

UNIVERSITY OF GHANA
DEPARTMENT OF PSYCHOLOGY

DETERMINANTS OF SEEKING PROFESSIONAL
PSYCHOLOGICAL HELP IN CONTEMPORARY GHANA

BY

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DECLARATION

I, Stella Serwaa Boafo, confirm that this work is my own and has not been presented by anyone for any academic award in this or any other University. All references used in this work have been fully acknowledged.

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We hereby certify that this thesis was supervised in accordance with procedures laid down by the University.

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DEDICATION

To God Almighty



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ABSTRACT

This study examined the determinants of seeking professional psychological help among contemporary Ghanaians. Specifically, the study investigated whether experience with mental health service, perceived social support (family, friends, and significant other), health locus of control (internal, chance, and powerful others), self-stigma, and cultural belief would uniquely and significantly account for attitudes toward seeking professional help after controlling for demographic characteristics and the other variables. Three hundred and fifty-four respondents were conveniently selected from Accra College of Education, a teacher training institution. Findings of the analyses revealed that none of the demographic characteristics predicted attitudes toward seeking professional psychological help. Furthermore, it revealed that experience with mental health service, family social support, friend social support, internal health locus of control, and self-stigma did not uniquely and significantly predict attitudes towards seeking professional help after controlling for other variables like demographic characteristics. However, chance health locus of control, powerful others health locus of control, and cultural belief were found to uniquely and significantly predict attitudes towards seeking professional help. Implications and recommendations of the findings are made for the clinicians and mental health professionals.

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CHAPTER ONE

INTRODUCTION

“Today’s increasingly demanding world presents us with many challenges. Sometimes we are able to cope on our own or with the help of family and friends. Sometimes life’s stresses become too much to handle and talking to a Clinical Psychologist, who is a skilled professional, does help” (Progressive Life Centre- Ghana).

1.1 Background of the Study

Understanding factors that influence help-seeking is a significant step toward improving the mental health of any community. Help-seeking is normally used to denote the behaviour of one actively seeking help from others which is, communicating with other individuals to attain help such as advice, information, treatment and general support in response to a problem (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

The awareness of psychological or mental disorders as an influential cause of morbidity is increasing globally. This has come about as there is a steady decline of morbidity due to nutritional disorders, communicable and other physical illnesses particularly, in countries going through epidemiological change and a shift to non-communicable diseases that were then the prevailing health problem (Mohammed, Zubair, Isa, & Muktar, 2004). Of ten (10) principal causes of disability throughout the world, five (5) are psychological or psychiatric illnesses related (Murray & Lopez, 1996). Mental health is defined as a state of well being in which every individual realizes his or her own potential, can cope with the normal stresses of life and is able to make a contribution to his or her community (World Health Organization [WHO], 2001). Mental health is therefore, more than just the “absence of disease” but includes a state of complete physical, mental and social well-being (WHO, 2001). In simple terms, mental health refers to a

person's health of the mind (Kozier, 2008). Thus, the impact of social, cultural, physical, and education can all affect an individual's mental health (Kitchener & Jorm, 2002).

Mental health is equally important as physical health and the two are closely linked. Studies have shown that when a person experiences a mental health problem, there is an increased risk of developing a physical health issue (Schniederma, 2007). Mental health problem is said to be a variety of mental health difficulties, which range from psychological distress to more severe mental health disorders. Globally, about three hundred and forty million people suffer from mental or psychological disorders, with the majority living in the developing world like Ghana (Fahad, Fahad, Hiba, & Kamila, 2006). It is estimated that approximately 25% of world's population will experience a mental health or behavioural problem at any given time (WHO, 2002). For instance, depression affects more than four hundred and fifty million people and is projected to become the second most significant cause of disability by 2020 (Omar, Green, Bird, Mirzoev, Flisher, Kigozi, Lund, Mwanza, & Ofori- Atta, 2010).

Again, it is estimated that the global burden of the disease from mental or psychological illness will increase from 12% to 15% by the year 2020 (Fahad et al., 2006). Evidence suggests that closely half the world's population suffers from some form of mental or psychological disorders which have an impact on their self-esteem, relationships and ability to function in their everyday life (Storrie, Ahern, & Tuckett, 2010). This is where the need for professional psychological services or help becomes important. Professional psychological help-seeking could be based on a number of psychological distressing problems in which the individual finds himself or herself but cannot deal with and would need some form of formalized help to aid the individual to solve, cope or manage the distressing problem. Decision of help-seeking starts the moment the individual

begins to notice and define the problem, then decides to seek-help and finally choosing the right treatment path (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002). The present study therefore, seeks to explore the variables that determine one's help-seeking behaviours. These include health locus of control, self-stigma, perceived social support, and cultural beliefs of the cause of disorder.

Psychological help-seeking or the process of how individuals come to seek assistance for psychological or mental health problems has been conceptualized by Wills and DePaulo (1991) as a coping mechanism aimed at alleviating emotional discomfort by voluntarily making contact with formal or informal system(s) of care.

Attitudes, intentions and behaviours are the categories on which help-seeking researches could be based. Personal and situational characteristics that are related to favourable psychological help could be identified with help-seeking attitudes. Help-seeking intention tries to determine the conditions under which people are willing or likely to seek help for psychological or mental health problem(s) while help-seeking behaviours could be communicating with other people to obtain help in terms of understanding information and general support in response to a problem or distressing experience (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

Help seeking is a multi-faceted topic, and acceptance of help-seeking is a crucial bridge between the onset of the psychological or mental health problem(s) and the professional psychological help sought. People depend on a number of factors including a person's beliefs (self-stigma and health locus of control), attitudes towards help-seeking, perceive social support, and help-seeking decision among others, before seeking help for psychological or mental health problems.

Psychosocial factors such as the degree of severity of one's problem and likely self disclosure also predict an individual's help-seeking behaviour. Help-seeking behaviour can also be influenced by how people define a problem and by what they perceive to be the cause and anticipated prognosis (Angermeyer & Dietrich, 2006). Available research evidence such as that of Eisenberg, Golberstein, and Gollust (2007) suggests that when people first develop psychological or mental health problems, they may not identify their problem as psychological or mental disorders that require treatment and may be reluctant to seek help.

Rickwood and Braithwait (1994) asserted that people are generally hesitant or reluctant to seek psychological help and there are indications that many individuals who suffer from psychological or mental problems do not seek professional psychological services. Some researchers have identified contributing factors to people's reluctance to seek psychological services. These include locus of control, perceived social support, fear of emotional disclosure, and cultural barriers (Barwick, de Man, & McKelvie, 2009; Rickwood & Braithwait, 1994; Tata & Leong, 1994; Vogel & Wester, 2003).

Self-Stigma and Help-Seeking Behaviours

Mental health disorders have been spurned in Africa and there are numerous reports of a higher prevalence of stigma towards mental health in developing countries including Ghana than in the first world countries (Barke, Nyarko, & Klecha, 2010). The "stigma associated with seeking mental health services is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable" (Vogel, Wade, & Haake, 2006, p. 325).

Alonso et al. (2008), and Sartorius and Schulze (2005) have indicated that there is a growing evidence of stigmatization of people with mental disorders worldwide. Studies by Lai, Hong, and Chee (2001), and Lee, Chiu, and Kleinman (2005) have shown that mental illness is more stigmatizing than physical illness. For instance, more stigmatizing attitudes are extended toward individuals diagnosed with mental illness such as depression, eating disorders (Corrigan, River, Lundin, Wasowski, Campion, Mathisen, Goldstein, Bergman, & Gagnon, 2000.; Mann & Himelein, 2004) among others but less towards physical illness. Perceived stigma seems to be cross-culturally influenced with developing countries exhibiting it more commonly than developed countries (Alonso et al., 2008). Recent research has shown that stigma is significantly associated to mental health (Mak, Poon, & Cheung, 2007).

Stigma linked with mental health treatment could be a significant factor in people's decision not to seek for professional help and there has been a great deal of research indicative of the strong stigma attached to mental disorders and seeking psychological services (Brown & Bradley, 2002; Gonzalez, Tinsley, & Kreuder, 2002; Sadow, Ryder, & Webster, 2002; Vogel, Wade & Haake, 2006). Thus, many individuals would hesitate to use mental health or psychological services to prevent them from being labelled as 'mental patients' and not to suffer any negative consequences that are linked with stigma of mental illness (Corrigan & Rusch, 2002). The stigma construct could be divided into two; self-stigma and perceived or public stigma (Vogel, Wade, & Hackler, 2007). Self-stigma, according to Van Brakel, Anderson, Mutatkar, Bakirtzief, Nicholls, Raju Das-Pattanayak, (2006), is an internalized stigma. It can also be defined as a perception of oneself being weak if the individual seek psychological help (Vogel, Wade, & Haake, 2006). An individual who perceives fear of losing self respect or self-esteem as a result of seeking help may likely not seek help even if the person needs help.

Most researches focused had been on self-stigma associated with mental illness. Findings from these studies indicated that negative interactions from others, along with largely negative perception of mental illness in the media, seeks to lower a person's self-esteem and self-efficacy (Corrigan, 2004), and also have a negative impact on mental health (Mak, Poon, & Cheung, 2007). The present study focuses on the self-stigma because it occurs when people have internalized their perceived stigma which affects the sense of self negatively. This becomes a barrier in their decision to seek psychological help.

Health Locus of Control and Help-Seeking Behaviours

In the quest to seek help for psychological problems, one's location of control may be an important factor. That is to say, one's decision or volitional behaviour of help seeking may depend on the person's locus of control. Health locus of control (HLC) was found to predict help-seeking behaviours, and individual differences in HLC have also been linked with the performance of important health behaviours. Locus of control refers to a person's assumed responsibility for his or her successes and failures (Rotter, 1954, 1975). Individuals with perceived internal locus of control believe they are in control of their lives and therefore, take responsibility of what happens to them. On the other hand, those with perceived external locus of control believe that outside forces, fate or chance circumstances control their lives.

This theory was first defined as a generalized perception of the control that individuals had over events that affected their lives (Rotter, 1975). Based on the theory's application to health behaviours, Wallston, Wallston, Kaplan, and Maides (1976) developed and popularized the theory of health locus of control, which was seen as an individual's attributions of responsibility for his or her physical and mental well-being. This was based on Rotter's belief that health

behaviours were closely entwined 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 indicated that the health locus of control assessed two different personality variables; health internal and health external. Individuals were tagged as 'health internals' if they believed that they were in control of their health or conversely as 'health externals', if they believed that powerful or outside, fate or chance is essentially responsible for their health outcomes. Evidence available suggests that internals were sensitive to health messages and were less prone to psychological and medical problems in relation to externals. This suggested that it is likely internals had more beliefs of personal capabilities affecting their lives.

Social Support and Help-Seeking Behaviour

Social support does not lend itself to a single definition, but may be generally defined as a range of interpersonal relationships or connections that have an impact on the individual's functioning (WHO, 2007). Social support has three sub-types; perceived support, enacted support and social integration (Barrera, 1986). Perceived support indicates the individual's subjective judgment of help to be offered in times of need. Enacted support is the specific supportive action offered by providers in times of need. While, social integration is the extent to which the individual is related or linked within a social network (Barrera, 1986).

Social support may be received from informal sources such as friends and family and formal sources such as counsellors, clinical psychologists and psychiatrists. Evidence available suggests a link between social support and help-seeking behaviour (Barrera, 1986; Cohen & Wills, 1985) and has a great influence on one's help-seeking decisions (Vogel, Wade, Wester, Larson &

Hackler, 2007). Norman, Malla, Manchanda, Harricharan, Takhar, & Northcott, (2005) reported that among schizophrenics, those with low social support have more symptoms of the disorder. Again, there are more suicidal ideation, alcohol and drug problems with individual's low social support (Lakey, & Cronin, 2008). A study by Friedlander, Reid, Shupak, and Cribbie (2007) on 128 first year undergraduate students, found that students who perceived that their social resources increased had lower level of psychological problems.

There are differentiations in sources of help according to the different stages of the lifespan (Rickwood et al., 2005) and relationships with friends are important in early adulthood (Bee, 1994). Friends could be helpful in help seeking decisions. But support provided by a professional is more suitable for the person than one provided by friends (McLennan, 1991), since some problems need professional intervention and friends and other informal sources are reported to be the main discouraging factor from seeking professional help (Setiawan, 2006). The current study focuses on the perceived social support, which help us to understand the individual's subjective judgment of help to be offered in times of need.

Cultural beliefs and help-seeking behaviour

Culture can be defined as an incorporated pattern of behaviour which consists of language, thoughts, customs, beliefs, values, and ethnic grouping of a society (U.S. Department of Health and Human Services [DHHS], 2001). Laungani (2004) asserted that culture involves shared characteristics including religion, heritage, language and values that differentiate one group of people from another. This definition is consistent with American Psychological Association's (2003) definition which indicated that culture is the shared learned behaviour and belief systems and value orientations that influence customs, norms, practices and social institutions. Kroeber and

Cluckhohn (1983) described culture as the sum total of a society's custom, habits, beliefs and values. Therefore, culture can be said to be the learned, shared and transmitted values, beliefs, norms and life and practices of a particular group that guide thinking, decisions and actions in patterned ways (Leininger, 1985). Brown (2000) opined that societies cannot exist without culture and so culture needs to fulfil both biological and psychological needs which contribute to certain behavioural patterns in human beings.

Culture does affect all spheres of health and illness, including the perception of it, explanations for it, and the behavioural options to promote health or relieve suffering (Saint Arnault, 2009). Differences in health behaviours will vary among people of various cultures. Social scientists assert that beliefs are shaped by culture, and to understand the beliefs and value systems of people, there is a need to look at the culture within which such beliefs were formed (Harris, 1998; Nuckolls, 1998). Cronk (1999), on the other hand believes that every individual is unique and all of an individual's behavioural features cannot accurately predict on the stereotype assumptions inherent within simplified definitions of culture and behaviours alone. Culture is the framework within which values are formed and values in turn shape the beliefs that determine behaviour. The cultural beliefs of Africans were embedded in their religion. This is affirmed by Abotchie (1997) that among the West Africans, religion is a way of life, which occupied the whole person's life, which health is no exception.

People from all cultural setup seek help for their distress, based on the meaning that their culture gives to the problem (distress). Cultural beliefs about the aetiology of mental illness do influence the decision of help-seeking. For example, perceived spiritual aetiology influences spiritual help (Twumasi, 2005). Ancient Africa had strong beliefs about supernatural forces.

Traditional African society's strong beliefs in the existence and activities of supernatural agents such as witches, ancestral spirits, sorcerers and diviners among others are still strong, and it is intensely believed that individual's wellbeing can be influenced through the cunning manipulation of these agents (Odejide & Oyewumi, 1989). Mental health problems and death are among the perceived as major causes of life misfortunes among African include the activities of these supernatural agents (Makinde, 1985).

In ancient times, and probably up to date, most treatments of illnesses including mental health problems involved magico-religious elements because there was the strong belief that supernatural powers caused illness (Twumasi, 2005). For instance, if one would believe that an individual suffering from clinical depression is being tested by a higher power to ascertain the person's strength of character or that a psychotic episode is a sign of evil possession, then in such situations, the individual might consider psychological services, which focus on cognitions and behaviours as being basically ineffective (Tata & Leong, 1994). This is also evident in Osei's (2001) research on kinds of psychiatric disorders that were found at the traditional shrines, and Nonye, Ekwueme, and Oseloka (2009) on health seeking behaviours of mentally ill patients of Enugu- Nigeria.

Therefore, differences in causal beliefs may influence a person's decision to seek help and whether, professional psychological help is sought. Opinion in recent years suggested a falloff in these beliefs due to growing influence of Western civilization and probably missionary religions (Simpson, 1980). But there is a strong argument to the contrary and most African scholars professed that despite the influence of Western civilization, the real test comes in times of trouble including mental or psychological problems. A huge percentage of Africans, irrespective of their educational level still consult traditional healers or spiritualists (Makinde, 1985; Morakinyo & Akiwowo, 1981).

It is difficult to identify which factors are influential in seeking professional psychological help. Cultural beliefs, health locus of control, self-stigma, and perceived social support are among the extensive list of factors influencing help-seeking behaviour and so realizing that professional psychological help seeking could be influenced by these variables or predictors of the individual, the present study will explore variables that predict people's help-seeking behaviours.

1.2 Statement of the Problem

Mental health involves finding an equilibrium to all aspects of life; physical, mental, emotional and spiritual (Haque, 2005). Mental well-being is said to be influential in quality living and personal growth (Mental Health America, 2007). However, people often take mental health for granted and fail to acknowledge the elements of mental well-being until problems and distresses surface. When problems and distresses surface that is where professional psychological services are needed.

As a nation develops and urbanizes, life becomes more complicated and problems associated with social, cultural, and economic changes arise. Ghana, a fast-growing country, and with the rapid growth of the country, the population, especially those living in the urban areas, often strives to cope with the fast pace of change, and the high stress and tension faced at work, school and in society. Stress and unhealthy lifestyles often contribute to complex health problems, including mental health problems. In Ghana, a rough estimate of about two million, eight hundred and sixteen thousand (2,816,000) people are suffering from moderate to severe mental disorders and it is projected that only 1.17% receive treatment (WHO, 2007). Mental health problems usually surface early in life, are linked with adverse academic, occupational, health, and social outcomes (Breslau, Lane, Sampson, & Kessler, 2008; Kessler, Walters, & Forthofer, 1998), hinting that timely and effective therapy may offer significant long-term benefits.

