Relationships between Stigma, Gender, Personality, Stress, Self-Efficacy and Quality of Life.

Paloma Bampi

Submitted in partial fulfillment of the requirements of the Bachelor of Arts degree (Psychology Specialization) at DBS School of Arts, Dublin.

Supervisor: Dr. Anne Davis

Head of Department: Dr. S. Eccles

April 2013

Department of Psychology

DBS School of Arts

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ACKNOWLEDGMENTS

For all those people who despite living in a world that seems insane still find strength to be kind to others.

ABSTRACT

An exploratory study looking into the relationships between stigma in mental health - related either to self-stigmatization and perceived stigmatization by others when seeking for psychological help – and gender role, personality type, perceived stress, self-efficacy and quality of life. Participants were approached through social network and psychometric questionnaires were applied online. A number of statistical tests were employed to measure for significant differences and relationships between variables. Results reported significant differences between males and females levels of self-stigmatization, significant relationship between self-stigmatization and Agreeableness, and also significant relationship among perceived stigmatization and self-efficacy.

INTRODUCTION

A 2007 report by the Health Service Executive (HSE) showed that 25% of the world population currently has a psychological disorder or has previously experienced one. In Ireland, the percent of people reporting that they have been suffering from a mental disorder lowers to 11%. This may indicate a number of people experiencing higher level of psychological distress didn't look for professional health support, such as the GP, psychiatrists and clinical psychologists; moreover, they have not yet been properly diagnosed. As mental disorder is still a complex term even for mental health specialists, it can cause confusion and misunderstanding among the general population. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) define mental disorders as:

> *A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological or biological dysfunction in the individual (American Psychiatric Association, 2000, p. 31, as cited in Kring, Johnson, Davison, Neale, 2009, p.4).*

However the low figure in Ireland followed by the avoidance in seeking for professional diagnostic and treatment may be a result of the high stigma surrounding psychological disorders. To support this hypothesis, the same report pointed that 85% of the people questioned believe that everyone is vulnerable to suffer from a mental illness, 62% would still prefer to keep it private. Contradictorily, having supported by someone to communicate

was cited as the most effective method of dealing with psychological issues, and for those who had admitted experiencing depression the levels in life satisfaction were higher when they had access to good social support, despite of the fact that personal distress is one of main characteristics that defines mental disorder, which is often a result of negative life experience (Kring et al., 2009).

Notwithstanding evidences of how stigma affects negatively those in need for psychological support, is still not clear the reason why the numbers continues high in times of easy access to information. Some studies refer to individual differences, such as gender and personality, to be a factor in predicting how vulnerable a person is in relation to stigmatization and it will be discussed throughout this research.

Stigma

Individuals experiencing psychological distress are further negatively impacted by stigma. Stigmas can be defined as beliefs and attitudes from a society directed toward specific groups, those who are considered different in some manners, and it can lead to discrimination, which usually results in negative behaviors toward a specific group (Kring et al., 2009; Baron, Branscombe, Byrne, 2009).

Misconceptions in relation to mental disorders, through stigmatization, can have negative consequences in terms of familial relationships, additionally can lead to social isolation and exclusion (Kring et al., 2009). According to theorists, stigmatization can also become a barrier for individuals going through psychological distress in communicating with health professionals, such as GPs, psychiatrists, and social workers, what can become an obstacle for treatment. Furthermore, it can be explained by the fact that people prefer to hide them from psychological concerns, avoiding proper diagnoses and treatment, to stay away from harmful consequences associated to stigma (Vogel, Wade & Haake, 2006).

Previous literature have been associated stigma in seeking psychological help services to public stigma, the reaction that the general population to those who have a mental disease. However, growing number of research has shown that the individual beliefs of mental illness related to his or her self-esteem (Corrigan, 2004, in Vogel et al. 2006). Vogel et al. (2006), defines self-stigmatization as an individual self-labeling as a person socially unacceptable, based on the low self-esteem, self-worth, self-concept and self-efficacy.

Statistics in stigma related to mental disorders, as the cause of discrimination against patients, are preventing those in need for seeking mental health care, as pointed by the World Health Organization (WHO). A public research supported by the same organization in South Africa showed a strong relationship between mental health and stress, where levels of self-stigmatization were higher among urban population with a high level of education (Kakuma, Kleintjes, Lund, Drew, Green, Flisher, 2010). The fact that population with easier access to information presenting higher levels of stigmatization is impressive.

Dingfelder (2009)'s article, published by the American Psychological Association (APA), reports that in spite of United States government's high investments in the last decades in public information campaigns to demystify the stigma regarding individuals with mental illness, stigmatization has achieved its highest level. The article is supported by data in health and social behaviour, where most of the population asking questions regarding personal feelings related to others in terms of psychological issues reported that they do not want a person with mental illness joining in the family or in their workplace.

Furthermore, individuals with mental illness are more likely to internalize society's beliefs about them, such as being incompetent, irrational and untrustworthy, which leads to increasing in self-stigmatization. Those thoughts can result in development or increase of distress that may turn to be more prejudicial than the psychological disorder itself. Dingfelder 2009's article related the unsuccessful results from public campaigns seeking to minimize the

stigma with the fact that mental health has been transmitted with focus in the illness, as an abnormality, instead of exhibiting the positive outcomes from seeking professional help and treatment.

The relationship between stigmatization and seeking for psychological treatment becomes even more critical when a recent research shows the significant growth in, frequency and severity, in a number of college students suffering from mental diseases, where most of those are not seeking for professional help, mentioning the fear of stigmatization is the main reason, this way preventing initiation or continuity for the proper treatment (Cheng, Kwan, Sevig, 2013).

