PREDICTORS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING BEHAVIOUR: A STUDY OF URBAN, PERI-URBAN AND RURAL DWELLERS IN GREATER-ACCRA REGION

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL CLINICAL PSYCHOLOGY DEGREE

JULY, 2018
PREDICTORS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING BEHAVIOUR

DECLARATION

I hereby declare that this thesis, entitled: “Predictors of Professional Psychological Help-Seeking Behaviour: A Study of Urban, Peri-urban and Rural Dwellers in Greater-Accra Region” is an outcome of my own research work carried out under the auspices of the University of Ghana Psychology Department, specifically under the supervision of two faculty members, namely; Professor Charity S. Akotia and Doctor Margaret Amankwah-Poku. This research work has neither been previously published nor has it been submitted for the award of any other degree elsewhere in the world. By means of complete references, I have duly indicated and acknowledged all the other research works conducted by other people which I have used in my work.

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DEDICATIONS

This work is dedicated, firstly, to my darling parents Mr. Collins K. Adjepong and Mrs. Elizabeth Adjepong, who encouraged me through it all. Thank you Mummy and Daddy, I can smile today because you gave me reasons to.

Secondly, I dedicate this research work to all the next generation of the Adjepong Family of whom I am certain that, they shall do great things for God and mother Ghana. May you be encouraged, perceiving the effort I committed into this mandate and may this become a sign of hope and inspiration for you to aspire to outshine all your challenges. Like I always say, “Impossible is absolutely nothing because God is not dead !!!.”

Thirdly, I dedicate this literature to all professional psychologists in Africa. May we be committed in finding contextual solutions to the African psychological challenges including how to get our people to appreciate and understand our profession in order for the African to benefit fully from our God-given talents, skills and abilities.
ACKNOWLEDGEMENT

“Every good gift and every perfect gift is from above, and comes down from the Father of lights…”

(James 1:17a).

Perceiving that I have achieved a very good and perfect gift, I am most grateful to the Lord God Almighty, the Father of lights who through the gift of the Holy Spirit inspired and guided me on this journey and helped me through the completion of this project work. The MPhil. Clinical Psychology program involved a lot of challenges and hurdles including difficult lecturers and several reading assignments and examinations. I am grateful to God because I know that without Him, I could not on my own have accomplished this mandate successfully.

I am also very thankful to my supervisors Prof. Charity Akotia and Dr. Margaret Amankwah-Poku for their patience, love and support they showed me beyond the academic assistance I needed for the success of this thesis. God richly bless you.

I wish to say thank you to my parents and my siblings Gifty and Portia for always believing in me and constantly praying for me to succeed.

I cannot forget to appreciate the support of those who together invested their hard-earned resources to offer me a great scholarship package; Dr. Yaw Amoateng-Adjepong, Mr. Kwasi Faakye Agyapong and Madam Janet Oforiwa, thank you for believing in me, God shall surely supply all your needs according to His riches in Glory, Amen.

I owe a lot to all my friends Lynda Dede Ahulu, Alexandra Adjei, Samuel Agyei Wiafe, Rita Nkrumah, Osei Yaw Sarfo, Eric Yao Aglozo, Mrs. Vida Ansah-Ayeh, Mariam Biritwum, Irene Botchway and to all my fantastic MPhil colleagues, your commitment to show love is incomparable. May my God supply all your needs according to His riches in Jesus name, Amen.
A special mention must be made of Mr. Enoch Kwesi Nyame Asante, Mr. K. Gyasi Bawuah, Miss Philipa Berko-Ampofo, Mrs. Betty Berko-Ampofo, Ruth Ama Sakyibea Opare and Miss Rita Abena Agyekum for their wise counsel and support. I’m glad God purposed us to meet in this life, our union and connections have been amazing. Thank you for everything.

I also thank all the participants who gave their consent, support and time to make this research project successful.

Finally, I am greatly indebted to my Spiritual Father, Rev. Fiifi Otabi Willson of Faith Temple, ICGC, Ofankor for giving me hope in my dark days and for being a wonderful mentor. God richly bless you.
# PREDICTORS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING BEHAVIOUR

## TABLE OF CONTENTS

DECLARATION ........................................................................................................................... i
DEDICATION .......................................................................................................................... ii
ACKNOWLEDGEMENT ......................................................................................................... iii
TABLE OF CONTENTS ........................................................................................................... v
LIST OF TABLES ................................................................................................................... vii
LIST OF FIGURES .................................................................................................................. vii
ABSTRACT .............................................................................................................................. viii

CHAPTER ONE ....................................................................................................................... 1
Introduction .......................................................................................................................... 1
  Background of the Study ................................................................................................. 1
  Statement of the Problem .............................................................................................. 12
  Aim and Objectives of the Study .................................................................................... 14
  Relevance of the Study ................................................................................................. 15

CHAPTER TWO ..................................................................................................................... 17
Literature Review .................................................................................................................... 17
  Introduction ..................................................................................................................... 17
  Theoretical Framework ................................................................................................. 17
  Review of Related Studies ............................................................................................ 22
  Rationale for the Study ................................................................................................. 31
  Statement of Hypotheses .............................................................................................. 33
  Research Question ........................................................................................................ 34

CHAPTER THREE ................................................................................................................. 35
Methodology ....................................................................................................................... 35
  Introduction ..................................................................................................................... 35
  Research Design ............................................................................................................ 35
  Research Settings .......................................................................................................... 36
LIST OF TABLES

Table 1: Demographic Characteristics of Participants.................................................40
Table 2: Demographic Characteristics of Interviewees.................................................42
Table 3: Descriptive Statistics of Scores and reliability of scales................................51
Table 4: Pearson Correlations Among Study Variables............................................53
Table 5: Descriptive Statistics of ATSPPH Based on Area of Residence & Education.....54
Table 6: ANOVA test of significance of Place of Residence and ATSPPH ...............56
Table 7: ANOVA test of significance of Educational Level and ATSPPH ...............57
Table 8: Predictors of Professional Psychological Help-Seeking Behaviour .............59
Table 9: Demographic Predictors of PPHSB..............................................................63
Table 10: ANOVA test of significance of Place of Residence and Cultural Beliefs.......64
Table 11: ANOVA test of significance of Place of Residence and Self-stigma.............65
Table 12: Predictors of PPHSB Based on Place of Residence.................................67

LIST OF FIGURES

Figure 1. Hypothesized Conceptual Model.............................................................34
Figure 2. Observed Model.......................................................................................69
Figure 3. Thematic Network of Knowledge and Understanding of PP Services........71
ABSTRACT

Professional psychologists offer very efficacious therapy, however many individuals battling with mental/psychological illness do not consult them for assistance. This study examined some predictors of professional psychological help-seeking behaviour among Ghanaians in the Greater-Accra region and explored their knowledge and understanding of professional psychological services. The sequential mixed method design was used in this study. Study 1 was a cross-sectional survey involving three-hundred and sixty participants (N=360=120 urban dwellers, 120 rural dwellers and 120 peri-urban dwellers). They completed measures of psychological help-seeking behaviour, health locus of control, cultural beliefs and self-stigma. Results revealed that urban dwellers showed significantly more willingness to consult professional psychologists for assistance than peri-urban and rural dwellers. Cultural beliefs and self-stigma negatively predicted professional psychological help-seeking behaviour significantly. Individuals with tertiary education also reported more willingness to consult professional psychologists than those with secondary and basic education. However, health locus of control (internal, chance and powerful others) did not predict professional psychological help-seeking behaviour. In Study 2, in-depth interviews about knowledge and understanding of professional psychological services were conducted among fifteen participants (N=15=5 urban dwellers, 5 rural dwellers and 5 peri-urban dwellers). Thematic analysis revealed that participants had some misconceptions about the work of professional psychologists as majority did not know their locations, thought that their services were very expensive, and believed that professional psychologists prescribe medications just as medical doctors. Participants indicated that supernatural forces caused mental illness and that prayers and herbal medications were alternative treatments for mental illness. These findings imply that professional psychologists need to deliberately educate the general public about mental/psychological illness and the benefits of professional psychological services.
CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Each day, individuals are confronted with series of health concerns such as physical, emotional, cognitive and behavioural indispositions. Those who suffer various physical conditions such as malaria, heart attack, typhoid, fever, diabetes, asthma, hypertension, and many more tend to consult health professionals (medics, pharmacists, nurses and physicians) for treatment. However, people who suffer from various psychopathological conditions such as clinical depression, anxiety disorders, alcoholism, emotional distress caused by broken heartedness, death of loved ones, and failure in school examinations, do not often consult professional mental health experts such as professional psychologists for assistance (WHO, 2014).

In order to understand why people may or may not seek help for their mental health and general well-being, some psychologists study help-seeking behaviour. Help-seeking behaviour has been defined as the processes by which individuals voluntarily (actively) seek help from others by means of communicating their challenges to other persons (usually perceived as being capable of assisting them to resolve their distress or challenges) with the hope and belief of getting help or assistance which usually involves an advice, information, treatment and general support in response to their challenges (Rickwood, Deane, Wilson & Ciarrochi, 2005). Professional psychological help-seeking behaviour therefore involves the decision and action taken by an individual to consult a professional psychologist for assistance. This kind of assistance given by professional psychologists is known as psychotherapy (Rickwood et al., 2005).

Professional psychologists are trained mental health experts whose responsibility is to use a variety of techniques such as Cognitive-Behaviour Therapy (CBT), Progressive Muscular Relaxation,
Biofeedback, Cognitive Restructuring, Assertiveness Training and Systematic Desensitization while considering people’s unique values, characteristics, goals and circumstances, to help them cope more effectively with life issues. Psychologists also help people through the treatment and management of emotional, cognitive and behavioural disorders such as anxiety disorders, depression, post-traumatic stress disorders and other mental health problems (APA, 2014). Additionally, professional psychologists are trained to understand how some psychosocial factors such as age, gender, education and socioeconomic characteristics influence the management and treatment of individuals who suffer physical or medical conditions such as cancer, renal disorders, traumatic injuries and human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS). Some examples of professional psychologists are clinical psychologists, counselling psychologists, and marriage and family therapists among others.

Evidence suggests that at one point in time, almost half of the world’s population may suffer from some form of mental or psychological disorders that would affect their everyday normal functioning, self-esteem and relationships with their families, friends and other social groups they belong to (Storrie, Ahern, & Tuckett, 2010). In cases such as these, it becomes necessary for some individuals who cannot solve, cope or self-manage their distressing problems to consult professional psychologists for assistance to alleviate their distresses and other psychological disorders.

In Ghana, it was estimated that about 2.7 million persons were suffering from various mental or psychological disorders (WHO, 2014). It might be expected that the high prevalence of mental disorders should be matched by high level of mental or psychological service utilization and associated positive help-seeking behaviour. On the contrary, there is a marked mismatch between the prevalence of psychological disorders and the level of professional psychological help-seeking
behaviour. It was estimated that only 2% of the 2.7 million Ghanaians were known to consult mental health experts such as professional psychologists for assistance (WHO, 2014).

Despite the underutilization of professional mental or psychological services (WHO, 2014), the efficacy of psychotherapy cannot be overemphasized. Research evidence has indicated that professional psychologists offer efficacious and effective treatment for a wide range of mental health conditions such as depression (Cuijpers, Andersson, Donker, & Van Straten, 2011; Feng et al., 2011; Huntley, Araya & Salisbury, 2012); generalized anxiety disorder (Hunot, Churchill, Teixera, & Silva de Lima, 2010; Stewart & Chambless, 2009); and posttraumatic stress disorder (Bisson et al., 2007; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010).

This notwithstanding, so many individuals are still reluctant or unwilling to seek psychological assistance. Thus some studies have been conducted to determine factors that influence people’s psychological help-seeking behaviour. Some studies have associated an individual’s decision to seek or not to seek professional psychological help to factors such as age, sex, educational backgrounds, socioeconomic status, and religion. Other factors are stigmatization, health locus of control, fear of emotional disclosure, perceived social support, cultural beliefs, lack of knowledge and understanding, availability, accessibility and cost of service among others (Andrews, Stefurak & Mehta, 2011; Barwick, de Man & McKelvie, 2009; Boafo, 2013; Doherty & Doherty, 2010; Girma & Tesafe, 2011).

Of these factors, the present study investigates how health locus of control, self-stigmatization and cultural beliefs about the causes of psychological (mental) disorders can influence individuals’ professional psychological help-seeking behaviours. More so, demographic characteristics such as where individuals’ reside and their educational levels are examined to ascertain the roles they play in individuals’ professional psychological help-seeking behaviours within the Ghanaian context.
Health Locus of Control and Help-Seeking Behaviour

Some psychologists believe that an individual’s locus of control; that is who or what controls the person’s health is highly associated with his/her willingness to seek for professional psychological assistance (Andrews et al., 2011). Locus of control refers to an individual’s assumed responsibility for his or her successes and failures (Rotter, 1954; 1975). Generally two kinds of locus of control exist; individuals who have internal locus of control (internalizers) and so believe that they are in control of their lives and are fully responsible for what happens to them, and individuals with perceived external locus of control (externalizers) and so believe that outside forces, fate or chance circumstances control their lives (Rotter, 1945).

Using Rotter’s (1945, 1975) locus of control theory, Wallston, Wallston, Kaplan, and Maides (1976) also developed the theory of health locus of control, which focused on individuals’ attributions of responsibility for their mental and physical health outcomes. Wallston and colleagues believed that health behaviours were inextricably intertwined to an individual’s experiences in a given circumstance and that an individual’s health locus of control beliefs are not as stable as his generalized locus of control (Wallston et al., 1976). They postulated that health locus of control assessed two different personality variables; ‘health internalizers’- individuals who believed that they were in control of their health and ‘health externalizers’- individuals who also believed that powerful or outside forces, fate or chance is essentially responsible for their health outcomes (Wallston et al., 1976).

Theoretically, since internalizers are inclined to believe that they are fully responsible for the outcome of events around them, they may be more likely to openly seek psychological help from an expert health professional. However, individuals who believe that predominantly external forces (fate, chance, supernatural beings) determine their success may not possess the agency to take actions such
as seeking psychological help. For instance, it has been found that individuals with stronger internal locus of control paid more attention to healthy nutrition and displayed a higher level of physical activity while those who scored higher on chance locus of control exhibited a higher likelihood of current smoking, lower physical activity and less attention to healthy nutrition (Helmer, Krame & Mikolajczk, 2012). Some authors have found that some individuals with health internalizing tendencies rather have lower health care utilization behaviours (Chipperfield & Greenslade, 1999). It is possible that some health-internalizers may see the process of consulting for health care less favourable than health-externalizers because the internalizer may feel they are losing control. Another interesting twist to how influential individuals’ locus of control impact their lives is in the discovery that in certain aspects of individuals’ lives, they are inclined to believe that both internal and external factors play significant roles in the outcomes of their lives (Connolly, 1980; Rotter, Seeman & Liverant, 1962). Based on the suggestion that there exist individuals who exhibit “bi-local or mix-loci of control”, there is the possibility that in the event that such an individual has a psychological distress, he/she may simultaneously hold the strong belief that external forces like God or evil spirits are responsible for his/her health outcome and at the same time also suspect that he/she is fully responsible for his distress and so he/she can find solutions to his/her distress. The idea of “bilocals” has been also supported by Wong and Sproule (1984), who asserted that the idea of locus of control is such that an individual’s perception of control may be found to lie somewhere along a continuum between an internal and an external locus of control. Researchers have been asked to bear in mind that, although a particular individual may be generally oriented to be an externalizer, an internalizer, or “a bilocalizer”, does not mean that particular individual may or may not transfer that particular control expectancy to more area-specific domain in life such as his/her health (Neal, Weeks & DeBattista, 2014). In as much as an individual’s health locus of control may determine his/her help-
seeking behaviour, however, the extent to which a person perceives mental disorders as stigmatizing will also determine help-seeking behaviours.

**Self-stigma and Help-Seeking Behaviour**

The fear of being stigmatized by others sometimes influences people to avoid seeking professional psychological help (Larson & Corrigan, 2008). Stigmatization can also be internalized such that an individual labels himself/herself as unacceptable because of having a psychological distress. This state of mind results in a drastic reduction in the probability or likelihood of seeking help. Understanding these different forms of stigma can enable psychologists to target interventions at different levels of the society to help individuals overcome the barriers to seeking help. As some researchers have found, before taking an action, people initially evaluate the state of stigmatization by friends and families in close proximity to them (Vogel, Wade, & Ascheman, 2009) and then stigmatization by the community they reside in (Corrigan, 2004), then finally they make a decision whether they will attempt to seek help or not.

According to Corrigan (2004), the two types of stigmatization that affect an individual’s decision to seek help are social/public stigmatization and self-stigmatization. Self-stigmatization has been described as an internal form of stigma, wherein one labels oneself as unacceptable because of having a mental health concern. On the other hand, public stigmatization occurs when members of the general public endorse stereotypes and act on discriminatory behaviours such as avoiding handshakes from someone who has attempted suicide (Corrigan, 2004; Larson & Corrigan, 2008; Vogel, Wade & Haake, 2006). Vogel and colleagues (2006) showed that when compared with public stigmatization, self-stigmatization more closely predicts attitudes towards seeking psychological help and willingness to do it. They indicated that when seeking professional psychological help is perceived as a threat to self-esteem, in spite of the emotional suffering, the individual may decide not to seek
help because taking help is perceived as a weakness and acceptance of failure. This may lead the individual to think that accepting the need for help is even worse than the emotional suffering (Vogel et al., 2006).

In furtherance, some studies have also suggested that when social stigmatization is internalized, the possibility of seeking help is decreased further (Larson & Corrigan, 2008; Vogel & Wade, 2009). Other researchers have also suggested that individuals’ decision not to seek for professional psychological help may be linked to strong self-stigma attached to mental disorders and seeking psychological health care (Brown & Bradley, 2002; Gonzalez, Tinsley, & Kreuder, 2002; Sadow, Ryder, & Webster, 2002; Vogel et al., 2006). Thus, understanding different forms of stigmatization and helping people to overcome burdens against seeking help is an important task for psychotherapist. So as self-stigma is strongly associated with the public stigma level that is manifested in the socio-cultural set-up of individuals, the cultural environment also plays significant role in the socialization of members of a society with the etiology of health challenges such as mental illness. The subsequent paragraph elucidates this point.

**Cultural Beliefs and Help-Seeking Behaviour**

Researchers have identified the institution of culture as one of the influential factors that underpin individual and community health systems. The cultural backgrounds of individuals and communities have been found to influence their illness perceptions, understanding of diseases and the systems and methods available for the promotion of healthy individuals in different communities (Saint Arnault, 2009).

Culture as a concept has been discussed and explained by many authors. For instance, Kroeber and Clackhohn (1983) described culture as the sum total of a society’s custom, habits, beliefs and values.
Leininger (1985) has also defined culture as the learned, shared and transmitted values, beliefs, norms and life way practices of a particular group that guides thinking, decisions and actions in patterned ways. According to Matsumoto (1996), culture is a dynamic system of rules, explicit and implicit, established by groups in order to ensure their survival, involving attitudes, values, beliefs, norms, and behaviour.

Thus, invariably, most authors view the concept of culture as essentially the framework within which values are formed and these values in turn shape the beliefs that determine people’s behaviour. This makes culture a multidimensional construct and so in order to understand fully how the cultural backgrounds of Ghanaians influence their health and their professional psychological help-seeking behaviours, it is imperative to investigate some of the elemental dimensions of what the Ghanaian culture involves.

According to Abotchie (1997) the cultural beliefs of Africans are embedded in their religion and among West Africans (of which Ghanaians are a part), religion is a way of life, which occupies the entire life of people including their health. Odejide, Oyewumi and Ohaeri (1989) also believed that the traditional African society’s beliefs in the existence and activities of supernatural agents such as witches, ancestral spirits, sorcerers and diviners among others are still strong. Again, in the African setting, it is strongly believed that an individual’s health and wellbeing can be influenced through the cunning manipulations of those supernatural agents (Odejide et al., 1989).

Moreover, among Africans, mental health challenges are believed to be misfortunes that befall people (Lasebikan, 2016). For instance, some Ghanaians, whose cultural beliefs were found to influence their concept of attribution of mental/psychological illness indicated that mental/psychological illness is predominately a supernatural illness (Opare-Henaku & Utsey, 2017). Other Ghanaians within rural communities who had strong traditional belief systems also held strong beliefs about the spiritual
causes of mental illness (Quinn, 2007). Similar opinions were held among some South-Western Nigerians, who indicated that psychological illness was a form of divine punishment (Gureje, Lasebikan, Ephraim-Oluwanuaga, Olley & Kola, 2005).

Although the spiritual aetiology for mental disorders cuts across most African cultures, some Africans also believe in other causes of mental illness. For example, Opare-Henaku and Utsey (2017) found that some Akans in Ghana mentioned several factors such as genetic, drug abuse, difficult economic circumstances such as basic needs like clothing, food and shelter, among others as the causes of mental/psychological illness. Another study conducted in Nigeria revealed that participants reported different causal reason for mental illness such as genetic inheritance, biophysiological factors, brain diseases, traumatic event or shock, poverty and stress (Gureje et al., 2005).

Cultural beliefs about the aetiology of mental illness do influence help-seeking decisions. Individuals with different cultural backgrounds seek help for their health challenges and distresses, based on the meaning that their culture gives to the distress. So in their quest to seek help for their health challenges, individuals in Africa, invariably, seek help from the known and available therapeutic avenues within their cultural set-ups. Thus the African traditional treatment methods for mental illness is one of the most patronized because the therapeutic processes focus on magico-religious elements which satisfy the strong cultural belief that supernatural powers are mainly responsible for mental illness (Lasebikan, 2016; Twumasi, 2005).

Another perspective that should be considered is that culture can be an individual construct. This is because it exists in each one of us individually as much as it exists as a global, social construct as alluded to by Matsumoto (1996). Thus individual differences in the Ghanaian cultural beliefs about the causes of mental/psychological illness may be observed in a Ghanaian according to the extent to which that individual adopts and engages in the beliefs that are popularly known to constitute
‘Ghanaians’ supernatural cultural beliefs about the causes of the mental/psychological illness. Hence, it is instructive to note that, it is possible to have some Ghanaians who will deviate from the supposed supernatural beliefs about mental/psychological illness irrespective of the fact that they live and are socialized in Ghana communities.

It should be expected therefore that, individuals who believe in other causal explanations for mental/psychological illness, will be more likely to also consult other mental health therapeutic service providers. For instance, an empirical finding has indicated that some Ghanaians practice pluralistic health-seeking behaviours: they consult medical professionals, pastors in prayer camps, herbalists, and traditional healers in their quest to get solutions for their conditions (Opare-Henaku & Utsey, 2017). Thus, differences in causal beliefs may influence a person’s decision to seek help and whether, professional psychological help will be sought.

Besides the fact that cultural beliefs about the cause of mental illness may influence individuals’ decision and choice of seeking help, socio-demographic characteristics such as the place of residence and the educational level of individuals have also been mentioned as significant players in determining whether individuals will seek help or not.

**Educational Background and Help-Seeking Behaviour**

Education in the general sense involves having or gaining knowledge in a broader sense. However in most respect, education is somehow equated to being formally educated in a school or college. Education is critical to social and economic development and has a profound impact on the health of a society/nation. Some researchers have linked individuals’ level of education (tertiary education, secondary education or basic education) to whether they would seek help or they would not seek help for their health challenges including physiological and psychological health challenges. Some
researchers have asserted that individuals with tertiary education and post-graduate degrees are more likely to understand the issues with their mental health and so will be more likely to seek professional psychological assistance than those with basic educational backgrounds (Zimmerman, Woolf, & Haley, 2015; Goldman & Smith, 2011; Olshansky, Atonucci, & Berkman, 2012).