Research evidence supports the view that psychotherapy, a form of psychological help is beneficial to clients and improves the person's overall health status (Buetler, 2007; Lambert & Bergin, 1994; U.S. Department of Health and Human Services, 1999). Receiving mental or psychological healthcare for mental health issues does often lead to a positive self-worth and satisfying relationships (Buetler, 2007). It had also been found that at the end of psychological treatment as compared to those who remain untreated; approximately eighty percent (80%) of psychological treatment receivers have reduction in psychiatric symptoms (Smith, Glass, & Miller, 1980). In another development, a three year longitudinal study of non-help-seeking third graders revealed that as the number of depressive symptoms increased, the reciprocal relationships and perceived quality of interpersonal relationships decreased (Rudolph, Ladd, & Dinella, 2007).

Furthermore, research revealed that psychological help-seeking behaviours could be influenced by certain variables such as perceived social support and stigma among others. The existing literature consistently indicated that less than a third of those who experience psychological distress seek professional help (Andrews, Issakidis, & Carter, 2001) and even though, there are evidences supporting the effectiveness of psychological treatment to mental health disabilities, these individuals seem hesitant or reluctant to seek psychological help.

Despite the fact that there have been many researches on help-seeking behaviours, these studies have been predominant among the European, American and Asian countries with no or limited research on Africa and Ghana is not an exception. These researches have even reported significant differences between Asians and Americans attitudes toward seeking psychological help (Atkinson, 2007). It is imperative to examine the current state of evidence in Ghana to ascertain the variables that predict/influence help seeking behaviours among contemporary Ghanaians. Hence the study.

1.3. Aims of the Study

This current study was to explore determinants of seeking professional psychological help among young adults (20-35 years) population of tertiary institutions in Accra. Hence, the study was guided by six main aims. The first aim was to examine whether experience with mental health service would significantly account for attitudes toward seeking professional help after controlling for demographic characteristics.

The second aim was to investigate whether, after controlling for demographic characteristics and experience with mental health service, perceived social support (being family, friends, and significant other) would significantly account attitudes toward seeking professional help

The third aim was to examine if health locus of control (internal, chance, and powerful others) would significantly account for attitudes toward seeking professional help after controlling for demographic characteristics, experience with mental health service, and perceived social support (family, friends, and significant other).

The fourth aim also investigated if self-stigma would significantly account for attitudes toward seeking professional help after controlling for demographic characteristics, experience with mental health service, perceived social support (family, friends, and significant other), and health locus of control (internal, chance, and powerful others).

The fifth aim was to find out if cultural belief would significantly account for attitudes toward seeking professional help after controlling for demographic characteristics, experience with mental health service, perceived social support (family, friends, and significant other), health locus of control (internal, chance, and powerful others), and self-stigma. Lastly, this study aimed to

account for all the factors that significantly predicted attitudes toward seeking professional help among Ghanaians.

1.4 Significance of the Study

Psychology affords us an opportunity to understand human behaviour and predict activities which help in the reduction of incidence of disorders in the population by concentrating on groups of healthy individuals or individuals at risk for developing one or more problems. Therefore, this study is to offer an understanding of determinants of individuals' psychological help seeking behaviours (Health locus of control, perceived social support, stigma, and cultural beliefs).

People may be in need of psychological help, but they may not prefer to seek professional help but rather seek help from their friends and family members. So decision of seeking professional help may be influenced by their social network. Therefore, by exploring the effects of social support on help-seeking behaviour, more information may be obtained about help-seeking behaviour of contemporary Ghanaians.

The study is also significant for clinical psychologists, counsellors among others to be aware of certain factors influencing or predicting help seeking behaviours of clients, this may assist them in their helping relationship. Again, this may be useful in the development of appropriate therapies, counselling service and effective intervention strategies to increase the amount of seeking psychological help which will in turn improve mental health status of clients. It will be useful to explain how individual's cultural beliefs influence/predict the help and resources they sought.

If the study reveals that stigma to treatment affects mental health services sought, probably the Ministry of Health; the governing health ministry in Ghana could mount a strategy that would make psychological services attractive to the populace. This could help individuals who need psychological services to have them. Currently, the literature that exists in this area is sparse. Therefore, the present study will contribute to the existing limited knowledge about help seeking behaviours of contemporary Ghanaians.

CHAPTER TWO

LITERATURE REVIEW

The review of literature involves the systematic identification, location and analysis or ‘digging’ of documents containing information related to the research problem. It makes the researcher aware of the various contributions scholars have made in relation to the problem. This chapter, therefore, attempts to present a review of the literature that explores determinants of seeking professional psychological help. It would also include a review of the literature that has facilitated the conceptual models of understanding volitional help seeking behaviour.

2.1 Theoretical Framework

This current study basically used three theories which are Reasoned Action, Attribution Theory, and Biopsychosocial’s model to clarify help-seeking behaviour since they have directed much of the volitional help-seeking behaviours.

2.1.1 Theory of Reasoned Action

The Theory of Reasoned Action (TRA) is a behavioural prediction theory and widely used to explain, understand and predict the determinants of health behaviour and help-seeking (Ajzen & Fishbein, 1980; Montano, Kasprzyk, & Taplin, 1997). This theory of reasoned action was developed by Ajzen and Fishbein (1980). It has been an influential theoretical framework that has been successfully used to predict a number of health-related behaviours such as alcohol abuse, weight loss, and mammography screening among others. It has been applied to understanding mental health related behaviours such as predicting intention to seek professional

psychological help for mental health problems (Bayer & Peay, 1997).

TRA was designed to predict intention or willingness to seek help and offered an association between beliefs, attitudes, intention, and behaviour. It was based on two basic assumptions being 1) Behaviour is under volitional control and 2) People are rational beings. This suggested that individuals behave in a particular way because they choose to do so and will use a rational decision-making process in their choice and planning of their actions (Ajzen & Fishbein, 1980). Therefore, an action can be understood as a product of one's attitude toward the behaviour and the person's intention to carry out the behaviour.

TRA posits that an individual's volitional behavioural intention depends on the individual's attitude about the behaviour and subjective norms surrounding the performance of the behaviour. Underlying a person's behavioural intent are the individual's positive or negative attitudes about the performance of a behaviour which is determined by an assessment of one's beliefs concerning the consequences arising from behaviour. For instance, if an individual anticipates a constructive outcome for certain behaviour such as seeking help will lead him not to feel worried anymore, then the person will see help seeking as a good thing but if opposite, then seeking help is a bad thing (Bayer & Peay, 1997). Subjective norms refer to the individual's perception of whether significant others to the individual think that the behaviour should be performed then that behaviour would be done (Ajzen & Fishbein, 1980). For instance, in Ghanaian setting, significant other plays a vital role in influencing an individual to seek help.

A revised version of TRA included a 'perceived control over behaviour' and referred to as the Theory of Planned Behaviour (TPB; Ajzen, 1985). TPB was introduced to explain non-volitional behaviour for predicting behavioural intention and actual behaviour, which critics believed TRA did not clearly give the explanation that behavioural intention does not always lead to actual behaviour (Ajzen, 2005). TRA hypothesized that the best predictor of future behaviour or distal outcomes are behavioural intentions, and behavioural intentions are directly linked with attitudes and subjective norms of any group for a specific phenomenon. The ultimate object of TRA is predicting behaviour and behaviour is influenced by the intention to perform the behaviour. From this standpoint, attitudes are separate from intentions but are the most significant determinants of intentions (Ajzen & Fishbein, 1980). Studies have shown that the best predictor of help-seeking intent and decision-making is the individual's attitude towards seeking professional help (Bayer & Peay, 1997). In the present study, the theory of Reasoned Action explains that people are rational beings and their behaviours are under volitional control. By this theory, people's actions can be understood as a product of their attitudes towards the behaviour and their willingness to carry out the behaviour.

2.1.2 Attribution Theory

Similar to any behaviour, the core of health behaviour and help-seeking is attribution, which explains the causal process used to understand the world. Attribution theory is primarily a model of human motivation and emotion based on the belief that individuals search for causal understanding of everyday events (Weiner, 1980, 1995). Attribution plays an essential role in deciding an act and decision-making of an action which differs across cultures (Anderson, 1999; Morris & Peng, 1994). Individuals of different cultural backgrounds make different attributions of illness, health,

and help-seeking (treatment). For example, African Americans may be likely to attribute illness externally to destiny or the will of God (equity attributions) and believe in the healing power of prayer (Gregg & Curry, 1994; Klonoff & Landrine, 1996), so may not seek help from a mental health professional when in need of one, compared to western population. Africans, on the other hand, may likely attribute mental illness to spiritual or social cause rather than physiological or scientific cause (Madge, 1998; Twumasi, 2005). An instance of a study of Ethiopians indicated that they attributed mental illness to cosmic or supernatural causes such as curses or spiritual possession (Mulatu, 2000). The Attribution theory explains in this study that individuals search for causal understanding of their everyday events. This helps them to decide which treatment regimen they would subscribe to when in need of help for mental/ psychological problems.

2.1.3 Biopsychosocial Model to Help-Seeking Behaviour

The biopsychosocial (BPS) model is concerned with biological, psychological and social factors, which play an important role in human functioning in connection with health, illness and health care delivery (Santrock, 2007). This model was developed by Engel (1977). The biological element explains how the cause of illness generates from the functioning of the individual's body. The psychological element searches for psychological causes for a health problem, for example, emotional trauma and negative cognitive thought. The social aspect examines how different social factors such as culture, socioeconomic status, social support, religion among others can influence health.

The BPS model of health is based on Social cognitive theory. It addresses the argument of the 'mind-body connection' which could be understood on the philosophical premise that the working

body can affect the mind and vice versa (Halligan & Arylward, 2006). Therefore, the elements need to be handled together as a growing body. The client's perceptions of health and threat of disease as well as obstacles in the social or cultural environment influence the client's engagement in treatment behaviour (DiMatteo, Haskard, & Williams, 2007). Biopsychosocial model is relevant to this present study because it helps us to understand the interaction of biological, psychological and social factors in help-seeking behaviours.

2.2 Review of Related Studies

Several studies (reviewed in this section) for the past two decades have in one way or the other touched on an aspect of these variables (cultural belief, demographic characteristics, experience of mental health service, social support- family, friends, and significant other- health locus of control- internal, chance, and powerful others and self-stigma) and its influence on attitudes towards seeking professional help. The following subsections, therefore, capture in detail the various studies done on attitudes towards seeking professional help.

2.2.1. Health Locus of Control and Attitudes towards Seeking Professional Help

A study by Tjihuis, Peters, and Foets (1990) examined the relationships between personality characteristics, demographic characteristics and network characteristics and orientation to help-seeking. Data was collected as part of the National Study of Morbidity and Interventions in General Practice. The study was made up of 10, 171 respondents of age 18 years who were randomly selected as part of 100 participants per participating general practitioner (GP). The analysis revealed that most people are prone to seek help for one or more emotional problems with people who are more prone to seek help being younger, have had more education, and have a

higher family income. They have more often acquaintances working in mental health care. It was also found out that people who are more prone to seek help do not see chance as the locus of control of health. The groups of people who are more willing to seek help from the GP compared to mental health professionals cannot be distinguished by these expectations. People who are more prone to seek help from a GP have a lower educational level.

Drawing on a college and community sample, Andrews, Tres Stefurak, and Mehta's (2011) study utilised hierarchical multiple regression to examine 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. Those holding a graduate degree, and those with treatment experience held more positive attitudes towards psychological help-seeking. While neither the locus of control nor religious problem-solving scales alone were related to help-seeking, several significant interaction effects were observed. It appeared that only older participants who had a more God-centred locus of control expressed a greater willingness to seek professional psychological help than older participants with less of a God-centred view of personal control. In other words, God-centred locus of control was a positive predictor of psychological help-seeking, but only for older participants. Chance locus of control was a negative predictor, but only for graduate degree holders. Last, self-directing religious problem-solving style was a negative predictor, especially for individuals also endorsing a deferring religious problem-solving style. Perhaps the composition of the sample—largely educated, religious African-American women gives some insight into the complex nature of these results (Andrews, Tres Stefurak, & Mehta, 2011).

White, McQuilian, Greil, and Johnson (2006) conducted a study which used data from a study of 196 infertile women from the Midwestern US to examine a general theory of help-seeking behaviour applied to infertility. The authors posited a model in which a cognitive dimension (perceived infertility) mediates between these predictors and medical help seeking. Symptom salience (experienced infertility while actively trying to get pregnant), low parity, and poor subjective health were found to be significantly related to perceived infertility, which is, in turn, significantly associated with help-seeking for infertility. It was also reported that cognitive dimension of identifying oneself as infertile is critical to help-seeking. Internal health locus of control was found to be associated with lower odds of help-seeking but not to perceived infertility. That is, a higher internal health locus of control was associated with lower likelihood of seeking treatment.

Demographic and psychological variables associated with seeking help from parents, friends, and professionals for coping with emotional problems during early and middle adolescence was studied by Schonert-Reichl, and Muller (1996) among 109 males and 112 females (aged 13–18 years) who completed measures assessing self-worth, self-consciousness, and locus of control. The results indicated that more adolescent females and middle adolescents report seeking assistance from mothers, friends, and professionals than males and early adolescents. Middle adolescent males were also more likely to report seeking help from their fathers than were younger adolescent males. Furthermore, females and adolescents with an internal locus of control were more likely to report seeking help than males and adolescents with an external locus of control.

Undergraduate students from an introductory psychology course who were currently not seeking professional help (n=81) were recruited and compared with a comparable sample seeking professional help at a university psychological services centre (n=53). Participants responded to an assessment instrument with reference to the problem currently upsetting them most. It was revealed that those students who were seeking help tended to internalize causality, report lower levels of perceived control over their problems, and consider themselves as more likely to expend time and energy in resolving their problem. It was further reported that internal locus of control is linked to positive help-seeking behaviour (Simoni, Adelman, & Nelson, 1991).

An individual's health beliefs or perception concerning their health and subsequent decision to seek help have been found to predict one's help-seeking behaviour. A research conducted by Ormel and Schaufeli (1991) found that people with external health locus of control developed more symptoms of psychological disorders than people with internal health locus of control.

Ustundag-Budak and Mocan-Ayidin (2005) examined the role of optimism, health locus of control, perceived health competence, and their effects on help-seeking behaviour. A sample of three hundred and forty-five (345) college students was drawn for the study. Regression analysis was used, and it was found that there was a negative correlation between internal health locus of control and symptom reporting. This suggests that the more a person possessed internal locus of control, the fewer the reported symptoms. The authors, therefore, concluded that people with internal control orientations tend to be preventive in their orientations, hence reporting fewer medical symptoms.

2.2.2. Self-Stigma and Attitudes towards Professional Help

A study was designed to use 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. The analyses revealed that lower levels of awareness, less confidence in dealing with mental health issues, negative attitudes to help seeking and social stigma emerge as particular issues for men and the under 40 age group. Women were reported to have more positive attitudes, 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, Doherty, Hope, Sixsmith, & Kelleher, 2000).

Gunnell and Martin (2004) hypothesised that the prevalence of psychiatric morbidity appears to be lower in rural than urban areas. Using the Fourth National GP Morbidity Survey (1991-1992), they compared patterns of GP consultation for mental illness by young people living in rural and urban areas to investigate whether the patterns of morbidity are reflected in GP help-seeking. The authors investigated whether urban-rural differences were due to differences in the socio-economic characteristics of residents. The results revealed that after controlling for socioeconomic differences between rural and urban areas, levels of mental illness were lower in rural compared to urban areas.

Hoyt, Conger, Valde, and Weihs (1997) conducted a study which examined the implications of exposure to acute and chronic stressors, and seeking mental health care, for increased psychological

distress. They used data from a panel study of 1,487 adults, and the analysis revealed that men living in rural villages of fewer than 2,500 or in small towns of 2,500 to 9,999 people had significantly greater increases in depressive symptoms than men living in the country or in larger towns or cities. Moreover, the size of place was also related to level of stigma towards mental health care and so persons living in the most rural environments were found to be more likely to hold stigmatized attitudes towards mental health care and these views were also strongly predictive of willingness to seek care. It was therefore discussed that the combination of increased risk and less willingness to seek assistance places men living in small towns and villages in particular jeopardy for continuing problems involving depressed mood.

