & Sher, 1991).

Researchers found that attitudes toward seeking psychological help are closely related to the intention to seek psychological help (Aldalaykeh et al., 2019). More positive attitudes toward seeking professional psychological help were positively associated with higher intention to seek such help (Carlton & Deane, 2000; Seyfi et al., 2013). Researchers also found that information and campaigns about mental health positively affected attitudes toward seeking psychological help. In one of these studies, the participants who were exposed to a campaign stated that their knowledge and awareness about depression increased. According to the researchers, although the public campaign did not affect the

public's general point of view that depression is a serious disease, some prejudices about causes of depression decreased compared to the control group which did not receive any information or campaign (Dietrich et al., 2010). Another study revealed that a training program, which included messages about depression as a treatable problem, increased adolescents' level of knowledge and positively affected their attitude toward help-seeking (Ruble et al., 2013).

Although attitudes predict behaviors to a great extent, attitudes may not turn into behavior if there are obstacles that cannot be overcome. A study examining the attitudes of college students toward psychological help in Guatemala confirmed this assumption. The results of the study showed that students had low levels of stigma and positive attitudes toward seeking psychological help, however, these positive attitudes could not be transformed into behavior because of the obstacles that they encountered when they wanted to receive psychological services. These obstacles were insufficient sources of psychological services and financial difficulties in accessing these services (Figueroa et al., 2020).

In addition to examining the relationship between attitudes toward seeking psychological help and intention to seek psychological help, the subject of attitudes was also examined in relation to demographic variables. For example, in a meta-analysis study examining the relationship between gender and attitude, gender was a significant predictor of attitudes toward seeking psychological help (Nam et al., 2010).

In summary, attitude is a learning-based process that involves a person's positive or negative tendency toward an object or a situation. Researchers talked about three different dimensions of attitudes: cognitive, affective and behavioral, and they investigated the relationship between these three dimensions. Attitude toward seeking psychological help is also a process that affects the behavior of the person seeking psychological help, which includes a positive or negative tendency to seek psychological help. Researchers have also shown that attitude is

related to many personal and environmental factors, such as age, gender. In the present study, the relationship between attitude toward seeking psychological help and intention to seek psychological help was investigated. Moreover, attitude is also associated with psychological concepts such as stigma. Understanding stigma provides further information about attitudes, intentions, and behaviors of seeking psychological help. The relationship between stigma and intention to seek psychological help was also examined in this study.

1.3. Stigma toward Seeking Psychological Help

The oldest and frequently cited definition of stigma was made by Erving Goffman (1963, p.3). According to this definition, stigma is a “deeply discrediting attribute” and “reduces person from a whole and usual to a tainted and discounted one.” Stigma is related to different social and cognitive constructs such as stereotype, prejudice, and discrimination. Stereotypes are negative beliefs about a group or person. Prejudice is a structure that is formed by the combination of negative stereotypes and it causes emotional reactions. Discrimination is the presentation of the prejudice as a behavior (Corrigan, 2004). It is possible to say that the stigma consists of a triple structure similar to the cognition, affect and behavior dimensions of attitude which was previously described.

Link and Phelan (2001) studied the components of stigma. The first component is that people distinguish and label differences. The second component is that the dominant culture attributes disliked features to the labeled person. In the third component, the labeled person is put in a separate category to achieve separation of *us* from *them*. According to the fourth component, the labeled person is exposed to status loss and discrimination, which constitute unjust outcomes. Finally, stigma depends on the social, economic, and political power, and they support the previous four components of stigma. In short, stigma is a social construct that involves labeling, stereotyping, separation, status

loss, and discrimination and needs a power structure to ensure the continuity and coexistence of these components.

People who experience stigma or belong to a stigmatized group become the target of prejudice, discrimination and oppression (Jones et al., 1984). Stereotypes about the stigmatized person generally justify the prejudices and discrimination and thus, they cause the continuity of the stigma. This continuity may create serious social problems. Croker and Major (1989) argued that stigma and stereotypes have important emotional, motivational, and interpersonal consequences for the stigmatized person. Stigmatized people experience attributional ambiguity all the time. They may constantly experience an uncertainty about the reason of other people's behavior toward them. They cannot be sure whether the negative attitude or manner they have confronted is due to their personal quality or the stigma. These ambiguities can affect the stigmatized person both personally and interpersonally. They may frequently question themselves, and they may have difficulty relating to their environment.

Studies focusing on mental illness stigma divide it into two groups: The public stigma (Corrigan, 2004) and the self stigma (Corrigan, Watson & Barr, 2006). Public stigma studies focus on the public's stigma toward a group. Self stigma is the internalization of this stigma imposed by the public (Corrigan & Watson, 2002). Both types of stigmas include stereotype, prejudice, and discrimination components.

People with psychological problems have been exposed to very negative stigmas for a long time (Taşkın, 2007). Mental illness related stigmas include some common stereotypes. Studies have identified three types of stereotypes that are particularly problematic for people with mental illness. One of these stereotypes is that a person who has mental illness is dangerous and should be avoided. Another is that mental disorders are caused by the weak character of people with mental problems. The third stereotype is that people with mental illness are inadequate and incompetent and need authority figures to make any decision (Corrigan et al., 2004).

Stigmatization of people with mental illness naturally brings the stigmatization of treatment of mental illness. Therefore, people who really need treatment may hide this fact and not seek psychological help. In support of this, researchers found a relationship between stigma and intention to seek help (Pheko et al., 2013; Shetchman et al., 2018). People who have stigma that mental disorders are caused by a person's weakness have fewer tendencies to seek psychological help and have less positive beliefs about professional resources of help (Yap et al., 2011).

Fighting stigma is important and necessary to promote the treatment of psychological problems and to enable more people to benefit from treatment. Corrigan and Penn (1999) mentioned three approaches in the fight against stigma. These approaches are protesting the prejudice about mental illness, public education about mental illness, and contact with a person who has a severe mental illness. The protest approach suggests that reacting to a situation involving a stereotype or stigma will reduce the effect of the stigma. However, there are not enough studies on this subject. Larson and Corrigan (2008) stated that protests may cause suppression of stereotypical thoughts. People can react negatively to the suppression of their thoughts and that they can adopt the opposite of the protested message. They may strengthen their stigmatized attitudes and behaviors. For this reason, it is necessary to be careful while using this method in the society.

The second method in fighting against stereotype and prejudice is to provide information that will conflict with stereotypes and demonstrate mistaken beliefs. In order to do this, standard training programs related to minority and stereotyped groups can be organized. According to a study conducted in the USA, Youth Aware of Mental Health Intervention program, a program that was presented to students, increased students' help seeking behaviors and mental health literacy, and decreased their stigmatizing attitudes toward mental illness (Lindow et al., 2020). However, it may be difficult to ensure the continuity of

these behaviors. Corrigan and Penn (1999) referred to examples from studies, indicating that education provided improvement in biased thoughts but these biased ideas reappeared after the training program was over.

The third and last method to fight against stigma is to contact a person with severe mental illness. As familiarity with mental illness increases, stigma decreases (Kosyluk et al., 2020). Therefore, contact with people who have mental problems will reduce the stigma. The effect of this contact would be more successful when equal conditions are created between people with and without mental illness.

In summary, people with mental illnesses experience a biased attitude, prejudice, and discrimination because of the stigma attributed to them and the group they belong to. Because of this, people may avoid seeking psychological help even though they need it. Stigma should be fought either by protesting these attitudes, by organizing appropriate education programs, or by creating opportunities to have contact and gain familiarity with people who have psychological problems.

1.4. Quantitative Research Findings about Demographic Variables, Attitude, Stigma, and Intention to Seek Psychological Help

Researchers indicated that there is a positive relationship between being a woman and attitudes toward seeking psychological help (Koydemir-Ozden&Erel, 2010; Leong &Zachar, 1999; Wendt & Shafer, 2015; Yousaf et al., 2020). Researchers also showed that women have lower stigma, more positive attitudes toward seeking psychological help, and higher intention to seek psychological help than men (Yu et al., 2015). These differences between two genders were thought to be caused by gender norms (Pattyn et al., 2015).

Gender and stigma were related and have often been studied in relation to each other. It was found that female participants have a lower level of self-stigma about seeking psychological help than male participants. In one study, stigma

was the strongest predictor of the attitude toward seeking psychological help and it mediated the relationship between gender and attitude (Yee et al., 2020). Gender role conflict is also related to stigma and seeking psychological help. People experience a conflict as a result of negative effects of gender roles. This conflict limits people and prevents them from revealing their potential. Gender role conflict in men involves the fear of looking feminine (O'Neil et al., 1986), creates a psychological discomfort and thus, people may hesitate to seek psychological support. Pederson and Vogel (2007) conducted a study with 575 undergraduate men and found that men with higher gender role conflict had higher self-stigma and lower self-disclosure. Moreover, men with higher gender role conflict had fewer positive attitudes toward receiving help and were less willing to receive help. In another study conducted in Korea with 246 adolescents between the ages of 13 and 18, it was found that intention to seek psychological help was highly related to female gender (Do et al., 2019).

There are also studies that investigated the relationship between age and seeking psychological help. Accordingly, older aged people had more positive attitudes toward seeking psychological help and their intention to seek psychological help was higher than younger groups (Mackenzie et al., 2008). In the study conducted by Mackenzie and colleagues (2006) with 204 people between the ages of 18 and 89, it was found that age was a significant predictor on intention to seek psychological help. As people's ages increased, they developed positive attitudes and intentions toward receiving psychological help.

In a study conducted by Chang (2008) with 995 university students, it was found that seeking psychological help from informal sources, such as family and friends, was more common compared to formal sources, such as psychologist and psychiatrists. Female students had more positive attitudes toward seeking psychological help than their male counterparts. In addition, students with previous counseling experience had higher intention to seek help from formal sources. There are other studies that show the positive effects of previous

experiences on seeking psychological help (Çebi& Demir, 2020; Elhai et al., 2008; Gulliver et al., 2010).

Several studies that examined attitudes and intentions regarding psychological help seeking have also been conducted in Turkey. Türküm (2005) and Köydemir-Özden (2010) found that gender had an effect on the attitude and intention of seeking psychological help. Accordingly, women had more positive attitudes and higher level of intentions to seek psychological help than men. In another study with 308 male and 264 female university students, a significant difference was found between male and female students in terms of their attitudes toward seeking psychological help. According to this study, female participants had more positive attitudes than male participants (Irkörücü, 2014). Topkaya (2014) also reached a similar conclusion. In addition to the effect of gender, she found that self stigma about mental health also affected attitude toward seeking psychological help. Seyfi and colleagues conducted another study with 456 university students and found that attitude toward seeking psychological help predicted intention to seek psychological help (Seyfi et al., 2013).

To conclude, many researchers examined the factors related to seeking psychological help. Briefly, women, elderly, and those who have received psychological help before had less social stigma, more positive attitudes, and higher intention to seek psychological help.

In the present study, in addition to the psychological variables such as attitude, stigma, and severity of mental health problems, the effect of demographic variables on intention to seek psychological help was also investigated. These demographic variables were education level, previous mental health experience, gender, and age. In line with previous findings, women and elderly were expected to have higher levels of intention to seek psychological help. In addition, it was thought that there would be a positive relationship between educational level, previous mental health experiences, and intention to seek psychological help.

1.5. Qualitative Research Findings about Psychological Help Seeking

Qualitative studies provided a deeper understanding of seeking psychological help compared to quantitative studies. In a study by Topkaya (2015), the underlying factors of deciding on receiving psychological help were examined through semi-structured interviews. After the analysis of the interviews, two themes emerged: factors that inhibited and factors that facilitated psychological help seeking in adults. Each theme had sub-themes. Sub-themes of factors that inhibited psychological help seeking were social stigma for receiving psychological help, unwillingness to share one's problems with an unfamiliar person, the belief that a person can solve his or her problems by himself or herself, the belief that private matters should be known only by family members, and not being aware of how to go about seeking psychological help. Sub-themes of factors that facilitated psychological help seeking were expanding availability of psychological services, believing in the benefits of psychological services, trusting in an expert, and receiving psychological services for free.

Winter et al. (2017) examined the behavior of seeking psychological help among medical students. After interviews with 20 students, themes similar to Topkaya's (2015) study emerged: Barriers to seeking help and drivers for seeking help. Subthemes of barriers to getting psychological help theme were *normalization of symptoms or situation, denial that a problem exists, failure to recognize a problem existed, fear of stigmatization, and perception about self, others and medical school*. Drivers that prompted psychological help seeking were *building trust with someone in order to confide in them later on, self-awareness about the need to maintain good mental health, and overt symptoms of psychological distress*.

Gulliver and colleagues (2012) conducted another qualitative study and found that the most important perceived barrier to seeking psychological help was fear of being stigmatized. In addition, lack of mental health literacy and negative past

experiences of help seeking were also important barriers to help seeking. Factors that facilitated psychological help seeking were encouragement from others to get psychological help, establishing a good relationship with the person who provided psychological help, and positive experiences about getting psychological help (Gulliver et al., 2012).

In summary, qualitative studies on getting psychological help have generally focused on factors that prevent or facilitate psychological help seeking. Accordingly, fear of stigmatization was one of the common factors that prevented psychological help seeking. One of the common factors that facilitated receiving psychological help was the trust-based relationship with the person providing the psychological help. In the qualitative part of this thesis, the mental health literacy level of the participants, their experiences in terms of both psychological problems and psychological help in addition to barriers and facilitators were examined. Moreover, coping strategies that were used by the participants regarding their psychological problems were explored.

1.6. The Current Study

Attitudes and stigma toward seeking psychological help, having mental health problems, and demographic variables have been measured as predictors of intentions to seek psychological help in previous studies. These predictors of help seeking behavior or intention, however, have been investigated by separate studies. In the present study, all these factors were analyzed together. As stated before, there is a treatment gap defined as the difference between the number of people who need care and those who receive care in the field of mental health. Understanding the factors that affect seeking psychological help will help to eliminate this treatment gap.

Also, there are many studies about psychological help seeking conducted in Turkey, however, these have generally been conducted with university students or people who live in urban areas. There is no other study that investigated the

level of knowledge and psychological help seeking practices of people living in rural areas. Therefore, we do not have clear data on the situation in the countryside of Turkey. The present study was conducted with the villagers living in the Köklük village of Ordu. Therefore, this was the first study to examine people's intention to seek psychological help in a village in Turkey.

The current thesis employed a mixed-method study design. Mixed method design was defined as “a type of research design in which qualitative and quantitative approaches are used in types of questions, research methods, data collection and analysis procedures and or inferences” (Tashakkori & Teddlie, 2003, p. 711). In this design “the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches in a single study or program of inquiry” (Tashakkori & Creswell, 2007, p. 4). Using mixed design has three main strengths. First of all, the subjects studied in social sciences usually have complex structures and it may be insufficient to study these with only one method. With the mixed method design, however, weaknesses of any one design can be eliminated with the other design. In addition, the mixed method design combines the strengths of both quantitative and qualitative designs. Finally, it can provide a deeper perspective (Creswell, 2009, p.203).

Creswell et al. (2003) mentioned six types of mixed method design. These types vary according to the timing and weight of the qualitative versus quantitative work in the mixed design. In the present study, the mixed design was created by two sequential studies (quantitative and qualitative). The quantitative data were used as inclusion criteria for the participants of the qualitative study. In the first study, questionnaires about attitude, stigma, psychological problems and intention to seek psychological problems were filled with 117 participants across the village. In the second study, interviews were conducted with participants who met the criteria determined among the participants of the first study. Detailed information about the mixed design used in this research will be given in the method section.

There were various reasons for using a mixed method design in the present study. First of all, the education and literacy levels of the villagers were very low and they might have had difficulty understanding the scale items and the Likert-type answer format. In order to eliminate this weakness, an additional qualitative study was necessary. The qualitative study enabled these participants to explain their views on psychological help seeking in a more detailed and subjective manner. In addition, we aimed to examine the sources of support and coping strategies of people who somehow did not receive professional help.

To the researchers' knowledge, this thesis was also the first study investigating the intention to seek psychological help using mixed method design. The main objective of the quantitative study was to test the mediating roles of attitude and stigma toward seeking psychological help in the relationship between mental health problems and intention to seek psychological help. Since these concepts are somewhat abstract and have never been researched in rural areas with people who have low educational levels, a complementary qualitative study was performed to delineate the interrelations between attitude, stigma, mental health problems, and psychological help seeking.

1.7. Hypotheses

The hypotheses of the current study were as follows:

1. Attitudes toward seeking psychological help will significantly and positively predict the intention to seek psychological help.
2. Stigma toward seeking psychological help will significantly and negatively predict the intention to seek psychological help.
3. Having psychological problems will significantly and positively predict the intention to seek psychological help.
4. Being woman will significantly and positively predict the intention to seek psychological help.

5. Age of the participants will significantly and positively predict the intention to seek psychological help.
6. Education level will significantly and positively predict the intention to seek psychological help.
7. Previous mental health treatment experiences will significantly and positively predict the intention to seek psychological help.
8. Attitudes toward seeking psychological help will mediate the relationship between having mental health problems and the intention to seek psychological help.
9. Stigma toward seeking psychological help will mediate the relationship between having mental health problems and intention to seek psychological help.

1.8. Research Questions

The following research questions guided the interviews in the qualitative study:

1. What are the villagers' thoughts about psychological problems?
2. What are the villagers' thoughts about psychological help?
3. For those who have psychological problems, what are the reasons behind not getting professional psychological help?
4. What kind of strategies do the villagers use to cope with psychological problem?

CHAPTER 2

METHOD

2.1. General Research Design

In the quantitative study, the researcher attempted to test whether attitudes and stigma toward seeking psychological help, having mental health problems, previous psychological help history, and demographic variables (age, gender, education level) predicted intentions to seek psychological help. The quantitative study also provided data to purposefully select interviewees for the second study. Then, qualitative interviews were conducted to understand help seeking tendencies of participants and possible reasons behind not seeking help that were not mentioned in the literature. As mentioned in the introduction section, mixed method design was used in the present study for three main reasons. First of all, psychological help has generally been examined with quantitative study designs, but a deeper understanding of the phenomenon is also needed, which can be provided with the qualitative part of the present thesis. Also, there is no research-based knowledge about the way individuals experience psychological problems and factors related to seeking psychological help among villagers. Finally, participants of the present study had low literacy levels which might have caused difficulties in reading and understanding questionnaires. In order to provide a deeper understanding and eliminate methodological problems caused by Likert-type questionnaires, qualitative interviews were conducted with purposefully selected participants from the quantitative study.

2.2. General Procedure

After getting ethical approval (see Appendix A) from Research Center for Applied Ethics of Middle East Technical University, necessary permissions from

the authors of the instruments were obtained. Initially, the researcher visited the villager's homes, and explained the study. Informed consents (see Appendix B), including information about the study and participants' ethical rights, were obtained from 117 people who agreed to participate in the study. At this stage, the participants were also informed about the second stage of the study. All the participants agreed to participate in the second part of the study, if needed. Participants' contact information was recorded on a separate form to be used in the second study. When selecting participants for the second study, the researcher wanted to capture those who had high levels of psychological problems but low levels of intention to seek psychological help. For this purpose, the difference between psychological symptom scores and intention to receive psychological help score was used. The participants were ordered from highest difference to lowest difference. Top 10 people in the ranking were identified and invited for the second study. The researcher contacted these 10 people and gave them the second informed consent (see Appendix C), which included information about semi-structured interviews, audio-recording, and ethical rights of the participants. The duration of the interviews ranged from 14 to 51 minutes. The average of the interviews' duration was 33.2 minutes.

2.3. Study 1: The Quantitative Study

In this part, participants, instruments, procedure and data analysis of the first study were presented.

2.3.1. Participants

The sample of quantitative study consisted of 117 individuals whose ages ranged from 18 to 74 ($M=39.43$ $SD=13.79$). There were 59 females (50.4%) and 58 males (49.6 %). Fifteen participants (12.8%) were illiterate, 6 (5.1%) were literate, 53 (45.3%) were primary school graduates, 15 (12.8%) were secondary school graduates, 17 participants (14.5%) graduated from high school, and 11 participants (9.4%) graduated from university. While 31 participants (26.5 %)

received psychological help before, 86 of them (73.5%) did not have psychological help experience. Finally, the participants were asked which resources they intended to use when they encounter a problem in the future. Fifty five participants (46.6%) preferred psychiatrists, 43 (36.4 %) preferred psychologists, 3 (2.5 %) choose primary physicians, 3 of them (2.5 %) choose religious healers, 1 of them (0.8 %) selected midwives and nurses, and 12 participants (10.2 %) stated that they would apply to other sources. Detailed information about the demographics were provided in Table 1.

Table 1

Demographic Characteristics of the Participants (N=117)

Study 1 Participants (N=117)		
Variables	F (%)	Mean(SD)
Age	117	39.43 (13.79)
Gender		
Female	59 (50.4)	
Male	58 (49.6)	
Education Level		
Illiterate	15 (12.8)	
Literate	6 (5.1)	
Primary School	53 (45.3)	
Secondary School	15 (12.8)	
High School	17 (14.5)	
University	11 (9.4)	
Marital Status		
Single	24 (20.5)	
Married	92 (78.6)	
Divorced	1 (0.9)	
Previous Psychological Help History		
Yes	31 (26.5)	
No	86 (73.5)	

2.3.2. Instruments

Sociodemographic Information Form, Brief Symptom Inventory (BSI), Attitudes Toward Seeking Professional Psychological Help Scale-Short Form

(ATSPPHS), Social Stigma Scale for Receiving Psychological Help (SSSRPH), and Help-Seeking Intentions Inventory for Adults (HSIIA) were used in this study.