**Place of Residence and Help-Seeking Behaviour**

The communities in which people reside or dwell influence their lives a great deal and health is not an exception. For instance, as compared with urban dwellers, rural dwellers may have a high sense of perceived lack of anonymity due to the fact that rural dwellers are more likely to be much closer to their nuclear and extended family members and friends than urban dwellers. As a result of the high public stigmatization attached to mental/psychological illness, the rural dweller may feel uncomfortable to consult mental health experts for assistance because his/her privacy may be at stake. On the other hand, an urban dweller may be more open to consult mental health experts for assistance because stigmatization may be lower in the cities than villages and he/she may have fewer family and friends around, which increases his/her privacy to an extent.

Another influence of place of residence on individuals’ help-seeking behaviour is the availability and accessibility of expert mental health services. Realistically, the probability that urban settings will have greater number of professional mental health expert services available than rural settings is very high; this implies that individuals who reside in rural communities may have some challenges relative to mental/psychological health care.

It is quite challenging to pin-point exactly which factors are influential in individuals’ professional psychological help-seeking behaviours. Cultural beliefs, health locus of control and self-stigma are among the extensive list of factors which may be influencing help-seeking behaviour and so realizing
that professional psychological help seeking could be influenced by these variables or predictors, the present study sought to explore some of these variables within Ghanaian communities.

1.2 Statement of the Problem

Mental health, according to the World Health Organization, refers to the state of well being in which an individual realizes his or her own potential, can cope with the normal stresses of life and is able to make a meaningful contribution to his or her society (WHO, 2001). This implies that as humans, our emotional and psychological health or well-being is at the pivot of our lives and so we invariably need to do our best to stay mentally healthy at all times. Among other means of staying mentally healthy, mental health professionals such as clinical psychologists, counselling psychologists and marriage and family therapists have been trained and licensed to help us to either maintain or improve our mental health through the prevention, diagnosis and treatment of psychological disorders such as depression, anxiety, suicidal ideations, insomnia and other social and physical conditions that impact our mental health negatively. Thus, being conscious of this fact, individuals who may be battling mental/psychological health challenges are expected to consult mental health experts such as clinical psychologists or counselling psychologists for assistance.

In recent times, among the Ghanaian populace, there are often complaints relative to people having attempted or committing suicide, excessive stress, financial difficulties, experiences of anxiety and sleeplessness, alcoholism, poor academic performance of students, abusive marriages and several other psychological problems. The question is, are Ghanaians genuinely seeking help for their mental/psychological health challenges and where, if they do?
It might be expected that the existence and availability of professional psychological services would mean that many Ghanaians consult professional psychologists for assistance. Contrary to this expectation, the actions/behaviours observed among many individuals are the exhibitions of reluctance or unwillingness to consult mental health experts such as professional psychologists for mental/psychological health care.

In fact, research evidence suggests that there is an alarming underutilization of professional psychological services in Ghana. This means that Ghanaians are not seeking help for their mental/psychological health challenges from mental health experts such as professional psychologists. For instance, the World Health Organization reported that, out of the over 2.7 million Ghanaians who were battling with mild, moderate and severe mental illnesses, 98% of them did not consult mental or psychological health professionals for assistance (WHO, 2014). This implies that either Ghanaians are not seeking help (self-help or no help) or they are seeking help from other sources.

In spite of the fact that Ghanaians may be unwilling or reluctant to seek help from professional psychologists, empirical evidences have shown that psychotherapy is beneficial to clients and it improves individuals’ overall health status (Buetler, 2007; Cuijpers et al., 2011; Feng, et al., 2011; Huntley et al., 2012). Again, receiving mental/psychological healthcare for mental health issues often lead to a positive self-worth and satisfying relationships (Buetler, 2007). Another proof that psychotherapy is efficacious is a three year longitudinal study of non-help-seeking third graders which reported that as the number of depressive symptoms increased, the reciprocal relationships and perceived quality of interpersonal relationships decreased (Rudolph, Ladd, & Dinella, 2007). Furthermore, more recently, the American Psychological Association stated that reviews of studies have shown that about 75 % of people who enter psychotherapy show some benefit. Other reviews
have found that average the person who engages in psychotherapy is better off by the end of treatment than 80% of those who don’t receive treatment at all (APA, 2017).

The consequences of not getting an effective treatment may include enormous amount of severe disability, human suffering, and economic losses among the people. There is therefore a need for a psychological health research to be conducted on professional psychological help-seeking behaviour in Ghana to understand some of the psychosocial factors that are likely to influence professional psychological help-seeking behaviour.

1.3 Aims and Objectives of the Study

The primary aim of this study is to empirically examine some psychosocial factors that influence professional psychological help-seeking behaviours (PPHSB) and also to explore knowledge and understanding of professional psychological services. The following specific objectives guided the study;

1. To investigate whether locality of residence influences PPHSB among Ghanaians

2. To determine the role education plays in PPHSB among Ghanaians

3. To examine the relationship between health locus of control and PPHSB among Ghanaians

4. To find out the association between cultural beliefs and PPHSB

5. To determine the relationship between self-stigma and PPHSB

6. To explore Ghanaians’ knowledge and understanding of professional psychological services in order to determine some reasons why Ghanaians do not seek professional psychological help.
1.4 Relevance of the study

The current study has profound significance for practice and literature. In terms of practice, people may be in need of psychological help, but they may not have adequate relevant knowledge and understanding about professional psychologists in Ghana. For instance if many Ghanaians do not know where to locate professional psychologists in Ghana, then there is surely going to be the underutilization of professional psychological services as a result of the lack or limited knowledge on professional psychological services in Ghana. Therefore, by exploring the knowledge and understanding Ghanaians have about professional psychological services, other context specific information may be obtained about why many Ghanaians who suffer mental/psychological challenges do not show up in the offices/consulting rooms of professional psychologists in Ghana.

Moreover, professional psychologists will gain context-specific knowledge and understanding about some specific psychosocial factors that may be peculiar to urban, peri-urban and rural dwellers. So that intervention programs such as psycho-educational campaigns that will address the specific barriers like cultural beliefs about the causes of mental illness and stigmatization of mental illness will be based on the empirical evidence obtained from a particular setting (urban, peri-urban or rural). This approach will make the intervention programs very effective.

Furthermore, professional psychologists can apply the insight gained from the study to develop community-based, cost-effective and accessible psychological health interventions programs for Ghanaians battling psychological challenges within communities. For instance, in addressing the perception that psychotherapy is very expensive, professional psychologists can strategically consider having the cost of their services tailored for specific communities, such that the charges for rural dwellers will be different from urban dwellers and in some cases “pro bono” services can be offered.
in order to give every Ghanaian the opportunity to access their services. This will go a long way to increase the level of confidence people have in psychotherapeutic services in Ghana.

The last but not the least relevance of the study is that, it will fill some part of the lacuna in psychological health research in Ghana and Africa since there is a paucity of current literature in the system relative to professional psychological help-seeking behaviour. Hence policy makers, researchers and students, particularly those studying community psychology, mental health and public health will benefit greatly from this study.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter consists of the theoretical framework and review of relevant literature. Three theories significant to this study have been considered. The review of related studies aims to critically review previous researches on some factors (variables) which are associated with professional psychological help-seeking behaviour and their important contributions to the literature.

2.2 Theoretical Framework

Three theories underpinned this study; Attribution theory (Weiner, 1980; 1995), the Biopsychosocial Model (Engel, 1977) and the Knowledge Attitude and Behaviour (KAB) model (Allport, 1935).

2.2.1 Attribution Theory (1980, 1995)

The attribution theory attempts to explain the world and to determine the cause of an event or behaviour such as why people do what they do? For example, why do some people seek psychological help while others are more reluctant to do so? In other words, the attribution theory simply refers to the causal explanation for an event or behaviour. The attribution theory postulated by Weiner (1995) is a classic theory and it can aid in our attempt to explain or make meaning of the phenomena of health and help-seeking behaviour.

According to Weiner (1980; 1995) the causal explanation or understanding individuals have relative to the issues or happenings around them influence their thoughts, motivations and emotions. This
outcome occurs because people tend to look for reasons that underlie their behaviours and the behaviours of others in their quest to gain understanding of the events and happenings around them. The theory holds that people go through a three-stage process in order to find underlying or causal reasons for behaviours and events in their lives; first, the individual perceives or observes an event or a behaviour, second, the individual assesses the event or behaviour to know the source, and then finally the individual determines if the event or behaviour occurred as a result of circumstances beyond his/her control or not.

So if determined that the event is within their control then they make internal attributions while if it is beyond their control then they give external attribution as the source. For instance, relative to health, it is not unusual to observe that when an individual becomes unhealthy and begins to think or plan the kind of treatment regimen to seek, the individual is most likely to consider first, the causes or risk factors of the condition. The causal element of attribution has been found to vary from culture to culture (Anderson, 1999; Morris & Peng, 1994). Individuals of different cultural backgrounds make different attributions of illness, health, and help-seeking (treatment). For example, some Africans may be more likely to reason that the cause of a certain psychological impairment has spiritual underpinnings or perhaps the will of the Almighty God has manifested the condition. Similarly, some Africans may be less likely to give scientific explanations to their psychological illnesses. As a result, they may believe in the healing power of prayers and hence will seek help from a pastor or traditional priest rather than to seek help from a mental health professional when the need arises (Twumasi, 2005). Thus, professional psychological help-seeking behaviour may be lacking or non-existent.
2.2.2 Knowledge-Attitude-Behaviour Model (Allport, 1935)

Allport (1935) was the first to present the classical model linking knowledge or information and attitudes with overt behaviour. The Knowledge-Attitude-Behaviour (KAB) Model postulated that people acquire information about a behaviour, which leads to the development of a predisposition to respond (which is called attitude), which in turn, leads to a behaviour that is in agreement with the attitude.

This model assumes that, one does not need to spend a long period presenting a subject with information, wait for an attitude to be formed, and then observe the desired behaviour. It assumes that one needs to merely send a persuasive message that attempts to induce some attitude, and then observe whether appropriate behaviours follow. The KAB model has been criticized by some researchers for lacking tact and that it is not enough to simply give people facts because the fact that obtaining information may influence a person’s attitude, change in attitude, on the other hand, may not necessarily result in change in behaviour (Fishbein, 1967; McPhee & Cushman, 1980). However, another researcher, McGuire (1969) has defended Allport’s classical claims by insisting that the problem with the KAB continuum is not the theoretical model, but the way in which the model is typically applied in real-life situations. According to McGuire (1969), whether the acquisition of a particular piece of knowledge or information will lead to some desired behaviour is dependent, in part, on whether the information has been appropriately “processed” by the receiver. McGuire (1978) has further argued that the knowledge-attitude-behaviour continuum can best be studied in a “matrix of persuasive communication”. He suggested that there are five independent variables which influence the communication process and these are: ‘the source’, ‘the message’, ‘the channel/medium’, ‘the receiver’ and ‘the destination’. McGuire (1978) further thought that, attitude change involves at least five behavioural steps; attention, comprehension, yielding, retention and
action. Applying the KAB model to this study, if most behaviours people exhibit are said to be influenced by first the kind of knowledge or information they have, because that information influences their attitudes which predisposes them to act in accordance with their attitudes, then the professional psychological help-seeking behaviour of Ghanaians will be shaped not only by the causal attributions they give to mental/psychological illness but also the relevant knowledge and understanding they have about professional psychological services in Ghana. For example, if people know professional psychologists offer tried, tested and very efficacious treatment for many mental/psychological illnesses and also know where to locate professional psychologists in Ghana, it will influence people to utilize or consult professional psychologists when they face mental/psychological health challenges. Therefore the study explored participants’ knowledge and understanding of professional psychological services since it influences their behaviour to seek professional psychological assistance or not.

2.2.3 Biopsychosocial Model (Engel, 1977)

This model was developed by Engel (1977) as an alternate model/explanation to the biomedical model that proposes that all health conditions are etiologically rooted in the biology of human beings, be it genetics or neurochemical imbalances. The biomedical model considers health as the result of the absence of diseases, and illnesses and treatment options are explained from biological perspectives. The Biopsychosocial (BPS) model on the other hand attempts to explain health on the grounds that our health is dependent not only on our biological make-ups but also other psychological and social factors equally play an important role in our human functioning. The BPS has been linked to not only our health and illnesses but also health care delivery (Santrock, 2007). The ‘bio’ component elucidates how the causes of illness/diseases emanate from the malfunctioning of the cells (eg. spermatozoa and neurons), systems (eg. nervous and digestive systems) and organs (eg. heart,
liver, kidney) within the human body. The ‘psycho’ component considers thoughts (cognition), feelings (emotions) and behaviours as the main causes of health challenges. The ‘social’ component of the BPS model focuses on how an individual’s health can be influenced by many social factors such as his/her interactions with friends and family, culture, sex (gender), age, economic status, place of residence, educational level, among others.

Moreover, the BPS model of health throws more light on the interaction or connection between the human body and the mind. It emphasizes the fact that the human body can affect the mind and the mind can also affect the human body (Halligan & Arylward, 2006). This implies that health experts need to consider all the three components in the process of health delivery in order to achieve optimum healthcare delivery. For instance, as observed by DiMatteo, Haskard, and Williams (2007), an individual’s knowledge and awareness of health, his/her perception of imminent danger of diseases as well as the impediments in his/her socio-cultural environment impacts the individual’s willingness to seek professional help. The biopsychosocial model is relevant to this study because it enables one to understand the interaction of the biological, psychological and social factors in help-seeking behaviours. For instance, an individual may be more likely to seek professional help if he/she made biological attributions to the cause of his/her psychological problems. Another individual may be unwilling to consult professional psychologists because there may be some socio-cultural factors negatively influencing such a behaviour, such as; a general negative attitude toward persons with mental illness in the community, the cultural beliefs about the cause of mental/psychological illness may indirectly be prescribing the treatment regimen they should use, etc. This study therefore ascertained how some psychosocial factors such as the place of residence (urban, peri-urban or rural), the educational background (basic, secondary or tertiary), and the cultural beliefs about the etiology of mental illness shaped peoples’ professional psychological help-seeking behaviours.
2.3 Review of Related Studies

2.3.1 Health Locus of Control and Professional Psychological Help-Seeking Behaviour

Who or what controls a person’s health is highly related to his/her willingness to go for professional psychological assistance as observed in a study by Andrews, Stefurak, and Mehta (2011). It has been found that some people who had a more God-centered locus of control expressed a greater willingness to seek professional psychological help than those with less of a God-centered view of personal control (Andrews et al., 2011). They studied the relative contributions of demographic variables, psychological treatment experience, religious service attendance, locus of control and religious problem-solving style in predicting attitudes towards psychological help-seeking using a survey. They sampled a total of 189 participants aged 16-81 years (70% being African Americans) from Alabama and of this sample size 129 of them were recruited from a small public university in southeastern Alabama and the remaining 60 participants were also recruited from church congregations in two of the largest cities in Alabama. The participants from the university chose to complete the web-based survey while those recruited from the churches completed the paper-and-pencil survey. Results indicated that locus of control interacted with higher education and older age to significantly predict individuals help-seeking behaviour. It seemed that only older participants who had a more God-centered locus of control were more willing to seek professional psychological help than older participants with less of a God-centered orientation of personal control (Andrews et al., 2011).

Considering the research by Andrew et al., (2011) the researchers employed a small sample size and culturally skewed (African Americans) participants hence precluding making certain conclusions from the data. Additionally the method of sampling in which case some participants were selected
from a university (web-based survey) and the others from churches (paper-based survey) may have biased the results.

Another study by Oluyinka (2011) indicated that people’s locus of control tend to influence their quest to seek professional psychological assistance. The study focused on ascertaining the influence of psychological factors (health locus of control, mindfulness, openness to experience, personal growth initiative, and sense of coherence) on attitude towards seeking professional psychological help among 452 students comprising of 234 (51.77%) males and 218 (48.23%) females with age ranges from 19 to 30 years (mean= 23.34, SD= 2.68). The researcher utilised a cross-sectional survey design in Olabisi Onabanjo University in Nigeria. Results revealed significant independent and joint influence of health locus of control, mindfulness, openness to experience, personal growth initiative, and sense of coherence on attitude towards seeking professional psychological help. This goes to support the fact that locus of control has an impact on help-seeking behaviour.

Locus of control has also been found to be associated with attitudes toward seeking professional psychological help (Kam, Ming, & Rebecca, 2006). In their study, Kam et al., (2006) investigated the correlation between primary and secondary control beliefs and attitudes toward seeking professional psychological help. The study involved a Singaporean sample made up of 52 males and 112 females (mean age 24.96 years) university students. The Primary-Secondary Control Scale and the Attitudes toward Seeking Professional Psychological Help Scale were administered to participants. Results showed that secondary control beliefs were related to more positive attitudes toward seeking help. This supports Oluyinka (2011) finding which suggests that positive attitude might be interpreted that individual ego was self-directed and was leading to more favourable perception toward seeking professional psychological help.
However, Rokke, Albsi, Lall, and Oswald (1991) have also found that internalizers showed a greater strength of self-efficacy and pain tolerance in comparison to externalizers. Such internalizers generate positive self-thinking in order to maintain or increase feelings of mastery when under stress and perseverance (Gianakos, 2002). For externalizers who lose control over their own lives, their subjective wellbeing levels were decreased (Karatas & Tagay, 2012). The probability that externalizers used avoidant and dependent decision-making style was high while internalizers employed rational styles of thinking which was negatively related to help-seeking (Biaocco, Laghi, & D’Alessio, 2009). However, individuals who depended on chance or luck had less positive attitude toward seeking help (Alex, Anton, & Stuart, 2009).

2.3.2 Self-Stigma and Professional psychological help-seeking behaviour

Mojtabai (2010) conducted a study to examine the assumptions that self-stigmatizing attitudes towards the mentally ill are linked to stigmatizing attitudes in the social milieu and that both the self-stigmatization and the social stigmatizing attitudes are major barriers to mental health treatment seeking. He used data from the 2005-2006 Eurobarometer general population survey with a sample size of twenty-nine thousand, two hundred and forty-eight (29,248) participants. Mojtabai (2010) specifically examined social stigmatizing attitudes in a random half of the sample while the individual stigmatizing attitudes were also assessed in the other half of the sample. The researcher additionally investigated the association of both individual and social stigmatizing attitudes with willingness to seek professional help. Results indicated that social stigmatizing attitudes were specifically and strongly associated with self-stigmatizing attitudes. In addition, both social and self-stigmatizing attitudes were associated with willingness to seek professional help. Believing the mentally ill to be dangerous or not likely to recover, or living in a community with such beliefs, were associated with increased willingness to seek help. However, believing that the mentally ill can be
unpredictable or blameworthy for their illness, or living in a community with strong beliefs in blameworthiness of the mentally ill, were associated with decreased willingness to seek professional help. Mojtabai (2010) concluded that, the view that all stigmatizing attitudes toward mental illness are associated with reluctance to seek professional help may be naive as some stigmatizing attitudes may be associated with increased willingness to seek help.

A study by Hackler, Vogel, and Wade (2010) examined the relationship between self-stigma, anticipated risks and benefits associated with seeking counselling, and attitudes towards seeking counselling among college students with disordered eating attitudes and behaviours. The survey results showed that self-stigma and the anticipated risks and benefits of counseling significantly predicted attitudes toward seeking counselling. A contrary finding by Boafo (2013) who also used a survey to collect data from 320 college students in Accra showed that self-stigma did not significantly predict attitudes towards seeking professional help even after controlling for demographic characteristics, experience with mental health service, perceived social support, and health locus of control.

Barry, Doherty, Hope, Sixsmith, and Kelleher (2000) used a combination of interviewer-administered questionnaire and the vignette method to describe needs assessment which explored the levels of awareness, current practices, attitudes and stigma concerning depression and suicide among a randomly selected quota sample of 1014 community members. Analyses revealed that lower levels of awareness, less confidence in dealing with mental health issues, negative attitudes to help seeking and social stigma, emerged as particular issues for men and the under 40 age group. Women were reported to have more positive attitudes, were more likely to use informal social support networks, and were more open about discussing mental health matters. Social relationships, negative thinking
patterns and social stresses were also reported to be perceived as being particularly important in explaining the origins of depression (Barry et al., 2000).

2.3.3 Cultural Beliefs and Professional psychological help-seeking behaviour

Fung and Wong (2007) examined the relationship among causal beliefs, perceived service accessibility and attitudes towards seeking mental health care after noticing that Asian immigrants in North America have lower rates of mental health service utilization. A sample size of thousand (1000) immigrant and refugee women from five ethnic minority communities in Toronto, including three Chinese Canadian communities (Hong Kong, mainland China and Taiwan), Korean Canadians and Vietnamese Canadians were selected. Data were collected by self-administered structured questionnaires to assess participants’ causal beliefs, perceived service availability and their attitudes toward mental health care. The results revealed that five ethnic minority groups of women differed in their explanatory models about mental illness and distress. In addition, the most significant factor predicting attitudes towards seeking professional help after controlling for other variables such as demographic characteristics and cultural beliefs was perceived access for all groups except the Hong Kong Chinese. Furthermore, those subscribing more to a Western stress model of illness in the last group had a more positive attitude towards seeking professional help, whilst those who had supernatural beliefs had a more negative attitude toward seeking professional help.

Al-Krenawi, Graham, Dean, and Eltaiba (2004) conducted a study which compared the attitudes of Arab Muslim female students from Israel, Jordan and the United Arab Emirates (UAE) towards mental health treatment. Finding showed that nationality did not predict a positive attitude towards seeking professional help. It is worth stating that high proportions of respondents were found among the nationalities who indicated they would pray to God during times of psychological distress. Some
studies have however found non-significant relationship between cultural beliefs and psychological help-seeking behaviour (Girma & Tesfaye, 2011; Sheikh & Furnham, 2000).

2.3.4 Socio-Demographic Variables (Sex, Age, Education and Place of Residence) and Professional Psychological Help-Seeking Behaviour

Previous studies have shown contradictory findings relative to socio-demographic variables such as the ability of sex and age to significantly correlate with individuals’ psychological help-seeking behaviours. For instance, Picco and colleagues (2016) examined the factor structure of the Attitude Toward Seeking Professional Psychological Help (ATSPPH)-Short Form scale to determine whether any significant socio-demographic differences exist in terms of help attitudes toward seeking professional psychological help. Singapore residents aged 18-65 years provided socio-demographic information and completed the ATSPPH-SF. The multiple linear regression analyses showed that age, ethnicity, marital status, education, and income were significantly associated with ATSPPH-SF scale. Among the three factor ATSPPH-SF scale, Picco et al. (2016) found various socio-demographic correlates associated with each factor. For instance, being a younger resident (18-34 years) was significantly associated with increased openness to seek professional psychological help. Other researchers have indicated that age related differences in help-seeking attitudes are inconsistent as they found that older adults rather display negative attitudes to help-seeking (Segal, Mincic, Coolidge, & O’Riley, 2005).

Previous researchers have also found that some socio-demographic variables such as sex and age are significantly related to people’s professional psychological help-seeking behaviours. Tedstone-Doherty and Kartalova-O’Doherty (2010) used a telephone survey to examine the socio-demographic and health status factors that predict help seeking for self-reported mental health problems for males and females from a general practitioner. They found evidence for age and sex differences in
predicting help seeking behaviours. Females in the older age of above 65 years were more likely to report mental health problems than their male counterparts.

Another study also explored age and gender differences in attitudes toward seeking professional psychological help, and to examine whether attitudes negatively influenced intentions to seek help among older adults and men, whose mental health needs are underserved (Mackenzie, Gekoski, & Knox, 2006). Two hundred and six community-dwelling adults completed questionnaires measuring help-seeking attitudes, psychiatric symptomatology, prior help-seeking, and intentions to seek help. Their study revealed that age and gender significantly influenced intentions to seek professional psychological help. Women exhibited more favourable intentions to seek help from mental health professionals than men, and older adults also exhibited more favourable intentions to seek help from primary care physicians than younger adults.

Another study (Boafo, 2013) conducted in Ghana which drew on samples from the population of students of the Accra College of Education between the ages of 20 years to 35 years. The researcher aimed to find out some determinants of seeking professional psychological help. She found that age and sex among other demographic variables (marital status and religion) did not significantly account for professional psychological help-seeking behaviour. Thus socio-demographic variables do not really influence people to either seek professional help or not.