Wrigley, Jackson, Judd, and Komiti (2005) examined the role of perceived stigma and attitudes to seeking care in predicting help-seeking from a general practitioner (GP) for mental health problems. A cross-sectional survey in 2002 with self-report questionnaires assessing current levels of symptomatology, disability, attitudes towards mental illness, knowledge of prevalence and causes of mental illness, contact with mental illness and help-seeking behaviour and preferences and attitudes toward seeking professional psychological help were used. Results revealed that there were no significant relationships between symptom measures and measures of disability as well as help-seeking. The variables found to be positively associated with general attitudes to seeking professional psychological help were lower perceived stigma, and biological rather than person-based causal attributions for schizophrenia. Furthermore, willingness to discuss mental health issues with a GP was predicted by the perceived helpfulness of the GP and by no other variable. Therefore, causal attributions and perceived stigma rather than participants' levels of symptomatology and disability influenced attitudes to help-seeking for mental health issues.

A study by Komiti, Judd, and Jackson (2006) aimed at examining whether attitudinal factors including perceived stigma influenced rural residents seeking help from general practitioners (GPs). Help-seeking for psychological issues was retrospectively reported by 300 community residents in rural north-west Victoria. Current distress levels, functional disability, and current or lifetime syndromal disorder were recorded. Attitudes towards seeking professional psychological help, perceptions of stigma about mental illness, and belief in helpfulness of GPs, were also measured. The analysis revealed that having a positive attitude towards seeking professional help, and believing that a GP would be helpful, were significant predictors of ever having sought help from a GP for mental health problems. Other independent variables found as predictors of help-seeking were having a mood, anxiety or substance use disorder, higher distress levels, and greater functional disability due to physical problems. However, perceived stigma, contrary to expectations, did not influence help-seeking.

Many people suffering from serious mental illness do not seek appropriate professional help as stigma of mental illness has been considered to be a potential cause for this reluctance in seeking help. To ascertain this, the narrative review of recent literature on stigma and help-seeking for psychiatric disorders was adopted in a study by Schomerus and Angermeyer (2008). The results showed that there is proof of a particular stigma attached to seeking help for a mental problem. Anticipated individual discrimination and discrimination qua self-stigmatisation are associated with a reduced readiness to seek professional help for mental disorders. Furthermore, intervention studies have shown that destigmatisation may lead to increased readiness to seek professional help, but other aspects like knowledge about mental diseases seem to be at least as important. The belief that seeking help for a mental health problem is actually helpful has also been shown to be at

the core of help-seeking intentions and hence, offers a promising target for information programmes (Schomerus & Angermeyer, 2008).

Barney, Griffiths, Jorm, and Christensen (2006) reported that people are reluctant to seek professional help for depression, especially from mental health professionals, which is presumed to be because of the impact of stigma (self stigma) which involve people's own responses to depression and help-seeking as well as their perceptions of others' negative responses (perceived stigma). Their study aimed to examine community help-seeking intentions and stigmatizing beliefs associated with depression using a total of 1,312 adults who were randomly sampled from an Australian community. The respondents completed a questionnaire providing a depression vignette and measures of self and perceived-stigmatizing responses, source-specific help-seeking intentions, current depressive symptoms and depression experience, and demographics. The results revealed that many people reported they would feel embarrassed about seeking help from professionals, and believed that other people would have a negative reaction to them if they sought such help. Self-embarrassment and expectations that others would respond negatively predicted the likelihood of help-seeking from professional sources.

A study by Mojtabai (2010) aimed to examine the assumptions that individual stigmatizing attitudes towards the mentally ill are linked to stigmatizing attitudes in the social milieu and that both the individual and the social stigmatizing attitudes are major barriers to mental health treatment seeking. So, data from the 2005-2006 Eurobarometer general population survey (N = 29,248) were used to examine the association of social stigmatizing attitudes assessed in a random half of the sample with individual stigmatizing attitudes assessed in the other half of the

sample, as well as to examine the association of both individual and social stigmatizing attitudes with willingness to seek professional help. The results showed that social stigmatizing attitudes were specifically and strongly associated with individual stigmatizing attitudes. Both social and individual 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. Therefore, 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 (Mojtabai, 2010).

The perceived stigma and anticipated outcomes of counselling may deter individuals experiencing disordered eating attitudes and behaviours from seeking the help they need. 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 results of hierarchical regression analyses demonstrated that self-stigma and the anticipated risks and benefits of counselling significantly predicted attitudes toward seeking counselling.

Obviously, many other important variables that play a role in an individual's decision to seek professional psychological help may exist. Stigma related with mental health issues continues to be

a significant barrier to help-seeking, which leads to negative attitudes about mental health treatment and deterring individuals who need professional help from seeking care. It has been frequently cited as one of several factors that negatively correlate with help-seeking decision (Corrigan, 2004).

The individual's self-stigma is most salient aspects of his or her life which are highly significant to the individual's self worth (e.g. mental health). A person with high perception of self-stigma of a mental illness will most likely try to conceal this perception. Seeking help for a problem would confirm the label and also draw attention to it. Self-stigma can be described as internalization of the perceived stigma of mental illness in the culture, such that it affects the stigmatized person's self-efficacy and self-esteem (Corrigan, 2004). Stigma may negatively influence the help-seeking behaviour of an individual and hinder the urge to stretch for help. This would invariably eliminate any potential benefit offered by a mental health professional (Vogel, Wade, & Hackler, 2007).

A study by Vogel et al. (2007) indicated a significant negative relation between social and self-stigma towards seeking mental health in college populations. Again, Vogel et al. (2007) in a sample of 676 college students found that social stigma contributed to the experience of self-stigma, which invariably influenced other help-seeking attitudes and willingness to seek help. This suggested that self-stigma seems to be a more proximal gauge of help-seeking attitudes and willingness to seek professional help than social support.

A study of young adults by Vanheusden, Mulder, van der Ende, van Lenthe, Mackenbach, and Verhulst (2008) showed that 24% of non-help-seeking young adults with clinical levels of psychopathology perceived help-seeking negatively. This could be that individuals tend to label

mentally ill people and so labelling plays an important part in help-seeking process. It is particularly important to young adults as they move relying on their parents to external sources of help (Rickwood, Deane, & Ciarrochi, 2005) and this is when mental disorders usually first occur (Kessler, Amminger, Aguilar-Gaxiola, Alonso, Lee, & Ustun, 2007).

Study of Asians tend to suggest an attached stigma to mental illness or emotional problems as well as receiving professional help for these issues, partly due to traditional cultural beliefs about the aetiology of mental problems and feeling of shame (Komiya, Good, & Sherrod, 2000; Ng, 1997).

There is a suggestive conflicting empirical data of the effect of stigmatizing beliefs on seeking help for mental disorders from a professional. Some of the studies have found a connection (e.g. Barney, Griffiths, Jorm, & Christensen, 2006; Mojtabai, Olfson, & Mechanic, 2002). Others did not. One possible explanation for the conflicting results may be the difficulty of the concept of stigma and the differences in measuring it (e.g. Schomerus, Matschinger, & Angermeyer, 2009). They were of the view that personal discriminatory attitudes tend to hinder help-seeking from depression while anticipated discrimination from others was unrelated to help-seeking for depression (Ng, Jin, Chua, Forns, & Lim, 2008).

2.2.3 Cultural Beliefs and Attitudes towards Seeking Professional Help

Cultural factors influence how individuals view, understand and experience the world. So an individual's cultural beliefs, values and preferences play a significant role in life, health and mental health care decision making. For anyone's decision making to be effective, that person's cultural

background and relevant beliefs must be considered throughout the decision making process. Beliefs about illness, health and mental health are extremely affected by culture. Considerable number of cultural groups assesses health and illness differently and research evidence suggests that beliefs about the causes of mental disorders vary within cultures. Nedetei (1986) reported in his study that an increased prevalence of paranoid disorder among African patients in a London hospital is attributable to 'cultural factors'. He made it clear that more than half of the thirty-four (34) African patients in the sample attributed their illness to evil spirit, witchcraft or magic. However, in Chinese cultures, individuals do understand and label mental health problems in physical terms, that is, to somatise their problem (Kleinman, Esenburg, & Good, 2006). These views may influence how individuals seek help to address problem. Theorists have agreed that beliefs about the causes of illness (mental health) are important for providing effective treatment for such problems (Scrimshaw, 2001).

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. The convenience sampling technique was used to select 262 female Muslim-Arab undergraduate university students from Jordan, United Arab Emirates (UAE) and Arab students in Israel who responded to a modified Orientation for Seeking Professional Help (OSPH) Questionnaire. Analysis of the data revealed that nationality was not statistically significant as a variable to positive attitude towards seeking professional help. However, year of study, marital status, and age were found to be significant predictors of a positive attitude towards seeking help. High proportions of respondents were found among the nationalities to call unto God through prayer during times of psychological distress.

Similarly, Fung and Wong (2007) examined the relationship of 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 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 and used for the study. The data were acquired through a self-administered structured questionnaire. Data analysis using MANOVA, ANOVA and stepwise multiple regression 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 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 subscribing more to supernatural beliefs had a more negative attitude. However, age and education were not significant predictors.

Another study examined perceived barriers to mental health care reported in two very similar community surveys in two cities that were not only on opposite sides of the world but also differed substantially in health care systems, size, and mix of ethnic groups. The respondents were asked about mental health care ever received, any failure to seek care when required, and symptoms of 14 psychiatric disorders according to DSM-III. The frequency with which respondents reported not seeking care and the popularity of specific reasons for not seeking care were almost identical among the two sites. Common reason offered for not seeking care was doubt about the need for professional help which appeared to be particularly common for people

with alcohol disorder. Respondents gave reasons that were mainly attitudinal such as believing that they would be strong enough to cope without professional help for those who failed to seek care when needed. Structural characteristics of services such as cost, times open, and travel distance were given less often. Socio-demographic factors had small or negligible effect on care seeking (Wells, Robins, Bushnell, Jarosz, & Oakley-Browne, 1994).

An investigation of the relationship between cultural beliefs about the aetiology of mental disorder and professional help seeking among British Asians, Westerners (English and Europeans) and Pakistanis conducted by Sheikh and Furnham (2000) showed that causal belief about mental distress were key predictors of professional help seeking for the British Asians and Pakistanis.

Examining the relationship between cultural beliefs, the potential causes of mental distress, and attitudes towards seeking professional help for psychological problems, Sheikh and Furnham (2000) did not find a statistically significant relationship once culture, treated as a variable, was studied along with participants' positive attitudes toward seeking professional psychological help.

Research on the dynamics of culture conducted by Van Dyk and Nefale (2005) indicated its relevance for Africans since many of Africa's countries have been affected by colonization and so their cultures have been diluted. Therefore, rarely encounters a pure, traditional culture. Although there are cross-cultural and ethnic differences in the culturally diverse Africa, there is a general belief that physical and mental disorders stem from varying external causes including violation of a taboo or customs, hostile ancestral spirits, spirit possession, demonic possession,

sorcery, natural causes and affliction by God or gods (Idemudia, 2003; Furnham, Akande & Baguma, 1999).

2.2.4 Perceived Social Support and Attitudes towards Seeking Professional Help

Social support by Gurung (2006) is the experience being valued, respected, cared about, and loved by others who are present in one's life. The social environment is an essential domain in the lives of individuals in any society, and may have positive influence on psychological health of the individual (Fallon & Bowles, 2001), especially among young adults and deficits in social support have been shown to be associated to several psychological problems such as depression, loneliness, and anxiety among young adults (Eskin, 2003).

Those close to an individual may be an important social influence or factor in the decision to seek professional help (Pescosolido & Boyer, 1999; Rickwood & Braithwaite, 1994). This has been buttressed by Angermeyer, Matschinger, and Riedel-Heller (2001) indicating that those closest to an individual are influential in whether or not a person in distressing situation will seek professional help.

Data were drawn from 1092 Canadians aged 15 to 24 years and identified as presenting a mood disorder, an anxiety disorder, or a substance-related disorder in the 12 months preceding the survey in its quest to identify the determinants of service used by young Canadians with mental health problems (Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005). The authors classified variables potentially associated with any type of service used for a mental health problem over a 12-month period according to predisposing, enabling, and need factors. Data analysis revealed that being

female and living alone were the predisposing factors associated with service use. However, none of the enabling factors predicted help seeking. That is, social support, size of social network, mental disorders among relatives, and province of residence did not predict help-seeking. Furthermore, for perceived need factors, those who had difficulties with social situations were more likely to use services as well as having a mood disorder and (or) having a diagnosed chronic illness being evaluated as the need factors associated with service use (Bergeron et al., 2005).

Bayer and Peay (1997) investigated the factors that were associated with intention to seek professional help for psychological problems. 142 patients waiting for consultations at a community based general practice were used to complete a questionnaire designed to assess seeking help from mental health professionals. Findings from the study supported the prediction of the intention to seek help from a mental health professional from the variables 'attitude towards the behaviour' and 'subjective norm'. However, personal attitudes toward seeking help were found to be more important than the approval or disapproval of significant others in predicting help-seeking intentions.

The decision to seek psychological help may also be hindered or facilitated by many factors with two of the potential factors that might facilitate help seeking being having a relationship with someone (a) who recommends seeking help or (b) who themselves have sought help as reported by Vogel, Wade, Wester, Larson, and Hackler (2007). In two of their studies (N 780, N 746), they explored the relationship between these factors and intentions to seek mental health services. In Study 1, it was revealed that those who received mental health services were more likely to have been prompted to seek help and to know someone else who had sought help than the general

population. Study 2 also revealed that being prompted to seek help and knowing someone who had sought help were related to more positive attitudes toward help seeking. Also, knowing someone who had sought help was related to the intention to seek help. Approximately 75% of those who sought psychological help had someone recommending that they should seek help and about 94% knew someone who had sought help. Furthermore, these factors were associated with differences in the anticipated outcomes and social norms of those who had been prompted to seek help and those who knew someone who had sought help.

A study by Lin, Goering, Offord, Campbell, and Boyle (1996) aimed to describe the distribution and predictors of mental health service use for a survey of Ontario household residents aged 15 to 64 years. Data from the Mental Health Supplement (the Supplement) to the Ontario Mental Health Survey were used to compare the socio-demographic, geographic, and diagnostic status characteristics of service users with these characteristics among non-users. Service use was specifically defined as any past-year contact with formal or informal health care providers for mental health reasons. Analysis revealed that help seeking differs within specific socio-demographic and geographic groups and that mental health services were used by 7.8% of respondents in the past year. The majority (57.8%) had a past-year University of Michigan Composite International Diagnostic Interview (UM-CIDI) diagnosis, although 27.1% had never met diagnostic criteria. In addition, other significant predictors were marital status, household public assistance, gender, age, and urban/rural residence.

To develop intervention methods of primary prevention for adolescents who are at high risk for mental health disorders, Takamura, Oshima, Yoshida, and Motonaga (2008) investigated help

seeking behaviour and the factors related to it. Data from 1168 junior high and high school students in Japan were used for this study. Correlation analysis and multiple linear regression analysis used revealed that among the sample students, 39% had previous knowledge of mental health consultation. However, only 10% said they would seek out a mental health specialist. Friends or senior students were frequently chosen (70%) as the initial consultant. It was also found out that image of and stigma towards psychiatry and psychological counselling and knowledge of mental health were the factors related to help-seeking behaviour. Furthermore, high school students were found to be more likely than junior high students to display help-seeking behaviour. Furthermore, students tended to choose friends and family rather than specialized professional support for their mental health concerns. The image of psychiatry, knowledge of services and stigma towards mental health problems and services were related factors (Takamura et al., 2008).

According to Teoh and Rose (2001), lower level of social support is one of the predictors of psychological problems. It is associated with higher level of depression, anxiety, attention problems, thought problems, social problems, somatic complaints, and lower self esteem. These notions are supported by the study of Friedlander, Reid, Shupak, and Cribbe (2007) on 128 first year undergraduate students. It was found that students who perceived that their social resources increased had lower level of psychological problems. This is an indication that high level of social support impact positively on individuals and decrease stressful situation. In other words, the higher the social support, the lower the psychological problems and the lower the social support, the higher the psychological problems.

A study by Rawson, Bloomer, and Kendall (1994) on 184 undergraduate students for example, found that students with good social support tend to have lower scores on stress compared to the students with low social support. Horwitz's (1977) original study showed that people with personal concerns generally discuss issues with at least four of their social network about their concerns before seeking professional help. Most researches suggested that friends and family (i.e. informal social support) is preferred to formal social support by college students and friends are the first stated choice of help (Kilinc & Granello, 2003). For instance, Dew, Bromet, Schulberg, and Parkinson (1991) used 186 individuals experiencing symptoms of depression if they had friends or relatives who suggested to them to seek help or had sought mental health services. A discriminant analysis indicated that those who sought help were more likely to have had friends or relatives recommending to them to get help than those who had not sought help.

The quality of social support perceived and received has been reported by many studies to relate positively with mental health than quantity of support received (Holahan, Valentiner, & Moos, 1995). This is because social support involves social resources that individuals perceive to be available or that are actually offered to them which could help protect against psychological problems (Tao, Dong, Pratt, Hunsberger, & Pancer, 2000) and therefore, social support serves as a buffer against life stressor as well as an agent promoting health and wellness (Dollete, Steese, Phillips, & Matthews, 2004).

A sample of 162 Mexican American students used by Miville and Constantine (2005) showed that lower perceived social support from family, higher perceived social support from significant others were important in helping or hindering a student's attitude towards seeking professional

help. The study helps us to understand the notion that in the process of deciding to seek psychological help influences such as support from friends and family may come to play to help or hinder one's attitude towards professional help.