2.3.2.1. Sociodemographic Information Form

Sociodemographic Information Form was developed by researcher, and it included questions about participants' age, gender, education level, marital status, occupational status, income level, previous psychological help history, relatives with mental health problems and future plan in terms of psychological help seeking. Previous psychological help history and having relatives with mental health problems were asked in a closed question format (see Appendix D).

2.3.2.2. Brief Symptom Inventory (BSI)

BSI (Derogatis, 1992) is a short form of Symptom Check List-90-Revised (SCL 90-R), which was developed for psychopathological evaluation of adolescents and adults. A total of 53 items with the highest loadings were selected from SCL-90-R to form BSI and a similar factor structure as SCL-90-R was obtained. BSI is a 5-point Likert-type checklist. The answers are scored as 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit), and 4 (extremely). Points that can be obtained from the inventory range between 0 and 212 and higher scores indicate higher intensity of symptoms. It consists of 9 primary symptom dimensions and 3 global indices of distress. The dimensions include obsessive-compulsive, paranoid thoughts, hostility, phobic anxiety, psychoticism, somatization, interpersonal relationships, depression, and anxiety. There are also 4 additional items which are not included in any of these primary symptom dimension. The global indices of distress are the General Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST).

Internal consistency reliability of BSI ranged from .71 to .85. in a sample of 1002 out-patients. Test-retest reliability of BSI in a sample of 60 community participants ranged from .68 to .91 (Derogatis & Melisaratos, 1983). These findings indicated that BSI is a reliable measure over time. Derogatis and Melisaratos (1983) also investigated the validity of the inventory. They compared BSI scores with SCL-90 scores. Accordingly, the correlations between subdimensions of the two inventories ranged from .92 to .99.

Şahin and Durak (1994) adapted BSI to Turkish with three separate studies (Şahin & Durak, 1994a; Şahin & Durak 1994b; Şahin, Durak & Yasak-Gültekin, 1994). Results of these studies showed that the Turkish version of this scale had five dimensions, including anxiety, depression, negative self, somatization, and hostility. In order to examine psychometric properties of BSI, Şahin and Durak reanalyzed the data from three separate studies using this inventory with different samples. According to the results, Cronbach Alpha internal consistency coefficients obtained for the total score of the inventory varied between .93 and .96 and the coefficients obtained for the sub-dimensions ranged between .63 and .86. (Şahin & Durak, 1994). In the present study, Cronbach Alpha internal consistency coefficient was .95 for the whole inventory (see Appendix E).

2.3.2.3. Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHS)

The short form of Attitude Toward Seeking Psychological Help Scale (Fischer and Farina,1995) consists of ten items that assess general attitudes toward seeking professional help for psychological problems. It is a 4-point Likert-type scale and the answers vary between(0) disagree and (3) agree. Items 2, 8, 9,and 10 are reverse scored. The lowest score that can be obtained from the scale is 0 and the highest score is 30. Higher scores from the scale reflect more positive attitudes toward seeking psychological help. In order to reveal factor structure of this scale, Fischer and Farina conducted an exploratory factor analysis and found that the scale had a single factor. Also, the correlation between the long and short

forms of the scale was .87. Test-retest reliability was .80 and Cronbach Alpha internal consistency coefficient was .84.

Topkaya (2011) translated and adapted this scale to Turkish. Cronbach's alpha coefficient was .76 for this translated version, then she conducted a confirmatory factor analysis and found that a single factor structure also provided a good fit for the Turkish data. The findings showed that psychometric properties of this scale were satisfactory. In the present study, Cronbach Alpha internal consistency coefficient was calculated as .67 for the whole inventory (Appendix F).

2.3.2.4. Social Stigma Scale for Receiving Psychological Help (SSSRPH)

Komiya et al. (2000) developed this scale in order to measure the perception of social stigma due to psychological help seeking and the scale consists of 5 items. The items of the scale are answered in 4-point Likert style, which varies between (1) strongly disagree and (4) strongly agree. The total score that can be obtained from the whole scale varies between 5 and 20. High scores obtained from the scale indicate that the individual has a high social stigma perception due to receiving psychological help. The Cronbach Alpha internal consistency was found .72 in original study. Komiya et al. (2000) conducted an exploratory factor analysis to reveal the factor structure of SSSRPH and found that the scale had a single factor. They also reported that there was a significant relationship between ATSPPHS and SSSRPH ($r=-.40$).

This scale was translated and adapted to Turkish by Topkaya (2011). Cronbach's alpha coefficient was .80 for the adapted version of SSSRPH. In order to examine the construct validity of the scale the goodness of fit values of the model were calculated. Topkaya conducted a confirmatory factor analysis and found that a single factor structure also provided a good fit for the Turkish data. These values showed that psychometric properties of this scale were sufficient, and this scale is a reliable and valid measure.

In the present study, the Cronbach's alpha for the scale was .71 (see Appendix G).

2.3.2.5. Help-Seeking Intentions Inventory for Adults (HSIIA)

This inventory was developed by Topkaya (2011) to measure how likely people would seek counseling if they were experiencing the problem listed. She developed this inventory by using literature about this issue and finalized it by expert opinion. Participants answered items on a 4-point Likert type scale ranging from 1 (very unlikely) to 4 (very likely). The inventory has three subscales which are relational problems, traumatic problems, and affective and behavioral problems. Total score that can be obtained for the entire inventory ranges from 12 to 48; 4 to 16 for relational problems sub-dimension; 3-12 for traumatic problems subscale, 5-20 for the affective and behavioral problems subscale. Higher scores indicate greater likelihood of seeking psychological help.

The Cronbach Alpha calculated for entire scale was .84, and Cronbach's Alpha was .76 for relational problems subscale, .72 for traumatic problems scale, and .68 for affective and behavioral problems subscale. In this study, the Cronbach's alpha for total scale was .85 (see Appendix G).

2.3.3. Procedure

There are approximately 800 individuals over the age of 18 who lived in the village according to the mukhtar of the village. Convenient sampling method was used to reach 117 of the villagers. Informed consent forms were given to participants and the participants were asked to fill out the rest of the instruments. Some participants were illiterate. Therefore, the researcher read the items out loud and filled out the responses for those participants. This process took approximately 30 minutes.

2.3.4. Data Analysis

In the current study, the Statistical Package of Social Sciences (SPSS) version 20 was used for data analyses. The primary aim of this study was to test the mediating roles of attitude and stigma toward seeking psychological help (M) in the relationship between mental health problems (X) and intention to seek psychological help (Y). Another important aim of this thesis was to measure whether attitudes, stigma toward seeking psychological help, having psychological problems, age, gender, education level, and previous mental health treatment experiences predict intention to seek psychological help.

Before the main analyses, descriptive analyses were conducted. In addition, Pearson's Correlational Analysis was performed to see the relationship between research variables. According to the results of the correlation analysis, some variables that were not significantly related to the intention to seek psychological help and were not included in the regression analysis. Preliminary analyses were also performed to see whether regression assumptions were provided. All assumptions of regression were met and there were no obstacles to analysis. To investigate the predictor roles of attitudes, stigma toward seeking psychological help, age, and education level in predicting intention to seek psychological help, multiple regression analysis was conducted. In order to test hypothesis 8 and 9, the mediation analyses were performed via PROCESS macro for IBM SPSS (Hayes, 2018).

2.4. Study 2: Qualitative Study

Methodological background, participants, procedure, data analysis and reflexivity of the second study are explained in this part.

2.4.1. Methodological Background

Qualitative methodology offers ways to reveal what people do, what they know, what they think, and what they feel through observations, interviews and document analysis. Qualitative methods can be used to add detail and depth to quantitative studies. Thematic analysis is one of qualitative methods that provides identification, analyzation and reporting of the themes and it “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p.87). According to Braun & Clarke (2006, p. 87), there are six steps in thematic analysis. These are ‘familiarisation with the data, coding, searching for the themes, reviewing the themes, defining and naming the themes, and writing up’. Thematic analysis is a more flexible method than other qualitative methods and therefore, was considered suitable for the current thesis.

The epistemological standing of the researcher is important in qualitative studies. In the present study, the researcher’s standing was a contextual constructionist position. According to this approach there are various ways to access informations. Both the researcher and the participants of the researcher reveal realities while trying to make sense of the world around them (Madill, et al.,2000). Therefore, the results of the research may be affected by the environment in which data is collected and analyzed. Results may also differ among people with different realities. In the contextual constructionist position the researcher interprets the data on their own reality. Data collection and analysis are carried out with the researcher's subjective assessment. For this reason, the subjectivity of the researcher is very important. Therefore, informing the readers about the researcher’s characteristics and the relationship between researcher and the research topic is important in terms of showing the effect of the researcher’s subjectivity (Willig, 2013). Relevant information about the researcher and the subjectivity of her was provided in the Reflexivity part of this chapter.

2.4.2. Participants

Participants of qualitative study were purposefully selected from the first part of the study. Individuals who had low intention to seek professional psychological help despite having psychopathological symptoms were invited to share their knowledge and experience about their psychological problems, psychological help seeking and ways of coping with their psychological problems. For this reason, 10 people with the highest score difference between BAI and HSIIA were selected and interviews were conducted with these people. Nine of the participants (90%) were female, and 1 of them (10%) was male. Their ages ranged between 21 to 66 ($M = 40.8$ $SD = 4.26$). The income level of all the participants was low. Although they had never received psychotherapy before, 6 of them (60%) declared that they went to psychiatrists and used psychiatric drugs at some point in their lives. Only 1(10%) of them continued to use medication under the control of the psychiatrist. The sources of psychological help that the participants considered to choose when they encounter a problem in the future were divided into three categories. While 5 (50%) of the participants thought of going to a psychiatrist, 3 of them planned to go a psychologist. One of the remaining 2 participants (10%) preferred social support from friends, while the other (10%) planned to solve the problems by himself or herself. The participants were numbered in order to make the interview analysis easier. Detailed information about the participants were given in Table 2.

Table 2*Sociodemographic Information of Participants (N=10)*

Number Given the Participants	Age	Gender	Education	Marital Status	Previous Psychological Help History	Future Plan
P1	35	F	Literate	Married	Yes	Other
P2	22	F	High School	Single	No	Psychiatrist
P3	39	F	Primary School	Married	Yes	Psychologist
P4	45	F	Primary School	Married	Yes	Psychologist
P5	53	F	Primary School	Married	Yes	Psychologist
P6	39	F	Primary School	Married	Yes	Psychiatrist
P7	40	F	Illiterate	Married	No	Psychiatrist
P8	66	F	Illiterate	Married	No	Psychiatrist
P9	48	F	Primary School	Married	No	Psychiatrist
P10	21	M	University	Single	Yes	Other

2.4.3. Material

For this part of the study, a semi-structured interview protocol was developed by the researcher in the light of the literature and with the help of the advisor. There were 10 open-ended questions in three main areas, which were psychological problems, psychological help seeking and coping strategies. After the formation of the interview protocol, a pilot interview was conducted with a 52-year old female villager to decide whether the questions were clear and to receive feedback. Based on this interview, necessary changes were made, and the edited version was presented to thesis advisor. The advisor edited and finalized the interview protocol (see Appendix H).

2.4.4. Procedure

After determining 10 people who met the inclusion criteria for this stage of the research, these people were called and informed about the second stage of the research. The content of the interview, audio-recording, planned usage of these recordings and confidentiality issues were explained during these phone calls. All 10 people agreed to participate in the interview. In June 2019, the researcher visited the village and went to the participants' homes. Prior to the interviews, verbal and written informed consents were obtained from the participants. Before the interview, the first participant said: 'Tell me that what kinds of answers are good for you and, I will respond in that way'. After this comment, all participants were informed that there were no correct answers to the questions and that they should answer based on what they think would be best for the study. The interviews were held in the participants' homes, in a quiet environment with no one else. At the beginning of the interviews, demographic questions were asked as a warm-up before the main part of the interview. After the interviews, participants who asked where to get professional psychological help were informed that they could receive professional help at the nearest public hospitals. These interviews lasted between 22 and 58 minutes.

2.4.5. Data analysis

The researchers actively participated in the analyzation of the data by constructing themes. Braun and Clarke (2006)'s guidelines for thematic analysis were followed. As mentioned earlier, according to the guideline, there are six steps in thematic analysis.

The first step is familiarizing with the data, which involves transcribing, reading the data and writing ideas. Accordingly, the researcher transcribed audio-recordings, and read these transcripts several times, and took notes on them. Generating initial codes is the second step. In this step, the reseracher tried to convert the data to codes. In order to do this, interview transcripts were

transferred to an excel file and divided into small meaning units. These meaning units provided the construction of codes and themes.

Searching for themes is the third step. In this step, codes are used to provide themes. There were lots of codes in the second step and some of them could be gathered under one theme. The names of the themes and the sub-themes, which were considered to represent meaning units, were written in front of each meaning unit. Thus, similar meaning units were gathered under the same theme.

The fourth step, which is reviewing the themes, consists of making decisions on the correctness and representativeness of themes and subthemes. In this step, the themes and sub-themes obtained from the previous step were reviewed and whether the themes were represented the meaning unit or not was examined. At this stage, it was noticed that there were sub-themes that overlapped with each other. For example, the participants' own attitudes toward seeking psychological help and the reactions of others toward seeking psychological help were placed under separate sub-themes in the previous step. During the re-examination of these themes, it was observed that the two sub-themes overlapped a lot and there was not much difference between them. For this reason, these two sub-themes were combined under one sub-theme, which was attitudes toward seeking psychological help.

Defining and naming themes is the fifth step. In this step, with the support of the thesis advisor and the review that was made in the previous step, the themes and sub-themes were finalized. At the end of this step, themes were ready to be written.

The final step is producing the report. At this stage, the themes and sub-themes created in the previous steps were written as a report. All these steps were carried out with the thesis advisor's help and feedback.

2.4.6. Reflexivity

Being aware of possible effects of the researcher's perspectives on the study provides more accurate evaluation of the research results. Reflexivity provides this awareness throughout all the stages of research. Thus, background information regarding the researcher was included below.

I am a 28 year-old female psychologist. I was born in the Köklük village of Ordu and spent all my childhood here. My family still lives there and I visit them during holidays. When I was a kid, I saw some *strange people* in the village and I was afraid of them because of their 'strange behaviors'. When these people went outside, the others hid from them and hesitated to talk with those strange people. One of these strange people was a man in his 30s. He walked quickly around the village. Sometimes he sang or sometimes he yelled. He spoke to himself. When I asked older people why he behaved that way, they said he was crazy. They added that he did not like being called crazy, and if he heard this, he would be very angry and could hurt others. When I asked why he was crazy, they said that this person was very smart and this kind of smartness might cause craziness. I was warned that being too smart was also harmful.

Another strange person living in our neighborhood was a woman. This woman threw out the dishes in her house and shouted from the balcony. Also, she sometimes swore and spoke to herself. Again, when I asked why this person behaved like this, they said that there was a fountain near this woman's house and there were a lot of jinns and fairies in wet places, and this woman was bewitched by them. My parents said that I should not go to such a place especially at night, and if I encounter such a situation, I should pray to protect myself.

When I was a child, I had a seizure. According to my family, my smartness caused evil eye from others and the evil eye caused seizure. To get rid of the evil eye, I had to pray and carry amulets.

When I became interested in science and psychology during high school years, I started to notice people's views on the psychological problems, the causes of these problems, and treatment methods. When I began my university education, I had a hard time explaining what psychology was because the literacy rate in our village was very low and very few people were educated beyond elementary school. With the passage of time, however, I realized that people's knowledge about psychology has increased and their attitudes have changed. I have observed that there are people who regularly go to the psychiatrist in the village and use antidepressants, which are defined as *nerve medicines*.

The participants of this research were villagers living in the village where I was born. Before I decided on the subject of this research, the issue of mental health literacy attracted my attention. However, as a result of reading the literature over time, I realized that the subject I was curious about was the experience of people with psychological problems and psychological help seeking rather than their level of knowledge. Especially, the Cultural Issues in Clinical Psychology course I took during my graduate education shaped my interest in this topic. I was very excited to scientifically examine the experiences of people living in the village where I was born and grew up. This work included not only investigating the lives of those people, but also a glance at my roots, about which I had complex feelings.

From a cultural anthropological perspective, this study was an emic study. In this approach, the researcher is from the culture that she investigates and becomes an active participant in the research (Hwang, 2016). The emic approach had advantages and disadvantages. Before I went to collect data, I thought that the villagers would not take my research seriously or they would be hesitant to explain their experiences, because they knew me. Yet, this was not what happened. On the contrary, being from the same culture as the participants made it easier for me to understand their perspective. Also, I had lived in the village for many years, so I knew everyone in the village, but I had not visited their homes before. I was worried that I had to visit their homes unannounced, because I did

not know their phone numbers. Yet, I was welcomed by the participants and they seemed comfortable with me throughout the research process.

I collected data for the quantitative study in the winter season. People often sat together in a room with a stove. In order to fill out the scales we had to move to another quiet but cold room. For this reason, some participants were embarrassed and apologized many times. Eventhough I did not have any requests, one of the participants gathered her relatives in her home and helped me to reach new participants. The son of this participant, who was also a participant, took me to other homes with his car.

Especially the female participants expected more approval. When the answering the scales, some women participants looked at me carefully and asked if they were right. Others wondered about their neighbors' answers to the questions. When that was the case, I reminded them that nobody's information would be shared. Since all of the male participants were literate, they filled their scales themselves except for the elderly ones. I thought the literacy rate would be low for women over middle age in the village, but I did not expect it to be so low. It made me sad to face this situation. During the collection of quantitative data, I talked to each participant about the second stage of the research and that I would contact them again if needed. Many participants were eager to attend the second meeting. I was very happy that the research was so well-received. I realized that the participants needed to share their experiences and knowledge and felt valued by my attention.

In the second stage of the thesis some of the participants with whom I had qualitative interviews were close relatives. I thought that this closeness might cause the participants to hide some of their thoughts, but again this did not seem to be the case. On the contrary, I felt that these people opened themselves to me more than ever. Some participants stated: 'You are an expert on this subject and you will understand me better.' They told me about their problems, such as sexual problems, anorexia, and obsessive thoughts, which were private topics

that they had not told anyone before. I thought that the participants would be hesitant about the audio recording, but this did not cause any problems either. The participants told me that they trusted me, because I was an expert. Their attitude towards me made me very happy. At the end of the meeting, although there was no therapeutic intervention, all of the participants said that they felt relieved and thanked me for including them in this second phase.

Cultural emic perspective was also very helpful in analyzing the data. For example, in the village, expressions such as *nefeti bulanmak*, *zivri daralmak* mean getting overwhelmed and frustrated. Some participants used these words instead of getting upset. There is also another different expression for nausea. Nausea in the village is expressed as *gönlü bulanmak*. In addition, all the participants spoke with the accent of the village. I had no difficulty in communicating with the participants and analyzing the data from the interviews, because I knew these concepts and the accent used in the village, I had no difficulty in communication the participants and analyzing the data from the interviews. Writing such different expressions even made the transcription process fun.

The idea of returning to the village years later and doing such a research was very exciting for me, so as soon as I got my ethical permission, I went to the village to collect my data. This excitement continued during the analysis phase and accelerated the process of completing my work.

In summary, the present research was conducted based on cultural emic perspective. Although the fact that I am from this village was initially worrisome, it made the research process easier form me. Even though the participants showed a positive attitude toward the research I may not know exactly what they feel. Therefore, taking this information and subjectivity of the researcher into consideration will provide a deeper understanding and a more appropriate perspective on the research findings.

CHAPTER 3

RESULTS

In this chapter, the results of the quantitative and the qualitative part of the study, were presented.

3.1. Study 1: The Quantitative Study

3.1.1. Descriptive Statistics for the Study Variables

Means, standard deviations, minimum and maximum scores were calculated for age, Brief Symptom Inventory (BSI), Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHS), Social Stigma Scale for Receiving Psychological Help (SSSRPH), and Help-Seeking Intentions Inventory for Adults (HSIIA). Descriptive information can be seen in Table 3.

Table 1

Descriptive Statistics of the Study Variables

Variables	N	M	SD	Min	Max
Age	117	39.43	13.79	18	74
Brief Symptom Inventory (BSI)	117	112.31	41.04	5	178
Attitudes Toward Seeking Professional Psychological Help	117	27.81	5.08	4	29
Social Stigma for Receiving Psychological Help	117	11.93	3.45	5	20
Help-Seeking Intentions Inventory for Adults	117	31.59	7.84	13	46

3.1.2. Correlations among the Study Variables

Pearson's correlational analysis was conducted to examine relationships between study variables which were age, gender, education level, previous psychological help experiences, having psychological problems, attitude toward seeking psychological help, social stigma toward seeking psychological help, and intentions to seek psychological help.

Results revealed that the dependent variable of the study, the intention to seek psychological help, was significantly and positively correlated with education level of the participants ($r=.271$, $p<.01$) and attitude toward seeking psychological help ($r=.469$, $p<.01$). Also, the intention was significantly and negatively correlated with age ($r=-.26$, $p<.01$), and stigma toward seeking psychological help ($r=-.263$, $p<.01$). There was no significant relationship between the intention to seek psychological help and gender of the participants, previous psychological help experiences, and having psychological problems.

Moreover, results showed that stigma toward seeking psychological help significantly and positively correlated with age ($r=.299$, $p<.01$) and having psychological problems ($r=.259$, $p<.01$) and negatively correlated with education level ($r=-.399$, $p<.01$) and previous psychological help experiences ($r=-.243$, $p<.01$). Having psychological problems was significantly and negatively correlated with gender ($r = -.362$, $p < .01$) and previous psychological help experiences ($r=-.239$, $p<.01$). Related to previous psychological help experiences, there were significant and positive correlations between previous psychological experiences and gender ($r = .208$, $p < .01$) and education level of the participants ($r = .320$, $p < .01$). Additionally, some of the demographic variables were correlated with each other. Bivariate correlations between all the variables of the present study are showed in Table 4.

