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Mental Health Problems and Perceived Barriers in Seeking Psychological Help: A Survey of Students at the University of the Witwatersrand

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University of the Witwatersrand

School of Human and Community Development

Department of Psychology

Master's Degree in Social and Psychological Research (MSPR)

Mental Health Problems and Perceived Barriers in Seeking Psychological Help: A Survey of Students at the University of the Witwatersrand.

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Submitted in partial fulfillment of the requirements for

the Degree of Master of Arts in Social and Psychological Research (PSYC7022)

in the Department of Psychology, School of Human and Community Development, Faculty of Humanities, at the University of the Witwatersrand, Johannesburg.

DECLARATION

I, Zinhle Penelope Ngcobo, declare that this research report is my original work. All sources used have been acknowledged in the report. This report is being submitted for the degree of Master's in Social and Psychological Research in the Faculty of Humanities, University of the Witwatersrand, Johannesburg. It has not been submitted previously for any degree or examination at any other University.



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First and foremost, I'd like to express my gratitude to God for his grace in my life and for providing me with the direction and strength I needed to complete this study.

Secondly, I'd like to offer my heartfelt gratitude to Dr. Vinitha Jithoo, my supervisor, for her advice and assistance throughout my research project.

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Last but not least, without participants, this study would not have been conceivable. Thank you so much to all participants for taking the time to take part in this survey- I genuinely appreciate it.

ABSTRACT

Aim: The study examined help-seeking behaviours and attitudes among students at the University of the Witwatersrand, Johannesburg. The goal was to investigate students' preferred sources of help while they were experiencing psychological distress, as well as the perceived barriers to getting psychological care. The Health Belief Model (HBM) was used as the theoretical framework, which attempted to discover whether the HBM variables predict formal help-seeking among students.

Methods: The data was acquired from a suitable sample of 165 students using a cross-sectional survey design. A demographic questionnaire, a list of different sources of assistance, the Health Beliefs about Mental Illness (HBMI) instrument, the Barriers to Care Evaluation (BACE) scale, and the Barriers to Help Seeking (BHSS) scale were all included in the survey. The Statistical Package for the Social Sciences (SPSS, version 27) was used to analyse the data.

Results: The findings revealed that only one-third (33.3%) of the students preferred seeking help from a mental health professional. The most important barriers identified were students preferring to deal with psychological issues on their own as they perceived symptoms not to be serious enough to warrant professional intervention; stress and anxiety were considered a normal part of life, and many students were unaware of helping resources and how to access them. The logistic regression analysis indicated that only the perceived benefits made a unique statistically significant contribution to the model, recording an odds ratio of 2.99. The results revealed that the odds of seeking formal help are about 3 times greater for students who perceive seeking formal help as beneficial compared to those who perceive formal help-seeking as not beneficial (OR 2.99; 95% CI: 1.45-6.20; $p = 0.003$).

Conclusion: Understanding barriers to psychological help-seeking is imperative to ensuring early access to psychological services and improving mental well-being. Therefore, the current findings suggest that strategies and initiatives such as psycho-educational programs and awareness campaigns highlighting the availability and purpose of psychological services on campuses, as well as the benefits of utilizing psychological services, are necessary. This would make psychological services more desirable to students, thereby reducing the identified barriers.

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CHAPTER 1: INTRODUCTION

Given the high prevalence of mental health problems among university students, it is critical to comprehend the factors that influence help-seeking and the use of psychological services by this demographic (Hurrioz et al., 2018; Storrie et al., 2010; Hunt & Eisenberg, 2010). In recent years, there has been a growing concern about the mental health crisis among university students (Auerbach et al., 2016). As a result, universities in high-income countries and middle to low-income countries such as South Africa introduced student mental health policies and psychological services to address students' mental health needs (Draper et al., 2009; Kaminer & Shabalala, 2019; University of Cape Town, 2018). Psychological services refer to a variety of services provided by psychologists and other members of the psychology profession (Dlamini, 2019). Counselling, psychological education, crisis response, assessments, and research are examples of these services (Sommers-Flanagan & Heck, 2013, as cited in Matabane, 2015). Thus, according to the Southern African Association for Counselling and Development in Higher Education (SAACDHE, 2017), counselling services in higher education institutions were introduced to: promote holistic wellness and development among students; enhance learning skills to effectively meet educational goals; and provide counselling and/or therapy for developmental, vocational, personal and/or psychological problems. However, such psychological or counselling services seem to be underutilized by students.

A study by Bowman and Payne (2011) explored the utilization and profile of students receiving services from the Emthonjeni Centre (EC) and Career Counselling and Development Unit (CCDU) at the University of the Witwatersrand, Johannesburg. The EC is an interdisciplinary psycho-social health service centre and training facility for social workers, community counsellors, and psychotherapists from the School of Human and Community Development at the University. The CCDU is the university's first point of contact for students, offering guidance ranging from career decisions to studies, bursary opportunities, and personal counselling. Unfortunately, the study reported underutilization of these centres in which only 3.1% of students were reported to have received services from the two counselling centres during 2008. Recently, a study conducted among 14 575 first-year students revealed that only 18.8% of students utilized mental healthcare in the past 12 months (Bantjes et al., 2020). Although this current study is not limited to psychological services on campuses, such findings do however lead to the question of which factors serve to enable or

act as barriers for students to seek help, especially having such services easily available to them.

Seeking help is conceptualized as a multi-step process that begins with the individual's awareness of the problem; followed by the expression of the problem; a need for external help; the identification of appropriate sources of help for the individual to access; and finally, the individual's willingness to use or seek help from the source of help identified (Gulliver et al., 2010). Barriers to psychological help can emerge at any stage in the help-seeking process, ranging from not being able to recognize one's own symptoms to concerns about how one is going to be perceived when he/she seeks help. A key barrier to professional help-seeking identified in numerous national and international studies is that of stigma toward mental illness and treatment(Egbe et al., 2014; Nohr et al., 2021; Seerane, 2016; Sullivan & Mancillas, 2015). Whilst there have been many concerted efforts to fight stigma against mental illness, recent research still shows stigma as the most prominent help-seeking barrier (Dingle et al., 2021). Stigma can be defined as negative attitudes or beliefs held by others (Arboleda-Florez & Stuart, 2012). These negative attitudes and beliefs may include associating mental health problems with weakness, and incompetence (Puspitasari et al., 2020). Those experiencing mental health problems may be reluctant to seek help to avoid stigma or being discriminated against. Moreover, research suggests that poor mental health literacy is a concerning barrier to seeking psychological help (Chandrasekara, 2016; Ratnayake & Hyde, 2019). Jorm (2000) states that mental health literacy is concerned with the ability to recognize or identify mental health-related symptoms and recognize appropriate help-seeking outlets.

Furthermore, research has shown a discrepancy in help-seeking behaviours between men and women, in which women are most likely to seek psychological help and have more positive attitudes toward seeking help (Bowman & Payne, 2011). Gender role socialization plays a role in how women and men perceive help-seeking (Broglia et al., 2021). Women are socialized to be more dependent, emotional, and forthcoming with their challenges, whilst men are socialized to be more independent, strong, and self-reliant. Therefore, it is socially acceptable for women to show vulnerability and the need for comfort, making women more likely to have positive attitudes toward seeking psychological help than men (Broglia et al., 2021).

1.1.Rationale and study aim

Mental health problems are common among university students, yet their willingness to seek help is still rather low (Bantjes et al., 2016). This predicament is alarming because it is during this stage of development when mental health problems surge (O'Connor et al., 2014).

Emerging adulthood is a developmental stage that occurs between the ages of 18 and 25 years (Arnett, 2000). This stage is characterized by a transitional period between adolescence and young adulthood. Emerging adulthood, according to Arnett (2000), is neither adolescence nor young adulthood in the sense that an individual has left the dependency of childhood and adolescence but has not yet reached the enduring obligations of adulthood. Emerging adulthood is the preparation to take on responsibilities that emerge in adulthood. For most, it is a period of some confusion, uncertainty, and instability as most seek to create a sense of self and make tough decisions regarding their career and relationships (Wood et al., 2018). According to Erik Erikson's Theory of Psychosocial development, the fifth stage; identity vs. role confusion occurs between the ages of 13 and 19(Maree, 2021). During this stage, adolescents search for a sense of self and personal identity through an intense exploration of personal values, beliefs, and goals. Additionally, the sixth stage occurs between the ages of 20 and 40, intimacy vs. isolation. During this stage, the major conflict centres on forming intimate, loving relationships with other people, other than a family member(Maree, 2021). For most young people, this time may coincide with being a university student (Arnett, 2000; Motau, 2015; Mboya et al., 2020).

Most explore various possibilities in relationships, work, and worldviews, whilst seeking to create an identity and independence (Arnett, 2000; Motau, 2015). As a result, emerging adulthood is said to be the most challenging time emotionally and socially (Arnett, 2006). According to Jithoo and Bakker (2011), the changing ecology of childhood and family relationships (a more individualistic attitude toward life); socio-demographic changes (joblessness); health difficulties (such as HIV/AIDS); substance misuse; trauma; and violence have a substantial impact on young people's wellbeing and mental health. As a result, emerging individuals are growing up, learning, and navigating their way to maturity and independence in a world that is becoming increasingly complicated and hard, with increasing levels of choice and opportunity, but also unprecedented levels of uncertainty and risk.

According to Wynaden et al. (2013), the age onset of engaging in tertiary education coincides with the onset of numerous mental disorders such as depression, anxiety, and substance-

related disorders, putting university students at a higher risk. University students experience various stressors that may lead to psychological distress (Dlamini, 2019; Mudau, 2020). Institutions of higher education present students with a number of academic obstacles which students need to overcome to succeed and graduate. For instance, the pressure to thrive academically, socially, and financially at university may lead to psychological distress among students (Tanga & Maphosa, 2018). Unlike in high school or secondary school, stress levels in some students increase due to different academic environments and teaching styles, as well as the pressure to perform well (Eisenberg et al., 2007). Additionally, the COVID-19 pandemic changed the mode of learning from face-to-face to online learning (e-learning), which inevitably widened the gap between the poor and the rich. In South Africa, major access disparities exist in terms of electricity, internet, and information technologies, which have created considerable challenges to online learning for underprivileged students(Mpungose, 2020). An analysis of students' feedback at a South African university during the COVID-19 lockdown revealed that the lack of access and resources was one of the most prominent issues experienced by students during this period(Fouche & Andrews, 2022).

Whilst most higher institutions provided laptops and data to students, this analysis indicated that some students had to borrow laptops from neighbours or relatives whilst some only accessed classes and study material on smartphones. Some students revealed that the data provided is (was) not enough and half of the provided data could only be used between midnight and 5 AM which was also a significant hurdle(Fouche & Andrews, 2022). Poor internet connection, load-shedding, and unplanned power cuts due to inadequate and poorly maintained South African electricity power system was also cited as a structural challenge to online learning, especially among students residing in rural areas(Walker, 2020). Among other challenges, Mpungose found students' home environment as a significant challenge as many students are first-generation students who come from households that do not understand how much time is needed for tertiary studies(Mpungose, 2020). Therefore, students cited too much noise, noisy neighbourhoods, and having too many chores as hurdles to meeting deadlines.

COVID-19 has also intensified uncertainties in terms of employment. According to the Quarterly Labour Force Survey (QLFS) of the 1st quarter of 2021, youth aged 15-24 and 25-34 recorded the highest unemployment rates of 63.3% and 41.3%, respectively(Statistics SA, 2022). Such high employment rates may be worrisome to university students as some may be in process of seeking employment in a form of internships, learnerships, entry-level jobs, etc.

Furthermore, student funding continues to be a challenge for South African students and the government. The National Student Financial Aid Scheme (NSFAS) faced a funding shortfall in 2021 which was partly due to COVID-19, budget cuts across government departments and the country's battered economy(South African Government News Agency, 2021). Unpaid student debt is also something students stress about as it hampers them from graduating within the stipulated period(Van der Merwe, 2022).

While stress, anxiety, and depression may be perceived as a normal part of university life, if these psychological problems are not attended to, they may lead to academic failure, and symptoms may progress to severe psychological problems or psychiatric disorders (Dlamini, 2019; Eisenberg et al., 2007). For example, a South African study at the University of Cape Town revealed that 25.0% of students were diagnosed by a health professional for depression, 25.0% for anxiety disorder and 28.1% students were receiving psychotropic medication (Van Der Walt et al., 2020). Bantjes et al. (2021) reported a twelve-month prevalence of 40.9% for suicidal ideation, 22.3% for suicidal plan and 3.9% for suicidal attempt amongst students at two South African universities. Therefore, it is imperative to promote mental wellbeing amongst students as well as understand help-seeking behaviours and attitudes due to their vulnerability. Understanding barriers to seeking psychological help constitutes an important endeavour for reducing the burden of mental illnesses, its consequences, and for the planning of mental health services.

Whilst previous studies provide compelling evidence suggesting a disconnection between the experiences of mental distress amongst students and the utilisation of psychological services; these studies do not provide conclusive reasons for this disconnect. Therefore, the study examined help-seeking behaviours and attitudes amongst students at the University of the Witwatersrand, Johannesburg. The aim was to explore students' preferred sources of help when experiencing psychological distress and to examine the barriers to seeking psychological help as perceived by students. Lastly, using the Health Belief Model (HBM) as a theoretical framework, the study aimed to explore whether the HBM variables predict the likelihood that students would report that they preferred formal help-seeking. The HBM is suggested to provide a structure for developing interventions and evaluating programs to address inaccurate beliefs and maladaptive attitudes about mental health and its services (Henshaw & Freedman-Doan, 2009).

1.2.Research objectives

- To determine students' preferred sources of help when experiencing psychological distress;
- To identify which HBM variables serve as barriers to utilising treatment
- To identify barriers to seeking psychological help as perceived by university students; and
- To determine if there is a significant difference between females and males mean score towards psychological help-seeking

1.3.Report layout

This research report consists of six chapters. This first chapter introduced the study by providing a brief introduction to the topic of psychological help-seeking and the rationale of the study. The chapter concluded with the research aims and research objectives.

In Chapter Two, the researcher engages with relevant literature in order to have a better understanding of help-seeking behaviours and barriers to seeking psychological help. The HBM constructs are also outlined in relation to psychological help-seeking. Chapter Three presents the research methodology including the research design, sampling and population, data collection procedure, ethical considerations, instruments, and data analysis. In Chapter Four, the results of all statistical analytical approaches employed in this study are reported. Firstly, the description of the demographic characteristics of the sample is presented, followed by the psychometric properties of the instruments (i.e., the Health Beliefs about Mental Illness (HBMI) instrument, Barriers to Care Evaluation (BACE) scale, Barriers to Help Seeking Scale (BHSS). The results of the descriptive analysis (e.g., frequency, mean scores, etc.) and results of the independent T-test and Analysis of Variance (ANOVA) are presented in this chapter in order to assess demographic differences. The results of the logistic regression analysis are also presented to determine which HBM variables predict formal help-seeking. Chapter Five elucidates the findings in relation to the literature review, followed by Chapter Six which presents the conclusion of the study, limitations, and recommendations for future studies.

CHAPTER 2: LITERATURE REVIEW

The prevalence of mental health problems has increased dramatically in recent years, with depression and anxiety being the most common mental disorders experienced by young people (Auerbach et al., 2018; Eloff & Graham, 2020). According to studies, students are more prone than non-students to suffer from mental health issues (Saleem and Naz, 2019; Mboya et al. 2020). This is because students are said to experience not only interpersonal, financial, and family issues, but also challenges that come with being a university student, such as the growing levels of academic and career demands (Motau, 2015). To deal with such demands and to achieve academic success, most universities offer psychological services to students to ensure the early intervention and treatment of mental distress (Dlamini, 2019). However, despite having these psychological services available, a large percentage of students do not utilize these facilities (Bantjes et al., 2020; Wao et al., 2022). Previous research has identified stigma, masculinity, mental health literacy, perceived ineffectiveness of therapy, lack of perceived need for therapy and, financial burden incurred by mental health services as the most common barriers to help-seeking among students (Ibraham et al., 2019).

In the literature review to follow, these aspects are discussed in further detail. The theoretical framework used as well as the common barriers in seeking psychological help are discussed, namely stigma, poor mental health literacy, gender, language and culture, perceptions of mental health professionals and mental health services and confidentiality, trust, and other barriers. Literature on mental health problems among students is reviewed, as well as psychological help in general, including the different sources of help.

2.1.Theoretical Framework: Health Belief Model

This study used the Health Belief Model to explore factors inhibiting students from seeking psychological help. In the 1950s, a group of social psychologists created the Health Belief Model to better understand help-seeking behaviour in relation to disease preventive programs and tactics (Rosenstock, 1966). The model concluded that it is people's beliefs that influence whether or not to take part in prevention programmes. Beliefs, according to(Norman & Conner, 2005), are personal traits that impact behaviour and can be acquired through primary socialization. Therefore, in relation to the HBM, the social psychologist hypothesized that health-related behaviours are influenced by a number of factors and beliefs, including the perceived susceptibility and severity of a certain health condition; perceived benefits of seeking help; and perceived barriers to seeking help or participating in prevention programs

(Norman & Conner, 2005) As research on HBM evolved, cues of action and self-efficacy were added. Traditionally, cues of action refer to anything that may prompt an individual to seek help, such as mass media campaigns or advice from others. Self-efficacy is the belief in one's ability to carry out health-related behaviours (Rosenstock et al., 1988).

