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The Cultural Beliefs and Mental Health Help-Seeking
Behaviors of People with Schizophrenia in Taiwan

A DISSERTATION

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Min-Ling Wang

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The Cultural Beliefs and Mental Health Help-Seeking
Behaviors of People with Schizophrenia in Taiwan

Min-Ling Wang, Ph.D.

Director: Sr. Ann Patrick Conrad, Ph.D.

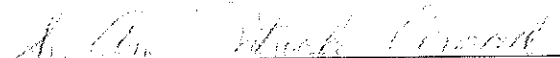
The purpose of this study was to explore the help-seeking behaviors of persons with schizophrenia in Taiwan. As the Literature indicates this illness has both biological and social causes and is one of the most misunderstood, stigmatized, and untreated diseases. Cheng (2003) estimated that of the 64,908 individuals with chronic mental illness in Taiwan, 60% were dysfunctional and required long-term continuous and rehabilitative care. Wynaden (2005) found that religion was an important factor influencing individual and family health beliefs and that in the Taiwanese culture, many people turned to Buddhism and Taoism for folk healing. He recommended that mental health professionals need to develop stronger linkages with religious groups in the community.

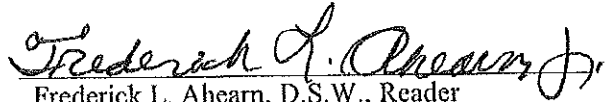
This study utilized the Behavioral Model of Health Service Use (Andersen, 1968) to test the combined influence of Predisposing Factors (family composition, social structure, and health beliefs), Enabling Factors (family and community resources), and Need Factors (including the severity of illness and the patient/family response). It was hypothesized that: 1) each of these characteristics would have a direct impact on the utilization of mental health services; and 2) cultural factors would have a moderating effect on the interrelationship of these Factors. The study included a random stratified sample of 125 persons diagnosed with schizophrenia from the four major geographic regions of Taiwan, including urban, suburban,

and rural regions. The study hypotheses were partially supported in that Predisposing Factors had a direct influence on informal service utilization, and Enabling Factors had a direct influence on utilization of formal services. Further, one Need Factor, level of distress, showed a direct influence on informal service utilization. As predicted, cultural factors, insight and stigmatization, had an indirect effect on the inter-relationships among the study factors.

These findings support the usefulness of the Andersen Behavioral Health Model as a tool for understanding mental health service utilization. They also highlight the importance of cultural sensitivity, particularly sensitivity to religious factors in mental health service planning and delivery in Taiwan.

This dissertation by Min-Ling Wang fulfills the dissertation requirement for the doctoral degree in social work as approved by Sr. Ann Patrick Conrad, Ph.D. as Director, and, Frederick L. Ahearn, D.S.W., and Karlynn BrintzenhofeSzoc, Ph.D. as Readers.


Sr. Ann Patrick Conrad, Ph.D., Director


Frederick L. Ahearn, D.S.W., Reader

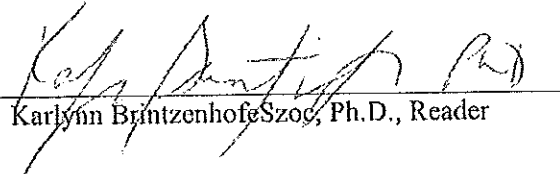

Karlynn BrintzenhofeSzoc, Ph.D., Reader

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CHAPTER I

INTRODUCTION

In his 1980 book, *Patient and the Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*, psychiatrist and anthropologist Arthur Kleinman described the Taiwanese plural health care system of the late 1970s; the system included western-style physicians, Chinese medicine doctors, bone-setters, and folk healers/fortune tellers (p. 1-2). He explored the cultural influences on the health care system, such as the beliefs about illnesses, the relationships between the professions and the patients, and the determinants of help-seeking behaviors. Kleinman (1980) concluded that the tasks of anthropology in the health field was to “widen and deepen the non-biomedical cultural perspective on health, sickness, and health care” and “do more than simply demonstrate the inadequacy of the epistemology underlying the biomedical framework” (p. 384-385).

Kleinman’s studies were conducted in a conservative society that hugely stigmatized mental illness and in an era when few resources drawing on western psychiatry and psychotherapy were available for people with mental illness. Thirty years later, the mental health care system has been improved significantly in Taiwan. Not only has the government increased access to western trained mental health care professionals and facilities through provision of the Mental Health Act of 1990, it also launched the National Health Insurance Program (NHIP) in 1995. This system allows people with mental illness to pay only small amount money to seek different models of psychiatric treatments—from inpatient services to community rehabilitation centers.

Clearly, the Taiwanese health care system is not quite the same as that described by Kleinman. The mental health system, in particular, tends to be much more westernized now than it was thirty years ago. Despite these changes, Taiwanese quite often shop around the medical institutions, clinics, Chinese medicine stores, and folk healers available through a plural care system (Lin, 2006). In fact, mental health professionals are often asked by the family members of people with mental illness: should we seek help from the folk healers? The appreciate role of non-western treatments has been a controversial question that mental health professionals have debated for a long time, especially in the wake of scandals such as the 1980s Lung Hwa Tung event, where an illegal folk asylum managed by monks and nuns was exposed by the media to be offering non-biomedical treatments in an inadequate environment (Wen, 1990). Such scandals have a negative impact on perceptions of psychiatric folk sectors both by public and mental health professionals. According to Wen (1990), mental health professionals were aware of the socio-cultural influences, but tended to attribute the use of folk sectors to the insufficiency of qualified mental health facilities (Wen, 1990).

However, to echo Kleinman's recommendations in his book, mental health professionals, who are mostly western trained, need to enhance their cultural sensitivity and attention when they work with their clients. They need to understand the cultural and social influences on illness beliefs and help-seeking behaviors in people with mental disorders. It is hoped that, through this study, the Taiwanese government and mental health professionals will recognize the value of approaches other than those based on a biomedical model, and will help develop a supportive and spiritual mental health care system in the future.

Statement of the Problem

Among mental disorders, schizophrenia is considered a major mental health problem in Taiwan (Lin, 2006). In 2008, there were 76,458 people with schizophrenia in Taiwan (Department of Health, Executive Yuan, 2008, as cited in Huang, Hung, Sun, Lin & Chen, 2009). According to several studies, the lifetime prevalence rate of schizophrenia is between 0.2% and 0.3% nationwide (Hwu, Yeh & Chang, 1989; Yang, Hsieh, Wu, Yeh & Chen, 1999; Huang, Yeh & Hwu, 2002; Hwu, 2002), compared to the lifetime prevalence rate 0.4% worldwide (Saha, Chant, Welham, & McGrath, 2005). Hwu (2002) found that the mortality rate among those with schizophrenia who were the first-time hospitalized was 6.9%; the major cause of death in people with schizophrenia was suicide (Lo, Kuo, Wang, Tsai, & Chen, 2004). Hwu (2002) stated that 4.2% of people with schizophrenia who were hospitalized the first time died because of suicidal behaviors, and 7.2% of this group had attempted to committed suicide.

Those suffering from schizophrenia generally require more than mental health services since they often suffer from comorbid conditions. The World Health Organization (1998) showed that people with schizophrenia often have higher comorbidity with depression and substance abuse, as well as vision and dental problems, high blood pressure, diabetes, and sexually transmitted diseases (Surgeon General's Report, 1998). Oud and Jong (2009) stated that people with schizophrenia often developed somatic co-morbidity, such as diabetes mellitus, the metabolic syndrome, coronary heart diseases, and cardiovascular diseases. Such findings indicate that people with schizophrenia need health care and related medical treatments.

Medical treatments, including mental health interventions, are dominated by the westernized biomedical model in Taiwan. According to Surgeon General's Report (1998), this biomedical model for people with schizophrenia emphasizes that treatments and interventions depend on the different clinical phases of schizophrenia (acute phase, stabilizing phase, stable or maintenance phase, and recovery phase). The treatments and interventions include pharmacotherapy (antipsychotic medications) and psychosocial interventions (supportive psychotherapy, family intervention, as well as psychosocial and vocational rehabilitation) (Surgeon General's Report, 1998). In Taiwan, people with schizophrenia accounted for 9.2% of those who received psychiatric outpatient service for the first time and 58% of people who received psychiatric inpatient service for acute conditions, and 80% of people who utilized long-term facilities were those with schizophrenia (Hwu, 2002). Hwu (2002) found that only 24% of people with schizophrenia sought help from the westernized biomedical treatments. These findings indicate that schizophrenia is considered a severe mental disorder and those with schizophrenia are undertreated in the mental health care system (Hwu, 2002).

During this decade, mental health professionals are dedicated to improving the mental health care system to solve the problem of the undertreatment of people with schizophrenia. Inspired by the western deinstitutionalization movement, Taiwanese mental health professionals have become aware of the psychiatric interventions for people with schizophrenia in the recovery phase, such as community rehabilitation centers, half-way houses, vocational training placements, home-care services, and day-care services. These interventions help those with schizophrenia to live with families in their communities and

prevent relapse (Yang, Hsieh, Wu, Yeh & Chen, 1999). Nevertheless, in addition to the westernized mental health interventions, people with schizophrenia or other mental disorders have sought help from other resources, such as families, friends, or religious/folk healers in Chinese culture (Cheung, 1987, was cited in Tseng, 1995, p.165). Hwu (2000) found that 13% of people with schizophrenia living in urban areas sought help from folk healers rather than from western trained medical professionals. Even people who are well-educated and living in urban areas may turn to the shamanistic healing rituals, meant to cast out evil or ancestral spirits (Davis, 1992, as cited in Kleinman & Kleinman, 1995, p.149.). This finding is consistent with other studies which showed that people with psychological problems first consult traditional healers in many eastern societies (Kleinman, 1980; Kua, Chew, & Ko, 1993).

There are multiple reasons why the folk healing approach has not been recognized as a supportive intervention within this unique cultural society for those with schizophrenia. It is important for Taiwanese mental health professionals to realize that people with schizophrenia utilizing a folk healing approach do so due to socio-cultural influences. However, they largely have not recognized the folk healing approach as part of an effective mental health care system for people suffering from schizophrenia and other mental disorders. In fact, some mental health professionals, including social workers, have dismissed the folk healing approach as preventing people with mental disorders from receiving effective treatments (Horng, 1994). Moreover, the folk healing approach was the most common reason that people with schizophrenia were discharged against medical advice

(Yang, Hsieh, Wu, Yeh & Chen, 1999). Additionally, the folk healers and facilities were not supervised by the government, and most of them were related to religious activities.

Although many studies have investigated the influence of the cultural factors on the help-seeking behaviors in Taiwanese people (Horng, 1994; Liou, 2004, Lin, 2006), none of them have explored this issue in people with schizophrenia. Hwu (2002) demonstrated that 70%-80% of people with schizophrenia did not seek help from western trained psychiatric professionals, especially those suffering from delusions. Moreover, 40% of people with schizophrenia and their families believed that the cause of schizophrenia was related to supernatural phenomenon (Yang, Hsieh, Wu, Yeh & Chen, 1999). Such data suggest that schizophrenia was, probably, one of the most misunderstood diseases in the Taiwanese society. Consequently, this study recognizes the value of the eastern folk healing approach as a supportive intervention for people with schizophrenia through a cultural perspective. Moreover, this study explores and analyzes the factors of the help-seeking behaviors which are explained by a social and cultural framework.

Purpose of the Study

The purpose of this study was to examine the predictors of help-seeking behaviors of people with schizophrenia within the context of contemporary Taiwanese culture, which might include using traditional folk medicine, treatments by western trained professionals, or a combination of the two. Many studies have emphasized that the westernized biomedical model should not be the only mental health intervention in a multicultural society. Therefore, this study aimed to reconcile the culture of eastern and western mental

interventions in order to provide a more supportive environment for people with schizophrenia living in communities.

Moreover, this study expected to find that mental health professionals, especially social workers, were capable of increasing their cultural sensitivity and competence. It was also the study's goal to provide knowledge about the help-seeking behaviors in people with schizophrenia through a cultural perspective. Once mental health professionals gained the cultural awareness, they were able to establish a unique care system to fulfill individuals' needs.

The final purpose of this study was to increase cultural awareness on the part of policy makers. The folk healing approach was utilized not only by the people with schizophrenia but also people with other diseases. Government officers and policy makers should be aware of the existence and the supportive function of the help-seeking process of people who suffer from illnesses. Moreover, the government should include the folk healing approach as part of the health care system and provide a well-developed monitoring policy.

Background of the Research Problem

It is important to understand some background information about the Taiwanese society when this study further discusses the help-seeking behaviors in a social/cultural framework. Geographically, Taiwan is an island nation which is located in the Pacific Ocean and separated from China by the Taiwan Strait (Taiwan Year Book 2004, Geography, ¶ 2). Due to the geographic factors, Taiwan has been deeply influenced by China historically, culturally, and politically. However, due to the fifty-year colonial presence of the Japanese

government, the Taiwanese culture is also influenced profoundly by Japan. Therefore, the Taiwanese heritage displays many Chinese cultural influences, but at the same time, the Taiwanese culture can not be considered to be identical to the Chinese one because of rapid westernization and industrialization.

The population of Taiwan is 23 million (CIA-The World Factbook, 2009). The majority of the population (98%) is made up of Han Chinese. The Han Chinese can be divided in three groups: the Fu-Ken, the Hakka, and the Mainlander. The Fu-Ken is the largest subgroup, which comprise 70% of the Taiwanese population. The Hakka people constitute about 20% of the Han Chinese population in Taiwan today. The mainlanders (14%), who arrived in Taiwan after 1949, followed the government of the Republic of China moving from Mainland China. The remaining minority: 2 % of Austronesian indigenous groups, originated from Southern China and Austronesia, has been living on the island for at least 15,000 years (Taiwan Year Book, 2008). Fourteen indigenous groups are officially recognized by the Taiwanese government (Taiwan Year Book, 2008); about half a million indigenous peoples inhabit the mountainous central and eastern part of Taiwan (U.S. Department of State, 2009).

The official language is Mandarin. However, the popularly recognized dialects for the Taiwanese are Fu-Ken and Hakka; the Austronesian languages are spoken by indigenous peoples (Taiwan Year Book, 2008). In addition to language, religion is another critical aspect of this multicultural society. According to the Civil Affairs Department, Ministry of the Interior (MOI) (2008, as cited in Taiwan Year Book 2009, Religion, ¶ 1), there are 26 religions recognized by the Taiwanese government. The mainstream religious belief system

in Taiwan is polytheistic, consisting of overlapping beliefs and popular practices, including Taoism, various kinds of Buddhism, and the folk religion which originated in China (Taiwan Year Book 2009, Religion, ¶ 2). Taiwanese society enjoys full freedom on religious beliefs, a right written into the Constitution (Taiwan Year Book 2009, Religion).

In addition to the background information of Taiwan, there are several factors associated with the mental health of the Taiwanese. During recent years, Taiwan has regularly suffered from the natural disasters. According to the CIA-The World Factbook (2009), typhoons and earthquakes are natural hazards in Taiwan. The mental health of the disaster survivors usually was affected by the natural disasters. According to Tang et al. (2000), the survivors of the 921 earthquake, which happened in 1999 and registered 7.3 on the Richter scale, had a higher prevalence of psychiatric disorders, such as PTSD (29.6%), major depression (16.7%), adjustment disorders (14.8%), and alcohol use disorders (7.4%). This study also showed that the majority of the study participants resorted to folk medicine, and only 10% of them were treated in primary care facilities because of physical problems (Tang et al., 2000).

Additionally, Taiwan has been struggling with issues related to immigrants, including foreign laborers and immigrant spouses. In 2007, foreign laborers accounted for about 74 percent of the total foreign population (Taiwan Year Book, 2008). One out of six marriages was an international one (24,700 couples), and children from these international marriages constituted 10.2 percent (20,905) of all new births (Taiwan Year Book, 2008). Most of the immigrant spouses are from mainland China and Southeast Asian countries like Vietnam, Indonesia, Thailand, and the Philippines (Taiwan Year Book, 2008). The immigrant

population has caused several social and family problems, such as adjustment, stress, social discrimination, poor children's education, and women trafficking.

Moreover, the proportion of people aged 65 and older has been steadily increasing. Taiwan has become an aging society; the percentage of the aging population was 10% of the whole population in 2007 (Taiwan Year Book, 2008). According to the Ministry of the Interior (2001), the population of over 65 was the biggest group (34.86%) of physically and mentally disabled citizens in Taiwan. The aging population usually faces depressive symptoms, dementia and other related physical diseases (Lai, 2009).

Mental Health in Taiwan

In 2002, the total number of individuals with chronic mental illness who were supported by social security in Taiwan was 64,908 (The Health Department, 2002, as cited in Chen, 2003). This population is increasing by 10% (i.e. seventy thousands people) per year (Chen, 2003). Among these patients, 60% are dysfunctional and require long-term, continuous and rehabilitative mental health care (Cheng, 2003). Zhuang and Cheng (1995, as cited in Cheng, 2003) found that around 90% of individuals with chronic mental illness are unemployed, and rely on family support. Chen (1997) indicates that a large number of these individuals occupy inpatient facilities and consume a large proportion of medical resources. According to Chen (1997), patients with acute mental illness spend 19 to 30 days on average as inpatients while patients with chronic mental illness spend 600 days on average.

After the Mental Health Act was enacted in 1990, along with the initiation of the National Health Insurance Program in 1995, medical expenditures for the mentally ill

increased to about 2.5% of the total medical budget for all patients (Chen, 1997). Tai (1998) indicated that community rehabilitation services such as community rehabilitation centers, half-way houses, vocational training placements, home-care services, and day-care services were included in the national health insurance program. Although community mental health facilities have increased by 15% during the past decade, they are still insufficient to meet the needs of the chronic mentally ill (Cheng, 2003). Yah (2004) and other researchers suggest that a comprehensive community mental health needs assessment is necessary for community members with chronic mental illness and their families. In-depth qualitative research is needed to provide detailed information regarding patterns of mental health help-seeking behavior to mental health professionals, advocates, and policy makers, in order to develop an adequate community mental health system in Taiwanese society.

The Mental Health Act in Taiwan

The Taiwanese Mental Health Act was written in 1990 and has been slightly amended three times, in 2000, in 2002, and again in 2007. The most important development is the protection of privacy for people with mental illness. Article 23 in the new version of the policy states that the media are not allowed to use terms that may be discriminatory towards those with mental illness since such usage results in negative images of them (Taiwanese Mental Health Act, 2007). Furthermore, the media are not allowed to reveal the names of people with mental illness nor their places of living without their or their guardians' consent. Moreover, people with mental illness who are in in-patient treatment facilities have more freedom to meet and communicate with their friends and family members. The new version

of this Act includes regulations regarding the community mental health service system and places an emphasis on preventive mental health services. Additionally, involuntary commitment now also includes community-based treatments of people with mental illness following their or their guardians' consent.

The Taiwanese National Health Insurance Program

Before the National Health Insurance Program (NHIP) was launched in 1995, 13 independent insurance systems covered only 60% of the population and left 40% of the population uninsured, including seniors, children, and the unemployed. The NHIP was based on the single-payer social health insurance system, which attempts to provide the equal access to health care for every Taiwanese citizen. All insured citizens have the freedom to choose from all contracted health care facilities (91.9%) for treatment, including pharmacies, home nursing care institutions, psychiatric rehabilitation centers, clinics, medical laboratories, and physical therapy services.

According to the Health Department (2007), 99% of the population is insured (22.3 million). Those insured are divided into six subgroups to determine how much they should pay for their premiums. The six categories include: 1) people who are public servants, private school teachers, employees, employers, self-employed, independent professionals, and technical specialists, 2) occupational union members or foreign crew members, 3) members of farmers', fishermen's and immigration associations, 4) people involved or associated with the military services, 5) low-income households receiving public assistance aid, and 6) the unemployed. Premiums are collected based on the individual's income, and

shared by the individual, the individual's employer or other insurance registration organizations, and the government. The premiums for individuals in category 4 and 5 are entirely subsidized by the government. For those unemployed and in the sixth category, the premiums are shared by the individuals (60%) and the government (40%).

Although the NHIP covers the full range of care, the insured are required to pay a small copayment for treatment. In addition, the copayment policy has been changed in order to encourage the insured to yield the referral system, which regional hospitals focus on secondary care and medical centers focus on tertiary care. The copayment charged is more if the insured visits a regional or medical center without a referral from community-based clinics. Moreover, if the medication prescribed to a patient exceeds a certain cost, a copayment for the drugs is also charged. Health care providers are paid based on a "fee-for-service" basis, under the "global budgeting mechanism." This means the medical sectors and the National Health Insurance system negotiate overall caps on total medical payments based on a fixed volume and range of medical services. Medical providers claim their medical services in points, and the Bureau converts the points into real dollars every quarter (the Health Department, 2007).

The NHIP has set three goals to improve the health care quality, including: 1) expanding the knowledge about and providing sufficient information on health care and available services and making the system transparent, 2) increasing the quality of medical services and providing equitable health care for the disadvantaged and those living in the remote areas, and 3) emphasizing patients' safety and changing the health care system to be more patient-oriented. Since the NHIP was launched, its success has captured attention from

the international community. Taiwan is only the second East-Asian country to launch the NHIP, and therefore, it is able to provide its unique experiences to other Asian countries (The Health Department, 2007).

Contribution and Implication to Social Work

In terms of knowledge-building in social work, the understanding of mental health help-seeking behavior from a cultural perspective will broaden the existing knowledge about the mental health care system in Taiwanese communities. Further, the results of this study will assist Taiwanese mental health professionals in developing an effective and practical approach. At a policy level, policy making can benefit from the research findings, and those policies will attempt to bridge the gap between theory and its practical application. Moreover, this study's results will enhance the cultural awareness and competence among social workers so they can better provide their professional service to people with schizophrenia in Taiwan.

Overview of Chapters

Chapter one presents the statement of the research problem and the purpose of this study, such as the composition of the Taiwanese society regarding ethnicities, cultures, and religions. Additionally, mental health problems, particularly schizophrenia, as they relate to cultural issues in Taiwan are discussed in this chapter. The contributions and implications of the study to the social work profession are described in this chapter.

Chapter two contains the literature review that provides relevant discussions of each variable in this study. It presents the discussions of symbolic interactionism from a cultural perspective. Additionally, this chapter provides detailed information of the Behavioral Model of Health Service Use (BMHSU), which is the major theoretical framework for this study.

Chapter three presents the study methodology, including research questions, research design, and hypotheses. It introduces the study setting, the study population, and the sampling approach. Furthermore, the data analysis plan, instruments, and human subject issues are discussed in this chapter. Most importantly, chapter three also presents the pilot study, which is used to test instruments and adjust the study process.

Chapter four is divided in to three sections. The first section presents the demographic characteristics of this study's population. The second section discusses the bivariate hypotheses of the major study variables. The third section analyzes the multivariate hypotheses of the study.

Chapter five presents the summary of the research findings. It discusses the limitations and the recommendations for the future studies and the implication for future social work practice. The appendices include the letters of permission and a copy of the entire questionnaire.

CHAPTER II

LITERATURE REVIEW

This chapter is divided into two components, including theoretical framework of help-seeking behaviors and literature review of potential factors in this study. In the theoretical framework section, the Behavioral Model of Health Service Use (BMHSU) is used to discuss schizophrenia and the help-seeking behaviors under the social/cultural view. In the literature review section, the representative literatures related to potential variables based on the structure of the BMHSU, such as predisposing characteristics, enabling resources, need factor, cultural factor, and the help-seeking behaviors were discussed in this section.

Theoretical Framework

The Behavioral Model of Health Service Use (BMHSU) was the major point of view to discuss the help-seeking behaviors among people with schizophrenia in this study. According to Andersen (1968), who constructed the BMHSSU, stated that the help-seeking behaviors could not only be viewed through the biomedical perspective, but also was examined through social, psychological, and economic viewpoints. Thus, this section presented the fundamental concepts which developed the BMHSU. Additionally, symbolic interactionism was applied to discuss the help-seeking behaviors under the cultural view. Moreover, stigma was discussed as a theory in this section.

The Andersen's view of the Behavioral Model of Health Service Use (BMHSU)

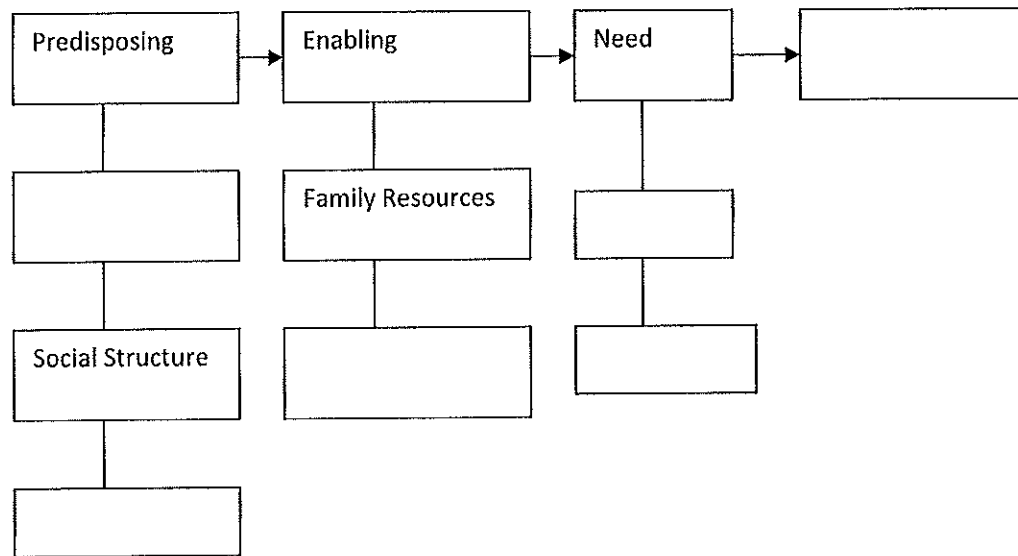
The Behavioral Model of Health Service Use (BMHSU) was constructed by Andersen and colleagues (Andersen, 1968; Andersen & Aday, 1974; Andersen & Newman, 1973, as cited in Fang, 2005; Andersen, 1995). Andersen (1968) stated that social and cultural issues were leading factors on the utilization of health care. Therefore, he analyzed several relevant studies that discussed economic/social-psychological models around the utilization of medical care to develop the BMHSU. Furthermore, Andersen (1968) summarized the results of his analyses to conduct the “families’ use of health services” model-the original version of the BMHSU.

According to Andersen’ view (1968), the economic model, including variables such as family income, health insurance, and the price of health services, addressed the level of people’s need to “attain services or translate their perceived need into economic demand” to use health services. In addition, the socio-psychological model was used to explain “differential perceptions of the need for health services.” Moreover, Andersen (1968) discussed several factors to understand the different patterns of utilizing health services, including the definitions of illnesses based on biological and social perspectives, the socio-demographic issues (education and social class), the perception of illness (values and attitudes). Furthermore, the family was viewed as a unit to utilize the health services (Andersen, 1968).

According to these economic/social-psychological perspectives, Andersen (1968) developed the three-stage model which included predisposing, enabling, and need components. This model demonstrated the utilization of health services was determined by:

1) the predisposition of the family, 2) the families' abilities to attain services, and 3) the families' need for those services (Andersen, 1968). The original Behavioral Model of Health Service Use was as follow:

Figure 1. The Behavioral Model of Health Service Use (Andersen, 1968)



Andersen (1968) further defined the three major components of this model. He explained that some family characteristics, which existed before the attack of the illnesses, could predict the family's tendency to use health services. These family characteristics included family composition (age, gender, and family size), social structure (employment, social class, occupation, race, and ethnicity), and health beliefs (beliefs about health services, physicians, and diseases) (Andersen, 1968). In this model, according to Andersen (1968), the predisposing characteristics were not directly influenced the utilization of health services but potentially influenced the path of using health services. In addition, Andersen (1968)

mentioned that social structure were not only associated with enabling resources (income and health insurance) and but also assumed to influence enabling resources.

Enabling was defined as a condition that accelerated a family to satisfy its need to utilize the health services and this condition included "the family means to attain services and geographic accessibility to services" (Andersen, 1968). The components which were used to measure the condition included family resources and health service resources of the community. According to Andersen (1968), family resources included economic and medical resources, such as family income, family savings, health insurance, regular source of care, and welfare care. Community resources was referred to the accessibility of medical or folk healing approaches, such as the number (or ratio) of the health professionals or psychiatric facilities in the region (Andersen, 1968).

Need represented "the most immediate cause of health service use", measuring by "the amount of illness perceived by the family" and by the way "the family responds to the perceptions" (Andersen, 1968). Amount of illness perceived by the family was defined as the diagnosis of physicians or the self-report of physical conditions. Response was defined as the family's reactions to illness when the family perceived the illness (Andersen, 1968). Generally speaking, the perceived need, or illness level, was defined as the biological demand or self-perception about the severity of illness, and the evaluated need was defined as the professional judgment about patients' health status (Andersen, 1995).

According to Andersen (1968), the utilization of health services was categorized in two types of family behaviors: discretionary and non-discretionary. Discretionary behaviors were referred to a family's decisions to use health services, and non-discretionary behaviors

were referred to the health professionals' decisions to use health services (Andersen, 1968). Additionally, as Andersen (1968) stated in his dissertation, "the more discretionary the behaviors, the more important will be the predisposing and enabling components in explaining this behaviors" and "the little family discretion is exercised, need will be the most important." Use of health service is general assumed to "involve less discretion than the purchase of most consumer goods and services." According to Andersen (1968), the family discretion was assumed to be lowest on hospitalization, intermediate on physician services, and highest on dental care.

Andersen (1968) then further discussed the weight of each component in this model. As he stated, the family composition (age, gender, and family size) and the illness perceived by the family had maximized effects on the utilization of health services. The family response to illness had mixed effect. Additionally, social structure, health beliefs, family resources, and community resources had minimized effects on the utilization of health services (Andersen, 1968).

The BMHSU was frequently used to test healthcare utilization. Additionally, it was used to evaluate whether and to what degree socio-demographic characteristics, health-related beliefs, and illness severity influence help-seeking behavior and service use (Goodwin, Koenen, Hellman, Guardino & Sturening, 2002). However, the BMHSU should be employed with caution because it did not specify how the three major components would work together to create an outcome (Chisolm, 2003, as cited in Fang, 2005).

Symbolic Interactionism

Symbolic Interactionism was a perspective that rooted in social psychology (Charon, 2004, p. 28). It was heritage the ideas from Scottish moral philosophers (Stryker, 2002, p.18) and developed the concepts of “I” and “me” which were the foundations of the major thoughts of symbolic interactionism “mind” and “self” (Benzies & Allen, 2001). Later symbolic interactionism was developed by Herbert Blumer and other pragmatic philosophers and scholars from University Chicago in the late 19th century, such as William James, John Dewey, Charles Horton Cooley, and George Herbert Mead (Benzies & Allen, 2001; Stryker, 2002, p.18-21). Moreover, the Iowa School contributed to develop the thoughts of symbolic interactionism, and Manford Kuhn was the leading scholar (Benzies & Allen, 2001).

There were five major ideas in the perspective of symbolic interactionism: 1) the role of social interaction, 2) the role of thinking, 3) the role of definition, 4) the role of the present, and 5) the role of the active human beings (Charon, 2004). Additionally, symbolic interactionism included five organizing principle: 1) symbol, 2) definition of the situation, 3) roles, 4) socialization and role-taking, 5) emergence of the self (Arena & Arrigo, 2005). A symbol was a social object used to represent whatever people agree they shall represent (Charon, 2004). Thus, this study would discuss the meaning of symbol and how it applied to explain the form of culture.