Table 4
Correlations Among the Study Variables

Variables	1	2	3	4	5	6	7	8
1.Gender	-							
2.Age	,011	-						
3.Education	,307**	-,685**	-					
4.Previous Experiences	,208*	-,168	,320**	-				
5.Stigma	-,134	,299**	-,399**	-,243**	-			
6.Attitude	,074	,014	,149	-,137	-,078	-		
7. Psychological Problems	-,362**	-,096	-,048	-,239**	,259**	,071	-	
8.Intention	,082	-,269**	,271**	,019	-,263**	,469**	,085	-

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

3.1.3. Multiple Regression Analysis

In the current study, a multiple regression analysis was conducted to examine the effects of age, education level, attitude toward seeking psychological help and social stigma toward seeking psychological help on intentions to seek psychological help.

Assumptions for multiple linear regression analysis were checked before proceeding to regression analysis. The first assumption is about sample size. According to Tabachnick and Fidell (2007), the equation for the required sample size is $N \geq 50 + 8m$ being the number of independent variables in regression analysis. Thus, the sample size which was 117 in this study was adequate for the analysis. According to the second assumption, there must be a linear relationship between the outcome variable and the independent variables. Also, there should

be normal distribution in residuals of the regression. The fourth assumption is homoscedasticity. A scatterplot of residuals and predicted values provides information about this. The last assumption is that there should be no multicollinearity between variables. Multicollinearity means having a high correlation between the independent variables. In order to check this, VIF and Tolerance values are examined. In order to avoid multicollinearity, VIF values must be less than 10 and Tolerance values must be greater than .1 (Field, 2013). When the VIF and Tolerance values of the variables of this study were assessed, it could be seen that the VIF values showed a distribution between 1.05 and 2.13 and the Tolerance values between .51 and .9. For this reason, there was no multicollinearity between the independent variables of the study.

After making sure that the assumptions were met, multiple linear regression analysis was conducted. According to the results of the correlation analysis, gender, previous psychological help experiences and having psychological problems variables were not significantly related to the intention to seek psychological help. Therefore, they were not included in the regression analysis. The results showed that there was a significant regression equation ($F(4, 112)=13.134, p=.000$), with an R^2 of .319. This model was able to explain 31% of the variance in participants' intention to seek psychological help. Regression coefficients showed that while attitude toward seeking psychological help ($B=.597, p < .05$) significantly and positively predicted the intention to seek psychological help, the age of the participants ($B=-.012, p < .05$) significantly and negatively predicted the intention to seek psychological help. In addition, stigma and education level of the participants did not significantly predict the intention to seek psychological help. Regression coefficients and standard errors can be seen in Table 5.

Table 5*Summary of Multiple Linear Regression Analysis*

Variables	B	SE B	<i>B</i>	t	Sig.
1. Age	-.012	.005	-.259	-2.307	.023
2. Education	-.017	.053	-.080	-.314	.754
3. Stigma	-.157	.081	-.192	-1.948	.054
4. Attitude	.597	.103	.459	5.819	.000

3.1.4. Mediation Analyses

In order to investigate the relationship between having psychological problems and intention to seek psychological help, and the mediator roles of attitude and stigma, mediation analyses were conducted by using PROCESS macro for IBM SPSS developed by Hayes (2018).

According to the results of the first mediation analysis, the mediation model (see Figure 1) was not significant ($F(1, 115) = .84, p > .05$). Having psychological problems was not a significant predictor for attitudes toward seeking psychological help ($b = .46, SE = .06, t = .75, p > .05; 95\% CI [-.07, .16]$). There was a significant association between attitude and intention ($b = .59, SE = .10, t = 5.62, p < .05; 95\% CI [.38, .80]$). The direct effect of having psychological problems on the intention to seek was not significant ($b = .04, SE = .06, t = .63, p > .05; 95\% CI [-.09, .18]$) when the mediating effects of attitude toward seeking psychological help was controlled. Additionally, the indirect effects of attitude were calculated by using 10000 bootstrap samples. The results also revealed that, the indirect effects of attitude ($b = .04, boot SE = .06, 95\% CI [-.05, .10]$) was not significant.

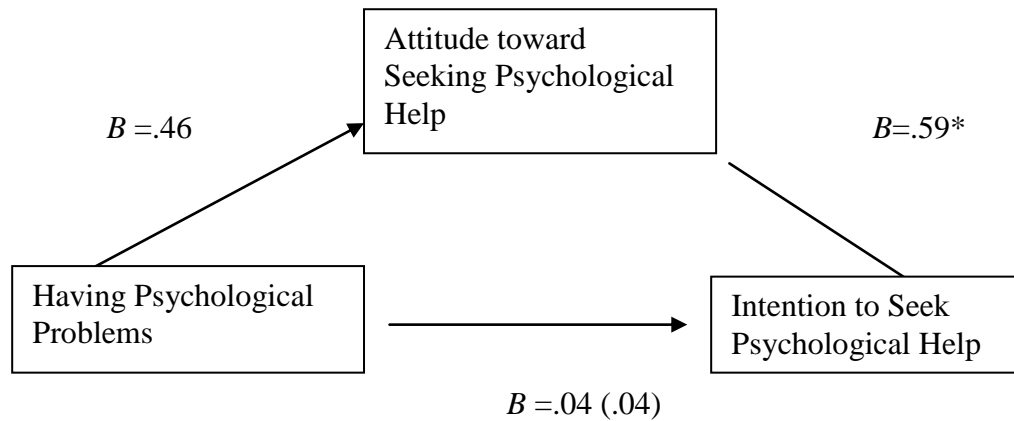
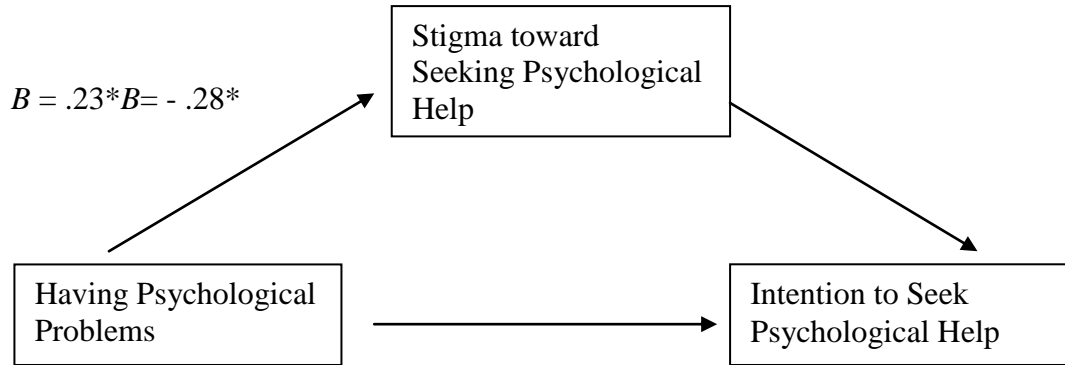


Figure 1. Having Psychological Problems and Intention to Seek Psychological Help with Attitude toward Seeking Psychological Help as the Mediator

Note .B = Unstandardized regression coefficient, * $p < .05$

According to the results of the second mediation analysis, the mediation model (see Figure 2) was significant ($F(1, 115) = 8.27, p < .05$) and it explained .06 % of the variance in intention to seek psychological help. The results showed that having psychological problems significantly predicted stigma toward seeking psychological help ($b = .23, SE = .08, t = 2.87, p < .05; 95\% CI [.07, .38]$). The stigma toward seeking psychological help was a significant predictor for intention to seek psychological help ($b = -.28, SE = .08, t = -3.30, p < .05; 95\% CI [-.46, -.16]$).

The direct effect of having psychological problems on the intention to seek was not significant ($b = .13, SE = .07, t = 1.66, p > .05; 95\% CI [-.01, .29]$), after controlling the mediating effects of stigma. The indirect effects of stigma toward seeking psychological help were calculated by using 10000 bootstrap samples. The results revealed that, the indirect effects of stigma ($b = -.06, boot SE = .03, 95\% CI [-.13, -.01]$) was significant. Specifically, it was found that stigma toward seeking psychological help mediated the relationship between having psychological problems and intention to seek psychological help.



$B = .13 (-.06^*)$

Figure 2. Having Psychological Problems and Intention to Seek Psychological Help with Stigma toward Seeking Psychological Help as the Mediator

Note . B = Unstandardized regression coefficient, * $p < .05$

3.2. Study 2: The Qualitative Study

As a result of thematic analysis of ten interviews, three superordinate and twelve subordinate themes were found (see Table 6). Relevant quotations from participants were included in each theme in order to better understand the themes.

Table 6

List of Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Psychological Problems	General Characteristics of People with Psychological Problems
	Perceived Causes of Psychological Problems
	Attitudes toward Psychological Problems
	Personal Experience of Psychological Problems
Psychological Help	Knowledge about Mental Health Professionals
	The Experience of Psychological Help
	Attitudes and Perceived Barriers towards Psychological Help
Coping Strategies	Engaging in Work
	Social Activities
	Religious Activities

3.2.1. Psychological Problems

The first superordinate theme was named *psychological problems*. This theme included participants' thoughts on the various dimensions of the psychological problems, such as general knowledge about, attitudes towards, and experiences regarding psychological problems. This superordinate theme had four subordinate themes: General characteristics of people with psychological

problems, perceived causes of psychological problems, attitudes toward psychological problems, and personal experience of psychological problems.

3.2.1.1. General Characteristics of People with Psychological Problems

The first subordinate theme was *general characteristics of people with psychological problems*. Participants' responses revolved around characteristics of a person with psychological problems. These characteristics included the physiological symptoms of psychological problems, such as lack of sleep, nausea, and the physical appearances of people with psychological problems. For example, P6 stated that she was able to differentiate people with psychological problems from normal people, because she also experienced this problem and added:

Some of them (people with psychological problems) have nausea and insomnia. They appear to be drowsy, and they experience convulsions. When I see these features, I wonder whether this person is a depressed patient, because, I have experienced these symptoms. They (people with psychological problems) appear to be thoughtful. Of course, not every thinking person is depressed, but these people are different. They look as if they stare into space meaninglessly.

In addition, the participants listed some of the behaviors of people with psychological problems that distinguished them from other people. According to P10, these people had many distinctive features. He argued that whether a person had a psychological problem could be understood by looking at these features:

It is understood from their behavior, the way they walk, their way of speaking, and the way they look. They turn their eyes away, and they seem to be desperate and bored. They look as if they are tired because of playing football for 10 hours. They look at their surroundings with this kind of tiredness. They cannot walk properly. For example, we are walking from one place to another with an aim, but these people may not have such a purpose. They are just walking to walk and they move aimlessly.

In addition, some participants stated that people with psychological problems could get angry quickly and in some cases they could harm the environment. For example, P7 said 'Having a psychological problem means beating, breaking,

hurting, and doing evil to someone.' Another participant, P8, mentioned a relative with a psychological problem and said that 'this person damaged the household items when she was angry.'

In summary, the participants' opinions about characteristics of people with psychological problems were included this sub-theme. The participants talked about the visible features of people with psychological problems and some participants explained that these people could harm their environment.

3.2.1.2. Perceived Causes of Psychological Problems

Perceived causes of psychological problems was the second subordinate them. The events or situations that the participants perceived as the cause of psychological problems constituted this sub-theme. All the participants stated that people with psychological problems could not share the problems that they experienced and they generally had to endure it silently. Accordingly, this was one of the causes of psychological problems. The problems that the participants could not share with others were mostly disagreements within their families. P3 received drug treatment for panic disorder and she could not use public transportation or stay in enclosed places because of her problem. She pointed out that this illness might be genetic. In addition, she thought that the real cause of her problems was not to tell anyone about these problems:

My family members generally act according to their feelings without thinking. They get angry quickly. My brothers are like that you know. My uncles also have psychological problems. I think psychological problems may have genetic origins, but actually, psychological discomfort stems from keeping daily problems to yourself. I think people should express their feelings. For example, they should be able to say: 'I did not like it and I got frustrated,' when they do not like something. However, I am not such a person. I have been married for about 20 years. I live with my mother-in-law. If you ask me, I wouldn't want to live together. I am 40 years old now. I have to get permission from her to go somewhere. I have to take care of her right now, because she has been ill. Actually, she has a bad effect on my psychological state, but I have to look after her. I had a lot of problems with her especially during the first years of my marriage. I was slandered by her. Still, my eyes fill up when I think about this. Not even one person in my family knows what I lived through with her. I could not cope with this problem. I could not tell anyone, I kept it inside. I

encountered psychological problems at that time, actually. I think she is the biggest cause of my psychological problems, that's why I hate her.

Similar to P3, P1 and P4 also had trouble with their mother-in-laws throughout their lives and they were slandered. Even though they lived in separate houses from their mother-in-laws, they still experienced psychological distress. On the other hand, P5 and P9 complained about their sons' wives and they were upset because they could not talk about the conflicts that they had with their brides to others. They did not feel psychologically well as a result of their constant crying.

In general, the participants stated that there was an event at the beginning of their problems and they talked about their psychological problems in connection to that event. For example, one night P1 went to the balcony to take wood. There was a cat sitting on the wood, but she could not see it because it was dark. Then, the cat jumped at her, she was very frightened, and then fainted. Her husband could not leave her alone for a year especially at nights, because her fear continued. After this incident, she was accused of stealing her mother-in-law's golden coins and that was the time when her psychological problems started. P10 described the period of adaptation to the new city that he went for university education as his psychologically problematic period. During the adaptation to the new city and university life, he lived in the dormitory and had difficulty making friends. Another participant, P4, had a dispute with her sisters during the allocation of inheritance, and her psychological problems started.

In addition, some participants considered the grief process they experienced after their relatives' death as a psychologically problematic period. P2, who lost his father 2 years ago, avoided sharing her problems with anybody else in order not to upset her mother at that time and she was upset that she could not alleviate her troubles. Similarly, P8 cried secretly after her husband's death in order not to upset her daughter and had a difficult time in that process. A traffic accident occurred in the village during the data collection phase of the present study. P4 lost her nephew in this accident. During the interview, P4 said that this loss made her very sad, but her older sister who was the mother of the person who died was

affected much more. She was not herself and slept constantly. She added that these kinds of events might cause psychological problems, and her sister had psychological problems because of the loss of her son. P7, who survived another traffic accident in the village during the same period, was not able to leave her home and took many drugs. She stated that ‘Those drugs ruined my psychological state. I almost died because of staying at home.’

When the participants were asked why they might have encountered these events that caused psychological problems, they generally said that they could not give any reason, and it should be because of their destiny. Also, they might have experienced these problems because God wanted this. A quote from P7’s interview can be given as an example:

Regarding the accident, I can say that this is my fate. This injury and bleeding would happen to me. These are written in my fate, I cannot change them. I say to myself all of them came from Allah, I cannot blame anyone about this accident.

P5 who had a grandson suffering from permanent disability as a result of an accident, also saw fate as the reason of the accident:

I cannot say that it is because of this. I can say that this is destiny from Allah. A test of Allah. My Lord wanted to test me. I do not blame any person. Everything comes from Allah. Everyone should be pleased with what comes from Allah. You have to submit to your fate. You should say that Allah deemed this worthy or suitable for me, then, I have to agree with this.

In summary, in this sub-theme, what the participants perceived as the causes of their psychological problems were discussed. Participants generally stated that they had problems due to family disputes and traumatic life experiences such as death and traffic accidents. Participants also said that these situations caused psychological problems, especially because they did not share their problems with others. Finally, some participants stated that these problems happened to them because they were destined by Allah.

3.2.1.3. Attitudes toward Psychological Problems

Attitudes toward psychological problems was the third subordinate theme. This theme included the others' reactions toward the participants who had psychological problems and participants' attitudes towards psychological problems in general. Generally, participants believed that their psychological problems were not understood and they were belittled by the society because of their psychological problems. Only one of the participants, P9, received support from his friends during the problematic period of his life. Yet, he also thought that if his problems were heard in the village, people would spread gossip about him. P3 who suffered from panic disorder, complained about negative attitude and reactions of others as follows:

Actually, nobody wants to get rid of this problem as much as I do. Who wants to be restricted? People say that my problems are not real. All of them are in my head and if I want to be normal, it will just depend on my own strength. They think that I can change the situation, if I want. I can end it all in my head. However, this is not the reality. Maybe they would understand me if they experienced only one percent of my problems.

Due to such attitudes of people, she preferred to hide her problems. She did not talk about her problems because she did not want to hear negative comments about herself. Similarly, P6 also did not share her problems with others for the same reason:

People around me think that I am comfy because of being in a better financial situation than they are. They ask me 'why are you getting angry even though there is no problem. What is your problem?' They think that this problem is insignificant. They behave like this instead of listening to me carefully. So, I choose not to talk about my problems.

In addition to people's insensitive attitudes, participants also faced stigmatizing attitudes. Participant1 who had close relatives in psychiatry clinics gave a very detailed account of this issue. She was exposed to rumors about her family and stigmatized in the village:

They usually talk behind my back. I hear their rumors later. They make fun of me and my family with bad nicknames, such as ‘crazy, nuts, bad seed.’ I have a brother. Sometimes he acts in strange ways in the village. For example, once he burned some of my mother's goods, then some of the villagers began to say that ‘you are all mad, your family is mad, too. You have a bad family. C family (The nickname of her family in the village) is completely mad.’ You know, I am from that family also. I hear all of those bad words and I feel humiliated. In this case, even though I do not have any psychological problems, they think that I have. Having these kinds of relatives is enough for people to label me as mad. I think all siblings can have different characteristics in a family. You cannot treat the whole family the same way. Before you criticize others, you should think first. You do not have the chance to know what people go through in their lives. You cannot exactly know the underlying reasons for people’s behaviors. You cannot know why he or she stole something, killed someone etc. Therefore, I never criticize my brother and other people.

In summary, participants generally faced negative attitudes towards their psychological problems. Some participants have been stigmatized by the society due to their psychological problems. For this reason, the majority of the participants refrained from sharing their problems.

3.2.1.4. Personal Experience of Psychological Problems

The fourth subtheme was *personal experience of psychological problems*. This theme included the participants’ experiences regarding their psychological problems. While some participants used more technical expressions to refer to their problems, such as panic, depression, stress, trauma, others described their problems with cognitive, affective, and somatic symptoms such as forgetfulness, nerves (sinir bozukluğu), pessimism, sadness, anger, constant crying, insomnia, nausea, anorexia, and blurred vision. The participants explained how their problems started and then mentioned the symptoms they experienced. A quotation from P3’s interview can exemplify this:

Ten years ago, I suddenly woke up with palpitation. I could not open my eyes properly. I could not look at the clock. I could only sit inside the bed. Everything was spinning around me. It was so strange. Later on, I could open my eyes and move. This scene would be in movies on TV. At that moment, I could only go to the sink by crawling. I turned on the tap, washed my hands and face. I did not know what happened to me at that moment. My heart beat increased, my body tingled, and I felt hot. The morning of that night I felt better,

but I did not know the reason of my discomfort. I have different explanations for that night. Blood pressure, heart attack etc. Later on, I had an increase in my appetite. I wanted to eat everything but I lost it after a short while. I could not eat anything. I only drank water. I felt weak. I could not do anything, any housework. Then, people said to me that 'you have to do something, you have to go to the doctor. You may have neural problems.' One of my relatives helped me and I went to a neurologist.

When P8 received the news of her husband's death, she had a burning sensation in her chest and experienced palpitations. She continued to experience these feelings from time to time. P4 had a problem with her sisters and her husband's family during the first years of her marriage and she often fainted. She explained the fainting spells she had during that period as follows:

I had a lot of trouble at that time. I was fainting but I did not go to the doctor. My hand and foot were numb. People didn't know what happened to me, but I knew that these faintings were psychologically based. I had a lot of convulsions. I was keeping everything inside (içime atıyordum). Therefore, I got psychological problems. I fainted, convulsed, but I could not get any help.

Even though most of the participants did not have any current problems, some of them still had problems at the time of the interview. P6 could not feel psychologically well since very young ages and she had various kinds of psychological problems at every stage of her life. She had fantasies about harming and cutting her children during the first few years of motherhood. At that time, she could not touch the cutting tools at home in order to avoid harming her children. According to her, fears about harming the children disappeared as time passed, but her fear had transferred to other areas of her life and increased when she felt bad:

I am afraid of the water, the blowing of the wind, the light, the fire and so on. I am even more afraid of these if I feel bad. For example, I still can't lay my feet on the ground. I still tuck up my legs because I think that the ground may pull my leg. That's the kind of disorder I have.

In summary, this theme included the participants' personal experiences of their psychological problems. The participants shared their experiences from the beginning of their problems. They gave examples about the symptoms of

psychological problems. These symptoms were generally related to bodily sensations. There were participants who still had psychological problems.

3.2.2. Psychological Help

The second superordinate theme was called *psychological help*. This theme included participants' reports on different aspects of professional psychological help. It encapsulated three subordinate themes: Knowledge about mental health professionals, the experience of psychological help, and attitudes and perceived barriers toward seeking psychological help.

3.2.2.1. Knowledge about Mental Health Professionals

The first subordinate theme was the *knowledge about mental health professionals*. The subjects of this theme were the opinions of the participants about the sources of professional psychological help, the differences between these sources, the participants' preferences in terms of mental health care providers, and participants' expectations regarding psychological help.