Moreover, very few research works have focused on the relationship between professional psychological help-seeking behaviour and level of education. For instance, Andrews and colleagues (2011) conducted a study which sought to examine the relative contributions of education, sex, age, psychological treatment experience, religious service attendance, locus of control, and religious problem-solving style in predicting attitudes towards psychological help-seeking. They tested one hundred and eighty-nine participants made up of both college and
community samples who had either a Master’s degree or a Bachelor’s degree. Results showed that participants with Master’s degree possessed significantly more positive attitudes about help-seeking for psychological illness and a greater willingness to use professional services. Additionally, women who held Master’s degree and those with treatment experience showed more positive attitudes towards psychological help-seeking than those with Bachelor’s degree.

It must be noted that Andrews and colleagues (2011) focused only on individuals’ with tertiary education, hence creating a gap as a result of its inability to be generalized to all levels of education such as those with basic and secondary educational backgrounds.

Another study by Yuan and colleagues (2016) sought to explore the underlying factors of the Attitudes to Mental Illness questionnaire among the general population in Singapore and the socio-demographic correlates of each factor. The study made use of a cross-sectional survey and sampled three thousand and six participants between the ages of 18 to 65 years from March, 2014 to April, 2015. Out of the 3,006 participants, 31.3 % had either ‘A’ Level, Polytechnic and other diplomas, 29.6 % of them had university degrees, 25.8 % possessed Secondary education which includes ‘O’/‘N’ Level and finally 13.4 % had Primary and below educational backgrounds. The outcome of the study showed that older age, male gender, lower education and socio-economic status were associated with more negative attitudes toward the mentally ill. Given that lower education was found to be linked with more negative attitudes toward mental illness, it suggested that individuals with higher education had greater knowledge relating mental illness or they had a better understanding of mental health issues as a result of their higher education.

Furthermore, few studies have investigated rural-urban differences in attitude toward seeking professional psychological help. Most of these studies which were conducted over ten (10) years ago suggest as per their findings, that rural dwellers were more likely to underutilize psychological health
services than individuals who dwelt in urban areas (Aderibigbe, Bloch, & Pandurangi, 2003; Rost, Fortney, Fischer, & Smith, 2002). A more recent study by Williams (2013) sought to examine the role of illness factors, predisposing factors and enabling factors using the factors of health service utilization model in adolescents’ attitude toward psychological help-seeking. Williams (2013) selected a large nonclinical sample of Jamaican adolescents from seven secondary schools in urban (n=5) and rural (n=2) areas. A total sample size of 339 students made up of 193 females and 146 males whose ages ranged between 15 to 19 years old were tested. The findings of the study indicated predisposing factors (gender, age, and opinions about mental illness) predicted attitudes toward seeking professional mental health care. Specifically, increased age, decreased authoritarian beliefs, and increased benevolence predicted more positive attitudes towards seeking psychological help. However, neither illness factors (beliefs about etiology of mental health issues and somatization levels) nor enabling factors (socioeconomic status and geographical location) did predict help-seeking attitudes significantly.

Another study by Aderibigbe, Bloch, and Pandurangi (2003) used a telephone survey and employed a random-digit dialing to explore socio-demographic characteristics and ethnic differences in the types of professionals sought for unexplained somatic and emotional problems among 1161 rural dwellers in eastern North Carolina. Results showed that the rural population made a sharp distinction between somatic symptoms and stress-related symptoms and in general, African-Americans selected help-seeking from clergy more often than European-Americans. The finding indicated that socio-demographic and cultural factors somewhat shaped or influenced help-seeking behaviour among rural dwellers.
2.4 Rationale of the Study

One of the available studies conducted in Ghana on professional psychological help-seeking involved an educated population of tertiary students (Boafo, 2013). Another similar study used a clinical sample of patients who were in mental health facilities in Ghana to measure their treatment seeking behaviour (Azeem, 2014). In the present study the researcher used community samples and compared urban, rural and peri-urban dwellers including participants across all levels of educational (basic, secondary and tertiary) backgrounds relative to their professional psychological help-seeking behaviours. This choice of community samples was informed by the fact that a wide range of mental disorders such as clinical depression, schizophrenia/psychosis, substance misuse, somatization disorder, suicidal ideations and self-harm have been found to exist among community samples in Ghana (Read & Doku, 2012) and hence there is a need for a psychological health research to ascertain why people are not seeking professional psychological assistance for their conditions among Ghanaians within communities.

Moreover, previous studies which sought to assess the influence of cultural factors on professional psychological help-seeking attitudes tested participants based on their nationalities or home-country. For instance, Fung and Wong (2007) purposively sampled immigrant and refugee women who at the time of the study resided in Canada but were either citizens of China, Hong Kong, Taiwan, Korea or Vietnamese for their study. Another, study by Al-Krenawi et al. (2004) also inferred cultural background from participants’ countries. They recruited Arab Muslim female students who were from Israel, Jordan and the United Arab Emirates and concluded that nationality (in this case being an Arab) did not predict a positive attitude towards seeking professional help. However, the fact that a group of individuals share the same country of birth or a similar cultural background does not necessarily imply that they will share same or similar cultural beliefs. This leaves room for many
extraneous variables such as individual differences in education levels, age and personality types to influence the result of the study.

Since Ghanaians have different cultural beliefs depending on their ethnicity, this study tested participants’ cultural beliefs and its influence on professional psychological help-seeking behaviour.

Additionally, there are some inconsistencies in previous studies on rural and urban comparisons. While some studies have reported no significant relationship between geographical location of individuals and their mental health seeking attitudes (Esters et al., 1998; Rost et al., 2002) another study has reported that an enabling factor such as where individuals reside influence their professional mental health seeking attitudes significantly (Williams, 2014). Besides this, Ghanaian communities extend beyond rural and urban communities to include the peri-urban or sub-urban communities because the later fall outside the criteria set out for marking a community as either urban or rural. To the best of the researcher’s knowledge, no known studies have focused on peri-urban communities hence the need to fill that gap in literature.

Finally, in order to gain information on additional important contextual factors that may influence professional psychological help seeking behaviours among Ghanaians, other variables such as knowledge and understanding of available psychological services, access to these known psychological services and the perception of cost of the available psychological services were explored qualitatively in the present study.
2.5 Statement of Hypotheses

Based on the literature reviewed above, the following hypotheses were formulated;

**Hypothesis 1:** Urban dwellers will show significantly more favourable attitude toward seeking professional psychological help than rural and peri-urban dwellers.

**Hypothesis 2:** Participants who have tertiary educational background will show significantly more favourable attitude toward seeking professional psychological help than those with secondary and basic school educational background.

**Hypothesis 3:** Health locus of control (Internal, Chance and Powerful Others) will independently predict professional psychological help-seeking behaviour after controlling for the effect of demographic variables.

**Hypothesis 4:** A statistically significant negative relationship will exist between cultural beliefs and professional psychological help-seeking behaviour after controlling for demographic characteristics and health locus of control (internal, chance, and powerful others).

**Hypothesis 5:** There will be a significant negative correlation between professional psychological help-seeking behaviour and self-stigma after controlling for the effects of demographic characteristics, health locus of control and cultural beliefs.
2.6 Hypothesized Conceptual Model

![Diagram of Conceptual Model]

Figure 1: Proposed Conceptual Model of Predictors of Professional psychological Help-Seeking Behaviour.

2.7 Research Question

1. What are Ghanaians’ knowledge and understanding of professional psychological services?
CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter provides an overview of the research design, research setting, population, sample and sampling techniques, inclusion and exclusion criteria, ethical considerations, instruments/measures as well as the procedure for gathering the research data.

Research Design

The researcher employed the sequential mixed-method (Quantitative+Qualitative) design (Creswell, Plano, Clark, Gutman, & Hanson, 2003) to accomplish the objectives of the study. The researcher conducted the quantitative aspect of the study first. The first study sought to determine the relationship between educational background, locality of residence, health locus of control, self-stigma and cultural beliefs and professional psychological help-seeking behaviour among Ghanaians using standardized measures to collect data in a cross-sectional survey. Based on the objective of the study, the qualitative section of the study was carried out subsequently to explore Ghanaians’ knowledge and understanding of professional psychological services in order to gain insight into some other context specific psychosocial factors that may be hindering Ghanaians from seeking professional psychological assistance.

In-depth individual interviews were conducted in the qualitative study using a semi-structured interview guide to collect the data needed. This enabled the researcher to acquire an understanding and description of Ghanaians’ knowledge and understanding of professional psychological services.
Research Settings

Three locations within the Greater-Accra region of Ghana, comprising an urban area, rural area and a peri-urban area constituted the settings of the study. The Greater-Accra region was chosen because it is the most cosmopolitan region in Ghana constituting several cities, towns and villages which serves as dwelling places for people from all walks of life. The Greater-Accra region occupies a total land surface of 3,245 square kilometres which is about 1.4 per cent of the total land area of Ghana. This makes the Greater-Accra region the smallest among the 10 administrative regions in the country. The Greater-Accra region has Accra as its capital and consists of 16 districts made up of 2 metropolitan assemblies, 7 municipal assemblies and 7 ordinary district assemblies as at the June, 2012 demarcation by the government at the time (Local Government Service-Ghana, 2015). Additionally, the Greater-Accra region has two major government-owned mental health hospitals (Accra Psychiatric hospital and Pantang Psychiatric hospital) aside other general hospitals which have professional psychologists working there. A number of other privately-owned professional psychological service providers also exist within the Greater-Accra region. Some of which are Progressive Life Society (PLC-Ghana), The Trust Hospital Ghana, The Brain Clinic, West African Rescue Association (WARA Ghana), Clinical Consult, and PW Psycho Clinic.

The researcher selected Adabraka a suburb in the Osu-klottey sub-metro of the Accra Metropolitan Assembly as the urban area, Pokuase a suburb in the Ga-West Municipality as the peri-urban community and Mempemehuasem which is also a farming settlement within the Ga-West municipal Assembly as the rural area. All these three localities were selected based on the 2010 Population and Housing Census (PHC) criteria for identifying an area as urban or rural. According to the PHC (2010) a community with a population of over 5000 can be said to be an urban area while a community of less than 5000 inhabitants can be said to be a rural settlement (Ghana Statistical Service, 2012). The
researcher’s selection criteria for a peri-urban area was based on Rambaud (1973) suggestion that a peri-urban area is proximate to an urban area but with a large population than a rural area and has some level of both ‘urbaness’ and ‘ruralness’ as part of its characteristics—agricultural lands and commercial areas with a population dynamic close to the urban areas (Rambaud, 1973). These criteria are also suggested by Griffiths, Chapman, and Christiansen (2010) that peri-urban areas are rural-urban transition zones where the rural folks and urban folks intermingle and dwell together.

Adabraka, a suburb within the Osu-Klottey Sub-Metro has been a dwelling place for over 600,000 people (Falling Rain, 2016). Dwellers in Adabraka are of different ethnic groups such as Gas, Akans, Ewes, Sisala, Dagomba among other ethnic groups found in Ghana. It is one of the major towns in the Greater-Accra region and has a lot of commercial businesses as well as a major market centre, hospitals and police station serving most of the smaller localities surrounding Adabraka. Adabraka was selected because it is one of the suburbs within Accra and so constitute a highly cosmopolitan area with people from diverse educational, cultural, religious and socioeconomic backgrounds.

Pokuase a peri-urban community within the Ga West Municipal Assembly comprises of both developed areas and underdeveloped (mainly agricultural) land sites. The town is located about 400 meters from the nation’s capital Accra and it is about thirty (30) minute drive from Accra, the capital city of Ghana. It serves as one of the six Zonal Councils within the Ga West municipality and other surrounding villages. The population which is about 14,000 (WaterHealth Ghana, 2016) is made up of indigenous Gas, Ewes, Akans, Dagombas, and some other ethnic groups. Additionally, the presence of Christians, Muslims and Traditionalists in Pokuase is quite significant. Although Pokuase is one of the fast growing towns in the Greater-Accra region, most of the urban features such as potable water (pipe-born water), tarred roads, banks, commercial and business centres are either absent or inadequate given the population size being more than 5,000. Pokuase was chosen because
its dwellers are made up of people of diverse ethnic, religious, educational and socioeconomic backgrounds and hence has some features of ‘urbaness’ and ‘ruralness’.

The rural setting was Mempemehuasem which is a village located in a valley within the Samsam-Odumase mountains within the Ga West Municipal Assembly of the Greater-Accra region of Ghana. It has a population of about 2500 inhabitants who are predominantly Akans and speak the Akuapem dialect, although some speak fluent Ga and English depending on their level of education. Most of the inhabitants are farmers who cultivate crops such as pineapple, maize, cassava, and other food crops whiles a few of them engage in petty trading. Mempemehuasem is underdeveloped; a river and dug wells serves as source of water, with no health post (clinic), no police station and no tarred roads. Mempemehuasem was chosen because of the dwellers’ socio-cultural educational, religious and ethnic backgrounds.

Population and Participants

Ghanaians living in the Greater-Accra region were the main population of interest. This population was selected because it is a cosmopolitan location comprising teenagers, young adults and old adults who have different cultural and educational backgrounds across the country.

Quantitative Dimension

The researcher selected one hundred and twenty (120) respondents from each of the three independent communities making a total of three hundred and sixty (360) respondents for the quantitative aspect. The sample size of 360, settled for the final analysis for the quantitative dimension was statistically adequate given the statistical test used for the analyses. This is based on the rule of the thumb suggested by Tabachnick and Fidell (2007) that the sample size, N, needed for any regression analysis should be equal or exceed 50 + 8x, where ‘x’ equals the number of predictor
variables. In this study, there were 3 predictors and so $X=3$. Therefore, the minimum sample size required for the study was:

$$N > 50 + 8(3) = 50 + 24 = 74$$

Thus, a sample size of more than 360 respondents is statistically adequate for analytical purposes.

The demographic characteristics of the 360 respondents showed that 189 were female and 171 were male and they represented 52.50% and 47.50% of the total respondents respectively. Of the 360 respondents, 63.10% (227) were Christians, 30.0% (108) professed to be Islamists and the remaining 6.9% (25) of them indicated that they were Traditionalists. Also 27.5% (99) indicated they either had only some form of education or had completed successfully their basic education (primary to JHS), 50.0% (180) said they had completed second cycle education (Senior High School (SHS)) while 22.5% (81) indicated they had tertiary educational backgrounds (nursing or educational colleges or polytechnic or university). This shows that most of the respondents (72.5%) had had some form of second cycle to tertiary educational experiences. It was also observed that, the participants who were in their youthful stages (18-35 years) were 163, those who were in their mid-adulthood (36-50 years) were 123 and those who were in their late adulthood (51-60 years) were 74 representing 45.30%, 34.20% and 20.60% respectively. Detailed demographic characteristics of the respondents can be found in Table 1 below:
Table 1: Demographic Characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>189</td>
<td>52.5</td>
</tr>
<tr>
<td>Male</td>
<td>171</td>
<td>47.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>360</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-35 years</td>
<td>163</td>
<td>45.3</td>
</tr>
<tr>
<td>36-50 years</td>
<td>123</td>
<td>28.9</td>
</tr>
<tr>
<td>51-60 years</td>
<td>74</td>
<td>20.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>360</td>
<td>100</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>99</td>
<td>27.5</td>
</tr>
<tr>
<td>Secondary</td>
<td>180</td>
<td>50.0</td>
</tr>
<tr>
<td>Tertiary</td>
<td>81</td>
<td>22.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>360</td>
<td>100</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>227</td>
<td>63.1</td>
</tr>
<tr>
<td>Islam</td>
<td>108</td>
<td>30.0</td>
</tr>
<tr>
<td>Traditional</td>
<td>25</td>
<td>6.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>360</td>
<td>100</td>
</tr>
<tr>
<td><strong>Residential Area</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>120</td>
<td>33.3</td>
</tr>
<tr>
<td>Peri-urban</td>
<td>120</td>
<td>33.3</td>
</tr>
<tr>
<td>Rural</td>
<td>120</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>360</td>
<td>100</td>
</tr>
</tbody>
</table>
Inclusion Criteria:

- The respondents were between 18 and 60 years at the time of participation.
- The interviewees and respondents were had the capacity to take volitional control of their health lives.

Exclusion criteria:

- Individuals who were not residents living in either Adabraka or Pokuase or Mempemehuasem.
- Individuals who had difficulty in communication due to serious physical or mental illnesses.

The researcher employed the purposive and convenience sampling techniques. In this case, the respondents and interviewees were selected considering their place of residence (urban, peri-urban and rural) and educational backgrounds (basic, secondary and tertiary). Participants were also selected based on their readiness and availability to participate and in addition focusing on only participants who were between 18-60 years of age and therefore have voluntary control of their health.

Qualitative Dimension

Fifteen (15) individuals were conveniently selected from among the three hundred and sixty (360) respondents in the quantitative study and engaged in a one-on-one in-depth interview concerning their knowledge and understanding of professional psychological services. These fifteen (15) participants were selected because they were more willing and available for the interviews after the survey. The age range of respondents was between 23 years and 55 years. Out of the fifteen (15) interviewees, nine (9) (60%) were female whiles six (6) (40%) were male with five (5) individuals each drawn from Adabraka, Pokuase and Mempemehuasem all within the Greater-Accra region of Ghana. The
occupations of the interviewees were four (4) farmers, six (6) traders, one (1) pupils’ teacher, one (1) sales and marketing personnel, one (1) journalist, one (1) nurse and one (1) taxi driver. The Table 2 below shows the demographic characteristics of the participants who were interviewed.

Table 2: Demographic Characteristics of Interviewees

<table>
<thead>
<tr>
<th>Participant’s Identifier</th>
<th>Sex</th>
<th>Age (Years)</th>
<th>Education Level</th>
<th>Place of Residence</th>
<th>Religion</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA1</td>
<td>M</td>
<td>32</td>
<td>Tertiary</td>
<td>Urban</td>
<td>Christian</td>
<td>Journalist</td>
</tr>
<tr>
<td>IA2</td>
<td>F</td>
<td>45</td>
<td>Secondary</td>
<td>Urban</td>
<td>Christian</td>
<td>Pupil Teacher</td>
</tr>
<tr>
<td>IA3</td>
<td>F</td>
<td>28</td>
<td>Basic</td>
<td>Urban</td>
<td>Islam</td>
<td>Trader</td>
</tr>
<tr>
<td>IA4</td>
<td>M</td>
<td>32</td>
<td>Secondary</td>
<td>Urban</td>
<td>Christian</td>
<td>Trader</td>
</tr>
<tr>
<td>IA5</td>
<td>F</td>
<td>24</td>
<td>Tertiary</td>
<td>Urban</td>
<td>Islam</td>
<td>Sales Person</td>
</tr>
<tr>
<td>IP1</td>
<td>M</td>
<td>52</td>
<td>Secondary</td>
<td>Peri-urban</td>
<td>Islam</td>
<td>Security personnel</td>
</tr>
<tr>
<td>IP2</td>
<td>M</td>
<td>23</td>
<td>Basic</td>
<td>Peri-urban</td>
<td>Christian</td>
<td>Driver</td>
</tr>
<tr>
<td>IP3</td>
<td>F</td>
<td>29</td>
<td>Secondary</td>
<td>Peri-urban</td>
<td>Christian</td>
<td>Trader</td>
</tr>
<tr>
<td>IP4</td>
<td>F</td>
<td>32</td>
<td>Secondary</td>
<td>Peri-urban</td>
<td>Christian</td>
<td>Trader</td>
</tr>
<tr>
<td>IP5</td>
<td>F</td>
<td>45</td>
<td>Basic</td>
<td>Peri-urban</td>
<td>Christian</td>
<td>Trader</td>
</tr>
<tr>
<td>IM1</td>
<td>M</td>
<td>38</td>
<td>Basic</td>
<td>Rural</td>
<td>Christian</td>
<td>Trader</td>
</tr>
<tr>
<td>IM2</td>
<td>M</td>
<td>48</td>
<td>Basic</td>
<td>Rural</td>
<td>Christian</td>
<td>Farmer</td>
</tr>
<tr>
<td>IM3</td>
<td>F</td>
<td>30</td>
<td>Basic</td>
<td>Rural</td>
<td>Christian</td>
<td>Trader</td>
</tr>
<tr>
<td>IM4</td>
<td>F</td>
<td>42</td>
<td>Secondary</td>
<td>Rural</td>
<td>Christian</td>
<td>Pupil Teacher</td>
</tr>
<tr>
<td>IM5</td>
<td>F</td>
<td>55</td>
<td>Basic</td>
<td>Rural</td>
<td>Traditional</td>
<td>Farmer</td>
</tr>
</tbody>
</table>

Measures for Data Collection

For the quantitative study, a questionnaire, made up of six sections, was administered. These included:

Section A: Demographic data: In this section, respondents’ personal information was gathered with self-designed questions. These questions included sex, age, religious affiliation, educational backgrounds and area of residence (see Appendix).
Section B: Multidimensional health locus of control (MHLC) scale – Form A

This assessed participants’ health locus of control. The Multidimensional Health Locus of Control (MHLC) scale is a standardized scale developed by Wallston, Wallston, and DeVellis (1976) with 18 items. The authors developed three different scales of the MHLC which are forms A, B and C.

The Form A was adopted for the present study and it is made up of three (3) subscales. (See Appendix) These are;

i) The Internal Health Locus of Control (IHLC) subscale: This measures the extent to which a person believes that internal factors are responsible for his/her health and illness.

ii) Chance Health Locus of Control (CHLC) subscale: This measures the extent to which a person believes that his/her health is simply predetermined by destiny (fate), luck or chance.

iii) Powerful Others Health Locus of Control (PHLC) subscale: This measures a person’s belief that his/her health, is influenced by powerful individual such as doctors, professional psychologists, nurses, etc.

The Multidimensional Health Locus of Control (MHLC) scale was made up of a six- point Likert scale response format ranging from 1 (strongly disagree) to 6 (strongly agree). The possible range of total scores for the 3 subscales is 6 to 36 points. A score range of 23 to 30 on any subscale means a person has a high inclination to the dimension measured; 15 to 22 meant a moderate dimension and 6 to 16 indicated a low dimension score.

The reliability coefficients for the overall MHLC-Form A and each of the six-item MHLC subscale has been found to be in the range of .67 to .86 (Wallston et al., 1978) and test-retest reliability on parallel forms of between .73 and .80 (Oberle, 1991). The MHLC has also been found to be reliable in Ghana with a Cronbach alpha of .73 (Boafo, 2013). In the current study the Cronbach alpha was between .95 to .98.
Section C: Self–Stigma of Seeking Help scale

The Self-stigma of seeking help scale (SSOSH) is a 10 item scale developed by Vogel, Wade, and Haake (2006; see Appendix). The SSOSH is on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly disagree). Individuals’ responses to the items are determined by the extent to which they might react in a situation about beliefs that seeking psychological help will damage their self-esteem and self-worth (self-stigma). Items numbers 2,4,5,7 and 9 were reversed scored. The total score of all the 10 items ranged between 10-50 points, with 10-22 indicating low stigma, 23-34 representing moderate stigma and 35-50 indicating high stigma. The SSOSH demonstrated a Cronbach alpha of .81 and a test-retest correlation of .72 (Vogel, Wade, & Haake, 2006). In Ghana, the reliability coefficient has been found to be .77 (Boafo, 2013). In the current study the Cronbach alpha was .92.