Most researchers would define culture as a set of shared values, beliefs, and norms. It included languages, religions, rituals, and arts. More importantly, culture is about how people act and respond in the society. In the perspective of symbolic interactionism, culture was defined as “the reference group” that shared general standpoint of action or interaction

(Charon, 2001, p.175). It was also a “generalized other” that guided the human society (Charon, 2001, p.175). Moreover, generalized other was “a moral system” that people internalize to become their personal actions (Charon, 2001, p.176).

Culture—language and other symbolic systems—represented “the meaning of human action” (Stryker, 2002, p. 56) and constructed the social interaction. Human action was based on the consensus and needed the guidance to interact with others (Charon, 2001, p.177). Besides, culture was continually changed; the cultural definition had been tested and revised through the process of interaction (Stryker, 2002, p. 57). Therefore, culture was created by social interaction, symbolic communication, and cooperation (Charon, 2001, p.179).

The explanation of culture within the symbolic interactionism perspective helped us to explore the relationship between the mental illness and help-seeking behaviors. The society had its own cultural definition on the mental illness. As the human history had shown before, mental illness was seen as a symbol of evil on individuals and could be cured by certain exorcism. However, in the past few decades, people believed that mental illness was resulted in biological causes. When individuals had different interpretations on mental illness, the help-seeking behaviors would change from seeking exorcism to medical treatments. The process from “evil possess” to biological perspective of mental illness have been through hundreds years. This was an example that how cultural change influenced people’s or society’s actions.

Culture also influenced how people perceived discrimination and stigma. There were two contexts of stigma—self stigma and public stigma (Vauth, Kleim, Wirtz, & Corrigan,

2007). Stigma could be seen as part of culture; it was the results of social interaction, communication, and cooperation between people with mental illness and people without mental illness. Self stigma was how people with mental illness internalized the ideas of stigma as their own and public stigma was the collective definition about mental illness and people who were suffered from the disease. Although the modern society had more friendly attitudes to people with mental illness, but different societies had different levels of stigma depending on cultures. The perception of stigma under Goffman's view would be presented in the next section.

Goffman's Theory of Stigma

According to these previous relevant studies of cultural factors and help-seeking, demographic and socioeconomic issues, personal conceptualization of mental illness, stigma, preference of mental health treatments, and family intervention are predictors related to help-seeking behavior among people with mental illness. Among these predictors, stigma can be seen as a major variable within Goffman's theoretical framework. Goffman (1963, p.3) developed the concept of stigma, which he defined as "an attitude that is deeply discrediting". He further described three types of stigma: physical deformity or disability, such as amputation or paralysis; blemished character, as in the case of mental illness; and membership in a particular race, nation, or religion (Goffman, 1963, p.4). Ferree and Smith (1979) further indicated that social stigma involves membership in a devalued group and may correspond to what is generally understood as "minority status" in our society; individual stigma refers to possession of a single discrediting attribute.

Goffman (1963) also makes the distinction between visible and invisible stigma. When one's stigma is apparent and obvious, there is no way to avoid the problematic responses of others; on the other hand, when it is not apparent, one can avoid such a response by deciding to keep one's identity secret, thereby passing for normal (Goffman, 1963, as cited in Bergart, 2003). According to Goffman (1963, p.42), people with an invisible stigma are continually engaged in "information control". For example, people with stigmatized mental or physical illness are often able to hide their identity, in order to avoid the situation of being disapproved and marginalized by the public (Bergart, 2003). Thus, stigma is a socially constructed label; even if stigmatized attributes, behaviors, or groups are vary across time and cultures (Major & O'Brien, 2005).

The Definition of Schizophrenia

Many studies explored the topic of schizophrenia from different perspectives, such as biological, psychological, social, and cultural. Although the cause of schizophrenia still remains unknown, the biological/genetic theories have been widely recognized (Torrey, 2006, p.138). However, many theorists believed that the beliefs of mental disorders were constructed by the society. According to Eshun and Gurung (2009), "symptoms of mental illnesses are manifested within the background of certain cultural concepts and constructs." As one of mental disorders, therefore, the term of schizophrenia was defined in the biological and social/cultural views.

The Biological View of Schizophrenia

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 2000), schizophrenia was defined as “a disorder that lasts for at six months and includes at least one month of active-phase in at least two following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms.” The cause of schizophrenia was proved to be related to human brain (Torrey, 2006, p.118). It included several subtypes, such as paranoid, disorganized, catatonic, undifferentiated, and residual (DSM-IV, 2000, p.298). The characteristics of schizophrenia involved cognitive and emotional dysfunctions.

Although the biological perspective explained mental illness as a disease of brain, and the psychological perspective viewed mental illness as a disease of mind, the sociological perspective viewed the mental illness as a “breakdown in the face of overwhelming environment stress” (Horwitz & Scheid, 1999, p.121). The explanation of schizophrenia from social and cultural perspective have been proved incorrectly (Torrey, 2006, p.152-p.154). Moreover, the DSM-IV, one of the wide accepted diagnostic manual, has been criticized because of its conventional categories (Kirmayer & Minas, 2000). In order to solve these problems, the influences of culture on mental health treatment have to be explored. Although the contemporary mental health professionals tend to recognize the cause of schizophrenia based on the biological factors, a certain number of mental health researchers have paid attention on the cultural psychiatry or cross-cultural psychiatry.

The Sociological View of Mental Illness

Horwitz (2002) indicated that mental illness was not developed in nature but defined in a specific cultural and social system (p.6). In addition, as an influential philosopher, Foucault (1965) described how madness people were excluded and associated with crime by the society after the disappearance of leprosy at the end of the Middle Age in the western societies:

“Poor vagabonds, criminals, and ‘deranged mind’ would take the part played by the leper, and we shall see what salvation was expected from this exclusion, for them and for those who excluded them as well. With an altogether new meaning and in a very different culture, the forms would remain-essentially that major form of a rigorous division which is social exclusion but spiritual reintegration.” (p.7)

The diagnosis of mental illness was defined as forms of social deviance (Horwitz & Scheid, 1999, p.222). Deviant behaviors could be seen as the behaviors out of the normality and social standard. Moreover, labeling theory mentioned that human society labeled behaviors which differed from the mainstream social values as symptoms of mental illness (Sands, 2001, p.18). Based on the sociological view of mental illness, it was applied to explain a broad social deviant phenomenon, such as crime, substance abuse, or anti-social behaviors, as symptoms of mental illness (Horwitz & Scheid, 1999, p.129). Whitley (2008) also indicated that when the society under rapid transformation, the mental health care, such as risk factors, help-seeking behaviors, the clinical encounter, and clinical outcome would be influenced.

Literature Review

Predisposing characteristics

Gender.

There were several differences in gender among people with schizophrenia. According to Torrey (2006), males with schizophrenia had a higher relapse rate, worse respond to antipsychotic medicine, poorer social adjustment, and lower functions than females with schizophrenia (p.104). DSM- IV (2000) also indicated that females with schizophrenia had a better prognosis than males with schizophrenia (p.308). In Taiwan, several studies also showed that male with schizophrenia were more likely to be hospitalized through emergency service than female counterpart (Chan, Lin, Shen & Yang, 2007).

Moreover, the onset age of schizophrenia was quite different in gender. According to DSM-IV (2000), the onset age for males was between 18 and 25 years old, and between 25 and the mid-30 for females. Torrey (2006) also indicated that men had first episode of schizophrenia were three to four years earlier than women in the United States (p.104). Additionally, Chien et al (2004) also indicated that men whose age were between 25-44 and women whose age were between 35-54 had higher prevalence rate of schizophrenia in Taiwan. However, women had higher frequency of schizophrenia occurring in later life than men (DSM-IV, 2000, p.307). Although the reasons of these difference in gender were unknown, Torrey (2006) assumed these findings were resulted in men were the weaker sex (p.105). This could be explained that men faced larger social and financial responsibilities than women.

Age.

In addition to the different onset age in gender, the general onset of schizophrenia was between the late teens and the mid-30s (DSM-IV, 2000, p. 307). Moreover, Loranger (1984, as cited in Arrmenteros & Davis, 2006) stated that the modal age for schizophrenia onset was between 21 and 22 years old; however, the majority of people with schizophrenia onset in their late adolescence. In the United States, three-quarter of those suffered from schizophrenia were onset between age seventeen and twenty-five (Torrey, 2006, p.96). According to Chien et al (2004), the highest prevalence of schizophrenia was in the age of twenty five to forty four, and the lowest was in the elderly group (65 and over) in Taiwan. This result was consistent with other studies that people with schizophrenia was onset in early adulthood. Moreover, Lin et al (2008) showed that people who had early age at onset of schizophrenia were more likely to be re-hospitalized in a short period of time in Taiwan.

Geographic Residence.

Several studies indicated that a higher risk of schizophrenia was associated with living in urban areas (Chien et al, 2004). However, Chien et al (2004) indicated that a higher prevalence of schizophrenia in suburban areas because of the high population density and greater stress for people who lie in such areas. There was no significant difference between regions in the prevalence and incidence of schizophrenia in Taiwan except the eastern region (Chien et al, 2004). Although the eastern region had the one of the largest long-term psychiatric facility, the accessibility of these facilities were limited by the difficult transportation.

Marital Status.

According to Lin, Chen, Wang, Lin, Chen, and Lin (2008), people with schizophrenia usually tended to be unmarried, and these unmarried usually have poor clinical outcome and high rate of rehospitalization. However, Chan, Lin, Shen and Yang (2007) indicated that marital status was not significantly related to hospitalization in people with schizophrenia although their study showed 53.8% of their study participants were unmarried.

Ethnicity.

According to Boydell et al (2001), the smaller proportion of the minority ethnic groups in a local area the higher incidence of schizophrenia in those groups. This could be explained that small minority ethnic groups were more likely to be marginalized by the society and more vulnerable because of less social network and support (Boydell, 2001). However, Chien et al (2004) in the study which used the sample from the National Health Insurance (NHI) enrollers showed that no significant difference between the Taiwanese aborigine population and the non-aborigines. It was also explained that a large portion of the aborigine population was not insured in the NHI program and therefore the findings could be influenced by this reason (Chien et al, 2004).

Religion.

Wynaden et al (2005) indicated that religion was a determinant factor influencing an individual's health beliefs, particularly Buddhism and Taoism. The idea of reincarnation, one of the important Buddhist beliefs, usually was used to explain the cause of mental

disorders; that was, people who suffered from schizophrenia were perceived punished for what they had done in their past lives. Moreover, Taoism was an important religion to provide the directions for people with mental disorders to receive folk healings, such as visiting/worshipping temples, and doing rituals in temples. Wynaden et al (2005) also mentioned that the mental health professionals needed to contact the community religious/spiritual leaders and distributed the written materials of related mental health information in temples or churches to provide accessibility for community members who suffered from mental disorders.

Enabling Resources

Enabling resources were defined as individual's and community's resources for people with schizophrenia in this study. Individuals' resources included social and economic status, such as educational level, household income, and employment. Moreover, community resources included types of mental health facilities, accessibility to these facilities, participants' awareness of these facilities, and transportation to reach these facilities. Chien et al (2004) stated that people with higher prevalence of schizophrenia were in lower social economic status. Moreover, lower social economic status was a risk factor for people with schizophrenia because of a higher incidence (Chien et al, 2004). Moreover, lower social and economic status caused higher psychosocial stress (Chien et al, 2004). Therefore, this study listed the variables associated with social and economic factors to examine its relationship with help-seeking behaviors in people with schizophrenia.

Educational Level.

In Taiwan, the onset age for people with schizophrenia was 19.5 years old, and the age of the first hospitalization was 22.6 (Hwu, 1999, p.12-13). Therefore, according to Chan, Lin, Shen and Yang (2007), people with schizophrenia were more likely to have 9-12 years of education (about high school) in Taiwan. Hwu (2002) also indicated that people with schizophrenia had lower level of education and could be the causes of impaired cognition functions and social withdrawal. It was assumed that lower level of education might lack of knowledge to find adequate mental health treatments (Goodwin, Koenen, Hellman, Guardino, & Struening, 2002).

Household Income and Employment.

Higher household income was assumed that could afford to seek helps other than medical treatments (Foster et al, 2000, as cited in Fang, 2006). However, Fang's (2006) study showed that income did not have direct relationship with the help-seeking behaviors. Eaton and Muntaner (as edited in Horwitz & Scheid, 1999) household income was measured as a person's economic resources and social class; however, most of the study participants with mental disorder tended to not reveal their financial situation. Additionally, unemployed people with schizophrenia were more likely to be hospitalized (87.7%) (Chan, Lin, Shen & Yang, 2007). This could be explained that working was a goal for people with mental illness for psychosocial rehabilitee (Sands, 2001, p.276).

Accessibility of Community Mental Health Facilities.

Wynaden, Chapman, Orb, McGowan, Zeeman, and Yeak (2005) mentioned that there were six major factors that influence the Asian population to access the mental health resources: shame and stigma, cause of mental illness, family reputation, hiding up, seeking help, and lack of collaboration. Moreover, language barrier was a issue that Chinese Americans had lower accessibility of mental health facilities (Spencer & Chen, 2004). Chou (2006) indicated that people with mental illness did not tend to frequently utilize the community rehabilitation programs in Taiwan; this situation could be explained that people with mental illness were in more severe conditions and with longer hospitalization.

Family Support.

According to Chen, Yang, Liao, Lee, Yeh, and Chen (2004), the mental health professionals should consider people with schizophrenia and their family members as a whole in order to improve their psychological well-beings. They also indicated that caregivers of people with schizophrenia were at high risk of developing mental health problems.

Son, Lin, and George (2008) mentioned that social support was a factor of affecting mental health. However, according to Huang, Hung, Sun, Lin and Chen (2009), the major caregivers of people with schizophrenia experienced a high level of burden which was caused by disease incurability, violent behaviors, disturbance of daily routine, and financial difficulty.

Need Factors**The Distress of Schizophrenic Symptoms.**

According to Chen, Yang, Liao, Lee, Yeh, and Chen (2004), the severity of the symptoms in people with schizophrenia was a predictor to the caregivers' distress. They also indicated that people with schizophrenia had poor life quality when they suffered from the distress of the symptoms and perceived stigmatization. Komiti, Judd, and Jackson (2006) mentioned that higher distress level was a predictor of help-seeking in people with mental disorders.

Self-Efficacy.

According to Schwarzer and Jerusalem (1995), self efficacy is conceptualized as a sense of personal coping ability to deal with stressors in order to have a functional life. Vauth, Klein, Wirtz, and Corrigan (2007) demonstrated that generalized self-efficacy was related to the experience of severe mental illness. However, Fung and Tsang's (2008) findings showed that the relationship between self-efficacy and help-seeking was mediated through other predictors.

Cultural Factors

Culture has been broadly defined as "the shared values, traditions, arts, history, folklore, and institutions of a group of people that are unified by race, ethnicity, nationality, language, religious beliefs, spirituality, socioeconomic status, social class, sexual orientation, politics, gender, age, disability, or any other cohesive group variable" (Singh, 1995, as cited

in Singh, McKay, & Singh, 1998). Singh, McKay & Singh (1998) stated that all behavior occurs in a cultural context. Kleinman (1980, p.24) indicated that a health care system should be seen as “a cultural system, a system of symbolic meaning anchored in particular arrangements of social institutions and patterns of interpersonal interactions”. Moreover, Wen (1997) also noted that the role of culture in an illness experience is totally outside the usual biomedical model inquiry, which is mainly concerned with the disease process.

Kleinman (1978, p.329) indicated that not just beliefs about illness but the behavior of a sick person and the response of family and practitioners can be seen as cultural reality, shaped distinctly in different societies and in different social settings within those societies. Mental health professionals should understand that the cultural context provides the basis for understanding and appreciating the behavior of people seeking mental health services (Singh, McKay, & Singh, 1998). Moreover, Kung (2004) pointed out that mental health treatment is sought depending on individuals’ perception of its helpfulness, and one’s conception about the nature of emotional problems. Wynaden (2005) indicated that “all cultures have a health belief system that determines how members will respond to illness, when they seek help, presenting symptomatology, the method used to treat illness, and the expected treatment.

Insight-Beliefs Concerning Schizophrenia.

Insight should be conceptualized as “a component of post-diagnosis identities that were defined in relation to other social identities, and under conditions of stigma against mental illness.” (Williams, 2008). A growing amount of studies have paid attention to how cultural beliefs impact mental health utilization behavior among different ethnic groups

internationally (Yamashiro & Matsuoka, 1997; Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik & Baydar, 2002; Auslander, Soffer & Auslander, 2003; Kung, 2003; Kung, 2004; Chiu, 2004; Nguyen & Anderson, 2005; Ayalon & Young, 2005, Fang, 2005). Several studies further discussed the association between cultural belief and the utilization of mental health services among different groups in Taiwan (Horng, 1994; Chang, 1999; Liou, 2004). However, there is no theoretical and empirical literature exploring this phenomenon for Taiwanese with chronic mental illness such as schizophrenia.

Several factors are related to mental health help-seeking behavior within cultural context. Nguyen and Anderson (2005) adopt five cultural dimensions to examine the help-seeking attitudes and utilization of mental health services, including problem prioritizing, traditional beliefs about mental illness, stigma, help-seeking preferences, and disclosure. Goodwin, Koenen, Hellman, Guadino and Struening (2002) also indicate that factors such as the stigma associated with mental illness, or limited health insurance coverage may prevent individuals from seeking needed professional services. In addition, Ying (1990, as cited in Chiu, 2004) also states that the conceptualization of the mental health problem among Chinese-American women influences their help-seeking choices.

As a leading researcher, Kung indicates various factors related to help-seeking behavior in her studies. Adopting the concept of medical anthropology, Kung (2004) concludes that factors such as relevance and credibility of mental health treatment, denial of need for services, and fear of stigma and loss of face are able to explain the cultural barriers to seeking mental health treatment for Chinese Americans. In another study of Chinese Americans' help seeking for emotional distress, Kung (2003) states that acculturation, locus

of control, hardiness, self-esteem, individuals' mental health condition, demographic and socioeconomic status variables as well as medical insurance are also important predictors. Additionally, Kung (2005) further points out that the centrality of the family, which is a traditional value under the hierarchical Confucian paradigm in Chinese culture, is also a crucial factor that influences seeking external help in case of mental illness in Chinese society.

In addition to the Western societies, where the individual makes the decision to seek mental health treatment, in Taiwan it is the family members who usually are decision makers in situation involving mental illness, especially in cases of psychoses and major mental disorders (Wen, 1997). Lin, Tseng and Yeh (1995, p.165) also mention that the way the Chinese deal with emotional distress is to communicate with their families or close friends rather than to seek professional help. In Chinese culture, families usually hide insane members at home and resist outsiders' help; it is the family that is expected to take the responsibility for help-seeking and care of a family member with mental illness (Wen, 1997).

Although some studies showed that people with schizophrenia believed in supernature cause responsible of mental illness had poor drug compliance, but Lan, Shiau, and Lin's study (2003) had different result. Their study showed that the illness belief and belief in therapy did not influence the drug compliance of people with schizophrenia.

Stigma.

Stigma is shaped by social and cultural beliefs based on Goffman's stigma theory and related studies. It is also demonstrated through social information and personal identity

(Goffman, 1963, p.43 & p. 51). Thus, stigma is defined as an individual perception of others' stigma toward him/her and stigma of an individual toward his/her mental illness in this study.

In Taiwan, the general public recognized people with schizophrenia as “walking bomb” and hold negative attitudes toward this population because of their violent and dangerous behaviors (Lin, Hsiung, Lin & Hwu, 2002). People with schizophrenia in Taiwan perceived the stigmatization from the general public in several categories, such as “having an unacceptable disease”, “ability being doubted by others”, “self-inflicted rejection”, “multiple losses” and “anticipatory life strain” (Lin, Hsiung, Lin & Hwu, 2002). Stigma of shame (losing face) was commonly associated with people with mental disorders or schizophrenia and their families (Huang, Hung, Sun, Lin & Chen, 2009; Fung & Tsang, 2008). In addition, Wynaden et al (2005) indicated that shame and stigma “prevented people from seeking help from mainstream mental health services.” Jamison (2006) mentioned that stigma insinuated itself into policy decision, access to care, health insurance, employment discrimination, and in research allocations and priority.

Utilization of Mental Health Services

Help-seeking behavior is defined as actions by individuals looking for and requesting assistance for their problems (Unrau & Grinnell, 2005). It refers to “a request for assistance from informal supports (e.g. families and friends) or formalized services (e.g. professionals and clergy) for the purpose of resolving emotional, behavioral, or health problems” (Srebnik, Cauce & Baydar, 1996, as cited in Unrau & Grinnell, 2005). Fisher and Turner (1970, p.79, as cited in Liou, 2004) also refer to help-seeking attitude as “one’s tendency to seek or resist

professional aid during a personal crisis or following prolonged psychological discomfort". According to Tranulis, Park, Delano, and Good (2009), the mental health professionals has been focus on early detection and intervention for people with schizophrenia in the past decade.

Formal Services.

Yang et al (1999) indicated that the caregivers of people with schizophrenia were more likely to utilize the community rehabilitation programs when they believed the biological causes of schizophrenia. They also mentioned that the biological cognition of schizophrenia from caregivers of people with schizophrenia was the most significant factor in rehabilitation for people with schizophrenia. Addington, Mastrigt, Hutchinson, and Addington (2002) stated that when people with mental disorders presented their symptoms, especially delusional thinking, hallucinations, depression, and suicidal ideation, they would begin their help-seeking in the early stage of mental disorders. Moreover, Addington et al (2002) mentioned that in the prepsychotic stage, family physicians were mostly contacted for treatment. However, when then symptoms presented, people with mental disorders sought help from emergency services, family physicians, and psychiatrists. Lauber, Nordt, Falcato, and Rossler (2001) stated that psychiatric treatments were considered to be more helpful for people with schizophrenia than for people with depressive symptoms. Moreover, among several psychiatric approaches, psychotherapy was considered to be most favored by the public, and psychotropic drugs were considered to be harmful (Lauber, Nordt, Falcato, and Rossler, 2001).

Informal Services.

Huang, Hung, Sun, Lin and Chen (2009) stated that the caregivers of people with schizophrenia usually used religious coping strategies, such as traditional herbal medicine, worshipping in the temples, or consulting shamans. Help-seeking behaviors of people with schizophrenia were often rooted in supernatural causality of the disease. According to Wu and Chang (1997), 23% of the caregivers used traditional herbal medicine, 41.5% worshipped in the temple, 24% consulted shaman, and 12% went to fortune tellers. Yang et al (1999) mentioned that people with schizophrenia and their families often utilized

Summary

The chapter II presented the theoretical framework of the study, the definition of terminology, and the literature review of related variables. The Andersen's Behavioral Model of Health Services Use was the major theory that was applied in this study to explain the interrelationships between possible predictors and the help-seeking behaviors. Symbolic Interactionism perspective was used to discuss how culture was constructed through the individuals, groups and societies. Additionally, the association between symbolic interactionism and culture was applied to discuss how culture influenced mental health care in human societies. Goffman's stigma theory, which was developed based on the symbolic interactionism, was included.

The literature review focus on the findings of possible predictors in this study. Although they related Taiwanese studies were limited, the studies about Asian or Chinese populations were used. Additionally, the discussion of predictors was not surrounded by the

phenomenon of schizophrenia; this was due to the limitation of related studies. Therefore, several studies which discussed predictors of help-seeking in people with mental disorders were also used.

CHAPTER III

METHODOLOGY

This chapter presents the research questions, research hypotheses, and research design. The methodology for the study was selected to analyze the correlations between factors that influenced the help-seeking behaviors in people with schizophrenia. Based on the adapted Health Utilization of Behavior Model, the dependent variables selected is the utilization of mental health services, and three independent variables selected include predisposing characteristics, enabling resources, and need factors. Additionally, the cultural factor was examined as the moderator in order to see whether it played a role in the relationships between the independent variables and the dependent variables.

This chapter also presents the study settings, sampling approach, and the questionnaire. The survey questionnaire was developed as an interview tool which includes not only demographic questions but also six instruments to represent variables such as social support, level of distress caused by symptoms, self-efficacy, stigmatization, insight, and help-seeking behaviors. The complete questionnaire appears in the appendices. Moreover, the conceptual and operational definitions of all variables are presented in this chapter. In order to test the reliability and validity of these instruments which were used in different populations, a pilot study was conducted in an institutionalized community rehabilitation center.

The data was collected by interviewing study participants and analyzed by several statistical approaches, including Pearson Correlation, Multiple Regression, and Path

Analysis. These statistical approaches were utilized to present the characteristics of variables and to test the hypotheses in predicting the possible relationships between independent and dependent variables. Furthermore, the protection of human subjects was assured through an approval process for the research; consent was secured for working with community mental health organizations, which provided consent for interviewing the study participants from these organizations.

Research Design

This study was a survey design, which “provides a quantitative or numeric description of trends, attitudes, or opinions of a population by studying a sample of that population” (Creswell, 2003, p.155). The purpose of this study design was to explore the factors influencing help-seeking behaviors and their correlations in people with schizophrenia. A cross-sectional design was used in this study. The cross-sectional study was used to examine “a phenomenon at one point in time by gathering information from a cross section of the population” (Thyer, 2001, p.137). According to Rubin and Babbie (2001, p.323), the cross-sectional design was “popular in social work research” and “commonly used in descriptive and exploratory research”. Additionally, to further examine the correlations between the influencing factors and the help-seeking behaviors in people with schizophrenia, a cross-sectional design was used because its internal validity was improved by the recent advanced multivariate statistical analysis (Rubin & Babbie, 2001, p.323).

Research Questions/ Hypotheses

In this study, the research question focused on how cultural/social beliefs influenced the help-seeking behaviors of Taiwanese people with schizophrenia. Based on the literature review, the study aims to answer such research questions as:

- 1) How are the help-seeking behaviors of people with schizophrenia determined by predisposing characteristics, enabling resources, and need factors influence?
- 2) How does cultural factor influence the relationships between predisposing characteristics, enabling resources, need factors, and the help-seeking behaviors?

The overarching study hypotheses are the following:

Hypotheses 1: The predisposing characteristics, enabling resources, and need factors will have a direct impact on the utilization of mental health services.

Hypothesis 2: Cultural factors will operate as moderating effects on the interrelationship of the above mentioned variables

Population and Settings

Established in 1997, the Alliance for the Mentally Ill of Taiwan (TAMI) is a non-profit and non-governmental organization, which is formed by a group of mental health professionals, individuals with mental disorders, and their families. The organization is located in Taipei city and works with 26 local group members in order to serve over 5,000 members in different areas of Taiwan. TAMI has played a key role in policy making, the education of the general public on the issues of mental health, and the implementation of the community-based models to serve its members with mental disorders, such as rehabilitation

centers, half-way houses, and club houses. Additionally, TAMI is involved in the anti-stigmatization movement nationwide to advocate and protect the rights of individuals with mental disorders in the Taiwanese society. Furthermore, TAMI has been the leading organization to participate in the reform of the Mental Health Act.

According to TAMI, the estimated number of members with schizophrenia in TAMI was 4,000, which was about 80% of the total number of its members (personal contact, 2008). Sixty percent of members with schizophrenia are male; most members with schizophrenia are unemployed and living with their families (personal contact, 2008). Based on this information, the researcher cooperated with TAMI and identified its members with schizophrenia as the study population group. Additionally, TAMI was the collaborator by assisting the research in negotiating and contacting with the twenty six member associations in cities and counties throughout Taiwan in this study. The member associations, on the other hand, helped the researcher to invite and prepare the participants for the interviews. After the study, TAMI will receive a report of the aggregate research findings extracted from the published dissertation.

Sampling/Participants

Sampling refers to “taking a portion of a population or universe as representative of that population or universe” (Kerlinger & Lee, 2000, p.164). A purposive sampling design was used to select a representative group of people with schizophrenia who received community-based mental health services in Taiwan. A purposive sampling is characterized “by the use of judgment and a deliberate effort to obtain representative samples by including

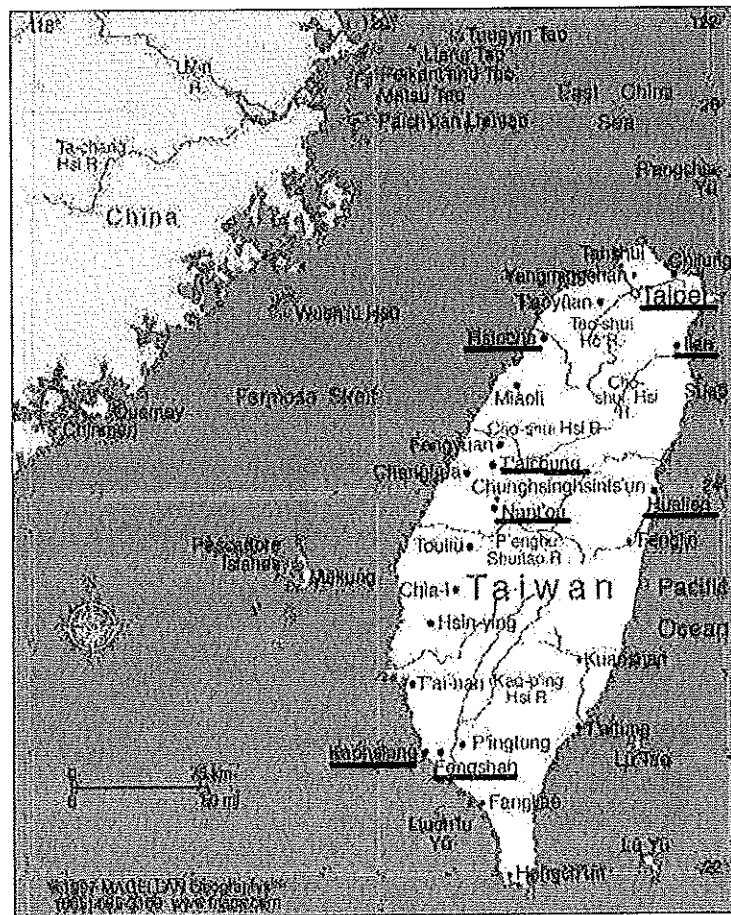
presumably typical areas or groups in the sample” (Kerlinger & Lee, 2000, p.179). Due to some difficulties to access the governmental files to get the accurate number of people with schizophrenia in each city/county, the purposive sampling approach was considered as the most appropriate way to select the potential study participants. Using a purposive sampling design, the researcher selected TAMI sites which were chosen from different cities/counties based on the urbanization level in Taiwanese districts (Tseng & Wu, 1986). Nine cities/counties were selected to ensure the inclusion of a quasi-representative sampling of urban, suburban, and rural populations. These nine cities/counties included Taipei City and County, Kaohsiung City and County, Hua-lian County, Tai-chung City, Na-tou county, Hsin-chu City, and I-lian County (see figure 1).

However, due to the difficulty of recruiting participants, the researcher had to use extra TAMI sites in the same cities/counties in order to recruit as many participants as the study needed. After the negotiations between TAMI, the researcher, and the member associations, the eleven members of TAMI associations agreed to participate in this study. Thus, the number of the sites chosen in the north of Taiwan was five, in the middle of the country-two, in the South-three, and in the East-one.

Participants had to meet these criteria: (a) at least 18 years of age, (b) DSM-IV diagnosis of schizophrenia excluding schizophrenia resulting from substance abuse and organic causes, (c) suffering from schizophrenia at least one year, (d) capable of self-expression and understanding the interview questions, and (e) Taiwanese born. The interviews with participants who did not meet these criteria were eliminated from this study; among this group, most had problems in understanding the questions and difficulties with

communications. Therefore, based on these criteria and the assistance of these eleven sites, the study participants were selected according to a convenience sampling to obtain a sample size of 125.