The participants were asked who the people providing professional psychological help are. The participants mentioned various mental health professionals in response to this question. Two of the participants stated that people giving psychological help were psychiatrists. Three of the participants thought that both psychologists and psychiatrists gave psychological help. One of the remaining participants mentioned the name psychological doctor, but probably meant a psychologist. Two of the participants stated that they did not know who gives psychological help. When they needed such help, they could get it from the nearest hospital. P1, who previously received psychiatric support, thought that the general surgeon or neurosurgeon was the source of professional psychological help and added:

If I feel uncomfortable in any part of my body, I have to go to the doctor who specializes on that part. For example, if one's arm gets hurt, he or she should go

to orthopedics. Therefore, if anything happens in the brain, he or she should go to the neurosurgeon first.

It was observed that the participants generally did not know the difference between the professionals who give psychological help. Only P3 and P6 could make this distinction more precisely. Both participants received psychiatric support for many years and still had psychological problems. P3 found psychiatrists more competent:

I think medication is better for me. I went to the psychologist and he asked the medications that I used. He told me to continue [using those], and he did not give any other medication. Therefore, I don't think they are competent. I want to go psychiatrists. I think they are more competent than any other professionals. Psychologists only listen to patients and neurologists only give medication. Psychiatrists, however, not only give medication but also listen to me and give advice.

P6, on the other hand, thought that psychologists dig down deep and therefore, she would prefer psychologists if she needed such help. P5 thought similarly. Although she did not know the names of mental help professionals very well, she made a distinction between psychiatrists and psychologists and said:

I do not know the names of the professionals exactly, but I heard that there were psychiatrists who prescribed drugs, there were others who treated people by talking. I think talking is better for people. It is good to tell what happened to you. I can relax by talking. Therefore, treatment by talking is better for me, but there may be people who need medication.

All of the participants expected to benefit from psychological help. These benefits were being good for their psychological health and finding solutions to their problems. The majority of the participants expressed their expectations from psychological help without elaborating. For example, P5 said 'to relieve me, to heal me,' P4 said 'to relax me,' P9 said 'to solve my problems,' P2 mentioned 'to relieve my troubles,' and P3 stated 'to get rid of my illness, be happy, and be positive.' P7 expected medical treatment from psychiatrists. Some participants expected professional support to change their lives. One of these participants, P10, went to a psychiatrist once and even though he had only one

meeting with the psychiatrist it helped him very much. P10 explained his expectations from psychological help as follows:

It (psychological help) can change my life. It can change the car I drive, the dress I wear, the city I live in. It can change everything. These changes should be provided based on the severity and type of my problems. For example, let's say, I am wearing black clothes, and these clothes may affect my mood. The doctor can say that why are you wearing these black clothes, you can prefer more colorful clothes. It means, doctors can give any kind of advice. As I said before, I used to watch war and horror films before visiting the psychiatrist. The doctor said to me that these kinds of movies might effect my mood badly, so I should watch something funny. His simple advice changed my movie preferences and affected my mood positively.

In summary, the sources of psychological help, differences between various providers and participants' preferences for different mental health care providers constituted this sub-theme. Although some participants provided different names for different professionals, they generally did not know the differences between the sources. Additionally, participants expected psychological help to solve their problems, to relieve them, and to create changes in their lives. Participants' expectations were positive and consistent with their attitude toward seeking psychological help.

3.2.2.2. The Experience of Psychological Help

The second subordinate theme was *the experience of psychological help*. This subtheme included the psychological help experiences of participants or experiences of others around them and their thoughts about this help. Six of the participants received professional psychological help at least once. The participants usually decided to get psychological help when they were in a very difficult situation and when their symptoms became more severe. Also, the participants who did not get any help before said that if they felt very uncomfortable, they would seek help. Five of the participants who received mental health care used medication for a while and four of them had negative attitudes toward medication. P5's excerpt can illustrate this attitude.

I took medication because I was crying all the time. Drugs stopped my crying, but they caused forgetfulness. I started to forget everything. For example, I started to forget what I was talking about. I would enter the kitchen in order to take a knife but I would take a spoon and go to another room. I was carrying items that belonged to the kitchen, such as hand towels and pots, to other rooms. Then I thought and said to myself that this could not continue like this. I used this medicine for a month, and then I quit taking it.

To conclude, half of the participants received services from mental health professionals and the other half thought that they would receive help if they needed it. Some participants had a negative attitude towards psychiatric medication. They thought that psychiatric drugs cause excessive sleep and lightheadedness.

3.2.2.3. Attitudes and Perceived Barriers toward Seeking Psychological Help

The third subordinate theme was *attitudes toward seeking psychological help*, which encapsulated both attitudes and reactions of the participants and others around them. This subordinate theme also included the barriers perceived by the participants in getting psychological help when they needed it and their suggestions for eliminating these barriers.

The participants' attitudes towards psychological help were generally positive. The majority of the participants thought that it was easier to share their problems with people they do not know and if they were to get professional help, they could easily share their psychological problems with the professionals. For example, P6 said that 'psychological help means to be well. It provides a feeling like holding onto something.' P4 also saw psychological help as a good thing and added that if she experienced a problem in the future, she would consider getting professional psychological help. Similarly, P3 considered psychological help as a necessity in some circumstances and trusted doctors very much.

On the other hand, all but one of the participants had a negative attitude towards medication. They thought that drugs numbed people who use them. P1 is one of the participants who deemed drugs as harmful. She reported:

I said that these people (mother-in-law and her family) do not understand me. If I consulted a doctor, he might tell me something and I might be fine. But if I told a friend instead of going to a doctor, it would be better. Why? Taking drugs is harmful for people over time. It damages the hormones. There are other problems. I used medication for 6 months. The medicine harmed my stomach, made me feel dizzy, and lowered my blood pressure. My hormones have become inoperative. For example, now I am having menstrual irregularities. I asked the doctor too. He said to me that the hormones went to sleep, because this was such a heavy drug.

P1 also added decreased sexual desire to her list of problems and linked these problems to her use of antidepressants in the past. She learned from a television program that sexual problems are real so psychological issues and she wanted to consult with professionals about this problem.

Even though most of the participants had positive attitudes towards talk therapy, almost all of the participants (9 participants) saw professional psychological help as the last resort. For example, P1 thought that she would go to professionals only if she were in a very difficult situation. She did not trust people, so, she would prefer to hide her problems even if she went to a psychologist. P6 had similar opinions about psychological help seeking and added that the rumors might prevent her from getting this help. For some participants, psychological help is not even the last resort. For example, P7 said that she had no barriers in terms of getting psychological help. Yet, she would not prefer to go to professionals even if she had difficulty in her life. P8 had similar thoughts. She did not believe that psychological help would solve her problems and therefore, she did not think of getting help.

Participants planned to try different ways of coping before seeking professional help to solve their problems. A quotation from P9's interview can exemplify this:

If you feel very bad, you have to go to the doctor. For example, let's say you always get angry and get upset. Then, you talked to your neighbors about your problems and sought their support, but your problem did not go away. When this is the case you should go to the doctor.

One of the reasons for thinking that psychological help should be the last resort was the fear of being stigmatized. The participants thought that the people they know might gossip about them if they knew about their psychological problems. This concern showed that the others' attitudes and reactions can have a negative influence of the participants' attitudes toward seeking psychological help. In fact, the majority of the participants (8) stated that the society has negative attitudes toward seeking psychological help. The remaining 2 participants thought that (P3 and P5) because psychological help is more common these days, people are more receptive towards it. P3 explained:

If I receive such help, I will not get a negative reaction. Maybe it would have been the case in the past, but I have not heard anything bad these days. They did not say anything negative to my face, but maybe they thought about it. Currently, I think at least three out of ten people have psychological problems in the society. People know and accept this situation. I don't think I would get negative reactions, because people know more about psychological problems and treatments. Even my relatives, my neighbors, my friends say that you should go to a professional again, maybe you will overcome your problems.

According to the majority of the participants, a person who receives psychological help was used to be considered crazy. P10 reported that especially older people had negative judgments in the village and if he got such help, he would be called crazy and mentally unstable. P7 and P9 also stated that they would hear similar words and therefore, if they received such help, they would keep it as a secret. Participants 7 and 9 were not the only ones who thought that they would hide it if they wanted to get professional help. P4 explained this situation in more detail:

People call them (people who received psychological help) crazy in the village. I feel a little shy about it. There would be gossip if I get such help. For example, I had a lot of menstrual bleeding. I stayed in the hospital. I can talk about this very comfortably, but if I have a psychological problem, I will hesitate to talk about it and its treatment. I had a herniated disc and I started taking medication.

I said to my neighbors that I was sick and I used drugs. I heard their whispers about me. They said that ‘P4 also uses psychiatric medicines, therefore, she became crazy and mad’. I went to them and said that I am not sick or mad. Although people use psychiatric drugs in the village, they keep it a secret.

In addition to these negative attitudes and stigmatization, there are other barriers to receiving psychological help. P2, P4, and P5 admitted that there were some obstacles in getting psychological help. According to them, financial difficulties and difficulty in accessing hospitals prevented them from getting psychological help. A quote from P5’s interview can explain this issue:

[The hospital] Being close to my house is very important. We are economically in a bad situation, so I cannot afford it unless it is accessible for me. If we lived in the city, I would go to the hospital just by paying 4 liras for the bus, but the situation is not the same in terms of living in the village. It is expensive. You must pay 20 liras for a return fare. When we add food prices, it becomes around 50 liras. It is really high for a villager.

According to P2 and P4, eliminating financial and transportation problems would make getting psychological help easier for them. P4 also underlined the need for state support:

We can get psychological help if the state supports us financially. Recently, the general practitioner gathered women in the village to do breast cancer screening. When we said we were going to the breast cancer screening, those who did not think of going wanted to come with us. Similarly, I think that if the state provides transportation, people would be willing to get psychological help. It would be nice to get psychological support from a place like family health center because of the proximity of these centers.

In summary, although the participants thought that psychological help was beneficial, they hesitated to use drugs. The participants thought that there is a negative attitude towards people who receive psychological treatment in the society and if they wanted to receive such help, they would keep it a secret. It was observed that fear of being stigmatized prevented these participants from seeking psychological help or led them to keep it as a secret. In addition, the majority of the participants did not think that there was an obstacle to receiving psychological help. Yet, the participants seemed to have a negative attitude toward getting psychological help. Some of the participants stated that financial

difficulties and transportation difficulties created obstacles. According to these participants, making psychological help more accessible by providing governmental support could help them to overcome the obstacles.

3.2.3. Coping Strategies

The last superordinate theme was *coping strategies*. Coping strategies used by the participants when they encountered problems or felt bad were grouped under this theme. The participants were asked about resources that would help them feel better, other than mental health professionals, and their answers constituted the sub-themes of coping strategies theme. Sub-themes of this theme were engaging in work, social support, and religious activities.

3.2.3.1. Engaging in Work

Under this theme, the participants talked about their work in the village and the positive effects of this work on their psychological state and coping with daily stress. Six of the participants used this strategy. For example, P8 regularly went to graze her cows. She got retired after her husband's death and she did not have financial difficulties, but she wanted to keep working nonetheless. Her neighbors thought that it was unnecessary for her to work, but P8 said that if she did not have cows, she would go to an asylum. She explained that she bred animals not only for financial gain but also for enjoyment. Additionally, she was engaged in agriculture. Feeding the animals and farming were both good for her. Similarly, P1 stated that taking care of animals was good for her. She shared her problems with her animals rather than talking to people because animals did not criticize her. P7 explained that not only doing housework but also gardening helps her:

I go to the garden when I am angry. I dig the soil, collect nuts, do agriculture. When I engage in the garden work, I feel better and relieved. After the garden work, I come home and do housework. I am trying my best to provide a good life for my husband and my children.

In summary, the participants talked about the positive effects of their work, such as gardening and animal care, on their psychological health. Participants did not consider such work as a burden, but as a healing activity.

3.2.3.2. Social Support

Under this theme, the social support resources of the participants and the positive effects of these resources on the participants were discussed. The most emphasized coping strategy was social support. When the participants encountered a problem, they shared this with their friends and neighbors, and the social support they received as a result of this sharing gave them morale. When the relatives of P2 and P8 passed away, their neighbors often invited them to their homes and cried with them. P8 described those days as follows:

My neighbors made good wishes. They said that ‘May Allah give you patience!’ at that time. They gave me support. We (the participant and her sister) usually went to H (one of their neighbors). We spent the last winter with her. She supported us. She and her mother talked to us. They offered tea. May God be pleased with them. If they were not with us, we could not have coped with this grief.

Participant 8’s neighbor, Ms. H is a 20-year-old woman who lives in the same neighborhood. Despite the participant’s advanced age, she preferred to talk to a young woman in her neighborhood for support. Ms.H received religious education from a Quran course. Therefore, she gave them not only social support, but also religious advice.

Some of the participants even shared their problems with strangers. For example, after the hospitalization of her grandson, P5 also stayed in the hospital as an attendant for the child. P5 stated that she shared her problems with the people at the hospital and relaxed. She added that if she did not share, she would go crazy. Although socializing and sharing problems with different people were important resources in solving problems and improving psychological well-being, some

participants preferred to be alone when they experienced psychological problems. One of the main reasons for this might be lack of trust in others.

In summary, social support appeared as an important coping strategy for the participants. Although, the participants sometimes felt free to share their problems to receive psychological support, other times they socialized without sharing their problems or they choose to be alone.

3.2.3.3. Religious Activities

Six of the participants used religious activities as a coping strategy. As stated in the perceived causes of psychological problems subtheme, for some participants, the problems they experienced came from God as a test. Thus, turning to Allah to cope with these problems was a logical problem solving method for these participants. Praying, chanting the name of God, and reading the Quran provided comfort. Literate participants explained that they read books containing suras from the Quran and prayers from prayer books. P5 explained her feelings as follows:

I recite *kelime i şahadet* [Islamic confession of faith] and commemorate my God. I start every work with his name. Before doing any work, I take ablution. I read verses from the Quran. All of these are good for me. Reading Yasin sura makes me feel better. I took the Quran with me to the hospital. I was reading some suras twice a day. In doing so, I read the Quran from start to finish. It was very good for me to do this. I felt like my grandson was getting better when I read.

The illiterate participants, on the other hand, explained that reciting the suras and the prayers that they memorized helped them feel relaxed and relieved their negative emotions. P1 was one of these participants. She stated that ‘If I cannot remember any sura or prayer, I recited *bismillah* (Basmala: In the name of Allah, The compassionate, the merciful) I repent and ask God for forgiveness (tövbe etmek) and praise my God. I pray to him to show me the right way. When I do these activities, I feel relieved’. Additionally, participants who practiced

religious activities recommended these methods to their relatives. To illustrate, a quote from P4's interview can be given:

I used drugs. It was not very good for me. I say to my neighbors that instead of using medicine, you should pray and read the Quran. God's power is sufficient for everything. He can give us what we want, so we need to ask him for all of our needs. There was a woman last night and she was using medication. She could not leave her home last year. She had psychological problems. I convinced her to attend Quran courses in the mosque. During these lessons, this woman got better. Now, she does not use any drugs.

In summary, religious practices were used as a coping method by the participants and made them feel better and relaxed. Most of the participants thought that religious activities have a psychological healing effect. Therefore, participants used these activities to improve their wellbeing and recommended them to their surroundings.

CHAPTER 4

DISCUSSION

The aim of the current study was to understand intention to seek psychological help. Accordingly, the current thesis employed a mixed-method study design, consisting of a quantitative and a qualitative study, to reach a more comprehensive understanding of processes involved in intention to seek psychological help. In the quantitative part of this study, it was hypothesized that attitudes, stigma toward seeking psychological help, having psychological problems, age, gender, education level, and previous mental health treatment experiences would predict intention to seek psychological help. Another hypothesis was that attitudes and stigma toward seeking psychological help would mediate the relationship between having mental health problems and intention to seek psychological help.

In the qualitative part of the current thesis, participants' experiences of psychological problems and psychological help seeking, reasons behind not getting professional psychological help, and coping skills were examined. For this purpose, semi-structured interviews were conducted with ten villagers who had higher scores of psychological problems but lower scores of intention to seek psychological help than the rest of the participants. Thematic Analysis was conducted to analyze the interviews. In the following section, the findings of both the quantitative and qualitative parts of the study were discussed in light of the related literature.

4.1. Study 1: The Quantitative Study

In order to test the first seven hypotheses of the quantitative study, multiple regression analysis was conducted. According to the results of the multiple regression analysis, attitudes toward seeking psychological help significantly and positively predicted intention and age of the participants significantly and negatively predicted intention. Only hypothesis 1 and 5 were supported by the results of multiple regression analysis. Results revealed that participants who had more positive attitudes toward seeking professional psychological help also had higher levels of intention to seek psychological help. In addition, older participants had lower levels of intention to seek such help, and this regression model was able to explain 31% of variance in the scores.

Although the intention to seek psychological help significantly correlated with stigma toward seeking psychological help and education level of the participants in the correlation analysis, no significant relationships were found in multiple regression analysis. The reason for this may have been the correlation between the variables and small sample size. In future studies, hierarchical regression can be done to understand which variables are more effective in this equation and sample size should be increased.

In the regression analysis, although stigma did not predict intention significantly, it was quite close to being significant ($p = .054$). Thus, stigma can still be an important variable in predicting getting psychological help. As a matter of fact, in the second stage, the interviews with the participants in the qualitative study showed that stigma is an important issue for the participants. This issue will be discussed in more detail in the qualitative discussion section.

Pheko and her colleagues (2013) conducted a study with university students in Botswana and found similar results. In this study, the authors used the same attitude and stigma scales as in the current thesis. Results revealed a negative relationship between attitude and stigma. In addition, significant relationships

were found between these two variables and intention. Students with more positive attitudes toward seeking psychological help had lower levels of stigma toward seeking psychological help and higher levels of intention to seek psychological help.

As stated before, although there was no significant relationship between education level of the participants and intention to seek psychological help in the regression analysis, a significant and positive relationship was found in the correlation analysis. The positive relationship between education level and intention in the current thesis was also supported by previous studies (Pilkington et al., 2012). For example, Picco et al. (2016), conducted a study with 3006 participants with different educational status. Their findings showed that the participants with higher education had more positive attitudes toward seeking psychological help. In the present study, participants with low levels of education mostly lived in the village. Therefore, their level of the knowledge about professional psychological help might be limited to the examples that they had seen in the village. However, the participants with higher education levels went out of the village to complete their education. At the time of data collection, these participants had completed their education and they had been living in the village for at least one year. These participants may have encountered more examples of psychological problems and professional help in the cities and schools in which they were educated. In addition, concepts related to psychological problems and psychological help mostly originate from the Western culture. Also, it can be said that the education system in Turkey is also based on a Western worldview. Therefore, receiving higher levels of education may have led to more westernization and to becoming more familiar with the Western concepts of psychology. Consequently, participants might have gained more knowledge and familiarity with professional psychological help resources and benefits of this help, which may have contributed to the positive attitudes of the participants.

There were contradictory findings in the literature regarding the relationship between age and intention. Although some researchers found a negative relationship between age and intention (Picco et al., 2016), studies generally showed a positive relationship between these two variables (Chen et al., 2020; Mackenzie et al., 2008). For example, Rüsçh et al. (2011) conducted a study with 1751 adults and found that positive attitudes about mental illness and psychological help predicted intention to seek psychological help. They also found that better knowledge about mental illness and older age were predictors of intention to seek psychological help. In the current study, however, there was a negative relationship between age and intention to seek psychological help. As the age of the participants increased, their intention to seek psychological help decreased. This may be due to the demographic characteristics of the participants in this study. Participants with higher levels of education were mostly younger and there was a negative relationship between age and education level. Also, there were more illiterate people among the elderly participants. As mentioned previously, the negative attitude of elderly participants towards receiving psychological help may stem from their level of knowledge about psychological help.

Also, researchers previously demonstrated that being a woman (Ando et al., 2018), having higher levels of education (Picco et al., 2016), and having previous psychological help experiences (Seyfi et al., 2013) are positively related with the intention and attitude toward seeking psychological help. In this study, however, these variables did not significantly predict intention to seek psychological help. Gender-related difference was thought to be mainly related to the level of education of the participants. The education level of the vast majority of female participants was quite low. All illiterate participants were women. Therefore, they presumably did not have enough information about psychological help. In addition, these women were mostly financially dependent on their spouses. Even if they wanted to get psychological help, they might have to make a decision with their spouses. They may find it difficult to afford psychological support alone because most of them did not have economic freedom.

In the present study, there was no significant relationship between previous psychological help experience and intention to seek psychological help. This could be due to the fact that the number of participants who stated that they had received psychological help was very few. Also, the psychological help mentioned by the participants usually involved one or two interviews with a psychiatrist. It seemed that psychological help was perceived as drug therapy. In this case, previously received psychological help may be insufficient for the participants to develop an intention to receive psychological help in the future.

There are studies showing that having psychological problems predicted the intention of seeking psychological help (Topkaya, 2011; Vogel & Armstrong, 2010; Vogel, Gentile & Kaplan, 2008; Vogel, Wade & Hackler, 2008; Vogel and Wei, 2005). In a study conducted by Topkaya (2014) with 506 university students, it was found that students with higher psychological difficulties had higher intentions to receive psychological help compared to those who reported less psychological distress. According to the findings of the current study, no relation was found between these two variables. This result can be understood from what psychological help meant for participants. Participants might not have enough information about the necessity and benefits of psychological help. In this case, having psychological distress may not bring along an intention to receive psychological help.

In the current study, it was hypothesized that attitudes and stigma toward seeking psychological help would mediate the relationship between having mental health problems and the intention to seek psychological help. Although there was no significant relationship between having psychological problems and intention to seek psychological help, mediation analyses could be performed by using Process macro (Hayes, 2018). The attitude and stigma variables, which were frequently used to predict intention to seek psychological help, were investigated as mediators in this study as well. Two separate mediation analyzes were applied to test hypothesis 8 and 9.