The same authors discussed the importance of assess levels of psychological distress when looking at help-seeking stigmatization, where higher levels of psychological distress can act as a predictor to highly perceived stigmatization by others and self-stigma associated with seeking psychological help. On their sample, perceiving stigmatization by others significantly and positively indicates self-stigma, and also significantly mediates the relationship between psychological distress and self-stigma of seeking psychological help.

Also researchers looking to understand how stigmatization decreases the search for psychological help, refers to a less result of the individual's perception towards the opinion of the society and more related to the influence from the individual's personal network (Vogel, Wade & Asheman, 2009). A new psychometric measure of stigma levels in individual's social network has been tested and presented by the same authors, and is suggested to be further research to test mediating or moderating factors in relationships stigmatization among related variables, such as personality and the level of distress.

Research in mental health, conducted by HSE, has demonstrated an increase in the cases of individuals suffering from psychological difficulties but if stigmatization, as theorist and health organizations have pointed, is a factor in decreasing in seeking for professional help,

as reported by the WHO, is possible that the percentage of population undergoing psychological issues might be higher than the number presented in reports. It is however, important to note the actual limitations on research conducted at stigmatization in seeking psychological professional help, in where the samples are still small in comparison to the population and mainly formed by college students. Also, there are no relevant intervention actions in minimizing stigmatization reported so far.

Gender differences

Gender schemas are organized mental structures, provided by gender-role socialization, that sustain society understanding of attributes and behaviors which are believed to be appropriate and expected for males and females (Bem, 1981, in Passer, Smith, Holt, Bremmer, Sutherland, Vliek, 2009). In certain cultures, men are attributed to emotional strength and self-sufficiency, while women are expected to develop interpersonal competencies and be helpful to others. Also, men are known to develop individualistic self-concept on the other hand women, inversely, would develop a sense of collectivism (Passer et al. 2009).

Substantial studies have examined the differences between males and females when seeking for psychological support, recent research points out that men's avoidance in communicating emotional issues with others, even among same sex, suggesting this might be associated to the male gender role. Accordingly, in the same study even when highly distressed males avoid seeking mental health support, becoming more vulnerable to psychological issues, for instance they suffer from depression and anxiety-disorder, as well as problematic abusive behaviour, as we can see in alcohol and drug abuse (Vogel, Wester, Hammer, Downing-Matibag, 2013).

Moreover, the individual's social network has influence in the categorization of how a man should react in terms of emotions, increasing self-stigmatization and discouraging to seek for

treatment. Research indicated that those who are endorsed to greatly restricted emotionality and restrictive affectionate behaviour to other people reported higher levels of self-stigmatization, and were also less willing to refer friends and family members for experiencing psychological issues to seek treatment (Vogel et al., 2013).

To complete the previous literature reviews and gender roles in stigma, a research applied to male police officers, suggests that there is a relationship between male gender role conflict and the anticipated risk associated with counseling and stigma, in other words seeking for professional help after experiencing a distress situation or psychological concern, is avoided by the perception that it will bring more negative outcome after the treatment than positive outcomes because of the perceived stigmatization by others, (Wester, Arndt, Sedivy, Arndt, 2010).

Personality traits

According to theorists personality traits refer to the consistent patterns in the way individuals think, feel and behave, as the person predisposition, or is disposed, to act over time and across situations, and seek to understand with which consistency an individual move through variations in life (Pervin & Cervone, 2010).

There are five aspects of personality traits, which show reliability and validity to remain stable through adulthood, as Lewis Goldberg called “Big Five dimensions”, according to Pervin & Cervone (2010), it is consisted by Neuroticism, Extraversion, Openness, Agreeableness and Conscientiousness. The low and high scores in each of these trait categories give meaning to describe individuals’ personality, where:

> *Neuroticism contrasts emotional stability with a broad range of negative feelings, including anxiety, sadness, irritability, and nervous tension. Openness to experience describes the breadth, depth, and complexity of an individual’s mental and experimental life. Extraversion and Agreeableness both*

> *summarize traits that are interpersonal; that is they capture what people do with each other and to each other. Finally, Conscientiousness primarily describes task- and goal-directed behaviors and socially required impulse control (Pervin & Cervone, 2010, p. 260).*

Therefore personality can be understood as what defines people in terms of who they are, having relationship with disposition to develop determine mental disorder, exert influence on personal judgment, as also in personal preferences. However personality type might have relationship in how a person experiences stigma, as shown in substantial research.

Brown (2012) conducted research in stigma related to severe mental illnesses, where some aspects of stigma shown relationship with less previous social contact, lower Openness and Agreeableness. It suggests that it is possible through research to understand how stigma develops and which individuals are more likely to develop stigmatization in relation to mental disease.

Previous research conducted also seeking the relationship between stigma and personality differences, looking at a sample of psychiatric patients suffering from depression and anxiety disorders, showed that there was a relationship among neuroticism and treatment stigma, secrecy, perceived stigma, and self-stigma. Also it was a relationship between extroversion and perceived stigma, public stigma, and self-stigma. Thus this study is proposed that personality has influence on individuals' perception and coping strategies related to stigmatization in experiencing a mental disease (Borecki, Gozdzik-Zelazny, Pokorski, 2010).

Stress

Stress can be defined as a pattern of cognitive appraisals, physiological responses and behavioral tendencies resulting from an imbalance between life situations and the resources needed to cope with them (Passer et al., 2009). It has shown the deep impact on a person's life, reflecting on both physical and psychological states.

Based on previous theories, stress can be explained by stressors, naming the stimulus found in the individual's environment, or by strains, as the body and mind responses to the environmental stimulus. A third perspective saw stressors and strains affecting individual's mutually, as in a complex circular system that involves a new term: transactions. Those are continuous interactions and adjustments between individuals and environment through affecting and being affected by each other (Sarafino & Smith, 2011). Those interactions are different among individuals, which is known that each person can react in a different way to the same stressors, yet how stress will affect someone depends on personal vulnerability.