The HBM has been empirically validated in the discipline of public health by various authors (Glan, 2009; Carpenter, 2010 and Hall, 2012), but only a few studies in the field of mental health services have been done (Kim & Zane, 2016; O'Connor et al., 2014; Langley, 2015). Rosenstock's (1974) original model was revised by Henshaw and Freedman-Doan (2009), who proposed that an amended HBM could predict help-seeking behaviour for mental health problems. The model (Figure 1) by Henshaw and Freedman-Doan (2009) suggests that demographic variables (education, age, sex and ethnicity) have an impact on the HBM factors (threat perception and expectation factors) which in turn influence help-seeking. Threat perception comprises two key beliefs: perceived susceptibility and perceived severity. Behavioural evaluation, however, comprises perceived benefits and perceived barriers. In this model, cues of action were included as an important variable influencing help-seeking.

Langley (2015) claims that there is insufficient evidence to demonstrate that demographic characteristics influence HBM constructs, but that demographic variables may be just as relevant as perceived threat and expectations in predicting help-seeking behaviour. Therefore, this study utilises the HBM by Langley, a modified HBM incorporating Henshaw and Freedman-Doan (2009), as demographic variables may predict help-seeking behaviours (Figure 2). Furthermore, demographic factors specific to the South African context must be taken into account in predicting help-seeking behaviours, necessitating model adaptation.

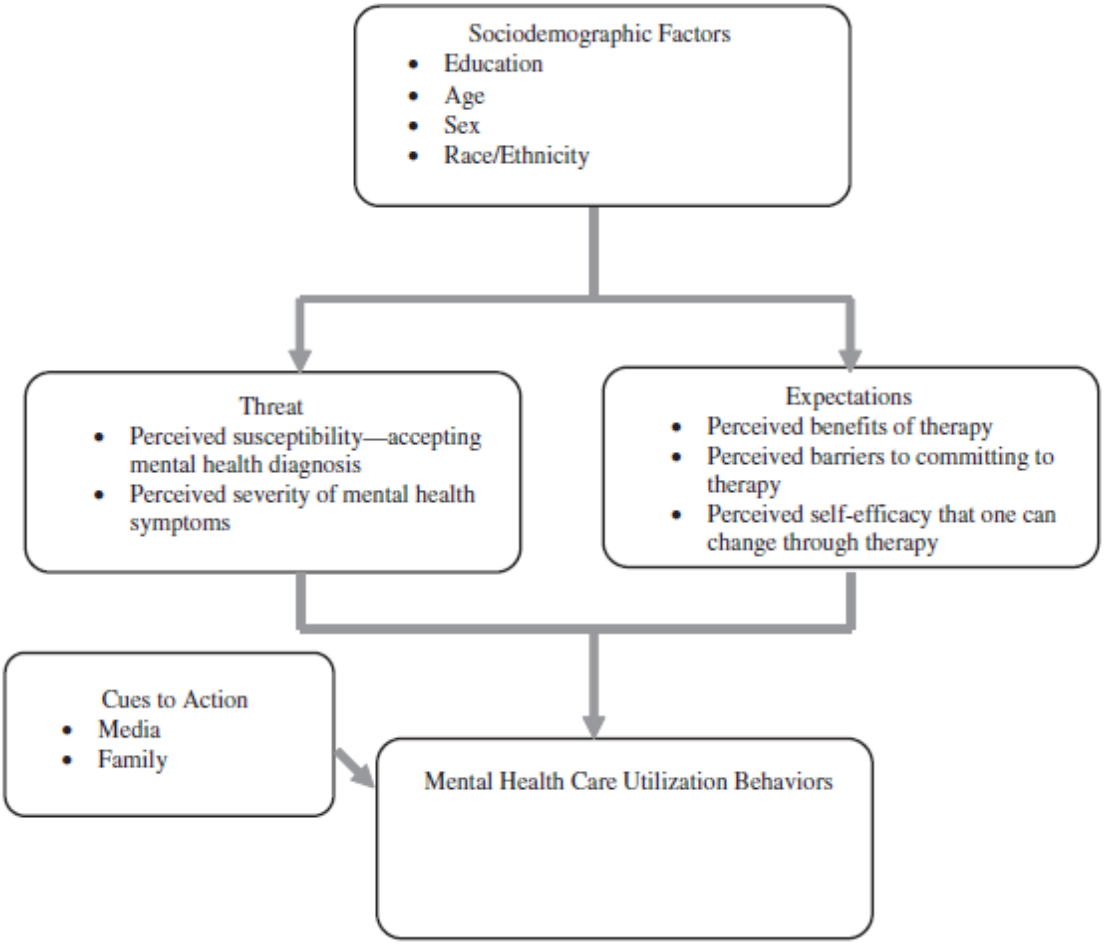


Figure 1: Conceptualising mental health care utilisation using the Health Belief Model *(Henshaw & Freedman-Doan, 2009).*

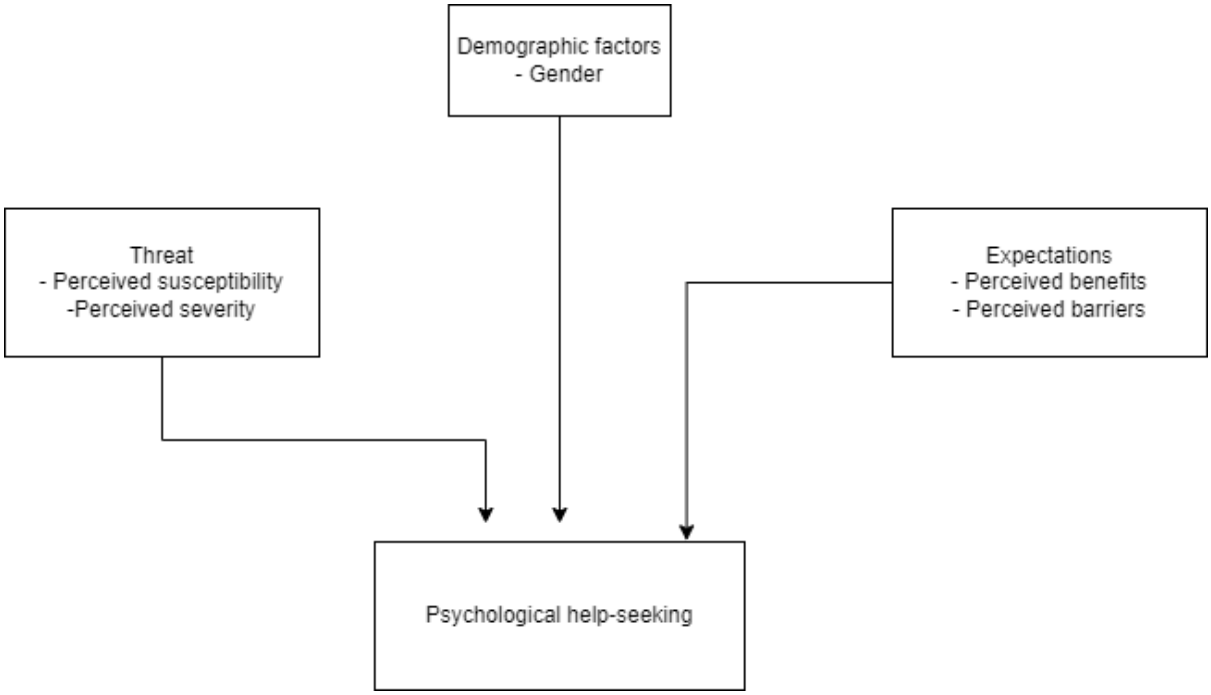


Figure 2. An evaluation of treatment barriers and help-seeking in anxiety disorders using the Health Belief Model *(Langley, 2015).*

2.1.1. Threat perception

2.1.1.1.Perceived Susceptibility and Perceived Severity

Threat involves perceptions of being vulnerable or susceptible to a given health problem (perceived susceptibility) and perceptions relating to the severity of that health problem (perceived severity). Henshaw and Freedman-Doan (2009) defined perceived susceptibility as an individual's acceptance of a mental health diagnosis or vulnerability to receiving one, and perceived severity as the perceived consequences of mental health symptoms when applying the HBM constructs to mental health service utilization.

There is growing research in the mental health field utilising the HBM to predict help-seeking behaviour. For example, the aim of O'Connor et al.'s (2014) study was to find predictors and modifiers of young adults' mental health help-seeking behaviour. The study reported perceived susceptibility as a non-significant predictor of help-seeking behaviours unless individuals perceived benefits of such behaviour and were health conscious. Thus, perceived severity and self-efficacy were reported to have a positive relationship with intention to seek help. Similarly, Stone (2021), there was a small positive association between perceived

severity and psychological help-seeking intention reported. Furthermore, Hayden (2009) found perceived susceptibility and severity to be the most powerful predictors in encouraging people to adopt healthier behaviours. Langley's (2015) study on anxiety disorders reported that 51% of variance in help-seeking intention was accounted for by the HBM, suggesting that demographics, perceived susceptibility, symptom severity, treatment benefits, treatment barriers, response efficacy and self-efficacy can predict help-seeking. In essence, such studies have indicated that individuals who perceive vulnerability to mental illness and severity of symptoms are more likely to engage in help-seeking. Thus, individuals perceiving that the intervention will be effective and those perceiving fewer barriers are more likely to engage in help-seeking.

2.1.2. Expectations

2.1.2.1.Perceived benefits and Perceived barriers

The HBM also emphasizes the expectations involved in seeking help. In this scenario, the expectation is that a certain health intervention will avoid a health problem for which people believe they are at risk. Furthermore, expectations involve perceptions about the benefits of and barriers to seeking help for a health problem. According to Henshaw and Freedman-Doan (2009), perceived benefits refer to one's belief about whether taking an action, specifically seeking psychological help, would reduce their chances of getting the condition and reduce its severity and symptoms; whilst perceived barriers refer to one's belief on the costs of acting as well as the perceived obstacles that may prevent an individual from taking health-related actions.

Previous studies have found perceived benefits and barriers to be amongst the strongest factors predicting mental health care utilisation amongst individuals (Vidourek et al., 2014; Kim and Zane, 2016; Chan et al., 2016; O'Connor et al., 2014; Carpenter, 2010). Individuals consider the rewards and drawbacks before deciding whether or not to act. In addition, individuals are more likely to seek treatment if they believe that mental health services are valuable and that the benefits outweigh the disadvantages. University students' perceived benefits of seeking psychological help have been under-studied. However, psychological help is often believed to promote emotional recovery and wellbeing. Watson (2016) found that one of the perceived benefits of seeking psychological help amongst African American women is learning new skills such as coping with symptoms and difficult emotions. Moreover, expressing emotions is reported to produce various benefits such as emotional relief, insight

and feeling understood. Vidourek et al (2014) indicate that improved mental health, reduced stress, and an increased ability to resolve one's problems were the top three perceived benefits amongst 682 students at Midwestern University. Additionally, O'Connor et al. (2014) reported a direct relationship between perceived benefits and psychological help-seeking intentions. In contrast, Mojtabai et al. (2016) found no direct relationship between perceived benefits and psychological help-seeking intentions. However, individuals who have engaged in psychological services before and who have had positive past experiences show greater belief in the effectiveness of therapy (perceived benefits) and greater intent to engage in psychological help-seeking (Gulliver et al., 2010; Vogel & Wester, 2003; Niegocki & Egisdottir, 2019).

Individuals are less likely to seek help for their mental health concerns due to perceiving barriers to receiving psychological help. Recently, Langley et al. (2018) found perceived barriers to be significantly related to psychological help-seeking intentions in which a direct negative relationship was reported. Additionally, Kim and Zane (2015) reported a negative relationship between help-seeking intentions and perceived barriers (i.e., social and self-stigma). Barriers identified in previous research are stigma, gender (masculinity), language, confidentiality and trust, mental health literacy, cost of services, preference for alternative sources of help etc. A brief discussion of these barriers is presented below. A lack of perceived need and perceived ineffectiveness of treatment are identified as barriers. However, these are related to perceived susceptibility and perceived benefits.

2.1.3. Stigma

Stigma is identified as a primary barrier to mental health services utilisations (Schnyder et al., 2017). Stigma, according to Arboleda-Florez and Stuart (2012), is a feeling of being unfavourably differentiated or regarded as a result of having a specific ailment or belonging to a specific group. In addition, Blaine (2000, p. 40) defined stigma as "a mark or flaw resulting from a personal and physical characteristic that is viewed as socially unacceptable". Links and Phelan's model of stigma alludes that stigmatization occurs when four interrelated factors come together: (1) people recognizing and labelling human differences; (2) those deviating from normalcy are labelled with undesirable characteristics, i.e. negative stereotypes; (3) labelled persons are placed in distinct categories, creating a degree of separation between 'us' and 'them'; and (4) labelled persons experience a loss of status and discrimination (as cited in Barke et al., 2011, p. 12).

There are several distinct types of stigma; with public stigma and self-stigma being the most common types. The term "public stigma" refers to collectively held negative stereotypes and prejudices about mental illness. (Kengeter, 2017; Schnyder et al., 2017). Self-stigma also known as internalized stigma refers to negative attitudes about oneself because of internalising stereotypes held by society (Zuma, 2018; Kengeter, 2017). According to Eisenberg et al. (2009) and Nohr et al. (2021), self-stigma occurs when a person with a mental illness accepts negative stereotypes and identifies with stigmatized groups or individuals. Expanding on these forms of stigma, Eisenburg et al. (2009) and Lally et al. (2013) explored various other forms of stigma, namely personal stigma, and perceived public stigma. Personal stigma refers to an individual's prejudices and stigmatizing attitudes toward people with mental illnesses, which when aggregated result in public stigma (Lally et al., 2013). Individuals' perceptions of public stigma, or the extent to which they believe the public has stigmatizing attitudes toward those with mental illnesses, are referred to as perceived public stigma (Lally et al., 2013).

Nevertheless, these forms of stigma are often related or develop sequentially once public stigma is present (Corrigan et al., 2006). Once an individual is aware of public stigma, personal attitudes (personal stigma) may be formed, which usually concur with perceived stigma, and then the individual may or may not apply these stigmatising attitudes to the self (self-stigma). Similarly, Chen and Chandrasekra (2016) suggested that public stigma may lead to self-stigma, for example, if significant others view those with mental illness in a negative light (i.e., people with mental illness are "crazy" or "dangerous"), an individual is more likely to internalise those views and as a result, this influences the individual's own evaluation of people with mental illnesses, leading to self-stigma (Chen & Chandrasekra, 2016).

Generally, stigma associated with mental illnesses has been found to impede mental health service utilisation (Kim and Zane, 2016; Topkaya, 2015; Salaheddin and Mason, 2016). Individuals with mental illnesses are often stigmatised and labelled by society. For instance, people with mental illnesses may be considered unpredictable, dependent, dangerous, blameworthy, weak, and lazy by society (Ibrahim et al., 2019 and Nohr et al., 2021). People with mental illness often experience stigmatization and discrimination within family, community as well from health care providers. There are reports of people with mental illness being beaten, shouted at, being made fun of, called names like "lunatic", and being denied food by family(Egbe et al., 2014).

It is therefore assumed that an individual may anticipate that they will experience discrimination from others because of seeking help or being diagnosed.

Jombo and Idung (2018) found that university students in Nigeria showed high levels of negative and stigmatising attitudes, with 82.6% of students believing that people with mental illnesses need the same control as young children; whilst 51.7% believed that people with mental illnesses are potentially dangerous; 41.3% believed that they should be isolated from the community; and 53.4% agreed that they would not marry someone who suffered from a mental illness. Pederson et al. (2022) found that students described mental illness as having spiritual origins such as demon possession, witchcraft and curses, which lead to forms of stigma such as discrimination and social distancing from the people with mental illnesses. Previously, Ben-Porath (2002) revealed that students described a depressed person seeking help as emotionally unstable in a case vignette. These studies do not review these stigmatising beliefs in relation to help-seeking. However, it may be assumed that students may anticipate that they would be perceived or treated the same if diagnosed with a mental disorder or if they seek help. In Jithoo (2017), however students expressed some anxiety about consulting psychologists and psychiatrists mainly because of the stigmas perpetuated by society and very importantly because they felt that these services required individuals to relinquish complete control of their personhood.

Kengeter's (2017) study on medical students revealed that many students believed that seeking psychological help, or rather being diagnosed with a mental disorder could be viewed as a sign of weakness and may impact their future occupational opportunities and relationships. Salaheddin and Mason (2016) conducted a study on 203 young adults in which perceived stigma is reported as an important barrier to seeking psychological help, whereby most participants reported feeling embarrassed and ashamed (31.1%); feeling concerned that being diagnosed might affect their chances of getting employment (24.3%); some saw it as a sign of weakness (22.0%); and some were concerned about being thought of as "crazy" (19.8%).

Findings from studies exploring each or all forms of stigma are quite mixed regarding which form of stigma is the most prominent barrier to help-seeking. For example, Broglia et al. (2021) found self-stigma to be a prominent reason for non-help seeking among students at a University in the United Kingdom. Additionally, Vogel et al. (2017) found that self-stigma predicted negative attitudes towards psychological help-seeking. Eisenberg et al. (2009)

found that perceived public stigma was higher than personal stigma, but that personal stigma was significantly and negatively associated with the perceived need and utilisation of mental health services, whereas perceived public stigma was not, implying that personal stigma is the more prominent barrier. Similarly, a cross-sectional study on 735 students revealed that personal stigma was significantly associated with the decreased likelihood of help-seeking intention, whilst perceived public stigma was found to be not significantly associated with help-seeking intention (Lally et al., 2013). Thus, Golberstein et al. (2008) found that perceived public stigma was not associated with help-seeking nor past-year service use. In contrast, Pederson and Paves (2014) revealed that perceived public stigma had an influence in the reluctance to seek help for mental health problems amongst students. In Schnyder et al. (2017), negative attitudes held about mental health problems (public stigma) and seeking help were revealed to be the most prevalent barrier to seeking psychological help.