Figure 1. The Regions of Taiwan



<http://www.infoplease.com/atlas/country/taiwan.html>

Data Collection

The data were collected through face-to-face interviews based on the questionnaire with demographic questions and several measurements. The researcher used the back-translation method to develop the Mandarin Chinese version of the questionnaire. Three bilingual translators who were graduate students and had lived in the United States at least for two years translated the source version of the questionnaire (English) into the target version (Mandarin Chinese). The researcher and another bilingual translator translated the target version of the questionnaire into the source version. The researcher then compared these two versions and also worked with two other psychiatric social workers to polish the Mandarin Chinese Version of the questionnaire. Some of the questionnaire words were slightly changed according to the feedback of the pilot study participants when the questionnaire was applied to the formal study participants.

The interview took between forty-five minutes to one hour depending on the participants' comprehension abilities. Most questions, such as demographic items, were asked by the researcher; other questions which involved personal feelings or were related to sensitive issues, such as the question "How ill do you think you are?" from the Self-Appraisal of Illness Questionnaire (SAIQ), were given to the participants in written form so that they could read and answer them by themselves. If the participants had difficulty reading the questions, the researcher would pose them to the participants during the interview sessions. All interviews were conducted in a private space. After the interview, some participants received a small bottle of a decaffeinated soft drink as a reward; others might

receive rewards through their agencies from the researcher's small amount of donation money.

Pilot Study

The pilot study was conducted to test the interview procedure and research instruments with a small group of participants ($n=30$) in October, 2008. The setting of the pilot study was a community-based rehabilitation institution operated by the Ching-Hai Psychiatric Hospital in Tai-chung County. It included a mental health day-care program and a half-way house. Most institutional members were from local areas in the middle part of Taiwan, with various types of psychotic diagnoses, such as schizophrenia or bipolar disorder. The institutional workers recruited over thirty members with a history of schizophrenia who were chosen randomly based on chart order. However, a few members who were not in good condition to do the interview were withdrawn from the pilot study, and were replaced with other members who qualified for the study.

The pilot study allowed the researcher to test the potential reliability and validity of the major study as well as to establish whether any refinements in the questionnaire or in the data collection procedures. The pilot study resulted in several changes, including the issues of language and instruments. The researcher frequently applied the Fu-Ken dialect to interview with the participants while using the Mandarin Chinese version of the questionnaire. Thus, the Mandarin Chinese version of the questionnaire needed to be written as simply as possible so that not only the participants could understand it easily but so that the researcher could interpret the questionnaire smoothly using Fu-Ken dialect. Furthermore,

a few questions needed to be eliminated in order to get higher reliability and validity because the instruments were cross-cultural used even though their reliabilities and validities were appropriate in the pilot study. The instrument section will describe the adjusted questions of the questionnaire.

Variables and Research Instruments

Based on Andersen's Model, the nineteen-page questionnaire was designed as an interview tool to measure the independent (predisposing characteristics, enabling resources, and need factors), the moderator (cultural factors), and the dependent variables (help-seeking behaviors). The demographic questions were used to measure the variables in the categories of predisposing characteristics and enabling resources. In addition, six instruments were used to measure the variables in the categories of need factors, cultural factors, and help-seeking behaviors.

The Multidimensional Scale of Perceived Social Support (MSPSS) was utilized to measure the social/family support which was in the enabling resources. The Brief Symptom Inventory (BSI) was used to measure the level of distress which related to the participants' symptoms. The General Self-Efficacy Scale (GSE) was utilized to measure the participants' level of self-efficacy. Both variables of the level of distress and the self of efficacy were in the category of need factors. The Devaluation-Discrimination Scale (DDS) was used to measure the participants' perception of stigmatization from the general public. The Self-Appraisal of Illness Questionnaire (SAIQ) was utilized to measure the participants' insight or personal beliefs of schizophrenia. The two variables of stigmatization and insight were in the

cultural factors category. Finally, the Help-seeking Behaviors Scale was used to measure the participants' frequency of using formal or informal mental health services.

Dependent Variables

Help-seeking behaviors, as the dependent variable in this study, were defined as "actions by individuals looking for and requesting assistance for their problems" (Unrau & Grinnell, 2005). It refers to "a request for assistance from informal supports (e.g. families and friends) or formalized services (e.g. professionals and clergy) for the purpose of resolving emotional, behavioral, or health problems" (Srebnik, Cauce & Baydar, 1996, as cited in Unrau & Grinnell, 2005). According to the definitions, the variable of help-seeking behaviors was categorized in two sections: formal services and informal services. The formal services were defined as the western psychiatric model, such as inpatient service, outpatient service, or community-based mental health facilities. The informal services were defined as the non-westernized psychiatric model, such as folk therapy, Chinese Medicine, or non-psychiatric physicians or self-medicating.

The variable of help-seeking behavior was measured by the adapted Help-Seeking Behaviors Questionnaire. The Help-Seeking Behaviors Questionnaire was originally developed by Horng (1994) to test the help-seeking behaviors in psychiatric outpatients in Taiwan. According to Horng (1994), the Help-Seeking Behaviors Questionnaire was a 16-item five-point Likert scale to measure the frequency with which people with psychiatric disorders received the services (15 items) and the length of delay, which showed that how soon these psychiatric outpatients consulted psychiatrists after their first attack (1 item). The

services were categorized in five groups: 1) Family members/social network, 2) Non-psychiatric physicians/self-medication, 3) Folk healing practice, 4) Chinese medicine practice, and 5) Counseling centers (Horng, 1994). Additionally, Horng (1994) indicated that the test-retest reliability of the Help-Seeking Behaviors Questionnaire ranged from .73 to .89 during a 10-day interval and was significant at the .01 level.

Due to the change of mental health system in Taiwan during this decade, the types of services has been expanded. Therefore, the researcher took nine items from the original Questionnaire (16 items), and added other items to develop the adapted version "the Help-Seeking Behaviors Scale". All the nine items from the original questionnaire were in the informal services category, such as the folk healing practice, Chinese Medicine using, and the non-psychiatric physicians/self medication. Additionally, the social worker who helped the researcher to implement the pilot study suggested that the researcher should add two items based on the social worker's experiences working with people with mental disorders. These two items were "change Feng Shui" and "Ask Shamans about the cause(s) of the illness." Therefore, the total number of items in the informal services category was eleven. The formal service category was developed based on the westernized psychiatric model. Items in this category covered all mental health services including institutional and community-based. The total item number was ten in the formal service category.

According to the findings of factor analysis in the pilot study, the revised informal services category of the Help-seeking Scale were divided into three subscales: 1) folk healing (feng shui, fortunetelling, and mi fang), and the reliability was $\alpha = .88$; 2) religious rituals (worship at the temple, seeking shou ching, prayer or priest counseling, Taoism rituals, and

shamanism), and the reliability was $\alpha = .79$; and 3) non-psychiatric practice, including Chinese medicine, non-psychiatrists, and self-medication, and the reliability was $\alpha = .70$. When the results of the pilot study were applied to the formal study, the Cronbach's Alphas were .68, .70 and .53 respectively.

The formal services category was developed based on the western psychiatric model, and the questions included seeing mental health professionals, using psychiatric medicine, utilizing the institutionalized or the community-based mental health services. Based on the feedback of the participants after the pilot study, one more question was added into the formal study (outpatient service). The findings of the factor analysis in the pilot study was not appropriate to divide the sub-categories; however, the reliabilities of the entire scale in the pilot study ($\alpha = .68$) and in the formal study ($\alpha = .63$) were moderated.

The assumption that the formal services category could not be divided into subscales could be the participants in Taiwan might not recognize the community-based services, such as half-way house or club house. Not only these services were new in Taiwanese mental health system, but most community-based services still under the management of the institutions. Some of the participants who used the community-based services were moved from the institutional service and might not have the awareness of what services they were using.

Independent Variables

The independent variables, based on the adapted Andersen's model, included predisposing characteristics, enabling resources, and need factors. The predisposing

characteristics, according to Andersen (1995), was conceptually defined as the potential factors that influence individuals incline to receive health services, such as demographic, social structure, and the health beliefs. The enabling resources were defined as factors that empower or hinder individuals to use health services, including personal/family or community resources (Andersen, 1995). Both the predisposing characteristics and the enabling resources were operationally measured by the demographic questionnaire which was conducted by the researcher. Additionally, family /social support, one of the variables in the enabling resources, was measured by the Multidimensional Scale of Perceived Social Support (MSPSS). The need factors were defined as the individual's requirements to receive the health services when he/she encounters the health related problems (Andersen, 1995). The variables of this category, included the symptom evaluation and the self efficacy, were measured by the Brief Symptom Inventory (BSI) and The General Self-Efficacy Scale (GSE).

Demographic Questionnaire.

The demographic questionnaire included questions related to the definitions of the predisposing characteristics and enabling resources. In the predisposing characteristics section, the variables included gender, age, ethnicity, religion, marital status, spouse ethnicity, major caregiver(s), geographical residence, and religious influence. Additionally, the variables of the enabling resources section included education, household income, employment, insurance, transportation, accessibility of community mental health resources, and family/social support. However, family support was measured by the Multidimensional

Scale of Perceived Social Support (MSPSS) as it was mentioned previously. The conceptual and operational definitions of the predisposing characteristics were presented in the table 3.1, and those definitions of the enabling resources were presented in the table 3.2.

Table 3.1

Definitions of the Predisposing Characteristics

Variable	Conceptual definitions	Operational definitions
Gender	Someone's self identified sexuality	1. Male 2. Female
Age	The periods of human life, measured by years from birth	The participants' birthday
Ethnicity	Someone's identity with a particular racial, national, or cultural group	1.Fuken 2.Mainlander 3.Hakka 4.Indigenous 5.Other
Marital status	The condition of being married or unmarried	1. Single never married 2.Living together with a partner without officially married 3.Married

Table 3.1 (Continued)

Variable	Conceptual definitions	Operational definitions
Marital status	The condition of being married or unmarried	4.Widowed 5.Divorced 6.Separated
Spouse Ethnicity	The ethnicity of someone's husband or wife	1.Taiwanese 2.Vietnamese 3.Indonesian 4.Mainland Chinese 5.Philippinos 6.Malaysian 7.Other
Geographical residence	The region that someone lives	counties of Taiwan based on the participants' self-report
Major caregiver	The key person who cares someone who is sick or disabled	1.father 2.mother 3.Spouse 4.Sibling 5.Children 6.Other

Table 3.1 (countiued)

Variable	Conceptual definitions	Operational definitions
Religion	A personal or institutionalized system grounded in such belief and worship	1.Buddhism 2.Taoism 3.Catholicism 4.Protestanism 5.Folk Religion 6.I-Kuan Tao 7.Other
Religious Influence	The degree of the religious power affecting on people	1.Not at all 2.Somewhat 3.Moderately 4.Quite a lot 5.Do not know

Table 3.2

Definitions of the Enabling Resources

Variable	Conceptual definitions	Operational definitions
Education	Years/the degree of schooling	Years of schooling is based on the self-report of participants

Table 3.2 (continued)

Variable	Conceptual definitions	Operational definitions
Education	Years/the degree of schooling	<p>The degree of schooling:</p> <ol style="list-style-type: none"> 1.Never went to school 2.Self-educated 3.Elementary school or less 4. Junior high school or less 5.Senior high school 6.Incomplete/GED program 7.Senior high school 8.Professional School 9.Five-year college 10.Bachelor's degree 11.Master degree 12.Doctorate
Employment	An occupation that a person makes a living for, based on the categories that defined by the Taiwanese government	<p>(1) The categories of the occupation:</p> <ol style="list-style-type: none"> 1.Unemployed 2.Servicemen 3.Elementary Occupations

Table 3.2 (continued)

Variable	Conceptual definitions	Operational definitions
Employment	An occupation that a person makes a living for, based on the categories that defined by the Taiwanese government	4. Plant and Machine Operators and Assemblers 5. Craft and Related Trades Workers 6. Agricultural, Animal Husbandry, Forestry, and Fishing Workers 7. Service Workers and Shop/Market Sales Workers 8. Clerks 9. Technicians and Associate Professionals 10. Professionals 11. Legislators, Government Administrators, Business Executives, and Managers 12. Other (2) Hours a day for the current job

Table 3.2 (continued)

Variable	Conceptual definitions	Operational definitions
Household income	the money that a person or a family earns monthly	The amount of money the participants reported that they or their family earned monthly
Transportation	The tool someone's using to get to the mental health facilities	(1) What transportation do you use? 1. Bus 2. Train 3. Subway 4. Taxi 5. Motorcycle 6. Bicycle 7. Car that you or your family own 8. Walk 9. Other

Table 3.2 (continued)

Variable	Conceptual definitions	Operational definitions
Transportation	The tool someone's using to get to the mental health facilities	<p>(2) How often do you travel to the mental health facilities that you are treated?</p> <p>(3) How long does it take you to get to the mental health facilities?</p> <p>(4) Does your major caregiver travel with you to the mental health facilities?</p> <p>(5) If your caregiver travels with you does/he/she go to meet with the mental health professionals?</p>
Accessibility of community mental health resources	The difficulty of approaching the community mental health services, including community-based agencies and individual support system	(1) The awareness of the community mental health services:

Table 3.2 (continued)

Variable	Conceptual definitions	Operational definitions
Accessibility of community mental health resources	The difficulty of approaching the community mental health services, including community-based agencies and individual support system	<ol style="list-style-type: none"> 1. In-patient service 2. Out-patient service of the hospital 3. Clinics providing medications 4. Home-care program 5. Day-care program in hospitals 6. Day-care program in rehabilitation centers 7. Half-way house 8. Club house 9. Long-term facility 10. Nursing home which accepts people with mental illness 11. Counseling center/clinics without providing medications

Table 3.2 (continued)

Variable	Conceptual definitions	Operational definitions
Accessibility of community mental health resources	The difficulty of approaching the community mental health services, including community-based agencies and individual support system	<p>(2) The utilization of the community mental health services (the same items as the first question)</p> <p>(3) The difficulty of using these services: (the same items of the previous questions)</p> <p>1. Extremely difficult</p> <p>2. Very difficult</p> <p>3. Difficult</p> <p>4. Slightly difficult</p> <p>5. Not difficult at all</p> <p>(4) In addition to the mental health institutions, other community resources that has been considered as helpful resources:</p> <p>1. Churches/temples(the clergy)</p> <p>2. Parents</p>

Table 3.2 (continued)

Variable	Conceptual definitions	Operational definitions
Accessibility of community mental health resources	The difficulty of approaching the community mental health services, including community-based agencies and individual support system	3. Spouse 4. Siblings 5. Children 6. Neighbors 7. Friends who live in the same city/county as you 8. Family physicians 9. Colleagues, classmates 10. Relatives other than your immediate family 11. Other

The Multidimensional Scale of Perceived Social Support (MSPSS).

The MSPSS (Zimet, Dahlem, Zimet, & Farley, 1988) is a 12-item with seven-point rating scale ranging from (1) very strongly disagree to (7) very strongly agree. It is a self-report scale designed to measure perceived social support from family (item # 3, #4, #8, #11), friends (item #6, #7, #9, #12), and significant others (item #1, #2, #5, #10) (Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS has been reported with an excellent internal consistency ($\alpha = .88$) and good factorial validity as well as concurrent validity in a college student group (Zimet et al, 1988). The scoring for total scale was to divide the total score

into 12, for the three subscales were divide the total scores of the subscales into four. This instrument was applied to this study to measure the variable of social support in enabling resource category.

In a study that the MSPSS was applied to psychiatric outpatients, the Cronbach's alpha of the schizophrenia group was .91 for the total scale, .85 for the significant other subscale, .89 for friends subscale, and .92 for the family subscale (Cecil, Stanley, Carrion, & Swann, 1995). According to Zhang and Norvilitis (2002), the reliability of the MSPSS in Chinese college students is high in total scale ($\alpha = .82$), and in male ($\alpha = .80$) as well as in female ($\alpha = .84$) groups. However, the result of factor analysis in this study showed that two factors in Chinese study group and only one in American counterpart. The authors explained that could be "the high interrelatedness among the hypothesized dimensions" (Zhang & Norvilitis, 2002). In the pilot study of "Help-seeking behaviors in Taiwanese people with Schizophrenia," the reliability of the MSPSS for total scale was .92, for the significant other subscale (SO) was .80, for the family subscale (FAM) was .82, and for the friends subscale (FRI) was .83. The total scale of the MSPSS also showed a high internal consistency in the formal study ($\alpha = .86$), as well as the subscales ($\alpha = .75$ of SO, $\alpha = .86$ of FAM, and $\alpha = .85$ of FRI).

The result of the factor analysis in this study showed two factors; nevertheless, when the 12-item scale was forced into three factors, the result was quite different from the original one. Most of the items fall into the first factor (#1, #2, #3, #4, #9, #10, #11, #12), and it was close to the original significant (#1, #2, #5, #10) and family (#3, #4, #8, #11) subscales. However, only one item was left in the third factor (#7), and this result indicated that the

friends subscale (#6, #7, #9, #12) was almost eliminated. This result was quite consistent to Zhang and Norvilitis's study (2002).

These results could be explained that people with schizophrenia had limited relationships with people other than either their family members or significant others. Additionally, people usually considered that significant others were part of the family in Chinese culture. Therefore, it was not surprised that the pilot study result showed that the family and significant other subscales could be combined as one. Moreover, in these items of the significant other subscale, the word "special person" could mean anyone – family members, friends, or professional workers- rather than just mean significant other in the Chinese version of the MSPSS. This also indicated why most items with "special person" fell into the same factor. Although the results of factor analysis were different from the original study, the MSPSS was still considered as reliable cross different cultures and populations (Zhang & Norvilitis, 2002). Furthermore, the reliabilities of the original three subscales showed pretty high and acceptable, so the study would maintain to use the three subscales.

The General Self-Efficacy Scale (GSE).

The GSE was a ten-item scale which was developed in German by Jerusalem and Schwarzer, and later translated into 27 languages to measure "a general sense of perceived self-efficacy in how people cope with daily hassles as well as adjust to different stressful life events" (The General Self-efficacy Scale, Origin section, ¶ 3). The GSE Scale was used to measure the self-efficacy, one variable of the need factor in the adapted Andersen's model. The GSE had been developed in Chinese version by Zhang and Schwarzer with a high

internal consistency ($\alpha = .91$) (Chiu & Tsang, 2004). In the pilot study, the GSE had a great internal consistency ($\alpha = .93$). Therefore, all items were kept to apply to the formal study, and the GSE also showed a good internal consistency ($\alpha = .91$).

The Brief Symptom Inventory (BSI).

The Brief Symptom Inventory (BSI) is a 53-item scale developed by Derogatis and Melisaratos (1983) to measure the psychological symptoms in adolescents and adults. Moreover, it is a five-point Likert rating from 0 (not at all) to 4 (extremely) to rank the intensity of distress in the participants during the past seven days (Derogatis, 2009). Furthermore, it includes nine symptom dimensions: Somatization (SOM), Obsessive-Compulsion (O-C), Interpersonal Sensitivity (I-S), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic Anxiety (PHOB), Paranoid Ideation (PAR), and Psychoticism (PSY). In addition, three global indices are developed to measure the overall “psychopathological status”, “psychometric appraisal”, and the general level of psychological well-being of the participants, including Global Severity Index (GSI), Positive Symptom Total (PST), and Positive Symptom Distress Index (PSDI) (Derogatis, 1993).

The Global Severity Index (GSI), which is a one of the global indices of the BSI, was used to evaluate the distress level of psychological symptoms on the participants with schizophrenia in this study. According to Derogatis (1993), the GSI is “the most sensitive indicators of the respondent’s distress level, combining information about numbers of symptoms and intensity of distress.” The score of the GSI is calculated using the sums of all items and divided by the total number of responses (Derogatis, 1993). According to

Derogatis (1993), no alpha reliability is reported for the GSI, but there is a test-retest reliability of .90 for the GSI. The GSI has been reported to have good validity (Derogatis & Melisaratos, 1983; Saunders, 1997). The reliability of the GSI in the formal study was .97.

The Moderator Variables

Cultural factors were placed as the moderator variables which might strength or weaken the influences between predisposing characteristics, enabling resources, need factors, and all the three towards help-seeking behaviors. It included two variables: the stigmatization and self-appraisal in people with schizophrenia. The Devaluation-Discrimination Scale (DDS) was used to measure how people with schizophrenia perceived the stigma from other people. Additionally, the Self-Appraisal of Illness Questionnaire (SAIQ) was utilized to measure how those with schizophrenia perceived the stigma from themselves and conceptualized their own illness.

The Devaluation-Discrimination Scale (DDS).

The Devaluation-Discrimination Scale (DDS) was originally a 12-item 6-point scale developed by Link, Cullen, Struening, Shrout, and Dohrenwend (1989), which is used to measure the extent to which participants believe that individuals who have received mental health treatment with discriminated against by others in jobs, friendships, and relationships (Link, Yang, Phelan & Collins, 2004). The internal consistency is .76 (Link et al, 1989) in an American group, and was .88 in a study of Korean Americans with mental illness (Shin & Lukens, 2002). The new version of the DDS was a 13-item 4-point scale when the researcher

requested the scale to apply in this study from Link in 2008. Half of the thirteen items (#1, #2, #3, #4, #8, #10) are scored from strongly disagree (4), Disagree (3), Agree (2), and strongly agree (1). The rest of the items (#5, #6, #7, #9, #11, #12, and #13) are reversed scoring. However, according to Boyd (2004), whose study used the 12-item 4-point DDS Scale, showed a good internal consistency ($\alpha = .85$) in a psychiatric outpatient group. In order to compare the reliability to this study, the researcher dropped the new question (#13) and applied the 12-item scale in the pilot study. The reliability of the total scale was .70 in the pilot study, and was .77 in the formal study.

The Self-Appraisal of Illness Questionnaire (SAIQ).

The Self-Appraisal of Illness Questionnaire (SAIQ) was a 17-item self-report instrument developed by Marks, Fastenau, Lysaker, and Bond (2000) to measure a need for treatment in people with schizophrenia as well as their perception of their mental problems. The SAIQ was a 4-point Likert scale, and the scoring was to sum items 1 through 17. Except items #1, #10, #11, #12, #13, #15, #16, all items were reverse scored.

According to Marks et al (2000), the SAIQ was divided into three subscales, including: 1) need for treatment, 2) worry, and 3) presence/outcome of illness. In addition, the reliability of the need for treatment subscale was .78, of the worry subscale was .87, and of the presence/outcome of illness was .74. The reliability of the whole scale was .83.

The SAIQ has been reported to have a fairly good internal consistency ($\alpha = .66$) with few revised items (Hodge, 2006). In the pilot study, the reliability of the total scale was .82. The reliability of the need for treatment subscale was .83, and of the worry subscale was .85.

However, the reliability of the presence/outcome of illness was not approved to be used in the pilot study. The same result was applied to the formal study. In the formal study, the reliability of the total scale was .64, of the need for treatment subscale was .87, of the worry subscale was .78, and of the presence/outcome of illness was not effective. Therefore, the presence/outcome of illness subscale was not analyzed in this study.

Table 3.3

Instrument Reliability

Scale	Number of Items	Reliability in Previous Studies	Reliability in the pilot Study	Reliability of the formal study
MSPSS	12	.88 (Zimet et al, 1988) .91 (Cecil et al, 1995) .82 (Zhang & Norvilitis, 2002)	.92	.86
GSE	10	.91 (Chiu & Tsang, 2004)	.93	.91
BSI	53	.90 (Derogatis, 1993)		.97
DDS	12	.76 (Link et al, 1989) .88 (Shin & Luken, 2002) .85 (Boyd, 2004)	.70	.77
SAIQ	17	.83 (Marks et al, 2000) .66 (Hodge, 2006)	.82	.64
HSBS- IFO	11		.85	.80
HSBS- FO	10		.68	.63

Note. MSPSS = The Multidimensional Scale of Perceived Social Support; GSE = The General Self-Efficacy Scale; BSI = The Brief Symptom Inventory; DDS = The Devaluation-Discrimination Scale; SAIQ = The Self-Appraisal of Illness Questionnaire; HSBS-IFO = The Help-seeking Behaviors Scale Informal Services; HSBS-FO = The Help-seeking Behaviors Scale formal Services.

Plan of Data Analysis

Once the questionnaires were collected, the consent forms which were attached to them were detached and a number was assigned to each questionnaire to avoid any disclosure of any personal information. The questionnaire was designed by utilizing the SurveyMonkey online survey tool and transformed into hard copies for the interviews. Therefore, all the participants' responses were coded into the online survey system by the researcher in order to develop a data set in Microsoft Excel format. After the researcher edited the data set, the completed data set was transformed into the Statistical Package for the Social Sciences (SPSS) format, and the SPSS was used as a statistical analytic tool. Due to the face-to-face interview process, missing data was minimal except one participant failed to answer questions in one particular section.

Because the instruments of this study had been applied to different ethnical populations, the factor analysis was utilized to restructure the instruments and reduce the instrument questions to avoid the highly correlated questions testing the same variables. Moreover, the factor analysis was used to categorize the subgroups of the instrument questions. In addition, the Cronbach's alpha test of internal consistency was used to test each instrument's and its subgroup's reliability. Furthermore, the Pearson Correlations and Chi-square were used to examine the statistically significant relationships among the demographic variables and the study bi-variate hypotheses. Plus, descriptive statistics, including frequencies, percentage, central tendency, and standard deviation were utilized to test the variables in this study.

The multivariate hypotheses were analyzed by the method of multiple regression and path analysis. According to Kerlinger and Lee (2000), multiple regression was often used to assess the effects and weight the magnitudes of the effects of multiple variables on one dependent variable (p.755). Moreover, multiple regression could be used to analyze a dependent variable through a combination of several predictors (independent variables) (Morgan, Leech, Gloeckner & Barrett, 2007, p. 134). Therefore, it was an adequate statistical approach to predict either the informal or formal services through the predisposing characteristics, enabling resources, need factors, as well as the cultural factors (moderator) predictors in this study.

Human Subjects

There are several local laws and customs in Taiwan to regulate legal consent and approval needed for biomedical researcher to conduct their physical trial studies. Additionally, the National Health Research Institute (NHRI) in Taiwan has developed a draft to help research units (e.g. medical centers, hospitals, and universities) to develop their Institutional Review Boards (IRBs). The Department of Health established the Joint IRB (JIRB) in 1997 to review biomedical research. According to the JIRB, the laws and regulations applied to clinical research in Taiwan involve three dimensions: 1) general law (including Civil Law, Criminal Law, The Computer-Processed Personal Data Protection Law, the Medical Care Act, and The Physician Act), 2) regulations (including The Enforcement Rules of Medical Care Act and the Guideline for Good Clinical Practice), and 3) guidelines (more specifically the Guidelines for Clinical Trial Committees of medical

institutes and the Human Research Ethics Policy Guidelines). The Human Research Ethics Policy Guidelines provides an eight-point guideline covering the purpose, definition, consent, and ethics of biomedical research.

These criteria were well integrated into the proposal requirements of the Catholic University of America Human Subject Guidelines. When this study proposal was submitted to The Catholic University of America Institutional Review Board (IRB), the Alliance for the Mentally Ill (TAMI) of Taiwan and the Ching-Hei Psychiatric Hospital, which were cooperating organizations, also received the study proposal and then gave the study consent. The TAMI and the Ching-Hei Psychiatric Hospital do not have any formal policies nor an ethics review committee; however, the General Secretary of TAMI asked the investigator to follow Human Research Ethics Policy Guidelines and the Board of Directors of TAMI approved the study proposal after a presentation by the General Secretary. A similar process was followed for the Pilot Study. The director of the social work department of Ching-Hai Psychiatric Hospital submitted this study proposal to the President and the President approved of the study. After this procedure, this study proposal was approved by The Catholic University of America Institutional Review Board (IRB).

Considering the possibility of cognitive function impairment in people with schizophrenia, this study took a more protective stance towards the rights of this population. All participants were screened by the institutional workers to assure that they were legally competent to give consent. Once the competent participants showed their interests in participating in this study, they were contacted by the researcher and received the invitation letter and the consent form. The researcher explained the invitation letter and the consent

form to ensure that the participants thoroughly understood all possible risks involved as well as the interview procedure before each interview began. Additionally, when the participants felt as if they were forced to participate in this study by authorities, the researcher encouraged them to participate, but simultaneously informed them about their rights to refuse to be interviewed.

When it came to the sensitive questions (e.g. The Self-Appraisal of Illness Questionnaire) related to psychotic symptoms and stigma towards schizophrenia), the interviewer did not ask participants directly. Instead, the interviewer encouraged the participants to check the answers for these questions on the questionnaire and intervened only when the participants needed any additional help with understanding the questions. When the participants completed the questionnaires, the copies of their consent forms were kept by the researcher unless the participants asked for carefully keeping them individually. This was an attempt to prevent the participants from tossing the consent forms in public environments, which could disclose the participants' identities to outsiders of the institutions. Furthermore, all completed questionnaires will be kept in a safe place to preserve confidentiality.

Summary

The purpose of this chapter was to present the research plan and statistical methods to describe the procedure to examine the relationships between the major independent and dependent variables. The major independent variables included predisposing characteristics, enabling resources, need factors. In addition, the research plan also examined the dependent

variable (help-seeking behaviors) and the moderator (cultural factors). This methodology chapter was also present the human subjects regarding the research ethics. This chapter was also a preparation for the study implementation and the study results.

CHAPTER IV

FINDINGS

The chapter will present the demographic characteristics of the study population and the interrelationships between the independent and dependent variables in this study. It will provide descriptive findings of all demographic variables, such as gender, age, and household income, which are categorized as predisposing characteristics and enabling resources. Moreover, the descriptive finding will present the results of all instruments that are used in this study. All the descriptive findings will show not only the frequencies, percentages, the mean, and the standard deviation but also include comparisons with related studies when possible.

In addition to the descriptive findings, this chapter will focus on the analysis of the major study variables, which are the predictors of the utilization of mental health services. Findings from the bivariate hypotheses that were conducted in order to determine the major predictors that will be used in the multiple regression analysis will be presented. Multiple regression will be used to test the multivariate hypotheses to understand the strengths of the predictors when dealing with the utilization of mental health services. The data was analyzed using SPSS for Windows (Version 17.0). A significance level of $p \leq .05$ has been used throughout the statistical analyses.

Descriptive Findings of the Predisposing Characteristics

The predisposing characteristics are the demographic factors that could potentially influence service utilization (Andersen, 1995). The variables in this category include gender, age, ethnicity, religion, geographic residence, marital status, spouse nationality, major caregiver, and religious influence. The findings showed that the study sample was representative of the population.

Gender

The study participants consisted 59% males ($n=74$) and 41% females ($n=51$), as shown in Table 4.1. This result coincided with the findings of Lee, Chen, and Lee (2007), who indicated that females with schizophrenia received less community rehabilitation services because of their better functioning and more opportunities for employment.

Age

The age range of the study participants was from 21 to 66 years with a mean age of 36.9 years and a median age of 35.5 years. The majority of the study participants ($n=50$, 40%) were between 30-39 years old. In this study, then, people with schizophrenia who used community mental health facilities tended to be young according to this result. Ninety percent of the participants ($n=112$) were under 50 years old; most of them were in the younger end of the age spectrum, as 77 out of 112 (nearly 80%) were under 40 years old (See Table 4.1).

Geographic Residence

Data on the participants' geographic residence demonstrated that it correlated closely with the distribution of the Taiwanese population in general, as shown in Table 4.1. The majority of the participants ($n=55$, 44%) lived in North Taiwan (including Taipei City/County, I-Lan County and Shin'chu City), followed by the group ($n=36$, 29%) who lived in Middle Taiwan (including Tai-chung City and Natou County). The number of the participants living in South Taiwan was 26 (21%), and the number of the participants living in the remote East area was only 7 (6%). (See Table 4.1)

Ethnicity

The ethnicity findings were representative of the Taiwanese population; the major ethnicity of the study participants being Fukien ($n = 88$, 70.4%), followed by Mainlander ($n=15$, 12.0%), and Hakka ($n=11$, 8.8%). Nine participants identified themselves as "indigenous" or "other" (See Table 4.1). This result could be because some Taiwanese felt hesitant to be identified or they identified themselves in the "other" category because of the intricate political issues and cross-ethnic marriages. Additionally, the findings also showed that the indigenous population was difficult to reach because most of them live in the mountainous remote areas, which made their traveling to the community centers difficult (personal conversation, Nantou County mental health community facility, 2008).