The personal evaluation through a stressful moment can be defined as cognitive appraisals (Lazarus 1984 in Sarafino & Smith, 2011). Primary appraisal search for the meaning of the stressful circumstances for the personal well-being, through: harm-loss, or as much harm has been caused to the person already; threats, referring to the expectation future results caused by the stress; and challenges, the chances of personal growth, that new demand causing stress may help to develop (Sarafino & Smith, 2011).

The secondary appraisal observes the available resources that the person has to cope with the harm-loss, threats and challenges. If the individual is questioned whether he has the necessary resources to deal with the demand (stressors), the answer would be not only an individual response (traits) to stressful situation, but also looking at longer and deeper results. Those results of how a person interacts with stress can be positive when goals are achieved, or negative if stress causes damages. Theories are also showing that personality can influence on how the person will perceive and deal with stressful situations, also the accumulations of stressors increase the possibility of being negatively affected, becoming chronic stress, or followed by physical or mental illness (Sarafino & Smith, 2011). It is however, important to note that an individual experiencing stress doesn't mean that it will turn into a trigger for

developing a mental disorder, but it shows that it's more likely to increase the possibility (Kring et al., 2009).

Further studies indicate that stress can be a bridge to increase the chances to develop mental illness and its maintenance. Hammen (2005) refers to the relationship between depression and negative episodic stressors, where consequential episodes of stress increased the probability of depression and in cases of a stress episode were succeeded by a major depression, accompanied by the period of a month after the event. Experiences of loss, in the form of grieving for someone close, a separation or any kind of life endings, are more likely to turn into negative stress and trigger to depression, also circumstances of chronic stress, recurring situations sustained by difficult relationships, financial or health problems, can also elevate the risk of mental illness.

Self-Efficacy

According to theorists, there is a relationship between mental health and self-perceptions. Self-efficacy represents people's belief that they are capable of performing behaviors, which will produce a desired outcome, being a key factor in how people regulate their life (Bandura, 1997, in Passer et al. 2009). Therefore, high levels of self-efficacy mean confidence in a personal ability to do what is needed to overcome obstacles and by this they can achieve goals.

Previous experience in similar situations can help to increase in confidence and self-efficacy, on the other hand emotional arousal, such as anxiety or tiredness can result in the opposite result (Passer et al. 2009). Perceived self-efficacy can act also as the confidence in the ability of enrolling and sustaining healthy habits, which sustain quality of life (Hollis, Carmody, Connor, Fey, Matarazzo, 1986).

A recent study showed that people suffering from depression symptoms are more inclined to become sensitized by daily social experiences, for instance rejection and acceptance, influencing negative feeling of social belonging and the perception of relationships, by this it has negatively affected the personal well being (Steger & Kashdan, 2009).

An experiment looking at the relation between depression and alcohol consumption shows that higher level of stress and lower level of self-efficacy can be predictors for future withdrawal from patients from treatment, specially patients with higher level of chronic stress and exhaustion of coping resources and more susceptible to learning helplessness (Tate, Wu, McQuaid, Cummins, Shriver, Krenek, Brown, 2008).

Recent study demonstrated that collective self-efficacy, that is the belief that a social or public problem can be addressed successfully through combined abilities in a group, could act as a mediator of the relationship between stress appraisal and compassion satisfaction, once those who with increased stress would see the environment more negatively and be less open to support others. On the other hand, strong collective self-efficacy can increase cooperation and help among people; therefore it helps to decrease stress and the negative perception (Prati, Pietrantoni, Cicognani, 2011).

Quality of life

Mental health is defined by the WHO (1958) as a broad range of activities directly or indirectly related to the mental well-being, whereas health itself is define as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Accordingly, health-related quality of life is composed by three domains: physical, emotional and social, also by the interaction of those. Moreover, mental health compromises the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of individuals affected by mental disorders.

The term, quality of life, isn't so far a unique meaning, and it tends to be substituted by other terms like health status and functional status. There is still a lack of clarity and consistency in defining how quality of life measures. Nowadays, based on the concept of mental health, it is believed that quality of life rather than describing a personal health status is supposed to be a reflection of the way people perceive and act in their health status interacting with others, non medical aspects of their lives.

For this, it is necessary to ask directly to individuals to rate their overall quality of life based on the importance of the individual items that affect their quality of life. It is also important to know that the overall quality of life includes not only health related factors, composed by physical, functional, emotional, and mental well-being, but also non directly health related factors, as well as jobs, family, friends, and other life circumstances (Thomas, Gill, Alvan, Feinstein, 1994). Despite quality of life may be a very individual and complex term to define, when using of measures average scores in a determine population help to place the person in a level of quality of life.

Furthermore, people experiencing mood disorders can demonstrate impairment in the positive quality of life, a research showed that psychotherapy can positively improve quality of life, there was also moderated correlations between changes in positive quality of life and changes in symptomatic response and in interpersonal functioning (Crits-Christoph, Gibbons, Connolly, Ring-Kurtz, Gallop, Stirman, Present, Temes, Goldstein, 2008).

Purpose of this study

According to the previous literature, there is complexity in defining psychological disorders, followed by the lack of knowledge concern to the subject and negative perception in the society. Correspondingly, stigma may be the reason for misconceptions surrounding mental disorders, and it also lowers seeking for professional support.

Theories indicated a strong relationship between mental health and stress, higher levels of stress can be related to poor mental health. Previous experience and emotional arousal are significant for development of self-efficacy. However a person level of stress and self-efficacy may cause impact the levels of quality of life, and vice versa.