According to the first mediation analysis, attitude did not significantly mediate the relationship between having psychological problems and intention to seek psychological help. Yet, the second mediation analysis showed that stigma mediated the relationship between having psychological problems and intention to seek psychological help. Although having psychological problems had no significant direct and total effect on intention to seek psychological help, the indirect effect through stigma was significant. Additionally, there was a positive and significant relationship between having psychological problems and stigma and negative and significant relationship between stigma and intention to seek psychological help. Thus, as psychological problems increased, stigma towards seeking psychological help increased, which in turn led to a decrease in intention to seek psychological help. As a result of mediation analysis, while hypothesis 8 was not supported, hypothesis 9 was supported. The reason why attitude significantly predicted intention in the regression analysis but was not significant in the mediation analysis may be due to the difference in the variables in both analyses. Future studies can perform these analyses by controlling the effects of possible demographic variables.

Although the effect of stigma and attitudes on intention to seek psychological help has been studied frequently, there is no study in the literature that examined the relationship between psychological problems and the intention to seek psychological help through stigma and attitudes as mediator variables.. Stigma was not significant in predicting intention to seek psychological help, but was significant in mediating the relationship between having psychological problems and intention. These results revealed the important effect of stigma on the intention to seek psychological help. Although people have psychological problems, they may avoid getting psychological help due to fear of stigma or stigmatized thoughts. Fighting stigmas can be an important step in seeking and accessing professional psychological help.

To conclude, attitude and age predicted intention to seek psychological help, which has also been supported by the results of many other studies in the

literature. On the other hand, although gender, education level, previous psychological help history, stigma, and psychological problems predicted intention to seek psychological help in previous studies, no such relationships were found in the present study. The reason for this may stem from the present study's sample characteristics. Additionally, although attitude did not mediate the relationship between having psychological help and intention to seek psychological help, stigma did. The mediation analyses revealed the importance of stigma in seeking psychological help.

4.2. Study 2: The Qualitative Study

In the qualitative study of the present thesis, the opinions and practices of the participants in regards to psychological problems, professional psychological help, and coping strategies were examined in detail. All of the participants talked about the characteristics of people with psychological problems. According to them, the basic cause of psychological problems was not being understood. The participants were afraid to talk openly about their problems because they thought that people around them might have negative attitudes toward people with psychological problems. Therefore, the participants preferred to hide their experiences regarding psychological problems and experienced psychological problems mostly through physical symptoms.

During the interviews, participants also explained their knowledge of and experiences about professional psychological help, their attitudes toward psychological help, and the barriers to access this help. Although the participants knew that there were different sources of professional help, they did not exactly know the differences between these sources. Participants' experiences mostly consisted of psychiatrist interviews and the use of antidepressants. Although participants regarded psychological help as a positive experience, they were afraid of others' negative attitudes and stigmatization. Financial issues and transportation challenges were also mentioned as barriers. They developed

various methods to deal with psychological and daily life problems. These methods were engaging in work, social support, and religious activities.

Psychological problems emerged as the first superordinate theme in the present study. The information given by the participants about the characteristics of people with psychological problems was mostly about their appearance and physical symptoms. Similarly, a study by Daros et al. (2016) revealed that physical appearance may be a clue in making psychopathological evaluations. In this study, the photographs of 30 people diagnosed with borderline personality disorder and 30 people with no mental disorder were shown to the participants and they were asked to classify these individuals regarding their susceptibility to psychological problems. Participants showed a statistically significant capacity to detect differences between the two groups.

Although the opinions of the participants about the possible causes of the psychological problems were various, all participants agreed that failure to share their problems was the basis of the psychological problem. Additionally, participants mentioned a relationship between psychological problems and stressful life events. They stated that losing significant others, moving to a new city, problems in the family may result in psychological problems.

Previous studies also demonstrated that stressful life events can play a part in developing psychological problems (Kendler & Gardner 2010; Low et al., 2012; Mazurka et al., 2016; Muscatell et al., 2009). In a study conducted with 4763 Iranian adults, Hassanzadeh and his colleagues (2017) investigated the association between stressful life events and psychological problems. In this study, the relationship between both personal and social stressors and common psychological disorders such as stress, anxiety, and depression were examined. Accordingly, both personal stressors (home life, education, loss and separation, sexual life, and health concerns) and social stressors (financial problems, social relations, personal conflicts, job conflicts, job security, and daily life) were significantly associated with psychological distress, anxiety, and depression.

The participants in the present study also emphasized destiny as one of the reasons for having psychological problems. For example, the participants who had problems with their mothers-in-law and saw their mothers-in-law as the basis of their problems thought that Allah gave such mothers-in-law to test the participants. They did not seem to blame anyone for their troubles.

Islamic concepts such as being tested by Allah (imtihan) and reliance on Allah (tevekkül) seem related to the participants' statements regarding destiny. According to Islam Encyclopedia of Religious Foundation of Turkey, (Diyanet İşleri Vakfı İslam Ansiklopedisi, 2020) God gives problems and distress to try people. Also, believers are expected to rely on Allah, surrender to Allah and trust him for everything. Therefore, difficulties are sent by God to test people, people should be patient without complaining about these difficulties and expect help from Allah. As stated in the previous sections of the discussion, most participants had low levels of education and they were mostly raised within Islamic culture rather than the western education system. For this reason, it was possible for these participants to have the belief of being tested (imtihan inancı), which is common in Islamic culture, and to turn to religious sources instead of seeking professional help. Similarly, Esen Ateş (2018) conducted a study with veterans and relatives of martyrs and veterans and found that the vast majority of the participants evaluated their traumatic experiences within the framework of being tested and this perspective was functional in terms of coping. According to Esen Ateş (2018), if a person attaches importance to religion, if there are prescriptions directly provided by religion regarding the problem situation he or she is experiencing, religious practices will gain importance as coping strategies.

All of the participants stated that the society had negative attitudes toward people with psychological problems and therefore they were hesitant to express themselves. Studies previous demonstrated that fear of exposure to stigmatization is one of the biggest obstacles to seeking psychological help (Corrigan, 2004). For example, Gutierrez et al. (2020) found that self-stigma of mental illness and self-stigma of help seeking have a direct effect on attitudes

toward help seeking. Social stigma due to psychological illness and psychological help is quite common and occurs in many different ways. In a study conducted by Çağlan and Göcen (2020) with 20 participants who had a psychiatric diagnosis, most of the participants stated that getting psychological support devalued the person and they could not share their situation with anyone in order not to experience stigma such as religiously inadequate, immature, etc., by their social environment. Although the participants of this study did not mention a religious stigma, their religious explanations about the problems and religious coping methods for these problems brings to mind the issue of religious stigma.

Fear of stigma of any type is a barrier that makes it difficult to seek treatment. Avcil and his colleagues (2016) reviewed studies about stigmatization in Turkey. They concluded that stigmatization has a long-lasting, strong and negative effect on healing and even being treated continues to make life difficult by causing stigmatization and a decrease in quality of life. Consistent with the existing literature, the present study showed that fear of stigmatization and fear of being exposed to negative attitudes of other people prevented participants from telling their problems and searching for a solution. For example, one of the participants, P4 said that she could not share her problems with anyone because people would judge her, and she never tried this before. Even when she went to the psychiatrist, she did not tell about these troubles because she was afraid of being stigmatized by the doctor.

The participants also explained their experiences of psychological problems through the definition of the problem, how it started, and what they experienced during this period. While some of the participants who went to a psychiatrist described psychological problems through more technical expressions such as depression, anxiety disorder, and panic disorder, others who did not encounter any mental health professionals defined psychological problems with symptoms, such as insomnia, anorexia, blurred vision, and inability to enjoy anything.

Psychological Help emerged as the second superordinate theme in the present study. According to the participants, the people who provided psychological help are psychiatrists, psychologists, and neurologists. Although the participants did not know exactly what these professional groups are doing and the distinction between them, their expectations from psychological help were generally positive. They believed that psychological help would solve their problems. Only 6 of the participants received professional psychological help at least once. Some participants clearly stated that they talked to a psychiatrist, while others mentioned names like the nerve doctor, the psychologist, and the doctor. This may be due to the fact that the participants did not know these mental health professionals' titles clearly. Five of the participants who received help before were prescribed medication, but one of them quit taking the medication after a while. All of the participants stated that the drugs made them sleepy and they had to stop using the drugs because being sleepy made it difficult for them to carry out the work in the village.

All this information about psychological problems and psychological help gave clues about the mental health literacy levels of the participants. The concept of mental health literacy (MHL) was introduced by Jorm et al. (1997) and defined as 'knowledge and beliefs about mental disorders which aid their recognition, management and prevention' (p.182). It consists of several components. These are:

- (a) the ability to recognition of specific disorders,
- (b) knowledge and beliefs about risk factors and causes;
- (c) knowledge and beliefs about self-help interventions;
- (d) knowledge and beliefs about professional help available;
- (e) attitudes which facilitate recognition and appropriate help-seeking; and
- (f) knowledge of how to seek mental health information (Jorm et al., 1997, p.182).

As can be seen from the above definition and components, recognition, knowledge and attitude themes stand out in mental health literacy. Early recognition of disorders may facilitate early help-seeking and provide more successful interventions. Similarly, having sufficient information about the problem and professional help will speed up the help seeking. Therefore, individuals with a high level of MHL can be expected to be more likely to seek professional psychological help and more likely to benefit from this help. Deficiencies in the 6 components of MHL mentioned above will result in a low level of MHL. Low level of MHL has been noted as a barrier in seeking psychological help (Wang et. al., 2020). According to Cheng and his colleagues (2018), MHL predicted attitudes toward seeking psychological help. Low level of MHL was significantly associated with negative attitudes towards seeking psychological help.

In the present study, it can be said that the mental health literacy (MHL) level of the participants was low. Participants described psychological problems mostly based on symptoms and did not mention any distinction between these problems. Participants' knowledge of psychological help resources was very limited. They did not know exactly professional help resources and the differences between them. Although they stated that they do not have negative attitudes toward seeking psychological help, they considered seeking psychological help as a last resort. Due to all these, it was concluded that the mental health literacy levels of the participants were low. According to Jorm (2012), in order to improve MHL, information campaigns can be organized at the country level. These campaigns can provide information about psychological problems and their symptoms through the media and explain that these problems are treatable. Education packages on psychological problems can be offered in schools. In the light of Jorm's suggestions (2012), training programs can be organized to increase the mental health literacy of individuals living in this village. Breast and uterine cancer screening is carried out periodically in the village through the ministry of health. For this purpose, villager women gather together. In addition, speakers on religious issues are sent to the village by the Presidency of Religious Affairs

(Diyanet İşleri Başkanlığı) at regular intervals, and the villagers come together at the mosque. Similar to these meetings can be held for mental health. By providing information about mental health in these meetings, villagers may open themselves, and they may develop more positive attitudes toward psychological help.

In addition to low mental health literacy, financial difficulties also caused the participants to refrain from getting professional psychological help. The nearest hospital was 45 kilometers away from the village and there were not very many busses that travel the distance during the day. The village bus usually went to town very early in the morning and returned to the village at noon. In addition, the fee for this round-trip was 30 liras when the present thesis was written. This money is hard-earned money for many people in the village. Most families in the village make a living by selling milk. For these families who sell one liter of milk for 1 lira, 30 liras correspond to their 3-day earnings. For this reason, it is difficult for these people to seek help not only for their psychological problems but also for their physical illnesses, unless there is a very urgent situation.

The barriers to getting psychological help and what needs to be done to eliminate these barriers have been addressed in many studies in the literature. In one of these studies, which was conducted by Tomczyk et al. (2019), the relationship between structural and attitudinal barriers and psychological help were examined. According to the results of the study, spatial and temporal distance from mental health services predicted help-seeking. Among the attitudinal factors, the belief that treatment would be beneficial strongly predicted getting psychological help. In addition, anticipated self-stigma was a significant barrier to seeking treatment. Suggestions for the elimination of these barriers in the literature were also put forward by the participants of this study. These suggestions are also similar to the suggestions for improvement of MHL. Making psychological help resources more accessible and organizing various campaigns regarding psychological diseases and treatment methods can help to eliminate these barriers (Salaheddin & Mason, 2016, Tomczyk et al., 2019). According to

the participants, they could overcome the obstacles with the support of the state. The mental health service that the public has difficulty in reaching can be made more accessible. For this, psychological help resources can be expanded, and villagers can be supported financially in transportation to hospitals. Moreover, seminars about psychological health and self-help methods can be given.

Coping strategies was the third and the last super ordinate theme in the current study. *Engaging in work* was the first coping strategy. The participants explained that the garden work and animal husbandry they did in the village were good for them and provided relief. These works in the village also provided a financial gain to the participants. For this reason, it was thought that these jobs helped people to feel useful and provided economic freedom. As a person who spent a long time in the village, the researcher was surprised to see that such work was described positively as a coping method. These jobs are very time-consuming jobs that require body strength. Yet, the participants thought that these tasks were good for them despite the exhausting nature of farming activities. Gardening may also provide silence and peace of mind. For example, P3 stated that after the death of her husband, she went to the hazelnut gardens, cried there, and relaxed. Another participant said that it was very crowded at home and she could not talk about her problems. When she went to the forest to take wood for the winter, she talked with the trees and relaxed.

In fact, their accounts were parallel with previous findings indicating that gardening was associated with health and well-being. While gardening activity increased physical activity levels, quality of life, social interaction, community involvement, it decreased psychological stress levels (Kingsley et al., 2009; Milligan et al., 2004; Soga et. al., 2017, van den Berg et al., 2011). In a study that was conducted by Scott and her colleagues (2014) with 331 gardeners, it was found that gardening provides people many psychological, physiological, and tangible benefits. These benefits were feelings of achievement, forming relationship with others, getting regular physical activity, and producing food.

Social support was the second coping strategy that was mentioned by the participants. Majority of the participants preferred getting social support from their friends rather than going to the doctors. Receiving support from friends and neighbors seemed to provide morale and helped the participants deal with their problems. Previous researchers also showed that as perceived social support increases, psychological well-being increases (Aydin et al., 2017; Lök & Bademli, 2020). It was also observed, however, that the participants were afraid of sharing their personal problems with others. Problems that the participants shared with neighbors or friends were often external problems and could have occurred in many homes. For example, the participants who had problems with their daughters-in-law and the participants who had problems with their mothers-in-law talked about such problems easily. Yet, the participants refrained from sharing their psychological problems such as obsessive thoughts and sexual problems. According to the participants, socializing itself was enough and good for them without disclosing themselves. Social support can be perceived as a social environment where they felt not to be alone and sociable.

Religious activity was the last coping strategy mentioned by the participants. Religious coping can be defined as using religious practices and beliefs in order to cope with stressful life circumstances (Pargament et. al., 2005). There are many studies examining the relationship between religious belief and practices and psychological health. For example Aranda (2008) conducted a study with 230 people with low income status. Results of the study showed that there were a negative relationship between religious involvement which was measured by frequency of attendance at religious services and private individual religious practices and depressive symptom levels of the participants. Similarly, another study pointed out that there is a strong positive relationship between daily spiritual experience, religious activities and psychological well-being (Ellison & Fan, 2008).

Consistent with the research findings, the majority of the participants of this study mentioned the positive effects of religious activities on their psychological

health. They thought that the troubles they experienced were means of being tested by Allah. Therefore, they saw praying to Allah as the logical problem-solving method. They believed that when they prayed, when they remembered the names of God, God would support and help them. The practices that were mentioned by the participants were usually performed alone. It can be thought that this method, like the engaging in work strategy, allowed the participants to be alone and listen to themselves.

According to the knowledge and observations of the researcher about this village, it can be said that religious practices are common in the village, as stated by the participants. These practices can be seen at many points of life in the village. It can be said that these practices are about women in particular. Almost all of the women living in the village wear headscarves, and a Quran course is opened for women in mosques in every winter. Worships such as prayer and fasting are more common, especially among women. In such an environment, the development and use of religious coping methods is an expected finding. As far as is known, there are no religious leaders and religious sects in the village, For this reason, there is no reference to any *hodja* or traditional healer in the statements of the participants.

To sum up, in this qualitative research, the opinions and thoughts of the participants regarding psychological problems, psychological help, and coping strategies were examined. The results of this study showed that the participants face many obstacles in accessing psychological help. Lack of knowledge and negative attitudes about psychological illness and psychological help led to low levels of MHL of the participants. In addition, the participants had a fear of being stigmatized. In addition to these cognitive and psychological barriers, the participants had difficulty in accessing professional psychological help due to the fact that they lived in a remote village and transportation to the city was relatively expensive. All these barriers made getting psychological help a last resort and caused low intention to seek psychological help. These participants,

who were reluctant to get professional help, turned to more informal resources such as engaging works, social support and religious activities.

4.3. General Discussion

The aim of the current thesis was to investigate intention to seek psychological help. Accordingly, a mixed method study was conducted with two separate data sets and two different data analysis methods. When the data of both studies were analyzed, it was seen that the results were supportive and complementary of each other. The main quantitative study gave information about factors related to intention to seek psychological help. Accordingly, while attitude toward seeking psychological help positively predicted intention to seek psychological help, age negatively predicted the intention. Also stigma mediated the relationship between having psychological problems and intention to seek psychological help. The qualitative study was performed in order to understand those factors and their effects for people who had low intentions to seek psychological help. This study provided an explanation for low intention in the village. Accordingly, lack of knowledge and stigmatized beliefs about psychological help were related with negative attitudes towards psychological help. These negative attitudes reduced the intention to seek psychological help. Because of fear of being stigmatized, participants refrained from sharing their problems and seeking solutions.

Also, the qualitative strand provided access to additional and detailed information that could not be obtained from the quantitative study. Participants talked about structural barriers, which were another barrier to getting psychological help, and possible solutions to overcome these barriers. The lack of psychological help centers close to the village and the high cost of transportation to the city posed an obstacle to accessing psychological help. The participants explained that in order to eliminate these barriers, the accessibility of the resources giving psychological help should be increased. In addition, the methods used by the participants to deal with their psychological problems were

discussed in qualitative study, which were not measured in the quantitative study. These coping strategies were engaging in works, social support and religious practices. Although coping strategies were not measured in the first stage, the coping methods used by the participants coincided with the results of the first stage. These methods were generally used by the participants individually, widely used in the village and would not cause stigma and a negative reaction from others.

Results of both the quantitative and the qualitative studies implied that all the factors related to low intention to seek psychological help can be related to low socio-economic status of the participants. Most of the participants had low levels of education and income and they faced social injustice in terms of accessing psychological help. Almost all of the participants were in the lower income group. It can be said that these participants generally had difficulties in meeting their basic needs such as basic health care, food, and shelter. Thus, it is understandable that they saw seeking psychological help as the last resort. Even if they did not have any stigma, these participants might not have any intentions to seek psychological help, because they could not access psychological help. For this reason, besides focusing on stigma and attitude, social class differences should also be studied in relation to seeking psychological help. In order to obtain a more clear understanding of the effect of class differences and social injustice on intention to seek psychological help, future studies may comparatively examine seeking psychological help in different geographical areas, among individuals with different education levels, or economic conditions.

4.3.1. Clinical Implications

Treatment gap is defined as the difference between the number of people who have psychological problems and the number of those people who are able to access and receive psychological treatments (Kohn et al, 2004). Untreated psychological disorders can lead to many problems. For this reason, intention of seeking psychological help and the obstacles to receiving psychological help

should be examined in detail. Studies have shown that there are psychological barriers such as stigma, as well as structural barriers, such as physical distances (Arnaez et al., 2018; Vanheusden et al., 2008) that keep individuals from seeking help. The findings of the present study were similar to those of previous studies in that participants talked about their fear of suffering from stigma as the most important barrier, followed by structural barriers to seeking help. In order to eliminate the effects of stigma on psychological help seeking, especially subtle stigmas made to be noticed. Mental health professionals working in small settlements like this village should be aware of fear of stigmatization and they should keep in mind that clients may need some time to disclose themselves. An environment without any stigma should be created where clients can express themselves easily. For this, the therapist must have developed self-awareness on this issue. Also, negative attitudes toward psychological help and fear of suffering from stigma should be investigated and the benefits of psychological help should be explained in detail to clients. As stated before, stigma can be tackled through training programs and seminars. As far as it is known, psychological education at any level has not been given in this village before. Therefore, there is no data on how the villagers will meet this kind of training programs. However, when the researcher went to the village, the villagers asked questions about psychological problems and coping strategies. Thus, it can be thought that they may have positive attitudes toward psychoeducational activities.

Besides increasing awareness about stigmatized thoughts, the cultural competence of the clinicians will be a facilitating factor in the treatment process. In order to become culturally competent, the therapist should be aware of his or her own culture and its effects on the treatment process, have knowledge about the client's culture, and should be able to use culturally sensitive intervention methods (Sue et al., 2019). The participants of this study stated that they generally trust the experts and that it would not be a problem if they and the clinicians come from different cultures. However, they may think like this because they did not receive professional psychological help before

This study was conducted in a village of Ordu, about 45 kms from the nearest hospital. Participants also complained about transportation difficulty and stated that this problem could be eliminated by accessibility of psychological help resources. Psychological barriers will be difficult to understand without eliminating these structural problems. In particular, mental health professionals working in small settlements should be aware of these structural barriers. As stated before, increasing the number of clinics that provide professional help, providing this service in small settlements and facilitating access to psychological assistance may contribute to the solution of this problem.

Clinicians working with clients with lower educational levels, such as participants of this study, should be aware of these kinds of barriers during therapy and should use such interventions that the client can understand and benefit. In order to increase the mental health literacy of these clients, psychoeducation may be required first. Using abstract expressions should be avoided in the psychoeducation. These clients' continuity to therapy may be hampered due to economic reasons. For this reason, it may be more appropriate to prefer brief and goal-oriented interventions. For these clients, there may not be a second therapy chance in their lives. Therefore, therapists can assist these clients in developing self help strategies that would be helpful in later life of them.