Marital Status and Spouse Nationality

The majority of the study participants identified themselves as single (i.e., never married) ($n=89$, 71.2%), 13 participants (10.5%) were married or lived with their partners, and 21 participants (17.1%) fell into one of the three categories: divorced, separated, or widowed (See Table 4.1). This result was consistent with one other study on the relationship between family structure or marital status and people with schizophrenia and bipolar disorder, which showed that nearly 80% (237 out of 284) of the study participants with schizophrenia were never married (Yang, Lui, Tung, & Ting, 2003). Twenty-four participants who were married or previously married responded to the question about their spouses' ethnicity. With only a few of them ($n=4$, 16.7%) being married to either Indonesian or Mainland Chinese (See Table 4.1). This result could be explained as followed: people with schizophrenia had difficulty getting married because of their impaired social functioning and cognition ability.

Major Caregiver

Nearly half of the study participants ($n=61$, 48.8%) responded that their mothers were their major caregivers. This finding could be attributed to the traditional Confucianism culture where women take the leading role in taking care of the family (Hsiao et al., 2006). Approximately the same number of the participants chose either their fathers ($n=37$, 29.6%) or their siblings ($n=31$, 24.8%) as their major caregivers. Less than 10% ($n=12$) of the participants reported that spouses and their children their major caregivers. This result can be explained by the cultural tradition of passing the duty of caring for ill family members to

the next generation. However, the findings also showed that a few participants considered people from outside of internal family, such as people who worked for community facilities or churches, their major caregivers. This could be also explained the fact that these participants permanently lived in community mental health facilities and had limited communications with their families. Most of the participants indicated that the ethnicity of their major caregivers was Taiwanese ($n=118$, 95.2%)

Religious Belief and Its Influence

The study's finding on religious beliefs showed that the participants chose multiple religions, which demonstrated the religious freedom in Taiwan. Half of the study participants selected Buddhism ($n=63$, 50.4%) as their religious beliefs, while 14.4% of the participants ($n=18$) chose Christian (Catholic and Protestant) as their religious beliefs. An approximately the same number of the participants chose Taoism ($n=15$, 12.0%) and Folk Religion ($n=11$, 8.8%) as their religious beliefs. Moreover, a small number of the participants ($n=8$, 6.4%) chose I-Kuan Tao (one approach of Buddhism) and other. Interestingly, nearly one-fifth ($n=22$, 17.6%) of the participants reported they had no religious beliefs; this result also reflected on the number of the participants ($n=28$, 22.4%) who were not influenced or who did not know whether they were influenced by the religion. The majority of the participants ($n=96$, 77.6%) considered that they were influence by their religious beliefs to some degree; nearly 30% of the participants ($n=37$) were "somewhat" influenced, 27.2% ($n=34$) were "moderately" influenced, and 20.8% ($n=26$) were influenced quite a lot by their religious beliefs. The findings were presented in the table 4.1.

Table 4.1

Predisposing Characteristics (n = 124)

Variables	n	%
Gender		
Male	74	59.2
Female	50	40.8
Age		
20-29	27	21.8
30-39	50	40.3
40-49	35	28.2
≥50	12	9.7
Geographic Residence		
North	55	44.4
Middle	36	29.0
South	26	21.0
East	7	5.6
Ethnicity		
Fukien	90	72.6
Mainlander	14	11.3
Hakka	11	8.9
Indigenous/ Other	9	7.3
Marital Status		
Single never married	89	72.4
Married/ Living together with a partner without officially married	13	10.5
Widowed/ Divorced/ Separated	21	17.1

Table 4.2

Predisposing Characteristics continued

Characteristic	<i>n</i>	%
Spouse Ethnicity		
Taiwanese	20	83.3
Indonesian/ Mainland Chinese	4	16.7
Major Caregiver *		
Father	37	29.6
Mother	61	48.8
Spouse	12	9.6
Sibling	31	24.8
Children/other	12	9.6
Caregivers' Nationality		
Taiwanese	118	95.2
Mainland Chinese/ Vietnamese/ Indonesian/ Other	6	4.8
Religion		
None	22	17.6
Buddhism	63	50.4
Taoism	15	12.0
Catholicism/ Protestantism	18	14.4
Folk Religion	11	8.8
I-Kuan Tao/Other	8	6.4
Religious Influence		
Not at all/ Do not know	28	22.4
Somewhat	37	29.6
Moderately	34	27.2
Quite a lot	26	20.8

*Total is greater than 100% because multiple responses were possible

The Descriptive Findings of the Enabling resources

Enabling resources refer to the individual or environmental resources that could impact the utilization of mental health facilities. These resources included individual/family resources, such as education, employment, household income, and family/social support. Additionally, the community resource was divided into these categories, such as the awareness and the accessibility of the community-based mental health facilities, as well as the non-medical model of resources, such as family members, friends, family doctors, or other community members.

Education

As mentioned in chapter I, the Taiwanese government provided nine-year basic education to the public as the compulsory education. The majority of the participants ($n=69$, 55.6%) hold ten to twelve years of education, but most of them went to the professional school ($n=43$, 34.7%), which provide skill training for those who wanted to work without the advanced degree. Although 24.2% of the participants ($n=30$) received more than 13 years of education, only 20% of them ($n=27$) indicated that they hold the at least college degree. The result was consistent with the previous studies that most of people with schizophrenia were prevented from higher education due to the early age of illness onset. Additionally, if people with schizophrenia received college education, they would have difficulties to finish it because of the illness and the impaired cognition functioning.

Employment

The majority of the participants (n=69, 55.2%) were in elementary occupation, which referred to simple and routine jobs, such as dish washers, janitors, or packing workers. A large portion of the participants (n=31, 24.8%) was unemployed. This result was consistent with other studies that people with schizophrenia were difficult to be employed because their poor social and physical functions. Moreover, even the participants were able to work for some simple jobs, their working hours were very. Nearly half of them (n=59, 47.2%) worked under four hours and not on regular daily basis. 19% of the participants (n=24) worked more than seven hours. This result indicated that most of the participants worked under the management of the rehabilitation centers and considered the occupation training as part of the rehabilitation. Therefore, unless the participants were under well-functioned and were able to work for non-institutional workplaces, most of them worked institutionally with part-time jobs.

Household income

The majority of the participants (54.4%) were aware of the amount of their household income. Among the participants who reported the amount of their household income, most of them (44.1%) were living under the monthly income NT\$ 19,999 (USD\$619.2). As matter of fact, this amount of monthly income was close to the poverty line in Taiwan (NT\$18,000, USD\$ 557.3 for a single person?). In addition, some of the participants considered the governmental support as part of the family income, so this result could be explained that most of the participants relied on the social security. Another interesting

result was that the second largest group (23.5%) in this category was the amount of monthly income over NTD\$ 50000 (USD\$ 1548).

Table 4.2-2

Employment (n=129) and working hours*

Characteristic	N	%
Employment (N=124)		
Unemployed	31	24.8
Elementary Occupations	69	55.2
Service Workers and Shop/Market Sales Workers	9	7.2
Technicians and Associate Professionals	6	4.8
Other (Plant and machine Operator and Assemblers/ Craft and Related Trades Worker/ Clerks/ Farm worker/Family Business)	14	8.0
Working Hours (N=106)		
0-1.5 hours	26	20.8
2-4 hours	33	26.4
4.5-7 hours	23	18.4
≥7.5 hours	24	19.2

*Total is greater than 100% because multiple responses were possible

Table 4.2-3

Household Income

Characteristics	n	%
Household Income (N=125)		
Aware of your household income	68	54.4
Not aware of your household income	57	45.6
Amount of Household Income (N=68)		
NT\$0- NT\$ 9999	12	17.6
NT\$10000-NT\$19999	18	26.5
NT\$20000-NT\$29999	8	11.8
NT\$30000-NT\$39999	7	10.3
NT\$40000- NT\$49999	7	10.3
≥50000	16	23.5

Transportation

In Taiwan, the motorcycle is the most popular transportation, although the public transportation is considered as the major transportation system in the northern metropolitan areas. The findings showed that the majority of the participants (46.4%) used motorcycle as their transportation to meet with their psychiatrists. 36.8% of the participants relied on the public transportation, such as bus, train, and subway. However, bus was the major public transportation that was used by the participants (27.2%). This could be explained that only

urban cities, such Taipei and Kaohsiung, have the subway systems. 12.0% (n= 15) of the participants utilized the transportation provided by the agencies to receive treatment.

Travel frequency and travel time

The majority of the participants (n=69, 58.0%) went to see their psychiatrics on the monthly basis, due to the Taiwanese National Health Insurance Program (NHIP). The NHIP allowed people with chronic illness to take at least one-month prescription medicine instead of the usual three-day treatment course. Only one-third of the participants (n=39, 32.8%) receive treatment at least on every other week basis. This result showed the group of the participants was categorized as “people with chronic schizophrenia” although the survey did not ask their years of illness. Most of the participants (n=78, 66.7%) spent 30 minutes or less on traveling to receive their treatment. Only very few participants (n=13, 11.1%) need to travel over one hour.

Caregivers of the Participants

Although the majority of the participants (n=72, 58.1%) traveled without their caregivers' company when they met with their mental health professionals, 41.9% of the participants (n=52) did. Moreover, the majority of the participants (n=100, 82%) indicated that their caregivers would meet with their mental health professionals sometimes or more frequently when they received treatment. This result showed that the participants with high family support to be involved in the mental health treatment.

Table 4.2-4

Transportation (n=172)

Transportation (N=125)	n	%
Bus	34	27.2
Train	3	2.4
Subway	9	7.2
Taxi	4	3.2
Motorcycle	58	46.4
Bicycle	19	15.2
Car that family own	12	9.6
Walk	18	14.4
Car that agency provided	15	12.0

*Total is greater than 100% because multiple responses were possible

Table 4.2-5

Travel frequency and travel time

Characteristic	n	%
Travel Frequency (N=119)		
Once a week or more	17	14.3
Once in every other weeks	22	18.5
Once in every three weeks	6	5.0
Once a month	69	58.0
Less than three months	5	4.2
Travel Time (N=117)		
≤ 15 minutes	40	34.2
16-30 minutes	38	32.5
31minutes-1 hour	26	22.2
1-2 hours	4	3.4
≥ 2hours	9	7.7

Table 4.2-6

Travel with caregiver and caregiver meet with mental health professionals

Characteristic	n	%
Travel with caregiver (N=124)		
Yes	52	41.9
No	72	58.1
Caregiver meets with the professionals (N=122)		
Never	22	18.0
Sometimes	59	48.4
All the time	41	33.6

Awareness of Community Psychiatric Facilities

Most of the participants were aware of the in-patient (n=113, 90.4%) and outpatient services (n=118, 94.4%) in their communities; followed by the awareness of Day-care program in rehabilitation centers (n=93, 74.4%), Half-way house (n=92, 73.6%), Day-care program in hospital (n=79, 63.2%), Clinics providing medications (n=76, 60.8%). On the contrary, the least awareness of community psychiatric facility was the counseling center/clinics without providing medications in their communities (n=32, 25.6%). The last result could be attributed to people with schizophrenia receive more medical treatment and maintain the services in facilities that apply medical or rehabilitation services. The second least awareness of community psychiatric facility in the participants was nursing home with

accepts people with schizophrenia (n=42, 33.6%), followed by the club house (n=44, 35.2%), long-term facility (n=53, 42.4%), and home-care program (n=55, 44.0%). Among these facilities, the club house model was new program that was just started in 2007 in Taipei and Kaohsiung Cities. Therefore, people with schizophrenia who lived in rural areas might not be aware of this service. Long term facility was located in certain areas in Taiwan, so such people with schizophrenia as the participants who received more community services might not have heard about this service. Although home-care program has been provided by the hospital system for years, however, the participants' awareness of this service tended to be low in this study. This result showed either the home-care service had not been promoted well or the participants were referred to the community program and might not have the opportunity to receive the service.

Utilization of Psychiatric Services

The most utilized psychiatric service was the "outpatient services of the hospitals" (n=112, 89.6%), followed by the "in-patient service" (n=91, 72.8%), and the "day-care program in rehabilitation center" (n=71, 56.8%). This result showed that the participants tended to use the institutionalized services while they were using community-based mental health programs. The least three utilized resources were "long-term facility" (n=6, 4.8%), "nursing home that accepts people with mental disorders" (n=6, 4.8%), and "counseling center/clinic without providing medications" (n=7, 5.6%). This result was slightly different from the participants' "awareness of community psychiatric facilities" because a small group of the participants were user of the club house. Moreover, the differences between the

“awareness of community psychiatric facilities” and the “utilization of Psychiatric Services” indicated that some participants might be aware of certain community resources but had never used them, or the participants were actually using (or had utilized) these resources but not aware of what kind of services they utilized. In addition to the most and the least utilized services, the distribution of other items were as below: 36.8 % of the participants had utilized “clinic providing medications” (n=46), 34.4 % of the participants had used “day-care program in hospitals” (n=43), 28.8 of the participants had used “half-way house” (n=36), 22.4 % of the participants had utilized “club house” (n=28), and 12.8% of the participants had utilized “home-care program” (n=16).

Table 4.2-7

*Awareness of community psychiatric facilities (n=797)**

Awareness of community psychiatric facilities (N=125)	n	%
In-patient service	113	90.4
Outpatient services of the hospitals	118	94.4
Clinics providing medications	76	60.8
Home-care program	55	44.0
Day-care program in hospitals	79	63.2
Day-care program in rehabilitation centers	93	74.4
Half-way house	92	73.6
Club house	44	35.2
Long-term facility	53	42.4
Nursing home with accepts people with mental illness	42	33.6
Counseling center/clinic without providing medications	32	25.6

*Total is greater than 100% because multiple responses were possible

Table 4.2-8

*Utilization of psychiatric services (n=462)**

Utilization of psychiatric services (N=125)	n	%
In-patient service	91	72.8
Outpatient services of the hospitals	112	89.6
Clinics providing medications	46	36.8
Home-care program	16	12.8
Day-care program in hospitals	43	34.4
Day-care program in rehabilitation centers	71	56.8
Half-way house	36	28.8
Club house	28	22.4
Long-term facility	6	4.8
Nursing home that accepts people with mental illness	6	4.8
Counseling center/clinic without providing medications	7	5.6

*Total is greater than 100% because multiple responses were possible

Level of Difficulty of Using Psychiatric Services

All types of psychiatric services which were listed in this question were not considered difficult to use. Most participants answered in-patients service and out-patient service of the hospitals because these two items were the most familiar ones to the participants regarding the psychiatric services. In in-patients service, although 55.6 % of the participants (n=60) selected "Not Difficult At All", nearly half of the participants (n=48,

44.4%) thought the in-patient service was difficult to use. This could be explained that the psychiatric beds were insufficient in some suburban and rural areas. 81.7% of the participants considered that the out-patient service of the hospitals was not difficult to use. The items of "Nursing home with accepting people with mental illness" and "Counseling center/clinic without providing medications" were the least participants (n=29) to answer. In "Nursing home with accepting people with mental illness" item, 44.8 % (n=19) of the participants felt no difficult to use this service. 55.2 % (n=16) of the participants selected "Not Difficult At All" in the item of "Counseling center/clinic without providing medications". Thirty participants answered the item of "Long-term Facility" and 13 of them (44.8%) did not consider difficult to use this service. In addition to in-patient and out-patient services, the "Day-care program in Rehabilitation Center" had 76 participants to answer this item, and 59 of them (77.6%) did not feel any difficulty to use this service. Seventy participants answered the item "clinics providing medications", and 47 of them (67.1%) did not think this service was difficult to use. There were 69 participants answered the item of "Day-care program in hospital", and 47 of them (68.1 %) selected "Not difficult At All" of using psychiatric services. The item of "Half-way House" had 57 participants to answer it, and 34 of them (59.6%) did not consider it was difficult to be used. There were 51 participants answer the item of "Home-care Program", and 35 of them (68.6%) selected "Not Difficult At All" of using it. Finally, 46 participants answered the item of "Club House", and 27 of them (58.7%) did not feel difficult to use this service.

Table 4.2-9

Level of difficulty of using psychiatric services

Characteristics (N)	Not difficult at all n (%)	Slightly difficult n (%)	Difficult n (%)	Very difficult n (%)	Extremely difficult n (%)
In-patient Service (N=108)	60 (55.6)	24 (22.2)	11 (10.2)	3 (2.8)	10 (9.3)
Out-patient Services of the hospitals (N=115)	94 (81.7)	10 (8.7)	5 (4.3)	3 (2.6)	3 (2.6)
Clinics providing medications (N=70)	47 (67.1)	10 (14.3)	9 (12.9)	1 (1.4)	3 (4.3)
Home-care program (N=51)	35 (68.6)	9 (17.6)	3 (5.9)	1 (2.0)	3 (5.9)
Day-care program in hospitals (N=69)	47 (68.1)	12 (17.4)	5 (7.2)	2 (2.9)	3 (4.3)
Day-care program in rehabilitation centers (N=76)	59 (77.6)	9 (11.8)	4 (5.3)	0 (0.0)	4 (5.3)
Half-way house (N=57)	34 (59.6)	11 (19.3)	4 (7.0)	1 (1.8)	7 (12.3)
Club house (N=46)	27 (58.7)	12 (26.1)	4 (8.7)	0 (0.0)	3 (6.5)
Long-term facility (N=30)	11 (36.7)	6 (20.0)	6 (20.0)	3 (10.0)	4 (13.3)
Nursing home with accepts people with mental illness (N=29)	13 (44.8)	6 (20.7)	5 (17.2)	3 (10.3)	2 (6.9)
Counseling center/clinic without providing medications (N=29)	16 (55.2)	8 (27.6)	0 (0.0)	1 (3.4)	4 (13.8)

*Total is greater than 100% because multiple responses were possible

Individual Support System

In this individual support system category, most participants considered their family members as the major support system. Ninety-eight participants (79.0%) selected parents and seventy-one participants selected their siblings (57.3%) as their individual support system. However, nearly half of the participants (n=62, 50.0%) considered the religion (Churches/Temple-the Clergy) was their support system. Additionally, family physicians and colleagues/classmates were considered as important support system (n=52, 41.9%). Although family members were the most important individual support system for the participants, only ten participants (8.1%) considered their spouses and fourteen (11.3%) considered their children as the their supporters. Nearly quarter of the participants considered their neighbors (n=30, 24.2%) or friends (n=34, 27.4%) as part of their support system. Thirty-eight participants (30.6%) chose relatives or other, such as social workers or school teachers as their supporters.

Table 4.2-10

*Individual Support System (n=461)**

Individual support resources (N=124)	n	%
Churches/Temple (the clergy)	62	50.0
Parents	98	79.0
Spouse	10	8.1
Siblings	71	57.3
Children	14	11.3
Neighbors	30	24.2
Friends	34	27.4
Family physicians	52	41.9
Colleagues/classmates	52	41.9
Relatives/ Other	38	30.6

*Total is greater than 100% because multiple responses were possible

The findings of the measurements

Table 4.3 presented the analysis of the variables of family support, the need factors, the cultural factors, and the help-seeking behaviors measures. All scales were discussed in the Methodology Chapter and contained in Appendix. Moreover, the scale means, standardized scale means, standard deviations, potential scale range, and the actual scale ranges were presented in this section.

Table 4.3

Description of the Instruments

Scale	Number of Items	Potential Range (Low-High)	Actual Range (Low-High)	Scale Mean (SD)	Standardized Scale Mean (SD)	Reliability
MSPSS	12	12-84 (1-7)	17-84 (1.42-7)	57.2 (11.27)	4.76 (.94)	.86
FAM	4	4-28 (1-7)	4-28 (1-7)	19.50 (5.16)	4.88 (1.29)	.86
FRI	4	4-28(1-7)	4-28(1-7)	17.67 (5.06)	4.41 (1.26)	.85
SO	4	4-28 (1-7)	8-28 (2-7)	19.98 (4.43)	4.99 (1.11)	.75
GSE	10	10-40 (1-4)	12-40(1.20-4)	24.8 (7.62)	2.48 (.76)	.91
BSI	53	30-80 (0-4)	30-78 (.57-1.47)	42.9 (10.87)		.97
DDS	12	12-48 (1-4)	15-42 (1.25-3.50)	28.9 (5.08)	2.41 (.42)	.77

Note. MSPSS = The Multidimensional Scale of Perceived Social Support; FAM = Family Subscale; FRI = Friends Subscale; SO = Significant Subscale; GSE = The General Self-Efficacy Scale; BSI = The Brief Symptom Inventory; DDS = The Devaluation-Discrimination Scale.

Table 4.3 (Continued)

Description of the Instruments

Scale	Number of Items	Potential Range (Low-High)	Actual Range (Low-High)	Scale Mean (SD)	Standardized Scale Mean (SD)	Reliability
SAIQ	17	17-68 (1-4)	23-57 (1.35-3.35)	37.5 (6.04)	2.20 (.36)	.64
Worry	7	7-28 (1-4)	7-28(1-4)	15.48 (5.38)	2.21 (.77)	.78
Need	6	6-24(1-4)	6-24(1-4)	11.29 (3.33)	1.88 (.56)	.87
Illness	4	4-16(1-4)	5-16 (1.25-4)	10.68 (1.79)	2.67 (.45)	
HSBS-FO	10	0-40 (0-4)	0-40 (0-4)	16.77 (6.36)	1.68 (.64)	.63
HSBS-IFO	11	0-44 (0-4)	0-40 (0-3.64)	9.44 (6.50)	.86 (.59)	.80
Folk	3	0-12 (0-4)	0-12(0-4)	1.89 (2.17)	.63 (.73)	.68
Non Psychiatric	3	0-12 (0-4)	0-8 (0-2.67)	1.91 (1.89)	.64 (.63)	.53
Religious Rituals	5	0-20 (0-4)	0-20 (0-4)	5.64 (3.85)	1.13 (.77)	.70

Note. SAIQ = The Self-Appraisal of Illness Questionnaire; Worry = Worry Subscale; Need = Need for Treatment Subscale; Illness = Presence/Outcome of Illness Subscale; HSBS-IFO = The Help-seeking Behaviors Scale- Informal Services; HSBS-FO = The Help-seeking Behaviors Scale- formal Services; Folk = Folk Subscale; Non-Psychiatric = Non-Psychiatric Treatment Subscale; Religious Rituals = Religious Ritual Approach Subscale.

The Help-seeking Behaviors

The dependent variables were measured by the Help-Seeking Behaviors Scale, which was revised based on the Help-Seeking Behaviors Questionnaire (Horng, 1994) in order to measure the frequency of receiving formal (the western psychiatric model) or informal (traditional or folk healing approaches) in the study participants. It was a five point Likert scale from 0 (Never) to 4 (Always) with eleven items in informal service category and ten items in formal service category. In the category of informal services, the scores of potential range were from 0 to 44, and the scores of actual range were from 0 to 40. The mean score was 9.4 (SD=6.5) and the standardized mean was .86 (SD=.59). This result indicated that the participants were less than “rarely” utilize the informal services. There were ten items in the category of formal services; the potential range of scores was from 0 to 40, and the actual range of scores was from 0 to 40. The mean score was 16.8 (SD 1.68), and the standardized mean of scores was 1.68 (SD=.64). The standardized mean showed that the frequency of utilizing the formal services among the participants was between the “rarely” and “sometimes”. Moreover, the participants with higher scores showed that they utilized the service of the reflected item more frequently.

There were three items in each subscale of the informal service (Folk healing, Non-psychiatric treatment, and the religious rituals). In folk healing subscale, the scores of the potential range were from zero to twelve, and the scores of the actual range were the same as the potential range. The subscale mean was 1.89 (SD=2.17), and the standardized mean was .64 (SD=.73). The scores of the potential range in the non-psychiatric treatment were between zero and twelve, and the scores of the actual range were from zero to eight. The

subscale mean was 1.91 (SD=1.89), and the standardized mean was .64 (SD=.63). The scores of the potential range in the religious ritual subscale were from zero to twenty, and the scores of the actual range were the same as the potential range. The subscale mean was 5.64 (SD=3.85), and the standardized mean was 1.13 (.77). These findings showed that the participants were more frequently utilizing the religious rituals for treating their illness.

Social Support

In addition to the demographic information, the variable of social support which was included in the enabling resources was measured by The Multidimensional Scale of Perceived Social Support (MSPSS). The MSPSS is a 12-item scale comprised of three subscales: family (items # 3, #4, #8, #11), friends (items #6, #7, #9, #12), and significant others (items #1, #2, #5, #10) (Zimet, Dahlem, Zimet, & Farley, 1988). Moreover, it is a seven-point Likert scale ranging from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree). The potential range of scores was between 12 and 84, and the actual scores ranged from 17 to 84. Higher scores indicated that the respondents received greater support from family, friends, and significant others. The Mean score was 57.2 (SD=4.76), with the standardized mean 4.76 (SD=.93). Among the subscales, all of them were 4 items with potential range from four to twenty-eight. The actual score range of the three subscales were from four to twenty (family and friends subscales) and from eight to twenty eight (significant other subscale). The standardized mean of the three subscales were quite close: 4.88 for family subscale, 4.41 for friends subscale, and 4.99 for significant other subscale. The standardized mean of both the whole scale and the subscales showed that the participants

“mildly agreed” that they obtained social support from their family, friends, and significant others.

Need Factors

Need Factors' category contained two variables: the level of distress and the level of self-efficacy. The level of distress was measured by the Brief Symptom Inventory (BSI), and the level of self-efficacy was measured by The General Self-Efficacy Scale (GSE). The Brief Symptom Inventory (BSI) is a 53-item five-point Likert scale ranging from 0 (not at all) to 4 (extremely) to measure the intensity of distress in the participants during the past seven days (Derogatis, 2009). As it was mentioned in chapter III, the BSI has nine symptom dimensions and three global indices; only the Global Severity Index (GSI) was used in this study. The GSI score was calculated by dividing the sum of the scores for each item by the number of responded items (Derogatis, 2009). The scores then were converted into standardized T scores in order to compare the responses of the individual participants with those of the outpatient psychiatric group (Derogatis, 2009). Table 4.3 showed that the mean of T score was 42.9 (SD= 10.87). The potential range of the BSI was from 30 to 80, and the actual range was 30 to 78. High scores indicated the higher levels of distress in the participants. The results showed that the average distress level in the study participants were between “Not At All” and “A Little Bit”.

The General Self-Efficacy Scale (GSE) was a ten-item 4-point scale (from 1 “Not At All True” to 4 “Exactly True”) to measure self-efficacy, and later was translated into 27 languages. In this study, the GSE used the Chinese version which was developed by Zhang

and Schwarzer (.Chiu & Tsang, 2004). As it was showed in table 4.3, the mean of the GSE scale was 24.8 (SD=7.62), and the standardized mean was 2.48 (SD=.76). The potential score range was from 10 to 40, and the actual score range of this study was from 12 to 40. Higher score showed the participants had a higher level of self-efficacy. Moreover, the standardized mean indicated that the average level of self-efficacy among the participants fell between “hardly true” and “moderately true”.

Cultural Factors

Cultural factors were used as moderator variables to test whether these variables influenced the relationships between the independent variables and the dependent variables. They were measured by the Devaluation-Discrimination Scale (DDS) and the Self-Appraisal of Illness Questionnaire (SAIQ). The Devaluation-Discrimination Scale (DDS) was a 12-item 4-point scale (from 1 “Strongly Disagree” to 4 “Strongly Agree”) which was used to measure whether the participants believed that the individuals with mental disorders were discriminated against because of receiving mental health treatments (Link et al, 1989). Six of the twelve items (#5, #6, #7, #9, #11, #12) were reversed to calculate scores by summing up that converted scores and dividing the sum by the number of answered items. In this study, the DDS was utilized to measure the level of stigmatization to which the study participants themselves and others were subjected. The scale mean in this study was 28.9 (SD= 5.08); the standardized mean of the scale was 2.41 (.42). The standardized mean showed that the participants average perception of stigmatization fell between “somewhat disagree” and somewhat agree”.

The potential scale scores ranged from 12 to 48, whereas actual scores ranged from 15-42. A higher score indicated that the participants perceived a higher level of awareness about stigmatization in the form of devaluation and discrimination.

The Self-Appraisal of Illness Questionnaire (SAIQ) was a 17-item four point Likert Scale to measure the variable of insight which identified as the study participants' perception of their own psychiatric illness. For the score calculation purpose, ten items were reverse scored among 17 items (items #2, #3, #4, #5, #6, #7, #8, #9, #14, #17). It included three subscales: Need for treatment (Items #1, #10, #11, #12, #15, #16), Worry (Items #2 to #7 and #14), and Presence/Outcome of Illness (Items #8, #9, #13, #17). The potential range of scores was from 17 to 68, with actual range of scores from 23-57. Higher scores reflected a greater degree of negative feelings towards one's illness (less insight). The mean score was 37.5 (SD=6.04) and the standardized mean was 2.20 (.36). This result showed that the participants overall perception on their illness was between slightly and moderately.

There were seven items in the worry subscale, with the score of the potential range from seven to twenty and the score of the actual range from seven to twenty eight. The worry subscale mean was 15.48 (SD= 5.38) and the standardized mean was 2.21 (SD=.77). This finding indicated that the level of worry about the illness in the participants were between slightly and moderate. Six items were in the need for treatment subscale, with the score of the potential range 6-24 and the actual range from six to twenty-four. This finding showed that the degree of need for treatment among the study participants was less than "Agree". Four items fell into the presence/outcome of illness subscale; the score of the potential range was between four and sixteen and the actual score range was five to sixteen. However, since

the presence/outcome of illness subscale did not have an approved reliability, this subscale was not applied to this study.

Bi-Variate Analyses

The major point of the bi-variate analyses focused on answering the hypotheses between the independent variables and dependent variables. Pearson's correlation was the major statistical approach used. Pearson's Correlation was used to examine whether a correlation existed between two variables with either interval or ratio scale. The statistical measures included correlation coefficient (r), and the .05 level or less was used as the acceptable confidence interval of significance. Table 4.4 presented a summary table of the bi-variate correlations between the study scales.

Social Support

The variable of social support was measure by the Multidimensional Scale of Perceived Social Support (MSPSS). The table 4.4 showed that there was no significant relationship between social support and the help-seeking behaviors, which meat that social support did not have any influence on the help-seeking behaviors. However, several weak relationships were showed between social support and the level of distress (BSI), self-efficacy (GSE), insight (SAIQ), and stigma (DDS). Lower social support as associated with higher level of distress ($r = -.330$, $p < .01$), lower level of self-efficacy ($r = .365$, $p < .01$), higher degree of insight ($r = -.199$, $p < .05$), and lower degree of stigma ($r = .275$, $p < .01$).

Moreover, higher level of social support was correlated with lower level of worry about illness ($r = -.201, p < .05$).

Additionally, level of distress and self-efficacy were associated with all three subscales. Lower level of distress was significantly correlated with higher family support ($r = -.271, p < .01$), higher support of friend ($r = -.222, p < .05$), and higher support of significant others ($r = -.271, p < .01$). Higher self-efficacy was associated with higher family support ($r = .190, p < .05$), higher support of friend ($r = .294, p < .01$), and higher support of significant others ($r = .372, p < .01$). Support of friend and significant others were also correlated with level of stigma. Higher level of stigma was associated with higher level of friend support ($r = .258, p < .01$) and higher support of significant others ($r = .336, p < .01$).