Section D: Cultural Beliefs scale

The Cultural Beliefs Scale (CBS) was adopted from the Health Belief System Scale which was developed by Asare (2006). This scale included 14 items which is on a six-point Likert scale which ranges from 1 (strongly disagree) to 6 (agree). The scale measures the extent to which individuals’ agree with the statement about cultural beliefs for seeking psychological help. Higher scores indicate a high influence of cultural belief system in help-seeking behaviours and lower scores indicate a less influence of cultural belief system in the help-seeking behaviours of individuals. The reliability coefficient has been found to be .70 (Boafo, 2013). In the current study the Cronbach alpha was between .84.
Section E: Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH):

In this study, the Attitudes Toward Seeking Professional Psychological Help scale (ATSPPH) was used to measure the professional psychological help-seeking behaviours of the respondents. Thus it was used a measure to indicate the extent to which respondents were willing to seek for professional psychological assistance or not. The scale was developed by Fischer and Turner (1970). It has 29 items which measures 4 factors that assess a person’s attitudes towards seeking professional psychological help. The researcher however adopted the 28-item instrument employed by Boafo (2013) in the Ghanaian setting. The 4 factors are; (i) recognition for need for psychological help (items 2,4,9,12,13,16,18 and 24) which measures the participant’s awareness of the need for professional psychological help; (ii) stigma tolerance (items 3,14,20,26 and 27) which measures perceived degree of shame or stigma attached to seeking psychological help; (iii) interpersonal openness (items 5,7,10, 17,21 and 28) is a measure of a person’s willingness to confide personal problems to others; and (iv) confidence in mental health practitioner (items 1,6,8,11,15,19,22,23 and 25) which assesses a person’s degree of trust and confidence in mental health professionals. The ATSPPH is developed on a four-point Likert scale format which includes 0 (disagree), 1 (somewhat disagree), 2 (somewhat agree) and 3 (agree) (see Appendix). The researcher relied only on the composite scores and not the sub-scale scores. An overall high score of 43 and above indicates a more favourable attitude toward seeking help from professional psychologists and an overall score of 42 and below indicates a less favourable attitude toward seeking help from professional psychologists. Thus in this study, a more or less favourable attitude toward seeking professional psychological help gave meaning to the extent to which an individual was willing or unwilling to consult professional psychologists for assistance. The Cronbach alpha for the overall ATSPPH scale was found to be .85 and ranged from .62 to .74 for subscale and the ATSPPH scale also has been found to possess an internal consistency of 0.83 (Fischer & Turner, 1970). In Ghana, the ATSPPH
has been found to possess an overall Cronbach Alpha reliability coefficient of .72 (Boafo, 2013). In the current study the Cronbach alpha was .95.

For the qualitative dimension of this study, a semi-structured interview guide was used to collect information from the interviewees. The questions on the semi-structured interview guide sought to explore Ghanaians’ knowledge and understanding of professional psychological services (see Appendix).

**Pilot Study**

For the quantitative study, thirty (30) persons were conveniently sampled in all but ten (10) individuals were purposively selected from each of the three localities within the Greater-Accra region (Adabraka, Pokuase and Mempemehuasem) and then used to pilot-test the four (4) different instruments of the questionnaire. The pilot was done to determine the meaningfulness of the items on each of the measures to the study population as well as to determine the Cronbach alpha of each measure.

The Cronbach Alphas for the four instruments are presented below:

**Section B: Multidimensional Health Locus of Control-Form A Scale;**

Internal Health Locus of Control (items 1,6,8,12,13 and 17): .98

Chance Health Locus of Control (items 2,4,9,11,15 and 16): .99

Powerful Others Health Locus of Control (items 3,5,7,10,14 and 18): .97

**Section C: Self-Stigma of Seeking Help Scale: .95**

**Section D: Cultural Belief Scale: .83**
Section E: Attitude Toward Seeking Professional Psychological Help scale:

Need scale (items 2,4,9,12,13,16,18 and 24): .89

Stigma scale (items 3,14,20,26 and 27): .71

Openness scale (items 5,7,10,17,21 and 28): .82

Confidence scale (items 1,6,8,11,15,19,22,23 and 25): .91

This showed that, all the scales had acceptable reliability for statistical analysis. Giving that the outcome of the pilot study presented acceptable reliability, the wording and other characteristics of the items were maintained in this study.

With respect to the semi-structured interview guide, a total of six (6) participants were involved in the pilot testing. The pilot indicated that some questions on the interview guide needed to be modified to make them comprehensible for the participants so that they could easily express their understanding of professional psychological services. For instance, “How will you define a psychologist?” was reworded as “In your view, who is a psychologist?”

Ethical Considerations

This study was approved by the Institutional Review Board of the College of Humanities, University of Ghana through the Department of Psychology. First an introductory letter obtained from the Department of Psychology was shown to the prospective participants so that they could confirm that the researcher and assistants were indeed students from the University of Ghana. The study was explained to the prospective participants and once they showed willingness to participate in the study, they signed the informed consent form. Participants were made aware that information gathered would be used only for the purpose for which it was collected, that is, to advance knowledge in
professional psychological help-seeking behaviour among urban, peri-urban and rural dwellers in Ghana. After that, assurance was given to them that they can withdraw as participants at any given time of their choice. Issues of confidentiality and anonymity were discussed with participants. Beside these, all aspects of the research were conducted to conform to the regulations regarding the conduct of research with human participants in the American Psychological Association’s (APA) code of conduct (2002). University of Ghana embossed pens were given to all participants after the successful completion of the questionnaires and interviews.

**Procedure for Data Collection**

A pilot study was first conducted to ascertain the psychometric properties of the questionnaires to be employed in the study and to ascertain the comprehensibility of the questionnaires for participants. The pilot study was also conducted to enable the researcher to determine if all the five measures would be able to assess the constructs they purport to measure as well as gain knowledge about the feasibility of the administration procedure. For the quantitative study, a total of 30 participants (Adabraka [10 respondents], Pokuase [10 respondents] and Mempemehuasem [10 respondents]) were pilot tested. For the qualitative study, two (2) interviewees were selected from each of the three residential groups in order to ascertain how comprehensible and effective the interview questions were for the contexts to be used in.

Due to the experience gathered following the piloting of the instruments, the researcher employed the services of two (2) independent translators (linguistic experts) to translate the items on the questionnaires and interview guide into Twi (Akan dialect). The first translator had to translate the items into Twi while the second translator also translated the Twi version back to English language in order to ensure that the new Twi versions were representative of the original English versions of the questionnaires and interview guide. This was necessary because during the piloting stage, most of the
participants exhibited some challenges relative to their ability to read and understand parts of the questionnaire which was in English language. The semi-structured interview guide was also translated into Twi to enable those participants who preferred to use the Twi language to freely express themselves. In addition, translating the instruments ensured that both the researcher and his assistants used the same language and words in asking the questions in an effort not to render the instruments unreliable because of a respondent’s lack of understanding and inability to read the English language.

For the main study, the assistance of three research assistants was sought in sampling and distributing the questionnaires to the respondents. The researcher and the assistants visited the participants in their various homes to inform them about the study and seek their consent to participate in the study. Those who were available at the time of the study and were willing to participate were involved in this study. The respondents were given the informed consent forms to read and sign before participating in this study. The questionnaires were given to the respondents to fill in their homes and collected a week after. They were informed that they could withdraw from the study at anytime without any penalty. The data collection for the quantitative study took a period of one month (February 6, 2017 to March 6, 2017) to complete.

The data collection for the qualitative study ensued after all the cross-sectional survey was done. In order to ensure that the opinions expressed through the questionnaires and the interview sections would all be gotten from same personalities within the same context of the study, the purposive sampling technique was employed to select interviewees from among the three hundred and sixty (360) respondents who participated in the quantitative study.

In the main qualitative study, the first set of interviews was conducted at Adabraka. Five (5) participants who indicated their willingness and availability to be part of the study were purposively
selected from among the one hundred and twenty (120) respondents who participated in the main quantitative study. The second set of interviews occurred at Mempemehuasem with five (5) participants who were willing and available at the period were purposively selected from the sample of rural dwellers who partook in the quantitative study. Then the last set of interviews also took place at Pokuase among five (5) of the peri-urban dwellers who participated in the quantitative study. The researcher with the help of two (2) assistants conducted the interviews in the homes of the participants. The research assistants were male between the ages of twenty-two (22) and twenty-five (25) with psychology backgrounds.

Interviews were conducted in either Twi (with a translated guide in Twi) or English based on participants’ choice. The interviews lasted from 25 minutes to 45 minutes based on a semi structured interview guide. After obtaining consent from the participants, the interviews begun and they were audio recorded.
CHAPTER FOUR

RESULTS

4.1 Introduction

This research study was done in two parts; the first part involved a quantitative study and the second part involved a qualitative study. In this chapter, the results from the analyses of the quantitative data were presented first. The data was analyzed using a series of statistical tests in SPSS v20 and then followed by detailed presentations of tables with their interpretations.

Subsequently, the qualitative findings were presented using the bottom-up approach to thematic analysis. It begins with a diagram of the thematic network based on the findings.

QUANTITATIVE RESULTS

4.2.1 Preliminary Analyses

It is important to note that a multivariate design involving regression test requires the assumption of multivariate normality and that each variable and all linear combinations of the variables are normally distributed. Additionally, all the measures (scales) used for the study were supposed to be reliable (measure what they purport to measure). For the researcher to test for these assumptions regarding regression analysis, preliminary statistical and graphical analyses were conducted to assess the fit between variable distributions and their acceptability. Skewness and kurtosis were the two forms of normality assessed while the reliabilities of the scales were tested using Cronbach’s reliability. This was done as a result of the fact that, a basic requirement for the use of parametric statistical tests is the normal distribution of the data involved.
With respect to the reliability of the scales, according to Tashakkori and Teddlie (2010), a scale is considered reliable if its reliability coefficient is above .70. As shown in Table 3 below, all the Cronbach’s alpha values were above .70. Therefore, the measures (scales) were all reliable and as such appropriate for the study. Considering the issue of normality, all the data were normally distributed (see Table 5). Normality was accepted when Skewness and Kurtosis were between -1 and +1 (Tabachnick & Fidell, 2007).

### Table 3. Summary of Descriptive Statistics, Normality and Reliability Test Results of the Measures (N=360)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
<th>α</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPH</td>
<td>25.49</td>
<td>18.03</td>
<td>.68</td>
<td>-.99</td>
<td>.95</td>
<td>3</td>
<td>63</td>
</tr>
<tr>
<td>MHLOC</td>
<td>60.75</td>
<td>6.44</td>
<td>.32</td>
<td>-.25</td>
<td></td>
<td>47</td>
<td>79</td>
</tr>
<tr>
<td>IHLOC</td>
<td>19.47</td>
<td>8.52</td>
<td>.77</td>
<td>-.70</td>
<td>.95</td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>CHLOC</td>
<td>24.67</td>
<td>9.58</td>
<td>-.22</td>
<td>-1.45</td>
<td>.98</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>POHLOC</td>
<td>16.62</td>
<td>10.13</td>
<td>1.18</td>
<td>-.25</td>
<td>.97</td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>Self-Stigma</td>
<td>33.29</td>
<td>10.72</td>
<td>-.70</td>
<td>-.58</td>
<td>.92</td>
<td>12</td>
<td>45</td>
</tr>
<tr>
<td>Cultural Beliefs</td>
<td>59.17</td>
<td>15.53</td>
<td>-.69</td>
<td>-.40</td>
<td>.84</td>
<td>39</td>
<td>73</td>
</tr>
</tbody>
</table>

#### 4.2.2 Correlations among Study Variables

A correlation matrix was computed using the Person Product Moment Correlation to establish the relationship between the variables. Results in Table 4 are the correlation matrix between all the continuous variables and attitude towards seeking professional psychological help of the study.
Table 4. Pearson Correlations among study variables

<table>
<thead>
<tr>
<th>1. Attitude Toward Seeking Professional Psychological Help</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Health Locus of Control (Total)</td>
<td>.10*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Internal Locus of Control</td>
<td>.08</td>
<td>.16*</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Chance Locus of Control</td>
<td>.10*</td>
<td>.02</td>
<td>-.51***</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Powerful Others Locus of Control</td>
<td>-.10*</td>
<td>.48***</td>
<td>-.26**</td>
<td>-.51***</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Self-Stigma of Seeking Help</td>
<td>-.63***</td>
<td>.000</td>
<td>-.05</td>
<td>-.06</td>
<td>.10*</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7. Cultural Beliefs</td>
<td>-.66***</td>
<td>-.10*</td>
<td>.05</td>
<td>-.12*</td>
<td>.08</td>
<td>.56***</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: * p < .05, ** p < .01, *** p < .001 (one-tailed)

Findings in Table 4 above indicated that there was a significant relationship between health locus of control (Total) and attitudes towards seeking professional psychological help \[ r(358) = .10, p < .05 \]. A significant relationship between chance health locus of control and attitude towards seeking professional psychological help was also observed \[ r(358) = .10, p < .05 \]. Additionally, a significant relationship between powerful others health locus of control and attitudes towards seeking professional psychological help was observed \[ r(358) = -.10, p < .05 \]. Self-stigma and Cultural belief were found to be significantly associated with attitudes towards seeking professional psychological help giving \[ r(358) = -.63, p = .001 \] and \[ r(358) = -.66, p = .001 \] respectively.

On the other hand, there was a non-significant relationship between internal health locus of control and attitude towards seeking professional psychological help \[ r(358) = .08, p = .074 \].
4.2.3 Initial Analyses of the Descriptive Statistics of Demographic Predictors and Dependent Variable

Table 5. Descriptive Statistics of ATSPPH Based on Area of Residence and Education

<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>S.E</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>120</td>
<td>39.09</td>
<td>17.46</td>
<td>1.59</td>
<td>6</td>
<td>63</td>
</tr>
<tr>
<td>Peri-urban</td>
<td>120</td>
<td>26.81</td>
<td>15.24</td>
<td>1.39</td>
<td>6</td>
<td>65</td>
</tr>
<tr>
<td>Rural</td>
<td>120</td>
<td>10.56</td>
<td>5.51</td>
<td>.50</td>
<td>5</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>360</td>
<td>25.49</td>
<td>18.03</td>
<td>.95</td>
<td>5</td>
<td>65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational Background</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>S.E</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>99</td>
<td>17.14</td>
<td>11.37</td>
<td>1.14</td>
<td>5</td>
<td>55</td>
</tr>
<tr>
<td>Secondary</td>
<td>180</td>
<td>24.74</td>
<td>17.91</td>
<td>1.34</td>
<td>5</td>
<td>63</td>
</tr>
<tr>
<td>Tertiary</td>
<td>81</td>
<td>37.35</td>
<td>18.76</td>
<td>2.08</td>
<td>5</td>
<td>65</td>
</tr>
<tr>
<td>Total</td>
<td>360</td>
<td>25.49</td>
<td>18.02</td>
<td>.95</td>
<td>5</td>
<td>65</td>
</tr>
</tbody>
</table>

Table 5 shows differences in area of residence and educational background on scores of Attitude toward Seeking Professional Psychological Help (ATSPPH). Respondents who resided in the urban area recorded the highest mean score on ATSPPH when compared with those who resided in the peri-urban and rural areas. In addition, respondents who had tertiary educational background recorded the greatest average score of ATSPPH in comparison to those with either secondary educational background or basic educational background.
4.2.4 Hypotheses Testing

As shown on Table 5, generally, there exist less favourable (negative) attitudes toward seeking professional psychological help among the respondents. The mean score (M = 25.49) on the ATSPPH scale was below 42.00. This suggested that they were not likely to seek help from psychotherapists in case they needed emotional or psychological help.

In order to ascertain the factors that could be responsible for the participants’ negative attitudes toward seeking professional psychological help, the researcher employed the hierarchical multiple regression analysis to test the extent to which mental health locus of control (chance and powerful others), cultural beliefs and self-stigma, independently accounted for the negative attitudes toward seeking professional psychological help. The one-way analysis of variance (ANOVA) was also used to test for differences in the professional psychological help-seeking behaviours among the urban, peri-urban and rural dwellers. Additionally, differences in the participants’ professional psychological help-seeking behaviours with respect to their educational levels (tertiary, secondary and basic) were tested using the one-way ANOVA.
**Hypothesis 1:** Urban dwellers will show significantly more favourable attitude toward seeking professional psychological help than rural and peri-urban dwellers.

To analyze this hypothesis, the one-way ANOVA was employed, because one independent variable (Place of residence) with three levels (urban, peri-urban or rural) was involved.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Place of Residence</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Df</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPH</td>
<td>Urban</td>
<td>120</td>
<td>39.09</td>
<td>17.46</td>
<td>2, 357</td>
<td>130.007</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>Peri-urban</td>
<td>120</td>
<td>26.81</td>
<td>15.24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>120</td>
<td>10.56</td>
<td>5.51</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From the Table 6 above, it can be observed that there was a significant difference in the ATSPPH among urban, peri-urban and rural dwellers \( F (2, 357) = 130.007, p = .001, \) two tailed. Post hoc comparisons using the Bonferroni test indicated that urban dwellers (M=39.09, SD=17.46) recorded more positive attitude toward seeking professional psychological help (ATSPPH) than both peri-urban dwellers (M=26.81, SD=15.24) and rural dwellers (M=10.56, SD=5.51). Hence the hypothesis that urban dwellers will show significantly more favourable attitudes toward seeking professional psychological help than rural and peri-urban dwellers was supported by the results.
Hypothesis 2

Participants who have tertiary educational background will show significantly more favourable attitudes toward seeking professional psychological help than those with secondary and basic school educational background.

This hypothesis was analyzed using the one-way ANOVA because one independent variable (educational background) with three levels (tertiary, secondary and basic school education) was involved.

Table 7: ANOVA test of significance of Educational Level and ATSPPH

<table>
<thead>
<tr>
<th>Variable</th>
<th>Educational Level</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Df</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPPH</td>
<td>Basic</td>
<td>99</td>
<td>17.14</td>
<td>11.37</td>
<td>2, 357</td>
<td>33.395</td>
<td>.001</td>
</tr>
<tr>
<td>ATSPPH</td>
<td>Secondary</td>
<td>180</td>
<td>24.74</td>
<td>17.91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ATSPPH</td>
<td>Tertiary</td>
<td>81</td>
<td>37.35</td>
<td>18.76</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From the Table 7 above, it can be observed that there was a significant difference in the ATSPPH among individuals with tertiary, secondary and basic school educational backgrounds [F (2, 357) = 33.395, p=.001, two tailed].

Post hoc comparisons using the Bonferroni test indicated that individuals with tertiary school educational backgrounds (M=37.35, SD=18.76) recorded more positive attitudes toward seeking professional psychological help (ATSPPH) than individuals with secondary school educational backgrounds (M=24.74, SD=17.91) and basic school educational backgrounds (M=17.15, SD=11.37). Therefore, the hypothesis that participants who have tertiary educational background will show
significantly more favourable attitudes toward seeking professional psychological help than those with secondary and basic school educational background was supported by the results.

For the remaining hypotheses (H3, H4 and H5), the hierarchical multiple regression analysis was used to test the extent to which the predictor variables (health locus of control, cultural beliefs and self-stigma) independently accounted for the participants’ negative attitudes toward seeking professional psychological help. The Table 8 below, shows the hierarchical multiple regression analysis for the three (3) remaining hypotheses.
Table 8. Predictors of Professional Psychological Help-Seeking Behaviour

<table>
<thead>
<tr>
<th>Model</th>
<th>B</th>
<th>β</th>
<th>S.E</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Sex</strong></td>
<td></td>
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<tr>
<td>Females (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>-5.05</td>
<td>-1.14</td>
<td>1.34</td>
<td>-3.78</td>
<td>.001</td>
</tr>
<tr>
<td><strong>Age of Respondents</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-35</td>
<td>-3.53</td>
<td>-1.00</td>
<td>1.52</td>
<td>-2.33</td>
<td>.02</td>
</tr>
<tr>
<td>36-50 (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>51-60</td>
<td>-2.49</td>
<td>-0.60</td>
<td>1.88</td>
<td>-1.33</td>
<td>.19</td>
</tr>
<tr>
<td><strong>Area of Residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Peri-urban</td>
<td>-11.66</td>
<td>-.31</td>
<td>1.70</td>
<td>-6.98</td>
<td>.001</td>
</tr>
<tr>
<td>Rural</td>
<td>-26.18</td>
<td>-.69</td>
<td>1.68</td>
<td>-15.55</td>
<td>.001</td>
</tr>
<tr>
<td><strong>Educational Background</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>-13.78</td>
<td>-.34</td>
<td>1.95</td>
<td>-7.06</td>
<td>.001</td>
</tr>
<tr>
<td>Secondary</td>
<td>-7.10</td>
<td>-.20</td>
<td>1.75</td>
<td>-4.06</td>
<td>.001</td>
</tr>
<tr>
<td>Tertiary (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Locus of Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chance Health Locus of Control</td>
<td>-.03</td>
<td>-.01</td>
<td>.08</td>
<td>-.32</td>
<td>.74</td>
</tr>
<tr>
<td>Powerful others Health Locus of Control</td>
<td>.008</td>
<td>.004</td>
<td>.08</td>
<td>.10</td>
<td>.92</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cultural Beliefs</strong></td>
<td>-.48</td>
<td>-.41</td>
<td>.04</td>
<td>-10.84</td>
<td>.001</td>
</tr>
<tr>
<td><strong>Step 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self-Stigma</strong></td>
<td>-.57</td>
<td>-.34</td>
<td>.06</td>
<td>-9.44</td>
<td>.001</td>
</tr>
</tbody>
</table>

*Note: RC= Reference Category; boldface= significant p value*

Step 1: $R^2 = .52; \ p = .001$, Step 2: $\Delta R^2 = .001; \ p > .05$, Step 3: $\Delta R^2 = .12; \ p = .001$, Step 4: $\Delta R^2 = .07; \ p = .001$
From Table 8 above, step 1, demographic traits (sex, age, area of residence and educational background) significantly accounted for 52.1% variance of the negative attitudes toward seeking professional psychological help among the participants \[ F(7, 352) = 54.68, p = .001, R^2 = .521 \].

In step 2 the model revealed that health locus of control (chance and powerful others) accounted for only 0.1% variance in the negative attitudes toward seeking professional psychological help among the participants \[ F(9, 350) = 42.33, p = .001, R^2 = .522 \]. Hence it was statistically non-significant \[ \Delta F(2, 350) = .10, \Delta p = .91, \Delta R^2 = .001 \].

In step 3 the model revealed that cultural beliefs uniquely contributed 12.1% variance in the less favourable attitudes toward seeking professional psychological help among the participants \[ F(10, 349) = 62.53, p = .001, R^2 = .643 \]. This means it was statistically significant \[ \Delta F(1, 349) = 117.49, \Delta p = .001, \Delta R^2 = .121 \].

The fourth and final step in the hierarchical multiple regression analysis accounted for 71.6% of the total variance in the participants’ negative attitudes toward seeking professional psychological help \[ F(11, 348) = 79.30, p = .001, R^2 = .716 \]. Hence self-stigma independently contributed 7.3% significant change to the model \[ \Delta F(1, 348) = 89.12, \Delta p = .001, \Delta R^2 = .073 \].

Therefore, as indicated by Table 8 above, the predictors that significantly accounted for the negative attitudes toward seeking professional psychological help were cultural beliefs \( \beta = -.41, p = .001 \) and self-stigma \( \beta = -.34, p = .001 \). It should be noted that some demographic characteristics (sex, area of residence and educational background) proved to be statistically significant and will be reviewed later in the chapter. In all, the factors accounted for 71.6% of the variation in professional psychological help seeking behaviour among urban, peri-urban and rural dwellers in Greater-Accra region of Ghana.
Hypothesis 3

Health locus of control (Internal, Chance and Powerful Others) will independently predict professional psychological help-seeking behaviour after controlling for the effect of demographic variables.

After the hierarchical multiple regression analysis to determine the independent effect of health locus of control (after controlling for the effects of demographic variables), step 2 in Table 8, revealed that health locus of control accounted for 0.1% change in the variance of the negative attitude towards seeking professional psychological help \([\Delta F(2, 350) = .10, \Delta p = .91, \Delta R^2 = .001]\). It further revealed that none of the three kinds of health locus of control significantly predicted the negative attitude towards seeking professional psychological help. That is, internal health locus of control did not significantly correlate with attitude toward seeking professional psychological help significantly and thus, was removed (see Table 4 above), chance health locus of control \((\beta = -.01, p = .74)\) and powerful others health locus of control \((\beta = .004, p = .92)\) were found to be non-significant. Therefore, the hypothesis that health locus of control (internal, chance, and powerful others) would significantly predict professional psychological help-seeking behaviour after controlling for demographic variables was not supported by the results.