From the interpretation of the previous research presented above, it is proposed an exploratory study with the aim of testing the hypotheses that stigma, once preventing people from seeking for support, has a relationship with poor mental health, associated in this study to high level of perceived stress, low level of self-efficacy and quality of life. Likewise it is supposed be a relationship among stigma and gender role and type of personality, to evaluate if there are certain individuals who are more vulnerable to stigmatization. Therefore is hypothesized below:

1. Is hypothesized that there will be a significant gender difference in self-stigmatisation and the perception of being stigmatised by others.

2. Is hypothesized that there will be a positive relationship between both self-stigmatisation and the perception of being stigmatised by others and Neuroticism.

3. Is hypothesized that there will be a negative relationship between both self-stigmatisation and the perception of being stigmatised by others and Openness, Conscientiousness, Extraversion, Agreeableness.

4. There will be a positive relationship between both self-stigmatisation and high levels of stress, low levels of self-efficacy and quality of life.

Above predictions will be examined and assessed by testing the statistical significance of each variables cited above in relation to self-stigmatization and perceived stigmatization.

METHODOLOGY

Participants

Volunteers were approached by opportunity sampling technique, also known as convenience sampling, in a non-probability sample selected through social media by those who were willingness to fill the questionnaires. The participants (n= 70), age range from 20 to 65 (mean = 30.41, SD = 6.950), from those 48 were female and 22 were male. Participants were asked in a voluntary basis, where no payment or incentives were offered.

Design

This research was structured in quantitative method, questionnaire-based (subjectively scaled), non-repeated measures and within-participants. This study was correlational designed with the purpose of exploring the relationship between measured criterion variables (self-stigmatization and the perception of being stigmatised by others) and predictor variables (gender, personality, stress, self-efficacy and quality of life). Independent sample t-test design was also used to test whether there was any significant difference in the dependent variables (self-stigmatization and the perception of being stigmatised by others) for the independent variables (gender).

Material

The participants were first introduced to the research through demographic questions were age to control for underage's do not participate and selection of gender as the survey is looking at differences between males and females, followed by five sections of self-report questionnaires:

Self-stigma of seeking psychological help scale (SSOSH) & Perception of stigmatization by other for seeking help (PSOSH): The SSOSH is a 10-item scale that measures the participant level of comfort or concern with regard to seeking psychological help from a therapist. The items are scored from 1 to 5 (1= Strongly Disagree, 2= Disagree, 3= Agree and Disagree Equally, 4= Agree and 5= Strongly Agree). From the 10 questions, 5 are reverse score items (see Appendix 3). The total score is the sum of all 10 items, having as possible range from 10 to 50, in a scoring algorithm leading to one of three ranges: Low Stigma (total= 10-22), Medial or Moderated Stigma (total= 23-32) and High Stigma (total= 33-50). The questions regard personal thoughts and feelings, once is expected that stigma influences negatively on individuals self-esteem (Vogel et al., 2006).

The PSOSH is a 5-item scale that measures the individual perception of whether seeking psychological help would be stigmatized by the people the person interacts with. The items are also scored from 1 to 5 (1 = Not at all, 2 = A little, 3 = Some, 4 = A lot and 5 = A great deal). The total score is given by the sum of the 5 items, with a range from 5 to 25, where higher scores indicate greater perceived stigma from one's social network. The questions are based on the believe of how other's person which the individual interact will react or think if he or she decides to seek psychological help (Vogel et al. 2009).

Big-Five Factor Markers (IPIP scale): is a 50-item scale, subdivided in 5 10-item sections measuring an individual levels of Extraversion (E), Agreeableness (A), Conscientiousness (C), Neuroticism (N) and Openness (O), considered as the most important traits to personality. The items are scored from 1 to 5 (1 = Strongly disagree, 2 = Disagree, 3 = Neither disagree nor agree, 4 = Agree and 5 = Strongly agree). From the 50 questions, 24 are reversing score items (see Appendix 3). The total scores are separated by personality trait, where high scores represent higher levels of extraversion, agreeableness, conscientiousness, neuroticism and openness to new experience. On other hand low scores represent high levels of introversion,

antagonism, lack or direction, emotional stability and closeness. The questions are universal and concern to individuals perception about their own in a variety of situations, focusing mainly in individual differences and human interaction (Pervin & Cervone, 2010).

Perceived Stress Scale (PSS): is a 10-item scale that measures an individual perception of stress in that given moment. The items are scored in 5-point scale (0 = never, 1 = almost never, 2 = sometimes, 3 = fairly often and 4 = very often). From the 10 questions, 4 are reverse score items (see Appendix 3). The score total is given by summing across all 10 items, where scores around 13 are considered average and scores of 20 or higher are considered high stress. The questions are from a general and temporal nature, focusing in how often a person had determined feelings and thoughts recently (Cohen, 1994).

Generalized Self-efficacy Scale (GSE): is a 10-item scale which measures and individual general sense of perceived self-efficacy. The items are scored in 4-point scale (1 = Not at all true, 2 = Hardly true, 3 = Moderately true and 4 = Exactly true). The range is from 10 to 40 points, where higher scores are considered high level of self-efficacy and lower scores represent the opposite. The questions are based in personal experience and therefore belief in coping successfully in difficult situations, it aim to assess a prediction that the individual will cope with daily hassles as well as if there was an increasing in self-confidence, as an adaptation, after experiencing all kinds of stressful life events (Schwarzer & Jerusalem, 1995).