Çebi (2009) has also reported that several studies have showed that professional help has superiority over informal social support in many ways that professionals learnt many things during their training such as human development, helping skills, personality which makes them well equipped in their helping relationships. McLennan (1991) examined the experiences of 147 undergraduate college students who sought help from formal counselling sources (counselling service staff member, health service doctor, and psychiatrist) as compared to those reported by students who sought assistance from informal helpers (friend, neighbours, and supervisor). They concluded that the two groups of students had similar types of problems but students who sought formal help have higher levels of satisfaction about the help compared to students who sought informal help although they reported higher levels of problem seriousness as well as lower levels of comfort with the interaction than the students who sought informal help.

2.2.5. Experience with Mental Health Service and Attitudes towards Seeking Professional Help

Bland, Newman, and Orn, (1997) examined demographic and clinical variables that determine help seeking behaviour for emotional or mental problems, the proportion of those with a disorder who sought help as well as categories of professionals sought by those who get care. A 2-stage random sample of 3956 adult residents of Edmonton, Alberta, Canada was interviewed by trained lay interviewers using the Diagnostic Interview Schedule (DIS) (73% completion rate). An average

of 2.8 years later, a systematic random sample of 1964 subjects was re-interviewed (an 86% completion rate) using the DIS and a health care utilization questionnaire. After adjusting for age and sex, the re-interview sample was representative of those with and without a diagnosis at the first interview. Data analyses indicated that only sex (female) and age (under 45) were the significant predictors out of the examined sex, age, marital status, education, employment, and income. Comorbidity was found to be highly significant. That is, the help-seeking rate for those with one diagnosis was 20.3% with those of more than one diagnosis having the rate 42.8% (OR = 2.94, $\chi^2 = 31.4$, $df = 1$, $P < 0.001$). Just over 28% of those with a diagnosis saw any health care professional, and 7.7% of those without a diagnosis sought help for a mental or emotional problem. It was also revealed that 46.7% of those with a major depressive episode sought help, but only 16.0% of those with alcohol abuse or dependence sought care.

A study investigating the prevalence and correlates of mental health service use in a nationally representative Canadian survey after noting that previous Canadian surveys have reported a wide range of prevalence rates for mental health service use but found no consistent relation between type of contact with mental health professionals and severity of illness (Sareen, Cox, Afifi, Yu, & Stein, 2005). Therefore, 125,493 respondents aged 12 years and over were used between year 2000 and 2001. Respondents were asked whether they had contacted a professional because of emotional symptoms in the past year and about their experience of barriers to treatment. DSM-IV major depression and alcohol dependence diagnoses were assessed with the Composite International Diagnostic Interview Short Form. The relation between a range of measures of clinical severity and the type of professional contacted for emotional symptoms was also examined. The prevalence of 12-month help seeking for emotional symptoms was found to be 8.3% with an

additional 0.6% of the sample perceived a need for treatment without seeking care. Respondents endorsing contact with multiple professionals or with psychiatrists only had higher levels of severity than those who had contact with family doctors only or non-physician professionals only (Sareen et al., 2005).

The purpose of another study was to examine if age, attitudes toward help-seeking, education, and sex were related to previous or intended future mental health utilization in a rural population (Smith, McGovern, & Peck, 2004). Data were collected from 438 adults and the data analysis suggested that positive attitudes toward help-seeking, being female, and being younger were significantly related to both previous and intended future mental health service utilization. Furthermore, prior mental health use was significantly related to whether one would seek out mental health services in the future.

Help-seeking in response to emotional problems was studied in a sample of Australian adolescents by Rickwood and Braithwaite (1994) after noticing that predictors of the attitudinal measure of orientation toward help-seeking for emotional problems have been shown to include demographic, social network, and personality variables. This study aimed to find out whether these same variables predict the behavioural outcome measure of help-seeking, both in general and from professional services in particular. Results indicated that general help-seeking was predicted by more symptoms of psychological distress, being female, availability of social support, knowing someone who had sought professional help, and the personality characteristics of high private self-consciousness and willingness to disclose mental health. However, when only those with emotional distress were considered, gender and willingness to disclose remained the only

significant predictors. Moreover, these same variables did not account for those who sought professional help rather than relying upon their informal network. In addition, level of psychological distress was found to be the only significant predictor of professional consultation. Psychological symptoms and gender were shown to be more relevant predictors of the behavioural measure of help-seeking than network or personality characteristics.

A study investigated attitudes to seeking help from mental health care professionals and their correlates after reporting earlier that little is known about these attitudes. Therefore, a survey that is representative of the adult population of six countries ($n = 8,796$) were derived from the European Study of Epidemiology of Mental Disorders. The results indicated that almost a third of respondents were of the opinion that professional help was worse than or equivalent to no help at all, in relation to serious psychiatric problems. Also, females, respondents under the age of 65, with a higher income, living in Spain or Italy, with a mood disorder, and those who had previously sought mental health care, more often stated that they would seek professional help if beset by a serious mental health problem. Moreover, all these groups, except for the younger than 65, also reported that they would feel comfortable discussing mental health problems with a professional or that they were receiving this kind of help. All these attitudes were associated with an increased chance that persons would use professional help if beset by mental health problems (ten Have, de Graaf, Ormel, Vilagut, Kovess, & Alonso, 2010).

In a representative population survey (in Germany 2007, $n = 2,303$) containing a depression vignette with a question on readiness to seek psychiatric care for this problem, a focus group developed scale anticipated discrimination when seeing a psychiatrist (ADSP), and a scale on

desire for social distance from someone seeing a psychiatrist (SDSP). The authors further elicited previous contact to psychiatric treatment, depressive symptoms, and socio-demographic data in its pursuit to examine two aspects of stigma related to seeing a psychiatrist and their association with help-seeking intentions for depression. Specifically, the anticipated discrimination by others when seeking help and the desire for social distance from those seeking help. The results indicated that both the general population and those with current depressive syndrome, and personal desire for social distance had significantly decreased willingness to seek psychiatric help, but anticipated discrimination by others did not. Other factors found to significantly relate to help-seeking were female gender and previous contact to psychiatric treatment or to psychotherapy. However, anticipated discrimination from others was unrelated to help-seeking intentions, while personal discriminatory attitudes seem to hinder help-seeking (Schomerus, Matschinger, & Angermeyer, 2009).

It has been reported that young people are more likely to seek help for mental health problems if they have some knowledge about mental health issues and sources of help, feel emotionally competent to express their feelings, and have established and trusted relationships with potential help providers. Young people have also been found to be less likely to seek help if they are experiencing suicidal thoughts and depressive symptoms, hold negative attitudes towards seeking help or have had negative past experiences with sources of help, or hold beliefs that they should be able to sort out their own mental health problems on their own. Moreover, young people may seek help through talking to their family and friends, with family being more important for younger adolescents, and friends and partners becoming more influential later on (Rickwood, Deane, & Wilson, 2007).

Male inmates from six New Zealand prisons were selected to participate in a study by Skogstad Deane, and Spicer (2006), with approximately 50% (n = 527) of those who initially expressed an interest in the study completing the self-report questionnaire. The study was aimed at assessing whether prisoners' intentions to seek help for a personal-emotional problem, including suicidal feelings, can be predicted using variables from the Theory of Planned Behaviour (TPB). Most participants completed the questionnaire in small-group meetings in the prison units and returned them to the researchers immediately after completion. Data analysis indicated that those with prior contact with prison psychologists had lower intentions to seek help for suicidal feelings than prisoners without such contact. Moreover, it was revealed that those older prisoners, those with more years of education, and those who have had previous contact with a psychologist outside prison tend to have higher intentions to seek psychological help.

Another study aimed at investigating Kuwait University (KU) students' attitudes towards seeking professional psychological help as well as investigating if family, friends, and societal support played a role in the students' decision to seek professional psychological help. A total of 529 participants were therefore selected to complete all five assessment tools. The data analysis showed that KU students have less favourable attitudes towards seeking professional psychological help than groups studied by other researchers. The results further supported previous research, which found females to have more favourable attitudes towards seeking professional help than males. Individuals who received previous counselling were also found to be more likely to have favourable attitudes towards seeking professional help than those who did not receive such help. Students who majored or minored in psychology also had more favourable attitudes towards counselling than those who were not psychology majors or minors (Al-Rowaie, 2001).

2.2.6 Demographic Characteristics and Attitudes towards Seeking Professional Help

The objectives of a study by Mackenzie, Gekoski and Knox (2006) were to explore age and gender differences in attitudes toward seeking professional psychological help, and to examine whether attitudes negatively influence intentions to seek help among older adults and men, whose mental health needs are underserved. Two hundred and six community-dwelling adults were sampled to answer questionnaires on help-seeking, psychiatric symptomatology, prior help-seeking, and intentions to seek help. Findings of the study indicated that older age and females were related to positive attitudes to help-seeking. Even though age and gender interrelated with marital status and education, there were unpredictable influences on different attitude factors.

Again, age and gender were found to impact intentions to seeking professional psychological help, while females show more favourable intentions to seek help from mental professionals than males. Furthermore, favourable intentions to seek help from primary care physicians were shown by older adults than younger adults. This finding was not explained by age differences in attitudes. Outcome of the study implied that negative attitudes linked to psychological openness which might influence males' underutilization of mental health services. Although, help-seeking attitudes did not appear to be a barrier to professional help seeking among older adults, their intentions to visit primary care physicians seem to be. The overall findings of the study proposed the need for education to enhance males' help-seeking attitudes and increase older adults' willingness to seek professional mental health services.

Kuo, Kwantes, Towson, and Nanson (2006) investigated the role of pan-cultural social beliefs, measured by Social Axioms Survey (SAS), in predicting attitudes towards seeking professional

psychological help. Four hundred ethnically diverse Canadian University students were sampled. Using a hierarchical regression, findings suggested that the collective input of the six SAS variables was significant in interpreting help-seeking attitudes. Significant predictors of help-seeking attitudes were gender, age, ethnicity, perceived stress, and two SAS factors. Also, gender and ethnic differences existed in help-seeking attitudes, perceived stress and all the six SAS factors. Comparing help-seeking processes between the onset of mental health problems and the provision of professional care of Arab Muslim female students in Jordan, the United Arab Emirates and Israel, Al-Krenawi, Graham, Dean, and Eltaiba (2004) sampled 262 female students from Jordan, the United Arab Emirates and Israel through convenience sampling technique, to answer a modified orientation for seeking professional help (OSPH). Findings indicated that nationality was not statistically significant as a factor in a positive attitude towards seeking professional help, however, year of study, marital status and age showed as significant predictors of positive attitude towards seeking help. Their findings revealed that high fraction of respondents among the nationalities referred to God through prayer in times of psychological distress.

A review by Jackson et al. (2007) was to ascertain which socio-demographic, illness-related and psychological/attitudinal variables influence a person's decision to seek help and factors related with attitudes to help-seeking in rural settings. Adopting computer search of literature and using the terms help-seeking and mental between the years 1990 and 2006, 350 studies were found. Two groupings of studies were initiated; i) studies dealing with help-seeking in rural settings ii) studies comparing rural and urban contexts all in relation to their aim. The review revealed a quantity of variables which were consistently predictive of mental health utilisation and attitudes toward professional help-seeking, including socio-demographic variables such as gender, age, and marital

status; illness-related variables such as having a mental disorder, comorbidity and psychological distress but psychological/attitudinal factors such as stigma, stoicism and self-efficacy were less in prediction. They concluded that psychological/attitudinal factors were poorly studied compared to socio-demographic and illness-related factors since their value may differ according to settings.

Ang, Lim, Tan, and Yau (2004) examined the effects of gender and sex role orientation on attitudes towards seeking professional psychological help in a sample of 163 teacher trainees (52 male and 111 females). Using ANOVA showed statistically significant main effects for gender and femininity on attitudes toward help-seeking. Precisely, females were reported to have more positive attitudes towards professional help-seeking than their male counterparts.

Consistent findings in the studies have concluded that men seek help less than women and underutilize medical and mental health services (e.g. Mansfield et al., 2003). For instance, the U.S. Department of Health and Human Services in 2001 found that irrespective of age, nationality and ethnic background, men make less contact with professional services in their life time than women. The assumption put towards is that masculine gender socialization elucidates underutilization and decreased help-seeking in men (Benett & Rosalind, 2006).

Doherty and Doherty (2010) concluded in their study, gender differences in predicting help seeking behaviours that 63% of females were willing to seek help as compared to males. One of the many reasons to explain the male help seeking behaviour was that they felt they will be thought less of if they were to accede to a mental illness problem. A replication of this study in Australia showed that males were likely to feel more discredited and less to open to admitting weakness in help

seeking behaviours. Gonzalez, Alegri, Prihoda, Copeland, and Zeber (2011) concurred to gender differences in help seeking behaviour and even indicated that less than half the males in comparison to females on the cohort showed a high willingness to seek out for any mental health problems they may be experiencing.

In another study, Turkum (2005) used 398 university students and found that consistently females have more favourable attitudes than males and students with prior help-seeking experiences had more favourable help-seeking attitudes than students who did not seek help before. However, Judd, Komiti, and Jackson (2007) indicated that females depicted a stronger openness to seeking help for mental disorders. Study of Nigerian students by Oluyinka, (2004) found no difference in the patterns of help seeking between males and females in their cohort.

2.3 Rationale of the Study

A general overview of previous studies reviewed reported significant relationships existing between social support and professional help-seeking (Friedlander et al., 2007; Takamura et al., 2008), self-stigma and professional help-seeking (Hackler et al., 2010; Vogel et al., 2007), health locus of control and professional help-seeking (Angermeyer et al., 2001; Simoni et al., 1991). However, all these variables (social support, self-stigma, and health locus control) were not studied in a single study as in this present study.

Moreover, most of the cultural factors reported to have influenced attitude towards seeking professional help were mostly inferred from country of residence (Al-Krenawi et al., 2004; Fung & Wong, 2007; Sheikh & Furnham, 2000). Hence, this current study is objectively measuring

cultural beliefs and its influence on attitude towards seeking professional help as differences exist between cultures. Hence, there was the need to get an African (Ghanaian) touch of the predictors of help-seeking.

Other variables like previous experience with mental health profession (Bland et al., 1997; Sareen et al., 2005, Smith et al., 2004) and demographic characteristics (Al-Krenawi et al., 2004; Jackson et al., 2007; Kuo et al., 2006; Mackenzie et al., 2006) have also been separately reported on attitudes toward seeking professional.

Hence, this study is aimed at examining all these variables which have separately been investigated in different studies at a go to see how they predict help-seeking behaviours among contemporary Ghanaians.

2.4 Statement of Hypotheses

Based on the literature reviewed, the following hypotheses were formulated:

1. Experience with mental health service would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics.
2. Perceived social support (being family, friends, and significant others) would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics and experience with mental health service.
3. Health locus of control (internal, chance, and powerful others) would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, and perceived social support (family, friends, and

significant others).

4. Self-stigma would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, perceived social support (family, friends, and significant others), and health locus of control (internal, chance, and powerful others).
5. Cultural belief would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, perceived social support (family, friends, and significant others), health locus of control (internal, chance, and powerful others), and self-stigma.

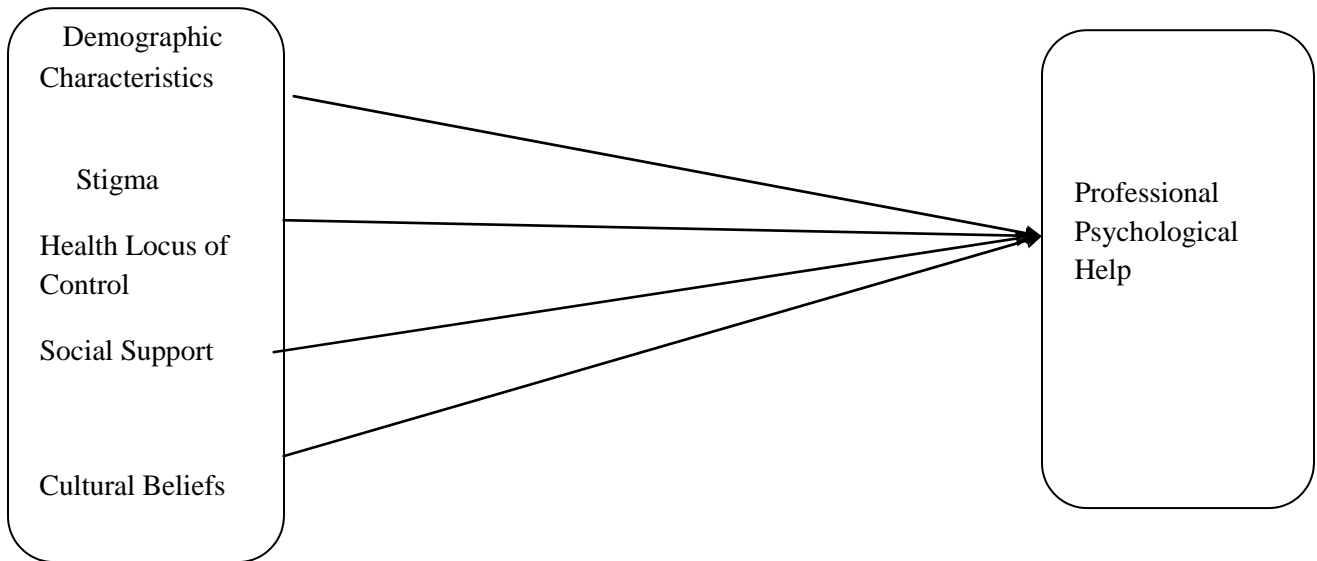
Figure 1: Hypothesised Conceptual Model**Determining variables****Professional Help-Seeking**

Figure 1 is the proposed conceptual model which outlines the hypothesized variables showing its likelihood to influence professional psychological help seeking behaviour in Contemporary Ghana.