Hypothesis 4

Cultural beliefs will significantly predict professional psychological help-seeking behaviour after controlling for demographic characteristics and health locus of control (internal, chance, and powerful others).

Results in Table 8, step 3, revealed that cultural beliefs significantly and independently accounted for 12.1% change in the variance of attitude towards seeking professional psychological help \([\Delta F(1, \ldots\ldots)\).
Specifically, cultural beliefs was found to significantly predict attitudes towards seeking professional help ($\beta = -.41, p = .001$). Therefore, the hypothesis that cultural beliefs would significantly predict professional psychological help-seeking behaviour after controlling for demographic characteristics and health locus of control (internal, chance, and powerful others) was supported by the results.

**Hypothesis 5**

*Self-stigma will significantly predict professional psychological help-seeking behaviour after controlling for demographic characteristics, health locus of control (internal, chance, and powerful others) and cultural beliefs.*

With respect to Table 8, step 4, self-stigma significantly accounted for 7.3 % change in the total variance in the negative attitudes towards seeking professional psychological help [$\Delta F (1, 348) = 89.12, \Delta p = .001, \Delta R^2 = .073$]. Furthermore, it was revealed that self-stigma ($\beta = -.34, p = .001$) significantly predicted and negatively correlated with the negative attitudes toward seeking professional psychological help. Therefore, the hypothesis that self-stigma would significantly predict professional psychological help-seeking behaviour after controlling for demographic characteristics, health locus of control (internal, chance, and powerful others) and cultural beliefs was supported by the results.

### 4.2.5 Supporting Analyses

As presented above, the four demographic variables (sex, age, educational background and area of residence) independently accounted for 52.1% variance in attitude toward seeking professional psychological help [$ F(7, 352) = 54.68, p = .001, R^2 = .521$]. Thus, the researcher sought to ascertain which demographic characteristics was the best predictor of attitude toward seeking professional
predictors of professional psychological help-seeking behaviour. Table 9 below indicates that after controlling for sex and age, educational background uniquely accounted for 15.8% of the 52.1% of the variance in attitude toward seeking professional psychological help, while after controlling for sex, age and educational background, area of residence independently accounted for 32.9% of the 52.1% of the variance in professional psychological help-seeking behaviour among Ghanaians. This means that the best predictors of professional psychological help-seeking behaviour is whether the person lives in an urban, peri-urban or rural community as well as the individual’s educational background.

Table 9. Demographic Predictors of Professional Psychological Help-Seeking Behaviour

<table>
<thead>
<tr>
<th>Model</th>
<th>B</th>
<th>β</th>
<th>S.E</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Males</td>
<td>-5.54</td>
<td>-.15</td>
<td>1.88</td>
<td>-2.94</td>
<td>.003</td>
</tr>
<tr>
<td>Age of Respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-35</td>
<td>-3.38</td>
<td>-.09</td>
<td>2.13</td>
<td>-1.59</td>
<td>.11</td>
</tr>
<tr>
<td>36-50 (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>51-60</td>
<td>-4.28</td>
<td>-.10</td>
<td>2.62</td>
<td>-1.63</td>
<td>.10</td>
</tr>
</tbody>
</table>

| Step 2 |     |     |      |      |     |
| Educational Background |     |     |      |      |     |
| Basic   | -20.28 | -.50 | 2.46 | -8.25 | .001 |
| Secondary | -13.02 | -.36 | 2.19 | -5.94 | .001 |
| Tertiary (RC) | -   | -   | -    | -    | -   |

| Step 3 |     |     |      |      |     |
| Area of Residence |     |     |      |      |     |
| Urban (RC) | -   | -   | -    | -    | -   |
| Peri-urban | -11.66 | -.31 | 1.63 | -7.14 | .001 |
| Rural    | -26.18 | -.69 | 1.68 | -15.55 | .001 |

Note: RC= Reference Category; boldface= significant p value
Considering the fact that area of residence was found to be the best predictor of professional psychological help-seeking behaviour among Ghanaians living in the Greater-Accra region and also significant differences existed between urban, peri-urban and rural dwellers professional psychological help-seeking behaviours, the researcher intended to find out how the three predictors of interest (Health Locus of Control, Cultural beliefs and Self-stigma) investigated played out within each of the three localities. Thus, the researcher conducted one-way ANOVA and hierarchical multiple regression to test this.

**Differences in Cultural Beliefs and Self-Stigma based on Place of Residence**

The study further examined differences in cultural beliefs and self-stigmatization among urban, peri-urban and rural dwellers in order to support the main findings that place of residence plays a role in individuals’ professional psychological help-seeking behaviours. The results are summarized in Table 10 and Table 11.

**Table 10: ANOVA test of significance of Place of Residence and Cultural Beliefs**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Place of Residence</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Df</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Beliefs</td>
<td>Urban</td>
<td>120</td>
<td>49.06</td>
<td>17.68</td>
<td>2, 357</td>
<td>53.18</td>
<td>.001</td>
</tr>
<tr>
<td>Cultural Beliefs</td>
<td>Peri-urban</td>
<td>120</td>
<td>61.74</td>
<td>12.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Beliefs</td>
<td>Rural</td>
<td>120</td>
<td>66.70</td>
<td>10.13</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From the Table 10, it can be observed that there was a significant difference in the cultural beliefs levels among urban, peri-urban and rural dwellers \[F (2, 357) = 53.18, p = .001, \text{two tailed}\].

---

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Post hoc comparisons using the Bonferroni test indicated that urban dwellers (M=49.06, SD = 17.68) had lower levels of cultural beliefs than peri-urban dwellers (M = 61.74, SD = 12.05) and rural dwellers (M = 66.70, SD = 10.13). This means that compared with urban dwellers, peri-urban and rural dwellers believe more in the supernatural causes of mental/psychological illness.

Table 11: ANOVA test of significance of Place of Residence and Self-stigma

<table>
<thead>
<tr>
<th>Variable</th>
<th>Place of Residence</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Df</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Stigma</td>
<td>Urban</td>
<td>120</td>
<td>27.78</td>
<td>13.06</td>
<td>2, 357</td>
<td>27.50</td>
<td>.001</td>
</tr>
<tr>
<td>Self-Stigma</td>
<td>Peri-urban</td>
<td>120</td>
<td>35.73</td>
<td>9.30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Stigma</td>
<td>Rural</td>
<td>120</td>
<td>36.38</td>
<td>6.59</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From the Table 11, it can be observed that there is a significant difference in the self-stigma levels among urban, peri-urban and rural dwellers [F (2, 357) = 27.50, p = .001, two tailed].

Post hoc comparisons using the Bonferroni test indicated that urban dwellers (M=27.78, SD = 13.06) had lower levels of self-stigma than peri-urban dwellers (M = 35.73, SD = 9.30) and rural dwellers (M = 36.38, SD = 6.59). This means that compared with urban dwellers, peri-urban and rural dwellers have higher sense of feeling that they will be stigmatized by people around them in case they consult psychotherapists for assistance.

The researcher proceeded to conduct a hierarchical multiple regression analysis for each area of residence. Table 12 (below), shows that the factors which significantly predicted professional psychological help-seeking behaviour among the urban dwellers were demographics [ F(5, 114) = 11.91, p = .001, R^2 = .34], cultural beliefs [ΔF(1,111) = 36.13, Δp=.001, ΔR^2 = .16] and self-stigma [ΔF(1, 109) = 86.12, Δp=.001, ΔR^2 = .22]. This means that the independent contributory effects of
cultural beliefs and self-stigma to the total variance of the negative attitudes toward seeking professional psychological help among the urban dwellers were 16.0% and 21.5% respectively. Both factors negatively correlated with professional psychological help-seeking attitudes. As revealed in Table 12, the factors that significantly accounted for the urban dwellers unwillingness to seek help from professional psychologists were cultural beliefs ($\beta = -.48, \ p = .001$) and self-stigma ($\beta = -.68, \ p = .001$). Implying that the greater the urban dwellers beliefs about the supernatural causes of psychological illness and the greater their feelings of being stigmatized the more unwilling they were to consult professional psychologists for assistance.

With respect to peri-urban dwellers, demographics, cultural beliefs and self-stigma significantly contributed 16.1% \[F (5, 114) = 4.37, \ p = .001, \ R^2 = .16\], 20.9% \[\Delta F (1,110) = 38.67, \Delta p = .001, \Delta R^2 = .21\] and 6.7% \[\Delta F (1,109) = 13.75, \Delta p = .001, \Delta R^2 = .07\] respectively to the total variance in professional psychological help-seeking behaviour of peri-urban dwellers. As revealed in table 4.8, the factors that significantly accounted for the peri-urban dwellers unwillingness to seek help from professional psychologists were cultural beliefs ($\beta = -.47, \ p = .001$) and self-stigma ($\beta = -.28, \ p = .001$). This means that among all the potential factors that may be contributing to the unwillingness among peri-urban dwellers to seek professional psychological help, their beliefs about the causes of psychological illness and self-stigma could explain 20.9% and 6.7% respectively.

Finally, it is instructive to note that, rural dwellers showed significantly the least favourable attitudes toward seeking professional psychological help when compared with dwellers in the urban and peri-urban areas (as was observed in the supported hypothesis 1). Now, according to Table 12, of all the potential factors that could explain their extreme negative attitudes toward seeking professional psychological help, cultural beliefs accounted for 9.9% \[\Delta F (1,110) = 12.79, \Delta p = .001, \Delta R^2 = .10\] of the variance while self-stigma accounted for 1.7% \[\Delta F (1,109) = 2.26, \Delta p > .05, \Delta R^2 = .02\] (even
though it was non-significant) of the variance among rural dwellers negative attitudes toward seeking professional psychological help. This means that among rural dwellers only their cultural beliefs ($\beta=-.32$, $p=.001$) significantly predicted their negative attitudes toward seeking professional psychological help.

Table 12: Predictors of Professional Psychological Help-seeking Behaviour Based on Place of Residence

<table>
<thead>
<tr>
<th>Model</th>
<th>Urban</th>
<th>Peri-urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Male</td>
<td>-.23*</td>
<td>-2.94</td>
<td>-.15</td>
</tr>
<tr>
<td><strong>Age of Respondents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-35</td>
<td>-.07</td>
<td>-.85</td>
<td>-.22*</td>
</tr>
<tr>
<td>36-50 (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>51-60</td>
<td>-.07</td>
<td>-.86</td>
<td>-.12</td>
</tr>
<tr>
<td><strong>Educational Background</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>-</td>
<td>-06***</td>
<td>-.39***</td>
</tr>
<tr>
<td>Secondary</td>
<td>-.32***</td>
<td>-3.60</td>
<td>-.103</td>
</tr>
<tr>
<td>Tertiary (RC)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Locus of Control</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal HLOC</td>
<td>-.15</td>
<td>-1.23</td>
<td>-.27*</td>
</tr>
<tr>
<td>Chance HLOC</td>
<td>-.11</td>
<td>-.87</td>
<td>-.20</td>
</tr>
<tr>
<td>Powerful others HLOC</td>
<td>-.07</td>
<td>-.76</td>
<td>-.19</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cultural beliefs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-.48***</td>
<td>-6.01</td>
<td>-.47***</td>
<td>-6.22</td>
</tr>
<tr>
<td><strong>Step 4</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Self-stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-.68***</td>
<td>-9.28</td>
<td>-.28***</td>
<td>-3.71</td>
</tr>
</tbody>
</table>

*p < .05; ** p < .01; *** p = .001
4.2.6 Summary of Quantitative Findings

- Generally, the participants showed less favourable attitudes toward seeking professional psychological help. Suggesting that they were unlikely to consult professional psychologists for assistance.

- Urban dwellers exhibited more favourable attitudes toward seeking professional psychological help than both rural dwellers and peri-urban dwellers. This supports hypothesis 1 of the study.

- Participants with tertiary backgrounds reported significantly more favourable attitudes toward seeking professional psychological help than those with basic and secondary educational backgrounds. This supports hypothesis 2 of the study.

- Health Locus of Control (internal, chance, and powerful others) did not significantly predict attitude towards seeking professional psychological help after controlling for demographic variables. Hypothesis 3 was therefore not supported.

- Cultural beliefs significantly predicted attitudes toward seeking professional psychological help after controlling for demographic variables and health locus of control. This supports hypothesis 4.

- Self-Stigma significantly predicted attitude towards seeking professional psychological help after controlling for demographic variables, health locus of control and cultural beliefs. This supports hypothesis 5.
4.2.7 Observed Model For Quantitative Findings

This model depicts the observed model from the hierarchical multiple regression that was used for the analysis.

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Dependent Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics:</strong></td>
<td>Professional</td>
</tr>
<tr>
<td>- Sex</td>
<td>Psychological</td>
</tr>
<tr>
<td>- Age</td>
<td>Help-Seeking</td>
</tr>
<tr>
<td>- Education</td>
<td>Behaviour</td>
</tr>
<tr>
<td>- Residential Area</td>
<td>(PPHSB)</td>
</tr>
<tr>
<td><strong>Cultural Beliefs</strong></td>
<td></td>
</tr>
<tr>
<td>$\beta = -0.41, p = .001$</td>
<td></td>
</tr>
<tr>
<td><strong>Self-Stigma</strong></td>
<td></td>
</tr>
<tr>
<td>$\beta = -0.34, p = .001$</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 2: Observed Model for Predictors of Professional Psychological Help-Seeking Behaviour**

In the hypothesized model, professional psychological help-seeking behaviour was hypothesized to be predicted by sex, age, education, and place of residence (demographic variables), health locus of control (internal, chance and powerful others), cultural beliefs and self-stigma. However, after controlling the effects of demographic variables only cultural beliefs and self-stigma predicted professional psychological help-seeking behaviour. Health locus of control (internal, chance and powerful others) did not predict professional psychological help-seeking behaviour.
In addition to the quantitative study, the researcher intended to also explore Ghanaians’ knowledge and understanding of professional psychological services qualitatively. Since the quantitative results have been presented in the previous section, the qualitative results of the current study will be presented in the proceeding section.

4.3 PRESENTATION OF QUALITATIVE RESULTS

4.3.1 Introduction

This sub-section presents the findings of the qualitative aspect of the study. Essentially, this sub-section covered the themes that originated from the responses of interviewees. To get the themes, sub-themes were derived from the quotes and then the sub-themes were grouped into the four (4) main themes. After analysis of the transcribed data, emerging themes were organized around four major thematic areas: Knowledge and Awareness of Professional Psychologists, Knowledge and Awareness of Professional Psychological Services, Understanding of Mental/Psychological Illness and Treatment of Mental/Psychological Illness. Thus, each theme had sub-themes which captured the pertinent voices reflecting the knowledge and understanding of the respondents about professional psychological services in Ghana (see Figure 3). To ensure anonymity, alphanumeric identifiers were given to each participant in the writing of this report. Specifically, urban, peri-urban and rural dwellers were assigned IA1-5, IP1-5 and IM1-5 respectively (see Table 2).
Figure 3: Thematic Network of Knowledge and Understanding of Professional Psychological services among Ghanaians.
4.3.3 Knowledge and Awareness of Professional Psychologists and their role

This theme captured participants’ knowledge of professional psychologists and how they work. Participants’ narratives indicate that they were generally aware of the existence of professional psychologists as people who care for the mentally ill. However, their knowledge about how psychologists assess mental illness was erroneous. One sub-theme was generated; “General Knowledge about professional psychologists”

**General knowledge about professional psychologists:** All participants mentioned that they have some knowledge about professional psychologists and were aware that professional psychologists are people who care for the mentally ill. Below are quotes to illustrate;

“They’s a doctor. It is a doctor who is supposed to take care of psychological illness...”
[IM1, Female, 38 years]

“..I will say a psychologist is a professional who evaluates and study the behaviour of mental processes...So when we say someone is a psychologist, you have to visit the psychologist when you are not mentally sound or you’re not too normal - you see the psychologist and he will psyche you up then you become normal...”
[IA1, Male, 32 years]

From the narratives, it was observed that the participants’ knowledge of who they thought a psychologist was, was similar irrespective of their level of education, religion, locality of residence (urban, rural or peri-urban) and sex (gender).

In addition to the participants’ knowledge of who psychologists were, nine (9) of the participants expressed the idea that psychologists can read the minds of people with mental illness. They
explained that professional psychologists give care to the mentally ill because they are trained to read the minds of their clients and help them. This is illustrated with the quotes below:

“It’s someone who can read someone’s mind and know what is wrong with the person and later help the person to solve that problem.” [IA2, male, 45 years]

“…they read or look through the mind of people in their abnormality then they find how to shift it to the normal way…” [IA5, female, 24 years]

“…by reading the mind of the person so that he can help them.” [IA3, female, 28 years]

Six (6) participants also believed that professional psychologists employ modern equipment in assessing mental patients in order to offer the needed help:

“...that they use machines and computers. As for me I know that in this modern Ghana, computers and technology are being used and so everything has become machine-machine...” [IM3, female, 30 years]

“...psychologists use machines to check the mind so that they can give the correct medicine to the patients...” [IP3, Female, 29 years]

As observed this kind of erroneous knowledge about the work of professional psychologists cuts across sex, area of residence, educational levels and religion. It is interesting to note that majority of the participants in the urban area suggested that psychologists read minds while most of the participants the rural dwellers mentioned that psychologists use machines and computers in order to help patients. This clearly shows that there is a general lack of knowledge about the way psychologists work among Ghanaians.
4.3.4 Knowledge and Awareness of Professional Psychological Services

Participants were asked about their knowledge and awareness of professional psychological services. Two sub-themes emerged from the narratives. These include “Location of professional psychological service providers” and “Perception of the cost of professional psychological services”

**Location of professional psychological service providers:** Majority (10 out of 15) of the participants indicated that they have no knowledge of where to locate any professional psychologist in Ghana. The extracts below are illustrations of the point above:

“As for that one, I don’t know where to locate where there are psychological service providers.” [IM1, Male, 38 years]

“...No, I have no idea where to locate any of them - psychologists, I don’t know where they are but maybe hospitals.” [IP4, female, 32 years]

A few participants however indicated they knew where to locate professional psychologists and gave specific places they believe psychologists operate in:

“I know of Accra Psychiatric hospital...” [IA3, female, 28 years]

“I know of Accra psychiatric Hospital, because definitely we should have psychologists there who will take care of the sick people...” [IA1, Male, 32 years]

“Yes, I have heard about a lot like around Asylum Down roundabout...and I think Korle-Bu but I have not been there before it is only the one at Asylum Down that I have passed there” [IP3, Female, 29 years]
It is interesting to note that all the participants who stated the places where professional psychological service providers could be found in Ghana were dwellers in the urban and peri-urban areas. This shows that there was a general lack of awareness among rural dwellers relative to where to find professional psychological service providers in Ghana.

**Perception of the cost of professional psychological services:** Respondents were asked about how much money they believe professional psychologists charged for their services. The participants indicated that the service charges of professional psychologists would be very expensive. Some of their responses are presented below:

“...let’s say they will charge more than the other doctors who take care of headaches, malaria, fever... I think it will be very expensive papa” [IP3, Female, 29 years]

“...the amount of money that is supposed to be charged should be very huge...it will be very huge and expensive...” [IM1, Male, 38 years]

“I think it will be very expensive ‘papa’!” [IP2, male, 34 years]

An intriguing deduction that could be drawn from the above information is that irrespective of the educational background or residential location (rural, urban or peri-urban), participants perceived professional psychological services as unaffordable per their living standards and hence they may find it difficult to obtain help from them.

It was further inquired from respondents about how much they thought they could offer in the event that they face any psychological challenge. Most of the participants (13 out of 15) indicated that their willingness to obtain psychotherapy would be based on the condition that professional psychologists served them free because they obviously have no budget intended for psychotherapy. Below are some extracts to illustrate:
“...As for that one, even if they dash it to me for free, I would like it. So if they don’t charge money, and that it is free of charge, I will like it.” [IM1, Male, 38 years]

“Oh!..to me, they must serve free of charge.” [IM2, male, 48 years]

“I think if they don’t charge any money at all, it will be good...it should be free.” [IM3, female, 30 years]

Two (2) participants who offered a different opinion suggested they were willing to pay for psychotherapy but thought that they could only offer some little amount of money;

“...but you let’s say I will wish to pay maybe something little like from GH 300.00 to GH 500.00” [IA2, female, 45 years]

“...For me, I think I can pay like GH 100.00 maximum, anything more than that, I can’t pay.” [IP3, Female, 29 years]

The above narratives indicate that majority of Ghanaians may not even attempt to seek professional psychological assistance in case they need help because currently there are no free professional psychological services in Ghana.

4.3.5 Understanding of Mental/Psychological Illness

When the participants’ understanding of mental illness was sought, their narratives indicated varied views as captured by the two sub-themes below.

**Mental/Psychological Illness Identification:** When the participants were asked about how they were able to identify persons with mental/psychological illness, below are what some of them had to say:
“...s/he can wear a cloth...the way s/he will even button up, you can sense that s/he is mentally ill. Someone can wear shorts, and also wear slippers (charlewote) and also put on socks. Aha.. So if such a person is moving around, no one should tell you that s/he is mentally ill. Ee..the kind of things s/he will be picking up, some kinds of filthy things s/he will be picking up, all these will show that there is something wrong with the person’s mind...this shows that s/he is mentally ill.” [IM1, Male, 38 years]

“...Oh! The attitude and behaviour of the person will tell. Maybe the person will be talking to himself or dress in a dirty way” [IA4, Male, 32 years]

“...you see someone coming by dancing with no music, throwing the dresses or the bags away, in a way you may feel that the person is challenged or the person has a problem. So with just a few sketches or actions, you will just know the person is abnormal...” [IA5, female, 24 years]

Generally, all the participants’ narratives were similarly to those above and so it can be deduced that all the participants thought that “appearance says it all”- in terms of how to identify or recognize persons with mental illness. It shows that the participants relied mostly on the behavioural or outward exhibitions of a person in determining whether someone is mentally ill or not, which is not far from the global understanding. However, the end result of this opinion is that some Ghanaians may overlook some symptoms which are not visually accessible, given that cognitive and emotional symptoms exist.

Moreover, some participants (6 out of 15 participants) also mentioned that sometimes mentally ill persons are noted by the fact that their thoughts and speech become altered. Two participants mentioned that:
“...or his/her speech, when you are conversing with the person, you will notice that his/her speech isn’t “going straight”. All the issues you have discussed with him/her, I mean, s/he can twist the issues.” [IM1, Male, 38 years]

“...when the person is speaking to you, you will realise that he says one thing, then says another thing, then says another different thing, which when put together does not make any sense at all...” [IA4, Male, 32 years]

The above narratives suggest that some of the participants had an understanding of the signs of mental illness since there are some mental illnesses such as schizophrenia in which case people with that condition can have a hard time organising their thoughts and they are not able to follow along when you have a conversation with them. Hence, for some participants to suspect mental illness upon noticing that someone’s speech is altered is accurate.

**Attribution of Mental/Psychological Illness:** This sub-theme captured participants understanding of why and how people get mentally ill. All 15 participants held the belief that mental illnesses are caused by supernatural forces. They mentioned that evil spirits, curses and witches are the reasons why people get mentally ill. The quotes below illustrate the above point:

“...we also have the spiritual causes too. (Do you get it?). Satan too can cause that. He can cause someone to have mental illness...” [IM1, Male, 38 years]

“...we have the spiritual aspect. Yea, spiritually someone can just-, let me say from your family or something, when they see you are good, they don’t want you to progress, they can just find some sort of sickness for you. And you will be mad..you will be mentally off, yeah.” [IA1, Male, 32 years]

“Someone will do something like stealing and will be cursed or witches can bring about
It is interesting to note that majority of the participants had a certain inclination to believe that supernatural forces are the cause of mental illness. To the extent that educational background and locality of residence did not influence the participants’ understanding that some spiritual agents were behind mental illness is very crucial for public health education on mental health.