Quality of Life Scale (QOLS): is a 16-item scale, which measures six conceptual domains of quality of life (material and physical well-being, relationships with other people, social, community and civic activities, personal development and fulfillment, recreation and independence or the ability to do for yourself). The items are scored in 7-point scale (7 = Delighted, 6 = Pleased, 5 = Mostly Satisfied, 4 = Mixed, 3 = Mostly Dissatisfied, 2 = Unhappy and 1 = Terrible). The sum score is given by adding up all responses, where the range is from 16 to 112 points, and higher scores are considered higher quality of life and the

average total score for healthy populations is about 90. The questions look at dimensions of satisfaction of a person experience in different domains in life related to overall well-being (Burckhardt & Anderson, 2003).

Apparatus

To realize this research was used a Sony Vaio (model PCG-7144M); the data was collected through the Google Drive Form, an online survey program, and after the answers were transferred to the SPSS (version 18) software for further data analysis.

Procedures

As mentioned before the research was distributed online, through social media (Facebook), where participants, during the period of a week, were invited to participated through online post on the researcher page openly to the network general public. Therefore, others cooperated to the research publishing the original post on their own pages. The post was an invitation to access the link for more information, and was necessary to the participants to have access to a computer device and Internet to take part. The first page consisted in detailed and explanatory text of: the purpose of the research, who was conducting the research, the time estimated to complete (15-20min), possible emotional challenges to be approached through the questions, the guarantee of anonymity followed by how the data would be collected and stored (as the researcher responsibility with the participant), and the consequences in participating in the research (see Appendix 1).

After reading the informed consent, the participants were asked to select a box where they confirmed they understood and consent the use the data for further analysis, followed by the demographic questions. Continuing the psychometric self-report questionnaires were separated in 5 pages, emphasizing the instructions on top, in the following order: Self-stigma

of seeking psychological help scale (SSOSH) & Perception of stigmatization by other for seeking help (PSOSH), Big-Five Factor Markers (IPIP scale), Perceived Stress Scale (PSS), Generalized Self-efficacy Scale (GSE), and Quality of Life Scale (QOLS) (see Appendix 3).

All participants answered the same set of questions and each question was selected as required by the online survey program, what mean that is mandatory to answer all the questions to complete the research, avoiding incomplete or partial responses. The questionnaires didn't specify what each was measuring (despite mentioning in the introductory), or the number of the questions. Following each question was the multiple answer scale to facilitate the understanding and optimizing the time effort to complete the survey.

Completing the last questionnaire was the final page consisting of: a thankful message for completing the questionnaires, the contact information to the researcher for further requests, and in the case of those who felt particularly in a low mood or under overstress were suggested to contact a GP or mental health professional, followed by well known mental support institutions contact number for further emotional support (see Appendix 2). Than was possible to send the answers concluding the questionnaire.

Therefore, a number of statistical tests were employed to measure for statistical significance between variables identified in this study for further analyses of the results.

RESULTS

An Independent Samples t-test was used to analyze statistically the hypothesis if there were significant differences between genders in levels of self-stigmatization in seeking for psychological help and perceived stigmatization from others when seeking for help.

Males (mean = 28.32, SD = 3.315) were found to have higher levels of self-stigmatization in seeking for psychological help than females (mean = 25.42, SD = 3.530). The 95% confidence limits shows that the population mean difference of the variables lies somewhere between 1.121 and 4.682. An independent samples t-test found that there was a statistically significant difference between self stigmatization levels of males and females (t(70) = 3.252, p = .002). Therefore the null can be rejected.

On other hand, males (mean = 9.77, SD = 3.308) were found to have slightly higher levels of perceived stigmatization by other for seeking for help than females (mean = 9.29, SD = 2.543). The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -.958 and 1.920. An independent samples t-test found that there wasn't a significant difference between levels of perceived stigmatization of male and females (t(70) = .667, p = .507). Therefore the null cannot be rejected.

Table 1: *An Independent Samples T-test table displaying the differences between gender and self and perceived stigmatization.*

Variables	**Groups**	**Mean**	**SD**	***t***	***df***	***p***
Self Stigmatization	Male	28.32	3.31	3.25	43.2	.002*
	Female	25.42	3.53			
Perceived Stigmatization	Male	9.77	3.31	.661	32.8	.507
	Female	9.29	2.54			

* *p* significant at .05 level.

A Pearson's r Correlation test was used to explore statistically the hypothesis if there were significant relationships between of self-stigmatization and the big five personality traits. The mean scores for self-stigmatization was 26.33 (SD = 3.69). The personality traits mean scores separately were Extraversion 30.71 (SD = 2.65), Conscientiousness 31.47 (SD = 4.09), Agreeableness 31.83 (SD = 2.75), Neuroticism 30.94 (SD = 6.23), and Openness 32.85 (SD = 2.92). A pearson correlation coefficient found that there was a moderate negative significant relationship between self-stigmatization and Agreeableness (r = -.354, p = .003), therefore, for this condition, the null can be rejected.

There wasn't a significant relationship between self-stigmatization and other four personality traits variables: Extraversion (r = .002, p = .985), Conscientiousness (r = .007, p = .955), Neuroticism (r = -.120, p = .323), and Openness (r = -.174, p = .150). Therefore the null cannot be rejected.

Table 2: *A Pearson R Correlation table displaying the relationships between self-stigmatization and the Big Five Personality Traits.*

Variables	**Self Stigma**	**Extraversion**	**Conscientiousness**	**Agreeableness**	**Neuroticism**	**Openness**
Self Stigma						
Extraversion	.002					
Conscientiousness	.007	.068				
Agreeableness	-.354**	.282*	.116			
Neuroticism	-.120	.112	.166	.090		
Openness	-.174	.178	.337**	.110	.284*	

* *p* significant at .05 level.
**p* significant at .01 level.