2.5 Definition of Terms

Mental illness and mental health problems

The term ‘mental illness’ and ‘mental health problems’ were used interchangeably to refer to emotional problems which cause disturbances to one’s daily routine and activities such as learning, communication, working and relationships. They may be used to refer to distressing reactions to life events and circumstances such as stress bereavement and trauma and it may be used to describe psychiatric conditions example depression and schizophrenia.

Help seeking

The term ‘help seeking’ is used broadly to refer to an individual’s attempts to seek help in the event of experiencing a mental health problem. It refers to attempts to access and take up a range of different sources of help including professional mental health services and/or informal support provided by family and friends.

Mental health professional/ Professional help/ Psychological help

The term ‘mental health professional’ is used to describe individuals who have been trained to deal with mental health problems including clinical psychologists, psychiatrists, and counsellors. The term will be shortened to ‘professional help’ or ‘psychological help’ at times throughout this study.

Mental health services

The term is used to refer to formal mental health services, usually staffed with mental health professionals including clinical psychologists, psychiatrists or counsellors.

Attitudes toward seeking professional psychological help

In this study, the attitude of individuals regarding the seeking of professional psychological help is defined as those individuals' perceptions and feelings that cause them to respond either favourably or unfavourably toward the seeking of help.

Cultural belief about mental health problems

A belief is defined as a state or habit of mind in which trust is placed in some persons or thing. Cultural beliefs are defined in this study as a state of mind characterized in part by a traditional or religious view of causes and treatment of mental health problems.

Self-stigma

The term, as used in the study, is defined as a perception of oneself being weak if the individual seek psychological help in case of mental health problem.

Perceived social support

The term perceived social support is used to refer to the individual's subjective judgement of help to be offered in times of need.

Health locus of control

It is the extent to which individuals attribute their well being to their own action (internal) or to outside factors (external), as measured by the Multidimensional Health Locus of Control (Wallston et al., 1976).

- Chance Health Locus of Control (CHLC) refers to the extent, to which one believes that health, is a matter of fate, luck or chance.

- Powerful Others Health Locus of Control (PHLC) assesses the belief that one's health is determined by powerful individual such as doctors.
- Internal Health Locus of Control (IHLC) refers to the extent to which one believes that internal factors are responsible for health and illness.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter covers the processes that were followed to gather data to evaluate the hypotheses. Focus will be on the population, respondents, sampling technique, inclusion and exclusion criteria, design, tools for data collection, tools for data collection, procedure, and ethical guidelines in gathering data.

3.2 Population

Male and female in public tertiary institutions in Accra were the main population of interest to this current study. This population was chosen because it constitutes young adults from different cultural background across the country that is able to take volitional decisions about their lives.

3.3 Respondents

The study used a total of three hundred and fifty-four (354) respondents from Accra College of Education. The mean age of these respondents were 24.46 years, standard deviation of 3.15 years, and ranging from 20-35 years. Respondents were made up of 171 (48.3%) males and 183 (51.7%) females. Majority (322) of the respondents were Christians with Muslims and Traditionalists being 31 and 1 respectively. The sample size was based on the rule of the thumb suggested by Tabachnick and Fidell (1996) that the sample size, N , should equal or exceed $50 + 8p$, where 'p' equals the number of predictor variables (cited in Dunlap, Xin, & Myers, 2004).

3.4 Sampling Technique

The study employed a non-probability sampling method being convenience sampling. This is a sampling technique where participants are selected because of their convenient accessibility. The researcher purposely picked one of the public tertiary institutions in Accra (Accra College of Education) as it was easy to be accessed. Moreover, most of the studies conducted usually used university samples, hence, the choice of these samples to examine their view on seeking professional help. Accra College of Education is a three year teacher training college. With the exception of the third year students who were on teaching practice at various places in Accra, the first and second year students who were in residence took part in this study. The respondents' ages ranged between 20-35 years.

Inclusive criteria

In order to be included in the study, respondents had to meet two general inclusion criteria. First, respondents should be between 20 and 35 years at the time of participation. Second, the respondents were required to be currently enrolled at the institution and should have lived in Accra for at least one year. The reasons for choice of this sample is that during this early adulthood period, young adults become independent of their lives and assume control of their lives and therefore take volitional/voluntary decisions for their lives including their health and help-seeking behaviours.

3.5 Design

This current study used the “multiple linear regression” as a general design strategy. As Punch (2005) postulated, the multiple linear regression is basically a statistical technique for analysis of

data, however, it can also be considered as a design strategy (regression analysis design). It best fits situations where the focus is on the dependent variable with a number of independent variables. This design was chosen because of the primary aim of this study, which was to examine the determinants of seeking professional psychological help among contemporary Ghanaians. The primary objective of this design is to account for variance in the dependent variable (seeking professional psychological help), and to see how the different independent variables, separately contribute to accounting for the variance. The independent variables in this study are demographic characteristics, self-stigma, perceived social support, cultural beliefs, health locus of control, and experience of mental health service.

3.6 Tools for Data Collection

A questionnaire, made up of six sections, was used for the study (refer to Appendix). These include:

(a) Demographic data

The demographical data formed the Section A of the questionnaire. It gathered personal information through the use of self-designed questions. These included sex, age and years stayed in Accra among others. Nine (9) questions relating to previous help seeking from professional psychological service were also explored in this part of the questionnaire. For instance, the first question sought to find out if participants had ever sought help from professional mental health services (e.g. from a Clinical Psychologist, Counsellor or Psychiatrist).

(b) Multidimensional health locus of control (MHLC) scale – Form A

Section B of the questionnaire assessed the participants' health control. MHLC is a standardized scale developed by Wallston, Wallston, and DeVellis (1978) with 18 items. The authors developed three different scales of the MHLC which were forms A, B and C. Form A was adopted for the present study and comprised of 3 subscales described below;

- i) The Internal Health Locus of Control (IHLC) subscale, which assessed the extent to which one believed that internal factors were responsible for health and illness.
- ii) Powerful Others Health Locus of Control (PHLC) subscale, which assessed the belief that one's health, was determined by powerful individual such as doctors.
- iii) Chance Health Locus of Control (CHLC) subscale, which measured the extent to which one believed that health, was a matter of fate, luck or chance.

The alpha reliability for the whole MHLC and each of the six-item MHLC subscale had been acceptable with coefficients ranging from 0.67 to 0.86 (Wallston, Wallston, & DeVellis, 1978) and test-retest reliability on parallel forms of 0.73 to 0.80 (Oberle, 1991). The MHLC is made up of a six- point Likert scale response format which determined the extent to which participants agreed to with statements about their health and illness. The sum of score of specific items on the scale (i.e. 1 = "strongly disagree" to 6 = "strongly agree") gave the total score for each subscale. No item was reversed-scored before summing all the subscales, independent of each other. The possible range of scores for the 3 subscales was 6- 36 points. A score range of 23-30 on any subscale meant a high inclination to the dimension; 15-22 indicated moderate and 6-16 indicated low score. For the present study, the reliability coefficient (Cronbach's Alpha) was 0. 73.

(c) Social support scale

Multidimensional scale of perceived social support (MSPSS) is a self-report measure designed by Zimet, Dahlem, Zimet, and Farley (1988) to assess perceived adequacy of social support (Section C). The scale is made up of 12 items with a respondent asked to rate how much he/she agrees with the statements on a seven-point Likert scale response format. The scores range from 1= very strongly disagree to 7= very strongly agree. Such statements include the following, *my family tries to help me and I can count on my friends when things go wrong*. Factor analysis revealed that the scale consists of three factors: perceived social support from family, friends, and a significant other. The scale also yields a total score of perceived social support. Higher scores on the scale indicate higher perceived social support. The total perceived social support was utilized in the current study.

The MSPSS has demonstrated strong psychometric properties. In the original study of the scale, (Zimet et al., 1988), with 275 Duke University undergraduates, coefficient alpha for the scales was reported as follows; Total scale (0.88), Family (0.87), Friends (0.85) and Significant other (0.91). Test-retest reliability of the Total Scale after 2 to 3 months was 0.85. The three subscales also demonstrated adequate stability with the following reliabilities: Family (0.85), Friends (0.75), and Significant other (0.72). Internal consistency of the MSPSS across the different samples was reported with the following coefficient alphas: Total scale (0.84–0.92), Family (0.81–0.90), Friends (0.90–0.94) and Significant other (0.83–0.98). For the present study, the overall reliability coefficient for the scale was 0.88.

(d) Self-stigma of seeking help scale

Self-stigma of seeking help scale (SSOSH) formed the Section D part of the questionnaire. It is a 10 item scale developed by Vogel, Wade, and Haake (2006). The SSOSH is on a five-point Likert scale ranging from 1 = “strongly disagree” to 5 = “strongly disagree”. Participants response to the items would determined the extent to which they might react in a situation about beliefs that seeking psychological help will be damaging to one’s self-esteem and self worth (self stigma). Such statement includes the following, “*I would feel inadequate if I went to a therapist for psychological help*” and “*seeking psychological help would make me feel less intelligent*”. In scoring the items, item numbers 2,4,5,7 and 9 were reverse-scored. The total score of all the 10 items ranged between 10-50 points. The scale had been divided into three levels: low, moderate and high, with 10-22 indicating low stigma, 23-32 representing moderate stigma and 35-50 indicating high stigma. In reliability tests, the SSOSH demonstrated an internal consistency co- efficient alpha of .81 and a test-retest correlation of .72 (Vogel, Wade, & Haake, 2006). For the present study the reliability coefficient was 0. 77.

(e) Cultural belief scale

Cultural Belief Scale (CBS) was adapted from Health Belief System Scale developed by Asare (2006). This scale comprised of 14 items which are on a six-point Likert scale response format (where 1=“strongly disagree” and 6=“agree”). The scale determined the extent to which participants agreed with the statement about cultural beliefs for seeking psychological help. No item was reversed before summing. A high score indicated a high influence cultural belief system in help-seeking behaviours. The reliability coefficient for the present study was 0.70.

(f) Attitudes towards seeking professional psychological help scale

The Attitude towards seeking professional psychological help scale (ATSPPH) was adapted for the present study (Section F). The scale was developed to determine the extent to which participants agreed with the statement about attitudes towards seeking psychological help. The scale was developed by Fischer and Turner (1970). It has 29 items which measure 4 factors that assesses an individual's attitudes towards seeking professional psychological help. The 4 factors are; (i) recognition for need for psychological help (8 items) which measures the individual's awareness of need for professional psychological help; (ii) stigma tolerance (5 items) which assesses perceived degree of shame or stigma attached to seeking psychological help; (iii) interpersonal openness (7 items) is a measure of an individual's willingness to confide personal problems to others; and (iv) confidence in mental health practitioner (9 items) which assesses an individual's degree of trust and confidence in mental health professionals. The ATSPPH has a four-point Likert scale format. The total score is the summation of all specific items responded on the scale (i.e., where 0="disagree" and 4="agree") by a respondent. A high score indicated a more positive attitude toward seeking help. The Cronbach alpha for the overall ATSPPH scale was .85 and ranged from .62 to .74 for subscale (Fischer & Turner, 1970). Internal consistency of the scale is .83. The present study adapted 28 items and overall Cronbach Alpha reliability coefficient was 0.72.

3.7 Procedure

A pilot study was first conducted to ascertain the psychometric properties of the scales in this study. The main study was then carried out after it was ascertained that the psychometric properties of the scales were good. The details of the pilot and main study are provided below.

3.7.1 The Pilot Study

A pilot study was conducted to determine the validity of the questionnaires used for all the six measures as well as the feasibility of the administration procedure. In all, 40 young adults from Ada College of Education in the Greater Accra Region were used for the pilot study. Results of the pilot indicated that almost all the participants understood the terms and content of each questionnaire. A reliability score for cultural beliefs scale was tested since it was a new constructed scale and had no original score. The reliability coefficient was 0.70 for the present study.

3.7.2 The Main Study

A letter of introduction from the Department of Psychology, University of Ghana, was taken and given to the head of the selected institution to help seek permission to conduct the study in the tertiary institution (Accra College of Education). The assistance of the Vice Principal Academic, students' academic overseer, and two research assistants were sought in sampling and distributing the questionnaires to the respondents. Respondents were met in their various classrooms to inform them about the study. They were asked to participate in the study. Those who were available and willing to be part of the study were used for this study. The respondents were made to sign informed consents which were detached from the questionnaire immediately in order to keep their anonymity. The questionnaires were distributed to them and were given a day to respond to it. They were further informed that they could withdraw at any time from the study without any penalty. Due to confidentiality and other ethical considerations, each respondent was made to sign a consent form. The respondents were given adequate information about the research. Hence, they participated on their own volition and were also given the opportunity to ask questions, especially, after the study, to diffuse any harboured misconception.

3.8 Ethical Considerations

This study used self-report questionnaires to obtain demographic information and data on the determinants of seeking professional psychological help in contemporary Ghana. Data obtained from the study was kept under lock and key. Confidentiality of information has been maintained. The code of ethics as prescribed by the American Psychological Association was also strictly followed. University of Ghana embossed pens were given to all participants for successful completion of questionnaire.

CHAPTER FOUR

RESULTS

4.1 Introduction

The study was guided by six main aims in its quest to examine the determinants of seeking professional psychological help in contemporary Ghana. The first aim was to examine whether experience with mental health service would significantly account for attitudes towards seeking professional help after controlling for demographic characteristics.

The second aim was to investigate whether, after controlling for demographic characteristics and experience with mental health service, perceived social support (being family, friends, and significant other) would significantly account attitudes towards seeking professional help.

The third aim was to examine if health locus of control (internal, chance, and powerful others) would significantly account for attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, and perceived social support (family, friends, and significant other).

The fourth aim also investigated if self-stigma would significantly account for attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, perceived social support (family, friends, and significant other), and health locus of control (internal, chance, and powerful others).

The fifth aim was to find out if cultural belief would significantly account for attitudes towards seeking professional help after controlling for demographic characteristics, experience with

mental health service, perceived social support (family, friends, and significant other), health locus of control (internal, chance, and powerful others), and self-stigma. Lastly, this study aimed to account for all the factors that significantly predicted attitudes towards seeking professional help among Ghanaians.

4.2 Analysis of Data

Five hypotheses were formulated based on the aims of the study. Inferential statistics like the correlation and hierarchical multiple regression were used to test the various hypotheses. The sixteenth version of the Statistical Package for Social Sciences (SPSS) software was used in analysing the data.

4.3 Demographic Characteristics of Respondents

A total of three hundred and fifty-four (354) respondents were used in this study with a mean age of 24.46 years, standard deviation of 3.15 years, and ranging from 20-35 years. This included 171 (48.3%) males and 183 (51.7%) females. Majority (322) of the respondents were Christians with Muslims and Traditionalists being 31 and 1 respectively.

Table 1: Demographic Characteristics

VARIABLES	FREQUENCY			PERCENTAGE		
	Males	Females	Total	Males	Females	Total
Religion						
Christian	147	175	322	41.5	49.4	91
Muslim	23	8	31	6.5	2.3	8.8
Traditionalist	1	0	1	0.3	0	0.3
Total	171	183	354	48.3	51.7	100
Marital Status						
Single	164	169	333	46.3	47.7	94.1
Married	6	13	19	1.7	3.7	5.4
Divorced	1	1	2	0.3	0.3	0.6
Total	171	183	354	48.3	51.7	100
Have you experienced a Mental Health Service?						
Yes	10	10	20	2.8	2.8	5.6
No	161	173	334	45.5	48.9	94.4
Total	171	183	354	48.3	51.7	100
Specialist seen						
Clinical Psychologist	4	1	5	21.1	5.3	26.3
Psychiatrist	2	2	4	10.5	10.5	21.1
Counsellor	3	7	10	15.8	36.8	52.6
Total	9	10	19	47.4	52.6	100
Was it voluntary?						
Yes	8	9	17	42.1	47.4	89.5
No	1	1	2	5.3	5.3	10.5
Total	9	10	19	47.4	52.6	100
Currently seeking a Mental Health Service?						
Yes	3	1	4	0.8	0.3	1.1
No	168	182	350	47.5	51.4	98.9
Total	171	183	354	48.3	51.7	100

All the respondents were students in a tertiary institution and have stayed in Accra for at least a year. Three hundred and thirty-three (333) respondents were single, nineteen (19) respondents married, and 1 respondent divorced. Twenty respondents admitted being seen by mental health specialist specifically, a clinical psychologist, psychiatrist and a counsellor. It was further revealed that majority of these respondents were seen as a voluntary case (89.5%) with session spanning within 1-6 times. Majority (52.6%) believed that the service offered was very helpful whilst 42.1% of the respondents believed it was extremely helpful, and 5.3% of the respondents believed they cannot tell. Currently, 5 respondents are being seen by a mental health specialist (clinical psychologist, psychiatrist, or a counsellor) as a voluntary case with the majority (60%) of these respondents being seen by a counsellor. Further detailed information is presented in Table 1.