Eight (8) out of the fifteen (15) participants also indicated that ‘worrying excessively’ could result in someone becoming mentally ill. Worrying too much about life, unpleasant events and unexpected circumstances according to some participants result in mental illness. Some respondents narrated that:

“...Maybe someone will have a problem but will not tell anyone and think about it alone so worrying about it can cause that illness..I think maybe broken heart or in the form of a business you lose so much money and all those kind of things..yeah, it can cause excessive worrying, I think that one too can cause mental illness” [IA1, Male, 32 years]

“...there are some people who always unfortunately get themselves into so many problematic situations. Like some people lose their parents early in life, then the person also get pregnant and the man run away from her- You see, such a person will always be found worrying excessively if she doesn’t get food and somewhere to sleep. So money problems can make someone worry too much and eventually affect his/her mind.” [IP4, female, 32 years]

Two (2) of the participants also mentioned that over use of substances such as alcohol and marijuana can affects peoples’ normal mental functioning. The extracts below illustrate the point:

“...Too much of alcohol; when taking too much of alcohol without any this thing, you can get mental problems - and drug abuse; if you abuse drugs in any form whether or be it herbs or
normal drugs that we take you can get mental illness.. yes when you take drugs, let’s say weed, when you abuse it, you will get mental problems” [IA1, Male, 32 years]

“I have heard that smoking ‘wee’ can cause mental illness…” [IP3, Female, 29 years]

Two other respondents thought that some physiological conditions could also result in mental challenges. The quotes below are an indication:

“...you let me say high fever, if you have high fever and it affects you without taking it to the hospital, you can get mental problems...” [IA1, Male, 32 years, Christian, Tertiary, Journalist]

“...some may be caused by vehicular accidents which can affect the brain; some too may be caused by pressure (High BP) which can affect the mind...” [IM3, female, 30 years, Christian, Basic, farmer]

4.3.6 Treatment of Mental/Psychological Illness

The participants explained how they believe mental illness is treated. Their narratives were captured by the two sub-themes below.

**Psychological Treatment:** When participants were questioned on how they think professional psychologists treat mental illness, the interviewees mentioned that psychologists solve people’s problems by talking with them and also prescribing medications for them. All 15 participants believed that psychologists give their clients medications. The extracts below are illustrations of the point:

“...they take care of the person, by giving the person drugs which will help the person if the person’s mind is not working normally/properly; it will be made normal; so those who give
psychological care give them drugs. [IM1, Male, 38 years]

“As and when you go to the hospital, your illness will be looked into for your treatment and the right medications will be given to you.” [IA5, Female, 24 years]

Other participants (6 out of 15) also indicated that psychologists talk with their clients in order to treat them. Below are extracts to illustrate the point:

“They normally speak with the person..like advice the person, like to stop smoking wee or stop worrying too much about her ex-boyfriend who has broken her heart - so they talk with the person and help the person to stop worrying.” [IA1, Male, 32 years]

“...they talk to the mad person, so that the person will begin to think like a normal person and behave well in the house and in town - so they talk to the sick people.” [IP1, Male, 50 years]

From the participants narratives, it was observed that majority of them, especially the rural dwellers, thought that professional psychologists treat mental illness by prescribing medication to the patients. This shows that they were not aware and hence do not understand the treatment methods used by professional psychologists in Ghana.

**Alternative Treatment for mental illness:** This sub-theme captured participants’ thoughts about other means of treating mental illness apart from the psychological interventions. The participants thought that there were other alternative treatments for mental illness and suggested prayers can actually heal mental illnesses.

All the participants mentioned that indeed there are other means of getting cured for psychological illnesses of which all participants expressed that prayers from their spiritual leaders, be it pastors or
mallams or traditional priest is the main alternative treatment mechanism they believe works. Some of the expressions are illustrated in the quotes below:

“... If it is the spiritual type, then prayers can treat. If those who are praying for the person, if all of you are of the same faith, because prayers can solve all problems..” [IM1, Male, 38 years]

“...It can be revealed to the mallam in the spiritual realm for him to also maybe pray for the person or do something that will let the person be free from the curse...” [IA3, Female, 28 years]

“...what I know and have seen before is that the traditional priest can pour libation and offer some prayers to the gods to cure the person. I have seen it before that’s why I’m talking about it.” [IM5, Male, 55 years]

Some participants also said that some people use herbal medications to cure mental illnesses. Nine (9) out of the fifteen (15) participants stated that there are herbal medications which can cure mental illness. This is illustrated in the extracts below:

“...and some people use herbal medicine to treat it” [IP3, Female, 29 years]

“...So I don’t go to hospital. I use herbs...” [IM5, Male, 55 years]

As observed from participants’ narratives, they had some understanding that herbal medication could also be used to treat mental/psychological illness.
4.3.7 Summary of Qualitative Findings

Participants have limited knowledge about professional psychologists and their roles. Some believe that professional psychologists in order to treat mental illness use machines and also read the minds’ of people after which they give medications and also talk to patients as means of treating their conditions. Majority of the participants had little knowledge about where to cite professional psychological service providers in the country and they also held the perception that professional care from psychologists would be very expensive. Furthermore, participants understanding of the causes of mental illness indicated that they mostly believe that supernatural events and sometimes excessive worrying were main triggers of mental illnesses. All the participants believe that prayers to their deity can heal persons with mental illness. Some participants also thought that some herbal medications can be used to treat mental illness.
CHAPTER FIVE

DISCUSSION

5.1 Introduction

This current study explored some predictors of professional psychological help-seeking behaviour among dwellers in three different Ghanaian contexts; dwellers in Adabraka – an urban city within the Greater-Accra’s capital of Ghana, dwellers in Pokuase – a peri-urban community within the Ga-West Municipal Assembly and Mempemehuasem – a rural community within the Ga-West Municipal Assembly. The study examined the dynamics of context-specific help seeking behaviours of urban, peri-urban and rural dwellers in Ghana. It also investigated whether individuals’ educational backgrounds, health locus of control, cultural beliefs and self-stigma significantly influenced their professional psychological help-seeking behaviours. Additionally, the study aimed to qualitatively explore Ghanaians’ knowledge and understanding of professional psychological services.

In this chapter, the findings from the study are discussed to elucidate how the aforementioned factors influenced the participants’ attitudes toward seeking help from professional psychologists. The theoretical implications of the findings from this study on mental/psychological health care in Ghana are also discussed. The chapter concludes with discussions of the limitations of the study and gives suggestions for future research.

5.2.1 Place of Residence and Professional Psychological Help-Seeking Behaviour

As hypothesized, results showed significant differences among urban, peri-urban and rural dwellers’ professional psychological help-seeking behaviours. The results specifically showed that urban dwellers had a more favourable attitude toward psychological help-seeking than rural and peri-urban dwellers. This means that where an individual resides or dwells influences his/her professional
psychological help-seeking behaviour significantly. Additionally, it indicates that there are certain community dynamics that predisposes individuals to have a more or less favourable attitude toward professional psychologists. The finding confirms earlier studies (e.g. Esters et al., 1998; Rost et al., 2002; Williams, 2014) that have reported that urban dwellers showed more favourable attitudes toward seeking psychological assistance than both rural dwellers. Although the previous research did not consider the peri-urban dwellers in their study, it is worth noting that the peri-urban dwellers in the present study also reported more favourable attitude toward seeking professional psychological help than rural dwellers.

Prior to attempting to posit any other possible explanations for why urban dwellers showed more willingness to seek professional psychological assistance than peri-urban and rural dwellers, it is instructive to first consider how the levels of cultural beliefs about the causes of mental/psychological illness and the self-stigma of seeking help from professional psychologists differed among the three independent communities. Results showed that, urban dwellers scored significantly lower on both cultural beliefs and self-stigma than rural and peri-urban dwellers. It makes sense to suggest then that the reason why the urban dwellers showed more willingness to consult professional psychologists for assistance than the peri-urban and rural dwellers was as a result of their significantly lower levels of cultural beliefs and self-stigma compared with the rural and peri-urban dwellers. To buttress this position, previous studies have associated high scores on cultural beliefs and self-stigma scales with negative attitudes toward seeking professional psychological help (Al-Krenawi et al., 2004; Fung & Wong, 2007; Hackler et al., 2010; Mojtabai, 2010).

However, more light needs to be shed on how the three independent communities’ attitudes toward seeking professional psychological help were influenced by the two predictors (cultural beliefs and self-stigma). Separate hierarchical multiple regression analyses conducted to ascertain whether
cultural beliefs and self-stigma would independently predict the professional psychological help-seeking behaviours of urban, peri-urban and rural dwellers, yielded interesting results.

First, only cultural beliefs about the causes of mental/psychological illness demonstrated to be the main significant predictor responsible for the respondents’ negative attitudes toward seeking professional psychological help across the three communities, but in varied degrees. Second, self-stigma of seeking help from psychotherapists was found to be a significant predictor only in the urban and peri-urban respondents’ willingness to seek professional psychological help or not.

Third, the context-specific nuances were much more surprising. In as much as cultural beliefs could explain some degree of the negative attitudes toward seeking professional psychological help within each community, it contributed a lot less to the help-seeking behaviours of the rural dwellers than the help seeking behaviours of the urban and peri-urban dwellers. Furthermore, the degree to which self-stigma contributed to the negative attitudes toward seeking professional psychological help among urban dwellers was a lot more than among the peri-urban dwellers. However, self-stigma of seeking help was a non-significant predictor among the rural dwellers’ negative attitudes toward seeking professional psychological help.

It is interesting to note that compared with the urban dwellers, the rural dwellers’ negative attitudes toward seeking professional psychological help could least be predicted by their cultural beliefs. In the same vein the self-stigma of seeking psychotherapeutic help greatly influenced the urban dwellers professional psychological help-seeking behaviours as compared with the peri-urban dwellers and rural dwellers; for whom it did not predict their help-seeking behaviour significantly.

Based on the outcomes of this study as discussed above, the researcher can conclude that the urban dwellers’ report of being more willing to consult professional psychologists for assistance compared
with peri-urban and rural dwellers cannot be related to their cultural beliefs and self-stigma. Thus, it is probably that other contextual factors may be responsible for the significant differences in the unwillingness of the urban, peri-urban and rural dwellers to seek professional psychological help.

Possible reasons for this outcome are that, educational levels of the participants may have played a significant role in the outcome obtained. Findings of the study showed that the number of participants who had tertiary educational background was significantly lower for the rural dwellers (11%) as compared with their counterparts who resided in the urban (44%) and peri-urban (44%) areas. This may be the reason why the urban and peri-urban dwellers showed significantly more favourable attitude toward seeking professional psychological help than those who dwelt in the rural area. Some studies have given credence to the fact that higher educational level shapes an individual’s attitude toward seeking professional psychological help and more favourable opinions about help-seeking for mental illness, and greater willingness to use professional services (Al-Darmaki, 2003; Williams, 2014). In the present study, even though urban dwellers and peri-urban dwellers had the same percentage of participants who had tertiary educational backgrounds, urban dwellers indicated that they were more willingness to consult professional psychologists than peri-urban dwellers. This could be because of the limited relevant knowledge about professional psychological service providers among the rural and peri-urban dwellers. This was observed in the qualitative study in which all the urban dwellers indicated they knew at least one location of where professional psychologists could be in Ghana. However, among the peri-urban interviewees, only one participant mentioned a location to find professional psychologists in Ghana, while all of the rural dwellers indicated that they had no idea where to locate professional psychologists in Ghana. Drawing on this, though an individual with a higher educational background may appreciate better, why he/she should seek professional psychological help when in distress, not knowing where to locate a professional psychologist may also reduce the individual’s willingness to consult a professional psychologist. Hence, the lack of
knowledge of where to locate professional psychologists in Ghana on the part of peri-urban and rural dwellers might have contributed to their less favourable attitudes toward seeking professional psychological help. On the other hand, while the advantage of having the Accra Psychiatric Hospital within the urban area might have favoured the urban dwellers in their willingness to consult professional psychologists for help than the peri-urban and rural dwellers.

Additionally, perceived ability to pay for the services of professional psychologists could be another possible reason why rural dwellers and peri-urban dwellers indicated more unwillingness to consult professional psychologists for assistance than urban dwellers. From the qualitative study, all the participants interviewed expressed the perception that professional psychological services will be very expensive. All the rural and peri-urban dwellers indicated that they could seek professional psychological assistance only if they offer free services, but majority of the urban dwellers mentioned some amount of money as the intended cash they could offer in case they needed psychological help. The fact that rural and peri-urban dwellers perceived professional psychological service charges as being very expensive and expecting that pro bono services were rendered before they could consider seeking professional psychological help, this can be a major reason why rural and peri-urban dwellers had less favourable attitudes toward seeking professional psychological help than urban dwellers. It can be deduced then that, in making a choice of whom to seek psychological help from, majority of the rural and peri-urban dwellers were less likely than urban dwellers to consider professional psychologists because the former may be poorer and hence perceive psychotherapeutic services as unaffordable. Lack of money has been found to prevent many individuals from utilizing modern health facilities in time of illness because transportation cost and consultation cost are factors which deter the poor from access to modern health facilities (Yikal Kefale, 2016).
If individuals’ willingness to seek professional psychological help is being driven by the ability to pay for the services and awareness of the location of professional psychologists in Ghana, then it means most individuals have other alternative avenues they may be seeking mental health service from. This brings in the next possible reason for the contextual differences in professional psychological help-seeking behaviour.

The perceived social support levels of the respondents may be another possible reason why urban dwellers were more willing to seek professional psychological assistance than rural and peri-urban dwellers. Perceived social support refers to an individual’s subjective judgment that, in times of need help will be delivered by persons around him/her such as parents, siblings, community members and religious leaders. To make the choice of whom to consult, some researchers have suggested that, individuals who seem to have strong social support, thus, they believe they can rely on their family, friends or religious leaders for the needed support may show less favourable attitudes toward seeking help from mental health experts in their times of need (Miville & Constantine, 2006; Schwarzbaum, 2004). Drawing from common sense, as compared with rural and peri-urban dwellers, urban folks are mainly people who have traveled to the cities to work and earn their livelihood. They mostly move away from their external families (sometimes including their nuclear families) and other friends for greener pastures. Their core family relatives are not often readily available to give them some support hence their lower sense of perceived support may tend to influence them to show more willingness to seek professional psychological assistance than the rural and peri-urban dwellers who are mostly around their families and community social networks.
5.1.2 Educational Background and Professional Psychological Help-Seeking Behaviour

Individuals who had tertiary educational backgrounds showed more favourable attitudes toward professional psychological help-seeking than individuals who had basic and secondary educational backgrounds. This outcome is consistent with previous studies that found that higher education was associated with more positive opinions about help-seeking for mental illness and greater willingness to use professional services (Al-Darmaki, 2003; Parslow & Jorm, 2000; Williams, 2014). Another study found that for each additional level of education, individuals were 15% more likely to see a psychiatrist, 12% more likely to see a family doctor, 16% more likely to see a psychologist and 16% more likely to see a social worker (Steele, Dewa, Lin, & Lee, 2007). This is an indication that educational level has significant influence on individuals’ willingness to consult health experts for their health needs. One possible explanation for the present finding may be that tertiary/higher education contributes significantly to human capital through the development of a range of skills and traits, such as cognitive skills, problem solving abilities, learned effectiveness, and personal control (Mirowsky & Ross, 2005). These various forms of human capital may all mediate the relationship between education and health in general. Thus, once an individual acquires higher cognitive and problem solving skills, he/she becomes more empowered to think through events more critically based on factual evidence in the process of finding solutions to challenges including health challenges. Some researchers have asserted that higher education develops a person’s capacity to gather and interpret ideas and to deal with problems on several levels and it also increases an individual’s potential to control events and outcomes in his/her life (Ross & Wu, 1995). Moreover, the process of obtaining higher education may result in individuals becoming more open-minded toward seeking help as it involves encountering and solving problems that are progressively more difficult, complex, and subtle which may lead to asking for assistance when needed. This may build problem-solving skills which do not make individuals feel less intelligent because they sought help in
order to overcome a challenge instead it may enable individuals to be more confident they are capable to solve problems.

Another plausible explanation for the present finding is the mediating role of perceived ability to pay for professional psychological services. Adults with higher educational backgrounds especially in today’s knowledge economy, have conspicuous advantages in securing employment and finding desirable jobs that offer job satisfaction and higher salaries as compared with jobs which are associated with secondary and basic educational levels. In that case, then the perception that professional psychological services are very expensive and hence inaccessible (as it was narrated by all the participants from the qualitative study) might not have impacted the willingness of participants with tertiary educational backgrounds to choose professional psychological help negatively as much as compared to those with either secondary or basic school educational backgrounds who were mostly petty traders and subsistent farmers.

It is worth noting that the findings of the study gives credence to the biopsychosocial model to the extent that social factors such as education level, place of residence and socioeconomic status may have some influence on individuals’ professional psychological help-seeking behaviour. This implies that, biological factors are not the only possible factors that may determine the health condition of individuals but also other psychological and social factors contribute significantly to the health outcomes of individuals.

5.1.3 Health Locus of Control and Psychological Help-Seeking Behaviour

The results revealed that none of the three health locus of control dimensions significantly predicted attitudes towards seeking professional psychological help. This means that health locus of control does not significantly influence an individual’s psychological help-seeking behaviour. Thus, an
individual’s willingness to seek professional psychological help may depend on other factors other than their health locus of control. This outcome is not in congruence with previous studies (e.g. Andrews et al., 2011; Boafo, 2013; Kam et al., 2006; Oluyinka, 2011) which found an association between at least one dimension of locus of control (internal locus of control and chance locus of control) and psychological help-seeking behaviour.

Three interconnected reasons may be responsible for this outcome. First, most of the participants in the study exhibited bilocal or mix-loci tendencies; majority of the participants had inclinations toward both internal and external (chance) loci of control as they scored high on both internal locus of control and chance locus of control (Neal, Weeks, & DeBattista, 2014). This implies that majority of the participants believed that they were somehow responsible for their health at the same time they also believed that their state of health was depended on some external forces (within the Ghanaian context, “it was by the grace of God”). Second, the participants believed that mental/psychological illness is caused by supernatural forces like witches and other evil spirits (based on their cultural beliefs scores). Since individuals’ beliefs of the cause of an illness usually correspond to its accepted treatment modality (Halligan, 2006; Horne, 2006; Reich, Bockel, & Mewes, 2015), participants were more likely to believe in the spiritual healing from their spiritual leaders (pastors, mallams or traditional priests) rather than from professional psychologists. Therefore these characteristic thinking patterns exhibited by the participants and finally the probable mediating role of social support from their spiritual leaders may have influenced their overall attitude toward seeking professional psychological assistance. Thus health locus of control (internal, chance or powerful others) could not predict professional psychological help-seeking behaviour significantly.
5.1.4 Cultural Beliefs and Psychological Help-Seeking Behaviour

One of the objectives of the present study was to find out the association between cultural beliefs about the causes of mental illness and professional psychological help-seeking behaviour. Findings from this study revealed that cultural beliefs about the causes of mental/psychological illness significantly predicted participants’ attitude towards seeking professional psychological help after controlling for demographic variables and health locus of control. This shows that among all the variables that would influence an individual to consult a professional psychologist for assistance, the cultural beliefs about the causes of mental/psychological illness contributed greatly to the person’s willingness to consult professional psychologists. Thus, a negative correlation was established between cultural beliefs and professional psychological help-seeking behaviour among the sample in this study. This outcome confirms earlier studies (e.g. Al-Krenawi et al., 2004; Fung & Wong, 2007) that found that cultural beliefs of the causes of mental illness predicted individuals’ attitudes toward seeking professional psychological help. Specifically, those who had supernatural beliefs about the causes of mental illness had more negative attitudes toward seeking professional psychological help (Fung & Wong, 2007).

The present finding suggests that, first, most of the participants strongly believed in the Ghanaian held cultural beliefs that mental/psychological illness is mainly caused by supernatural forces such as witches and curses (Opare-Henaku & Utsey, 2017; Quinn, 2007). Also, in support of this assertion are narrations from the qualitative interviews conducted by the researcher in this study. Participants’ narrations revealed that all the interviewees believed that mental illness can be caused by supernatural forces beyond ones physical understanding. Second, participants across locality of residence (urban, rural or peri-urban dwellers) showed significantly negative attitudes toward seeking professional psychological help. Putting the two points together, it means that the participants’ indication of their
unwillingness to consult professional psychologists for assistance in times of mental distress was influenced by their strongly held beliefs that mental illness is caused by supernatural forces.

One possible explanation as to why majority of the participants reported that they were unwilling to consult professional psychologists may be the African (Ghanaian) ontological position that healing is bestowed by the Supreme Being. As such they may rather prefer to seek help from “the representatives” of the Supreme Being on earth (pastors, mallams and traditional priests). This suggestion is in congruence with the Knowledge Attitude Behaviour (KAB) model which posits that the kind of knowledge an individual has will determine his attitude which invariably influences his action. In the subject under discussion, the participants held an ontological and culturally based knowledge that supernatural forces were responsible for mental illness. Their attitudes were therefore positive towards solutions that involved the perceived causal force, then finally their unwillingness to consult professional psychologists who may have been perceived as not having the remedy to their challenges because they do not represent the Supreme Being on earth who is able to heal all diseases and illnesses.

Additionally, the qualitative findings confirm this position because the narratives from the informants indicated that they believe Satan or evil spirits or curses are part of the causes of mental illness. Based on their attribution they are likely to consult other alternatives like pastors or mallams or traditional priests for help when the need arises. Additionally, they could consult others for herbal medications since they believe in that treatment regimen too.

Another reason could be the presence and availability of a wide range of health care options including herbalists, traditional priests, hospitals and spiritualists in Ghana which may be competing with professional psychological services. These available choices compete with professional psychological services. Unfortunately, for professional psychologists, the cultural beliefs which influences the
modality of treatment normally does not go in their favour. For instance, previous studies found that people in sub-Saharan Africa have a preference for traditional and spiritual healers as their first choice for treatment of mental illness (Ae-Ngibise et al., 2010; Adewuya & Makanjuola, 2008; Roberts, 2001).

5.1.5 **Self-Stigma and psychological Help-Seeking Behaviour**

The outcome of the study revealed that self-stigma negatively predicted professional psychological help-seeking behaviour. This implies that the more respondents felt stigmatized internally for attempting to consult professional psychologists for help, the less favourable were their attitudes toward seeking professional psychological assistance.

Several studies have found self-stigma of seeking help to be one of the factors that makes an individual reluctant to seek help from mental health experts (e.g. Barry et al., 2000; Hackler, et al., 2010; Mojtabai, 2010) and the present finding did not deviate from the previous studies. Some plausible explanations for this outcome may be that majority of the respondents in the study had basic and secondary school educational backgrounds and hence their stigma levels were high. Some studies have found that tertiary education diffuses the effect of stigmatization from becoming internalized (e.g. Bland, Newman, & Orn, 1997; Mackenzie et al., 2006; Skogstad, Deane, & Spicer, 2006; Takamura, Oshima, Yoshidat, & Motonaga, 2008).

Another plausible reason why self-stigma predicted professional psychological help-seeking behaviour negatively may be because none of the participants in the current study had had the opportunity to experience any form of professional psychological service as at the time the study was conducted. Having previous contact with mental health professionals tend to lower the level of stigmatization about mental illness. Some empirical evidence suggests that people’s attitude toward
seeking psychological help becomes relatively more favourable when those individuals have had previous contact with mental health professionals, as it increases their propensity to seek the help needed from these professionals (Al-Rowaie, 2001; Schomerus, Matschinger, & Angermeyer, 2009; Smith, McGovern, & Peck, 2004). For example some researchers have revealed that persons who have had prior experience with a psychologist in a particular situation develop higher intentions to seek psychological help (Skogstad et al., 2006).