Regarding to perceived stigmatization, which mean scores 9.44 (SD = 2.79), a pearson correlation coefficient found that wasn't a significant relationship between perceived

stigmatization when correlated with all of the personality trait variables: Extraversion (r = -.100, p = .410), Conscientiousness (r = -.120, p = .323), Agreeableness (r = -.178, p = .139), Neuroticism (r = .221, p = .065), and Openness (r = .097, p = .426). Again the null cannot be rejected.

Table 3: *A Pearson R Correlation table displaying the relationships between perceived stigmatization and the Big Five Personality Traits.*

Variables	**Perceived Stigma**	**Extraversion**	**Conscientiousness**	**Agreeableness**	**Neuroticism**	**Openness**
Perceived Stigma						
Extraversion	-.100					
Conscientiousness	-.120	.068				
Agreeableness	-.178	.282*	.116			
Neuroticism	.221	.112	.166	.090		
Openness	.097	.178	.337**	.110	.284*	

* *p* significant at .05 level.
**p* significant at .01 level.

A Pearson's r Correlation test was also used to explore significant relationships between both self stigmatization and perceived stigmatization and the continuous variables perceived stress (mean = 21.75, SD = 3.66), self-efficacy (mean = 30.13, SD = 5.52) and quality of life (mean = 81.10, SD = 15.81). A pearson correlation coefficient found that there was a weak negative significant relationship between perceived stigmatization and self-efficacy (r = -.263, p = .028), and wasn't a significant relationship between perceived stigmatization and perceived stress (r = .169, p = .161), also quality of life (r = .183, p = .130), partially confirming the hypothesis.

Therefore a pearson correlation coefficient found that there wasn't a significant relationship between self-stigmatization and perceived stress (r = -.192, p = .112), self-efficacy (r = -162, p = .179) and quality of life (r = -.047, p = .701), so the null in this case cannot be rejected.

Table 4: *A Pearson R Correlation table displaying the relationship between self and perceived stigmatization in relation to perceived stress, self-efficacy and quality of life.*

Variables	**Self Stigma**	**Perceived Stigma**	**Perceived Stress**	**Self-Efficacy**	**Quality of Life**
Self Stigma					
Perceived Stigma	-.020				
Perceived Stress	-.192	.169			
Self-Efficacy	-.162	-.263*	-.295*		
Quality of Life	-.047	-.183	-.286*	.688**	

* *p* significant at .05 level.
**p* significant at .01 level.

Furthermore, the pearson correlation coefficient showed significant weak to moderate negative relationship between perceived stress and self-efficacy ($r = -2.95$, $p = .013$), also quality of life ($r = .286$, $t = .016$). A pearson correlation coefficient found that there was a strong positive relationship between self-efficacy and quality of life ($r = .688$, $p < .001$). As well, to conclude the results description, the pearson correlation coefficient demonstrated that there was no significant relationship between the two criterion variables, self-stigmatization and perceived stigmatization ($r = -.020$, $p = .870$).

DISCUSSION

This study was aimed to explore the relationships between stigma in mental health - related either to self-stigmatization in seeking for psychological support and perceived stigmatization by other also when seeking for professional help - and gender role, personality type, perceived stress, self-efficacy and quality of life.

Results shown a significant difference between males and females in relation to self-stigmatization. Regarding to the personality influence in individual stigma associated to mental health can be observed a negative significant relationship between self-stigmatization and Agreeableness, though moderate. Relative to perceived stigmatization, it's observed a significant, however weak, negative relationship with self-efficacy. Although, there is a significant negative relationship between perceived stress related to self-efficacy and quality of life, likewise, self-efficacy and quality of life shown to have a significant strong positive relationship. Interestingly, self-stigmatization and perceived stigmatization, do not demonstrate to correlate.

The results of the present study however only partially supported the hypothesis. In relation to differences in gender in stigma, it can be accept that there is a significant difference between males and females, in which men did scored significantly higher in self-stigmatization. On other hand the finding does not support the hypothesis of a strong relationships between stigma and personality traits. Variables related to personal well being, such as stress, self-efficacy and quality of life, also did not correlated to stigma levels as expected, just weakly in relation to self-efficacy, therefore the hypothesis is in part accepted.

The significant difference between genders, where is confirmed the hypothesis that men experience higher levels of self-stigmatization compared to women, suppose that gender role attributed to men, such as emotional strength and self-sufficiency (Passer et al. 2009), impact

in increasing or sustain their self-stigma in seeking psychological help. Can be supposed that the male population would continue longer without professional support when experiencing a psychological issue, what can result in worst consequences (Vogel et al. 2013). The non-significant differences in perceived stigmatization can be interpreted that the belief that professional help be ineffective that may influence in not seeking for support, and not the belief of negative outcome from others perception (Wester et al. 2010).

Proceeding with the analysis, stigma levels correlated to personality traits shown that lower levels of agreeableness are correlated to higher levels of self-stigmatization. Agreeableness assess the quality of interpersonal interaction, where high levels are related to compassion and low levels to antagonism (Pervin & Cervone, 2010). Through this study it can be speculated that individuals that present higher concern to others well-being, may also have less stigma related to seeking to their own well-being. Therefore is less likely to be a relationship between stigma in mental health and personality type, at least among a population with average levels of perceived stress and quality of life. It is supposed that in a population that has been diagnosed those results may be different as shown in previous research (Brown, 2012, Borecki et al. 2010).

Continuing exploring the correlational results, the relationship between self-efficacy and perceived stigmatization support the theory that lower levels of confidence in oneself, increasing the sensitiveness to others opinion may increase the perception of others opinions (Steger & Kashdan, 2009), or even overestimate those. Furthermore is also speculated also that self-efficacy may increase intentions in help others through emotional issues (Prati et al. 2011), it can seem logical that the opposite can happen, therefore those less susceptible to help may also believe that others, belonging to their social network, will also be negatively perceived.