4.4 Descriptive Statistics

Table 2: Means and Standard Deviations of Continuous Variables

Variables	N	Mean	Std. Deviation
Age	354	24.46	3.15
Health Locus of Control	354	71.82	13.04
Internal health locus of control	354	27.11	5.76
Chance health locus of control	354	20.23	6.48
Powerful others health locus of control	354	24.48	5.47
Perceived social support	354	61.16	13.61
Family social support	354	20.64	5.41
Friend social support	354	18.25	5.51
Significant others social support	354	22.27	5.85
Self-stigma	354	24.42	6.60
Cultural belief	354	49.49	11.19
Attitudes towards seeking professional help	354	47.53	8.92

Table 2 presents the mean and standard deviation scores for the various continuous variables used in this current study.

4.5 Results of the Correlation Matrix

Results in Table 3 are the correlation matrix between all the continuous variables and attitudes towards seeking professional help of the study. Findings in Table 3 indicated that there are significant relationships between cultural belief and attitudes towards seeking professional help [$r(352) = .324, p=.000$], health locus of control (Total) and attitudes towards seeking professional help [$r(352)=.198, p=.000$] as well as its sub-scales (chance health locus of control and powerful others health locus of control) and attitudes towards seeking professional help [$r(352) = .194, p = .000$; $r(352) = .195, p = .000$, respectively], and perceived social support (total) and attitudes towards seeking professional help [$r(352)=.162, p=.001$] as well as the subscales friend and significant others social support and attitudes towards seeking professional help [$r(352)=.105, p=.024$; and $r(352)=.205, p=.000$] respectively.

Table 3: Correlation Matrix

	1	2	3	4	5	6	7	8	9	10	11
1. Self-Stigma	-	.240**	-.040	-.246**	.166**	-.033	-.094*	-.105*	.012	-.132**	.064
2. Cultural Belief		-	.368**	.106*	.391**	.303**	.186**	.143**	.153**	.156**	.324**
3. Health Locus of Control (Total)			-	.674**	.738**	.799**	.279**	.285**	.140**	.254**	.198**
4. Internal Health Locus of Control				-	.143**	.383**	.227**	.238**	.063	.249**	.044
5. Chance Health Locus of Control					-	.424**	.158**	.159**	.104*	.123**	.194**
6. Powerful others Health Locus of Control						-	.237**	.239**	.143**	.197**	.195**
7. Social support (Total)							-	.817**	.776**	.842**	.162**
8. Family Social Support								-	.434**	.568**	.079
9. Friend Social Support									-	.462**	.105*
10. Significant Others Social Support										-	.205**
11. Attitudes toward seeking professional psychological help											-

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

However, according to Table 3, there were no significant relationships between self-stigma and attitudes towards seeking professional help [$r(352) = .064, p = .115$], internal health locus of control and attitudes towards seeking professional help [$r(352) = .044, p = .207$], and family social support and attitudes towards seeking a professional help [$r(352) = .079, p = .070$].

4.6 TESTING OF HYPOTHESES

4.6.1 Hierarchical Multiple Regression Analysis

The hierarchical multiple regression analysis was used to test the various hypotheses in order to assess the extent to which mental health experience, perceived social support (family, friends, and significant others), mental health locus of control (chance, internal, and powerful others), self-stigma, and cultural belief, uniquely account for attitudes toward seeking professional help. Hence, Table 4 presents the hierarchical regression analysis for all the stated hypotheses.

Table 4: Hierarchical Multiple Regression Analysis testing Demographics, Mental Health Experience, Social Support, Locus of Control, Self-Stigma, and Cultural Belief

	B	SEB	β
Step 1			
Constant	47.19	.80	
Sex (Males)	-0.20	0.99	-.01
Religion (Muslim)	0.19	1.78	.01
(Traditional)	5.01	9.06	.03
Marital Status (Married)	-1.23	2.37	-.03
(Divorced)	-0.32	6.93	-.00
Age (26-30)	0.49	1.18	.02
(31-35)	2.73	2.73	.06
Years lived in Accra (1-2 years)	1.18	1.45	.05
(3-4 years)	1.39	1.57	.05
(5-6 years)	-0.53	1.40	-.02
Step 2			
Mental health experience	2.48	2.11	.06
Step 3 (Social Support)			
Family Social Support	-0.12	0.11	-.07
Friends Social Support	0.03	0.10	.02
Significant Other Social Support	0.40	0.11	.26**
Step 4 (Health Locus of Control)			
Internal Health Locus of Control	-0.11	0.09	-.07
Chance Health Locus of Control	0.18	0.08	.13*
Powerful others Health Locus of Control	0.25	0.10	.15*
Step 5			
Self-stigma	0.07	0.08	.05
Step 6			
Cultural Belief	0.22	0.05	.28**

Note: * $p < .05$, ** $p < .001$

$R^2 = .009$ for step 1, $\Delta R^2 = .004$ for step 2, $\Delta R^2 = .051$ for step 3, $\Delta R^2 = .048$ for step 4, $\Delta R^2 = .002$ for step 5, $\Delta R^2 = .058$ for step 6.

According to Table 4 step 1, demographic characteristics accounted for 0.9% variance in attitudes towards seeking professional help although it was not significant [$F(10, 343) = .306, p = .979, R^2 = .009$]. Step 2 also accounted for 1.3% in the total variance in attitudes towards seeking professional help although it did not significantly contribute to the model [$F(11, 342) = .405, p = .954, R^2 = .013$]. That is, it uniquely accounted for 0.4% change in the total variance in attitudes towards seeking professional help although it is not significant [$\Delta F(1, 342) = 1.389, \Delta = .239, \Delta R^2 = .004$].

Step 3 accounted for 6.5% variance in attitudes towards seeking professional help although it did not significantly contribute to the total model [$F(14, 339) = 1.653, p = .064, R^2 = .064$]. However, it uniquely contributed 5.1% significant change to the model [$\Delta F(3, 339) = 6.164, \Delta p = .000, \Delta R^2 = .051$]. The fourth step further significantly accounted for 11.2% to the total model [$F(17, 336) = 2.502, p = .001, R^2 = .112$]. It also uniquely and significantly accounted for 4.8% change in attitudes towards seeking professional help [$\Delta F(3, 336) = 6.115, \Delta p = .000, \Delta R^2 = .048$]. The fifth step also significantly accounted for 11.4% to the variance in attitudes towards seeking professional help [$F(18, 335) = 2.406, p = .001, R^2 = .114$]. However, it uniquely contributed 0.2% change to the total variance in attitudes towards seeking professional help which was not significant [$\Delta F(1, 335) = .787, \Delta p = .376, \Delta R^2 = .002$]. Step 6 significantly accounted for 17.3% variance in attitudes towards seeking professional help [$F(19, 334) = 3.669, p = .001, R^2 = .173$]. That is, the model uniquely and significantly accounted for 5.8% change in the total variance in attitudes towards seeking professional help [$F(1, 334) = 23.510, \Delta p = .000, \Delta R^2 = .058$].

Therefore, as revealed in Table 4, the factors that significantly accounted for attitudes towards seeking professional psychological help were perceived social support from significant others ($\beta = .22, p=.001$), chance health locus of control ($\beta=.13, p=.025$), powerful others health locus of control ($\beta=.15, p=.01$), and cultural belief ($\beta=.28, p=.000$). In all, the factors accounted for 17.3% of the variation in seeking professional psychological help among contemporary Ghanaians.

Hypothesis One

The first hypothesis stated that experience with mental health service would significantly predict seeking professional psychological help after controlling for demographic characteristics. The hierarchical multiple regression analysis was used to analyse this hypothesis and the result is presented in Table 4 (step 2). According to Table 4 (step 2), the addition of experience with mental health service led to 0.4% increase in the amount of variance explained in attitudes toward seeking professional help [$\Delta F(1, 342) = 1.389, \Delta p = .239, \Delta R^2 = .004$]. That is, experience with mental health did not significantly predict attitude towards seeking professional help after controlling for demographic characteristics ($\beta = .06, p = .239$). Therefore, the hypothesis that experience with mental health service would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics was not supported by the data.

Hypothesis Two

The second hypothesis stated that social support (being family, friends, and significant other) would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics and experience with mental health service. The hierarchical multiple regression was used to analyse this hypothesis and the result presented in Table 4 step 3 indicate

that perceived social support in general, uniquely and significantly accounted for 5.1% of the total variance in attitudes towards seeking professional help [$\Delta F(3, 339)=6.164, \Delta p = .000, \Delta R^2= .051$]. However, it was found out that each perceived social support type did not significantly predict attitudes towards seeking professional help except for significant other social support. That is, family social support ($\beta = -.07, p = .299$) and friend social support ($\beta = .02, p = .283$) did not significantly predict attitudes towards seeking professional help but not for significant other social support ($\beta = .26, p = .000$). Hence, the hypothesis that perceived social support (being family, friends, and significant other) would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics and experience with mental health service was rejected.

Hypothesis Three

The third hypothesis stated that health locus of control (internal, chance, and powerful others) would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, and perceived social support (family, friends, and significant other). Table 4 step 4 revealed that health locus of control uniquely and significantly account for 4.8% change in the variance in attitudes towards seeking professional help [$\Delta F(3, 336) = 6.115, \Delta p = .000, \Delta R^2 = .048$]. It further revealed that two out of the three health locus of control types significantly predicted attitudes seeking professional help. That is, chance health locus of control ($\beta = .13, p = .025$) and powerful others health locus of control ($\beta = .15, p = .014$) were found to significantly predict attitudes towards seeking professional help but not for internal health locus of control ($\beta = -.07, p = .243$). Therefore, the hypothesis that health locus of control (internal, chance, and powerful others) would significantly predict attitudes towards seeking professional help after controlling for demographic

characteristics, experience with mental health service, and social support (family, friends, and significant other) was supported by the data.

Hypothesis Four

The fourth hypothesis stated that self-stigma would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, social support (family, friends, and significant other), and health locus of control (internal, chance, and powerful others). Table 4 step 5 indicated that self-stigma accounted for 0.2% change in the total variance in attitudes toward seeking a professional help but the change was not significant [$\Delta F(1, 335) = .787$, $\Delta p = .376$, $\Delta R^2 = .002$]. Furthermore, it was revealed that self-stigma ($\beta = .05$, $p = .376$) did not significantly predict attitudes towards seeking professional help. In other words, the hypothesis that self-stigma would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, perceived social support (family, friends, and significant other), and health locus of control (internal, chance, and powerful others) was not supported by the data.

Hypothesis Five

The fifth hypothesis stated that cultural belief would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, perceived social support (family, friends, and significant other), health locus of control (internal, chance, and powerful others), and self-stigma. Results in Table 4 step 6 indicated cultural belief significantly and uniquely accounted for 5.8% change in the variance of attitudes towards seeking a professional help [$\Delta F(1, 335) = 23.510$, $\Delta p = .000$, $\Delta R^2 = .058$]. Specifically, cultural belief was found to significantly predict attitudes towards seeking professional help ($\beta =$

.28, $p = .000$). Therefore, the hypothesis that cultural belief would significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, perceived social support (family, friends, and significant other), health locus of control (internal, chance, and powerful others), and self-stigma was supported by the data.

4.7 Additional Analyses for Respondents who have not Experienced Mental Health

The hierarchical multiple regression analysis was used to assess the extent to which social support (family, friends, and significant others), mental health locus of control (chance, internal, and powerful others), self-stigma, and cultural belief, uniquely account for attitudes towards seeking professional help among respondents who have not experienced mental health ($n = 334$). Hence, Table 5 presents the hierarchical regression analysis.

Table 5: Hierarchical Multiple Regression Analysis testing Demographics, Social Support, Locus of Control, Self-Stigma, and Cultural Belief

	B	SEB	β
Step 1			
Constant	46.944	.816	
Sex (Males)	-.035	1.017	-.002
Religion (Muslim)	-.671	1.852	-.021
(Traditional)	5.091	9.028	.031
Marital Status (Married)	-.558	2.631	-.013
(Divorced)	.947	6.981	.008
Age (26-30)	.747	1.216	.035
(31-35)	1.627	2.908	.038
Years lived in Accra (1-2 years)	1.468	1.469	.058
(3-4 years)	1.154	1.614	.041
(5-6 years)	-.284	1.453	-.012
Step 2 (Social Support)			
Family Social Support	-.089	.115	-.055
Friends Social Support	.008	.103	.005
Significant Other Social Support	.402	.108	.268**
Step 3 (Health Locus of Control)			
Internal Health Locus of Control	-.104	.093	-.068
Chance Health Locus of Control	.174	.081	.126*
Powerful others Health Locus of Control	.247	.103	.152*
Step 4			
Self-stigma	.046	.079	.034
Step 5			
Cultural Belief	.229	.048	.290**

Note: * $p < .05$, ** $p < .001$

$R^2 = .008$ for step 1, $\Delta R^2 = .055$ for step 2, $\Delta R^2 = .046$ for step 3, $\Delta R^2 = .001$ for step 4, $\Delta R^2 = .061$ for step 5.

According to Table 5 step 1, demographic characteristics accounted for 0.8% variance in attitudes towards seeking professional help although it was not significant [$F(10, 323) = .254, p = .970, R^2 = .008$]. Step 2 also accounted for 6.3% in the total variance in attitudes towards seeking professional help although it did not significantly contribute to the model [$F(13, 320) = 1.643, p = .072, R^2 = .063$]. That is, it uniquely accounted for 5.5% change in the total variance in attitudes towards seeking professional help although it is not significant [$\Delta F(3, 320) = 6.231, \Delta p = .000, \Delta R^2 = .055$].

Step 3 accounted for 10.9% variance in attitudes towards seeking professional help and it significantly contribute to the total model [$F(16, 317) = 2.418, p = .002, R^2 = .109$]. It uniquely contributed 4.6% significant change to the model [$\Delta F(3, 317) = 5.479, \Delta p = .001, \Delta R^2 = .046$]. The fourth step further significantly accounted for 11% to the total model [$F(17, 316) = 2.291, p = .003, R^2 = .110$]. However, it accounted for 0.01% change in attitudes towards seeking professional help [$\Delta F(1, 316) = 0.342, \Delta p = .559, \Delta R^2 = .001$]. The fifth step also significantly accounted for 17.1% to the variance in attitudes towards seeking professional help [$F(18, 315) = 3.610, p = .000, R^2 = .171$]. It also uniquely and significantly contributed 6.1% change to the total variance in attitudes towards seeking professional help [$\Delta F(1, 315) = 23.281, \Delta p = .000, \Delta R^2 = .061$].

As revealed in Table 5, the factors that significantly accounted for attitudes towards seeking professional psychological help among respondents who have not experienced mental health services were perceived social support from significant others ($\beta = .27, p = .000$), chance locus of control ($\beta = .13, p = .034$), powerful others locus of control ($\beta = .15, p = .017$), and cultural belief ($\beta = .29, p = .000$). In all, the factors accounted for 17.1% of the variation in seeking professional psychological help among contemporary Ghanaians. Therefore, comparing this table (Table 5) to

Table 4, it could be noted that there was only 0.2% decrease in the variation in seeking professional psychological help among contemporary Ghanaians. However, the factors that significantly accounted for attitudes toward seeking professional psychological help were the same for those who have or not experienced mental health services.