Moreover, the MSPSS Scale was highly correlated with its three subscales, which showed that the MSPSS was adequate to be applied in this study. Higher social support was associated with higher family support ($r = .726, p < .01$), friends' support ($r = .748, p < .01$), and support of significant others ($r = .845, p < .01$). Furthermore, the three subscales were correlated with each other. Higher family support was associated with higher support of friend ($r = .194, p < .05$) and significant other ($r = .462, p < .01$). Higher friends' support also correlated with higher support of significant other ($r = .536, p < .01$).

Level of Distress Caused by Schizophrenia

Level of distress caused by schizophrenia was measured by The Brief Symptom Inventory (BSI). It was significantly correlated with non-psychiatric treatments and religious rituals. Higher level of distress was associated with higher tendency of seeking non-

psychiatric treatments ($r=.268, p<.01$) and religious rituals ($r=.210, p<.05$). Additionally, level of distress had weak relationships with self-efficacy and stigma but strong relationships with insight and worry about illness. Higher level of distress was correlated with lower level of self efficacy ($r=-.243, p<.01$), higher level of insight ($r=.626, p<.01$), higher level of sorry about illness ($r=.652, p<.01$), and lower level of stigma ($r=-.256, p<.01$).

Level of Self-efficacy

Level of self-efficacy was measured by The General Self-Efficacy Scale (GSE). The level of self-efficacy was not correlated with the help-seeking behaviors. However, it had a weak relationship with degree of stigmatization. Higher level of self-efficacy was associated with higher level of stigmatization ($r=.318, p<.01$). The relationships between self-efficacy and other variables were discussed in the previous sections.

Degree of Insight

The variable of insight was measured by The Self-Appraisal of Illness Questionnaire (SAIQ). Table 4.4 showed that there was a relationship between the degree of insight and the informal services. Higher degree of insight had higher tendency of seeking informal services ($r=.263, pM<.01$). Additionally, higher degree of insight was associated with higher tendency of seeking non-psychiatric treatments ($r=.320, p<.01$) and religious rituals ($r=.215, p<.05$). Moreover, degree of insight had impact on level of stigmatization. Higher degree of insight was associated with lower level of stigmatization ($r=-.243, p<.01$). Among the three subscales of the SAIQ, only need for treatment was correlated with the informal services

($r=.256$, $p<.01$). Higher level of need for treatments was associated with higher tendency of seeking non-psychiatric treatments ($r=.296$, $p<.01$) and religious rituals ($r=.198$, $p<.05$). Furthermore, worry about illness was significantly correlated with the level of stigmatization. Higher worry about illness was associated with lower level of stigmatization ($r=-.417$, $p<.01$).

Because the Presence/Outcome of Illness Subscale did not show adequate reliability in the study group, this subscale was not applied to this study. The SAIQ scale was correlated with the subscales of need for treatment and worry about illness. The participants who perceived more insight also perceived higher need for treatment ($r=.447$, $p<.01$) and higher worry about their illness ($r=.820$, $p<.01$).

Level of Stigmatization

The level of stigmatization was measured by The Devaluation-Discrimination Scale (DDS). It did not have any influence on the help-seeking behaviors. However, it was correlated with social support, the level of distress, the self-efficacy, and the degree of insight. All these correlations were presented in the previous discussions.

The Help-seeking Behaviors

The help-seeking behaviors were measured by The Help-seeking Behaviors Scale. It was divided into two parts: formal services and informal services. The relationships between the help-seeking behaviors and other independent variables were presented in previous discussions. The relationships between the complete scale and the subscales as well as

between the subscales were strong and all positive, which showed that the Help-seeking Behaviors Scale was adequate in this study. The informal services scale was highly correlated with three subscales. The participants with higher tendency to utilize the informal services were also with higher tendency to use folk healing ($r=.828, p<.01$), non-psychiatric service ($r=.662, p<.01$), and religious rituals ($r=.897, p<.01$). Additionally, the participants who strongly tended to utilize the folk healing was also with higher tendency to utilize the non-psychiatric services ($r=.474, p<.01$) and religious rituals ($r=.600, p<.01$). Moreover, the participants with higher tendency to use religious rituals tended to use non-psychiatric services ($r=.360, p<.01$). The formal service did not show any relationship with other independent variables.

Table 4.4

Correlation Matrix of Depend and Independent Variable Scale Measures

	Folk	N-psy	Formal	Family	Friend	S.O	BSI t.	GSE	SAIQ	Need	Worry	DDS
Informal Services												
Folk	.828**											
Non-psychiatric	.662**	.474**										
Religious ritual	.897**	.600**	.360**									
Formal services												
MSPSS												
Family				.726**								
Friends				.748**	.194*							
S. Others				.845**	.462**	.536**						
BSI t-score				-.330**	-.271**	-.222*	-.271**					
GSE			.268**	.365**	.190*	.294**	.372**	-.243**				
SAIQ	.263**		.320**	-.199*	-.191*			.626**				
Need	.256**		.296**						.447**			
Worry				-.201*				.652**	.820**			
DDS				.275**		.258**	.336**	-.256**	.318**	-.243**		-.417**

Note. MSPSS = The Multidimensional Scale of Perceived Social Support; FAM = Family Subscale; FRI = Friends Subscale; SO = Significant Subscale; GSE = The General Self-Efficacy Scale; BSI = The Brief Symptom Inventory; DDS = The Devaluation-Discrimination Scale; SAIQ = The Self-Appraisal of Illness Questionnaire; Worry = Worry Subscale; Need = Need for Treatment Subscale; Illness = Presence/Outcome of Illness Subscale; HSBS-IFO = The Help-seeking Behaviors Scale- Informal Services; HSBS-FO = The Help-seeking Behaviors Scale- formal Services; Folk = Folk Subscale; Non-Psychiatric = Non-Psychiatric Treatment Subscale; Religious Rituals = Religious Ritual Approach Subscale.

* $P < .05$ ** $p < .01$

Multivariate Analyses

The Multiple Regression Analysis was used to examine the hypothesized effects of three independent variables as well as the cultural moderator on the help-seeking behaviors. The Enter model was applied to this study to examine the assumption that all predictors had effects on the dependent variables. Moreover, the Stepwise model was applied to not only include a set of predictors but also add or remove predictors that did not show significant effects on the dependent variables.

Predisposing Characteristics on the Help-seeking Behaviors

The findings showed that there was no effect of predisposing characteristics (gender, age, geographic residence, marital status, ethnicity, and religion) on the formal service utilization. However, the results demonstrated that the predisposing characteristics had an effect on the informal service utilization. Table 4.5 showed that three variables of predisposing characteristics could predict the utilization of informal services. Gender, Buddhism, Taoism, and unmarried explained 14 % of the variance in the informal service use ($F = 6.08, p < .05$). Gender had the positive impact on the informal service use ($Beta = .213$). Religion had also the positive impact on the informal service use – Buddhism ($Beta = .232$) and Taoism ($Beta = .280$). Additionally, unmarried was a predictor of positive impact on the informal service use ($Beta = .170$). The results indicated that female, Buddhism or Taoism believers, and unmarried participants intended to use informal services more frequently.

Table 4.5 Regression of predisposing characteristics and the informal services

	B	Beta	t	Sig.
Gender	.233	.213	2.461	.015
Religion-Buddhism	.250	.232	2.713	.008
Religion-Taoism	.474	.280	3.266	.001
Unmarried	.209	.170	1.987	.049
Constant	.405		3.604	.000

$F = 6.084, p < .05$

$R \text{ Square} = .17; \text{Adjusted } R \text{ Square} = .14.$

Enabling resources on the Help-seeking Behaviors

Table 4.6 showed that three variables of enabling resources could predict the utilization of formal services. Inpatient service and support of parents had positive effects on the formal services use (Beta = .404 and .225, respectively). However, support of siblings had a negative effect on the formal services use (Beta = -.172). The three predictors explained 17% of the variance in the utilization of formal services ($F = 9.664, p < .05$). The results demonstrated that the experience of using inpatient service and support of parents led to use of the formal service more frequently. On the other hand, support of siblings caused less use of formal services.

Table 4.6 Regression of enabling resources and the formal services

	B	Beta	t	Sig.
Inpatient service	.579	.404	4.864	.000
Community –parents	.350	.225	2.659	.009
Community-siblings	-.220	-.172	-2.050	.043
Constant	1.106		7.155	.000

$F = 9.664, p < .05$

R Square = .20; Adjusted R Square = .17.

Table 4.7 showed that two variables of the enabling resources could predict the informal service use. Community resources-church/temple had a positive impact on the informal service use (Beta = .325) while community resources-Children had a negative impact on the utilization of the informal services (Beta = -.267). Community resources - church/temple and Children – explained 12% of the variance in the utilization of the informal service ($F = 9.230, p < .05$). The findings demonstrated that the experience of going to church/temple as a community resource led to the more frequently of using the informal services. On contrary, having children as a community resource caused the less use of the informal services.

Table 4.7 Regression of enabling resources and the informal services

	B	Beta	t	Sig.
Community-church/temple	.384	.325	3.706	.000
Community-Children	-.498	-.267	-3.046	.003
Constant	.721		10.157	.000

F = 9.230, $p < .05$

R Square = .13; Adjusted R Square = .12.

Need factors on the help-seeking behaviors

Need factors did not show any impact on the utilization of formal services. Table 4.8 presented that only the distress of schizophrenia could be the predictor on the informal service use. The level of distress caused by schizophrenia had a positive impact on the utilization of the informal services (Beta = .229). It explained 5% of the variance in the informal service use ($F = 6.812$, $p < .05$). The findings showed that the higher level of distress caused by schizophrenia, the more frequency of using the informal services.

Table 4.8 Regression of need factor and the informal services

	B	Beta	t	Sig.
BSI-the distress level	.012	.229	2.510	.010
Constant	.324		1.533	.128

F = 6.812, $p < .05$

R Square = .05; Adjusted R Square = .05.

Predisposing Characteristics and Enabling Resources on Need Factors

Table 4.9 presented the findings of the predisposing characteristics with enabling resources on the need factors. When the dependent variable was the level of distress caused by schizophrenia, the predictors were age, geographic residence – East, and religion – Taoism. Age had a negative impact on the level of distress (Beta = $-.247$) while geographic residence – East and religion – Taoism had positive impacts on the level of distress (Beta = $.252$ and $.189$, respectively). The three predictors explained 11 % of the variance in the level of distress ($F = 5.917$, $p < .05$). The results showed that younger participants, living in the East area of Taiwan, and Taoism believer led to higher level of distress.

When the dependent variable was the level of self-efficacy, the predictors were social support, home-care service use, the use of clinic providing medications, and religion – Catholicism. All four predictors had positive impacts on the level of self-efficacy (Beta = $.385$, $.308$, $.251$, $.169$, respectively). The four predictors explained 30 % of the variance in the level of self-efficacy ($F = 14.211$). Then findings showed that higher level of social support, more use of home-care service, more use of clinic providing medications, and Catholic believer caused higher level of self-efficacy.

Table 4.9 Regression of predisposing Characteristics and enabling resources on the need factors

	B	Beta	t	Sig.
Dependent Variable: The Level of Distress				
Age	-.290	-.247	-2.807	.006
Residence – East	11.722	.252	2.855	.005
Religion-Taoism	6.233	.189	2.196	.030
Constant	52.109		13.308	.000
F = 5.917, p < .05 R Square = .13; Adjusted R Square = .11.				
Dependent Variable: The Level of Self-Efficacy				
Social Support	.312	.385	5.084	.000
Homecare service use	.698	.308	4.042	.000
Clinic providing medications	.397	.251	3.306	.001
Religion-Catholicism	.729	.169	2.231	.028
Constant	.737		2.428	.017
F = 14.211, p < .05 R Square = .32; Adjusted R Square = .30.				

Predisposing Characteristics with Enabling Resources through need factors on the Help-seeking Behaviors

Table 4.10 showed the impacts of predisposing characteristics combining with enabling resources through need factor on the help-seeking behaviors. The utilization of inpatient service, support of parents, and the level of distress were predictors on the formal services. Inpatient service use, support of parents, and the level of distress had positive impacts on the utilization of formal services (Beta = .413, .229, and .166, respectively). The Adjusted R Square was .20, meaning that 20% of the variance in the combination of inpatient service use, support of parents, and the level of distress ($F = 8.469$, $p < .05$). The results demonstrated that the more frequently use of inpatient service, the higher support of parents, and the higher level distress caused by schizophrenia led to the more utilization of formal service.

The predictors of predisposing characteristics combining with enabling resources through need factors on the informal services included Buddhism believers, support of churches/temples, and support of children. Buddhism believer and support of churches/temples had positive impacts on the informal services use (Beta = .242 and .265, respectively) while support of children had a negative impact on the utilization of informal services (Beta = -.243). The Adjusted R Square was .17, meaning that 17 % of the variance in the combination of the three predictors - Buddhism believer, support of churches/temples, and support of children ($F = 7.284$, $p < .05$). The findings showed that being a Buddhism believer and considering churches/temples as community support caused the more utilization

of informal services. Additionally, considering children as community support led to the less utilization of informal services.

Table 4.10 The Predisposing Characteristics/Enabling Resources through Need Factors on the Help-seeking Behaviors

	B	Beta	t	Sig.
Dependent Variable: Formal Service				
Inpatient	.592	.413	5.027	.000
Community-parents	.357	.229	2.747	.007
BSI- the level of distress	.010	.166	2.032	.044
Constant	.643		2.347	.021

F = 8.469, $p < .05$

R Square = .22; Adjusted R Square = .20.

Dependent Variable: Informal Services

Religion-Buddhism	.287	.242	2.856	.005
Community-Church/Temple	.314	.265	3.031	.003
Community-Children	-.454	-.243	-2.816	.006
Constant	.574		6.820	.000

F = 7.284, $p < .05$

R Square = .20; Adjusted R Square = .17.

Cultural Factor as Moderators

The cultural factor was hypothesized as moderator in this study. It did not have impact on the help-seeking behaviors or other variables, but it would strengthen or weaken the impacts between independent and dependent variables. The cultural factor did not show any influence on the regression of predisposing characteristics on the informal service use, the regression of enabling resources on the formal service use, and the regression of need factor on the informal service.

Enabling resources on informal services with cultural factor

The cultural factor slightly influenced the regression of enabling resources on the utilization of informal services. Moreover, as a predictor, the degree of insight had a positive impact on the utilization of informal services (Beta = .196). In addition, the support of churches/temples had a positive impact on the informal service use (Beta = .299) while the support of children had a negative impact on the informal service use (Beta = -.249). The Adjusted R Square was .14, meaning that 14 % of the variance in the combination of the three predictors – support of churches/temples, support of children, and the degree of insight ($F = 7.284, p < .05$). The findings demonstrated that higher support of churches/temples, less support of children, and higher degree of insight caused the more utilization of the informal services (see Table 4.11).

Table 4.11 Enabling Resources on Informal Services with Cultural Factor

	B	Beta	t	Sig.
Community – churches/temples	.354	.299	3.447	.001
Community-children	-.466	-.249	-2.886	.005
SAIQ – the degree of insight	.019	.196	2.337	.021
Constant	.221		.981	.328

$F = 8.201, p < .05$

$R \text{ Square} = .17; \text{Adjusted } R \text{ Square} = .14.$

Predisposing Characteristics and Enabling Resources on the need factor with the influence of cultural factor

Table 4.12 showed that cultural factor influenced the regression of predisposing characteristics and enabling resources on the need factor. Geographic residence – East remained as a predictor on the level of distress and the degree of insight became a factor to predict the level of distress. Other predictors, such as age and religion – Taoism were eliminated. Both geographic residence – East and the degree of insight had positive impacts on the level of distress (Beta = .188 and .573, respectively). Since the change of predictors, the total variance was increased. The two predictors explained 41 % of variance in the level of distress ($F = 22.533, p < .05$). The results showed the participants living in the east side of Taiwan and higher degree of insight caused higher level of distress.

Additionally, the cultural factor changed the regression of predisposing characteristics and enabling resources on the level of self-efficacy. The original predictors, including social

support, use of home-care service, use of clinic providing medications, and religion – Catholicism were kept, and the level of stigmatization was the new predictor. All predictors, including social support, use of home-care service, use of clinic providing medications, religion - Catholicism, and the level of stigmatization, had positive impact on the level of self-efficacy (Beta = .273, .269, .260, .164, and .175, respectively). The four predictors explained 33 % of the variance in the level of self-efficacy ($F = 12.954$). The results showed that higher social support, more use of home-care service, more use of clinic providing medications, Catholic believer, and higher level of stigmatization led to higher level of self-efficacy (see Table 4.12).

Table 4.12 Regression of predisposing Characteristics and enabling resources on the need factors

	B	Beta	t	Sig.
Dependent Variable: The Level of Distress				
Residence – East	8.738	.188	2.609	.010
SAIQ	1.009	.573	7.944	.000
Constant	20.512		4.031	.000
F = 22.533, p < .05 R Square = .43; Adjusted R Square = .41.				
Dependent Variable: The Level of Self-Efficacy				
Social Support	.273	.336	4.346	.000
Homecare service use	.611	.269	3.525	.001
Clinic providing medications	.410	.260	3.506	.001
Religion-Catholicism	.708	.164	2.209	.029
The level of stigmatization	.316	.175	2.230	.028
Constant	.170		.437	.663
F = 12.954, p < .05 R Square = .35; Adjusted R Square = .33.				

The influences of cultural factor on the help-seeking behaviors

Table 4.13 showed the cultural factor influenced the regression of the predisposing characteristics and enabling resources through need factors on the help-seeking behaviors. Although neither the degree of insight nor the level of stigmatization became the predictors, the Adjusted R Square was reduced. According to table 4.13, 18 % of the variance was explained by the combination of the inpatient service use, support of parents, and the level of distress ($F = 10.037$, $p < .05$). All three predictors (use of inpatient service, support of parents, and the level of distress) had positive impacts on the formal services use (Beta = .573, .310, and .011, respectively). The findings demonstrated that more inpatient service use, more support of parents, higher level of distress caused the more utilization of formal services.

Additionally, the cultural factor slightly changed the regression of the predisposing characteristics and enabling resources through the need factor on the informal service use. Buddhism believer, support of churches/temples, support of children, and the degree of insight were predictors on the utilization of informal services. Buddhism believer, support of churches/temples, and the degree of insight had positive impacts on the informal services use (Beta = .226, .325, and .210, respectively) while support of children had a negative impact on the utilization of informal services (Beta = -.250). The Adjusted R Square was .19, meaning that 19 % of the variance in the combination of the four predictors - Buddhism believer, support of churches/temples, support of children, and the degree of insight ($F = 8.381$, $p < .05$). The findings showed that being a Buddhism believer, considering churches/temples as community support, higher degree of insight caused the more utilization of informal services.

Additionally, considering children as community support led to the less utilization of informal services.

Table 4.13 The Predisposing Characteristics/Enabling Resources through Need Factors on the Help-seeking Behaviors

	B	Beta	t	Sig.
Dependent Variable: Formal Service				
Inpatient	.573	.399	4.840	.000
Community-parents	.310	.199	2.413	.017
BSI- the level of distress	.011	.186	2.266	.025
Constant	.535		1.982	.050
F = 10.037, $p < .05$ R Square = .20; Adjusted R Square = .18.				
Dependent Variable: Informal Services				
Religion-Buddhism	.267	.226	2.752	.007
Community-Church/Temple	.384	.325	3.706	.000
Community-Children	-.467	-.250	-2.973	.004
SAIQ – the level of insight	.021	.210	2.566	.012
Constant	.721		10.157	.000
F = 8.381, $p < .05$ R Square = .22; Adjusted R Square = .19.				

Summary

This chapter was divided into three sections. The first section presented the descriptive findings of all demographic variables, such as gender, age, or education. The demographic variables were included in the predisposing characteristics and enabling resources. The findings of predisposing characteristics showed that the majority of the participants were males, between 30 and 39 years of age, living in the North Taiwan, Fu-Ken ethnicity, single never married, mother as major caregiver, and Buddhism believers. Additionally, the results of the enabling resources showed that most of the participants hold a 12-year professional school degree, worked for elementary jobs, met with psychiatrists on monthly basis, earned monthly income \$619.2 dollar, mostly used outpatient service, recognized their parents as the major community support.

Regarding the findings of measurements, the results indicated that the participants less than "rarely" utilized the informal services, and more frequently utilized the religious rituals for treating their illness. Additionally, the participants "mildly agreed" that they had social support from their families, friends, and significant others. The level of distress caused by schizophrenia among the participants was less than "A little Bit." The level of self-efficacy among the participants was between "hardly true" and "moderately true." Moreover, the analysis of two variables in the cultural factor category showed that the participants' perception of stigmatization was between "somewhat disagree" and "somewhat agree"; the participants' overall insight was between slightly and moderately.

The second section demonstrated the results of bivariate analysis. The results included the correlations which were examined by Pearson's Correlation between the major

variables. The findings showed that the variable of the help-seeking behaviors was associated with the degree of insight and the level of distress caused by schizophrenia.

The third section was the multivariate analysis. The findings demonstrated that certain variables could work as predictors to explain the correlations towards the help-seeking behaviors and their interrelationships. Gender, unmarried, Buddhism, and Taoism were the predictors of the predisposing characteristics to predict the utilization of the informal mental health services. Additionally, accessibility of psychiatric treatments (e.g. inpatient service and clinic providing medications) and support of the family members (parents, siblings, and children) as community resources in the enabling resources category determined the influences towards the help-seeking behaviors. The level of distress caused by schizophrenia in the need factor stimulated the use of the informal services. Moreover, the cultural factor (the degree of insight and the level of stigmatization) was found to be a predictive variable as well.

CHAPTER FIVE

SUMMARY AND IMPLICATIONS

Help-seeking behaviors have been discussed in many fields, such as biomedicine, psychology, sociology, anthropology, and social work. Through the literature review, schizophrenia is not only defined as a biological but a social cause. As one of the most misunderstood and stigmatized disease, the help-seeking behaviors in people with schizophrenia are limited and undertreated. This study provides an opportunity to examine the predictors on the help-seeking behaviors of those suffered from schizophrenia through Andersen's Health Model of Utilization in Taiwan. Therefore, the study proves will be reviewed from the statement of the research problem, the purpose of the study, the theoretical framework and the literature review, the study methodology as well as the findings will present in this final chapter.

The Purpose of the Study

As this study mentioned in its first chapter, the purpose of the study tried to explore the social and cultural predictors of help-seeking behaviors in people with schizophrenia through the Model of Health Utilization in Taiwan. Additionally, since this study was under the framework of social and cultural issues, it is expected to increase the cultural awareness and competence in social workers who have been working with people with schizophrenia. It is, not only to gain the knowledge of diverse cultures, but also to equip with the sensitivity to understand the individual's unique social and cultural background in order to help their clients to solve their difficulties. Moreover, this study

tries to bring some discussions for the mental health professionals, family members of people who suffered from mental disorders, and policy makers in order to establish a well-developed mental health care system Taiwan.

Overview of the Theoretical Framework

The Behavioral Model of Health Service Use (BMHSU) was the major point of view to discuss the help-seeking behaviors among people with schizophrenia in this study. According to Andersen (1968), who constructed the BMHSSU, stated that the help-seeking behaviors could not only be viewed through the biomedical perspective, but also was examined through social, psychological, and economic viewpoints. Thus, this section presented the fundamental concepts which developed the BMHSU. Additionally, relevant theories, such as the concept of stigma was also reviewed in this section.

The Behavioral Model of Health Service Use (BMHSU)

The Behavioral Model of Health Service Use (BMHSU) was constructed by Andersen and colleagues (Andersen, 1968; Andersen & Aday, 1974; Andersen & Newman, 1973, as cited in Fang, 2005; Andersen, 1995). Andersen (1968) stated that social and cultural issues were leading factors on the utilization of health care. Therefore, he analyzed several relevant studies that discussed economic/social-psychological models around the utilization of medical care to develop the BMHSU. Furthermore, Andersen (1968) summarized the results of his analyses to conduct the "families' use of health services" model-the original version of the BMHSU.

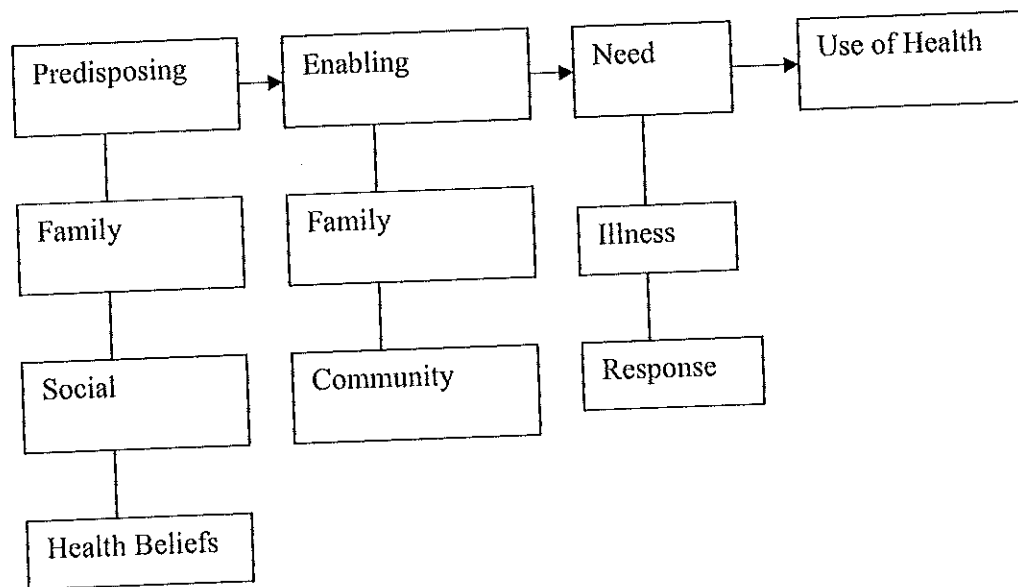
According to Anders' view (1968), the economic model, including variables such as family income, health insurance, and the price of health services, addressed the level of people's need to "attain services or translate their perceived need into economic demand" to use health services. The socio-psychological model, on the otherhand, was used to explain "differential perceptions of the need for health services." Additionally, Andersen (1968) discussed several factors to understand the different patterns of utilizing health services, including the definitions of illnesses based on biological and social perspectives, the socio-demographic issues (education and social class), the perception of illness (values and attitudes).

According to these economic/social-psychological perspectives, Andersen (1968) developed the three-stage model which included predisposing, enabling, and need components. Andersen (1968) demonstrated the utilization of health services was determined by: 1) the predisposition of the family, 2) the families' abilities to attain services, and 3) the families' need for those services. The original Behavioral Model of Health Service Use was as showed in Figure 1.

Andersen (1968) defined the three major components of this model. The predisposing characteristics were referred as some family characteristics, which existed before the attack of the illnesses, could predict the family's tendency to use health services, including family composition (age, gender, and family size), social structure (employment, social class, occupation, race, and ethnicity), and health beliefs (beliefs about health services, physicians, and diseases) (Andersen, 1968). The predisposing characteristics were not directly influenced the utilization of health services but potentially influenced the path of

using health services. In addition, social structure were not only associated with enabling resources (income and health insurance) and but also assumed to influence enabling resources.

Figure 1. The Behavioral Model of Health Service Use (Andersen, 1968)



Enabling resources was defined as a condition that accelerated a family to satisfy its need to utilize the health services and this condition included “the family means to attain services and geographic accessibility to services” (Andersen, 1968). The family resources included economic and medical resources, such as family income, family savings, health insurance, regular source of care, and welfare care. The community resources was referred to the accessibility of medical or folk healing approaches, such as the number (or ratio) of the health professionals or the number (or ratio) of psychiatric facilities in the region.

Need represented “the most immediate cause of health service use”, measuring by “the amount of illness perceived by the family” and by the way “the family responds to the perceptions” (Andersen, 1968). Amount of illness perceived by the family was defined as the diagnosis of physicians or the self-report of physical conditions. Response was defined as the family’s reactions to illness when the family perceived the illness. Generally speaking, the perceived need, or illness level, was defined as the biological demand or self-perception about the severity of illness, and the evaluated need was defined as the professional judgment about patients’ health status (Andersen, 1995).

The utilization of health services was categorized in two types of family behaviors: discretionary and non-discretionary (Andersen, 1968). Discretionary behaviors were referred to a family’s decisions to use health services, and non-discretionary behaviors were referred to the health professionals’ decisions to use health services. According to Andersen (1968), the family discretion was assumed to be lowest on hospitalization, intermediate on physician services, and highest on dental care.

The BMHSU was frequently used to test healthcare utilization. Additionally, it was used to evaluate whether and to what degree socio-demographic characteristics, health-related beliefs, and illness severity influence help-seeking behavior and service use (Goodwin, Koenen, Hellman, Guardino & Sturening, 2002). However, the BMHSU should be employed with caution because it did not specify how the three major components would work together to create an outcome (Chisolm, 2003, as cited in Fang, 2005).

Goffman's Theory of Stigma

Among the predictors of the help-seeking behaviors in the previous studies, stigma could be seen as a major variable based on Goffman's theoretical framework. Goffman (1963, p.3) developed the concept of stigma, which he defined as "an attitude that is deeply discrediting". He further described three types of stigma: physical deformity or disability, such as amputation or paralysis; blemished character, as in the case of mental illness; and membership in a particular race, nation, or religion (Goffman, 1963, p.4). Ferree and Smith (1979) further indicated that social stigma involves membership in a devalued group and may correspond to what is generally understood as "minority status" in our society; individual stigma refers to possession of a single discrediting attribute.

Goffman (1963) also made the distinctions between visible and invisible stigma. When one's stigma was apparent and obvious, there was no way to avoid the problematic responses of others; on the other hand, when it was not apparent, one could avoid such a response by deciding to keep one's identity secret, thereby passing for normal (Goffman, 1963, as cited in Bergart, 2003). According to Goffman (1963, p.42), people with an invisible stigma were continually engaged in "information control". For example, people with stigmatized mental or physical illness were often able to hide their identity, in order to avoid the situation of being disapproved and marginalized by the public (Bergart, 2003). Thus, stigma was a socially constructed label; even if stigmatized attributes, behaviors, or groups were vary across time and cultures (Major & O'Brien, 2005).

The Definition of Schizophrenia

Many studies explored the topic of schizophrenia from different perspectives, such as biological, psychological, social, and cultural. Although the cause of schizophrenia still remains unknown, the biological/genetic theories have been widely recognized (Torrey, 2006, p.138). However, many theorists believed that the beliefs of mental disorders were constructed by the society. According to Eshun and Gurung (2009), "symptoms of mental illnesses are manifested within the background of certain cultural concepts and constructs." As one of mental disorders, therefore, the term of schizophrenia was defined in the biological and social/cultural views.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 2000), schizophrenia was defined as "a disorder that lasts for at six months and includes at least one month of active-phase in at least two following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms." Moreover, schizophrenia included several subtypes, such as paranoid, disorganized, catatonic, undifferentiated, and residual (DSM-IV, 2000, p.298).

However, while the psychiatrists treat people with schizophrenia through the universal rule of providing medications based on the biological/genetic model, the major factor that allows people with schizophrenia living in communities is the social support system. Moreover, the explanation of schizophrenia from social and cultural perspective have been proved incorrectly (Torrey, 2006, p.152-p.154) In order to answer these questions, the influences of culture on mental health treatment have to be explored. However, the contemporary mental health professionals tend to recognize the cause of schizophrenia is the

biological factors. The DSM-IV, one of the wide accepted diagnostic manual, has been criticized because of its conventional categories (Kirmayer & Minas, 2000).