Kengeter (2017) referred to stigmatization as a product of poor mental health literacy. Similarly, Jung et al. (2017) asserted that increasing mental health literacy may mediate the effects of public stigma and self-stigma on seeking help for psychological problems. Masuda et al. (2012) also highlighted difficulty with disclosure as being positively associated with stigma, especially regarding sharing personal information that may be thought of as embarrassing.

2.1.4. Mental Health Literacy

According to Jorm (2000, p. 182), "mental health literacy can be defined as knowledge and beliefs about mental disorders which aid their recognition, management or prevention". Jorm et al. (1997) further concluded that mental health literacy consists of several components. To begin with, it refers to one's ability to recognize and identify the signs of various mental illnesses. Secondly, it comprises information and beliefs about risk factors and causes, as well as self-help and professional support to reduce symptoms. Finally, it refers to people's attitudes that help them recognize and seek help when they need it, as well as their understanding of how to find mental health information. Thus, Jorm et al. (1997) suggested that mental health literacy also encompasses the ability to differentiate between normal or general stress and a mental condition.

Kutcher et al. (2016) also used other components to define mental health literacy. Understanding how to achieve and maintain good mental health; understanding mental disorders and their treatment; knowing when and where to seek evidence-based mental health

care; and having competencies to improve self-care are amongst them. Almanasef (2021) described mental health literacy as knowledge of mental health that assists in recognising, managing, and preventing mental disorders. Therefore, mental health literacy has a variety of benefits as it allows for early intervention to manage symptoms. In contrast, poor mental health literacy is assumed to be a factor that hampers people from seeking psychological help. The failure to recognise and identify symptoms early may delay the help-seeking process making the symptoms worse over time. Self-identification is the first step of the help-seeking process (Schomerus et al., 2019). According to Jithoo (2017), students believe that mental disease is veiled and hidden, and they frequently struggle with the intangible and illusory aspect of mental health, thereby instilling anxiety and doubt. Moreover, many students believe that mental ill health is difficult to identify unless it reaches crisis levels, and therefore a lack of knowledge may have kept them from seeking treatment sooner (Jithoo, 2017).

A study conducted by Hugo (2003) found that a majority of the research participants could not identify symptoms which were present, therefore preventing early intervention which is seeking appropriate help. Stansbury et al. (2011) found that 37% of students were unable to differentiate between normal stress and when the stress had led to mental health problems such as depression and anxiety. A certain level of stress is part of university life and if students lack emotional intelligence or have poor mental health literacy, it can easily lead to depression and anxiety(Doyle et al., 2021; Martínez-Monteagudo et al., 2019).

Samar and Perveen (2021) indicated high mental health literacy amongst Undergraduate students in Malaysia. However, the study revealed that this did not translate to help-seeking. Thai and Nguyen (2018) found that students who were aware and can recognise symptoms for depression through the vignette reported positive attitudes towards psychological help-seeking. In addition, a study by Petersen (2019) on nursing students revealed that those who participated had good knowledge of mental disorders and maintained positive attitudes towards help-seeking for mental illness. Cheng et al. (2018) reported high mental health literacy levels, specifically the accurate recognition of Generalised Anxiety Disorder amongst students. The study also reported that mental health literacy predicted help-seeking attitudes. Students may be more likely to indicate high mental health literacy as they are more exposed to mental health information compared to the public. Most universities have psychological services on campus and students are exposed to a larger social network which means that they have greater possibilities to learn about mental health (Ibrahim et al., 2019).

Additionally, some students- especially in the health professional disciplines- may be exposed to psychology, majoring in psychology or have taken psychology as one of the modules, increasing their mental health literacy levels (Almanasef, 2021).

It is imperative to recognise that external help is needed and to have knowledge about where to seek help or access services (Pace et al., 2018). Students may not know about the mental health services offered in institutions and those who lack this knowledge may under-utilise these services compared to those who are aware of their availability. For instance, Atik and Yalcyn (2011) reported that students who had awareness and knowledge about the mental health services being offered at their institutions had positive attitudes towards help-seeking and were more likely to use these services. Gagnon et al. (2017) found that some students reported financial constraints as one of the barriers to seeking help regardless of services being offered for free on their campus indicating a lack of knowledge about the mental health services offered by universities.

Kutcher et al. (2016) as well as most western scholars suggest that being unable to identify and recognise mental disorders according to the Diagnostics and Statistical Manual of Mental Disorders (DSM) or the non-alignment with the biomedical understanding of mental illness implies poor mental health literacy. Such ideas ignore the fact that different people derive their information from diverse worldviews, which influences how mental illnesses are conceptualized (Kometsi, 2020). One needs to understand that perceptions of mental illness may also be influenced by their cultural beliefs, socio-economic and ethnic backgrounds (Aluh et al., 2019). In support of this, Ganasen et al. (2008, p. 13) stated that "to be mental health illiterate may not only mean that one has little or no evidence-based knowledge of mental illness or of treatment but may also mean that the knowledge and beliefs that they hold may be derived from other sources". Similarly, the model of help-seeking by Liang et al. (2005) emphasizes three interconnected aspects of help-seeking: recognizing a problem, deciding to seek help, and selecting a provider (as cited in Cheng, 2018, p. 12). Furthermore, the model suggested that cultural worldviews influence all three aspects. Culture influences whether certain problems may be perceived as mental health related and in turn also influences what type of services are acceptable to the person. The African viewpoint implicates the spiritual realm in the understanding of behavioural problems and most indigenous people (non-western) lean heavily towards the expertise, influence and meaning of traditional healers and historically transmitted rituals(Akomolafe, 2012; Tibebe & Tesfay, 2015). For example, a study on a Xhosa tribe discovered that a large number of participants

believed that schizophrenia was caused by evil spirits or witchcraft, thus their cultural beliefs informed the appropriate source of help which was traditional healing (Campbell, 2017). However, there is an increased recognition for the incorporation of traditional healing methods into the mainstream psychotherapeutic praxis to build a more inclusive and holistic approach to mental health care(Hartmann & Gone, 2012; Mokgobi, 2013). For example, institutions like the University of KwaZulu-Natal have had services of traditional healers complementing their counselling services for registered students to improve access to mental health services(Nduna, 2020). Medical pluralism is increasingly becoming a norm in South Africa, with many mental health clients resorting to mental health professionals and traditional healers simultaneously(Mokgobi, 2013).

2.1.5. Gender/masculinity

Gender disparities are often expressed in mental health literacy and help-seeking, with female students being more willing to receive professional services if the need arose (Jithoo, 2017). These differences, according to Jithoo (2017), are due to ego development, with most male students maintaining traditional views of masculinity and hence construing any form of emotional vulnerability as a sign of weakness. Similarly, Tang et al. (2014) found that college-going men were affected by masculine discourses, making it difficult for them to acknowledge mental ill health and reducing their ability to seek professional help. Bushell's (2008) results revealed that male students from the University of Kwa-Zulu Natal had low intentions and rates for help-seeking from various sources of help, more especially from formal sources of help. However, the study revealed that there was no relationship between ideas and practices of masculinity and help-seeking behaviours.

Men's attitudes towards help-seeking can be discussed following the concept of hegemonic masculinity(Clark et al., 2020; Staiger et al., 2020). According to Staiger et al (2020) "hegemonic masculinity is defined as the dominant cultural ideal serving as a normative orientation for men concerning heterosexuality, rationality, success, strength, or control" (p.7). Therefore, the sociological concept describes a cultural ideal of masculinity in a given society, such as men don't cry, 'men don't seek help' gender stereotypes(Mahalik & Di Bianca, 2021). This than influences men's decision to not seek help as they may expect social isolation as a result of not matching masculine role norms(Staiger et al., 2020).

Some studies have found cultural views of manhood and socialisation to be the main cause of non-help seeking behaviour amongst men (Motau, 2015; Matabane, 2015; Tang et al., 2014; Masuda et al., 2005) According to Zuma (2017), the discrepancy in how girls and boys are raised makes it socially acceptable for young girls to be more expressive about their feelings and emotions whilst making the expression of disharmonious emotions (like anger) as socially acceptable for boys. It is socially acceptable for young women to show vulnerability and the need for comfort. Hence, women are found to be more likely to disclose personal problems and seek professional help for their psychological problems as compared to men.

Men may believe that they should solve problems by themselves; not express emotions; and be resilient as seeking help would translate to admitting weakness and vulnerability, which are traits that are against traditional male norms (Seidler et al., 2016). The vulnerability, disclosure and introspection needed in psychotherapy and psychological treatment deviates from the socially accepted masculine gender roles (Seidler et al., 2016). Additionally, Corboy et al. (2011) concluded that seeking psychological help may be disempowering for men as heads of their families. Matabane (2015) reported that men are reluctant to go to therapy due to fear of the emotional bond that might develop with the mental health providers, especially a male therapist as that bond is associated with homosexuality.

Yousaf and Hunter (2015) found that men's reluctance towards psychological help-seeking was mainly influenced by their attitudes about how men should behave and think. In the study, men scored higher on the Male Role Norm Inventory Scale (MRNI-R) and lower scores were observed on the Inventory of Attitudes towards Seeking Mental Health Services (IASMHS) compared to women suggesting that men's ideas about masculinity were more exaggerated in turn influencing their unwillingness to utilise psychological services. Similarly, Juvrud and Rennel's (2017) study indicated that personally endorsed gender stereotypes predicted men's help-seeking attitudes and behaviours whilst gender stereotypes did not predict women's help-seeking attitudes and behaviours.

Consequently, men who face psychological problems are found to be more likely to resort to maladaptive coping strategies such as alcohol and substance abuse, violence, and high-risk sexual behaviours (Ezeugwu & Ojedokun, 2020)

2.1.6. **Language and culture**

Few studies have identified language proficiency as a barrier to help-seeking. However, global studies on international students have identified this as an important barrier in

adjusting to the university environment (Mesidor & Sly, 2016; Malaklolunthu & Selan, 2011; Madlala, 2018; Stephen, 2004). According to Ma (2020), language and culture are two main barriers identified by Chinese international students in adjusting to the host culture or country. The cultural barrier consists of; difficulties in adapting to the new culture and an inability in balancing the contradictions between different cultural values and customs. The language barrier involves difficulty in understanding people's speaking or the frustrations of not being understood; difficulty in understanding jokes or slang; and a lack of confidence to speak English. Similarly, South Africa has seen a drastic increase in students gaining access to higher education, mainly due to the greater access and enrolment of black students in the higher education system (Tjonneland, 2017). However, some black students come from poor socio-economic backgrounds, and some migrate from low-income rural areas to urban universities. Black students coming from rural areas are said to encounter myriad challenges, one of which is language adjustment (Hlatshwayo, 2020). Most secondary schools in South African rural areas lack the necessary resources, with some teachers not even particularly proficient in the English language, consequently learners are being taught in their mother tongues, leaving no room to learn or improve their English vocabulary (Fandie & Naude, 2019). A study on first-year students from the University of Venda revealed that students found it challenging learning in English, experiencing difficulties with grammar, word pronunciation, expression, an adequate comprehension of module contents and interferences of first language when using English (Mutepe et al., 2021). Consequently, the study found that this translated to poor academic performance, inactive participation, and high failure rates amongst students.

Low English proficiency affects many other aspects of university life. Mesidor & Sly (2016), reported that linguistic and cultural barriers prevent international students from seeking and accessing the support services available to them. These services compromise services for physical health, mental health services and academic help. In Matabane (2015), participants revealed being worried of not finding a native Zulu speaker and only finding English speaking professionals, thereby "being forced" to explain feelings/distress in English.

According to Ohtain et al. (2015), the diagnoses and clinical assessment of symptoms as well as the treatment of psychiatric conditions rely heavily on the patient's ability to communicate clearly about those symptoms to a mental health provider. Therefore, if the patient and mental health provider do not share the same language, it may result in miscommunication, which may lead to inadequate care, misdiagnosis, and delayed treatment (Bauer et al., 2010). Van

Den Berg (2016) asserted that successful outcomes for patients seeking psychological help rely on the amount of information shared between the mental health provider and patient, in which the patient is in full control of the dialogue between the two.

South Africa has 11 official languages and consultations are mostly held in the patients second or third language. Thus, a national survey for all registered psychology practitioners by the Psychological Society of South Africa (PsySSA, 2017) revealed that the majority of psychology practitioners were female, English speaking, white and between the ages of 31 and 40. Previously, Duemert (2010) mentioned most professional service providers are English and Afrikaans speakers. In contrast, the majority of the South African population speak indigenous languages. After conducting a survey study in the Western Cape, Van Den berg (2016) concluded that the language barrier negatively influenced participants' help-seeking behaviours, and the language discrepancy resulted in dissatisfaction with care as most mental health professionals speak English and the participants spoke a different language which was Xhosa. Within the same study, patients blamed themselves for not being able to communicate effectively with the mental health care provider to the extent that patients admitted to agreeing with whatever the mental health professional was saying in order to not challenge the professional or seem stupid. In Lewenthal et al. (2012), several participants expressed that they felt misunderstood by mental health professionals and experienced challenges in explaining to the mental health professionals what they are feeling and going through. Therefore, it can be concluded that miscommunication due to the language barrier poses a threat to proper diagnoses and treatment. Furthermore, people with limited language proficiency have been assumed to be the least likely to access and utilize professional psychological services (Ohtani et al. 2018).

Culture has been recognised as influencing the conceptualisation of mental illness, causes of mental illness and the appropriate source of help. Each culture has different explanations and beliefs with regard to mental illness, causes of mental illnesses as well as treatment approaches (Bracke et al., 2019; Arnault, 2009). Western conceptualisations of mental illness tend to only emphasize individual factors whilst other explanatory models emphasise external factors. For instance, African culture is mostly informed by religious and spiritual beliefs in which mental illness is attributed to evil spirits, witchcraft or as punishment from the non-living (ancestors) (Kometsi, 2020). While Western medicine and treatments are widely accepted, it is important to consider other cultures and tailor treatment accordingly (Mosotho et al., 2011). Cultural sensitivity and understanding psychological disorders within different

cultural contexts is imperative and has major implications for help-seeking amongst individuals of different cultural backgrounds. Leong and Kalibatseva (2011) showed that the likelihood of misdiagnosis is greater for African American clients due to cultural insensitivity amongst clinicians and the use of invalidated diagnostic instruments that were standardised with Caucasian samples.

According to Jithoo (2017), students have a dichotomized understanding of the aetiology and treatment of mental health problems, with physical, economic, and psycho-social elements clustered together and cultural factors considered as autonomous and unique. From a cultural standpoint, mental health issues were thought to arise as a result of ancestors communicating unhappiness and displeasure (often, problems in children were a sign that a parental figure had caused a problem), or as a result of the practice of demonism and witchcraft, or the calling to be a healer with the intervention entailing the ritual sacrifice of an animal and a prayer, drinking of traditional medicine or muti, and repentance (Jithoo, 2017). Despite the fact that many emerging individuals share their parents' ethnicity, many students took a more critical posture and questioned numerous traditional customs (Jithoo, 2017). While there was a great awareness of cultural rituals, Jithoo (2017) found that the majority of students felt they could no longer subscribe to these understandings and questioned those healing methods.

Moreover, some languages have similar words which may have a completely different meaning in a different cultural context. Therefore, sometimes what the patient says or their responses to what is asked may be misinterpreted if the mental health provider lacks cultural competency. In Ruane's (2010) qualitative study, participants expressed concerns with regard to the psychologist's race, as they felt that white psychologists lacked cultural sensitivity and lacked knowledge of black communities in South Africa. In addition, participants expressed that black psychologists were not any different due to the acculturation that occurs during training. This is because most professionals are trained using Western models which only encounter Western beliefs (Zita, 2018).

2.1.7. Negative perceptions of mental health services

The perceptions of mental health services are associated with the stigma surrounding mental illness. For instance, in a qualitative study by Yelpaze and Ceyhan (2019), most participants expressed that seeking professional psychological help is only for those experiencing severe psychological distress, thus seeking help meant that one was troubled. In accordance with this

finding, Jithoo (2017) revealed that students who knew about the mental health services offered on campus often associated these services with serious mental illness rather than as services being accessible to those experiencing less severe emotional problems as well. Moreover, Yelpaze and Ceyhan (2019) concluded that most students in the study confused psychological counselling with psychiatric services with one participant stating that seeking psychological help involved drug treatment in which one is "forced" to take drugs which leads to an addiction and reliance on that drug.

This implies that people may lack understanding and fail to differentiate between different mental health professionals and what services they provide. Some participants in the same study believed that the only solution provided by psychological counselling is listening to one's problem. One participant mentioned, "I don't think talking solves any problems" (Yelpaze and Ceyhan, 2019 p. 129). Additionally, Wilson et al.'s (2005) study revealed that participants felt that seeking psychological help meant being forced into or passed to a psychiatric hospital/setting.

2.1.8. Confidentiality and trust

When it comes to help-seeking behaviours, trust and confidentiality are important factors to consider. Many emerging adults believe that disclosing emotional suffering may be extremely sensitive and that they would need reassurance that anything that could harm their self-concept and impair their self-esteem would be kept private (Jithoo, 2017). Moreover, Hall (2018) concluded that the issue of confidentiality consists of two components. Firstly, it refers to the fear that one's attendance will be known and not kept secret. Secondly, confidentiality refers to the individuals' concern that whatever is discussed in the session will be shared with third parties outside the session. Therefore, people who generally do not like sharing personal information are less likely to seek professional psychological help as they may be concerned that what they share with the counsellor will be known by others.