4.3.2. Limitations and Strengths

There are several limitations in the present thesis. First of all, the literacy level of the participants was low. Some participants were illiterate. Therefore, the researcher read the items out loud and filled out the responses for those participants. The participants may have given politically correct answers to be socially desirable. Although the researcher read the scale items for each participant without changing, the answers might be affected from her readings. Also, some participants who encountered scale items might not have fully understood what they read or heard. Therefore, their answers might not reflect

their true thoughts. For example, when the researcher applied SSRPH to an older participant, the researcher asked him to read and rate 'It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems'. The participant understood the word weakness, as physical weakness and replied 'No. I don't think so. For example, I am a fat man and if I need this help, I would take also.' The researcher tried to explain to the participant that this was not about weight, then he said he understood and rated the item, but the researcher could not be very sure about it.

Finally, the data were collected from only one village of Ordu and 9 out of 10 participants who met the criteria for joining the second stage were women. Bigger and a more diverse samples from different populations are needed to generalize the findings.

The main strength of the current study was that the research design was based on mixed method. Quantitative and qualitative analyses were used complementarily. While the quantitative study provided a solid ground to analyze the relations between the variables under investigation; the qualitative study provided a deeper understanding in terms of psychological help seeking processes. Although intention to seek psychological help has become a well-studied subject in the contemporary literature, there is no study to examine this issue in mixed method design and in a rural population in Turkey. To the best of the researchers' knowledge, this was the first study to examine people's intention to seek psychological help in a village in Turkey. Moreover, this study was based on a culturally emic perspective. The researcher has lived in this village for many years and knows the lifestyle and culture of the people in the village. She is also familiar with the language used by the participants. This kind of familiarity helped the researcher in collecting and analyzing the data.

4.3.3. Conclusion

According to the results of the research, in accordance with previous studies, attitude and stigma were found to be significantly associated with the intention to seek psychological help. As a result of in-depth interviews with the participants, it was again seen that stigma was an obstacle in the search for psychological help. In addition to stigma, there are also structural obstacles such as transportation and financial barriers to psychological help. In order to eliminate all these obstacles, state support and educational programs are needed.

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APPENDICES

A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

 ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

DUMLUYINAR BULVARI 08060
ÇANKAYA ANKARA/TÜRKİYE
T: +90 312 210 22 31
F: +90 312 210 79 50
SAYI: 28620816 / 684
WWW.ETIK.METU.EDU

03 OCAK 2019

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (IAEK)

İlgili: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Doç.Dr. Deniz Canel ÇINARBAŞ

Danışmanlığımızı yaptığımız Semanur GÜNES'in "Ordu İlinin Köklük Mahallesinde Profesyonel Psikolojik Yardım Alma Niyetinin İncelenmesi: Bir Karma Yöntem Araştırması" başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek gerekli onay 2018-SOS-246 protokol numarası ile araştırma yapması onaylanmıştır.

Saygılarımızla bilgilerimize sunarım.


Prof. Dr. Tuğba GENÇÖZ
Başkan


Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR
Üye


Prof. Dr. Zafer KONDARCI (4.)
Üye


Doç. Dr. Emre SELÇUK
Üye


Doç. Dr. Pinar KAYGAN
Üye


Dr. Öğr. Üyesi Ali Emre TURGUT
Üye

B. INFORMED CONSENT FORM 1

GÖNÜLLÜ KATILIM FORMU 1

Bu araştırma, ODTÜ Psikoloji Bölümü öğretim üyesi Doç. Dr. Deniz Canel Çınarbaş danışmanlığında Klinik Psikoloji Anabilim Dalı yüksek lisans öğrencisi Semanur Güneş tarafından yürütülen tez çalışmasıdır. Bu form sizi araştırma koşulları hakkında bilgilendirmek için hazırlanmıştır.

Çalışmanın Amacı Nedir?

Araştırmanın amacı, psikolojik yardım alma niyetine ve bu niyeti etkileyen faktörlere dair bilgi toplamaktır.

Bize Nasıl Yardımcı Olmanızı İsteyeceğiz?

Araştırmaya katılmayı kabul ederseniz, sizden verilen yedi adet ölçeği size en uygun şekilde doldurmanız beklenmektedir. Yaklaşık olarak kırk beş dakika sürmesi beklenen bu ölçeklerde sizlere psikolojik yardım alma niyeti, psikolojik yardım almaya karşı tutum ve damgalamalar, psikolojik rahatsızlığa karşı tutumlar, kişisel bilgiler ve psikolojik semptomlar gibi boyutları kapsayan sorular yöneltilecektir.

Sizden Topladığımız Bilgileri Nasıl Kullanacağız?

Araştırmaya katılımınız tamamen gönüllülük temelinde olmalıdır. Çalışmada sizden kimliğinizi belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak, sadece araştırmacılar tarafından değerlendirilecektir. Katılımcılardan elde edilecek bilgiler toplu halde değerlendirilecek ve bilimsel yayımlarda kullanılacaktır. Sağladığımız veriler gönüllü katılım formlarında toplanan kimlik bilgileri ile eşleştirilmeyecektir.

Katılımınızla ilgili bilmeniz gerekenler:

Çalışma, genel olarak kişisel rahatsızlık verecek sorular içermemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakıp çıkmakta serbestsiniz. Böyle bir durumda çalışmayı uygulayan kişiye, çalışmadan çıkmak istediğinizi söylemek yeterli olacaktır.

Araştırmayla ilgili daha fazla bilgi almak isterseniz:

Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için tez danışmanı Doç. Dr. Deniz Canel Çınarbaş (dcanel@metu.edu.tr) veya tez yürütücüsü Semanur Güneş (semanurgunes1993@gmail.com) ile iletişim kurabilirsiniz.

Yukarıdaki bilgileri okudum ve bu çalışmaya tamamen gönüllü olarak katılıyorum.

İsim Soyad

Tarih

İmza

C. INFORMED CONSENT FORM 2

GÖNÜLLÜ KATILIM FORMU 2

Bu araştırma, ODTÜ Psikoloji Bölümü öğretim üyesi Doç. Dr. Deniz Canel Çınarbaş danışmanlığında Klinik Psikoloji Anabilim Dalı yüksek lisans öğrencisi Semanur Güneş tarafından yürütülen tez çalışmasıdır. Bu form sizi araştırmanın ikinci aşaması olan mülakat koşulları hakkında bilgilendirmek için hazırlanmıştır.

Çalışmanın Amacı Nedir?

Araştırmanın bu aşamasının amacı, psikolojik yardım alma niyetine ve bu niyeti etkileyen faktörlere dair sizlerle yapılacak mülakatlar aracılığıyla bilgi toplamaktır.

Bize Nasıl Yardımcı Olmanızı İsteyeceğiz?

Araştırmaya katılmayı kabul ederseniz, size psikolojik yardım alma niyetine yönelik sorular sorulup görüşlerinize başvurulacaktır. Bu mülakatların yaklaşık 1 saat sürmesi beklenmektedir. Daha sonra içerik analizi ile değerlendirilmek üzere cevaplarınızın ses kaydı alınacaktır.

Sizden Topladığımız Bilgileri Nasıl Kullanacağız?

Araştırmaya katılımınız tamamen gönüllülük temelinde olmalıdır. Çalışmada sizden kimliğinizi belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak, sadece araştırmacılar tarafından değerlendirilecektir. Katılımcılardan elde edilecek bilgiler toplu halde değerlendirilecek ve bilimsel yayımlarda kullanılacaktır. Sağladığınız veriler gönüllü katılım formlarında toplanan kimlik bilgileri ile eşleştirilmeyecektir.

Katılımınızla ilgili bilmeniz gerekenler:

Çalışma, genel olarak kişisel rahatsızlık verecek sorular içermemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakıp çıkmakta serbestsiniz. Böyle bir durumda çalışmayı uygulayan kişiye, çalışmadan çıkmak istediğinizi söylemek yeterli olacaktır. Görüşmeler sırasında alınan kayıtlar güvenli bir yerde saklanacak sadece araştırmacı ve danışman tarafından dinlenebilecek, ve gerekli süre dolunca bu ses kayıtları imha edilecektir.

Araştırmayla ilgili daha fazla bilgi almak isterseniz:

Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için tez danışmanı Doç. Dr. Deniz Canel Çınarbaş (dcanel@metu.edu.tr) veya tez yürütücüsü Semanur Güneş (semanurgunes1993@gmail.com) ile iletişim kurabilirsiniz.

Yukarıdaki bilgileri okudum ve bu çalışmaya tamamen gönüllü olarak katılıyorum.

(Formu doldurup imzaladıktan sonra uygulayıcıya geri veriniz).

İsim Soyad

Tarih

İmza

D. DEMOGRAPHIC INFORMATION FORM

Cinsiyetiniz: Kadın Erkek

Yaşınız(Belirtiniz):.....

Eğitimidurumunuz:

İlkokul Ortaokul Lise Üniversite Lisansüstü

Medenidurumunuz:

Bekar

Resminikahlıevli

Resmiolmayannikahlıevli

Boşandı

Çalışmadurumunuz: Çalışıyor Çalışmıyor

Gelirdurumunuz:

Gelirgiderdenaz Gelirgidereşit Gelirgiderdenfazla

Dahaöncebiruzmandanpsikolojikyardımdıydınız mı?

Evet Hayır

Önceki soruyayıntınız ‘evet’ ise;

Bu yardımı ne zamanvekimdenaldınız?

Bu yardımsırasındabirtanıaldınız mı? Aldıysanız ne tanıdıaldınız?

Ne türbirtedavıaldınız?

İlaç(varsa adı) Terapi

Psikolojiksıkıntısıolanbir yakınınız varmı?

Var Yok

Önceki soruyayıntınız “var” isebukişiyelanyakınlığınız:

Annesiyim Kardeşiyim Eşiyim

BirAkrabasıyım Arkadaşıyım Diğer(belirtiniz).....

Psikolojik bir rahatsızlıkla karşılaşırsanız öncelikle yardım alacağınız birey:

Psikiyatır Psikolog

Pratisyenhekim Muskacı (Hacı-Hoca)

Hemşire-Ebe Diğer(belirtiniz).....

E. BRIEF SYMPTOM INVENTORY

KISA SEMPTOM ENVANTERİ

Aşağıda, insanların bazen yaşadıkları belirtiler ve yakınmalar belirtilmiştir. Listedeki her maddeyi lütfen dikkatlice okuyunuz. Sonra, o belirtinin sizi BUGÜN DAHİL SON BİR HAFTADIR NE KADAR RAHATSIZ ETTİĞİNİ her maddenin karşısında bulunan numaralardan birini yandaki düzeylere göre işaretleyerek belirtiniz.		Hiç	Biraz	Orta derecede	Epey	Çok fazla
1.	İçinizdeki sinirlilik ve titreme hali	1	2	3	4	5
2.	Baygınlık, baş dönmesi	1	2	3	4	5
3.	Bir başka kişinin sizin düşüncelerinizi kontrol ettiği fikri	1	2	3	4	5
4.	Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu düşüncesi	1	2	3	4	5
5.	Olayları hatırlamada güçlük	1	2	3	4	5
6.	Çok kolayca kızıp öfkelenme	1	2	3	4	5
7.	Göğüs ve kalp bölgesinde ağrılar	1	2	3	4	5
8.	Meydanlık (açık) yerlerden korkma duygusu	1	2	3	4	5
9.	Yaşamınıza son verme düşünceleri	1	2	3	4	5
10.	İnsanların çoğuna güvenilmeyeceği hissi	1	2	3	4	5
11.	İştahta bozukluklar	1	2	3	4	5
12.	Hiçbir nedeni olmayan ani korkular	1	2	3	4	5
13.	Kontrol edemediğiniz duygu patlamaları	1	2	3	4	5
14.	Başka insanlarla beraberken bile yalnızlık hissetme	1	2	3	4	5
15.	İşleri bitirme konusunda engellenmiş hissetme	1	2	3	4	5
16.	Yalnızlık hissetme	1	2	3	4	5
17.	Hüzünlü, kederli hissetme	1	2	3	4	5
18.	Hiçbir şeye ilgi duymama	1	2	3	4	5
19.	Ağlamaklı hissetme	1	2	3	4	5

KISA SEMPTOM ENVANTERİ'NİN DEVAMI

Aşağıda, insanların bazen yaşadıkları belirtiler ve yakınmalar belirtilmiştir. Listedeki her maddeyi lütfen dikkatlice okuyunuz. Sonra, o belirtinin sizi BUGÜN DAHİL SON BİR HAFTADIR NE KADAR RAHATSIZ ETTİĞİNİ her maddenin karşısında bulunan numaralardan birini yandaki düzeylere göre işaretleyerek belirtiniz.		Hiç	Biraz	Orta derecede	Epey	Çok fazla
20.	Kolayca incinebilme, kırılma	1	2	3	4	5
21.	İnsanların sizi sevmediğine inanma	1	2	3	4	5
22.	Kendini diğerlerinden daha aşağı görmek	1	2	3	4	5
23.	Mide bozukluğu, bulantı	1	2	3	4	5
24.	Diğerlerinin sizi gözlediği ya da hakkınızda konuştuğu düşüncesi	1	2	3	4	5
25.	Uykuya dalmada güçlük	1	2	3	4	5
26.	Yaptığınız şeyleri tekrar tekrar doğru mu diye kontrol etme	1	2	3	4	5
27.	Karar vermede güçlükler	1	2	3	4	5
28.	Otobüs, tren, metro gibi umumi vasıtalarla seyahatlerden korkma	1	2	3	4	5
29.	Nefes darlığı, nefessiz kalma	1	2	3	4	5
30.	Sıcak, soğuk basmaları	1	2	3	4	5
31.	Sizi korkuttuğu için bazı eşya ya da etkinliklerden uzak kalma	1	2	3	4	5
32.	Kafanızın "bomboş" kalması	1	2	3	4	5
33.	Bedeninizin bazı bölgelerinde uyuşmalar, karıncalanmalar	1	2	3	4	5
34.	Günahlarınız için cezalandırılmanız gerektiği düşünceleri	1	2	3	4	5
35.	Gelecekle ilgili umutsuzluk duyguları	1	2	3	4	5
36.	Konsantrasyonda (dikkati birşey üzerinde toplamada) güçlük/zorlanma	1	2	3	4	5
37.	Bedenin bazı bölgelerinde zayıflık, güçsüzlük hissi	1	2	3	4	5
38.	Kendini gergin ve tedirgin hissetme	1	2	3	4	5

KISA SEMPTOM ENVANTERİ'NİN DEVAMI

Aşağıda, insanların bazen yaşadıkları belirtiler ve yakınmalar belirtilmiştir. Listedeki her maddeyi lütfen dikkatlice okuyunuz. Sonra, o belirtinin sizi BUGÜN DAHİL SON BİR HAFTADIR NE KADAR RAHATSIZ ETTİĞİNİ her maddenin karşısında bulunan numaralardan birini yandaki düzeylere göre işaretleyerek belirtiniz.		Hiç	Biraz	Orta derecede	Epey	Çok fazla
39.	Ölme ve ölüm üzerine düşünceleri	1	2	3	4	5
40.	Birini dövme, ona zarar verme, yaralama isteği	1	2	3	4	5
41.	Birşeyleri kırma, dökme isteği	1	2	3	4	5
42.	Diğerlerinin yanındayken sürekli kendini gözleyip, yanlış birşeyler yapmamaya çalışmak	1	2	3	4	5
43.	Kalabalıklarda rahatsızlık duymak	1	2	3	4	5
44.	Bir başka insana hiç yakınlık duymamak	1	2	3	4	5
45.	Dehşet ve panik nöbetleri	1	2	3	4	5
46.	Sık sık tartışmaya girmek	1	2	3	4	5
47.	Yalnız bırakıldığında/kalındığında sinirlilik hissetmek	1	2	3	4	5
48.	Başarılarınız için diğerlerinden yeterince takdir alamamak	1	2	3	4	5
49.	Yerinde duramayacak kadar huzursuz hissetmek	1	2	3	4	5
50.	Kendini değersiz görmek/değersizlik duyguları	1	2	3	4	5
51.	Eğer izin verirsiniz insanların sizi sömüreceği duygusu	1	2	3	4	5
52.	Suçluluk duyguları	1	2	3	4	5
53.	Aklınızda bir bozukluk olduğu düşüncesi	1	2	3	4	5

**F. ATTITUDE TOWARD SEEKING PROFESSIONAL
PSYCHOLOGICAL HELP SCALE-SHORT FORM**

**PSİKOLOJİK YARDIM ALMAYA İLİŞKİN TUTUM ÖLÇEĞİ-KISA
FORM**

Lütfen, ölçeğin maddelerinde yer alan ifadelere katılma düzeyinizi, her maddenin karşısında bulunan numaralardan birini yandaki düzeylere göre işaretleyerek belirtiniz.		Kesinlikle katılmıyorum	Katılmıyorum	Katlıyorum	Kesinlikle katlıyorum
1.	Akıl sağlığında bir bozulma olduğunu düşünürsem, ilk tercihim bir uzmandan yardım almak olur.	1	2	3	4
2.	Sorunlar hakkında bir psikologla konuşma fikri, bana, duygusal çatışmalardan kurtulmanın kötü bir yolu gibi geliyor.	1	2	3	4
3.	Hayatımın bu döneminde ciddi bir duygusal kriz yaşasam, psikoterapi olarak rahatlayabileceğimden eminim.	1	2	3	4
4.	Bir kişinin, gerektiği hâlde bir uzmandan yardım almadan çatışmalarıyla ve korkularıyla baş etmeyi istemesi takdir edilecek bir tutumdur.	1	2	3	4
5.	Uzun bir süre endişeli veya üzgün olsam, psikolojik yardım almayı isterim.	1	2	3	4
6.	Gelecekte psikolojik danışma almayı isteyebilirim.	1	2	3	4
7.	Duygusal bir sorunu olan kişinin bunu tek başına çözmesi mümkün değildir; bu sorununu, bir uzmandan yardım olarak çözebilir.	1	2	3	4
8.	Gerektirdiği para ve zaman açısından psikoterapinin değeri benim için şüphelidir.	1	2	3	4
9.	Kişi, sorunlarını kendi çözmelidir; psikolojik danışma almak başvurulacak son çare olmalıdır.	1	2	3	4
10.	Kişisel ve duygusal sorunlar, başka birçok şey gibi, genellikle kendi kendine çözülürler.	1	2	3	4

**G. SOCIAL STIGMA SCALE FOR RECEIVING PSYCHOLOGICAL
HELP**

**PSİKOLOJİK YARDIM ALMA NEDENİYLE SOSYAL
DAMGALANMA ÖLÇEĞİ**

Lütfen, ölçeğin maddelerinde yer alan ifadelere katılma düzeyinizi, her maddenin karşısında bulunan numaralardan birini yandaki düzeylere göre işaretleyerek belirtiniz.		Kesinlikle katılmıyorum	Katılmıyorum	Katlıyorum	Kesinlikle katlıyorum
1.	Duygusal veya kişiler arası sorunlar nedeniyle psikoloğa gitmek, toplum tarafından damgalanmayı da beraberinde getirir.	1	2	3	4
2.	Duygusal veya kişiler arası sorunlar nedeniyle psikoloğa gitmek, kişisel zayıflığın veya yetersizliğin bir işaretidir.	1	2	3	4
3.	Eğer insanlar, bir kişinin psikoloğa gittiğini öğrenirlerse, o kişiye olumsuz bir gözle bakarlar.	1	2	3	4
4.	Bir kişinin, psikoloğa gittiğini insanlardan gizlemesi akıllıca bir davranıştır.	1	2	3	4
5.	İnsanlar psikolojik yardım alan kişileri pek sevmezler.	1	2	3	4

H. HELP-SEEKING INTENTIONS INVENTORY FOR ADULTS (HSIIA)

PSİKOLOJİK YARDIM ALMA NİYETİ ENVANTERİ

Aşağıda, insanların bir uzmandan (psikolojik danışman, psikolog, psikiyatrist vb.) psikolojik yardım aldığı başlıca sorunların bir listesi verilmiştir. <i>Bu sorunları siz yaşıyorsanız, bir uzmandan psikolojik yardım alma olasılığınızı ne olur? Bir uzmandan psikolojik yardım alma olasılığınızı, lütfen her sorunun karşısında bulunan numaralardan birini yandaki düzeylere göre işaretleyerek belirtiniz.</i>		Kesinlikle yardım almam	Yardım almam	Yardım alırım	Kesinlikle yardım alırım
1.	Uyum sorunları (yeni bir ortama veya duruma uyum sağlayamama)	1	2	3	4
2.	Öz güven eksikliği	1	2	3	4
3.	Evlilik/ilişki sorunları (eşle/sevgiliyle anlaşmazlık, geçimsizlik)	1	2	3	4
4.	Boşanma/ayrılık	1	2	3	4
5.	Sevilen bir kişinin, ölümcül bir hastalığa (ör., AIDS, kanser) yakalanması veya vefat etmesi	1	2	3	4
6.	Bir hastalık veya engel (ör., bedensel engel) ile ilgili duygusal veya sosyal sorunlar	1	2	3	4
7.	Đstenmeyen/travmatikyaşantılar(ör.,cins elistismar, cinsel taciz, şiddete maruz kalma)	1	2	3	4
8.	Duygudurum sorunları (ör., depresyon)	1	2	3	4
9.	Kaygı, korku, panik ve stres gibi duygularla ilgili sorunlar	1	2	3	4
10.	Cinsel sorunlar (ör., cinsel işlev, cinsel davranış veya cinsel kimlik sorunları)	1	2	3	4
11.	Yeme sorunları (ör., belli dönemlerde düzenli olarak, kontrolsüz bir biçimde yemek yeme, yediklerini çıkarma veya hiç yemek yememe)	1	2	3	4
12.	Alkol veya diğer uyuşturucu/uyarıcı madde/hap kullanım sorunları (ör., madde bağımlılığı, madde kötüye kullanımı)	1	2	3	4

I.SEMI-STRUCTURED INTERVIEW QUESTIONS

Mülakat Soruları

1. Psikolojik sorun dendiğinde aklınıza neler geliyor?
 - Hayatınızın herhangi bir döneminde bir psikolojik sorun yaşadınız mı?
Siz bu soruna ne ad verirsiniz?
 - Şu anda hissettiğiniz herhangi bir sorun var mı?
 - Yaşadığınız psikolojik sıkıntı ile ilgili sizi en çok ne rahatsız ediyor?
 - Çevrenizde psikolojik sorun yaşadığını düşündüğünüz biri/ birileri var mı? Varsa bu kişileri böyle değerlendirmenize sebep olan özellikler nelerdir?
2. Bu sorunların sebepleri ile ilgili düşünceleriniz nelerdir?
 - Bu sorunlar neden sizin başınıza gelmiş olabilir?
 - Bu soruna sebep olan herhangi bir olay yaşandı mı?
 - Bu olay yaşanmasaydı yine de böyle bir sıkıntı hisseder miydiniz?
 - Yakın çevrenizin bu soruna bakışı nasıldır?
3. Bu sorunlarınızın daha da kötüye gitmesine sebep olan herhangi bir şey yaşıyor musunuz? Varsa nelerdir?
4. Psikolojik yardım denince aklınıza neler geliyor?
 - Böyle bir yardıma hangi durumlarda ya da ne hissederseniz ihtiyaç duyarsınız?
 - (Hangi durumda, 'Ben kesinlikle psikolojik destek almalıyım' dersiniz?)
 - Psikolojik yardım veren kişiler kimlerdir?
 - Bu kişiler arasında bir farklılık var mı?
 - Siz hangisini tercih edersiniz?
 - Psikolojik yardımdan ne beklersiniz?
 - Bu yardımı en yakın nereden alabilirsiniz?
5. Psikolojik bir yardımın sorunlarınızı çözeceğine inanıyor musunuz?
 - Daha önce böyle bir yardım aldınız mı?
 - Böyle bir yardım aldıysanız bu yardım hakkında ne düşünüyorsunuz?
Sizin için faydalı oldu mu?

