"A QUALITATIVE INVESTIGATION INTO THE PERCEIVED BENEFITS AND BARRIERS IN ACCESSING PSYCHOLOGICAL SERVICES AMONGST FIRST YEAR UNIVERSITY STUDENTS"

BY:

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Short dissertation submitted in partial fulfilments of the requirement for the degree of Masters in Clinical Psychology

In the

School of Applied Sciences, Psychology discipline

At the

University of KwaZulu-Natal, Howard College

SUPERVISOR: MR S. VALJEE

February 2015

DECLARATION

I Pebetse Rahab Garlie Matabane declare that the study titled **"A qualitative investigation into the perceived benefits and barriers in accessing psychological services amongst first year university students"** is a reflection of my own work unless otherwise stated. I declare that all the sources used for this study are indicated and acknowledged by means of complete references.

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ACKNOWLEDGEMENTS

DEDICATION

MY SON AMOGELANG ZWELETHU DUARTE MATABANE FOR BEING SUCH A PATIENT, DESCIPLINED YOUNG MAN WITHOUT MOMMY'S PRESENCE.

"MAY THE LORD ALMIGHTY BLESS AND PROTECT YOU"

ABSTRACT

Aim:

This study aimed at investigating the perceived benefits and perceived barriers in accessing psychological services amongst 1st year humanities' students from University of KwaZulu-Natal (Howard College).

Methodology:

Purposive sampling was employed to select the 16 participants in this study. Semi-structured interviews were conducted. The sample was stratified according to race and thematic analysis was used to analyse data.

Results:

The findings from this study suggest that the participants do not have sufficient knowledge regarding the purpose of psychological services and the psychologists' scope of practice. Gender roles, cultural belief and language were identified as barriers in accessing psychological services. Furthermore, participants indicated that denial, stigma and shame were perceived as indirect threats regarding their decisions to access psychological services and this was most likely the case when their illness had physical symptoms and appeared severe. The majority of the participants preferred other forms of interventions such as traditional healing, ancestral offerings and prayer. However these were dependent upon the participant's socio-cultural context.

Conclusion:

The results from this study suggest that even though the participants are aware of some of the benefits of utilising psychological services they often prefer sources of help that they are familiar with while the perceived barriers served as justification for not utilising these services even when they could easily access them within the university setting.

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CHAPTER 1

1. GENERAL INTRODUCTION TO THE STUDY

1.1. Introduction

Psychological services refer to different services rendered by psychologists or people in the profession of psychology. These services include counselling, therapy, research, psycho-education, crisis interventions and assessments (Sommers-Flanagan & Heck, 2013). According to the Health Professional Council of South Africa (HPCSA), Form 223, a psychologist is a person registered with the HPCSA board of psychology.

The development of South Africa since 1994 has allowed mental health to gain recognition as an important public health sector (Kakuma, Kleintjes, Lund, Drew, Green, Flisher & MHaPP Research Programme Consortium, 2010). Deumert (2010) stated that the apartheid era has given the white community the privilege to wealth and education as compared to the formerly oppressed black South Africans. Furthermore, being white and wealthy was a privilege; therefore the white population received quality health care treatment while the black population had inferior or no services. During the apartheid era, most people from the black population had difficulties accessing psychological services because a majority of them were located in the rural areas (Deumert, 2010). Furthermore, the limited access to mental health services may be a result of low economic status (unemployment, illiteracy, poverty) and social factors (stigma, lack of support from family or friends) (Kakuma, et al., 2010; WHO, 2009). In addition the WHO (2009) stated that up to 85% of people from low economic countries do not have access to adequate health care services as compared to those in high income countries and that the majority of psychological services are located in urban areas, with minimal services offered in rural areas.

Karuri-Sebina, Hemson and Carter (2010) reported that to move from the old apartheid bureaucracy and empower South Africans to have equal rights to health services the new South African government established Batho Pele Principles in 1997. "Batho Pele" is a seSotho expression meaning "putting people first". In addition, they stated that the principles were put in place to ensure free and effective service delivery in public sectors. According to Constable Mabena and Minishi-Mjanja (2007) Batho Pele principles emphasises that all patients have the right to utilise public services. In Constable Mabena et al. (2007) it is stated

that all service providers are urged by the government to prioritise the needs of each patient and deliver services that are acceptable and of good quality.

Batho Pele principles stipulate that; patients should have a choice about the services they are receiving; they should be informed about the quality of services rendered; all citizens are entitled to equal access of services; patients should be treated with courtesy and consideration; they are entitled to full information regarding the services they are about to receive; they have the right to know the person in charge and how the facility operates; when they are not satisfied with services, they are entitled to an apology and an alternative way to remedy the mishap and the public services should be provided professionally in order to render quality services to the public (Constable et al., 2007; Karuri-Sebina, 2010).

During the apartheid regime indigenous languages were oppressed, therefore English and Afrikaans were used as a medium of communication (Deumert, 2010; Ross & Deverell, 2010). Service providers or government officials were unresponsive, rude and refused to speak or learn other languages (Karuri-Sebina, 2010). Since the advent of democracy in 1994, the government attempted overcoming discrimination even with the access to health care (Deumert, 2010).

According to Deumert (2010) most service providers are English and Afrikaans speakers and language may influence the effectiveness of service delivery in public sectors. A study at three different hospitals (urban, rural and secondary metropolitan) in Western Cape, South Africa aimed at investigating the institutional response to linguistic diversity at public hospitals in South Africa (Deumert, 2010). It also explored the use of informal interpreters during consultations. It was found that the majority of health care providers with the exclusion of nurses have difficulties in interacting with patients in their indigenous languages. Furthermore use of informal interpreters was found to have a negative impact on history taking and diagnosis. Informal interpreters may reshape the messages conveyed and be overwhelmed by emotional responsibilities while acting as mediators between language and culture (Deumert, 2010). Moreover, there is a need for service providers to learn different African vernacular languages and understand black African cultures in order to understand certain symptoms in the patient's context and the patient's explanatory model. The assumption was that a language learner would gain competence in their level of communication to be able to understand an individual's complexities through the depth of dialogue that mental health practitioners engage in. Furthermore, this will also help

psychologists to be able to understand patients in the context they exist in rather than focusing on Western models of assessment and diagnosis (Deumert, 2010; Naidoo, 2000). Guo (2012) asserts that the lack of understanding other's languages is the cause of most misdiagnosis and communication breakdowns during consultations. In addition some languages may have the same words but its meaning could be completely different. Therefore a patient's reasoning and responses may sometimes send mixed messages to health care providers if their cultural beliefs and values are not known (Guo, 2012; Ross, & Deverell, 2010).

The lack of knowledge of how psychological services can benefit students, language, the level of education, culture, religion and gender appear to be significant barriers contributing to the lack of motivation towards help seeking behaviour (Bathje & Pryor, 2011; Campbell, Kearns & Patchin, 2006; Deumert, 2010; Vogel, Wade & Haake, 2006).

1.2.   The Dynamics of Help Seeking Behaviour

According to Mesidor, Gidugu, Rogers, Kash-MacDonald and Boardman (2011) there are various factors that could prevent some people with psychological problems to seek professional help. Moreover these factors may range from individualistic, societal or even the community's perspective. The individual may assume that the psychologist will not understand what they say or how they feel. This misunderstanding may make patients feel inadequate and reduces their motivation toward seeking psychological help.

Loewenthal, Mohamed, Mukhopadhyay, Ganesh and Thomas (2012) stated that culture is deemed to influence individuals' access to psychological services. There are different cultures globally therefore most psychological concepts may have different meanings to a diverse community. According to Hornea, Graupnera, Frosta, Weinmanb, Wright and Hankinsa (2004) culture is learned not inherited. They further stated that learned behaviour from a particular social group may include a collection of thoughts, behaviour and conduct. Therefore these patterns distinguish an individual from a certain social group.

The mental health care providers at the University of KwaZulu-Natal Howard College reported that they offer students from the College of Humanities psychological services as individuals or in groups. Individual services include personal counselling, career assessment, career counselling, crisis management, psychotherapy and academic support. Group services

include support groups, career workshops, interview skills and workshops on various relevant topics. These services are offered freely to all students registered with the College of Humanities from different cultural, racial and socio-economic backgrounds.

According to the statistics obtained from the student support services offering students from the College of Humanities with psychological services, from July 2012 to March 2014, 565 students utilised the services. A total number of 7263 students which comprises of 1366 post graduates and 5897 under graduate students are thus far enrolled at the College of Humanities for 2013. Amongst the 565 students who accessed psychological services 30% of students were male whereas 70% of the students were female. The majority of students who utilised psychological services were, respectively, black Africans (73%), Indians (10.2%), others (6.3%), whites (6.2%) and coloureds (4.3%).

1.3.   Statement of the Problem

According to Petersen (2010) the prevalence of mental disorders worldwide has risen to 450 million and estimates attribute approximately 14% of the disease burden worldwide to neuropsychiatric disorders such as substance abuse, psychosis, depression and anxiety disorders. Following other infectious diseases such as HIV/AIDS, neuropsychiatric disorders are the third leading cause of disease burden in South Africa (Kakuma et al., 2010). The World Health Organisation (2009) estimates that 54 million people globally are suffering from severe mental disorders and that approximately 154 million are living with depression. WHO (2009) further stated that approximately 80% of people from low income countries suffer from different types of untreated mental disorders. Those mental disorders include intellectual disabilities, epilepsy, schizophrenia and depression. Moreover, common disorders like anxiety and depression are not prioritised as much as mental disorders such as schizophrenia, bipolar and psychosis. People from low income countries with untreated mental disorders may have a high suicide risk (WHO, 2009). Moreover, the high suicide rate may be a result of the lack of access to mental health services and untreated mental problems. According to Burns (2014) 75% of South Africans with mental disorders do not receive mental health treatment. The 2007 October household survey reported that the 43% of white South Africans have easier access to private health care as compared to the 7% of the black South Africans, 19% of coloureds and 31% Indians in South Africa (Deumert, 2010). Additionally there is a wide treatment

gap between the low and high socio-economic countries in South Africa, Africa and other countries (Burns, 2014; WHO, 2009).

1.4. Significance of the study

This research will attempt to investigate what students perceive as barriers and benefits of accessing psychological services. It will further explore the student's knowledge regarding mental health and the services rendered by psychologists. Based on the statistics obtained from the faculty of humanities' student counselling center at the University of Kwa-Zulu Natal (Howard College), there was an indication of a small percentage of the students from the faculty of humanities accessing psychological services as compared to the general population. This does not preclude that other students may access services privately or in public hospitals. There was also a discrepancy in gender and race regarding the access of psychological services. This discrepancy may be a result of interpersonal or intrapersonal factors. At the beginning of the year (January-February) the majority of students from the College of Humanities utilised the services for career counseling and academic degree/course information. In the middle of the year (June-August) student support services were accessed due to (respectively) academic degree/course information, food insecurity, depression and anxiety. Towards the end of the year (September-October) students utilised psychological services due to relationship problems, depression and anxiety. In comparison to the previous years (2012 and 2013), March 2014 seemed to have an increase in access and a variation in the presentations or diagnosis. Students seem to have presented with relational problems, depression and anxiety early in the year while they were usually expected in the middle or towards the end of the year. The researcher's hypothesis regarding the different diagnosis or referral reasons is that during the beginning of the year most students are usually undecided of their career path and adjusting to the new environment. In the middle of the year students form relationships with peers and partners while the anxiety and depression may be precipitated by the final examination period.

The researcher found it necessary to investigate the reasons for minimum access, discrepancy on race and gender and the students' knowledge of the purpose of psychological services and psychological problems through this qualitative study. The

findings of the study may assist mental health providers on campuses to improve and promote mental health care to students.

1.5. Motivation of the study

This study was motivated by the researcher's assumption that students lack information regarding psychological services. This is due to the limited number of students accessing psychological services at the University of KwaZulu-Natal at Howard College (College of Humanities). The other motivation is to disseminate information to students about the purpose of psychological services and improve the access of psychological services. The researcher assumes that this may be achieved by establishing annual mental wellness visits in the Universities.

1.6. The study's hypothesis

Social stigma, language and the lack of knowledge regarding what psychological services are on offer may be the reason for the lack of motivation towards help seeking behaviour. Students with adequate knowledge and perceived control over the social stigma related to mental health may be more likely to access psychological services.

1.7. Definition of key concepts

1.7.1 Acculturation

Acculturation is the adoption of values, beliefs, cultural traditions, assumptions and the practices of the dominating culture by ethnic cultural minorities (Pillay, 2005).

1.7.2 Culture

Culture is defined as "the set of beliefs, rules of behaviour and customary behaviour maintained, practiced and transmitted in a given society" (Cole, Stevenson & Rodger, 2009, p2).

1.7.3 Mental health

Mental health is our psychological, emotional and social state of wellbeing. It determines how we think, relate to others, create balance between life activities, cope with normal stress, feel, make moral choices and contribute to the community (WHO, 2001).

1.7.4 Others

In this study, the term "others" refer to all the black participants who are registered as students at University of KwaZulu Natal (Howard College) and are from neighbouring countries.

1.7.5 Psychological services

All services rendered by a psychologist and these include psychotherapy, crisis interventions and assessments (Sommers-Flanagan & Heck, 2013).

1.8. Delimitation and study site

This study is delimited to 1st year students at the University of KwaZulu-Natal (Howard College) in the School of Humanities. This focus will make it easy for the researcher to control the participants of the study. The University of KwaZulu-Natal (Howard College) is situated in Durban in the province of KwaZulu-Natal South Africa. It was initially an institution for predominantly white students but currently consist of a number of diverse students. It was ranked third in South Africa and in the 401-500 worldwide by the Academic Ranking of World Universities in 2010.

1.9. Conclusion

The study focuses on the perceived benefits and perceived barriers that University of KwaZulu-Natal (Howard College) 1st year students have towards accessing psychological services. The students' views will be explored further and this study aims on bringing awareness to both students and psychologists on how to bridge the gap between available psychological services in urban areas and communities in the rural areas

CHAPTER 2
2. LITERATURE REVIEW

2.1. Introduction

This chapter will review literature that explores the barriers and benefits of accessing psychological services from both a global and South African perspective. It will attempt to bring an understanding of psychological services by focusing on psychological interventions and psychological assessments. Influences of help seeking behaviour and the effect the services will have if they are reframed will be detailed. The attitude towards seeking professional psychological help and the difference between psychotherapy and coaching will be elaborated further. Moreover, cross cultural beliefs will be explored from the global and South African perspective. Furthermore, predictors of help seeking behaviour will also be discussed. In this study the attitudes towards seeking psychological help and factors affecting help seeking behaviour such as personal belief, gender, cross cultural factors and acculturation will be explored.

2.2. Psychological Intervention and Psychological Assessment

Sommers-Flanagan and Heck (2013) asserts that psychological interventions refer to an action taken by a mental health professional with the intention to change or modify behaviour. Moreover, change can be enabled using psychotherapy which is a unique encounter between psychotherapist and patient. According to Sommers-Flanagan and Heck (2013) this unique encounter typically includes interactions designed to build the therapeutic relationship (rapport), collecting assessment data, developing a case formulation and initiating psychotherapy. Furthermore, it may determine the type of intervention suitable for the patient as well as the relevant psychological test to be administered.

According to Foxcroft and Roodt (2009) psychological assessment involves the process of gathering information using psychological measures or tests and qualitative information collected from the client. In South Africa, populations with low supply of psychological services seem to have a high demand for mental health services and psychometrics. Furthermore, psychometrics may be useful in areas (mostly rural) whereby psychological

assessments for mental retardation or scholastic problems need to be done (Petersen, 2004). Factors such as adaptation and development of psychological assessment in South Africa need to be considered during assessment as they are under statutory control (Foxcroft, Paterson, le Roux & Herbst, 2004; Foxcroft & Roodt, 2009). In addition, the results of the assessment tools used have to be valid and reliable as they may be used during forensic and psycho legal cases to identify, diagnose, and determine personality and intellectual capacity.

In Foxcroft and Roodt (2009) it is stated that in South Africa the distribution of resources during the development of psychological assessment was unequal, based on race and not adapted for the diverse population. Moreover, in order for psychological assessments to be considered valid and reliable they must be in the context of the population, be in the language that the tests taker is most proficient in (mother tongue) and must not be culturally biased. Furthermore, South Africa still needs to bridge the gap of the development, adaptation and translation of psychological assessments in its context.

2.3. Influences on Help Seeking Behaviour

Erkan, Cihangir-Cankaya, Ozbay and Terzi (2012) stated that help seeking behaviour refers to the extent to which an individual utilise different external sources against a situation that threatens their regular functioning in order re-establish equilibrium. Usually most people only consider accessing mental health services when they have exhausted other alternative treatments or forms of interventions (Erkan et al., 2012; Ross & Deverell, 2010).

According to Erkan et al. (2012) people's decision making processes related to professional help seeking may be similar. In addition, it was discovered that after patients recognise that they have a problem they may start by contemplating to get help, observe the intensity of their problem and when they perceive that it is beyond them, they then decide to consult a professional to help deal with their problem. Furthermore, people's health belief may also influence the way some sicknesses are perceived and their behaviour while sick. Erkan et al. (2012) reported that individuals are most likely to seek psychological help when their psychological distress level increases and when their attitude towards psychological services is positive. Moreover, people may display help seeking behaviour for different reasons. Erkan et al. (2012) further asserts that these reasons may be prompted by their fears, weaknesses, and failure while others may voluntarily express their problems to professionals. In addition

factors that are likely to lead to health seeking behaviour may also include high frequency of stressful and unwanted events, intensive health problems and a lack of social support. It is believed that some people may consult friends or family members for their opinions, try to heal themselves and even go to traditional healers before considering accessing psychological services (Erkan et al., 2012; Helman, 2007).

In the study conducted by Cole, Stevenson and Rodger (2009) ethnicity, physical health and cultural health beliefs were found to be the main predictors of help seeking behaviour. The study explored the relationship between cultural health beliefs, general health, ethnicity, gender, general mental health and the use of mental health services. The sample in the study consisted of African American and non-Hispanic white adults aged 65 years or older.

According to Cole, Stevenson and Rodger (2009) elderly people believe that being sad is normal and part of life and that a person is capable of controlling their own mental health problems. In the study older white adults believed that physical disability and old age may decrease mental wellbeing, African Americans believed that good health can be maintained by prayer, religious faith and attending church regularly. The majority of African Americans from rural areas reported that God is responsible for all the healing process, therefore religious belief may also influence health management. The outcome of the Cole, Stevenson and Rodger (2009) study assumed that people's beliefs about health may be influenced by culture. Similarly Helman (2007) stated that elderly people's help seeking behaviour may be influenced by cultural and religious factors. Furthermore, the white population was found to be reporting their mental health problems more than the African American population. There were no significant gender differences in cultural health belief (Cole, Stevenson & Rodger, 2009).

2.4. Reframing Psychological Services

A study conducted by Shy and Waehler (2009) examined whether reframing psychological services as counselling or coaching have an impact on the student's expectations, participation, intentions to seek and access professional psychological services. In the study most participants were females and a majority of participants had past experience in accessing psychological services or have previously received counselling. It was hypothesised that individuals may access psychological services if the term was changed. It

was further stated that reframing mental health services as consultation or even seminars may help reduce fears associated with accessing psychological services. In their study males were more inclined to receiving directions from the coach while females were inspired and expected better outcome from psychological services. The outcome of Shy and Waehler's (2009) study suggested that regardless of which terminology was used students still had similar expectations, motivation and intention to seek psychological help.