Wilson et al. (2005) found that the majority of the study participants felt that if they were to seek help the counsellor would not keep what was shared as a secret; they feared that their families would find out, and some reported that they are too embarrassed to talk to the counsellor. Therefore, the concerns of confidentiality may be viewed as associated with the stigma attached to mental illness and seeking psychological help. Similarly, Kakhnovets (2011) suggested that if people are assured confidentiality and professionals showed that they are interested in their problems, people are most likely to have a positive attitude toward

seeking psychological help. People are most likely to talk to someone they trust, therefore creating that sense of trust is in the hands of the counsellor to ensure that the counselling relationship is not terminated prematurely.

2.1.9. Other barriers

Other barriers may include not having time to seek psychological help. Seeing a professional means that one needs to book an appointment and fulfil that appointment. Furthermore, the long waiting list may be a problem for most university students. This may be problematic for students due to busy schedules and workloads. In addition, past experiences or the experiences of others may influence one's decision as to whether to seek psychological help (Matabane, 2015).

Due to the Coronavirus, the internet has become an integral part of everyday life and it has influenced university learning and help-seeking among students. To contain the spread of the Coronavirus, governments all over the world-imposed measures such as lockdown and social distancing which ultimately changed psychological help-seeking from traditional face-to-face interaction to online help-seeking. Online help-seeking may have many benefits such as eliminating the interpersonal aspect which may cause many to experience perceived public stigma (Rickwood et al., 2012); it provides anonymity (Kauer et al., 2014) and helps prepare individuals for face-to-face consultations. However, whilst online help-seeking may be considered easily accessible to some, it may not be the case for others. Some may lack the necessary equipment needed for online help-seeking, such as a smartphone, internet connection, and a laptop. Consequently, it becomes difficult to seek psychological help during this pandemic.

2.2. Mental Health Problems amongst Students and Common Reasons for Seeking Help

Mental health issues amongst young people are a major global concern, particularly because depression is one of the leading causes of morbidity and mortality (Asante, Meye-Wietz & Petersen, 2015). The most common psychological problems among students globally include depression, anxiety, suicidality, stress, and substance abuse (Holm-Hadulla & Koutsokou-Argyraki, 2015; Kaess et al., 2014; Wynaden et al., 2013). According to Pedrelli et al. (2015), anxiety disorders such as generalized anxiety disorder, social phobia, and post-traumatic stress disorder are the most common psychiatric problems amongst university students. Depression with suicidal ideation was also prevalent, followed by a few other psychiatric

disorders such as attention-deficit disorder with hyperactivity, eating disorders and substance use disorders. Similar trends have been identified in South Africa. For instance, Bantjes et al. (2019) found major depression and generalised anxiety to be the most prevalent disorders amongst students at two South African universities. Alabi (2021) conducted a study at Nelson Mandela Bay Municipality and found that 24.5% and 9.6% students indicated a lifetime prevalence of suicidal ideation and plans in the preceding 12 months, respectively. Pather ‘s (2019) study at the University of Kwa-Zulu Natal indicated that there was a high prevalence of mental distress, with most students indicating symptoms for depression. Most students reported feeling depressed, hopeless, sad, worthless, tired, and as if everything was an effort. Recently, a study by Visser and Law-Van Wyk (2021) investigated students’ mental health and emotional well-being during the COVID-19 pandemic, wherein 45.6% reported experiencing anxiety and 35.0% reported experiencing depression.

Studies have suggested that mental health problems are more common amongst university students compared to non-students (Wahed & Hassan, 2015 and Oluyinika, 2011). Unfortunately, whilst being a university student may allow for personal growth and work opportunities, it also comes with increased mental health vulnerability. University education is said to be challenging on both the emotional and intellectual levels (Saleem et al., 2013). According to Beiter et al. (2015), students’ sources of distress or reasons for help-seeking amongst students can be explored at three levels. The *individual* level sources of distress include academic achievement, success, concerns about life after graduation, self-esteem, and motivation. The *interpersonal* level includes concerns regarding friends, peers, and family. Lastly, the *intrapersonal or the institutional* sources of distress include finances, workload, living status, and experiences of the academic environment.

In accordance, academic troubles, housing difficulties, financial problems, and the death of a family member were the most often reported stressors amongst students by Pillay and Ngcobo (2010), who investigated sources of stress among students at a historically black university. Thus, according to Pedrelli et al. (2015), there are two different kinds of college students: typical college students and non-traditional college students. Traditional students are those who have just graduated from high school and are attending college for the first time. Many of these typical students are faced with adult-like duties without the requisite skills; many begin to build significant relationships; and coping with a growing academic workload may all contribute to their emotional discomfort. Non-traditional college students

are those who are older and are dealing with the stress of balancing their academic workload, full-time work, and family obligations, all of which can lead to mental anguish.

As a result, the most common reasons for seeking assistance amongst students are academic, financial, and interpersonal issues (Rathebe, 2017).

2.3. Types of help-seeking

Gulliver et al. (2010) defined help-seeking as a process in which the individual first becomes aware of the existence of a problem, followed by the expression of the problem and recognition that one may need help from others. This is then followed by the evaluation of the available sources of help and identifying which source of help is appropriate and most comfortable. The last step in this process is the individual acting and seeking help by utilising whatever services or sources of help that the individual is comfortable with. Rickwood and Thomas (2012) described this concept of help-seeking within the mental health context and defined the term as "an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns" (p. 180). Further, the authors conclude that help-seeking involves actively seeking help from others or communicating with others as a means to obtain assistance in terms of understanding, information, treatment, advice and general support in response to the problem.

Two main types of help-seeking have been presented in literature, namely formal and informal help-seeking. Formal help-seeking refers to assistance from professionally trained individuals who have a legitimate and recognised professional role in providing treatment, support or even advice (Kerebih et al., 2017). Formal help-seeking may be referred to as professional help or psychological help. Therefore, for the purpose of this study, the term 'psychological help' refers to psychological assistance sought from a professional health provider/worker who have the necessary qualification and training to deal with psychological problems (Zuma, 2017; El Kahi et al., 2012). Health providers may include psychologists, psychiatrists, mental health counsellors, therapists, and social workers.

Seeking help from a medical doctor or a general practitioner is also a form of formal help-seeking. The preference of medical doctors has been explored amongst students (i.e., D'Avanzo et al., 2012 & Motau, 2015), in which Motau (2015) revealed that this source of help was ranked fourth. Consulting a general practitioner is less stigmatising and more socially acceptable than seeking psychological or psychiatric services. Medical doctors are widely known to deal with physical symptoms in which an individual cannot be blamed for.

Hence individuals may be more willing to seek help for psychological problems from their general practitioners.

Informal help-seeking refers to assistance from a person's informal social networks (i.e., friends, family members, religious healers, traditional healers, etc.) (Kerebih et al., 2017). This type of help-seeking comprises a personal relationship and not a professional relationship with the source of help (Rickwood & Thomas, 2012). Rickwood and Thomas (2012) further suggest that help-seeking does not necessarily always have to comprise communication with an actual person, as people are now able to seek help through computer-mediated processes. Thus, self-reliance has been identified as a form of help-seeking and may involve reading books, watching television, etc. (Kerebih et al., 2017).

Self-reliance as a form of help-seeking has been found to be common amongst students (Salaheddin & Mason, 2016; Al-Krenawi et al., 2009; Al Darmaki, 2011). Similarly, informal help-seeking has been preferred by students. For instance, a study amongst the University of Kwa-Zulu Natal's students reported that close friends were most consulted or the preferred source of help, followed by self-reliance and family members (Motau, 2015). These findings were similar to the findings of Adegoke et al. (2013) and Nkwanyana (2013). According to Rickwood et al. (2005) the availability of established and trustworthy help-seeking pathways is the most crucial aspect in the help-seeking process. Moreover, informal help is characterised by companionship, closeness, and reciprocity; whilst formal help is characterised by time limitations, professional competencies, and scheduling. Therefore, informal sources may be preferred due to familiarity, accessibility, and immediacy.

Additionally, in order to offset the rising demand for psychologist, a burgeoning sector of support services is being provided to students under the name of peer advisors(de Klerk, 2021). Peer advisors are students that have been selected and trained to offer academic advising services to their peers(Howard, 2019). Such services are purposefully created to support student adjustment, contentment, and persistence in pursuing their academic goals(Howard, 2019). Peer advisors are not professionals, however they serve as an institutional contact point in which they refer students to a professional health worker, if need be(de Klerk, 2021; Ellis & Gershenson, 2020).

Limited research has explored the role of spiritual healers and traditional healers as a source of mental health care; but it has been reported that they constitute the least consulted and preferred source of help (Motau, 2015). This may be influenced by urban living, education,

and adherence to the Western way of living amongst students. Furthermore, Ndlovu (2016) suggests that there is on-going stigma attached to this form of practice. Bomayi's (2011) findings, on the other hand, suggested that traditional African ways of healing are needed, particularly for cultural bound syndrome and identity creation.

2.4. Chapter summary

This chapter reviewed relevant literature on general help-seeking behaviours and barriers to psychological help-seeking. It has been shown that students experience a variety of challenges which may compel them to seek help. The literature reviewed showed a preference for self-reliance and informal help-seeking when experiencing psychological distress. Therefore, the low rates in seeking psychological help or the under-utilisations of psychological services is rather concerning. Stigma has been reported as a major barrier in seeking psychological help, which may suggest the need for awareness campaigns and psychoeducation on mental health illness as well as psychological services. Lastly, the HBM has been found useful in the domain of mental health. Studies indicate that the HBM variables are predictors of help-seeking behaviours, thus indicating an association.

CHAPTER 3: METHODOLOGY

This research study adopted a quantitative methodology to ascertain students' behaviours and attitudes towards psychological help-seeking. Quantitative research is "a formal, objective and systematic process of collecting and analysing numeric data in order to obtain information and describe variables" (Creswell 2003, p.94). Expanding on this definition, Apuke (2017) states that quantitative research entails gathering data in the form of numbers from a large number of people and analysing it using statistical methods. It is concerned with answering questions related to what, who, when, how much, how many, and how (Apuke, 2017). Furthermore, quantitative research relies more on positivist principles, emphasizing that there is a single reality that can be defined by careful measurement (Blanche et al., 2006).

According to Williams (2011), quantitative research begins with the identification or statement of a problem, followed by generating research questions; reviewing related literature; the collection of numerical data and a quantitative analysis of the data. Furthermore, according to Sukamolson (2007), there are different types of quantitative research, namely survey research, experimental research, and correlational research. This study is a survey research study in which questionnaires were utilized to collect data from the population under investigation. The researcher then made use of statistical analyses to better understand their behaviour and attitudes as they relate to the study topic. The study attempted to aggregate and quantify individuals' responses to form overall measures for the sample.

3.1. Research Questions

1. What sources of help students prefer using when experiencing psychological distress?
   a) Do students prefer informal help-seeking as opposed to formal help-seeking?
2. Which HBM variables serve as barriers to seeking psychological help?
   a) What HBM variables predict seeking psychological help among university students?
3. What are the barriers to seeking psychological help as perceived by university students?
4. Is there a significant difference between females and males mean score towards psychological help-seeking?

a) Do female students have more positive attitudes towards seeking psychological help compared to male students?

3.2. Hypothesis of the study

1. Students prefer seeking help from significant others (i.e., informal help-seeking)

2. Perceived barriers is the best predictor for not seeking psychological help

3. Stigma is the most common barrier to seeking psychological help among students

4. female students have more positive attitudes towards seeking psychological help compared to male students

5. Male students are more likely to prefer self-reliance compared to female students

3.3. Research Design

Polit and Hungler (1999) define research design as "a researcher's overall plan for obtaining answers to the research questions guiding the study" (p.155). Therefore, to answer the study's research questions, the researcher employed a cross-sectional design. This study is cross-sectional as the data was collected from a large number of respondents at a specific point of time (Blance et al., 2006). The study describes, explains, and compares students' behaviours and attitudes as they relate to psychological help-seeking and preferred sources of help at a particular point in time, specifically from September 2021 to October 2021. Moreover, this study made use of the survey research design in collecting its data. A survey was constructed using relevant questionnaires and then administered to students. Students' responses were captured in numerical form and the researcher made use of statistical analysis to aggregate and describe trends of students' responses to the questions.

There are a number of advantages associated with using these designs: firstly, the use of surveys is inexpensive, quick and convenient as the researcher can test different demographic variables while simultaneously assessing more than one outcome or a number of phenomena (Salkind, 2010; Sedgwick, 2014). For example, the study explored whether gender differences correlate with help-seeking behaviours and attitudes, and their preferred sources of help. In other words, this design allows one to compare differences between groups. Secondly, these designs allow for generalisability in that the statistical inferences made from the study sample can be used in relation to a larger population of interest.

Lastly, this study may be described as a non-experimental study as no variables were manipulated and there was no random assignment involved. The study is descriptive in nature.

3.4. Participants

Purposive and convenience sampling strategies were used in combination. A purposive sampling strategy involves specifying particular characteristics/criteria that participants should possess in order to be able to participate in the study, which are often determined by the purpose of the study (Blanche et al., 2006). Therefore, the inclusion criteria for this study were that participants needed to be registered as a university student at the University of the Witwatersrand as the target population, and participants were required to be 18 years old and above.

The convenient sampling strategy is a non-probability sampling strategy used when the researcher seeks to collect data from participants who are easily accessible and available (Cohen et al., 2007). This is an effective strategy in student-based research due to students' willingness and availability to participate in research studies (Bryman, 2016). However, this means that the findings of the study may not be generalised due to the sample not being fully representative of the entire population.

Students were sent an email invitation via their University of the Witwatersrand (Wits) student emails. A total of 165 students participated in the study. There was a mixture of undergraduate and postgraduate students from the Sciences, Commerce, Law, Business Management, Engineering, Health Sciences and Humanities faculties/departments at the university. Thus, participants ranged in age from 18-51 years old and were of different gender and race groups.

3.5. Procedure

Due to the highly infectious disease COVID-19, the research data was collected online through REDCap (Research Electronic Data Capture). REDCap is a secure, web-based software platform developed by Vanderbilt University to capture data for research studies. According to Harris et al., (2009) the REDCap project was developed "to provide scientific research teams intuitive and reusable tools for collecting, storing and disseminating project-specific clinical and translational research data" (p. 377). To gain access to this platform, one's institution needs to have an institutional agreement with Vanderbilt University. The

University of the Witwatersrand, Johannesburg has this agreement with Vanderbilt University, implying that the researcher had free access to this platform. The researcher had an online meeting with a REDCap administrator for training as per requirements of this platform. A REDCap account was created, and the designing of the study survey began (Appendix D).

The students were recruited via email in which the email sent contained an invitation, a brief description of the study and a link to the online survey (Appendix C). The email was sent via the University Registrar, not personally by the researcher. The email was sent as an automatic no-reply email in which the researcher and students were not able to identify or obtain potential participants' email addresses or any other contact details. Potential participants were informed that by clicking the link and completing the online survey, they were considered as giving full consent for participation. The advantage of online surveys is that it allows for flexibility; participants could complete the survey at their own time, pace, and space; and they could use any electronic device most convenient to them (i.e., smart-phone, laptop, computer or iPad). The online survey was open for two months, from September to October 2021.

3.6. Measures

In order to address the research questions, the study utilised a structured survey questionnaire that consisted of three sections (Appendix D).

Section A consisted of the demographic questionnaire created by the researcher to collect participants' demographic information such as age, gender, level of study, race and faculty. The demographic information was collected for the purpose of comparisons with regard to the most preferred source of help and the most prominent barriers in a particular demographic group/s.

Section B consisted of different sources of help and participants were asked to choose the most relevant and preferred sources of help when experiencing psychological distress. These included mental health professionals, medical doctors, spiritual leaders, friends, family members, partners and others. This section was included to answer Research Question One, relating to students' preferred sources of help.

Section C comprised items from the Health Beliefs about Mental Illness (HBMI) instrument, the 30 item Barriers to Care Evaluation (BACE) scale and the Barriers to Help-Seeking Scale

(BHSS). This section was included to answer Research Question Three and Four, relating to students' barriers to seeking psychological help. In addition, responses from the HBMI were used to answer whether formal help-seeking can be predicted based on the perceived susceptibility, perceived severity, perceived benefits, and perceived barriers.

The HBMI was developed by Saleeby (2000) to measure health beliefs about mental illness. In the context of mental health, the instrument assesses the five fundamental HBM components. As a result, this instrument is intended to assess an individual's susceptibility to developing mental health problems; the negative impact of developing mental health problems (perceived severity); the benefits of addressing potential mental health problems; perceived barriers to performing preventative behaviours; and general health motivation. The instrument comprises 9 sub-scales with 49 items. However, some sub-scales (i.e., perceptions about mental illness in relation to drug and alcohol problems) and items were excluded due to their relevance to this study. On a Likert-type scale ranging from strongly disagree (1) to strongly agree (5), participants were asked to express their degree of agreement with questions. For each of the sub-scales, possible scores ranged from 4 to 35 depending on the number of items within each sub-scale. A high score on the sub-scales indicated positive beliefs and behaviours related to one's health. The HBMI has produced reliable and valid scores in previous research. Saleeby (2000) reported Cronbach's alpha coefficients ranging from 0.69 to .95, with only one sub-scale emotional/nervous benefit falling below .70 (.69).

Researchers at King's College London's Health Services and Population Research Department created the 30 item Barriers to Care Evaluation (BACE) in order to determine both internal and external barriers to mental health treatment in England. Participants' responses were rated using a 4-point rating scale ranging from 1 to 4. Higher scores indicate perceiving items as a prominent barrier. Similar to the HBMI scale, some items were excluded due to their relevance to the study. This instrument has been reported to be valid and reliable. Salaheddin and Mason's (2016) study assessed the internal consistency of the overall BACE scale and a Cronbach alpha of 0.93 was reported by the authors. Similarly, James et al. (2019) reported an internal consistency reliability for the overall BACE scale of 0.80. Thus, this instrument has been used amongst a South African sample (i.e., Hathorn et al., 2021), and the instrument is therefore considered valid and reliable for the population under investigation.