5.2.5 Knowledge and Understanding of Professional Psychological Services

The objective of the qualitative study was to explore individuals’ knowledge and understanding of professional psychological services. Participants who were tested had no prior experience of professional psychological services. The findings of the qualitative study highlight some important outcomes regarding the knowledge participants in the current study had about professional psychological services and how they understood the works of professional psychologists.

The findings specifically illuminate the knowledge some Ghanaians have about who professional psychologists are, their awareness of where to locate professional psychologists in Ghana; and their perception of the cost of professional psychological services. The findings also highlighted participants’ understanding of mental/psychological illness and their beliefs about the treatment modalities for mental/psychological illness.

Knowledge and Awareness of Professional Psychologists

All the participants exhibited through their narratives that they were aware of who professional psychologists were, stating that they take care of the mentally ill. However, their level of awareness was superficial as their subsequent narratives indicated that their knowledge and awareness of who professional psychologists were, was not enough for them to willingly seek their services. For
instance, majority of the participants suggested that professional psychologists ‘read the minds’ of their patients in order to help them. Previous researchers of barriers to mental/psychological health help-seeking have found limited mental health literacy as a significant barrier to mental health help-seeking (e.g. Gulliver, Griffith, & Christensen, 2010; McCann, Mugavin, Renzaho, & Lubman, 2016; Staiger, Waldmann, Rusch, & Krumm, 2017). These studies however, did not focus on how the limited mental health literacy could negatively influence individuals’ willingness to consult them.

A possible reason why all the participants were aware that professional psychologists take care of the mentally ill may be because they might have heard on radio or television about psychologists as some psychologists make presentations on radio and televisions. With respect to why majority of the participants thought that psychologists read the minds of their patients, it may be because of the fact that they had no prior experience of professional psychological services. Additionally, although the participants might have gained some knowledge about psychologists from the radio or television, the relevant knowledge they had about how psychologists work to help the mentally ill may be based on the long-standing misperception or myth in Ghana, that psychologists read the minds of people. This is because the radio and television programs do not directly focus on educating Ghanaians about the job of professional psychologists but quite often just discuss specific mental health issues.

The perception that psychologists read minds may serve as a barrier for some Ghanaians to seek help because it may put fear in some people and create uncomfortable emotions. The Knowledge Attitude Behaviour (KAB) Model can be used to explain this finding. For example, because individuals have the knowledge that psychologists read the minds of people, some may feel uncomfortable with such perception about psychologists and may develop negative attitudes toward psychologists and psychological help-seeking behaviours.
Awareness of Professional Psychological Service Providers

Two findings were obtained under this theme. First, the researcher found that majority of the participants had no knowledge of where to locate professional psychologists in Ghana. This outcome is consistent with previous studies which were conducted to find out barriers to mental health service utilization. The researchers found that lack of information about existing mental healthcare services was one of the main barriers (Bartolomei, et al., 2016; Jack-Ids & Uys, 2013). In the present study, a plausible reason why majority of the participants had no knowledge about where to locate professional psychologists may be due to circumstantial factors such as low levels of relevant mental health education and the unavailability of mental/psychological health facilities (especially within rural and peri-urban areas). In addition, the lack of awareness about the location of professional psychologists as indicated by majority of the participants may be as a result of the fact that the few mental/psychological health facilities available in Ghana may not be advertising their services well enough to create awareness among the populace.

Second, all the participants had the perception that the cost of professional psychological services will be very expensive. This supports the findings by Connolly (2017), Chikovani et al., (2015), Ghafoori, Barragan and Palinkas (2014) and Gulliver et al., (2010) who found that limited resources and the high costs of mental health services like psychotherapeutic services prevents individuals from seeking help. A possible reason why participants perceived professional psychological services to be very expensive may be because they probably perceive themselves as poor. Considering that most of the participants were either traders or subsistence farmers, they might have perceived that their incomes were not adequate to support the kind of services professional psychologists render.

Furthermore, participants’ perception that the brain (mind) is a more complex organ than other organs of the human body might have informed their narratives that psychotherapy will be very expensive.
Thus, they might have inferred that the amount of money that required in caring for the brain (mind) will be very expensive than the amount of money needed in caring for other organs in the body. The perceived cost of professional psychological services may therefore be a crucial determinant of some Ghanaians’ professional psychological help-seeking behaviour.

Understanding of Mental/Psychological Illness

This study revealed that in identifying persons with mental/psychological illness ‘appearance says it all’. According to the participants’ narratives, the way an individual is groomed and the kind of clothing he/she is wearing are key pointers to determine whether an individual is mentally/psychologically stable or unstable. Besides a person’s physical appearance, majority of the participants also mentioned that an individual with mental/psychological challenges may also exhibit incoherence in their speeches and thought patterns. Thus when the speech and thought patterns of an individual become altered, he/she may be said to be suffering from mental/psychological illness. These findings confirms the results of earlier studies conducted in Ghana (e.g. Adombini-Naba, 2013; Okyere, 2015; Opare-Henaku & Utsey, 2017) which also found that the signs which some Ghanaians associated with mental/psychological illness included the appearance of the person (neglect of his/her personal hygiene, the way he/she is dressed and the kind of clothing the person is wearing), inability to follow conversations, talking to one’s self, going naked in public, among others.

One possible reason why the participants in this study focused on the overt or outward appearance of other persons to identify their mentally/psychological states was the socio-cultural norms regarding clothing and dressings. Within the Ghanaian socio-cultural set-up, clothing defines the kind of person an individual is. For instance, when a group of chiefs meet, they may all be dressed in a similar way but the paramount chief is easily identified by the kind of clothing he is wearing. In the same vein, people in Ghana form impressions about others by the way others appear to them. Thus, it is a
cultural belief or expectation in Ghana that only mentally unstable people deviate from the norms of dressing by leaving their hairs unkempt and wearing shabby clothes. Evidences suggest that some Ghanaians (especially men) who keep on dreadlocks are often stigmatized against because people put them in the same category as mentally ill persons and smokers of marijuana (Boakye, 2016; Koomson, 2016). Furthermore, a plausible reason why some participants reported that people who are mentally unstable may have their speeches and thought patterns altered may be because their narrations were based on what they had observed from other people they believed were battling with mental/psychological illness.

**Attribution of Mental/Psychological Illness**

Findings obtained in the current study showed that all the participants implicated supernatural force such as evil spirits, witches and curses as being responsible for mental illness. This outcome did not deviate from previous research findings which alluded to the fact that some Ghanaians hold a strong belief about the supernatural causes of mental illness (e.g. Ofori-Atta et al., 2010; Opare-Henaku & Utsey, 2017).

Some earlier studies had suggested that the supernatural attributions which are held on strongly by some Ghanaians are deeply embedded in their ontological beliefs of ubiquitous socio-cultural factors such as evil machination of the enemy through witchcraft, invocation of negative spirits and ancestral curses (Danquah, 1982; Field, 1960). To buttress the above point, the Dual Causality Theory by Gyekeye (1995) may provide some plausible explanation for the supernatural attributions that were made by the participants relative to mental/psychological illness. According to Gyekeye (1995), the Akans of Ghana (who make up the largest ethnic group in Ghana), in their attempt to explain events/occurrences in the physical world make both supernatural and non-supernatural attributions of events/occurrences in their physical world.
Participants in the present study also mentioned some non-supernatural causes of mental illness such as excessive worrying, brain injury as a result of accident and the overuse of substances like marijuana. According to participants’ narratives when an individual worries excessively about things such as loss of money and broken heartedness, he/she may end up becoming mentally ill. This finding is also consistent with previous studies conducted among community samples in Greater Accra-region which reported that participants’ thoughts about causes of mental illness included excessive worrying, substance abuse and socioeconomic challenges such as poverty and broken home (Adeeku, 2015). This, to an extent, shows that many Ghanaians have some understanding about some causes of some mental/psychological illness.

**Treatment of Mental/Psychological Illness**

Closely linked to the causal understanding of mental/psychological illness is its mode of treatment. Usually, the kind of attribution an individual proffer will influence the treatment modality or the kind of treatment he or she will seek (Halligan, 2006; Horne, 2006; Reich, Bockel, & Mewes, 2015). The findings in the current study indicated that, there were several alternative treatment avenues available within the Ghanaian socio-cultural set-up which participants referred to such as prayers, pouring of libation and use of herbal medications. Other researchers have also found that these alternative treatment methods are used more often by Ghanaians than expert mental health service (Ae-Ngibise et al., 2010; Okyere, 2015). If an individual believes that his/her disorder is as a result of machinations of evil forces then the probability that he/she will resort to the services of persons who purport themselves to be operating in that realm will be very high. Hence this could explain why pastors, mallams and traditional priests are often consulted by many Ghanaians when they are mental/psychological ill.
Some participants reported that psychotherapy was another means of treating mental psychological illness. They however indicted that psychologists give medications to their patients. This shows that many participants had certain erroneous perception about how professional psychologists treat mental illness. Other participants also mentioned that psychologists talk with clients to advice them and help them. However, the idea about medication prescriptions may have detrimental effects on professional psychological help-seeking. For instance, with such understanding, if an individual consults a professional psychologist and does not receive any form of medication as expected, he/she may find psychotherapy to be very unfruitful or inefficient and hence may end up not going back for therapy again. Lack or limited relevant mental health knowledge and understanding about the work of professional psychological services may be responsible for the participants’ erroneous knowledge that psychotherapists give medications.

5.3 Limitations, Implications and Recommendations

There are some limitations of the current study that should be recognized. Similar to other studies, the quantitative findings are based on self-reported data from participants. It is possible that participants may have offered socially desirable responses to some statements in the measures used, did not completely understand the statements.

Another limitation is related to generalizability of the data to all Ghanaians and other populations. The current sample consisted on only Ghanaians between the ages of 18-60 years who resided at Adabraka (urban), Pokuase (peri-urban) or Mempemehuasem (rural) in the Greater-Accra region. More so, Ghanaians who have experienced professional psychological services were not tested. Since the characteristics of the urban, peri-urban and rural dwellers in Greater-Accra may vary from those in other regions of Ghana and also none of the participants had previously used the services of a
professional psychologist, different responses may have been elicited from participants with different qualities as mentioned above. Finally, the current study is a cross-sectional analysis, and no conclusions can be drawn about causality of observed relationships.

Despite its limitations, the study has revealed important information on why Ghanaians residing in different localities may not be seeking professional psychological assistance.

**Recommendations for future research:**

For future empirical studies, sample of other participants from other regions and communities outside the Greater-Accra region should be tested. Again a sample of individuals who have experienced professional psychological services should be considered.

Another suggestion is that, future researchers in their quest to replicate this study should include perceived social support as a predictor variable and its mediating role should also be investigated since it might have mediated the relationships between professional psychological help-seeking behaviour and some predictor variables examined this study such as health locus of control and self-stigma. More so, given that majority of the participants reported high inclination toward both internal and chance health locus of control (bilocals), the spiritual health locus of control scale by Holt, Clark, Kreuter and Rubio (2003) can be used in the future. It assesses directly the belief that a higher power has control over one’s health and is found to be culturally more sensitive to specific populations such as those high in spirituality/religiosity, like Ghanaians. The spiritual health locus of control specifically includes two dimensions; “Active” and “Passive”. An individual may be said to have an active spiritual health locus of control when he/she believes that a higher being empowers a person to be proactive about health behaviours or that one works in partnership with a higher power to stay in good health. An individual may be said to possess a passive spiritual health locus of control when
he/she believes that since only a higher power is in control of health outcomes, there is no reason to engage in health behaviours such as help-seeking.

Additionally, future studies should explore the professional psychological help-seeking behavior of Ghanaians after some psychological health educational interventions within some rural communities and compare with other urban and peri-urban areas.

**Practical Recommendations**

The study found that context is relevant in understanding individuals’ professional psychological help-seeking behaviours. Specifically, rural and peri-urban dwellers with lower levels of education are less likely to seek help from professional psychologists. It is therefore recommended that professional psychologists and other public health experts should focus on educating the public in order to demystify professional psychological services. In carrying out such public health education, they should bear in mind that the urban, peri-urban and rural dwellers may have different reasons why they may not be seeking help from professional psychologists so that those peculiar issues are dealt with expediently.

In addition, there is the need to encourage Ghanaians to pursue higher education as this will go to influence their health behaviours such as their professional psychological help-seeking behaviours. This suggestion is especially crucial in Ghana and Africa since the finding of the study demonstrated that individuals’ who had tertiary educational background reported significantly more willingness to consult professional psychologists than those with secondary and basic educational levels despite the general negative attitudes toward seeking professional psychological help that was recorded across level of education.
Again, the high levels of self-stigmatization associated with seeking help from professional psychologists as recorded in the study implies that there exist high levels public of stigmatization toward mental/psychological illness. Thus, professional psychologists should make it a priority to join forces with other public mental health agencies to use social media and main-stream radio and TV programs to inform and educate the general public about what mental/psychological illness is and in the process help to destigmatize mental/psychological illness and use of professional psychological services. If measures such as being recommended are not put in place, the worst repercussion will be the loss of jobs for mental health experts like professional psychologists in the near future. Hence there is the need to act swiftly to curtail the challenge of mental/psychological illness stigma in Ghana.

Finally, one key recommendation is that professional psychologists should creatively organize outreach programs in collaboration with the spiritual leaders to make themselves known to the people. This will also enable them to clear some misconceptions about psychotherapists and their services such as the perception that their services are very expensive. This is necessary, as this study revealed that individuals may not be willing to consult professional psychologists as a result of their strongly held cultural beliefs about the supernatural causes of mental/psychological illness.
5.4 Conclusion

Findings from this study indicated that despite the general unwillingness of Ghanaians to seek professional psychological assistance, urban dwellers had a more favourable attitude toward seeking professional psychological help than rural and peri-urban dwellers. In addition, individuals with tertiary educational background were more willing to consult professional psychologists than those with secondary and basic educational backgrounds. Again, it was revealed that the more participants held onto the belief that supernatural forces were responsible for mental/psychological illness the less likely they were to seek help from professional psychologists. Furthermore, participants were less willing to consult professional psychologists as a result of their high self-stigma levels. However, participants health locus of control (internal, chance and powerful others) orientations did not influence their willingness to seek professional psychological help or not. Finally, factors such as the negative misconceptions about the job of professional psychologists, lack of awareness of where to locate professional psychologists, the perception that psychotherapeutic services are very expensive may be contributing significantly to the high levels of unwillingness of Ghanaians to consult professional psychologists for assistance and thus, individuals need to be educated.
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APPENDICES

Appendix I: Ethical Clearance

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)
P. O. Box LG 74, Legon, Accra, Ghana

21st December, 2016

My Ref. No.

Mr. Harry Asamoah-Adjepong
Department of Psychology
University of Ghana
Legon

Dear Mr. Asamoah-Adjepong,

ECH 046/16-17: PREDICTORS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING BEHAVIOUR: A STUDY AMONG URBAN, PER-URBAN AND RURAL DWELLERS IN GREATER ACCRA REGION

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below.

Expiry Date: 13/06/17
On Agenda for: Initial Submission
Date of Submission: 17/10/16
ECH Action: Approved
Reporting: Quarterly

Please accept my congratulations.

Yours Sincerely,

Row Prof. J. O. Y. Mante
ECH Chair

CC: Dr. Maxwell Asumeng, Department of Psychology

Phone: +233-302413068
Fax: +233-302413068
Email: palette@ug.edu.gh | echa@ug.edu.gh

VALID UNTIL 13 JUN 2017
Appendix II: Departmental Introductory Letter

Ref. NRSYC 2/33/02

24th January, 2017

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION
MR. HARRY ASAMOAH-ADJEPOG

The above-named is an M.Phil Clinical Psychology student at the University of Ghana, Legon.

In partial fulfillment of the requirement for the award of the M.Phil degree Mr. Harry Asamoah-Adjepong has to write and submit an original thesis. He has selected the topic: “Predictors of Professional Psychological Help-Seeking Behaviour: A Study among Urban, Per-Urban and Rural Dwellers in Greater Accra Region.”

To enable him collect data for his work he would need to administer questionnaires and/or conduct interviews. He has selected your institution as suitable for his data collection.

Attached is his institutional approval/clearance to enable him carry on with his research work.

Any assistance you may give him would be greatly appreciated.

Yours faithfully,

(Dr. Maxwell A. Asumeng )
HEAD OF DEPARTMENT

COLLEGE OF HUMANITIES
P. O. Box LG 84, Legon, Accra-ghan
• Telephone: +233 (0) 289 550 463  • Email: Psychology@ug.edu.gh  • Website: www.ug.edu.gh
Appendix III

Questionnaire (English Version)

SECTION A
DEMOGRAPHIC DATA

Please tick (√) the appropriate box

1. Sex: Male [ ] Female [ ]

2. Age: 18-30 [ ] 31-40 [ ] 41-50 [ ] 51-60 [ ]

3. Religion: Christian [ ] Islam [ ] Traditional [ ]

Others (please specify) ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………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<th></th>
<th>Predictors of Professional Psychological Help-Seeking Behaviour</th>
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</thead>
<tbody>
<tr>
<td>9</td>
<td>Most things that affect my health happen to me by accident.</td>
</tr>
<tr>
<td>10</td>
<td>Whenever I don’t feel well, I should consult a medically trained professional.</td>
</tr>
<tr>
<td>11</td>
<td>I am in control of my health.</td>
</tr>
<tr>
<td>12</td>
<td>My family has a lot to do with my becoming sick or staying healthy.</td>
</tr>
<tr>
<td>13</td>
<td>When I get sick, I am to blame.</td>
</tr>
<tr>
<td>14</td>
<td>Luck plays a big part in determining how soon I will recover from an illness.</td>
</tr>
<tr>
<td>15</td>
<td>Health professionals control my health.</td>
</tr>
<tr>
<td>16</td>
<td>My good health is largely a matter of good fortune.</td>
</tr>
<tr>
<td>17</td>
<td>The main thing which affects my health is what I myself do.</td>
</tr>
<tr>
<td>18</td>
<td>If I take care of myself, I can avoid illness.</td>
</tr>
<tr>
<td>19</td>
<td>Whenever I recover from an illness, it’s usually because other people (e.g. doctor, nurses, family, friends) have taken good care of me.</td>
</tr>
<tr>
<td>20</td>
<td>No matter what I do, I’m likely to get sick.</td>
</tr>
<tr>
<td>21</td>
<td>If it’s meant to be, I will stay healthy.</td>
</tr>
<tr>
<td>22</td>
<td>If I take the right actions, I can stay healthy.</td>
</tr>
<tr>
<td>23</td>
<td>Regarding my health, I can only do what my doctor tells me to do.</td>
</tr>
</tbody>
</table>

**SECTION C**

**Instructions:** People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale (i.e. where 1 =“strongly disagree, 2 = Disagree, 3 =Neutral, 4 = Agree, 5 = “strongly agree”) to rate the degree to which each item describes how you might react in this situation.
### Predictors of Professional Psychological Help-Seeking Behaviour

<table>
<thead>
<tr>
<th>NO.</th>
<th>STATEMENTS</th>
<th>1 Strongly Disagree</th>
<th>2 Moderately Disagree</th>
<th>3 Slightly Disagree</th>
<th>4 Slightly Agree</th>
<th>5 Moderately Agree</th>
<th>6 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>I would feel inadequate if I went to a therapist for psychological help.</td>
<td></td>
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<td>25</td>
<td>My self-confidence would NOT be threatened if I sought professional help.</td>
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<td>26</td>
<td>Seeking psychological help would make me feel less intelligent.</td>
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<td>27</td>
<td>My self-esteem would increase if I talked to a therapist.</td>
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<td>28</td>
<td>My view of myself would not change just because I made the choice to see a therapist.</td>
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<td>29</td>
<td>Asking a therapist for help would make me feel inferior.</td>
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<td>30</td>
<td>I would feel okay about myself if I made the choice to seek professional help.</td>
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<td>31</td>
<td>If I went to a therapist, I would be less satisfied with myself.</td>
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<tr>
<td>32</td>
<td>My self-confidence would remain the same if I sought professional help for a problem I could not solve.</td>
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<td>33</td>
<td>I would feel worse about myself if I could not solve my own problems.</td>
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### SECTION D

**Instruction**: Please answer each of the following statements by ticking one of the number (1-6) which reflect how you **strongly disagree (1) or strongly agree (6)** with the statement about your belief. The more you agree with a statement, the higher the number you tick; and the less you agree with a statement, the lower the number you will tick (√).

There is no right or wrong answers. 1: Strongly disagree, 2: Moderately disagree, 3: Slightly disagree, 4: Slightly agree, 5: Moderately agree, 6: Strongly agree.

<table>
<thead>
<tr>
<th>NO.</th>
<th>STATEMENTS</th>
<th>1 Strongly Disagree</th>
<th>2 Moderately Disagree</th>
<th>3 Slightly Disagree</th>
<th>4 Slightly Agree</th>
<th>5 Moderately Agree</th>
<th>6 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Should I experience any mental health problem, it must be the work of evil spirits.</td>
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<td>35</td>
<td>If I offend my ancestors, they can cause severe illness to me.</td>
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<tr>
<td>NO.</td>
<td>STATEMENT</td>
<td>0=Disagree</td>
<td>1=Somewhat Disagree</td>
<td>2=Somewhat Agree</td>
<td>3=Agree</td>
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<td>36</td>
<td>Today, evil spirits are causing mental health problems for most people.</td>
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<td>37</td>
<td>Our health is in our control.</td>
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<td>38</td>
<td>No matter what I do, if God decides I should get sick, I will be sick.</td>
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<td>39</td>
<td>Witchcraft practices cause illness to some people.</td>
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<td>40</td>
<td>I believe that curses can cause illness.</td>
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<td>41</td>
<td>Spiritual traditional healers are more potent in healing mental health problems than any other person.</td>
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<td>42</td>
<td>All mental health problems are caused by evil spirits and demonic attacks.</td>
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<td>43</td>
<td>Gods do not cause people to fall sick and die.</td>
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<td>44</td>
<td>If I have not wronged anyone, no matter how worse my medical/psychological condition may be, I will surely recover.</td>
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<td>45</td>
<td>When I recover from illness, it is mainly because some people have been praying for me.</td>
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<td>46</td>
<td>If I get sick, God will determine how soon I will get well again.</td>
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<td>47</td>
<td>Mental Health Professionals cannot help when I have a mental health problem.</td>
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SECTION E

Please respond to the following items as accurately and honestly as possible. Remember that your responses are anonymous and confidential. There are no wrong answers. It is important that you answer every item. For each statement below, decide whether you 0=Disagree, 1=Somewhat Disagree, 2=Somewhat Agree, or 3=Agree.