According to Lannin, Guyll, Vogel and Madon (2013) the willingness to seek or access professional psychological services also played a vital role in obtaining positive outcomes in therapy. Vogel and Wester (2003) reported that reframing the term from psychological services to coaching, education or consultation may not have any impact on the expectation and intention to access or seek psychological professional help. However Shy and Waehler (2009) believed that changing of terminology may increase the likelihood of the general public to access psychological services and that these terms may be used interchangeably (Shy & Waehler,2009;Vogel & Wester, 2003). Psychotherapy is about uncovering and recovering while coaching is about discovering. Psychotherapy and coaching have a lot of similarities and this could be the reason most people confuse them (Wang, 2013).

2.5. Difference between Psychotherapy and Coaching

2.5.1. Psychotherapy

The definition of psychotherapy is not universal as it depends on one's preferred theory. However according to Prochaska and Norcross (2010) psychotherapy is an informed intentional therapeutic process that involves an interaction between a patient and a trained professional. Truscott (2010) believed that for the therapeutic process to be effective a patient and a trained professional must have faith in it and each other. In addition, therapeutic alliance is said to be of paramount importance during psychotherapy. It is often posed as the explanation for why therapy works. The therapeutic alliance has its roots in psychodynamic theory, where it was defined as a healthy, trusting aspect of the patient-therapist relationship. Moreover, the effectiveness of psychotherapy may be influenced by the patient's characteristics, motivational level and willingness to participate in the therapeutic sessions (Kadzin, 2009; Lannin et al., 2013; Norcross, 2011).

Prochaska and Norcross (2010) states that during psychotherapy different kinds of methods and techniques may be applied in order to explore thoughts and feelings of those experiencing psychological problems and mental distress. Moreover, the aim of psychotherapy is to maintain, manage, modify, uncover, improve the sense of wellbeing and recover from certain psychological problems. Norcross (2011) stated that discussing the goals of psychotherapy beforehand may make treatment easy and strengthens the therapeutic alliance.

The American Psychological Association (APA, 2013) stipulated that psychotherapy may be offered by trained psychologists, psychiatrists, counsellors, social workers etc. to individuals, groups, couples or families. In addition, Wang (2013) reported that these professionals are bound by ethical and legal obligations which serve to protect the rights of patients. According to Shy and Waehler (2009) therapeutic sessions are approximately 50 minutes to an hour. Paris (2013) believed that some patients may benefit from a brief course of therapy while others benefit from long-term therapy. Furthermore, the extent of psychotherapy is determined by the patient's presentation at the psychological services and the professional offering the services. Shy and Waehler (2009) further hypothesised that some of the fears or stigma attached to seeking psychological intervention may in fact be that prospective patients have limited ideas as to what interventions they are likely to encounter for their problems and hence see psychologists as "digging" into their private world with no purpose.

2.5.2. Coaching

According to Wang (2013) coaching is a collaborative partnership that involves the process of evolving and manifesting potential between a coach and the coached. Coaching deals with the conscious mind, emphasises the present and the future and focuses mainly on external issues. Shy and Waehler (2009) assert that during coaching the coach directs the patient on what to do or how to do things. In addition, coaching aims to discover a client's unused potential that may play a part in maximising life fulfilments. Furthermore, coaching comprises of non-directive facilitation approach and directive instructional approach. The relationship between the coached and a coach is essential as it determines the outcome and motivational level of attaining change (Wang, 2013). Coaching can be offered by trained coaches to individuals, groups or peers and its session may last for over an hour. Wang

(2013) further stated that although there is an ethical obligation to protect and respect the coached, the universal code of ethics in coaching has not been established.

2.6. Attitudes Towards Seeking Professional Psychological Help

There are various factors that contribute to students' attitudes towards accessing psychological services. Attitudes towards seeking professional psychological help includes factors such as interpersonal openness regarding one's openness, recognition of personal need of professional help, tolerance of stigma associated with psychotherapy and confidence in the ability to be assisted by a psychologist. It is believed that factors such as interpersonal openness and stigma are related to help seeking orientation (Masuda, Suzumura, Beauchamp, Howells, & Clay, 2005).

According to Masuda et al. (2005) demographics and personality may affect people's attitudes towards accessing psychological services. Furthermore, past experiences in seeking professional psychological help may also contribute to students' attitudes towards accessing psychological services. Most students who have been to a psychologist or know someone who accessed the services and benefited may also believe that accessing psychological services may benefit them. Masuda et al. (2005) asserts that students who have had past experience with psychotherapy are more likely to have a positive attitude towards accessing psychological services. In addition women are said to be more likely to access psychological professional services than men (Masuda et al., 2005).

Drapeau et al. (2009) conducted a study to determine the role of gender difference in accessing mental health care among the population in Canada. In the study it was found that culture plays a role in help seeking behaviour among men. Drapeau, Boyer and Lesage (2009) reported that factors relating to culture and stigma have an influence on the limited number of men accessing psychological services. In addition, men are associated with certain social roles and expectations in the society. They are perceived as masculine figures and because of the cultural values and beliefs of the society females are expected to depend on them for support (Drapeau et al., 2009; Ross & Deverell, 2010). Corby, McDonald and McLaren (2011) reported that men are expected to possess physical strength, be aggressive, be competitive, control their emotions and not seek help. However, the society finds it acceptable for females to get sick and access health care services (Ross & Deverell, 2010).

According to Ross and Deverell (2010) most cultures and societies perceive men who express their emotions as weak. Due to these perceptions it becomes challenging for men who conform to a masculine ideology that upholds self-reliance and restrictive emotionality to seek for help or disclose their feelings to others (Corby et al., 2011).

According to Drapeau et al. (2009) males are not as open minded as females, therefore they may be reluctant to acknowledge their mental health problems. In addition the male's marital status may also determine help seeking behaviour. Drapeau et al. (2009) stipulated that married men may be easily influenced by their spouse to access psychological services. Although females may have a positive influence in encouraging access of psychological services by their spouses the cultural norms and belief may result in a limited number of males accessing psychological services (Drapeau et al., 2009). In Ross and Deverell (2010) it is stated that men's low rate of access to mental health care may result in higher rates of hospitalisation because they usually seek help when the illness is severe.

2.7. Cross Cultural Beliefs: Global and South African Perspective

According to Swartz (2002) there are different cultures globally therefore most psychological concepts may have different meanings in different contexts. In Cole, Stevenson and Rodger (2009, p.2) culture is defined as "*the set of beliefs, rules of behaviour and customary behaviour maintained, practiced and transmitted in a given society*" (p.2). Similarly Swartz (2002) viewed culture as a set of guidelines inherited by a member of a certain society which informs them how to behave, view the world and experience emotionally in relation to their natural environment. These guidelines are passed on to the next generation by the use of language, symbols, rituals, observation and art (Cole, Stevenson & Rodger, 2009; Swartz, 2002). Ross and Deverell (2010, p. 101) quoted what Huff and Kline (1999) believed culture comprised. It is said to comprise a '*common pattern of communication, sound system, or language unique to the group; similarities in dietary preferences and preparation methods; common patterns of dress; predictable relationship and socialisation patterns among members of the culture; and a common set of shared values and beliefs*". Cole, Stevenson, and Rodger (2009) stated that culture does not only define the causes of illness, but also defines how illness is interpreted and presented. Illness is expressed based on what people may have observed and how their worldviews have been guided.

Loewenthal, Mohamed, Mukhopadhyay, Ganesh and Thomas (2012) conducted a study with the aim to investigate how they can improve access to psychological services particularly to Bengali, Urdu, Tamil and Somali speaking communities living in the United Kingdom. The outcome of the study was that minority groups residing in the UK do not have sufficient knowledge about psychological problems or services; furthermore language, culture and religion were noted to be barriers in accessing psychological services among them. It was further stated that psychological services in the UK do not have sufficient resources to meet the needs of these minorities. Moreover, amongst population from Somalia it was reported that the concepts of depression and anxiety were not well understood. The population perceived these psychological problems as daily life struggles. Loewenthal et al. (2012) asserts that while other countries like Somalia were not aware of these psychological concepts, some members of the population from South India felt that their culture deprived them from discussing their problems. As a result community members may not disclose their challenges to avoid shame, feelings of guilt or being ostracised by community members.

In Loewenthal et al. (2012) it emerged that the community and family members play a significant role in people's perceptions towards psychological services. In addition family ties may influence an individual's openness to mental health and access to psychological services. Bojuwoye (2013) asserts that people from African indigenous cultures perform rituals (e.g. death anniversary,) to unite family members, get sense of belonging, identity and good health (resolve anxieties). Furthermore, such unity may also be beneficial for psychotherapist as family members (family ties) may have a positive contribution or influence to a patient's wellbeing, reduction of stigma.

Culture bound syndromes are real syndromes that can only be found or explained by specific cultures. They are said to be indigenous illnesses. Those who usually do not meet the DSM-IV-TR criteria for any illness or disorder and their explanatory models of the presenting problems are understood in their cultural context are said to be presenting with culture bound syndromes (DSM -IV-TR, 2000; DSM-5, 2013). Certain illnesses may only be understood and cured in a certain way within a particular culture, while people outside that culture may not be aware of the presenting problem. In contrast to culture bound syndrome, in the Western society illness may be viewed bio-medically and the emotional turmoil may therefore be explained as an imbalance of neurotransmitters (Ross & Deverell, 2010). Helman (2007) stated that people's different beliefs regarding the causes of illness may prompt them to seek different kinds of interventions in order to control physical and

emotional pain. Moreover, they may use herbal remedies, medication, meditation, consult a medical physician, speak to elders, psychotherapy or consult with traditional or religious people. Seabi and Samouilhan (2010) conducted a study and sampled students from the University of Witwatersrand South Africa. The aim of the study was to explore students' false perception of the cause and treatment of mental illness that results in them not accessing the services. Some participants reported that some mental illness (e.g. schizophrenia, depression) may be caused by chemical imbalance, drugs or witchcraft. Moreover, black Africans may believe that mental illness is caused by witchcraft or precipitated by ancestors not looking over a person. Therefore, to bring harmony a traditional healer is consulted or certain rituals need to be performed in order to appease the ancestors (Bojuwoye, 2013; Wei, 2012).

Traditional or spiritual healers are preferred mostly by indigenous communities and they focus on consciousness. Moreover, some community members believe that mental illness is caused by misfortunes, witchcraft and lack of ancestral guidance. Furthermore rituals to appease the ancestors may be performed (Bojuwoye, 2013; Bojuwoye & Edwards, 2011; Edwards, Makunga, Thwala and Mbele, 2009). Refugees from traditional society may prefer a combination of traditional and western medicine. Moreover, this helps them have a sense of belonging, autonomy, identity and cultural continuity (Helman, 2007). Similarly, in South Africa the need for traditional, spiritual and mental health providers to co-operate with each other emerged because the mental health users utilise the services concurrently or consecutively. Additionally, the collaboration or co-operation of these healing systems will promote cultural congruence and encourage people to access psychological services (Helman, 2007; Petersen & Lund, 2011).

According to Julliard, Klimenko and Jacobs (2006) mental health is less prominent than the medical model and this could be because mental health was developed later than medicine and most hypotheses were derived from the medical model. For the most part we are oriented towards a medical model of illness due to the fact that mental health is less recognized than physical health. In addition, medical doctors are traditionally perceived as the dominant health care providers because they provide patients with medication. Helman (2007) stated that people may consider accessing services offered by medical doctors for any other problems they are experiencing and psychotherapy is considered as the last option (Julliard, Klimenko & Jacobs, 2006).

According to Helman (2007) the individual's explanatory model of mental health problems is informed by cultural conceptualisation. Julliard et al. (2006) stated that the medical model defined health as the absence of disease, the bodily state in which all parts are functioning. Medical models are not consistent in different parts of the world. It is sometimes adjusted based on the context and perspectives of health care providers and may be different depending on the area they are practising in (Helman, 2007). Furthermore, medical treatment should not only focus on an individual but should acknowledge different dimensions of illness namely social, religious, emotional and behavioural. Moreover, the failure to understand the underlying meaning of the presentation of illness and failure to acknowledge a patient as a holistic being may lead to the wrong diagnosis. Western medicine may fail to understand the patient's explanatory model of their presentation as it may involve social, moral and cultural aspects (Helman, 2007). The presentation of symptoms may be explained based on cultural and religious beliefs. Patients may explain their symptoms to be the result of supernatural or interpersonal factors (Helman, 2007; Ross & Deverell, 2010).

Julliard et al. (2006) criticised the medical model for only focusing on external factors, curing and eradicating illness. In Helman (2007) it is stated that some patients may not feel ill but physical abnormalities may be discovered on the biochemical level. This is called disease without illness and may be the reason people do not adhere to their treatment. In addition, the medical model's definition of health may be the reason most people believe that the absence of disease means they are in good health or as Cole, Stevenson and Rodger (2009) have mentioned in their study that people perceive some psychological problems or stressors as part of life.

The majority of people may not access service if they are asymptomatic even if they are told by medical doctors they are not well (Helman, 2007). It is further stated that some patients may present with what is called illness without disease. As a result in this case the patient may feel like they are not physically, emotionally, socially and spiritually well even though at the biochemical level physical abnormalities are not found. According to Levin and Browner (2005) the definition of health may be socially constructed therefore a person must be viewed holistically. In addition, spiritual, emotional, mental, physical and cultural aspects of an individual should also be considered in order to define health. Moreover, people from various cultural groups may believe that the physical quality of the body is the one that set limitation

and opportunities to their daily functioning. Levin and Browner (2005) further stated that people's interaction plays a vital role on the perception of health.

Culture has an influence on people's beliefs about health (Cole et al., 2009; Helman, 2007). Moreover, an individual's psychological problems must be interpreted and dealt with based on their cultural values, norms and belief. As a result, in some cases individuals may find it difficult to discuss their personal problems with health care providers due to the family's disapproval of help seeking behaviour outside the family system (Cole et al., 2009; Helman, 2007). According to Ross and Deverell (2010) family members may wish to provide their own support structure. In addition they may want to contribute to a patient's wellbeing and serve as a source of strength by encouraging them to talk about their difficulties, health, elevate their self-esteem and comfort them. Even though people may understand health differently across cultures, there has been an evolution on how health is being defined (Levin & Browner, 2005).

Levin and Browner (2005) stated that the World Health Organisation conceptualised the definition of health since 1946. The WHO (2011) argued that health is not just the absence of disease but also the state of one's physical and mental well-being. Furthermore, WHO defines mental health as the state of well-being whereby an individual has the ability to cope with the normal life stressors, makes meaningful contribution to their community, lives a fruitful life and realises their full potential. In addition the dimensions of wellness may include physical, emotional, spiritual, social, occupational, cultural, environmental and intellectual satisfaction of a person. WHO further asserts that a person should be aware of self as a whole and there should be a balanced interaction in all those dimensions. The WHO (2011) encourages multidisciplinary teams for dealing with patients. In Ross and Deverell (2010, p. 6) it is stated that in 1988 the WHO defined the multidisciplinary approach as *"a group of people who share a common health goal and common objectives, determined by community needs, to the achievement of which each member of the team contributes, in accordance with their competence and skill, and in coordination with the functions of others"*. Furthermore, the interesting thing is that most health professionals work in a multidisciplinary team to be able to understand a patient from a bio-psychosocial point of view. This gives professionals an opportunity to identify some underlying symptoms beyond their scope of practice and refer to relevant departments (Levin & Browner, 2005; Ross & Deverell, 2010). An individual's help seeking behaviour in relation to culture and belief may be addressed by the exploration of folk sector, popular sector and biomedical sector.

2.7.1. Folk Sector

A person's worldview informs the type of services they will access when they need help (Helman, 2007; Ross & Deverell, 2010). According to Helman (2007) the World Health Organisation suggested the incorporation of traditional folk healers and the medical system in the year 2000. Professionals in South Africa need to acknowledge the existence of traditional healers and be aware of their belief and the way in which they intervene (Ross & Deverell, 2010). Helman (2007) stated that the folk sector is a form of practice that most people consider accessing especially if they are not comfortable with the way the medical model explains what they present with or when they feel misunderstood. In addition the folk sector includes traditional healers, spiritual healers, shamans and herbalists. Moreover to become a traditional practitioner can be due to inheritance, revelation, or having acquired a unique skill on your own.

The aetiology of mental or physical illness may be perceived as disequilibrium and to restore equilibrium traditional healers need to introduce the natural balance and harmony by integrating the patient with earth, spiritual world and their community (Erkan et al., 2012; Ross & Deverell, 2010).

According to Ross and Deverell (2010) traditional healers are consulted for physical, social and psychological problems. Folk healing is informal and there is no formal education required for it (Helman, 2007) but in 2004 the South African government passed the Traditional Health Practitioner's Bill (Ross & Deverell, 2010). According to Ross (2010) this act only applies to those using traditional medicine and does not apply to spiritual healers as they believe in prayer to treat ailment. This act gave traditional healers rights to practice without being discriminated against, refer to other professionals and to issue medical certificates. Furthermore it regulates the registration, training and practice of service providers. It also serves to protect the people utilising traditional healers' services. Ross (2010) reported that people who belief in traditional healing may benefit from the use of traditional medicine. In addition traditional healers and western doctors share the same goal which includes comforting loved ones, helping in high school level right through to the community level by working together with community leaders and curing the sick, bringing harmony and relief from pain and suffering. As a result some services offered by professionals that focus on both folk and biomedical model are perceived to be the most utilised in different contexts. Just like other models, these practices have their disadvantages.

The limitation on this aspect is that traditional healers may be exposing their patients to infections by using unsterilised equipment, dangerous herbal remedies and the belief that other disorders may be perceived as misfortunes (Ross, 2010; Ross & Deverell, 2010).

2.7.2. Popular Sector

According to Helman (2007) popular sector is the way people attempt to make sense of some presentations of illness. Moreover it is stated that usually non-professionals and lay society members may notice that they are not well and interpret their illnesses based on their experiences or those of people around them. People prefer seeking advice from family members, churches, engaging in self-healing or buying treatment without a prescription (Erkan et al., 2012; Helman 2007). According to Helman (2007) popular sector is unstructured, informal and it is done without expectations of being paid. It is believed that "*today's patient may become tomorrow's healer*" (Helman, 2007, p.83). Furthermore, in popular sector women are usually considered as primary health care providers. Those with long experience of a particular illness, people who have frequent contact with the public or church members may be consulted or asked advice regarding treatment of certain illnesses. Helman (2007) asserts that those people are responsible for diagnosing and making homemade remedies for the ill. In addition, rituals, confessions, prayers, charms and fasting may be used as tools to cure illness in popular sector. Popular sector differs according to cultural groups and it is strongly believed that some illnesses are a result of the way people in that society behave. Moreover, other societies may perceive illness as a sign of bad luck or witchcraft thus rituals may be performed or a use of charms to chase the evil spirit away may also be an option. Some patients in either rural or urban areas usually consider self-treatment, and if it does not work out they may consider traditional healing. It is only when all options are exhausted that biomedical intervention is considered (Helman, 2007).

2.7.3. Biomedical Sector

According to Helman (2007) professional sector refers to the biomedicine services which are offered by professionals who have been formally trained and have tertiary qualifications. It includes physicians, physiologists, psychologists, nurses etc. In addition it is the most dominating and professionalised healthcare provider. Ross and Deverell (2010) stated that

biomedicine focuses on healing a person physically and providing treatment. Furthermore, it states that no one is responsible for their own illness and that there is always an organic aetiology. Biomedicine focuses firstly on curing and investigating the aetiology through microscopic lenses before considering social problems to be the precipitating factor (Ross & Deverell, 2010).