Figure 2: Revised Conceptual Model

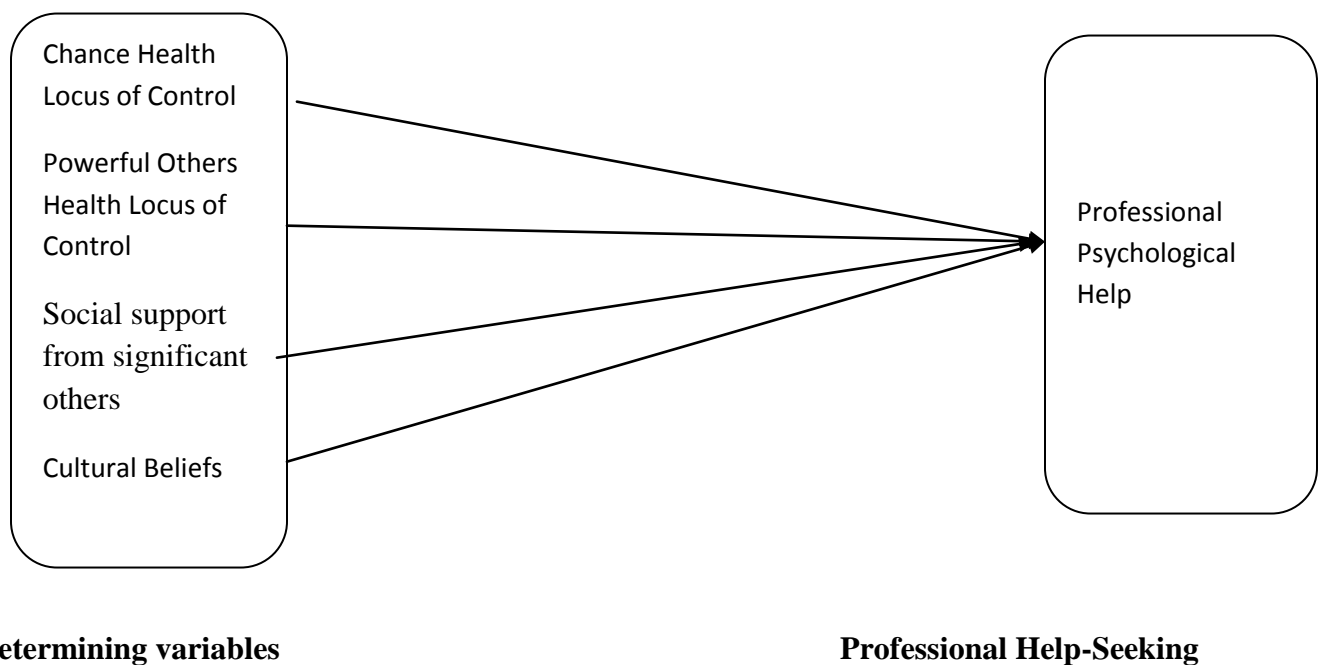


Figure 2 is the conceptual model which outlines the variables that significantly predicted professional psychological help seeking behaviour among contemporary Ghanaians.

4.7 Summary of Findings

In all, this study tested five hypotheses to unearth the determinants of seeking professional psychological help in contemporary Ghana. The findings observed from the data analyses are presented below:

1. Experience with mental health service did not significantly predict attitudes towards seeking professional help after controlling for demographic characteristics.
2. Family social support and friend social support did not significantly predict attitudes towards seeking professional help but not for significant other social support.
3. Chance health locus of control and powerful others health locus of control were found to significantly predict attitudes towards seeking professional help whilst internal health locus of control was not.
4. 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 (family, friends, and significant other), and locus of control (internal, chance, and powerful others).
5. Cultural belief was found to significantly predict attitudes towards seeking professional help.
6. Furthermore, the factors that significantly accounted for attitudes towards seeking professional psychological help were found to be perceived social support from significant other, chance health locus of control, powerful others health locus of control, and cultural belief.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This current research was guided by six main aims in its quest to examine the determinants of seeking professional psychological help in contemporary Ghana. The first aim was to examine whether experience with mental health service would significantly account for attitudes towards seeking professional help after controlling for demographic characteristics. The second aim was to investigate whether, after controlling for demographic characteristics and experience with mental health service, social support (being family, friends, and significant other) would significantly account attitudes towards seeking professional help.

The third aim was to examine if health locus of control (internal, chance, and powerful others) would significantly account for attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, and social support (family, friends, and significant other). The fourth aim also investigated if self-stigma would significantly account for attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, social support (family, friends, and significant other), and health locus of control (internal, chance, and powerful others).

The fifth aim was to find out if cultural belief would significantly account for attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, social support (family, friends, and significant other), health locus of control (internal, chance, and powerful others), and self-stigma. Lastly, this study aimed to account for all the factors that significantly predicted attitudes toward seeking professional help among

Ghanaians. The discussion is based on these five main aims.

5.1.1 Mental Health Service and Attitudes towards Seeking Professional Help

The result revealed that prior experience with mental health service does not predict one's attitudes toward seeking professional help. That is, after controlling for demographic characteristics, locus of control (internal, chance, and powerful others), self-stigma, and social support (family, friends, and significant others), one's mental health experience did not predict attitudes towards seeking professional help. Hence, whether one has experienced mental health service before or not, it does not have any effect on one's attitudes towards seeking a professional help. As suggested by the theory of reasoned action, an individual's behaviour depends on the choice to do so and their use of rational decision-making process (Ajzen & Fishbein, 1980). Furthermore, an individual's volitional behavioural intention depends on the individual's attitude about the behaviour and subjective norms surrounding the performance of the behaviour. Hence, an action can be understood as a product of one's attitude towards the behaviour and the person's intention to carry out the behaviour and not necessarily having experienced it.

Possible explanation for the non-significant result could be that some situations or factors such as distress condition influence an individual to seek the help of a professional. This finding is inconsistent with some previous studies (e.g Al-Rowaie, 2001; Schomerus, Matschinger, & Angermeyer, 2009; Smith et al., 2004), who have indicated that previous contact with mental health professionals aid or predict one's intention to seek the help needed from these professionals. For instance, a study by Skogstad et al. (2006) revealed that individuals who have had contact with a psychologist in a particular situation (and in their study, outside the prison life) have higher intentions to seek psychological help. This situational variable was further

reported in the study by Skogstad et al. (2006). They reported that those respondents in their study who have had previous contact with prison psychologists had lower intentions to seek help. Therefore, one (with these findings in mind) can assume that some situational factors contribute to an individual's continual intention to seek help from a professional psychologist or psychiatrist.

Another plausible explanation for the non-significant result lie in the fact that sometimes when someone even recommends a mental health service for an individual, he/she would seek help. This finding is consistent with results of previous researches, which found recommendation from someone could even make people seek psychological help. For instance Takamura et al. (2008) and Vogel et al. (2007) pointed out in their study that not only personal contact with professional psychologists or psychiatrists predicts one's attitudes towards seeking professional psychological help. When there is the evidence of professional psychologist's or psychiatrist's ability to help in the current situation then an individual will seek their service and not necessarily their prior experience. Yet, another study found out that it is not always the case that knowing someone who had sought this kind of help predicts one's attitudes towards seeking professional psychological help (Bergeron et al., 2005). They reported in their study that having relatives with mental disorders do not significantly predict one's attitudes towards seeking professional psychological help. Other studies have also revealed that people would seek professional psychological help if they are in greater psychological distress or when the illness is very severe and not necessarily their prior contact (Bland et al., 1997; Rickwood & Braithwaite, 1994; Sareen et al., 2005).

Therefore, an individual's attitudes towards seeking professional psychological help go beyond the knowledge of these professional's services to their efficacy in helping during the crises. That

is, whether patients or clients were able to receive the help they were seeking during the previous visit. A study by Sareen et al. (2005) revealed that one of the barriers in seeking professional psychological help is the feeling that treatment would not be adequate. Hence, when the patient or client is satisfied with the service gotten from these professionals then it is most likely he or she will continuously seek their help. In other words, they would have positive attitudes towards seeking professional psychological help. Hence, it can be said that all these issues discussed possibly reflected the reasons why prior mental health experience did not predict attitudes toward seeking professional psychological help.

5.1.2 Social Support and Attitudes towards Seeking Professional Help

Findings from the study revealed that only “significant other” social support was able to significantly predict one’s attitudes towards seeking professional help after controlling for demographic characteristics and experience with mental health service. Family social support and friend social support did not significantly predict attitudes towards seeking professional help after controlling for demographic characteristics and experience with mental health service. This, with respect to current study, means that an individual’s attitudes towards seeking professional help would depend on the support offered by significant others in his or her life but not from the family or friends (taking only social support into consideration). However, in general, social support uniquely and significantly accounted for 5.1% variance in attitudes towards seeking professional help. This percentage indicates that among all the variables that would predict an individual’s attitudes towards seeking professional help, social support (being family, friends, and significant other) contributes that much to one’s intention in seeking professional psychological help.

Several studies have found social support to be one of the factors that “cushions” an individual against life pressure which sometimes lead to several psychological problems (Friedlander et al., 2007; Rawson et al., 1994; Teoh & Rose, 2001). In other words, the immediate social environment is said to have positive influence on our psychological health (Fallon & Bowles, 2001). Hence, those closest to an individual may be an important social influence or factor in the decision to seek professional help (Pescosolido & Boyer, 1999; Rickwood & Braithwaite, 1994). This has also been supported by Angermeyer et al., (2001) indicating that those closest to an individual are influential in whether or not a person in distressing situation will seek professional help. Further studies (e.g. Horwitz, 1977; Kilinc & Granello, 2003) have even revealed that people with personal concerns generally discuss issues with at least four of their social network about their concerns before seeking professional help. Most researches suggested that friends and family (i.e. informal social support) are preferred to formal social support by college students and friends are the first stated choice of help (Horwitz, 1977; Kilinc & Granello, 2003). A study by Dew et al. (1991) further supported that among individuals experiencing symptoms of depression, those who sought help were more likely to have had friends or relatives recommending to them to get help than those who had not sought help.

However, the reverse was experienced in this current study. Therefore, it can be assumed that family and friends might be serving as a buffer against life stressors whilst significant other acts as agent promoting health and wellness (Dollete et al., 2004). In other words, friends and family members can serve as protective factors against psychological problems but when they fail or it happens that this protected individual is now having psychological problems then significant others’ reparation service will be needed in the form of recommending or helping the individual to seek professional psychological help. This has further been proven by Miville and Constantine

(2005). They reported that lower perceived social support from family and higher perceived social support from significant others were important in helping or hindering a student's attitude towards seeking professional help. Furthermore, it has also been reported that among students who had similar problems sought help, it was revealed that those who sought formal help from significant other (special person) had higher levels of satisfaction about the help as compared to those who sought help from friends and families although they reported higher levels of problem seriousness as well as lower levels of comfort with the interaction than the students who do not sought help. Lin et al. (1996) also revealed in their study among urban residents that public assistance for individuals in the urban centres, as like respondents of this current study, is a significant predictor of attitudes towards seeking professional help.

5.1.3 Health Locus of Control and Attitudes towards Seeking Professional Help

Findings of the analysis revealed that health locus of control uniquely and significantly account for 4.8% change in the variance in attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, and social support (family, friends, and significant other). In other words, the percentage indicates that health locus of control exclusively contributes 4.8 out of 100 (of all potential variables) to an individual's attitudes towards seeking professional help. It further revealed that two out of the three health locus of control types significantly predicted attitudes towards seeking professional help. Specifically, chance health locus of control and powerful others health locus of control were found to significantly predict attitudes towards seeking professional help but not for internal health locus of control.

The results gotten are quite not far from the reality taking Africans' causal inference of disease into consideration. In other words, it has been reported that Africans are more likely to attribute

an illness to an external agent, spiritual or social cause rather than physiological or scientific cause (Madge, 1998). They are more likely to seek help in that respective domain (spiritualist) than from professionals. For example, studies (Gregg & Curry, 1994; Klonoff & Landrine, 1996) have revealed that African Americans were likely to attribute illness externally to destiny or the will of God (equity attributions) and believe in the healing power of prayer, so may not seek help from a mental health professional when in need of one. Specifically, among Ethiopians, mental illness is attributed to cosmic or supernatural causes such as curses or spiritual possession (Mulatu, 2000) which is likened to chance health locus of control and powerful others health locus of control as compared to internal health locus of control which is mostly linked to physiological or scientific causes.

It has also been noted in a study (Ustundag-Budak & Mocan-Ayidin, 2005) that there is a strong negative relationship between internal health locus of control and symptom reporting. This further suggests that those individuals who possess more internal health locus of control would be reporting fewer symptoms and at the worst case scenario would not even like to seek help from a professional (White et al., 2006) as individual's health beliefs or perception concerning their health and subsequent decision to seek help have been found to predict one's help-seeking behaviour (Ormel & Schaufeli, 1991).

However, some studies among adolescents have revealed that females with internal locus of control were more likely to report seeking help than male adolescents with external locus of control (Schonert-Reichl & Muller, 1996; Simoni, Adelman, & Nelson, 1991). Andrews et al. (2011) also posited that locus of control alone did not relate help-seeking behaviour but their interactions did. They reported that chance locus of control negatively predicted psychological

help-seeking among only degree holders. In other words, they believed that chance or fate determined outcomes of illness, hence, the less likely that they would seek help.

Furthermore, those individuals who believed more in powerful others or had more God-centred locus of control expressed a greater willingness to seek professional psychological help than those who did not. With respect to this study, chance health locus of control and powerful others locus of control significantly and positively predicted attitudes towards seeking professional psychological help which means that these respondents are more likely to seek professional psychological help. However, there is also the greater possibility that they would also seek the help of spiritualist due to the powerful others locus of control.

5.1.4 Self-Stigma and Attitudes towards Seeking Professional Help

Results from the study revealed that self-stigma uniquely accounted for only 0.2% variance in the total attitudes towards seeking a professional help. It was also found that self-stigma did not significantly predict attitudes towards seeking professional help after controlling for demographic characteristics, experience with mental health service, social support (family, friends, and significant other), and health locus of control (internal, chance, and powerful others). This means that self-stigma, according to this study, does not influence an individual's attitudes toward seeking professional psychological help. An individual's decision or attitudes towards seeking professional psychological help therefore would depend on other variables but not self-stigma. This can be explained from the point of view that the respondents used in this study were tertiary students trained to serve as educationists hence, might have had their stigma level diffused as education has been found to present this effect (Bland et al., 1997; Mackenzie et al., 2006; Skogstad et al., 2006; Takamura et al., 2008).

A study has revealed that even the anticipated individual discrimination and discrimination qua self-stigmatisation are associated with a reduced readiness to seek professional help for mental disorders (Schomerus & Angermeyer, 2008). It has also been reported that other people would feel embarrassed about seeking help from professionals, and believed that they would have a negative reaction if they sought such help (Barney et al., 2006). Studies have also demonstrated that self-stigma and the anticipated risks and benefits of counselling significantly predicted negative attitudes toward seeking counselling (Hackler et al., 2010; Corrigan, 2004; Wrigley et al., 2005). Hence, the destigmatisation may lead to increased readiness to seek professional help, but other aspects like knowledge about mental diseases seem to be at least as important (Schomerus & Angermeyer, 2008).

With respect to this study, self- stigma would not have any significance on an individual's attitude towards seeking professional psychological help except for other stigma like social stigma (Vogel et al., 2007) as self-stigma is described as the internalization of the perceived stigma of mental illness in the culture which affects the stigmatized person's self-efficacy and self-esteem (Corrigan, 2004; Komiya et al., 1997; Vogel et al., 2007).

More so, social stigmatizing attitudes have been found by Mojtabai (2010) to be strongly associated with individual stigmatizing attitudes. It has also been noted that the view that all stigmatizing attitudes toward mental illness are associated with reluctance to seek professional help is naive as some stigmatizing attitudes are associated with increased willingness to seek help. Specifically, social and individual stigmatizing attitudes have been reported to be associated with willingness to seek professional help (Mojtabai, 2010).

In a similar study by Komiti et al. (2006), the factors that significantly predicted one's attitudes toward seeking professional psychological help were the belief in the treatment modality, a mood, anxiety or substance use disorder, higher distress levels, and greater functional disability due to physical problems but not for stigma. That is, their results had several variables predicting attitudes toward seeking professional psychological help but stigma was not. Moreover, a study by Hoyt et al. (1997) found out that the size of place was also related to level of stigma toward mental health care. Hence, persons living in the most rural environments were more likely to hold stigmatized attitudes towards mental health care which strongly predicts one's willingness to seek care. This result is partly similar to this current study as the respondents used in this study were from the urban area hence, are expected to have minimal or no stigma toward seeking professional psychological help. This supports the results of this current study.

5.1.5 Cultural Belief and Attitudes towards Seeking Professional Help

The results indicated that cultural belief significantly and uniquely accounted for 5.8% change in the variance of attitudes towards seeking a professional help. Specifically, cultural belief was found to significantly predict attitudes towards seeking professional help. The cultural beliefs of the aetiology of an illness usually correspond to its treatment modality. The attribution theory explains that individuals search for causal understanding of everyday events (Weiner, 1980, 1995) based on their belief. It has also been noted that these attributions differ across cultures (Anderson, 1999; Morris & Peng, 1994). Hence, individuals of different cultural backgrounds may make different attributions to illness, health, and help-seeking (treatment). African Americans have been reported to attribute illness externally to destiny or the will of God (equity attributions) and believe in the healing power of prayer (Gregg & Curry, 1994; Klonoff & Landrine, 1996) whilst Western populations may attribute illness to physiological or scientific cause (Madge,

1998). Specifically, a study among Ethiopians indicated that they attributed mental illness to cosmic or supernatural causes such as curses or spiritual possession (Mulatu, 2000). This study's result is similar to the African Americans and Ethiopians beliefs about health and illnesses (Gregg & Curry, 1994; Mulatu, 2000). Ghanaians, like other Africans, believe in spiritual causation of illnesses. Hence, spiritualists usually become the first point of call in times of mental illnesses. However, orthodox treatment is not completely out of the picture as medical doctors are consulted at a point in time to complement the spiritual treatment. This is believed to be the exact situation among respondents used in this particular study.