On the one hand results shows that higher levels of stress, or low levels of self-efficacy and quality of life can only be partially related to the influence exercise by stigma, on the other it provides the acknowledge that there is a relationship between the three variables. More specifically was found that stress has a negative relationship with self-efficacy, however it may implicate in seeking for support, reaching goals and continuing treatment, as can increase in learned helplessness (Tate et al. 2008). Stress episodes, related to acute or chronic stress, have shown to affect negatively in quality of life, and thereby in mental health (Hammer, 2005). Moreover self-efficacy and quality of life strong positive relationship is consistent with the stability of the measures in a longer period, and to the own belief in the capability in maintain the appropriate behaviour to sustain healthy habits and quality of life (Hollis et al., 1996), and otherwise improved quality of life can support in individuals respond to changes when coping with psychological issues (Crits-Christoph et al. 2008).

In particular to the study limitations the sample size may be not representative enough to declare conclusions, therefore is suggested that the research to be replicated to a larger sample. On the other hand by a mature sample, in relation to age average, distinguish this actual research from the previous studies composed mostly for college students.

A consequence from this research is to test the use of online survey to apply questionnaires. Online survey can help to improve psychological research, by positive outcomes such as: make possible to participants to answer to questionnaires on their own privacy and convenience; guarantee the participants anonymity, once the data is safely transferred from the online software, used to data collection, to the computer program. used for statistical analyses, making difficult to associate answers to a specific person; controlling for non answered questions avoiding missing responses; and not requiring the contact with the researcher during this process, by this reducing possible bias. Also, bringing to discussion the

use of internet when looking at determined population, it can facilitate to reach to samples more effectively, through appropriated period of time and access channels.

In relation to future research, looking in attitudes associated to mental health, and likelihood in seeking to psychological help, it would be interesting to add a question concerning the fact if the person has already been diagnosed with a psychological problem and has needed some sort of treatment. Herewith would be possible to have a between subjects design, comparing those who had experienced a psychological issue who those haven't, also in example of stress, self-efficacy and quality of life, test if those who haven't enrolled in some sort of treatment, or even not appointing a diagnosed, shown an imbalance in their measures in well-being.

Regarding the complexity in relation to define mental disorder, presented in the start of this study, such as the attempts to elucidate society that mental and social well-being is as important as physical functioning to a healthy life (as WHO definition of health), the knowledgment in theory should be enough to increase people mental care as part of their routine, such as diet and physical exercise. However psychological disorders are still mostly related to negative perceptions such as stigma, and care related to mental health is also perceive mostly to individuals in extreme cases (Kring et al., 2009). Therefore if the review of interventions in clarify mental health to the population, focused in mental disorder, demonstrated so far negative results (Dingfelder, 2009) is recommended that new interventions approach to mental care include to the general health care, and not only to abnormalities.

Concluding, contradicting recommendations to study and establish profiles more likely to be affected by stigma (Vogel et al., 2006) can be discarded, as no strong relationships were found. Although gender role related to men can cause lower acceptance in seeking for psychological treatment, and may be explored not only related to stigma, but also in how to approach the male population. On other hand a different approach in interventions is

suggested, not focusing in minimize stigma, but in improve mental health care, as it shown relationships between stress, self-efficacy and quality of life, and those variables are highly likely to affect mental health.

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APPENDIX

Appendix 1: Cover Page, Informe Consent & Demographic Questions

My name is Paloma Bampi and I am conducting an exploratory study looking at the relationships between stigma, gender, personality, stress, self-efficacy and quality of life. This research is being conducted as part of my studies in the Department of Psychology of Dublin Business School and will be submitted for examination. You are invited to take part in this study and participation involves completing the following survey. The time estimated to complete the research is 15-20 minutes.

While the survey asks some questions that might cause some minor negative feelings, it has been used widely in research. If any of the questions do raise difficult feelings for you, contact information for support services are included by the end the survey, where you will be ask to submit your answers.

Your participation is completely voluntary, and so you are not obliged to take part. Also, participation is anonymous and confidential, the questionnaires will be securely stored and data from the questionnaires will be keep on electronic format and stored on a password protected computer. Thus responses can not be attributed to any one participant. For this reason, it will not be possible to withdraw from participation after the questionnaire has been submitted.

You must be 18 years old or over to be eligible to participate in this research.

It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study.

I read and understood the above and I am giving my consent. (checkbox)

Demographic questions:

What's your age? (space to write in Arabic numbers)

What's your gender? (checkboxes: female and male)

Appendix 2: Debriefing Page

Thank you for completing this survey.

Should you require any further information about the research, please contact:

Researcher Paloma Bampi, 1563065@gmail.com

Supervisor Dr. Anne Davis, anne.davis@dbs.ie

Dublin Business School Psychology Department +353(0)14177575

If you feel you mood is particularly low or over stress don't hesitate to contact your GP or a mental health professional.

For further support:

Samaritans +353(0)1850 60 90 90 (available 24 hours a day)

1Life (Free Phone) +353(0)1800 247 100 (available 24 hours a day)

Aware (LoCall) +353(0)1890 303 302

Appendix 3: Psychometric Questionnaires

Self-stigma of seeking psychological help scale (SSOSH)

Instructions:

People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

Response format:

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

Questions:

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help. (Reversed)
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist. (Reversed)
5. My view of myself would not change just because I made the choice to see a therapist. (Reversed)
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help. (Reversed)
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve. (Reversed)

10. I would feel worse about myself if I could not solve my own problems.

Perception of stigmatization by other for seeking help (PSOSH)

Instructions:

Imagine you had an emotional or personal issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would _____.