Ross and Deverell (2010) stated that the bio-psychosocial model focuses more on factors that people usually neglect or consider at a later stage. According to the bio-psychosocial framework people are not responsible for the aetiology of their illness but they can play a major role in leading to their recovery. The bio-psychosocial model focuses on behavioural changes and maintaining good health and that people's everyday activities (interaction with society) have an influence on their access of health care services. Furthermore, this model considers individual's explanatory models of their illness and the different interventions sought. Both the biomedical model and the bio-psychosocial model are scientific, in high demand, scarce to access and the difference between them is the context in which health is traced. The biomedical model view biological factors while bio-psychosocial model incorporates the biological and the social context (Ross & Deverell, 2010).

According to Helman (2007) those practising scientific medicine are perceived to have high status, earn a lot and their positions are upheld by the law. Moreover their relationships with patients may have an unequal power dynamic. In addition these professionals usually have power over patients and patients may fear them, feel obliged to answer any questions posed by them as they perceive them as powerful and knowledgeable. As a result patients may seek other forms of treatment (folk and popular sector) to avoid being permanently "labelled". Helman (2007) stated that the "labels" given to patient's presentation may affect their social and economic lifestyle. Kakuma et al. (2010) further asserts that a diagnosis may often lead to unfair discrimination, unemployment, victimisation by society or family members and affect the rights to housing. These factors may result in the lack of access to mental health care services which can exacerbate their mental illness. In Helman (2007) western medicine may be practiced in a similar structure but certain things may be adjusted depending on the context (location and quality of services). Professionals may study further to improve or enhance their knowledge, their understanding and definition of health may also change (Helman, 2007).

2.8. Acculturation: Global and South African Perspective

The influence of acculturation is explored in this section however it is of importance to firstly differentiate between acculturation and enculturation. Both acculturation and enculturation involve a process of socialisation and can either have a negative or a positive indicator on mental health. These indicators may include satisfaction with life, self-esteem, depression, negative affect and psychological distress (Yoon et al., 2013). Acculturation refers to a process of adopting values, beliefs, cultural traditions, assumptions and the practice of the dominating culture (Masuda et al., 2005). During acculturation the beliefs and behaviour of the majority in the society is adopted by the minority. Musada et al. (2005) further asserts that some students' attitude and values may be influenced when exposed to a foreign academic environment. On the other hand, Yoon et al. (2013) defined enculturation as the socialisation of a person into their culture of origin. In addition it is the acquisition of social norms, cultural identity, boundaries, values, language and knowledge of the society they reside in. Yoon et al. (2013) further asserts that the acquisition is established through the interaction within the social context. Furthermore, the interaction may enable individuals to be acquainted to socially acceptable norms and fit best in the society.

Pillay (2005) conducted a study with a sample of African American college students at a predominantly white academic institution to examine if acculturation, gender and racial identity could be the predictors for accessing psychological services. In the study the black population presented with a negative self-opinion and this was associated with racial factors. Furthermore, the study stated that the history of slavery may have robbed African Americans of their heritage. Pillay (2005) further stated that African Americans are perceived as a race not as people with certain cultural values. As a result, the majority of mental health providers tend to overlook issues of culture and this could also explain the reason students find themselves immersed in acculturation. The study found that most African American students in academic institutions dominated by whites presented with what is known as acculturation stress as compared to those in an academic institution dominated by black Americans. Pillay (2005) defined acculturation stress as the stress triggered by racial or cultural crisis. In addition it may be related to anxiety and depression. Furthermore, it was stated that positive self-esteem and pride in one's race may result in a lower level of acculturative stress due to the ability to manage cultural conflict. Most students who are acculturated may present with low self-esteem, low self-actualisation, lack self-acceptance, feelings of inferiority and anxiety (Pillay, 2005; Yoon et al., 2013).

In Rabelo's (2005) unpublished study it is stated that there is no adequate research within the South African context regarding the process and influence of acculturation on mental health. Acculturation in South Africa is traced back to 1994 with the advent of democracy whereby every South African citizen earned equal rights (Louw, Breen & Katzman, 2004; Naidoo & Mahabeer, 2006; Rabelo, 2005). Currently people have the freedom to be in contact with one another without any restriction regardless of race or culture. Furthermore, freedom has allowed people to integrate their African culture with the western culture and also gave opportunity to the black South Africans to live their lives in a manner that incorporates western norms and values. Rabelo (2005) further reported that black South Africans are now exposed to previously "privileged" western cultures and norms through education and alternate care. In addition, learning institutions currently accept individuals from different cultural and racial background to be exposed to equal education and in the same environment.

Naidoo and Mahabeer (2006) conducted a study at UKZN Westville campus where they sampled Indians and black South African students (males and females). The aim of the study was to explore the "*pattern of acculturation and integration attitudes of university educated students of Asian Indian and African ethno-cultural origins*" (p. 121). One question aimed to find out the mode of acculturation preferred by black South Africans and Indians. The outcome of the study showed that both racial groups have immersed into acculturation, into western culture, which had both benefits and disadvantages. Both racial groups in Naidoo and Mahabeer (2006) indicated an adoption of western cultures in their home environment. However, black Africans indicated the use of their artistic expression in a form of music, poetry, painting and dance.

Students from the two cultural background found that academic institutions play a major role in acculturation as they need to meet each other half way with communication and similar dress code in order to have the sense of belonging and to avoid discrimination (Naidoo & Mahabeer, 2006). Even though the students' identification or adoption of other cultural traits seems to alienate them from their cultural beliefs it allowed them to cope in their new environments (Le Grange, Louw, Breen & Katzman, 2004). According to Naidoo and Mahabeer (2006) ancestral and western values are being integrated into the cognitive systems of individuals as they grow and the world evolves. Therefore, students preferred an integrated mode of acculturation which is a correlation of both traditional and western values.

Black Africans preferred communicating with their indigenous languages at home which may indicate that they are still in touch with their culture (Le Grange et al., 2004; Naidoo & Mahabeer, 2006). However, in Rabelo (2005) it is stated that the level of acculturation may be assessed or determined by the people an individual socialises with, the language use or preference at home, work and at school.

In a study conducted by Rabelo (2005) it is stated that migration may lead to the individual to an experience identity crisis, challenges in language and adjustment. Rabelo (2005) argues that acculturation may disrupt the developments of an individual's personality and cause psychological conflict to the self-concept. Reddy and Crowther (2007) reported that cultural conflict may also result in psychological and emotional distress. Furthermore, individuals of colour who engaged in acculturation may be more vulnerable to mental health problems and their psychological and behavioural problems may be attributed to the prejudice, discrimination and economic deprivation of the apartheid era. In Drennan's (2003) study (as cited in Rabelo, 2005:p.58) it is indicated that "*there is an association between the absence of familiar cultural context and a high incident of stress which results in psychiatric conditions.*"

Rabelo (2005) stated that exposure to an environment dominated by western values may change the way people perceive the world and themselves. In addition, their religious values, moral development, behaviour and belief may divert from those of their ancestral origin. According to Reddy and Crowther (2007) the differences in culture may often mediate the relationship between ethnic teasing and body dissatisfaction. Furthermore, this mediation may reduce likelihood of maladaptive behaviours. WHO (2004) stated the importance of adapting intervention programmes to culture. In addition, professionals need to tailor interventions to culture and not tailor culture to interventions.

2.9. Predictors of Help Seeking Behaviour

Musada et al., (2005) conducted a study to explore students' (undergraduates) attitude towards seeking professional psychological help. In the study students from the United States and Japan were provided with a questionnaire known as Attitudes Towards Seeking Professional Psychological Help (ATSPPH) which was used to measure students' attitudes

towards seeking professional help. The purpose was to determine if there was a difference in attitude towards accessing psychological services amongst students from the United States and Japan. According to Musada et al. (2005) although the outcome of the study showed that past experience and gender were predictors of help seeking behaviour in both countries there was no significant difference in gender among Japanese students. Furthermore, this may be due to the Japanese expectation to confide in family members as going outside the family which may be perceived as bringing shame to the family. In addition, family values, lack of knowledge about psychological services and cultural stigma in relation to disclosure may also result in negative attitude towards psychological services. Musada et al. (2005) stated that knowledge about psychological services, family, individual and traditional values may serve as mediators of help seeking attitudes among Japanese citizens.

In the United States gender played a role and was perceived as a predictor to accessing psychological services. Moreover, female students from the United States have a favourable attitude towards psychological services than males. It is stated that individuals who have a history of accessing psychological services or know someone who has accessed the services may perceive them as helpful and beneficial (Musada et al., 2005). In addition, Musada et al. (2005) asserts that these individuals have a positive attitude towards the services and are confident that the psychological services will assist them. Usually students with a negative attitude towards psychological services expresses less interpersonal openness regarding their problems and they do not have confidence that mental health professionals would be of great assistance (Masuda et al., 2005). Furthermore high level of acculturation may result in a positive attitude towards accessing psychological services. Acculturated students are said to be equipped with the ability to notice when they need psychological help, have a high stigma tolerance and have no difficulties in disclosing their psychological problems to psychologists (Musada et al., 2005).

2.10. Benefits in Accessing Psychological Services: Global Perspective

According to Musada et al. (2005) in countries like France age, level of education, gender, knowledge of a person who accessed and benefited from psychological services may predict help seeking behaviour while in Britain predictors of help seeking behaviour includes the number of years an individual stayed in the country, severity of emotional distress and past experience in accessing psychological services. In addition, Shy and Waehler (2009) reported

that factors such as gender, perceived social support, level of education and the level of psychological stress increase the likelihood of students accessing psychological services. Moreover, lower tendencies to disclose distressing information, increased feelings of risks with self-disclosure and perceived consequences are known as avoidance predictors of students' attitude towards accessing professional psychological services. Shy and Waehler (2009) further reported that people respond differently to the manner in which they are addressed and approached therefore a male's response to psychological services may also be determined and influenced by the way they were addressed. In addition changing terminologies used may make services more attractive for them.

2.10.1. Factors that enable accessing of psychological services

According to Milstein, Manierre and Yali (2010) religious beliefs may be both harmful and beneficial to students. Students' perceptions about accessing psychological services may be influenced by their personal belief or religious belief. Shy and Waehler (2009) further assert that if students possesses a strong belief that accessing psychological services may be beneficial they may therefore access the services. Furthermore, students with a negative attitude towards psychological services are less likely to benefit from the services. Milstein et al. (2010) reported that some people may seek help from clergy when experiencing psychological problems. In addition some psychological problems like depression may be perceived as a punishment from God. As a result people go to a clergy for support, counselling and comfort.

According to Milstein et al. (2010) some religious denominations may encourage their members to get support from both the clergy and psychological services. In addition, they may go as far as psycho educating the congregation about psychological problems and psychological services. This effort is done in an attempt to reduce stigma attached to psychological problems and psychological services. People who utilise psychological services believed that for stigma to decrease and for the community members to support people experiencing psychological problems, clergies needed to intervene. Furthermore, in New York members of certain congregations were offered emotional and spiritual support prior a referral to a psychologist by a chaplain. Chaplains usually refer suicidal and abuse cases (Milstein et al., 2010).

Hage (2006) reported that professionals are also spiritual beings but need to refrain from imposing their own beliefs on patients. Furthermore, there should be a distinction between the patient's and the psychologist's belief. Moreover, Milstein et al. (2010) reported that psychologists need to be cautious, adhere to their scope of practice and not divulge a lot in relation to their personal beliefs when treating a religious patient. Hage (2006) further stated that most professionals do not have the ability to intervene on a spiritual or religious level of a patient. As a result this may be perceived as a downfall of psychological services as healthy spiritual function may result in positive treatment outcome. In addition, spirituality or religion may form part of an individual's identity and shape their world. Patients may be encouraged to use their familiar religious rituals to minimise the level of psychological distress (Milstein et al., 2010). According to Hage (2006) the integration of patients' cultural belief during psychotherapy may be beneficial.

2.11. Barriers in Accessing Psychological Services: Global Perspective

According to Shy and Waehler (2009) people may be reluctant to access psychological services due to the traditional gender roles and socialisation. In addition, there a various factors which may serve as barriers in accessing psychological services and they include culture, language, religion, gender, stigma etc.

2.11.1. Language

According to Guo (2012) the difference in languages is the cause of most communication breakdown. According to Loewenthal et al. (2012) some languages may comprise of similar words which may have completely different meanings in different context. Therefore a patient's reasoning and the way they respond to what it is said to them may sometimes send mixed messages if their cultural beliefs and values are not known. This is also influenced by the cultural values and beliefs of the community. There may sometimes be confusion in the social interaction (Guo, 2012; Helman, 2007).

Loewenthal et al. (2012) stated that refugees may hesitate to access psychological services due to language barriers. Furthermore, they may feel misunderstood and experience challenges in explaining to the services providers what they are going through.

2.11.2. Religion

Wei (2012) stated that religion may also be perceived as a barrier in accessing psychological services (Loewenthal et al., 2012). Religion was defined as a special form of culture and has to do with the nature of death, life and creation. It is spiritual and psychological therefore it can influence a person's way of life in many ways (Wei, 2012). According to Loewenthal et al. (2012) most religious people believe in praying to God whenever they are experiencing life challenges. Furthermore, some may perform religious rituals such as showering with holy water in order to deal with mental illness. This is performed with the belief that bad spirit (mental illness) is being washed away or they are saving the patient from evil spirit (mental illness). Loewenthal et al. (2012) reported that the population in Tamil believed that other people's thoughts should be respected as they are private. Therefore, no one should question people's private thoughts. Furthermore, utilising mental health services may be perceived as irrelevant. In addition, this mentality of devaluing mental health services and providers may be influenced by religious beliefs.

2.11.3. Gender/ Masculinity

The study conducted by Corby et al. (2011) stated that an individual's characteristics such as age, attitude and ethnicity may form part of predisposing factors in accessing psychological services. Perceived barriers to accessing support services among men living with cancer in rural Australia were explored. Corby et al. (2011) asserts that men living with cancer may experience psychological problems and require intervention. In addition the environment where a person stays may influence the attitudes and the beliefs of men towards psychological services. Furthermore, men residing in rural areas have a negative attitude towards seeking professional psychological health compared to residents in the urban area. Moreover, men from rural areas in Australia reported being stigmatised for accessing health care services (Corby et al., 2011; Drapeau et al, 2009). Moreover, this could be the result of people from small regions and towns being aware of each other and each other's whereabouts (Corby et al., 2011).

Drapeau et al. (2009) stated that help seeking behaviour is associated with the role the society expects either men or women to play. Corby et al. (2011) reported that being seen utilising psychological services may be disempowering for men as heads of the families. In addition,

masculinity seems to shape the values of men living in rural areas. The attitude of these men is influenced by cultural values which are immersed through socialisation (Corby et al., 2011; Drapeau et al, 2009). Women are more sensitive and emotional than men therefore they are more likely to seek psychological help (Drapeau et al., 2009; Iordan, Dolcos, Denkova & Dolcos, 2013). Males are expected to possess physical strength, be aggressive, be competitive and control their emotions. It becomes challenging for males who conform to a masculine ideology that upholds self-reliance and restrictive emotionality to seek for help or divulge their feelings to others. These males are expected to be strong, not to cry or express any emotions. Men who do not access psychological services are at high risk of having suicidal ideations (Corby et al., 2011). According to Drapeau et al. (2009) men access services when their illness or problems are more severe and on the other hand females seek help whenever they are not feeling well (being mild or moderate). Furthermore, men's perspectives regarding psychological services differ according to cultural values in the society. Corby et al. (2011) stated that men who access psychological services and have confidence in it may perceive therapy as beneficial and are likely to recommend or seek help in future. In contrast, men who do no not have confidence in psychological services may restrict their emotions during therapy. By restricting their emotions they may be preventing the development of the emotional bond with the mental health providers and this may be the reason some perceive therapy or treatment as less helpful (Corby et al., 2011).

2.11.4. Stigma

Stigma plays a significant role in influencing student's choices and perceptions about accessing professional psychological services. Stigma is defined as the perception of the society to individuals who are perceived as socially unacceptable and inappropriate (Drapeau et al., 2009; Vogel et al., 2006). In addition, Bathje and Pryor (2011) stated that there are different forms of stigma and they include public and self-stigma. According to Bathje and Pryor (2011) public stigma is a form of prejudice, comprised of cognitive, effective and behavioural reactions from the society and may result in negative attitudes towards accessing psychological services (Vogel et al., 2006). In contrast, Bathje and Pryor (2011) defined self-stigma as an internalised psychological impact of possessing a stigmatising characteristic. Furthermore, Bathje and Pryor (2011) assert that self-stigma has a negative influence on help seeking behaviour as those who have stigmatised themselves experience emotions of fear, shame, inferiority, alienation and embarrassment. In addition, their internalised thoughts may

prevent them from socialising with community members as they fear that their internal thoughts may be confirmed. In contrast an individual may maintain a positive self-image to avoid accessing psychological services. Maintaining a positive attitude towards psychological services may result in less public and self-stigma ((Bathje & Pryor, 2011).

According to Vogel et al. (2006) most people may refuse to access psychological services, not adhere to treatment, terminate treatment at a premature phase and hide their psychological concern in order to protect themselves from being ostracised or negatively labelled by the society as mentally ill or psychologically unfit. Accessing psychological services may be perceived as a sign of weakness and acknowledging failure (Bathje & Pryor, 2011) or a confirmation to the society that they are mentally ill, psychologically unfit and deviate from the society (Vogel et al., 2006). Vogel et al. (2006) asserts that some people may go to an extent of paying cash after accessing psychological services to avoid having a record of accessing psychological services in their medical aids.

Stigma of mental illness has long been recognised as one of the most powerful of all stigmas. Moreover, most people with mental health concerns may opt not to access psychological services to avoid being stigmatised, isolated or discussing distressing personal information (Drapeau et al., 2009; Vogel et al., 2006). The lack of knowledge regarding psychological problems and psychological services may result in the society expressing lack of sympathy towards those with psychological problems by blaming them for their mental state (Bathje & Pryor, 2011).

2.12. Psychological Services in South Africa

According to Burns (2011) mental health provision and promotion in South Africa is inadequate, inaccessible (particularly for rural communities) and inappropriate. In 2003, the National Department of Health implemented compulsory community services for South African training clinical psychologists in order to facilitate geographic redistribution (Campbell, Kearns, & Patchin, 2006; Swarts, 2013). The purpose of this initiative was to improve mental health care and promote quality and equality of access to all South African citizens especially the previously underserved (rural) areas (Swarts, 2013). According to Campbell et al. (2006) due to insufficient resources in rural areas, service providers are urged to adjust their practices in order to fit the settings in rural areas.

Naidoo (2000) highlighted an imbalance of psychological services in South Africa and that psychologists are predominantly white, middle class and male. In addition, the majority of these psychologists are English and Afrikaans speakers and cannot speak indigenous languages. Petersen et al. (2012) stated that as a result, the majority of patients who access psychological services are middle class white individuals as compared to the black community. Naidoo (2000) asserts that the language issue is a problem in South Africa as psychologists may not understand culture bound syndromes and the patient's explanatory model of illness in a predominantly black population. Furthermore, certain cultural symptoms may be perceived as pathological while patients perceive them as an indication of an ancestral calling.