<table>
<thead>
<tr>
<th>NO.</th>
<th>STATEMENT</th>
<th>0=Disagree</th>
<th>1=Somewhat Disagree</th>
<th>2=Somewhat Agree</th>
<th>3=Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>Although there are clinics for people with mental health difficulties, I would not have much faith in them.</td>
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<td>49</td>
<td>If a good friend asked my advice about a mental health problem, I might recommend that he/ she see a mental health professional.</td>
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<td>50</td>
<td>I would feel uneasy going to a mental health professional because of what some people would think.</td>
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<td>PREDICTORS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING BEHAVIOUR</td>
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<tr>
<td>51</td>
<td>A person with strong character can get over mental health difficulties by him/herself, and would have little need for a mental health professional.</td>
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<td>52</td>
<td>There are times when I felt completely lost and would have welcomed professional advice for a personal or emotional problem.</td>
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<td>53</td>
<td>Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.</td>
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<td>54</td>
<td>I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.</td>
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<td>55</td>
<td>I would rather live with certain mental health difficulties than go through the ordeal of getting professional mental health assistance.</td>
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<tr>
<td>56</td>
<td>Personal and emotional troubles, like many things, tend to work out by themselves.</td>
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<td>57</td>
<td>There are certain problems which should not be discussed outside of one’s family.</td>
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<td>58</td>
<td>A person with a serious emotional disturbance would probably feel most secure in a good mental health facility.</td>
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<td>59</td>
<td>If I believed I was having mental health difficulties, my first inclination would be to get professional attention.</td>
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<td>60</td>
<td>Keeping one’s mind on a job is a good solution for avoiding personal worries.</td>
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<td>61</td>
<td>Having been a mental health patient/client is blot on a person’s life.</td>
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<td>62</td>
<td>I would rather be advised by a close friend than by a mental health professional, even for an emotional problem.</td>
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<td>63</td>
<td>A person with an emotional problem is not likely to solve it alone; he/she is likely to solve it with professional help.</td>
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<td>64</td>
<td>I resent a person—professionally trained or not—who wants to know about my personal difficulties.</td>
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<tr>
<td>65</td>
<td>I would want to get professional mental health attention if I was worried or upset for a long period of time.</td>
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<tr>
<td>66</td>
<td>The idea of talking about problems with a mental health professional strikes me as a poor way to get rid of emotional conflicts.</td>
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</tr>
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<td>67</td>
<td>Having been mentally ill carries with it a burden of shame.</td>
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<tr>
<td>68</td>
<td>There are experiences in my life I would not discuss with anyone.</td>
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<tr>
<td>69</td>
<td>If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in mental health services.</td>
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<td>70</td>
<td>There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to Professional help.</td>
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<td>71</td>
<td>At some future time I might want to have psychological counseling.</td>
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</tr>
<tr>
<td>72</td>
<td>A person should work out his/her own problems; getting psychological counseling would be a last resort.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>Had I received treatment in a mental health facility, I would not feel that it ought to be covered up.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>74</td>
<td>If I thought I needed professional mental health assistance, I would get it no matter who knew about it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and pastors.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Questionnaire (Akan-Twi Version)**

**NSEMISA**

**NKYIKYEMU A EKIKAN**

**WOHO NSEM**

Mepawokyew ticki adaka a ene wo nsusuyɛ efa.

1. Wɔbɔbre  Bɛɛma [ ]  Ṣbaa [ ]
2. Wonfie  Du-nwɔtwe kɔsi Aduasa [ ]  Aduasa Baako kɔsi Aduanan [ ]  Aduanan Baako kɔsi Aduonum [ ]  Aduonum Baako kɔsi Aduosia [ ]
3. Esom a wowom:  Okristoni [ ]  Kremoni [ ]  Atetesɛm sodifɔɛ [ ]  Se esom a wowom no enka neɛɛwɔɛɛso ro yi ho a, twere .................................
4. Nea wadesua koduru:  Mmofra sukuu [ ]  Sukuu Ntoasɔɛ [ ]  Sukuu Kunini [ ]  Menkɛ sukuu da [ ]
5. Bɛbiawo:  .................................................................
Predictors of Professional Psychological Help-Seeking Behaviour

Nhyehyɛɛ: Adeɛ biara a ɛwɔ ɛfam no ɣe gyideɛ asemfua a ɛfa w’adwene mu apomuden gyinapɛn a wo bɛgyi atum anaa wongye ntum.

Adeɛ biara no, wɔbɛ ticki numri a ṣgyina ho ma nsemfua a wogyi di anaa wongy nni. Mpen dodoɔ a wɔbɛgyi asemfua bi atum no, na numri a wɔbɛ ticki no ɛdɛɛso.


<table>
<thead>
<tr>
<th>NUMRI</th>
<th>NSƐMFWA</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>ɛse meyarɛ a, ɣey mea me suba nan ekyerɛ se meho be to me ntem biom</td>
</tr>
<tr>
<td>7</td>
<td>ɛnfa ho ne nea meye bia se mebejɛre a, meyarɛ</td>
</tr>
<tr>
<td>8</td>
<td>ɔkwan paa mefa so a meynarε ne se mekɔ se ɛhu me dɔkɔta</td>
</tr>
<tr>
<td>9</td>
<td>Nnneɛm a dodoɔ a ɛha mapomuden no ɣey nkwanhyia</td>
</tr>
<tr>
<td>10</td>
<td>ɛberɛ biara meho ɛfam no, ɛwɔɛse mekɔ ɔkunini a waben wa apomuden hwe mu</td>
</tr>
<tr>
<td>11</td>
<td>Medi mapomuden so</td>
</tr>
<tr>
<td>12</td>
<td>ɛse meyarɛ anaa meyanarɛ gyina mabusua so paa</td>
</tr>
<tr>
<td>13</td>
<td>ɛse meyarɛ a, mea na ɛwɔ se ɣeyɛbe me soboɔ.</td>
</tr>
<tr>
<td>14</td>
<td>Meti a ɣey di mayaresa mu akotene paa.</td>
</tr>
<tr>
<td>15</td>
<td>Apomuden boafoɔ no di m’apomuden so.</td>
</tr>
<tr>
<td>16</td>
<td>Apomuden a mewɔ no gyina meti a ɣey so.</td>
</tr>
<tr>
<td></td>
<td>Adeɛ pɔɔti a ɛh a m’apomuden ye nneɛma a mea me yɛ</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>18</td>
<td>Sɛ mehwe meho so yie a, metumi ɛsi yareɛ ano kwan</td>
</tr>
<tr>
<td>19</td>
<td>Sɛ meyarɛ na meho ɛm me a na ɛye Anursifɔɔ, Dɔkɔtafoɔɔ, Mafɛfoɔɔ ne Màbusua na ahwe me so yie</td>
</tr>
<tr>
<td>20</td>
<td>Ɛnfa ho ne nea meyɛ biara metumi ayare</td>
</tr>
<tr>
<td>21</td>
<td>Sɛ ɛsɛɛ ɛnɛya apomuden a, ɛmɛnya</td>
</tr>
<tr>
<td>22</td>
<td>Sɛ meyɛ nea ɛsɛɛ meyɛ a, ɛmɛnya mpomuden</td>
</tr>
<tr>
<td>23</td>
<td>Sɛ ɛfa mpomuden ho no, nea apomuden mu bofoɔ beka ɛ ɛnɛya nkɔa na meyɛ</td>
</tr>
</tbody>
</table>

**NKYIKYƐMU A ƐTƐSO MMIENSA**

_Akwankyere:_ Nkurofoɔ hunu amane a wɔrepe ano mmuaɛ ɛnna ne pemasibɛ. Ɛyi betumi ama wahunu sêdeɛ wɔn nneyɛɛ besi aye ɔwɔ bere a wɔre hwehwe mmoa no. Anidie mu ara, fa saa araɛɛ nnum a edidi sɔɔ yi yi nsɛmmisa ahodɔɔ yi ano

<table>
<thead>
<tr>
<th>NUMRI</th>
<th>NSƐNKAƐX</th>
<th>1 METIA PAA</th>
<th>2 MENGYINNI KORAA</th>
<th>3 MENGYINNI</th>
<th>4 MEGYIDI</th>
<th>5 MEGYIDI PAA ARA</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Sɛ megyɛ mмоa firi obi a ωhwe adwene mu yadɛɛ hɔ a, na mabu me ho animtia</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25</td>
<td>Sɛ megyɛ adwenkyɛɛ ɛnna mмоa firi okunini bi hɔ a na ɛnkyɛɛ se mennyɛ me ho nni</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>26</td>
<td>Sɛ megyɛ m моa firi obi a ωhwe adwene mu yadɛɛ hɔ a, ebeyɛ me sëdeɛ mennyim nyansa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Sɛ me ne Oduyefoɔ di nkutaho a, ebɛma ma gye me ho adi kese</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Sedeɛ mesi hunu me ho fa no nsesa se megyɛ mмоa firi adwene mu yadehwefoɔ hɔ a</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUMRI</td>
<td>NSÉMFUA</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>-------</td>
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</tr>
<tr>
<td>29</td>
<td>Sê megye mmoa firi Oduyefoɔ hɔ a, na mabu mɛ ho abomfeaa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Sê meye mädwene sê megye mmoa afiri Okunini bi hɔ a, ebɛma mɛ ho atɔ me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Sê mɛkɔ Oduyefoɔ hɔ a, me ho nntɔ me papa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Sedere megye mɛ ho di fa no nsesa sê megye mmoa ɔwɔ Okunini hɔ bere a mantumi ammoa mɛ ho</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Sê mantumi aŋsɔ mɛ me haw ano a, ebɛ ma mahokyɛre aye kese</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**NKYIKYEMU A ÉTÝSO NNAN**

**Akwankyere:** Anidie mu ara, bere a woreyi nsɛm yi ano yi, yi agyinae ahodoɔ nsia yi mu biako a ebekeyere sedeex wo gyidie teɛ wɔ nsɛnkaɛa edidosɔ yɛ mu: adenkyɛre anaa agyinae nsia no nie:
Efiri mennyɛ nni koraa (1) anaase megyedi paa ara (6) esiane sɛ worebeyi adwenkyɛre no mu biako a ɛkyɛre wo gyedie nti bere a wo ne nsɛnkaɛ korɔ no reye adwene no, na woaginae no nso ɛredɛɛsɔ wo nsɛnkɔrɔ no ara ho. Saa ara na nsɛnkaɛ a wo ne no nnyɛ adwene no na wo agyinasie no nso rete wɔ asɛnkɔrɔ no ara ho (√).

Anoyie biara ye: 1: Metia paa, 2: Mengyinni koraa, 3: Mengyinni, 4: Megyidi, 5: Megyidi kakra, 6: Megyidi yie paa
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>Abayisem de yadeɛ bre nnipa bi nom</td>
</tr>
<tr>
<td>40</td>
<td>Me gyedi se duabɛ nso de yadeɛ ba</td>
</tr>
<tr>
<td>41</td>
<td>Wǝn a wɔyɛ honhom mu ayaresa no nkooa na wɔtumi sa adwene mu yadeɛ sene obiara</td>
</tr>
<tr>
<td>42</td>
<td>Ahonhom mmɔne ne adamoni tumi na ede adwene mu yadeɛ ba</td>
</tr>
<tr>
<td>43</td>
<td>Anyame nketewa no ntumi mfa yadeɛ mmɔɔ nnipa mma wɔn nwu</td>
</tr>
<tr>
<td>44</td>
<td>Se me nyɛɛ obi bone a, yadeɛ biara a ebɛko me no me ho betɛ me, anaase sedeɛ yadeɛ no</td>
</tr>
<tr>
<td></td>
<td>keseɛ teɛ biara ebɛko</td>
</tr>
<tr>
<td>45</td>
<td>Se me yare na me ho ɛɛ me a, na ekyɛɛ se nkurofoɔ rebo mpaeɛ ma me</td>
</tr>
<tr>
<td>46</td>
<td>Se me yare a, Onyankopɔn na ɔnim bere ko a meho betɛme ntem</td>
</tr>
<tr>
<td>47</td>
<td>Akukudamfoɔ a wɔwɔn ɔnɔ wɔwɔ adwene mu yadeɛ no ntumi mmoa me bere a manya adwene mu</td>
</tr>
</tbody>
</table>

**NKYIKYEMU A ETɛSO NNUM**

Anidie mu ara, yi saa nsem yi ano pepɛpe ewɔ nokware die mu seder ese. Mma wo were mfiri se wo anoxye biara yede bɛsie se asumasem a yɛnna no adie mma obiara nhunu se eyɛ wo a. Anoyie biara nni hɔ a ennyɛ nokore. Ehia paa ara se wobeyi nsem no nyinaa ano.

Wɔ nsɛkaɛ a edidi soɔ yi ma yenhunu wadwene se:

0= **Wone no nnyɛ adwene koraa**

1= **ɔkwɔn bi so wo ne no nnyɛ adwene**

2= **Wone no ye adwene kakra**

3= **Wone no ye adwene**
<table>
<thead>
<tr>
<th>NUMRI</th>
<th>NSEMFAU</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ewɔ mɔ sɛ yɛ ayaresabea ma wɔ a wɔ wɔ adwene mu yadeε dɛ, nansɔ mɛnni wɔ mɔ gyidie.</td>
<td></td>
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</tr>
<tr>
<td>48</td>
<td>Sɛ mɛ yɛnko bɛbɛn bɛ bi biau afutuo fa wɔ a wɔ wɔ adwene mu yadeε ho a, mɛtu no fo sɛ mɛnwehwe mɔna wɔakwadare wɔ adwene mu yadeε ayaresa hɔ.</td>
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<tr>
<td>49</td>
<td>Ênam sɛdɛɛ ebinom besi adwene afa me ho nti sɛ me yare a, me ho nsane me sɛ mɛkɔ akukudamfɔ a wɔsɔ adwene mu yadeε hɛ.</td>
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</tr>
<tr>
<td>50</td>
<td>Obi a ne suban yɛ no sɛ onya adwene mu yadeε a, ne ho betumi atɔ no a enhia pii sɛ ɛbɛkɔ wɔ a wɔwehwe adwene mu yadeεɔ nkyɛn.</td>
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</tr>
<tr>
<td>51</td>
<td>Êmmere bi duru nase anidasɔ apa asesa me nhunu nea mɛnnyɛ me ho a, menyɛ afotuo firi akukudamfɔ a wɔnwehwe mɔnɔ wɔ ɔnwehwe wɔ adwene yadeεɔ nkyɛn.</td>
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</tr>
<tr>
<td>52</td>
<td>Ankɔ a ho akɔ sɛm a se sɛ mehemwe mmɔa anaa ayaresɛ afiri saa akukudamfɔ a yɛ hɔ a, na ama ɛho nni mfasɔɔ pii mmɔ obi a ɛte sɛ me.</td>
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</tr>
<tr>
<td>53</td>
<td>Anka mɛfiri me mu aκa mádamasɛm akyɛrɛ obi a ɔbɛtumi abo a me anaa sɛ obi a ɛye me busu a me de me wɛre ahye ne mu.</td>
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</tr>
<tr>
<td>54</td>
<td>Anka medi mádwene mu yadeε yɛ betɛna hɔ akɔ owu o mɛn sɛ mɛfɔ ɔwɛ awɛ ne amanɛɛɛ ne ɛho aeteɛɛ bɛɛv a mehwɛɛ mmɔa afiri ayaresafoɔ ɔhɔ.</td>
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</tr>
<tr>
<td>55</td>
<td>Yɛn haw nw yamanɛɛ ɛwɔ ɛwɛn atenka ho no, ɛnɔ ara na ɛde ne ho ba</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>56</td>
<td>Êhaw ne amanɛɛ bi wɔ hɔ a, wontumi nsane wabusa ho nka ho asem.</td>
<td></td>
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</tr>
<tr>
<td>57</td>
<td>Oniŋa a wɔ wɔ amanenya kesεɛ wɔ natenka ho no ɛbeye ama no anaeε ɛbenya ahɔtɔsɔ kesεɛ paa ara sɛ ɛbɛkɔ bea a yɛwehwe yeadwene mu.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>59</td>
<td>Se megye tum se madwene mpomuden no asesa a, nee ebeba madwene mu ne se mehwehwe mmoa afiri won a wakwadare ayaresa mu.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>60</td>
<td>Se wo mpe se wo dwendwene a, ma wani nkwo adwuma ho.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>61</td>
<td>Se wonya adwene mu yadee a edi wo dem wo woabrab fo mu.</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>62</td>
<td>Memadamfo atu me fo mmom sene se meko adwene mu ayaresafo hco, mpo se yadee no wo cwo matenka mu a.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Onipa a cwo atenka mu haw no ntumi mmoa ne ho wo ayaresa kwan so na mmom cbehwehwe mmoa afiri nimdefo cfo hco.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Won a wacete won saa kwan no so no, won ho ye me abufu paa ara se wo cpe se wo cwo hnu me ntuo mu bere a me wo ahohiahia mu.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Se medwedwen kyee anaase biribi ha me kye a, mepe se won a wakwadare wo adwene mu ayaresa ho no be boa me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>Se meka me haw a cwo adwene mu yadee ho kyere obi a woagye nteee efia adwene mu ayaresa hc a, na manfa kwan papa so anhwehwe matenka ho mmuaee.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>67</td>
<td>Eeye fereee se wadwene mu beka.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>68</td>
<td>Me wo suahunu wo mabrabo mu a, mentumi ne obi nkyee.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Se mewo atenka ho amanee anaee cahaw kesse paa ara wo mabrabo mu a, menyaa ahotsocoy efiri se beee bi wo cco hco a metumi akc ho akc gye ayaresa.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>Won a woctumi de won haw hye won ho wo abre a wonnye mmoa mfiri akukudamfohco ho no,eye a na wo cye ye anibere anaase anika.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>Daakye bi no mpe se megye akwankyre afiri won a wohyehey adwene mu haw hc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>Wo anka sa dwene wo haw ho na wobeye akwankyere afiri adwene mu ayaresafoc hco a, na ekyre se wani dasoc asa.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>Se megye ayaresa anaase mmoa efiri adwene mu ayaresafo ho a, enni kkwan se meye no kataso muomuaso.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Enfa ho ne dee ebehunu se madwene mu ka me, se me hia ayaresa a, menya.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>Eye a na eden se wobka wasumasem akyere won wrasua ade akyiri. Obi te se Oduyefo, Akyerekyerefo, ene aso cofho.</td>
<td></td>
<td></td>
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</tr>
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</table>
Appendix IV: Interview Guide (English Version)

KNOWLEDGE, PERCEPTIONS AND UNDERSTANDING OF PROFESSIONAL PSYCHOLOGICAL SERVICES IN GHANA

DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Sex</td>
<td>Male ( ) Female ( )</td>
</tr>
<tr>
<td>Age</td>
<td>(……………)</td>
</tr>
<tr>
<td>Place of Residence</td>
<td>……………………………………</td>
</tr>
<tr>
<td>Religion</td>
<td>Christian ( ) Islam ( ) Traditionalist ( ) Other ……………………………………</td>
</tr>
<tr>
<td>Educational background</td>
<td>No Schooling ( ) Primary ( ) JHS ( ) SHS ( ) Tertiary ( )</td>
</tr>
</tbody>
</table>

1. In your view, who is a professional psychologist?
2. What are some of the roles of a professional psychologist?
3. Can you explain further the roles of professional psychologists you mentioned?
4. How do you know someone is mentally/psychologically ill? Tell me about it?
5. What do you think causes mental/psychological illnesses?
6. Have you heard of psychological services? Where did you hear of it?
7. Do you know where to locate any psychological service provider?
8. How did you get to know about the place?
9. Tell me what will make you seek help from a psychologist?
10. Have there been instances where you have sought the services of a psychologist before?
11. What is your perception of the cost of professional psychological services?
   - **Probe:** what do you think about the cost of psychological services? How much do you think psychologists should charge? How much do you want to pay for psychological services?
12. What do you think psychologists should do for Ghanaians/people to use their services?
   **Probe:** How do you view Ghanaians’ attitude toward seeking professional psychological assistance?

13. Why do you think being mentally ill carries with it a burden of shame?

14. Do you believe personal and emotional troubles, like many things, tend to work out by themselves? Why?

15. Do you think there are certain problems which should not be discussed outside of one’s family? **Probe:** Tell me some of them?

16. How do you think mental illness can be treated/managed?

17. Do you think your Pastor/Mallam/Traditional priest can treat mental illness?

18. How does your Pastor/Mallam/Traditional priest treat mental illness?
   **Probe:** Please explain how your religious leaders help persons with psychological distress/crisis. How does the treatment regimen (eg. Prayers, fasting, counseling, deliverance, etc) works?

19. Is there anything else you would like to talk about that I have not mentioned?

**DISCLOSURE**

- How did you feel being interviewed?
- Are there any questions you want to ask me?
- Are there aspects of these issues we have discussed that you wish was done or asked in another way? If any, tell me some of them?

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**Interview Guide (Akan-Twi Version)**

**NTOTOANO NHWESO**

**NIMDEF, ADWENE NE NTEASEF A ƐWƐ ADWENE MU HO DWUMADIE A ƐWƐ
GHANA**

**WOBŒBRŒ HO NSEM**

Wobosuo: Barima ( ) criptor ( )

Nfie: (.........)

141
PREDICTORS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING BEHAVIOUR

Baabi a wote:

Nyamesom: Kristoni ( ) Kramoni ( ) Atetesem sodi ( ) Deɛ Ekėka ho ………………..
Deɛ wadesua koduru: Menkɔ sukuu da ( ) Mmofra sukuu ( ) Sukuu Ntoasɔ ( ) Sukuu Kunini ( )

- Wo w’adwene mu no, hwan ne obia ɔhwɛ adwene mu yadeɛ?
- Ne dwumadie bi ne sɛn?
- Wobɛtumi akyɛɛkyɛɛ ne nnwumadie no mu bi yie paa ara?
- Ẹdeɛn na ęde adwene mu yadeɛ ba?
- Ẹdeɛn na ɛda adi ma wo hunu obi a n’adwene mu ka no anaa ɔɔɛ cɛ adwene mu yadeɛ?
- Woate mmoa ahodɔɔ a wɔn a ɔhwɛ adwene mu yadeɛ de ma? Ehen na wote firiɛ?
- Woakɔ adwenemuhweɛɛfoɔ ɛɛ ɛn akɛgyɛ mmoa?
- Wonim faako a obia ɔhwɛ adwene mu yadeɛ wɔ?
- Ẹyeye ɛn na wo hunuu ho?
  - Ẹdeɛn na ebɛma woakɔ gye mmoa ɛfiri adwenemuhweɛɛfoɔ ɛɛ?
  - Wo ɔrawleru mwo no, ɛ ɛwɔkɔ obia ɔhwɛ adwene mu yadeɛ ho a, sika sɛn na ɛsɛ wotua?
  - Bisabisa mu yie: sika sɛn anaa ɛbɔɔ bèn na ɛsɛ sɛ cɛɛ ɔwɔ? Sika sɛn wɔpe sɛ wotua?
  - Ẹdeɛn na wosusu sɛ adwenemuhweɛɛfoɔ ɛye a ebɛma Ghanafɔɔ akɔ wɔn nkyɛn akɛpɛ mmoa?
  - Ẹn na wohunu Ghanafɔɔ ahɔkeka ne wɔn nneyɛɛɛ ɛfa obi a ɛɛpɛ sɛ ɛɔkɔ gye mmoa firi obia ɔhwɛ adwene mu yadeɛ ho?
  - Adɛn nti na ɛye fɛɛ se obi bɛhunu se obi wɔ adwene mu yadeɛ?
  - Wo gyedi ɛɛ yɛɛ amaneɛ ne yɛɛ haw a ɛwɔ yɛɛ atenka ne yɛɛ ahonim mu no, ɛnɔ ara na ɛdɛ ne ho ba? Adɛn?
  - Wo dwene se ɔhwɛ na amanɛɛ bi wɔ ho a wo ntumi nsan abusua ho nka ho asem? Bobɔ saa
    ɔhwɛ anaa amameleonbi bi kyɛɛ me.
    - ɔkwan bèn so na wɔdwene se ɣɛbɛfa so asa adwene mu yadeɛ anaa se wɔbɛɛsa wɔn
      yadeɛ?
    - ɔkwan bèn so na ɔsɔfo/Mallam/ɔkɔmfo fa so sa wɔn a ɔwɔɛɛɛ adwene mu yadeɛ?
    - Anidie mu ara, kyɛɛ ɔkwan a ɔsɔfo anaasɛ Nyamesofɔɔ adikanfoɔ fa so boa wɔn a
      adwene mu yadeɛ adi wɔn nya.
PREDICTORS OF PROFESSIONAL PSYCHOLOGICAL HELP-SEEKING BEHAVIOUR

✓ Ko so ara na bias ɔkwɔn a saa mmoa no fa so di dwuma. Ebi ne, mpaebo, akɔnyene, afotuo, ɔgyee ne de ɛtete saa.

DEɛ EDɛ ADIE

• Berɛ a metoto wo ano yi, w oho ye wo stɛn?
• Nsemisira bi wo ho a wopɔɛ wo bisa me?
• Nsem a ye\ adwendwene ho yi wo wo asɛm bisa bi wo ho anaa, anaasɛ wopɔɛ sɛ wo da no adie ɔkwɔn fofoɔ bi so?