The Barriers to Help-Seeking Scale (BHSS) is a 31-item scale initially developed to assess the reasons that men identify for not seeking psychological help for mental and physical health problems (Mansfield et al., 2005). The instrument was tested amongst a sample of undergraduate male students, and it consists of 4 factors/sub-scales, namely need for control and self-reliance; minimizing problems and resignation; concrete barriers and distrust of caregivers; privacy and emotional control. This instrument has been found useful amongst both genders, even though it was initially designed for males (Divin, 2018). The BHSS uses the 5-point Likert-type scale to rate each item, with lower numbers indicating that the item is less of a barrier. Furthermore, a study conducted by Mansfield et al. (2005) assessed that the internal consistency for the entire scale was 0.95. The coefficient alphas for each item ranged from 0.79 to 0.93, indicating good internal reliability.

3.7. Data analysis

Following the completion of the data collection process, the raw data was exported from the REDCap platform into SPSS, where the data was cleaned and analysed. The Statistical Package for the Social Sciences (SPSS) version 27 was used for the analysis of the data. Specifically, descriptive statistics and inferential statistical analyses were performed to organise, summarise, and interpret the data. Descriptive statistics were used to describe basic features of the study data and summarise data for each measure before the inferential statistical analyses. Inferential statistics provided a more thorough analysis and drew inferences about the data collected and population of interest (Gravetter et al., 2004).

The descriptive statistical analysis using frequency distribution was performed first to achieve the following: to display the distribution of the variables under investigation and measures of central tendency; to simplify large amounts of data by easily identifying how many participants belong to a certain demographic group; and to determine which source of help is most preferred by students and what are the most common, major barriers in seeking psychological help. Tables were used to provide an easy graphic presentation of the results. Skewness and Kurtosis coefficients were calculated for each variable and histograms were assessed to determine whether the variables were normally distributed.

The inferential statistical methods used in this study included the Cronbach Alpha Analysis, Independent Sample T-test, and logistic regression analysis. Cronbach Alpha was used to assess the internal consistency reliability of the scales. The reliability coefficient always needs to fall between 0 and 1 and typically, a coefficient closer to 1 is considered reliable

(Blanche et al., 2006). Logistic regression analysis was used to examine whether formal help-seeking can be predicted based on perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. The independent T-test was used to determine mean score differences on the scales used amongst gender. Cross Tabulation was used to determine the most preferred source of help amongst different genders as well as the most common barrier/s in each group. The sample-size of 165 may be considered small, but a small sample size is not problematic for the inferential statistical methods used in this study.

3.8. Ethical considerations

Ethical approval was sought from the Human Research Ethics Committee (non-medical) at the University of the Witwatersrand (protocol number: MASPR/21/05) (Appendix A). Additionally, permission from the University Registrar was obtained in order to gain access to the participants, who were students at the university (Appendix B). The email containing the invitation was sent via the University Registrar, not personally by the researcher (Appendix C). Ethical considerations form a major element in any research. The ethical considerations of this research study were largely influenced and guided by the four basic philosophical principles developed to guide research with human participants. The four basic philosophical principles include autonomy, non-maleficence, beneficence, and justice (Varkey, 2021).

Autonomy involves respect for human dignity and respecting participants' autonomy to choose to participate in a research study, or not (Schofield, 2014). Therefore, individuals were required to volunteer and provide consent for their participation. In this study, the researcher clearly stated in the invitation that participation was completely voluntary and that by clicking the survey link and completing the questionnaires, participants would be considered as giving consent for participation (Appendix C). To make an informed decision on whether to participate, the invitation included the topic, aim and nature of the research study, the duration for completing the questionnaire, and the details of the primary researcher. The researcher's and supervisor's details were included to allow participants to ask any questions relevant to the study. Participants also had the freedom to withdraw from the study at any time with no repercussions.

Non-maleficence involves conducting research that does no harm to the research participants, whether it is physical, psychological, or social harm. This also involves assuring participants' confidentiality and anonymity (Schofield, 2014). Confidentiality means that information

collected will not be discussed or disclosed to a third party, at least not without the participant's permission. Anonymity refers to the identity of the participants being unknown. Anonymity was protected as participants were not asked any identifying features such as their names or contact details. The researcher did not have access to the student's email addresses, however, the invitation was sent to students via the University Registrar as an automatic no reply email. The survey was completed anonymously, the researcher had no way of linking the responses to an email address or participants' name. The researcher used unique identification numbers assigned to each participant. Only the researcher had access to the REDCap account and the raw data which was stored on a password protected computer. Thus, REDCap provides a secure environment to collect and store highly sensitive data (Harris, 2018). Since the study is on mental health problems and help-seeking attitudes, questions asked on the survey may be triggering for those who are or who have been in mental distress. Therefore, the Wits student crisis line and toll-free line for the Counselling and Career Development Unit were provided on the invitation.

Beneficence involves the benefits associated with participating in the study. The study had no direct benefits for the participants. However, it provides insightful knowledge and awareness with regard to students' mental health and help-seeking attitudes. Lastly, the principle of justice requires the researcher to treat participants with fairness and equity so that participants receive what is due to them (Varkey, 2021).

3.9. Chapter summary

In this chapter, the methodological procedure was discussed. Firstly, the research design, which is a cross-sectional and survey research design, was explained. Then, the sampling procedure and the study's processes were outlined. Lastly, the instruments used, ethical consideration and techniques used in data analysis were discussed. This chapter included reasons for using specific research designs, the sampling strategy, instruments and data analysis methods.

CHAPTER 4: RESULTS

This chapter presents the findings of the current study on psychological help-seeking attitudes amongst students at the University of the Witwatersrand, Johannesburg. Firstly, the demographic information of the sample is presented followed by psychometric properties, descriptive statistics and the normality of the measures used. The results are then presented in accordance with each of the research questions formulated.

4.1.Socio-demographic characteristics of the sample

A summary of the socio-demographic variables is depicted in Table 4.1 below. The sample was heterogeneous and differed on the following variables i.e., gender, age, race, level of study and faculty. However, the data shows an unequal participation based on gender with, male students being underrepresented (N=47, 28.5%) in comparison to female students who were overrepresented (N=114, 69.1%). A small percentage of students also preferred not to be identified by gender (N=3, 1.8%) and other (N=1, .6%). Participants ranged in age from 18-51 years old, with most belonging to the 18–26-year-old category (N=130, 78.8%) followed by those who belonged to the 27–35-year-old category (N=19, 11.5%), with 36 years and above comprising the smallest group (N=16, 9.7%).

The race group representation of the participants was as follow: 50% of the participants were Black Africans (N=83, 50.3%), with the remaining 50% comprising White (N=45, 27.3%), Indian (N=23, 13.9%) and Coloured (N=9, 5.5%) students. Additionally, a small percentage chose not to be subject to racial classification (N=5, 3.0%). The majority of participants were undergraduates (N=92, 55.8%) and the rest were postgraduates (N=73, 44.2%). Students from different faculties and departments across the campus participated, with the majority being from Humanities (N=46, 27.9%), followed by Health Sciences (N=32, 19.4%); The Science faculty (N=31, 18.8%); Engineering (N=24, 14.5%); Commerce (N=17, 10.3%); Law (N=8, 4.8%) and Business Management (N=7, 4.2%).

Table 4.1

Demography of participants

Characteristics	N	%
Gender		
Male	47	28.5
Female	114	69.1%
Prefer not to be identified by gender	3	1.8
Other	1	.6
Race		
Black African	83	50.3
White	45	27.3
Indian	23	13.9
Coloured	9	5.5
Other	5	3.0
Faculty and Departments		
Sciences	31	18.8
Commerce	17	10.3
Law	8	4.8
Management	7	4.2
Engineering	24	14.5
Health sciences	32	19.4
Humanities	46	27.9
Level of study		
Undergraduate student	92	55.8
Postgraduate student	73	44.2
Age group		
18-26 years	130	78.8
27-35 years	19	11.5
36 years- 51years	16	9.7

4.2.Psychometric properties of the measures

As is evident in Table 4.2, the Cronbach's alpha reliability coefficient for the HBMI scale was *a* =0.845. The subscales of the HBMI scale had acceptable internal consistency as the Cronbach alpha coefficient for the emotional/nervous susceptibility subscale was *a= 0*.918; the emotional/nervous severity subscale was *a= 0*.800; the emotional/nervous benefits subscale was *a*= 0.790; and the Cronbach alpha for the emotional/nervous barriers subscale was slightly lower (*a*= 0.687). Nonetheless, this suggested that the HBMI and subscales were internally consistent. The Cronbach alpha coefficient for the BACE scale was *a*= 0.874 and for the BHSS scale *a*= 0.896. Both scales were above the suggested value of *a*= 0.7 (DeVellis, 2003). The subscales for BHSS scale also had acceptable internal consistency, ranging from 0.631 to 0.828.

4.3.Descriptive statistics and normality of the measures

Table 4.2 shows the descriptive statistics, with the measure of skewness and kurtosis showing an acceptable level of normality for all scales and subscales (Tabachninck and Fidell, 2013).

Table 4.2

Descriptive statistics analysis and normality

	N	**Min**	**Max**	**Mean (SD)**	**Skewness**	**Kurtosis**	***a***
HBMI	117	2.10	5.00	69.10(11.22)	.241	.460	.845
Emotional/nervous susceptibility	142	1.00	5.00	17.64(4.64)	-.278	-.561	.918
Emotional/nervous severity	142	1.00	5.00	21.09(5.37)	.108	.215	.800
Emotional/nervous benefits	142	2.75	5.00	16.51(2.52)	-.295	.782	.790
Emotional/nervous barriers	142	1.00	5.00	13.85(3.87)	-.253	.167	.687
BACE	117	1.10	3.95	39.28(10.74)	1.455	3.333	.874
BHSS	117	1.00	4.00	66.69(12.62)	-.288	.767	.896
Need for Control and Self-reliance	111	1.00	4.00	28.55(5.71)	-.241	.423	.828
Minimising problem and resignation	111	1.00	4.00	15.22(3.99)	.110	-.069	.769

Concrete barriers and distrust of caregivers	111	1.00	4.00	12.41(2.63)	-.730	.514	.631
Emotional Control	111	1.00	4.00	10.36(3.37)	-.101	-.821	.796

4.4.Presentation of the results in accordance with the research questions

4.4.1. Research Question One: What sources of help do students prefer using when experiencing psychological distress?

The preferred sources of help are summarised in Table 4.3 below, which shows the rank ordering of the sources of help seeking from the most consulted to the least. As shown below, the most preferred source of help is specialist mental health professionals (i.e., psychologists). The least preferred is medical doctor/general practitioner. Those who indicated 'other' mentioned relying on themselves, listening to music, substance abuse, journaling, seeking support from a mentor and prayer.

Table 4.3

Sources of help from most preferred to the least consulted

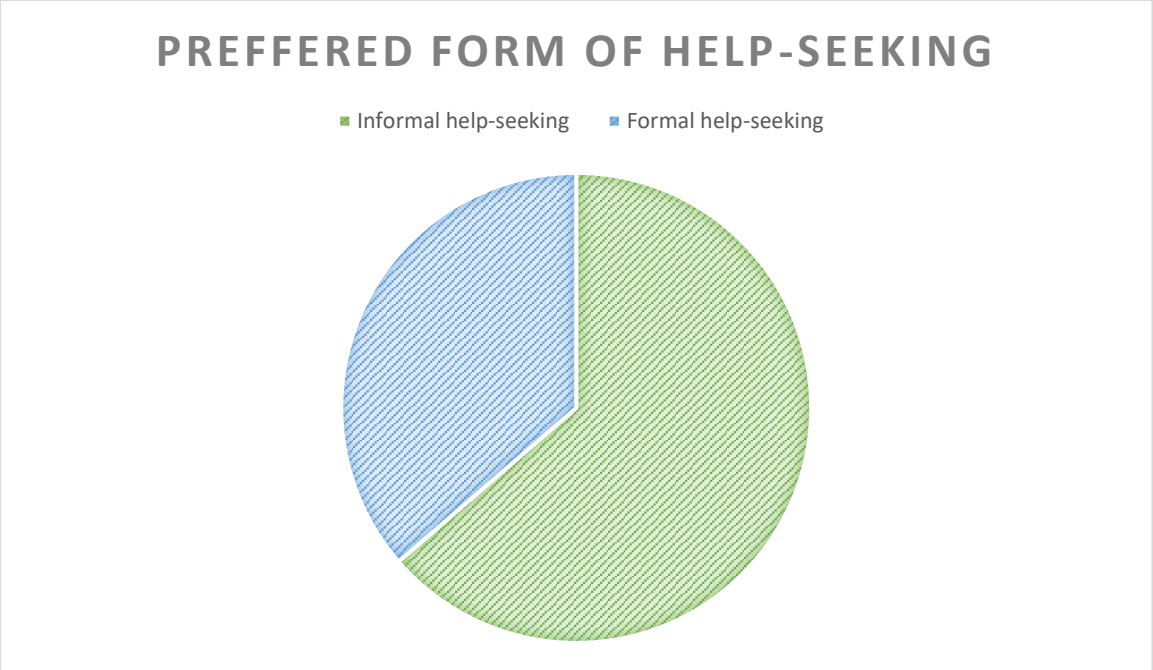
Source of help	**Frequency (%)**	**Rank**
Specialist Mental health professionals (Psychiatrist, Psychologist, Social workers, Psychiatric nurse)	55 (33.3)	1
Friends	32 (19.4)	2
Family members	30 (18.2)	3
Partner (romantic partner)	23 (13.9)	4
Other	13 (7.9)	5
Spiritual leaders (Priest, spiritual healer)	7 (4.2)	6
Medical doctor/General Practitioner	5 (3.0)	7

Students' preference and consulted sources of help were divided, creating a categorical variable. Those who preferred formal help-seeking were in one group and those preferring

informal help-seeking were in the other group. In this case, formal help-seeking included the preference of seeking help from specialist mental health professionals and medical doctors. Informal help-seeking included those who preferred friends, family, partners, spiritual healers and others. Figure 3 below indicates that a majority preferred informal forms of help-seeking.

Figure 3

Preferred form of help-seeking



4.4.2. Research Question Two: Which HBM variables serve as barriers to utilising treatment?

The logistic regression analysis was used to understand whether formal help-seeking can be predicted based on the HBM variables. The results are presented in Table 4.4 below. As previously mentioned, the sources of help were divided into categories, namely those who preferred seeking help from a formal source and those who preferred seeking informal help (i.e., friends, family, etc.).

The predictor variables entered were perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. As shown below, the results of the logistic regression analysis revealed that the full model consisting of the four predictor variables was statistically significant x^2 (4, N= 111) = 15.38, p < .05 (Omnibus Tests of Model Coefficients). This

implies that the model was able to distinguish between students who reported the preference of formal help-seeking and informal help-seeking. The "pseudo" R estimates indicate that the model explained between 12.9% (Cox and Snell R square) and 17.7% (Nagelkerke R square) of the variance in seeking formal help, and correctly classified 70.3% of cases. From the four predictors, the perceived benefits made a unique statistically significant contribution to the model, recording an odds ratio of 2.99, thus implying that this variable is the best predictor for formal help-seeking. This means that students who perceived benefits in seeking formal help were about 3 times more likely to report preferring or having consulted formal help than those who do not perceive formal help as beneficial (OR 2.99; 95% CI: 1.45-6.20; $p = 0.003$).

Table 4.4

Results of the Logistic Regression in predicting formal help-seeking

Variables	B	S.E.	Wald	df	Sig.	Odds of Ratio	95% C.I. for EXP (B)	
							Lower	Upper
Perceived Susceptibility	.374	.268	1.949	1	.163	1.454	.860	2.458
Perceived Severity	.124	.346	.129	1	.720	1.132	.575	2.231
Perceived Benefits	1.097	.371	8.730	1	.003	2.995	1.447	6.200
Perceived Barriers	-.273	.299	.830	1	.362	.761	.423	1.369
Constant	-6.140	1.894	10.508	1	.001	.002		

Note. CI = Confidence Interval

4.4.3. Research Question Three: What are the barriers of seeking psychological help as perceived by university students?

The results for the above research question are presented in Tables 5 and 6 below. This section consisted of statements from the BACE and BHSS scales. The categorical responses for the BACE scale are 'not at all', 'a little', 'quite a lot' and 'a lot'. In this instance, 'not at all' is indicative of not perceiving the statement as a barrier and 'a lot' as a perceived barrier. 'Quite a lot' and 'a little' were collapsed into one category and identified as reporting the item as a barrier to any degree. Additionally, 'a lot' was categorised as reporting item as a major barrier.

As shown below (Table 4.5), the most highly rated barriers were 'being unsure where to go to get professional help' (60.5%) and 'thinking the problem would get better by itself' (64%).

Furthermore, ‘wanting to solve the problem on my own’ was rated as a barrier, whereby 56.1% reported this as a barrier to any degree and 36.8% reported this as a major barrier; 48.2 % reported ‘difficulty taking time off work/school’ as a barrier and 31.6% reported this as a major barrier. Moreover, 44.7% reported ‘dislike of talking about my feelings, emotions or thoughts’ as a barrier and 31.6% reported this as a major barrier.