Naidoo (2000) stated that the mental health needs of black South Africans and disadvantaged communities (rural) have been largely neglected and unmet. In Melville et al. (2006) it is stated that primary health care services have an important role in addressing the high level of unmet health needs in South African facilities. According to Campbell et al. (2006) the difference in rural and urban communities is beyond the population density figures. Furthermore in rural areas there is a high level of poverty, unemployment and less formal education than in urban areas. Barriers in accessing psychological services may include the following; the shortage of services in rural areas, lack of knowledge in relation to psychological services, not having medical insurance, social norms, inappropriate mental health policies, centralised mental health care services and scepticism towards non-local residents (Melville et al., 2006).

In addition, Naidoo (2000) reported that the provision of psychological services was criticised for being centralised in urban areas. As a result the purpose of community services was to decentralise psychological services (Swarts, 2013). The location of these services may make it difficult for people from disadvantaged backgrounds to afford travelling to access the psychological services (Naidoo, 2000). There has been progress in decentralising mental health services but there are still service gaps across the country (Petersen et al., 2012). Furthermore, there is a high need for increasing access to psychological services in rural areas and improving the quality of psychological services, therefore bridging the gap may be beneficial. In addition, service provision gaps may be bridged through task shifting which involves training non-specialists health workers (lay counsellors) in the community to fill the gaps for the shortage of specialists. Petersen et al.(2010) stated that the non-specialist health

workers may include police officers, community mental health care workers, traditional healers, spiritual healers (priests), teachers, nurses etc. within the community in need. In addition, they will be provided with support and be supervised by a qualified specialist. Moreover, their duty will be to identify mental health disorders, refer, provide counselling and encourage community members to utilise psychological services. According to the WHO (2004) this may strengthen the community members' capacity to deal with emotional problems and reduce stigma and discrimination.

2.13. Barriers in Accessing Psychological Services: South African Perspective

2.13.1. Language

Language is a tool used in the social construction of reality which patients use to express themselves and relate their experiences (Deumert, 2010; Ross & Deverell, 2010).
According to Deumert (2010) during every interaction between the patient and the health care provider, language is always significant. The health care provider who is unable to speak the patient's language creates a communication barrier and access to services (Ross & Deverell, 2010). In Schlemmer and Mash (2006) it was stated that South Africa is a diverse country that has 11 official languages. Deumert (2010) stated that out of the 11 official languages English is perceived as the most common spoken language but not everyone is fluent in it, especially those who use it as second language. Moreover, elderly people often struggle with a second language or English as a medium of communication, particularly those who did not go through basic education. Furthermore, it may be challenging for those who speak indigenous languages to express their needs and feelings during consultations.

Deumert (2010) asserts that although language may be a barrier in accessing psychological services, it is the most important tool during therapy as it is used in building rapport. Moreover, it is important for mental health care providers to understand patients in their context to avoid avoidance behaviour from patients. Furthermore, patients with avoidance behaviour are reluctant to access psychological services and only utilise them when their problem is severe. This may be due to the fear of being misunderstood or being alienated by the use of psychological or medical jargon during interventions. Service providers often use medical or psychological terminologies that patients may find difficult to understand (Levin, 2008). Inadequate communication may result in errors during diagnosis and management of

patients by mental health providers and patients may develop feelings of failure and despair (Deumert, 2010). Patients who have difficulties in understanding their mental health care providers may not understand the severity or seriousness of their condition and this may result in defaulting treatment or not complying with it (Duemert, 2010; Helman, 2007).

Deumert (2010) stated that sometimes patients' response may be based on what they can say in English and not what they have been asked because they fear being ridiculed or to humiliate themselves if they report that they do not understand. Consequently, this may result in a patient's presentation of the problem being misinterpreted. When patients feel that their indigenous language is not recognised they may feel invisible (Deumert, 2010) and believe the notion that mental health services is a profession that has unbalanced power dynamics as English is associated with power and high level of education (Drennan & Swartz, 2002). Deumert (2010) gives a typical example of a service provider who avoids calling a patient with a native name because they cannot pronounce it properly. According to Drennan and Swartz (2002) in most cases language as a barrier results in conversations being dominated by professionals.

Some patients may prefer to be accompanied by family members to interpret or close the language gap between them (Deumert, 2010; Schlemmer & Mash, 2006). Additionally, if family members are not available to interpret indigenous languages, mental health providers usually uses black African nurses, potters or in patients as interpreters (Drennan & Swartz, 2002). Consequently, according to form 223 of the HPCSA this act is unethical because it may constitute a multiple relationship and there is potential for misinterpretation and confidentiality may be breached. Form 223 of HPCSA asserts that only competent interpreters fluent in two languages but with proficiency to the patient's language may be allowed to interpret. Searight and Armock (2013) stated that interpretation by an incompetent or unqualified interpreter may influence the outcome of psychotherapy, diagnosis, treatment and the relationship between a healthcare provider and a patient. Furthermore, they may be overwhelmed and experience emotional distress when discussing sensitive matters (Drennan & Swartz, 2002). In conclusion, Deumert (2010) stated that it is vital for mental health care providers to learn the language used in the area they work in, in order to have a clear understanding of patients' presentation.

2.13.2. Stigma

Sorsdahl, Kakuma, Wilson and Stein (2012) reported that there is limited research in South Africa in relation to stigma and mental health. The fear of being stigmatised is strongest when individuals consider the reactions of those they interact with. Furthermore, stigma associated with seeking psychological services is associated with the view that seeking psychological help makes individuals less socially acceptable. Moreover, the individual who accesses psychological services may be perceived as deviating from the societal norms (Drapeau et al., 2009; Vogel et al., 2006).

In Vogel, Wade and Ascheman (2009) it is stated that some people may regard patients diagnosed with and using treatment for depression as emotionally unstable, less interesting and less confident than an individual seeking treatment for back pain and an individual having depression but not seeking treatment. As a result, according to Sorsdahl et al. (2012) individuals may experience anticipated, experienced or self-stigma. In addition, some individuals may expect or predict that they may experience discrimination from community members due to their mental illness while others may have experienced discrimination or prejudice as a result of their mental illness. Moreover, Sorsdahl et al. (2012) asserts that some individuals may experience internal negative thoughts or beliefs associated with mental illness and apply them. Consequently these negative internal beliefs may result in low self-esteem and may negatively influence help seeking behaviour.

In the study by Sorsdahl et al. (2012) members of the South African Depression and Anxiety Group (SADAG) were provided with questionnaires with the aim to explore the effect of internalised stigma towards accessing psychological services using the Perceived Devaluation and Discrimination scale (PDD) as a measure. The majority of the participants reported a high level of education and they were fully aware of their diagnosis (e.g. depression, bipolar mood disorder, anxiety etc.). Furthermore, the outcome of the study showed that individuals have socially withdrawn due to the experienced discrimination. In addition, although the results for self-stigmatisation were low, people still felt that community members stigmatise and reject people who are mentally ill (Sorsdahl et al., 2012).

Vogel, Wade and Ascheman (2009) assert that the public's stigmatisation of people utilising psychological services may influence help seeking behaviour and predict attitudes towards

psychological services. Consequently, an individual who is willing to seek psychological help may avoid treatment to reduce being stigmatised, discriminated or isolated.

2.14. Conclusion

This chapter has highlighted barriers and benefits of accessing psychological services from both the global and South African perspective. Moreover, barriers and benefits of accessing psychological services were found to be similar in different countries.

The literature reviewed has given evidence that cross cultural factors plays a major role in help seeking behaviour; therefore it is essential for psychologists to understand individuals within their context to avoid misdiagnosis and misunderstandings.

Based on the literature reviewed there has not been enough research done in South Africa that focuses on the benefit of accessing psychological services. There seem be insufficient mental health providers in rural communities. Moreover, the gap between psychologists and other community workers needs to be bridged by bringing the services to the communities in order to understand the patient's explanatory models. In addition, language, stigma and the lack of knowledge or understanding of the purpose of psychological services appeared to be of significance in rural communities. This chapter has also illustrated alternative forms of interventions (priests, traditional healers etc.) that people consult before accessing psychological services. Educating community members, bridging the language gap and offering equal services in rural and urban communities may be beneficial.

CHAPTER 3
3. RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research design and method used by the researcher to collect data. It will indicate how data was collected and consider instruments and procedures used in this study. Struwig and Stead (2001) define research methodology as a process of specifying the scientific methods that the researcher will use to gather and analyse information in order to arrive at a solution of the problem. This chapter will also elaborate on the type of the sample size that was selected and the procedures used in the study that helped in gathering and analysing the data.

3.2. Objectives of the study

- To identify perceived benefits and perceived barriers in accessing psychological services amongst first year university students.
- To identify perceptions around motivation for help-seeking behaviour.
- To identify perceived susceptibility towards psychological problem.

3.3. Research questions
- What are the barriers and benefits of accessing psychological services?
- What motivates students to access psychological services?
- What factors hinder students from accessing psychological services?

3.4 The study

3.4.1 Research design

A research design can be referred to as a plan whereby research participants are obtained so that data can be extracted from them. We describe what we are going to do with the participants with the view of reaching conclusions about the research problem. In addition,

one should specify the number of participants and the type of research design to be used (Welman, Kruger & Mitchell, 2005).

3.4.2. Qualitative Research

Qualitative methodological approach was employed in this study. Qualitative research deals with subjective data produced by the interviewees. The interviewer attempts to understand participants from their context and the data relied on is presented in language not in digits. It is more flexible and seeks to explore the participant's daily routines or things that affect their daily lives (Welman, Kruger & Mitchell, 2005). According to Golafshani (2003) qualitative research does not manipulate the area of interest but understand phenomenon in their real world setting. Natural methods such as observations or interviews are employed when conducting a qualitative research study. In this study the method used to obtain data was through semi-structured interviews. During qualitative study the researcher is the instrument.

3.4.3 Participants

The target population for this study was 1st year students from the University of KwaZulu-Natal (Howard College). The participants were from different racial backgrounds and they were interviewed individually. A total number of 16 participants were selected to participate in this study. The sample was stratified according to race involving blacks (4), whites (4), Indians (4) and others (4).

3.4.4 Sample description

A sample of 16 was drawn from the University of KwaZulu-Natal (Howard College), Faculty of Humanities' 1st year students. The sample consisted of 8 males and 8 females participants; there was equality in terms of gender. Participants were selected regardless of their age, religion and knowledge or experience in accessing psychological services. Non-probability sampling method was used in this investigative research study. According to Welman, Kruger and Mitchell (2005) when using non-probability sampling method not everyone in the population has a chance of being selected as a participant. An example of non-probability sampling that was used is purposive sampling. Purposive sampling is more focused, selective and has a goal. It was used because 1st year students are easily accessible (Welman, Kruger & Mitchell, 2005).

3.4.5 Measuring instruments and data collection

An interview is a way of gathering information from people in order to get the interviewer's questions answered. It is a conversation between two or more people and can take place in different settings. It can either be face to face, by telephone or even through the use of questionnaires or panel. It is more exploratory and conducted in order to understand the other's experiences (Welman, Kruger & Mitchell, 2005).

In this study data were collected through semi-structured interviews in order to understand the students' perceptions towards psychological services. According to Halgin and Whitebourne (2009) a semi-structured interview is a method of research used in social sciences. It comprises of standardised series of questions and because of its flexibly it allows the researcher to ask follow up questions based on the response given.

According to Chrzanowska (2002) individual interviews are conducted when the subject is sensitive to other participants and responding in front of a group may bring discomfort. Individual interviews are easy to handle or control and the relationship between the interviewer and the participants is maintained. Furthermore, confidentiality is easily maintained as it is between the participant and researcher and not a group. Semi-structured interviews were used with the aim of giving the participants an opportunity to express their feelings about psychological services.

The interview schedule was developed based on the assumptions of the Health Belief Model that gave the participants an opportunity to express their perceptions regarding psychological services. The model assumes that perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers may be used to explain a person's behaviour. The development of the semi-structured interview schedule was devised in order to address the objectives of the study (see APPENDIX ONE). Core themes to be addressed in the semi-structured interview were developed on the basis of review of relevant empirical literature (Halgin & Whitebourne, 2009), consultation with identified national and international experts in the fields of research methodology and academics and Mental Health Care Workers at the University Of KwaZulu-Natal Howard College.

3.4.6 Procedure

Most participants engaged in tutorial programs in the College of humanities where else others were approached and selected randomly during their registration and orientation days. They were informed verbally about the aim of the study before the interview commenced. Before the interviews were conducted participants were informed about the purpose and the aim of the study. The researcher went through the consent form with each participant before they signed it to prove that their participation was voluntarily. They were reminded of their rights to withdraw from the study should they wish to do so. Permission to use a digital voice recorder during the interview process was obtained from each participant. The participants were interviewed individually for 30-45 minutes and the interview was only done once. The interview schedule for this study was written in English and the researcher used English when asking questions during interviews. When giving responses some participants switched from English to isiZulu. The researcher did not experience challenges with the use of both languages while transcribing as she is fluent in both languages. In the presentation of results participants' responses were transcribed as verbatim in their mother tongue and then translated to English. Furthermore, to maintain consistency and reliability in terms of the translation process, the researcher used one of the co-researchers who are fluent in both languages to review the interpretations (back to back translation) of what was said.

According to Deumert (2010) language is a tool used in the social construction of reality and patients use it to express and relate their experiences. Expression through the use of their mother tongue allowed participants to express their emotions and associate them with their experiences. Expecting participants to respond only in English would have restricted them from expressing their true feelings, being in touch with their experiences or even distort their responses.

3.4.7   Data Analysis

Data analysis is a process of modelling, evaluating and transforming data using analytic and logical reasoning. It involves highlighting and assessing useful information in order to arrive at a conclusion. The data analysed is usually in a form of interview transcripts or field notes (Blanche, Durrheim, & Painter, 2006). In this study, during data collection a digital voice recorder was used to record the participants' perceptions about accessing psychological services. After gathering the desired information, data were analysed using Braun and Clarke's thematic analysis. Thematic analysis is a widely used method that is used to analyse,

identify and report patterns (themes) within the data collected. It focuses on the reality of the participant's experiences and what those experiences mean to them. Thematic analysis understands individuals from their social context and examines the way participants make meaning of their experiences. It is transparent and reflects on the realities of experiences (Braun & Clarke, 2006). The steps used during thematic analysis includes familiarising yourself with the data collected; generating initial codes; searching for themes; reviewing themes; defining and naming themes and producing the report (Braun & Clarke, 2006).

3.5. THEORETICAL FRAMEWORK : HEALTH BELIEF MODEL

History and Orientation

The Health Belief Model was used in this study. This model is associated with the barriers and benefits of utilising services. The Health Belief Model (HBM) is a socio-cognitive approach that was pioneered by social psychologists of public health in the 1950s. It attempts to explain and predict health behaviours by exploring people's motivations in participating in health prevention programs. The aim was to explore the reasons why individuals become encouraged or discouraged in participating in the health prevention programs. It focuses on the individual's personal perception which is influenced by a range of intrapersonal factors affecting health behaviour e.g. attitudes, beliefs, knowledge, motivation, self-concept, past experiences, developmental history and skills. There are four main perceptions that construct this model that can be used to explain behaviour. They include; perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers. All these four variables may be influenced or modified by demographic variables such as race, age, culture, sex, ethnicity, personality, knowledge, socio-economic status, educational level, experience, motivation and skill (Henshaw, & Freedman-Doan, 2009). In addition to the four variables above Rosenstock added cue to action and self-efficacy with the assumption that they influence behaviour related to mental health utilisation through activating the readiness to act and stimulating behaviour.

According to Henshaw and Freedman-Doan (2009) social psychologists argued that most people may become concerned and respond to their health because of the following reasons; if they think that they may be afflicted by a certain condition (perceived susceptibility), that their daily functioning may be impaired if they do not respond (perceived severity), if they

believe that there may be reduced susceptibility in their condition if they respond to it (perceived benefit). Moreover individuals may believe that attending to their conditions may not yield any changes. An individual may not respond to their condition or access services due to its costs, embarrassment or stigma (perceived barriers). Cue to action is a social factor that serves as a reminder in the lives of people. Moreover, external cues such as watching health related advertisements on television may influence how the individual responds to a condition. Personal experiences or witnessing a family member being severely ill may also cue a person to take action for the threat experienced. Individuals need to have confidence in themselves that by responding to their condition, the severity of the condition will be reduced (self-efficacy). People may not access psychological services if they assume that it will not benefit them. Modifying factors like the media, health professionals, personal relationships, incentives and self-efficacy of recommended health action can affect behaviour compliance (Henshaw & Freedman-Doan, 2009). In addition, the media plays a vital role in health promotion and awareness (Ross & Deverell, 2010). It is a tool that disseminates information and motivates help seeking behaviour.

According to Henshaw and Freedman-Doan (2009) health behaviour is determined by personal beliefs or perceptions about the disease and strategies available to decrease its occurrence. It is difficult to convince people to change their behaviour if there is nothing for them to gain. People are unlikely to seek professional help if they do not believe that they will benefit from the professional services, even though they are aware that their symptoms need attention. Similarly, the probability that people will change their health behaviours to avoid consequences depends on the perceived consequences. People do not change their health behaviours unless they believe that they are at risk or perceive that they could contract the illness or be susceptible to the illness. Most people may not change their behaviour with the perception that its consequences may be unbearable (accepting mental health diagnosis). Social obstacles (barriers) that may prevent individuals from accessing psychological services includes cost of treatment, time, transportation, not knowing where to go in order to access services and the fear of being unable to adjust to new behaviour (Henshaw, & Freedman-Doan, 2009).

Smith (2009) asserts that emotional factors such as fear and shame may also limit individuals' to access psychological services. HBM has been criticised for being unable to address the emotional components of certain health behaviours (Henshaw & Freedman-Doan,

2009; Timothy, 2009). Henshaw and Freedman-Doan (2009) reported that there are a limited number of publications stating the usefulness of HBM predicting the utilisation of mental health services. Although HBM is being given credit for showing how the society's perception and belief regarding psychological services can have an impact on an individual's help seeking behavior (benefits and barriers). It is limited in predicting treatment adherence or adherence to long term therapy and health (Henshaw & Freedman-Doan, 2009). In addition Carpenter (2010) reported that HBM is not a good predictor of future behaviour. Furthermore, it predicts behaviour but does not examine the effect each variable has on the behaviour. The HBM is considered unreliable in predicting behaviour because people's beliefs may automatically fade or change with time. These changes may be influenced by friends and moving from one socio-economic status to another. For example getting insurance benefits may improve one's access to healthcare services. Carpenter (2010) conducted a meta-analysis to explore the effectiveness of health belief model variables in predicting behaviour. In the meta-analysis perceived benefits were found to be stronger predictors of treatment behaviour rather than prevention of behaviour. Susceptibility and severity were perceived as weak predictors. Furthermore, susceptibility and severity were considered to have indirect effect on behaviour however it mostly depended on individuals and their beliefs. Given the above in the current study participants may have been able to share their current perceptions on the perceived barriers and benefits of accessing psychological services through considering their current beliefs and knowledge. However, these perceptions may or may not predict their future behaviours or responses but only shed light on current behaviours.

3.6. Validity and reliability

Validity and reliability are not treated separately during qualitative studies. The reliability and validity of the study should be judged in its own paradigm's term. Therefore trustworthiness and confidence in both participants and the findings is crucial. The consistency of data will be verified through process notes or raw data. Through the data collected by the researcher, the reality of the circumstances can be achieved by different individuals. Terms like confirmability, consistency, neutrality and credibility are to be used in qualitative studies (Golafshani, 2003). Therefore participants in this study were interviewed individually in their natural setting in order to produce results that would unfold naturally without any manipulations. The researcher managed to maintain the distinction between

personal values and those of the participants by using the HBM to guide the current study and allowing the identified national and international experts in the fields of research methodology and Academics and Mental Health Care Workers at the University of KwaZulu-Natal Howard College to approve the questionnaire.