The biopsychosocial model to help-seeking also accounts for the different factors that influence human health, illness and health care delivery (Santrock, 2007). The social aspect of this model examines how the different social factors such as culture, socioeconomic status, social support, religion among others can influence health, illness and health care delivery. Specifically, Ghanaians will consult the spiritualist, medical doctor, and other significant persons in their social setting for help in times illnesses.

Different cultures believe in different aetiology of illnesses which therefore calls for their respective treatment models. A study by Fung and Wong (2007) revealed that even individuals from the same continent or country can have different cultural beliefs about illnesses. The findings revealed that cultural beliefs of Ghanaian respondents were positively related to attitudes toward seeking professional help. This further indicates that Ghanaians' cultural beliefs would enhance one's intention of seeking professional psychological help. This also indicates that these respondents are willing to use the scientific services of professionals as compared to Koreans who were more likely to actively endorse traditional, non-Western beliefs, including both “non-

Western physiological” and “supernatural beliefs” (Fung & Wong, 2007). This also presupposes that an individual would seek professional help based on how that individual perceives the illness.

5.2 Contributions of the Study

Issues surrounding individuals’ attitudes towards seeking professional help or the willingness to seek professional help have been gaining popularity among clinical researchers. However, the factors related to the attitudes towards seeking professional psychological help are still not extensive worldwide and almost none have been reported among Ghanaians. The examination of the attitudes towards seeking professional psychological help among Ghanaians would therefore, go a long way to advice policy makers in devising appropriate measures to help counter the barriers to professional psychological help-seeking behaviour. Moreover, the knowledge and understanding of the relationship between these variables will help therapists to comprehend how diverse individuals seek professional help. With respect to this current study, the variables that were found to positively predict an individual’s attitudes towards seeking professional help among contemporary Ghanaians were perceived social support from significant other, chance health locus of control, powerful others health locus of control, and cultural belief. This current study being the first of its kind in Ghana, presents these variables as determinants of seeking professional among Ghanaians. Finally, the study adds to the literature in general.

5.3 Limitation of the Study

Despite the importance of these findings, some limitations of this study should be noted. Firstly, the results are based solely on self-report measures and as such, social desirability response biases might be present.

Also, the convenience sampling strategy (a non-probability sampling technique) was employed in helping to select respondents for the study. The weakness of this sampling technique is its limits to generalization. The reason for this technique was partially due to the apparently reluctant attitude of the trainees, thus more respondents were selected to compensate for the weakness of the sampling strategy used. It is therefore, important that caution should be exercised when generalizing the results of the study.

Again, this study addresses only perceived factors that are to determine one's help-seeking reported by young people, given that they may not be aware of all the potentially influential factors.

5.4 Implications and Recommendations

The current study has practical implications for clinicians and further studies.

Clinicians

Information concerning mental health is continuously changing and the dynamics that influence help-seeking are varied among societies, thus, mental health professional are being advised to continually update their facts about it. This study presents factors that significantly predict professional psychological help-seeking. The results of the study found that cultural beliefs about the causes of illness predict attitudes for seeking psychological help and individuals from varying cultural settings make different attributions to illness, health and help-seeking. Of another clinical importance are the varying effects of social support and locus of control, especially significant others and powerful others for social support and locus of control respectively. Therefore, clinicians should understand the cultural and personal dynamics of their clients in order to have a good therapeutic relationship.

Further Studies

Findings of this study revealed that self-stigma, friends' support and family support do not predict help-seeking behaviour. Since self-report measure was used in the study, it is recommended that a qualitative study be used to ascertain in-depth reasons for such results.

This study should be replicated but using uneducated (no formal education) population to ascertain the variations of results. Future researchers should also consider variables like, knowledge of available psychological services, access to these known psychological services and knowledge or perception of cost of psychological services. These could give additional important contextual factors that may impact help seeking behaviours.

The study employed the convenience sampling technique to sample respondents, which limits the extent of generalization of the findings of the study. Therefore, future researches should use probability random sampling methods to enhance representativeness of sample and wider generalization.

5.5 Conclusion

The current study examined the determinants of seeking professional psychological help using three hundred and fifty-four contemporary Ghanaians. Specifically, it investigated whether prior experience, perceived social support, health locus of control, cultural beliefs would uniquely predict help-seeking behaviours. From the findings, significant other social support significantly predicted professional help-seeking but family and friends social support did not. It can therefore be concluded that individuals within early adulthood have special persons in their lives, who share their joys, sorrows and are around in times of need. Hence, individuals are willing to rely on these significant others in times of difficulties.

It was also found that chance and powerful others health locus of control significantly and positively predicted attitudes towards seeking professional help. In this view, it can be said that individuals are likely to attribute their illness to external agents, such as spiritual or social cause rather than internal factors being responsible for their health and illness.

Finally, cultural beliefs were found to significantly predict attitudes toward seeking professional help. It suggests that the more the cultural beliefs of an individual, the more his/her attitudes toward seeking professional help. In all, chance and powerful others health locus of control, significant others social support, and cultural beliefs were found to be the determinants of attitudes towards seeking professional psychological help among contemporary Ghanaians.

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APPENDICES

Appendix 1: Letter of Introduction



UNIVERSITY OF GHANA
DEPARTMENT OF PSYCHOLOGY

Tel: (233-0302) 500381 Ext.3754/3310
028 955 04 63

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PSYC 2/33/02

May 9, 2012

Our Ref. No:.....

The Principal
Accra College of Education
Accra

Dear Sir or Madam

**LETTER OF INTRODUCTION
STELLA SERWAA BOAFO**

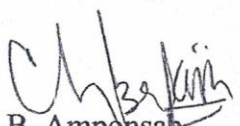
The above-named is an M.Phil Clinical Psychology student at the University of Ghana, Legon.

In partial fulfillment of the requirement for the award of the MPhil degree Ms **Stella Serwaa Boaf** has to write and submit an original thesis. She has selected the topic: "*Determinants of Seeking Professional Psychological Help in Contemporary Ghana.*"

To enable her collect data for her work she would need to administer questionnaires and or conduct interviews. She has selected your institution as suitable for her data collection.

Any assistance you may give her would be greatly appreciated.

Yours faithfully


Dr. B. Amponsah
Head of Department

Appendix 2: Informed consent

DEPARTMENT OF PSYCHOLOGY**UNIVERSITY OF GHANA****0302-500381**

Psychology@ug.edu.gh

**DETERMINANTS OF SEEKING PROFESSIONAL PSYCHOLOGICAL HELP IN
CONTEMPORARY GHANA****INFORMED CONSENT STATEMENT**

Invitation to Participate and Description of the Project. You are being asked to participate in the study Determinants of seeking professional psychological help in contemporary Ghana.

1. This topic is being investigated to understand what factors influence people's help-seeking behaviours. Your participation in this research is voluntary. Before agreeing to be part of this study, please read and/or listen to the following information carefully. Feel free to ask questions if you do not understand something.

2. Description of Procedure. If you participate in this study, you will (may) be asked to:

- a. Provide personal information (excluding your name) and information about what factors influence help seeking behaviour.
- b. Answer questionnaires by either ticking or circling the appropriate response as it applies to you.
- c. The entire experiment will take not more than forty (40) minutes.

3. Risks and Inconveniences. You will not be exposed to any significant risk. However, you may be tired during the answering of the questionnaire. You will be allowed enough time to be able to complete the questionnaires.

4. Benefits. Participating in this study is expected to enhance knowledge about factors that influence help-seeking behaviours.

5. Confidentiality. Any information provided in this study will be kept confidential within the limits of the law. The data will be stored in a securely locked cabinet. Only persons taking part in this study like my supervisors will have access to this information you are providing. Your names are not required in this study hence no reference will be made to you in particular.

7. Voluntary Participation. Your participation in this study is entirely voluntary. You may refuse to participate in this research. Such refusal will not have any negative consequences for you. If you begin to participate in the research, you may at any time, for any reason, discontinue your participation without any negative consequences.

Authorization: I have read or listened to the above information and I have decided that I will participate in the project described above. The researcher has explained the study to me and answered my questions. I understand that the purpose of the study is to explore factors of seeking – help. If I don't participate, there will be no penalty or loss of rights. I can stop participating at any time, even after I have started.

I agree to give permission for my participation in the research, 'Determinants of seeking professional psychological help'. My signature below also indicates that I have received a copy of the consent form and have adequately understood the implications of the study.

Print Initials

Address

Phone Number

Email

Participant signature

Date

If you have further questions about this research project, please contact the principal investigator on Telephone number +233-208719634 or through e-mail at amabee70@yahoo.com or the Supervisors: Prof. S. A. Danquah (Tel: 0265-191-590) and Prof. Charity, S. Akotia (0208127695).

Appendix 3: Questionnaire used in study

DEMOGRAPHIC DATA**SECTION A**

Please tick (✓) the appropriate box

1. Gender: Male[] Female[]
2. Age:
3. Religion: Christian[] Moslem [] Traditional[]
Others (please specify)
4. Marital status: Single[] Married [] Divorced[]
5. Level of education: Basic [] Secondary[] Tertiary []
6. How many years have you lived in Accra? 1-2years[] 3-4[] 5-6[] More than 6 years []
7. What is your occupation? Student [] Unemployed [] Worker []
8. Have you ever been a client to professional mental health services (e.g. from a Clinical Psychologist, Psychiatrist or Counselor).
.....YesNo (if no skip question 9 and continue from question 13).
9. If you answered yes to question 8, please indicate to the best of your knowledge who you saw for mental health services
..... Clinical Psychologist
..... Psychiatrist
.....Counselor
..... Other (Indicate who).

10. Was your participation in mental health treatment voluntary?

.....Yes No

11. How many sessions did you have?

12. Generally speaking, how helpful were your experiences with mental health services?

i. Extremely unhelpful ii. Very unhelpful iii. Cannot tell iv. Very helpful
v. extremely helpful.

13. Are you currently a client of professional mental health services (e.g. clinical psychologist, psychiatrist or counselor)?

.....Yes No

14. If Yes which one?

..... Clinical psychologist

..... Psychiatrist

..... Counselor

15. Is your current participation in mental health treatment voluntary?

..... Yes No

16. So far, has your experience with mental health services been positive, negative or neutral.

SECTION B**MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL**

Instructions: Each item below is a belief statement about your medical/ psychological condition with which you may agree or disagree. For each item tick the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher will be the number you circle. Please make sure that you answer **EVERY ITEM** and **ONLY ONE** number per item. This is a measure of your personal beliefs and there are no wrong answers. For each statement below, decide whether you **1: Strongly Disagree, 2: Moderately disagree, 3: Slightly disagree, 4: Slightly agree, 5: Moderately agree, 6: Strongly agree.**

NO		1	2	3	4	5	6
1	If I sick, it is my own behaviour which determines how soon I get well again.						
2	No matter what I do, if I am going to get sick, I will get sick.						
3	Having regular contact with my physician is the best way for me to avoid illness.						
4	Most things that affect my health happen to me by accident.						
5	Whenever I don't feel well, I should consult a medically trained professional.						
6	I am in control of my health.						
7	My family has a lot to do with my becoming sick or staying healthy.						
8	When I get sick, I am to blame.						
9	Luck plays a big part in determining how soon I will recover from an illness.						
10	Health professionals control my health.						
11	My good health is largely a matter of good fortune.						
12	The main thing which affects my health is what I myself do.						
13	If I take care of myself, I can avoid illness.						
14	Whenever I recover from an illness, it's usually because other people (e.g. doctor, nurses, family, friends) have been good care of me.						
15	No matter what I do, I'm likely to get sick.						
16	If it's meant to be, I will stay healthy.						
17	If I take the right actions, I can stay healthy.						
18	Regarding my health, I can only do what my doctor tells me to do.						

SECTION C**MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT**

Instruction: Please answer each of the following statements by ticking one of the numbers (1-7) which reflect **how very strongly you disagree (1) or very strongly you agree (7)** with the statements about your social support.

There are no wrong answers. For each statement below, decide whether you **1: Very strongly disagree, 2: Strongly disagree, 3: Mildly disagree, 4: Neutral, 5: Mildly agree, 6: Strongly agree 7: Very strongly agree.**

NO		1	2	3	4	5	6	7
1	There is a special person who is around when I am in need.							
2	There is a special person with whom I can share my joys and sorrows.							
3	My family really tries to help me.							
4	I get the emotional help and support I need from my family.							
5	I have a special person who is a real source of comfort to me.							
6	My friends really try to help me.							
7	I can count on my friends when things go wrong.							
8	I can talk about my problems with my family.							
9	I have friends with whom I can share my joys and sorrows.							
10	There is a special person in my life who cares about my feelings.							
11	My family is willing to help me make decisions.							
12	I can talk about my problems with my friends.							

SECTION D**SELF STIGMA OF SEEKING HELP**

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.

NO		1	2	3	4	5
1	I would feel inadequate if I went to a therapist for psychological help.					
2	My self-confidence would NOT be threatened if I sought professional help.					
3	Seeking psychological help would make me feel less intelligent.					
4	My self-esteem would increase if I talked to a therapist.					
5	My view of myself would not change just because I made the choice to see a therapist.					
6	It would make me feel inferior to ask a therapist for help.					
7	I would feel okay about myself if I made the choice to seek professional help.					
8	If I went to a therapist, I would be less satisfied with myself.					
9	My self-confidence would remain the same if I sought professional help for a problem I could not solve.					
10	I would feel worse about myself if I could not solve my own problems.					

SECTION E**CULTURAL BELIEF SCALE**

Instruction: Please answer each of the following statements by ticking one of the number (1-6) which reflect **how strongly disagree (1) or 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.**

NO		1	2	3	4	5	6
1	When I experience any mental health problem, I believe it is the work of evil spirits.						
2	If I offend my ancestors, they can cause severe illness to me.						
3	Today, evil spirits are causing most people with mental health problems.						
4	Our health is in our control.						
5	No matter what I do, if God decides I should be getting sick, I will be sick.						
6	Witchcraft practices cause illness to some people.						
7	I believe that curses can cause illness.						
8	Spiritual traditional healers are more potent in healing mental health problems than any other person.						
9	All mental health problems are caused by evil spirits and demonic attacks.						
10	gods have not cause people to fall sick and die.						
11	If I have not wrong anyone, no matter how worse my medical/ psychological condition may be I will surely recover.						
12	When I recover from illness, it is mainly because some people have been praying for me.						
13	If I get sick, God will determine how soon I will get well again.						
14	Mental Health Professional cannot help when I have problem with mental health.						

SECTION F**ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP
SCALE**

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 **disagree**, **somewhat disagree**, **somewhat agree**, or **agree**. Circle one number for each statement to indicate your response.

		Disagree	Somewhat Disagree	Somewhat Agree	Agree
	For this study the term 'mental health professional' refers to any of the following person: clinical psychologist, counsellor, or psychiatrist.				
1	Although there are clinics for people with mental health difficulties, I would not have much faith in them.	0	1	2	3
2	If a good friend asked my advice about a mental health problem, I might recommend that he/ she see a mental health professional.	0	1	2	3
3	I would feel uneasy going to a mental health professional because of what some people would think.	0	1	2	3
4	A person with strong character can get over mental health difficulties by him/ herself, and would have little need for a mental health professional.	0	1	2	3
5	There are times when I felt completely lost and would have welcomed professional advice for personal or emotional problem.	0	1	2	3
6	Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	0	1	2	3
7	I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	0	1	2	3
8	I would rather live with certain mental health difficulties than go through the	0	1	2	3

	ordeal of getting professional mental health assistance.				
9	Personal and emotional troubles, like many things, tend to work out by themselves.	0	1	2	3
10	There are certain problems which should not be discussed outside of one's family.	0	1	2	3
11	A person with a serious emotional disturbance would probably feel most secure in a good mental health facility.	0	1	2	3
12	If I believed I was having mental health difficulties, my first inclination would be to get professional attention.	0	1	2	3
13	Keeping one's mind on a job is a good solution for avoiding personal worries.	0	1	2	3
14	Having been a mental health patient/client is blot on a person's life.	0	1	2	3
15	I would rather be advised by a close friend than by a mental health professional, even for an emotional problem.	0	1	2	3
16	A person with an emotional problem is not likely to solve it alone; he/ she is likely to solve it with professional help.	0	1	2	3
17	I resent a person- professional trained or not- who wants to know about my personal difficulties.	0	1	2	3
18	I would want to get professional mental health attention if I was worried or upset for a long period of time.	0	1	2	3
19	The idea of talking about problems with a mental health professional strikes me as a poor way to get rid of emotional conflicts.	0	1	2	3
20	Having been mentally ill carries with it a burden of shame.	0	1	2	3
21	There are experiences in my life I would not discuss with anyone.	0	1	2	3
22	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.	0	1	2	3
23	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.	0	1	2	3

24	At some future time I might want to have psychological counseling.	0	1	2	3
25	A person should work out his/ her own problems; getting psychological counseling would be a last resort.	0	1	2	3
26	Had I received treatment in a mental health facility, I would not feel that it ought to be 'covered up.'	0	1	2	3
27	If I thought I needed professional mental health assistance, I would get it no matter who knew about it.	0	1	2	3
28	It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and pastors.	0	1	2	3