The least perceived barriers included ‘concern that people I know might find out’ (5.3%); ‘concern that I might be seen as crazy’ (5.3%); professionals from my own ethnic or cultural group not being available’ (6.1%); ‘being too unwell to ask for help (7.0%); ‘having had previous bad experiences with professional care for mental health’ (8.8%); and ‘preferring to get alternative forms of care (e.g., traditional/religious healing or alternative/complementary therapies)’ (8.8%).

Table 4.6 is a summary of the findings from the BHSS scale. The categorical response for the scale is ‘strongly agree’, ‘agree’, ‘neither agree nor disagree’ and ‘strongly disagree’. ‘Agree’ is indicative of perceiving the statement as a barrier to any degree and ‘strongly agree’ as perceiving the statement as a major barrier. The most highly rated barriers were ‘I don’t like feeling being controlled by other people’ (64.9%); ‘I like to be in charge of everything in my life’ (64.9%); ‘I wouldn’t want to overact to a problem that wasn’t serious’ (64.0%); ‘I would prefer to wait until I’m sure the health problem is a serious one’ (62.2%); and ‘problems like these are part of life, they are just something you have to deal with’ (59.6%). The least perceived barriers found in the BHSS scale were ‘It would seem weak to ask for help’ (2.6%); ‘asking for help is like surrendering authority over my life’ (2.6%); ‘I do not want to appear weaker than my peers’ (3.5%); ‘I would think less of myself for needing help (4.4%); and ‘I don’t trust doctors and other health professionals’ (4.4%).

Table 4.5

Barriers to Care Evaluation Scale (BACE) results (N= 114)

	Statements	**Reporting item as a barrier to any degree % (n)**	**Reporting item as a major barrier % (n)**
1.	Being unsure where to go to get professional care.	60.5 (69)	9.6 (11)

2. Wanting to solve the problem on my own.	56.1 (64)	36.8 (42)
3. Fear of being put in hospital against my will.	24. 5 (28)	14.0 (16)
4. Thinking the problem would get better by itself.	64 (73)	20.2 (23)
5. Concern about what my family might think, say, do or feel.	46.4 (53)	15.8 (18)
6. Preferring to get alternative forms of care (e.g., traditional/religious healing or alternative/complementary therapies).	26.3 (30)	8.8 (10)
7. Concern that I might be seen as "Crazy"	33.3 (38)	5.3 (6)
8. Thinking that professional care probably would not help	46.4 (53)	13.2 (15)
9. Professionals from my own ethnic or cultural group not being available	25.4 (29)	6.1 (7)
10. Being too unwell to ask for help	36.8 (42)	7.0 (8)
11. Concern that peoples I know might find out	30.7 (35)	5.3 (6)
12. Dislike of talking about my feelings, emotions or thoughts.	44.7 (51)	31.6 (36)
13. Concern that people might not take me seriously if they found out I was having professional care	35.9 (41)	7.0 (8)
14. Concerns about the treatments available (e.g., medication side effects)	48.2 (55)	14.9 (17)
15. Not wanting a mental health problem to be on my medical records	42.9 (49)	11.4 (13)

16. Having had previous bad experiences with professional care for mental health	17.5 (20)	8.8 (10)
17. Thinking I did not have a problem	49.1 (56)	15.8 (18)
18. Concern about what my friends might think, say or do.	32.4 (37)	3.5 (4)
19. Difficulty taking time off work/school	48.2 (55)	31.6 (36)
20. Having no one who could help.	42.1 (48)	17.5 (20)

Table 4.6

Barriers to Help Seeking Scale (BHSS) results (N=114)

Statements	**Reporting item as a barrier to any degree % (n)**	**Reporting item as a major barrier % (n)**
I would think less of myself for needing help	16.6 (19)	4.4 (5)
I don't like other people telling me what to do	50.8 (58)	15.8 (18)
Nobody knows more about my problems than I do.	57.8 (66)	21.1 (24)
I'd feel better about myself knowing I didn't need help from others.	37.7 (43)	7.0 (8)
I don't like feeling controlled by other people.	64.9 (74)	22.8 (26)
It would seem weak to ask for help.	13.1 (15)	2.6 (3)
I like to make my own decisions and not be too influenced by others.	50 (57)	14.0 (16)
I like to be in charge of everything in my life.	64.9 (74)	20.2 (23)
Asking for help is like surrendering authority over my life.	12.2 (14)	2.6 (3)

I do not want to appear weaker than my peers.	26.3 (30)	3.5 (4)
The problem wouldn't seem worth getting help for.	43.8 (50)	11.4 (13)
The problem wouldn't be a big deal; it would go away in time.	35.9 (41)	7.9 (9)
I wouldn't want to overreact to a problem that wasn't serious.	64.0 (73)	19.3 (22)
Problems like this are part of life; they're just something you have to deal with.	59.6 (68)	20.2 (23)
I'd prefer just to suck it up rather than dwell on my problems.	50 (57)	12.3 (14)
I would prefer to wait until I'm sure the health problem is a serious one.	62.2 (71)	19.3 (22)
People typically expect something in return when they provide help.	35.9 (41)	8.8 (10)
I don't trust doctors and other health professionals.	10.5 (12)	4.4 (5)
Privacy is important to me, and I don't want other people to know about my problems.	43.8 (50)	14.9 (17)
This problem is embarrassing.	23.6 (27)	9.6 (11)
I don't like to get emotional about things.	55.2 (63)	23.7 (27)
I don't like to talk about feelings.	52.6 (60)	24.6 (28)
I'd rather not show people what I'm feeling.	57.8 (66)	24.6 (28)
I wouldn't want to look stupid for not knowing how to figure this problem out.	26.3 (30)	10.5(12)

4.4.4. Research Question Four: Is there a significant difference between females and males mean score towards psychological help-seeking?

4.4.4.1. Gender group differences on BACE and BHSS measures

The independent sample *t*-test results determined whether males and females had different mean scores on the BACE and BHSS measures. The results show that there was no significant difference in the BACE mean scores for males (M= 1.88, SD= .36) and females (M= 1.95, SD= .47). Similarly, there was no significant difference in the BHSS mean score for males (M= 2.74, SD= .538) and females (M= 2.78, SD= .426).

Table 4.7

Independent-sample t-test results for BACE and BHSS by gender

Variables	**Male**		**Female**		***t*-value**	***df***	**95% CI**		**P-value**
	Mean	**SD**	**Mean**	**SD**			**LL**	**UL**	
BACE	1.88	.36	1.95	.47	-.761	101	-.267	.119	.448
BHSS	2.74	.53	2.78	.42	-.414	101	-.239	.157	.680

Note. CI- Confidence interval, LL- lower limit, UL- Upper limit.

4.4.3.2. Gender cross tabulation on preferred source of help, BACE and BHSS measures

Table 4.8

Preferred sources of help by gender

Source of help	**Male**	**Female**
	N (%)	**N (%)**
Specialist Mental Health professionals (Psychiatrist, Psychologist, Social workers, Psychiatric nurse)	9 (30)	25 (34.2)
Medical doctor/general practitioner	1 (3.3)	1 (1.3)

Spiritual leader (Priest, spiritual healer)	1 (3.3)	2 (2.7)
Friends	7 (23.3)	11 (15.0)
Family members	4 (13.3)	18 (24.6)
Partner	3 (10)	11 (15.0)
Other (specify)	5 (16.6)	5 (6.8)

Table 4.8 above shows that slightly more females (34.2%) preferred seeking help from a specialist mental health professional compared to male students (30%). However, it should be noted that male students were underrepresented in this study. The results from Table 4.9 reveal that slightly more male students rated 'wanting to solve the problem on their own' (96.6%); 'thinking the problem would get better by itself' (83.3%); 'being unsure where to go to get professional care' (76.6%); and 'thinking that professional care would not help' (70%). Female students rated 'having had previous bad experiences with professional care for mental health' (30.1%) compared to male students (10%). Table 4.10 revealed that slightly more male students perceived 'nobody knows more about my problems than I do' (73.3%); 'I like to be in charge of everything in my life' (66.6%); and 'problems like these are part of life. They're just something you have to deal with' (66.6%). Female students rated 'I'd rather not show people what I'm feeling' (68.4%) and 'I wouldn't want to look stupid for not knowing how to figure this problem out' (31.5%) slightly more compared to male students.

Table 4.9

Barriers to Care Evaluation Scale (BACE) results by gender

Statements	**Male (N= 30) N (%)**	**Female(N=73) N (%)**
Being unsure where to go to get professional care.	23 (76.6)	51 (69.8)
Wanting to solve the problem on my own.	29 (96.6)	68 (93.1)
Fear of being put in hospital against my will.	13 (43.3)	24 (32.8)
Thinking the problem would get better by itself.	25 (83.3)	62 (84.9)
Concern about what my family might think, say, do or feel.	21 (70)	45 (61.6)
Preferring to get alternative forms of care (e.g., traditional/religious healing or alternative/complementary therapies).	10 (33.3)	25 (34.2)

Concern that I might be seen as "Crazy"	12 (40)	28 (38.3)
Thinking that professional care probably would not help	21 (70)	42 (57.5)
Professionals from my own ethnic or cultural group not being available	9 (30)	21 (28.7)
Being too unwell to ask for help	12 (40)	34 (46.5)
Concern that peoples I know might find out	11 (36.6)	26 (35.6)
Dislike of talking about my feelings, emotions or thoughts.	23 (76.6)	58 (79.4)
Concern that people might not take me seriously if they found out I was having professional care	12 (40)	32 (43.8)
Concerns about the treatments available (e.g., medication side effects)	17 (56.6)	48 (65.7)
Not wanting a mental health problem to be on my medical records	20 (66,6)	35 (47.9)
Having had previous bad experiences with professional care for mental health	3 (10)	22 (30.1)
Thinking I did not have a problem	17 (56.6)	51 (69.8)
Concern about what my friends might think, say or do.	11 (36.6)	27 (36.9)
Difficulty taking time off work/school	24 (80)	59 (80.8)
Having no one who could help.	17 (56.6)	45 (61.6)

Table 4.10

Barriers to Help Seeking Scale (BHSS) results by gender

Statements	**Male N=30** **N (%)**	**Female N= 73** **N (%)**
I would think less of myself for needing help	8 (26.6)	7 (9.5)
I don't like other people telling me what to do	13 (43.3)	41 (56.1)
Nobody knows more about my problems than I do	22 (73.3)	40 (54.7)
I'd feel better about myself knowing I didn't need help from others	16 (53.3)	23 (31.5)

I don’t like feeling controlled by other people	17 (56.6)	50 (68.4)
It would seem weak to ask for help	3 (3)	9 (12.3)
I like to make my own decisions and not be too influenced by others	17 (56.6)	34 (46.5)
I like to be in charge of everything in my life	20 (66.6)	46 (63)
Asking for help is like surrendering authority over my life	3 (10)	8 (10.9)
I do not want to appear weaker than my peers	8 (26.6)	20 (27.3)
The problem wouldn’t seem worth getting help for	11 (36.6)	35 (47.9)
The problem wouldn’t be a big deal; it would go away in time	9 (30)	28 (38.3)
I wouldn’t want to overreact to a problem that wasn’t serious	19 (63.3)	48 (65.7)
Problems like this are part of life; they’re just something you have to deal with	20 (66.6)	43 (58.9)
I’d prefer just to suck it up rather than dwell on my problems	16 (53.3)	36 (49.3)
I would prefer to wait until I’m sure the health problem is a serious one	19 (63.3)	49 (67.1)
People typically expect something in return when they provide help	10 (33.3)	26 (35.6)
I don’t trust doctors and other health professionals	3 (10)	5 (6.8)
Privacy is important to me, and I don’t want other people to know about my problems	19 (63.3)	27 (36.9)
This problem is embarrassing	6 (20)	19 (26.0)

I don’t like to get emotional about things	18 (60)	41 (56.1)
I don’t like to talk about feelings	15 (50)	41 (56.1)
I’d rather not show people what I’m feeling	12 (40)	50 (68.4)
I wouldn’t want to look stupid for not knowing how to figure this problem out	5 (16.6)	23 (31.5)

4.5.Chapter summary

This chapter presented the results of this study. Firstly, the results showed that the majority of students preferred informal sources of help, even though mental health professionals were ranked first. Secondly, perceived benefits were indicated to be an important and strong predictor for formal help-seeking. Lastly, the students had mixed feelings with regards to formal help-seeking as they demonstrated both negative and positive attitudes towards seeking help from a professional.

CHAPTER 5: DISCUSSION

This chapter interprets and discusses the findings of the study in relation to existing literature on psychological help-seeking. The study examined attitudes towards psychological help seeking amongst students at the University of the Witwatersrand, Johannesburg. The study identifies students' preferred source of help when in psychological distress, as well as students' common barriers to seeking psychological help. Lastly, using the Health Belief Model (HBM) as a theoretical framework, the study explored whether the HBM variables predict the likelihood that students would report that they preferred formal help-seeking. The discussion in this chapter will be guided by the research questions investigated.

5.1. Research Question One: What sources of help do students prefer using when experiencing psychological distress?

According to the findings, only 33.3% of the students preferred seeking help from a mental health professional, even though this modality was ranked first. The majority of the students preferred seeking alternative sources of help. Therefore, the preference of seeking help from a professional is still relatively low and concerning. Several studies examining the use of psychological services constantly reported the rate of utilizing psychological services among students to be rather low (Ennis et al., 2019; Auerbach et al., 2016; Topkaya, 2021; Kahi et al., 2012; Brown et al., 2014; Gulliver et al., 2010). For instance, a study by Kahi et al. (2012) reported a high prevalence of psychological distress (N= 543, 57.2%) amongst students at a university in Lebanon, whilst only 3.3% consulted a professional or a health provider for psychological problems. Recently, Ennis et al (2019) reported that only 37.8% students from Ulster University preferred seeking help from a mental health professional. Additionally, Edwards and Crisp (2017) sampled 98 Australian students (clinicians in training) in which 57 % admitted that there has been a time where they felt they needed to consult a professional but had not done so. A South African study amongst first-year university students reported that only a total of 18.1% of students had used mental healthcare in the preceding 12 months (Bantjes et al., 2020).

Various barriers have been identified in relation to seeking help from a mental health professional, and the preference of seeking alternative help has been identified as one of the barriers (Gulliver et al., 2010; Motau, 2015; Kahi et al., 2012; Brown et al., 2014; Salaheddin and Mason, 2016). In this current study, the majority of students preferred informal sources

of help (i.e., friends were ranked as the second preferred source of help; family members were ranked third and seeking help from a partner(s) was ranked fourth).

A study by Motau (2015) on University of Kwa-Zulu Natal students revealed that close friends were the most consulted and preferred source of help when experiencing psychological distress. This finding was in accordance with Salaheddin and Mason (2016). Friends may be preferred due to their immediate availability and accessibility, and friendship is usually established based on trust. Moreover, family members were ranked third compared to friends, usually because students spend most of their time with their university friends, away from family, consequently making friends more ideal and readily available when in distress. In fact, Rickwood et al. (2015) suggested that during childhood and adolescence, help is often sought from parents, whereas young adults are more likely to seek help from friends, and even willing to seek help from professionals. However, during the time of data collection, students were more likely to be studying at home due to COVID-19, making family members more ideal and readily available when in psychological distress.

According to Gulliver et al. (2010), friends and family members form the basis of social support and may be instrumental in facilitating formal help-seeking through encouragement. When the individual's friends and family have sought help and perceive benefits, they may encourage the individual, making them more likely to seek psychological help. Alternatively, individuals who perceive that their friends and family stigmatise psychological help will be less likely to seek psychological help (Eisenberg et al., 2007).

Brown et al. (2014) found that perceived severity is associated with informal help-seeking. The authors indicated that those who rated themselves as healthy and not having any long-standing illnesses were more likely to seek informal help (i.e., friends) compared to those who perceived themselves as having severe psychological issues.

There are studies that have found informal help-seeking to be least preferred or consulted (Seera et al., 2020). Many may perceive that they will be stigmatised, judged or even side-lined by friends or family members if they express the need for help, or for having a mental health problem (Cheng et al., 2018). In other cases, many young people may be reluctant to seek help from parents or other family members if they perceive them to be part of the problem (Leavey et al., 2011). Moreover, Jithoo (2017) added that friends and family members are not bound to maintain confidentiality like mental health professionals, hence making it difficult to disclose psychological distress to family and friends. It is also quite

important to note that while students may be more likely to seek informal help, they may not receive the type of help that they necessarily need from these sources. For example, seeking help from a mental health professional has been found to be more beneficial and effective than informal help-seeking, even for non-severe psychological issues (Vidourek et al., 2014). Mental health professionals are trained to diagnose psychological conditions and provide the appropriate treatment for the purpose of improving individual's mental health and well-being. Therefore, it is imperative to inform students about the benefits of seeking professional help and what mental health professionals do.

Seeking help from a partner was another preferred source of help, which was ranked fourth. An intimate relationship is formed based on a bond and friendship which is characterised by trust. People are more likely to seek help from those that they trust (Kakhnovets, 2011). According to Crits-Christoph et al. (2019), in all types of relationships, trust and respect is the most important ingredient for a well-functioning relationship, and this includes the client-counsellor relationship. Seeking psychological help involves sharing private matters and those private matters can only be shared with those who are trusted to keep matters confidential, whereas mental health professionals may be regarded as strangers who may not be trusted with those private matters.