In this study data was collected through semi-structured interviews and the researcher trusted and had confidence in the variety of information provided by participants. The information obtained from participants was informed by secondary sources. The audio tapes were made available to the supervisor to provide his own understanding and interpretation. This process ensured the consistency of transcriptions provided by the researcher.

According to Struwig and Stead (2007) generalisability refers to the relevance the results have beyond the situation investigated. It looks into whether the data collected can be generalised in the same group or different group and still yield the same results. In qualitative studies groups with unique attributes are described and the sample size is usually small. This study comprised of 16 participants from the Faculty of Humanities at UKZN Howard College. Amongst the participants there were 8 female and 8 male participants. The sample was stratified according to race involving blacks (4), whites (4), Indians (4) and others (4), therefore due to the limited number of participants used, the results of this study cannot be generalised to other University students in or outside Kwa-Zulu Natal. Contextual issues must be taken into consideration before generalisability is applied. The participants were asked to comment on what they perceived as barriers and benefits of accessing psychological services. Different perceptions may be obtained from different Universities across the country as a result of the demographics. Should there be a need to generalise the research findings demographics should be taken into consideration as the use of a small sample size may limit or affect the trustworthiness and reliability of the research.

3.7. Ethical considerations

Ethical clearance was obtained from the University of KwaZulu-Natal's Ethics Committee. Permission was sought from the Centre for Applied Psychology at the University of KwaZulu-Natal (Howard College). Permission to interview students from the School of Humanities was sought from their gate keepers (APPENDIX FOUR). Each participant was provided with an informed consent which they signed (APPENDIX TWO). Participants were

made aware of their right to withdraw from the study at any stage, should they wish to do so. During the interviews permission to use a digital voice recorder or take down notes was sought from the participants. The Student Support Service was informed beforehand that should participants evidence any distress by the interview process or request to see a professional, they would be referred to Student Support Services for management (APPENDIX THREE).

3.8. Costs

The overall cost of this study was approximately R1500, 00. This included making copies for appendices, transcripts, proposal, printing of the final research study and purchasing a digital voice recorder.

3.9.Conclusion

A total number of 16 participants, 8 males and 8 females, were selected and interviewed to share their view on the perceived barriers and benefits of accessing psychological services. Semi-structured interviews were used to collect data. The participants were interviewed individually. Permission to conduct research was obtained from the Centre for Applied Psychology at the University of KwaZulu-Natal (Howard College). The students also had a right to give consent for themselves by signing the consent forms. The researcher collected data from participants from different racial groups and ensured that the data collected answered the research questions. The outcome of the interviews will be discussed in the next chapter.

CHAPTER 4

4. RESEARCH FINDINGS

4.1. Introduction

The aim of this study was to investigate the perceived benefits and perceived barriers in accessing psychological services among 1st year University students from the Faculty of Humanities. In this chapter the researcher has identified barriers and benefits of accessing psychological services from the participants through interviews. From the interviews conducted 12 different themes emerged. The participants provided their personal perspectives regarding mental health care. Under each theme, the responses were stratified according to race. Thematic analysis was used to analyse the participants' responses. The themes and the sub-themes that emerged during the interviews will be explored and discussed in depth. The data has been coded using a key that is attached as appendix five in the appendices.

4.2. Knowledge About Mental Health Services

4.2.1. Understanding of psychological services

The majority of participants from different racial groups and gender have an awareness of psychological services, however from their perspective these services benefited people who suffer from mental illness and traumatic experiences. Further to this, most of the participants perceived such services to only be available off campus (i.e. hospitals and private practices). Participants from different racial groups said that:

SABM1

> *"Uhmm, what I understand about psychological services is that it is psychologist's work at hospitals, (hesitation) they deal with mentally-ill patients. They counsel them, those who are mentally-ill".*

SABF3

"To people maybe that have problems, like mentally disturbed or something. Because that where people go when they, like me as a student, or maybe someone who's been in an accident they need to send someone to talk to and then they will go to see a psychologist and then they'll offer them some help".

SAWM3

"To be honest with you the only bit of information I got from anything to do with psychological services is through my brother because he studied psychology in his 1ˢᵗ year. But in terms of services at Howard I haven't really been informed about that level".

SAWF4

"I don't have much understanding but I think they like help people to sort out problems, I think".

SAIM2

"Mmm, my understanding of psychological services is that mm if you (how can I say this) are a psychologist and you offer your services whether being clinical, or depending where you are branched of that is the services that you offer to us".

SAIF1

"Mmm, I think what psychologist does is more tries and understand people and how they operate and try to help them and stuff".

AF2

"Mmhm okay basically I know psychology is about something related with counselling".

AM4

"What I understand is it's a broad concept or across-cutting discipline".

"You know where you provide counsellor services, where you provide uhmm support services, where you provide uhmm care and so forth."

AM1

"Uhmm, I'm not very much familiar with it, but according to the little information that I have it is more like uhmm counselling and diagnosing someone's problems".

4.3. Students' Perceptions of Psychological Problems That People Are Likely To Seek Help For.

Mental health problems that they believed are likely to motivate help seeking behaviour are stated below.

SABM4

"Eerh let's say mhlampe bek'thiwa umuntu ebeyeney'nkinga mhalmpe kwi-car accident".

"Mhlampe wayakwi-coma, mhlampe bam'siza ukuthi a-recover, yabo. Mhlampe wa-loser ne-memory".(Eerh let's say maybe a person was involved in a car accident, then maybe that person was in a coma. They can maybe help the person recover maybe after they have had memory loss"

SABF3

"Uhmm, like maybe if you are...Let's say you are a woman and maybe your husband passed away or you are a child and then your parents passed on and so you are stressed and you can't concentrate and then you have to see a psychologist to talk to".

SAWM2

"Bipolar, stress, mmh….suicidal behaviour, like yeah those are the ones".

"(Laugh) no not really, I don't know any".

SAWM3

"Reasons, as I said previously for divorce or any kind of trouble they have in their life. Like for managing their psychological wellbeing".

SAWF2

"Uhhmm anxiety disorders, eating disorders, phobias".

SAIF1

"I think like with children if they are a bit disturbed like maybe their parents got divorced and they are not handling the situation well or after a traumatic situation you do not know and you feel like you are in this dark black whole you don't know how to get out and can't even see the lights".

SAIM2

"Uhm I think you need to see one if you have like bipolar, schizophrenia that type of thing".

SAIM3

"Depression most likely is depression and anger management aswell".

SAIF4

"Umm, like I would think like more emotional problems. If you can't deal with something like death or maybe the loss of a job, regret, when you do not know what to do in your life you feel you need like assistance".

AF

"Okay other people maybe suffer from depression".

AM4

"You know like suicidal and so forth".

AF2

> *"Yah somebody may start being isolated. Be feeling suicidal. Eerh eish, just doing things the wrong way, taking wrong decisions".*

AM1

> *"When you are mad, feeling suicidal and taking wrong decisions or there are social, emotional and psychological problems".*

When the researcher probed further regarding the word "mad", the participant defined "mad" people as:

> *"Or others they're on and off, somebody today is yah the person that I know. Tomorrow it's a different person. And one minute it's another person, so you can't even understand what kind of a person they are.*

4.4. Availability of Mental Health Care Services In Communities

All the participants from different racial groups reported that there are a limited number of psychologists and psychological services in their communities. The lack of access is associated with shame and the lack of information regarding psychologists' scope of practice. Participants assert that they have never seen or heard about psychological services around their areas or on campus. They further reported that they may be in public hospitals or urban areas and those in private clinics and hospitals may be expensive. The following comments attempt to capture this theme:

SABF2

> *"No, we only get them in hospitals from my own understanding. I haven't seen them in my community".*

SABF3

> *"No, uhmm, not that they are not available but I don't think they are available in every community because like where I come from there are no psychologists".*

SAWM1

"In mine No, but here (Durban) I have seen a few".

SAWF2

"No I don't think so, because umm, I think it is about shame to actually seek help. I think a lot of people will be embarrassed".

SAWM3

"Not knowing where. Like normally we have psychologist within schools, within hospitals, within institutes but I have never really seen a psychological office just on its own that you can go to like you go to a doctor or an optometrist's office. But there is never really a psychologist's office".

One participant said that even though he has never seen a psychologist in his community, he believed that they are available and not utilised. Moreover he reported that people may not be well informed about the services and this leads to poor access. *SAWM3* was quoted saying:

"Uhm personally I do not think they are as well used as they should be. I do not think there are a lot of people accessing them. Maybe they are not well informed about it".

SAIF4

"Umm it's like very private, like I wouldn't know where to go".

SAIM2

"I think they are (available) but not for all. It is for people that can pay and maybe at government hospital they are not as available as in private".

AM4

"Where I'm from the services are not available to the people in the communities, especially the rural area. It's only people who are staying in the developed villages that can access those services you know".

AF2

> *"No, they are not that much, because like it's a...it's a rare thing to...to find psychologists as compared to just ordinary counsellors. They are usually in urban areas".*

AF3

> *"It's not available; the idea is not really developed where I come from".*

4.4.1. Perceptions of what promotes accessibility to such services

Participants reported that psychological services are unavailable in communities. They further reported that in order to bridge the gap between service providers and communities at large, service providers must offer psycho-education. According to most participants psychologists should reach out to the community starting from a high school level to the community level by working together with community leaders. They believe that this may encourage people with psychological problems to access the services as it may reduce the stigma attached to accessing psychological services.

SABM1

> *"What I'd love to add is just that eerh (hesitate) people uhmm (hesitate)...Maybe the Department of Psychology should come to the communities to speak about professional help and teach people about psychological services so that people can have a clear understanding about what it is and how to deal with it".*

SABF2

> *"I wish that they can try maybe giving advice to the rural schools. And tell them about what psychologists do because others do have people who are mentally ill and they don't have any knowledge, they don't know about it. So they can try campaigns, pamphlets and write about everything so that people can see".*

SAWF4

"Well you can visit high schools and because I know there are times whereby you can go talk to students about psychologist and what you do. Or you can go to communities and organize meetings to people who needs it and disseminate information".

SAIF1

"Ummh, I think people need to know that psychologists are available at like hospitals and community centres and something like that. I think that is a good idea because you know we need to stop making people feel bad and embrace the fact that they are people who have problems".

SAIM3

"I think maybe at school levels. Start more from I think like grade 2 or 3. Start introducing children what a psychologist do and what is a psychologist because the more they know about them it will be the more they will come to them and learn about them as the year goes by".

SAIF4

"Uhmm, I think like more on the media I think, like at places like where people are sick maybe in hospitals or schools and stuff. And at places stereotypically people might have problems".

AM4

"Go through communities, you know, call a public meeting, make house to house visits if there is a need, engage the local leaders community leaders, you know, have the councillors, the chiefs and so forth you know".

AF2

"In rural areas, providing maybe free services. Yah advertising. And just providing a free service for a day or so. Yah in a form of an expo".

"Firstly maybe I think you can uhmm, start by educating the community, including ama-students in high schools to encourage to go...to realise these

social illnesses that the communities are going through and encourage them maybe to go a field in line of psychology when they go to university so that e have a number of psychologists".

4.5. Understanding The Role of Mental Health Services In Relation To Wellness

4.5.1. Students' perceptions regarding psychological services

Identified factors that seem to prevent students from accessing psychological services on campus include the lack of information and knowledge regarding the availability of psychological services on campus and the fear of disclosing their personal information. Students are under the impression that one must have money in order to access psychological services. One participant from the white population reported not being aware of the role of psychologists. She was quoted saying *"Personally I don't know what they do; I just know that they deal with mentally ill people only because nobody's ever taught me about it before".*

> ### *SABF2*
>
> *"I think they think that it's scary and not easy to talk to a psychologist".*
>
> ### *SABF3*
>
> *"If you want to go and see a psychologist you have to have money so I don't think everyone can like go to a psychologist. Maybe some people will be afraid to talk to a psychologist about their problems".*
>
> ### *SABM4*
>
> *"Mmm (hesitation) ukuthi angicabangi, ukuthi abantu ba... (hesitate) Ukuthi indaba yama-psychologists ayi...lokhuzana, indaba nje encane, ayidumile yabo? Abantu abaningi engathi abanalo ulwazi for ama-psychologists".* Mmm (hesitation) just that I don't think that people they…(hesitation), just that this thing of psychologists it's not eh, it is a small thing and not well known you see? It is like a lot of people do not have any knowledge regarding psychologists.

SABM1

"When you tell them your problem they usually tell others about your problem, so it is not easy for people to go to psychologists since some of the psychologists do not eerh (hesitate) maintain the confidentiality of patients".

SAWF4

"Uhm, I wouldn't know like for me they are just some sort form of doctors helping. Well otherwise I wouldn't know".

SAWF2

"I think most people think they are unnecessary; they probably will not really want to get help".

SAWM1

"I don't think they know that they are psycho… psycholo…, psychological services available here".

SAIM2

"Umm how can I uhm, I don't think they are readily available for them".

SAIM3

"That psychologists are very, very smart. They are smart people, very patient, like to observe and like to listen. That's what most student think".

SAIF1

"I think we do not know a lot of it, we just know the surface maybe like a general idea. I don't think we actually know what it is like the core of it".

SAIF4

"It can give them a different perspective of how to change a problem into a solution and show them that they are not actually alone; there is actually someone who understands them. Instead of just taking it as a person that you

pay to like listens to your problems, that person actually understands and is giving them solutions".

AM4

"I don't know maybe if you go to a psychologist people will think maybe somehow you're on the verge of being a lunatic and so forth".

AF2

"Mmhm I don't even know if they have that much information about psychologists".

"Oh for them talking to someone like a psychologist it will be like they are exposing themselves".

Two participants (**SAWM1 and AF2**) reported the following in relation to accessing psychological services:

"Mmm Yeah, I have heard that if you see a psychologist you are like mad, that is just like a rumour going around".

"(Laugh) Associated with mentally disturbed people".

4.5.2. Students' perceptions regarding vulnerability to psychological distress (biological determinants)

Students reported that the chances of them being vulnerable to having psychological problems may encourage their help seeking behaviour. They believed it is genetically predisposed and it may provoke fear in them because they would not want to end up suffering like their family members. Some of the students reported that a person's belief has an impact in their behaviour or determines their way of life. They reported that if one believes they may be vulnerable, they will definitely be vulnerable to mental illness and act with fear.

SABF2

"Because seeing people go (hesitate)...I think that if a person goes to see a psychologist it means that they may have genes that lead to them being mentally-ill".

SABF3

"Uhmm, it would influence my behaviour a lot because I would act strangely towards that person because I would be afraid of him or her and then maybe I would even move out depending on the situation of that person. Yah the situation can also make me see a psychologist because if it's like my mom I would be stressed because my mom is sick and then I can also need to see a psychologist".

SAWM1

"Well my mother has bipolar so it affects us because sometimes she gets so depressed and we have to act cautious around her so we don't upset her and sometimes she gets very upset I mean it's just not good. Yeah, yes because I do not want to end up like my mother so if I don't say it then they won't be help".

SAWF2

"Well if family member has a mental illness, they are more likely to become mentally ill. Ohw, I think it will probably influence you to get help, especially if the person who has had a mental disorder has a negative effect on you. You probably would not want to carry on that path".

SAWF4

"They might become more insecure about the things that they do. Like they won't interact as much I would assume. So their self-esteem will go down. Yes if I were to think if I had a mental illness I wouldn't feel so confident enough to do some things".

SAIF1

"Umm well sometimes if someone has a mental illness they may try and ostracize them and stuff like that, but sometimes they may try to care and help the person and try to be more comfortable and just be more lenient towards them and do stuff".

SAIM2

"Umm I will see a psychologist because I think that you may think that it may be passed down through genes. Maybe you may think that, that may be passed on unto you".

SAIM3

"Oh congenital (inau) diseases. It all depends on a person's will aswell. Seeing someone like that in pain, you will obviously get like paranoid and will wonder if you will end up like that, maybe not now but over time with Alzheimer's, dementia aswell as ADD in your parents when they were young. I recently discovered ADD in adults' aswell. It all depends on how much attention you pay to it aswell".

SAIF4

"The fact that they believe that might actually make them vulnerable even if they are not, so like if they are like upset about something the fact that they believe that it will affect them it may affect them".

AF2

"Some of which being psychological problems or having a lot of social problems you'd be encouraged to avoid being...ending up being like the person that is around you. Yah and it is hereditary, I don't know. I'm just not sure whether it is psychological".

AM4

"So obviously you're affected even the member within the household who's going through that kind of sickness, you know, you as the family members who

are stable need to be counselled, you need to be able to be in a situation where you have to accept that person, you have to assist that person, you know. Yah".

4.6. Students' Perceptions of Personal Vulnerability to Mental Health

All 16 participants reported that people only sought professional help when their problems are severe. They said that people tend to be in denial and convince themselves that they have everything under control or they can handle the challenges experienced. It is only when the emotional, mental or physical problem is severe, that they access services. These are some quotes from other participants:

SAWF4

> *"Well it depends on a person, because others will like ignore it until it gets too big for them to handle. It depends on when they feel it's necessary and that is usually when the problem is severe and visible".*

SAWF2

> *"Horribly feeling. When you have reached that breaking point and you feel really overwhelmed".*

SAWM3

> *"When their actions start affecting them. When they can't any longer uhm. When their wellbeing is being threatened I guess, when their mental and emotional wellbeing is being threatened".*

SAIF1

> *"I think like if it is very severe because normally people will just try brush it under the carpet and they think it will go away. So I think probably like if they can refer to a psychologist by like a doctor or something maybe".*

SAIM2

> *"When it has gone too far, like when it is medicated psychology maybe".*

SAIM3

"Yes when it is more severe and progressive aswell because you do not want that disrupting your whole life which may turn out that it may be a one day thing, like you are having a bad day".

AM1

"People go when they're seriously sick. Sometimes they do not go by themselves but they wait till they are taken there. So it's highly...It's unlikely for a person to stand up and say…"

AM4

"When it's more severe, yes that's when they tend to seek services yah or when it is more visible and affecting other people around them".

4.7. Students' Perceptions of Mental Health Services

4.7.1. Students' perception on how psychological services can be of benefit

SABM1

"Eerh I don't know".

"Eerh it can help me with the way I think, how I behave. Psychology is all about that. On making good decisions as a person and things you should avoid, so it can help me a lot. It can give me advice".

SABF2

"They can help by showing support and not judging a person by saying they are crazy and things like that. Yeah showing support that they really care and not judge a person and things like that and that they care about that person so he or she can feel wanted as a person like they are alive (mentally stable) and not crazy".

"I think it can help me because I can release anger".

SABM4

"So if umuntu eding i-memory bangam'siza ukuthi akhumbule ukuthi kwenzakalani noma acabange, angazi but noma mhlampe angazi bayam'siza yini if umuntu e-stressed". (If a person has lost memory they may help her regain it but I'm not sure if they help in stress related matters).

SAWM1

"They listen to you and prescribe a way that you can get away from the problems that you have like emotionally or stress or, whatever is bothering you. It can help me deal with the stress of studying and stuff which it can be stressful. They can give you support".

SAWF2

"Well especially if there is a lot that is going on at home and they know that they can access counselling away from their family members I think that can help. Especially ummh it can help depressed students who are struggling to pass their exams. I think it is very handy".