Response format:

1 = Not at all 2 = A little 3 = Some 4 = A lot 5 = A great deal

Questions:

1. React negatively to you
2. Think bad things of you
3. See you as seriously disturbed
4. Think of you in a less favorable way
5. Think you posed a risk to others

Big-Five Factor Markers (IPIP)

Instructions:

The following statements concern your perception about yourself in a variety of situations. Your task is to indicate the strength of your agreement with each statement, in a scale where 1 denotes strong disagreement, 5 denotes strong agreement, and 2, 3, and 4 represent

intermediate judgments. There are no "right" or "wrong" answers, so select the number that most closely reflects you on each statement. Take your time and consider each statement carefully.

Response format:

1 = Strongly disagree 2 = Disagree 3 = Neither disagree nor agree 4 = Agree 5 = Strongly agree

Questions:

1. Am the life of the party. (E+)
2. Feel little concern for others. (A-)
3. Am always prepared. (C+)
4. Get stressed out easily. (N-)
5. Have a rich vocabulary. (O+)
6. Don't talk a lot. (E-)
7. Am interested in people. (A+)
8. Leave my belongings around. (C-)
9. Am relaxed most of the time. (N+)
10. Have difficulty understanding abstract ideas. (O-)
11. Feel comfortable around people. (E+)
12. Insult people. (A-)
13. Pay attention to details. (C+)
14. Worry about things. (N-)
15. Have a vivid imagination. (O+)
16. Keep in the background. (E-)

17. Sympathize with others' feelings. (A+)

18. Make a mess of things. (C-)

19. Seldom feel blue. (N+)

20. Am not interested in abstract ideas. (O-)

21. Start conversations. (E+)

22. Am not interested in other people’s problems. (A-)

23. Get chores done right. (C+)

24. Am easily disturbed. (N-)

25. Have excellent ideas. (O+)

26. Have little to say. (E-)

27. Have a soft heart. (A+)

28. Often forget to put things back in their proper place. (C-)

29. Get up easily. (N-)

30. Do not have a good imagination. (O-)

31. Talk to a lot of different people at parties. (E+)

32. Am not really interested in others. (A-)

33. Like order. (C+)

34. Change my mood a lot. (N-)

35. Am quick to understand things. (O+)

36. Don't like to draw attention to myself. (E-)

37. Take time out for others. (A+)

38. Shirk my duties. (C-)

39. Have frequent mood swings. (N-)

40. Use difficult words. (O+)

41. Don't mind being the center of attention. (E+)

42. Feel others' emotions. (A+)

43. Follow a schedule. (C+)

44. Get irritated easily. (N-)

45. Spend time reflecting on things. (O+)

46. Am quiet around stranger. (E-)

47. Make people feel at easy. (A+)

48. Am exacting in my work. (C+)

49. Often feel blue. (N-)

50. Am full of ideas. (O+)

Perceived Stress Scale (PSS)

Instructions:

The questions in this scale ask you about your feelings and thoughts. In each case, please indicate with a check how often you felt or thought a certain way.

Response format:

0 = never 1 = almost never 2 = sometimes 3 = fairly often 4 = very often

Questions:

1. Lately, how often have you been upset because of something that happened unexpectedly?

2. Lately, how often have you felt that you were unable to control the important things in your life?

3. Lately, how often have you felt nervous and "stressed"?

4. Lately, how often have you felt confident about your ability to handle your personal problems? (Reversed)

5. Lately, how often have you felt that things were going your way? (Reversed)

6. Lately, how often have you found that you could not cope with all the things that you had to do?

7. Lately, how often have you been able to control irritations in your life? (Reversed)

8. Lately, how often have you felt that you were on top of things? (Reversed)

9. Lately, how often have you been angered because of things that were outside of your control?

10. Lately, how often have you felt difficulties were piling up so high that you could not overcome them?

Generalized Self-efficacy Scale (GSE)

Instructions:

For each of the following statements, please indicate with a check the choice that is closest to how true you think it is for you. The questions ask about your opinion. There are no right or wrong answers.

Response format:

1 = Not at all true 2 = Hardly true 3 = Moderately true 4 = Exactly true

Questions:

1. I can always manage to solve difficult problems if I try hard enough.

2. If someone opposes me, I can find the means and ways to get what I want.

3. It is easy for me to stick to my aims and accomplish my goals.
4. I am confident that I could deal efficiently with unexpected events.
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.
6. I can solve most problems if I invest the necessary effort.
7. I can remain calm when facing difficulties because I can rely on my coping abilities.
8. When I am confronted with a problem, I can usually find several solutions.
9. If I am in trouble, I can usually think of a solution.
10. I can usually handle whatever comes my way.

Quality of Life Scale (QOLS)

Instructions:

Please read each item and indicate the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or dissatisfied with not doing the activity or having the relationship

Response format:

7 = Delighted 6 = Pleased 5 = Mostly Satisfied 4 = Mixed 3 = Mostly Dissatisfied 2 = Unhappy 1 = Terrible

Questions:

1. Material comforts home, food, conveniences, financial security
2. Health - being physically fit and vigorous
3. Relationships with parents, siblings and other relatives - communicating, visiting, helping

4. Having and rearing children

5. Close relationships with spouse or significant other

6. Close friends

7. Helping and encouraging others, volunteering, giving advice

8. Participating in organizations and public affairs

9. Learning- attending school, improving understanding, getting additional knowledge

10. Understanding yourself - knowing your assets and limitations - knowing what life is about

11. Work - job or in home

12. Expressing yourself creatively

13. Socializing - meeting other people, doing things, parties, etc

14. Reading, listening to music, or observing entertainment

15. Participating in active recreation

16. Independence, doing for yourself