The research study also indicated that students used "other" sources of help when experiencing psychological distress. 'Other', without any specification on the questionnaire, was ranked fifth. Those who selected 'other' prefer seeking help from no-one. These findings were similar to Kahi et al.'s (2012) study in which it was reported that 21.1% of students (N=543) did not seek any help but rather preferred handling things on their own. Similarly, Ennis et al. (2019) found that students who had suicidal thoughts and behaviours rated wanting to handle things on their own. According to Willis and Depaulo (1991) people are most likely to attempt to handle things on their own first before seeking help, or when seeking help from a friend has failed. Lawrance (2009) also suggested that students may prefer self-reliance because they are unaware of the services available on the university campus. Others referred to listening to music and keeping a journal to document feelings and emotions to deal with psychological distress. These two sources have been closely linked to mental wellbeing. Music has been found to elevate mood and motivation, reduces stress, and helps relax the human mind. Thus, it has been associated with the reduction of anxiety and stress (Laukka, 2007; Grau-Sanchez et al., 2017). Similarly, journaling has been found to reduce stress and anxiety, and creates awareness and regulates emotions (Smyth et al., 2018).

Alarmingly, a few students mentioned substance use as a source of help. Whilst plentiful studies have shown a high prevalence of substance use amongst students (Young & Mayson, 2010; Yong & Klerk, 2008; Kyei & Ramagama, 2013; Pengpid et al., 2013), this finding is quite concerning as substance use has been associated with impaired relationships, inefficiency in life function, sleep deprivation, increased absenteeism, and poor academic performance amongst students (Bedaso et al., 2020).

The least consulted preferred sources of help by students were spiritual leaders and medical doctors, ranked sixth and seventh respectively. In Southern Africa, Christianity is regarded as the most dominant religion, with pastors and ministers providing emotional support to church members(Banda, 2019; Wild-Wood et al., 2021). Furthermore, those who believe that psychological distress is a form of punishment from God are most likely to consult a pastor or pray about the issue. For instance, Wild-Wood et al examined the role of churches in early responses to COVID-19 in four African countries including South Africa. The authors found that clergy/pastors continued to offer spiritual and emotional support to the congregation online(Wild-Wood et al., 2021). They offered themselves as repositories of public trust and assisted churchgoers make sense of the pandemic.

Medical doctors are understood as professionals offering western forms of help which emphasize a science-based approach to healing (Zuma, 2017). Medical doctors diagnose physical and mental illnesses; and injuries, but; they are more widely known to deal with physical illness. Therefore, it is quite expected that students consult a medical doctor when experiencing physical symptoms only as they might not be aware that they can consult a medical doctor for psychological issues as well.

5.2. Research Question Two: Which HBM variables serve as barriers to utilising treatment?

Expectations about the outcomes of help-seeking and psychological treatment influence attitudes towards help-seeking (Watsford & Rickwood, 2013). Having positive attitudes towards help-seeking and believing that seeking help would be helpful in alleviating symptoms influence actual help-seeking behaviours (Komiti et al., 2006). Expectedly, the study's findings indicated the perceived benefits as a significant predictor of formal help-seeking. Specifically, the results indicate that students who perceived benefits in seeking formal help were more likely to report preferring formal help-seeking than those who do not perceive formal help as beneficial.

Individuals who believe that the intervention or rather seeking help from a professional will be effective in reducing symptoms are more likely to seek formal help (Henshaw and Freedman-Doan, 2009). For example, in a study of Australian university students, O'Connor et al. (2014) discovered that perceived benefits were the most important and greatest predictor of help-seeking behaviour. The study found that students were more likely to seek help when they perceived the benefits to be worthwhile. Similarly, Harthorn et al. (2021) indicated that 42.6% of the variance in help-seeking intention was explained by the HBM constructs, and perceived treatment benefits were the only significant predictor of help-seeking intention for obsessive-compulsive disorder.

Thus, using structural equation modelling, Cannon (2019) reported perceived benefits as one of the strongest predictors of intentions to seek mental health care, in addition to perceived barriers and self-efficacy. Langley's (2015) standard multiple regression analysis indicated that 51% of the variance in help-seeking intention can be accounted for by the HBM, with gender and perceived treatment benefits contributing significantly to the model. Previous studies have also found a direct relationship between perceived benefits and help-seeking intentions. Stone (2021), for example, looked at psychological help-seeking behaviours and intentions in a UK sample and discovered a strong link between perceived benefits and psychological help-seeking intent. As a result, the current findings, in combination with earlier findings, provide persuasive evidence that raising treatment's perceived benefits may be an effective method for enhancing help-seeking behaviour amongst young adults, including students.

The perceived benefits may have been influenced by students having previously sought help from a mental health professional. Henshaw and Freedman-Doan (2009) found that perceptions of the effectiveness of mental health treatment and benefits of treatment were greater amongst those who have already experienced contact or have consulted with a mental health professional. Additionally, in Harthorn (2021), the majority of the sample had positive past experiences, resulting in more positive attitudes towards psychological help-seeking. Gulliver et al.'s (2010) study showed that individuals who had positive experiences with professional help-seeking were more likely to engage in help-seeking as they had previously experienced the benefits.

Individuals are more likely to view seeking formal help more positively if they have had a personal experience with previous therapy or if they know someone (i.e., friend or family

member) who had the experience of consulting a therapist and had a positive experience. For instance, Disabato et al. (2018) revealed that past experiences are not limited to direct contact with services, but the study also revealed that participants used information obtained from their peers and family to decide whether to seek help. The study found that students who were aware of significant others' (i.e., friends, family members, etc.) help-seeking were two times more likely to have sought formal help themselves. Participants with previous help-seeking experience or vicarious experience may demonstrate confidence in professionals and may believe that they would be assisted again or may be assisted as well, leading to positive attitudes towards psychological treatment. Interestingly, the least perceived barriers found in this current study were participants having had previous bad experiences with professional care for mental health and participants not trusting doctors and other health professionals. Perhaps, previous counselling experience or vicarious experience may decrease treatment fears and misconceptions as this allows the individual to know what to expect from therapy.

Mental health literacy and psychoeducation regarding sources of help, specifically mental health services may encourage positive attitudes towards mental health treatment (Harthorn, 2021). Cannon (2019) revealed that self-efficacy, perceived barriers, and perceived benefits mediate the relationship between mental health literacy and help-seeking intentions. The results indicated that an increase in mental health literacy results in an increase in perceived benefits resulting in an increase in help-seeking intentions. The study further concluded that mental health literacy does not translate into action, but it predicts better knowledge of the benefits of formal help-seeking, ultimately leading to an increase in the likelihood of seeking help.

Contrary to expectation, the other three HBM factors (perceived susceptibility, perceived severity, and perceived barriers) did not make significant contributions to the model. This was particularly surprising. The HBM suggests that it is people's beliefs that influence whether or not to participate or take part in prevention programmes. These beliefs are related to perceived susceptibility and perceived severity to a given health problem; perceived benefits in engaging in or participating in prevention programs; and perceived barriers to seeking help or participating in prevention programs (Rosenstock et al., 2005). Henshaw and Freedman-Doan (2009) used the HBM to conceptualize mental health and defined the HBM construct as follows: perceived susceptibility is defined as an individual's acceptance of a mental health diagnosis or, rather, subjective perception of the risk of developing the illness; perceived severity is defined as the perceived consequences of mental health symptoms;

perceived benefits is defined as the benefits of therapy; and perceived barriers is defined as the barriers to therapy or factors impeding help-seeking behaviours. Based on Henshaw and Freedman-Doan's (2009) conceptualisation, it is suggested that high perceived susceptibility to illness or perceiving that one is at risk of developing a mental health problem should predict taking action (i.e., help-seeking). Consequently, perceiving the seriousness of symptoms should predict taking action, or rather seeking help to reduce symptoms. Furthermore, if individuals perceive fewer barriers such as stigma, they are more likely to seek formal help. Therefore, the results of this study are inconsistent with what Henshaw and Freedman-Doan (2009) suggested.

Previous studies have found perceived severity and perceived susceptibility to be nonsignificant predictors of formal help-seeking as well (Cannon, 2019; O'Connor et al., 2014; Langley et al., 2017; Kim and Zane, 2016). In addition, some studies have reported perceived barriers to be a predictor for formal help-seeking (O'Connor et al., 2014, Cannon, 2019). However, little support has been found that all the HBM variables (especially perceived susceptibility and perceived severity) predict help-seeking behaviours or intentions. Therefore, does this mean the HBM is not a good fit for mental health decisions. Further investigation is required to answer such. However, the role of perceived benefits as a predictor has been well demonstrated across many studies, including this current study (Kim and Zane, 2016; Langley et al., 2017; Cannon, 2019).

5.3. Research Question Three: What are the barriers to seeking psychological help as perceived by university students?

This study sought to understand factors that may impact students' decisions to seek psychological help. Therefore, considering the trends found in the data, the preference of self-reliance was the most endorsed barrier identified. For example, the findings indicated that students preferred solving psychological problems on their own, thus reflecting the need to control emotions such as not wanting to talk to others about feelings, emotions and thoughts as well as not wanting to feel controlled by others as they preferred being in charge of everything with regards to their lives. In line with the current findings, Ennis et al. (2019) found that the most important barrier amongst college students at Ulster University was the need to handle problems on their own. Similarly, using the WHO World Mental Health (WMH) survey across multi-national universities, Andrade et al. (2014) reported that the desire to handle problems on one's own was the most common barrier amongst students.

Self-reliance may coincide with the increased need for autonomy during this stage of development (Czyz et al., 2013).

Consequently, students may wish to preserve their independence in accordance with their self-image and thus avoid becoming dependent on psychological services. According to Arnett (2014) emerging adults desire independence in various aspects of their lives and behaviours that are seen to renounce independence and control may be avoided. Therefore, seeking professional help may conflict with emerging adults' desire for self-reliance and independence as seeking help requires one to disclose information about themselves and potentially allow themselves to be guided by someone else (Gulliver et al., 2010). Thus, according to Fischer et al. (1983), help-seeking can be "a threatening experience because it creates a superiority inferiority relationship between the one giving and the one receiving help, and conflicts with values like self-reliance and independence reinforced during the whole process of our socialization" (as cited in Zartaloudi, 2013, p. 72). It is therefore not unexpected that students prefer self-reliance and the need to feel more in control of their emotions. Seeking help is seen as an acknowledgement of one's inability, immaturity, and insufficiency (Zartaloudi, 2013).

Furthermore, the COVID-19 restrictions such as social distance inevitably changed formal help-seeking from traditional face-to-face to online interaction, and this has formed new barriers to treatment access(Upton et al., 2021). Although higher education institutions introduced initiatives to increase access to mental health support during the pandemic, including increased online support, there may be a delay in university students accessing this support(Power et al., 2020). Online help-seeking may be considered easily accessible and beneficial; however, it may not be the case for some students, hence the preference of self-reliance(Upton et al., 2021). Some students may lack the necessary equipment needed to seek professional help online, such as a laptop, smartphone, internet connection etc. One of the key benefits of online help-seeking is privacy, however, students coming from distractive neighbourhoods or home environments (i.e., noisy homes or have a lot of relatives and siblings in one roof), it may be difficult for those students to find a quiet space necessary for a one-on-one conversation with a therapist or university counsellor. As a result, it becomes difficult for them to seek professional help during the pandemic.

Thus, most students were isolated from their friends who they normally talk or confide in when in psychological distress, hence the preference of self-reliance(Theurel & Witt, 2022).

Moreover, studies conducted during the pandemic alluded to the increase in self-help behaviours(Montagni et al., 2020; Shanahan et al., 2022). For instance, Montagni (2020) revealed that seeking mental health-related information on the internet was a relatively common behaviour, with depression, stress, anxiety, and general information on mental health problems being the most searched topics by students. The high rates of self-help behaviours and self-reliance may be encouraging; however, it may reflect a pattern of help-avoidance and may lead to self-diagnosing.

As cited in previous research, another possible explanation of such a barrier is stigma. Andrade et al. (2014) alluded to stigma being related to the desire to handle problems by oneself. It has been well established that stigma and labelling associated with mental health problems are the most significant barriers to help-seeking (Cheng et al., 2018; Clement et al., 2015). For example, public attitudes towards mental illness and the fear of being isolated or discriminated against may prevent students from revealing their own mental health issues to others and consequently, they do not seek help. Students may fear seeking help as it may be perceived as an acknowledgement of one's inability to manage one's own problems and might be interpreted as a weakness of character by those around them (Zartaloudi, 2010). Notably, stigma is not only associated with formal help-seeking, but students may also prefer self-reliance and prefer to keep their mental health concerns concealed from their friends and family due to the concerns of being judged and potentially misunderstood (Pattyn et al., 2014). Additionally, when significant others seem to be opposed to help-seeking, the individual may internalise these views, which may then influence one's own evaluation of the behaviour thereby leading to self-stigma (Chen & Chandrasekara, 2016). Therefore, students may rely on themselves if they perceive or expect to be discriminated against by others.

In addition, Jennings et al. (2015) found that self-reliance mediated the relationship between stigma and help-seeking. Specifically, the study indicated that students with higher levels of perceived stigma were more likely to have stigmatising attitudes toward themselves (higher levels of self-stigma) and increasing preferences for handling problems on their own, which is in turn related to negative attitudes towards seeking formal help. Correspondingly, Keller's (2022) mediation analysis also indicated that public stigma leads to greater levels of self-stigma followed by higher self-reliance and finally leading to more negative attitudes towards help-seeking. However, it should be noted that in this study students held low stigma-related attitudes, i.e., one of the least perceived barriers was the concerns of being seen as weak or crazy; concerns about significant others finding out; concerns about seeming weak for asking

for help and concerns about appearing weaker than peers. This finding deviated from existing research, where public and self-stigmatising beliefs around mental health were found to be the most highly rated barrier/s to help-seeking among students (Salaheddin & Mason, 2016; Rathebe, 2018).

Furthermore, self-reliance may be related to confidentiality. Students may be concerned that their counsellor will discuss private problems with their instructors or their parents if they are financially contributing to their tuition because the university campus is a small setting (Hall, 2018). In that sense, students may not want to risk or worry that their attendance will not be kept confidential or whatever they share in the sessions will be discussed outside.

The findings further suggested that students lacked knowledge of available resources and how to access them which may have influenced their preference of self-reliance. However, a lack of knowledge with regard to where to access assistance may be considered as poor mental health literacy, as per the requisite for mental health literacy described by Jorm (1997). This finding is quite unexpected as students are often exposed to information about mental health and where to access professional help in the university environment (Gagnon et al., 2017). Therefore, this suggests that students are unaware that the University of the Witwatersrand offers free psychological services, in turn impacting on help-seeking behaviours. Correspondingly, Eisenberg et al. (2007) indicated that only half of the students knew where to go to get mental health care and the other half never utilised mental health services because they were unaware that there were free services being offered by the university. Stebleton et al. (2014) reported about 80% of students who had never even heard of the services being offered by their university.

Students' preference of waiting until they are sure that the health problem is a serious one; not wanting to overact to a problem that is not serious and thinking that problems are part of life suggest that students are more likely to perceive their psychological issues as less severe. The HBM suggests that health behaviour is determined by the individual's assessment of threat, costs, and perceived benefits. Those who perceive threats and benefits are more likely to have positive attitudes towards psychological help-seeking; whilst those who perceive costs are more likely to have negative attitudes. In this case, students do not perceive psychological distress as a threat or believe that the distress will have detrimental consequences if left untreated, thus influencing their decision to not consult a mental health professional. Moreover, this may also indicate that students are unable to differentiate

between normal stress and serious mental health problems, which may suggest poor mental health literacy amongst students.

Jones (2014) explored students' readiness to seek mental health services and found that students' appraisal of the severity of symptoms is positively associated with readiness to seek help. Thus, Gagnon et al. (2017) stated that students believed that what they are confronted with may not warrant professional help, thereby delaying help-seeking. Furthermore, according to Jennings et al. (2015) students may prefer self-reliance because they are unaware of when a mental health problem warrants professional help which may also indicate poor mental health literacy. Moreover, the study findings may suggest that students have the perception that problems need to be of a particular severity or impair functioning in order to seek help. In accordance with this finding, Yelpaze and Ceyhan (2019) revealed that participants did not see the need to seek help as it is only meant for those experiencing severe psychological distress. Jithoo (2017) also revealed that students who knew about the mental health services offered on campus often associated these services with serious mental illness rather than services being accessible to those experiencing less severe emotional problems as well.

As expected, a busy time schedule was also reported as a barrier to seeking psychological help. Students are confronted with never-ending workloads as well as a social life. Therefore, students must often balance their university work life and social life. Some students may also undertake full or part-time paid employment (Broglia et al., 2021). Thus, seeking formal help means making an appointment with a mental health professional or being on a waiting list, students may prefer seeking informal help due to immediacy and not having time to fulfil such appointments. This may also explain students' preference of relying on oneself when in distress.

5.4. Research Question Four: Is there a significant difference between females and males mean score towards psychological help-seeking?

This study found no statistically significant gender differences in relation to help-seeking behaviours. However, the cross tabulations of the BACE (Table 9) and BHSS (Table 10) measured by gender indicate that poor help-seeking behaviours were slightly more pronounced in male students than female students. Male students were less likely to prefer mental health professionals as a source of help compared to female students. This finding is in accordance with previous findings (i.e., Umubyeyi et al., 2016).

Cultural views of manhood and socialisation are identified as the main cause of men being reluctant to seek psychological help (Motau, 2015; Matabane, 2015). This is because girls are taught to be more caring, kind, dependent and sensitive whilst boys are taught to be strong, fearless, and self-reliant. Such discrepancy in how girls and boys are socialised makes it socially acceptable for young girls to be expressive of their feelings and emotions whilst making the expression of disharmonious emotions socially acceptable for men. Additionally, it is socially acceptable for women to show vulnerability and the need for comfort. Therefore, women are found to be more likely to have positive attitudes towards seeking psychological help compared to men. Men are taught to be strong, aggressive, competitive, to avoid expressing vulnerable feelings, be fearless and control their emotions. Hence, it is suggested men are less likely to seek psychological help. Male students in this study were not found to necessarily hold stigmatised attitudes towards mental illness as previous research has suggested. However, the preference of self-reliance, perceiving problems as a non-threat, not knowing where to go for professional care and thinking that professional care will probably not help were common barriers amongst male students. These findings were similar to those of Andrade et al. (2014) and Umubyeyi et al. (2016).