SAWM3

"I think people will obviously think there is problem with them. They obviously would not want to approach them so they will suffer from isolation definitely but so as a psychologist you will tell them that listen you do not have to let anyone know it is just between you and me"

SAIF1

"I think they can help them like show them that they are not just stuck in this one situation they can get out and show them that like a better way of doing things and how to handle situations better. Yeah. Emotionally I think if you like offer them a bit of support and allow them to talk because sometimes some people just need to tell their story and just vent and just you know. I think mentally it might go with that aswell goes with that and may offer them advice aswell. I'm not sure about physically (laugh)".

SAIM2

"Uhm it will ease their problems in a way".

AM1

"I think he (they) identifies problems in someone's mind, or state of mind, and then tries to help the person dissolve the problem. By observing, uhmm maybe by asking questions".

AF2

"Yah, if you believe that a psychologist can help you, you go there with the trust and the hope of getting help. So you'll be there saying whatever your problems are and with the hope that 'from here I'm going to leave this place different".

4.7.2. Obstacles to accessing Mental Health Services

Participants identified barriers of accessing psychological services. They included lack of knowledge/ information, costs, language and the level of education. Participants reported that the fear of being discriminated against when people find out that they utilise the services may also serve as an obstacle to accessing mental health services.

Most participants reported that the reason people do not access the services may be because they are not readily available. One participant *(AF2)* was quoted saying:

"that is the other thing that make people attach psychological services to stigma, because people are not used to them so when they see the services and people accessing them, it becomes a shock"

Only one participant from the white population reported that language, level of education and costs are not barriers to accessing psychological services. Participant **SAWM3** further said that:

"South Africa has developed therefore it is easy for every person in need to utilize the services".

4.7.3. Students' Perceptions on Barriers of Accessing Psychological Services

(a) Cost as a barrier

SABM1

"Some of them...Some (hes). Maybe in private hospitals one has to have money to see psychologists".

SABF2

"I think it costs a lot. It's expensive. People who are poor, who don't have any jobs can't go".

SABF3

"Uhmm, some of them might go, but I don't think all of them can go because if you want to go and see a psychologist you have to have money so I don't think everyone can like go to a psychologist. Maybe some people will be afraid to talk to a psychologist about their problems".

SABF3

"Yah cost can be a problem, you know, because sometimes you may feel that you need to see a psychologist but then you have the financial...You don't have enough money to go there and then you end up not going".

SAWF2

"Yes I do think it is expensive (lau)".

SAWF4

"I don't know much about the costs but I have seen the doctor's fees are quite expensive and those who don't have enough money may not go".

SAIF1

"Ohw yah I think it is a bit hard for some people because it is a lot of money".

SAIM2

"Uhm either service availability and cost that may affect them".

SAIF4

"It can because like some people, like people with lots of money ok maybe they do have problems but most of the time it is people who are average or poor. They are the ones with lots of problems because they are trying to get up there. So if they do not have much money it may be a barrier because they won't be able to access the services".

AM1

"The services are found in towns or more developed places, or sometimes the service is expensive especially if it is private. I don't know how much hospitals cost".

(b) Lack of information as a barrier

SABM1

"Even in general hospitals it is rare to find psychologists. Eerh (hes) people also don't want to talk about their personal issues so that is what prevents them from going to see psychologists".

SABF3

"Yah, but if they don't have information on what they do they can actually discriminate you".

SAWM1

"The fear of finding out that there is something wrong with you is like you don't want that to happen so what is it happens it's not good".

SAWF2

"Their pride (lau)".

SAWF4

"Uhm they don't want to be judged by the society by admitting that they have a problem may cause other people to judge. So it could be that they fear to know they have a problem or they don't want to address the problem. And some people just want to ignore it and let it go".

SAIF1

"I think sometimes you do not know where to go to access services and certain people are very apprehensive about accessing it. Like they don't want to seek help while some need to be told. And people with mental illness are seen as bad".

SAIF4

"Maybe they do not understand that there is something wrong with them, they are in denial or they, uhm, people have been putting them off and telling them it is a bad idea if they spoke to someone. Or they think they can help themselves, they do not need help. Or they think it is something that they can get over".

AM1

"Yah, yah more especially if you don't understand the role of a psychologist".

"Because you saw somebody who was...who has a mental illness going to the psychologist, so you think if you go there people will think that you also have a mental problem".

AF2

"Oh so it's usually people being pushed than standing up and saying...For instance maybe there is little understanding what a psychologist is or what they do".

(c) Language as a barrier

SABM1

"Yes the language can also be a problem, sometimes when you are a Zulu speaking person when you go to a psychologist who is an Indian it will be difficult to communicate with that person, with that psychologist. So language can also be a problem".

SABF2

"Mhm it's English, it can also make people not go, because not all of us are educated".

SABF3

"Yah the language can be a problem as well, because like if I'm a black person and I go there and the person there is not a Zulu-speaking person they speaking English and so sometimes I cannot understand what that person is saying to me. So language could be a barrier".

SAWF2

"I think it should vary from what home language. So it would be preferable that if I am seeing a black person I should use their first language if they understand it better than their second language".

SAIF1

"Ohw I think that might be the problem aswell because not everyone speaks English and then they may have difficulties in explaining to someone who speaks English. You may feel like they might not understand you properly".

AM4

"Language can be a barrier yes, it can be a barrier. It is a barrier in fact. Like the Batswana, like the Zulu so we're using the legal language which is English"

AF2

"Uhmm it will depend, mostly it's good to express yourself in your mother tongue especially when you're expressing your problems".

(d) Level of education as a barrier

SABF3

"That also has an impact because if you are educated you'll know that 'Okay around there are psychologists who help' but if I'm not educated I don't even know what a psychologist is, so I won't know anything about them and then I won't go".

SABM4

"Kwesinye is'khathi vele mawungafundile uzoba naleyonto ukuthi vele i-psychologist ay, kanti vele umuntu ofundile nomuntu ongafundile bacanga ngendlela engafani. Yabo, so if umuntu efundile obviously unayo leyonto leyo yokuthi ay no i-psychologist iyasiza, kumele ng'hambe ngiyoyibona, mawungafundile uzothi ay. Uma mhlampe unez'nkinga uthi ay zizoz'phelela noma kunomuntu wakini onjani uthi ay izobuya inqondo yakhe, iyogcina isibuyile. "(If you are not educated you may not know what a psychologist is and not access the services. You may convince yourself that your mental state will be okay with time but it is different to those who are educated as they see the difference in their well-being).

SAWM1

"Yes because if people are not aware of psychologists then they won't know about it so they will just ignore the problem. So I think it plays a big role".

SAWF2

"Well I think if you are more educated you become more aware of what a psychologist can do for you".

SAWF4

> *"Yes I would think so. Some people may not even know what a psychologist is and the need to be more educated in that and the services they offer. I doubt they really know much about psychologists".*

SAIM2

> *"That is also important because you wouldn't understand what is going on if you haven't had your basic education. Same applies to the language".*

SAIM3

> *"It would yeah, like different people at different educational levels will have different problems".*

AM1

> *"That one is obvious; people who are not educated don't even understand what a psychologist is and what it does. But educated people understand because of their level of education".*

AF2

> *"Yah normally people who go and see a psychologist or who know and understand about psychologists are educated people otherwise you meet other people out there they will associate to other factors like traditional, witchcraft, whatever". "Yah and educated people those who aren't religious they will use both maybe spiritual help and psychological, combine the two. But those who are not educated they will cling to what they believe in".*

4.8. Students' Perception Regarding Gender and Accessing Psychological Services

16 Participants were interviewed and only 1 participant from the Indian population reported that access to psychological services is shared equally between genders. 15 participants from all racial groups believed that females are most likely to access psychological services. They said that females enjoy talking about their problems while societies expect males to be macho

and not express their emotions. This societal expectation may be the cause of limited number of males accessing psychological services. Participants said that:

SABM1

> *"Females go to see psychologists than males. Most males don't want to talk about their problems and they don't like admitting that they are not well".*

SABF2

> *"Oh okay, men bottle up their problems and females prefer to talk. Men just sit around and talk to nobody, if a man has a problem he'll keep to himself and won't tell anyone, not even his wife (Laugh)".*

SABF3

> *"Uhmm females are sensitive and emotional but for males, I think it can be hard for the males to believe that they can be helped by someone else. They always think they can do things on their own and they need to be strong, so they can be ashamed of going to see a psychologist and maybe they will think that their friends or other people will say they're not strong as they're meant to be because they are now seeing a psychologist".*

SABM4

> *"Ngoba ama-males analento ye-pride yabo" (Because males have this thing called pride, you see).*

SAWM3

> *"I don't believe so personally. I think it is shared equally but I think the girls are probably more prone to go to see them "psychologist" though, because guys or men are do not want to show their emotional insecurities".*

SAWF4

> *"Well I think its females, because men are like macho and they don't think they should see a psychologist because they do not want to address problems".*

SAWF2

"I think they are more proud and prefer to keep their problems inside".

SAIF1

"Gender, I don't think. I think more females will seek services, because men just want to buff and you know pretend that they can handle everything".

'I think like in society men are just supposed to be this brave person who can just handle everything and I think they have that kind of stigma attached to them".

SAIM3

"Uhm eish I cannot say, but I can say from a certain age onwards it is mostly men. There is always a balance between men and woman. But I think because men are not comfortable opening up to their wives or husbands if homosexual or stuff like that but they may go to the professional. They may feel like less of a person and like they are exposing themselves and not being that man. There is an underlying notion that they can sort themselves out because they are old enough and that they can handle it. Especially with midlife crisis a lot of men I know seek psychological help".

"Females like to talk about their problems and that is a good thing. It's not a bad thing it is a great thing because they know that something is wrong with them and they want help from somebody. Men are too proud".

AM1

"Eerh females are very much worried about their health and everything, so they talk about such things and usually they know, they have information about where to find what. So usually they're the most people who access such services or facilities if they are".

AF2

"If something concerns them they'd really want to...to get over it and they'll make sure that they find help as for males, they're always in denial".

4.8.1. Masculinity as an obstacle

Participants from all racial groups have indicated that men do not find it easy to express themselves as compared to women. In this section racial groups are grouped according to similarities raised during interviews.

SAWM1

> "Yes because males are supposed to be like a strong figure in the family and they are not supposed to need help like that. Yeah, well that is a general conclusion or what the society says".

SAIF1

> "I think like in society men are just supposed to be this brave person who can just handle everything and I think females find it easy to express themselves while men are expected to be man and be brave. I think they have that kind of stigma attached to them".

According to the participants' responses males from the black population (South Africans and Africans) seem to be living with the society's expectations of them being the pillar of the whole family. They live by the notion that men do not cry to avoid being perceived as weak or not being man enough.

AM1

> "I think maybe it's our African culture. Or the way grow up and perceive things, that we are strong, unless if there is anything that is bothering much, if it's something little so we just need to deal with it".

AF3

> "Oh, stigma does exist in our society".

AM4

> "Yah, culture and societal values and so forth they contribute. Like I said as men we're groomed to be brave enough, to be acceptive of the problems that we have, you know. That is the way we are brought up yah".

"Yah so we men, we tend to like put on a brave face you know, thinking that all will be well while deep inside we're hurt. But while deep inside the pain is growing, it's building up".

SABM4

"Ngoba ama-males analento ye-pride yabo". (Because males have this thing called pride, you see).

4.9. The Influence of Society in Relation to Mental Health and Psychological Services

SABF3

"Yah, but if they don't have information on what they do they can actually discriminate you".

SAWF4

"Well students could accept themselves and accept that they have a problem and maybe overcome that problem that they have if the society have confidence in them and accepts them".

SAIM3

"We like to small talk and gossip and things like that. So obviously it may spread and they will tell people what they believe this person is going through and it may not be the truth. That can be destructive but on the whole, it depends aswell lets say the person is a higher family member and I know he is going through this and I suggest that please go see a psychologist. Sort yourself out maybe you are depressed or something like that. If a lot of people know that this person is going through personal hell or trauma then they will have to understand that this person is going to a proper place to sort themselves out. And be accepting and understanding about it".

SAIF4

"In the Indian community people are very judgmental so like if you're seeing a psychologist you will just be the talk of the town if you have problems and no one will be there for you as people, it will be more like something to talk about than something to help about. It will just be very odd if people help you. It will be like a barrier".

AF3

"Eerh, some people in societies think maybe people with mental issues are dangerous to them, maybe they can attack them and then they isolate them. I think the society should embrace them (people with mental illness) and help them".

AM1

"One, it might...maybe looking at the community or people around with the mentality that if you see a psychologist you have a mental problem so if you go there it means you also in the same situation with that person. But make you maybe even think you can't go at all even when you think you need to see the psychologist".

4.10. The Influence Peers have on Access to Psychological Services

SABM1

"They would think that there's something wrong with my mind and maybe some of my friends would turn their backs on me. And stop being my friend because they would say that maybe I am psychiatric".

SABF2

"Other students will laugh at them".

SABF3

"Some might support me, and encourage me like to continue going there but I don't others they can. Maybe they can just sneak from being my friends".

SABM4

"If abayi-understand bangaku-discriminate because bazocabanga ukuthi une-mental problem". (If they do not understand what a psychologist does, they may discriminate you and assume you have a mental illness).

SAWM1

"They will classify you as crazy".

SAWF2

"Well they will possibly see me as being a bit more weak (laugh)".

SAWF4

"Well, uhm the people I have around don't judge but some people may judge you if you see a psychologist. Well because they will think that there is a problem with you and they won't treat you like other people because they will assume it is a mental problem".

SAWM3

"I think people will obviously think there is problem with them. They obviously would not want to approach them so they will suffer from isolation definitely but so as a psychologist you will tell them that listen you do not have to let anyone know it is just between you and me".

SAIF1

"When friends or other peers find out someone is seeing a psychologist they kind of just judge the person and suddenly think that something is wrong with you. And treat you differently and stuff".

SAIM2

"Not my friends, with my friends it doesn't matter. They wouldn't have a problem. But with others maybe they will think that something is wrong with you mentally or that it is silly. I think talking to peers or people who have the same problems or group session or something like that".

AM1

"I don't think it can influence me in a way because they do not know what I'm talking or communicating to the psychologist about".

AF2

"Obviously there is going to be a sort of stigma. They will start asking you 'what's going on, are you fine?"

4.11. Students' Perception of Protective/ Risk Outcome for Accessing Psychological Services

4.11.1. The effect of confidentiality on students' access to services

SABM1

"It would be comfortable to see a psychologist if I don't know that psychologist and the psychologist doesn't know me".

"Because some of the professionals do not maintain the confidentiality of the patients. They usually tell other people about the personal issues of patients, so it would be difficult if that person knows me".

SAWM1

"If it is confidential yes, I can recommend it to friends".

SAWM3

"Yes I would see a psychologist, if the psychologist agrees that things will remain confidential".

SAIM2

"Because I know it is between me and them."

AM1

"Only when I'm sure it is between us then i will access the services".

AF3

"Psychologist are trained and have skills therefore they understand confidentiality and the trust put in by their clients".

4.11.2. Personal perceptions regarding confiding/ disclosing to a professional

SABM1

"Eerh, most of them don't feel comfortable but if you know that the psychologist is professional maybe it will be comfortable. And if you got to a psychologist that doesn't know you I think it will be comfortable".

SABF3

"No, actually I don't like going to see people and talking to people about stuff so no I wouldn't go there. I don't believe that if I talk to someone about a problem my problem will be solved".

SAWM1

"Well if it's confidential then I think it's okay, but most people won't say everything because some details are just too personal".

SAWF2

"Well I think it's quite difficult but I think psychologists can come in handy and in order to heal yourself I think you need to disclose everything".

SAWF4

"Mmh it depends on the person, mmh it depends on how comfortable they are feeling and the psychologist they chose is friendly and inviting".

SAWM3

"Mmh I think it will never be completely disclosed, I think you will have to keep a hold back just so that the psychologist can get a gauge on the improvement and the wellbeing of the person".

SAIF1

"I don't think it is easy because not all the people like to admit that they have a problem and even if they do don't really want to talk about it. People like to keep a brave face and try to act like they got it all together and stuff. I think it is because of the society. They do not want to be looked down upon and they do not want people to think any less of them so they are trying just to…".

SAIM2

"Uhm it will depend on the individual now but for me personally no, I won't disclose any information".

SAIM3

"Uhm that is different because people have different personalities. Some people may want to hold it in and bottle up and some people just want to be stubborn. But talking usually takes everything off your mind. Because you are isolating your problem and presenting it helps take it off your chest".

AF3

"I think psychologists are trained to deal with such issues, so I trust in their opinions personally".

AF2

"With elderly people, forget it. They will never disclose anything. They will start looking at your age and if you related or not and from there they would never tell you anything. They confide in relatives".

"Young students do not want to say their problems, they feel like they are exposing themselves".

4.11.3. Students' understanding and expectations of the therapeutic alliance

SABF2

"And the way the psychologists approach people. Others, I don't but (hesitate)...I am not sure but I think, from my understanding, you have to be caring, kind and try to be caring to people and not just be someone who's quiet and only ask questions, without even a smile. So that a person can feel wanted and welcomed".

SABF3

"No, talking to people is not easy for me because you may never trust a person".

SABM4

"Yah, mhlampe kuyo-depend yabo, njengoba bengithi abantu be...ama-female analento le yabo, so mhlampe mangingafica noma let's say. Yah male, mhlampe kungaba ngcono ngoba ngikhuluma engathi ngikhuluma nomunye umjita, ngiwumngani wakhe yabo. It has to be man to man". (It would depend, as a man I will not comfortable with a female psychologist; it has to be man to man).