The Literature Review of the Major Variables

Predisposing Characteristics

There were several differences in gender among people with schizophrenia. According to Torrey (2006), males with schizophrenia had a higher relapse rate, worse respond to antipsychotic medicine, poorer social adjustment, and lower functions than females with schizophrenia (p.104). DSM- IV (2000) also indicated that females with schizophrenia had a better prognosis than males with schizophrenia (p.308). In Taiwan, several studies also showed that male with schizophrenia were more likely to be hospitalized through emergency service than female counterpart (Chan, Lin, Shen & Yang, 2007). Additionally, Chien et al (2004) also indicated that men whose age were between 25-44 and women whose age were between 35-54 had higher prevalence rate of schizophrenia in Taiwan. However, women had higher frequency of schizophrenia occurring in later life than men (DSM-IV, 2000, p.307). Although the reasons of these difference in gender were unknown, Torrey (2006) assumed these findings were resulted in men were the weaker sex (p.105). This could be explained that men faced larger social and financial responsibilities than women.

In addition to the different onset age in gender, the general onset of schizophrenia was between the late teens and the mid-30s (DSM-IV, 2000, p. 307). Moreover, Loranger (1984, as cited in Arrmenteros & Davis, 2006) stated that the modal age for schizophrenia onset was

between 21 and 22 years old; however, the majority of people with schizophrenia onset in their late adolescence. In the United States, three-quarter of those suffered from schizophrenia were onset between age seventeen and twenty-five (Torrey, 2006, p.96). According to Chien et al (2004), the highest prevalence of schizophrenia was in the age of twenty five to forty four, and the lowest was in the elderly group (65 and over) in Taiwan. This result was consistent with other studies that people with schizophrenia was onset in early adulthood. Moreover, Lin et al (2008) showed that people who had early age at onset of schizophrenia were more likely to be re-hospitalized in a short period of time in Taiwan.

Chien et al (2004) indicated that a higher prevalence of schizophrenia in suburban areas because of the high population density and greater stress for people who lie in such areas. There was no significant difference between regions in the prevalence and incidence of schizophrenia in Taiwan except the eastern region (Chien et al, 2004). Although the eastern region had the one of the largest long-term psychiatric facility, the accessibility of these facilities was limited by the difficult transportation.

According to Lin, Chen, Wang, Lin, Chen, and Lin (2008), people with schizophrenia usually tended to be unmarried, and these unmarried usually have poor clinical outcome and high rate of rehospitalization. However, Chan, Lin, Shen and Yang (2007) indicated that marital status was not significantly related to hospitalization in people with schizophrenia although their study showed 53.8% of their study participants were unmarried.

According to Boydell et al (2001), the smaller proportion of the minority ethnic groups in a local area the higher incidence of schizophrenia in those groups. This could be explained that small minority ethnic groups were more likely to be marginalized by the

society and more vulnerable because of less social network and support (Boydell, 2001). However, Chien et al (2004) in the study which used the sample from the National Health Insurance (NHI) enrollers showed that no significant difference between the Taiwanese aborigine population and the non-aborigines. It was also explained that a large portion of the aborigine population was not insured in the NHI program and therefore the findings could be influenced by this reason (Chien et al, 2004).

Wynaden et al (2005) indicated that religion was a determinant factor influencing an individual's health beliefs, particularly Buddhism and Taoism. Moreover, Taoism was an important religion to provide the directions for people with mental disorders to receive folk healings, such as visiting/worshipping temples, and doing rituals in temples. Wynaden et al (2005) also mentioned that the mental health professionals needed to contact the community religious/spiritual leaders and distributed the written materials of related mental health information in temples or churches to provide accessibility for community members who suffered from mental disorders.

Enabling Resources

Enabling resources were defined as individual's and community's resources for people with schizophrenia in this study. Individuals' resources included social and economic status, such as educational level, household income, and employment. Moreover, community resources included types of mental health facilities, accessibility to these facilities, participants' awareness of these facilities, and transportation to reach these facilities. Chien et al (2004) stated that people with higher prevalence of schizophrenia were in lower social

economic status. Moreover, lower social economic status was a risk factor for people with schizophrenia because of a higher incidence (Chien et al, 2004). Moreover, lower social and economic status caused higher psychosocial stress (Chien et al, 2004). Therefore, this study listed the variables associated with social and economic factors to examine its relationship with help-seeking behaviors in people with schizophrenia.

Among people with schizophrenia experiencing hospitalization, the average education level was nine to twelve years. In Taiwan, the onset age for people with schizophrenia was 19.5 years old, and the age of the first hospitalization was 22.6 (Hwu, 1999, p.12-13). It was difficult for people with schizophrenia to continue their education after they were diagnosed (Chan, Lin, Shen & Yang, 2007). Unemployed people with schizophrenia were more likely to be hospitalized (87.7%) (Chan, Lin, Shen & Yang, 2007). According to Chen, Yang, Liao, Lee, Yeh, and Chen (2004), the mental health professionals should consider people with schizophrenia and their family members as a whole in order to improve their psychological well-beings. They also indicated that caregivers of people with schizophrenia were at high risk of developing mental health problems.

Son, Lin, and George (2008) mentioned that social support was a factor of affecting mental health. However, according to Huang, Hung, Sun, Lin and Chen (2009), the major caregivers of people with schizophrenia experienced a high level of burden which was caused by disease incurability, violent behaviors, disturbance of daily routine, and financial difficulty.

Need Factors

According to Chen, Yang, Liao, Lee, Yeh, and Chen (2004), the severity of the symptoms in people with schizophrenia was a predictor to the caregivers' distress. They also indicated that people with schizophrenia had poor life quality when they suffered from the distress of the symptoms and perceived stigmatization.

Cultural Factors

Culture has been broadly defined as "the shared values, traditions, arts, history, folklore, and institutions of a group of people that are unified by race, ethnicity, nationality, language, religious beliefs, spirituality, socioeconomic status, social class, sexual orientation, politics, gender, age, disability, or any other cohesive group variable" (Singh, 1995, as cited in Singh, McKay, & Singh, 1998). Singh, McKay & Singh (1998) stated that all behavior occurs in a cultural context. Kleinman (1980, p.24) indicated that a health care system should be seen as "a cultural system, a system of symbolic meaning anchored in particular arrangements of social institutions and patterns of interpersonal interactions". Moreover, Wen (1997) also noted that the role of culture in an illness experience is totally outside the usual biomedical model inquiry, which is mainly concerned with the disease process.

Insight should be conceptualized as "a component of post-diagnosis identities that were defined in relation to other social identities, and under conditions of stigma against mental illness" (Williams, 2008). A growing amount of studies have paid attention to how cultural beliefs impact mental health utilization behavior among different ethnic groups internationally (Yamashiro & Matsuoka, 1997; Cauce, Domenech-Rodriguez, Paradise,

Cochran, Shea, Srebnik & Baydar, 2002; Auslander, Soffer & Auslander, 2003; Kung, 2003; Kung, 2004; Chiu, 2004; Nguyen & Anderson, 2005; Ayalon & Young, 2005, Fang, 2005). Several studies further discussed the association between cultural belief and the utilization of mental health services among different groups in Taiwan (Horng, 1994; Chang, 1999; Liou, 2004). However, there is no theoretical and empirical literature exploring this phenomenon for Taiwanese with chronic mental illness such as schizophrenia. Although some studies showed that people with schizophrenia believed in supernatural cause responsible of mental illness had poor drug compliance, but Lan, Shiau, and Lin's study (2003) had different result. Their study showed that the illness belief and belief in therapy did not influence the drug compliance of people with schizophrenia.

Stigma is shaped by social and cultural beliefs based on Goffman's stigma theory and related studies. It is also demonstrated through social information and personal identity (Goffman, 1963, p.43 & p. 51). Thus, stigma is defined as an individual perception of others' stigma toward him/her and stigma of an individual toward his/her mental illness in this study.

In Taiwan, the general public recognized people with schizophrenia as "walking bomb" and hold negative attitudes toward this population because of their violent and dangerous behaviors (Lin, Hsiung, Lin & Hwu, 2002). People with schizophrenia in Taiwan perceived the stigmatization from the general public in several categories, such as "having an unacceptable disease", "ability being doubted by others", "self-inflicted rejection", "multiple losses" and "anticipatory life strain" (Lin, Hsiung, Lin & Hwu, 2002). Huang, Hung, Sun, Lin and Chen (2009) indicated that the stigma of shame (losing face) was commonly associated with people with mental disorders and their families. In addition, Wynaden et al

(2005) indicated that shame and stigma “prevented people from seeking help from mainstream mental health services.” Jamison (2006) mentioned that stigma insinuated itself into policy decision, access to care, health insurance, employment discrimination, and in research allocations and priority.

The Help-seeking Behaviors

In addition to the Western societies, where the individual makes the decision to seek mental health treatment, in Taiwan it is the family members who usually are decision makers in situation involving mental illness, especially in cases of psychoses and major mental disorders (Wen, 1997). Lin, Tseng and Yeh (1995, p.165) also mention that the way the Chinese deal with emotional distress is to communicate with their families or close friends rather than to seek professional help. In Chinese culture, families usually hide insane members at home and resist outsiders’ help; it is the family that is expected to take the responsibility for help-seeking and care of a family member with mental illness (Wen, 1997).

Help-seeking behavior is defined as actions by individuals looking for and requesting assistance for their problems (Unrau & Grinnell, 2005). It refers to “a request for assistance from informal supports (e.g. families and friends) or formalized services (e.g. professionals and clergy) for the purpose of resolving emotional, behavioral, or health problems” (Srebnik, Cauce & Baydar, 1996, as cited in Unrau & Grinnell, 2005). Fisher and Turner (1970, p.79, as cited in Liou, 2004) also refer to help-seeking attitude as “one’s tendency to seek or resist professional aid during a personal crisis or following prolonged psychological discomfort”. According to Tranulis, Park, Delano, and Good (2009), the mental health professionals has

been focus on early detection and intervention for people with schizophrenia in the past decade.

The Research Methodology

The research methodology chapter presented the research questions, hypotheses, and research design. Additionally, the definition of variables, the data collection process, and the data analysis plan were discussed in this chapter. Moreover, the human subjects regarding the research ethics in mental health field was addressed.

Research Questions and Hypotheses

The research questions contained two major points: 1) how were the help-seeking behaviors of people with schizophrenia determined by predisposing characteristics, enabling resources, and need factors? And 2) how did cultural factor influence the relationships between predisposing characteristics, enabling resources, need factor, and the help-seeking behaviors? The hypotheses, which were used to answer the research questions, presented as the following statements: 1) the predisposing characteristics, enabling resources, and need factors would have a direct impact on the help-seeking behaviors, and 2) cultural factor would work as moderator on the interrelationships between other variables.

Study Population and Sampling

The study population was defined as the adult members with schizophrenia of the Mentally Ill of Taiwan (TAMI). As the leading mental health rehabilitation organization in

Taiwan, TAMI had been very active in policy making, advocating, education, and the implementation of different types of services, such as rehabilitation centers, half-way houses, job training programs, and club houses. However, due to the financial issues, the club houses were dissolved in 2009.

Based on the urbanization level in Taiwan Districts, nine cities/counties were selected to ensure the inclusion of a quasi-representative sampling of urban, suburban, and rural populations. These cities/counties included the north (Taipei city and county, Hsin-Chu City, and I-Lian County), the Middle (Tai-Chung City and Na-Tou County), the South (Kaohsiung City and County), and the East (Hua-Lian County). A purposive sampling was used to recruit the participants by contacting eleven local associations of TAMI in these selected nine cities/counties. The final sample size obtained 125 participants.

Data Collection and Pilot Study

The data were collected through a face-to-face interview by using a questionnaire with demographic questions and six measurements. The back-translation approach was used to develop the Mandarin Chinese version of the questionnaire. The interview took between forty-five minutes to one hour depending on the participants' comprehension abilities. The interviews were conducted in a private space in order to keep the privacy.

Additionally, a pilot study was conducted to test the interview procedure and research measurements. A small group of the pilot study participants ($n=30$) who were members in a community-based rehabilitation institution operated by the Ching-Hai Psychiatric Hospital in the middle Taiwan. The pilot study not only tested the potential reliability and validity of the

study measurements but also resulted in several changes, mostly were about the language issues. The Fu-Ken dialect and the Mandarin Chinese were applied to the interview process depending on the participants' preference. However, the questionnaire was written in Mandarin Chinese so the content had to be written as simple as possible so the researcher could smoothly interpret the questionnaire into Fu-Ken dialect.

Variables and Measurements

The research was used cross-sectional design to examine the interrelationships between predisposing characteristics, enabling resources, need factor, and the help-seeking behaviors based on Andersen's the Behavioral Model of Health Service Use. In addition, cultural factor was hypothesized as moderator. The predisposing characteristics included such variable as gender, age, ethnicity, religion, marital status, geographic residence, and major caregivers. The variables of the enabling resources included education, employment, household income, transportation, accessibility of community mental health resources. All these variables were measured by the demographic questions. The variable of social support was included in the enabling resources and measured by the Multidimensional Scale of Perceived Social Support (MSPSS).

The need factor included the level of distress caused by schizophrenia and self-efficacy. The level of distress was measured by The Brief Symptom Inventory (BSI) and the self-efficacy was measured by The General Self-Efficacy Scale (GSE). The Cultural factors were placed as the moderator which might strength or weaken the influences between predisposing characteristics, enabling resources, need factors, and all the three towards help-

seeking behaviors. Two variables were included in this category: the stigmatization and insight in people with schizophrenia. The Devaluation-Discrimination Scale (DDS) was used to measure how people with schizophrenia perceived the stigma from other people. Additionally, the Self-Appraisal of Illness Questionnaire (SAIQ) was utilized to measure how those with schizophrenia perceived their own illness.

The variable of help-seeking behavior was measured by the adapted Help-Seeking Behaviors Questionnaire. Due to the change of mental health system in Taiwan during this decade, the types of services has been expanded. This questionnaire was divided into two parts: the formal and the informal of mental health services. The questionnaire of the formal mental health services measured the frequency of the participants using the westernized mental health treatments, such as inpatient service, outpatient service, or community-based psychiatric services. The questionnaire of the informal mental health services measured the non-westernized approaches, such as folk healing, non-psychiatric treatments, and religious rituals.

The assumption that the formal services category could not be divided into subscales could be the participants in Taiwan might not recognize the community-based services, such as half-way house or club house. Not only these services were new in Taiwanese mental health system, but most community-based services still under the management of the institutions. Some of the participants who used the community-based services were moved from the institutional service and might not have the awareness of what services they were using.

All the measurements were tested to show satisfied reliability and validity to be applied to the study, except the presence/outcome of illness subscale of The Self-Appraisal of Illness Questionnaire (SAIQ) was eliminated due to the unsatisfied reliability.

Data Analysis

A data set was developed after the data collection in order to begin data analysis. The Statistical Package for the Social Sciences (SPSS) was used as a statistical analytic tool to implement the data analysis plan. The factor analysis was utilized to restructure the instruments and reduce the instrument questions to avoid the highly correlated questions testing the same variables. The Cronbach's alpha test of internal consistency was used to test each instrument's and its subgroup's reliability. Moreover, descriptive statistics, including frequencies, percentage, central tendency, and standard deviation were utilized to test the variables in this study.

The multivariate hypotheses were analyzed by the Multiple Regression Analysis. According to Kerlinger and Lee (2000), the Multiple Regression Analysis was often used to assess the effects and weight the magnitudes of the effects of multiple variables on one dependent variable (p.755). Moreover, it could be used to analyze a dependent variable through a combination of several predictors (independent variables) (Morgan, Leech, Gloeckner & Barrett, 2007, p. 134).

Human Subjects

This study proposal was approved by The Catholic University of America Institutional Review Board (IRB), the Alliance for the Mentally Ill (TAMI) of Taiwan and the Ching-Hei Psychiatric Hospital. Although the TAMI and the Ching-Hei Psychiatric Hospital did not have any policies nor an ethics review committee; however, The General Secretary of TAMI and the director of the social work department of Ching-Hai Psychiatric Hospital approved the study proposal after they presented the purposal to the Board of Directors of TAMI and the President of Ching-Hai Psychiatric Hospital.

Considering the possibility of cognitive function impairment in people with schizophrenia, this study took a more protective stance towards the rights of this population. All participants were screened by the institutions to assure that they were legally competent to give consent. The researcher explained the invitation letter and the consent form to ensure that the participants thoroughly understood all possible risks involved as well as the interview procedure before each interview began. Additionally, when the participants felt as if they were forced to participate in this study, the potential participants had the right to refuse to participate in the study. When the participants completed the questionnaires, the copies of their consent forms were kept by the researcher unless the participants asked for carefully keeping them individually. It was considered by the researcher to prevent the participants from tossing the consent forms in public environments and disclosed the participants' identities to the outsiders of the institutions. Furthermore, all completed questionnaires will be kept in a safe place to preserve confidentiality.

The Major study Findings

The major findings included the demographic profile of the participants, the correlations and the interrelationships between the major variables. The demographic profile of the participants was analyzed by the descriptive statistical approach. The demographic variables included gender, age, household income, which are categorized as the predisposing characteristics and enabling resources. Additionally, the correlations between the major variables were tested by the Pearson's correlation method in order to determine the major predictors and present the correlations between the instruments. The Multiple Regression was used to test the multivariate hypotheses to understand the strengths of the predictors toward the utilization of mental health services. All data had been analyzed by SPSS for Windows (Version 17.0). A significant level of $p \leq 0.05$ had been used throughout the statistical analyses.

The Demographic profile: Predisposing Characteristics

The variables in predisposing characteristics included gender, age, ethnicity, religion, geographic residence, marital status, spouse nationality, major caregiver, and religious influence. The participants were 59 % of males and 41% of females, between the ages of 21 and 66 years, with a mean age of 36.9 years. The majority of the study participants were between 30-39 years old. Most of the participants lived in the north Taiwan ($n=55$, 44%). The major ethnicity of the study participants was Fu-ken, and most of them were single. Most of the participants considered their mothers as major caregivers. Half of the study

participants were Buddhism, and nearly 78% of the participants considered that they were influenced by their religious beliefs.

The Demographic profile: Enabling Resources

The results of the enabling resources showed that most of the participants hold a 12-year professional school degree, worked for elementary jobs (e.g. dish washers, janitors, or packing workers), and nearly half of them worked under four hours and not on regular daily basis. Most of the participants were living under the monthly income NT\$ 19,999 (USD\$619.2), which was close to the poverty line in Taiwan. Additionally, the analysis showed that the majority of the participants used motorcycle as their transportation to meet with their psychiatrists. Moreover, the majority of the participants traveled without their caregivers' company when they met with their mental health professionals.

Regarding the accessibility of community resources, most of the participants were aware of the in-patient and outpatient services in their communities; however, the counseling center/clinics without providing medications was least aware of in their communities. The most utilized psychiatric service was the outpatient services of the hospitals and in-patient service. The result showed that the participants' tendency of utilizing the psychiatric services due to the awareness of these services in the participants. Moreover, most participants considered their family members as the major community support system. A large portion of the participants selected their parents, siblings, children as their supporter. On the contrary, nearly half of the participants considered the religion (Churches/Temple-the Clergy) was their support system.

The variable of help-seeking behaviors was measured by The Help-seeking Behaviors Scale, and the analysis findings showed that the participants were less than “rarely” utilize the informal services, and more frequently utilizing the religious rituals for treating their illness. Additionally, the results of social support which was measured by The Multidimensional Scale of Perceived Social Support (MSPSS) demonstrated that the participants “mildly agreed” that they received social support from their families, friends, and significant others. The findings of the level of distress caused by schizophrenia, which was measured by The Brief Symptom Inventory (BSI), showed that the participants were less than “a little bit” distress. The General Self-Efficacy Scale, which was used to measure the level of self-efficacy, showed the findings that the level of self-efficacy was between “hardly true” and “moderately true” among the participants. Moreover, the variable of perceived stigmatization was measured by The Devaluation-Discrimination Scale (DDS), and the findings demonstrated that the participants’ perception of stigmatization was between “somewhat disagree” and “somewhat agree.” Additionally, the variable of insight was measured by The Self-Appraisal of Illness Questionnaire (SAIQ), and the results showed that the participants’ overall insight was between slightly and moderately.

The Bivariate Analysis of the Major Variables

The major point of the bivariate analyses focused on examining the correlations between the major independent variables and dependent variables. Pearson’s correlation (r) was used as the major statistical approach. The .05 level or less was used as the acceptable confidence interval of significance. Moreover, the major variables in the bivariate analysis

section included social support, the level of distress caused by schizophrenia, the level of self-efficacy, the degree of insight, the level of stigmatization, and the help-seeking behaviors.

The help-seeking behaviors were measured by The Help-seeking Behaviors Scale. It was divided into two parts: the formal services and the informal services. The results showed that the level of distress was significantly correlated with non-psychiatric treatments and religious rituals. Higher level of distress was associated with higher tendency of seeking non-psychiatric treatments and religious rituals. Additionally, there was a relationship between the degree of insight and the informal services. Higher degree of insight had higher tendency of seeking informal services. Moreover, higher degree of insight was associated with higher tendency of seeking non-psychiatric treatments and religious rituals. Furthermore, higher level of need for treatments was associated with higher tendency of seeking non-psychiatric treatments and religious rituals. There were significant relationships between the informal services and its three subscales as well as among the three subscales. The participants with higher tendency to utilize the informal services were also with higher tendency to use folk healing, non-psychiatric service, and religious rituals. Additionally, the participants who strongly tended to utilize the folk healing were higher tendency to utilize the non-psychiatric services and religious rituals. Moreover, the participants with higher tendency to use religious rituals tended to use non-psychiatric services. However, the formal service did not show any relationship with other independent variables.

The variable of social support was measured by the Multidimensional Scale of

Perceived Social Support (MSPSS). The findings showed that there was no significant relationship between social support and the help-seeking behaviors, which indicated that social support did not have any influence on the help-seeking behaviors. However, social support had significant relationships with the level of distress (BSI), self-efficacy (GSE), insight (SAIQ), and stigma (DDS). Lower social support was associated with higher level of distress, lower level of self-efficacy, higher degree of insight, and lower degree of stigma. Moreover, higher level of social support was correlated with lower level of worry about illness, which was a subscale of SAIQ (measured insight).

Additionally, level of distress and self-efficacy were associated with all three subscales of the MSPSS. Lower level of distress was significantly correlated with higher family support, higher supports of friend, and higher support of significant others. Higher self-efficacy was associated with higher family support, higher support of friend, and higher support of significant others. Support of friend and significant others were also correlated with level of stigma. Higher level of stigmatization was associated with higher levels of friends' supports and higher supports of significant others. Moreover, the MSPSS Scale was highly correlated with its three subscales, and there were also significant relationships between the three subscales. The findings showed that the MSPSS was adequate to be applied in this study to measure the social support of the participants.

Level of distress caused by schizophrenia was measured by The Brief Symptom Inventory (BSI). The findings showed that the level of distress had weak relationships with self-efficacy and stigmatization but had strong relationships with insight and worry about

illness. Higher level of distress was correlated with lower level of self efficacy, and higher level of insight, higher level of sorry about illness, and lower level of stigmatization.

Level of self-efficacy was measured by The General Self-Efficacy Scale (GSE). The results indicated that the level of self-efficacy was not correlated with the help-seeking behaviors. However, it had a weak relationship with degree of stigmatization. Higher level of self-efficacy was associated with higher level of stigmatization. This finding could be explained that the study participants had different interpretation to the GSE's items from the western participants.

The variable of insight was measured by The Self-Appraisal of Illness Questionnaire (SAIQ). The results showed that the degree of insight had an impact on level of stigmatization. Higher degree of insight was associated with lower level of stigmatization. Furthermore, the subscale of worry about illness was significantly correlated with the level of stigmatization. Higher worry about illness was associated with lower level of stigmatization. In addition, the SAIQ scale was correlated with its subscales of need for treatment and worry about illness. The participants who perceived more insight also perceived higher need for treatment and higher worry about their illness. However, the Presence/Outcome of Illness Subscale was not applied to this study because it did not show adequate reliability in the study group.

The level of stigmatization was measured by The Devaluation-Discrimination Scale (DDS). It did not have any influence on the help-seeking behaviors. However, it was correlated with social support, the level of distress, the self-efficacy, and the degree of insight. All these correlations were presented in the previous discussions.

Multivariate Analyses

The Multiple Regression Analysis was used to examine the hypothesized effects of three independent variables as well as the cultural moderator on the help-seeking behaviors. The Enter model was applied to this study to examine the assumption that all predictors had effects on the dependent variables. Moreover, the Stepwise model was applied to not only include a set of predictors but also add or remove predictors that did not show significant effects on the dependent variables.

The findings demonstrated that certain variables could work as predictors to explain the correlations towards the help-seeking behaviors and their interrelationships. Gender, unmarried, Buddhism, and Taoism were the predictors of the predisposing characteristics to predict the utilization of the informal mental health services. Additionally, accessibility of psychiatric treatments (e.g. inpatient service and clinic providing medications) and support of the family members (parents, siblings, and children) as community resources in the enabling resources category determined the influences towards the help-seeking behaviors. The level of distress caused by schizophrenia in the need factor stimulated the use of the informal services. Moreover, the cultural factor (the degree of insight and the level of stigmatization) was moderated the interrelationships between the major variables.

The findings showed that there was no effect of predisposing characteristics (gender, age, geographic residence, marital status, ethnicity, and religion) on the formal service utilization. However, the results demonstrated that the predisposing characteristics had an effect on the informal service utilization. Gender, religion (Buddhism and Taoism), and unmarried had the positive impacts on the informal service use. The results indicated that

female, Buddhism or Taoism believers, and unmarried participants intended to use informal services more frequently.

Three variables of enabling resources could predict the utilization of formal services. Inpatient service and support of parents had positive effects on the formal services use, but support of siblings had a negative effect on the formal services use. The results demonstrated that the experience of using inpatient service and support of parents led to use the formal service more frequently. On the contrary, support of siblings caused less use of formal services. The results indicated that community resources-church/temple had a positive impact on the informal service use while community resources-Children had a negative impact on the utilization of the informal services. The findings demonstrated that the experience of going to church/temple as a community resource led to the more frequently use the informal services, but having children as a community resource caused the less use of the informal services.

Need factors did not show any impact on the utilization of formal services. Only the distress of schizophrenia could be the predictor on the informal service use. The level of distress caused by schizophrenia had a positive impact on the utilization of the informal services. The findings showed that the higher level of distress caused by schizophrenia, the more frequency of using the informal services.

In addition, the use of inpatient service, support of parents, and the level of distress were predictors on the formal services. Inpatient service use, support of parents, and the level of distress had positive impacts on the utilization of formal services. The results demonstrated that the more frequently use of inpatient service, the higher support of parents,

and the higher level distress caused by schizophrenia led to the more utilization of formal service.

The predictors of predisposing characteristics combining with enabling resources through need factors on the informal services included Buddhism believers, support of churches/temples, and support of children. Buddhism believer and support of churches/temples had positive impacts on the informal services use while support of children had a negative impact on the utilization of informal services. The findings showed that being a Buddhist and considering churches/temples as community support caused the more utilization of informal services. Additionally, considering children as community support led to the less utilization of informal services.

The cultural factor was hypothesized as moderator in this study. It did not have impact on the help-seeking behaviors or other variables, but it would strengthen or weaken the impacts between independent and dependent variables. The cultural factor did not show any influence on the regression of predisposing characteristics on the informal service use, the regression of enabling resources on the formal service use, and the regression of need factor on the informal service.

However, the cultural factor slightly influenced the regression of enabling resources on the utilization of informal services. The findings demonstrated that higher support of churches/temples, less support of children, and higher degree of insight caused the more utilization of the informal services. Additionally, the cultural factor influenced the regression of predisposing characteristics and enabling resources on the need factor.

The results showed the participants living in the east side of Taiwan and higher degree of insight caused higher level of distress. Moreover, the cultural factor changed the regression of predisposing characteristics and enabling resources on the level of self-efficacy. The results showed that higher social support, more use of home-care service, more use of clinic providing medications, Catholic believer, and higher level of stigmatization led to higher level of self-efficacy.

The cultural factor also influenced the regression of the predisposing characteristics and enabling resources through need factors on the help-seeking behaviors. The findings demonstrated that more impatient service use, more support of parents, higher level of distress caused the more utilization of formal services. Additionally, the cultural factor slightly changed the regression of the predisposing characteristics and enabling resources through the need factor on the informal service use. Buddhism, support of churches/temples, support of children, and the degree of insight were predictors on the utilization of informal services. The findings showed that being a Buddhist, considering churches/temples as community support, higher degree of insight caused the more utilization of informal services. Additionally, considering children as community support led to the less utilization of informal services.

Strengths and Limitations of the Study

1. There were some limitations on sampling and sample size. This study focused on the people with schizophrenia and living in the community. Therefore, the study worked with the Alliance for the Mentally Ill of Taiwan (TAMI) because it was the organization which

applied community-based model of mental health facilities to people with mental disorders. However, there were under estimated number of people with mental disorders reaching the community mental health facilities. The ideal sampling frame should be the statistical data from the National Health Insurance Program (NHIP). The advantage of using the data of the NHIP was that 99% of the population registered in this program, and this program covered the community mental health services. Nevertheless, it would be complicated to access the data because it was governmental and confidential information. If the NHIP data could be accessed for future studies, the sampling would be less bias and more accurate.

2. This study tried to recruited ethnic populations; however, it was failed because the ethnic populations, such as Hakka and Aborigines, were under estimated using community mental health facilities. This issue caused the weakness of the study to explore the diverse cultural influences on the help-seeking behaviors. If it was feasible to recruit a certain portion of minority populations might increase the representativeness of the study sample.

3. The instruments have some bias regarding the translations and the language used in the interview process. Moreover, it involved the social/cultural definition of some specific terms. For example, the word "significant others" and "the most important person" in Chinese culture could mean any family members and not only indicated someone who had intimate relationships with the participants. Additionally, when the participants answered the sensitive questions, they would become more denial or felt uncomfortable to answer those questions. Therefore, the westernized instruments had their limitations when they were

applied to other ethnic populations. Moreover, the reliability and validity of these instruments would be influenced by these language and wordy issues.

4. Many mental health professionals discussed the help-seeking behaviors through the biological point of view, such as the westernized psychiatric treatments or medications. However, schizophrenia was a disease not only caused by biological reasons, but also by the definition of social and cultural values. Therefore, it was important to examine the help-seeking behaviors in people with schizophrenia through social/cultural perspectives in order to increase the cultural awareness and provide advanced knowledge for all mental health professionals.

Recommendations for Future Researches

1. The instruments used in this study were developed by the western professionals. Although most of the instruments had applied to Asian populations, they were hardly used in the Taiwanese with mental disorders. Therefore, the reliability and validity of the instruments were influenced by the translation and language problems. It was necessary to discuss the reliability and validity issues of these instruments in future studies among the Taiwanese people. T
2. The study focused on the experiences of the help-seeking in individuals with schizophrenia. However, due to the traditional culture, family was the most important factor regarding the decision making of the help-seeking. Moreover, the Andersen's model

recognized the family as a unit when determined what treatments should be sought (Andersen, 1968). Therefore, it would be important for future studies to recruit the major caregivers of people with schizophrenia as the study subjects.

3. This study was designed in the form of quantitative research. However, in the interview process, the researcher found several questions needed to be explored in depth, such as the attitude towards the utilization of informal services, and the perceptions of stigmatization or insight. It would be essential using mixed methodology research design to explore the help-seeking behaviors in future studies.

4. The help-seeking behaviors in people with schizophrenia was an inter-disciplinary study which crossed biological, psychological, social, and even the religious perspectives. It would be crucial to conduct studies related to the help-seeking behaviors in people with schizophrenia or mental disorders by the interdisciplinary research teams in order to explore this topic extensively and provide advanced knowledge thoroughly.