5.4. Chapter summary

The results in relation to the study's research questions were discussed with reference to previous research. The study findings were in accordance with past research as most participants indicated preferring informal sources of help, even though mental health professionals were ranked first. Secondly, the findings were consistent with previous studies in that perceived benefits is a strong predictor for formal help-seeking. However, with regard to the other three HBM variables, the findings were inconsistent in that these variables were found to be non-significant. Lastly, students indicated both positive and negative attitudes towards psychological help-seeking, but the most common barriers as perceived by students were perceiving psychological problems as not severe and the preference for self-reliance.

CHAPTER 6: CONCLUSION

The conclusions drawn from the findings, limitations of the study and recommendations for future research are discussed in this last chapter.

6.1. Conclusions

Despite the growing concern over mental health problems and the availability of mental health services, help-seeking remains rather low amongst the student population. Therefore, the primary focus of this study was to determine help-seeking behaviours among students at the University of the Witwatersrand, Johannesburg. Students preferred sources of help when in psychological distress were examined as well as the perceived barriers to seeking psychological help. The prediction value of the HMB variables were explored for formal help-seeking.

Amongst the students who participated, mental health professionals were ranked first. However, only a third of the students preferred seeking help from a mental health professional when experiencing psychological distress. This suggests that a majority of the students preferred seeking alternative sources of help or rather informal help from family, friends, etc. In fact, 64% of the participants preferred informal help-seeking. Friends were ranked second, and family members were ranked third. This finding may suggest that students prefer immediacy of care in relation to help-seeking.

Interestingly, studies have shown that people talk to their friends, family, pastors, etc. before seeking help and therefore, the influence of such sources cannot be under-valued (Vogel et al., 2007). Social support from friends and family is important to mental health wellbeing, if not equally important with support from professionals (Lauzier-Jobin & Houle, 2021). The role of informal help-seeking has been much less frequently researched. However, studies have shown that seeking professional help has several benefits. According to Ehlers et al. (2004), mental health workers contribute to society in ensuring the psychological wellbeing of people. They are trained to assess and support individuals with mental health problems (Zuma, 2017). Therefore, interventions are needed to promote the use of mental health services for improved mental health amongst students. Noteworthy is that mental health professionals were ranked first, which shows that increasingly more students understand the role of psychologists and the benefits of utilising psychological services. Medical doctors were the least consulted when experiencing psychological distress, which may be because medical doctors are more widely known to deal with physical symptoms. The findings also

suggest that there is no linear method in help-seeking as some students mentioned other sources of help (i.e., music) that were not mentioned in the questionnaire.

The results from the logistic regression analysis reported perceived benefits as a significant predictor of formal help-seeking. Specifically, the results indicate that students who perceived benefits in seeking formal help were more likely to report preferring or having consulted formal help than those who do not perceive formal help as beneficial. The results are in accordance with previous results (Langley et al., 2017; Cannon, 2019; O'Connor et al., 2014). The study also suggests that perceived susceptibility, perceived severity, and perceived barriers are non-significant to formal help-seeking. This is contrary to what the HBM suggests. The HBM suggests that those who perceive high susceptibility to the illness and seriousness of the symptoms are more likely to seek psychological help. Furthermore, previous research has suggested that those who perceive less barriers are more likely to seek formal help (Henshaw & Freedman-Doan, 2009).

The most common barriers reported by students were those of self-reliance and perceiving symptoms as not severe or serious. Most students preferred dealing with issues on their own, and further reported a dislike of feeling controlled by others and talking about feelings, emotions, and thoughts. Furthermore, students preferred to wait until they were sure that the problem is serious, as well as not wanting to overact to a problem that was not serious and reported perceiving problems as normal or to be part of life. Students may have preferred to rely on themselves because they may have perceived problems as not warranting professional help, which may suggest that students are unable to differentiate between normal stress or anxiety and mental health problems. Moreover, students indicated a lack of knowledge of where to access helping resources (i.e., mental health services), which may have resulted in students relying on themselves. Furthermore, previous studies have reported that students are less likely to seek psychological help if they perceive that they will be judged, discriminated against, or even isolated if they do seek help or are diagnosed (Vidourek et al., 2014). Therefore, perceived stigma and self-stigma could explain the preference of self-reliance. Moreover, male students indicated negative attitudes towards help-seeking and perceived more barriers to seeking psychological help.

This study's findings have potential relevance for health promoters, mental health providers and the university. The findings revealed the need for interventions to reduce barriers and potentially improve access to mental health services amongst students. Considering the desire

for self-reliance and the perception of problems being less severe, this suggests that interventions may be needed to improve mental health literacy and reduce stigma. Moreover, previous studies have suggested that HBM provides a suitable structure for developing interventions to eliminate inaccurate beliefs about mental health (Henshaw & Freedman-Doan, 2009). Therefore, the current findings suggest a need for strategies and initiatives such as awareness campaigns and psychoeducational programs highlighting the benefits of utilising psychological services and their effectiveness. Such initiatives must especially target male students. Lastly, strategies are recommended to inform students about services offered by the university and what they entail.

6.2. Limitations of the study

Inevitably, there are some limitations to this study including the research design, sampling strategy, sample size and measures used. Firstly, the cross-sectional design does not allow for behaviours and attitudes to be assessed over a period of time, as it only measures participants behaviours and attitudes at a specific time. This means that responses may have been influenced by what the participant was feeling at that specific time during which the questionnaire was completed. Therefore, responses may not reflect participants actual behaviours and attitudes. Secondly, the questionnaires had closed-ended questions limiting participants' viewpoints on barriers to seeking psychological help. Thirdly, the sample size was small, and the use of a non-probability sampling strategy means that the findings may not be generalizable to the entire student population of the university. In addition, the sample was skewed as females were overrepresented, as were students who were in the 18-26 years age group, undergraduate students, and black African students. Another possible limitation of the study was the measures used. Some elements were not fit for the South African population because the metrics were originally intended for a Western demographic. Some factors that would have been considered barriers in the South African context were not included in these measures (i.e., language). In essence, the findings of this study must be interpreted with caution. Lastly, the limitations of this study include the use of an online survey for data collection, which excluded students without internet access.

6.3. Recommendations for future research

Based on the limitations identified above, qualitative research with individual interviews and focus groups may be useful in obtaining a deeper and richer understanding of students' preferred sources of help and their perceived barriers or barriers they have encountered in their attempts to seek psychological help. Qualitative research will also allow the researcher to engage more with the participants and explain psychological terms in order to get accurate descriptions from students. It is also recommended that developing a measure that is more relevant to the South African population which includes barriers that South Africans may encounter would be worthwhile and beneficial to help-seeking behaviours studies. A larger sample that is more representative is also recommended for generalisability purposes. Lastly, research studies specifically targeting the utilisation of services provided by the University are recommended.

Moreover, the findings suggest a need to adopt measures for improving help-seeking behaviours that take into account students' preference for self-reliance. Interestingly, digital tools appear as a promising means to increase access to mental health support among university students(Theurel & Witt, 2022). Also, the COVID-19 pandemic has highlighted the need for evidence-based self-help materials and online self-help programs or mental health mobile applications (Apps). Such tools have been found to be very useful because they can prevent barriers such as stigma(Upton et al., 2021; Wong et al., 2021). Further, many university counselling centres are unable to provide immediate counselling due to being understaffed and lengthy waiting list. Such tools will be able to make up for that. The online self-help program should include emotional competence training to improve mental health literacy as well as act as a gateway to professional help-seeking(Pretorius et al., 2019). However, it should be taken into considerations the expenses involved in seeking psychological help online (i.e., the cost of data) as some students may be at a disadvantage. Therefore, there is a need to develop self-help mobile apps that are free of charge or at a low-cost to accommodate those students. However, given that the entire impact of the pandemic may not yet be realised, ongoing monitoring of mental health outcomes and help-seeking behaviours is necessary.

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APPENDICES

Appendix A

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE

CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE: PROTOCOL NUMBER: MASPR/21/05

PROJECT TITLE: Mental health problems and perceived barriers in seeking psychological help: A survey of students at a university in South Africa.

INVESTIGATOR Ngcobo Zinhle (1918445)

SCHOOL/DEPARTMENT OF INVESTIGATOR SHCD/Psychology

DATE CONSIDERED 10 June 2021

DECISION OF THE COMMITTEE Approved unconditionally

RISK LEVEL Minimal Risk

EXPIRY DATE 31 December 2023

ISSUE DATE OF CERTIFICATE 21 June 2021 **CHAIRPERSON** ____ _ (Dr Sahba Besharati)
cc: Prof. Kennedy Amone-P'Olak (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

_____ _____/_____/_____

Signature Date

Appendix B

30 August 2021

Zinhle Ngcobo
Student Number (1918445)
MA (Social and Psychological Research)
School of Human & Community Development

TO WHOM IT MAY CONCERN

"Mental health problems and perceived barriers in seeking psychological help: A survey of students at a university in South Africa."

This letter serves to confirm that the above project has received permission to be conducted on university premises, and/or involving staff and/or students of the University as research participants. In undertaking this research, you agree to abide by all University regulations for conducting research on campus and to respect participants' rights to withdraw from participation at any time.

If you are conducting research on certain student cohorts, year groups or courses within specific Schools and within the teaching term, permission must be sought from Heads of School or individual academics.

Ethical clearance has been obtained. (Protocol number: MASPR/21/05) Research Expiration: (31 December 2023)

Nicoleen Potgieter
University Deputy Registrar

Cc Professor Kennedy Amone-P'Olak

Appendix C

Dear valued participant,

You are hereby invited to participate in the following research study: **Mental health problems and perceived barriers in seeking psychological help: A survey of students at a university in South Africa.**

My name is Zinhle Penelope Ngcobo, a master's student in Social and Psychological Research (Research Psychology) at the University of the Witwatersrand, Johannesburg. As part of this degree, I am undertaking a research study exploring factors that hinders students from seeking psychological help, under the supervision of Prof. Vinitha Jithoo. Participation in this study will require you to complete a survey which will approximately take 15 - 30 minutes to complete.

Participation is completely voluntary, should you choose not to participate in this study, that will not be held against you in any way. You may exit the questionnaire anytime should you feel you no longer want to participate in the study. There are also no direct benefits or foreseeable risks for participating in the study. Further, your participation and responses will remain confidential, and your anonymity is guaranteed. At no time will we know who you are, since the questionnaire requires no identifying information and responses will be saved in a secure database which is password protected. By clicking the link below and completing the questionnaire, you are providing consent for your responses to be used in the data analysis stages of this research study.

Please click on the link below to complete the survey:
https://redcap.link/studentsmentalhealthsurvey

Should you require any further information regarding this study, please do not hesitate to contact myself or my supervisor. My contact details as well as my supervisor's details are provided below. In case of any psychological distress, kindly contact the Wits crisis line 0800 111 331.

Thank you for taking the time to read this and your participation would be truly appreciated.

Zinhle Penelope Ngcobo

Prof. Vinitha Jithoo

ngcobozinhle48@gmail.com vinitha.jithoo@wits.ac.za

Appendix D

Section A

Demographic information

Please read each item given below and tick the one that applies to you.

1. Age:
2. Gender:

Male	
Female	

3. Level of study:

Undergraduate student	
Postgraduate student	

4. Race:

Black African	
White	
Indian	
Coloured	
Other (specify)	

5. Please indicate which facility you are in by ticking below:

Sciences	
Commerce	
Law	
Management	
Engineering	
Health Sciences	
Humanities	

Section B

Please indicate by a tick in the space provided, which of the following are/is the most preferred source of help when experiencing mental health problems. If you have not

experienced any mental health problems, kindly indicate which source of help would you prefer/seek.

1. Specialist Mental health professionals (Psychiatrist, Psychologist, Social workers, Psychiatric nurse)	
2. Medical doctor/General Practitioner	
3. Spiritual leaders (Priest, spiritual healer)	
4. Traditional healer (i.e. Sangoma, Inyanga)	
5. Friends	
6. Family members	
7. Partner (romantic partner)	
8. Other (Please specify)	

Section C

Health Beliefs about Mental Illness (HBMI) instrument

Please carefully read the following statements and on a scale of 1 to 5, how much do you agree with these statements?

1= Strongly disagree (SD)

2= Disagree (D)

3= Neither agree or disagree (ND/A)

4= Agree (A)

5= Strongly Agree (SA)

Emotional/Nervous problems also refers to psychological problems or disorders such as depression and anxiety.

Statements	**1-SD**	**2- D**	**3-ND/A**	**4- A**	**5-SA**
Emotional/Nervous Susceptibility Scale					
1. It is extremely likely that I will have an emotional or nervous problem in the future.					

2. My chances of having emotional or nervous problems are great.					
3. I am more likely than the average person to have emotional or nervous problems.					
4. There is a good possibility that I will develop emotional or nervous problems in the next 10 years.					
5. I feel I will develop emotional or nervous problems in the future.					
Emotional/Nervous Severity Scale					
6. Emotional or nervous problems would threaten my relationship with family or friends.					
7. Thinking about emotional or nervous problems makes me nervous.					
8. The thought of having an emotional or nervous problem scares me.					
9. If I had an emotional or nervous problem, my whole life would change					
10. I am afraid to think about emotional or nervous problems					
11. If I developed emotional or nervous problems, I would not live as long as the average person					
12. Difficulties I would experience with emotional or nervous problems would last a long time.					
Emotional/Nervous Benefits Scale					
13. Getting help for emotional or nervous problems would prevent major problems with family and friends.					

14. Getting help for emotional or nervous problems would increase my ability to function at home, work and at school					
15. Getting help for emotional or nervous problems would make me feel better about myself.					
16. A burden would be lifted off me if I were to get help for emotional or nervous problems					
Emotional/Nervous Barriers scale					
17. Getting help for emotional/nervous problems is embarrassing					
18. Getting help for emotional or nervous problems would cost too much money.					
19. Getting help for emotional/nervous problems would take too much time.					
20. Health professionals would not understand someone like me if I went to them for emotional or nervous problems					
21. People would think differently about me if I were to get help for emotional/nervous problems.					

Barriers to care evaluation (BACE) scale

Instructions:

Below you can see a list of things which can stop, delay or discourage people from getting professional care for a mental health problem, or continuing to get help. By professional care, we mean care from staff such as a GP (family doctor), member of a community mental health team (e.g. care coordinator, mental health nurse or mental health social worker), psychiatrist, counsellor, psychologist or psychotherapist.

Have any of these issues ever stopped, delayed or discouraged you from getting, or continuing with, professional care for a mental health problem? This has stopped, delayed or discouraged me?

0= Not at all

1=A little

2=Quite a lot

3= A lot

Statements	Not at all	A little	Quite a lot	A lot
21. Being unsure where to go to get professional care.				
22. Wanting to solve the problem on my own.				
23. Fear of being put in hospital against my will.				
24. Thinking the problem would get better by itself.				
25. Concern about what my family might think, say, do or feel.				
26. Preferring to get alternative forms of care (e.g. traditional/religious healing or alternative/complementary therapies).				
27. Concern that I might be seen as “Crazy”				
28. Thinking that professional care probably would not help				

29. Professionals from my own ethnic or cultural group not being available				
30. Being too unwell to ask for help				
31. Concern that people I know might find out				
32. Dislike of talking about my feelings, emotions or thoughts.				
33. Concern that people might not take me seriously if they found out I was having professional care				
34. Concerns about the treatments available (e.g. medication side effects)				
35. Not wanting a mental health problem to be on my medical records				
36. Having had previous bad experiences with professional care for mental health				
37. Thinking I did not have a problem				
38. Concern about what my friends might think, say or do.				
39. Difficulty taking time off work/school				
40. Having no one who could help.				

Barriers to Help Seeking Scale (BHSS)

Please indicate to what extent you agree with the following statements:

	Strongly agree	**Agree**	**Neither agree or disagree**	**Disagree**	**Strongly disagree**
Factor 1: Need for Control and Self-Reliance					
I would think less of myself for needing help.					
I don't like other people telling me what to do.					
Nobody knows more about my problems than I do.					
I'd feel better about myself knowing I didn't need help from others.					
I don't like feeling controlled by other people.					
It would seem weak to ask for help.					
I like to make my own decisions and not be too influenced by others.					
I like to be in charge of everything in my life.					
Asking for help is like surrendering authority over my life.					
I do not want to appear weaker than my peers.					
Factor 2: Minimizing Problem and Resignation					
The problem wouldn't seem worth getting help for.					
The problem wouldn't be a big deal; it would go away in time.					
I wouldn't want to overreact to a problem that wasn't serious.					
Problems like this are part of life; they're just something you have to deal with.					
I'd prefer just to suck it up rather than dwell on my problems.					

I would prefer to wait until I'm sure the health problem is a serious one.					
Factor 3: Concrete Barriers and Distrust of Caregivers					
People typically expect something in return when they provide help.					
I don't trust doctors and other health professionals.					
Privacy is important to me, and I don't want other people to know about my problems.					
This problem is embarrassing.					
Factor 5: Emotional Control					
I don't like to get emotional about things.					
I don't like to talk about feelings.					
I'd rather not show people what I'm feeling.					
I wouldn't want to look stupid for not knowing how to figure this problem out.					

Kindly specify any other barriers to seeking psychological help that you have encountered or factors that hinders you from seeking psychological help (If applicable):