SAWF2

> *"The relationship between the psychologist and the patient is important. It needs to be solid and there should be trust".*

SAWF4

> *"Uhm it depends on whether I trust a person but, Yes I would. But trust between us is very important if I have to confide to someone".*

SAIF4

> *"I think at first it may be hard because at first you may not know the person, that is why people are really like to keep to themselves when they have problems but I guess when you get into it and once you start talking everything will like come out".*

AM1

> *"Psychologist will be asking very complicated questions that may scare someone away. At the end of the day and then thinking of going back there it will be something else and maybe you can even spread the wrong gospel that 'ey that place is not a place to visit".*

4.12. Alternative Forms of Interventions

4.12.1. *The impact of culture, tradition and religion on mental illness*

Only one male participant from the white South African population reported that he is not religious nor have hold on any cultural beliefs therefore if he experiences any problems he will prefer being seen by a psychologist. The one participant from the white population also said:

SAWF4

> *"Ohw ok, yah uhm I don't have any religious beliefs, so I wouldn't know, uhm I am more scientific so I would say psychology and counselling would be more beneficial. Then prayer would come afterwards".*

It seems like religious and cultural beliefs differ according to race. Black South Africans and African participants believe that family values, supernatural forces and traditional rationale can aid as other alternative forms of intervention, while Indians and whites are either religious or scientific. The responses from participants from different racial groups are quoted as follows:

SABF2

> *"You have to go to a traditional healer or ancestors and get umuthi. Because we believe it can help them, these things are caused by witches".*

SABM1

> *"According to my culture or religion we believe that if a person is mentally ill they must go to a traditional healer because it maybe witchcraft which is capable of leading to mental illness in a person".*

SABF3

> *"Uhmm they (hes)...We believe that our ancestors guide us and provide care, like if we need something we know that we have to perform some rituals for them. And then they'll help us with whatever that we have a problem with".*

SAWM1

> *"Oh ummh...I heard of people talking to, Catholics I think, talking to their father about their confessions and stuff, it may help them. I think that its more like eerh, it helps them feel better about the mistakes that they made. The God that you believe in. Praying normally in more religion helps you deal with the problems. But praying it is".*

SAWF2

> *"I don't have anything against it as long as it is to their advantage then why not? If they believe in it they might as well go for it".*

SAWF4

> *"Just psychologists and doctors".*

SAWM3

>*"Seeing a minister aswell as a psychologist".*

Participant **SAIF4** said that having religion as an alternative intervention is *"silly as it limits people from getting better". She is quoted saying "Well I'm not very religious to be quite honest, (hesitate) uhm it's just something like I know at home because they are all religious. So it will be something I will have to keep it inside and I won't talk to someone. They won't see it as a psychological problem or a big matter so you may just have to deal with it. So it's either you keep it inside and they won't see it as something important. So you can tell a family member but it will just end there or tell family member and it will end there".*

SAIF1

>*"Umm I'm not sure maybe like if there is a counsellor that you feel comfortable speaking to someone at your church like a priest or a nun. Even someone you look up to in the community and you might feel comfortable with". "(Laugh) I don't know about traditional healers, like they not really like specifically trained so maybe they may not know exactly what is going on in a person. Uhm I think for us we will talk to our priest and tell them what is going on or like a nun or something".*

SAIM2

>*"Uhm I am a catholic so it's good to speak like for example confession and stuff like that".*

SAIM3

>*"Yes especially amongst Indian communities. I'm Indian and hindu and a lot of time people get overtime they get delusional and they are confused. They become Christians and they get baptize. It does have positive aspect in them because it is something new and it is a fresh start and things like that. Indians believe more in religion because they are very superstitious".*

AM4

> *"Alternative (hesitate), within the community we have, even at home counselling is provided within the family, prayer and talking to family".*

> *"The elders can provide services, counsellor services, even though it's informal you know. But they do help; spiritual healing is also part of it".*

AF2

> *"Or who are just spiritual will cling to one, but mostly those who are educated either they cling to cultural or religion they can use both"*

> *"People who are not educated with cling to what they believe in and which is that when you have mental illness it is either bad spirit or you are bewitched. They will therefore seek spiritual intervention or traditional healers".*

4.13. Motivation Towards Help Seeking Behaviour

4.13.1. Students' perceptions of support on behaviour change

SABM1

> *"Yes, support from family also counts. If they support you they would advise you to go to see a psychologist early".*

SABF3

> *"Yah it does, like if you are sick and your family supports you and they really care about you and they know about know about psychologists they can talk to you and they can take you to the psychologist. But then if your parents are against going to see a psychologist it will affect you because you'll end up not wanting to go to a psychologist because you know that 'Okay my family doesn't believe that psychologists help' so it will influence you".*

SAWM1

> *"Yes if the family supports you it is easier to deal with problems and if you are not alone".*

SAWF2

"Yes definitely because if you don't have any support from family then you going to rely more on the psychologist on campus".

SAWF4

"Well I think that is pretty important because then they will encourage you to keep on seeing a psychologist and keep working on that problem. Otherwise if you do not get support you may feel like you don't have to see them anymore. So I think support is very important".

SAIF1

"Ohw I think if your family supports you, you may be more willing to be doing something because if you are like alone you don't know what to do. If you do not have the support you will just wallow in one place".

SAIM3

"Then the person obviously is like, I heard that in psychology there use therapy or a half-way house and if there is no support and family does not supply a home or away from the psychologist or psychiatrist. External influence can put this person back into the place that they were for example temptations, drugs, alcohol, abuse, social demographics of the person's location and things like that".

AM1

"Yah it can influence because if somebody, if I'm aware that this person is sick or he needs such assistance and then maybe talk to the person, convinces the person to see or seek such services the person might end deciding to seek for such help. But if we just don't have or don't advise some people won't even think of going, or if they're not aware of such services whilst I'm and not advising such a person to go there so it won't even help".

4.14. Factors That May Cue Students To Take Action

Students believe that the media's advertisements of psychological services may normalise accessing the services and may cue people to access. They reported that if one hears or sees it from somewhere else (media) they may begin to realise that they have similar problems. Students believed that past experience can also determine a person's help seeking behaviour. They further stated that some people do not access the services because they are not aware that they have a problem (sometimes due to the lack of education) therefore advertisements, campaigns, talks and posters may benefit people in need.

SABM1

"I think what can motivate people uhmm (hes) what can I say? (Prolonged silence) The thing that can motivate people to go see a psychologist is that they can be taught about psychology and the use of psychology because most people don't go to psychologists as they don't know what psychology is and are not well educated about it, so I think it must be advertised in the media. There must be educational talks about it so that people can have knowledge".

SABF2

"Maybe when they see one who got helped then they realise that they have a problem. Yes, someone who had a problem and got helped it can also make them go there".

SABF3

"Maybe for some people it may be due to their previous experience, like maybe they once went to a psychologist and it didn't help then they don't want to go there again".

SABF3

"Eerh, I think if the person sees and notices that things are not going well for him or her and it is affecting him and maybe if I'm a student I can see that I'm even failing now at school and I can't concentrate and then I'll decide that I need to see someone, to talk to someone who can help me. Or you can hear from other people, your friends or everyone, who has been to a psychologist,

he or she can advise you that you must go and see a psychologist if it helps you".

SAWM1

"Ummh if they can't cope anymore then yeah I think that's when they look for help. Well in the campus I think, if you can have a day where like you know like the condom protest thing. Yeah if you can do something like that for psychology and psychological services then I think people will be more aware of them and yeah spread the word".

SAWF2

"Ummh, maybe advertise a bit more and become clear of what psychologists can do. Yeah, I think maybe uhm just spread the word more around campus. Yeah more general so its less in their face. For especially people who are very proud they don't want their peer to know".

SAWF4

"Ahh maybe not (help desk) (Lau). Maybe just talking to people in general and not expecting people to come to the desk and not having things written psychology. Having mental awareness days where everyone is invited".

"When their well being is threatened. Advertisements can motivate help seeking behaviour".

SAIF1

"Like uhm, I don't know but maybe have like a website where people Google psychologist you know like something like that or at the hospital have like a little billboard or something saying your services are here. Just make them more aware".

SAIM2

"I'm not sure but people look at posters (laugh). So you can put posters".

SAIF4

> *"I guess if people tell them that there is something wrong with them, campaigns or advert. They would visually look at it and see it applies to them or people will talk to them and tell them or the word of mouth".*

AF2

> *"Advertising and doing expos".*

4.15. Conclusion

There seem to be similarities in students' perspective of what is perceived as barriers or benefits of accessing psychological services. Even though different factors have been mentioned, lack of information and the knowledge of what psychological services offers seem to take precedence. Therefore the findings indicated that the lack of information regarding psychological services may result in the scarcity of utilisation of psychological services. Participants reported the need for psychologists to psycho-educate community members starting from high school learners all the way to community leaders. In addition, mental illness may not be perceived as a taboo condition and may increase the likelihood for community members to access, identify and recommend the services for those in need.

Having campaigns and posters on campus was perceived as an easy method of disseminating information to students while advertisements through media were perceived as a cue for the people to take action and identify their own problems. Participants further reported that people utilise the services when the problem is severe or when they perceive that they may be vulnerable to mental illness due to biological predisposition.

Masculinity is perceived as a predictor for help seeking behaviour. Participants assert that males seem to be living up to the cultural standard and expectations set by the society. They further reported that females are sensitive and prefers to talk about their problems while males are said to be weak and not man enough if they express their feelings.

Culture and religion seem to play a vital role in help seeking behaviour. Most black South Africans or Africans reported going to traditional healers for alternative forms of interventions while South Africans from the white and Indian race perceived religion as

helpful. Apart from race, religion and cultural values participants emphasised the importance of confidentiality during consultations. Rapport should be well established between patients and the psychologist in order for patients to disclose with ease. According to Castonguay, Constantino and Holtforth (2006) therapeutic alliance may result in positive therapeutic change during the treatment process. They further stated that the therapeutic alliance may determine treatment outcome. Contradictory to family support that is perceived as a necessity and a motivation to accessing psychological services, the influence of peers seems to have a negative influence to the access of services. The next chapter will focus on the discussion of the acquired results.

CHAPTER 5

5. DISCUSSION OF RESULTS

5.1. Introduction

The results of the perceived benefits and barriers of accessing psychological services amongst 1st year students from the Faculty of Humanities will be discussed in the section below and are presented under dominant themes which are: Perceived susceptibility, perceived barriers, perceived benefit, perceived seriousness, self- efficacy, perceived benefits and cue to action.

5.2. Perceived Susceptibility

5.2.1 Knowledge about mental health services: Understanding of psychological services

According to the data collected there was an indication from the participants in this study that the lack of help seeking behaviour is influenced by the students' lack of knowledge and understanding of psychological services and mental illness. Similarly, Seabi and Samouilhan (2010) found that the students' negative attitude towards psychological services and mental illness may be a result of the lack or limited knowledge regarding mental health. The majority of participants associated mental illness with witchcraft that needs ancestral rituals. Bojuwoye and Edwards (2011) asserted that people from African indigenous cultures may believe that mental illness is caused by witchcraft or precipitated by ancestors' dissatisfaction with a person. Therefore, seeking traditional healing is mostly preferred rather than western forms of healing that do not address witchcraft.

Some of the participants in this study reported that even though they may be aware of the psychological services that are available to them they still opt for other sources when dealing with psychological stress. These include consulting with a GP, talking to family members or prayer and may consider consulting with a psychologist as their last resort. Similarly, Seabi and Samouilhan (2010) study reported that although community members may be aware that when one experiences psychological distress they need to consult a psychologist they still believe that the best way to deal with mental illness is to consult a general practitioner, talk to family members or pray. Participants further reported that even though they recognise the

usefulness of consulting a psychologist they often feel that they do not necessarily need them. It should be noted that the form of intervention preferred by the participants is dependent upon their socio-cultural environment and resources that are available to them. Participants further stated that the attitudes of their peers towards psychological services may also influence their perceptions and help seeking behaviour.

Similarly, participants in this study reported that their help seeking behaviour may be determined by their perceived vulnerability to psychological problems (witnessing a family member having an episode of mental illness). Likewise, the HBM argues that people are most likely to access services if they perceive themselves to be vulnerable to illness.

5.3. Perceived Barriers

5.3.1. Availability of mental health care services in communities

Gibson (2004) stated that the post-apartheid South African government has introduced several systems to overcome inequalities in health care sectors but despite their efforts the distribution of health care services is still unequal. Moreover, since 2003 all training clinical psychologists had to serve 12 months community services to underserved communities as a way of decentralising and allowing access to the African majority (Gibson, 2004). Participants of different races in this study reported that psychological services are not readily available for everyone. In addition, they indicated that they have never seen them in their communities and that they are only based in urban areas. Also, they were not aware of the availability of psychological services in their local hospitals while some reported that they are aware of their availability in private settings at a higher cost. Having no access to psychological services may contribute to the perceptions that the participants expressed towards these services as well as their willingness or lack thereof to access them when introduced at a tertiary level. . The government's effort to send training psychologists to do community service in disadvantaged areas does not seem to be recognised by participants.

In South Africa most communities from disadvantaged areas utilise public hospitals or primary health care clinics which may comprise of several barriers (poor service delivery, unavailability of drugs, and travelling costs or the lack of mental health services in these institutions) that may compromise their treatment adherence (Bradshaw, Mairs & Richards, 2006; Kagee & Van der Merwe, 2006). This may result in limiting certain treatments due to

shortage of health service inputs as the public health sector is underfunded (Gibson, 2004). Barriers such as poverty, unemployment, inability to pay for treatment, lack of money for transportation, poor system of referrals and limited availability of health service inputs (equipment, staff, drugs etc.) may result in patients losing contact with their mental health care providers and other professionals (Bradshaw et al., 2006; Goudge et al., 2009). Moreover, the majority of these patients are re-admitted at a later stage as a result of poor treatment adherence and defaulting. Lund et al. (2012) further state that the inability to be integrated in the community and insufficient support from community and family members after discharge from mental institutions may also result in relapse and re-admissions. In addition to that participants reported that psychologists should provide "*half way houses*" that accommodate patients whose family are not supportive to avoid negative external influences that may result in relapse.

5.3.2. Students' perception on barriers of accessing psychological services

Language emerged as a potential barrier in accessing psychological services. South Africa has 11 official languages and out of these languages English is the dominant and the mostly used medium of communication in mental health care (Schlemmer & Mash, 2006). The majority of professionals in public sectors cannot speak the language of their patients or may often use medical or psychological terminologies that patients may find difficult to understand (Deumert, 2010; Levin, 2008). According to Levin (2008) language as a barrier may have negative consequences on the health of patients. Deumert (2010) stated that language is a powerful tool that assists in diagnosis, treatment, management and in building rapport between the patient and the mental health provider.

Patients may have their own culture specific illness and use a certain explanatory model influenced by their culture. As a result, this may lead to miscommunication between patients and service providers and may also result in patients being intimidated, unsatisfied or not accessing services (Levin, 2008; Schlemmer & Mash, 2006). Participants in this study perceived language as the barrier to accessing psychological services. They reported that some uneducated individuals who speak indigenous languages may experience difficulties communicating with a mental health provider who speaks English. According to Campbell, Kearns and Patchin (2006) illiteracy seems to be a serious issue in South Africa and can be one of the barriers in accessing professional psychological services. Moreover, the population

in rural communities consists of a large number of illiterate and unemployed individuals. As a result, the low level of education may influence help seeking behaviour.

Participants in this study assert that people who are not educated may not know or understand the purpose of psychological services therefore they may not know appropriate places to seek help when they are experiencing psychological problems. Similarly, Campbell, Kearns and Patchin (2006) further assert that community members may also experience challenges in understanding the purpose of psychological services or expressing personal matters to a stranger. Participants reported that they would feel more comfortable expressing themselves using their mother tongue as this will allow them to express in detail how they really feel. Williams and Bekker (2008) further stated that patients have a right to consult health care services using their language of preference to avoid providing limited information. Levin (2008) asserts that it is important for service providers to learn indigenous languages, explanatory models of illness and cultures of the majority of patients of their target.

Moreover, untreated mental health problems and limited access to services are frequently cited as common problems in rural communities. The majority of people residing in rural areas utilising public hospitals are unemployed. However, this is a challenge as they may be faced with barriers such as lack of transport money. In addition to this, participants reported that accessing psychological services may be a challenge as psychologists are found in private hospitals and at a high cost. According to Kremer and Gesten (2003) the high costs in private practices may also be a barrier in accessing psychological services therefore systems that accommodate people who cannot afford private practices must be put in place. Financial difficulties may result in poor treatment adherence which has negative implications for recovery time and quality of life (Kagee, & Van der Merwe, 2006).

5.4. Perceived Benefits
5.4.1. Students' perception on benefits of accessing psychological services
All the participants who were interviewed for this study reported that they have never accessed or utilised psychological services. Participants reported that if they were to consult a psychologist they may be helped in making informed decisions about life and will be provided with emotional support. Furthermore, participants reported that even though they will find it difficult to disclose everything they may find comfort in talking to a neutral person who will listen to their stories with no judgements. Participants further reported that if you have a positive attitude towards psychological services you are likely to respond

positively towards the intervention offered. This is in connection with the HBM's argument that individuals only access services if they belief it will yield changes. The majority of the participants reported that confiding in family members may benefit them while others argued that it is beneficial to talk to someone you have no relation to in order to avoid judgements. Participants further reported that psychological services may be beneficial during exams as they usually experience high level of distress. Additionally, Shy and Waehler (2009) perceived social support and the high level of psychological distress as a motivation for help seeking behaviour.

5.5. Perceived Seriousness
5.5.1. Degree of personal susceptibility in relation to mental health

Thompson, Hunt and Issakidis (2004) stated that most people do not access psychological services till their symptoms are severe. Moreover, barriers such as attempting self-healing, having a stoic attitude, personal belief or lack of knowledge about mental health and mental illness may delay help seeking behaviour and lead to access of services only when symptoms are severe. Participants in this study reported that most people may only access psychological services when their illness has advanced and is more severe and visible. The health belief model argues that people access services when they perceive illness as serious or themselves as susceptible to illness. Furthermore, participants indicated that some people may convince themselves that they are only going through a certain phase in life and that everything is under control. According to Ditto, Jemmott and Darley (1988) some people may gauge the consequences related to the perceived threat and if they appear benign they may not seek help. Furthermore, until the symptoms are severe patients perceive symptoms as possibilities and do not consider what the consequences of not treating the symptoms may be. In addition, patients may be in denial of the threat, diagnosis or prognosis, and minimise it (Ditto, Jemmott & Darley, 1988).

Participants reported that the delay or avoidance of help seeking behaviour may be associated with pride and shame that is associated with mental illness and psychological services. This is in line with literature that indicates that some patients may feel ashamed or embarrassed of their mental state and may think that they will be stigmatised because of their mental health (Seabi & Samouilhan, 2010; Thompson, Hunt & Issakidis, 2004). According to Seabi and

Samouilhan (2010) public stigma is caused by lack of information about mental illness and psychological services.

5.6. Self-Efficacy

5.6.1. The influence of society in relation to mental health and psychological services: *Masculinity and gender imbalance as an obstacle*

Gender was revealed to be a determining factor in the accessing of psychological services. This study suggests that the limited number of males accessing psychological services is a result of the society's expectations on men. Participants reported that men are raised and groomed to be macho and be the pillars of strength in their families. In Drapeau et al. (2009) study men were found to be less likely to seek or access psychological services due to cultural or societal expectations. Similarly, participants in this study reported that men's lack of access is associated with pride, stigma and societal or cultural values. In addition, the society expects men to be brave and not express their feelings, cry or seek help as they will be perceived as weak or not man enough. Moreover, access to psychological services may result in stigma, shame or delay in access. Based on the statistics received from UKZN Student Support Services amongst the 565 students who accessed psychological services from July 2012 to March 2014 only 29.5% students were males. Drapeau et al. (2009) asserts that females are more emotional than men. Similarly, participants in this study reported that females are sensitive and find it easier to talk about their problems than men. O'Mahony and Donnelly (2007) assert that women are more sensitive and susceptible to mental illness due to their gender roles and some women's help seeking behaviour may be discouraged or disapproved by their husbands. According to Drapeau et al. (2009) gender difference remains significant in determining access of psychological services even though there seems to be a change that may be influenced by socio-economic factors such as education and women empowerment.

5.6.2. The importance of disclosure, confidentiality and therapeutic alliance

Participants in this study stated that the relationship between patients and their therapist is very important. Helman (2007) stated that practicing professionals may be perceived as people of high status and who have power over their patients. Consequently, these perceptions may aggravate fear and discomfort. Moreover, participants reported that their

access to psychological services may be determined by the assurance that the sessions will remain confidential. In addition, therapeutic alliance may determine the outcome of therapy and progress of the therapeutic intervention. In addition, Kremer and Gesten (2003) stated that discussing conditions of confidentiality is another crucial tool that may maintain the therapeutic relationship. Furthermore, some therapists may fail to inform patients about the limitations of confidentiality. Confidentiality is an important concern to patients during psychotherapy as its conditions may have an influence in treatment decision and outcome (Kremer & Gesten, 2003). Participants reported that whether they continue with therapy will be determined by the level of reassurance that they receive from the therapist, such as the confidentiality of what they share. Similarly to Bojuwoye and Edwards' (2011) study participants in this study stated that their therapist's personality and manner of approach was the key factor that will determine if they will disclose personal matters or honour their follow up appointment. Other participants reported that even though they trust psychologists' judgment as they are trained to assess, they are not sure if disclosing may be an easy process.