-Etrafınızda psikolojik yardım alan birisi var mı? Bu kişi ve aldığı yardım hakkında neler biliyorsunuz? Aldığı yardım bu kişi için faydalı olmuş mu?

6. Psikolojik yardım alma konusunda harekete geçmenizde ihtiyaç duyduğunuz herhangi bir destek var mı? Ne olsa daha kolay yardım alırsınız?
7. Böyle bir yardımı almanızı engelleyen herhangi bir durum var mı?
 - Varsa bu engelleri ortadan kaldırmak için neler yapılabilir?
 - Böyle bir yardım alsanız ne gibi tepkiler gelir?
 - Tanımadığınız birine sorunlarınızı anlatmayla ilgili ne düşünürsünüz?
 - Bazen doktor ve hastalar farklı kesimlerden geldikleri için birbirlerini yanlış anlama durumu söz konusu olabilir. Sizin böyle bir kaygınız var mı?
8. Uzmanlar dışında sizi daha iyi hissettirecek başka herhangi bir destek alıyor musunuz? -Varsa bu destekler nelerdir?
 - Bu destek size yardımcı oldu mu? Nasıl?
 - Sorunlarınızla başa çıkmak için geçmişte ne tür yöntemler kullandınız?
 - Şimdi neler kullanıyorsunuz?
 - Bu yöntemlerden hangileri sizin için en çok faydalı oldu/oluyor?
 - Şimdiye kadar yaşadığınız sorunlarda herhangi bir destek almadınızsa;
 - Gelecekte böyle bir sorun yaşarsanız neler yapmayı düşünürsünüz?
9. Farklı kaynaklardan yardım almanızı engelleyen bir şey var mı?
 - Varsa neler?
 - Bu engelleri ortadan kaldırmak için neler yapılabilir?
10. Yakınlarınızdan biri psikolojik bir sorun yaşasa ona neler tavsiye edersiniz?

J. TURKISH SUMMARY / TÜRKKÇE ÖZET

BÖLÜM 1

GİRİŞ

Toplumda psikolojik problemleri olanların sayısı önemli bir oran oluşturmaktadır. Türkiye'de yapılan en büyük epidemiyolojik çalışmalardan biri olan Türkiye Ruh Sağlığı Profili'ne göre 18 yaş üstü nüfusta ruhsal bozuklukların görülme sıklığı% 17,2 iken tedavi arayanların oranı% 4,7 (Erol ve ark., 1998). 2004 yılında yapılan başka bir araştırmanın sonuçlarına göre Türkiye'de ruh sağlığı hizmetine ihtiyaç duyan ancak profesyonel tedavi istemeyenlerin oranının % 60 olarak düşünülmektedir (Kohn ve ark., 2004). Bu oranlar, psikolojik sorunları olan ve psikolojik tedavi arayanların sayısı arasında bir uçurum olduğunu göstermektedir. Bu uçurum, psikolojik yardım almaya karar verme sürecinde bazı mekanizmaların etkili olabileceğini akla getirmektedir. Tedavi edilmeyen psikolojik problemler daha ciddi hastalıklara sebep olabilir. Bu sebeple psikolojik yardım arayışına engel olan faktörleri anlamak son derece önemlidir. Bu kapsamda, bu çalışma psikolojik yardım arama niyetini etkileyen faktörleri incelemeyi amaçlamıştır.

1.1. Yardım Arama Niyeti ve Davranışı

Kişinin yaşantısının farklı alanlarında karşılaştığı psikolojik sorunlarla ilgili yardım alma isteği psikolojik yardım alma niyeti olarak tanımlanmaktadır (Topkaya, 2012). Bu yardım alma niyetinin eyleme dönüşmesini belirleyen pekçok faktör olabilir. Psikolojik yardım alma davranışı ve niyeti çeşitli davranış modelleri çerçevesinde incelenmiştir. Bu modeller Sağlık İnanç Modeli, Transteoretik Model ve Planlanmış Davranış Teorisidir. Bu çalışmada

alanyazında psikolojik yardım arama niyeti konusunda sıklıkla kullanılan Planlanmış Davranış Teorisinden (PDT) yararlanılmıştır.

Tutum yapıları, sosyal normlar, algılanan davranışsal kontrol (engellerin algılanması) ve davranışı anlama ve tahmin etme niyeti bu modelin temelini oluşturur (Ajzen ve Madden, 1986). PDT'ye göre niyet, davranışın ana yordayıcılarından biridir ve bir kişinin bu davranışı başarmaya hazır olmasıdır. Niyetin üç ana göstergesi vardır. Bir davranışa yönelik tutum, bir kişinin o davranış hakkındaki değerlendirmesini ve görüşünü içeren ilk göstergedir. İkinci gösterge, o davranışın performansı hakkında algılanan sosyal baskı ile ilgili olan öznel normdur. Niyetin son yordayıcısı, davranışı gerçekleştirmeye yönelik algılanan kolaylaştırıcıları ve engelleri içeren davranışsal kontroldür (Ajzen, 1991).

PDT'ye göre, bir kişinin bir davranışa yönelik tutumları, örneğin ruh sağlığı hizmetleri aramak, başkalarının bu davranış hakkında ne düşündüğüne dair öznel inançları ve algılanan engellerin derecesi, kişinin ruh sağlığı hizmetleri arama niyetini etkiler. Bu nedenle psikolojik yardım alma niyetinin incelenmesi, psikolojik yardım alma sürecini etkilemesi açısından önemlidir. Bir kişi psikolojik yardım almaya yönelik olumlu tutuma sahipse, bu kişi olumsuz tutumları olan bir kişiye göre daha çok psikolojik yardım aramaya niyetlenecektir. Kişi psikolojik yardım aldığı için toplumda olumsuz tepkilere veya etiketlemeye maruz kalacağından endişelenmiyorsa, bu kişinin de yardım alma niyeti yüksek olabilir. Son olarak, kişi psikolojik yardımı almak ve sürdürmek için yeterli güce sahip olduğunu düşünüyorsa ve kişinin bu konudaki algılanan kontrolü yüksekse, bu kişi için yardım alma olasılığı daha yüksek olabilir (Morris ve ark., 2012).Psikolojik yardım arama niyetine odaklanan bu çalışmada PDT'nin tutum, niyet ve öznel norm gibi kavramları kullanılmışsa da bu teori test edilmemiştir.

1.2. Psikolojik Yardım Almaya Yönelik Tutum

Davranışsal niyet ve psikolojik yardım üzerine yapılan araştırmalar, tutumların davranış üzerindeki etkilerini sıklıkla vurgulamıştır. Psikolojik yardım aramaya yönelik tutum, gerektiğinde ruh sağlığı uzmanlarından yardım arama eğilimi olarak tanımlanmaktadır (Fischer ve Farina, 1995).

Araştırmacılar, psikolojik yardım aramaya yönelik tutumların, psikolojik yardım arama niyetiyle yakından ilişkili olduğunu bulmuşlardır (Aldalaykeh ve diğerleri, 2019). Profesyonel psikolojik yardım aramaya yönelik daha olumlu tutumlar, bu tür bir yardım aramaya yönelik daha yüksek niyetle pozitif olarak ilişkilendirilmiştir (Carlton ve Deane, 2000; Seyfi ve diğerleri, 2013).

Tutumlar davranışları büyük ölçüde öngörse de, üstesinden gelinemeyecek engeller varsa tutumlar davranışa dönüşmeyebilir. Guatemala'daki üniversite öğrencilerinin psikolojik yardıma yönelik tutumlarını inceleyen bir araştırma, bu varsayımı doğrulamıştır. Araştırmanın sonuçları, öğrencilerin düşük düzeyde damgalanma ve psikolojik yardım aramaya yönelik olumlu tutumlara sahip olduklarını, ancak bu olumlu tutumların psikolojik hizmet almak istediklerinde karşılaştıkları engeller nedeniyle davranışa dönüştürülemediğini göstermiştir. Bu engeller, yetersiz kaynaklar ve bu hizmetlere erişimde mali zorluklardır (Figuroa ve diğerleri, 2020).

1.3. Psikolojik Yardım Aramaya Yönelik Damgalama

Psikolojik sorunları olan kişiler uzun süredir çok olumsuz damgalanmalara maruz kalmaktadır (Taşkın, 2007). Bu kişilerin damgalanması, doğal olarak hastalığın tedavisinin damgalanmasına da neden olur. Bu nedenle gerçekten tedaviye ihtiyacı olan kişiler bu gerçeği gizleyebilir ve psikolojik yardım aramayabilirler. Araştırmacılar damgalanma ile yardım arama niyeti arasında bir ilişki bulmuşlardır (Pheko ve diğerleri, 2013; Shetchman ve diğerleri, 2018).

Zihinsel bozuklukların bir kişinin zayıflığından kaynaklandığına dair damgalanan kişiler, psikolojik yardım aramaya daha az eğilimlidir ve profesyonel yardım kaynakları hakkında daha az olumlu inançlara sahiptir (Yap ve diğerleri, 2011).

Damgalama ile bu tutumları protesto ederek, uygun eğitim programları düzenleyerek ya da psikolojik sorunları olan insanlarla ilişki kurma fırsatları yaratarak mücadele edilebilir.

1.4. Demografik Değişkenler, Tutum, Damgalama ve Psikolojik Yardım Arama Niyeti İle İlgili Nicel Araştırma Bulguları

Alanyazında psikolojik yardım aramaya ilgili faktörleri inceleyen pek çok çalışma mevcuttur. Bu çalışmalara göre kadınlar, yaşlılar ve daha önce psikolojik yardım almış olanlar daha az sosyal damgalamaya, daha olumlu tutumlara ve daha yüksek psikolojik yardım arama niyetine sahiptir.

Bu çalışmada ruh sağlığı sorunlarının tutum, damgalanma ve şiddeti gibi psikolojik değişkenlerin yanı sıra demografik değişkenlerin psikolojik yardım arama niyeti üzerindeki etkisi de araştırılmıştır. Bu demografik değişkenler eğitim seviyesi, önceki ruh sağlığı deneyimi, cinsiyet ve yaşdır. Önceki bulgulara paralel olarak, bu çalışmada da kadınların ve yaşlıların psikolojik yardım alma niyetlerinin daha yüksek olması beklenmiş ve eğitim düzeyi ile önceki ruh sağlığı deneyimleri ile psikolojik yardım arama niyeti arasında pozitif yönlü bir ilişki olacağı düşünülmüştür.

1.5. Psikolojik Yardım Aramaya Yönelik Nitel Araştırma Bulguları

Psikolojik yardım almaya yönelik nitel araştırmalar genellikle psikolojik yardım aramayı engelleyen veya kolaylaştıran faktörlere odaklanmıştır. Buna göre damgalanma korkusu, psikolojik yardım arayışını engelleyen yaygın faktörlerden

biridir. Bu tezin nitel bölümünde, katılımcıların ruh sağlığı okuryazarlık düzeyleri, psikolojik yardıma ulaşmalarındaki engellerin ve kolaylaştırıcıların yanı sıra hem psikolojik sorunlar hem de psikolojik yardım açısından deneyimleri incelenmiştir. Ayrıca katılımcıların psikolojik sorunları ile ilgili kullandıkları baş etme stratejileri araştırılmıştır.

1.6. Mevcut Çalışma

Bu çalışmada karma yöntemli bir çalışma tasarımı kullanılmıştır. Karma tasarım iki ardışık çalışma (nicel ve nitel) ile oluşturulmuştur. Nicel veriler, nitel araştırmanın katılımcıları için dahil edilme kriteri olarak kullanılmıştır. İlk çalışmada, Ordu ilinin Köklük Köyü genelinde 117 katılımcı ile tutum, damgalanma, psikolojik sorunlar ve psikolojik yardım arama niyetiyle ilgili ölçekler uygulanmıştır. İkinci çalışmada, ilk çalışmanın katılımcıları arasında belirlenen ölçütleri karşılayan katılımcılarla görüşmeler yapılmıştır.

Nicel çalışmanın temel amacı, ruh sağlığı sorunları ile psikolojik yardım arama niyeti arasındaki ilişkide psikolojik yardım aramaya yönelik tutum ve damgalanmanın aracı rollerini test etmektir. Bu kavramlar biraz soyut olduğundan ve düşük eğitim düzeyine sahip insanlarla kırsal kesimde hiç araştırılmadığından, tutum, damgalanma, psikolojik sorunları ve psikolojik yardım arama arasındaki ilişkileri tanımlamak için tamamlayıcı bir nitel çalışma yapılmıştır.

BÖLÜM 2

YÖNTEM

2.1. Genel Araştırma Tasarımı

Nicel araştırmada araştırmacı, psikolojik yardım aramaya yönelik tutum ve damgalanmanın, psikolojik problemlerin, önceki psikolojik yardım öyküsünün ve demografik değişkenlerin (yaş, cinsiyet, eğitim düzeyi) psikolojik yardım arama niyetlerini yordayıp yordamadığını test etmeye çalışmıştır. Daha sonra, katılımcıların yardım arama eğilimlerini ve alanyazında belirtilmeyen yardım aramamanın arkasındaki olası nedenleri anlamak için nitel görüşmeler yapılmıştır.

2.2. Çalışma 1: Nicel Çalışma

Bu bölümde ilk çalışmanın katılımcıları, araçları, prosedürü ve istatistiksel analizi sunulmuştur.

2.2.1. Katılımcılar

Nicel çalışmanın örneklemini, 59'u kadın (% 50,4) ve 58'i erkek olan (% 49,6) yaşları 18 ile 74 arasında değişen 117 kişiden oluşmaktadır. On beş katılımcı (% 12,8) okuma yazma bilmezken, 6'sı (% 5,1) okuryazar, 53'ü (45,3) ilkokul mezunu, 15'i (% 12,8) ortaokul, 17'si (% 14,5) lise mezunu ve 11 katılımcı (% 9,4) üniversite mezunudur. 31 katılımcı (% 26,5) daha önce psikolojik yardım alırken, 86'sının (% 73,5) psikolojik yardım deneyimi yoktur.

2.2.2. Materyaller

Arařtırmacı tarafından geliştirilen Sosyodemografik Bilgi Formu, Kısa Semptom Envanteri (Derogatis, 1992; řahin ve Durak, 1994), Profesyonel Psikolojik Yardım Aramaya İliřkin Tutumlar Ölçeđi-Kısa Form (Fischer ve Farina, 1995; Topkaya, 2011), Psikolojik Yardım Alma Nedeniyle Sosyal Damgalanma Ölçeđi (Komiya vd., 2000; Topkaya, 2011) ve Psikolojik Yardım Arama Niyeti Envanteri (Topkaya, 2011) bu arařtırmada veri toplama araları olarak kullanılmıřtır.

2.2.3. Prosedür

Katılımcılara uygun örnekleme yöntemi ile ulařılmıřtır. Katılımcılara bilgilendirilmiř onam formu verilmiř ve ölekleri doldurmaları istenmiřtir. Okuma yazma bilmeyen katılımcılar için ölekleri arařtırmacı ölek maddelerini yüksek sesle okumuř ve katılımcıların yanıtlarına göre doldurmuřtur. Bu iřlem yaklaşık 30 dakika sürmüřtür

2.2.4. İstatistiksel Analiz

Bu alıřmanın veri analizlerinde Sosyal Bilimler İstatistik Paketi'nin (SPSS) 20. sürümü kullanılmıřtır. Aracı deđiřken analizleri, Hayes (2018) tarafından IBM SPSS için geliştirilen PROCESS makro aracılıđıyla gerekleřtirilmiřtir. Arařtırma deđiřkenleri arasındaki iliřkiyi görmek için korelasyon analizi ve regresyon analizleri yapılmıřtır.

2.3. Çalışma 2: Nitel Çalışma

2.3.1. Katılımcılar

Nitel çalışmanın katılımcıları, nicel çalışmaya katılan psikopatolojik belirtileri olmasına rağmen profesyonel psikolojik yardım alma niyeti düşük olan bireyler arasından seçilmiştir. KSE ile PYANE arasında en yüksek puan farkına sahip 10 kişi seçilmiş ve bu kişilerle görüşmeler yapılmıştır. Katılımcıların 9'u (% 90) kadın, 1'i (% 10) erkektir. Yaşları 21 ile 66 arasında değişmektedir. Tüm katılımcıların gelir düzeyi düşüktür. Daha önce hiç psikoterapi görmemiş olmalarına rağmen 6'sı (% 60) hayatının bir döneminde psikiyatriste gittiğini ve ilaç kullandığını belirtmiştir. Sadece 1'i (% 10) psikiyatrist kontrolünde ilaç kullanmaya devam ettiğini belirtmiştir. Görüşme analizini kolaylaştırmak için katılımcılar numaralandırılmıştır.

2.3. 2. Materyal

Araştırmanın bu bölümü için araştırmacı tarafından literatür ışığında ve danışman yardımıyla yarı yapılandırılmış bir görüşme protokolü geliştirilmiştir. Bu formda, psikolojik sorunlar, psikolojik yardım arama ve baş etme stratejileri olmak üzere üç ana alanda 10 açık uçlu soru vardır.

2.3.3. Prosedür

Araştırmanın bu aşaması için dahil edilme kriterlerini karşılayan 10 kişi belirlendikten sonra bu kişiler aranarak araştırmanın ikinci aşaması hakkında bilgilendirilmiştir. Bu telefon görüşmelerinde görüşmenin içeriği, ses kaydı, bu kayıtların planlanan kullanımı ve gizlilik konuları anlatılmıştır. Görüşmeler katılımcıların evlerinde sessiz bir ortamda gerçekleştirilmiştir. Bu görüşmeler 22 ile 58 dakika arasında sürmüştür.

2.4.5. Veri analizi

Araştırmanın veri analizi için Braun ve Clarke (2006) 'nın tematik analiz için önerdiği yönergeler takip edilmiştir.

BÖLÜM 3

SONUÇLAR

3.1. Çalışma 1: Nicel Çalışma

3.1.1. Değişkenler Arası Korelasyon Analizleri

Bulgular, araştırmanın bağımlı değişkeni olan psikolojik yardım alma niyeti ile katılımcıların eğitim düzeyi ($r = .271, p < .01$) ve psikolojik yardım aramaya yönelik tutumlarının ($r = .469, p < .01$) anlamlı ve pozitif yönde ilişkili olduğunu ortaya koymuştur. Ayrıca, niyet yaşla ($r = -.26, p < .01$) ve psikolojik yardım aramaya yönelik damgalanma ($r = -.263, p < .01$) ile anlamlı ve negatif yönlü korelasyon göstermiştir. Katılımcıların psikolojik yardım alma niyetleri ile cinsiyetleri, önceki psikolojik yardım deneyimleri ve psikolojik sorunları olması arasında anlamlı bir ilişkiye rastlanmamıştır.

3.1.2. Çoklu Regresyon Analizi

Regresyon analizi için gereken varsayımların karşılandığından emin olunduktan sonra çoklu doğrusal regresyon analizi yapılmıştır. Korelasyon analizi sonuçlarına göre, cinsiyet, önceki psikolojik yardım deneyimleri ve psikolojik probleme sahip olma değişkenleri ile psikolojik yardım arama niyeti arasında anlamlı bir ilişki bulunmamıştır. Bu nedenle bu değişkenler regresyon analizine dahil edilmemiştir.