5. It would be valuable to conduct studies focusing on the minority populations, such as Hakka and Aborigines, to explore their help-seeking behaviors in different cultures. In addition, to understand the help-seeking behaviors within different cultural frame would strengthen the delivery system of community mental health. For future study, the population should include the immigrants, people with intra-marriage, and the next generation of the intra-marriage.

Implications

Within the diverse contexts of cultural perspective, help-seeking behaviors were constructed by the specific societies, groups, and individuals. However, under the increasingly influences of globalization, mostly in the western style, will the help-seeking behaviors become globalized within different societies and cultures? The discussions of the implication would around this circumstance and focus on three areas: areas: 1) the implications in practice, 2) the implications in policy making, and 3) the implications in theory development. Furthermore, although it was not specifically pointed out, the implications in academia learning would be included.

Implications in Social Work Practice

According to the study's findings, several predictors were correlated with the informal services, such as gender, religion (Buddhism and Taoism), marital status (unmarried), and visiting churches or temples. Additionally, distress of the need factor was a predictor to the informal service use. Among these predictors, religion was the one which derived the researcher's attention because it involved not only about the community support but also the need of spirituality in people with schizophrenia or mental disorders.

The psychiatric social workers usually were trained in the westernized medical perspective and emphasized the importance of the formal services use. Although being aware of the existence of the informal services, the psychiatric social workers did not recognize the support of the informal services and considered the informal services were the factor that hindered people with mental disorders from receiving the westernized psychiatric

treatments. The correlations between the utilization of the informal services and the formal services should be discussed in the future studies; however, the training of psychiatric social workers should change its medical root and extend its contents in social and cultural perspective based on the study's findings.

The training of the psychiatric social workers should focus on two aspects: school education and practical supervision. Both school education and practical supervision should increase the cultural competence of the potential and the clinical psychiatric social workers. This would be more important because the Taiwanese society tended to be multicultural, and the psychiatric social workers should be able to recognize the unique of their client's cultures and special needs.

Implications in Policy Making

The study findings revealed the importance of religion in the utilization of the informal services and community support in people with schizophrenia. Some religion related medical facilities also provided religious support for their consumers. However, it was illegal if the folk healing facilities provided medical treatments to people with schizophrenia or other diseases because those people in the folk healing facilities were not medical professionals.

Although the folk healing facilities could not provide treatments for people who suffered from mental disorders, those facilities should be recognized and supervised in the health care system. The reasons that the folk healing facilities should be included in the

health care system because they were part of the community help-seeking system and some fraud issues could be prevented from the government supervision.

Although the newest version of the Mental Health Act in Taiwan emphasized the importance of community care system, it did not recognize the support of the community religious facilities. The Taiwanese government should develop a well-managed mental health system which included the folk healing facilities as part of the community support. Additionally, people who worked in the folk healing facilities should receive trainings when they provided not the medical treatments but the spiritual support to those with mental disorders. Furthermore, the government should establish a referral system between the formal services and the informal services.

Implications in theories development

Many studies analyzed the help-seeking behaviors in people with mental disorders based on different perspectives, mostly were about the biological point of view. This study was based on the social/cultural framework to analyze the help-seeking behaviors in people with schizophrenia. The findings revealed that the use of inpatient services, support of parents, and the distress were predictors on the formal services. Buddhist, support of the churches/temples caused the more utilization of the informal service, and support of children was a negative predictor and led to the less utilization of the information services.

Based on the findings, the predictors on the help-seeking behaviors in people with schizophrenia could provide the fundamental knowledge to the future studies related to the analyses of the help-seeking behaviors. Although the study used The Behavioral Model of

Health Service Use (BMHSU), other theoretical framework could be used to analyze the help-seeking behaviors, such as labeling theory or other psycho-social theories. Additionally, the help-seeking behaviors would change because of the change of the society, such as the change of population structure, the accessibility of mental health resources, and the public education of mental health. However, the social ideology, such as stigma and insight towards mental health was difficult to be changed in a specific society. Therefore, conducting studies in this area was necessary to build a well-developed theory.

Conclusion

This study examines how cultural factors influenced the help-seeking behaviors among people with schizophrenia in Taiwan on the basis of the socio-behavioral model. Based on the literature reviews and past studies, ethnic minorities are more likely to use informal mental health services within their traditional cultural beliefs (Fang, 2005). Social work practitioners can serve an important role in connecting the Western and Eastern treatment approaches. It is also expected that this study can promote cultural recognition among the mental health professionals, encouraging the establishment of an integrated and culture-oriented mental health service delivery system in Taiwan.

Additional researches and evaluations should be conducted to ascertain the effectiveness and safety of informal mental health interventions. Currently, the majority of Chinese traditional medication is managed and included in the National Health Insurance Program, but not included the folk healing approach. If future studies can demonstrate the

effectiveness of traditional Chinese Medication and the support of the folk healing in people with mental disorders, the validity of informal treatments will be strengthened.

Furthermore, several religious mental health asylums and long-term facilities are operated by non-professional mental health workers, and the qualities of these facilities are criticized. In order to integrate these religion-based facilities into community resources, the Taiwanese government has the responsibility to provide adequate trainings for these facilities. Moreover, it is needed for policy makers to revise mental health policy to integrate these resources as part of the community mental health service system.

In Taiwan, mental health professionals focus on secondary and tertiary prevention (Horng, 1994); primary prevention and community-based mental health programs have not received much attention until recently. This phenomenon makes it difficult to develop a community mental health service network. Additionally, most mental health facilities and resources are dominated by psychiatric professionals. This study can help mental health professionals to build a network which includes the primary, secondary, and tertiary services as well as enhances the development of rehabilitation programs for people with chronic mental illness in Taiwan.

Appendix A
Permission Letters for Obtaining Scales

The Multidimensional Scale of Perceived Social Support (MSPSS)

Dear Min-Ling,

I am happy to give you permission to use my scale, the Multidimensional Scale of Perceived Social Support (MSPSS), in your dissertation research. I have attached the original English version and a version in Chinese that you should feel free to test and adapt as needed. Also attached is a document listing several articles that report on the psychometric properties of the MSPSS.

Please let me know if you have additional questions.

I hope your research goes well.

Best regards,

Greg Zimet

The Brief Symptom Inventory (BSI)

Purchased from <http://www.pearsonassessments.com>

U.S.: 800-627-7271, ext.3225

Devaluation-Discrimination Scale (DDS)

Bruce Link to Min-Ling show details 4/25/08

Sure -- if you can use the attached measure.... Devaluation discrimination measure is item 1 through 13. Good luck, Bruce

General Self-efficacy Scale (GSE)

Dear Wang,

Thanks for your email. I'd like to give you permission of using GSE in your research, as long as you fill in and send me back the attached application form. The form is used only for records of documents.

Sincerely,

Zhang Jianxin

Institute of Psychology, CAS

P.S. The form is in Chinese. Can you read Chinese there?

Self-Appraisal of Illness Questionnaire (SAIQ)

Min-Ling,

I would be honored if you would further the research and/or clinical use of the SAIQ in any way! Good luck in your studies. They sound very interesting.

Cinda

Appendix B
Permission Letters from the Study Institutions



社團法人中華民國

康復之友聯盟

The Alliance for the Mentally Ill of R.O.C. Taiwan (TAMI)

2F, No. 604, Sec. 4, Pateck Rd., 105

Taipei City, Taiwan (R.O.C.)

TEL : 011-8366-2-2747-7605 e-mail: taminoe@ms41.hinet.net

April 23, 2008

School of Social Service

The Catholic University of America

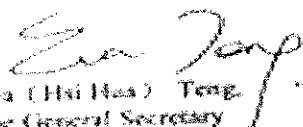
Washington, D.C., 20064, USA

To Whom It May Concern,

This letter is to provide consent for Min-Ling Wang to conduct her study entitled "Cultural beliefs on Mental Health Help-seeking Behavior of the Taiwanese with schizophrenia" at The Alliance for the Mentally Ill of Taiwan (TAMI). We have reviewed the research proposal and understand that Min-Ling Wang will recruit participants among our members. Additionally, we also realize that Min-Ling Wang will work with our staffs to reach the participants and their families in order to obtain their consent for the study.

TAMI was founded in 1997 and currently has 26 group members from local associations of 23 counties in Taiwan. TAMI provides public education on mental disorders and families, supports research, and advocates adequate health insurance, housing, rehabilitation at community level, as well as promotes job training programs for people with serious psychiatric illnesses. We hope our mental health professionals through Min-Ling Wang's study will raise their cultural awareness in order to understand the help-seeking behaviors in our members suffering from schizophrenia.

Sincerely Yours,



Eva (Hsi Hui) Teng

The General Secretary

The Alliance for the Mentally Ill of Taiwan (TAMI)



中華民國康復之友聯盟

社團法人中華民國 康復之友聯盟 總社設於台北市松山區民生路338號604室二樓之十號 TEL: 100-7747-7605 FAX: 100-7748-2830
The Alliance for the Mentally Ill, R.O.C., Taiwan 2F, No. 604, Sec. 4, Pateck Rd., Taipei, Taiwan, R.O.C.
E-mail: taminoe@ms41.hinet.net

CHING-HAI PSYCHIATRIC HOSPITAL

No. 41-2, Xiakeng Lane, Shihang St.,
Shigang Township, Taichung County, 422 Taiwan
Phone: 011-886-4-2572-3332
011-886-4-2572-1694
Fax: 011-886-4-2572-2710

April 23, 2008

Ms. Min-Ling Wang
The Catholic University of America
National Catholic School of Social Service
Shahan Hall
620 Michigan Ave, Washington, D.C. 20064

Ms. Wang,

Ching-Hai Psychiatric Hospital confirms that the pre-test for your study "The Culture and Mental Health Help-seeking Behaviors in Taiwanese People with Schizophrenia" will be operated in our setting. Ching-Hai Psychiatric Hospital will assist you with doing the pre-test for this study and encouraging our consumers to participate in it. Moreover, Ching-Hai Psychiatric Hospital realizes that your pre-test needs a minimum of thirty consumers who have been diagnosed with schizophrenia who have received treatments through our out-patient service.

We also assure you that we will assist you in every possible way.

Sincerely Yours,

ching-hai chen

Ching-Hai Chen
Superintendent
Ching-Hai Psychiatric Hospital
Taichung County, Taiwan



Appendix C
English Versions of
Cover Letter/ Consent Form/ Questionnaire

Cover Letter

CUA



THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service

*Shahan Hall
Washington, D.C. 20064
202-319-5458
Fax 202-319-5093*

XX XX, 2008

Dear participant,

You are invited to participate in this study to help us understand how cultural factors influence the help-seeking behavior in Taiwanese people with schizophrenia. You have been selected through the Alliance of the Mentally Ill in Taiwan (TAMI), the organization with which this study cooperates. You are encouraged to participate in the study voluntarily; you have the right to decide not to participate or drop out of the study at anytime without any penalty or losing your benefits that the association provides. Additionally, you will receive the consent form twice. When you are reached by the investigator or the TAMI's workers/case managers, you will receive a consent form the first time. The consent form will introduce the purpose of the study and the interview process. It also will help you and your major caregiver to decide whether you want to participate in the study or not. Later on, the researcher will meet with you and give you the consent form the second time. The same

consent form will be used to confirm your participation. Moreover, if you have any questions or concerns before the interview, the investigator will clarify them before you sign the consent form.

Once you decide to participate in the study, all your personal information will be kept strictly confidential, including your demographic information, and the answers that you give during the interview. The researcher will not have access to any of your medical records. When the study is completed, all your personal information will be destroyed. Your interview results will be combined with the responses of other participants as a collective summary. There will be no identifying information presented on the questionnaire. Your return of the consent form will only indicate your agreement to participate in the study. However, it does not give any legal power to the researcher to disclose any of your personal information received in the study. Your participation will give the mental health professionals a further understanding about the importance of cultural influences on the mental health help-seeking behaviors in the Taiwanese society.

You have the right to obtain the study results if you are interested in them. Moreover, if you have any concerns about the study, please contact Min-Ling Wang through the TAMI. Thank you for your participation. We greatly appreciate your time and patience.

Sincerely,

Min-Ling Wang, MSW

Consent Form

CUA



THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service

*Shahan Hall
Washington, DC 20064
202-319-5458
Fax 202-319-5093*

CONSENT FORM

Name of Study: Cultural beliefs and Mental Health Help-seeking Behaviors of the
Taiwanese with Schizophrenia

Investigator: Min-Ling Wang, M.S.W.

Research Supervisor: Sr. Ann Patrick Conrad, Ph.D.; Frederick L. Ahearn, Jr.,
D.S.W.; Karlynn BrintzenhofeSzoc, Ph.D.

I. Research Purpose

I understand that this study is designed to explore the influence of cultural factors on mental health help-seeking behaviors of people with schizophrenia in Taiwan. I am also aware that this study will be conducted by Min-Ling Wang to fulfill the requirements of a Ph.D. degree in social work at The Catholic University of America in Washington, D.C. in the USA. Moreover, I realize that this study's results will help the mental health professionals to improve the delivery system of mental health services in Taiwan.

II. Study Procedure

My major caregiver and I will be contacted by the investigator after I have been selected to participate in the study. Meanwhile, we will receive the consent form and the cover letter, which will provide sufficient information about the purpose and the procedure of the study to help me decide whether I should participate in it or not. If I agree to participate in the study, the same consent form will be given to me again before an interview.

If I decide that I will participate and after I sign the consent form, I will have a face-to-face interview with the researcher. The responses to the questions I am asked will be recorded by the researcher on a special interview schedule designed for this study. This will take from fifty minutes to one hour. In the interview, I realize that the investigator will expect me to say what I really think or feel when answering the questions posed. I understand that the interview questions will include:

- (1) Demographic information, such as my age, gender, and educational level,
- (2) My history of help-seeking behaviors,
- (3) The symptoms of my illness,
- (4) My beliefs about schizophrenia,
- (5) My cultural identity, and
- (6) The stigmatization of my condition by others

III. Risks, Inconveniences, and/or Disclosures

I understand that the interview might include some questions that may cause discomfort or unpleasant memories of difficult experiences. Moreover, some questions in the interview might be very sensitive such as asking about my intimate relationships and family conflicts. Therefore, I do not have to answer any question that I do not feel comfortable answering. I can also interrupt the interview whenever I feel uncomfortable and then decide whether I should continue the interview or not. I understand that I am free to withdraw from the study at any time after I begin participation. If the interview questions bother or stir up my emotions, I will receive the help I need to discuss these issues with my therapist or case manager.

IV. Possible Benefits:

I understand that I might not personally benefit from the study. However, I am aware that my participation in this study will contribute to broadening the knowledge of mental health profession. This study may help to improve the service delivery and policy making of mental health services at a community level. Moreover, I understand that my participation in this study may increase the awareness of the necessity of improving the mental health resources in Taiwanese rural areas.

V. Confidentiality:

I understand that the investigator will know my name in the initial procedure of the study; however, the investigator will not put my name and personal information on the questionnaire to identify me. I have been assured that none of my medical records will be used in this research. Instead, my name will be replaced by a unique identified number. Moreover, the investigator will be the only person who has the right to access my personal information. I also realize that all the information that I provide in the interview will be kept confidential as the law requires. The questionnaire that I complete will be kept in a locked file and placed in a safe place. Furthermore, I understand that the results gathered by the study will be reported in Min-Ling Wang's dissertation and future publication. No information related to my identity will be revealed without my consent.

VI. Voluntary Nature of the Study:

I understand that whether I decide to participate in the study or not will not change the way people treat me in the Alliance for the Mentally Ill of Taiwan (TAMI) which contacted me about this study. Moreover, my decision will not have an effect on how I am treated if and when I do any business with The Catholic University of America. Furthermore, I realize that I or my insurance program will not be charged for my participation in this study. My involvement in this study is fully optional. If I have any concerns or discomforts in the interview, I will discuss these issues with the investigator or withdraw from the study. Although my major caregiver might help me to make decision to participate in the study, my

interview responses will not be revealed to him/her. As a volunteer in this study, I will not be penalized if I choose not to continue this study at anytime.

VII. Contact and Questions:

I am aware that the investigator of this study is Min-Ling Wang and I may ask any questions I have either before, during, or after the interview. If I have any concerns or questions, I may contact the investigator through the TAMI. If I want to discuss my concerns with someone other than the investigator, I can call the TAMI to get a referral to or receive the help I need through my case manager. The contact information is on the last page of the consent form.

VIII. Statement of Consent:

I have read this consent form and I clearly understand Min-Ling Wang's study procedure, as well as its possible risks and benefits. I am aware of my rights in this study and hereby give my consent to participate in Min-Ling Wang's study as described. I have been offered a copy of this consent form.

Signature of Participant

Date

Signature of the Major Care Giver

Relationship with the Participant

Date

Signature of Researcher

Date

Please direct any concerns, comments, or complaints about your involvement in this study to the list as below:

(1) The Secretary for the Committee for the Protection of Human Subjects, Office of Sponsored Programs and Research Services, The Catholic University of America, Washington, D.C. 20064; TEL: 202-319-5218 (USA)

(2) The Alliance for the Mentally Ill of Taiwan, 2F.-15, No.604, Sec. 4, Bade Rd., Songshan District, Taipei City 105, Taiwan. TEL: 02-2747-7605 (Taiwan)

Appendix D

Pilot Study (Chinese Versions):

Cover Letter/ Consent Form/ Questionnaire

Pilot Study Cover Letter

CUA



THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service

Shahan Hall

Washington, D.C. 20064

TEL: 202-319-5458/Fax 202-319-5093

10月6日, 2008

您好：

誠懇的邀請您參加此研究計畫“台灣精神分裂症患者的文化信仰與求助行為”。

本研究想要了解文化因素如何影響台灣精神分裂症患者的求助行為，因此

在與『青海醫院』的合作與協助下，選擇您來參與我們的計畫。我們鼓勵您參加我們的研究計畫，但是您有權力決定是否參與，並且可以在研究過程中退出。您不參與或者退出研究計畫不會影響『青海醫院』對您提供的服務。

在研究開始之前，您將會收到同意書兩次。第一次是在研究主持人或者『青海醫院』的個案工作人員拜訪您時，本研究的同意書將會交付給您。這份同意書將提供研究目的及訪問歷程等相關資訊，以協助您以及您的主要照顧者決定是否接受訪談。之後研究主持人將與您碰面，並再給您一份一模一樣的同意書。第二次的同意書將確

認您的同意及在同意書上簽名，您才正式參與本研究。若在進行訪談前有任何疑問，我們會在您簽署同意書前，更進一步向您說明。

當您決定參加本研究，研究主持人對於您的個人資料，包括：姓名、身份證字號、聯絡電話、地址及訪談內容會全面進行嚴格的保密工作。除此之外，研究主持人沒有權力取得您的醫療紀錄。一旦研究完成，我們就會銷毀您的個人資料，以保障您的隱私和權益。您個人的訪談內容也將與其他參與者回答以綜合結論的方式呈現，且訪談問卷上將不會有任何標示以辨認出您個人的相關資料。你繳交回來的同意書只會顯示出您參與本研究的意願，並無任何法律效力授權研究主持人公開您個人資料。由於您的參與，我們將能夠對心理衛生專業人員提供更深入的協助，讓他們了解在台灣社會中，文化因素對於心理疾病求助行為的影響。

若您對本研究的結果感興趣，您有權力獲知本研究結果。此外，如果您對於此研究有任何的疑問，請透過『青海醫院』聯絡研究主持人王敏菱小姐。謝謝您參與本研究，我們竭誠感謝您的時間以及耐心。

博士候選人 王敏菱
美國天主教大學社會工作學院

Pilot Study Consent Form

CUA



THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service

Shahan Hall

Washington, DC 20064

Tel: 202-319-5458/ Fax 202-319-5093

同意書

研究名稱：台灣精神分裂症患者的文化信仰與求助行為

主持人：美國天主教大學社會工作學院 博士候選人 王敏菱

指導教授：Sr. Ann Patrick Conrad, Ph.D.; Frederick L. Ahearn, Jr., D.S.W.;
Karlynn BrintzenhofeSzoc, Ph.D.

一、研究目的

我了解這一個研究的設計，主要目的是探索台灣文化對於患有精神分裂症者求助行為之影響。我也知道王敏菱小姐是這一個研究的主持人，這個研究計畫是她為了完成在美國天主教大學（美國華盛頓特區）的社會工作博士學位所必須達到的學習要求。此外我也瞭解這一個研究的結果，將能夠促使台灣心理衛生專業以及服務傳遞系統更改善。

二、研究過程

當我獲邀參與本研究，研究主持人將和我及我的主要照護者聯絡。在此同時，我們也將會收到研究說明書與同意書，其中提供了足夠的重要訊息說明本研究的目的與實施過程，這將幫助我決定是否參與本研究的意願。如果我同意參與這個研究，在接受面談時還會再一次收到同意書。

若我決定參與本研究並簽署同意書，即表示我將參與這個研究，並且同意與研究主持人進行面對面會談。我將會在與研究主持人所約定的時間內，回答問卷相關問題，並且由研究主持人進行紀錄，大約需費時五十分鐘至一個小時。我也了解在訪談過程中，研究主持人期待我對於問卷的問題說出心裡的感受或者真正的想法。訪談問題包括以下幾個方向：

- (7) 個人基本資料：諸如年齡、性別、教育程度等等訊息。
- (8) 我過去求助行為的經驗。
- (9) 我的疾病症狀。
- (10) 我對於精神分裂症的看法。
- (11) 我的文化認同。
- (12) 他人對於我的狀況是否有標籤化的現象。

三、潛在的風險與不便

我了解面談將觸及過去的經驗，產生一些可能令我不舒服或者不愉快的回憶，甚至有一部份的問題，涉及我的親密關係以及家庭衝突等敏感議題，因此，對於令我不舒服的問題，我可以不回答。在面談過程中，當我感覺不舒服時，我也可以隨時中斷，然後決定要不要繼續。雖然開始參與，但我了解我可以隨時退出。面談過程中，如果有一些問題困擾我或者是攪亂了我的情緒，我會跟我的治療師或者是專案督導討論我的狀況。

四、預期效益:

我知道我將不會直接從這個研究中受益，然而，我了解藉由參與這一個研究，能夠貢獻我的力量，促使心理健康專業的知識增加。這個研究結果，很有可能對社區的服務傳遞以及政策制定產生影響，也希望藉由這一個研究，能夠提升大家對於偏遠地區精神健康資源提升的重要性，產生更強烈的意識。

五、保密條款

我知道研究主持人在研究一開始就知道我的名字，不過她不會將我的姓名放在問卷上，讓別人辨認出我來，並且我確定本研究將不會引用我任何的醫療紀錄。研究者將以一組特別的號碼來取代我的名字，且我所提供的資料內容除了研究者有權使用之外，絕對完全保密；完成的訪談問卷將放置在一個安全保密的地方，以保障我的隱

私和權益。此外我了解在研究中所得到的結論將在王敏菱小姐博士論文中呈現，未來可能對外公開發表；然而若沒有得到我的同意，所有與我有關的個人資料將不會公開。

六、參與意向

不論我決定是否參加此研究，『青海醫院』工作人員對我的態度將不會有所改變。即使我與美國天主教大學有任何商業往來，我的參與也不受到特殊待遇，一律公平對待。此外，我了解參與本研究將不會導致我的保險有額外收費的情形。我的參與完全是自願性質，若在面談過程中，我有任何疑慮或情緒方面的不舒服，我將與研究主持人王敏菱小姐討論或考慮退出本研究。雖然我的主要照顧者可能幫我決定參與本研究的意向，但我的訪談內容將不會公開給任何人，包括主要照顧者。由於本研究是自願性質，若我選擇退出參與也不會受罰。

七、連絡方式

我了解本研究是由王敏菱小姐主持，且不管在訪談前、中、後，如果我有問題皆可隨時提出。我可以透過『青海醫院』與王敏菱小姐聯絡來討論我的問題或疑慮。若我想與其他人討論我的問題，可以打電話聯絡『青海醫院』尋求轉介服務或透過我的專案督導員得到應有的協助。通訊聯絡資料列於同意書的最後一頁。

八、同意說明

我已閱讀此同意書並清楚了解王敏菱小姐所主持的研究；包括所有研究流程、潛在的風險與受益。我了解在研究中我該有的權利，在此我同意參與本研究，並保留一份同意書做為存檔。

若對本研究有任何意見與想法，請透過以下方式與我們聯絡：

(3) 研究受試者保護委員會秘書、研究審議委員會辦公室、美國天主教大學，華盛

頓特區 20064；連絡電話：002-1-202-319-5218 (美國)

(4) 青海醫院，422 台中縣石岡鄉金星村下坑巷 41 號之 2

連絡電話：04-25723332 (台灣)

文化信仰及心理健康求助行為問卷

第一部份 基本資料 (Predisposing Factors)

1. 你的性別是什麼？

☐ 男 ☐ 女

2. 你的出生年月日為何？

月/ 日/ 年

3. 你(家人)的現居地是哪一個縣市？

4. 你會把自己界定為哪一個族群？

5. 你的婚姻狀態為何？

☐ 單身從未結婚

☐ 同居

☐ 已婚

☐ 喪偶

☐ 離婚

☐ 分居

☐ 其他(請註明)

6. 如果已婚, 請註明配偶國籍

☐台灣

☐越南

☐印尼

☐中國

☐菲律賓

☐馬來西亞

☐其他(請註明)

7. 對於求助行為最具影響的人我們將其定義為主要照顧者

依此定義請問你認為誰是你的主要照顧者?

☐父親

☐母親

☐配偶

☐兄弟姊妹

☐子女

☐養子女

☐其他(請註明)

8. 你的主要照顧者國籍為何?

☐台灣

☐中國

☐越南

☐印尼

☐菲律賓

☐馬來西亞

☐其他

9. 你目前的宗教信仰是什麼？

☐無

☐佛教

☐印度教

☐道教

☐天主教

☐基督教

☐摩門教

☐民間信仰

☐伊斯蘭教

☐一貫道

☐其他(請註明)

10. 你的宗教信仰對你日常生活影響有多少？

☐ 無

☐ 一些

☐ 適度

☐ 極大

☐ 不知道

第二部分 Enabling Factors

1. 你的最高學歷為何？

☐ 從未就學

☐ 自學

☐ 小學或以下

☐ 國中或以下

☐ 高中同等學力

☐ 高中

☐ 高職

☐ 五專

☐ 學士

☐ 碩士

☐ 博士

受教育之年數：

2. 下列哪一項是你過去一年所從事的職業？

☐ 無業

☐ 服務員

☐ 基層人員

☐ 工廠及機械操作員, 組裝員

☐ 工藝及手工藝

☐ 農畜林漁

☐ 店員及售貨員

☐ 職員

☐ 技術人員及專業助理

☐ 專業人員

☐ 立法官員 政府行政主管 企業主管 經理

3. 你的現職每天工作時數是多少？

4. 你的家庭每月總收入是多少？

5. 看門診時請問你使用何種交通工具？

☐ 公車

- ☐火車
- ☐捷運
- ☐計程車
- ☐腳踏車
- ☐自家轎車
- ☐步行
- ☐機車
- ☐其他(請註明)

6. 你每週往返心理衛生治療中心有多少次？

7. 你從家裡（或康復之家）到心理衛生治療中心需要多久？

8. 你的主要照顧者是否陪伴您往返心理衛生治療中心？

☐是

☐否 本人獨自往返

如果主要照顧者沒有陪伴您 請問誰陪伴您往返心理衛生治療中心？

9. 如果主要照顧者陪伴你往返 請問他/她是否與中心專業人員接觸？(例如 醫師 心理師 護士 或 社工)

☐從不

- ☐有時
- ☐總是

如果答案為從不 原因為何?

10.就您所知您居住的縣市有哪些心理衛生服務?

- ☐住院
- ☐門診
- ☐醫療診所
- ☐居家照護
- ☐院內日間照護
- ☐復健中心日間照護
- ☐康復之家
- ☐社區交誼復健中心
- ☐長期養護機構
- ☐精神護理之家
- ☐諮商中心 無提供藥物
- ☐其他 (請註明)

11. 以下各項心理衛生服務中，請選出在過去的求醫經驗中曾使用過的服務為何?

- ☐住院
- ☐門診
- ☐醫療診所

- ☐居家照護
- ☐院內日間照護
- ☐復健中心日間照護
- ☐康復之家
- ☐社區交誼復健中心
- ☐長期養護機構
- ☐精神護理之家
- ☐諮商中心 無提供藥物
- ☐其他 (請註明)

12. 就下列院所服務的取得你是否覺得有困難？

- | | | | | | |
|----------|------------------------------|-------------------------------|-----------------------------|-------------------------------|------------------------------|
| 住院 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 門診 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 醫療診所 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 居家照護 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 院內日間照護 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 復健中心日間照護 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 康復之家 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 社區交誼復健中心 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 長期養護機構 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |
| 精神護理之家 | <input type="checkbox"/> 極困難 | <input type="checkbox"/> 非常困難 | <input type="checkbox"/> 困難 | <input type="checkbox"/> 有些困難 | <input type="checkbox"/> 不困難 |

諮商中心 無提供藥物 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

其他 (請註明)

13. 除了心理衛生機構, 以下哪些社區資源您認為對你的心理健康有幫助?

☐教堂/寺廟

☐父母

☐配偶

☐兄弟姊妹

☐子女

☐鄰居

☐同鄉鎮的朋友

☐家庭醫師

☐同事

☐同學

☐旁系親屬

☐其他(請註明)

14. 你如何繳納你的健保費?