5.7. Preferred/ Reported forms of healing

5.7.1. *The impact of culture, tradition and religion on mental illness*

South Africa is a diverse country and comprises of different cultural beliefs and explanatory models (Edwards, Makunga, Thwala and Mbele, 2009). In this study other alternative forms of interventions explored differed according to race. Most white and Indian South Africans preferred going to see a priest and praying during difficulties. They further stated that if they were to experience psychological problems they would prefer praying about their problems before consulting a psychologist. Similarly some participants in Seabi and Samouilhan (2010) reported that prayer was a means to deal with psychological problems.

Edwards et al. (2009) assert that most people from African Zulu cultures believe in the soul, spirit and God. Black South Africans and African participants from other parts of the continent reported a belief in traditional interventions. According to Bojuwoye and Edwards (2011) indigenous communities in South Africa's construction of mental illness, interpretation of illness and the explanatory model (Bojuwoye, 2013) may be influenced by different indigenous cultures. Moreover, those indigenous cultures may include ancestral spirit, witchcraft, traditional healing and spiritual healing. Participants further reported that for one to be healed ancestral ceremonies or rituals needs to be performed in order to appease

the ancestors. In addition, challenges during psychological intervention may arise from individuals in indigenous communities who have a strong attachment to ancestral spirits. Moreover, indigenous community members may perceive themselves as vulnerable to mental illness, witchcraft or misfortunes due to the ancestors' withdrawal of their protection towards them (Bojuwoye & Edwards, 2011; Edwards et al., 2009). Similar to what participants reported, Bojuwoye and Edwards (2011) asserts that African traditional healers may also believe that mental illness is caused by witchcraft, disharmony or ancestral punishments. Bojuwoye (2013) asserts that people from African indigenous cultures perform rituals (e.g. death anniversary) to unite family members, get sense of belonging, identity and good health (resolve anxieties). Moreover, such unity may also be beneficial for psychotherapists as family members may have a positive contribution or influence in a patient's wellbeing. In addition, a united family may result in reduction of stigma and promote familial support through recovery. African traditional healers are perceived as powerful people whom ancestors gave power to deal with or heal mental illness and bring harmony (Bojuwoye & Edwards, 2011).

5.7.2. Psychological problems that students are likely to seek help for

According to (Lazarus, 2006) in 2001, the Department of Education has implemented education support services to ensure effective learning and teaching in order to overcome barriers that may result in poor academic performances. Barriers faced by South African schools include high rates of suicide, violence, substance abuse and poor mental health. Moreover, students need to be looked at holistically by assuring that they are well taken of psychologically, spiritually and ensure that their environment is conducive in order to yield a better performance (Lazarus, 2006).

The University of KwaZulu-Natal (Howard College) offers registered students from the Faculty of Humanities psychological services as individuals or in groups for free. Most participants in this study have reported that they were not aware that the University offers psychological services. Based on the statistics, from the Faculty of Humanities' Student Support Services, there was an indication that only a small percentage of the students from the Faculty of Humanities accessed psychological services. This does not preclude that other students may access services privately or in public hospitals. The statistics indicate that the

majority of students who utilised psychological services were respectively black Africans (73%), Indians (10.2%), others (6.3%), whites (6.2%) and coloureds (4.3%).

Mackenzie et al. (2011) assert that most students experience their first psychiatric episode during their 1st year at University due to transitions (new environment, independence, identity, increased demands and academic challenges). Moreover, the statistics from the Student Support Services indicated that the students' presentation of the problems differed according to the months they utilised the services. Student Support Services reported high prevalence of the need for career counselling and academic degree/course information during the beginning of the year, while in the middle of the year students are said to be presenting with academic degree/course information, food insecurity, depression and anxiety. Towards the end of the year students presented with problems relating to relationships, depression and anxiety. This may be the result of students being undecided about their career choice while in the middle and year end the depression and anxiety may be associated with the level of relationships formed and academic pressure. In this study, participants reported depression, anxiety, suicide, trauma and loss as the psychological problems people are most likely to seek psychological help for. In addition, Mackenzie et al. (2011) assert that undergraduate students are reported to be more vulnerable to depression and anxiety due to academic impairment as compared to postgraduate students. Moreover, most students who are depressed may be at a high risk for being suicidal, failing modules and substance abuse. According Schlebusch (2005) teenagers ranging from the age of 15-24 years are high risk for suicidal attempt and usually teenagers in that age group are enrolled in Universities.

The fear of isolation or being stigmatised during the 1st year of study if seen accessing psychological services reduces the chances of utilising services. The limited access to psychological services may be associated with low economic status and social factors such as stigma and the lack of support from family and friends (Kakuma, et al., 2010; WHO, 2009). This may also explain the limited number of students accessing Student Support Services during the beginning of the year and how in the middle of the year they're diagnosed with depression.

5.8. Cue to action

5.8.1. Students' perception on influence of help seeking behaviour

According to Ross and Deverell (2010) social cues may result in some people seeking help. In addition, witnessing a family member experiencing severe illness may positively influence help seeking behaviour. Similarly, participants in this study also reported that witnessing a family member with psychological problems or who has accessed and benefited from psychological services may motivate them to seek help. Furthermore, participants reported that being informed or educated by a person who has benefited from psychological services may also influence their perception of the services. In the literature it is stated that past experiences in seeking professional psychological help may also contribute to students' attitude towards accessing psychological services. Moreover, according to Masuda et al. (2005) students who have been to a psychologist or know someone who accessed the services and benefited may also believe that accessing psychological services may benefit them. The HBM suggests that exposure to information through television; personal experience or witnessing relative experiencing health problems may positively influence people's help seeking behaviour. The participants reported that advertising services on campus notice boards, television and having mental health awareness may benefit students and community members.

5.9. Summary

The findings of this study suggest that students do not have enough knowledge or information about psychological services or mental illness. Moreover, media (advertisements) was perceived as a good and popular method of disseminating information to the community. Untreated mental illness, which leads to increased severity or poor treatment adherence, may be associated with shame, stigma or embarrassing feelings attached to mental illness and psychological services. Participants indicated different factors such as culture, cost, level of education, masculinity and language as factors that may hinder student's help seeking behaviour. Moreover, cultural and religious interventions were identified as other forms of interventions apart from psychological services which were perceived as beneficial and preferable. 1st year students are most likely to be vulnerable to mental health problems due to academic pressure and adjustment difficulties.

CHAPTER 6

6. SUMMARY, LIMITATIONS AND RECOMMENDATIONS

This research study was aimed at investigating the perceived benefits and perceived barriers in accessing psychological services among 1st years University students at UKZN from the Faculty of Humanities. This chapter will summarise the main findings, and discuss the limitations of the study and the recommendations for future researchers.

6.1. Summary of findings

The findings of the study revealed that there was a lack of knowledge about psychological services offered on and off campus. The participants attributed this lack of knowledge to poor publicity of the services. Media (advertisements, posters and campus notice boards) was identified to be a helpful resource in disseminating information regarding psychological services (cue to action). In addition, participants emphasised that if psychological services or problems are not portrayed as a private matter then the stigma attached to psychological services and mental illness will decrease as the society will get used to the idea of its availability and purpose. Psycho-education to schools and under privileged communities was recommended and perceived as a method of bridging the gap between rural and urban areas. Concerns were raised about the lack of services provision in communities and it is believed that psychological services are found in urban areas and at a high price.

6.1.1. Cultural Beliefs

Cultural background may determine students' attitude towards accessing psychological services. Consequently, different preferred forms of interventions were identified as helpful to people of different cultures. The majority of black South Africans and participants from neighbouring countries reported that help could be sought from traditional healers and placed importance on appeasing ancestors. South African Indians and white participants reported that prayer and talking to family members may be helpful (perceived benefits) therefore, service providers need to be aware that people are cultural beings therefore they need to understand them in their cultural context. Collaboration of traditional healers and psychologists may benefit both parties and their patients. Traditional healers will be trained

on identifying and referring people experiencing psychological problems while psychologists will get an opportunity to understand culture bound syndromes and patients' explanatory models.

6.1.2. Gender Differences

Females were reported to be more sensitive and are more likely to access psychological services as compared to males. The males' role in the community was perceived by both males and female participants to be a barrier in accessing psychological services. According to participants males are expected to be strong for their families and they are not expected to seek help as people rely on them for strength. Pride and shame were identified as males' obstacles to accessing mental health services (self-efficacy). The above mentioned perceptions support the health belief model's assertion that people's belief may influence their help seeking behaviour and that action is taken when there is a cue to action or when they perceive their illness as severe or themselves as vulnerable.

6.1.3. Perceptions of Mental Illness

Participants reported that mental illness is perceived as being due to a genetic predisposition and that their help seeking behaviour may be positive or high if a family member had psychological problems and they have witnessed how it may disrupt the family system (perceived susceptibility). Participants' perceptions of psychological problems that people are likely to seek help for included: trauma, suicidal behaviour, depression, anxiety, divorce, loss (job or loved ones) and emotional problems. Suicidal behaviour, depression and trauma took precedence. The personality, approach and attitude of the psychologist may determine if students will consider coming back for a follow up session. Doubt about therapist-patient confidentiality was raised.

Mental health providers in general need to psycho-educate the public about their profession and scope of practice. Psychologists on campuses have the responsibility to do campaigns to improve access to services and raise mental health awareness. Through the above mentioned the public and students may have confidence when confiding in mental health providers and knowing what their session will entail.

Although participants were asked to identify perceived benefits and barriers in accessing psychological services it seemed as if they were mainly aware of barriers. This can be attributed to the lack of knowledge about psychological services as it is evident by the lack of access due to certain perceptions. Students in the study perceived psychological services as beneficial in providing support during difficulties. Students further reported that most people tend to be in denial of their illness and only access services when the problem is more visible (physical) or severe (perceived seriousness). Barriers in accessing psychological services include language, level of education, stigma and gender roles (perceived barriers).

6.2. Limitations of the study

The study may not be a full representation of the population outside the University of Kwa-Zulu Natal (Howard College) especially in different tertiary levels of their studies since it only focused particularly on 1st year students at Howard College from the Faculty of Humanities. A larger sample would have been better in terms of validity and reliability and a correlation study across different tertiary institutions would indicate differences in terms of beliefs regarding perceived benefits and barriers.

6.3. Recommendations from the study

Mental health providers should at least be fluent in English and an indigenous language of an area they are based at. Collaboration of traditional healers and psychologists may benefit both parties and patients. Traditional healers should be trained on identifying and referring people experiencing psychological problems and in turn psychologists should accommodate patients' explanatory models and alternative explanations. Mental health providers in general and in tertiary institutions can psycho-educate students and the public around the services they offer to help reduce the negative attitudes towards psychological services. They can distribute pamphlets or do interactive workshops at schools, churches, clinics and during imbizo. In addition to the above mentioned, mental health providers can also do community outreach programmes. In their workshops they must distinguish their roles from the counsellors' and social workers' role. The public must be informed of how psychological services can be accessed. Mental health providers based in public hospitals can raise mental health awareness every month end for an hour by having information desks that all patients

have access to (in and out patients) and also have an interactive presentation the in the waiting areas. Information regarding mental health on campus can be disseminated during orientations through helpdesk presentations and by distributing pamphlets to the students.

6.4. Recommendations for future research

Psychological services have always been attached to stigma around mental illness. More studies should be conducted promoting mental health care and awareness. Research studies should place more emphasis on the benefits of accessing psychological services as opposed to the overstating the barriers. Researchers should also consider conducting qualitative studies that explores the students' family systems. A more comprehensive study which includes students of all tertiary levels from different campuses would allow for greater generalisability of the results. Based on the results of the study there is a need for 1st year students to be informed about psychological services and the service is better advertised on campus during orientation and before stressful periods such as exams.

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APPENDIX ONE

SEMI STRUCTURED INTERVIEW

Core Theme 1: Knowledge about Mental Health Services

- What is your understanding of psychological services?

- What do you think a psychologist does?

- What services do you think are offered by a psychologist?

Probes: Perceived availability in community, reasons for seeing a psychologist, who is likely to see a psychologist.

Core Theme 2: Understanding the role of Mental Health Services in relation to wellness

- What perception do you think people (especially students) have about psychological services?

Probes: Belief about talk therapy, myths about seeing a psychologist.

Core theme 3: Perceived vulnerability

- How do you think a person's belief that they may be vulnerable to mental illness influences their help seeking behaviour?

Probes: Disclosure, isolation, discrimination.

Core Theme 4: Degree of Personal Threat in Relation to Mental Health

- At what stage do you think people consider accessing psychological services?

Probes: Severity, nature of problems (types of mental illness) that a person is likely to seek psychological assistance for.

Core Theme 5: Effectiveness of Mental Health Services

- How do you think psychological services can help a person in need?

Probes: Emotionally, physically, and mentally.

Core Theme 6: Obstacles to accessing Mental Health Services

- What do you think prevents people from accessing psychological services?

Probes: Support, stigma, gender, language, costs, educational level etc., alternative forms of intervention (i.e. religious, traditional)

Core Theme 7: Factors encouraging Help Seeking Behavior

- What do you think motivate help seeking behaviour?

Probes: Mental awareness day, severity

Core Theme 8: Perception of Protective/ Risk Outcome for Accessing Psychological Services

- How do you think accessing psychological services can benefit you?

- Would you willingly confide personal matters to a psychological professional (e.g. psychiatrist, psychologist or counsellor?) WHY?

- Would you recommend anyone (friend, family etc.) to seek professional psychological help?

- According to your cultural or religious belief who or what is considered to be helpful when a person is experiencing any psychological problems?

Probes: Health, personal problems; church/ elders/traditional healers/peers etc.

General:

Is there anything more that you would like to add or discuss?

<center>**APPENDIX TWO**</center>

INFORMED CONSENT FORM

Dear Participants

My name is Pebetse Rahab Garlie Matabane. I am a postgraduate student pursuing my Master's degree in Clinical Psychology at the University of KwaZulu-Natal (Howard College). As part of my course I am required to conduct a research study. The study I will be conducting is titled "*A QUALITATIVE INVESTIGATION INTO THE PERCEIVED BENEFITS AND BARRIERS IN ACCESSING PSYCHOLOGICAL SERVICES AMONGST FIRST YEAR'S UNIVERSITY STUDENTS*". The participants in this study must be students at the University of KwaZulu-Natal (Howard College) currently in their first year of study. The interview process will take approximately an hour. Permission to audio tape the interview process will be sought from the participants.

The interview process will be kept confidential and anonymity will be maintained. Your participation is voluntary and you may withdraw from this study anytime you wish to do so. The research data will be secured for at least five years in a steel cabinet in my supervisor's office and once the five years has elapsed the transcripts will be shredded and the tapes will be incinerated.

If you wish to obtain information regarding the outcome of the study or have any queries, you may contact the researcher and/ or the supervisor at the contacts provided below.

Thank you for your co-operation and contribution to this study.

Yours Sincerely,

Researcher: Pebetse Garlie Matabane   Supervisor: Sachet Valjee

UNIVERSITY OF KWAZULU-NATAL   UNIVERSITY OF KWAZULU-NATAL

HOWARD COLLEGE CAMPUS   HOWARD COLLEGE CAMPUS

SCHOOL OF PSYCHOLOGY	SCHOOL OF PSYCHOLOGY
Contact numbers: 072 5524649	Tel: (031) 260 7613
Pebblex.matabane@gmail.com	valjees@ukzn.ac.za

Should you wish to obtain information on your rights as a participant, please contact Phumelele Ximba, at the University of Kwazulu-Natal's Research office on (031) 3603587.

DECLARATION

I………………………………………….. (Full names of the participant) from the University of KwaZulu-Natal (Howard College) have willingly agreed to participate in this research study.

I confirm that the aim of this research study has been clearly explained to me and that I understand the content of this document and nature of this research project. It has been clearly explained to me that I can withdraw from participating in this study anytime I wish to do so. I am aware that the information obtained from me will be kept strictly confidential and will only be used for the purpose of this study. I have been informed that the interview process will be recorded; therefore I hereby consent/ do not consent to have this interview recorded.

Gender : …………………………

Age : …………………………

Race : …………………………

SIGNATURE OF PARTICIPANT

……………………………………

Signed at…………………………………………………………………………………… on this date……………………….

UNIVERSITY OF
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

04 December 2013

To Whom It May Concern,

RE: REQUEST TO REFER STUDENTS FROM THE COLLEGE OF HUMANITIES PARTICIPATING IN RESEARCH BY RESEARCHER PEBETSE RAHAB GARLIE MATABANE

The College of Humanities Student Support Services hereby acknowledges that it has been informed about the research project entitled *A Qualitative Investigation into the Perceived Benefits and Perceived Barriers in Accessing Psychological Services Amongst First Year University Students* to be conducted by Pebetse Rahab Garlie Matabane (Student Number: 212545097). The College of Humanities Student Support Services is available to all students from the College of Humanities who wish to seek psychological services, including those students participating in the above mentioned study.

Please do not hesitate to contact me should you need to.

Kind Regards

Joanne Goss
Clinical Psychologist
Student Support Services
College of Humanities
University of KwaZulu-Natal
Howard College Campus
Tel: 031 260 2668
Email: goss@ukzn.ac.za
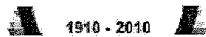
14 January 2014

Ms Pebetse Rahab Garlie Matabane
School of Psychology
College of Humanities
Howard College Campus
UKZN
Email: 212545097@stu.ukzn.ac.za
            Pebblex.matabane@gmail.com

Dear Ms Matabane

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

"A qualitative investigation into the perceived benefits and perceived barriers in accessing psychological services amongst first year's University students".

It is noted that you will be constituting your sample by interviewing first year students from the College of Humanities on the Howard College campus.

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

MC BALOYI
REGISTRAR

21 January 2014

Ms PRG Matabane   212545097
School of Applied Human Sciences (Psychology)
Howard College Campus

Dear Ms Matabane

Protocol reference number: HSS/1448/013M
Project title: A qualitative investigation into the perceived benefits and perceived barriers in accessing psychological services amongst first (1st) year's university students

Full Approval – Expedited

This letter serves to notify you that your application in connection with the above has now been granted **Full Approval**

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project; Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation.   Please quote the above reference number for all queries relating to this study. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

Best wishes for the successful completion of your research protocol

Yours faithfully

Dr Shenuka Singh (Chair)
Humanities & Social Science Research Ethics Committee

/pm

cc Supervisor: Mr Sachet Valjee
cc Academic Leader: Professor DP McCracken
cc School Administrator: Ms Shivani Chetty

APPENDIX SIX

KEYCONCEPTS USED IN CHAPTER 4 OF RESEARCH FINDINGS.

Africans in this study refers to all participants from South Africa's neighbouring countries

KEY	*MEANING*
SABM1	South African Black Male, participant number 1
SABF2	South African Black Female, participant number 2
SABF3	South African Black Female, participant number 3
SABM4	South African Black Male, participant number 4
SAWM1	South African White Male, participant number 1
SAWF2	South African White Female, participant number 2
SAWM3	South African White Male, participant number 3
SAWF4	South African White Female, participant number 4
SAIF1	South African Indian Female, participant number 1
SAIM2	South African Indian Male, participant number 2
SAIM3	South African Indian Male, participant number 3
SAIF4	South African Indian Female, participant number 4
AM1	African Male, participant number 1
AF2	African Female, participant number 2
AF3	African Female, participant number 3
AM4	African Male, participant number 4