Regresyon katsayıları, psikolojik yardım aramaya yönelik tutumun ($B = .597$, $p < .05$), psikolojik yardım arama niyetini anlamlı ve pozitif olarak yordadığını gösterirken, katılımcıların yaşının ($B = -.012$, $p < .05$) bu niyeti anlamlı ve negatif olarak yordadığını göstermiştir. Ayrıca, katılımcıların damgalanma ve eğitim düzeyleri, psikolojik yardım alma niyetini anlamlı bir şekilde yordamamaktadır.

3.1.3. Aracı Değişken Analizleri

Psikolojik sorun yaşama ile psikolojik yardım arama niyeti arasındaki olası aracı değişken etkisini görebilmek için Hayes (2018) tarafından IBM SPSS için geliştirilen PROCESS makro kullanılarak aracı değişken analizleri yapılmıştır.

Bu analizlerde yordayıcı değişken psikolojik soruna sahip olmak iken sonuç değişkeni psikolojik yardım arama niyetidir. Aracılık etkisi incelenecek değişkenler ise psikolojik yardım aramaya yönelik tutumlar ve damgalanmadır.

İlk arabuluculuk analizinin sonuçlarına göre, arabuluculuk modeli anlamlı değildir ($F(1, 115) = .84$, $p > .05$). Psikolojik sorun yaşama, psikolojik yardım aramaya yönelik tutumların anlamlı bir yordayıcısı değildir ($b = .46$, $SE = .06$, $t = .75$, $p > .05$; % 95 CI [-.07, .16]) tutum ve niyet arasında anlamlı ilişki ($b = .59$, $SE = .10$, $t = 5.62$, $p < .05$; % 95 CI [.38, .80]). Psikolojik yardım aramaya yönelik tutumun aracılık etkisi kontrol edildiğinde, psikolojik sorun yaşamının, psikolojik yardım arama niyeti üzerindeki doğrudan etkisi anlamlı değildir ($b = .04$, $SE = .06$, $t = .63$, $p > .05$; % 95 CI [-.09, .18]).

İkinci arabuluculuk analizinin sonuçlarına göre arabuluculuk modeli anlamlıdır ($F(1, 115) = 8.27$, $p < .05$) ve psikolojik yardım arama niyetindeki varyansın % .06'sını açıklamıştır. Sonuçlar, psikolojik sorunlara sahip olmanın, psikolojik yardım aramaya yönelik damgalanmayı anlamlı şekilde yordadığını göstermiştir ($b = .23$, $SE = .08$, $t = 2.87$, $p < .05$; % 95 CI [.07, .38]). Psikolojik yardım

aramaya yönelik damgalama, psikolojik yardım arama niyetinin önemli bir yordayıcısıdır ($b = -.28$, $SE = .08$, $t = -3.30$, $p < .05$; % 95 CI [-.46, -.16]).

Psikolojik yardıma yönelik damgalamanın etkisi kontrol edildiğinde psikolojik sorun yaşamamanın psikolojik yardım arama niyetine doğrudan etkisi kontrol anlamlı değildir ($b = .13$, $SE = .07$, $t = 1.66$, $p > .05$; % 95 GA [-.01, .29]). Sonuç olarak, psikolojik yardım aramaya yönelik damgalanmanın, psikolojik sorunlar yaşamakla psikolojik yardım arama niyeti arasındaki ilişkiye aracılık ettiği bulunmuştur.

3.2. Çalışma 2: Nitel Çalışma

On görüşmenin tematik analizi sonucunda üç üst ve on iki alt tema bulunmuştur.

3.2.1. Psikolojik problemler

Bu tema, katılımcıların psikolojik problemlerle ilgili genel bilgi, tutumlar ve deneyimler gibi psikolojik problemlerin çeşitli boyutları hakkındaki düşüncelerini içermektedir. Bu üst temanın dört alt teması vardır: Psikolojik sorunları olan kişilerin genel özellikleri, psikolojik sorunların algılanan nedenleri, psikolojik sorunlara yönelik tutumlar ve psikolojik sorunların kişisel deneyimleri.

3.2.1.1. Psikolojik Sorunu Olan Kişilerin Genel Özellikleri

Katılımcıların psikolojik sorunları olan kişilerin özelliklerine ilişkin görüşlerine bu alt temada yer verilmiştir. Katılımcılar psikolojik sorunları olan kişilerin görünen özelliklerinden bahsetmiş ve bazı katılımcılar bu kişilerin çevrelerine zarar verebileceklerini söylemişlerdir.

3.2.1.2. Psikolojik Sorunların Algılanan Nedenleri

Katılımcıların psikolojik sorunların nedeni olarak algıladıkları olay veya durumlar bu alt temayı oluşturmuştur. Tüm katılımcılar, psikolojik sorunları olan kişilerin yaşadıkları sorunları paylaşmadıklarını ve buna genellikle sessizce katlanmak zorunda kaldıklarını belirtmişlerdir. Buna göre bu, psikolojik sorunların nedenlerinden biridir. Bazı katılımcılar yaşadıkları bu problemlerinin belli bir sebebi olmadığını, kaderlerinde olduğu için başlarına geldiğini anlatmışlardır.

3.2.1.3. Psikolojik Sorunlara Yönelik Tutumlar

Bu tema, diğerlerinin psikolojik sorunları olan katılımcılara tepkilerini ve genel olarak katılımcıların psikolojik sorunlara yönelik tutumlarını içermektedir. Katılımcılar genellikle psikolojik sorunlarının anlaşılmadığına ve psikolojik sorunları nedeniyle toplum tarafından aşağılandıklarını düşünmektedirler. Bu sebeple katılımcılar psikolojik problemlerini açmaktan çekinmektedirler.

3.2.1.4. Psikolojik Soruna İlişkin Kişisel Deneyimi

Bu tema, katılımcıların psikolojik sorunları ile ilgili deneyimlerini içeriyordu. Bazı katılımcılar panik, depresyon, stres, travma gibi problemlerine atıfta bulunmak için daha teknik ifadeler kullanırken, diğerleri problemlerini unutkanlık, sinir (sinir bozukluğu), karamsarlık, üzüntü, öfke gibi bilişsel, duygusal ve somatik belirtilerle tanımlamıştır. Katılımcılar, sorunlarının nasıl başladığını ve ardından yaşadıkları semptomlardan bahsetmişlerdir.

3.2.2. Psikolojik Yardım

Bu tema, katılımcıların profesyonel psikolojik yardımın farklı yönleri hakkındaki beyanlarını içermekte olup üç alt temadan oluşmaktadır: Ruh sağlığı uzmanları

hakkında bilgi, psikolojik yardım deneyimi ve psikolojik yardım aramaya yönelik tutumlar ve algılanan engeller.

3.2.2.1. Ruh Sağlığı Uzmanları Hakkında Bilgi

Bu temanın konuları, katılımcıların profesyonel psikolojik yardım kaynakları hakkındaki görüşleri, bu kaynaklar arasındaki farklılıklar, katılımcıların ruh sağlığı hizmeti sağlayıcıları açısından tercihleri ve katılımcıların psikolojik yardıma ilişkin beklentileridir. Katılımcılar ruh sağlığı alanında hizmet veren uzmanlar arasındaki ayrımı yapamamaktadırlar. Bununla birlikte böyle bir yardım alacak olsalar bu yardımın kendilerine iyi geleceğine inanmaktadırlar.

3.2.2.2. Psikolojik Yardım Deneyimi

Bu alt tema, katılımcıların psikolojik yardım deneyimlerini veya çevrelerindeki diğerlerinin deneyimlerini ve bu yardımla ilgili düşüncelerini içermektedir. Katılımcılardan altısı daha önce en az bir kez profesyonel psikolojik yardım almıştır. Katılımcılar genellikle çok zor bir durumda olduklarında ve semptomları daha şiddetli hale geldiğinde psikolojik yardım almaya karar vermişlerdir. Ayrıca daha önce yardım almayan katılımcılar, kendilerini çok rahatsız hissedersen yardım isteyeceklerini söylemişlerdir. Katılımcıların ilaç kullanımına ilişkin olumsuz tutumları vardır.

3.2.2.3. Psikolojik Yardım Aramaya Yönelik Tutumlar ve Algılanan Engeller

Üçüncü alt tema, katılımcıların ve çevrelerindeki diğerlerinin hem tutumlarını hem de tepkilerini özetleyen psikolojik yardım aramaya yönelik tutumlardır. Bu alt tema, katılımcıların ihtiyaç duyduklarında psikolojik yardım almada algıladıkları engelleri ve bu engelleri ortadan kaldırmak için önerilerini de içermektedir.

3.2.3. Başetme stratejileri

Katılımcıların sorunlarla karşılaştıklarında veya kendilerini kötü hissettiklerinde kullandıkları baş etme stratejileri bu tema altında gruplanmıştır. Katılımcılara ruh sağlığı uzmanları dışında kendilerini daha iyi hissetmelerine yardımcı olacak kaynaklar sorulmuş ve cevapları baş etme stratejileri temasının alt temalarını oluşturmuştur.

3.2.3.1. İş yapmak

Bu tema altında katılımcılar köydeki çalışmaları ve bu çalışmanın psikolojik durumları ve günlük stresle başa çıkma üzerindeki olumlu etkileri hakkında konuşmuşlardır.

3.2.3.2. Sosyal Destek

Bu tema altında, katılımcıların sosyal destek kaynakları ve bu kaynakların katılımcılar üzerindeki olumlu etkileri tartışılmıştır. En çok vurgulanan başa çıkma stratejisi sosyal destektir. Katılımcılar bir sorunla karşılaştıklarında bunu arkadaşları ve komşuları ile paylaşmışlar ve bu paylaşım sonucunda aldıkları sosyal destek onlara moral vermiştir.

3.2.3.3. Dini Faaliyetler

Katılımcılardan altısı başa çıkma stratejisi olarak dini faaliyetleri kullandıklarını söylemişlerdir. Psikolojik sorunların algılanan nedenleri alt temasında belirtildiği gibi, bazı katılımcılar için yaşadıkları sorunlar bir test olarak Allah'tan gelmiştir. Dolayısıyla bu sorunlarla baş etmek için Allah'a yönelmek, bu katılımcılar için mantıklı bir problem çözme yöntemidir. Katılımcılar Kuran'dan sureler ve dua kitaplarından dua okumanın kendilerine iyi geldiğini anlatmışlardır.

BÖLÜM 4

TARTIŞMA

Bu çalışmanın amacı, psikolojik yardım arama niyetini anlamaktır. Buna göre, psikolojik yardım arama niyetiyle ilgili süreçlerin daha kapsamlı bir anlayışına ulaşmak için nicel ve nitel bir çalışmadan oluşan karma yöntemli bir çalışma tasarımı kullanılmıştır. Bu araştırmanın nicel bölümünde, psikolojik yardım aramaya yönelik tutumların, damgalanmanın, psikolojik sorun yaşamının, yaşın, cinsiyetin, eğitim düzeyinin ve önceki ruh sağlığı tedavisi deneyimlerinin psikolojik yardım arama niyetini yordayacağı varsayılmıştır. Diğer bir hipotez, psikolojik yardım aramaya yönelik tutum ve damgalanmanın, psikolojik sorunlara sahip olma ve psikolojik yardım arama niyeti arasındaki ilişkiye aracılık edeceğidir. .

Mevcut tezin nitel bölümünde, katılımcıların psikolojik sorunlar ve psikolojik yardım arama deneyimleri, profesyonel psikolojik yardım almamanın nedenleri ve başa çıkma becerileri incelenmiştir. Bu amaçla, diğer katılımcılardan daha yüksek psikolojik sorun puanına sahip ancak daha düşük psikolojik yardım arama niyeti puanına sahip on köylü ile yarı yapılandırılmış görüşmeler yapılmıştır. Görüşmeleri analiz etmek için Tematik Analiz yapılmıştır. İlerleyen bölümde, çalışmanın hem nicel hem de nitel kısımlarının bulguları, ilgili literatür ışığında tartışılmıştır.

4.1. Çalışma 1: Nicel Çalışma

Nicel araştırmanın ilk yedi hipotezini test etmek için çoklu regresyon analizi yapılmıştır. Çoklu regresyon analizi sonuçlarına göre, psikolojik yardım aramaya yönelik tutumlar psikolojik yardım arama niyetini anlamlı ve pozitif olarak yordarken, yaş anlamlı ve negatif olarak yordamaktadır. Bu durumda yalnızca hipotez 1 ve 5 çoklu regresyon analizinin sonuçlarıyla desteklenmiştir.

Korelasyon analizinde psikolojik yardım arama niyeti, katılımcıların psikolojik yardım aramaya yönelik damgalanma ve eğitim düzeyi ile anlamlı düzeyde ilişkili olmasına rağmen, çoklu regresyon analizinde anlamlı bir ilişki bulunamamıştır. Bunun nedeni değişkenler arası olası korelasyon olabilir. Bundan sonraki çalışmalarda, bu denklemde hangi değişkenlerin daha etkili olduğunu anlamak için hiyerarşik regresyon yapılabilir ve örneklem büyüklüğünün artırılması gerekir.

Regresyon analizinde damgalama, psikolojik yardım arama niyetini anlamlı olarak yordamasa da anlamlı olmaya oldukça yakındır ($p = .054$). Bu nedenle, damgalama psikolojik yardım almayı öngörmede hala önemli bir değişkendir. Nitekim ikinci aşamada nitel araştırmada katılımcılarla yapılan görüşmeler, damgalanmanın katılımcılar için önemli bir konu olduğunu göstermiştir.

Daha önce belirtildiği gibi regresyon analizinde katılımcıların eğitim düzeyi ile psikolojik yardım arama niyetleri arasında anlamlı bir ilişki olmamasına rağmen, korelasyon analizinde anlamlı ve pozitif bir ilişki bulunmuştur. Mevcut tezde eğitim düzeyi ile niyet arasındaki pozitif ilişki önceki çalışmalarla da desteklenmiştir (Pilkington vd., 2012). Bulgular yüksek eğitimli katılımcıların psikolojik yardım aramaya yönelik daha olumlu tutumları olduğunu göstermektedir. Bu çalışmada, düşük eğitim seviyesine sahip katılımcılar çoğunlukla köyde yaşamaktadır. Bu nedenle, profesyonel psikolojik yardım konusundaki bilgi düzeyleri, köyde gördükleri örneklerle sınırlı olabilir. Ancak, yüksek eğitim seviyesine sahip katılımcılar eğitimlerini tamamlamak için köy dışına çıkmışlardır. Bu katılımcılar eğitim gördükleri şehirlerde ve okullarda daha fazla psikolojik sorun ve profesyonel yardım örneği ile karşılaşmış olabilir. Ayrıca psikolojik sorunlar ve psikolojik yardımla ilgili kavramlar çoğunlukla Batı kültüründen öğrenilmiş kavramlardır. Bu nedenle, daha yüksek eğitim seviyeleri almak daha fazla batılılaşmaya ve Batılı psikoloji kavramlarına daha aşina olmaya yol açmış olabilir. Sonuç olarak, katılımcılar profesyonel psikolojik yardım kaynakları ve bu yardımın faydaları hakkında daha fazla bilgi

ve aşinalık kazanmış olabilir, bu da katılımcıların olumlu tutumlarına katkıda bulunmuş olabilir.

Öte yandan, önceki çalışmalarda cinsiyet, eğitim düzeyi, önceki psikolojik yardım öyküsü, damgalanma ve psikolojik sorunlar psikolojik yardım arama niyetini yordamakla birlikte bu çalışmada bu tür bir ilişkiye rastlanmamıştır. Bunun nedeni, mevcut çalışmanın örneklem özelliklerinden kaynaklanıyor olabilir. Ek olarak, psikolojik yardım alma ile psikolojik yardım arama niyeti arasındaki ilişkiye tutum aracılık etmese de, damgalama aracılık etmiştir. Aracı değişken analizleri, psikolojik yardım aramada damgalanmanın önemini ortaya koymuştur.

4.1. Çalışma 2: Nitel Çalışma

Bu nitel araştırmada katılımcıların psikolojik sorunlar, psikolojik yardım ve başa çıkma stratejilerine ilişkin görüş ve düşünceleri incelenmiştir. Bu çalışmanın sonuçları, katılımcıların psikolojik yardıma erişimde birçok engelle karşılaştığını göstermiştir. Psikolojik hastalık ve psikolojik yardım hakkında bilgi eksikliği ve olumsuz tutumlar, katılımcıların düşük ruh sağlığı okur yazarlığı seviyelerine neden olmuştur. Ayrıca katılımcıların damgalanma korkusu vardır. Bu bilişsel ve psikolojik engellere ek olarak, uzak bir köyde yaşamaları ve şehre ulaşımın nispeten pahalı olması nedeniyle katılımcılar profesyonel psikolojik yardıma erişimde zorluk çekmektedirler. Tüm bu engeller psikolojik yardım almayı son çare haline getirmiş ve psikolojik yardım arama niyetinin azalmasına neden olmuş olabilir. Profesyonel yardım alma konusunda isteksiz olan bu katılımcılar, gündelik işler, sosyal destek ve dini faaliyetler gibi profesyonel olmayan kaynaklara yönelmişlerdir.

4.2. Genel Tartışma

Hem nicel hem de nitel çalışmaların sonuçları, psikolojik yardım arama niyetinin düşük olmasıyla ilgili tüm faktörlerin, katılımcıların düşük sosyo-ekonomik statüleriyle ilişkili olabileceğini işaret etmiştir. Katılımcıların çoğunun eğitim ve gelir düzeyi düşüktür ve psikolojik yardıma erişim konusunda sosyal adaletsizlikle karşı karşıyadırlar. Bu nedenle psikolojik yardım aramayı son çare olarak görmeleri anlaşılır bir durumdur. Herhangi bir damgalanma olmasa bile, bu katılımcılar psikolojik yardıma erişemedikleri için psikolojik yardım alma niyetinde olmayabilir. Bu nedenle, damgalanma ve tutuma odaklanmanın yanı sıra, sosyal sınıf farklılıkları da psikolojik yardım arama ile ilgili olarak incelenmelidir. Sınıf farklılıklarının ve sosyal adaletsizliğin psikolojik yardım arama niyeti üzerindeki etkisinin daha net bir şekilde anlaşılması için ileride yapılacak araştırmalar, farklı eğitim düzeylerine ve ekonomik koşullara sahip bireyler arasında farklı coğrafi alanlarda psikolojik yardım aramayı karşılaştırmalı olarak inceleyebilir.

4.3.1. Klinik Çıkarımlar

Bu köy gibi küçük yerleşim yerlerinde çalışan ruh sağlığı uzmanları, damgalanma korkusunun farkında olmalı ve danışanlarının kendilerini açmak için biraz zamana ihtiyaç duyabileceklerini akılda tutmalıdırlar. Danışanların kendilerini kolayca ifade edebilecekleri, damgalamanın olmadığı bir ortam yaratılmalıdır. Bunun için terapistin bu konuda bir öz farkındalık geliştirmiş olması gerekir. Ayrıca, psikolojik yardıma yönelik olumsuz tutumlar ve damgalanma korkusu araştırılmalı ve danışanlara psikolojik yardımın faydaları ayrıntılı olarak anlatılmalıdır. Daha önce de belirtildiği gibi, damgalama eğitim programları ve seminerler yoluyla ele alınabilir.

4.3.2. Sınırlılıklar ve Güçlü Yönler

Bu tezde birkaç sınırlılık vardır. Öncelikle katılımcıların düşük okur yazarlık düzeyi sebebiyle araştırmacı ölçek maddelerini okuyarak çalışmaya dahil olmuştur. Ayrıca veriler Ordu'nun sadece bir köyünden toplanmıştır ve ikinci aşamaya katılma kriterlerini karşılayan 10 katılımcıdan 9'u kadındır. Bulguları genellemek için farklı popülasyonlardan daha büyük ve daha çeşitli örneklere ihtiyaç vardır.

Bu çalışmanın temel gücü, araştırma tasarımının karma yöntem dayalı olmasıdır. Nicel ve nitel analizler birbirlerini tamamlayıcı olarak kullanılmıştır. Nicel çalışma, incelenen değişkenler arasındaki ilişkileri analiz etmek için sağlam bir zemin sağlarken; nitel araştırma, psikolojik yardım arama süreçleri açısından daha derin bir anlayış sağlamıştır. Psikolojik yardım alma niyeti çağdaş literatürde iyi çalışılmış bir konu haline gelmesine rağmen, Türkiye'de bu konuyu karma yöntem tasarımında ve kırsal nüfus içinde irdeleyen bir çalışma yoktur. Dahası, araştırmacı uzun yıllardır bu köyde yaşayan ve köydeki insanların yaşam tarzını ve kültürünü yakından bilmektedir. Bu da verilerin toplanması ve analiz edilmesi aşamalarını kolaylaştırmıştır.

4.3.3. Sonuç

Araştırmanın sonuçlarına göre, önceki araştırmalarda olduğu gibi tutum ve damgalanmanın psikolojik yardım arama niyeti ile anlamlı düzeyde ilişkili olduğu bulunmuştur. Katılımcılarla yapılan derinlemesine görüşmeler sonucunda, damgalanmanın psikolojik yardım arayışına engel olduğu bir kez daha görülmüştür. Damgalanmaya ek olarak, psikolojik yardımın önünde ulaşım ve mali engeller gibi fiziksel engeller de vardır. Tüm bu engelleri ortadan kaldırmak için devlet desteğine ve eğitim programlarına ihtiyaç vardır.

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YAZARIN / AUTHOR

Soyadı / Surname : GÜNEŞ ÇAKMAK
Adı / Name : SEMANUR
Bölümü / Department : Psikoloji / Psychology

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