☐未納保

☐僱主

☐眷保

☐家人代繳

☐政府補助（如低收入家庭）

☐慈善機構輔助

☐其他（請註明）

15. 當你加入全民健保時 是否由於接受心理衛生服務而需要給付部分負擔或自付額？

☐是

☐否

16. 在加入全民健保的情況下 您是否對部分負擔或自付額的負擔感到有困難？

☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

17. 除了全民健保 是否有參與其他公家保險

☐是

☐否

種類

18. 如果有參與私人保險 是否有涵蓋心理衛生服務的需求？

☐是

☐否

☐無私人保險

19.對你而言 負擔私人保險有多困難？

☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

第三部份 感受社會支持多面量表

說明: 我們想知道您對下列敘述的看法。請仔細閱讀各項問題, 在最能描述您感受的項目打勾(V)。

1. 每當我有需要時, 我生命中有人會出現幫我

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

2. 有個特別的人能讓我分享快樂與悲傷

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

3. 我的家人的確努力要幫我

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

4. 我能從家人那得到我在情緒上所需要的協助與支持

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

5. 有位特別的人是我慰藉的主要來源

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

6. 我的朋友的確努力要幫我

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

7. 當萬事不順遂時,我可以依賴我的朋友
☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意
8. 我可以告訴家人我的煩惱
☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意
9. 我有朋友可以分享我的快樂與悲傷
☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意
10. 我生命中有個特別的人會關心我的感受
☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意
11. 我的家人樂意幫我下決定
☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意
12. 我可以告訴我的朋友我的煩惱
☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

第四部份 Brief Symptom Inventory

我將為你讀下列一般人偶爾會面臨的問題。請仔細把每個問題聽清楚，如果以下的敘述在過去的七天中(包括今天)曾經造成你的壓力或困擾，請選出最適合描述你狀況的程度。

1. 緊張(焦慮)或心裡感覺不安
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
2. 暈倒或暈眩
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

3. 有其他人會控制你想法
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
4. 感覺其他人在責備你造成大部份的麻煩
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
5. 記不住事情
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
6. 容易受刺激而生氣或不舒服
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
7. 心臟或胸口疼痛
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
8. 在開放空間中或在街道上感到害怕
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
9. 想結束自己生命
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
10. 無法信任多數人
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
11. 胃口差
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
12. 突如其來的恐懼
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
13. 突然脾氣發作且無法控制
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
14. 即使跟其他人在一起時仍感到寂寞
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
15. 感覺作事情有障礙
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

16. 感到寂寞
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
17. 感覺憂鬱
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
18. 對任何事都不感興趣
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
19. 有恐懼感
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
20. 感覺很容易受到傷害
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
21. 感到其他人對你不友善或不喜歡你
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
22. 感覺低人一等
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
23. 噁心或胃不舒服
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
24. 感覺有人在監視你或談論你
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
25. 入睡困難
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
26. 經常重複確認自己已經做的事
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
27. 很難下決定
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
28. 害怕搭乘公車地鐵或火車
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

29. 感覺呼吸困難
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
30. 有忽熱忽冷的徵狀
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
31. 避開那些令你恐懼的事物地點或活動
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
32. 你的腦袋會突然感到一片空白
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
33. 身體某些部份感到麻木或刺痛
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
34. 有為你所犯的罪受到懲罰的念頭
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
35. 對未來感覺毫無希望
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
36. 很難專心
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
37. 你身體的某些部份感到虛弱
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
38. 感到緊張或興奮
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
39. 有死亡或去死的念頭
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
40. 有傷害毆打其他人的念頭
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
41. 有打破或損毀事物的衝動
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

42. 與人相處時感到非常忸怩害羞
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
43. 感覺在人群中無法輕鬆例如在購物或看電影時
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
44. 從不覺得跟其他人很親近
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
45. 會有一段時間的驚駭恐慌發作
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
46. 經常陷入爭論中
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
47. 當你被單獨留置時會感到緊張
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
48. 其他人並沒有因你的成就而給你適當的稱讚
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
49. 感覺煩躁所以無法坐直
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
50. 感覺毫無價值
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
51. 感覺如果你退讓，其他人將會佔你便宜
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
52. 有罪惡感
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾
53. 有心智有點不對勁的念頭
☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

第五部份 一般自我效能量表 (The General Self-Efficacy Scale)

回答下列問題時請選擇一個您認為最好的選項

1. 如果我盡力去做的話，我總是能够解決難題的。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
2. 即使別人反對我，我仍有辦法取得我所要的。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
3. 對我來說，堅持理想和達成目標是輕而易舉的。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
4. 我自信能有效地對付任何突如其來的事情。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
5. 依我的才智，我定能應付意料之外的情況。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
6. 如果我付出必要的努力，我一定能够解決大多數的難題。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
7. 我能冷靜地面對困難，因為我可信賴自己處理問題的能力。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
8. 面對一個難題時，我通常能找到幾個解決方法。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
9. 有麻煩的時候，我通常能想到一些應付的方法。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確
10. 無論什麼事在我身上發生，我都能應付自如。
☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確

第六部份 Devaluation-Discrimination Scale

以下的問題是一些關於精神疾病的敘述。請從中選擇出最能反應出你如何相信其他人對精神疾病的感覺或情緒問題治療的想法。關於你的論點，沒有所謂的正確答案。第一印象通常是最理想的答案。

以下的問題是一些關於精神疾病的敘述。請從中選擇出最能反應出你如何相信其他人對精神疾病的感覺或情緒問題治療的想法。關於你的論點，沒有所謂的正確答案。第一印象通常是最理想的答案。

1. 多數人會願意接受一位有精神困擾的人當朋友
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
2. 多數人相信一個曾住過院接受精神治療的人和一般人一樣聰明
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
3. 多數人相信一個曾住過院接受精神治療的人和一般人一樣值得信任
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
4. 多數人會接受一個曾接受精神科治療但精神狀態穩定的人擔任公立學校學童的老師
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
5. 多數人覺得住院接受精神治療是一種個人失敗的象徵
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
6. 多數人不會僱用一個有精神病史的人來照顧他們的幼兒即使他有時狀況良好
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
7. 多數人較看低一個曾住院接受精神治療的人
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
8. 大部份的雇主會僱用有精神病史且有資格和能力擔任工作的人
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
9. 找工作時大部份的雇主會僱用一般人而避免用有精神病史的人
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

10. 我的鄰居對待有精神病史的人就像對待其他人一樣

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

11. 多數年輕女性會和有精神病史的男子約會

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

12. 多數人一旦知道某個人曾住院接受精神治療他們就不會太在意這個人的意見

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

13. 多數人認為一個曾因嚴重的精神疾病住院的人是危險和不可預測的

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

第七部分 Self-Appraisal of Illness Questionnaire (SAIQ)

我想要瞭解你對自己疾病的感覺。在下列的敘述中，請選擇最能反應出你感覺的選項。

1. 當你聽到有人推薦現在進行的治療方式時，你對這樣的推薦感覺為何？

☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意

2. 你會常常擔心某些事嗎？

☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常

3. 你會擔心目前的病況嗎？

☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常

4. 你會因為你的病況所產生的不便而擔心嗎？

☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常

5. 你會因為目前的病況而擔心失去朋友嗎？

☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常

6. 你會因為目前的病況而擔心你會無法工作嗎？

☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常

7. 你擔心疾病無法康復的程度為何?
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常
8. 我認為我的病況會自動康復
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
9. 在我心中毫無疑問地我將會好起來
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
10. 你相信現在的治療是必需的嗎?
☐ 絕對相信 ☐ 有一些相信 ☐ 有一點不相信 ☐ 絕對不相信
11. 假設如果你從未接受過治療你認為你目前應該會是什麼狀況?
☐ 非常糟糕 ☐ 有點糟糕 ☐ 還不錯 ☐ 非常好
12. 我可以從治療中得到許多好處
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
13. 假設我現在中斷治療我會變好
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
14. 你的想法和感覺會影響你去完成一件事
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常
15. 我認為我的狀況需要接受精神醫療
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
16. 我有精神疾病的症狀
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
17. 你認為你疾病輕重為何?
☐ 完全沒有 ☐ 輕度 ☐ 中度 ☐ 重度

第七部分 Self-Appraisal of Illness Questionnaire (SAIQ)

我想要瞭解你對自己疾病的感覺。在下列的敘述中，請選擇最能反應出你感覺的選項。

1. 當你聽到有人推薦現在進行的治療方式時，你對這樣的推薦感覺為何？

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

2. 你會常常擔心某些事嗎？

☐0 完全不會 ☐1 有一些 ☐2 中等程度 ☐3 非常

3. 你會擔心目前的病況嗎？

☐0 完全不會 ☐1 有一些 ☐2 中等程度 ☐3 非常

4. 你會因為你的病況所產生的不便而擔心嗎？

☐0 完全不會 ☐1 有一些 ☐2 中等程度 ☐3 非常

5. 你會因為目前的病況而擔心失去朋友嗎？

☐0 完全不會 ☐1 有一些 ☐2 中等程度 ☐3 非常

6. 你會因為目前的病況而擔心你會無法工作嗎？

☐0 完全不會 ☐1 有一些 ☐2 中等程度 ☐3 非常

7. 你擔心疾病無法康復的程度為何？

☐0 完全不會 ☐1 有一些 ☐2 中等程度 ☐3 非常

8. 我認為我的病況會自動康復

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

9. 在我心中毫無疑問地我將會好起來

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

10. 你相信現在的治療是必需的嗎?

☐0 絕對相信 ☐1 有一些相信 ☐2 有一點不相信 ☐3 絕對不相信

11. 假設如果你從未接受過治療你認為你目前應該會是什麼狀況?

☐0 非常糟糕 ☐1 有點糟糕 ☐2 還不錯 ☐3 非常好

12. 我可以從治療中得到許多好處

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

13. 假設我現在中斷治療我會變好

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

14. 你的想法和感覺如何影響你去完成一件事?

☐0 完全不會 ☐1 有一些 ☐2 中等程度 ☐3 非常

15. 我認為我的狀況需要接受精神醫療

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

16. 我有精神疾病的症狀

☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

17. 你認為你疾病輕重為何?

☐0 完全沒有 ☐1 輕度 ☐2 中度 ☐3 重度

第八部分 求助行為量表

因為精神分裂症，在過去的一年中，你或許曾和一些人討論或嘗試不同的治療方式。下列是一些你可能接觸過的人或方式。請選出最適切描述你使用狀況的選項。

1. 非正規方式的求助行為

1. 拜拜

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

2. 收驚

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

3. 祈禱 / 告解

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

4. 做法事

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

5. 改風水（住宅、祖墳）

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

6. 求神問佛（乩童 道士 廟祝）

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

7. 算命

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

8. 密方（藥酒、草藥、食療、涼補或熱補）

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

9. 中醫師開的藥方

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

10. 非精神科醫師

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

11. 自我療法（自己買成藥吃）

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

12. 其他（請註明）

2. 正規方式

1. 精神科醫師心理治療

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

2. 使用精神科醫師開處方之藥物

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

3. 心理師

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

4. 社工

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

5. 醫療機構

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

6. 日間照護

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

7. 居家照護

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

8. 社區交誼復健中心

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

9. 其他(請註明)

問卷結束！謝謝您的合作！

Appendix E

Formal Study (Chinese Versions):

Cover Letter/ Consent Form/ Questionnaire

CUA



THE CATHOLIC UNIVERSITY OF AMERICA

*National Catholic School of Social Service
Shahan Hall*

Washington, D.C. 20064

TEL: 202-319-5458/Fax 202-319-5093

您好：

誠懇的邀請您參加此研究計畫“台灣精神分裂症患者的文化信仰與求助行為”。本研究想要了解文化因素如何影響台灣精神分裂症患者的求助行為，因此在與『中華民國康復之友聯盟』的合作與協助下，選擇您來參與我們的計畫。我們鼓勵您參加我們的研究計畫，但是您有權力決定是否參與，並且可以在研究過程中退出。您不參與或者退出研究計畫不會影響『中華民國康復之友聯盟』對您提供的服務。

在研究開始之前，您將會收到同意書兩次。第一次是在研究主持人或者『中華民國康復之友聯盟』的個案工作人員拜訪您時，本研究的同意書將會交付給您。這份同意書將提供研究目的及訪問歷程等相關資訊，以協助您以及您的主要照顧者決定是否接受訪談。之後研究主持人將與您碰面，並再給您一份一模一樣的同意書。第二次的同意書將確認您的同意及在同意書上簽名，您才正式參與本研究。若在進行訪談前有任何疑問，我們會在您簽署同意書前，更進一步向您說明。

當您決定參加本研究，研究主持人對於您的個人資料，包括：姓名、身份證字號、聯絡電話、地址及訪談內容會全面進行嚴格的保密工作。除此之外，研究主持人沒有權力取得

您的醫療紀錄。一旦研究完成，我們就會銷毀您的個人資料，以保障您的隱私和權益。您個人的訪談內容也將與其他參與者回答以綜合結論的方式呈現，且訪談問卷上將不會有任何標示以辨認出您個人的相關資料。你繳交回來的同意書只會顯示出您參與本研究的意願，並無任何法律效力授權研究主持人公開您個人資料。由於您的參與，我們將能夠對心理衛生專業人員提供更深入的協助，讓他們了解在台灣社會中，文化因素對於心理疾病求助行為的影響。

若您對本研究的結果感興趣，您有權力獲知本研究結果。此外，如果您對於此研究有任何的疑問，請透過『中華民國康復之友聯盟』聯絡研究主持人王敏菱小姐。謝謝您參與本研究，我們竭誠感謝您的時間以及耐心。

王敏菱, 博士候選人

美國天主教大學社會工作學院

民國 97 年 10 月 6 日

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THE CATHOLIC UNIVERSITY OF AMERICA

National Catholic School of Social Service

Shahan Hall

Washington, DC 20064

Tel: 202-319-5458/ Fax 202-319-5093

同意書

研究名稱：台灣精神分裂症患者的文化信仰與求助行為

主持人：王敏菱, 博士候選人

指導教授: Sr. Ann Patrick Conrad, Ph.D.; Frederick L. Ahearn, Jr., D.S.W.;
Karlynn BrintzenhofeSzoc, Ph.D.

一、研究目的

我了解這一個研究的設計，主要目的是探索台灣文化對於患有精神分裂症者求助行為之影響。我也知道王敏菱小姐是這一個研究的主持人，這個研究計畫是她為了完成在美國天主教大學（美國華盛頓特區）的社會工作博士學位所必須達到的學習要求。此外我也瞭解這一個研究的結果，將能夠促使台灣心理衛生專業以及服務傳遞系統更改善。

二、研究過程

當我獲邀參與本研究，研究主持人將和我及我的主要照護者聯絡。在此同時，我們也將會收到研究說明書與同意書，其中提供了足夠的重要訊息說明本研究的目的與實施過程，這將幫助我決定是否參與本研究的意願。如果我同意參與這個研究，在接受面談時還會再一次收到同意書。

若我決定參與本研究並簽署同意書，即表示我將參與這個研究，並且同意與研究主持人進行面對面會談。我將會在與研究主持人所約定的時間內，回答問卷相關問題，並且由研究主持人進行紀錄，大約需費時五十分鐘至一個小時。我也了解在訪談過程中，研究主持人期待我對於問卷的問題說出心裡的感受或者真正的想法。訪談問題包括以下幾個方向：

- (1) 個人基本資料：諸如年齡、性別、教育程度等等訊息。
- (2) 我過去求助行為的經驗。
- (3) 我的疾病症狀。
- (4) 我對於精神分裂症的看法。
- (5) 我的文化認同。
- (6) 他人對於我的狀況是否有污名化的現象。

三、潛在的風險與不便

我了解面談將觸及過去的經驗，產生一些可能令我不舒服或者不愉快的回憶，甚至有一部份的問題，涉及我的親密關係以及家庭衝突等敏感議題，因此，對於令我

不舒服的問題，我可以不回答。在面談過程中，當我感覺不舒服時，我也可以隨時中斷，然後決定要不要繼續。雖然開始參與，但我了解我可以隨時退出。面談過程中，如果有一些問題困擾我或者是攪亂了我的情緒，我會跟我的治療師或者是專案督導討論我的狀況。

四、預期效益:

我知道我將不會直接從這個研究中受益，然而，我了解藉由參與這一個研究，能夠貢獻我的力量，促使心理健康專業的知識增加。這個研究結果，很有可能對社區的服務傳遞以及政策制定產生影響，也希望藉由這一個研究，能夠提升大家對於偏遠地區精神健康資源提升的重要性，產生更強烈的意識。

五、保密條款

我知道研究主持人在研究一開始就知道我的名字，不過她不會將我的姓名放在問卷上，讓別人辨認出我來，並且我確定本研究將不會引用我任何的醫療紀錄。研究者將以一組特別的號碼來取代我的名字，且我所提供的資料內容除了研究者有權使用之外，絕對完全保密；完成的訪談問卷將放置在一個安全保密的地方，以保障我的隱私和權益。此外我了解在研究中所得到的結論將在王敏菱小姐博士論文中呈現，未來可能對外公開發表；然而若沒有得到我的同意，所有與我有關的個人資料將不會公開。

六、參與意向

不論我決定是否參加此研究，『中華民國康復之友聯盟』工作人員對我的態度將不會有所改變。即使我與美國天主教大學有任何商業往來，我的參與也不受到特殊待遇，一律公平對待。此外，我了解參與本研究將不會導致我的保險有額外收費的情形。我的參與完全是自願性質，若在面談過程中，我有任何疑慮或情緒方面的不舒服，我將與研究主持人王敏菱小姐討論或考慮退出本研究。雖然我的主要照顧者可能幫我決定參與本研究的意向，但我的訪談內容將不會公開給任何人，包括主要照顧者。由於本研究是自願性質，若我選擇退出參與也不會受罰。

七、連絡方式

我了解本研究是由王敏菱小姐主持，且不管在訪談前、中、後，如果我有問題皆可隨時提出。我可以透過『中華民國康復之友聯盟』與王敏菱小姐聯絡來討論我的問題或疑慮。若我想與其他人討論我的問題，可以打電話聯絡『中華民國康復之友聯盟』尋求轉介服務或透過我的專案督導員得到應有的協助。通訊聯絡資料列於同意書的最後一頁。

八、同意說明

我已閱讀此同意書並清楚了解王敏菱小姐所主持的研究；包括所有研究流程、潛在的風險與受益。我了解在研究中我該有的權利，在此我同意參與本研究，並保留一份同意書做為存檔。

若對本研究有任何疑慮、想法或抱怨，請直接聯絡以下的機構：

(5) 研究受試者保護委員會秘書、研究審議委員會辦公室、美國天主教大學，華盛

頓特區 20064；連絡電話：002-1-202-319-5218 (美國)

(6) 中華民國康復之友聯盟，105 台灣台北市松山區八德路四段 604 號 2F.-15；連

絡電話：02-2747-7605 (台灣)

參與者簽名： _____ 日期： _____

研究者簽名： _____ 日期： _____

文化信仰及心理健康求助行為問卷

第一部份 基本資料 (Predisposing Factors)

1. 編碼：

2. 你的性別是什麼？

☐ 男 ☐ 女

3. 你的出生年月日為何？

年/ 月/ 日/

4. 你和你家人的居所是哪一個縣市？

5. 你會把自己界定為哪一個族群？

☐ 本省漢人

☐ 外省漢人

☐ 客家人

☐ 原住民

☐ 其他(請註明)

6. 你的婚姻狀態為何？

☐ 單身從未結婚 (請跳答第七題)

☐ 同居

☐ 已婚

☐ 喪偶

☐ 離婚

☐ 分居

☐ 其他(請註明)

7. 如果已婚, 請註明配偶國籍

☐ 台灣

☐ 越南

☐ 印尼

☐ 中國

☐ 菲律賓

☐ 馬來西亞

☐ 其他(請註明)

8. 對於求助行為最具影響的人我們將其定義為主要照顧者（主要帶你看醫生及接受治療的人）。依此定義，請問你認為誰是你的主要照顧者？

☐ 父親

☐ 母親

☐ 配偶

☐ 兄弟姊妹

☐ 子女

☐ 養子女

☐ 其他(請註明)

9. 你的主要照顧者國籍為何？

☐ 台灣

☐ 中國

☐ 越南

☐ 印尼

☐ 菲律賓

☐ 馬來西亞

☐ 其他

10. 你目前的宗教信仰是什麼？

☐無

☐佛教

☐印度教

☐道教

☐天主教

☐基督教

☐摩門教

☐民間信仰

☐伊斯蘭教

☐一貫道

☐其他(請註明)

11. 你的宗教信仰對你日常生活影響有多少？

☐無

☐一些

☐適度

☐極大

☐不知道

第二部分 Enabling Factors

1. 你的最高學歷為何？

☐從未就學

☐自學

☐小學或以下

☐國中或以下

☐高中同等學力

☐高中

☐高職

☐五專

☐學士

☐碩士

☐博士

受教育之年數：（從什麼時候開始中斷學業？）

2. 下列哪一項是你過去一年所從事的職業？

☐ 無業

☐ 現役軍人

☐ 非技術工及體力工

☐ 機械設備操作工及組裝工

☐ 技術工及有關人員

☐ 農林漁牧工作人員

☐ 服務人員及售貨員

☐ 事務工作人員

☐ 技術員及助理專業人員

☐ 專業人員

☐ 民意代表 政府主管 企業主管及經理人員

☐ 其他（請註明）

3. 你的現職每天工作時數是多少？

4. 你的家庭每月總收入是多少？

5. 請問你使用何種交通工具到達你接受精神醫療及心理衛生服務的院所？

☐ 公車

☐ 火車

☐ 捷運

☐ 計程車

☐ 機車

☐ 腳踏車

☐ 自家轎車

☐ 步行

☐ 其他(請註明)

6. 你每週往返你所接受治療的心理衛生治療機構有多少次？

7. 你從家裡（或復健之家）到你所接受治療的心理衛生治療機構需要多久？

8. 你的主要照顧者是否陪伴您往返心理衛生治療中心？

☐ 是

☐ 否 本人獨自往返

如果主要照顧者沒有陪伴您 請問誰陪伴您往返心理衛生治療中心？

9. 如果主要照顧者陪伴你往返 請問他/她是否與中心專業人員接觸？(例如 醫師 心理師 護士 或 社工)

☐從不

☐有時

☐總是

如果答案為從不 原因為何？

10. 就您所知您居住的縣市有哪些精神醫療及心理衛生服務？

☐精神科住院

☐精神科醫院門診

☐精神科診所

☐居家照護

☐院內日間照護

☐復健中心

☐康復之家

☐社區交誼復健中心

☐長期養護機構

☐精神護理之家

☐諮商中心 無提供藥物

☐其他 (請註明)

11. 以下各項心理衛生服務中，請選出在過去的求助經驗中，您曾使用過的服務為何？

☐精神科住院

☐精神科醫院門診

☐精神科診所

☐居家照護

☐院內日間照護

☐復健中心

☐康復之家

☐社區交誼復健中心

☐長期養護機構

☐精神護理之家

☐諮商中心 無提供藥物

☐其他 (請註明)

12. 就下列院所服務的取得你是否覺得有困難？（例如經濟困難或交通問題）

精神科住院 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

精神科門診 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

精神科診所 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

居家照護 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

- 院內日間照護 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難
- 復健中心 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難
- 康復之家 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難
- 社區交誼復健中心 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難
- 長期養護機構 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難
- 精神護理之家 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難
- 諮商中心 無提供藥物 ☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難
- 其他 (請註明)

13. 除了心理衛生機構, 以下哪些機構或人您認為是對你心理健康有幫助的社區資源?

- ☐教堂/寺廟
- ☐父母
- ☐配偶
- ☐兄弟姊妹
- ☐子女
- ☐鄰居
- ☐同鄉鎮的朋友
- ☐家中常去看的或認識的醫師
- ☐同事 /同學

☐ 旁系親屬

☐ 其他(請註明)

14. 你如何繳納你的健保費？

☐ 未納保

☐ 僱主

☐ 眷保

☐ 家人代繳

☐ 政府補助（如低收入家庭）

☐ 慈善機構輔助

☐ 其他（請註明）

15. 當你加入全民健保時 是否由於接受心理衛生服務而需要給付部分負擔或自付額（醫藥費）？

☐ 是

☐ 否

如果答案是否 請問原因為何？

16.在加入全民健保的情況下 您是否對部分負擔或自付額的負擔感到有困難？

☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

17.除了全民健保 是否有參與其他公家保險

☐是

☐否

種類

18.如果有參與私人保險 是否有涵蓋心理衛生服務的需求？

☐無私人保險

☐是

☐否

19.對你而言 負擔私人保險有多困難？

☐極困難 ☐非常困難 ☐困難 ☐有些困難 ☐不困難

第三部份 感受社會支持多面量表

說明: 我們想知道您對下列敘述的看法。請仔細閱讀各項問題, 在最能描述您感受的項目打勾(V)。

1. 每當我有需要時, 我生命中有個特別的人會出現幫我

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

2. 有個特別的人能讓我分享快樂與悲傷

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

3. 我的家人的確努力要幫我

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

4. 我能從家人那得到我在情緒上所需要的協助與支持

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

5. 有位特別的人是讓我感到安慰的主要來源

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

6. 我的朋友的確努力要幫我

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

7. 當萬事不順遂時, 我可以依賴我的朋友

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

8. 我可以告訴家人我的煩惱

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

9. 我有朋友可以分享我的快樂與悲傷

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

10. 我生命中有個特別的人會關心我的感受

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

11. 我的家人樂意幫我下決定

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

12. 我可以告訴我的朋友我的煩惱

☐非常強烈不同意 ☐強烈不同意 ☐有些不同意 ☐沒意見 ☐有些同意 ☐強烈同意 ☐非常強烈同意

第四部份 Brief Symptom Inventory

我將為你讀下列一般人偶爾會面臨的問題。請仔細把每個問題聽清楚，如果以下的敘述在過去的七天中(包括今天)曾經造成你的壓力或困擾，請選出最適合描述你狀況的程度。

1. 緊張(焦慮)或心裡感覺不安

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

2. 暈倒或暈眩

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

3. 有其他人會控制你想法

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

4. 感覺其他人在責備你造成大部份的麻煩

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

5. 記不住事情

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

6. 容易受刺激而生氣或不舒服

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

7. 心臟或胸口疼痛

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

8. 在開放空間中或在街道上感到害怕

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

9. 想結束自己生命

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

10. 無法信任多數人

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

11. 胃口差

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

12. 突然產生的恐懼

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

13. 突然脾氣發作且無法控制

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

14. 即使跟其他人在一起時仍感到寂寞

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

15. 感覺作事情有障礙

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

16. 感到寂寞

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

17. 感覺憂鬱

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

18. 對任何事都不感興趣

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

19. 有恐懼感

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

20. 感覺很容易受到傷害

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

21. 感到其他人對你不友善或不喜歡你

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

22. 感覺低人一等

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

23. 噁心或胃不舒服

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

24. 感覺有人在監視你或談論你

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

25. 入睡困難

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

26. 經常重複確認自己已經做過的事

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

27. 很難下決定

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

28. 害怕搭乘公車地鐵火車或其他交通工具

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

29. 感覺呼吸困難

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

30. 有忽熱忽冷的徵狀

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

31. 避開那些令你恐懼的事物地點或活動

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

32. 你的腦袋會突然感到一片空白

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

33. 身體某些部份感到麻木或刺痛

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

34. 有為你所犯的過錯（例如：說謊、偷竊、暴力行為等）受到懲罰的念頭

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

35. 對未來感覺毫無希望

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

36. 很難專心

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

37. 你身體的某些部份感到虛弱

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

38. 感到緊張或興奮

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

39. 有死亡或去死的念頭

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

40. 有傷害毆打其他人的念頭

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

41. 有打破或損毀事物的衝動

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

42. 與人相處時感到非常忸怩害羞

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

43. 感覺在人群中無法輕鬆例如在購物或看電影時

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

44. 從不覺得跟其他人很親近

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

45. 會有一段時間的驚駭恐慌發作

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

46. 經常陷入爭論中

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

47. 當你被單獨留置時會感到緊張

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

48. 其他人並沒有因你的成就而給你適當的稱讚

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

49. 感覺煩躁所以坐立不安

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

50. 感覺毫無價值

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

51. 感覺如果你退讓，其他人將會佔你便宜

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

52. 對疾病或生活上有罪惡感

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

53. 有心智有點不對勁的念頭

☐0 不會造成困擾 ☐1 有一些困擾 ☐2 中等程度的困擾 ☐3 相當程度的困擾 ☐4 非常困擾

第五部份 一般自我效能量表 (The General Self-Efficacy Scale)

回答下列問題時請選擇一個您認為最好的選項

11. 如果我盡力去做的话，我總是能够解决難題的。

☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確

12. 即使別人反對我，我仍有辦法取得我所要的。

☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確

13. 對我來說，堅持理想和達成目標是輕而易舉的。

☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確

14. 我自信能有效地對付任何突如其來的事情。

☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確

15. 依我的才智，我定能應付意料之外的情况。

☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確

16. 如果我付出必要的努力，我一定能够解决大多數的難題。

☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確

17. 我能冷靜地面對困難，因為我可信賴自己處理問題的能力。

☐完全不正確 ☐尚算正確 ☐多數正確 ☐完全正確

18. 面對一個難題時，我通常能找到幾個解決方法。
☐完全不正确 ☐尚算正確 ☐多數正確 ☐完全正確
19. 有麻煩的時候，我通常能想到一些應付的方法。
☐完全不正确 ☐尚算正確 ☐多數正確 ☐完全正確
20. 無論什麼事在我身上發生，我都能夠應付自如。
☐完全不正确 ☐尚算正確 ☐多數正確 ☐完全正確

第六部份 Devaluation-Discrimination Scale

以下的問題是一些關於精神疾病的敘述。請從中選擇出最能反應出你如何相信其他人對精神疾病的感覺或情緒問題治療的想法。關於你的論點，沒有所謂的正確答案。第一印象通常是最理想的答案。

10. 多數人會願意接受一位有精神困擾的人當朋友
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
11. 多數人相信一個曾住過院接受精神治療的人和一般人一樣聰明
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
12. 多數人相信一個曾住過院接受精神治療的人和一般人一樣值得信任
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
13. 多數人會接受一個曾接受精神科治療但精神狀態穩定的人擔任公立學校學童的老師
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
14. 多數人覺得住院接受精神治療是一種個人失敗的象徵
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
15. 多數人不會僱用一個有精神病史的人來照顧他們的幼兒即使他有時狀況良好
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

16. 多數人較看低一個曾住院接受精神治療的人
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
17. 大部份的雇主會雇用有精神病史且有資格和能力擔任工作的人
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
18. 找工作時大部份的雇主會雇用一般人而避免用有精神病史的人
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
10. 我的鄰居對待有精神病史的人就像對待其他人一樣
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
14. 多數年輕女性會和有精神病史的男子約會
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
15. 多數人一旦知道某個人曾住院接受精神治療他們就不會太在意這個人的意見
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意
16. 多數人認為一個曾因嚴重的精神疾病住院的人是危險和不可預測的
☐1 強烈同意 ☐2 同意 ☐3 不同意 ☐4 強烈不同意

第七部分 Self-Appraisal of Illness Questionnaire (SAIQ)

我想要瞭解你對自己疾病的感覺。在下列的敘述中，請選擇最能反應出你感覺的選項。

1. 當你聽到有人推薦現在進行的治療方式時，你對這樣的推薦感覺為何？
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
2. 你會常常擔心某些事嗎？
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常
3. 你會擔心目前的病況嗎？
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常

4. 你會因為你的病況所產生的不便而擔心嗎？
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常
5. 你會因為目前的病況而擔心失去朋友嗎？
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常
6. 你會因為目前的病況而擔心你會無法工作嗎？
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常
7. 你擔心疾病無法康復的程度為何？
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常
8. 我認為我的病況會自動康復
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
9. 在我心中毫無疑問地我將會好起來
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
10. 你相信現在的治療是必需的嗎？
☐ 絕對相信 ☐ 有一些相信 ☐ 有一點不相信 ☐ 絕對不相信
11. 假設如果你從未接受過治療你認為你目前應該會是什麼狀況？
☐ 非常糟糕 ☐ 有點糟糕 ☐ 還不錯 ☐ 非常好
12. 我可以從治療中得到許多好處
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
13. 假設我現在中斷治療我會變好
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意
14. 你的想法和感覺會影響你去完成一件事
☐ 完全不會 ☐ 有一些 ☐ 中等程度 ☐ 非常
15. 我認為我的狀況需要接受精神醫療
☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意

16. 我有精神疾病的症狀

☐ 強烈同意 ☐ 同意 ☐ 不同意 ☐ 強烈不同意

17. 你認為你疾病輕重為何?

☐ 完全沒有 ☐ 輕度 ☐ 中度 ☐ 重度

第八部分 求助行為量表

因為精神分裂症，在過去的經驗中，你或許曾和一些人討論或嘗試不同的治療方式。下列是一些你可能接觸過的人或方式。請選出最適切描述你使用狀況的選項。

1. 非正規方式的求助行為

1. 拜拜

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

2. 收驚

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

3. 祈禱 / 告解

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

4. 做法事

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

5. 改風水（住宅、祖墳）

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

6. 求神問佛（乩童 道士 廟祝）

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

7. 算命

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

8. 密方 (藥酒、草藥、食療、涼補或熱補)

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

9. 中醫師開的藥方

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

10. 非精神科醫師

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

11. 自我療法 (自己買成藥吃)

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

12. 其他 (請註明)

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

II. 正規方式

1. 精神科醫師心理治療

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

2. 使用精神科醫師開處方之藥物

☐ 未曾使用 ☐ 很少使用 ☐ 有時候使用 ☐ 時常使用 ☐ 一直使用

3. 心理治療師

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

4. 社工

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

5. 住院

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

6. 門診

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

7. 日間照護

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

8. 居家照護

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

9. 康復之家

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

10. 社區交誼復健中心

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

11. 其他(請註明)

☐未曾使用 ☐很少使用 ☐有時候使用 ☐時常使用 ☐一直使用

問卷結束！謝謝您的合作！

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